CHALLENGES AND POSSIBLE SOLUTIONS FOR ENSURING HEALTH OF URBAN MIGRANTS AS A PART OF INDIA'S AGENDA FOR A SUSTAINABLE URBAN GROWTH STORY

DPhil RESEARCH

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Dedicated to

All migrant workers, who are creating and maintaining glorious cities of the world, and also developing the countryside with their remittances, while remaining obscure and vulnerable, being excluded from the most basic entitlements – health, education, sanitation, housing and much more; a tenuous tale of toil, tenacity and constant tumult.



Sketch credit: Anjali Borhade

This sketch symbolizes the essential but unrecognized contribution by migrant workers who are at the forefront of building cities

"As long as you look at migration as a problem, as something to solve, you're not going to get anywhere. You have to look at it as a human reality that's as old as humankind. It's mankind's oldest poverty reduction strategy. As citizens, we have to find a way to manage it"

William Lacy Swing, Director General, International Organization for Migration

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Challenges and Possible Solutions for Ensuring Health of Urban Migrants as a Part of India's Agenda for a Sustainable Urban Growth Story

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ABSTRACT

Internal labour migration is an important livelihood strategy for poor groups worldwide.

Aims and objectives
This research aims to answer the question "What is appropriate policy framework to address the health needs of the Indian urban migrants?" The research analyses existing policies and compares policies in arrange of countries that have developed mechanisms to address migrant's health needs. Transferable lessons will be drawn to develop a policy framework to address health needs of Indian migrants. Recommendations to improve the health of urban migrants will be made.

Methods
The research involves a mixed methods approach - literature review, questionnaire survey, qualitative interviews and site visits to understand successes and challenges in the implementation of migration and health policies in India and other countries. A literature review was conducted to understand the impact of migration - its health outcomes and policies in India and abroad. A pre-tested, interviewer-administered questionnaire survey was conducted using random sampling with 4000 migrants in Nashik to understand their access to health care. In-depth interviews were conducted with policy makers in ministries including health and labour, migrant's organizations and international agencies in India, China, Philippines, Sri Lanka and Vietnam to understand the successes and challenges in the implementation of migration and health policies and learn from their experiences.

Conclusions
Internal migration is rising in India mainly from the scheduled tribes and castes. Lack of migration specific data, state specific programmes/policies linked with state citizenship and lack of federal structures are key challenges to meet the unique needs of Indian migrants.

Lessons for India were learnt from other countries included initiating a migration census, introducing a national portable health insurance and a comprehensive 'whole government approach'.

Recommendations were made to enable the government to facilitate appropriate policy to improve the health and status of the migrants.

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LIST OF ABBREVIATIONS

ACP	African, Caribbean and Pacific Group of States
ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Anti Natal Check up
AWC	Anganwadi Centre
AWW	Anganwadi worker
BBS	Bangladesh Bureau of Statistics
BPL	Below Poverty line
CALD	Culturally and Linguistically Diverse
CBO	Community Based Organization
CMW	Convention of Migrant Workers
CSDRN	Coordinative Severe Disease Reimbursement Network
DFID	Department for International Development
DRC	Democratic Republic Countries
ECDC	European Centre for Disease Prevention and Control
FECCA	Federation of Ethnic Communities' Councils of Australia
FSW	Female Sex Worker
GDP	Gross Domestic Product
GSO	General Statistics Office
GSS	Ghana Statistical Services
H&UMICs	High and Upper Middle Income Countries
ICDS	Integrated Child Development Service
IFA	Iron and Folic acid
ILO	International Labour Organization
IOM	International Organization for Migration
LAC	Latin America and the Caribbean
LMIC	Low- and middle-income countries
MAP	Medical Assistance Program
MC	Migrant Camps
MCW	Male Construction Worker
MDG	Millennium Development Goals
MDR	Multi Drug Resistant
MISM	Medical Insurance System for Migrant Employees
NBS	National Bureau of Statistics
NCD	Non- Communicable Disease
NCMS/ NRCMS	New Rural Cooperative Medical Scheme
NFHS	National Family Health Survey.
NGO	Non-Governmental Organization.
NMR	Neonatal Mortal Rate.
NNS	Non-Notified Slums.
NS	Notified Slums
OS	Open Spaces.
RED	Reach Every District
RGICS	Rajiv Gandhi Institute of Contemporary Studies
RTI	Reproductive tract infection

SAP	Structural Adjustment Program
SHG	Self-Help Groups.
SLBFE	Sri Lanka Bureau of Foreign Employment
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
UCS	Universal Coverage Scheme
UHC	Universal Health Coverage
UK	United Kingdom
ULB	Urban Local Bodies
UN	United Nations
UNAIDS	United Nations Program on HIV and AIDS
UNDP	United Nations Development Program
UN DESA	United Nations Department of Economic & Social Affairs
UNESCO	United Nations Educational Scientific Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nation International Children Education Fund
UPR	Universal Periodic Review.
URS	Urban Resident Scheme
USA	United States of America
WHA	World Health Assembly
WHO	World Health Organization.

CHAPTER 1

INTRODUCTION AND BACKGROUND

INTRODUCTION

Mobility of population is an inevitable demographic feature of any region of the world; it is a process that accelerates or slows down depending on many interacting factors, resulting in trends over time. The focus of researchers has predominantly been on international migration, its consequences and the recommendation on how to manage it effectively.[1] However, internal migration takes place in every country and sometimes to a greater extent than international migration.[2] It is estimated that about 214 million people migrate internationally and approximately three-quarters of a billion people migrate within their own country.[2] It has been observed that internal migration is an inevitable corollary to growth and development; it is both the cause and the consequence of economic growth and urbanisation.[1,3] Demand for workforce increases in regions of economic development, and the cheap workforce from rural areas acts as the fuel for urbanisation, industrialisation and economic development. The movement of population from one part of a country to another may be in search of opportunity, higher income or education, or sometimes it may be forced movement due to natural calamity, war or government-sponsored resettlement plans. This usually has an impact on the economic, social and health status of the migrant population.[1,2,4] It also leads to social change, environmental challenges and health issues for the receiving community and has economic consequences for the region and the country.[1] The impact can be both positive and negative, and depends on the safeguards and policy measures adopted by the national or regional government bodies. In practice, it is observed that internal migration is not matched with corresponding policy measures and requires more coordinated effort by policy-makers to ensure the well-being of vulnerable internal migrants.[1–4,5] The community and region do not realise the full potential of internal migration due to a combination of inadequate understanding of the process, trends, determinants, impact, structural, institutional and policy barriers, discrimination and social exclusion of internal migrants.[1,5,6]

To utilise the potential of internal migration and ensure equitable economic and social development and positive health consequences for migrants in particular and society in general, it is important to understand the concept of internal migration including its reasons, extent, impact of the process on the lives of internal migrants and commensurate existing policies in different regions of the world. Research in this area suggests that a protectionist approach is usually adopted by most countries such as migrant-screening, and the simplistic view of migration as a one-way trajectory[1,4,5,7]

An appreciation of the research in this area and the existing policies will contribute to a better understanding of the issues related to internal migration and the problems faced by this vulnerable group.

BACKGROUND

Internal migration is a feature in all countries. However, the internal movement within different regions has increased in last two decades particularly in the Asian region and developing nations characterized by transformation from centrally planned economy to market economy that encouraged foreign investment and individual entrepreneurship[1,8]. The direction of internal migration may be from rural to urban, rural to rural, urban to urban or urban to rural depending on the need and economic status of migrants and availability of employment opportunities in different regions[1,2].

In Vietnam, Doi Moi i.e. renovations or economic reforms was introduced in 1986. The introduction of the household contract that means an individual worker or group was able to be in

charge of several phases of farming under contract with cooperatives in the rural sector led to a large number of unbound farmers, resulting in a landless workforce moving to urban areas where the emerging industrial and technological areas requiring significant cheap workforce for construction and maintenance, led to the availability of work[8,9]. Similarly, China passed two important reforms in 1980, one to restructure the economy and the other designed to limit population growth. The economic reforms led to a vast surplus of rural labour. The industrial areas and foreign investors needed cheap labour for their enterprises to maximize profits. These two factors act as push and pull factors and contribute to increase in rates of internal migration[10].

Rapid economic growth and expansion is marked by disparities across different regions as opportunities have produced different rate of economic growth in different regions leading to movement from disadvantaged region to developed region in search of better opportunities[9,11]. Some countries like China and Vietnam introduced the distinction between urban-rural areas by Household Registration system[8,9,12]. This restrictive tool which was designed to curb population movement from rural to urban areas and to reduce pressure on urban infrastructure has been instrumental in creating illegal and unauthorized internal migrants who are not able to access the public or health services due to their 'unauthorised' status. Household Registration system which restricts use of health and other public services only in regions where they are registered, is thus an institutional barrier in migrant's access to services and leading to inequity[12]. These are the most vulnerable groups as their health needs are usually not taken care of and discontinued as they are not enumerated as residents of any of the regions of the country as they are a mobile population.

Further, development of new means of communication and transportation has acted as catalyst to increase the pace of internal migration. At an individual level, new opportunities for higher

income, employment opportunities, education and health facilities lead to population movements between different regions. The objective was not only to better their own living conditions but also to support their families left behind in source places through remittances[9].

Migration is therefore characterized by a range of temporal and spatial facets and there is no consistent definition of migration, it is defined differently in different contexts. There are broad classifications of migration in migration research including economic migration, high-skilled and low-skilled labour migration, marriage and family migration, forced and involuntary migration (including trafficking, and internally displaced persons [IDPs].[13] The definition provided by Joint United Nations Program on HIV/AIDS incorporates internal or domestic migrants which refer to movement of people from one place to another within the same country. The definition of internal migrants has been further classified in the Vietnam migration related documents as organized/sponsored/government controlled migrants, the so called legalized or authorized internal migrants and spontaneous/ voluntary migrants, usually designated as unauthorized internal migrants and so more vulnerable in terms of access to public and health schemes[8,14]. This classification as some migrants as 'unauthorised' as outlined above is the result of restrictive and protective policies adhered by many countries with respect to internal migration. It is one of the main barriers to equitable access of internal migrants to different schemes and health facilities in their destination. This makes it worse for this already vulnerable group as it leads to social exclusion, discrimination and stigma among the community they have moved to and even among the health service providers. This discrimination of migrants, (authorized and unauthorized) when the migration is from one region to the other of the same country is unwarranted and needs to be removed to ensure equity.[1,4,5,15,16]It is necessary to further the understanding on the patterns of internal migration, to include seasonal and temporary movements along with permanent internal

migration as most of the labourers and workers provide their services for a particular project and move back to their source community or to new places in search of new opportunities[1,4]. Labour migration flows dominate the picture, both in terms of the actual volume and number of migrants, and are a major area of focus for policymakers and others engaged in migration research.

Taking the above factors into account for the purpose of this research, the definition of migrants is considered as 'people who move from one place to another temporarily, seasonally, or permanently for a host of voluntary and/or involuntary reasons within their own country'.

TRENDS AND PATTERNS OF INTERNAL MIGRATION

Evidence shows that more people migrate internally; internal migration is important almost everywhere and in some countries is far greater than international migration. Data on migration are imprecise because of the diversity in definition of migration and difficulty in the counting of undocumented migrants. It is estimated that internal migrants are about four times higher than international migrants'.[1] In Asia, migration studies have shown a rural-urban migration trend throughout the continent[6]. There are significant increases in Southeast and East Asia, both short and long-term migration. Studies in Indonesia from the 1970s show an increase in circular migration (which is temporary and usually repetitive movement of a migrant worker between home and host areas, typically for the purpose of employment) and commuting from rural to urban areas[17]. China is unique as a number of changes have occurred simultaneously, all creating more movement of people. These include market liberalization and the spread of export oriented manufacturing and the lifting of employment and movement controls[18]. Data on internal migration trend in China shows that 225 million Chinese people migrated to cities from rural areas for jobs over the past two decades (National Bureau of Statistics of China, 2009)[19]. About half of these

movements were inter-provincial, from under- developed parts of the country to the east coast, and the remaining were intra-provincial movements within the eastern provinces. Majority of these movements were circular in nature, and retain strong links with their rural families. They were also termed as the floating population in China[1].

Internal migration has been an essential component of Vietnam since the '*doi moi'* economic reforms. The inter- provincial migrants increased both in absolute and relative terms in Vietnam during the decade from 1989-1999[20]. The 1999 Vietnam census data indicated that nearly 4.35 million people migrated internally. The migration to urban areas was mainly to Ha Noi and Ho Chi Minh City of Vietnam and the nature of migration was permanent. However, the census did not capture seasonal and temporary migration in Vietnam, most of which is to the industrial zones; the Northern Key Economic Zone focusing mainly on agricultural products, includes Hanoi, Hai Phong City and the provinces of Bac Ninh, Ha Tay, Hai Duong and Hung Yen. The Central Key Economic Zone known for its marine economy, includes Da Nang City and the provinces of Binh Dinh, Thua Thien Hue, Quang Nam and Quang Ngai. The Southern Key Economic Zone is dedicated to the development of commerce, exports, technology, services, and telecommunications, include Ho Chi Minh City and the provinces of Binh Duong, Ba Ria-Vung Tau, Dong Nai, Tay Ninh and Binh Phoc.[13,21]. Concentration of the population in a few cities combined with inadequate infrastructure resulted in over- urbanization in Vietnam with a proportion of the urban population not having access to basic amenities like toilets and clean drinking water[20,22,23].

