



# STORIES OF CHANGE

2021-2022

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VOLUME III

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Case Studies on  
Development Action and Impact

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Azim Premji University Publication

# STORIES OF CHANGE

**2021-2022**

**VOLUME III**

Case Studies on  
Development Action and Impact

**Special Edition**

Response to COVID-19 crisis by Civil Society

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## VII. Project Swaasthya: Primary care for migrant workers using telemedicine

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Daily Wage Worker Platform

### Abstract

The COVID-19 crisis devastated the health and lives of migrant workers, daily wage-earners and other informal workers who constitute 92 percent of India's total workforce.<sup>1</sup> The majority of these workers reside in slums with inadequate safe drinking water, poor housing and overcrowding. As a result, they suffer from a range of acute as well as chronic health disorders such as diabetes, cardiovascular diseases, hypertension, asthma and long diarrhoea. Migrant and daily-wage workers face difficulties in accessing basic healthcare, which increased exponentially with the loss of livelihoods and food security during the nationwide lockdowns. With formal health systems overwhelmed and resources directed towards the management of COVID-19, the most vulnerable were left with little or no access to health services, especially to treat non-COVID-related diseases.

The Daily Wage Worker Platform (DWWP) is an NGO that emerged as a response to COVID-19 in April 2020, with the aim of supporting migrants and daily-wage workers with access to food security, healthcare, jobs, skills, government welfare schemes and awareness of the new labour laws. The organisation was formed in Geneva, Switzerland, and Delhi, in partnership with Jindal Global University and Shawview Consulting, Australia. DWWP began by documenting 200 relief efforts by NGOs, corporates and states to support migrants during

the lockdowns across India. DWWP developed and implemented evidence-based pilot projects to address the diverse needs of migrant workers with the support of donors, NGOs and volunteers. Over the past year, it has:

- Raised USD 50,000 to feed 30,000 families in Dharavi, Mumbai
- Provided basic healthcare to 15,000 workers in the slums of Hyderabad and Delhi
- Conducted a survey of 8,000 migrants impacted by COVID-19 in Odisha, Bihar and Maharashtra
- Developed a comprehensive framework to address the root causes of the migrant worker crisis
- Contributed to the development of the draft national policy for migrant workers
- Managed COVID-19 helpdesk on the availability of medical supplies during the second wave
- Conducted a vaccine resistance survey among 200 migrants in five cities after the second wave
- Connected 6,000 migrants in Odisha to 3-5 government welfare schemes

This case study documents how DWWP developed and implemented the idea of an emergency health package to provide basic services to migrants without access to healthcare. DWWP partnered with Smile Foundation to implement Project Swaasthya among 10,000 workers across 10 slums in Hyderabad, supported by the Swiss Agency for Development Cooperation. Smile Foundation is a national-level NGO formed in 2002, currently benefiting more than 7,50,000 underprivileged communities through more than 200 welfare projects in education, healthcare, livelihood, women's empowerment and advocacy across 25 states of India. Under its health intervention, Smile Foundation seeks to improve access to essential health services through doorstep medical facilities to the vulnerable and the marginalised. Considering the lagging health status of rural and urban slum populations of India, Smile Foundation initiated the Smile on Wheels programme in 2006, to provide last-mile healthcare delivery using mobile medical vans.

DWWP's aim is to develop and test innovative, low-cost and effective pilots to provide healthcare to remote communities, using digital health and telemedicine. With the support of a group of health experts, the organisation developed a three-month emergency health package for migrant workers affected by the pandemic, lockdowns and the monsoon. After discussions with several NGOs, the concept of Project Swaasthya evolved to provide workers with basic health services at their doorstep. These included screening, diagnosis, treatment, counselling and referrals. The project was implemented through telemedicine because social distancing was crucial to preventing the spread of COVID-19.

