Barriers To Healthcare For Sri Lankan Tamil Refugees In Tamil Nadu, India

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Abstract

Health is a fundamental human right and is also considered as a worldwide social goal. It is an important determinant of well being and healthcare is regarded as a public right, and an important responsibility of governments to provide this care to all people irrespective of race, religion, caste or creed, rural or urban, rich or poor. In India, the effort to improve the health status of the population is a major thrust and it is under the social development programmes being undertaken in India. Public health programmes play a very significant role in the physical and mental well being of the citizens of every nation. The improvement of the health status of people is connected to several factors such as household income, public expenditure on healthcare delivery system, availability of private healthcare facilities and general environmental conditions affecting the incidence of diseases. The health status of the population of a nation was assumed to affect the utility of the people directly by the value that individuals place on good health and indirectly through increasing healthy time and labour income of the person [1]. Unlike the health services available to the citizens, the same services are not made available to refugees who are living in the country. This study attempted to analyse the extent and issues of health care access and the health concern of Sri Lankan Tamil camp living refugees in Thiruvannamalai and Vellore district. For the study, Pethi Kuppam refugee camp in Thiruvallur district and Kasthambadi camp in Tiruvannamalai district were selected. Due to the restriction in entering the camp, the interview was conducted outside of the camps and respondents were selected through the convenience sampling method. Thirty camp inmates were interviewed with the help of a semi-structured interview schedule. The study revealed that the location of the camp is one of the major determinants of health care access. The people living in the camp of rural area need to travel long hours to access health care. The government health care services to refugees are inadequate and improper. There is a delay in receiving the benefit of health care schemes and the procedures for application is complicated. Besides, refugees are manual labourers and they remain unemployed for half of every month. Therefore, the problem of affordability came into existence. An intervention on the part of the government is required to facilitate adequate health care services for the refugees and health insurance should be extended to them also.

Keywords: Sri Lankan Tamil Refugees, Healthcare Services, Accessibility, Healthcare Concern, Camp life.

Introduction

India has a long relationship with Sri Lanka as it is the neighbouring country located 20 miles away from the southern tip of India. During the 19th century, British East India Company hired Tamil labourers from Tamil Nadu to work in the coffee and tea plantations in Sri Lanka. The labourers brought from India are settled in the north-eastern parts of Sri Lanka. The Sri Lankan population comprises of mostly Buddhist population. The Tamils from India are Hindus and are later known as Sri Lankan Tamils. The seeds of the inter- ethnic conflict were sown following independence from the United Kingdom in 1948, soon after which the new government of the Sinhalese-dominated United National Party disenfranchised Tamil plantation workers; the Sinhalese majority stoked more antagonism when it made Sinhala, rather than ethnic-neutral English, the national language in 1956,

and promoted policies that further disenfranchised the Tamil minority [2]. Tensions erupted into armed conflict in 1983, with the Black July riots that claimed the lives of thousands of both Sinhalese and Tamils while the Tamil secular-nationalist LTTE launched attacks claiming both military and civilian lives. The fear of retaliatory violence by the Sinhalese Army and the growing sense of insecurity among the Tamil populace in their home country forced them to seek asylum in other countries. However, the lack of facilities in the countries of asylum left them frustrated with a low quality of life. To a refugee, the most important thing is to be alive, and so being alive takes precedence over their quality of life. Most of these refugees have fled over time leaving all that they had built in their lifetime and that of their ancestors [3].

Having left all their belongings back in their home country, refugees also leave behind their self-esteem, self-confidence, identity, dreams for the future, etc. When they reached the shores of India, many of them were not only without worldly belongings but also lacked the spirit. The difficulties they faced at the port of entry, being herded into camps and the suspicious faces of the on-lookers stripped what little self-respect remained in them. Most of the refugees in the camps do not live; they just exist. Yet many have recuperated and have done wonders with whatever little that they have. The children of refugees go to school and college; the older ones work and save for the day, when they will be back in their country of origin [3].

