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A Sociological View of Management of Health of the Migrant Workers in Kolkata

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Kolkata, the economic capital of eastern India, attracts skilled and semi-skilled labourers, who migrate for a living. The migrants include sex workers, taxi drivers, shoemakers, porters, rickshaw pullers and child labourers. They migrate from Bihar, Jharkhand, Uttar Pradesh and different regions of West Bengal. Migrants, who migrate by taking the help of a village migration network, usually take shelter in slum areas. Such places are identified by the city administration as places of extra attention to prevent outbreak of diseases. The municipal corporation puts in place a robust malaria control plan in the city. The present paper would analyse how migrant labourers are governed by the city administration as a part of its malaria-control drive and how the perceptions of health and illness of these migrant labourers change in the process.

Keywords: migrant labourer, malaria, governance, medicalization, illness, identity, body.

Introduction

A young person seeking medical attention arrived at a Municipal Corporation run Malaria clinic with fever around 10 in the morning. Lab technicians enquired about his age in broken Hindias the person was struggling with his Bengali. The person replied coyly that he was twenty. Hearing the reply, the lab technician started laughing loudly while saying to the other people who were present at that very room that how could one be twenty years without having moustache. This small incidence is indicative of the health condition of migrant labourers and medicalization of their body in the metropolitan Kolkata. The city is bearing the legacy of colonial rule not only in its architecture but also in the form of health governance. Traditional grounds of racial and indigenous medical system's identity are dispersed, whenever they

are found to rest in the narcissistic myths of nationalism or western cultural supremacy. In this paper, I have made an attempt to explain how migrant labourers are governed to suppress the malaria situation in the city and change their perception about health and illness in the process.

Kolkata[1] and its migrants

Kolkata is the economic capital and the only metropolitan city in eastern India. Due to its proximity to river port and seaport and the road junction point to reach various economic zones[2], people from Bihar, Uttar Pradesh, Jharkhand, Odisha have migrated to Kolkata for livelihood. Migrants with/without having any particular skill take the help of village networks[3] to reach in the city and look for cheap shelter in the slum areas of the city. Such slums[4] are the hubs of informal sector economic activities and located near various economic zones of the city[5]. Such slums are distributed in the north, middle and south parts of the city. The migrants prefer slum areas because it suits their budget and also because they find a lot of people who are already known. They can also identify with the slum life easily since it carries a lot of their village culture and it provides a place where they can live without the pressure of social segregation. Here the migrant labourers get an opportunity to taste of their village food, share emotion, and a sense of belongingness. The slum life gives them a sense of security.

Social and cultural background of migrants

Suppression of skill/s as sustenance technique in host place is the first lesson that migrants learn after arriving at Kolkata. They want to protect themselves from the insecurities that the new place offers by using the already existing network which landed them to the city. Unskilled or skilled migrants do the kind of works for sustenance that the Bengalis do not want to do. The male migrants do the work like porter, taxi driver, plumber, mason and so on. Migrant women prefer domestic work, or work as helpers in construction work and sex-worker. Bengalis love to call migrants by different nicknames. Bengalis call people from Bihar as "khotta", people from Odisha as "ure" and Muslims as "nyara" – all in derogatory sense. The migrants mostly belong to the lower

castes. Shadow of caste is very apparent on their lives and that shadows turn long and dark during their search for jobs and when seek supports during certain emergencies. One of the most sordid situations or emergency happens in the life of migrant labourers when they fall sick due to the dreaded disease called malaria. Malaria can happen to people in Kolkata throughout the year. The reasons are complex and multi-layered. The major reason is the tropical climatic condition of Kolkata. Mosquitos, which are the carrier of the malaria parasite, can easily sustain and multiply their population in tropical weather condition. Mosquitos keep changing their behavioural pattern; they change the hiding place, breeding condition and place for their sustenance with the changes in disease governance policies and programmes (Biswas 2010). The ill-informed migrant labourers, busy earning their livelihood, want to keep themselves away from the sultry, sweaty dark shelter room and sleep at night on the pavements. Not used to mosquito net they become the easy victims of the disease. Malaria mosquitos prefer to bite human being between dusk and dawn, to collect protein for their eggs (NVBDCP 2014).