Evidence indicates that in most of the regions of the world, internal migrants are predominantly young adults, particularly aged 20 to 22 in the rural to urban migration. It has been observed that

the propensity to migrate increases with the level of education. The internal migrants account for a large proportion of workers engaged in the service sector mainly in the retail trade, transportation, domestic and personal services. The emerging trend is increase in the number of female worker migrants relative to males during the 1990s. They are involved in manufacturing and service sectors and are vulnerable to sexual abuse and violence[2,6].

Estimates from the Bangladesh Bureau of Statistics; 'sample vital registration system' suggest that lifetime internal migration has increased significantly. The data show that around 46% of the total migration occurred from rural to urban areas in the 1990s. Rural to urban migration is the most prevalent form of migration in Bangladesh[24]. Internal Migration data from the Philippines indicate that between 1960-2000, urban population grew 4 times while rural population only doubled[25].Evidence from Mongolia indicates that Mongolia has experienced rapid migration from rural to urban areas, especially to the capital Ulaanbaatar. Currently, 60% of the population live in urban areas[26]. The recent pattern of migration has indicated that internal migration is also due to development of informal mining sites for mining of gold and feldspars resulting in child labour, school dropouts and homelessness.[28]In Pakistan, the phenomenon of rural-urban migration is a result of economic factors. The last three censuses have shown similar trends across major cities in Pakistan[27].

Analysis of trends in countries in sub-Saharan Africa indicates that an estimated 50-80% of rural households have at least one migrant family member[28]. For example, a participatory poverty assessment (PPA) in Ghana found that 52% of the respondents were migrants. Studies from Ghana showed that more than 80% of the migration is internal and about 70% of these migrants go to urban areas. [29]. In Ethiopia, too, mobility has increased as population movement controls have

been relaxed or removed. Movements are to a few in-migrating areas which have large, often irrigated farms[30].

Internal migration for livelihood is growing phenomenon in India. Evidence of migration is from less economically successful states, such as Bihar or Uttar Pradesh, to wealthier states, such as Maharashtra or Delhi[6,31].The National Commission on Rural Labour estimates the number of internal labour migrants in rural areas in India to be around 10 million[32]. The 64th round National Sample Survey 2007 estimates 30 million internal migrants for livelihood, are part of the informal economy[33]. However, various estimates based on micro-level studies suggest that the figure is closer to 100-120 million[31]. (10-12 crores or roughly 10% of India's population). Large number of migrants are employed in the unorganized sector such as cultivation and plantations, brick-kilns, quarries, construction sites and fish processing and the urban informal economy[31,32,33].

In high and upper middle income countries (H&UMICs) internal migration is predominantly migration from rural to urban areas[34]. In Japan, internal migration started with the industrial revolution in the Meiji period. Initially, cities of population concentration were Tokyo and Osaka bur later, migration rates increased from the 3 major cities (Tokyo, Osaka, Nagoya) to non-urban zones; inter big cities migration numbers grew[35] and inter-prefectural migration also increased. Research shows that in the USA, migration rates between states were higher during 20th century and propensity to migrate falls with age, but rises with education and the migration rates are similar for men and women[36]. Research suggests that in the US migration is higher for unemployed and renters but similar across income groups. However, internal migration has been on the decline since 1980s and migration rates have fallen for most distances, demographic and socioeconomic groups, and geographic areas in the country during last three decades[36,37]. In Mexico, due to

shortage of jobs and saturation of the labour market short distance migration is on the decline and people even started looking to migrate to USA[38]

In the UNDESA Technical Paper 2013/1[39], the analysis of five year internal migration intensity shows that between 1990 and 2000, inter-provincial migration is stable or declining across much of Latin America and the Caribbean, and in the new world countries of Australia, Canada and the United States of America. It is not possible to identify the causal mechanisms on the available evidence on declining pattern of internal migration. However, declining five-year intensities in Asia and Latin America and the Caribbean between the 1990 and 2000 round of censuses may be due to a decrease of labour migration flows during the financial crises of the late 1990s whereas the observed decline in five-year migration intensity in Australia, Canada and the United States are likely to have a different origin. There is evidence that a decline in mobility is related to the completion of the urban transition, economic maturation and population ageing.[34,39] Researchers have suggested that studies should be undertaken to understand the factors for the decline in internal migration in countries like the USA[36].

IMPACT OF INTERNAL MIGRATION ON THE ECONOMIC, SOCIAL AND HEALTH OF MIGRANTS AND THE COMMUNITY

Economic Impact

Internal migration and development go hand in hand, hence having positive consequences for growth and development for the region as whole and increased income for individuals and their families. Internal migration is both the cause and effect of rapid expansion, growth and urbanization[1]. However, internal migration also has consequences for the environment, health, sanitation, hygiene and social fabric of society. The large inflow of internal migrants puts pressure on governments to ensure their safety, health, social protection, provision of efficient labour markets, employment, work security and protection against accidents and work related illnesses[6,19].

Many studies have been undertaken worldwide to assess the economic impact of internal migration from the perspective of migrants, their households and the sending and receiving communities. Studies have shown that increased mobility is positively associated with development. Regions that witness higher levels of socio-economic development, women's empowerment and other development variables witness higher inter-regional migration[1,4,6,11].despite the paucity of data on remittances in many countries, there is mounting evidence through micro-studies as well as large surveys that migration can reduce poverty, inequality and contribute to overall economic growth and development[1,40–45].

The evidence from South Asia is more mixed but there appears to be growing evidence of the poverty reducing effects of migration[1]As far as impact on the development of regions, precise estimates are unavailable. However, based on data from Bangladesh, China, Vietnam and the Philippines Anh (2003)[46] concludes that migration is a driver of growth and an important route out

of poverty with a significant positive impact on people's livelihoods and well-being. In the case of China, Murphy (2005) notes that migration has made major contributions to development, by accelerating economic growth, building up cities and establishing rural–urban linkages and return flows[47]. Research by Chinese scholars estimates that labour migration from rural to urban areas contributed to 16% of the total GDP growth in China over the past 18 years. They argue that migration has remained one of the key reasons that China is able to sustain GDP growth rates above 8 per cent over the past 25 years. A cheap and literate workforce has given China a competitive advantage relative to other countries. It has also been noted that migration has stimulated the transport sector[1,47].Most of the studies have reflected the view that internal migration in general and rural-urban migration in particular is viewed favourably in the economic development literature.

Social Impact

Perceived inequity is associated with poor health status and lower personal income. The poverty of internal migrants has multiple consequences on both social and health status. The theory underlying this approach is credited to Amartya Sen, who put forward the framework of capabilities and well-being and incorporated the concepts of relative deprivation, inequality and social exclusion[48,49]. The poor economic condition of migrants is correlated with their social status which in turn leads to poor urban neighbourhood lacking water, sanitation, daily assault of health threats, non-accessibility of health and other services. The social status determines the quality of services received and sometimes even if the migrants can pay for health care, receive low quality of health care. The monetization of urban living, spatial concentration of the population in environments not supplied by appropriate public services, the economic and social diversity make the situation of migrants more vulnerable.

Research shows that migrants tend not to use government facilities as they are not conveniently located, unaffordable, judgmental and discriminatory. Sometimes the service providers perceive migrants as outsiders and a burden on the system. Further, migrants are sometimes involved in illegal activity and are difficult to identify as they remain hidden in the population. Migrants are away from home and more vulnerable in the absence of family ties, societal norms and community expectations on the one hand and on the other hand the accessibility to the sex industry and drugs in their urban environment [3,5,15,16]. Due to lack of information they are at a greater risk to infectious diseases. In many countries, migrants show a higher drug use and less consistent condom use. Women are more at risk to sexual exploitation and unsafe working environments[4,16,50].

The social policy and legal framework further exposes migrants who often live and work with poor access to social services, and with varied levels of stigma and discrimination. Migrants are usually less informed and aware about public services and health–seeking behaviour, which leads to self-medication and delayed visits to health services. Many migrants lack registration and insurance with the government agencies, which then results in inability to access to the public health services[5,15,16,51].

Research on social impact and consequences, indicates that there is an interaction between internal migration and various dimensions of social development. Social and economic development are two sides of the same coin. Evidence from China shows that though China has experienced rapid economic development due to internal migrant population, little attention has been paid to social development. The role of migration is discussed in rural income growth and poverty alleviation

achievements but the migrant labourers in China are facing labour market discrimination and social exclusion. Research suggests that policy reforms are required for removing various institutionalized constraints like abolishing the hukou system which is a record in a government system of household registration required by law in China and establishing a transferable social security system for rural migrants[18,19,52]

Similar evidence is obtained from the research project "Social Protection for Rural- Urban Migrants in Vietnam" which demonstrates that the lack of adequate policies and institutional programmes for social protection for migrants and the residence based nature of the current social policies are largely responsible for the vulnerability and marginalization of rural-urban migrants. It finds Ho khau, which is household registration system and the absence of a legal framework for protection of internal migrants as an institutional barrier to social protection for internal migrants in Vietnam. The impact is observed on the employment, housing, health care and education of their children. Against the backdrop of risks and vulnerabilities, migrants' access to social protection is limited. However, at the individual level, social network of migrants has been documented to be a crucial form of social protection at the place of destination[53]. At the structural level, migrants can be protected by the labour laws and some recent policy changes were developed by the government to improve the well-being of migrants at risk[8,53].

Health Impact

The Commission on Social Determinants of Health in its publication, "Health Equity from root causes to fair outcomes" has emphasised that health of a person and community is not only determined by the biological factors but also by the conditions in which they live, grow, work and age. Inequalities in these conditions result in inequality in health. Health and its determinants are

underpinned by social justice, human rights, equity, politically relevant and are pre-requisite for people's participation and economic success of a society. The inequality in social and economic conditions of migrants effects their lives and determine their risks of illness and actions taken to prevent or treat illness when it occurs[54]. Adding to the inequality is the inequity in access to health and public services. The employers of the migrants are not interested in the improvement of their access to safe housing, health and safe working conditions[14]. The housing provided to internal migrants exist without basic utilities such as water, sewage, hygiene and safety. Hence, internal migrants suffer from high rates of illness, particularly infectious disease and malnutrition as they have access to little food, unclean water, low levels of sanitation and shelter. This situation is made worse by the lack of appropriate health facilities and lack of health insurance resulting in high out of pocket expenses. This economic burden of health generally forces the internal migrants to avoid their health issues until it results in an emergency with more expensive consequences.[5,51,52,54]

INTERNAL MIGRATION AND POLICY

The trends of internal migration as discussed above, indicate that the magnitude of internal migration in most developing nations has increased with the rapid expansion, growth and particularly differential development of different regions[1,2,39]. This migratory flow can be contained with adoption of policies by respective governments for equitable socio-economic growth of different regions of the nation so opportunities are available for the deprived and far flung sections of society and these sections. Subsequently they will not be required to migrate for better income, employment and educational opportunities. The pattern also indicates internal migration of young adults with an increasing proportion of females in many countries. This trend should alert policy makers to develop appropriate programmes for women and young migrants. A number of different policy approaches are targeting women internal migrants. They focus on a

better understanding of the migration of women, both in a negative (exploitation, vulnerability) and positive dimension (empowerment, learning new skills, and gaining independence)[3,5].

Some of the current policies in many countries including India are restrictive and protective with respect to internal migration and is one of the main barriers to equitable access of internal migrants to different schemes and health facilities in the destination place[5]

Areas where internal migrant specific policies are required include policies for documentation of internal migrants and enhancement of surveillance and information system to ensure utilization of disaggregated data for introducing appropriate initiatives, protection of rights, etc. to avoid exploitation. Provision of sufficient and safe channels of remittance back to their families and migrant friendly universal health care services will also contribute to improving the health and well-being of the migrants [1,4,54]. If managed properly, internal migration can be a tool for poverty reduction. The situation demands designing comprehensive multi-territorial strategies that balance rural and urban development, as well as positive facilitation of migration[1,5].

Migration and its significance in relation to SDGs

The relation between migration and health is complex. There are three arguments[55] why health of migrants should be included in the discourse of the post 2015 development agenda:

1. Migrants' Right to Health

The right to health is an all-inclusive human right that encompasses equal opportunity for everyone. The human right to health is closely interrelated and interdependent with other basic rights, such as housing, education, employment, etc. Yet, for migrants, the right to health is

often not fully realized, due to legal, social, economic, linguistic and cultural barriers, which persist regardless of international and national legal commitments.

2. Inclusion of migrants in the health systems improves public health outcomes

Addressing migrant's health needs should be a *critical component of any effective public health policy*. Assurance to migrant's equitable access to health promotion, primary health care, and their inclusion in all disease control and national health programmes improves public health outcomes for both the migrants and the general population.

3. Healthy migrants contribute to positive development outcomes

It is now widely recognized that migration conveys a development potential, due to migrants' intellectual, cultural, social and financial contribution and their active participation in both source and destination communities. *Being and staying healthy is a prerequisite for migrants to work, be productive and contribute to social and economic development* of their communities of origin and destination, i.e. via remittance and shared knowledge. Thus, it is important to include migration as a cross-cutting issue in the new development framework. It is important to include the marginalized migrant population in universal health coverage, as this would contribute to strengthening the positive impact of migration on development.

