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# Health and Policy Environment of Internal Labour Migrants in India – A Literature Review and Future Direction

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## ABSTRACT

Designing and implementing equitable health policies requires greater participation from the all groups of stakeholders. However, disadvantaged groups are under-represented in Indian policy making fora. Internal labour migrants in India, for example, are consistently left-out from the various social and development policies and lack a voice in the programmes that are intended to benefit them. This can jeopardize the responsiveness of health and social needs for migrants and undermine their overall development. It is necessary therefore to design innovative strategies that can bolster migrants participation. This paper looks at the current situation of internal migrants in India including their health and policy environment and offers several insights that could transform policy making it more inclusive. It suggests more funding opportunities for future research activities and implementation of sound migrant-friendly health initiatives.

**Key Words:** Migration, Internal labour migrants, Policies for migrants, Health risks, India

## INTRODUCTION

Since the beginning of human existence and civilization migration has been an integral part of life.[1] All over the world, millions of people leave their native places to get better opportunities such as employment, education, secure their essential needs and lead a better life. This behavioural landscape of migration among people has added to a change in traditional boundaries between linguistics, dialects, societies and ethnic gatherings of both national and global regions. Thus, migration stands as an evolving process that not only influences migrants but also the lives of people both in origin and destination nations.[2,3,4]

India stands low and middle income countries is currently experiencing a significant growth in economy; yet, there are low priority geographical areas where pockets of disadvantaged groups stay whose development indicators are disturbing.[5] One of such groups belong to the internal labour migrants and this segment of populations face exclusion from various developmental programmes, such as education and health. According to the United Nations Educational, Scientific and Cultural Organization (UNESCO), internal migration is defined by as a movement of people from one area (city, district or region) to another within the same country.[6] In India, free movement is a fundamental right and there is no restriction for internal movements. The Indian constitution 1950, states *"All citizens shall have the right to move freely throughout the territory of India; to reside and settle in any part of the territory of India"*[7]

### Internal migration in India

2011 Indian census estimated the population of India to be 1.21 billion.[8] Approximately 309 million of people constitute as internal migrants in India[9] which is 30% of the India's total population.[9] The National Sample Survey Office of India estimates around 326 million to be internal migrants (28.5 per cent).[10] The internal labour migrants are projected to be more than 10 million (nearly 6 million of intra-state migrants and 4.5 million of inter-state migrants) in the country.[11] The labour migrants are mainly employed in plantation and cultivation, construction sites, quarries, brick-kilns, fish processing, transportation and manufacturing units.[11,12] Further, the leading source state of migration in India includes Tamil Nadu, Uttar Pradesh, Uttarakhand, Andhra Pradesh, Bihar,

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Odisha, Madhya Pradesh, Rajasthan, Jharkhand and Chhattisgarh and the destination places are mainly Delhi, Punjab, Haryana, Karnataka, Gujrat and Maharashtra. There are also main corridor of migration within the country mainly Odisha to Gujarat, Odisha to Andhra Pradesh and Rajasthan to Gujarat, Uttar Pradesh to Maharashtra, Bihar to National Capital Region Delhi and Bihar to Haryana and Punjab.[13]

The current projection estimates that the internal migrants may increase to 400 million[14] which far exceeds the estimation made by the Indian governments i.e. 11.4 million.[15] However, some scholars argue that the actual number of internal migration in India is grossly underestimated as the Indian census and National Sample Surveys do not adequately capture the data on rural-rural migration, short-term migration, and women's migration which occurs due to non-marital reason and trafficking- all of which tremendously contribute to migration.[16] In India, among every ten individuals, three are internal migrants[7] and the government has given low priority to internal migration. There are mainly two types of migration in India: (a) long-term migration and (b) short-term migration/circular migration. Long-term migration is defined as the relocation of an individual or family members, whereas short term or seasonal/circular migration is defined as both coming and going movements between origin and destination place. Estimation suggest that the number of short term migration in India ranges from 15 million[10] to 100 million.[17] In addition, seasonal migration has been rising in recent years where women are usually employed as house maids and head-load transporter and men choose manual labours.[12]

