Migrant's (Denied) access to health care in India

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ABSTRACT:

In most countries international migration has received more attention than internal migration. Even though internal labour migration has become an important livelihood strategy for many poor groups across the world, these migrants are often neglected or excluded from the various welfare or health programmes of their respective countries, such as various mainstream programmes in education, health, adequate living conditions, minimum wages and freedom from exploitation and harassment. This increases the vulnerabilities of the migrants and leads to their poor health status, which has significant public health implications.

This paper concludes that a multitude of factors affects the health of migrants including inadequate nutrition, poor housing conditions, hazardous occupational conditions, lack of access to health care services and a low level of awareness. Hence a population health approach is necessary which will align strategies, policy options and interventions for improving health outcomes among migrants. Possible strategies to improve the health of migrants can be: promoting migrant-sensitive health policies, assessment of the health of migrants and identifying and filling the gaps in service delivery to meet their health needs, sensitizing and training relevant policy-makers and health stakeholders' and initiating migrant–friendly public health services for those with special needs. There is also a need for convergence of the existing programmes at source and destination levels, so that the needs of marginalized migrants are accommodated in the programmes such as the food security, education for migrant children, and Integrated Child Development Services.

Key words: India, internal labour migration, magnitude of migration, health risk, health needs, HIV/AIDS, millennium development goals, malaria, tuberculosis, sexual and reproductive health, mother and child health, occupational health, health programmes and policies for migrants.

INTRODUCTION:

The primary goal of this paper is to understand the vulnerabilities of migrant workers to various health issues and their public health implications. The paper also focuses on the absence of programmes and policies to address special health needs of migrants in India, and the ways forward.

Internal labour migration has become an important livelihood strategy for many poor groups across the world[8], but this segment of the population faces exclusion from the various existing mainstream programmes such as education and health, which serves to increase their vulnerabilities. In the case of internal migrant labourers, their susceptibility to various health problems stems from their peripheral socio-economic existence in the host area. This leads to their poor health status that has significant public health implications pertaining to infectious and occupational diseases[3].

The rationale for this paper is to understand these vulnerabilities and the ensuing public health issues, the current programme and policy environment and to provide recommendations for improving the health status of migrants. This paper addresses voluntary internal labour migration (within the country, interstate and intrastate) for paid work, which includes both permanent (residing in undeclared urban slum areas) and temporary migration (for 2-6 months in a year) from rural-rural, urban-urban, urban-rural and rural-urban areas.

INTERNAL LABOUR MIGRATION:

India currently stands at the brink of an era that is expected to bring tremendous economic growth; yet there are pockets of neglected populations whose development indicators are disconcerting[10]. One such neglected group is internal labour migrants. Seasonal migration for livelihood is a growing phenomenon in India. The National Commission on Rural Labour[20] (NCRL) estimates the number of internal labour migrants in rural areas in India alone to be around 10 million (including roughly 4.5 million interstate migrants and 6 million intrastate migrants). The 2001 census has recorded about 53.3 million rural to rural migrations within the country. While the latest 64th round NSS survey puts a figure of 30 million on internal migration, various estimates based on micro-level studies[8] suggest that the figure is close to 100-120 million Intra and interstate labour migration is an important feature of the Indian economy. Most of this movement has been from the most populous and poorest states with net in-migration being higher for the more developed states.

According to NCRL[20], a large number of migrants are employed in cultivation and plantations, brick-kilns, quarries, construction sites and fish processing. A large number of migrants also work in urban informal manufacturing construction, services or transport sectors and are employed as casual labourers, head loaders, rickshaw pullers and hawkers.

Most seasonal migrants seek work in above mentioned unorganized sectors as daily labourers providing unskilled services; Men usually work as manual labourers while women are employed as domestic workers, head-load transporters or agricultural workers.

VULNERABILITIES OF MIGRANT WORKERS:

While migration is an important livelihood strategy for many and has shown to have social and economic benefits[5,8], it also has serious negative repercussions[3]. A combination of factors at the area of destination complicates the vulnerability, which is primarily premised on the alien status of the migrants. Limited choice and reduced capacity to negotiate result in increased discrimination in life chances. A migrant is considered an 'outsider'. Various surveys and studies have shown that migrants are disadvantaged relative to the native population regarding employment, education and health.[4,24] It is difficult to pinpoint specific separate reasons for this, such as deficient education, inferior health care provision, poor wages, initial prejudice and sustained discrimination, but these factors mutually reinforce each other. For instance, a bias against the migrants may translate into health providers' neglect, which in turn perpetuates poor migrant health[3].

The degree of vulnerability in which migrants find themselves depends on a variety of factors, ranging from their legal status to their overall environment. The hiring of migrants in an irregular situation allows employers to escape providing health coverage to them, and then the labour force becomes cheaper than recruiting locals/natives. In the case of internal migrants, their fluidity in terms of movement and their working conditions in the informal work arrangements in the city debar them from access to adequate curative care[4, 43,44.]

Determinants associated with the health of migrants[2, 4,34,43,]

Different types of migration lead to diversified vulnerability among internal migrants. The common determinants of health risks among migrants are the motivational factors (reasons for migration, occupations at the source of origin) and occupation related factors. In addition the living conditions of migrants' affect their health, these factors are inter-correlated, these being[1,3,25]

- Overcrowding living conditions which facilitate increased transmission of infectious diseases
- Poor nutritional status (consequent lowered immunity) due to lack of food before, during and after migration.
- Inadequate quantities and quality of water to sustain health and allow personal hygiene
- Poor environmental sanitation
- Inadequate or no shelter without sanitation facilities.
- Choices of occupation and working conditions.

