British Journal of Research
ISSN: 2394-3718

Open Access Mini Review

Seasonally Migrated Sugarcane Cutters and Health Services in the Sugar Belt in Maharashtra, India

Saroj Shinde*

Department of Health Science, Tata Institute of Social Sciences, Mumbai, India

ABSTRACT

This article underlines the role of sugar factories and the government health system in providing health services to sugarcane cutters. It highlights if and how existing health service providers solve workers' health issues by emphasizing the nature of health services on which these workers depend. Every year sugarcane cutters seasonally migrate from the drought-prone or tribal districts towards the sugar belt of Maharashtra. It mainly constitutes illiterate/less educated, poor, lower castes and landless/small landholders. It is well known that these workers confront numerous problems and compromise at multiple levels. Specifically, exploitation of labor rights, issues related to housing and sanitation, deprivation of children from education, issues related to accessing citizenship rights, etc. Together these issues accentuate that these workers are neglected multilaterally. In the same way, their health issues are sidelined and not even a part of at least any discourse.

Keywords: Pediatrics; Phthalates; Hazardous chemicals; Health

INTRODUCTION

At the beginning of 2019, in Maharashtra, there was news highlighting the high proportion of removing the uterus among women sugarcane cutters. As a result, the issue of hysterectomy was discussed in the media and various other platforms. Since then, sugarcane cutters in Maharashtra have become part of social and political discourse. Diverse media platforms have tried pinning several issues of sugarcane cutters in Maharashtra. It predominantly includes issues of labor rights, education of children, the health of the workers and the practice of hysterectomy. However, practically none of the issues reached a solution. All the discussions stressed the need for systems to work for these workers meticulously [1].

LITERATURE REVIEW

Firstly, it is crucial to understand which population strata migrate towards the sugar belt. According to the facts available, seasonal migration is not limited to workers (men and women); it also involves newborn babies and school-going/school dropout children. Surprisingly even pregnant and lactating women are no exceptions. The population with different age groups eventually demarcates migrants' different health needs [2].

Remarkably, the majority of workers tend to report work-related health issues as the nature of sugarcane cutting is terrifically laborious. The pregnant and lactating women sugarcane cutters require reproductive health services to register their pregnancy, access at least three ANCs, two injections of TT, institutional delivery, immunization, family

Received:	22-May-2023	**Manuscript No:**	IPBJR-23-16543
Editor assigned:	25-May-2023	**PreQC No:**	IPBJR-23-16543 (PQ)
Reviewed:	08-June-2023	**QC No:**	IIPBJR-23-16543
Revised:	13-September-2023	**Manuscript No:**	IPBJR-23-16543(R)
Published:	11-October-2023	**DOI**	10.35841/2394-3718-10.10.91

Corresponding author: Saroj Shinde, Department of Health Science, Tata Institute of Social Sciences, Mumbai, India, E-mail: Shinde.saroj4@gmail.com

Citation: Shinde S (2023) Seasonally Migrated Sugarcane Cutters and Health Services in the Sugar Belt in Maharashtra India. Br J Res. 10:91.

Copyright: © 2023 Shinde S. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

© Under License of Creative Commons Attribution 4.0 License
This article is available in: https://www.primescholars.com/british-journal-of-research.html

planning and related emergency and essential health services [3].

In this regard, basic queries are, how do these workers fulfill their health needs at the destinations? Has anybody noted that sugarcane cutters are involved in risky jobs and need special health services? Or do health services at the destination or sugar factories address workers' health needs? The answer to all these questions varies according to the destination district [4]. Because of the routined seasonal migration of these workers to different districts and sugar factories, they can identify the difference in hospitality, services and treatment received in a particular district. While informing the difference, workers consider health service availability and other services for that area. However, one cannot disagree that in Maharashtra, no district or sugar factory comprehensively addresses the health care needs of these workers [5].

DISCUSSION

Even if we consider the Pune district of Maharashtra, the sugar belt of this district receives workers from the drought-prone and tribal districts of Maharashtra. Outrageously, these workers' health and other basic needs are primarily unanswered. At the implementation level, nobody (Local public health services at the destination and sugar factories) ensures the health of these workers. As a result, like other basic needs and labor rights issues, the health of these workers is unresolved. On one side, there is an argument where we see not only Maharashtra but the entire country with a similar public health system structure [6]. Indian constitution grants the free movement of people anywhere in India. Then why are these workers away from public health services after the migration? One can even raise the possibility that these workers are denied health service access at the sugar belt based on their migration status. However, the answer to all arguments and questions is multilateral. Workers can have access to public health services at the sugar belt. Nevertheless, the work of sugarcane cutting is without any edge; working conditions are miserable; no fixed working times/hours, no breaks or weekly holidays [7].