What is malaria?

Malaria is a vector borne disease. It is transmitted into human body by a mosquito bite. Malaria is found mainly in hot humid climate and in a marshy place. Malaria is caused by parasites of the genus Plasmodium. The parasites spread to people through the bites of an infected Anopheles variety of mosquitoes, called "malaria vectors," which bite mainly between dusk and dawn (WHO 2010). Biting time of each vector species is determined by its generic character but can be readily determined by environmental conditions.

Impact of malaria on human body

Malaria is an acute febrile illness. If not treated properly and on time, this disease can progress to critical illness including multi-organ failure, often leading to death (WHO 2014). Most of those who fall ill survive after an illness of 10-20 days but 1-3% of those who contact *P. falciparum* do not. However, environmental disturbance, malnutrition and the failure of drugs once used to control the disease have conspired to make malaria as serious a

problem now as it was during the first half of the twentieth century (http://www.malaria.org/lifehealth.html).

Economic impact of malaria

In a report, prepared by Malaria Foundation International for Centre for Development (Harvard University and London School of hygiene and tropical Medicine, 2014) explained: 'these considerations indicate that the cost of malaria is substantially greater than economists have previously estimated. Traditional estimates have looked at some of the short-run costs of malaria without taking into account the longer-term effects of malaria on economic growth and development. Short-run costs — including lost work time, economic losses associated with infant and child mortality and morbidity, and the costs of treatment and prevention — are typically estimated to be higher than one percent of a country's gross national product. These estimates, however, neglect many other short-run costs. For instance, very few studies include the economic costs of the pain and suffering associated with the disease. Yet researchers have found that households might be willing to pay several times the direct income loss caused by malaria in order to avoid it, suggesting that the pain, suffering and uncertainty associated with the disease is very high and should certainly be included among its short-term costs' (pp. 1-13). This economic impact actually drove colonial rulers to initiate research to find out possible solutions and to introduce system of public health in Kolkata (Calcutta).

Malaria in Kolkata[6]: The importance of locale in governance

The presence of malaria in Kolkata is reflected in the writings of colonial rulers more than in Indian medical books (Harrison 1994, Arnold 2000, Samanta 2010, and Debroy 2013). The simple reason of such hyped literary expression of colonial time is the impact of the disease that adversely impacted finance of the East India Company and threw a spanner on the attempt to earn by utilising a place's natural condition like weather for cultivation of cash crops. The uncanny feeling towards the space and people of the place propelled them to search out every possible reason of sustenance of the suspicious diseases. Colonial rulers were extremely concerned about the financial loss in plantation sector

and weakening strength of army. One of the major reasons of this remarkable financial loss and weakening of army was the repetitive occurrence of malaria among both the labourers and army. Migrant labourers were encouraged to migrate from different areas of India to work in tea gardens of North Bengal. The frequent attack of malaria among the migrant labourers had disrupted the daily plantation work and due to such disruption, financial loss was unavoidable. In an attempt to protect, to recover financial loss in plantation sector, and to restore the spirit of army the colonial rulers established a research laboratory in Kolkata and Sir Ronald Ross had been engaged to unearth the malaria conundrum. Nandini Bhattacharya (2011) in her recent research has found that the "locale" and its economic interest instigated the colonial masters to patronize research and medicalization of this menace called malaria. This importance of "locale" also prompted experiments with the concept of "public health" (Harrison 1994) in Kolkata and its nearby areas. Kolkata was first to witnessed the hegemonic expansion of western medicine and treatment; the fringe areas of Kolkata also got the flavour of the western medicine as the part of the plan of expansion of business of medicine. However, in rural Bengal traditional medicine continued to play a dominant part for many years. However, the post offices had begun to publicize the news about the overarching power of western medicine. Colonial rulers did not confine their research on the role of mosquito in spreading the disease but they had searched out the role of the migrants in spreading this disease. Colonial mechanism of knowledge generation and knowledge networks[7] helped the rulers to build and protect their castle in India. Their art of listening to and understanding Indian people and their culture was not flawless.