After evaluating the capacity of different healthcare partners, Smile Foundation was chosen to implement the pilot in Hyderabad, where it already had mobile health vans. DWWP added the telemedicine component through leveraging the Smile Foundation's existing infrastructure to connect slum populations to doctors remotely. Patients who visited the mobile vans were screened by a nurse, who connected to the doctor by phone and sent prescriptions to the patient through WhatsApp. Patients could collect the drugs for free at the mobile van dispensary. The pandemic led to increased recourse to telemedicine in Europe, Asia and North America, and there appeared to be consensus on the desirability of bringing it into the mainstream, both to prepare for future pandemics and to improve the functioning of the healthcare system as a whole.<sup>1</sup>

## Healthcare challenges faced by migrant workers

### a. Lack of healthcare for migrants

With the surge in migration observed in the past two decades, there has been a deterioration in the healthcare of migrant workers. The article, "Migrants and health" suggests that the geographical mobility of migrants aggravates the health challenges faced by them in their source, transit and destination states. They are privy to health-related risks due to limited access to healthcare services, poor hygiene, sanitation and insufficient nutrition. Hence, the migrant workers were especially vulnerable to the spread of COVID-19. To add to the complexity, the current housing conditions of migrants pose a grave risk during the pandemic. They reside in congested accommodation, where social distancing and isolation cannot be practised due to space constraints. As stated in the report by the

International Organization for Migration, their risky working conditions may also pose health concerns. The majority of migrant workers fall under the category of unskilled to semi-skilled, employed in industries such as agriculture, construction, garbage collection and cleaning services. The lack of flexibility to operate remotely, close contact with people and lack of protective gear (masks and gloves) further jeopardises their health. They also face other health-related issues such as psychosocial disorders, reproductive health problems, higher infant mortality, nutrition disorders, drug abuse, alcoholism and exposure to violence – increasing their vulnerability to non-communicable diseases (NCDs).

**b. Catastrophic out-of-pocket expenditure**

The second wave of COVID-19 exposed the catastrophic consequences of a lack of prevention and planning that resulted in the collapse of India's health systems. By April 2021, the country was reeling with 4,00,000 new cases per day. As per the latest National Health Profile 2019, India's aggregate health spending accounts for less than 1.3 percent of GDP. According to the International Organization for Migration, migrant workers are unequipped to prevent transmission of COVID-19 and resort to visiting hospitals. Local primary care centres were ill equipped to respond to patients. The hospitals were overburdened and unable to cope with the sudden surge in COVID-19 patients.

**c. Challenges faced in accessing healthcare**

Despite the government's sustained efforts to combat the pandemic, the struggles of migrants were overlooked. They failed to receive consistent access to public healthcare services and COVID-19 containment measures. Accurate data on the demographics of migrants in the country is not readily available, especially as seasonal and short-term migrants are not represented in the national population census or migration surveys by the National Sample Survey Office. Since migrant workers are constantly on the move, their documentation does not pertain to their place of work or residence. Valid documentation was vital to avail of financial and social welfare schemes, especially during the lockdowns.

#### **d. Knowledge of COVID-19 precautions**

The lockdowns have increased one's overall dependence on the internet. However, during the pandemic, the disadvantaged sections of society such as migrant workers were deprived of devices and a stable internet connection. The lack of internet along with illiteracy aggravated the challenge for the poor. Lack of access to the internet is correlated with low levels of literacy. Since they lacked the awareness on the degree of risks associated with the pandemic, the alarming need to maintain social distancing and isolation was not a priority for them. They were not abreast with the latest COVID-19 data and protocols. The limited knowledge on COVID-19 precautions, along with minimal compliance to rules such as wearing a mask and hand washing, made it tougher to mitigate the risks of COVID-19.

### **Migrant health survey**

DWPP designed a detailed survey to collect primary data from migrants living in slums on their health-seeking behaviour, disease profiles, access to health services during COVID-19 and social distancing. Since the study was aimed at migrant workers, the survey was used as a method of data collection to ensure that the target population's opinion, behaviour, knowledge and disease profile are captured properly. The survey was field-tested in the slums of Hyderabad and subsequently adapted to local conditions by Smile Foundation. The findings reflected the healthcare challenges that the migrants in slums face.

### **Sampling method**

Convenience sampling method was chosen wherein the survey was conducted door-to-door in 10 slum areas, covering a sample of over 3,000 people. These included Krishna Nagar, Arjun Nagar, Airlines Gate, Mohammadiya Nagar, Anna Nagar, Shiva Nagar, Balam Rai, Indiramma Nagar, CBN Nagar and Ambedkar Nagar. The households were randomly selected by the surveyors. Those availing of the services of the Swaasthya Project, i.e., visiting the tele medicine unit, were also surveyed.



