COMMENT

Migrants and medical refugees: a short report

ANURAG BHARGAVA

Jan Swasthya Sahyog, village and P.O. Ganiyari, District Bilaspur, 495 112 , Chhattisgarh INDIA email: anuragb17@gmail.com

"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 1,500 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 that is all too visible at bus stops, railway platforms, and in the general compartments of trains bound for Delhi, Punjab, Gujarat, Bihar and Uttar Pradesh. The migration, to which according to some administrators the people of these parts are habituated, 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 very often, a serious illness.

A person blinded while making India shine

This is one patient that I am unlikely to forget, even case-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 out-patient department 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 her nose. Within a span of two or three days this spread to involve both her eyes, which became swollen, and then later to her right leg. In a matter of days she lost sight in both eyes. The couple had sought therapy from a local doctor and in the process they spent their entire savings (about Rs 3,500) which had been accumulated over many months of labour. They realised 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 recognisable. 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 wrought with anxiety. 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, knowing little about where to go for treatment.

Working for the army till the very end

Ajit staggered into the OPD in a dishevelled state, gasping for breath, his face completely pale, his feet swollen with oedema, the neck veins engorged in a tell-tale sign of heart failure. He had come back home just a few days earlier 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 haemoglobin 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 anaemia 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 2,000 km and many days of travel away, for treatment.

He had to be referred to the local medical college for admission in the intensive care unit, 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 to home which did not

Shravan hailed from a village 40 km from our centre, but had been living and working for the past six years in Satna (Madhya Pradesh) with his father. Ten months earlier, 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 Revised National TB Control Programme (RNTCP). But they lacked a ration card and, hence, proof of local residence so the district TB officer did not register him under the Directly Observed Treatment Strategy programme. (I was later told by Dr L S Chauhan, the deputy director general, TB division, when I narrated this case study in a presentation, that the card was not really required.) Shravan was advised by the district TB officer 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 him over to his private clinic and writing a prescription which cost him Rs 1,800. 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 community health centre 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 a day for preparing 1,000 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 1,000. 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 nation building. But they are truly stateless individuals–absent from their states of origin and not recognised 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 "below the poverty" line (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 get access to cheaper 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 getting food is a problem, getting healthcare is even more difficult. I feel that there is nothing more miserable in this world than to be poor and ill-and realise 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 state-wide 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 negotiate their healthcare needs in the alien and forbidding environments of the local medical colleges, and they are hardly the stuff of which medical tourists are made. 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 actually 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 failed to eliminate leprosy as a public health problem–apparently 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 in Bangalore showed default rates of 25% and 45% in a cohort of new and re-treated patients respectively, it was later discovered that many of these were largely poor migrants working in Bangalore who had gone back to their villages after developing the disease (1,2). This is a logical course of action for the patient but an 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.

People, even if poor, who migrate for reasons of livelihood are usually viewed as voluntary migrants rather than, for example, those displaced by dams, mining, or political or ethnic unrest. 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 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 the impact of displacement or various kinds and 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 are situations to which they can relate. Apart from those who migrate, even people who are otherwise settled in a rural area (and we have about 720 million such people in India) have no assurance in terms of access to healthcare. They seek often in vain, and often at the cost of forfeiting their future with debts, a solution to their health problems -- with the village quack, the private doctor, the public health system in the rural areas or, ultimately, our medical colleges. These actions, sometimes referred derisively as "doctor shopping", are really the actions of medical refugees. The crowds seen within those of our hospitals which do function, or seen squatting outside even the All India Institute of Medical Sciences, are made up of migrants and medical refugees–people at a loss where to turn. 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.

(The names of the persons have been changed to protect their identity)

Acknowledgements: *This paper was first presented in a draft form at the 34th Annual meet of the Medico Friends Circle which was held at the campus of the Action North-East Trust in village Rowmari, district Chirang, Assam in January 2009. The theme of the meet, was "Forced Displacement and Health". Many thanks to Yogesh Jain for numerous discussions on such issues. My thanks also to my fellow voluntary migrants in Chhattisgarh -- my wife Madhavi and my friends Madhuri and Biswaroop Chatterjee, Rachna Jain, Anju and Raman Kataria, Ramani Atkuri and Ravi D'souza. I have reported what has been our common experience.*

References

1. Vijay S, Balasangameshwara VH, Jagannatha PS, Saroja VN, Kumar P. Defaults among tuberculosis patients treated under DOTS in Bangalore city: a search for solution. *Indian J Tuberc.* 2003;50:185-95.
2. Jaggarajamma K, Muniyandi M, Chandrasekaran V, Sudha G, Thomas A, Gopi PG, Santha T. Is migration a factor leading to default under RNTCP? *Indian J Tuberc.* 2006; 53:33-36.v