Health Issues of Out-Migrants: A Study of Migrated Workforce from Banpur Block of Odisha, India

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ABSTRACT

Mismatch of regional supply and demand of workforce warrants migration. Workforce gets migrated from abundantly available regions to scarcely endowed regions. Migration reduces the pressure of unemployment in the regions of abundance and facilitates capital formation. At the same time, migrated workforce comes across multiple adversities at their migrated places leading to complication in many fronts like adaptability to climate, culture, practice, language, food, etc. All these issues have direct bearings with the health of the migrants. As hypothesised before this research, based on observation of a few cases, migration put a toll on the health of the migration owing to failure in adaptability. However, a hypothesis based on judgment needs to be tested, and hence the foundation of this research is laid. This paper is based on qualitative research wherein Case study method is adopted, and seven cases (i.e., migrants) have been highlighted through in-depth interviews with those migrants, their family members and health-care consultants of those migrants for ascertaining whether migration has gifted them some diseases. In the process, this study also unfolds the availability, affordability and accessibility of the health care facilities in the migrated places by the migrant workforce.

INTRODUCTION

Structure of the economy of Odisha State vis-a-vis that of the country, i.e., India is unique in a way for migration being one of the sources of employment. The problem of unemployment and uncertainties in the primary sector is responsible for making 'Migration' a sector-like status in the context of accommodating the workforce. As people are not finding any job in the local area, they prefer to migrate outside their native places. Migration is the backbone of Odisha economy. The credit of the growth of the State economy goes to the migrated workforce, somehow. Migrants are of different types, such as seasonal, cyclical, legal, illegal, temporary, permanent, educated, uneducated, etc. Though unemployment is one of the reasons for migration, still other factors are responsible for migration. Prominent factors among those are marriage, education, family dispute, lack of land, unfavourable climatic conditions, etc.

It is found that at the migrated places (i.e., workplaces) most of the migrants get affected by different types of disease like HIV/AIDS, hair falling, low fertility rate, malaria, hypertension, etc. And get addicted to drinks, smoke, drugs and suicidal tendency. The main reasons for such type of diseases/addiction are many like; staying outside from
home, not getting family affection, not getting biological needs, coming in contact with bad friends, eating low-quality food, staying at unhygienic conditions, doing excess labour, lack of sleeplessness etc. Though migration is an important livelihood destination of the State economy, the migrant workforce gets neglected and often excluded from the various health programmes. Thus, it enhances the vulnerabilities of the migrants, and that leads to low health status.

**OBJECTIVES AND METHODOLOGY**

**Objectives**

Following are the objectives of this study,

1. To ascertain the diseases that the migrant workforce is vulnerable to
2. To find out the availability of health-care facilities at migrated places.
3. To trace the accessibility of health-care facilities by migrants at migrated places.
4. To figure out the affordability to health-care facilities by the migrant workforce.

**Methodology**

This study is based on qualitative research wherein Case study method is adopted and seven cases (i.e., migrants) from Banpur Block of Odisha State, India have been highlighted through in-depth interviews. In-depth interviews are taken among those seven migrants, their family members and health-care consultants of those migrants for ascertaining whether migration has gifted them some diseases. Besides seven Cases, data have also been collected from 30 migrants from Banpur Block based on a semi-structured questionnaire. Seven Cases and 30 migrants have been selected based on judgmental and snow-ball sampling.

**Review of literature**

The study establishes the link between health practices of migrants with two things, i.e. inequalities for accessing health care practices at the origin and destination of migrant people and how privatisation helps for this. The study shows that health-care practice is the cause of social mobility. Further, it shows that privatisation in health-care has increased in Ireland and Romania (Stan, 2015).

The availability for accessing health facility and the quality of provisions for minority ethnic groups is unsatisfactory. People find difficulty in accessing health facility because of higher cost, language problem, lack of information, differences in opinion about health and medical care and lack of social sensitivity among health personnel. This is the reason why migrants seek medical facility in their own country (Migge and Gilmartin, 2011).

