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KERALA HEALTH WORKERS AND THEIR HEALTH WORK IN THE PANDEMIC – COVID-19

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ABSTRACT

The paper focuses on outlining the healthcare workers, who are the frontline workers in any pandemic, and how their health - physical and mental is neglected during such outbreaks where they are required to pitch in extra hours, selfless work without consideration (at often times), expected to isolate without any contact with family, or without any mental health checkups. Panning through the previous pandemics, and how India handled the outbreak, starting from its peak in Kerala, and how Kerala HCWs were then expected to work in these growing demands despite no acknowledgement. They turned around the situation and made it to be the first constricted zone in India despite the way the state and central governments handled the situation, and this paper seeks to focus on the same.

I – INTRODUCTION

The Corona virus disease 2019 (COVID-19; hereafter "covid-19") swept across the globe, attaching itself to the history of humanity as one of the deadliest outbreaks which put the world at a pause. Middle-upper class workers, aristocrats, all had the privilege to work from home. The ones that were left were the daily wage earners – rag pickers, vendors, small shop owners, taxi drivers, migrant workers, health care workers; this was statistically, physically, mentally, a time worse than the previous pandemics, not only because no lessons were learnt from those, but that because of the recession, the implication of a fascist, classist 21st century government, with respect to its workers and economy, came into light. And this paper seeks to focus on the front line healthcare workers (hereafter "HCW") and their plights wrt labour laws, and specifically the Kerala HCWs in light of the worker model followed during the pandemic.

HCWs play the front and the most pertinent role of providing care to the infected. In such a situation that cannot be overseen or tracked, they chance a higher risk of exposing themselves to the virus, as well as the hours of overworking that can harm their mental health, causing PTSD, anxiety, depression, overwork-exhaustion, etc.[1]

[1] Gupta S, Sahoo S., *'Pandemic and mental health of the front-line healthcare workers: a review and implications in the Indian context amidst COVID-19.'* General Psychiatry 2020; 33:e100284. (Dec. 15, 2020) doi: 10.1136/gpsych-2020-100284.

II – PANDEMICS AND EPIDEMICS AROUD THE WORLD

Pandemics include the global transmission of emerging or re-emerging infectious disease epidemics that affect people across the globe, often resulting in deaths, socio-economic volatility, and bio-psychosocial impacts.[2] Covid-19 was discovered in Wuhan, China, in 2019 around December, which slowly showed its impact and was declared a pandemic by WHO earlier in March, 2020.[3] Other pandemics or flu pandemics of the 20th and 21st centuries, like the 2003 SARS covid-19 pandemic that killed less than 1,000 people; or the Asian flu in 1957-1958 estimated that over 1.1 million people were killed, or the Hong Kong flu pandemic of 1968-1970 that caused 1 million deaths. Comparatively, the 2009-2010 swine flu pandemic, such as the H1N1-like-Spanish flu, that had confirmed deaths up to 18,500, excluding the unconfirmed, unreported deaths, etc., was milder in number due to various reasons. The manner in which pandemics hit masses is different in its demography, or its variants and causes. Covid-19 and Asian flu mostly affected the people of higher age over 65, Spanish flu affected the younger, and stats show that 99% of the demography was less than 65 years, mostly 20-40 years of age, similar to the stats of the 2009 swine flu.[4] As of 4th December, 2020, Covid-19 has found 65.8 million cases, 42.2 million recoveries, and 1.52 million deaths, worldwide; and it is a pandemic still ongoing, not accounting the other uninfected deaths that were caused due to the turmoil of stress and depression of the pandemic itself.

III – HEALTH CARE WORKERS IN WORLD AND THE CYCLICAL STRESS OF A PANDEMIC

Lot of literature exists that surveys the growing numbers of death of the infected during a pandemic, but often shadows the health of the ones taking care of the infected. Front line HCWs are required to put in their physical work as well as unchartered mental health issues. A study

[2] Madhav, Nita, et al. *Disease Control Priorities: Improving Health and Reducing Poverty*. 3rd edition; Washington (DC): The International Bank for Reconstruction and Development/The World Bank; 2017, 'Chapter 17: *Pandemics: Risks, Impacts, and Mitigation*'.

