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MIGRATION, RESETTLEMENT AND HEALTH: A MEDICAL ANTHROPOLOGICAL PERSPECTIVE

Migration is a characteristically human adaptive strategy. For many human groups, even the sedentary life-style made possible by the domestication of plants, the industrial revolution, and modern urbanization has been simply a pause for a generation or so in the ongoing search for a favorable environment. Throughout recorded history, the occurrence of migration as an activity has been exceeded only by its use as the subject of philosophical speculation by utopian idealists (Mumford 1962).

The philosophical dimensions of migration are far more than a matter of historical curiosity. Utopianism has always been one of the principal motives for migration and resettlement, particularly in the Western Hemisphere. The Dominican resettlements of Central America (Hanke 1935), the Jesuit reductions of South America (Morner 1953), and the Franciscan mission system of the American Southwest (Spicer 1962) were but archetypes for countless contemporary church-sponsored resettlement programs (Morrissey 1978).

As commonly used, "migration" is a generic term, applied to activities varying greatly with respect to motive, duress, planning, process, time span, place and manner of resettlement, and impact on various dimensions of social organization. By identifying distinctive features of specific migrations, authors acknowledge implicitly the existence of an underlying typology. There remains, however, considerable need for the construction of a comprehensive typology that takes into account both the structural similarities and formal differences of various types of migration.

The objective of this article is to identify and discuss the range of migration-related issues of actual or potential concern to medical anthropologists. By noting and expanding on classification schemes encountered in the literature, this article, it is hoped, will also advance the cause of typology development.

Migration and resettlement are interrelated concepts. Migration is the process by which an individual or group moves from one physical and

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social environment to a new one. Resettlement is the process whereby migrants become situated in and adjusted to the environment of the place of arrival. The environments of both point of origin and place of arrival are composed of highly complex assortments of physical and social variables, all of which have an impact on the outcome of the migration.

Refugeeism occurs when some aspect of the social environment of the point of origin presents such an imminent threat to survival that a population seeks refuge elsewhere. Typically, the flight is precipitous — undesired and unplanned. Typically, too, the decision to resettle elsewhere is finalized only after a place of refuge is reached. The overriding concern while in flight is simply escape. Use of the term "camp" for the place of refuge suggests that migration is not necessarily intended, and that there is even an assumption that refugees might return home. When this proves impossible or inadvisable, refugeeism becomes migration.

Dyadic Features of Migration

Many of the features that characterize migration can be reduced to dyads. Some are disjunctive, others indicate opposite extremes of a continuum. Identification of these features facilitates an understanding of the range of possibilities for theoretical and applied work in medical anthropology. This identification does not, of itself, constitute a typology, but is an important prerequisite for the development of one.

Perhaps the most frequently encountered attribute of migration is the deceptively useful distinction between internal and external migration. The terms are disjunctive and verifiable, and they provide convenient, intelligible categories for a library's card catalog. Their presumed utility lies in the assumption that external migration involves areas of difficulty not found in internal migration, such as border crossing procedures and dealings with an unfamiliar government bureaucracy.

The experience of some countries, however, suggests that migrants who submit to border exit and entry procedures are generally well equipped to deal with them, and those who are not are highly resourceful at devising ways to bypass them. Moreover, migrants frequently originate from remote areas where they had little interaction with their national government before migration. The difficulties of dealing with the bureaucracy of a new nation are not much different from those they would face if they moved to urban areas within their own country. Undoubtedly, there are international migration situations where exit, entry, and the laws and procedures of an unfamiliar government are major sources of difficulty. This lack of a direct correlation between the complexity of migration and its external or internal character limits significantly the utility of the internal/external distinction.

In the prologue to an anthology dealing with mental health aspects of migration, Pfister-Ammende (1982) lists five types of migration and mobility. This schema identifies three additional features of migration. The elements of the schema are (1) biological mobility, related to stages in the life cycle; (2) sociological mobility, related to career advancement; (3) voluntary and planned mobility; (4) forced, planned mobility; (5) forced, unplanned mobility. The first two elements of this schema suggest a dichotomy between migration that functions as an integral part of a society's adaptive strategies and migration that serves to extricate a group from a context where existing strategies are perceived as no longer effective. The former operationalizes established adaptive strategies; the latter requires the development of new ones.

This schema also identifies planning and volition as important features of migration. Even though the concepts of "planned" versus "unplanned" and "voluntary" versus "forced" suggest dichotomies, a continuum is a more accurate model of the wide range of variation found in real life. A further distinction can be made between planning done at the departure stage and that done at the resettlement stage. Planning can also be distinguished according to source. It may be done by the migrants themselves or by outsiders, who may be countrymen, nationals of the place of resettlement, or total foreigners.

The amount of planning involved can vary widely. In the case of the refugeeism, which in the extreme might be as drastic as fleeing on a moment's notice with just the clothes on one's back, planning would be an unavailable luxury. Further along the continuum there are the small-scale migrations of individuals, families, or groups, who plan their own move and prepare in advance for resettlement in a new location. A major obstacle to planning at this level is the lack of control by groups of this sort over the variables encountered in the new environment. The term "spontaneous" is sometimes used to describe the resettlement phase of migrations of this sort.

At the other extreme is the highly planned migration, where preparations, the actual move, and eventual resettlement in new surroundings are all characterized by a high level of planning. Though it is possible for migrants to plan such moves for themselves, they are often directed by persons outside the migrating population, and sometimes by persons who are not nationals of the nations involved. The element of volition is frequently an important factor in migrations of this sort. Participation may range from the completely voluntary to forced resettlement in settings such as "strategic hamlets" or "model villages."

Volition encompasses an especially wide range of variation. Force is clearly present when one flees for one's life before a hostile armed invasion. A different kind of force, but force nevertheless, is involved when one makes a decision to migrate after observing a steady decline in the productivity of one's

soil until it reaches the point where it can no longer support one's family. Volition is affected not only by factors that motivate one to leave an undesirable situation but also by the attractiveness of an alternative. Kunz (1973) distinguishes between refugees, who are "pushed" out of their homeland, and immigrants, who are "pulled" away from it. A strong enough "push" or "pull" might precipitate migration, but it is also possible that neither alone would be sufficient, while the two working in conjunction would be.

Although migration usually involves resettlement in an area already occupied by other human populations, there is a specialized form of resettlement called colonization, where the environmental niche at the place of arrival is unoccupied. Colonization presents both problems and opportunities not found in more conventional resettlement settings. Time depth is another factor of major significance in the study of migration. Although the migration experience would seem to have a declining impact over time, a residual effect could conceivably survive into succeeding generations. Although it is probably not possible to identify a specific point beyond which migration is no longer a factor, it is legitimate to examine the migration history of an individual or group to determine whether or not it is a factor in adjusting to the contemporary environment.

Medical Anthropological Issues

The domain of medical anthropology extends to all issues of health and health-related behavior, including illness, treatment, and the organization and delivery of health services. Its contribution, as a discipline, lies in its efforts, through research and applied programs, to relate cultural factors to health behaviour. Kasl and Berkman (1983) point out that morbidity and mortality studies among refugees actually require studies of three distinct groups: the population at point of origin, the migrants themselves, and the host population at the place of arrival. Similarly, the application of medical anthropological methods to migration may be complicated by the need to take into account multiple populations and the interaction of their respective cultures. Mental health issues are perhaps the best studied of migration-related health issues. Under the best of circumstances, it is stressful to uproot oneself and one's family and move to a new location. Migration rarely provides the best of circumstances. Moreover, it sets the stage for situations that might adversely affect mental health long after the actual migration is completed. Obtaining and holding employment in a strange setting can be very stressful for an adult; going to school where children and teachers talk an unfamiliar language might be more than a child can endure. The literature on this subject has matured to a point where it not only provides extensive coverage of the field, it also warrants literature review articles. In his overview of the health and mental health situation of Indochinese refugees, Van Deusen (1982) reports that he encountered over 100 references to this topic in the literature. An

important characteristic of migration-related mental health issues is that their impact is felt over a long period of time. This provides medical anthropologists with an extremely broad window for investigation, ranging from the time when a group first experiences anxiety over an impending migration, through the stress of the actual move, to the long-term process of adjustment by the migrants, and even their descendants, to a new environment. The mental health implications of long-term adjustment to a new social environment are brought out by a number of articles in the recently published proceedings of two congresses of the World Federation for Mental Health (Nann 1982), which deal with the adjustment of the children of migrants to the larger host society (Verdonk 1982; Stockfelt-Hoatson 1982; Ashworth 1982; Chud 1982).