India, today, is a fast-growing economy and one of the democratic countries in the world which does not have a refugee integration strategy. The needs of asylum seekers and refugees are subsumed under those of minority ethnic groups which are currently best addressed through the domestic laws in an ad hoc manner. So far in the case of Sri Lankan Tamil refugees, the common factors such as language, religion and ethnicity played a significant role in integration. Indian Tamils are most generous towards Sri Lankan Tamil Refugees and both State and Union governments have extended support to refugees during the ethnic conflict and since then. On arrival, all refugees are registered and accommodated in a transit camp. Later, they are shifted to various government-run camps and are provided with facilities such as shelter, food, water supply, electricity, sanitation and health care. Also, monthly financial assistance, clothes, vessels, free education and various pensions and assistance are provided. These schemes have a significant impact in integrating refugees with the host society. It was in 1991, when the former India Prime Minister Rajeev Gandhi was assassinated by LTTE, a Tamil separatist organisation in Sri Lanka that created an atmosphere of dread and caused disintegration. Sri Lankan Tamils were arrested and imprisoned and the local people maintained a distance from refugees due to the presence of militants among refugees. The assassination of former India Prime Minister is the main reason that wiped out any sympathy and affinity for the refugees. Since 1991, refugees are living with some degree of restrictions and are away from local settlements. Refugees are allowed to work, provided with free education, health care and all other benefits that are available to the local community except citizenship.

The settlement in the camps has initially cured the wounds. But the camp life was like confinement and their socio-economic and living conditions were dilapidated. Women dealt with the problem of ill health, lack of privacy, sexual exploitation and mental stress. The atmosphere is not conducive to improve the socio-economic status. The assassination of Rajiv Gandhi by the LTTE and the fear of terrorism among refugees in India have resulted in the imposition of strict restrictions especially in freedom of movement, access to education and other human rights. Later, the situation has changed and the degree of restriction was slowly removed. The women are permitted to work and provided education free of cost by the government. The access to securing jobs nearby camps is very difficult for women. The poor economic status has induced many women to seek employment away from the camp. The healthcare requirements of women are not met properly. Pregnant and aged women faced difficulty in accessing health care due to the remote location of the camp. In course of time, the government has introduced numerous policies for the welfare of the refugees to facilitate the socio-economic development of refugee women. The schemes for education, marriage, healthcare, skill training and employment are very relevant in contributing towards the upliftment of women refugees. Importantly, the implementation of SHGs in the camps has empowered sections of women by providing facilities for cottage industries, marketing business and agriculture activities. The refugees have made marked progress in the socio- economic indicators along with integration in the host society which has accelerated the process of empowerment.

Objectives of the Study

The general objective of the study is to analyse the barriers in accessing healthcare services to Sri Lankan Tamil refugees living in camps. The specific objectives of the study were formulated as the following.

- To analyze the extent of accessibility and affordability of healthcare services to refugees.
- To find out the relationship between camp location and healthcare accessibility.
- To identify the barriers in accessing healthcare services to the refugees.

Methodology

The refugee camps in Tamil Nadu numbered 108 which are scattered across the state. Since 1983, there is a sum total of 3, 04,269 refugees who arrived in four phases. Now 63,351 refugees are living government camps and 37,268 are non-camp refugees. The total number of families living in the camps is 19451. The non-camp refugees have the freedom to settle anywhere in Tamil Nadu and have the right to work away from their settlement but they need to register with the local police station near to their place of living. The non-camp refugees cannot avail the benefit of government welfare schemes. The study only considered camp living refugees who are suffering from the problems of affordability and accessibility of basic healthcare due to the several factors which are treated as barriers.