[3] Valsan, Neethi, et al. *'Willingness and psychological preparedness to attend to COVID-19 patients among healthcare workers in a tertiary care private hospital in Kerala-A mixed method study.'* Kerala Journal of Psychiatry (2020). (Dec. 20, 2020), https://kjponline.com/index.php/kjp/article/view/204.

[4] Gavi, the Vaccine Alliance; *'How does COVID-19 compare to past pandemics?'* (Dec. 20, 2020), <https://www.gavi.org/vaccineswork/how-does-covid-19-compare-past-pandemics>.

undertaken by the Department of Psychiatry, All India Institute of Medical Sciences, Bhopal, India and Department of Psychiatry, Post Graduate Institute of Medical Education and Research, Chandigarh, India, studied the impact of pandemics on HCWs.[5] They found emotional stress, burnout, anxiety disorders, depression (and symptoms), insomnia, acute stress reactions, PTSD, low personal achievement stress, lack of control on their lives, poorly perceived health, etc., as common arrivals in the lives of HCWs, and narrowed down certain interesting factors that lead to these;

- ***Biological factors*** – History of mood swings or the advent of having to take care of someone earlier in life. Or having a family member, be it an elderly or a child to take care of.
- ***Psychological factors*** – they suggested that the nature or temperament of the HCW also plays a factor. Hereditary susceptibility to psychological stress, anxiety, paranoia, conflict between the professional and the personal, having to resort to defense mechanisms and denial, all these heighten the stress.
- ***Socioenvironmental factors*** that included;
    - ***Lack of information and communication –*** no information loop from the higher authorities, or proper guidance, about the ever-changing guidelines in addition to the already existing uncertainty and apprehension.
    - ***Risk of exposure to infection –*** working as an HCW during a pandemic that requires a lot of physical and mental work, includes taking out time from personal to add to the professional front. At some point, although there are changing shifts to accommodate the HCWs, it is also much an empathetic and altruistic work that requires willingness, when they can choose to opt out. This requires keeping in mind that the moment they step into their workspace – which becomes wherever the infected is, they are exposing themselves to risk of getting that infection, and more often than risking family to that same risk of exposure. In such sensitive circumstances, the worry is not just for themselves, but acting as a carrier to anyone and everyone else. Also the beginning of the pandemic is not hopeful work, it's watching the crying of

[5] Supra 1.

patients and their families, watching their patients die, and all this takes an emotional toll more so than daily HCW struggle because with rapid increase in number comes more stress.

- ***Social distancing*** – they need to maintain distance from everyone around them, being the ones to work in a hands-on manner with the infection. This includes them being deprived of emotional, social, physical support of their loved ones.
- ***Work-related stress*** – once HCWs start contracting the virus, this adds to shortened staff, longer hours, more stress, less familiar and friendly faces and environment, more staying in the suffocating gear…changing duties, the helpless feeling of looking at their infected colleagues and not being able to help. All very sensitive issues that add on to further stress. This includes the lack of support from their colleagues, because work stress leads to distancing from each other on a certain level as well.
- ***Self-protection equipment stress*** – limited supply of personal protective equipment (PPE), or working under the limited area of the PPEs, both have been found to cause stress to the HCWs.
- ***Misinformation*** – it becomes very minimally easy for the spread of false information due to panic and rumour that spreads due to social media;

Etc. they also don't have precedented means to seek mental help from professionals at that time, not just because of lack of time and overworking, but because of unavailability of professional psychiatrists due to their own overbooking.

What could have been of help would have been to encourage regular communication, affirmations, mental support to the HCWs, professionally involving mental health professionals in the circle for their workers, transparency with respect to strategies and being flexible in understanding the needs of the HCWs, ensuring availability of PPEs due to an immediate response, a better resource system, to spread the correct information and discourage rumour based information. These may seem an idealistic trope, but not an unachievable feat, if the governments gave more indication and credit to their health systems – asking them what they need, instead of making the decisions themselves.