Parthun (1976) also discusses the mental health implications of adaptation to a new social environment, in the case of Italian immigrants in Canada. An important but as yet unresolved issue arises in connection with literature dealing with health and migration: the need for a clarification of the disciplinary criteria for medical anthropology. Bibliographic materials on migration and health range widely, from epidemiology to sociology to geography to pharmacology. Although all might provide useful data, not all analyze the data in terms of cultural factors. Malzberg and Lee (Malzberg 1940; Malzberg and Lee 1956) were among the earliest contemporary authors to attempt this. Weenberg (1955) shows that factors in the broader social context can affect volition and consequently increase the stress of migration.

More recent authors have found a wealth of research material on the interaction between social environment and mental health in the situation of refugees worldwide. Cohon (1981) notes that the psychological risks are greater for in-voluntary refugees than for voluntary migrants. He observes, with regard to Vietnamese refugees, that psychological dysfunctions can manifest themselves in a variety of somatic complaints, resulting from, among other things, cultural beliefs about illness. Letcher (1981), studying South American refugees in Argentina, discusses the psychological impact of the uncertainty and emotional isolation that can be experienced by refugees, particularly when confined to refugee camps. Mattson and Ky (1978) observed a high level of psychosomatic complaints among Vietnamese refugees who had not yet been permanently resettled. A sampling of other authors who have noted a relationship between the stresses of migration and mental health risks include the following: Naditch and Morrisey (1976) have studied role stress among adolescent Cuban immigrants in Miami; Canino *et al.* (1980) have done a similar study of stress among Puerto Rican children in New York; Reubens (1980) describes the psychological needs of immigrants from the Caribbean, particularly the Dominican Republic; Roglera (1978) reports on informal patterns of seeking help for mental illness, including schizophrenia, among Puerto Rican families in the south Bronx; Harwood (1977) develops the thesis that spiritists who serve as informal treaters of mental health problems among

Puerto Rican families also serve a larger role as legitimizers of cultural behavior. A second well-studied health issue related to migration is the matter of fertility. In 1975, an entire issue of International Migration Review (Macisco and Myers 1975b) was devoted to this topic. Among the features included was an extensive bibliography (Myers and Macisco 1975). The reader is referred to this for background information.

Macisco and Myers (1975a) have pointed out that there is often a marked difference in reproduction rates between point of origin and place of arrival of migrating groups. Rindfuss (1976) suggests that migration generally results in a lowering of fertility. A substantial amount of literature is devoted to verifying and attempting to explain changes in fertility. Bach (1981) suggests two hypotheses to explain this: one holds that a change in fertility is attributable to migration per se; the second points to the interaction of influencies from both point of origin and point of arrival. Harbison and Baker (1981) have studied the phenomenon of decreased fertility in urban areas among Samoan migrants in Hawaii; Hiday (1978) studied it in the Philippines; and Rindfuss has studied it in the case of Puerto Rican migrants to the United States. Although the evidence shows that urban fertility is decidedly lower, a study by the Interdisciplinary Communications Program of the Smithsonian Institution (1976) maintains that "rural to urban migration is unlikely to be a major influence in lowering natural fertility." Far from contradicting the evidence, this merely supports the medical anthropological position that many forms of health-related behavior must be explained in terms of social and cultural factors rather than natural or environmental ones.

There are a number of health-related studies of migration that focus on specific epidemiological topics. Many of these are concerned with health problems that might be traced to dietary change. Hornick and Hanna (1982), who have studied coronary risk factors among migrating Samoans, point out that increases in degenerative diseases are a well-documented consequence of urbanization. They maintain, however, that adoption of a Western life style, rather than migration as such, is the factor increasing risk. Gerber and Madhaven (1980) have compared coronary heart disease mortality rates among Chinese migrants in Hawaii and New York. They cite findings of the Centers for Disease Control as indications that coronary heart disease mortality increases after migration. Ward and Prior (1980) have studied high blood pressure among the Tokelau population and concluded that both genetic and sociological factors have contributed to an increase. A different sort of epidemiological study is found in Gordon's article (1978) on post migration drinking behavior of Dominicans. Most of these authors provide excellent bibliographies that can serve as guides for further research. Those provided by Hornick and Hanna (1982) and by Gerber and Madhaven (1980) are particularly valuable. At times, migration appears to precipitate unusual occurrences of known diseases; at other times it seems to give rise to new

diseases, previously unknown to both migrants and contemporary scientific medicine.

Curing behavior can be affected by migration in a number of ways. A migrating population can be separated from its traditional healers and be unable to obtain medical help because of its unfamiliarity with, or distrust of, the curing practices of the people of the new social environment. On the other hand, traditional healers might be available, but the new natural environment might not provide the herbs or other elements needed to exercise their art; or the rules of the new social environment might not allow them to practice medicine; or perceived changes in the spiritual environment might prevent them from engaging this dimension of their curative powers. In addition to issues relating to migrating populations as patients, there are a number of other issues of interest to medical anthropologists, including a consideration of migrating health practitioners.

An issue of major importance is the matter of the migration of health providers from their homelands. Pernia (1976) and Stevens, Goodman, and Mick (1978) are among the authors who have studied this "brain drain." A more pressing issue has to do with efforts on the part of the receiving society, or concerned third parties, to provide migrants with health care. The United Nations High Commission on Refugees has taken on a larger role in coordinating the efforts of all involved (Cuny 1981). The administration of health services for migrants and refugees remains difficult, encompassing several matters of direct relevance to medical anthropologists. Among the difficulties are such matters as language differences, failure to understand the culture of the migrants, difficulties in gaining access to the migrants (particularly in circumstances where they are refugees, or considered to be "illegal" in their new environment), the logistics of transportation of personnel and supplies, as well as higher-level administrative issues involving relief organizations, political considerations, international agreements, financing, planning, evaluation, etc. Literature on the subject of providing health services to migrants is beginning to reflect the recognition of the critical need for effective administration of health services. Recent articles dealing with this issue include the following. Migration Today (1980) describes the seriousness of the problem of health administration among refugees in Somalia; Arnold (1979) and Chavez (1983) discuss the difficulties, in the United States, of establishing an effective policy for providing health services to migrants; Zimmerman (1981) points out the difficulties of administering health services for migratory workers.

A Case Study on the stone crushers of Balasan river bed

The studied area is located in the foothill region of North Bengal, i.e. in the foothill of North Eastern Himalayan belt of West Bengal, India. North Bengal is a region of varied landscape and distinctive cultural practices. The

varied landscape and varied people give a number of cultural traits and trait complexes. Naturally with the changing environment the concept of basic needs and the ways to acquire those needs are variable too. The Rajbanshis are one of the early settlers of North Bengal and Bangladesh. They were villagers and primarily depended on agriculture as well as far from urban attractions. Their way of life and mode of behaviour were totally based on folk culture with a very simple mind. Their existence was totally enmeshed with their land and with their neighbours.

But the dimension of time, place and situations is always changing. During the decade of 1970's (1970) there took place a number of political changes in this region. In 1971, there occurred a severe political unrest in Bangladesh. As a result a huge number of migrants took shelter in Siliguri and other suburban and rural areas. Among them the Rajbanshis were large in number. Question of daily existence was a prime factor for the migrated and landless people who were devoid of any source of income. Thus the land pressure and the lack of purchasing capacity forced them to search for a permanent occupation to give a backbone regarding their establishment as early as possible. In this regard Siliguri is the most important place and it is the largest urban centre of North Bengal. Its importance lies in its role as a commercial centre at the gateway with the North Eastern states of India as well as with International Borders like Nepal, Bhutan, Bangladesh, China, Myanmar. Still it is a developing urban centre. On the other hand many rivers like Mahananda, Balasan pass through the heart of the Siliguri town and natural resources like boulder, stone, sand come downward from the high hilly regions. These natural resources are used as the raw materials for various urban constructions and it is the only earning source for a large number of people.