Figure 1: Health workers collecting data from residents of slum areas



## Survey findings

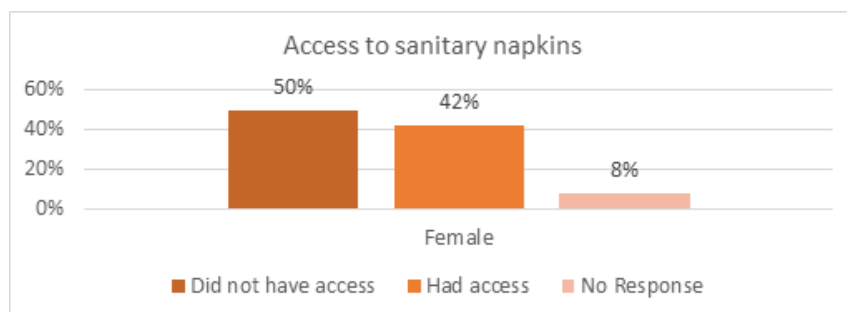
### 1. Demographics

Out of the total number of respondents (3,120), 58 percent were female and 42 percent were male. In terms of age, 88 percent of those surveyed were between 20-59 years old and 12 percent were 60+ years old. Fifty-five percent were self-employed migrants at the time of the survey while 19 percent were daily-wage workers, 14 percent were in regular non-governmental jobs and the rest 12 percent had other occupations.

### 2. Access to sanitary products

In light of COVID-19, it was essential to have access to personal hygiene products in order to minimise the spread of the virus. Through the survey, we tried to assess if the respondents had regular access to such products. The majority of the respondents had some access to soap, water and sanitisers. But as is typical for urban slums, menstrual hygiene products are not readily available, with 50 percent women being unable to access sanitary napkins or other related products (Figure 2).

Figure 2: 50 percent women did not have access to sanitary products



Source: Swaasthya Survey

### 3. Health profile

During the survey, it was found that out of the total respondents (3,120), 12 percent suffered from a chronic cardiac ailment, 12 percent had diabetes, 2 percent had skin ailments, 4 percent had asthma and less than 1 percent had tuberculosis.

Looking at the prevalence of addictive substances in the population, it was also observed that 21 percent of men surveyed consumed alcohol, 15 percent consumed tobacco, 14 percent consumed gutkha, and 2 percent consumed some other addictive substances (marijuana, bhang, etc.).

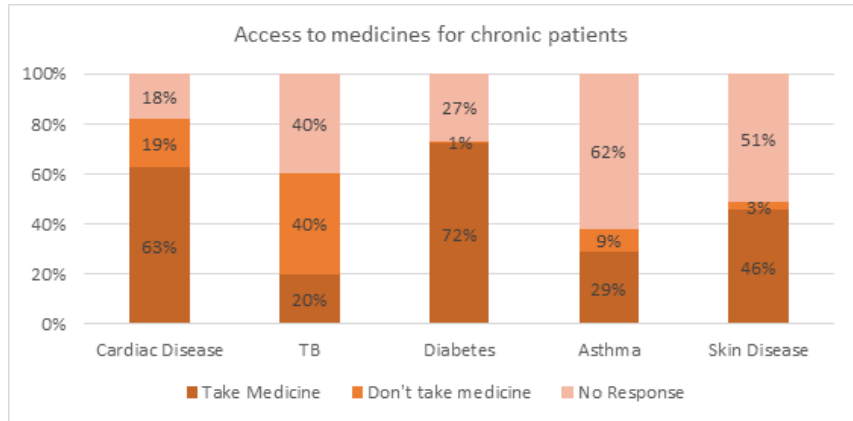
### 4. Access to healthcare

During the survey, it was found that less than 1 percent of respondents surveyed visited any healthcare facility (hospitals, private clinics, nursing homes, etc.) in the month of August 2020. The main challenges faced by the population were transportation issues, unavailability of healthcare professionals, financial constraints and fear of the ongoing COVID-19 pandemic.

On being questioned about the type of medical facility visited by the respondents in case of an emergency, it was found that 77 percent preferred going to private clinics/hospitals, and the remainder that they visit government establishments and charitable clinics for availing healthcare services.

It was found that out of those suffering from a cardiac ailment (12 percent of total sample), only 63 percent were taking medication for it. Only 20 percent of tuberculosis patients (less than 1 percent of the total sample) were taking Anti Tuberculosis Treatment (ATT). Seventy-two percent of diabetes patients (12 percent of total sample), were taking medication while out of those with asthma (4 percent of total sample), and skin diseases (2 percent of total sample), only 29 percent and 46 percent, respectively, were taking medicines.

