Working Conditions of Ayahs in Private Healthcare

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Ayahs in private hospitals face a precarious life and poor working conditions. The findings of a study of ayahs in private hospitals in Siliguri, West Bengal are analysed here. As caregivers, their work benefits patients and their families as well as the hospitals, but the issues they face are paid scant attention to by all the beneficiaries.

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In the 91% informally employed workforce in India, the proportion of women is very high (Srija and Shirke 2014). Women have a tendency to concentrate on informal "care" activities involving domestic work, education and health activities (Neetha 2014; Srija and Shirke 2014). In the Asia Pacific regions, nearly 30% workers in these sectors are without social protection or rights at work. Additionally, these sectors are witnessing changes in labour market structures with flexibilisation and casualisation of employment relationships (ILO 2018a). This results in growing numbers of workers who are outside any employment relationships, although they work in the formal health or education sectors (ILO 2018a). In countries like India, healthcare sectors are reliant on female community healthcare providers, informally employed to provide care services (Mazumdar and Neetha 2011; ILO 2018a). Ayahs form one category herein, where the ayah's work is closely associated with nurturing and caring for the sick, elderly and the infirm. It falls within the domain of care work (England and Folbre 1999; England et al 2002; England 2005; Razavi 2007) and is deemed a feminised occupation with places of work either being in the private spaces of people's homes or public healthcare organisations, controlled by market or state or both. In the public sphere, ayahs exchange their services against wages in the organisational setting of the hospital or nursing home. Their work carries attributes of informal workers that include lack of standard wages, uncertainty and irregularity of work and income and non-recognition at workplace.

Nevertheless, within the healthcare organisations, ayahs comprise the most important care providers to patients. As their work concerns intimate physical caring of patients—bathing/sponging, dressing, feeding and emotional healing—their services are of utmost significance to patients. However, in the increasingly formal, bureaucratic and corporatised workplaces, ayahs are witnessing gradual eradication or restructurings. The problems faced by ayahs thus shed light on concerns of care workers as informalised workers in formal institutional work settings as well as the factors associated with devaluation of care as work. This article attempts to understand the conditions in which ayahs work in the absence of bounded employment relations in healthcare organisations that restrict their rights, recognition and entitlements as workers (ILO 2005). It looks at the ayahs' emergence from their historical roots in colonial households, how they came to be employed in healthcare organisations with the growth of private healthcare in the context of the city of Siliguri, and analyses the findings pertaining to the organisation they work in and the nature and conditions of their work.

Private healthcare began flourishing since the onset of liberalisation in the 1990s, and it comes under the formal sector in India (Nandraj 1994, 2012; Bhat 1993, 1996, 1999; Baru 1998, 2000, 2003, 2006; Nanda and Baru 1994; Baru et al 2002; Khot and Nandraj 2003; Rao et al 2016; Rao 2012; Gill 2016; Nair 2011, 2012; Nair et al 2016). In the 1980s, it was dominated by small-bedded clinics/maternity homes of less than 10 beds (Bhat and Jain 2006). These institutions were self-owned or run on partnership basis by doctor-entrepreneur(s) in semi-urban and urban areas (Nanda and Baru 1994). Over the 1990s, the concept of super-speciality/multi-speciality hospitals gained importance in metropolitan cities (Jesani and Anantharam 1993; Bhat 1993, 1999; Yesudian 1994; Nanda and Baru 1994, 1998, 2003), spreading to peri-urban and non-metropolitan towns with support from municipal governments (Nanda and Baru 1994, 1998, 2003). The development was facilitated by a cheap labour pool from adjoining regions. Men and women from local as well as other states or districts come to work here, contributing to the pool of skilled, semi-skilled and unskilled workers. These small-bedded nursing homes underwent structural transformations into super-speciality and multi-speciality hospitals. As far as the health sector is concerned, workers in both private and government health organisations are seen to be suffering after adoption of marketisation in healthcare (Nandraj 1994, 2012; Bhat 1993; Nanda and Baru 1994; Baru 1998; Muraleedharan 1999). Workers in private healthcare constitute an unorganised and more significantly, unrecognised part of health workforce.