The stone field of Balasan River bed thus became unquestionably the best option for the uprooted and resourceless people as it does not need any kind of capital investment. Moreover the Balasan River bed provided them the land to establish a new residence. Since 35 years the roofless, resource less migrated Rajbanshis are living in the Balasan River Bed by forming a Colony named as "Balasan Colony". The study was done on 200 families of the said colony who were engaged with stone based economy. The studied families had 1012 populations, with 507 males and 505 females; and the sex ratio was 997. The socio-economic scenario, socio-cultural factors and surrounding environment had a direct impact on their livelihood and on their health situation.

Health Situation of the Studied People: Migration was a prime factor which forced the Rajbanshis to leave their early settlement and traditional agricultural occupation. As a result the previous environmental background was totally changed and they were exposed in a new ecological niche. Naturally the new environmental scenario brought new cultural practices to them. It is already stated that irrespective of any climatic condition,

the stone crushers were engaged in their work throughout the whole day. The working atmosphere on the Balasan river bed was dusty and polluted. Simultaneously the stone crushers always had to work in touch with the river water. They worked day long under scorching sunlight, shivering cold and under heavy showers. Naturally, the working atmosphere resulted in a number of health hazards to them. The little amount of income was a severe constraints for the poor stone crushing families to consume the adequate balance diet. All of the studied families mainly took rice, pulses and little amount of vegetables in their daily diet. It was almost impossible for them to purchase expensive animal protein from the market. Hardly they could manage to consume least expensive fishes once a week. To provide milk and fruits particularly to the children was a seldom happening factor. The stone crushing people who were primarily engaged in the work took their lunch directly in the dusty and open river bed in most of the cases. Even they fed the children at the same place along with them. Mostly they were able to take lunch and dinner. Even during the pregnancy period, the conceiving mothers were also depended on same sort of diet. To earn a fold of rice among 270 ever mother, 160 (59.26) worked for long time even upto 5-6 hours in the stone field during their pregnancy period. The pregnant women had to face both the situation of hard manual labour and malnutrition. Among the total 270 ever mother, 202 (75.00) had more than one child and they all had given birth every child in the consecutive year. The feature of malnutrition during pregnancy period along with the hard work at the same time may tell upon the health of the new born baby and they often become malnourished too. The process of immunization was conducted under the influence of the worker of colony health subcentre but concerned women were unable to keep it in their remembrance. Among total 270 ever mother, 65.23 per cent had given birth to their children only in houses and in presence of mid wives, 20.29 percent had given birth to their children both in house and medical college and 14.48 percent had given birth to their children only in medical college. It reveals that the cases of child birth mostly took place without any proper medical attention.

Further considering the fact of drinking water and water usage for household work gives another highlighting issue. More than 80 per cent of the families depended either on uncovered wells or on the river directly for the said purposes. They consumed the water without any sort of disinfection and boiling. The expensive rate of fuels were a great hindrance for them to boil the water but the lack of awareness also had prevented the people to take the water even after filtrating it by cloths. The wells were seldom disinfected by the concerned authorities and they got contaminated with a number of germs. It may have resulted serious water borne diseases like dysentery throughout the entire year in the colony. The children were the worst sufferers of these diseases. Meanwhile along with the lacking of purified drinking water most of their houses were devoid of proper sanitary means and drainage systems, as a result those houses had become a key birth place of germs.

The stone crushing occupation itself results in a number of health hazards to the concerned people. Their diseases would be divided into two broad categories like short term diseases and long term diseases. Short term diseases were seen often among them and they got partial recovery from them with a little treatment. But long term diseases were those from which the concerned people were suffering for a long time and it required proper medical check up. During the stone crushing work often the people made themselves injured with stone chips or with the iron implements. Those sorts of injuries could be seen on their hands and eyes.