The Sustainable Development Goals (SDGs) recognize the importance and interrelation between health and migration indirectly. SDG3 aims to ensure healthy lives and promote well-being for all at all ages, including that of migrants. A number of other SDGs incorporate elements relating to health outcomes and migration. The 2030 Agenda for sustainable development identified migrants, refuges and internally displaced people as vulnerable populations that 'must be

empowered'[56]. For health, as for other sectors, migrants face specific challenges that must be addressed if the world is to meet the aspiration to 'leave no one behind' The evidences suggest a number of issues need to be tackled to ensure that migration contributes to, and does not undermine, the achievement of the SDGs[57].

THESIS OVERVIEW

Internal migration for livelihood is on the rise in India. Although there is a significant body of work on migrant health conditions in India, there is lack of comprehensive policy initiatives (including health) on internal migration, since most entitlements are 'residence' based migrants are unable to take advantage of these entitlements. The Indian government as well civil societies have initiated some measures and attempted to develop appropriate policies for migrants. There is research gap in the analysis of these existing policy measures.

This research focuses on internal labour migrants as internal migration in terms of actual volume is a major area of focus for policymakers and others engaged in migration research. The research explores the challenges faced by internal migrants in India and to understand and critically analyse existing policy initiatives on internal migration. The objective of this research is to suggest a framework for developing a comprehensive policy to address the health needs of internal migrants in India.

The proposed research will analyse existing policies and compare selected low, middle and high-income countries that have developed mechanisms to address migrant's health needs. Based on these comparisons, results will be analysed to draw transferable and practical lessons for India to develop a policy framework to address health needs of migrants'. It expects to offer possible solutions for improving the health of urban migrants.

This research aims to answer the key research question "What is appropriate policy framework to address health needs of the urban migrants in India?"

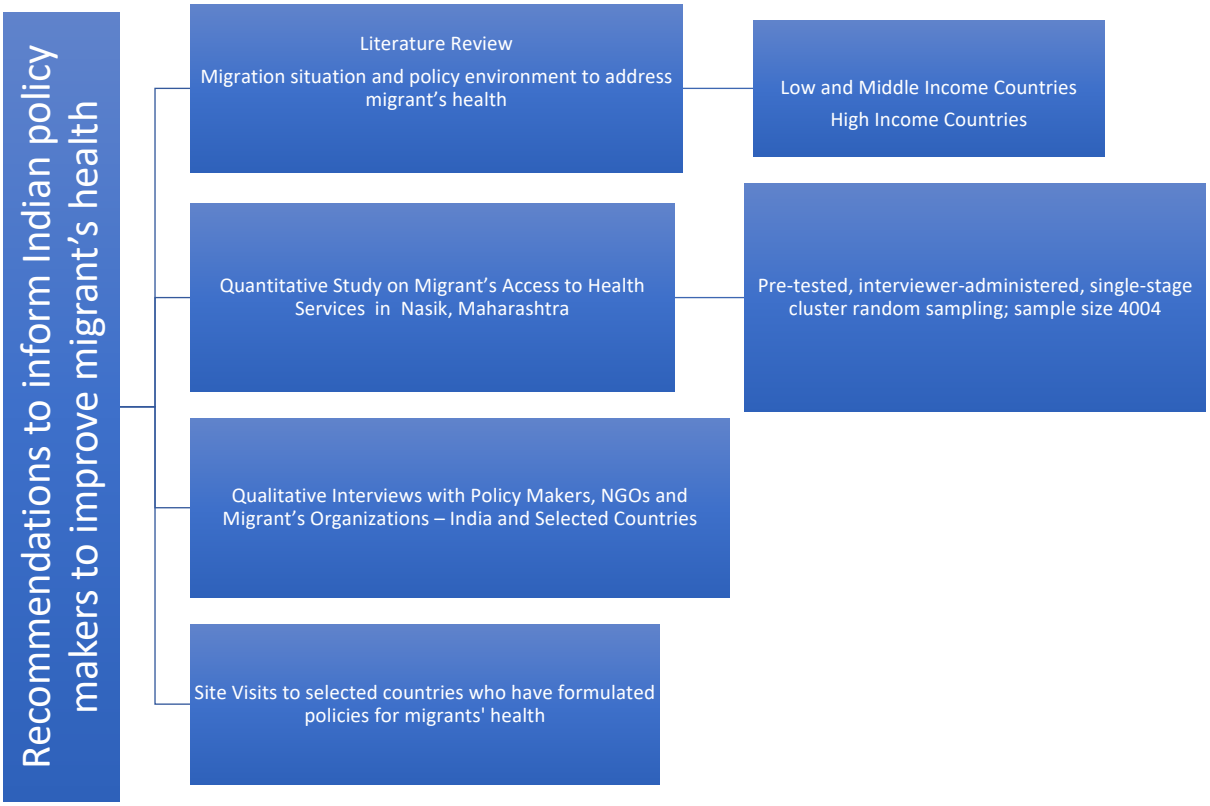
The **definition of study population** is internal labour migrants (within the country, interstate and intrastate) who migrate for paid work, which includes both permanent (residing in unofficial urban slum areas), seasonal and circular migration (which takes place anytime between 30 days to 12 months in a year) from rural-rural, urban-urban, urban-rural and rural-urban areas, who do not have legal citizenship of destination locations, and are poor and most vulnerable due to their mobile status. Generally, 6 months is considered as the minimum period of stay in a place in the Census of India and National Sample Surveys; however, this research considers a minimum at 30 days (one month) to include seasonal/circular migrants.

The PICO framework for this research is;

- **Population**-Urban migrants in India
- **Intervention**-Policies to address migrant's health needs
- **Comparison**-Policies in low, middle and high-income countries
- **Outcome**- Evidence based policy framework for addressing health needs of urban migrants in India.

The research involves a mixed methods approach; literature review, quantitative survey, qualitative interviews and site visits to understand successes and challenges in the implementation of migration and health policies in India and other countries. Figure one indicates methodology details.

Figure 1: Methodology Approach for Proposed DPhil Research



The thesis consists of 6 chapters;

First chapter of the thesis has introduced the topic and set the scene by describing internal migration in India and other low, middle and high-income countries, migration and its impact on health, and the emerging need for migrant friendly policies.

Chapter two is the literature review, exploring the situation in India and low, middle and high-income countries in terms of health status of migrants, and current policies.

The chapter describes -

- Challenges in ensuring health of migrants in India: current status and the policies

- Health policies related to migrants in low and middle-income countries: lessons and possible solutions for India
- Policies and planning, initiatives that include migrants especially related to health, in developed economies: Lessons and possible solution for India

The literature review will help to build a preliminary framework for addressing health needs of migrants in India, and also plan second phase of the study i.e. data collection from India, LMICs and H&UMICs.

Chapter three is the description and analysis of a survey to understand migrant's access to health care in Nashik city of Maharashtra state, India. It seeks to understand who the migrants are, where they migrate from, what their demographic profile is, what problems they face when they are in the city including access to health care. This chapter describes and analyses a pre-tested, interviewer-administered questionnaire, using a single-stage cluster random sample in Nashik. The data collected includes information on socio-demographic characteristics of migrants, and availability and access to general health and mother and child health care among the migrant population.

Chapter four explores the views of policy makers and stakeholders on internal migrants, available policies, challenges and successes in implementing policies. It describes the qualitative research which consisted of semi-structured interviews and focus group discussions conducted in India and other countries with key policy makers and implementers including officials of World Health Organization (WHO), International Labour Organization (ILO), and International Organization for Migration (IOM), and also key leaders of civil societies working in the migration and health sector.

Chapter five describes the challenges and successes in other countries in relation to migration and health policies and what lessons can be learnt in the Indian context.

Chapter six discusses the key findings, and proposes some policy recommendations for ensuring the health needs of migrants in India are met.

CHAPTER 2

THE IMPACT OF INTERNAL MIGRATION ON SOCIO-ECONOMIC CONDITIONS AND HEALTH AND POLICIES RELATED TO INTERNAL MIGRATION IN LOW, MIDDLE AND HIGH AND UPPER MIDDLE-INCOME COUNTRIES AND INDIA: A LITERATURE REVIEW

INTRODUCTION

This chapter will describe the literature review of the current state of internal migration and the policies and initiatives developed in India and abroad to improve migrant health. The purpose of literature review is to understand the state of migration, its health outcomes, and policies and initiatives taken by low, middle and high-income countries to address the health and social security needs of internal migrants. The review will inform the policy framework that can mitigate pressures of urban-rural migration and address health inequity among the vulnerable migrant population in India.

AIMS

The aim of this review was to understand the problems faced by internal migrants in accessing healthcare services, policies and initiatives taken by various countries across the globe and study the current policies to address the issues related to the health of internal migrants in order to identify ways and means to improve health of internal migrants in India.

OBJECTIVES

Key objectives of the literature review are:

i. To understand the socio-economic, and more particularly, health impact of internal migration among internal migrants in low, middle and high-income countries.
ii. To understand the issues related to and the different policy measures taken by different low middle and high-income countries in response to situation and problems of internal migrants in their respective countries.
iii. To undertake an in-depth look at factors related to internal migration in India to inform the development of a policy framework for internal migrants' in India

METHOD

The empirical, non-empirical papers, reports from various agencies, regional forums and international conferences were retrieved from the following databases - Pub Med, Lancet, Google Scholar, Advanced Google, Popline by K4 Health. Further, papers from country official websites, government publications and conference proceedings were also retrieved. In addition to these databases reports of international agencies were taken from University of Sussex migration section, International Organization for Migration (IOM), World Health Organization (WHO), International Labour Organization (ILO), United Nations Development Programme (UNDP), and Department of International Development (DFID). Policy papers on migration and health of different countries were also included to understand the existing policies and measures for health care delivery and social welfare of internal migrants.

The search focused on literature on the

(i) prevalence of internal migration

(ii) the impact of internal migration on economic, social and health status of migrants and

(iii) health policy issues and other incentives developed in relation to internal migration in LMICs and H&UMICs.

Definition of Study Population

For the purpose of study, internal migrants are defined as, "people who move from one place to another temporarily or permanently for a host of voluntary and/or involuntary reasons within their own country, either interstate and/or intrastate for paid work, which includes both permanent (residing in unauthorized urban slum areas) and seasonal and circular migration (migrating anytime between 30 days to 12 months in a year) from rural-rural, urban-urban, urban-rural and

rural-urban areas, and who do not have legal citizenship of destination locations". (Derived from [1]IOM's definition)

Definition of countries

Definition and list of low, middle, high and upper middle-income countries was as per the World Bank's classification. (available via http://data.worldbank.org/about/country-and-lending-groups)

Criterion for selection of articles:

Inclusion and exclusion criterion for selection of material was as below;

Inclusion criteria:

- Primary empirical studies matching the objectives of the literature review between 1970 to 2016, in English language.
- Reports of conferences/ meetings matching the objectives of the literature review
- Related to labour migrants who make the move for livelihood, within their countries.

Exclusion criteria:

Studies focusing on the following groups were excluded:

i. International professional migrants
ii. Internal professional migrants (within country)
iii. Internal migrants' due to marriage and education
iv. Refugees/asylum seekers

[1]**IOM Definition of "Migrant"**
IOM defines a migrant as any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is. Available on https://www.iom.int/who-is-a-migrant

Keywords

The keywords used at different search engines were India, low- and middle-income countries, high and upper middle income countries, urbanisation, internal labour migration, rural-urban migration, migrant workers, internal migrants, health problems and/or issues of migrants, health of migrant women and children, social determinants of migrants health, health improvement in migrant health, health services for migrants, social inclusion of migrants, health policies for migrants, social security policies for migrants, right-based approach for migrant health, migrant health and human rights. These keywords were used in various combinations with each other and with different low-middle and high upper middle income countries as listed on the [2]World Bank website.

Databases searched include: Pubmed, *The Lancet*, Google Scholar, Advanced Google, Popline by K4 Health, reports of international agencies, country official websites, government publications and conference proceedings. Material search was restricted to English.

RESULTS

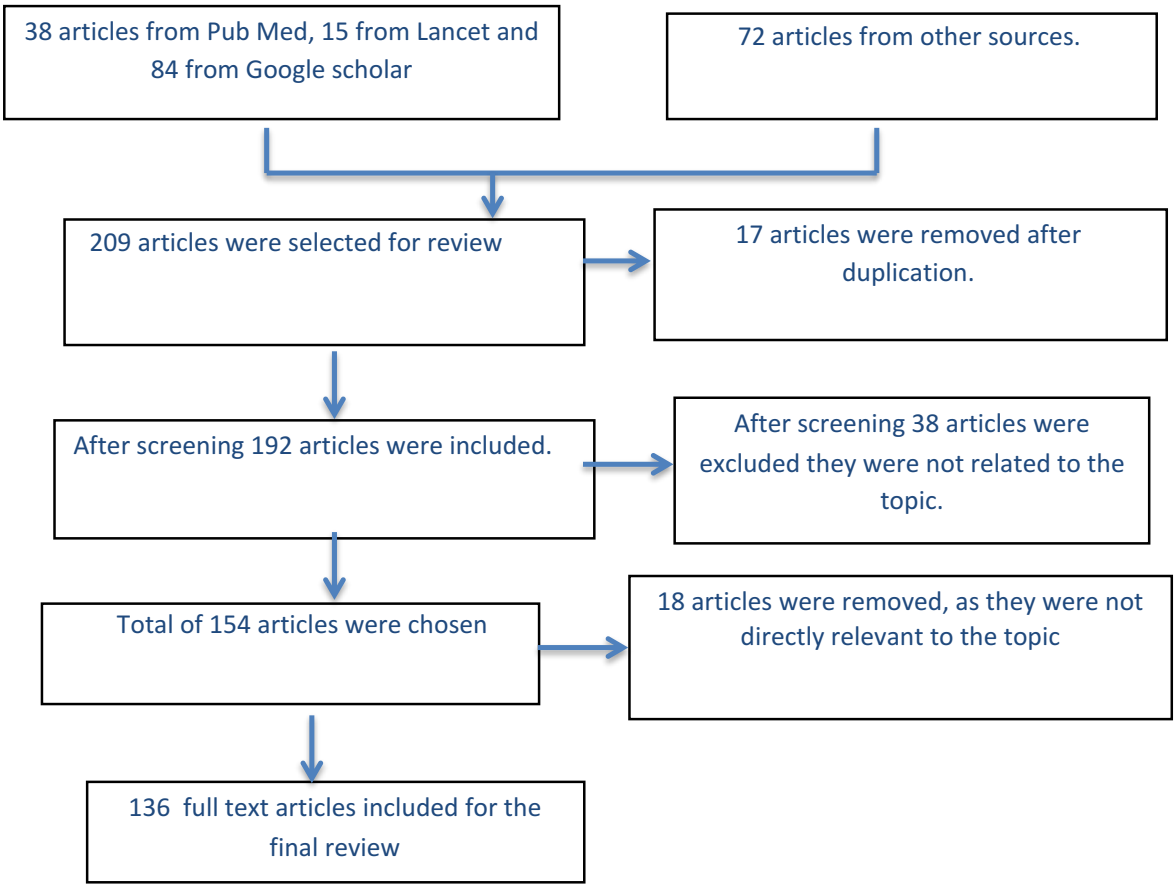
The literature review is discussed in three sections - migration and health policy in low and middle-income countries (LMICs), high and upper middle income countries and an in-depth look at the factors in the Indian context.