Their issues and concerns have not been addressed until in the recent past.[1] The Balaraman Committee Report (2012)[2] in the context of private health sector in Kerala even noted the prevalence of bonded labour alongside non-standardised pay and exploitation at various levels and degrees. The problems of underpayment, employment of underqualified employees, long working hours and worsening conditions of employment can be said to be getting compounded with change in structures of nursing homes from small-bedded doctor-owned to large-bedded corporate hospitals (Baru 2000).

In the context of India, ayahs and their work have appeared in a number of historical studies on colonial households, in reference to the employment of female care providers to the wives and children of colonial administrators (Chaudhuri 1994; Ray 2000; Gossman 2001; Divakaruni 2014; Conway 2016). In terms of the work and status, ayahs are identified with domestic workers. In West Bengal, the rise of female work participation in low-end informal service occupations was linked to the expulsion of women from agriculture, industrial work and the partition of Bengal (Banerjee 1985; Ray 2000). All these factors led to migration of women to cities in search of work. On the other hand, the fashion of employing domestic workers, a legacy left by colonial rulers, was progressively imbibed by the new Bengali middle-class urban residents (Ray 2000) and they employed these women as ayahs and maids in households. Alongside domestic work, there were other options in urban informal economy that became available to women, such as those in public services (Chakravarty and Chakravarty 2016). Ayah work in public institutions can be said to have emerged with the participation of women in wage work in healthcare and educational, community-led institutions. However, the absence of studies on ayahs makes it difficult to trace how the once domestically performed ayah work gradually transformed into wage employment option in public services for women. Nevertheless, the work and status of ayahs continue to be treated as synonymous to domestic servants working in private households (Chaudhuri 1994). While there have been a few studies that have tried to understand the role of ayahs as caregivers in domestic settings of households, there is a dearth of studies exploring their work as care providers in formal workplace settings and how they have contributed to the growth of healthcare organisations.

The National Sample Survey Office (NSSO) highlights how ayahs presently form a significant section of healthcare workforce, and their numbers have been consistently rising over various rounds of the NSSO (Table 1). While the National Classification of Occupations (NCO) makes the differentiation in the categories of ayahs based on workplace, whether domestic or institutional, the differentiation is not essentially reflected in the data, as observed over the various rounds. Nevertheless, as the nature of work and role of ayahs identifies with caring as the main type of activity, it would not be an exaggeration to state that while the percentage of professional nurses have always remained low compared to the nursing attendants and aides, ayahs have been the important providers of care in both domestic as well as institutional spaces. Among the three groups, ayahs are the most dominant, and their percentage increase over the years has been significantly high (Table 1). The percentages of ayahs have risen from 15.9% to 64.7% in the 55th to 68th rounds. Professional nurses have increased from 0.13 to 3 over the 55th to 68th rounds. The increasing importance of ayahs vis-à-vis other categories of nursing workers reveals how they comprise an important group of care providers.

Table 1: Percentage of Ayahs and Nurses in India

	55th Round		61st Round		66th Round		68th Round	
	Percentage of Health Workforce	Percentage of Service Employment	Percentage of Health Workforce	Percentage of Service Employment	Percentage of Health Workforce	Percentage of Service Employment	Percentage of Health Workforce	Percentage of Service Employment
Ayah	15.97	0.16	17.92	.49	56.78	1.27	64.7	1.21
P Nurse	0.13	0.12	10.11	.28	6.08	0.14	3	0.10
Nurse attendant and aides	10.47	0.04	13.84	.38	15.34	0.34	23	0.43

The NCO classifies nurses into two categories. Professional nurses include the group of general, industrial, specialist and professional nurses. The nurse attendant and aides include a miscellaneous group of nursing attendants, aides, masseurs and other workers. Ayah includes those working in domestic and institutional workspaces.
Source: Extracted by the author from various rounds of the NSSO.

Ayahs in Private Healthcare Organisations in Siliguri

Siliguri, located in West Bengal, has served as a hub of healthcare facilities to the entire north-eastern India. Like other non-metropolitan cities in India, Siliguri has been witnessing an expansion of primary and secondary healthcare organisations (Baru 1998, 2000, 2003, 2006; Nanda and Baru 1994;

Baru et al 2002). Limited progress in state-assisted healthcare led to the emergence of privately managed and financed, doctor-owned, maternity services providing small-bedded[3] nursing homes. The doctor-entrepreneurs, comprising "management," used their own human and financial resources to set up the nursing homes. Various categories of workers were employed for assisting in care and cure tasks. These services were provided by women who found that work as ayahs was an emerging employment option in the urban economy. Ayahs played a major role in setting up of the nursing homes, and their services were important determinants of quality care supply to patients. Since the early 1990s, the development of private healthcare facilities received a further boost with the arrival of technology in investigation and diagnostics, creating a large medical market across northern Bengal.