Women are also constituting an overwhelming number of internal migrants: 70 percent based on Indian Census of 2001 and 80% according to NSSO (2007-08). Further, marriage is mentioned by women participants as the most frequent reason for migration, quoted by 91.3 percent of women respondents in rural areas and 60.8 percent from urban areas.[10] Around 30 per cent of youth in the age group of 15-29 years[9,14] and 15 million of children are internal migrants.[18,19] Further, studies argue that circular migration are frequently representative of the vulnerable sections of the society such as the Scheduled Casts (SCs), Scheduled Tribes (STs) and Other Backward Castes (OBCs) who are poor and face economic and livelihood deficit to live and prosper.[17]

## Health status of internal labour migrants in India

Though migration is considered as an alternative livelihood strategy and brought benefits to many individual and family income, voluminous negative consequences still remain.[20,21] Internal labour migrants are highly susceptible to unhygienic environment, staying in deprived and filthy environment, afflicted with occupational hazards and facing long-time separation from spouse and family members. In addition, they are often excluded from various government developmental schemes such as health and education that prevents access to affordable health services. This has resulted in multipronged health complications such as communicable diseases like malaria[22], HIV/AIDS and Tuberculosis[23]. Occupational health issues such as eye problem and stomach pain are common among male migrants, whereas women migrants suffer from reproductive tract infections, anaemia and violence at large. Also, a large number of migrant labourers working on construction sites are commonly injured by falls and injuries caused by machines resulting in amputations.[24] Poor health care utilization among migrant populations in government health facilities have also contributed in the increase of maternal and child health indicator. Further, migrant children suffer from poor immunization and malnutrition. The National Family Health Survey (NFHS) – III, 2005-06 mention that for the age under-five mortality rate among the urban migrants is 72.7 which is significantly higher than the urban national average of 51.9.[25]

## Policies, laws and programmes pertaining to migrants' health

The existing policies and laws do not specifically mention legal and social protection of the migrant workers in India. In spite of the fact that, India is signatory to the International Labour Organization (ILO) conventions it has not yet ratified to the Convention of Migrant Workers (CMW) that allows a common platform for protecting the migrants. The United Nations Convention on Migrant Workers clearly stated various laws on migrant's rights and puts migrants subject as a global issue. However, India neither adopted these conventions nor set clear agenda on migrant issue. Therefore, the rights of migrants are not protected, including the most important aspect of migrant health. The important health policies in India such as National Health Policy (2001) aim to achieve acceptable standard of health among general population with emphasis on equitable access to public health services across the country. However, it does not address migrant health in specific[26]. At present, within the national framework of health programmes and policies, there is little address of health of migrant workers. For example, the National Population Policy (2002) of India articulates the government's commitment towards informed and voluntary choices for citizenswhile availing the reproductive and other health care services.[27] Also, the "Vison 2020" policy of India aim to achieve universal health coverage by 2020 and envision that India would be healthier, prosperous and more educated than at any time in the history of its development.[28] However, all these policies aim at improving population health in general, neglecting the migrant's health in specific.

Deshinkar and Sandi (2012) argues that, if migrants positive impact harness properly, then migrants can stand as a core of human development.[29] There are few labour laws in India that mention about the conditions of migrant workers. The

Inter-state Migrant Workmen Regulation Act (ISMWRA), 1979 talks about contractor-led movements of inter-state migrant labour and mainly focuses on how to prevent exploitation caused by out-of-state contractors. However, it is not enforced properly. One major flaw in ISMWRA is that the family members of the migrant workers who find job independently do not fall under ISMWRA.[30] Another law of migrant workers under the Building and Other Construction Workers Act, 1996 aims to improve the quality of life among migrants and sets a 20-kg load for women as a handling limit. Under this act, considerable amount of funds has been collected by welfare boards of construction department for migrants in several states, but programme implementation was found negligible due to paucity of registration of migrant workers. The main disadvantage of this act is that it does remain silent about locational benefit or inter-sectorial mobility and perceive construction worker as an immobile.[31] Further, The Minimum Wages Act (1948) and The National Employment Guarantee Act 2005 bring some hope by providing little financial security to migrants.

