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# HEALTH OF MIGRANT WORKERS: A STUDY AT WORKER'S PLACE OF ORIGIN IN RURAL BIHAR

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ABSTRACT

The paper aims at understanding health of migrant workers at their place of origin in Bihar (India). Migration is a social reality in which push and pull factors are the major determinants. In case of rural Bihar push factors are instrumental in large scale migration of workers. The research literature on Bihar suggests that lowest socio-economic indicators and high population density are primary reasons of the push enabled migration. This research among workers of scheduled caste found them at a double edged road. They are already characterised by weaker institutional framework, and when they migrate for work, they get uprooted from the existing set up at place of origin and simultaneously do not find space in the institutional setup at place of destination. This creates a situation where their behavioural patterns become vulnerable to the extent that it severely affects their health status and health seeking behaviour. They unknowingly brought back infections with them and infected their family. The research found migrant workers getting exposed to communicable diseases, and many among them faced terminal diseases along with their family. Most such workers have poor or no access to public health utilities and such health crisis marginalise them further.

KEYWORDS: *migration, unskilled workers, health experience, Bihar, Tuberculosis, HIV-AIDS.*

## INTRODUCTION

Migration is a social reality as people world over have been migrating for socio-economic and political reasons. This can be categorised under push and pull factors. Sociological studies of migration are diverse and usually form part of larger problems in research into kinship, social networks, development, etc. Push factors are usually viewed as inducing migration of a conservative, security-maximizing nature; while the pull factors are dependent on economic expansion in the host country or region, and they encourage risk-taking and income-maximizing migration . Movement of people between countries is distinguished as external or international migration, while between regions is known as internal migration.

The recent decadal census in India counted one third population as migrants, who lived at

places other than their place of birth at the time of enumeration. A significant number among them migrated for work. This study focuses on health of internal migrant workers from Bihar to other states in India. Bihar is the second most populous state in India characterized by highest population density and lowest socio-economic indicators (Kumar & Raj 2013). This created a strong push factor resulting into distress migration. The research found that almost all who migrated in search of work are young male population, who went on seasonal migration to support their families back home. Most that migrated were not-literate, and therefore, they joined the sea of unskilled manual workforce in the states having high demand of such workers. This offered them better remuneration as compared with what they received at their native places in Bihar; hence resulting into a chain migration through networks of their caste and kinship, what Granovetter (1993) says "strength of weak ties." This push enabled migration from Bihar got reflected at national level where it contributed second largest number of total out-migrants, highest net-migration, highest not literate migration as well as highest seasonal male migration rates (GOI 2010).

This paper is based on our field study among male migrant workers from a rural block in Bihar. We engaged with these workers upon their return to place of origin. During engagement with them, we came to know that many faced illness during course of migration, and some suffered severe or terminal diseases. All migrated as single when they were adolescents and physically fit. Their condition started changing at place of destination when they experienced changes in their living conditions, food habits, cultural contexts and the people who they interacted with. The situation interested us to understand their health experiences and health seeking behaviour during course of their migration and its consequences when they returned back to the place of origin.

## FIELD AND THE FIELD WORK

The study area is primarily agricultural and has four times higher population density than the national average. Major population of the region is of intermediary and scheduled castes, who had little or no land ownership till British rule prevailed and upper caste landlords ruled over them. The situation saw some changes in independent India when ownership over land was transferred to tillers in many cases, and intermediary castes benefited with it. The condition of scheduled castes did not see significant improvements. Though, the region is well connected to major rail and road networks of the country since colonial rule due to production of commercial cash crops. It lacked modern industrialization and has no major business activities. Now commercial crops were replaced by cereals and vegetable due to increasing population in the region, where status of scheduled castes remained mostly of manual cheap laborers. The rail and road network of the region connects it with many industrial towns and metropolitan cities in Northern and Eastern India directly, which has high demand of manual workers.

We randomly selected inter-state migrant workers in Dalsingsarai block of Bihar who had been working outside Bihar for five or more years. They visited home during festivals and special social occasions, i.e., three-four times a year for few weeks, and kept their spouse and children at home in supervision of parents or extended family. In field engagements we realised that incidence of communicable diseases, especially Tuberculosis (TB) and HIV-AIDS has been increasing in the region with increase in migration of workers. To probe this further, we conducted in-depth interviews with selected migrant workers to understand their health status before migration, and what changed at place of destination which brought changes in their health status and health seeking behavior. We learnt that workers returned home for treatment and care, when they were unable to afford its treatment at place of destination. In this paper we are presenting analysis of such cases studies where

workers faced severe and terminal health conditions during or after their migration tenure which affected their family life at the place of origin. Interestingly most of such workers who faced such a situation came from scheduled castes, a traditionally marginalized community. Name of respondents has been changed in the paper to protect their identity.