Figure 3: Data on patients taking medicines for various health conditions



Source: *Swaasthya Survey*

### 5. Universal health coverage

The Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) launched by the Government of India in 2018 aims to provide universal health coverage via two major components – Health and Wellness Centers (HWCs) and Pradhan Mantri Jan Arogya Yojana.

However, during the pandemic, there was a sharp decline in the enrolment of beneficiaries under the scheme. According to our survey data, less than 1 percent of the total respondents had an AB-PMJAY card, 55 percent did not have it (but were aware about the scheme). The remaining 44 percent were unaware about the AB-PMJAY scheme – indicating a serious lack of awareness about the AB-PMJAY scheme and its benefits among slum populations.

## Telemedicine package for migrants

Post the survey, the findings were used to study the disease profile of slum residents and, accordingly, provide them the necessary medicine, diagnostic tests, counselling and referrals. The survey findings were used to ensure COVID-19 protocols are practised by the slum residents – through awareness about use of masks, following social distancing, provision of soaps and sanitisers to limit the spread of infection. It was also observed that menstrual hygiene products are not readily available, hence provision of sanitary napkins was also used as an intervention in the Swaasthya project.

*Figure 4: Mobile van providing health services during lockdown; Doctor on a tele-consultation with slum dwellers*



Smile Foundation identified 10 slums in the heart of Hyderabad city, covering a total population of 10,000. The occupations of people in these slums are primarily daily wagers, construction labourers, rickshaw pullers, domestic helps and street vendors. Due to the lockdown, many construction sites were shut down. With the onset of a major economic recession, workers were struggling to feed their families and access basic healthcare. In the periphery of these 10 slums, there is only one government hospital and no other affordable healthcare facility within 6 km.

Smile Foundation adopted a combination of telemedicine, whereby a full-time doctor provided diagnosis and treatment over the phone and the deployment of a mobile medical unit staffed by a qualified nurse and pharmacist conducted basic tests and dispensed over 80 types of drugs to patients in the slums.

Community mobilisers spread awareness about the OPD clinics by using pamphlets that were designed by DWWP in the local language of the slum residents and distributed by the community health workers. About 60 camps were held across the slums targeting over 4,000 workers over three months. The camps stressed the importance of social distancing, hand washing and wearing masks. The project focussed particular attention on the needs of women and children. Through the door-to-door household survey, we learned that women are often relegated into positions where they are not only more vulnerable to suffering from health problems, but also have less access and control over healthcare resources than men. Hence over 70 percent of project beneficiaries comprised women and children.

Table 1: Lab tests conducted by a mobile medical unit during lockdown

Lab Test Bifurcation					
Type of test	July 2020	Aug 2020	Sep 2020	Oct 2020	Total
HB	0	1	2	2	5
RBS	0	35	58	102	195
UPT/Pregnancy	0	2	4	3	9
Others	0	3	4	8	15
<b>Total</b>	<b>0</b>	<b>41</b>	<b>68</b>	<b>115</b>	<b>224</b>

Table 2: Common diseases found amongst migrants

Disease pattern July to October 2020						
Sl No	Type of disease	July-20	Aug-20	Sep-20	Oct-20	Total
	Acid peptic disease (APD)	0	3	7	19	29
	Acute diarrhoea	2	9	12	12	35
	Acute gastritis	19	57	63	87	226
	Acute gastroenteritis	1	3	5	7	16
	Anaemia under evaluation	1	3	3	4	11
	Aphthous ulcers	2	31	5	33	71

Disease pattern July to October 2020						
Sl No	Type of disease	July-20	Aug-20	Sep-20	Oct-20	Total
	Burn (first degree)	0	2	3	5	10
	Dental caries	1	5	19	29	54
	Dermatitis	0	8	22	28	58
	Diabetes mellitus type 2	4	54	131	141	330
	Diabetes mellitus type 2 and hypertension	4	52	33	31	120
	Functional constipation	1	5	12	7	25
	Hypertension	6	47	112	68	233
	Infected wound	1	5	8	9	23
	Leucorrhoea under evaluation	0	2	3	1	6
	Lower backache under evaluation	9	56	66	84	215
	Osteoarthritis (knee)	18	58	76	99	251
	Otorrhoea left ear	0	3	4	3	10
	Pain abdomen under evaluation	6	5	6	8	25
	Scabies	0	2	3	5	10
	Tension headache	4	0	73	128	205
	Trauma	1	21	56	66	144
	Upper respiratory infection (URI)	36	131	606	794	1567
	Urinary tract Infection (UTI)	0	2	1	2	5
	Vulvovaginitis	0	2	3	1	6
	Weakness under evaluation	3	58	53	48	162
	<b>Total</b>	<b>119</b>	<b>624</b>	<b>385</b>	<b>1,719</b>	<b>3,847</b>