The study shows that policies made in Spain, Portugal, and Ireland for the improvement of the health facility of the immigrant are based on the equity principle. The health policy focuses on giving health rights to foreigners and for improving the diversity management capacity of health centres (Ledoux et al., 2018).

The study highlights that migrants in India are excluded from getting benefits from different programmes as no policies are available exclusively meant for them. So it suggests for the development of a National Migration Policy to resolve it. Further coordination among states and departments are necessary to improve the status of migrants’ health (Borhade, 2011).

The study explores that migrants generally return their home country for accessing health-care. It examines that Korean immigrants make a trip to their homeland for getting medical operations (Lee et al., 2010).

The study shows that most countries in Europe do not have information related to the health status of migrant. So it creates a problem in monitoring and improving the health status of migrants. Further, a universally accepted definition of a migrant is not available in all the countries of Europe. Moreover, very few countries conduct extensive scale survey to know the health status of migrant and for the health care utilisation (Rechel et al., 2012).

**MIGRATION AND HEALTH**

**Factors that Affect the Health of Migrated Workforce**

As a migrant workforce stays outside its home, following are different factors that affect the health status of a migrant.
1. Availability of drinking water facility,
2. Suitability of environment,
3. Condition of the room where they are living,
4. Number of persons living in a room,
5. Ventilation facility of the room,
6. Latrine facility,
7. Availability of apt food,
8. Job satisfaction,
9. Love and affection from the people surrounded by,
10. The nature of work (whether chemical contaminated or any dangerous things like that attached),
11. Age of the worker,
12. Marital status of the migrant
13. Addiction to any bad things like alcoholism, etc.

**Policies for Migrant Workforce**

Following are the provisions for the migrant workforce in India,

1. Indian constitution contains basic provision relating to the conditions of employment, non-discrimination, right to work etc. (for example Article 23(1), Article 39, Article 42, Article 43) which are applicable for all workers including migrant workers within the country.
2. Various labour laws
3. The Interstate Migrant Worker act has been in force since 1979
4. National health programmes and policy
5. India has ratified many International Labour Organization’s conventions but is neither a signatory nor ratified the 2 Convention of Migrant Workers (CMW), which provides the formal sanction for protection of the migrants. Similarly, 3 UN Convention of Migrant Workers spells the global focus on the human rights of migrants. Still, India has not adopted either of them and hence interests of migrants are not protected, including health.
6. National Health Policy 2001
7. National Population Policy 2002
8. Integrated Child Development Scheme (ICDS)
9. In the case of food security, the Public Distribution System (PDS)
10. Jivan Madhur Yojana (insurance programmes)
11. Rashtriya Swasthya Bima Yojana (RSBY)
12. National Rural Health Mission (NRHM),
13. National Urban Health Mission (NUHM)

**The rationale to Address Migrants’ Health**

Evidence suggests that internal migration can play an essential role in poverty reduction and economic development. Hence, positive facilitation of safe migration should be specially emphasised, which includes access to basics and public services, mainly health, education and livelihood. Further, the high volume of migration and inter-linkages of the health needs of migrants with all Millennium Development Goals and national policies (National Health Policy, National Population Policy and India Vision 2020) means that success in meeting these needs can help support the achievement of the MDGs and these policies. Hence, the increased emphasis is required to address the unique health needs of the migrant population, which can help to improve their health indicators as well the overall experience of migration.

Migrants are poor, uneducated, socially excluded and face a very alien environment when they come to urban landscapes. They have trouble-proving identity/eligibility; language is a barrier, have insufficient awareness of entitlements/rights, little understanding of how hospitals and insurance providers operate, etc. Thus, there is an urgent need to design health programmes and policies for them that are simple and easily accessible.