Gradually, corporate entities made their appearance in Siliguri's healthcare market, leading to the opening of super-speciality and multi-speciality hospitals. Nursing homes began adopting corporate structures. Over the last 15 years, several nursing homes are seen to be transforming into limited companies through mergers or acquisitions by corporate healthcare chains. The transformation is occurring along with large-scale investments in the laboratory, operation theatre, logistics management, and so forth. However, this restructuring of private healthcare organisations as corporate service providers did not accompany changes in workers' compositions, especially the care workers. Labour relations continued to be highly informal with the presence of migrant semi-skilled and unskilled workers. Primary information from field data has revealed that nearly 80% of the total combined clinical and non-clinical staff comprise female care providers including ayahs.

Sixty-three ayahs from six nursing homes and super-speciality hospitals were qualitatively interviewed on their work, employment relations in corporatising work cultures and their changing work relations since the transformation of the nursing homes to super-speciality hospitals. Visits to their rest rooms and changing rooms were made to understand their rights, safety and dignity at the workplace. To protect the identity of participants in the study, their names and workplaces have been changed. Among the 63 ayahs, 54% women belong to middle and senior age groups (41–60 years). Another 21% are above 61 years of age. The percentage of young women of less than 30 years is found to be significantly less. Most of these young women are daughters or daughters-in-law of existing or retired ayahs. Of these, 70% have studied either till primary level or upper-primary level. Ethnicity of the ayahs reveals mostly the presence of Bengalis[4] (89%) and a few Biharis[5] (10%). The caste distribution shows general and Scheduled Caste (SC) categories (41% each). A majority of the ayahs are widowed (49%), 38% have studied till the primary level, while another 33% have studied till upper-primary level. Again, 30% workers have migrated from Bangladesh and settled in and around Siliguri, and 6% have arrived from the southern districts of West Bengal (Nadia, Birbhum or even Kolkata). Rural and urban districts, including Jalpaiguri, Cooch Behar, Alipurduar and Malda contribute 15.8%, while Bihar and Assam contribute 6.3% each. However, 33% reported themselves as locals.

Work Organisations, Work Profiles and Income

Ayahs are placed among the lowest in the hierarchy of care workers in nursing homes and corporate hospitals (Basu 2019). Above them are various categories of nurses: trainees, juniors, semi-senior nurses, senior nurses, matron/nursing intendent. The ayahs share similar work responsibilities with trainees and junior nurses and most of them are concerned with direct caring for the patient. Nevertheless, as trainees and juniors are within the hierarchical structure, it reflects their status as employees of the organisation, which is not the case with ayahs. Irrespective of whether the work takes place in public hospitals or in nursing homes, ayahs work on casual/temporary basis as users of the premises of hospitals for drawing livelihoods and are not recognised as employees.

Their ambiguous status is further complicated by the presence of multiple stakeholders that include management on the one hand and the patients' families on the other. Ayahs' wages are fixed by the management, but paid by patients' families. Currently, the wage varies from ₹150 to ₹170 daily across nursing homes. The exceptions are two super-speciality hospitals. In one of them, ayahs in the women's ward get a monthly wage of ₹3,200, and in the other, they are paid ₹200 "per duty." The organisation does not pay wages or provide social security to ayahs. Although most of them have been working over a considerable time period, they have no written documentation or proof of their work period. Ayahs' workspaces mainly consist of the wards or private cabins—male and female; general, maternity and surgical. They are sometimes required to work even in the operation theatres.

The nature and characteristics of this work suffer from the lack of uniformity across workplaces. The work of the 63 workers in the sample is divided into separate batches of day and night of 12 hours duration each. Duties are taken on a day-to-day basis with little certainty of getting the same work next day. Their work is structured through the nurses as well as lower management staff. In the 12-hour stretch, there is a 10 minutes lunch/dinner/toilet break. The terms of employment and wage structures vary even within the organisation where ayahs are divided into "old" and "new" (contract) workers. The old workers are required to regularly report to work and are entitled to a wage rate of ₹200 against 12 hourly duties. These ayahs were engaged by the organisation over a long period of time, and when the organisation underwent restructuring in 2007, they were retained as regular workers and were called for duty on a regular basis.