IV – COVID-19 IN INDIA

The first case that was reported in India was on 30th January, 2020, in a group of students who had arrived from Wuhan, to Kerala. From there on, statistics showed that 80% of the cases were asymptomatic. India, being the world's second most populous country, incurred terror in these terms of a widespread pandemic. There is a huge number of the population living in *kachcha* houses, slums, and if one person from the communities were to catch that virus, it would spread like wildfire. The issues arose and were brought to the frontline again, lack of sanitizing materials, lack of access to water[6], migration workers and the panic around their livelihood[7], majority of population under the poverty line[8]. Government of India ("GOI") imposed a 40 day lockdown, and extended it to 8 weeks. And soon after, observed increase in numbers because of lack of information in the public, which then lead to an extended lockdown with due relaxation, still ongoing as of December, 2020.

To be able to control this pandemic, the GOI, under the National Disaster Management Act (2005), likened Covid-19 to a national disaster, and laid down policies and guidelines, social distancing, testing, to ensure a timely check.

V – THE FIRST STATE TO CONTRACT IT AND TO CONTROL IT – KERALA

What helped Kerala was the aggressive lockdown and quarantine rule it placed on its cases, observing and the testing strategy, tracing contacts.

[6] Khan MI, Abraham A., Econ Polit Wkly 2020; '*No 'room' for social distancing: a look at India's housing and sanitation conditions.'* 55.
[7] Tumbe C. *'A million migrations: journeys in search of jobs.'* Livemint. (Dec. 25, 2020), <https://www.livemint.com/Politics/8WPPsZygqR7Mu6e3Fgy55N/A-million-migrationsJourneys-in-search-of jobs.html>.
[8] Government of India. Ministry of Social Justice and Empowerment. State-wise percentage of population below poverty line by social groups, 2004–05. (Dec. 25, 2020), <http://socialjustice.nic.in/UserView/index?mid=76672>.

Table 1: Number of Persons Affected in Kerala (30 January 2020–2 May 2020)

Period	Number of Persons				
	Placed in Home Quarantine	Under Isolation in Hospitals	Tested	Positive and Put on Treatment	Discharged After Being Cured
30/01 to 15/02	3,430	207	415	3	0
15/02 to 29/02	289	30	70	0	3
01/03 to 07/03	433	62	197	0	0
08/03 to 14/03	6,863	549	1,215	19	0
15/03 to 21/03	46,301	452	1,819	30	0
22/03 to 28/03	83,792	926	2,351	130	13
29/03 to 04/04	52,218	1,007	3,677	124	34
05/04 to 11/04	10,160	1,090	4,419	67	93
12/04 to 18/04	534	725	4,611	26	114
19/04 to 25/04	2,260	755	3,586	58	81
26/04 to 02/05	4,424	719	8,823	42	62

[9] Source: Kerala Health Department.

Undisputedly, Kerala's stringent response to Covid-19 was due to its pertinent health system that has a history of strong fights for education for itself. Demanding social movements, intervention by governments and others on the supply front, spread of education in wide ambit to its people, especially women, all added to the front that led to its immediate response and learning from the other continents facing this pandemic.

[9] Isaac, Thomas, & Sadanandan, Rajeev; *'COVID-19, Public Health System and Local Governance in Kerala'*. Economic & Political Weekly. Vol. 55, Issue No. 21, 23 May, 2020. 35.

VI – THE LABOUR CODES AND UNPAID LABOUR OF KERALA HCW

Labour laws fall under the Concurrent list of the Constitution. Labour codes are under; (1.) industrial relations, (2.) occupational safety, health and working conditions, (3.) wages, and (4.) social security. Covid-19 saw a prevalent relaxation of labour laws and codes to achieve its goal of undermining the virus to control it. But in this process, May 2020 onwards, it also saw a downgrade in response for the labour. Change of working hours, but no appropriate compensation. States like Rajasthan, Gujarat, Madhya Pradesh, all issued notices to maintain a work time of 12 hours per day. For the purposes of this paper, we shall continue to look at the OSHWC and how it fails the HCWs. With respect to the occupational safety, health and working conditions-code ("OSHWC"), there are no provisions that specifically talk about the caretaking of HCWs, especially during the sensitive period of a pandemic. Including the Provisions explicitly state that a child below 14 cannot be paid or put into labour – this deregulation only incorporates trafficking, exploitation, and forced child labour everywhere.