During a health emergency, if a worker takes leave to access health services, the contractors cut more money than the worker's daily earnings. For instance, if a pair (husband and wife) of workers earns Rs 500 to 600 a day, the contractor deducts the amount of Rs 1000 to 1200 from the salary. Therefore, workers avoid taking leaves and work with ill health [8].

Another side of reality is that if workers stay in a surrounding area of a sugar factory, they may access the health services available near the factory. However, larger numbers of workers reside in the form and migrate from village to village for sugarcane cutting. In such cases, sugar factories do not provide health and other services to these workers. Suppose the backbreaking work of sugarcane cutting does not allow workers to maintain their health; it becomes the responsibility of sugar factories and local public health services to respond to the health needs of these workers. Nevertheless, we are still waiting to see that happening. In most cases, workers face occupational health issues. At least sugar factories should recognize the occupational impact on workers' health and make health services available [9].

Many workers inform that sugar factories provide health insurance, but no worker is informed on how to be benefited from it. Often workers fall from the vehicle, get cuts and wounds because of sickle, receive scorpion or snake bites and sometimes even die. Still, factory insurance is nonresponsive. The question remains, what happens to the insurance offered by sugar factories? We will seek the answer to it at last [10].

Before that, we will understand the role of team leaders or contractors in providing health services. It is already emphasized that most sugarcane cutters are deprived of health services. Then the obvious question is what they do in an extreme health emergency. This can be answered in two ways. First, workers take leave, bear the financial exploitation by contractors and access public health services. Secondly, several times contractors surprisingly open an account of each worker in a private hospital. They ask workers to access the health services from that hospital. At the end of the sugarcane cutting season, contractors calculate the amount of each worker from the private hospital and reduce it from the worker's salary. That amount can be up to 5 to 10 thousand. Therefore, workers feel it unjust and unfair to spend that amount on health for one season. They sense financial exploitation and avoid service access [11].

There is no alternative system where we expect contact between workers and public health services at sugar belt. Therefore, these workers choose the private hospital against their wishes and expend money despite their incapacity. Possibly many workers stay away from going to the hospital. At large, these workers are poor, so they cannot afford to access private health services. Therefore, workers take painkillers from nearby medicals for work-related health problems such as body pain and pain in the hand or leg, neck, knee, joint, waist, etc. If a worker dies at or after work, the family does not receive any insurance benefits or financial help from the sugar factory. Conversely, the contractors try to take the money back taken by the worker in advance. Clearly, it is a case of exploitation. Therefore, sugar factories should clarify the insurance mechanism for workers to access insurance benefits; create awareness among the workers on insurance [12].

Sugar factories and local public health services at large do not address the health needs of workers is a reality. Along with it, they do not give any special consideration to the health needs of women sugarcane cutters. Women workers also involve pregnant or lactating women working for the sugar factories. Even they are deprived of essential reproductive health services. From the tribal districts of Maharashtra, under-aged but newly married, pregnant or lactating women migrate to the sugar belt. Such women workers barely get access to services. Subsequently, we witness incidents like women delivering babies on the sugarcane farm, women without the registration of pregnancy or ANCs and children without

immunization. We also observe early motherhood and high parity among the women sugarcane cutters [13].

CONCLUSION

Sugar belt fails to provide health services to these workers as there is a lack of an attempt to understand the social and economic circumstances around the migrated population. First and foremost, there is a need to accept the apparent possibility that because of the work of sugarcane cutting, these workers need various health services. Secondly, local public health services or sugar factories should be responsible for the workers' health. Otherwise, we will keep listening to the fact that these workers cannot access health services at their destination. In the present situation, it is necessary to bridge these workers to any health services to ensure their access during the health crisis. The other foremost concern is that if workers cannot access the required services because of the heavy burden of work, there is a need to protect the labor right by structuring the nature of work in terms of work conditions, working hours, weekly holidays and more. Even more, team contractors should receive the guidelines regarding labor rights to avoid the financial exploitation of workers. There are several incidents where contractors did not allow workers to go to the tehsil place to access the health services as contractors think that workers would abscond to their native place.

In fewer incidents, local public health personnel try to vaccinate sugarcane cutters' children but hardly encounter each other because of different work timings. Therefore, a comprehensive attitude is required to maintain the health of these workers and their children. It is necessary to systematically consider whether these workers are provided health services at the workplace or whether mobile health services will be effective in the same regard. Ignorance of local public health services towards the seasonal migration of these workers and their involvement in the risky and unsafe work, the deprivation of these workers from health service access, compromised reproductive rights of women sugarcane cutters, contractor's logic behind opening accounts of workers in a private hospital to financially exploit them, all these realities open the door to work extensively for the sugarcane cutters.