[2]List of low, middle, high and upper middle-income countries as per World Bank's list available via http://data.worldbank.org/about/country-and-lending-groups

A. Low and middle-income countries

The search specifically related to LMICs yielded 209 articles - 38 from Pubmed. 15 from the Lancet, 84 from Google scholar and 72 from other sources. Out of 209, 17 articles were duplicates and 38 irrelevant and were excluded resulting in 154 articles. These 154 articles were further screened, and 136 were included. See Figure 2.

Figure 2: Selection of Literature Flow Diagram for the Review in Low and Middle Countries



Internal Migration in LMICs- Reasons and prevalence

Migration of persons within national borders is far greater than migration across international borders. According to the UNDP Human Development Report[2] in 2009 the number of people who moved across the major zonal demarcations within their countries was nearly four times more (740 million) than those who moved internationally (214 million). In Asia, Africa and Latin America, approximately 40 per cent of urban growth results from internal migration from rural to urban areas[58].

Estimate of internal migration in selected countries

The table 1 presents data from the available literature

Table 1: Estimate of Internal Migration in Selected Countries

Country	Estimate of internal migrants	Source	Comments
India	30 million[33]	National Sample Survey 2006-07	Micro-level studies suggests the estimate close to 100-120 million[31]
China	247 million[59]	Migrant population development report 2016	18% of total population are migrants
Vietnam	19.7% of the total population[60]	Population and Housing census 2015	Among total migrants aged between 15 and 59 years, 52.4% are women, consolidating the outcome of "female migration"
Bangladesh	13.5 million[61]	Population and housing census 2011	The rate of internal migration in 2011 was 9.7 per 100
Philippines	2.9 million Filipinos migrated from 2005 to 2010[62]	Census of population and housing 2010	Between 1960-2000, the urban population grew 4 times while rural population only doubled
Mongolia	20.7% of the total population[63,64]	Census 2000	Rapid migration from rural to urban areas, currently, 60% of the total population live in urban areas.
Sub-Saharan countries	Estimated 50-80% of rural households have at least one migrant member[28]	Macro studies	No government data available
Cameroon	mobility index estimated 32.5% migrants[65]	Government data	The socioeconomic migration and social migration are predominant with 64 % and 21.6 % respectively of migratory flux towards the cities
Sri Lanka	20% of the total population (2001)[66]	Government data	Major migration during the separatist conflict for safety, labour migration on high rise for livelihood from rural to urban areas. However, no specific data is available.
Ghana	40% of the total population[67]	Government data	Out of it, 70% of population migrates for livelihood.

Impact of Internal Migration on the Social, Economic and Health Aspect of Migrants and Community in LMICs

Socio-economic impact

Internal migration is both the cause and effect of rapid expansion, growth and urbanization[1]. Several studies were undertaken worldwide to assess the economic impact of internal migration from the perspective of migrants, their households, and sending and receiving communities. Studies have shown that mobility is positively associated with development. Regions that witness higher levels of socio-economic development, empowerment of women and other development variables witness higher inter-regional migration[1,68,69]. In-spite of limited data on remittances in many countries, there is mounting evidence through micro-studies as well as large surveys that migration can reduce poverty, inequality and contributes to overall economic growth and development[1,42].

Health impact

There is growing evidence that the process of migration and health of individuals are intertwined in complex ways. Health itself can influence the decision to move and migration may affect the health of those who move, those who stay and even those who host migrants[70,71]. 'Healthy migrant hypothesis' which states that migrants represent a selectively healthy group that are not representative of all potential migrants from origin societies. There is evidence from studies which shows that the health of migrants is generally better than the native populations as indicated by mortality rates, chronic conditions, mental health, etc.; though this advantage deteriorates with time[72]. Such situation is referred to as epidemiological paradox, as migrants usually face disadvantages at the new place that have negative impact on their health. Therefore, migrants are

expected to have worse health outcomes. The phenomenon was validated in a research study in Indonesia and Vietnam[72]. Similarly, a study conducted in China[73] also demonstrated the healthy migration effect. However, poor living conditions and may make them vulnerable to poor long-term health. The impact in the long run can be minimized by providing affordable health care to uninsured migrants and the urban poor. Discrimination, stigma, inequity, perceiving migrants as the 'Cause of disease and burden on urban infrastructure', lack of social and community support – have all been associated with the process of internal migration and poor health status of migrants

Migrants are perceived to be the carriers of disease and also a burden on the health system[74]. Research indicates that most migrants are young and travel when they are healthy. It has also been shown that migrants usually utilise private services and bear out of pocket expenses and are not a burden on the public health system[19,72,74] . However, the environment in which migrants live and work make them more vulnerable and are therefore at higher risk of infection. Work related health concerns are due to the work migrants are able to find and conditions of labour. Many construction sites, mines, factories and companies where migrants live are not regulated and not properly maintained resulting in exposure to physical and chemical hazards. In some settings migrants are exposed to abuse and sexual exploitation[74–76]. This suggests that migration is not a risk in itself, nut the poor living and working conditions to which the migrants are exposed, makes them vulnerable to disease and is threat to their wellbeing. The common determinants of health risks among internal migrants are summarised in Table 2.

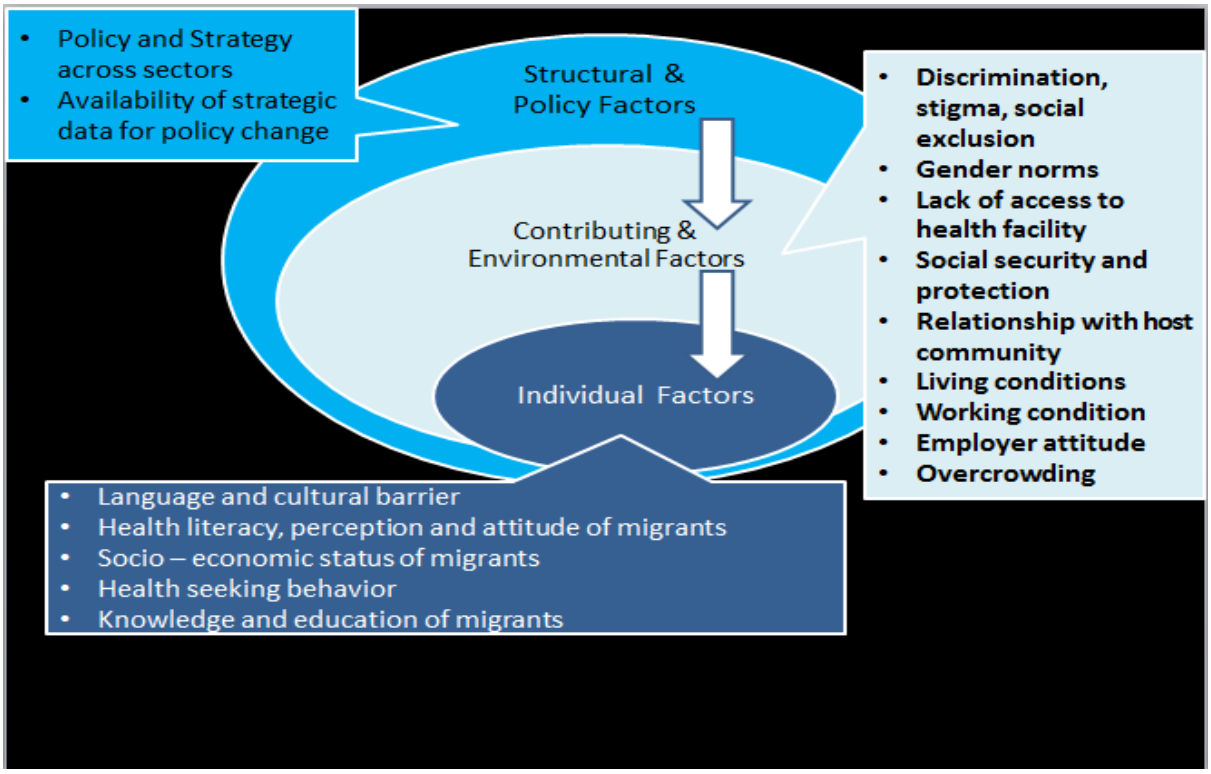
Box 1: Determinants of health risks of migrants[15,16,51,77,78]

- **Overcrowded and poor living conditions**
- **Exposure to hazardous working conditions**
- **Lack of sanitation and clean drinking water**
- **Poor nutritional status**
- **Poor environmental conditions**
- **Lack of awareness and knowledge about health risks and unhealthy behaviour**
- **Exposure to new urban pressures – drugs and risky sexual behavior**
- **Lack of easy access to affordable, quality health care**
- **Lack of insurance scheme and registration system**
- **Lower level of income and education**
- **Temporary employment**
- **Lack of legal status at the destination**

A combination of factors at the area of destination complicates the vulnerability, which is primarily defendant on the alien status of the migrants. Limited choices and reduced capacity to negotiate result in increased discrimination as the migrant is considered an 'outsider'. Surveys and studies have shown that migrants are disadvantaged relative to the native population with regard to employment, education and health[15,16,77,79–81]. Migrants are inherently vulnerable from the time they leave home to initiate their migration. Migrants' vulnerability is shaped by many factors, including political and social marginalization and a lack of socio-economic and societal resources. While living in host states migrants may not understand the language(s), are unfamiliar with the workings of the legal system and administration and are disconnected from traditional support and family networks. Thus, vulnerability of the migrants arise because of living in a place which is different in culture, language, social settings, legal protection, entitlements and consumption habits from their native places and the loss of the traditional support systems they enjoyed before migration[16,79,80,82].

Social factors affecting migrant's health can be classified into individual, environmental and structural factors[79] (Figure 3).

Figure 3: Factors Affecting Migrant's Health[79]



Diseases pattern among migrant populations:

The impact of migration on health can be broadly classified into three major categories based on the literature review.

1. Communicable Diseases

Crowded living conditions, lack of clean water supply, poor drainage systems, unhealthy practices and unacceptable sanitary conditions expose the migrants to various kinds of health risks predetermined by their standard of living and their choice of occupation[15,48,70]. Their living conditions and health behaviours increase their susceptibility to infectious disease. Infectious

diseases such as malaria, hepatitis, typhoid fever, and respiratory infections such as tuberculosis have a higher incidence among migrants. Migrants are approximately 6 times more likely to have tuberculosis than the general population[80]. 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. Migration was a matter of concern in relation to Millennium Development Goals (MDGs) for HIV/AIDs, tuberculosis, malaria and other infectious diseases. It is also seen as matter of concern for Sustainable Development Goals (SDGs)[55,83,84]

Internal migrants are not carriers of disease but victims of circumstances and their vulnerable working and living conditions.

2. Maternal and Child Health

Maternal and child health is one of the most critical components of the overall health care of migrant population, in particular due to poor living conditions and marginalization of many migrants. There is a growing body of research about the health inequities among migrant women. Poor healthcare utilization rates have been shown to have an impact on several maternal and child health indicators among migrant populations. On every maternal and infant indicator, the migrant population fares worse than the resident urban population. Maternal health of migrants is a challenge for urban health care system. The results suggest that, after taking into consideration socio-economic characteristics, access to health insurance and differences in morbidity, recent migrants are less likely than both the native born and migrants of longer duration to receive timely health care. There are clear inequities with respect to both service access and pregnancy outcomes between permanent residents and migrants. The low use of antenatal care (ANC) services by the migrants is responsible for higher risks. Migrants as group are affected by a range of factors - lack

of legal status, low social status, lower income and education and lack of insurance which marginalizes them. Vaccination rates among migrant children are reported to be significantly lower than the average native population[10,76,85–92].