After independence the "locale", has not yet lost any significance in administration. Even in post-colonial governance formation and dissemination of knowledge about disease have been along the line of "white mask black skin" syndrome. The government, that consists of personnel who are to provide services to the fellow citizens are carrying the mentality like the colonial masters. Colonial rulers established their identity as master (Fanon 1986). Even after independence, it has been observed that Government officials are guided by the perception that the citizens whom they are serving must behave like slaves. Infected citizens without letter

of recommendation from a higher officials or politicians are not be attended to by the officials of lower administration. If these citizens are from the "underprivileged" section the government officials would expect more servitude and silence. Migrants are considered as the permanently alien in their own country (Fanon 1986). They live in a state of absolute depersonalization. Rural fringes along with distant areas of India are still under the grip of traditional medicine. The persistence of colonial attitude[8] towards illiterate labourers/ villagers and restricted access to medical service oblige them to end their quest for medical assistance at the door of traditional doctors.

Malaria among the migrant labourers and their resistance

Municipal Corporation[9] has been assigned, as part of the public health and sanitary conservancy programme, the responsibility to address the malaria menace in Kolkata. Municipal Corporation works in its 141 wards providing basic amenities to the citizen while making them aware about their rights. The term "citizen" is not a homogenous category. The migrant labourers placed at the bottom of the category of citizens. In other words, they are "less citizens" in terms of their rights. Among them, the situation of the sex-worker is more complex because of the profession's non-legal status. This practice of categorization is the importunity of the practice of the colonial rulers that seems to linger in the postcolonial discourse and governance.

Labourers who migrate from Bihar, Odisha, Utter Pradesh, and Jharkhand prefer to remain as unnoticed to protect themselves from the unknown complications. They are constrained to follow the village network to find the *locale*[10] for job and night shelter. This locale is the slums where they have developed small ghettos of their village/district people. This locale actually has achieved a significance space in disease governance. This space has become the centre of development but actually provide a context of conflict between governance and development. As migrant labourers find this space as their backbone they continually search out their survival strategy, resistance and negotiation patterns.

Majority of these migrant labourers are of the lower castes and have a very small amount of cultivable land in their villages. They do not have bank accounts rather they prefer to keep money at

moneylender's box but they keep mobile phone to communicate with family and village mates. Another significant feature about these migrant labourers is that a few of their villages have been turned into battlefield between Maoist groups and the government forces. Physical and psychological stresses are part and parcel of their lives.

Migrants after reaching Kolkata, countenance the pressure of cultural domination. This cultural domination/ethnic supremacy tries to create the impact upon their everyday life and push them in a locale. Inside this locale, a good number of migrants cannot sleep inside one mosquito net. They use bed sheet to cover their body parts in their effort to stay away from mosquito, albeit without success. Very often they become easy prey to malaria.

However, the migrant labourers continue with their everyday life, clinging to their conventional way of life (the mode of sleeping), including food habit and language and daily work routine. Yet, a few changes in their food habit can be noticed; they now eat rice twice a day, instead of roti, and one variety of lentils[11]. A very few of them can afford non-vegetarian food. Their dietary habit keeps them undernourished and anaemic with low level of resistance to diseases. They are found wanting when they fall the victims of malaria and when they are forced to cooperate with the government initiative to control the vector. Water containers, which are used by these labourers to meet their need of sanitation and hydration of body, are considered as the source of mosquito. When the representatives of KMC undertake anti-malaria drive and try to destroy the places of mosquito breeding throw the water from the water-containers and sometimes confiscate them. They even threaten the labourers with eviction drive. This creates moments of tension and conflict between the urban administration and the migrant labourers.