Two camps are selected purposively for the study. Pethi Kuppam refugee camp in Thiruvallur district and Kasthambadi camp in Tiruvannamalai district were selected. The Pethi Kuppam camp is located around 3 km away from Gummudipoondi town, where most of the facilities are available. Kasthambadi Kamp is located around 30 km away from Polur town. The location of this camp is extremely rural where most of the basic facilities are scarce. The camp inmates are engaged in agriculture works, painting, and tailoring, concrete work and masonry, loading work and laying underground cable. Most of the camp inmates work as labourers in various fields for daily wages which is available only a few days in a month. While in Pethi Kuppam camp, refugees engaged in jobs like the shopkeeper, driver, electrician, mechanic, sales representatives, petty shops, the street seller in the market and hotel. They are getting jobs throughout the month and their wages are higher than that of refugees of Kasthambadi camp.

The outsiders are not allowed to enter the camp. Therefore the interview was done outside of the camps. A semi-structured schedule was used to interview the refugees when they were going out of the camps. Those refugees sitting in nearby tea shops and bus stops were met and a detailed interview was carried out. A sum of 20 refugees was interviewed from this camp. The respondents are selected based on the convenience of the researcher. The questions related to the availability, accessibility and affordability are asked to the respondents. Also, the basic socio-economic details are gathered. The qualitative research design was adopted for the study. The collected data was analysed with the help of SPSS and tabulated for camp wise comparison. The interview mainly focused on three main areas: accessibility, availability and affordability of healthcare facilities which are regarded as the main barriers of healthcare. In addition to field data, the study partly relies on reports of Commissioner of Rehabilitation and Welfare of Non-Resident Tamils, Government of Tamil Nadu.

Living Condition of Refugees

Life in the refugee camps are remarkably miserable in nature. Camps are largely overcrowded and there is no social privacy. Women in the camp endured more suffering and hardship than the males. There are no adequate latrine facilities in the camp. Indeed, even in a couple of toilets, water facilities are not provided. Subsequently, people need to go to open area or close-by forest to defecate. Due to the absence of such non-existent practices in Sri Lankan culture, women endured lot of misery and shame. When women go out to relieve themselves; they confront prodding issues in a few zones [4] or individuals in adjacent crapping zone hit them with stones. Another issue that the women face in the camp is the deficiency of drinking water. In a few camps, open taps and wells are provided by the government and NGOs, yet water comes just for a brief period. Women need to make a long distance trip to collect water.

There is no work allowed in India, even though refugees are granted habitation licenses to find work in the local area. Low wages, segregation in wages and misuse by the Businesses is extremely common among women labourers. For women who can find work in remote areas as household helps

through an outside system of refugees, however, they are not ready to accept these open doors because of the confinements to their right side of development far from the camp. Sri Lankan Tamils have been granted opportunity of development inside the camp territories, empowering work facilities for them as easygoing work. For a single-headed family, women have the monetary duty and subject to wage work. The non-availability of land, domesticated animals and properties, actuate them to subordinate altogether on nearby work advertise. The accessibility of business relies on the area of the camp. On the off chance that refugees acquire work far from the camp and need to remain around there for several days, subsequently, they are in the danger of losing enlistment at the camp. Thus the refugees are kept in the camps which augment the issue of economic backwardness.

Psychological stress because of the partition of family and the death of relatives is basic among women in the camp. At least one individual has kicked the bucket or missing from one family. Now and again, relatives are dispersed over various camps and their unification required significant investment. Inside the camp, life is truly hopeless since the assassination of Rajiv Gandhi, the former Prime Minister of India by the LTTE. The strict rules of authorities have increased mental and emotional issues. Food shortage and malnutrition issues are normal in prior days and nourishment grains given to them are of low quality. Besides, they don't approach an agreeable place to rest or get sustenance. Separation and maltreatment by authorities and nearby individuals are common in their day-to-day lives. [5]. Likewise, stringent confinement, exploitation and racial segregation by specialists are high in camps. They are under the twenty-four hours reconnaissance and surveillance of the security officers and the opportunity to exit the camp was limited between 6.00 A.M to 6.00

P.M inconsistently. The government has been negligent in providing restorative treatment at government healing centres and PHCs. Health workers and medical officers regularly visit the camps and offer fundamental treatment. In any case, the infections, for example, tuberculosis, typhoid and looseness of the bowels are predominant. Access to medical facilities are another issue, since numerous camps are situated far from urban regions where restorative services are available. Countless people, particularly women e have experienced issues identified with psychological illness.