But often their negligence over short term diseases made them complex ones and it had been turned out as a serious problem to them. Ignorance of injuries on eyes created the swelling of eyes with burning sensation and problem in eyesight. Improper care over minute physical injuries during works turned into blisters with mucous secretion. They worked for long in touch of water. In this concern the moisture and their unclean bathing along with the uses of unclean dresses may have resulted the fact that skin diseases were quite common to them. Their continuous work in the dusty and polluted stone field as well as the dust emitted out from the broken up stones, repeatedly being inhaled by them through their respiration and it may have turned out the fact that adult and elderly people were suffering from acute respiratory problem and chest pain which may turn into chronic asthma. Lack of proper nutritive food and hard manual labour may have resulted acute nutritional imbalance among them and it had turned into anemia among both male and female. Another major problem was the tuberculosis. According to the health staffs of the colony health sub center, lack of nutrition, heavy work load together with dusty working environment and their alcoholism and smoking may had resulted this disease. From field observation it could be interpreted that their lack of nutritive food despite hard manual labour together with irregular schedule of food intake might be a prime cause behind this disease. Moreover the concerned people were suffering from fever, cold and cough almost through out the year but they had a little oppurtunity for their proper treatment. Those simple problems became complex with expensed time because their poverty was a great hindrance for them to go through proper medical check up for long duration. Another major issue here was with their problem of menstrual cycle like leucorrhea, irregular discharge. It may have resulted due to their involvement in a polluted working atmosphere, malnutrition and heavy workload altogether. Thus, the stone crushing occupation related with other probable factors had created a number of health hazards to the concerned people.

Most of the people with their ailments went to the colony health sub-centre for primary treatment but it was not always provided with adequate medicines and the infrastructure of necessary diagnostic tests. The concerned people with numerous health sufferings went to the nearest Primary Health

Centre and Medical College. But they were unable to bear the expenses regarding medicines and other required clinical diagnosis. Even they could not seek medical consultancy from the private doctors due to unaffordable expenses. To get rid from various diseases they first of all went to the quacks of local medical shops and often availed indigenous health care practices. The requirements of traditional medicinal plants were lacking very much and that's why the indigenous treatment was facing a serious problem. In this circumstance they have to depend on quacks for their treatment in most of the cases. Their lack of economic backbone and health awareness had prevented them to go through concerned diagnosis and proper medical check up. Meanwhile, it is to be mentioned here that the diagnosis through modern medical check up requires along time and specific regulations of medicine and diet. The studied people because their adequate poverty of think that the expenditure of valuable time will ultimately cut short their working involvement and they had to suffer more economic hardship in the forthcoming period. On the other hand the medicines provided by the quacks gave them a fast remedy and they could rejoin their work in quick succession.

Meanwhile the traditional healers also played a role in the prevention of diseases. They gave sanctified lockets and extract of various leaves and tubers in the form of tablets to the people. But in many cases these supernatural beliefs were unable to prevent their sufferings and they could not get the remedy. The expensed times behind those sorts of practices made the cases more critical for the health staff of the subcenters to deal properly and they often referred the patient to their higher authorities. But the expensive medical treatment and the duration of treatment become unaffordable to the studied people. Their time bound hard labour was a great hindrance in this concern because only their labour could provide them a fold of rice and they thought that expenditure of time behind medical check up made the valuable working period to spend in vain. Lack of educational knowledge, laborious working schedule and acute poverty were the main factors which had made most of the stone crushing families far away from proper medical care and health awareness. Insufficient infrastructure of modern health institution was an added criterion in this regard. Thus this occupation had resulted health hazards and malnutrition as a part of their daily livelihood.

General Observation

Migration comprises a wide variety of activities, each posing its own unique problems with respect to health and health care. Medical anthropology can contribute to the resolution of these problems in both an analytic and an applied way. By analyzing health-related factors of the place of origin-status, beliefs, practices, practitioners, expectations, etc., and comparing them with similar traits of the new society, the medical anthropologist can facilitate the process of communication needed for diagnosis, patient education, and

treatment. Alternatively, by analyzing the structure and organization of the health delivery systems available to migrants, the medical anthropologist can contribute to the design and implementation of modes of health services delivery that are intelligible and acceptable to the persons they are intended to serve. Cohon (1981) points out that worldwide the number of refugees is about 16,000,000. Both the numbers involved and the complexity of the cultures they represent pose a major challenge to medical anthropologists.

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