Culture of illness among migrant labourers: Passive acceptance of systemic decisions

In Kolkata, the migrant labourers generally live with the concept of illness that they have learnt in their villages. Even, the shared perception of illness has a strong community (caste/communal) dimension. The community decides the pattern of everyday life and within this pattern of life the perception of and mode of

treatment of illness is also included. Migrants from Bihar and Uttar Pradesh share almost the same understanding of illness. For them fever is the most significant indicator of illness; reasons of fever are secondary to them. Firstly, they say that 'Sharir hay to bimar hay' (it's natural to catch disease so long as we are alive). Some of them would say "disease is God's grace". A very few of them would acknowledge that they do not have a proper place to live, that they live in unhealthy condition, and they are significantly malnourished. The hard physical labour and the unhealthy work condition also do not help them living a healthy life. The sex workers would generally say they have done "sin" and that is why the God m with diseases. They hardly recognize mosquito bite as the root cause of the malaria.

Mellor and Shilling (1997) have rightly observed: 'bodies are not just a source of work but are a location for the effects of work' (p. 98). Again, Shilling has observed: 'the disciplining of worker's body was not accomplished purely on the basis of overt physical coercion, but relied heavily upon an associated *reorganization of space and time.* In terms of space, Foucault (1979) highlights how modern factory production, enclosed, partitioned, and ranked bodies in order to facilitate their functional productivity. The *enclosure* of bodies within factories confined work to the particular space, a space that visibly belonged to the employer and over which the labourers had no rights. Manufacture supplemented this process and helped neutralize the dispositions groups brought with them into the workplace' (pp. 79-80). The performance of sick role and deceptive perception of illness of the labourers can be analysed in the light of above perspective. The cumulative impact of the workspace that is found as small, cramped, damp, dingy, and the pressure to complete the work within the given time is the source of tension among the migrant labourers. They do not feel comfortable within the workstation. They do not sleep or eat properly. They understand the problem but the solution was beyond their means. The women who work as sex workers, domestic help or construction worker confront 'the double burden of waged labour and reproductive body work'. Being unskilled, they do odd jobs in the informal sector, where exploitation exists in its crudest form, in order to subsist. At the same time, they have to pretend to be healthy and sustain their hard-working image to prevent dismissal from work. They cannot afford to be

"ill" because that would mean ill-treatment, verbal abuse, wage loss, and even dismissal.

Migrant labourers do not come to the city with a clear understanding of malaria, but those who are living in Kolkata more than a year and those who had someone suffered from malaria develop their own perception about the disease. From their experience, they can relate symptoms like heavy body ache, loss of appetite, "feeling cold", cough and cold with malaria. The migrant labourers often get confused when they have to answer the queries of the health workers or lab technicians who visit them occasionally. Most of the time, the workers and their family members are reluctant to speak about their illness and are confused about the symptoms. This could be strategic or out of ignorance. Ignorance is present because they do not know for sure what could be the difference between a normal viral fever and malaria fever. Strategic because they do not want to be labelled malaria infected and lose their livelihood. Through conversation with the health workers, they also change their conventional understanding of illness. Greater and clearer knowledge about illness make them depressed and worried because the implications of malaria could unsettle their mental composure. The migrant sex workers generally put their symptoms differently than other migrant workers. They do not get an opportunity to express their uneasiness arising out of fever. Detected illness or symptoms like body ache, cough and cold can directly affect their livelihood. Migrant sex workers suffer from various STDs, HIV/AIDS, RTIs[12] and problems associated with alcohol consumption. For them fever is normal and is not considered illness. They cannot claim to ill unless pimps tell them to do so. Pimps decide the time of consultation with a doctor. As a partial solution, the sex workers have set up an NGO named Durbar. Durbar organises medical camps and routine blood test to prevent HIV/AIDS. However, pimps and *malkins* do not allow the sex workers to go to the clinic or camp to do so. With peer-group pressure, the sex workers are allowed to do a routine blood test.