ETHICAL ISSUES

This article is prepared based on research on reproductive health issues of women sugarcane cutters in Maharashtra. All methods were carried out in accordance with relevant guidelines and regulations. Firstly, before conducting the study on this particular population, this research proposal had sought ethical clearance from the Institutional Review Board (IRB) of Tata Institute of Social Sciences (TISS), Mumbai. The suggestions of IRB helped frame the consent form for the study. All the relevant information was provided when opting for research approval from the IRB committee, TISS. It specifically involved the research protocols included in conducting a study, protecting the rights of participants and the researcher. The information sheet also clarified the publishing of relevant data conducted through the research.

Secondly, all participants were informed about the purpose of the research. Informed consent was taken from all participants. The consent form and the research tools (Interview guide) were translated into the Marathi language. The consent form included sufficient information about the study. Content in the consent form was comprehensive, easy to understand and well documented by focusing on major principles of human research ethics: Respect for participants, non-maleficence autonomy, beneficence and justice. Permission/informed consent was taken from the parents/in-laws/ husband of the participants under 16. Permission was taken while taking the photographs.

In the case of illiterate participants, the researcher read the consent form. The researcher belonged to the sugar belt and was well aware of the illiteracy among the sugarcane cutters in Maharashtra. Therefore, before conducting the study, the concern of opting for permission from illiterate participants was raised by a researcher to the IRB, TISS. After a discussion IRB committee permitted the information provided in the consent form can be read out aloud (In a local Marathi language).

Utmost care was taken to avoid the violation of the study participant's rights while conducting the study and handling the information provided by the participants. The identifiable information of study participants is kept strictly confidential. Notably, the ethical concerns and rights of the study participants were protected while conducting the study. Especially while opting for permission and respecting their autonomy to be involved in the study, one hamlet of the workers was visited once to 6 times.

CONSENT FOR PUBLICATION

Not applicable.

COMPETING INTEREST

I declare no conflict of interest in the research work presented in the paper and the authorship.

FUNDINGS

We received no grant to conduct the work presented in the research paper.

ACKNOWLEDGMENT

We thank every woman sugarcane cutter for participating in this study despite their highly tight work schedule. We thank Dr. Bal Rakshase, Dr. Mathew George and Dr. Shailaeshkumar Daroker for providing timely guidance.

REFERENCES

1. Abbas R (2016) Internal migration and citizenship in India. J Ethn Migr Stud. 42(1):150-168.
2. Bansode P (2013) Seasonal migrants and quality of life: Sugarcane cutter migrants at destination and source. Artha Vijnana. 55(4):366-381.
3. Chatterjee P (2019) Hysterectomies in Beed district raise questions for India. Lancet. 394(10194):201-202.
4. Shrivastava AK, Srivastava AK, Solomon S, Sawnani A, Shukla SP (2011) Sugarcane cultivation and sugar industry in India: Historical perspectives. Sugar Tech. 13:266-274.
5. Crowe J, Wesseling C, Solano BR, Umana MP, Ramirez AR, et al. (2013) Heat exposure in sugarcane harvesters in Costa Rica. Am J Ind Med. 56(10):1157-1164.
6. Kendre B (2011) Socio-economic background and seasonal migration of sugarcane harvesting workers. Int J Humanit Soc Sci. 1(2):14-15.
7. Keshri K, Bhagat RB (2012) Temporary and seasonal migration: Regional pattern, characteristics and associated factors. Econ Polit Wkly. 81-88.
8. Li SP, Meng YM, Ma FL, Tan HH, Chen WX (2002) Research on the working mechanism and virtual design for a brush shape cleaning element of a sugarcane harvester. J Mater Process Technol. 129(1-3):418-422.
9. Shinde S, Rakshase B (2022) Insights on the practice of hysterectomy among the women sugarcane cutters in Maharashtra (India). Femin Res. 6(1):26-29.
10. Pakhare AP, Pawar R, Lokhande GS, Datta SS (2014) Does seasonal migration for sugarcane harvesting influence routine immunization coverage? Indian J Public Health. 58(2):116-120.
11. Thomas, M. D. (1958) Air pollution with relation to agronomic crops: I. General status of research on the effects of air pollution on plants. J Agron. 50(9):545-550.
12. Triunfo S, Ferrazzani S, Volpe M, Scambia G, Lanzone A (2020) Old and novel insights into emergency peripartum hysterectomy: A time-trend analysis. Arch Gynecol Obstet. 301:1159-1165.
13. Laliberte R, Satzewich V (1999) Native migrant labour in the southern Alberta sugar-beet industry: Coercion and paternalism in the recruitment of labour. Can Rev Sociol 36: 65-85.