Challenges of Indian Health System Supporting Migrant Healthcare during a Pandemic

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**Authors' contributions**

This work was carried out in collaboration between both authors. Authors MK and RN designed the study, wrote the protocol and wrote the first draft of the manuscript. Author MK managed the analyses of the study. Author RN managed the literature searches. Both authors read and approved the final manuscript.

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1. BACKGROUND

The Coronavirus disease (COVID-19), is an acute respiratory disease caused by the novel coronavirus (SARS-CoV-2). It received worldwide attention from its emergence in Wuhan, China. By January 20th, 2020, The World Health Organization officially declared COVID-19 as a “public health emergency of international concern” and deemed it a “pandemic” on March 11th \([1,2]\). One concern was that few carriers of the virus were asymptomatic, and may unknowingly spread the disease. Thus, the primary line of defense was instituting social distancing measures, limiting contact between individuals and thereby reducing the spread of disease \([3]\).

India was one of the few countries to very quickly enforce a national lockdown in response to the Coronavirus, starting on March 24\(^{th}\). In fact, they have been commended by the World Health Organization, who called the government’s actions “tough and timely” \([4]\). The initial lockdown was planned for 21 days (and repeatedly extended), where only essential services, like hospitals, police departments and fire departments remained open. Additionally, citizens returning from other nations were told to quarantine themselves for fourteen days. While

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this lockdown was instituted, the Indian government did not do widespread testing, as experts had suggested. Still, compared to few other countries, namely the United States, the Indian Government’s actions were swift and decisive, and may have mitigated the spread [5].

However, there were mixed sentiments. Many were apprehensive about the lockdown’s effect on daily wage earners [6]. The short time between the announcement and enforcing the lockdown left many vulnerable populations at risk, especially migrant workers. Migrants in these situations are vulnerable to COVID-19 due to the various health risks linked with congestion, inadequate sanitation, poor housing, and underlying health conditions [6].

According to the 2011 census, nearly 37% of India's population are migrant workers. However, this is a conservative estimate, as it does not count those traditionally excluded from worker data, like street vendors [7]. Migrant workers are those that have travelled searching for work; often, they are daily wagers. Migrants are already at a disadvantage in Indian society. Not only are they poor, but are also often left out of government programs that aid poorer communities, because they lack residential proof. In fact, more than 94% of migrant workers lack any worker identity card [8]. This means that their access and usage of healthcare resources are insufficient, and only exacerbated by this pandemic.

Traditionally, only the laborers migrate in search of work. Their earnings are not only spent on their own needs, but also sent back to their native villages for their extended family members. So, the breadwinner of one migrant worker family supports an entire network of people. Hence, distress from the pandemic in the migrant workers - in physical and mental health - impacts many. Children of these migrant workers face many of the consequences. Often, they are left with grandparents in the native villages while their parents migrate to bigger cities for earning. In many situations, older siblings, who are capable of manual labor, migrate with their parents while the younger children are brought along later. This pattern leads to broken family systems. One of the health consequences is in regard to vaccinations. Due to the lack of direct parental involvement in these young children’s lives, regular vaccinations are missed; records are poorly maintained for true data to emerge for discussion and policy drafting. Another consequence is in mental health. These areas will be explored in the subsequent section where Indian migrant health is analyzed in the context of the pandemic.

2. MIGRANT WORKERS AND FAMILIES DURING THE COVID-19 LOCKDOWN

Once India’s lockdown was announced, many restaurants, factories, and shops immediately shut down. These are the employers to most migrant workers. Hence, this population was left without pay or housing indefinitely - and with little warning to prepare. So, many chose to move back to their native villages. While some were able to board packed trains, others had no transportation. Instead, they walked hundreds of miles to their native places, travelling in groups, and thus increasing the risk of Covid-19 spread. Once they reached their villages, they were often stigmatized, and seen as carriers of the virus. This stigmatization is not new for migrant populations in India. During the HIV/AIDS epidemic of the 80’s, this group was seen as carriers and a population at risk. Several studies have detailed the effect of stigmatization on individuals’ mental health, negatively impacting their sense of ‘self’ and their relationship with the groups they identify with [9].

One study researched the COVID-19 related suicide incidences in India, and found that of the total 72 cases identified, three had been migrants unable to travel to their native places [10]. The fear of infection, coupled with loneliness from the lockdown measures and financial loss lead to poorer mental health and potential suicide. D’Souza’s work suggests implementation of a nationwide tele-mental health service to prevent this loss of life, which we support. Another study found similar trends in suicides among poor and migrant communities in Bangladesh. They suggested not only increasing mental health resources, but also offering financial support to these migrant communities and offset some of the monetary burden that drives poor mental health [11].

In addition to this mass exodus’s effect on the worker, it also impacts their vulnerable children. Their education is disrupted as they move from an urban center to a rural village. Additionally,
they lose the formative connections made at that young age, leading to serious mental health considerations. However, mental health resources are not widely available in this country, let alone a possible resource for these low-income migrant communities. Instead, these children will be forced to bear these psychological consequences for the remainder of their lives.

In addition to the mental health considerations, on both the worker and their children, vaccination rates are also impacted. This pandemic has affected transportation, infrastructure, vaccination supply chains, and coordination of primary health care centers. Several sources have already reported decreased vaccination rates for routine vaccines in low and middle income countries [12]. In fact, a decrease in pediatric vaccinations has also been observed in developed countries, like the United States. According to the CDC Vaccine Surveillance data, fewer pediatric vaccines are being ordered, like that for measles [13]. As social distancing guidelines are lifted, the risk of these children contracting preventable illness in all regions of the world increases. It may be difficult to assess the exact impact on vaccination rates, as data is not easy to collect at this time. For these migrant populations, fear of the virus while accessing the health centers, inadequate staff in primary health care centers, and difficulty for pregnant women or new born babies to transfer health centers clearly show how vaccination rates decline. The disparity in healthcare resource availability between urban centers and the rural villages they are returning to also limits access to vaccinations. Overall, the Coronavirus crisis has impacted mental health and childhood vaccination rates in already vulnerable populations of migrant workers.

CONSENT

It is not applicable.

ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES