

## COVID-19, Migrant Workforce and Regional Health Infrastructure in North Bengal

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### Abstract

*The paper tries to explore the space relations of migrant workforce and health infrastructure during COVID-19 pandemic. The geographies of labour supply and demand have been affected and a preparation of COVID-19 infrastructure is developed at national and regional level. The growth of COVID-19 cases and development the regional health infrastructure in West Bengal with reference to North Bengal has been analysed. The testing facilities and their expansion during lockdowns have been critically looked and found that the private laboratories are confined to urban centres only. The existing health infrastructure at district level and its preparation to combat COVID-19 is also captured systematically. The paper identifies how health infrastructure is mostly urban-centric and reverse migration towards villages defeats the objective of lockdown. The character of governance and interference of judiciary in respect to migrant workforce and testing laboratories is highlighted. Lastly, it also reflects on the relations of state, capital and laboring conditions and massive reverse movement of migrant workforces likely to change rural-urban spaces in India.*

### Introduction

Public Health is of prime importance for any society, region or a country. Modern medicine plays an effective role in protecting human health. Human health can be damaged by communicable diseases by its intensity and speed. Health infrastructure is inversely related with any epidemic – better the infrastructure of any geographic region lesser the harm that can result on human health in any point of time. India is lagging behind many countries of the world in respect of such facilities. Under this circumstance, it is utmost important for the provincial and national governments to effectively utilize the existing resources of health infrastructure and plan strategies

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during global pandemic and lockdown. The Coronavirus pandemic began its journey from Wuhan in China in December 2019 travelling through Europe (Jan-Feb 2020) and West Asia (Mar 2020). It reached to the new world USA and India in Mar 2020. The intensity and speed is so fast that the best available health infrastructure in countries like Italy, Germany, France, USA etc. were dismantled, unsuccessful and bowed down to its spread. Till today, a millions of people are suffering from COVID19 worldwide and have died in affected countries. International Monetary Fund has accepted and declared global economic slowdown.

India was fortunate enough to experience it little later and have received ample opportunity to prepare and face this gigantic global pandemic. In the middle of March 2020, the country wide consultations started and partial lockdown in various parts particularly Kerala, Rajasthan, Maharastra were introduced. Finally, *Janta Curpnew* was introduced as preparatory phase on March 22, 2020 and later on, nation-wide lockdown was announced, precautions and preparedness started. Coronavirus Pandemic was announced as National Health Disaster and the National Disaster Act, 2005 was implemented throughout the country. However, nationwide lockdown was obviously a bold step to prevent and safeguard the human health of its citizens. But the question arises, whether such initiative was supported by enough planning and coordinated efforts with the various sectors and provincial governments.

It is an accepted fact that India has 90 percent of workforce engaged in unorganized sector where there is no universal social security in place till date. Most of them are out-migrants and concentrated in cities particularly million plus cities e.g. Delhi, Kanpur, Chennai, Hyderabad, Bengaluru, Ahmedabad, Mumbai, Pune etc. Agrarian crisis in their home state and rural geographies compel them to migrate outside their places to earn better living and livelihoods. In this context, Regional Development (RD) should be viewed as the articulation of qualitative changes in the geo-bio-techno-social complex of interdependent phenomena in such a manner that the quality of human life improves within the framework of the integrity of the ecosystem (Raza, 1988). The RD refers to change in regional productivity as measured by population, employment, income and laboring conditions. It also means social development which includes quality of public health and welfare, environmental quality and creativity. The RD does not mean the exploitation of virgin territory or the domination of one culture over other but, instead, improving the conditions of chronically underdeveloped regions or regions undergoing cyclical change (Nelson, cf. Bingham & Mier, 1993). In such a situation, one can find two types of space relations are identical: *Geographies (regions) of Labour Supply* and *Geographies (regions) of Labour Consumption*. The supply regions are mainly Assam, West Bengal, Orissa, Bihar, Uttar Pradesh, Chattisgarh, Madhya Pradesh, Rajasthan, Uttaranchal etc. It is estimated that around eight crores of migrant workers were stranded in India and their state-wise distribution is 142.00 lakhs in UP, 86.45 lakhs in Bihar, 70 lakhs in Maharastra, 60.10 lakhs in West Bengal, 56.64 lakhs in Madhya Pradesh. 44.66 lakhs in Rajasthan, 40.19 lakhs in Karnataka, 38,25 in Gujarat, 35.73 lakhs in Tamil Nadu, 26.37 lakhs in Jharkhand,

26.82 lakhs in Andhra Pradesh, and 25.15 lakhs in Assam (Uttarbanga Samba, May 17, 2020). It is a typical demand-supply relationship that exists within same country and complementarity exist in geographic space as conceptualised long before by Ullman (1956). Ullman suggested that spatial interaction to occur between regions depends on three interrelated conditions: Complementarity, Intervening Opportunity and Transferability. 'Complementarity' refers to the need for supply and demand relationship to exist prior to any movement occurring between places. This kind of spatial interactions has many existential realities and daily life of migrant labourers when global pandemic like COVID19 occur in countries like India. Many of them reside in slums and squatter colonies of the cities and engage themselves in various urban services with outsourcing agencies. A large numbers of them also work on construction sector where there is no parent employer and traceability is of big concern. The sudden lockdown had impacted millions of lives of poor out-migrants and suddenly become roofless where state has failed to protect its own citizens. Therefore, failing protection from state and closures of internal transportation system, many labourers walked down to streets aiming for their native places located hundreds of kilometers away from their place of work. This poses a serious question on part of governance whether such crowding without protection of basic health has any bearing on human health in general and current COVID19 pandemic. It is reported that 21486 relief camps were set up across states and around 6 lakhs of migrant labourers are given shelter in these relief camps (Live NDTV, MoHFW Press Release, April 01, 2020). Considering the grave concern, 5000 railway coaches were prepared for of isolation and quarantine centres which may house approximately 3.2 lakhs beds spread over different major railway stations in India.

### **Beginning of COVID-19 Pandemic in India: A Regional Analysis**

The first case of the 2019–20 coronavirus pandemic in India was reported on Jan 30, 2020 which originated from China. As of March 29, 2020, the Ministry of Health and Family Welfare have confirmed a total of 1024 cases, 96 recoveries, 1 migration and 27 deaths in the country. As on March 28, 2020, the COVID-19 cases was spread over 158 districts and 979 positive cases were found. During that time high concentration of cases are found in Maharashtra followed by Kerala, Karnataka, Telegana, Gujrat, UP, Rajasthan, Tamil Nadu and Delhi (<https://www.mohfw.gov.in/index.html>). As on April 03, 2020, the states which were considered as hotspots were Tamil Nadu (411), Delhi (384), Maharashtra (335), Kerala (295), UP (172), Andhra (161), Telengana (156), Karnataka (125), Assam (20) as reported by NDTV Live. Within a period of 24 days (i.e. on 21.04.2020), it was found that 429 districts reported covid cases with 18985 infected persons (<https://www.mohfw.gov.in/index.html>). The highest positive cases were found in Maharashtra (4669), Delhi (2081) and Gujrat (2066). As per the communication of Department of Health and Family Welfare (GOI, April 30, 2020), all the districts of India were classified into three groups: *Red Zone* (130), *Orange Zone* (284) and *Green Zone* (319). A district is considered as green if there is no

confirmed case and no reported case in last 21 days. The hotspots, red zones and orange zones were based on incidence of cases, cumulative cases, doubling rate, extent of testing and surveillance feedback to classify the districts. The list was dynamic and revised weekly or earlier as per the communications and directions under the Disaster Management Act, 2005. All the million plus cities like Delhi, Kolkata, Mumbai, Hyderabad, Bengaluru etc. were identified as hotspots and red zones.