However, the restructuring also entailed a demand for large number of ayahs. This demand was fulfilled by contracting ayahs through an agent, who was also an employee of the hospital. The ayahs under the contractual system earn ₹175, and ₹25 is deducted by the agent as his commission. In another super-speciality hospital, post restructuring, the management has abolished the posts of ayahs. The work is presently performed by "ward ladies" as regular wage workers in the organisation.

They have eight-hour day duties and 12-hour night duties, twice a week. The maximum educational qualification has been capped at Class 8. The 16 to 18 ward ladies are entitled to four rest days a month and two days of paid leave per year. Notably, the hourly wage rate in the case of ayahs working in super-speciality hospitals is slightly higher compared to nursing homes (in the range of ₹14 to ₹17 compared to ₹12.50 in nursing homes). Nevertheless, the higher hourly wage rate is accompanied by the rise in the intensity of work in super-speciality hospitals compared to nursing homes.

Not just the terms of work, but also the number of duties performed per month reflects a considerable variation. It depends on the capacity of workers to manage duties, and it also partly depends on the age and health conditions. As most ayahs are around 41 years and above, the number of 12-hour duties they can do is limited by the age factor. Thirty percent workers manage to do seven to 19 days work in a month. These include cases of four workers who work for less than 10 days per month due to old age coupled with ill-health. Forty-seven percent get work for 20 to 25 days per month. Eleven percent workers get work for 26–28 days per month, while five workers work for all 30 days.

Relations at Work and Its Transformation

Most of the workers got work through their co-workers; this includes those whose mothers were working, and subsequently, the daughters took up the work. However, nearly 40% self-approached the nursing home for work. The role and importance of social networks has changed over time. During the inception of the hospital, doctor-entrepreneurs were in need of a steady stream of workers; workers easily got work by approaching the doctor-entrepreneurs at the nursing homes. Gradually, references (through existing workers or even ward counsellors) began playing an important role, and workers without any known contacts are seldom kept at work. Years of work indicate the amount of experience and extent of association of workers with their workplace. Fourteen percent workers are working for less than 10 years in their current workplace. Twenty-four percent of workers have been working for 11 to 20 years, and another 22% are working for over 21 to 30 years. Interestingly, for about 24% workers, total years of employment in ayah work range between 31 and 40 years, while two workers reported having worked for over 50 years in the nursing home. This includes senior ayahs of over 55 years of age who had entered work in their early 20s.

The monthly income for about 26% ayahs is less than ₹3,000 per month. These mainly include the senior ayahs of over 60 years of age who can work for lesser number of days. Thirty-two percent workers' monthly income ranges between ₹3,000 and ₹4,000, while another 33% workers' income ranges between ₹4,000 and ₹5,700. This total monthly income is inclusive of extra income from double duties or tips as well as from secondary sources. Interestingly, 34 ayahs recorded themselves as single-income earners. It includes those whose children were not able to support themselves either because they were young and had not begun earning, or even if they earn, they cannot support their mothers. Only four ayahs of the 63 ayahs said they have secondary sources of income, which include running *kirana* shops (grocery) or selling imitation jewellery. Incomes from tips/bonus/overtime/double duty are mostly intermittent and vary between ₹201 and ₹400 per month for 44% of the workers. However, another 41% earn between ₹401 and above. Nevertheless, all of the sample of 63 ayahs take goods on credit to run their households, thereby indicating insufficiency of incomes to cover daily expenses.

The relations between the management and ayahs started with recruiting women who approached doctor-entrepreneurs at the time of setting up the nursing home. The nature of dominance however changed over the phase of transformation of nursing homes to super-speciality hospitals. Earlier, there was mutual dependence, recognised by both doctors and ayahs. According to Kanan (65 years), ayahs shared a relation of mutual respect with doctors from whom they learnt various kinds of work associated with caring and even curing, across operation theatres and wards. She says:

> working with doctors, we learnt all type of work—dressing wounds, administering saline, patient care, including how the bed has to be arranged. Some doctors mandatorily wanted us in the OT. Seeing our expertise, some of us were offered to rise as nurses … considering experiences, many of us have more skills than nurses. Doctors trust us more in the workplace.