Result and Discussion

The three greatest challenges faced by our country nowadays are accessibility, availability and affordability of basic healthcare facilities [6]. The government introduced various programmes and policies to eliminate these problems across the country but these programmes are not as much effective as to curb issues at the grass root level. In many villages in India, basic healthcare facilities are unavailable. They have to travel long distances to receive treatment. Citizens fail to access healthcare at a short distance. There are number of non-Indians settled in India or settled non-Indians. They are commonly referred to as 'refugee'. A refugee is defined by 1967 protocol of UN convention as:

"...who owing to (a) well-founded fear of being persecuted for reasons of race, religion, nationality or political opinion is outside the country of his nationality and is unable or, owing to such fears *or for reasons other than personal convenience*, is unwilling to avail himself of the protection of that country, or who, not having a nationality and being outside the country of his former habitual residence, is unable, or owing to such fear *or for reasons other than personal convenience*, is unwilling to return to it".

The refugees have faced so many problems in the host country, especially they are the victims of massive violence, and thus, their physical and mental condition is extremely bad. Therefore, their physical and mental condition required a well advanced medical assistance for recovery. The government, on humanitarian grounds, provided a number of schemes for the healthcare of refugees. This study intends to explore the extension of healthcare accessibility, availability, and affordability of Sri Lankan Tamil refugees in two selected camps. In addition, the socio-economic characteristics such as sex, age, educational qualification, employment, income and expenditure of respondents are investigated to analyse the influence of these factors on the healthcare choices of the respondents.

The study has covered two refugees camps- one urban camp from Pethikuppan, Gummudipoondi taluk in Tiruvallur district. This is one of the biggest camps in Tamil Nadu with 938 families comprising 3051 individuals. The camp is close to the Gummudipoondi town and thus camp inmates have higher job opportunities and better access to basic services. The second camp is a rural one-Kasthambadi camp in Polur taluk, Tiruvannamalai district. This is the biggest camp in

Tiruvannamalai district with 270 families consisting of 832 individuals. From these two camps, 20 respondents were interviewed. The interviews were held outside of the camps due to the restriction in the entry to inside of the camps. Major findings about the socio-economic conditions of the respondents are pointedbelow.