As per the Govt. of West Bengal, there were four districts considered as hotspots and *Red zones*, eleven under *Orange zone* and eight under *Green zone*. The *Red zone* (4) districts are Kolkata, Howrah, North 24 Pargana and Purba Medinipur. The *Orange zone* (11) districts were Darjeeling, Kalimpong, Jalpaiguri, Malda, Murshidabad, Nadia, Purba Bardhaman, Paschim Bardhaman, Hoogly, Paschim Medinipur and South 24 Pargana. The *Green zone* (8) districts were Alipurduar, Cooch Behar, Uttar Dinajpur, Dakshin Dinajpur, Birbhum, Purulia, Bakura and Jhargram (Uttarbanga Sambad: April 30, 2020). In contrary, Government of India order dated April 30, 2020, ten districts were considered as *Red zone*, five in *Orange* and eight in *Green*. The *Red zone* districts were Kalimpong, Darjeeling, Jalpaiguri, Malda, North 24 Pargana, South 24 Pargana, Kolkata, Howrah, Purba Medinipur and Paschim Medinipur. The *Orange* districts were Murshidabad, Nadia, Purba Bardhaman, Paschim Bardhaman and Hoogly. The identified *Green* districts were Alipurduar, Cooch Behar, Uttar Dinajpur, Dakshin Dinajpur, Birbhum, Purulia, Bakura and Jhargram (Ananda Bazar Patrika: May 02, 2020). There were confusion and differences in identifying the districts into different categories which has bearing on regional health and its preparedness.

### **COVID-19 and Regional Health Infrastructure in North Bengal**

The regional health care has always been a neglected segment for Government of West Bengal since independence. The epicentre of regional health care in North Bengal and only referral hospital is the *North Bengal Medical College and Hospital* which was set up in 1968. Until recent past, it was the only Medical College catering health services in North Bengal and its catchment starting from Malda (300 kms) in the South, Cooch Behar (200 kms) in east of Assam, Darjeeling (80 kms) and Sikkim (120 kms) in North and adjoining Bihar and Nepal in West. However, four Medical Colleges have come up in recent past and these are situated at Malda (2011), Berhampore (2012), Raiganj (2018) and Cooch Behar (2018). It is well-known fact that all the northern districts of the State of West Bengal i.e. Cooch Behar, Jalpaiguri, Darjeeling, North and South Dinajpur, Malda, Murshidabad etc. are considered as the supply zone for unskilled labour to most of the cities of India and the migrant labourers are engaged in various kinds of urban services typically known as *Unorganised Sector* in economic terms (Hannan, 2020: [www.vikalp.ind.in](http://www.vikalp.ind.in)).

Given this backdrop, an attempt is made to look into the rural health infrastructure in North Bengal vis-à-vis the aggregates for West Bengal. Table-1 shows that average population served per rural health care institution is very high in North Bengal as

compared to rest of Bengal, although, the population density is low in the districts of North Bengal with 804 persons per sq.km as compared to 1029 persons per sq. km in the state of West Bengal (Census, 2011). The figures given in the table also indicate that there are insufficiencies of rural health infrastructure in North Bengal to treat majority of the rural patients in normal times.

**Table 1: District/Region-wise Health Infrastructure (Institutions) in West Bengal (As on 31.12.2016)**

Districts/ Geographic Regions	Number of Health Institutions				Average Rural Population served per Institution (Computed as per Census, 2011)			
	SC	PHC	BPHC	Rural Hospital	SC	PHC	BPHC	Rural Hospital
Darjeeling	230	22	3	9	4865	50857	372953	124318
Jalpaiguri	537	39	1	13	5237	72115	2812495	216346
Koch Bihar	406	29	4	8	6231	87229	632413	316207
Uttar Dinajpur	344	19	3	6	7689	139206	881635	440818
Dakshin Dinajpur	248	18	1	7	5806	79999	1439981	205712
Maldah	511	34	0	16	6746	101388	0	215449
Kolkata	-	-	-	-	-	-	-	-
North Bengal	2276	161	12	59	6148	86914	1166090	237171
Rest of the Bengal	8093	753	64	214	5955	63997	752969	225187
West Bengal	10369	914	76	273	5997	68034	818199	227777

Note:

- As per IPHS, one Sub-Centre established for every 5000 population in plain areas and for every 3000 population in hilly/tribal/desert areas whereas a Primary Health Centre (PHC) covers a population of 20,000 in hilly, tribal or difficult areas and 30,000 populations in plain areas and each CHC thus catering to approximately 80,000 populations in tribal/hilly areas and 1, 20,000 populations in plain areas.
- Kolkata is an urban district in West Bengal which does not have any rural health care institutions

Source: Computed from Census of India (2011), Health on March 2015-16 (Draft Copy), Directorate of Health Services, Government of West Bengal

Table-2 shows the availability of beds in various Health Centres and Rural Hospital and the average population served per health centre and rural hospital. PHC, BPHC and rural hospital The availability of beds are higher in North Bengal as compared to the state average and rest of the Bengal. However, average population served per BHC beds in North Bengal is higher in comparison to average number of persons served in the state. The corresponding figure for PHC and rural hospital beds in North Bengal also show a similar picture. This reflects the unequal regional health infrastructure at the aggregate level. But a comparison across districts and regions reflects that Kolkata and surrounding areas are better served than the distant areas.

**Table 2: District/Region-wise Health Infrastructure (Institutional Beds) in West Bengal (As on 31.12.2016)**

Districts/ Geographic Regions	Number of Beds in Health Institutions				Average Rural Population served per bed (Calculated as per 2011, Census)			
	PHC	BPHC	Rural Hospital	Total Rural	PHC Beds	BPHC Beds	Rural Hospital Beds	Total Rural Beds
Darjeeling	170	60	320	550	6582	18648	3496	2034
Jalpaiguri	266	10	450	736	10573	281250	6250	3821
Koch Bihar	224	40	240	504	11293	63241	10540	5019
Uttar Dinajpur	132	40	180	352	20037	66123	14694	7514
Dakshin Dinajpur	180	10	210	400	8000	143998	6857	3600
Maldah	270	0	515	785	12767	0	6694	4391
North Bengal	1242	160	1915	3327	11267	87457	7307	4206
Rest of the Bengal	5730	1045	7436	14211	8410	46115	6481	3391
West Bengal	6972	1205	9361	17538	8919	51604	6643	3546

Source: Computed from Census of India (2011), Health on March 2015-16 (Draft Copy), Directorate of Health Services, Government of West Bengal

But these facilities remain Kolkata-centric and would have no meaning for rural mass and labour supply zones of the State if facilities are not decentralized and percolate down further. In fact, it is reported that 50 doctors of Raiganj Medical College and Hospital, Uttar Dinajpur were on leave and stayed in Kolkata till 24.03.2020. They were brought back from Kolkata with the intervention Mr. Arvind Mina, DM Uttar Dinajpur to work in the Medical College (Uttar Banga Sambad: 25.03.2020). The same situation is found in North Bengal Medical College and Hospital, Darjeeling and reportedly that most of the senior resident doctors, Assistant Professors and Associate Professors were on leave and stayed put at Kolkata due to sudden lockdown (Uttar Banga Sambad: 25.03.2020). Reportedly in all the newly established regional medical colleges in the State, senior experienced doctors' work only for three days and rest of the days in a week, they remain in Kolkata. This not only hampers regular treatment and the lack of advisory and consulting facilities for the upgradation of regional health care and peripheral regions in the State compounds problems in respect of proper guidance and planning. The North Bengal region is one of such examples.

### COVID-19 and Preparedness of Health Infrastructure

To overcome the current pandemic, the Government of West Bengal went into collaboration with private health care providers and 67 hospitals are converted into COVID-19 designated hospitals (Govt. of West Bengal: 30.04.2020). All these hospitals are grouped into three categories as Level-2, Level-3 and Level-4. The Level-2 and Level-3 are preliminary and initial process of identification, quarantine and isolation of COVID-19 cases. These hospitals particularly will observe and send samples for

testing to the nearby ICMR approved laboratories for confirmation. The Level-4 is considered as highest category of COVID-19 hospital and identified positive cases are referred here for treatment.

**Table 3: Regional Pattern of COVID-19 (Level-4/State Level) Hospitals in West Bengal (As on 30.04.2020)**

District/Regions	Name of the Hospital	Location of the Hospital	Hospital Category	No of Isolation Beds	No of ICU Beds	No of Ventilators
Birbhum	Glocal	Bolpur	Private	50	8	2
Hoogly	Shramajibi	Srirampur	Private	100	20	8
Howrah	ILS	Golabari	Private	30	21	4
Nadia	SNR Carnival	Kalyani	Private	100	6	1
North 24 Parganas	GNRC Nursing	Kadambagchi	Private	80	12	14
Paschim Bardhaman	Sanaka Med. College & Hosp	Durgapur	Private	370	74	3
Purba Medinipur	Baromaa	Panskura	Private	180	11	5
Southern Region	Seven (7) Hospitals		All are Private	910	152	37
Kolkata	AMRI	Salt Lake	Private	51	12	5
Kolkata	ID & BG	Kolkata	Govt.	82	24	10
Kolkata	MR Bangur	Kolkata	Govt.	1100	24	32
Kolkata	Desun	Kolkata	Private	60	30	10
Kolkata (U) Region	Four (4) Hospitals			1293	90	57
Uttar Dinajpur	Mikki Megha	Raiganj	Private	36	6	1
Darjeeling	Dr Chang's	Siliguri	Private	100	20	10
North Bengal Region	Two (2) Hospitals		All are Private	36	6	1
West Bengal	Thirteen (13) Hospitals			2339	268	105

Source: Computed from Notification No. HF/SPSRC/20/2020/47, dated 16.04.2020, and HF/SPSRC/20/2020/60, dated 30.04.2020, Govt. of WB

This chain of health network is supposed to be well-connected to the district administration and disseminate information to the public for larger interest. For the 9.12 crores of population (Census, 2011), there were only thirteen COVID-19 hospitals for direct treatment in West Bengal out of total 67 designated health care centres with 2339 isolation beds, 268 ICU beds and 105 ventilators (see table-3). The regional distribution was somewhat depressing if one further gleans through the data. The entire Southern districts except Kolkata central, there were only seven COVID-19 hospitals with 910 isolation beds, 152 ICU beds and 37 ventilators. The Kolkata (Urban) central region has four State Level dedicated hospitals with 1293 isolation beds, 90 ICU beds

and 57 ventilators. The North Bengal eight districts had only two COVID-19 hospitals with 136 isolation beds, 26 ICU beds and 11 ventilators. The geographical spread of North Bengal is wider than Southern Region. It has inaccessible mountain district of Darjeeling and lack of transport facility as compared to other parts of West Bengal. Therefore, preparedness and planning for health infrastructure was shortsighted and resulted adverse impacts of COVID-19 pandemic at district and regional level.

**Table 4: District-wise COVID-19 Infrastructure and Outcomes in West Bengal**

Districts/ Regions	ICMR Laboratories [As on 30.05.2020]	COVID-19 Health Infrastructure (Nos) [As on 30.04.2020]				COVID-19 Cases (Nos) [As on 02.06.2020]		
		COVID Hospitals	Total Beds	CCU Beds	Ventil ators	COVID Cases	Recovery Cases	Mortality Cases
Darjeeling <sup>8*</sup>	1	6	525	73	40	49	9	1
Kalimpong	-	-	-	-	-	7	6	1
Alipurduar	1	1	100	6	6	5	-	-
Cooch Behar	-	1	120	26	6	149	-	-
Jalpaiguri	1	1	200	4	3	15	4	-
Uttar Dinajpur	1	2	81	16	7	173	31	-
Dakshin Dinajpur	1	1	20	4	4	41	6	-
Malda	2	2	130	14	13	144	88	-
North Bengal	7	14	1176	143	79	583	144	2
South Bengal	13	48	5375	622	214	3610	1341	110
Kolkata	20	5	1485	94	62	2411	1015	230
West Bengal	40	67	8036	859	355	6604	2500	342