3. Workplace Injury and Occupational Health

Migrants are usually employed in jobs that are not wanted by urban workers and have high health risks, which are sometimes referred as 3D- dirty, dangerous and demanding/difficult jobs[91].The outsider status of migrants, lack of insurance cover, lack of awareness, weak enforcement of regulations and little or no occupational safety measures contribute to the health problems of the internal migrants.[81,81,93–95]

Evidence from some countries indicate an increase in the prevalence of mental health problems in both the migrants and the families left behind.[3,96–98]

The evidence with respect to non-communicable diseases (NCDs) are less well documented, as chronic diseases i.e. diabetes and hypertension tend to be more prevalent in older populations. In general, rural-urban migration is considered as a risk factor for chronic disease. However, it is difficult to establish causal inference between internal migration and chronic diseases.[99–101]

Health Policies for Internal Migrants in LMICs

Policy with respect to welfare and health issues of internal migrants in LMICs are in the early stages of development. Governments are beginning to understand that internal migration cannot be neglected and measures are required to address the issues related to migration. Some countries have taken few positive steps to address migration related challenges. Table 2 summarises policy measures taken by various countries for internal migrant populations.

Existing policies and initiatives taken by some countries with respect to providing an inclusive, secure environment in general and equitable, accessible and affordable health care services in particular demonstrates that a right based approach is preferred to the controlling and restrictive strategies of migration. Though not all but some of the countries, where the magnitude of internal migration is increasing at an alarming rate due to rapid expansion have initiated pro-active steps to ensure better living and health facilities to internal migrants. Countries like Sri Lanka[102] and Thailand[103] have taken a multi-sectoral and comprehensive approach through national migration policy. Other countries have taken a coordinated, multi-sectoral and decentralized approaches to cope with HIV/AIDS like Nepal[11],Phillipines[104]. Countries like China[59] and Vietnam[20,60] have realized the importance of having invested in collecting appropriate information on migration to develop evidence based policies. In Bangladesh greater efforts have been made on the part of government to ensure that its poverty reduction strategy (PRSP) addresses the needs of the migrants, particularly urban poor migrants who often suffer eviction, ill health and other problems associated with vulnerability; by developing infrastructure and providing a good standard of social services, hospitals, schools and colleges and a decentralization of key decisions to enforce a unified labour code[24].Evidence from South African countries indicates that member states have developed disease specific strategies especially for communicable diseases like HIV,TB and Malaria. Major contributions include harmonization of protocols and standardization of referral system and research activity on mobile populations[79] The existing policy measures taken by LMICs is summarized in Table 2

Table 2: Existing Policies to Address Health and Social Security Needs of Internal Migrants in LMICs

COUNTRY	EXISTING PROGRAMMES AND POLICY MEASURES	RESPONSIBLE AGENCIES	SUPPORTING INSTITUTIONS
*Sri Lanka[66,105]	Sri Lanka National Migration Health Policy for internal and international migrants, adopted evidence-based and multi-stakeholder approach for promotion of the right to health Special programs launched for migrants- Language and culture sensitive health services offered for psychological and reproductive health Insurance and other social welfare schemes Retirement Scholarship scheme for children of migrants Four subsidized loan types offered to migrants for housing, self-employment, basic amenities and pre-departure	Ministry of Health Co-ordination with thirteen key government ministries	International Organization for Migration World Health Organization
**China[18,59,69,106–111]	No comprehensive migration policy exists. Reform of Hukou system for registration of urban and rural migrants Extension of Rural Cooperative Medical System Social Insurance Program NGOs involvement in health care of migrants Establishing alternative clinics set up by migrants themselves	Ministry of Public Security Ministry of Health	International organization for migration World Health Organization

	Education & training to migrant population Empowering migrants through trade unions, Improving the working & living conditions for rural migrants; Providing skills, training and information on applicable law Local policies are being piloted in different cities of China with focus on tuberculosis, sexually transmitted disease and maternal health	Ministry of Labour	International Labour Organization Local NGOs and Trade unions
**India[87,112–119]	No comprehensive policy on internal migration Comprehensive migration support program piloted for tribal migrants in Maharashtra state during 2013-16, to be soon extended in other tribal areas of India	National Commission for Scheduled Tribes, Ministry of Tribal Affairs, New Delhi & Maharashtra State Tribal development department	UNDP, India Disha Foundation (NGO)
	Interstate Migrant Workers Act 1979 provides comprehensive protection and welfare services to inter-state migrant workers	Ministry of Labour and Employment	International Labour Organization World Bank
	Integrated Child Development Scheme provides health care services to migrant women, children and adolescents at destination cities.	Ministry of Women and Child Welfare	World Bank
	Portable National Health Insurance program 'Rashtriya Swastha Bima Yojana'	Earlier Ministry of Labour and Employment, recently it has moved to Ministry of Health and Family Welfare	The Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH (GIZ)

	National Urban Health Mission 2013 plans to cover migrants in the health programs	Ministry of Health and Family Welfare	
	Jharkhand and Rajasthan states have made provision for registration of out-migration at source areas	State Labour Department	
**Vietnam[20,22,60]	No comprehensive migration policy exists. Vietnam internal migration survey conducted in 2004 and 2015 to build national level data on migration. The survey led to the need of mainstreaming migration in the National Poverty Alleviation Programme, develop coordination between sending and receiving communities, improving access of migrants to basic services and low cost housing, health insurance and abolition of household registration system 'doi moi' which acts as a barrier in accessing basic and health services	General Statistical Office, Vietnam Ministry of Planning and Investment (MPI)	United Nations Population Fund World Bank
*Thailand[79,103,120,121]	National Migration Policy exists but does not focus on internal migrants. Policy focuses on holistic and multi-sectoral approach for improving health of migrants laying emphasis on social and environmental determinants Universal coverage of health security was introduced through social security and universal coverage schemes (UCS)	Ministry of Health	World Health Organization International Organization for Migration

	Good Practices includes involvement of migrants as community health workers, migrant friendly health services, establishment of six migrant health posts		
**Mongolia[63,122–124]	No comprehensive migration policy exists. Reach Every District (RED) strategy adopted for outreach to cover mobile and unregistered remote migrant population for improved access to immunization, maternal and child health and other health services	Ministry of Health	World Health Organization
**Philippines[62,104,125]	No comprehensive migration policy exists. Presence of a legal framework for protection of migrants and Internally Displaced Persons Special initiatives for migration and HIV Portable national health insurance	Ministry of Health Philippine Health Insurance Corporation	World Health Organization International Organization for Migration
**Malaysia[90,126,127]	No comprehensive migration policies exist Mandatory HIV Testing, Emphasis on accessibility to health care services in terms of physical, economic and information criteria Vision of Malaysian government is to provide equitable, affordable, efficient, technologically appropriate and consumer friendly health system Health care accessibility is available 24 hours at minimal	Ministry of Health	World Health Organization International Labour Organization

	cost. Free of cost services for treatment of infectious disease Appropriate housing and basic amenities to migrants is ensured under Minimum Standard of Housing and Amenities Act 1990		
*Cameroon[65,128]	No comprehensive migration policy exists. Creation of a National institution for set up of proactive governance of internal migration (F-PGIM), with the goal of transforming internal migration into an engine of balanced national development and equitable and sustainable human development Efforts are being made to establish a National Centre for the integrated monitoring of internal migration, emphasis on promoting community health by creating health and sanitation committees in urban neighbourhoods, health training programs for city dwellers in techniques of primary health care at the neighbourhood level	Ministry of Territorial Administration with several other ministries.	African, Caribbean and Pacific (ACP) Observatory on Migration European Union UNFPA International Organization for Migration IOM Development Fund
*Ghana[42,67,129]	Recent Creation of a National Migration Bureau (NMB) an inter-ministerial committee later renamed as Migration Unit (MU), task is to formulate National Migration Policy to	Ministry of Interior	International Organization for Migration

	mainstream migration into development plans National Population Policy1994 recognizes that instead of stopping migration, it is important to monitor and manage migration Ghana's Poverty Reduction Strategy (GPRS) also focuses on reducing poverty among migrants particularly labourers	Inter-ministerial Migration Unit team	
**Democratic Republic of Congo (DRC) [130]	No comprehensive migration policy exists. But efforts are made by National Government to incorporate migrant health into its overall programs and policies associated with the reform Strategy of the Ministry of Public Health; Health strategy of DRC for migrants 2013-2017 highlights migration health as one of principal intervention method, public health approach adopted to the health of migrants, by ensuring their health rights, avoiding health disparity in health status by providing accessible, available, acceptable and quality health care	Ministry of Health, Immigration, labour and social welfare	International Organization for Migration World Health Organization UN agencies (UNICEF, UNFPA, UNAIDS, UNHCR) Local civil societies and academia

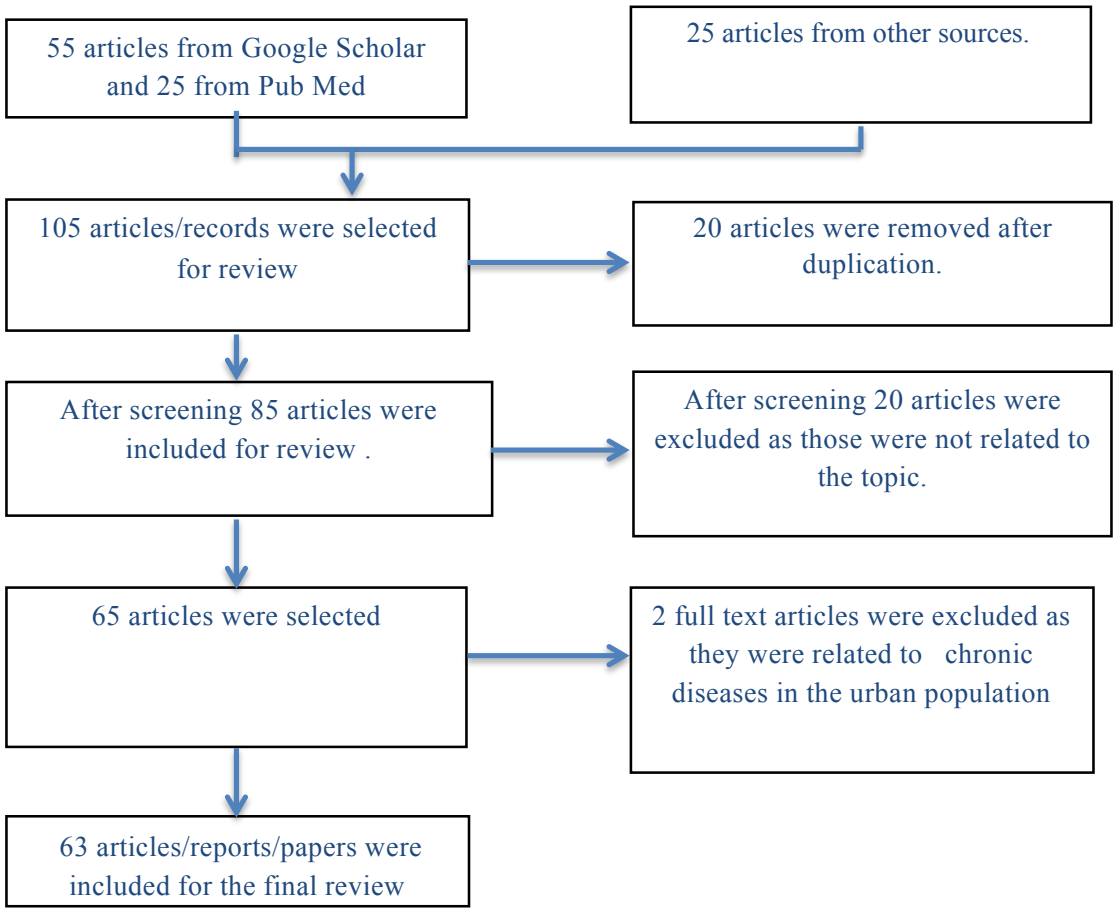
International conventions, and policy commitments[131–134]	The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 2001	United Nations	National governments of respective countries
	Declaration of Commitment on HIV/AIDS, which calls for "national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrant and mobile workers" and also includes refugees and internally displaced persons	Human rights, Office of the High Commissioner	
	The Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, and the Protocol against the Smuggling of Migrants by Land, Sea and Air	United Nations General Assembly Special Session	
	The World Health Assembly Resolution on Health of Migrants.		
		United Nationals office on Drugs and Crime	
		World Health Organization	

B. High and Upper Middle-Income Countries

The search related to H&MICs yielded 105 articles/reports/papers of which 25 were from Pubmed and 5 from the Lancet, 55 from Google scholar and 20 from other sources. 20 duplicates were

removed leaving 85 articles to be screened. After screening abstracts 65 were included as 20 were not relevant to the topic. Finally, 2 full text articles were removed as they were not relevant and 63 articles were included in the final review. See figure 4.

Figure 4: Selection of Literature – Flow Diagram for the Review in High and Upper Middle-Income Countries (H&UMICs)



Internal Migration in H&UMICs- Reasons and prevalence

According to the United Nations, internal migration is by and large driven by economic and political factors. However, there are other drivers for internal migration which include local

conflicts or persecution, displacement due to natural calamities and disasters. Evidence suggest that the basic reasons for internal migration are different for different countries.