To address and monitor the migrant workers HIV/AIDS, India established a National HIV and AIDS Policy and the World of Work in 2009, with the ratification of International Labour Organization Convention No 111 on Discrimination in respect of Employment and Occupation. This policy statement brings a compressive framework where non-discrimination against labour workers was made on the basis of their real or perceived HIV status. This helped Indian government to expand its HIV policy and programmes in the work-place as a key component of mainstreaming strategy under third phase National AIDS Control Program (NACP III 2007-2012). Under this policy, all public and private enterprises, formal and informal sectors are encouraged to establish workplace policies and programmes based on the principles of non-discrimination, gender, equity, health work environment, non-screening for the purpose of employment, confidentiality, prevention and care and support.[32]

At present, the most of the migrant health service are provided by Non-Governmental Organization (NGOs) and there are few evidences where government policy support migrant population. The Integrated Child Development Scheme (ICDS) – A Government of India runs a programme allowing all migrant children to obtain nutritional supplements at destination sites from the anganwadis centre (the place where nutrition supplements are given and connected with existing health care services). Pregnant mothers are availing antenatal and postnatal services from these anganwadi centres which are further linked to nearest health care centres. Adolescent girls are also given nutritional requirements for anaemia and are provided with life skills and sex education under ICDS programmes. One Indian Non-Government Organization (NGO) named Disha foundation working with migrant communities in Maharashtra since 2002, have identified the sites for establishment of such anganwadis that are convenient for migrant workers and encouraged them to avail the existing government health services at affordable cost. There are also some programmes for migrant workers in the informal sector where migrants require registration cards, in some cases identity cards. To facilitate this process, another organization named Aajeevika Bureua in Rajasthan state of Udaipur provides a number of services to migrants helping in the registration process and issuing of identity cards[d] for the migrant workers.[7]

The National Rural Health Mission (NRHM) is India's flagship health programme undertaken by the government of India and launched in April 2005 with an objective to address the health needs of undeserved population in rural areas.[33] Since, NRHM targets the rural population, urban migrants remain neglected. However, the National Urban Health Mission (NUHM) has been approved by the Government of India in 2013 and implemented in all state capitals, district headquarters and cities/towns to meet the health care needs of the urban poor.[34] It specifically focuses on slum dwellers, other marginalized groups like construction workers, urban migrants, street vendors and homeless people and targets the provision of essential primary health care through community involvement and greater partnership. Thus, it is a good news for health planers, experts and implementers to see to what extent policies would be formulated and implemented under NUHM for targeting better migrant's health.

## Future direction

India runs several central government sponsored vertical health programmes in the areas of both communicable and non-communicable diseases. These programmes are often set for long period and need constant supervision to improve its quality. At the same time, it poses challenges in maintaining quality services and monitoring health outcomes among migrant populations.[34] At present, a very few government run programmes have data on migrants; almost no other health programmes have data too. Even if data remains, it is only confined to labour market. There is an urgent need to channel and store all information pertaining to migrant health and develop proper tracking mechanisms for better health outcomes.

Currently, National AIDS Control Programme IV (NACP IV 2012-17) aims at providing outreach services among migrant populations. It provides preventive and curative services to a few migrant population categories such as sex workers, truckers and construction workers. Some of the preventive approach under this programme includes condom promotion strategy, peer outreach approach, spreading educational message and community mobilization activities. In addition, capacity building activities for grass root health workers has been in place to identify risk and vulnerability among migrant populations. Counselling facility for the migrant

