HEALTH PROBLEM AND TREATMENT BEHAVIOUR AMONG MIGRANT CONSTRUCTION WORKERS IN DELHI

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Abstract

Migration has been most vibrant component of demographic, brings sudden and most dynamic change within an economy. On one hand it indicates economic development and on the other reveals the imbalance development in a country especially where the migrants are mostly labour class people, living with bare necessities at the place of destination. A study has been conducted in Delhi on the constructional migrant workers focusing on their living condition and health care behaviour at the place of destination. 87 per cent are in the age group of 18 – 40 years, symbolizing stress migration. They come looking for some sort of regular-paid work in urban centres atleast for whole of one season during which they would not be engaged in fields back home. Urban centers with new development work requiring semi-skilled and unskilled workers act as pull factor. Besides being the basic input for economic and industrial development at the country, the construction sector provides numerous employment opportunities to the poor especially from the rural areas as unskilled labor as well skilled labor.

This paper is an empirical study covering living condition and health care practice among migrant constructional workers at the destination using mixed methodology. The study focuses around the health problem and treatment behaviour of these workers. As a human capital, health forms to be the key component in creation of wealth or income. Lack of social security and low level of income compels them to compromise with duration and type of treatment. Vulnerability factor which usually lies is the fact that their origin differs from the place of present urban residence resulting in adverse association of migration and utilization of healthcare services. Making it utmost important to examine the treatment pattern and factors influencing such treatment behaviour among migrant constructional workers.

The study was a pilot study for project on "Accessibility and utilization of health care services among migrants" carried out in 2011. It was conducted in National Capital Territory (NCT) of Delhi. In the present study migrant construction workers has been considered as sample. These samples were identified from 6 construction sites out of which 2 were government building, 1 was

residential quarter constructed by private company, 1 of them was an over bridge construction and last one was a commercial building, shopping mall. The sites selection was done by dividing Delhi into 5 clusters. These clusters were basically administrative zones. Atleast one site was selected from each zone. After selecting the sites which totally lied on the permission of the concerning authority at the construction site data was collected from 150 construction workers. This was totally on convenience as data was collected from work place of the migrant construction workers.

INTRODUCTION

Migration being most vibrant component of demography can bring sudden and most dynamic changes within an economy. Internal migration in a country helps in redistributing its population. In recent decades it has been accentuated by process of globalization and liberalization. The people from rural areas move to urban areas in order to join the second largest occupation (construction) of India (Vankar, 2005; Bharara, 2012; Chawada et.al. and Singh 2012). It's a stressful event. Migration status is responsible for lower uptake of health care services; migrant adaptation may also play a role as integration into the new society progresses (Barretto & Rodrigues 1992).

Migration and health has a complex relation (Kahn, 2003). After Alma Ata Declaration of 1978, "health for all", most governments of the world have declared universal and equitable access to quality of health care for their citizens. Indian government embraced the objective of promoting the health of the poor and the disadvantaged in its policy statements and actions, emphasizing 'Health for All', in 1985[1] but already existing socio-economic inequality resulted in unequal distribution of resources once again. Most of the public campaigns often target native population, but fail to catch the attention of migrants. Status of being new to the city forms a major obstacle for not utilizing healthcare services (World migration report, 2005). Being not familiar with the new area and environment they prefer to avoid recognizing illness and seeking treatment (Grondin, 2004). Thus accessibility can be another vital reason in delaying or not seeking treatment once illness is recognized. The accessibility and utilization of the health care services becomes a problematic issue for migrant. The health policies and health system related to vulnerable groups (migrant population) affects accessibility and provisions of healthcare as people are continuously pouring into cities (Chatterjee, 2006). Highest risk to migrant health occurs when there is irregularity in the migration process. They are not much welcomed by the host society in many ways and face a lot of problem in every sphere of life (World migration report, 2005).

Globalization mostly associated with casualization of work favored unskilled migrants, getting absorbed in low paid jobs with higher prospect of health hazard. At the employers end they always look for new and younger so that they get the best from them in less time and expense. Construction industry is on move and so is its worker. Foremost part of their occupational lives spends in harsh and unhygienic environment with almost no facilities available for sufferings from serious health problems (Parasuraman, 2007). Construction work is most hazardous occupation which has higher rate of serious injuries than national average (ILO, 2009; 2011).