PUBLIC HEALTH ISSUES STEMING OUT OF MIGRATION:

Migrants are often exposed to difficult and unsafe conditions, face occupational hazards, live in poor conditions and are without their supportive family and societal structure. In addition, they are excluded from several mainstream programmes including those on education and health. As a consequence, they are susceptible to several categories of health problems, as discussed below.

Morbidity pattern among migrants:

The morbidity patterns among migrants vary with type of migration and its potential for generating health risks. For instance, in the case of migration into big cities like Mumbai, which takes place on a more or less permanent basis, the susceptibility of the migrants to health problems stems from their peripheral socio-economic existence in the host areas.[30,34,39] In the case of migration for agricultural labour for three or four months, returning home after the harvest, such as those who go from Nandurbar (Maharashtra) to Gujarat, specific problems for the migrants include infectious diseases, chemical-and pesticide-related illnesses, dermatitis, heat stress, respiratory conditions, musculoskeletal disorders and traumatic injuries[29]. Itinerant sugar-cane harvesting groups in Maharashtra and other states differ enormously from other migrant categories. Sugar cane workers have a high level of occupational accidents and are exposed to the high toxicity of pesticides. They may also have an increased risk of lung cancer, possibly mesothelioma. This may be related to the practice of burning foliage at the time of cane cutting. Bagassosis is also a problem specific to the industry as it may follow exposure to bagasse (a by-product of sugar cane). The workers may also be affected by chronic infections, which reduce their productivity[29,41]. Migrants are working in stone quarries scattered all over India and work related illness endemic to stone industry include the respiratory diseases of silicosis and tuberculosis (TB) due to prolonged inhalation of silica dust[35].

Infectious Diseases[2, 4,12,16]:

Lack of proper water supply, poor drainage system, unhealthy practices and deplorable sanitary conditions expose the migrants to various kinds of health risks predetermined by their standard of living and their choice of occupation. Their living conditions and health behaviors increase their susceptibility to infectious disease. Infectious diseases such as malaria, hepatitis, typhoid fever, and respiratory infections are found to have a higher incidence among migrants. Migrant labourers avail themselves of curative care but they fall outside the coverage of preventive care largely due to their fluidity of movement caused by uncertainty of employment.

Malaria and Tuberculosis (TB):

Migration is a matter of concern in relation to Millennium Development Goal (MDG) for HIV/AIDs, malaria and other major diseases[40]. In case of malaria, migration may increase exposure to disease, transport mosquitoes to new areas and/or create habitats that are favorable to mosquitoes. Migration may also help spread resistance to drugs.

The 44th World Health Assembly[42] (1991) recognized the growing importance of TB as a public health problem[4]. Migrants are approximately 6 times more likely to have tuberculosis than the general population[37]. Migration is an important reason for the persistence of TB, besides other reasons such as poor management of TB control programmers, poverty, population growth, and a significant rise of TB cases in HIV endemic areas. [6,17,18] The study[15] in the tuberculosis unit of Tiruvallur district of Andhra Pradesh identified migration as an important factor for treatment default under The Revised National Tuberculosis Control Programmers (RNTCP). The migration was mainly due to occupational reasons and then returning home. The study concludes that irregular and incomplete treatment on account of migration is likely to increase the burden of TB in the community. Since migration, whether temporary or permanent, contributes to nearly one fourth

of default, it is important to work out strategies to overcome this. Providers should be sensitized on the fact that migration is an important factor for default and encouraged to motivate the patients to take regular treatment for the prescribed duration. Recently the RNTCP programme has started providing a duplicate card to migrants to continue TB treatment anywhere in India, which is significant step to reduce the default cases due to migration.

The International Organization for Migration (IOM)[36] also identifies the linkages among migration and MDGs (including MDG 6- prevention of TB, Malaria and other infectious diseases) and the potential to deal with the challenge and achieve the MDGs.

Migration and HIV/AIDS:
Many studies show that migrant worker is more susceptible to HIV/AIDS infection. Prevalence of HIV/AIDS among male migrants is 0.55 percent while it is only 0.29 percent among non-migrants.[21] IOM argues that migrants and mobile people become more vulnerable to HIV/AIDS, but by itself being mobile is not a risk factor for HIV/AIDS. It is the situations encountered and behaviors possibly engaged in during the mobility or migration that increases vulnerability and risk. Migrant and mobile people may have little or no access to HIV information, prevention (condoms, STI management), and health services.[36]

Occupational Health:
The occupation related commonly reported problems among migrants workers working in the informal sector are cold-cough fever, diarrhea, tiredness, lack of appetite, giddiness, weight loss, stomach pain, hip pain, headache, pain in the neck, swelling of legs, swelling of hands, hair loss, skin diseases, injuries, chest pain and eye problems.[4,16] Other illnesses include infectious diseases, chemical and pesticide related illnesses, dermatitis, heat stress, respiratory conditions, musculoskeletal disorders and traumatic injuries, reproductive health problems, dental diseases, cancer, poor child health, and social and mental health problems.[2,29,35]

Mother and Child Health:
The low health status of migrant women can be seen from indicators such as antenatal care coverage, prevalence of anaemia, prevalence of reproductive tract infection and violence against women[19]. Temporary migration to their native villages, especially of pregnant women for delivery results in missing out receiving services from either residence. Mother and baby do not receive services in the village due to distances, unavailability of previous record of services received and lack of awareness and negotiating capacity. Despite availability of government and private hospitals at destinations, the urban migrants prefer home deliveries.[22] Expensive private healthcare facilities, perceived unfriendly treatment at government hospitals, a more emotionally secure environment at home, and non-availability of caretakers for other siblings in the event of hospitalization are some of the reasons for this preference.[4,22]