Due to lack of education, psychological barrier and social denunciation sex worker hesitate to ask for any kind of assistance from the larger society. The control of the pimp and malkins over their body is so complete that they live with the illusion that both pimp and malkins are aware about their health problems and

they have the capacity to control all kinds of hazards including health. For sex workers, health problem is a hazard. They feel uncomfortable in describing their health problem but can give a name to their private organs. They live with fear about the government institutions, particularly police. Sex workers do not want to visit government hospitals because their experiences in government hospitals have created a strong sense of exclusion in them. Those who went to government hospital could not express their identity because sex work is illegal in India. The illegality of their profession makes them ineligible to access health benefits. HIV/AIDS is very common among the sex workers. They never tell the customers about their infection, even when they know about it. The disclosure would mean loss of livelihood. When their health condition deteriorates to an unbearable level they hesitate to visit the government hospitals, where they would have received highly subsidized medical treatment, because of the fear of ostracization. When the visit to government hospital becomes an absolute necessity, they visit with a lot of fear about disclosure of their identity.

About the modern health system Foucault has observed: 'medical certainty is based not on the completely observed individuality but on the completely scanned multiplicity of individual facts'. He has argued that after being informed about the medical history the medical practitioners are stricken within "stylised repetition of act"[13]and hence they withdraw themselves from the role of medical practitioners. Migrant sex workers have been socially conditioned to feel that they are the "polluting person".[14] Foucault has further said: 'clinical experience sees a new space opening up before it: the tangible space of the body, which at the same time is that opaque mass in which secrets, invisible lesions, and the very mystery of origin lie hidden. The medicine of symptoms will gradually recede, until it finally disappears before the medicine of organs, sites, causes, before a clinic wholly ordered in accordance with pathological anatomy' (Foucault 2003: 150).

Reflecting back to their journey to the point of being sex workers one can see that many of these women are the victims of the child marriage and after having children they were thrown away from their in-laws' house. I met with one girl who was thrown out because she failed to give birth of child. She could not bear that agony. In order to make a living she initially searched for a manual

job. However, her parents and brother assured her of support for modest living. She did not wish to live on the mercy of others. With the help of a local agency she migrated to the city and became a sex worker. In the initial stage, even after repeated counselling, she did not take any precaution by using condoms. Therefore, she became pregnant. Worried that a child can affect her work she went for abortion, albeit beyond the legally permissible period.[15] Drawing confidence from her pregnancy she filed a lawsuit against her in-law's and husband demanding the return of the dowry money that her father had given at the time of marriage. She met the cost from her saved money. She now feels that her body is genuinely feminine, which demystifies the "infertile body" that her in-laws had labelled on her. She now lives with a sense of injustice and a lot of grudges meted to her. At the same time, she feels low because of the abusive nature of her job and the accumulated ailments that are out to cripple her body.

For the pimps and *malkins* life is no better. They live in fear. They avoid the NGO Durbar. Only in problems like STDs, RTDs they consult the organization's doctor. Otherwise, they visit private doctors or nursing homes when faced with ailments. The pimps and *malkins* want to maintain total secrecy about their body and diseases. They avoid government hospitals in fear of being exposed. They generally think that the government keeps records about them to inform police but does not provide the desired services.

Fever, including the one related to malaria, but a very few of them consult government-run hospital. They have a general tendency not to pay importance to malaria or any other fever. They have developed this "pattern" of behaviour out of the experience they have drawn from their interactions with the doctors in the past. Their life-style also conditions their perceptions. They begin their work in the late morning after taking breakfast and alcohol. During the daytime, they mainly consume beer but since afternoon, they start taking other kinds of alcohols. Since evening, they lose their normal sensations to the extent that they cannot sense mosquito bite. Sometimes, when they cannot keep track of their money they start shouting on their clients and the fellow sex workers. Pimps are supposed do a settlement between the client and drunken sex worker to avoid police intervention. For them this is a routine task and it is difficult for them to understand the health condition of the sex workers. Usually people learn about