Patients were provided with free medicines for the project duration. Only generic drugs from reputed manufacturers were procured through a bulk drug purchase discount to keep project costs low. The most common drugs included metformin for diabetes, amlodipine for hypertension, paracetamol for fever, ranitidine for acidity, loperamide for diarrhoea, naprosyn, dextromethorphan, etc.

Awareness activities were conducted to educate workers and their families about ways to prevent COVID-19 and manage NCDs. The project focused on NCD patients (hypertension and diabetes type II) and 683 consultations were recorded and about 200 rapid tests with blood and urine samples were conducted. Forty-seven patients were referred to nearby hospitals such as Basti Dhavakana and Gandhi Hospital for advance treatment. Of these, 35 people were successfully treated and 11 patients remain under treatment. Three thousand hygiene kits, including sanitary napkins and soap, were also distributed. These kits also helped reduce social taboos and raise awareness about menstrual hygiene.

In order to successfully implement the Swaasthya Project, DWWP provided regular technical assistance and guidance to the Smile Foundation. This included advice on staffing needs, surveys, monthly reporting and jointly addressing operational challenges. DWWP developed a format for monthly narrative and financial reports and held bi-monthly calls with the Smile Foundation to review progress and offer advice. It also ensured that all staff members were in PPE kits while distributing the hygiene kits, conducting surveys, distributing medicines, screening and counselling patients. Smile Foundation secured the health and safety of all their staff and front-line workers to protect them against COVID-19.

*Figure 5: Free medicines were distributed to among 4,000 patients; Social distancing was maintained during access to health services*



## Project results and impact

Due to the persistent efforts and rigorous approach followed by Smile Foundation, supported by the DWWP team, the Swaasthya Project was successfully able to exceed its targets by catering to 3,847 slum residents (target was to cater to approximately 2,500 slum residents) in a matter of three months. It is one of the pioneers to have successfully delivered primary healthcare to migrants and daily-wage workers since the onset of COVID-19 and ongoing lockdowns. The pilot project was completed in three months at a cost of INR 1.50 per patient per day, which depicts that delivery of healthcare package services can be achieved at a reasonable cost.

### Project highlights

- 3,847 beneficiaries were treated through 60 OPDs
- 1,130 of the beneficiaries were male, 2,044 were females and 673 were children
- 224 point of care (PoC) tests were conducted
- 3,000 hygiene kits were distributed in the operating slums
- 34 community meetings were conducted to increase community participation in issues concerning health especially on COVID-19 and NCDs
- 47 cases were referred to specialists in government hospitals
- 3,120 survey forms completed in the operating slums

## Key factors for success

**1. Telemedicine to beat lockdowns:** Initially, the plan was to rent an office where patients would be attended by a nurse. But with the rapid rise in COVID-19 cases and the lockdowns, a mobile van was proposed. In order to provide innovation in the delivery of healthcare services to the slum residents, the use of telemedicine was suggested by DWWP. The Swaasthya Project intended to cover a population of 10,000 and was accordingly implemented in 10 slums in Hyderabad. In order to ensure that the health services are delivered within close proximity of the slum residents, the mobile van developed a roster to provide services at different locations on a regular basis.



**2. Medical staff and coverage:** In order to provide healthcare services to the population via telemedicine, there was a doctor employed who was available for six to eight hours daily. The healthcare service was provided by using a mobile van (“Smile on Wheels”) having a nurse for aiding the screening, testing and consultation via telemedicine route with the doctor along with one helper for aiding in the distribution of medicines.

**3. Staffing:** Having adequate human resources to complete the designated task is an important step in achieving the targets set within the defined timelines. One challenge was the initial unavailability of a pharmacist for distribution of medicines to the patients at the start of the programme. The private sector was paying higher salaries with the onset of COVID-19. The Smile Foundation continued the distribution of medicines by involving the nurse and other team members via the Smile on Wheels.