Back in April, families of HCWs were guaranteed a total of 80 hours of paid leave to its workers due to medical issues from Covid-19. The guidelines by government even 'encouraged' its workers to take rest and break if they showcased symptoms. However, these were to naught, because live reports showed how workers who didn't show up to work were harassed. The legislation does not specify who or what comes under the ambit of a 'health care worker' and this makes it easier for the hierarchical upper bodies to exploit the workers.[10]

In turn, a lot of HCWs were shying away from applying for positions of help. There was low pay, and short term contracts. In West Bengal, there were 300 nurses that quit their jobs due to this disparity in law and its execution.[11] They got a stipend of Rs. 13,400 per month.[12] This proved the intention of the government and its lack of care for the healthcare workers during a time of pandemic and recession in the country. The government did not address a pertinent issue of lack of PPEs, and only focused on the violence against healthcare workers. The current government

[10] Long, Michelle, & Rae, Matthew; 'Gaps in the Emergency Paid Sick Leave Law for Health Care Workers', KFF. (Jan. 3, 2021), <https://www.kff.org/coronavirus-covid-19/issue-brief/gaps-in-emergency-paid-sick-leave-law-for-health-care-workers/>.

[11] Jacob, Nidhi, et al., 'Hospitals struggle to get healthcare workers as Covid-19 cases spike', Business Standard. (Jan. 4, 2021), <https://www.business-standard.com/article/current-affairs/low-pay-poor-amenities-deter-health-workers-from-covid-care-as-cases-surge-120073100588_1.html>.

[12] *Ibid.*

passed an Epidemic Diseases (Amendment) Ordinance 2020, to amend the Epidemic Diseases Act, 1897, and made violence against HCWs, a cognizable and non-bailable offence, during a pandemic/epidemic.[13] Further, it ignored the structural reforms that were needed and focused on one issue to highlight the work that was not enough – unsafe working conditions, doctors being asked to pay to avail quarantine facilities, no infection control audits, fake reports of positive cases, these tipped public health law more towards the point of crisis.

VII – CONCLUSION

The International Labour Organization ("ILO") codes and standards require its members to have a national system for such dire situations to handle stringent conditions. GoI had insinuated with the OSHWC that it would focus on all the frameworks that would make workplaces a better environment; however, there is still no explicit inclusion of health care workers. During a time of a pandemic with occupational hazards that could lead to serious damage and death, without proper framework in place, the kind of harassment that HCWs can face are close to unlimited. In May 2020, ILO released key provisional FAQ of labour standards to be kept in mind during the pandemic. These included provisions like, recommending an adoption of "*promoting social dialogue and collective bargaining*," and "*taking measures, as appropriate, for the socio-economic reintegration of persons who have been affected by a crisis, including through training programmes that aim to improve their employability*", etc.,[14] to enable a strategic response and build resilience. It further explains that the 'Employment and Decent Work for Peace and Resilience Recommendation, 2017 (No. 205)' in particular emphasizes the need for this social dialogue on a national, sectoral, or enterprise level, including the 'Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87)', and the 'Right to Organise and Collective Bargaining Convention, 1949 (No. 98)', which taken in the view of this paper, could be associative to determining issues pertaining to the health sector, and eradication of any scope for maltreatment of workers or inaccessibility of any tangible/intangible equipment, especially with

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[13] Shrivastava, Shreya, *'India's healthcare workers are the most vulnerable, but there is no framework for their health'*, The Print. (Jan. 4, 2021), <https://theprint.in/opinion/indias-healthcare-workers-most-vulnerable-but-no-framework-for-their-health/459827/>.

[14] ILO Standards and Covid-19 (coronavirus) FAQ, 29 May 2020 - Version 2.1, '*Key provisions of international labour standards relevant to the evolving COVID19 outbreak*'; International Labour Organization.

the insider information, and what they would need, through these HCWs. This would not only ensure a better and quicker implementation of policies, but carries with it an enhanced form of working health sector in the country. This crisis of a pandemic should not only be used as a wakeup call, but also an updated version of Indian standards to deal better and do better by its frontline workers.