Ayahs considered the doctor-entrepreneurs as their father-figures who gave them a source of livelihood, which helped them to overcome poverty and starvation. However, this paternalistic relationship has undergone changes after hierarchies have become more important for managing the various categories of workers. The nature of domination changed its form from direct to being mediated by other actors, such as senior nurses, matron and the contractor. Ayahs lost their position of closeness with doctors, leading to a rise in the feelings of alienation.

Some of the ayahs, after working over a period of time were offered to be upgraded by the doctor-entrepreneurs. A few among them accepted the offer and are now working as senior nurses or ward in-charges. This upgradation was not offered to all ayahs, neither did all ayahs who were offered this upgradation accept it. According to some of the ayahs, while on the one hand, upgrading from ayah to nurse did signify recognition of skill of the worker, on the other hand, it was mainly done with the motive of bringing the workers under the management's control. Those who wished to continue to work as ayahs, narrated how the organisation has been steadily devaluing their skills and work. Noyona, aged 55 years, says,

> we are not permitted to give medicines … we have experience, many of us are working alongside nurses who have similar years of experience and are without formally acquired skills, training or qualification. They are senior nurses with higher respect and salaries. But as ayahs, we are not even recognised as workers.

Ayahs also have their own perception about their status in the work hierarchy and efficiency at work. Kanan considers efficiency more important in this job than her position. Although she is not given recognition as a worker, Kanan does not hesitate to do the tasks that are beyond her immediate obligations. This attitude has made the doctors dependent on such senior ayahs. Ayahs' expanded roles and functions are outlined by Sima (60 years) who observes,

our roles and functions still continue to extend from wards to OT, as it was in the past, especially at the pre- and post-operative care stages.

However, according to both Kanan and Sima, only those who have been working since the inception of the nursing home are allowed to enter the operation theatre and work with the doctors, because of the trust factor. Although senior ayahs' roles continue to expand across workspaces, the mobility from ayah to nurse is no longer allowed. Maintenance of hierarchies is considered to be of utmost importance in a bureaucratic set-up. However, hierarchies also have little connection with the skill or efficiency of the worker. The position of workers in the hierarchy is not always determined on the basis of their qualifications or skills. Entry-level trainee nurses are higher in the hierarchy due to educational qualifications, but they cannot match the skill levels of the experienced ones.

According to Arati (55 years), till the mid-1990s, there used to be a register with the names of the ayahs, but which they did not sign. With time, even this little documentation was withdrawn. Abuses from doctors and management have now become very common. Ayahs say they are constantly referred to as "thieves," "dogs and cats," and "unwanted." They are continuously reminded of their subordinate status in the establishment and in the labour market as a whole, through statements such as "you are eligible for domestic work only." Ayah Lily says, "the management frequently tells us, 'you are nobody to us, you do not belong to us.'" Senior nurses now check their work, and they are required to consult and inform the nurses about each and every detail concerning the patient.

The employment relations between ayahs and the management are marked by ambiguity and direct and indirect controls on income, skill formation and even mobilities, and there is an attempt to discipline, monitor and control their movements. These are visible in the way management controls wage payments, double duties, or access to basic amenities, such as rest rooms, food, drinking water or toilets. The presence of multiple cadres of nurses indicates how ayahs are subjected to control by nurses, and even the trainees subjugate the ayahs. Despite the ayahs' existence since the inception of nursing homes, they are not considered a part of the organisation; whereas trainees with less than a year's presence in the nursing homes are accorded the status of employees. Managements' attitude represents the easy disposability and replaceability of ayahs with trainees, even without the need for compensation or alternative livelihood arrangements. Thus, many of the nursing homes are in the process of abolishing the posts of ayahs, appointing trainees to take over their work, restructuring the care hierarchy, or outsourcing the ayahs through a contract system in super-speciality hospitals.

In all of these attitudes and strategies, the management's aim is to distance and alienate ayahs from the workplaces. The ayahs suffer from various strategies of subjugation, alienation and domination arising from the gendered nature of care work, class power, or even the stigma attached to ayah work, that it is dirty and constitutes no real work. The management infuses a feeling that ayahs have been able to survive because the management has allowed them to work in the premises, and therefore, ayahs need to have a sense of allegiance to the organisation, beyond rights or demands as workers. When ayahs at two nursing homes joined a Centre of Indian Trade Unions (CITU)-led[6] union 15 years ago, to resist arbitrary dismissals, sudden work stoppages, low wages and ill-treatment and raise their voice against the harassments and malpractices of the management, their relations with the management progressively deteriorated.