**CASE STUDIES**

**Case study-1**

Ramachandra Sahoo, 24 years old of Punjima Sasan, Block-Banpur, District-Khordha, Odisha worked at Muscat, Oman. He worked at AL-RAWAHI International Company as a Scaffolder. He stayed there for two years. He was earning 110 oman rial per month by offering eight hours of work a day and some overtime work. The Company bears the food cost. They were staying ten people in one room with an AC connection and attached latrine bathroom. The atmosphere is suitable for him. During the period of stay, he was suffering from fever for 4-5 days. He gets a medical check-up at
CAL-FAROOQ POLYCLINIC. The doctors are good, and they communicate in the Hindi language. The Company bears the medical cost. Hospital is 7 km away from the mess. The Company gives two months’ wage as a bonus. The Company bears the ticket fare for travelling from India to Oman. He complains that as per work he gets less wage and food served at the mess is of low quality.

Case Study-2
Jitendra Kumar Behera, 25 years old of Punjijama Sasan, Block-Banpur, District-Khordha, Odisha worked at Abudhabi (Banyasi). He worked at AL-RAWAHI International Company as a Scaffolder. He stayed there for two years. He was earning 110 oman rial per month by spending eight hours of work a day and some overtime work. The Company bears the food cost. They were staying ten people in one room with an AC connection and attached latrine bathroom. The atmosphere is suitable for him. During the period of staying, he was suffering from fever for 4/5 days. He gets a medical check-up at CAL-FAROOQ POLYCLINIC. The doctors are outstanding, and they communicate in the Hindi language. The medical cost bore by the Company. Hospital is 7 km away from the mess, and the Company gives two months’ wage as a bonus. The Company bore the ticket fare for travelling from India to Oman. He complains that as per work he gets less wage and food served at the mess is of low quality.

Case Study-3
Balabhadra Maharana, 24 years old of Punjijama Sasan, Block-Banpur, District-Khordha, Odisha worked at Abudhabi (Banyasi). He worked at the Company named ALFUSAN, was receiving Rs 15000-16000/- (850 UAE Dirham per month) per month, and he was engaged as labour in the construction of housing. He stayed there for two years and was staying eight persons in one room. He was not affected by any disease during his two years of stay. He is addicted to alcohol. Hospital is five km distance from his mess. Insurance facility is available. The atmosphere is friendly, and people are cooperative. He gets one month salary as a bonus. He is not satisfied with the wage rate. Further, his complaint is that food is of low quality. He returned because of low wage rate and low quality of food.

Case study-4
Rashmi Behera, 24 years old of Keshapur, Block-Banpur, District-Khordha, Odisha worked at Abudhabi (Banyasi). He worked at the Company named ALFUSAN. He was receiving Rs 15000-16000/- (850 UAE Dirham per month) per month and was engaged as labour in the construction of housing. He stayed there for two years. They were staying eight persons in 1 room. He was not affected by any disease during his two years of stay. Hospital is five km distance from his mess. Insurance facility is available. The atmosphere is friendly, and people are cooperative. He gets one month salary as a bonus. He is not satisfied with the wage rate. Further, his complaint is that food is of low quality. He returned because of low wage rate and low quality of food.

Case Study-5
Mitu Sahoo, 28 years old of Sana Nairi, District-Khordha, Odisha worked as a painter at Tamilnadu (Tandrum). He earns Rs 500/- per day from the Company. Gets engaged by the local people earns Rs 600/- per day. He is staying in a mess and food is prepared by Self. Water is not suitable for him. The atmosphere is also not friendly, and dustbins are dumped there. He is affected by fever for 4-5 days and gets treatment in the local clinic. They are charging excess concerning the real cost of treatment. They are treating differently to local people and differently to out migrants. The clinic is of two km away from the mess. Self bears the cost of treatment, and no insurance is available.

Further, a problem arises in communicating correctly to the doctor due to language difference. Then he is affected by hair falling. He did not do any check-up for that. The main reason of hair falling is a chemical infection, tension due to staying away from the family, and polluted water.

Case study-6
Dilu Sahoo, 31 years old of Sana Nairi, District-Khordha, Odisha worked as a painter at Tamilnadu (Tandrum). He earns Rs 500/- per day from the Company. If he gets engaged by the local people earns Rs 600/- per day. He is staying in a mess and food is prepared by Self. Water is not suitable for him. The atmosphere is also not friendly, and dustbins are dumped there. He is affected by fever for 4-5 days and gets treatment in the local clinic. They are charging excess concerning the real cost of treatment. They are treating differently to local people and out-migrants. The clinic is of two km distance from the place of stay. Self bears the cost of treatment, and no insurance is available.