## CASE STUDIES

Case Study-1: Ad-hoc TB treatment during migration lead to multi-drug resistant (MDR) TB 39 years old Shyam belonged to a scheduled caste named "chamar". His family was relatively better off in comparison to his neighborhood, as his father was a teacher in a government school. Following tradition of the caste, Shyam was married when still an adolescent. After marriage he discontinued education to earn quick money. He joined a group of his friends who were heading to Punjab for work in 1993. He had been hearing that wage rate in Punjab was 4-5 times higher than what workers received in his village. From 2005 he started facing occasional cough and fever, but always trusted local chemists for medicine as that gave him quick relief and he continued working. Since beginning he smoked ganja (a type of marijuana) and also had hooch (local drinks) with peer. In 2010, while at work, he fell severely ill with cough, fever and occasional blood in sputum. In few weeks when situation did not improve, he returned home. He still did not prefer visiting public health facility, and continued depending on medicines from quacks and chemist shop.

This was the time when Shyam's financial condition was getting narrower after his father's retirement and then sudden death. When his Shyam's health deteriorated further he was taken to a private physician few miles away from his home, and there for the first time his sputum test was conducted which confirmed TB infection in lungs. The local community health worker helped him to join government sponsored directly observed treatment sub-system (DOTS) programme where free diagnosis and treatment of TB was available. In few weeks of treatment with DOTS Shyam's health condition improved, and he discontinued the medication thinking he was cured now. He went to Punjab without letting his DOTS provider knowing about him. In less than a year his TB symptoms resurfaced with severity, and he again came back home to join the government DOTS.

This time he was diagnosed with category-II TB and was prescribed DOTS for 8-9 months along with two months injection on alternate days. Despite continuing the treatment routinely this time his condition was not improving, and in a follow up test in next two months, he was a MDR TB patient. The ad-hoc treatment and ignorance about severity of TB made the situation worse for Shyam. Now the government provided MDR TB drugs were to continue for 24-27 months. A proper treatment of TB also required a good nutritional intake, as a weak body was not able to digest heavy doses of antibiotics. This was not possible for Shyam as he had six members in family to support. Against Shyam family tradition, his wife joined agricultural work with village farmers to help him run the family. This was still insufficient to support family's basic needs. He wanted to fight back and rebuild what he left due to illness and his negligence. MDR-TB medicines made initial improvement and he showed recovery, by in Dec-2013 his condition started worsening once again and he succumbed to his MDR TB in mid-2014.

Case Study-2: HIV-AIDS infection brought home by a migrant worker, unknowingly transmitted to spouse

In a routine field visit a community health worker found Kareena (26 years) coughing and upon enquiry learnt that she had fever too. The health worker suspected her for TB infection and referred her to the sub-divisional hospital in Dalsingsarai. Her diagnosis for TB was negative, but the compulsory HIV-AIDS test found her positive. The facilitator did not disclose HIV test result to Kareena, and

requested her to bring her husband for a check up as soon as possible. Ashraf (30 years) was working in Delhi, and on Kareena's request he came back home in few days and was brought to the hospital for HIV test. He too was found HIV-AIDS positive.

The couple were told about the test result, counselled and referred to the nearest antiretroviral therapy (ART) centre at Muzaffarpur, about 50 miles away. They were shattered knowing the test result but decided to follow the treatment advice. At the ART both were re-diagnosed and found positive and their ART medication started after counselling.

The couple belonged to a sub-caste named "dusadh" among scheduled castes. When we approached Ashraf for an interview along with his spouse, first he denied, but later agreed to meet without his spouse. He decided to meet us away from his house, as he did not want either Kareena or anyone else to know about the conversation as he feared this could lead to stigma and his social outcaste. Ashraf told us that he became a migrant worker when he was just 12 years old when his father passed away. To support his mother financially, he accompanied his cousins to Rajasthan for manual work. In few years he shifted to Mumbai, and finally chose Delhi's Azadpur vegetable wholesale market to work as a loader. He never wished to work close to home in Bihar, as wage rate in the region was substantially low in comparison with what he earned outside. During this period he came home only on important social occasions, and continued supporting his widow mother financially. During work in the vegetable wholesale market, Ashraf stayed in go-downs with co-workers and they occasionally hired sex workers who were easily available in the market, which had excessive presence of migrant workers. He also had alcohol with co-workers.