Conclusions

The article is based on a microanalysis of the work and employment relations of ayahs as a feminised work, broadly exploring problems that these workers face in institutional work settings. Ayah work had emerged as a job option in Siliguri with the setting up of nursing homes and clinics, and local women considered ayah work over domestic work since it meant daily in-hand cash. Ayahs constitute a distinct class of workers whose labour power consists of the acquired tacit skills of caring and empathy. Recruitment of workers has followed an informalised process. Previously, one got work by simply approaching the doctor-entrepreneurs, which began to be replaced by the reference system. But, it reflected no requirements for documenting the presence of ayahs. It indicates the prevalence of a system where getting work is determined by word of mouth, and a worker has to maintain fair relations with the management to keep her work. Ayah work provides an important livelihood option for mainly older widowed women. Nevertheless, the presence of middle-aged women implies that ayah work is not altogether withering away. A significant section among them are from the working-age group whose mobility to alternative jobs is restricted because they have not been able to either save money for business or enhance the skills required for other jobs. This implies that in the event of eradication, they may completely lose livelihood, sending families into spirals of poverty and destitution. The lack of dignity, limited entry options and gradual withdrawal of service from the health-care institutions are factors inhibiting young women from joining this occupation.

Age is also one category of discrimination and alienation being used by the management. However, they cannot stop working as they are not under any social protection cover.

Ayahs represent a section of paid care workers in public services, and the challenges they face at the workplace embody many of the challenges faced by women workers as a whole, not limited to only those working in informal sectors (ILO 2018b). Care workers working in both institutional and home settings are found to suffer due to very low pay across developed and developing countries (ILO 2018a). As an employment option, it is necessary to understand whether ayah work protects workers against poverty. The wages that ayahs obtain can be analysed from the point of prevailing daily average wages. ILO (2018b) notes that the average daily income in India for all types of workers (self-employed/wage worker) in 2011–12 was about ₹247 per day. The labour department, Government of West Bengal, has made a minimum wage criterion for various levels of skilled, semi-skilled and unskilled hospital employees[7] and revises it twice in a year. Interestingly, ayahs have also been classified under the category of workers. However, on the policy front, there is a disjunction between work

categorisation and status of ayahs in the nursing homes and that which is given by the state. Ayahs are categorised as unskilled and semi-skilled workers and are recognised as employees, who are covered by minimum wage stipulations. Private healthcare organisations, on the other hand, do not implement the stipulations.

One of the problems concerning care workers is the lack of recognition of the skills and experiences garnered during work by the organisation as well as by the general people. Ayahs share a tripartite relation at the workplace, with two important stakeholders, namely, the organisation and the patient's family, which gives the ayahs an ambiguous identity at workplace. Although both management and the patient gains from their services, the organisation keeps itself outside any employment relationship with the ayahs. In the patriarchal-paternalist relation with the management, although the services are utilised, there is no obligation to recognise ayahs' contributions in building the institution.

NOTES

1 In a writ petition in 2011, by Trained Nurses Association of India, the issues of nurses and their working conditions in private nursing homes and hospitals across the country was brought up. The honourable Supreme Court recognised the deplorable situations of nurses in private sector and ordered the formation of a committee within four months from 29 January 2016, to submit a report on the working conditions of nurses and their pay structures, https://indiankanoon.org/doc/189389715.

2 Unpublished report Committee for studying the problems being faced by nurses in private hospitals of Kerala, chaired by S Balaraman in 2012.

3 Following Baru's (2000) study, less than 30 bed size are classified as nursing home.

4 The most dominant among the respondents, Bengalis include the people speaking the language of "bangla." They are both locals (Siliguri) and migrated from neighbouring towns, districts as well as from the neighbouring country of Bangladesh.

5 Biharis refer to primarily who hail from Bihar, a northern state of India and neighbouring state of West Bengal.

6 CITU (Centre of Indian Trade Unions) is aligned to the leftist ideology of the Communist Party of India (Marxist) and has been effectively mobilising the working class in West Bengal.

7 https://www.peoplestrong.com/wp-content/uploads/2016/05/West-Bengal-Minimum-Wages-Notification-NursingHome-Dated-5th-jan-2016.pdf.

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