**4. Awareness among patients:** When the project was implemented in the month of July 2020, there were less patients who came to avail of services via Smile on Wheels. The main reason was the fear of catching the deadly virus and lack of information among the slum residents with regards to the benefits of Project Swaasthya. DWWP developed an information, education and communication campaign through the use of flyers in local languages. Smile Foundation disseminated the materials across the 10 slums to educate the community about the precautions being used by the project team in the delivery of services. Also, while distributing the sanitary kits there was some opposition faced by the community male head of households due to socio-cultural barriers. DWWP advised the team to overcome this through counselling and communicating directly with the women. As a result, Smile Foundation was able to increase the awareness and uptake of sanitary kits in the communities.

**5. COVID-19 and flood issues:** While the project was being implemented, the project manager tested positive for COVID-19. Keeping in mind the safety and welfare of the community members, the project services were suspended for about 10 days. The project was also affected by heavy rainfall and floods. However, to meet their timelines, Smile Foundation increased the number of volunteers and community health workers from other ongoing projects to cover up the gap.

## Project recommendations

- With the collapse of health systems across the country during the second wave, it became clear that the public sector alone cannot deliver healthcare to 1.3 billion people.
- The importance of partnerships is evident through the case study, whereby DWWP and Smile Foundation leveraged each other's strengths to reach the poor. While DWWP developed the Swaasthya model, health survey, raised funds and provided technical advice; Smile Foundation helped with the technology, healthcare professionals and community workers to execute the project on the ground.
- During the first wave, thousands of front-line health workers contracted the virus from hospitals and patients due the limited availability of PPE kits and established COVID-19 protocols. The use of telemedicine proved an effective way to safeguard the health of doctors and nurses and, at the same time, reach communities located in overcrowded slums.
- Telemedicine programmes also helped the implementation of prevention and awareness programmes among daily-wage workers and migrants with limited access to information.
- Behaviour change is a critical response to combating the pandemic. The Swaasthya pilot demonstrated the effectiveness of community outreach programmes in promoting the widespread adoption of COVID-19 prevention measures such as using masks, hand washing and social distancing.
- In order to improve the health-seeking behaviour, accessibility needs to be improved as well. Migrant labourers and daily-wage workers do not get the time off to visit healthcare centres that are located far away from their places of work and dwellings. In such cases, they often postpone their visits to hospitals, which can be dangerous in terms of ailments. Tele-consultations where doctors provide online/remote screening, advice and prescriptions to such patients can save a lot of time, resources as well as the expenses of commuting.

- As seen through the implementation of Project Swaasthya and the Smile on Wheels initiative, mobile vans with diagnostic and testing capacity can easily reach out to areas where healthcare is sparse and provide necessary relief in the form of medicines, consultations and referrals.
- Going forward, such approaches will become the order of the day to provide decentralised healthcare service delivery at the local levels. As these models expand, they will enable patients to seek care at the primary level, thereby reducing the burden on tertiary care facilities. A proper triage and referral system will ensure that basic healthcare is provided at the community level and only patients with critical care needs are directed to hospitals.
- The use of generic medicines instead of branded drugs can play a vital role in keeping costs down to make the treatment affordable for vulnerable groups that prefer to opt for private healthcare. This was one of the key factors that kept the project costs low enough to provide the package at INR 1.5 per patient, per day.
- The lessons from these pilots can be used to design effective vaccination programmes to provide last-mile service delivery using telemedicine to reach mobile populations like migrant workers that comprise 955 million people today. The approach followed by project Swaasthya can be effectively applied to mobilise rural communities and reduce misinformation and fears about taking the vaccine.
- The project can also be scaled up to provide low-cost primary care to vulnerable communities suffering from non-COVID diseases such as tuberculosis, diabetes and mental illness.
- Enrolment in state health and social security schemes could be increased through the model of mobile vans/stations which issue registration forms on the spot for people who are eligible. Through awareness programmes, adverts, flyers, etc., the services under this scheme need to be extended to the daily-wage workers and migrants who are usually most deprived of healthcare in their destination cities.
- The National Telemedicine programme is beginning to deliver healthcare remotely across the country. It can benefit from the experience of Project Swaasthya in bringing together technology, communities and healthcare professionals to collectively deliver healthcare remotely.

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