*Note: \*In Darjeeling district, the testing laboratory and COVID hospital is situated in Siliguri only. Source: Computed based on ICMR Notification (30.05.2020). GoWB Notification (30.04.2020), Health Bulletin GoWB (02.06.2020).*

As on 02.06.2020 (Table-4), the COVID cases had increased to 583 in North Bengal during lockdown 4.0 and their district-wise distribution was Uttar Dinajpur (173), Cooch Behar (149), Malda (144), Darjeeling (49), Dakshin Dinajpur (45), Jalpaiguri (15), Kalimpong (7) and Alipurduar (5). In response to this flare up cases, there was no COVID hospital developed in hill stations of Darjeeling and Kalimpong town. The Uttar Dinajpur had highest number of COVID cases but the COVID hospitals were situated in Raiganj only and Islampur subdivision was deprived though there was an existence of super specialty hospital. The arrangement of bed capacity was not developed proportionately in response to pandemic. Institutional quarantine facility was not improved despite knowing the reverse migration of workforce, situation worsened in rural areas in North Bengal also in rest of the areas of the state. This reflects the pitiable handling of the global pandemic and decentralized governance of the state. All these had bearings on health outcomes e.g. the recovery rate was



37.9 percent in West Bengal against 48.3 percent in India. Within the state, there was regional variation; it was 24.7 percent in North Bengal, 37.1 percent in South Bengal and 42.1 percent in Kolkata urban agglomeration. The mortality rate was 5.2 percent in West Bengal (2.8 percent in India), 9.5 percent in Kolkata and 3.0 percent in South Bengal. The mortality rate was higher in West Bengal in comparison to the national average.

### COVID-19 and Testing Progression in West Bengal

The all-India and state-wise (Top 20) cumulative testing data showed that the top five states — Maharashtra, Rajasthan, Tamil Nadu, Uttar Pradesh and Gujarat — accounted for over 50 per cent of the tests conducted in the country till April 18, 2020. Kerala had, of course, led the way in testing and contact tracing, becoming the first state in the country to flatten the curve of new confirmed cases. Bengal had been lagging way behind most others in testing and it recorded the worst per capita testing rate in the country. Only one out of every 20,000 people in Bengal was tested for Covid-19 till April 18, when the all-India average was already above five. The Hon’ble High Court of Calcutta had admitted bunch of writ petitions questioning the state’s handling of the pandemic on April 17, 2020 and asked the state government to report its “adherence to effective screening on war-footing” and “acceleration of the rate of sample collection and testing” (The Telegraph, April 23, 2020). The factual data of COVID-19 testing was available at aggregate level and the regional and district-level picture was not available in public domain. As on April 30, 2020, it was found that only 181 per person were tested per ten lakh population (Table-5). A Reuter’s Report published on April 14, 2020 pointed out that West Bengal had done “just 33.7 tests per million, compared to a national average of around 156.9 per million, and 442 per million in Rajasthan” (Sreemoy Talukdar, *Firstpost*, April 22, 2020).