Migrant children suffer from malnutrition and lack of immunization when their parents are in perpetual low-income uncertain jobs that necessitate frequent shifts based on availability of work[22]. Measles is found to be common among migrants mainly among children who do not have immunization[13] As per the re-analysis of the NFHS III data, Under 5 Mortality Rate (U5MR) among the urban poor migrants is at 72.7 percent, significantly higher than the urban average of 51.9 percent. About 47.1 percent of urban migrant children under-three years are underweight as

compared to the urban average of 32.8 percent and the rural average of 45 percent. Among the urban poor, 71.4 percent of the children are anaemic as against 62.9 percent of the urban average. 60 percent of the urban poor migrant children miss complete immunization as compared to the urban average of 42 percent.[22]

Reproductive Health. Prolonged standing and bending, overexertion, dehydration, poor nutrition, and pesticide or chemical exposure contribute to an increased risk of spontaneous abortion, premature delivery, fetal malformation and growth retardation, and abnormal postnatal development.[11,28,32]

Migrant workers are also at increased risk for urinary tract infections, partly as a result of a lack of toilets at the workplace and stringent working conditions that promote chronic urine retention.[27,28] Urinary retention in turn encourages bacterial growth and stretches and weakens the bladder wall; this in turn promotes chronic infections or colonization[12].

Social and Mental Health. Migration brings out numerous stress factors for migrants, including job uncertainty, poverty, social and geographic isolation, intense time pressures, poor housing conditions, intergenerational conflicts, separation from family, lack of recreation, and health, shelter and safety concerns.[12,37] Manifestation of stress includes relationship problems, substance abuse, domestic violence, and psychiatric illness. Heavier alcohol usage and risky sexual behavior have been noted in communities of predominantly single men compared with those consisting primarily of families[24]. Children of migrant workers experience a six fold greater risk of mistreatment than children in the general population.[33,37]

Prolonged stay at destination cities leads to an increased risk of psychiatric disorders; the increased risk may be attributed to the loss of protective socio-cultural factors (e.g., cohesive communities based on strong social support, family ties, language and group identity), or it could represent initially healthy migrants becoming less psychologically healthy with acculturation over time.[1,12]

ADDRESSING MIGRANTS' HEALTH: CURRENT POLICY AND PROGRAMME ENVIRONMENT IN INDIA

Policy Environment:

Although India does not have a comprehensive policy on internal migration, fragmented policies for the protection of migrants do exist[3]. Indian constitution contains basic provision relating to the conditions of employment, nondiscrimination, right to work etc (for example Article 23(1), Article 39, Article 42, Article 43) which are applicable for all workers including migrant workers within the country. Migrants are covered under various labour laws. However, those [1]laws, which do exist to protect the rights of migrant workers, are widely disregarded by employers and intermediaries because of a lack of political will to implement them, and ignorance among illiterate

[1] Existing Central and State legislation for unorganized sector migrant workers in India include: National Employment Guarantee Act 2005, The Minimum Wages Act (1948); the Inter-State Migrant Workmen Act (1979); the Contract Labour System (Regulation & Abolition Act) (1970), the Bonded Labour System (Abolition) Act (1975), for women under the Equal Remuneration Act (1976), the Construction Workers Act (1996), or the Factories Act (which e.g., sets a handling limit for women of 20kg).

migrants of their rights as workers. Additionally, as migrants do not have fixed employers, the latter escape from their responsibilities to provide various benefits to migrants that are mandatory under the existing laws. These laws hold the government as well as the employers responsible for contributing financially towards providing benefits such as basic health care, insurance and an education allowance for children of workers. The Interstate Migrant Worker act has been in force since 1979, and has great potential to address interstate migration issues, but is not implemented due to lack of awareness among migrants as well NGOs, and the lack of willpower among politicians and government officials dealing with interstate alliance. It is crucial to activate and implement the available laws to address migrants issues related to exclusion of services. However, within national health programmes and policy, currently there is little related to the health of migrant workers[3].

India has ratified many International Labour Organization's conventions but is neither a signatory or ratified the [2]Convention of Migrant Workers (CMW), which provides the formal sanction for protection of the migrants. Similarly [3]UN Convention of Migrant Workers clearly spells the global focus on the human rights of migrants, but India has not adopted either of them and hence interests of migrants are not protected including health.

Some important policies such as the National Health Policy 2001[26] aim to achieve an acceptable standard of health amongst the general population, and to promote equitable access to public health services across the social and geographical expanse of the country. Similarly, the National Population Policy 2002[25] affirms the commitment of the government to voluntary and informed choice and consent of citizens while availing of reproductive and health care services, and the continuation of the target free approach in administering family planning services. As per Vision 2020[14], by 2020 the people of India will be more numerous, better educated, healthier and more prosperous than at any time in our long history. While all these policies aim to achieve improved health status for the whole population of India, they do not however address health issues specifically pertaining to migrants[3].

There are very few examples of government policies to support the migrant population in India. Currently, most of migrant healthcare is in the non-governmental sector (wherever such organizations exist). The existing central government guidelines allow all migrant children to avail

[2] The Hague Declaration focused on adopting a more humane approach to migrants and migration, have two sets of international instruments for migrants rights: first the core human rights treaties such as the International Covenant on Civil and Political Rights, whose provisions apply universally, and thus protects migrants; and second CMW and the ILO conventions which specifically apply to migrants. Despite several attempts, migrants continued to be protected under an amalgam of general internal law, human rights law, labour law and international law, but with CMW the provision for the protection of the migrants' received formal sanction. CMW was adopted by General Assembly at its 45th session on 18 December 1990.