their body, illness and sick role from their family members or from peer group or the agency with whom they interact. For these sex workers, it is not possible to address their health problems. They live in confinement. They are not allowed to interact with each other. They are informed categorically by the pimp and *malkins* that, in this profession nobody wants to listen to others. Therefore, they should not tell anyone about their physical problem and related psychological issues. Only pimps and *malkins* are there to listen to them. Only when some serious illness or problem arises the fellow sex workers come to know about it. Migrant sex workers do not get the opportunity to share their problem even with their family members. Those who regularly commute by train are able to interact with other daily commuters, share their problem to receive their counsel in solving other problems. Thee pimps and the *malkins* want total control. They generate the belief that allopathic treatment is no good for their health. They advise them to consult homeopathic doctors and quacks and sorcerer. They advise to avoid allopathic doctor due to their financial instability. The quack doctors interact with them in their own language and understand their problem better and the waiting patients resemble the class of the sex workers. This makes them comfortable seeing them rather than the doctors representing the modern medicine.

With the allopathic doctors, the sex workers feel a strong language and cultural gap; they cannot follow what the doctors say. They also cannot explain the symptoms properly; there is wide gap in their perception of body and the way the doctors want to understand. The sex workers feel that their body is stigmatised. The conversation with doctors gives them a feeling of embarrassment. They do not want to allow a person like a doctor who has different prestige in society touch their body. Another fear that prevents them from taking medical help is that if they are identified as ill and are out of their job then who will look after their children and their kin. Consequently, even if they visit a modern medical practitioner they do not continue with the follow-up visits. Sex workers and pimps become silent carriers of the diseases and suffer in the process.

Pimps[16], after diagnosis of the malaria, prefer to return home or are brought to Kolkata from their home for treatment. Disclosure of identity is not the only issue that worries for the pimps and *malkins*. Concealment of their sick role is a strategy to maintain

their position in the social hierarchy (Alcoff et. al. 2006)[1]7. They want to develop the image that they are free of any illness, especially of STDs. This identity of free from any illness allows them to negotiate with the sex worker, NGO workers and clients. To uphold the identity and hierarchy they even try to hide the illness of the sex workers. Both pimps and sex workers are advised to consult the quacks and most frequently, sex workers' identity and mental state are moulded the way the pimp, *malkin* and specially the clients want.

The nature of job of migrant labourers (including the sex workers) is tiring and hazardous. They do not stay in the workplace for more than six months at a stretch. Those who come from rural Bihar, Uttar Pradesh and Jharkhand give equal attention to their agricultural land because agricultural produce helps them to maintain their family. Most of them take their children to Kolkata, mainly the male children, and sometimes relatives' children to learn some skills and earn some money. Child labourers usually work for a low wage with board and lodging. Child labourers, like the adult ones, also work for six months and then they return home to work in the agricultural field. After completing their agricultural work, they interact with other village mates to decide their next destination. Sometimes they carry on their work in the same workplace where they worked six months back. Due to this pattern of migration, workshop owners who are also migrants from Bihar put extreme pressure on the workers to complete work within a specified time. They continually push them to work for longer hours with less time for rest. Owners are aware of recurrence of malaria but they know that the labourers are not. Labourers are never encouraged to consult government clinic and they are never advised to use a mosquito net. Only a few migrant labourers use coils to protect them from mosquito bite. With growing public awareness and pressure, the KMC sends health workers to the residential areas to locate breeding spots and the infected persons. The workshop owners in the slum areas however take little preventive care. Due to work pressure, migrant labourers work on weekends and on holidays too. Relentless work by sitting in one position makes their life stressful. To get relief from stress they often visit the nearby red-light zone and catch STDs. Consumption of local variety of alcohol keeps them less aware about the real problems of their life and the problems of their body.