He was married with Kareena when he was 18 years of age, it was a match arranged by his mother at home. Now Ashraf visited home every few months and his wife and mother stayed at home. The couple had three children in the last 12 years and they lived with mother and grandmother at home. While enquiring about their three children's test for HIV, we learnt that Ashraf deliberately concealed information about children when health workers at ART center asked the couple about children. Ashraf was fearful that if children were brought to hospital, they may speak about it in neighbours, and eventually their health status could be known to everyone. He himself had heard about HIV-AIDS while working in Delhi. The children might be having HIV infection as Ashraf's sexual behaviour was vulnerable before he got married. The couple's ART treatment was continuing and we tried making them understand the risk their three children carried.

Case Study-3: Childhood friends brought home HIV-AIDS and TB infection from migration, transmitted to family

Amar (28 years) and his childhood friend Ramu (30 years) too belonged to the "dusadh" sub-caste among scheduled castes. They grew up together in same hamlet and went to same school.

Amar and Ramu's migration journey began together and their health experiences too had many commonalities. Both entered a profession of unskilled workers outside home simultaneously as they needed to support their families. As adolescents, they started working as cleaners in inter-state bound buses originating from Bihar and going to West-Bengal and Jharkhand. While on work, they spent most of their nights in their bus at depots in Kolkata and Ranchi. Having exposure to meet easily available sex workers at bus depots in night, they experienced sex life long before their marriage. Later they parted ways, Ramu continued working with long distance transport service and Amar went to Gujarat and Delhi for work.

Ramu married Ruhi few years later and when we met them, the couple had two young children, and Ruhi was expecting the third. Amar too got married in 2010 the couple had a year old child. We

could not meet his wife, as she deserted him few months ago when we met him.

Amar's last job was a car chauffeur when he fell ill seriously in early 2013. He had incessant coughing, occasional blood in sputum, weight loss, loss of appetite and fever in evening. These were signs of TB, and he knew them well. It was the second occasion when he faced these. He had these symptoms in 2011, with the help from a community health worker he was diagnosed with TB at sub-divisional hospital Dalsingsarai and was provided DOTS. He felt considerable improvement in health in two months, and then left the six months DOTS course abruptly without completing it. In a year's time, the A TB symptoms returned to Amar, and he came back home to resume the DOTS treatment. Now he was marked a category-II TB patient and in mandatory HIV test he was found HIV-AIDS positive. He was referred to nearest government ART centre some 40 miles away from his home. He could not go there alone due to weakness and lack of support in family. He weighed less than 30 kilogram. When his wife saw him in deteriorating health and with no visible chance of recovery, she deserted him and went back to her parents with her son, without either of them being tested for HIV.

Finally, his friend Ramu came forward to help, but with a condition of getting Rs. 5000/- in hand for the sake of treatment cost. This was an eyewash by Ramu, as all treatment at ART center was free of cost, only out of pocket expenditure in travel and food was borne by the patients. Unsuspecting Amar borrowed the amount from moneylender and gave it to Ramu, and this way Amar had his first visit to the ART center where Amar's test reconfirmed HIV-AIDS positive. He was given ART medicines for a month and was asked to come back for a follow up visit after consuming the ART and TB medicines.

After a month when Amar reminded Ramu for accompanying him again to the ART centre, Ramu stopped visiting him by saying that Rs. 5000/- was finished in last month's treatment and he would accompany to ART center only when he gets more money. After that Amar could not muster courage to ask for help in going to ART center again and left himself to fate due to fear of further debt. There was some improvement initially when ART and TB drugs both continued, but as ART stopped, he started deteriorating again. He weighed only 28 kg in May, 2013. Finally it resulted in Amar's untimely death at the age of 29 years in December 2013 when he was reduced to just 23 kg in weight. His family and community, who could not help him at the time of need in treatment, but they gathered for his last rights and community feast to put his ailing parents further in debt.

As we knew about friendship of Amar and Ramu, we approached Ramu and his wife Ruhi for an interview. After initial inhibitions the couple told us that they were too HIV-AIDS positive and were receiving ART treatment. They showed us their ART cards, and when enquired about their two young children's HIV test, we learnt that the couple did not disclose about having children when asked at ART center. This was surprising, the couple was careful about themselves; they were complete careless about possible HIV infection to their young children.

Ramu said he was physically well built until few years ago, then he started having irregular loose motion problem and despite medication from chemist shop, he was not getting much relief. At last he consulted a private physician, and there after a test the physician told him about HIV-AIDS infection. The physician advised Ramu to visit the ART centre soon with wife and children for a confirmatory test and treatment. The couple visited ART centre, but without their children as they feared social stigma. In diagnosis the couple were confirmed HIV-AIDS positive, and their ART started over six months ago when we met them for interview. Moreover, during the counselling the couple were advised against having next pregnancy, but despite that we learnt that Ruhi was four months pregnant with the third child. The couple did not bother to get checked their foetus's HIV status checked. Upon enquiry we learnt that Ramu was aware about the threat of HIV infection to his children, but he avoided their tests due to the fear of stigma. In December-2013 the couple had their 3rd child born at home with help from

traditional birth attendants. In all likelihood the third child too could be carrying HIV AIDS infection.