In H&UMICs internal migration is predominantly migration from rural to urban areas. In Japan, internal migration started with industrial revolution in Meiji period. From the beginning, dominant cities of population concentration were Tokyo and Osaka. Research shows that in the USA, migration rates between states were higher during 20th century and propensity to migrate falls with age, but rises with education whereas the migration rates are same for men and women. Research on the effect of economic status on internal migration in USA, suggests that migration is higher for unemployed and renters but similar across income groups. In terms of magnitude, largest differences in propensity to move are between homeowners and renters, between the unemployed and individuals who are either employed or not in the labour force, between individuals with at least some college and those with less education, and between individual's younger than 34 and those older than 45. However, the internal migration has been on decline since 1980s and migration rates have fallen for most distances, demographic and socio-economic groups, and geographic areas in the country[2]during last three decades. In Mexico, due to shortage of jobs and saturation of labour markets short distance migration has declined and people even looking to migrate to the USA[35–38]

The UNDESA Technical Paper 2013/1, analysis of five-year internal migration intensity shows that between 1990 and 2000, inter-provincial migration is stable or declining across much of Latin America and the Caribbean, and in new world countries of Australia, Canada and the United States of America. It is not possible to determine the causal mechanisms on the available evidence on declining pattern of internal migration. However, declining five-year intensities in Latin America

and the Caribbean between the 1990 and 2000 round of censuses may be due to a dampening of labour migration flows during the financial crises of the late 1990s whereas the observed decline in five-year migration intensity in Australia, Canada and the United States are likely to have a different origin. There is evidence for a structural decline in mobility is related to the completion of the urban transition, economic maturation and population ageing[39]

One of the most significant trends in migration has been entry of women into migration streams. About half of the migrants in the world today are women, as has been the case for several decades. Most women move voluntarily, but a significant number are forced migrants who have fled conflict, persecution, environmental degradation, natural disasters and other situations that affect their habitat and livelihood. In H&UMICs some data is available to suggest the main causes for internal migration e.g. the census data on geographic mobility in the USA suggests that the Americans migrate for jobs[37]. Similarly, data from 2007 surveys show that economic reasons were the driving force for New Zealanders to change residence and employment was the main cause for moving from one region to another**.** Migration is also often linked with educational opportunities and adults with higher education are most likely to be internal migrants[136]

Impact of Internal Migration on the Social, Economic and Health Aspect of Migrants and Community in H&UMICs

Socio-economic impact

Migrant workforce has become crucial to economies of many countries worldwide, evidence is available from various sectors including mining, construction, health care, engineering, domestic work etc[55]. Internal migrants are gainfully employed and participating in economy of the country.

Internal migrants also receive financial help from within the country but literature suggest that internal migrants are more likely to send financial help than receive it. Though, there are no available global estimates of size of internal remittances, research shows that households are three times more likely to get financial help from internal migrants (9%) compared to international migrants (3%)[137]. However, internal migrants, especially women, are not employed in the formal sector. Majority of them are employed in low wage work in unregulated informal sectors like construction, domestic work, farms[80,138,139].

Health impact

Health of migrants is determined by factors outside the health sector as conditions in which migrant's travel, live and work often carry exceptional risks for their physical, mental and social well-being, determined by inequalities experienced by them. General health problems, such as malnutrition, poor dental health, obesity, cardiovascular disease, diabetes mellitus, anaemia, and mental disorders are also more common in this group.

Different categories of migrants i.e. students, economic migrants and asylum seekers face different health challenges having different access to health and social services. These inequalities combined with social and economic inequalities impact on the health status of migrants. Migration can expose individual and groups in many settings to various health risks, abuse, exploitation and discrimination.[54,55,140–142] As migrants are vulnerable to stigmatization, discrimination and xenophobia. These factors interact with social inequalities and can result in or can be a result of social exclusion[54]. Evidence suggest that rights, safety and security of women migrants are low with poor access to primary and reproductive healthcare services.[76,135,143] Studies suggest that the factors responsible for poor access to healthcare include linguistic and cultural barriers in accessing

healthcare, poor knowledge and awareness about the healthcare programmes or facilities available at destination, lack of awareness about the personal safety and preventive health measures, lack of financial protection at destination, healthcare provider's lack of knowledge of epidemiological profile of migrants' home community and apathy or limitations in care for disadvantaged migrants, lack of appropriate national policies to ensure social inclusion and equitable access to healthcare to internal migrants[144–148].

1. Communicable Diseases

Migrants are influenced by their own cultural beliefs about what is hygienic, healthy or unhealthy and approaches to death and diseases. Women migrants face additional risk of exploitation and sexual abuse which makes them vulnerable to STDs and HIV[76]. Comparing men internal migrants with women and girls migrants, research shows that women and girls face physical and sexual abuse[147,148]. Both men and women migrants are at greater risk of HIV/AIDS, STIs. However, though the immunity plays an important role in case of diseases like TB/HIV/AIDS, women face additional risk of exploitation and sexual abuse, making them more vulnerable to HIV/AIDS and Sexually Transmitted Diseases. Self-diagnosis and medication are frequently used as cheap alternatives that can endanger individual and public health as in the case of Multiple Drug Resistant tuberculosis. There exist huge gaps in internal migrants' access to healthcare. Wherever they get access they often have to leave treatment midway due to lack of time for regular check-ups, fearing loss of wages for the day, due to return to place of origin or migration to some other place in search of better opportunities. Abandoning treatment midway results in vulnerability to infections, deterioration of health status, developing drug resistance and even death. Link between migration (internal as well international) and infectious diseases can be understood through a study conducted for nine countries of Europe which suggests that the incidence of TB was low till 1990s

and the same increased with increase in migratory flows. Specifically, in Netherlands, TB rose by 45% between 1987 and 1995; over 50% of the known cases occurred amongst migrants[141].

2. Maternal and Child Health

Disadvantaged migrants are generally involved in informal sector with heavy physical work. Their jobs involve prolonged standing, bending and dehydration. They are at risk of exposure to pesticide, chemicals, and malnutrition. These factors may lead to spontaneous abortion, premature delivery, foetal malformation and abnormal post-natal development. Low socio-economic status, early marriage, lack of ante-natal care, lack of knowledge also results in poor reproductive/maternal health. A study in California on internal farm worker who were migrant women in USA showed that 24% of them suffered one miscarriage or still birth. Further, children of migrants face problem of homelessness, frequent movements, poor schooling, psychological and developmental risks[151–155].

3. Workplace Injury and Occupational Health

Labourers and seasonal farm workers constitute the majority of vulnerable internal migrants and face occupational health problems including accidents, pesticide-related illness, musculoskeletal and soft-tissue problems, dermatitis, non-infectious respiratory conditions, reproductive health problems, health problems of farm worker children in the fields, climate-related illnesses, communicable diseases, urinary tract infections, kidney disorders, eye and ear problems[76,80,95,156].

Health Policies for Internal Migrants in H&UMICs

The review suggests that the majority of H&UMICs have policies for international migrants, refugees, and internally displaced people in place but do not have specific policies related to

internal migrants (See Table 3). Perhaps this could be due to the decline in H&UMICs. Another explanation that could be given for the non-existence of specific policies for internal migrants in H&UMICs could be that these countries have better health systems which are less strained and have optimum resources to ensure that the internal migrants do not face health problems as those faced by internal migrants in lesser developed countries. However, there are no empirical data to suggest this. Overall, UN's agency International organization for migration appears to be the lead agency worldwide that provides technical support to governments of respective countries.

Table 3:Existing Policies for Addressing the Issues Related to Health of Migrants In H&UMICs (mainly for international migrants but open to access for internal migrants)[74,157–160]

Region/Country	Initiatives by International Organisation for Migration (UN Agency for migration) with strong engagement of government of respective countries
Central and North America and the Caribbean	
Trinidad and Tobago[158]	* to strengthen the capacity of the Counter-Trafficking Unit of the Government. * To organize awareness campaigns and training, development of standard operating procedures and establishment of referral mechanisms for Trinidad and Tobago. * To assist the Government of Trinidad and Tobago in improving migration management. To develop a migration policy (including labour migration policy) and to contribute to the development of a migration data management system.
United States of America[37,80,158]	* Continuing addressing the issues related to counter trafficking * to provide training to law enforcement agencies, prosecutorial officials and judiciary from specific regions seriously affected by trafficking There is no uniform definition of migrant and seasonal farm workers among government agencies hence data brought out by different departments is not comparable. Every year migration census is conducted for disease surveillance.

Latin America and the Caribbean[128]	Recently, Latin America & Caribbean (LAC) have shown a strong political commitment at the central government level for legal and regulatory reforms with respect to land policy, programs to regularize land tenure and social inclusion policies, locally driven initiatives linked to social programs in partnership with local community organizations, and programs focused on engaging the private sector, as another source of support for the upgrading of slums.
South America[158]	
Chile	To conduct a comprehensive situational assessment of migration health related challenges with particular focus on health vulnerabilities and HIV prevention, treatment care and support-related issues, especially in the northern regions of Chile, where migrants are more at risk and vulnerable to pandemic.
Uruguay	To work with national institutions to reinforce the protection system, including the implementation of shelters, for vulnerable migrants and victims of trafficking.
Asia Pacific[158]	
Australia	Providing support to the offshore Australian Humanitarian Settlement Programme by providing health assessments to accepted immigrants and refugees resettling in Australia.
Iran	To conduct situational assessments to determine mobility and cross-border patterns, and identify services and migration health policy gaps. IOM will work with the Ministry of Health and key relevant ministries and partners to develop a national migrant health strategy
Japan[35,158]	To support the Government of Japan in addressing its migration challenges through the implementation of Japan-funded projects in the area of voluntary return and reintegration of victims of trafficking.
Korea	Increase its efforts to reduce migrant exploitation, specifically trafficking in persons for sexual exploitation, and will increase awareness of the trafficking issue among the relevant government actors and the general public. IOM intends to build on victim identification and referral of victims to justice and towards voluntary return.
Europe[124,138,242]	
Austria	Support the Austrian Government to develop evidence based policies for orderly and humane migration management.
Belgium	IOM will continue to provide support to health assessments undertaken for government-funded and self-paying immigrants bound for resettlement countries.
Croatia	IOM participates in the regional Equi-Health project to bring together partners in the EU /EEA, Croatia and Turkey for the purpose of improving access to and appropriateness of health-care services, health promotion and disease prevention measures to meet the needs of migrants, the Roma people and other vulnerable groups.
Czech Republic	

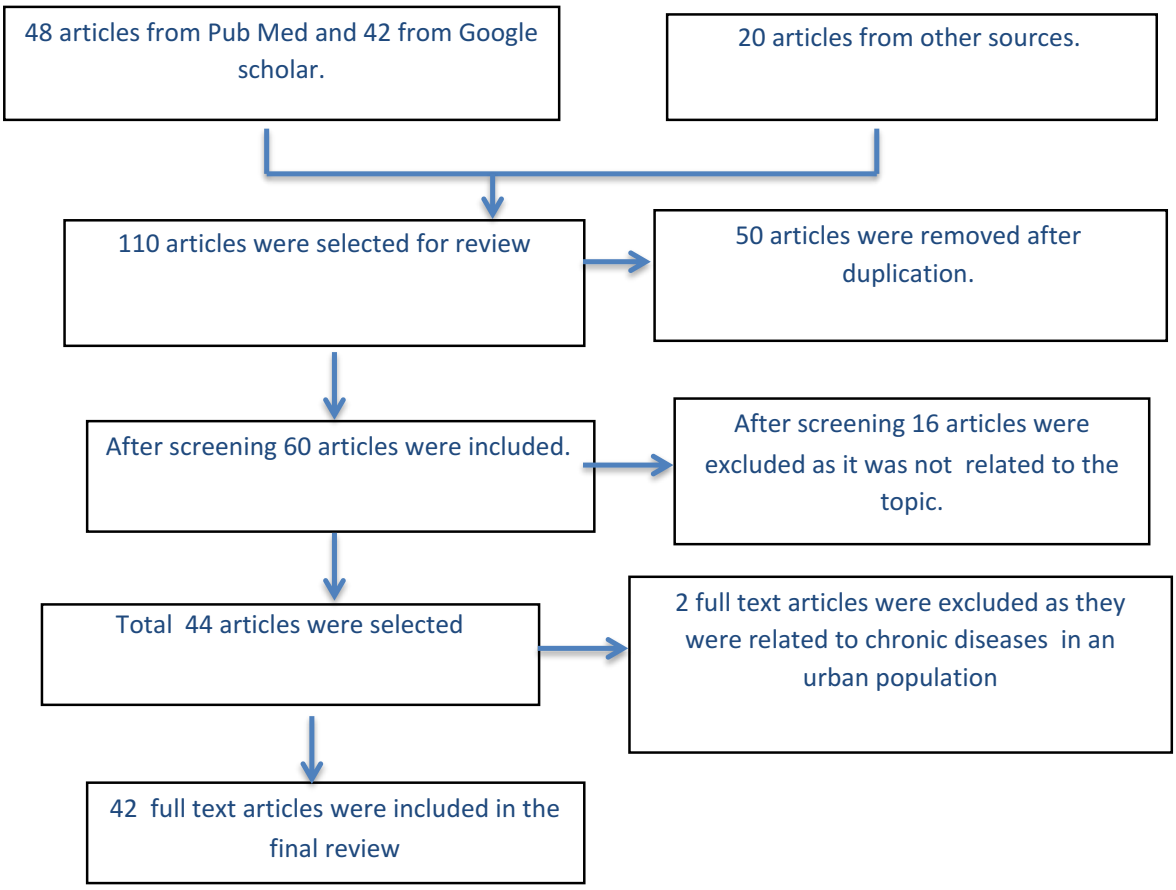
	IOM advocates equity in access to health-care services for migrants, and more precisely calls for solving the problem by granting migrants access to the public health insurance scheme, especially vulnerable groups, including migrant children.
Finland	IOM continue to work on advocating health of migrants by targeting vulnerable migrants and promoting migrant health counselling and referral services to be available for migrants throughout the country. In addition, IOM plans to: (a) provide helpline and web services in which health professionals disseminate information on health issues; and (b) implement outreach activities on the services provided to health institutions and other recipients (e.g. the pharmacy sector).
Greece	IOM is participating in the 36-month Equi-Health project aimed to bring together partners in the EU /EEA, Croatia and Turkey for the purpose of improving access to and appropriateness of health-care services, health promotion and disease prevention to meet the needs of migrants, the Roma people and other vulnerable groups.
Hungary	To contribute to improvement of access and the quality of health-care services and health promotion to meet the needs of migrants, the Roma people and other vulnerable minority groups.
Italy[161]	IOM continue to promote migrants' access to health-care services by involving migrants' associations and communities in Italy in information and awareness-raising activities. In addition, capacity building via training of social workers at reception centres and specialized services will improve the psychosocial assistance provided to vulnerable migrants.
Malta	Assistance provided to the Maltese Government in the framework of IOM's EU -funded Equi-Health project on fostering health provision for migrants, the Roma people and other vulnerable groups.
Poland	While asylum-seekers are granted the same health care provisions as Polish citizens, irregular migrants face many obstacles in receiving health assistance. IOM plans to conduct in-depth research on the current situation, needs and expectations of irregular migrants towards the health-care system to identify barriers and develop recommendations for the improvement in migrants' access to health care.
Portugal	IOM continue to work in collaboration with all national stakeholders responsible for health, integration and immigration policies to improve migrants' health and to promote better access to health services. Piloting a national training programme on migration and health.
Spain	Following a change in law in 2012, which excludes migrants from free medical coverage under the public health system, IOM intends to analyse the impact of the implementation of this law on migrants as well as assess the gap it creates on their migration health needs.