[3] The United Nation's International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families entered into force on 1st July 2003. It constitutes a comprehensive international treaty regarding the protection of migrant workers' rights. It emphasizes the connection between migration and human rights, which is increasingly becoming a crucial policy topic worldwide. The Convention aims at protecting migrant workers and members of their families; its existence sets a moral standard, and serves as a guide and stimulus for the promotion of migrant rights in each country.

of nutritional supplementation under the Integrated Child Development Scheme (ICDS) at destination cities irrespective of whether or not they are registered in the area (see annexure 1). As a result, all migrant children can benefit from the childcare centre (*anganwadi*) services in or near where the migrants reside (*nakas*). Pregnant women can also avail of antenatal and post-partum care through these *anganwadis*, which will be linked to government health services. Adolescent girls can be given treatment for anemia at these *anganwadis,* and, in addition, be provided life skills and sex education through the ICDS programmes. [4]Disha Foundation, an NGO based in Nasik, has played a role in identifying sites for the establishment of such *anganwadis* that are convenient for migrants, as well as in encouraging migrants to make use of the facilities. This guideline has tremendous potential to address the health concerns of migrant children, adolescents and women; hence its effective implementation is of the utmost importance.

Similarly in case of food security, the Public Distribution System (PDS) has issued a Government Resolution (see annexure II), which affirms the right of seasonal migrants to access and use a temporary ration card during their stay in a destination city and the obligation of each district Collector (Administrative head of the district) to issue these temporary ration cards. This GR is implemented at Nasik by the Disha Foundation and the PDS has issued 50 temporary cards to migrant families. However this needs the continuing support of the government and NGOs.

Other examples of policies that have helped migrants include the government health insurance in a few states of India. An example is the *Jivan Madhur Yojana* (insurance programmes) where the government and the migrants each contribute half the insurance premium which covers health problems and accidental death of the worker, and also provides an education allowance for the children of workers studying in the 8th to 10th standard of school. These programmes have been effective and helpful for poor migrants but the eligibility criteria are different in different areas, and the workers from one state are not covered if they move to a different state. This needs to be looked into in order to foster collaboration between the different state governments and insurance companies.

Another example is the [5]*Rashtriya Swasthya Bima Yojana* (RSBY) scheme (http://www.rsby.gov.in) launched on 1 April 2008 by Ministry of Labour and Employment, Government of India, to provide health insurance coverage for Below Poverty Line (BPL) families. RSBY is a smart-card based health insurance system with unique portability of access to healthcare services. Thus this scheme can be used by migrant labour at source and at destination.

[4] Disha Foundation is an NGO based in Nasik, Maharashtra state of India. Disha is one the pioneer NGO working with migrant communities in Maharashtra since 2002, to facilitate the internal labour migration via direct intervention with migrants and policy dialogue with governments, to address migration and different needs of migrants including health, education, livelihood and rights in general.

[5] The objective of RSBY is to provide protection to BPL households from financial liabilities arising out of health needs that involve hospitalization. In the absence of the desired scenario of universal access to healthcare by the government, affordable health insurance such as RSBY is one way of providing protection to BPL households against the risk of expenditures on illness. With a one-time enrolment fee of merely Rs. 30, the scheme provides coverage to five members of a family and an annual total coverage of up to Rs. 30,000. It covers several serious illnesses and procedures that require hospitalization, but excludes maternity benefits.

The scheme has few major limitations. A major limitation is its restriction to hospitalization benefits and the absence of provision for outpatient treatment. This is an extremely critical limitation because the majority of the medical expenses of the poor are incurred for outpatient treatment. Even for hospitalization the coverage is low. Migrant workers face the risk of occupational injuries and in the absence of workplace coverage the low amount of coverage is a bigger problem. It is worth noting that the poor may be willing to pay more for better coverage as experienced by the NGO Nidaan in Bihar.

The restriction of RSBY to BPL households is a considerable problem for migrant families. Migrants may not be able to register in their source village. Migrant families often do not have location-specific identity documents. They are casual labourers who earn their income in cash and they have no means to establish income proof. Further, most seasonal migrants are attached to contractors and dependent on them for services at destinations. It is extremely difficult to reach out to them.

Migrants also have difficulty in accessing the RSBY because the local administration in many areas does not recognize the presence of seasonal migrants. For example, in Gujarat, the brick kiln workers were denied access to RSBY because they were told that enrollment in the scheme is to be done only in the home state.

Despite the drawbacks of RSBY it must be recognized that there have been some changes made in the scheme based on the learning from implementation and feedback from the field. To enable greater utilization there is the facility to get a "Split Card" for migrant families, which can be used by migrant workers at destination, as well at source by his family members. Some state governments have linked their Emergency Transport System with RSBY; some are about to hire civil society organizations for increasing awareness.

Evidence suggests that despite good health policies, the special health needs of migrants are unmet due to proper outreach to this population. This could be due to lack of official data on labour migration. Gaps in available data lead to corresponding gaps in policy. In the absence of a proper database regarding the extent and scale of distress migration, and a better understanding of its impact on both families and communities, the issue is unlikely to find a place in the policy discourse or, therefore, in national or state planning frameworks.