They forget their past and cannot remember if they had ever suffered from malaria. Because of their mobile nature and work pressure, they do not keep record of their past ailments. The case of a house cleaner in a clinic can be relevant here. This woman in her mid-30s is the mother of two children. She visited the clinic to collect the blood test report of her sixteen-year-old boy. The report confirmed malaria vivax positive. She came for the report on the next day of the test day although she was advised to collect the report a day earlier. Asked about the reason, she said that she could not manage leave. She was under pressure to complete her day's work in order to be in the good book of her employer. As the lab technician could remember that the woman's another boy suffered from malaria few days ago, he tried not to repeat the doses of the medicine to her. This woman admitted that she forgot the entire doses and other things associated with it. However, asked about the reason of the cause of the disease to her boys she replied that the presence of the pond in her locality was the root cause.

A lab technician talked about one patient, a migrant from Bihar, who, having caught malaria, swallowed all the medicines at once. He did it to get rid of fever sooner, without understanding the implications. Those who are alcoholic take the medicine with drink and not with water. Once I met a trucker in a clinic. He was a migrant from Uttar Pradesh. He came to the clinic malaria test because he had suffered from malaria. Previous year he was not aware about this disease and did self-medication. When he was almost unconscious, his friends had brought him to the clinic. He had the belief that this clinic has some special power to cure his disease. He stays vary far from the clinic, but faith had brought him here. However, he does not know the proper reason or the role of the mosquito behind this disease; he had a vague understanding his movement during night might be the cause of this fever. Now he understands that this fever is different from other fevers and needs special treatment. Since he had to cover a long distance to come to the clinic he stayed there and collected his report and medicine. Because of the last years' experience, he reached the clinic at the earliest without wasting a day after catching fever. He wanted to be cured early.

It is found that the migrant labourers who have been coming to this city for job for several years have suffered from malaria more than once. Despite this, their knowledge about the disease is shrouded with wrong information. They have revealed the fact that the degree of suffering in their first experience with the disease has gradually been lesser in their second and third experiences. They actually became habituated with the experience of the disease. Their stock of knowledge about the bodily feelings due to the disease has developed a mental stability against this fever. They, over the years, learn to take the disease and the related sufferings lightly and get on with their regular activities.

The newer migrants depend on the migrants who have been in the city for many years for advice on selection of doctor, medicine and foods when they are down with malaria. New migrants usually take shelter in the village ghettos in city. The male members outnumber the female migrants and they do not follow any ritual during their illness, although they all are very religious. They take the fever as god gifted and visit the nearby temple praying for early recovery. They perform a gesture touching the ears with hand and simultaneously doing the sit ups. Few among them prefer to go to Kalighat Kali temple to offer special prayer. The Muslims, on the other hand, offer their prayer at the mosque.

Conclusion

Migrant labourers in Kolkata are the victims of the medicalization of malaria and medicalization of their body. Both of these forms of medicalization are inter-related. While the health and civic administration holds migration as the one of the root cause of the spread of malaria, the migrant labourers are taken to the ones who are largely responsible for the spread of the disease in the city. However, neither the centre nor the state government has a declared policy to give special medical attention to migrant labourers or to control migration process in order to check the spread of malaria. The state administration resorts to suppression of the voice of migrants in order to prevent the spread of panic in the city and tries to manage the crisis with highly inadequate and ineffective medical intervention leaving the migrants in a state of confusion. In the absence of an effective and free medical setup, the affected migrants depend on homeopathy treatment and on

the quack doctors, thus complicating the eradication of the menace. Moreover, their inability to identify the symptoms of the disease (because of lack of consciousness) and, most importantly, the compulsion of presentation of a fit body in their work place makes them suppress the truth about their illness They are the victims of the situation and play their part dictated to them by the power hierarchy. The livelihood compulsions make them surrender to the system while suppressing their critical agency. Acceptance of these strategies by the migrant labourers gives permission to the government to validate the medicalization of malaria and body of migrants. Thus, the migrant labourers who have never been registered in any government document and as they select their place of work in community specific areas for existence become the moorings of the malaria governance of the city administration.