**Table 5: Progression Number of COVID-19 Tests in West Bengal**

Parameters	22.03.2020	30.03.2020	7.04.2020	15.04.2020	23.07.2020	30.04.2020
Samples Tested	128	519	1487	3470	7990	16525
Tests/Per 10 lakh	1.4	5.6	16	38	87	181
Expiry (No)	NA	2	5	7	15	33
Discharge (No)	NA	NA	NA	NA	103	139
Active Case(No)	4	22	69	132	334	572

Source: Computed from Health Bulletin, GoWB (for <https://www.wbhealth.gov.in/pages/corona/bulletin>)

*The Wire* has reported that the highest number of COVID-19 tests was conducted in Maharashtra (30,766), followed by Rajasthan (18,000) and Kerala (12,710) (Wire, April 11, 2020). The state of West Bengal has performed the least number of tests (1889) for the virus amongst all the large states in India. Consequently, several litigations were filed before the hon’ble High Court at Kolkata and on hearing a bunch

of Writ Petitions 5328 of 2020 (Faud Halim)/5334 of 2020 (Vimal Khawas)/5335 of 2020 (Ritesh Tewari)/5336 of 2020 (Raja Satyajit Banerjee), Calcutta HC ordered for monitoring steps taken by Bengal in tackling Covid-19 outbreak and consequently, the Government of West Bengal started publishing district level information in health bulletin since 04.05.2020.

The response of the state machinery in respect of North Bengal districts makes an interesting study. As per ICMR Notification dated 24.03.2020, there were only two government laboratories situated in West Bengal and both were located in Kolkata only. As on 30.05.2020, there were 40 COVID testing laboratories set up in West Bengal of which 29 were government sector and 11 private laboratories (see table-1). Out of 11 private laboratories, 10 were located in Kolkata urban agglomeration and one in Durgapur. In North Bengal, there were only seven (7) laboratories approved by ICMR. In South Bengal, there were 12 government and one private laboratory spread over different districts excluding Kolkata. The Kolkata urban had 10 government and 10 private laboratories. Therefore, if we consider the geographical spread of North Bengal from distance point of view starting from Malda to Cooch Behar in plain areas (500 kms), and Darjeeling and Kalimpong the two hill stations (400 kms) were covered by seven (7) laboratories only. In Darjeeling district, the only government laboratory is situated at North Bengal Medical College and Hospital at Sliguri. At the same time, all the 11 private laboratories are situated in Kolkata (10) and Durgapur (1). In nutshell, the testing infrastructure is not satisfactory in North Bengal and periphery remains neglected by the state. This testing infrastructure also gives an impression of low priority of peripheral districts in governing health care services in West Bengal.

### **COVID-19 and Migrant Workers : What does the Death of a Migrant Labour Reveal**

There was a news report of a migrant labour committing suicide in Islampur subdivision in the district Uttar Dinajpur (Uttarbanga Sambad, April 07 2020). As per local reports, there are many such workers who lost their work but this was reportedly the first case of death due to food crisis. The deceased Shah Alam (27) left behind his wife, two daughter and a son of five years. As revealed by the family members Alam travelled across different states in search of work and managed his family living in dire crisis. He returned from Sikkim just few days before lockdown. In an interview on April 18, 2020, the Medical Officer, Islampur Sub-Divisional Hospital in his statement to Uttarbanga Sambad, revealed that collection of samples for detection of COVID-19 started and were sent to NBMCH on April 17, 2020. The first rounds of samples were found negative. A total of 12272 migrant labourers who returned back, were sent for home quarantine and 95 persons were sheltered in government quarantine centres spreading over four blocks i.e. Chopra, Islampur, Goalpokar-I & Goalpokhar-II in district Uttar Dinajpur. As per correspondence between Government of India and West Bengal, *Shramik* trains were arranged to bring migrant workers in the state back home. In the first phase in May 2020, ten *Shramik* trains (two from Punjab, two from Tamil Nadu, three from Karnataka, one from Rajasthan, one from Kerala