United Kingdom[162]	IOM provides support to offshore health assessments and travel health assistance activities for government sponsored refugees and self-paying immigrants bound for the United Kingdom under the United Kingdom Gateway Programme and the United Kingdom Tuberculosis Detection Programme, respectively. A global strategy is followed in UK to reduce social inequality in health. Similarly, training courses for government officials on citizenship and inter cultural relations have been developed.
Denmark[163]	The Danish Red Cross is responsible for the health of asylum seekers, who are offered screening on arrival and can visit general practitioners attached to the asylum centres. Asylum seekers are not covered by the national health insurance scheme, so they only have the right to help in the case of acute illness, unless they are pregnant women or children.
Switzerland[145]	In Switzerland, the medical services adopt two means to address the problem of language i.e. through informal interpreters which include relatives of patients, hospital staff etc. or through qualified interpreters. However, informal interpreters often fail to assist proper diagnosis and prescription for lack of knowledge of language and sensitive issues concerning health of the patients.
Russia[164]	Russian Government is constitutionally required to provide free medical care to all citizen. However, internal registration system is a big barrier in access to healthcare for internal migrants in Russia.

C. The Indian context

The search for articles specifically related to India yielded 110 articles - 48 from the Pubmed 3 from the Lancet, 42 from Google scholar and 17 from other sources were retrieved. 50 duplicate articles were removed, abstracts of the remaining 60 articles were screened, after which 44 were included as 16 articles unrelated to the subject were removed. Of these 44 articles 1 was excluded as it did not have specific information on the subject. A total of 43 articles were finally included in the review. See figure 5.

Figure 5: Selection of Literature - Flow Diagram for the Review in India.



Trends in Internal Migration in India: National and State level overview

India is rapidly urbanizing, the cities of Mumbai, Delhi, and Kolkata are among the world's top ten most populous urban areas, and India has 25 of the 100 fastest-growing cities worldwide[165]. A significant source of this growth is rural-to-urban migration, as an increasing number of people do not find sufficient economic opportunities in rural areas and move to towns and cities. Provisional 2011 census data shows that for the first time, India's urban population has grown faster than its rural population since the last census[166]. In 2007-08, the National Sample Survey measured the migration rate (the proportion of migrants in the population) in urban areas at 35%[33].

Indian constitution encompasses basic provision relating to the conditions of employment, non-discrimination, 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 [3]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 migrants of their rights as workers. There are few piecemeal policies and programmes available that address health and social security needs of migrants in India.

The Interstate Migrant Worker Act has been in force since 1979[114], 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[51].

India has ratified International Labour Organization's conventions but is neither a signatory or ratified the [4]Convention of Migrant Workers (CMW), which provides the formal sanction for

[3] 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).

[4]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

protection of the migrants. Similarly, [5]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 2017[167] 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 2000[168] 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.

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[51]. 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

provision for the protection of the migrants' received formal sanction. CMW was adopted by General Assembly at its 45th session on 18 December 1990.

[5]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.

and devise "tracking strategies" for improving health outcomes of migrants.

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[115] allow all migrant children to avail of nutritional supplementation under the Integrated Child Development Scheme (ICDS) at destination cities irrespective of whether or not they are registered in the area. [6]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. Public Distribution System (PDS) has issued a Government Resolution, 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[169].

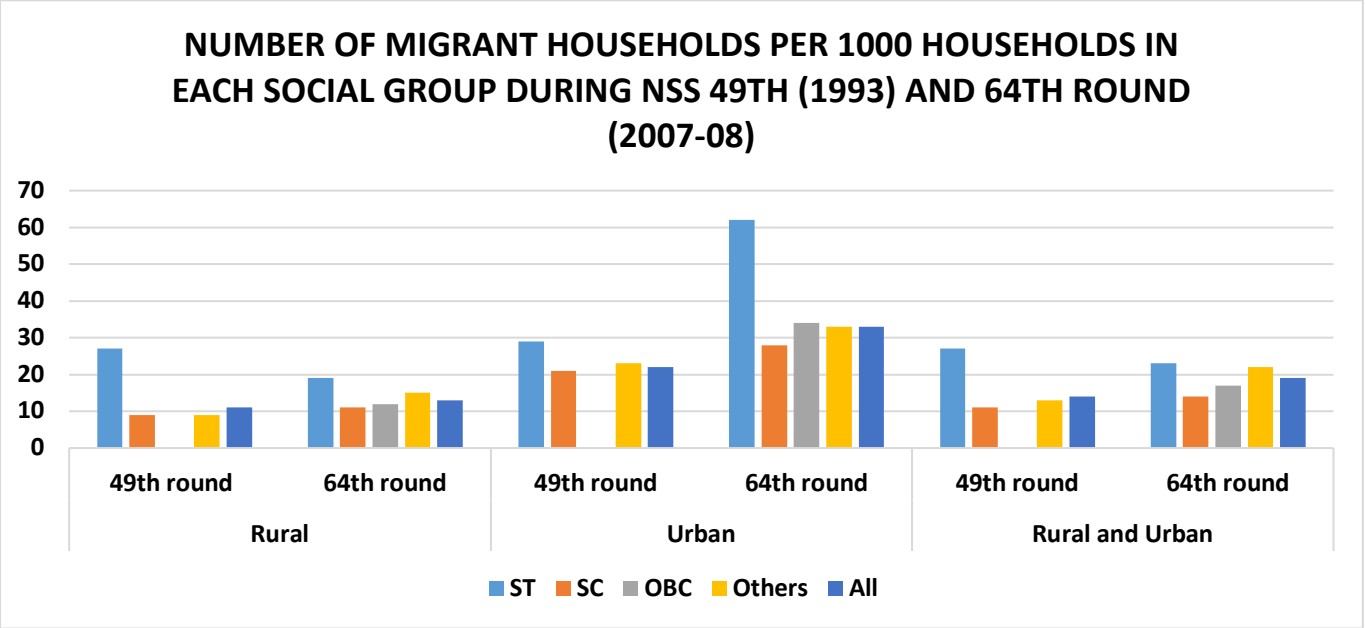
Migration trends:

Figure 6 shows the migrant households in different social groups and changes over time by number of migrant household per 1000 households in each social group during NSS 49th round (1993) and 64th round (2007-08). It clearly shows that in both rounds of NSS, migration rate of STs is higher than other social groups, in both rural and urban settings (23 for STs compared to 14 for SCs, 17

[6]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

for OBCs). Also, urban migration of STs has increased almost three times in the 64th round compared to the 49th round of NSS (62 compared to 29). Migration is mainly for better employment opportunities, and livelihood.

Figure 6: Ratio of Migrant Households to Per Thousand Households across Social Groups from 1993-94 to 2007-08



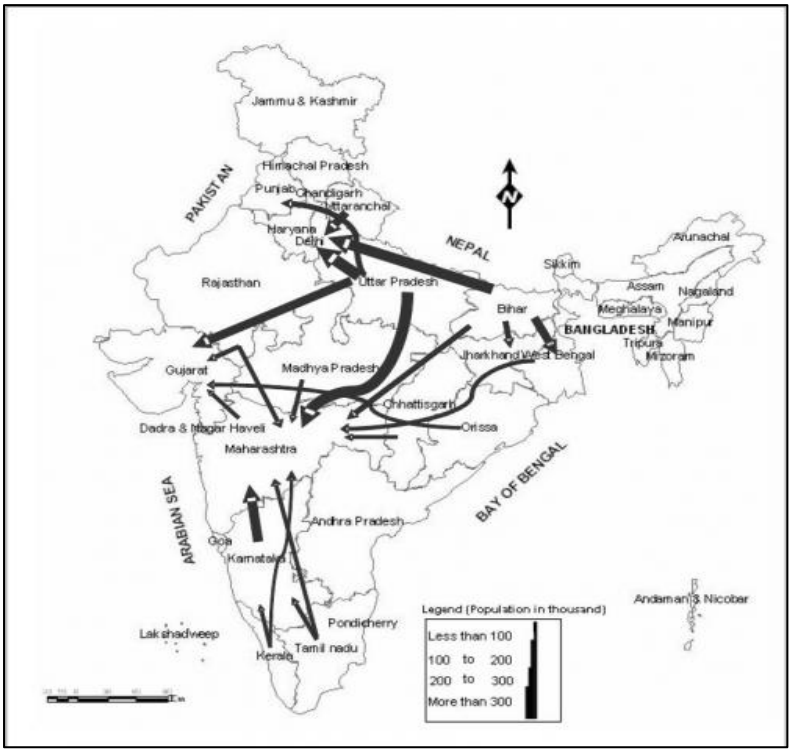
Source: NSS Report No. 533: Migration in India, NSS 64th Round (July 2007 – June 2008) , MOSPI

Migration flows in India

The northern states of Uttar Pradesh and Bihar have the highest percentage of rural populations, 18.6% and 11.1%, respectively, according to the 2011 Census[166]. These states constitute the largest migrant sending states. Substantial flows of labour occur from Uttar Pradesh and Bihar to Maharashtra, Delhi, West Bengal, Haryana, Gujarat, and other states across northern and central India. Other major migrant-sending states are Rajasthan, Madhya Pradesh, Andhra Pradesh, Chhattisgarh, Jharkhand, and Orissa. Figure 7 shows migration flows from different states, thickness of the flow indicates volume of migration. The major sending states are uniformly

characterized by poor social and economic development indices and the destinations as growing economic magnets of urbanization[170].

Figure 7: Major Net Internal Migration Flows in India, 2001



Source: R.B. Bhagat and S. Mohanty, "Emerging Pattern of Urbanization and the Contribution of Migration in Urban Growth in India," Asian Population Studies, vol. 5 no. 1 (2009): 5-20;
*Thickness of arrows indicates volume of migration

According to National Commission for Rural Labour (NCRL), Government of India, 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 the urban informal manufacturing construction, services or transport sectors and are employed as casual labourers, 'head' loaders, rickshaw pullers and hawkers[32]. The construction sector is the highest employer of migrants (40 million), domestic work (20 million), textile (11 million), brick kilns (10 million) followed by transportation, mines & quarries and agriculture[31]. Within these sectors, migrants are

mostly employed to work doing menial tasks which entail hard labour and maximum risk, tasks which the local labour are not willing to undertake.

Challenges to collecting migration data

In recent years, rural to urban migration for livelihood has become a growing phenomenon in India. There is limited official data available on internal migration; labour-related migrants are estimated to be over ten million (including roughly 4.5 million interstate migrants and 6 million intrastate migrants) [32]. The 55th round of the National Sample Survey indicates that there are 10 million (1% of the population) short-term migrants in India[171]. The 2001 census recorded about 53.3 million rural to rural migrants within the country[172]. While the latest 64th round NSS survey puts a figure of 30 million on internal migration[33], but various estimates based on micro-level studies suggest that the figure is close to 100-120 million. (roughly 10% of India's population)[31]

Internal migrants have widely varying degrees of education, income levels, and skills, and varying profiles in terms of caste, religion, family composition, age, and other characteristics. National-level data such as Census and National Sample Survey that identify trends in these characteristics are not available. However, micro-surveys suggest that most migrants are young between age group of 16 and 40 years, particularly among semi-permanent and temporary migrants, whose duration of stay may vary between 30 days and one year. Scheduled tribes and castes—the tribal and caste groups that are explicitly protected in India's constitution because of their historic social and economic inequality, are dominant groups of labour migrants in short-term migration flows[31].