Programme Perspective

India runs several vertical programmes for health (funded by the central government), which include those against diseases like HIV/AIDS, TB and malaria. Interventions pertaining to these programmes are often long-term and require follow-up, thus these programmes often find it extremely challenging to maintain continuity of medical care and monitor health outcomes in migrant populations.[22] 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.[3]

Some currently functioning programmes like the National AIDS Control Programmes[24] have a mandate to provide outreach services. This programmes has adopted an outreach approach for HIV/AIDS prevention and treatment for few categories of the migrant population viz. truckers, sex workers and construction workers in India. 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 the support of the 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 carefully study programmes such as the ones mentioned above and draw lessons for replicability and scaling up of other public health outreach interventions for migrants[2].

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" approach.[43]

The National Rural Health Mission (NRHM), India's flagship health programmes launched in 2005, has generated some interest in demarcating "vulnerable" populations in decentralized state and substate health plans[23]. These plans have been useful in identifying some earlier neglected pockets of the 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 NUHM aims to provide essential primary care to all urban poor, through partnerships with the private sector, social insurance schemes and community involvement.[22] Thus, it is a good time for academicians and programmes implementers to reflect on what would enable upcoming health programmes and policies to better target migrants.[3]

RATIONALE TO ADDRESS MIGRANTS' HEALTH:

Evidences suggests that internal migration can play an important role in poverty reduction and economic development, hence positive facilitation of safe migration should be specially emphasized which mainly includes access to basics and public services mainly health, education and livelihood. Further, the high volume of migration and inter-linkages of the health needs of migrants with all Millennium Development Goals and national policies (National Health Policy, National Population Policy and India Vision 2020) means that success in meeting these needs can help support the achievement of the MDGs and these policies. Hence increased emphasis is required to address the special health needs of the migrant population, which can help to improve their health indicators as well the overall experience of migration.

Migrants are poor, uneducated, socially excluded and face a very alien environment when they come to urban landscapes. They have trouble-proving identity/eligibility, language is a barrier, have insufficient awareness of entitlements/rights, little understanding of how hospitals and insurance providers operate, etc. Thus there is an urgent need to design health programmes and policies for them that are simple and easily accessible.

CURRENT CHALLANGES AND WAYS FORWARD TO ADDRESS MIGRANTS HEALTH NEEDS:

1. Need of Improved definition of migrants: Unlike categories such as Schedule Caste, Schedule Tribe or Other Backward Caste groups (who are categorized as "vulnerable populations" in all development sector strategies), "seasonal migrants" are rarely culled out as a vulnerable group in different health studies and programmes. This is partly due to the fact that definitions of internal labour migrants are still not consistent.[3]

Recommendation:
An improved definition of the internal migrant population and its subcategories is necessary to enable more accurate measurements of healthcare utilization indicators and health outcomes within this group.

2. Detailed Mapping of Internal Migration at a Countrywide level: One of the serious constraints in framing an effective policy response to internal migration is lack of credible data on the volume of migration. While the latest 64th round NSS survey puts a figure of 30 million on internal migration, various estimates based on micro-level studies suggest that the figure is close to 100-120 million. Concerted efforts are required to address this knowledge gap on migration.

Recommendations:
I. One way is to involve the *Panchayat Raj* Institutions (PRIs) to initiate a countrywide documentation of migrant workers moving out of rural areas. Civil society organizations and the labour department can take a proactive role in supporting this initiative. At the source, civil society organizations can support PRIs in undertaking surveys/registrations. The database being built as a result of this effort could be computerized and then integrated at successive block, district and state levels. Registration of migrants at destination cities can be done collectively by the labour department of the receiving state and civil society organizations.

Reference cases:

1. Disha Foundation, Nasik works in Maharashtra with PRIs to register the villagers who migrate for livelihood. The Migration register is maintained by PRI and the data is used for implementation of various government and non-government programmes for the migrants' families.
2. Rajasthan Labour department has initiated such registration through an NGO, Aajeevika Bureau in Southern Rajasthan. The NGO registers migrant workers, issues Photo IDs and maintains a database of migrant workers. The database is shared with the Rajasthan Labour department on a quarterly basis. The *Panchayats* being the closest link to migrant workers in the chain act as the signing and verifying authority on the Photo ID cards.

II. The second approach could be by way of adapting the Census and NSS methodology to capture seasonal and circular migrant populations, but this needs to be done with care because, as mentioned earlier, both in the Census and NSS the reported figures of migration are gross underestimates.

3. Healthcare Service Delivery: Health care utilization rates among migrants are often found to be poor.[22] 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[3]. Constantly changing destinations is also a problem.

Recommendations:

A system for universal access to health care for migrants is crucial. Ways in which this could be achieved as below:

- There is need to consciously channelize information pertaining specifically to migrants into the health sector and devise "tracking strategies" for improving their health outcomes. Providing mobile health cards to migrants that can be utilized both at source and destination in any state would be crucial. The migrant health card can be tracked by any health official at any location in order to continue treatment. (This would be similar to the RNTCP and RSBY programmes, which provides a duplicate card to a migrant to continue the treatment anywhere in India.). Co-ordination among health facilities at village, block, district and state levels is crucial for the effective implementation.

- It is important to carefully study programmes such as the Indian Population Project and a few initiatives by NGOs, and draw lessons for replicability and scaling up of other public health outreach interventions for all categories of migrants.

- Initiating or reinforcing migrant-friendly public health services, and creating greater awareness about those services among migrants would be important to address migrants' special health needs. Onsite mobile health services or providing special assistance to migrants in regular health services would be helpful.