and one from Telengana) were permitted by the Government of West Bengal. No train was arranged from Maharashtra and it is reported that minimum 16 trains are required alone from Maharashtra. The first labour train reached NJP station in North Bengal from Bengaluru and Telengana carrying 3115 persons of Cooch Behar, 151 persons of Alipurduar, 60 persons of Jalpaiguri, 117 persons of Darjeeling and 3 persons of Kalimpong (Uttarbanga Sambad: 10.05.2020). Later on, the Government of West Bengal released a schedule of 105 trains from various states to bring migrant workers back home starting from 17.05.2020 to 15.06.2020 (Ananda Bazar Patrika: 14.05.2020). An estimate of the migrant workers from 23 districts of West Bengal returning during three phases of the Lockdown 1, 2, and 3 shows that the figure may be little over 20 lakhs. The Government of West Bengal stated that all the migrants could not be brought back due to insufficient health infrastructure in the state. The return of the entire migrant labour force would require effective PDS to combat food crisis and transparent MGNREGA for job opportunity during 2020-21 (Hannan, 2020: [www.vikalp.ind.in](http://www.vikalp.ind.in): 11.05.2020). Reportedly, an estimated 3,12,081 migrant labourers returned home during lockdown in North Bengal. The district-wise distribution as per government sources was 1,43,073 persons in Cooch Behar, 84,174 persons in Malda, 74,927 persons in Uttar Dinajpur, 52,026 persons in Dakshin Dinajpur, 31,755 persons in Darjeeling, 30,106 persons in Jalpaiguri, 25,000 persons in Alipurduar (Uttarbangasambad, June 28, 2020).

### **Concluding Remarks**

During pandemic, the improvement of health infrastructure and COVID-19 hospitals were developed in urban areas and metro cities of labour supplying states of Bihar, West Bengal, Odisha, UP etc. There is an urgent need to stimulate the chain of Rural Health Care Network of Sub-Centres, Primary Health Centres, Block Primary Health Centres and Rural Hospitals to address the impinging health care facilities in the wake of the ongoing pandemic. The rural health care network has been in shambles across most of the states in India more so for the states which form the supply hub of migrant labourers to major metros of the country. The pandemic has revealed how concentration of testing facilities in urban areas has revealed the absence of basic health care support required to address the pandemic situation in rural areas. As the foregoing analysis and data has shown in West Bengal, the growth of pathological test laboratories have grown in Kolkata but the same has not grown in other districts of the state. During pandemic the alliance with private health facilities in West Bengal was attempted but the urban concentration of the facilities failed to strengthen the rural and health care system in other regions of the State.

That the migrant workers are the most vulnerable has been reinforced by the current pandemic situation across the country more especially for the states that remain the bulk suppliers of migrant workers. The absence of a data base on migrant workers was the biggest pitfall in the attempt to manage the migrant labour crisis. This has underscored the necessity to create a real-time data base on migrant workforce across India so

that one could analyse the demand and supply relationships that exist across different geographies and formulate policies that address the gaps that have been thrown open by the current pandemic situation. The MGNREGA and PDS which are two prime programmes that could ensure minimum support to rural and the poor people across urban and rural areas need to be strengthened to combat food crisis and the alternative livelihood options in villages and rural areas. Any government intervention requires data base for designing and implementing policies, and India is yet to come up with a robust data base on migrant workers which forms the back bone of the unorganized sector which has highest share in workforce engagement. A web portal at national level may be introduced to register the migrant workers and safety nets may be geared up to boost up urban informal economies. This would minimize vulnerabilities of moving migrant workforce and restoring their public health and protection from exploitative conditions and better working environment in future. While corporate incentives continues to be a priority of the neoliberal Indian state to boost industrial production, there is a need to rethink the relationship of state, capital and labour market with respect to the unorganized sector in India which has an employment share 83% of the work force in the Indian economy. The issue of migrant labourers and labour welfare measures need prioritization a the massive return of migrant workforce or reverse migration from cities to their natives has shown the vulnerability of these workforce. Their defying long marches during lockdown daunting the precarious condition of survival can be understood as a symbolic protest and spontaneous response of workers between *Geographies of Labour Supply* and *Geographies of Labour Consumption* against their working conditions. The pandemic has revealed the precarious condition of India's rural health care system and the vulnerability of the vast rural migrant workforce especially in major labour supplying states like West Bengal.

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