## Analysis

Most of the respondent migrant workers who faced life threatening diseases were from the scheduled caste, the most deprived strata of the society. Traditionally these castes were untouchables and had least access to mainstream society. Though in recent decades things started changing in their favor with respect to social justice when leaders from intermediary castes came to control the political space in the State, but the culture of poverty, lack of education and their socio-cultural behavioral patterns still keeps them backward as compared with the mainstream society.

As Gupta (2000 & 2004) displays beyond doubt that there is not a single caste hierarchy to which every caste acquiesces ideologically, rather there are as many hierarchies as there are castes in India. He adds that implementation of hierarchy depends more on political power than the ideological acquiescence. Taking an analogy from what Gupta said, it helps to understand the situation with migrant workers. When a migrant worker get disconnected to the social institutions at his place of origin, he fails to get associated to similar institutions at the place of destination as socio-political dynamics and hierarchies change all together. The workers have a complete alienation feeling while trying to adjust with those institutions, and they are often left outside it.

There is a commonality in the pattern of cases of the workers interviewed who brought life threatening infectious diseases back home, destroyed their own life as well as infected their spouse. The study found a common aspect about role of institution/s with all workers interviewed. These were both formal and informal institutions which guides and regulates behaviour of most of us, be it family, education, marriage, institutions of health, social welfare, governance etc. We observed that when workers start they journey of migration, their institutional link with their place of origin gets weakened or uprooted which otherwise regulated their social behaviour and guided them into a normative life. When they try joining the society of place of destination while working, they never get embedded into the institutional set up their which could have guided them into the normative practices of the destination society. This leaves them in a peculiar situation, where they are neither guided by institutions of place of origin nor place of destination. Be it regulation of their behaviour in absence of family, their entitlement in welfare provisions, and finding space in public health institutions when they fell sick.

At the level of their behaviour and life style, this leads them into such behavioural practices which many a times exposes them to communicable infections and diseases; many of them are related with their sexual health which are life threatening in nature. The infection travels with them back place of origin when they visit their family and they unknowingly transmit them to their family and community. It is evident from rising cases of TB, many of resistant strain, and HIV-AIDS in Bihar. This is increasing the burden of public healthcare facilities which is already inadequate and inequitable in delivering healthcare services to the marginalised population. We cannot change the course of migration, as it is social reality. With the fast transition happening at the locus of migrant workers, it is resulting in breaking down of social institutions at the place of origin and at the same time new social institutions are not developing to guide and shape the genuine need and behavior of migrant workers at the place of destination. Ironically, the workers are not counted for any welfare benefits of the institutions at place of destination, and suffer for their entitlements including basic human rights (Chatterjee 2006 & 2007). This prevalent dispensation leaves the unskilled, not literate migrant workers at their own where most of them are left at losing end sooner or later.

We also identified some of the factors which increased their vulnerability to poor health status

and health seeking behavior that affects their immunity and consciousness of well being. These are: vicious cycle of malnutrition, unregulated use of tobacco, overwork and insufficient diet at work, use of contraband drugs in tea by their employer in few states, etc. These factors together make immunity of the migrant workers vulnerable, and its most serious effect is seen on their health.

## CONCLUSION AND RECOMMENDATION

None can change the course of migration, as it has its natural flow. As Kapur (2010) said that when young population from Gujarat and Punjab migrated to western countries for high paid work, there was a natural demand of manual labour in the region. At the same time the eastern states faced higher population growth, which needed work and experienced relative deprivation. It was a natural push from a state like Bihar towards the states which needed cheap and hardworking labour. We can only change the quality of migration, i.e., instead of large scale unskilled and not-literate migrants, if we change their quality by value addition with help of their education and consciousness building, this can bring a catalystic change. As we know that when an educated employable youth migrates to work in organised sector, he gets well with the new institutions and power dynamics at the place of destination. We, as a collective of state and civil society, can intervene by ensuring continuous health education programmes at place of origin of migrant workers by involving primary institutions of the society. Providing medical facilities to the migrant workers at place of destination as well as place of origin after their return is simultaneously needed. A systematic educational initiative is needed for increasing literacy and skill building among youths at place of origin so that they can join work more in organized sector which can have better benefits for them and less exploitation.

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