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ORIGINAL PAPER

Health of internal labour migrants in India: some reflections on the current situation and way forward

Essay

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Abstract Social and development policies have not been successful so far in mainstreaming health issues of internal labour migrants in India. This opinion paper reflects on the current situation of migrants and puts forth some perspectives on the way forward. It suggests some avenues for further research and scaling up of migrant-friendly health programmes.

> "I was scared to go to the government hospital because I felt I was not a resident of Nashik. As I stay in Nashik only temporarily, I feel I don't have the right to use the health services in the city. So I have never visited the government hospital which is very close to the settlement."
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> (Male migrant, 21 years, Nashik) (Borhade 2006)

India stands currently at the brink of an era that is expected to bring in tremendous economic growth; yet, there are pockets of neglected population whose development indicators are disconcerting (Government of India, National Human Development Report 2001), one such is the group of internal labour migrants. Internal migration, defined by UNESCO as a move from one area (a province, district or municipality) to another within one country is significant in India (UNESCO website); only labour-related migrants are estimated to be over ten million (including roughly 4.5 million interstate migrants and 6 million intrastate migrants) in the country (National Commission on Rural Labour 1991). The main occupations that attract migrant labourers include cultivation, working in quarries and construction sites, fish processing, manufacturing and transportation (Deshingkar and Grimm 2004, NCRL 1991). Seasonal migration has been growing in the recent years

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with men usually opting for manual labour and women getting employed as domestic helper and head-load transporters (Deshingkar and Grimm 2004).

While migration is an important livelihood strategy for many and has been shown to have economic benefits (Karan 2003, Club Du Sahel 2000), it also has serious negative repercussions. Internal labour migrants are often exposed to difficult and unsafe conditions, face occupational hazards, live in poor conditions and lose their supportive family and societal structure. In addition, their exclusion from several mainstream programmes including those on education and health lead to poor health status. As a consequence, they are susceptible to several health problems (Chatterjee 2006) these include infectious diseases like malaria (Waddington and Black 2005), TB and HIV/AIDS. Prevalance of HIV/AIDS among male migrants is 0.55% while it is only 0.29% among non-migrants (National Family Health Survey-III Data National Family Health Survery-III 2005–2006). Occupational health conditions like stomach pain, hip pain, pain in the neck, swelling of limbs, skin diseases, injuries, chest pain, eye problems, etc. are common, whereas women are susceptible to anaemia, reproductive tract infections and violence. Poor healthcare utilization rates have been shown to have a toll on several maternal and child health indicators. Expensive private healthcare facilities, perceived unfriendly treatment at government hospitals, emotionally secure environment at home and non-availability of caretakers for other siblings in the event of hospitalization are some of the reasons for the preferences of home deliveries among migrants (National Urban Health Mission Draft 2008). Migrant children suffer from malnutrition and poor immunization. The under five mortality rate among the urban poor migrants is at 72.7, significantly higher than the urban national average of 51.9 (National Family Health Survey-III Data 2005–2006).

While India does not have a comprehensive policy on internal migration, fragmented policies for the protection of migrants do exist: the National Employment Guarantee Act 2005 and The Minimum Wages Act (1948) provide some amount of financial security to migrants; the Construction Workers Act (1996) sets a handling limit of 20-kg load for women; and the Inter-State Migrant Workmen Act (1979) focuses on prevention of exploitation by out-of-state contractors. However, there is currently little related to health of migrant workers within national health programmes and policy. India's current national health policy of 2002 does not address health issues pertaining to migrants in specific. Currently, most of migrant healthcare is in the non-governmental sector (whenever such organizations exist). Considering the increasing volume of migrant workers, the public health consequences of the neglect of migrant's health is tremendous.

The National Rural Health Mission (NRHM), India's flagship health programme launched in 2005, has generated some interest in demarcating "vulnerable" populations in decentralized state and substate health plans (National Rural Health Mission 2005). These plans have been useful in identifying some earlier neglected pockets of migrant population, but since the mission targets rural areas, urban migrants remain neglected. There is strong political interest in rolling out a "National Urban Health Mission"(NUHM) in the next few years, focusing on the health of the underserved poor urban population dwelling in slums and other temporary sites (like construction sites). The mission aims at providing essential primary care to all urban poor, through partnerships with the private sector, social insurance schemes and community involvement (NUHM Draft 2008). Thus, it is a good time for

academicians and programme implementers to reflect on what would enable upcoming health programmes and policies to better target migrants.

There seem to be two important gaps in Indian academic research on migration. One is that Indian studies on migration tend to emphasize the impoverishing effects of migration, but have rarely posed the question of what these households and individuals would have done in the absence of the opportunity to migrate. This becomes an important interdisciplinary policy question to tackle the roots of migration issues. Secondly, unlike categories such as Schedule Caste, Schedule Tribes or Other Backward Cast groups (who are categorised as "vulnerable populations" in all development sector strategies), "seasonal migrants" are rarely culled out as a vulnerable group in different health studies. This is partly due to the fact that definitions of internal labour migrants are still not consistent. An improved definition of the internal migrant population and its subcategories would enable more accurate measurements of healthcare utilization indicators and health outcomes within this group.

India runs several vertical programmes for health (funded by the central government). These include programmes against important diseases like HIV/AIDS, TB and malaria. Interventions pertaining to these programmes are often long-term and require follow-up, but these programmes often find it extremely challenging to maintain continuity of medical care and monitor health outcomes in migrant populations (NUHM Draft 2008). Currently, few government databases have data pertaining to migrants; almost none have data over time. Even when this information exists, it remains confined to the labour sector. There is need to consciously channelize this information into the health sector and devise "tracking strategies" for improving health outcomes of migrants.

Healthcare utilization rates among migrants are often found to be poor. To some extent, this can be attributed to migrants feeling alienated from the government health system at temporary destinations and private facilities being too expensive. Migrant populations often cannot access the services/programmes due to their migration status, timings of their work and distance to services. In India, urban local bodies are statutorily responsible for provision and maintenance of basic infrastructure and services in cities and towns. At present, these bodies undertake very limited outreach activities pertaining to health. It is clear that public health services need to initiate and reinforce more "migrant-friendly" services. There is a strong need for scaling up outreach programmes and other onsite mobile health services that can provide special assistance to migrants.

Some currently functioning programmes like the National AIDS Control Programme have a mandate to provide outreach services. This programme has adopted an outreach approach for HIV/AIDS prevention and treatment for few categories of migrant population viz. truckers, sex workers and construction workers in India. (National AIDS Control Organization 2007). Another example of outreach services for migrants is the Indian Population Project. This project was initiated by the Ministry of Health and Family Welfare with support of World Bank. It has been undertaken in some cities like Chennai, Bengaluru, Kolkata, Hyderabad, Delhi and Mumbai, to improve urban health service delivery. The project uses link-workers for improving reproductive and child health in urban slums. It is important to study programmes such as the ones mentioned above carefully, and draw lessons for

replicability and scaling up of other public health outreach interventions for migrants.

Sensitizing and training of concerned policy makers and health stakeholders such as NGOs, employers association of migrants, insurance companies, financial institutions, academic institutions and health professionals involved with migrants' health also needs to be done on a large scale. Building partnership with NGOs working at source and destination levels of migration towards raising awareness, and encouraging strong collaborations on migrant's health can enable migrants to stay more aware and updated about health services available to them. Migrants, unlike tribal groups in India, have rarely had visible champions to take up their causes. The few struggles and rights movements around migrant issues have focussed on survival and exploitation issues while health has been given a back-seat. It is about time to mainstream health into discourses on migrant development.

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