Reference case: Disha Foundation has initiated migrant friendly health prgorammes in Nasik; Migrant's awareness building about health issue and empowerment for utilization of government health services is major component of the programme. Sensitization of government health providers is also initiated. A formal referral system for utilization of government health services is introduced, which is approved by district health services. A triplicate referral form is developed for migrants, government health services (civil hospital, urban health center etc) and Disha. Migrants are referred to health services by Disha through its trained community leaders. The referral system is getting popular among migrants as it helps them to get direct treatment from doctor without much discussion, as the medical history and related details are provided in the form. The backside of form also contains contact information of all government health services; the referral service provides increased access levels to health care for migrants, and it also helps for increased awareness level to government health system. (see annexure IV for more details)

- Employment State Insurance Corporation's (ESIC) hospitals and health centers can be made accessible to migrant workers of all categories; as ESIC's latest guideline includes workers in construction sector, similar guideline can be broaden for inclusion of all types of migrants.

- Since the health of migrants is affected by a multitude of factors, hence a [6]population health approach is necessary in order to align strategies, policy options and interventions for improving health outcomes among migrants.[43] Strengthening the existing inter and intrastate programmes for migrants especially convergence of the health insurance, Mother and child health and other programmes at source and destination levels with respective government departments. For one thing RSBY should be revised and also made applicable to non-BPL families, and it should also cover OPD use. For another, since mother and child health care is genuine concern in the case of migrants due to their mobility the Central Government's guideline for utilization of ICDS services for migrants (Annexure I) should be strictly followed. **Strict implementation of this guideline and resource allocation for it would be a significant step as none of the states are implementing this programmes where both the state and central governments have major role to play.**

  4. Addressing basic needs of migrants in cities would be crucial step as these are important determinants affecting the status of migrants.
  i. Improving living and work conditions: Crowded living conditions without basic amenities constitute the most important determinant of poor health status of migrants.(See Annexure III) Temporary accommodation with basic amenities in cities is a significant need for migrant workers. Hence night shelters, short-stay homes and seasonal accommodation for migrant workers must be provided in cities. The current Jawaharlal Nehru National Urban Renewal Mission programme has the potential to set up such shelters in cities.

  The 11th five year Plan (Vol 1, para 4.48) is explicit in the recognition of a severe gap in policies vis-à-vis migrants, the Plan argues for improving the living and working conditions of migrants. The Ministry of Labour and Employment has piloted an intervention to improve the work and living conditions in Orissa and Andhra Pradesh for migrant workers in the brick kiln sector in 2009-10. The learning's can be used for its replication in other states. But it seems that the implementation envisaged in the 11th Plan has not happened on a large scale. It is important to understand why such extensive implementation has not occurred and a study should be commissioned to find out the reasons, only then can an effective plan be put in place for the 12th Plan.

  ii. Food and nutrition: Food and nutrition expenses account for a significant share of living expenses for daily wage workers in cities. A study done by Aajiveeka Bureau on migrants in Ahmedabad suggests that on an average 41 percent of their income is spent on food. It is been observed migrant children suffer from malnutrition when their parents are in perpetual low-income uncertain jobs that necessitate frequent shifts based on the availability of work.[22] There is a need to

[6] **Population approach (Rose6):** Its objective is to decrease health inequalities between socially defined groups. The intervention target is Shift distribution of population risk exposure toward a lower mean through changes in environmental conditions that lead to increased risk. (World Health Organization)

create provisions for low cost and good quality food options for migrant workers.

Recommendation:

Portability of PDS for migrant workers across state borders. A national roaming (mobile) ration card for such migrants can be provided. A few states such as Maharashtra and Andhra Pradesh have started such an initiative. But because of the lack of awareness there is low usage of this provision. More information needs to be disseminated about this, and other states need to take it up. A national roaming ration card would be proactive step to address food insecurity among migrants.

Reference Cases: Disha Foundation has worked with the PDS, Maharashtra towards the activation of the GR for providing a temporary ration card for migrant workers. According to this GR, intrastate migrants of the BPL category should be able to get a temporary ration card at the destination city, and can avail of up to 35 kg of food grains during the migration period. It is working successfully in Nasik. This GR can be replicated in other states of India, and a system can be set up within PDS to make the temporary ration cards available to inter and intrastate migrants.

Bhopal Municipal Corporation has initiated low cost food facility for migrant workers in Bhopal. Similarly Aajiveeka Bureau has started low cost Tiffin facility for migrant workers in Ahmadabad. These models can be studied for wider applications in the country.

iii. S**etting up of Migrant Resource/Assistance Centers** at the major source and destination locations which provide information and counseling and respond in the case of public services including health, education and other emergencies.

Reference case: The [7]National Coalition for Migrants security have set up such assistance centers by the name of *Shramik Sahayata evam Sandarbha Ke*ndras (Migration Resource Centers) which provide such services to migrant workers both at source and destination. These centers are being run in five states including Utter Pradesh, Orissa, Maharashtra, Rajasthan, and Gujarat by 23+ organizations. Such models can be studied and replicated in other high migration corridors.

5. Capacity building

[7] The National Coalition of Organizations for Security of Migrant Workers is a network of organizations working on issues related to internal migration and urban poverty. The Coalition represents 40 plus organizations spread across states of Maharashtra, Uttar Pradesh, Rajasthan, Bihar, Orissa, Madhya Pradesh, and Gujarat. The Coalition has been working to mainstream concerns of migrant workers at the state and national level and make the existing policies sensitive to the rising incidence and complexity of rural to urban and inter-state migration. It is currently convened by Disha Foundation, Nasik

- Sensitizing and training of concerned policy-makers and health stakeholders for effective implementation and convergence of state policies would be important to address migrant health issues. These stakeholders can be the nodal ministry i.e. the Ministry of Health and Family Welfare (MOHFW), other ministries such as Labour and Employment, Urban Development, Rural Development, Women and Child Welfare Municipal corporations, etc. Further stakeholders could include NGOs, migrant employers' associations, insurance companies, financial institutions, academic institutions and health professionals involved with migrants' health.