- There were 65 per cent of male respondents whereas, 35 per cent were females in the sample. It is to note that the interview was carried out from the outside of the camp. Mostly males are coming out of the camp than females. Because males have jobs outside of the camp and females are staying inside the camp and many are engaged in tailoring works. Therefore, males exceed females in the study. A large number of female respondents (20 per cent) are interviewed from Kasthambadi Camp.
- Age wise distribution of the respondents reveal that large number of the respondents (40 per cent) belong to the age group of 20-30 years. 25 per cent of the respondents were in the age group 30-40 years and 20 per cent and 15 per cent of the respondents come under the age group 40-50 years and above 50 years respectively. It is found that the majority of the respondents (65 per cent) in the study are aged between 20-40 years.
- Educational qualification of the sample respondents shows that majority (60 per cent) have primary level education only. There were 25 per cent of the respondents who have secondary level education and the remaining 15 per cent have higher secondary and polytechnic qualification. The number of respondents attaining higher education were very few. It is obvious that the respondents were dynamic in their education however they were still far from the higher education institutions which is so vital to improve their poor socio- economic conditions. It is found that majority of the respondents from Kasthambadi camp (rural camp) are educated upto primary level.
- Refugees are for the most part employed in the local labour market and they are confined to get the government jobs in India. It is observed that about 40 per cent of the respondents are painters, 10 per cent are agricultural labourers, 50 per cent are construction workers who are mainly engaged as electricians, plumbers, masons and 10 per cent are drivers and remaining 10 per cent are salarised persons. It is therefore, summarised that in rural camp, respondents are either construction workers or agricultural labourers but in urban camps, refugees are employed as private sector employees and drivers. The standard of living of the people is higher in urban camp as compared to rural camp due to the access of better employment opportunities in urban areas. In rural camps, many workers who are employed as painters are also doing this job due to the absence of proper employment opportunities.
- The income earned by the respondents is investigated to analyse their affordability to healthcare facilities. It is found that about 40 per cent of the respondents are earning Rs. 8000-10000, 20 per cent are earning Rs. 10000- 12000, another 20 per cent of the respondents are earning Rs. 12000-14000, 10 per cent are earning 14000-16000 and rest 10 per cent are earning 16000- 18000 every month. It is estimated that majority of the respondents (80 per cent) are earning income ranging from Rs. 8000 to 14000 per month. It is evident from the analysis that majority (80 per cent) of the respondents in the rural camp are earning lower income as compared with urban respondents.
- The healthcare expenditure of the respondents is analysed to have a brief picture on how much they spent on healthcare in a given period. The data shows that about 30 per cent of the respondents are spending amounts ranging from Rs. 3000 to Rs. 4000 in an year, 20 per cent spending Rs. 4000-5000, 15 per cent are spending amounts between Rs. 5000-6000 and about 35 per cent are spending Rs. 6000 and above annually. It is thus found that large numbers of respondents are spending the highest amount forhealthcare.
- The prevalence of chronic diseases among the respondents were studied. It is found that out of the total respondents, three respondents are suffering from chronic diseases such as Asthma, Diabetes and Hypertension. They often require medical care and the expenditure for treatment is very high for them.

The analysis of the socio-economic condition of the respondents has shown that the urban refugees have better living conditions than rural refugees. The availability of a job, and access to educational institutions and healthcare services have made their life more improved than the rural living refugees. In rural areas, agriculture was the main occupation, followed by manual labour in the non-agricultural sector. The facilities for education and health are very limited. Therefore, refugees have to travel a long distance to access these basic facilities.

Healthcare Availability, Accessibility and Affordability

Availability and accessibility of services depends upon the nature of area or location. In urban areas, basic services are available very easily and are abundant in nature. For example, number of hospitals, educational institutions and transportation facilities are higher in urban areas. Therefore, the question of availability and accessibility is ruled out. As far as the rural area is concerned, the basic services are very poor and scarce. The development of service sector is very low in the rural areas where agriculture is the dominant sector.

The accessibility and availability of healthcare services for refugees are provided by government and NGOs. The government has been providing free health services in government hospitals for refugees. Poor sanitation, lack of water and free space, limited access to healthcare facilities are the persistent problems in the refugee camps of Tamil Nadu [7]. During the initial period of influx of refugees to Tamil Nadu, the government has provided health services to refugees within the camps and appointed healthcare professionals who regularly visited the camps and monitored the health status of refugees. It is reported by the Refugees Council, London, (1999) that there was a higher prevalence of diseases such as tuberculosis, typhoid, and diarrhea in several camps. Moreover, a large number of refugees are suffering from problems related to mental health. Unfortunately, most of the camps are located in remote areas; therefore it is very difficult to find healthcare services away from the camp [8]. The accessibility, availability and affordability varies in accordance with the location of the camp.

The respondents from Pethikuppam camp in Tiruvallur district (urban camp), argued that they have higher access to private healthcare facilities than public healthcare. The government hospital in this area lack healthcare infrastructures such as labs, staff and beds. Therefore, refugees prefer the Government Medical Colleges in Chennai, Vellore and Tiruvallur districts. It is observed that many camp refugees had undergone surgeries in the medical colleges free of cost and the government has provided Rs. 15000 for those who underwent surgery.