A further problem arises in communicating correctly due to language difference. Then is affected by hair falling. He did not do any check-up for that. The main reasons for hair falling are; chemical infection, tension due to staying outside the family, and polluted water. Further, he is affected by infertility.

Case Study-7
Rajesh Kumar Sahoo, 22 years old, of Sana Nairi,
District - Khordha, worked at Jamnagar Refinery which is a Private sector crude oil refinery owned by Reliance Industries Limited in Jamnagar, Gujarat, India. He earns in between Rs 12000 to Rs 14000/- per month by working 12 hours a day. The Company has the canteen where they can get their food. Fooding charge is in between Rs 2200 to Rs 2500 per month, which is borne by Self. He is affected by fever and nausea sometimes. The Company has its Medical facility. The distance of the Medical is around two Kms to three Kms. The Company bears the Medical cost. They were staying four people in one room. They were using a standard toilet. He came to know about this Company from one of his brothers. According to him, the work atmosphere is friendly. He returned to for higher study. Now he is pursuing his Diploma in Civil Engineering at Bhubaneswar. This is the reason for which he came back.

Findings

The study area we have taken is Banpur Block of Khordha District. Here most of the people are dependent on migration. They are migrating to different places as migrant labourers. Some are migrating outside India like Oman, Saudi Arabia, Russia, etc. Other people are migrating to different places of India like Kerala, Andhra Pradesh, Surat, Tamilnadu, etc. As per the objectivity of the study, a sample study is made by making 30 people migrating to different parts (both within India and Outside India)

Prevalence of Diseases

They were affected by different types of disease like hair falling, infertility, alcoholism, fever etc. As claimed by the migrants and their family members, before migration, they were not affected by any such type of diseases. Thus, migration has gifted them such type of diseases.

Accessibility to Health Facility

Most of the hospitals or clinics are within 10 km of their living place. And they are facing no difficulty in reaching the hospital at the time if necessary. But the matter of concern is that medical benefits applicable to the local people are denied to them. At some places, they are exploited while accessing the medical facility.

Availability of Health Facility

As per the information collected from the Cases, most of the migrated places do have Hospitals or Clinics. So they are not getting any difficulty in getting a medical check-up. But they were treated differently as compared to the local people. Further migrant workers are not able to communicate appropriately to the doctor because of the language problem. They pay more medical fees as compared to the local people.

Affordability

At some working places, medical cost is borne by the Company. But at some other places, medical cost is borne by Self. Further, they were unable to get proper medical facilities because of the unavailability of Fund. So it gives a mixed response from the migrant workforce.

CONCLUSION

It is found that migration has upgraded the economic status of the households of the migrated workforce. However, this positiveness has been in the cost of the health condition of the migrated workforce. Due to different climatic condition, food pattern and lifestyle, migrants used to get affected by one or other diseases. In a few cases, medical expenses are borne by the organisation the migrant works with, but in the majority of cases, the expenses are borne by the migrants themselves. In the former case, health issues are handled aptly, and the migrants get encouraged. In the latter case, since the migrants are to spend from their earnings, they usually neglect, and ultimately they put themselves in more significant trouble owing to irreparable health hazards. In some migrated places, while health-care facilities are available, the migrated workforce fail to access those owing to either they don’t qualify for those, or they fail to afford to. There are some places where the availability of health-care facilities is a question mark. To make migration a lucrative destination for employment, the migrants need to be given free health-care facilities and/or health insurance facilities from the organisations. Moreover, any health-related facilities provided to the domestic people by the government needs to be extended to the migrated people also. Thus, people can have hassle-free migration leading to a balance between demand for and supply of workforce.

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Conflict of Interest

We declare that we have no conflict of interest to report regarding the present study.
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