(205)

'Migrants'and 'Medical Refugees': A short report **draft for discussion**

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'What is the "catchment" area of your hospital?' The well-meaning person from the funding agency asked. I responded with our oft-quoted figure of people from over 1500 villages coming to us for healthcare, including many from the adjoining parts of Madhya Pradesh. But what I did not tell him then were the life experiences of some people from these villages, in an era where all aspects of rural life seem to be in a crisis. As the harvest season of the single rain-fed crop draws to a close and no other employment is in sight, an annual exodus begins, all too visible at bus stops, railway platforms, and in the general compartments of trains bound for Delhi, Punjab, Gujarat, Bihar, and U.P. The 'migration', which according to some administrators the people of these parts are 'habituated' to, has begun. And as the monsoons draw closer, the return journey home begins. For many, however, the work so far away is interrupted by what is unexpected for the well to do, but always close at hand for the poor— illness; and again more often for only the poor—a serious illness.

A person blinded while making India Shine

This is one patient that I am unlikely to forget, even hardened as I am by the exposure, day after day, to a level of deprivation and misery that has parallels only in the mid-nineteenth century descriptions of Dickens' England. The OPD was closing as a man came in carrying in his arms one of the thinnest women I have ever seen, and lay her down on the bed. They had come straight from Delhi, he said—from Gurgaon, one of the symbols of India Shining, where they lived on the construction site of a shopping complex. Geeta had become unwell only two weeks earlier, when she developed a boil around the nose. Within a span of 2-3 days this spread to involve both the eyes, which became swollen, and then later to the right leg. In a matter of days she lost sight in both eyes. They had sought therapy from a local doctor, and in the process spent their entire savings (about Rs. 3500), which had been accumulated over many months of labor. They realized then that there was just enough money left to go back home. Geeta weighed 22 kg at around 30 years of age, her right eye had been reduced to a mess, and the left eye was opaque but recognizable. Her right leg had a large abscess. Given her state of nutrition, a simple bacterial infection had spread extensively, causing so much damage. What was completely unsettling for us was her composure as she lay, without a murmur of complaint, responding to any questions with a calm, " I am better", in a situation which would have driven any other person insane. Geeta's right eye had to be enucleated at the Medical College Hospital in Bilaspur.

The couple was from a village about 10 km away, and this had been their first experience as migrant labourers. The husband later told us that she had been carrying loads of about 25 kg on her head till a few days before her illness, that she had been earning Rs. 50 per day. It had been difficult to get leave to get her treated properly. Not that they knew where to go, anyway. . . .

Working for the Army, till the very end....

Ajit staggered into the OPD, in a disheveled state, gasping for breath, his face completely pale, his feet swollen with edema, the neck veins engorged in a tell-tale sign of heart failure. He had come back home just a few days ago, and a lower respiratory infection had made matters worse. He had come from Chinta, a town 150 km from Jammu, where he and his brother had been involved in constructing homes for the army, earning Rs. 75 per day. He had rheumatic heart disease (a form of heart disease that damages the cardiac valves, and is especially common among the poor), and a hemoglobin of only 6 gm/100 ml, yet he denied having any symptoms for a long time. It was inconceivable for me how he could have worked with heart disease as well as anemia of that severity. There was a local hospital in his place of work, but that

was only for army men, not for the likes of Ajit. He had to come back home, nearly two thousand km and many days of travel away, for treatment.
He had to be referred to the local Medical College for admission in the ICU, where he later died . . . . . at the age of 21 years, leaving a young widow and a child behind.

A story from Maharashtra which ended well....
Meerabai worked at a construction site in Aundh (Pune), where she and her husband had been going for the past three years, leaving their children in the care of grandparents. She developed a cough and fever, lost weight, and spat out a small amount of blood one day. Alarmed, they went to a clinic in Aundh where an x-ray was taken and tuberculosis was diagnosed. The very next day, she coaxed her husband to accompany her back home. Her sister had been treated by us for TB successfully, so she too came to us for treatment. I tried to suggest that I could give her a letter of referral to the local Medical College. But she would have none of it, and went back only after completing her course of anti-tubercular treatment.

And one closer home which didn't.....
Shravan hails from a village 40 km from our centre, but had been living and working for the past six years in Satna (MP) with his father. Ten months ago, he developed symptoms of tuberculosis. Instead of going to quacks or private practitioners like many other people, he visited the government hospital where he was diagnosed as having sputum smear-positive tuberculosis. His could have been one of the success stories of the RNTCP. But they lacked a ration card, and hence proof of local residence, so the district TB officer did not register him under DOTS. (I was told by the DDG (TB) Dr. L.S. Chauhan, when I narrated this case study in a presentation, that the card was not really required). He was advised to go back to his village in Bilaspur district and register at the nearest treatment centre. The same doctor, however, had no problems in calling Shravan over to his private clinic and writing a prescription which cost him Rs. 1800. Within the very first month, this exhausted all their resources, and it was hardly surprising then that he discontinued the treatment, bought drugs only once more for a few weeks, and then did nothing... Six months later, when the disease progressed, he finally came back to his village. Despite a few visits, the local CHC failed to provide him with TB treatment. He then came to us, every inch of his lungs affected with the disease. He was started on treatment, but a few weeks later he did not turn up on the appointed date. Our field coordinator made a home visit, during which his father related tearfully that Shravan had become very depressed, left home without notice one day, and was still missing.