- Building partnerships with NGOs working at source and destination levels of migration to raise awareness among migrants to become more knowledgeable and stay updated about the available health services.

- Human resource development and cadre building among government (MOHFW, Labour Ministry) as well private sector would be crucial step to address migrant's health and related other development issues.

- Promoting collaboration among government, different donor agencies, and agencies working on migration for health polices/programmes implementation would be important step for capacity building of these stakeholders.

6. Research:

- Encouraging health and migration knowledge production, including both quantitative and qualitative studies are crucial.

- Documentation and dissemination of best practices and lessons learnt in addressing migrants' health needs at source and destination would be important step to create a knowledge bank on migration and health.

- Identifying the required convergences of existing health services and filling gaps in service delivery to meet migrants' health needs would be crucial.

- Promotion of a National Policy Think Tank for advice on matters of migration health and development should be initiated jointly by The Ministry of Health and Family Welfare and Ministry of Labour and Employment. The think tank would also undertake the above-mentioned programme and policy research.

7. Advocacy and policy development

- There is strong need to advocate for strengthening the existing programmes for migrants specially convergence of the programmes at source and destination level with respective government departments, including interstate.

- Covering all categories of migrant workers is crucial under government's different national health programmes, including occupational health, HIV/AIDS prevention and treatment programmes, testing and counseling, RTI/STI diagnosis and treatment, antenatal check-ups and family planning services. There is urgent need for rolling out of the proposed National Urban Health Mission, which recognizes and plans to cover these health needs of migrants.
- Promoting migrant-friendly health policies that aim to address the diverse health needs of migrants would be crucial. India currently does not have a comprehensive **national migration policy** that could act as an umbrella under which the health, education, livelihood and rights issues of migrants could be addressed and which would define the roles of the states in execution of policy

CONCLUSION

India is facing migration challenges and has increasing need to formulate and implement policies to improve migrants' health. Currently, India has **few or no structural policies** or programmes targeting the migrant issues in totality and this segment of the population still faces exclusion from the various mainstream programmes. There is a need to modify the existing policy structures and pr**o**grammes so that the needs of this marginalized group are accommodated in the various national policies and programmes. **Development of a National Migration Policy** would be proactive step towards it. Effective implementation of the available programmes, as well as their convergence at source and destination level, at both inter and intrastate level would be important to improve the status of migrants' health. For this, interstate collaboration is required among government departments, to assess and subsequently tackle occupational risks and their health consequences before, during and after migrants' period of work, both in their place of origin and destination.

Sensitization and capacity building of concerned policy makers and health stakeholders mainly Ministries of Health and Family Welfare, Labour and Employment, Urban Development, NGOs networks, employers associations of migrants, insurance companies and financial institutions needs to be done on large scale. The cadre building among government as well private sector would be critical. The provision of basic services would require better coordination among departments located in different sectors and different areas. The central government has a major role to play in the whole process including promoting an alliance among key health services providers and their respective departments, their capacity building, and resource allocation.

Migrants have rarely had visible champions to take up their causes. The few struggles and rights movements around migrant issues have focused on survival, livelihood and exploitation issues while health has been given a back seat. It is high time to mainstream health into dialogues' on migrant's development.

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Annexure *I:* *Integrated Child Development Scheme guideline for migrant women, children and adolescent in India*

ICDS guidelines

Office of the Commissioner
Integrated Child Development Services
Raigarh Bhawan, Rear Wing, First Floor
CBD, Belapur
22 May 2006

Sub: Central Government directive regarding nutritional supplementation

Ref:
1. Central Government letter no. 1-5/92-Cd-2 dated 6.11.1992
2. Central Government letter no. 19-5/2003-Cd (PT) dated 7.3.2006
3. Central Government letter no. 1-2/2006-CDI dated 8.3.2006
4. Department of Women and Child Development letter no. ABV -2006/ No. 80/ dated 15.4.2006

With reference to Central Government letter no. 1, all pregnant and lactating mothers and their children should be eligible under ICDS for nutritional supplementation and should be allowed to take advantage of all other services of ICDS. All pregnant and lactating mothers and their children (6 months to 6 years) who are not registered with ICDS anganwadis are also eligible to receive nutritional services under ICDS.

All beneficiaries who migrate should be provided a certificate from the anganwadi in their village of origin. When they migrate to other villages/ towns, they should carry the original certificate with them and should submit it in the anganwadi at the destination so that they can avail of uninterrupted services. A copy of the certificate is annexed.

Central Government letter no. 19-5/2003-Cd (PT) dated 7.3.06 has the following clarifications on nutritional supplementation: The Government has not fixed a precise number of beneficiaries for each anganwadi for the distribution of nutritional supplementation. There is no upper or lower limit for beneficiaries but the number of beneficiaries is expected to vary according to the population.

All anganwadis should register all children below the age of 6 years and all pregnant and lactating mothers for the purpose of nutritional supplementation. It is mandatory to provide nutritional supplementation to all children below 6 years. ICDS services are applicable not just to malnourished children but to all children in this age group as well as pregnant and lactating mothers. The ICDS scheme is open to all and not just to children and women below the poverty line. The scheme is in no way linked to income category or the nutritional status of the beneficiary.