spouses has also been carried out for psychosocial support, risk and vulnerability reduction. Further, the Link Worker Scheme (LWS) introduced under NACP III (2007-2012), aims "to reach out the high-risk population in rural areas which are basically scattered and also for the invisible rural migrants with a comprehensive package of preventive services".[35] Another project is Indian Population Project which was initiated by Ministry of Health &Family Welfare, Government of India with the support from the World Bank and aims at providing outreach service to migrants. It has been implemented in few selected cities of India such as Mumbai, Delhi, Bengaluru, Hyderabad, Kolkata and Chennai with an objective to improve health service delivery in urban areas. This project also takes help of link-workers in addressing child health and reproductive health in urban slum areas. It is important to study carefully these projects and gain lessons how to scale up and replicate such outreach interventions in other parts of the country for better migrants health.

Migrant populations are sometimes alienated from the government health services due to their migration status as they are considered to be temporary workers. In addition, private health care is too expensive for them resulting a poor utilization of health care. In India, urban local bodies (ULB) have taken power and authority to improve city infrastructure and services. However, it is increasingly seen that, these ULBs are still controlled by the state governments and less focused on health outreach activities. According to the 74$^{th}$ Amendment to the constitution of India, ULBs are responsible for planning and development of urban areas, but in reality there are not involved in doing that. Due to this, migrants' issues and concerns are not reflected in many urban plans and services[36] and thus, urban planning seems to be failure in India.[37] Therefore, it is paramount that ULBs initiate public health outreach activities and devise more 'city migrant-friendly' initiative, so that supportive assistance to migrants can be given. Further, there is strong requirement for implementing mobile health services, so that migrants can access onsite health service delivery instantly.

There are two important urban development programmes initiated by central government. One is *Jawaharlal Nehru Urban renewal Mission* (JNNURM) and another is *Rajiv Awas Jojana* (RAY). JNNURM aims to improve urban infrastructure and provides basic services to urban poor, whereas RAY aims at providing housing facilities for urban slum dwellers. Both programmes are significant step towards addressing the needs of urban poor and slum dwellers. However, these programmes are silent in addressing the specific issues of migrants, though shelters are most basic requirements for many migrants and slum dwellers as a large number of homeless people are still located in many large cities of India.[30] Therefore, providing night shelters and building hostels for working men and women could be the answer while developing the development plans in the urban areas.

Existing literature suggests that preventing migration could be counterproductive[7,38,39] because migration helps in human development and fulfils human aspiration. The recent UNESCO publication (2013) mentions weak integration of migration at the destination places and recommends ten key areas for integration and inclusion of migrant services in developmental plans of India (See Box 1).[7]

Box 1: Key Strategies for Integration and Inclusion of Migrants in Urban Areas

i) *Registration and Identity* – It is important that internal migrants are given with a proof of identity cards that are universally recognized and enable them to access various government welfare schemes anywhere in India.
ii) *Political and Civic Inclusion* – Assurance of voting rights of internal migrants can be made through special provisions and their inclusion in planning and decision making process can be strengthened.
iii) *Labour Market Inclusion* – Dialogue with labour market employer for various opportunities that migrants intend to benefit and need for training, skill up-gradation programme and placement for internal migrants with the support from NGOs are needed. Where ever migrants are illiterate and poor, awareness generation is required to know their rights.
iv) *Legal Aid and Dispute Resolution* – Special mechanisms are needed where internal migrants should be able to access legal aid and counselling support, so that they can safeguard themselves against wage and work associated malpractices. Further, provision of enabling environment helps migrants to be able to negotiate with contractors or employers in managing grievance and dispute-handling.
v) *Inclusion of Women Migrant* – Identify research gaps and add knowledge to the gender dimension of migration. Mechanisms are needed to address exploitation, discrimination and women trafficking.
vi) *Inclusion through Access to Food* – Essential basic services such as access to food for internal migrants can be made convenient through the public distribution system (PDS) where migrant populations reside at any place can benefit.
vii) *Inclusion through Housing* – Provide rental house, dormitory accommodation and private house to the uneducated and labour migrants. In addition, slum areas need to be upgraded with provision of basic services.
viii) *Educational Inclusion*– Construction of hostels are required at the source place where left behind children can be retained in school hostels and worksite schools at destination place can be established where children can go with their parents.
ix) *Public Health Inclusion* – Avoid stigmatization as migrants are prone to various diseases and recognize that children and women migrants are vulnerable to health

risks and infections. Thus, inclusion of public health intervention and out-reach health services needs to be strengthened that can be accessible at affordable cost.

x) *Financial Inclusion* - Strengthen banking facilities for saving purpose and ensure that remittances transfer should be made safe and secure in the source and destination areas.