This is the zero sum game being played out in the lives of thousands of poor 'migrants'. Chhattisgarhi men and women often go to work in brick kilns which are predominantly rural or peri-urban in location. They get paid about Rs. 150 for preparing 1000 bricks, and live largely confined to these kilns. They get some payment up front which goes towards settling previous debts. For much of the duration of their stay they receive a subsistence dole for buying food, and then a lump-sum payment of dues at the end in which many get cheated. Life at construction sites is no better. One of our patients went to Delhi when his brother died from a fall while working for a construction company. The compensation to the family was a mere Rs. 1000. Who would have registered a case against the company, and what could this man have done? He had no alternative but to return with his brother's widow.

Issues such as children's education come second to the issue of survival. Another generation is destined, then, to live in poverty, but will perhaps wage its own struggles when the time comes.

These migrant workers are involved in the enterprise of 'Bharat Nirman', but are truly stateless individuals, absent from their states of origin and not recognized officially by their states of temporary residence. The notion of citizenship and its entitlements, especially for the poor, is confined to whatever social services a BPL card can confer—be it lower cost food, healthcare, or even a house or toilet. . But what of the poor Chhattisgarhi who is fortunate enough to have a BPL card, but works in Delhi? He cannot access lower-cost food but will buy rice at what will seem to him an astronomical price in the local market. We have discovered that for many, the possibility of getting this magically enabling card disappears due to the migration itself. It has been the experience of a large number of people that when the last poverty survey was conducted, they were away in another state.

If accessing food is a problem, accessing healthcare is even more difficult. I feel that there is nothing more miserable in this world than to be poor and ill—and realize that to 'purchase' healthcare and thereby buy back your 'health' is beyond your reach. And what if you are poor and ill and away from home? Your knowledge of the local area is often scanty. The BPL card, which can provide access to healthcare at public health facilities, again has a limited statewide currency. People invariably go to quacks or private doctors, and lose a large portion of their resources by spending on irrational therapy. They are unable to access or negotiate their healthcare needs in the alien and forbidding environments of the local medical colleges, and they are hardly the stuff 'medical tourists' are made of. Rather, they are 'medical refugees' who often head back home in desperation, although eventually even that may not assure proper healthcare.

Migrants are not only not anybody's concern, they are often unpopular in public health terms. They push down public health indicators and are often seen as one of the pools and vectors of many communicable diseases. Delhi has apparently failed to eradicate leprosy because many of the patients are 'migrants' from other states. When there was an outbreak of falciparum malaria in Vellore a decade ago involving predominantly migrant workers, the contractors sent the affected workers back with unseemly hurry. The linkage in the public mind between migrants and HIV disease is now common, even if HIV is now an indigenous infection all over India. When the RNTCP programme in Bangalore showed default rates of 24% and 40% in a cohort of new and retreatment patients respectively, it was later discovered that these were largely poor migrants working in Bangalore who had gone back to their villages after developing the disease. This is a logical course of action for the patient but anathema for the programme, which could have anticipated this turn of events and arranged for a transfer of treating centres. In all these scenarios, a convenient label is stuck on people, and victims become villains...

I may have digressed from the theme of this meeting, which is the issue of forced displacement and health. Can these people be classified as 'internally displaced persons'? If one's migration is driven by hunger, is it voluntary? Can we not describe them as 'forced migrants' if a daily wage of Rs. 25 rupees and uncertain employment at home has forced the move ? There are people who are affected by 'development induced displacement', but what about those affected by a 'lack of development induced displacement'? Are victims of structural violence really different from those of ethnic or communal violence? Do they not suffer a destruction of their present and their future, their way of life, and their dignity? Are discussions of migrants' health not ultimately a matter of semantics, because in the final analysis it is only the poor who are invariably involved?

To some these case studies may seem as depicting extreme situations, but to many these would be situations they can relate to. Even people who are otherwise settled in a rural area have no assurance in terms of access to healthcare. Their numerous attempts to seek a solution to their problems – with the village quack, the private doctor, the public health system in the rural areas, and ultimately with our medical colleges, or even AIIMS (while squatting on the pavements outside them) are the actions of 'medical refugees'. The neat boundaries of states on our country's map mean little to those whose lives do not follow a neat pattern, and whose movements across boundaries do not register on the maps of our healthcare system and public health programmes.

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