Notes

1. I have only given a very brief sketch of the city.
2. Economic zones include business hubs and manufacturing units.
3. Village network means a network of human agents who give information and contact for jobs in the city. They help the villagers and their family members to migrate throughout India and even outside.
4. For more details about the slums of Kolkata one may read W. C. Schenk, 'Slum Diversity in Kolkata', *Columbia Undergraduate Journal of South Asian Studies*, Vol. 1, Issue 1, Fall 2009.
5. Development of slum in Kolkata is associated primarily with industrialization and partition of Bengal in 1947.
6. History of malaria in the history of city Kolkata is pretty old and intriguing. However, the fever malaria was not known as "malaria" before the colonial intervention to know the cause of the fever that actually had become a great threat to the pink health of the colonial army and financial loss at plantation sector. The city plan of the Calcutta was designed to separate the geographical space of the city into two distinct spaces. In the one space, colonial rulers had settled with provisions to prevent diseases like malaria etc. and in the other space were for the natives without much civic

arrangements. Due to this reason "locale'' or the space played very important role during colonial rule and after independence this model is continuing in urban planning and governance (Pati & Harrison 2009)

7. The native labourershad a"hand to mouth" existence. Agrarian crowding furthered migration to cities, where the poor were packed into sub-human living conditions in slums. 'Modern economic circumstances combined with caste, educational and other traditional impediments to upward… poor class of Indians who were especially prone to succumb to disease'. Ira Klein, 'Death in India',*The Journal of Asian Studies*, 1973, Vol. 32, No. 4: 639-659.

8. 'The fantasy of the native is precisely to occupy the master's place while keeping his place in the slave's avenging anger'. F. Fanon, *Black Skin White Masks* (translated by Charles Lam Markmann), UK: Pluto Press, 1986.

9. The 74th Amendment of the Indian Constitution empowers the municipal corporations to enhance and guarantee the rights of the citizens.

10. Or the social place where the slum dwellers or the migrant labourers face caste related oppression/conflict/ state induced violence.

11. Rice is relatively cheaper and easier to cook compare to Roti.

12. HIV/AIDS (Human Immuno Virus/ Acquired Immuno Deficiency Syndrome) – which breaks down the body's immune system, leaving the victim vulnerable to a host of life threatening infections, neurological disorders or unusual malignancies. STD (Sexually Transmitted Diseases) are transmitted predominantly by sexual contact and caused by a wide range of bacterial, viral, protozoal, and fungal agents and ectoparacites. RTI standa for Reproductive Tract Infection. Park K. (2011). *Park's textbook of preventive and social medicine*. 21st Edition. M/s Banarsidas Bhanot. Jabalpur.

13. According to Judith Butler (2012) gender is an identity tenuously constituted in time, instituted in an exterior space through *stylized repetition of acts*. The effect of gender is produced through the stylization of the body and hence, must be understood as the mundane way in which bodily gestures, movements, and styles of various kinds constitute the illusion of an abiding gendered self. Pp. 191-192

14. According to Mary Douglas (1966) 'a polluting person is always in the wrong. He(sic)as developed some wrong condition or simply crossed over some line which should not have been crossed and this displacement unleashes danger for someone'. Pp. 56.

15. For greater details one can see: Medical Termination of Pregnancy Act 1971-When pregnancies may be terminated by registered medical practitionershttp://www.medindia.net/Indian_Health_Act /medical-termination-of-pregnancy-act-1971-when-pregnancies-may-be-terminated-by-registered-medical-practitioners.htm#ixzz2w1OZxpwu

16. Pimps migrate from a small village of Medinipur District of West Bengal, which is located at West Bengal-Odisha border.

17. 'often we create positive and meaningful identities that enable us to better understand and negotiate the social world…Like identities, identity politics in itself is neither positive nor negative. At its minimum, it is a claim that identities are politically relevant, an irrefutable fact. Identities are the locus and nodal point by which political structures are played out, mobilized, reinforced and sometimes challenged...Obviously, identities can be recognized in pernicious ways…for the purposes of discrimination' (Alcoff and Mohanty,*Identity politics reconsidered*. New York: Palgrave Macmillan, New York, 2006, p. 6).

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Harvard University and the London School of Hygiene and Tropical Medicine, pp. 1-13