Accessibility, availability and affordability of healthcare services in the urban areas

The urban refugees have better income and their healthcare expenditure is also high. The higher ability of refugees to pay in the urban areas indicate the access to advanced healthcare services. It is evident from the field that majority of refugees in the urban camp preferred private healthcare due to its easy accessibility and availability. The higher income enabled them to choose high cost treatment rather than preferring the costless government services. In Gummudipoondi town, small clinics and hospitals with inpatient services are numerous. The government hospitals are less and they are not adequately equipped to provide medical care to even local people. It is found by data that the refugees with chronic diseases or those who need surgery would prefer government medical college, which is far away. For communicable diseases, they prefer nearer clinics or private hospitals where time of waiting is very less and where the doctors consult them properly. It is revealed that rather than seeking treatment in government hospitals at free of cost; urban refugees prefer private healthcare services due to its higher availability and accessibility. The refugees can overcome the affordability problem with their higher income. It is therefore, summarised that the urban refugees have higher accessibility, availability and affordability of healthcare services but most are preferring private sector on account of poor availability and accessibility of public healthcare system in the urban area. Most refugee camps are located in remote regions and only few are in urban areas. The development of urban areas in India is unequal, therefore, refugees have to travel from one urban region to another for healthcare services. The refugees of this camp often prefer medical colleges in Chennai. It is not only due to the availability of advanced healthcare facilities in the medical colleges in Chennai but also due to advancement of transportation facilities. This is the advantages of refugees in the urban areas. If healthcare facilities are inappropriate in the nearby hospital, they can easily access healthcare facilities in another area due to the advancement of transportation facilities. But this is not available to rural refugees.

A refugee expressed that "*we are looking for healthcare benefits in Chennai, where satisfactory services are accessible and we can move there effortlessly from here. The government staff will visit just on the off chance that we illuminate them about the sickness or commonness of communicable illnesses is recognized. This is the case of most of the refugee camps in the state*." Another refugee revealed that "*we are secure in the camp and our children are receiving free education however they are segregating in a few grounds. The overwhelming one is the*

nonattendance of citizenship. This will compel many of us to pick private schooling and healthcare facilities."

Urban refugees have higher access to educational institutions and jobs in service sector. Therefore, they have better living conditions and higher standard of living as compared to rural refugee households.

Accessibility, availability and affordability of healthcare services in the rural areas

Low accessibility, availability and affordability of healthcare services are the main problem in rural areas. It is found that rural refugees either move to urban areas or prefer local clinics, PHCs and government hospitals for treatment. For major surgeries, they go to hospitals in urban areas. The respondents clearly mentioned that the rural location of the camp has hampered their socio-economic development. In the Kasthambadi Camp (rural camp), a private clinic is located five kilometer away from the camp and a government hospital is around 10 kilometer away. These services are inadequate to treat deliveries and grave injuries. In these cases, they preferred government hospitals in Tiruvannamalai, Vellore and Chennai districts. It is noted the poor economic background has induced them to choose government hospitals, where healthcare is free including surgeries. It is to be pointed out that the government has appointed healthcare staff in the PHCs to provide health treatment to ill persons in the camp. . If any health issues are reported in the camp, the health worker will visit and provide medical attention. In addition, some NGOs are providing healthcare services. It is therefore, summarised that rural refugees have limited access to healthcare facilities and the availability of health care is very low. The economic backwardness causes the problem of affordability. The healthcare of rural refugees remains unachieved due to the improper setting for healthcare. Therefore, an initiative from the part of the government is required to facilitate healthcare to refugees in the rural areas.