The Commissioner
Integrated Child Development Services
State Government of Maharashtra

Copy:

1. Dy. Chief Executive Officer, Zilla Parishad, 2. Child Development Project Officer, Urban (Nasik)

Copy submitted for information: Secretary, Department of Women and Child Development, Mantralaya, Mumbai

Copy of Certificate for Mothers and Children

Copy of certificate for beneficiaries who migrate to other villages/towns to allow them to avail of ICDS services

Name of beneficiary	*Name of ICDS project* *In village/town at place of origin*	*Beneficiary's current nutritional status and illness if any*	*If beneficiary is malnourished, degree of malnutrition*	*Name of ICDS project to which beneficiary is migrating*	*Remarks*

Signature of ICDS Project Officer in village/town/anganwadi at place of origin

Signature of ICDS teacher/worker in village/town/anganwadi at place of origin

Annexure II: Temporary Food Ration Card Directives For Migrants In Maharashtra, Government of Maharashtra, India

Extract from the State Government Resolution 1000/G.R.399/2000/NP28
Issued on 9 November 2000 for providing ration cards to migrant (temporary) and unorganized workers in urban areas

…As workers in the unorganized sector migrate in search of employment, do not reside in a fixed place and do not live in their native place, they do not have documentary proof, such as a birth registration certificate or a certificate for school enrolment for their children.

It is also very difficult to get documentary proof on migration. Since these families are generally eligible for services under the Public Distribution System, the requirements of documentary proof are hereby relaxed. The normal procedure for getting a ration card-- to complete an application form--should be observed on the basis of this information being given by the applicant, and the Supply Inspector should physically verify the living conditions of the family members and then the procedure to issue temporary ration cards for a certain period should be adopted. If the family wishes to reside at the same address for a longer period, the ration card should be renewed for such further period as necessary…

(Translated from Marathi-local official language of Maharashtra state of India)

Annexure III: Poor Living Conditions of Migrants (Photo Source; Disha Foundation, Nashik)

Annexure IV: Addressing Health Needs of Migrants: Learning's from Disha, Nasik

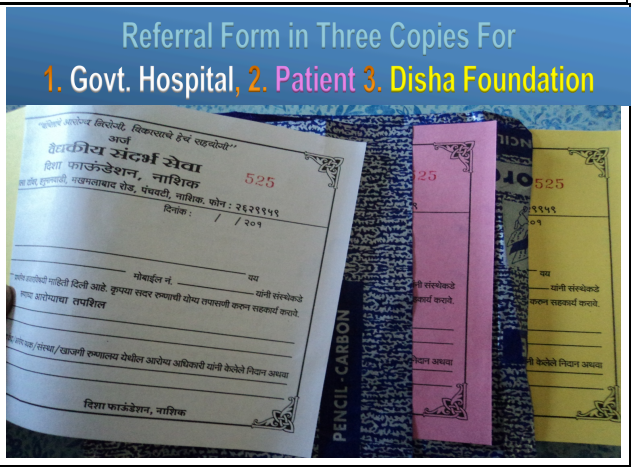
Disha Foundation piloted a project that intended to improve sexual and reproductive (SRH) health of migrant in Nasik, India, covering about 15,000 migrants in Nasik comprising 40-45% are women in the age group 12-55 years. Migrants are largely seasonal and they remain in Nasik for 8-10 months in a year. The project adopted a participatory approach for improving the quality of life of migrants. Migrant workers were directly involved in indentifying their needs and approaches followed for getting access to public services. The project also initiated need-based advocacy with authorities to address the SRH health needs of migrants.

Conclusions and lesson learnt: While the initial objective was to address the health needs of the migrant population, it became wider to address issues related to overall quality of life. Seasonal migrants were made aware of their rights and a communication link was established between the migrants and government authorities to facilitate the provision of public services.

The project helped migrants to gain access to basic amenities including health services; water supply and food through temporary ration cards. Child-care services were introduced, children were enrolled in schools, and birth registration certificates issued. It helped to develop vocational skills and provided access to financial security through insurance schemes.

The project discovered that motivating the beneficiaries is not enough; public authorities must also be sensitized. Polices and programs needs to modify suiting to the health needs of migrants. It is difficult to sustain the motivation of temporary migrants to adhere to the time-consuming processes of obtaining services.

Without a strong institutional structure, provision of services to migrant workers will remain ad-hoc and unsustainable. Hence a formal referral health service is introduced with government health services. A triplicate referral form is developed for migrants, health providers and Disha. Migrants are referred to health services by Disha through its trained community leaders. The form is helpful for migrants to get direct treatment from doctor without much discussion, as the medical history and related details are provided in the form; the backside of form also provides contact information of all available government health services in Nasik. The referral service provides increased access levels to health care for migrants, and it also helps for increased awareness level to government health system.



In short, the project highlights that in order to address the needs of seasonal migrants one must work at both the level of the population of seasonal migrants and the administration. A variety of priorities and concerns need to be addressed that influence their lives. Moreover, one must work to enable seasonal migrants to gain access to services to which they are entitled, as well as to apprise them of their rights and support them to access their rights. This project has had limited success in making this population self-sufficient as a result of their mobility, the nature of their irregular migration to destination cities, and the difficulty in tracking seasonal migrants. The project has had some success in galvanizing the administration but it is apparent that seasonal migrants will continue to need a mediator to help them address their multiple needs. The lessons learned from the implementation of this project are valuable, and should have wider application among similarly disadvantaged mobile populations across the country. (Borhade 2006)