## CONCLUSION

India faces tremendous challenges on internal migration and need to formulate proper policies and programmes to improve migrants' health. The existing programmes need to be expanded and upgraded and effective implementation of these programmes as well as their integration of source-exit-destination levels would be crucial in improving the status of migrants health. Further, migration policy should not be viewed as a labour policy but need to be incorporated with city development plans and programmes as it is increasingly clear that rural to urban migration is predominate in India. In addition, social security benefits must be embedded in labour policy as 90 per cent of the workforce employ in informal sector. Access to health services and decent living conditions must be included in the migration policy ensuring that migrant rights prevail and that they should not deny access to basic services such as housing and health. The 12th Five Year Plan (2012-17) prepared by Planning Commission of India sees rural to urban migration as a 'distress migration' which mainly arise due to poverty and thus, implementation rural development programmes are crucial in curtailing rural to urban migration.[37,40] Further, sensitization and capacity building workshop for policy makers, experts and stakeholders concerned with migrants health such as ministry of health & family welfare, Non-Governmental Organizations, Urban development, Labour and Employment, Employees association of migrants, financial institutions and insurance companies needs to be carried out in a large scale to deal with the complexities and problems among migrant population. It is therefore a high time to mainstream migrant programmes and policies for better inclusion of migrant development.

## NOTES

a. Migration data of Indian Census 2001 is used in this study, since the data on migration from the Indian Census 2011 is not yet formally available. See http://www.censusindia.gov.in/2011-common/census_data_2001.html

b. There are two types of international tool on migrant rights: first is the International Covenant on Civil and Political Rights that mainly protects human rights and its facility apply universally; and second is the CMW and the ILO conventions that primarily focus on migrants. Despite of such several efforts, migrants are still continued to be protected under the umbrella of general internal law, international law and labour law, human rights law. However, with the adoption of CMW, the provisions of protecting migrants obtained formal sanction. The CMW was adopted in the 45th session of the General Assembly on 18 December 1990. See http://www2.ohchr.org/english/bodies/cmw/cmw.htm

c. The United Nations International Convention on the protection of the Rights of all Migrant Workers and their family members came to force on 1 July 2003. It establishes a compressive international treaty that aims at protecting migrant workers' rights and emphasize on building a link between migration and human rights, which later on increasingly seen as a crucial policy issue globally. The main objective of this convention is to protect migrant workers and their family members and promotion of migrant rights in each country. See http://unesdoc.unesco.org/images/0014/001435/143557e.pdf

d. The Government of India has launched a programme called 'ADHAR' – a biometric based Unique Identity (UID) for the inhabitants of India. Under this programme, migrants have the opportunity to get an ADHAR card which can be used as a residential proof and identification and helps in accessing welfare schemes of government. In this process, many migrants have found to be lacking supportive documents for their identification. For facilitating the inclusion of migrant workers in the UID programme, a memorandum of understanding has been signed with National Coalition of Organization for Security of Migrant Workers, Unique Identification Authority of India (UIDAI) and a group Non-government Organization (NGOs). See http://uidai.gov.in. However, the current governor of Reserve Bank of India, Mr Raghuram Rajan has allowed migrant workers to open bank accounts without producing residential address documents.
See http://timesofindia.indiatimes.com/business/india-business/Raghuram-Rajan-throws-weight-behind-government-move-to-have-bank-accounts-for-all/articleshow/40067746.cms

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