Barriers of Healthcare

Availability and accessibility of services depend upon the nature of area or location. In urban areas, basic services are available very easily and are abundant in nature. For example, the number of hospitals, educational institutions and transportation facilities is higher in urban areas. Therefore, the question of availability and accessibility is ruled out. As far as the rural area is concerned, the basic services are very poor and scarce. The development of the service sector is very low in rural areas where agriculture is the dominant sector.

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The respondents from Kasthambadi camp in Thiruvannamalai district argued that they have higher access to private healthcare facilities than public healthcare. The government hospital in this area lacks healthcare infrastructures such as labs, staff and beds. Therefore, refugees prefer Government Medical Colleges in Chennai, Vellore and Tiruvallur districts. It is observed that many camp refugees had undergone surgeries in these medical colleges free of cost and the government has provided Rs. 15000 for those who underwent surgery.

Rural refugees face severe problems in accessing basic healthcare services. In rural, the main occupation is agriculture [9] and their ability to seek high-cost medical treatment away from the place of residence is comparatively low due to poor financial stability. Low accessibility, availability and affordability of healthcare services are the main problems in rural areas. It is found that rural refugees either to move urban areas or prefer local clinics, PHCs and Government hospitals for treatment. For

major surgeries, they go to hospitals in urban areas. The respondents mentioned that the rural location of the camp has hampered their socio-economic development. In the Kasthambadi Camp (rural camp), a private clinic is located five kilometer away from the camp and a government hospital is around 10 kilometer away. These services are inadequate to meet the needs of deliveries and grave injuries. In these cases, they preferred government hospitals in Tiruvannamalai, Vellore and Chennai districts. It is noted the poor economic background has induced them to choose government hospitals; where healthcare is free including surgeries. It is to be pointed out that the government has appointed healthcare staff in the PHCs to provide health treatment to ill persons in the camp. . If any health issues are reported in the camp, the health worker will visit and provide medical attention. Also, some NGOs are providing healthcare services. The complete healthcare of rural refugees remains unachieved due to the improper setting of the healthcare system. Therefore, an initiative from the part of the government is required to facilitate healthcare to refugees in rural areas.

A refugee aged 60, stated that "*I am suffering from old age problems and some injuries from civil war in Sri Lanka still affecting my health. The absence of proper healthcare facilities nearer has induced me to travel long or remain ill without any treatment*." Practical hindrances obstruct access to health-care services for refugees like deficient information and mindfulness about the availability of services, lacking money related means, limited access to transport, socially cold-hearted care, and insufficient arrangement of helpers. Besides, poor access to health-care services associated with segregation and constrained social rights in this manner strengthening avoidance as the main driver of sick wellbeing among refugees in the rural area.

Conclusion

Several barriers retard the refugees to access health care in the host country. The location of the camp is very significant in this regard. The remote location of the camp causes the problem of accessibility to better healthcare for the refugees. The poor earnings of the refugees are not enough to meet the expenditure of advance health care and other related expenses. Private medical services are too expensive for refugees. The provision of free health care under the public sector is inadequate in the region. Therefore, the refugees have to travel a long distance to access public healthcare services. The camp restriction is not a barrier in accessing healthcare services. The healthcare barriers to the refugees are mainly associated with the nature of the area of their settlement.

The Indian government has implemented specific schemes for refugees to ensure their well-being. In 2012, the Tamil Nadu Chief Minister Jayalalitha ordered extension of the government's comprehensive health insurance scheme to Sri Lankan Tamil refugees; a scheme initially targeting poor people in the state was extended to them. Over the years, the government of Tamil Nadu has contributed actively to the welfare of Sri Lankan Tamil refugees within the state by giving them certain access to benefits established for Indian nationals as well as contributing to their well-being. The health of the refugees is always a concern of the government. But the barriers exist in rural camps in a large extent due to the geographical isolation of the camp from the mainstream population. The government should extend the healthcare services to rural areas with advance facilities to solve the problems associated with accessibility, availability and affordability.

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