[1] Lok Sabha Secretariat (1985); National Health Policy, Lok Sabha Secretariat, New Delhi.

Discrimination in national health-care plans is often witnessed against migrants. The elaborate delivering system has done a lot but still it is out of the reach of certain section of population. Forcing migrants to delay the treatment till the condition is sufficiently hazardous to justify going to emergency clinics. Another factor which their fluidity in terms of movement and their working conditions in the informal work arrangements in the city debars them access to adequate curative care. Migrant workers predominate in the lower income labor market mostly in construction sector with higher risk of exposure to unsafe working conditions. They do not have any identity proof. These people are excluded from the public distribution system as they do not have ratio cards (Sarawati, 2011). Thus migrants become more vulnerable as they lack few of the basic resources for which they would not have suffered at their natives. Despite regulations were passed and importance of work was know by the urban planner in Delhi during the common wealth game but little or nothing was done to uplifted the living and working condition of the construction workers (Ghosh, 2009). Meeting cheap and flexible demand of labour, these workers come under manifold discrimination. They are devoid of basic human rights, such as health care facilities, education, social security, and in the worst case bodily integrity and physical security (Jha, 2005; Franck and Spehar, 2010). Keeping in view above scenario, present study focuses on health vulnerability of the migrant construction worker in Delhi which has not been much touched by the scholar in the past.

METHODS

The study was a pilot study for project on "Accessibility and utilization of health care services among migrants" carried out in 2011. It was conducted in National Capital Territory (NCT) of Delhi. In the present study migrant construction workers has been considered as sample. These samples were identified from 6 construction sites out of which 2 were government building, 1 was residential quarter constructed by private company, 1 of them was an over bridge construction and last one was a commercial building, shopping mall. The sites selection was done by dividing Delhi into 5 clusters. These clusters were basically administrative zones. Atleast one site was selected from each zone. After selecting the sites which totally lied on the permission of the concerning authority at the construction site data was collected from 150 construction workers. This was totally on convenience as data was collected from work place of the migrant construction workers.

Face to face interviews were carried on after taking concerns of the respondents. Before taking concerns rapport were built through general talk about research which is being carried out. 24 female were interview alongwith 126 male. Schedule dealt with information related to demographic and socio-economic condition, migration history, health problems and treatment behaviour. Health related questions were probed further in-order to get detailed information on the subject. 15 in-depth interviews were conducted which mostly focused on living and working condition of the migrant construction workers. All in-depth interviews were recorded with the consent of the respondents. The in-depth interviews were transcribed and translated from Hindi to English language. Based on these translations, analysis of narrative was done.

RESULTS

The demographic features of the migrant construction workers have been summarized in table 1. 15 per cent of the sample taken were female and rest male. Majority of them belong to the age groups of 20 – 24 and 25 - 29 approximately nearly 52 per cent. 30 per cent of them are in the age group of 30 – 34 years. 16 per cent of them were below 20 years of age. Out of which 3 per cent of them were below 18 years and no one was below 15 years of age. 7.24 per cent of the migrant workers involve in construction works have education up to primary level. 12 per cent attended school up to secondary level. Only 2.67 per cent are graduated and 6.24 per cent are Sr. secondary passed. The basic reason for migration was in search of better and regular employment which could serve as a continuous source of income other than farming. Respondent were mostly unskilled to semi-skilled daily waged laborers. 48 per cent of them work as labors. 36 per cent of them are semi – workers.

Only 2.61 per cent of them lived in pucca (metalled) houses. They were those workers who resided out of construction premises either owning houses or living in rented. At times company provided houses to its workers on sharing bases. The ownership and type of house depends on the duration of stay in the city. Workers with own house were those migrant who or one their family member migrated Delhi more than 3 years ago.

TABLE 1: DEMOGRAPHIC AND OTHER CHARACTERISTICS OF THE STUDY SAMPLE

SEX	
Male	84.64
Female	15.36
AGE GROUPS	
>20	16.16
20-24	30.79
25-29	20.58
30-34	13.09
35-39	8.56
40 & above	11
EDUCATIONAL STATUS	
No formal education	37.05
1 - 5 years of education	18.03
6 - 10 years of education	34.10
11 - 15 years of education	10.81
RELIGION	
Hindu	75.16
Muslim	23.02
Other	1.82
CASTE	
General	28.54
Other Backward Caste	35.01
Schedule Caste	33.08
Schedule Tribe	2.94
TYPE OF HOUSE	
Kaccha (unmetalled)	65.69
Pucca (metalled)	2.61
Semi-Pucca	32.89
POSSESSION OF RATION CARD	
No	98.04
Yes	1.96
OWNERSHIP OF HOUSE	
Own	1.63
Rented	1.96
Temporary	96.41

Usual dwelling of these people were one room flat lacking any ventilation, light or sanitary facilities or any combination of these factors, are detrimental to safety, health or morals (Kumar, 2004) erected within the construction premises. This made then easily available for work at odd

hours also. 98 per cent of the migrant construction workers do not possess ration card. 40 per cent of the workers with own house in the city but are not given the facilities of PDS. None of them are aware of the temporary ration card. They act as a helping hand in possess of some basic necessities of one's livelihood and even saved money for some other purpose like education or health. At times if a person has BPL or the Anthyodiya ration cards they are give free health service. Often act as a relief from extra financial burden which one faces on the arrival of any illness.

Data related to awareness regarding health care facility in their locality reveals that majority of the respondents have knowledge about the existence of private clinic in their locality. These private clinics are mostly attended unqualified practitioner. There is poor availability and poor access to government health services among migrants (Babu, 2010). All the surveyed construction sites had medical room which was supposed to provide first aid. Doctors visited once or twice in a week but a large number of workers working there did not know about the availability of any such facilities inside the premises of construction sites. 13 per cent of them knew not about any health care facility in the city. They were not even aware of the medical room that existed within their very own construction site where they had been working for days.

AWARNESS OF HEALTH FACILITY IN LOCALITY

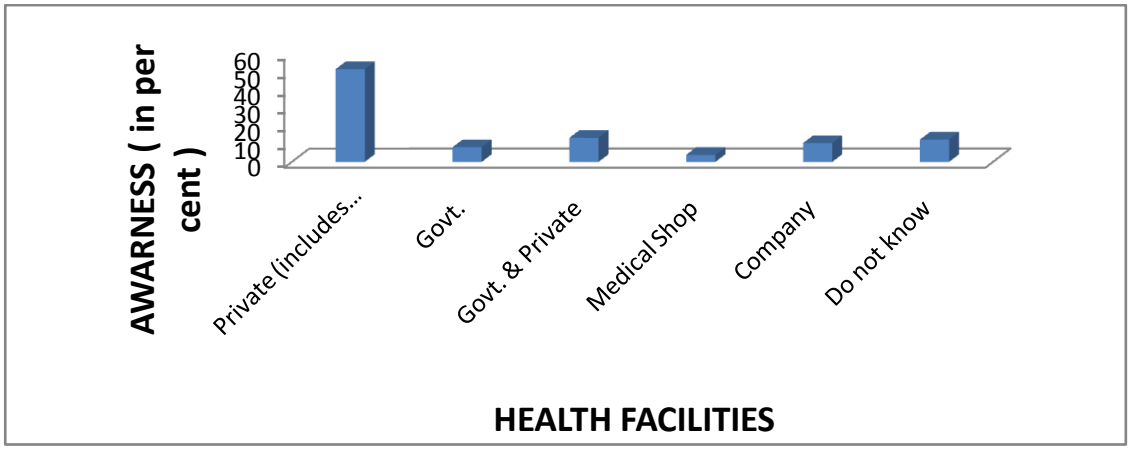

Fig 1

Incidence of illness was gathered into three different sub-sections (i.e. episodic, hospitalization and chronic illness). Episodic illness was collected for past 3 months as it occurs often and recalling is easy followed by hospitalization which was consider for 1 year and finally chronic illness considered lifelong diseases. 30.1 per cent of workers had at least one episodic illness during this period. When asked about the seriousness of their illness 86.8 percent of them considered it as serious and 12 percent did not. 1.1 per cent was not able to say clearly about their view regarding the serious of the illness. Fever was most commonly found illness. Nearly 57 per cent of the respondent suffered from it. Then it was cold and cough followed by stomach ache/disorder.

Table 2 : HEA LTH PROBLEM AND TREATMENT SEEKING BEHAVIOUR	
EPISODIC ILLNESS REPORTED	
Body Pain	5.20
Chest Pain	1.50
Cold & cough	16.97
Dengue	2.20
Fever	57.14
Jaundice	1.10
Loose motion	6.30
Malaria	1.10
Skin problem	1.10
Stomach ache	7.40
TYPE OF DOCTOR / FACILITY VISITED FOR TREAMENT	
Govt. hospital/health centre	5.69
Private doctor/nursing home	25.57
Private- Ayurvedic	2.78
Unqualified Practitioner	32.77
Medical shop	12.07
Company Doctor	5.34
Did not seek care	15.78
REASON FOR NOT SEEKING CARE	
Could not go away from work	43.00
Illness was not serious	20.00
No proper treatment done by Doctor	37.00
MODE OF PAYMENT FOR TREATMENT	
Own money	58.56
Borrowed from co-workers/money lender	20.73
Did not have to pay	11.86
Took from work place	8.85

Out of total sick respondents 37 per cent did not sought care and reported that the doctor did not provide proper treatment to them when they last visited them so they carried out self treatment or took medicine from medical store by themselves or left the illness to recover on its own. More than half of them paid for their treatment out off their own pockets. 20 per cent of them did borrowed from friends/ relatives and 8 per cent borrowed from their work place. The amount borrowed from work place acts as an advance which would be deducted from their future wage. 56 per cent of the respondents suffering from episodic illness did not lose their wage due to their illness. It includes 90 per cent of those who did not went for treatment as they were not able to leave their work or did not consider their illness serious enough to visit a doctor. Earlier studies

done in India have shown that poor send a considerably larger proportion of their income on healthcare as compare to better of people.

There were 11 hospitalization cases reported which included one female. 64 per cent of the sick got admitted in private hospital/private nursing home and rest visit government hospitals. In case of hospitalization for 30 per cent their company paid, 50 per cent of them paid by themselves and 10 per cent of them borrowed money from money lender. 12 cases of chronic cases came up of which asthma is most common due to the working environment. All of them were on regular treatment. In this situation people preferred going to government hospital as these illnesses take very longer period to stabilize and lessening the economic burden of treatment as it require regular checkup.

The qualitative data it clear that quality of life is not very good and these people spent their lives in the city with little or no goods of basic necessities. Majority these workers are aware of either private or government facility. Those who knew not any health facilities reported that they had never fallen ill during their migratory visit there was no need to visit a doctor and some had no free time from work to explore the city. Most of them never left the construction premises once they arrived there from their native. Usually government hospitals were not preferred by them for minor treatments because they had to spend time and money for it. Time was wasted as there they found a huge queue of patients and waiting in queue resulted in loosing wage of morning hours. However it becomes a primary health care provider when it comes to some major illness. Some of the respondent compared the quality of care with those at their native and preferred going back home for some major aliment.

Local unqualified practitioners were main source of health care facility. When asked about their preference of health care facility majority of them preferred private practitioners. The reason which they gave for not using any such facility was that the service was expensive and they have limited money. Some of them preferred government hospitals but due to large queue, medicines were not given and at time staffs were rude did not used it.

A few of them had any health coverage. Majority of them were not even aware of any such facility. Those who had this health insurance were mostly covered under a government scheme called as Rasthiya Swastha Bima Yojna. Nothing of that sort was provided by the company they worked for but rather it was made back at their respective homes. For them it was of no use as almost none of them knew what to do with it; when, where and how to use it? Some who had little idea about what it was and how to use it did not carried it alongwith them while coming from native thing that it would be of any use in Delhi.

DISCUSSION

The present study has put forth the quality of life and treatment behaviour among the migrant construction workers. According to Zhou (2004) quality of life where construction migrant workers dwell and work are untoldable. They become the victim of urban pollution and insanitation. Chawada et.al, (2012) in his study on Surat women construction found the similar

living condition as it was found in the present study. Respondents dwelling were nothing more than a temporary hut with brick wall and tin roof. Type of houses they live had no safety for extremes of weather condition as it was narrated by one respondent,

"We live here in this type of room with no ventilation with a tin roof. Our room burns like oven during summer of Delhi. Most of cannot bare this and get sick. People get fever. I myself have for last four days. Just come inside and see. Roof just a few feet above our head, can feel the heat on one's head. There is no option the air to circulation. These rooms are like match boxes. We do not have any option other than this as we are not familiar with the city……We drink from the tap. The water is brackish. Do not like it." (Singh, twenty eight years, foreman)

Local bias stigmatizes migrant and is used as an excuse to supply substandard care of all type ultimately resulting in social and culture constrain (Chatterjee, 2006). Lower health status is the result of poor living condition and quality of water.

There is as such no social security for these migrant construction workers. They avail no health coverage facility from the company they work for even after working for years with the same company. The sites authorities do not register most of them even though it has been made mandatory to register every employer under the Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act 1979. Under this act a registered worker are given a lot of facilities which could ease the hardship of these workers. The hardship like this as thirty year old mason narrated that,

"*Once I was sick went to a hospital. There people get free treatment. They only charge Rs. 2 for health card and rest is free. There I was asked for an identity card, which could reveal that I am a resident of city. I could not present him such proof to the man as I did not have any identity card. I said him so and even told I work here in such and such place. The man said its ok but you have to show that you work there and then only the health card would be made. So you see there is no option than to go to these medical shops tell them their illness and get medicine from there. When it becomes serious we go back to our natives and get the treatment done there. Majority of us go back leaving our works the contractors arrange things for us and then when we get well we come back for work.*" (Suresh, twenty five years, mason)

Ghosh (2009) analyses of construction workers reveals that registration was never fully covered by employers. Registration process incorporated benefit of temporary ration cards to be used in Delhi, pension, social security, access to healthcare service, life insurance and scholarships for children. Some of the temporary ration cards were distributed in Delhi during November 2007 just for political fanfare, which soon died out completely and no follow up was done. Similar was the case with children's scholarships which was supposed to be for two children of registered construction workers. Only 20 such scholarships were provided that too when the school was closed during summer vacation.

Working hours in a construction site is not fixed. At place the work goes on 24 hours in shifts. On some sites a labour is made to work for hours without any breaks. Respondent told that

they have to work for 12 hours in a day with one hour break given twice a day. These works have reported long working hours with no breaks as one of the major cause for not seeking treatment. Often they work without any payment for 3-4 months. They are not paid regularly by their employers because the employers believe that if they pay to the workers ever month, workers may go back to their natives. A twenty two years man states that,

"*These people make us work for hours. Some days we are made to for twelve hours with no breaks. Only one hour break for lunch. They do not let us go out easily. Not given money for 4 months. I want to go home but I cannot go without money.* "

One of the women labour responded that,

"We have been working on this site two years. I came with my husband. This time we came here to work because we needed money to build our house back home. Go home after 5-6 months. We get our money then. It's good we get huge some together and we can go back and build our house as it has fallen down. Sorry, I have to prepare lunch; he (contractor) will come. I did not cook for them (her children) in the morning as I went to take medicine for myself. I am having stomach ache since 2 weeks could not go due to work. I told contractor. He gave me money to day and asked me to go there (making gesture with her hand toward the direction of hospital). Got the medicine and I came right now."(Sona, forty years, labour)

The children residing in migrant camps are left unfed as their mother is busy working. Children are left alone with no one to look after them (Praveen, 2010). Food which they ate was very simple and mainly consists of rice and pulses. The children living there are usually malnourished and are deficient in number of ways (Singh, 2012). Eat chapattis and spicy chutney even before they learn to digest these. Sugar is replaced by jiggery; vegetables and milk are often beyond their reach (Madhok, 2005). They do not spend money on protein and vitamins. They got limited amount to spend on their monthly expenditure from their contractors. This was cut from their wage so the worker too tried to make it minimum from their ends also.

Looking at the illness table it is clear that these workers suffered from water born diseases mostly. Water available for drinking or cooking purpose was tap or tanker water. Delhi tap water is brackish in nature not suitable drinking. This water can causes stomach ache, diarrhea, and sore throat which often lead to fever. The health problems on worksite injuries in women construction laborers included: severe muscular pain, intestinal problems, gastroenteritis, fevers, coughs and colds, pains and more serious ailments like pneumonia, tuberculosis, leprosy, etc. are mentioned by Basu et al. (2009). Most of the load carriers suffer from musculoskeletal disorder due to carrying over loaded vessels (Das et.al, 2007).

"I went to this government hospital. I was suffering from fever. Doctor gave medicine. Ate that medicine for two days but did not recover. I felt cold and had high fever. Then they took me to the private nursing home. There they admitted me. I was there for three days they did a lot of tests but failed to find the illness of which I was suffering. My condition became more fragile. I was not able to stand also. Then I decided to go back home (to native place). There I was admitted and there the doctors told me I was suffering from malaria. They started the medicine that day itself. These paddle of

water all round here mosquitoes breed in these. They bit us. And we become sick. Recently one more man got malaria. He has gone home. I stayed at home for 2 months. I was so weak to work. I was on bed rest form complete month. A lot of money was spent even though I was in a government hospital there. The medicine cost a lot. They did not took the room charge only. Rest all was paid by us. My father had some saved money and some he borrowed from relatives. Now I have to earn and repay them back. It will take little time. But anyways I m happy I got well. Here all the expense was born by the company. (Shatish, twenty five years, mason).

The construction sites provide hospital facility to their workers but only for illness happening working hours rest was to be covered by the workers themselves. As one of the respondent spoke of it that

"We are taken to this hospital. It's near only, just next to this over bridge. Our contractors goes alongwith us. He buys the medicines when something accidental occurs during working hours company pays the hospital expense. For the rest one has to pay on his own. Whenever anything happens to me he gives money. It would be cut from my wage. " (Jai, thirty one year, labour)

Entire expenses of the treatment were born by the concern authority but incidence should occur during working hours. The expense of treatment was fully covered by the company for 14 per cent of the reported hospitalization cases in the present study. Person falling sick beyond working hours has to go out looking for suitable health facility according to their pocket and time. It's one of the main causes for preferring cheap and local facility. It saves both time and money (Babu, 2010). Preference is given to these types of health care facilities because they are easily available at odd hours. One respondent narrated his convenience,

"There in slum we can go any time. After work at 8 o' clock by then the government hospitals closed. There is a big line in the government hospital. Whole morning goes there if we visit there and that too they just do checkup, medicine we have to buy from outside. We cannot go during daytime as we have to work. During daytime we would lose our wage so we go to the doctor after the day's work get over. He sits till 10 o' clock. At that time there is not much patient. He looks and gives medicine also and only takes Rs. 30-40. " (Rakesh, thirty five year labour)

They do not have to wait long hours in queue unlike in government and took less money at one time which are convenient for them to give. The working condition in the informal sectors in the city debars them from access to adequate healthcare. Majority of respondent (95 per cent) visiting such clinics felt the service received to be satisfactory and would not prefer any other source.

CONCLUSION

Preferences are given to unqualified practitioners for treatment as they are easily available and cost less at one time for episodic illness. But the case is just the opposite for seeking care of chronic illness. They go for government hospitals. Most of the financial arrangements are made by themselves and at times they are helped by co-workers/relatives. In case of hospitalization borrowing of money is found in large number as it requires a good amount of money. This is leads

to heavy toll of indebt. These migrant workers should also be cover under some sort of health schemes. It could save them from a number of vulnerabilities giving a sense of security. Hence, making the health system responsive particularly to vulnerable, socio-economically disadvantaged migrants could help in achieving proper health care facility.

All through the study the issues which has come up was about awareness about health related issues which is not taken seriously both by the government and the companies which employee these migrant workers. The employing authorities should provide their workers with some basic enmities as it's their duty and workers right according to construction and building regulation. Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act 1979 should be reinforced and construction companies should be compelled to abide by Acts doctrine inorder to save guard the rights of migrant construction workers.

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