While India's internal migration flows are substantial, they are difficult to enumerate. Migration data from the 2011 Census was collected, but not yet released. The 2001 Census and the 2007-08

National Sample Survey (NSS) both provide some information on internal migration, but miss important aspects of India's internal migration patterns. The Census defines migrant as a 'migrant anyone who lives in a place that is different than their place of birth or place of last residence'. This definition is very broad as it includes people who move over very short distances, within the same district. On the other hand, it misses a significant number of seasonal migrants, who have as much of a chance of being counted in their place of birth or last residence as they do at their new destination. The Census reflects the numbers of permanent and semi-permanent migrants, but does not provide information on circular, seasonal, or temporary flows. Similarly, the National Sample Survey, conducted by the Ministry of Statistics and Program Information, defines migration as 'those who have stayed for six months or longer in a place that is different from their prior "usual place of residence." As with the Census, temporary, seasonal, and circular migrants are difficult to estimate through the NSS data, and the survey's estimates of seasonal migration are far below those of other analysts. The NSS counted 15 million short-term migrants, but other estimates have placed the number at about 100 million.

Internal Labour Migration impact on poverty alleviation and development

Internal migration is an activity undertaken primarily by young adults in India followed by teenagers and children along with their parents. Migration is a routine livelihood strategy of poor households, which helps to compensate for seasonal income fluctuations and earn extra cash to meet contingencies or increase disposable income. There is evidence that migration can reduce poverty and stimulate economic growth. This is clearly noticed in situations where economies are growing rapidly as in Asia. While some studies on migration have tended to emphasize the impoverishing effects of migration they have rarely posed the question of what these households and individuals would have done in the absence of the opportunity to migrate[51,173].

The analysis of [7]remittance flows has usually focused on flows between rich and poor countries. Internal remittances (sending earnings/money to their home town by migrant workers) has not received much attention. The strongest evidence of internal remittances contributing to poverty reduction is from economies where urbanization and manufacturing have increased significantly, and where rural-urban migrants earn substantially more than they would in rain-fed farming. In situations where urban wages are high and employment is regular (even if informal) remittances can be significant. A study of migration in Madhya Pradesh, Rajasthan and Gujarat in India found that 80% of cash income in project villages was derived from migration. Karan's study in Bihar showed that remittances from migrants accounted for one-third of the average annual income of landless and marginal households. Scheduled castes, scheduled tribes and Muslims earned 29% of their income through migration. This contributes to the evidence that internal migration can play an important role in poverty reduction[43,174,175].

It is evident that migration can have multiplier effects on the sending area through stimulating land and labour markets, increased agricultural production and improved nutrition, health and education. There is compelling evidence to demonstrate that the returns from migration can improve over time as migrants acquire more knowledge, confidence and skills; when they can eliminate exploitative middlemen and contractors[15,31,174].

Migration also plays an important role in social development such as women's empowerment. It is evident that migration of women has increased in the informal economy due to availability of women oriented jobs such as domestic work, the garment industry, construction and agriculture[6].

[7]A **remittance** is a transfer of money by a foreign worker to his home country. In this thesis, it refers to the transfer of money by migrants from destination to their home/source area.

It was noted among women who do not migrate and stay back in their villages that the prolonged absence of male decision makers can result in a change in the social order with women becoming more vocal in village decision making and participating more often and openly. It was also pointed out in the synthesis report of the PPA[8](Participatory Poverty Assessment) that family dissolution is not necessarily a disempowering experience for women, and it is certainly empowering for some women. This illustrates that internal migration can play an important role in development. However, migration has not been recognized at a programme and policy level and migrants remain a neglected sub group of the population in India[5,31,174,176].

Vulnerabilities of migrants

While migration has been shown to have economic and other development benefits, it also has serious negative repercussions. As with LMICs migrant's vulnerability is influenced by several factors, including political and social marginalization and a lack of socioeconomic and societal resources[15,16,81,82,177].

Legal protection

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 on 'irregular' conditions rather than recruiting locals ensures a cheaper labour force. It allows employers to get away from providing them with basic minimum services including health, education of children, appropriate living and working conditions etc. These migrant workers are included in the category

[8]A Participatory Poverty Assessment (PPA), is an iterative, participatory research process that seeks to understand poverty in its local, social, institutional, and political contexts, incorporating the perspectives of a range of stakeholders and involving them directly in planning follow-up action. PPAs can be defined as an instrument for including poor people's views in the analysis of poverty and the formulation of strategies to reduce it through public policy.

of the unorganized sector, and are eligible to be protected by existing labour laws, but as they do not have a fixed employer it is difficult for the Labour Department to implement these existing labour laws. In case of internal migrants, their fluidity in terms of movement and their working conditions and informal work arrangements in the city exclude them from access to appropriate wages, entitlement and adequate care[5,15,134,178]

Identity and Access to entitlements

Usually, benefits of the schemes run by individual state governments are available to those having resident status and/or legal identity in the respective state which requires documentation of residence such as a local ration card, electricity bill, PAN card, passport or the newly launched national identification AADHAR card. Migrants, in general, do not have resident status in the destination state. Lack of legal identity in the destination state makes it impossible for the migrants to access basic entitlements including social security, health insurance, education for children, financial inclusion and basic services during their migration period[179,180].

The interstate migrants (both intra and interstate) lose their entitlements when they cross the borders of their native state or district. For instance, a migrant labourer from states like Bihar, Orissa, West Bengal or Assam migrates to Kerala who receive rice or wheat and other provisions at subsidized price through the Public Distribution System (PDS) in the home state is unlikely to benefit from the PDS in Kerala. Some states have also been providing essential food items at subsidized rates through its outlets for example by the Kerala State Civil Supplies Corporation, a federation of Cooperatives for which a local ration card is necessary. Thus, the migrants have to depend solely on the open market and become more vulnerable to the price differences in the open market compared to the local community[82].

A similar situation exists in accessing state specific health insurance programmes. Usually states do not provide insurance coverage to migrants from other states. Rashtriya Swasthya Bima Yojana (RSBY) is the only national health insurance scheme where migrants can move benefits to anywhere in the country, but the scheme has few major limitations. The restriction of RSBY to below poverty line (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. Similarly, access to other entitlements are also linked to identity[177,179].

Education

Migration is a leading cause for high dropout rate of children from schools. At the workplace, the children are usually away from care and protection, health and nutrition, and education in comparison with their peers in the source village. They face problems in enrolling in education and school systems at destination cities for these children due to their mobility, language barriers (in case of interstate migration), and availability of resources for inclusion of migrant children[181,182].

Financial vulnerability

Once a migrant leaves their home area they are often no longer eligible for social insurance, health benefits or entitlements to livelihood support systems and even formal welfare schemes[173]. Lack of identity documents at the destination cities means migrants are not able to open bank accounts. They usually carry all their money with them since their dwellings at destination locations are not secure. This also makes them vulnerable to being robbed. As stated by Mr. Avadhesh Kumar from one of the migrant labourers from Bihar working in Delhi 'they consider us outsiders here. We

can't keep our money at home due to security reasons. So, we carry it all with us[5]. Often local rowdies beat us up and snatch our money'. Migrant labourers also face a number of problems sending money back to their source villages. To send money back to their villages, migrants use few available options[44]

- carrying it back themselves or sending it through friends and relatives visiting home
- sending it through the post office by a money order
- sending it through a bank by bank draft or
- sending it through an informal remitter.

Among these options the first and the last involve the informal market; the second is seen as expensive and sometimes difficult by remitters (a form has to be filled out in the language of the destination). Sending money through a bank is rarely feasible since most migrants don't have a bank account, either at origin or destination or both. Due to lack of options for money transfer, migrants cannot send money home as regularly as necessary. A study of remittances to Andhra Pradesh has shown that only 15% of remittances are sent to families on a regular monthly basis, 35% are irregular and 44% are sent only every three to four months. Transaction costs are also an issue to most migrant labourers with the cost of doorstep delivery being quite high. The post office, for instance, charges 5%, while clients reportedly have to travel to the post office to pick up the remitted amount. In this situation, most of the migrants prefer to send their money through friends and relatives visiting home, which has major risk of robbery or even cheating. Migrants are most vulnerable and including them in the formal financial system would a be a step towards integration and towards economic betterment[44,180].

Health

The morbidity patterns among migrants vary with type of migration and its potential for generating health risks. For instance, in the case of migration to big cities like Mumbai, which takes place on a more or less permanent basis, the susceptibility of the migrants to health problems results from their peripheral socio-economic existence in the host areas[153]. 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, problems include infectious diseases, chemical-and pesticide exposure related illnesses (i.e. dermatitis), heat stress, respiratory conditions, musculoskeletal disorders and traumatic injuries[184], 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 high levels of toxicity from 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. Migrants working in stone quarries scattered all over India face illnesses endemic to stone industry including respiratory diseases such as silicosis due to prolonged inhalation of silica dust and tuberculosis (TB) [184–186].

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, there are 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[51,87].

Some currently functioning programmes like the National AIDS Control Programme have a mandate to provide outreach services[27]. 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[187]. 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[188]. 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

Evidence suggests that migrants suffer from lack of knowledge and poor utilization of health services. As they are away from their usual place of residence, the dependence on their regular systems for seeking health care is compromised. An important aspect of the migrants' vulnerability is that they live in open spaces and migrant's camps (provided by the employers), where they don't have basic amenities like sanitation, toilets, drinking water etc. Many adult and young women face risks related to maternal health (including sexual and reproductive health) and lack knowledge and skills to make informed choices and use services effectively. As they come from the villages, and away from their traditional systems of health care, invariably, there is resistance to use services

from providers of modern medical care. Migrant women are particularly isolated with respect to health care including ante-natal care during pregnancy. Providing appropriate information about maternal health and facilitating access to services is clearly necessary[189].

A combination of factors at the area of destination complicates migrant's vulnerability, which is primarily premised on the alien status of the migrants. Limited choice and reduced capacity to negotiate result in increased discrimination. A migrant is considered an 'outsider'. Evidence suggests that migrants are disadvantaged relative to the native population in areas such as employment, education and health. It is difficult to determine specific reasons for this, however, factors such as lack of education, lack of health care provision, absence of outreach programmes, low wages, initial prejudice and sustained discrimination of health providers play a role. For instance, a bias against the migrants may translate into health providers' neglect, which in turn perpetuates poor migrant health[15,82].

Infectious Diseases:

Evidence suggest that similar to the factors in LMICs crowded living conditions, lack of clean water supply, poor drainage systems, unhealthy practices and unacceptable sanitary conditions expose the migrants to various kinds of health risks predetermined by their standard of living and their choice of occupation[78,94]. Infectious diseases, such as malaria, hepatitis, typhoid fever, and respiratory infections are found to have a higher incidence among migrants. Migrant labourers use curative care but they fall outside the coverage of preventive care because of their fluidity of movement caused by uncertainty of employment[190,191].

Malaria and Tuberculosis (TB):

Migration was seen as a matter of concern in relation to Millennium Development Goal (MDG) for HIV/AIDs, malaria and other major diseases, and it is also seen as concern in relation to Sustainable Development Goals[55,190,191]. In case of malaria, migration may increase exposure to disease, transport mosquitoes to new areas and/or create habitats that are favourable to mosquitoes. Migration may also help spread resistance to drugs. The 44th World Health Assembly (1991) recognized the growing importance of TB as a public health problem.[174]Migrants are approximately 6 times more likely to have tuberculosis than the general population[80]. A study in the tuberculosis unit of Tiruvallur district of Tamil Nadu identified migration as an important factor for treatment default under The Revised National Tuberculosis Control Programmers (RNTCP). The study concluded that irregular and incomplete treatment due to migration is likely to increase the burden of TB in the community[190,191,194,195].

Migration and HIV/AIDS

Studies show that migrant workers are more susceptible to HIV/AIDS infection in India. Prevalence of HIV/AIDS among male migrants is 0.55% compared to 0.29% among non-migrants[187]. While, International Organization for Migration (IOM) argues that migrants and mobile populations are more vulnerable to HIV/AIDS, being mobile in itself is obviously not a risk factor. It is the situations encountered and behaviours possibly engaged in that increases vulnerability and risk. Migrant and mobile populations may have little or no access to HIV information, prevention (condoms, STI management), and health services[84].

Maternal and Child Health

The poor health status of migrant women is obvious from indicators such as antenatal care

coverage, prevalence of anaemia, prevalence of reproductive tract infection and violence against women. Despite the availability of government and private hospitals at destinations, the urban migrants prefer home deliveries. 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 choosing home delivery. Migrant children suffer from malnutrition and lack of immunization when their parents are in perpetual low-income uncertain jobs that necessitate frequent moving based on the availability of work. Under 5 Mortality Rate (U5MR) among the urban poor migrants is at 72.7%, significantly higher than the urban average of 51.9%t. 47.1% of urban migrant children under-three years are underweight compared to the urban average of 32.8% and the rural average of 45% percent. Among the urban poor, 71.4% of the children are anaemic compared to 62.9%t of the urban average. Measles is found to be common among migrants mainly among children who do not have immunization; 60% of the urban poor migrant children miss complete immunization as compared to the urban average of 42%[15,77,87,91,174].

Workplace and Occupational Health:

The occupation related commonly reported problems among migrant workers working in the informal sector are cold-cough fever, diarrhoea, tiredness, lack of appetite, dizziness, 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[78,184]. 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[77,184,186].

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, foetal malformation and growth retardation, and abnormal postnatal development. 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 resulting in chronic urine retention; urinary retention in turn encourages bacterial growth and results in chronic infections and associated complications[78,80,186,196].

Mental Health

Migration results in a range of 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. Manifestation of stress includes relationship problems, substance abuse, domestic violence, and psychiatric illness. Heavier alcohol consumption and risky sexual behaviour have been noted in communities of predominantly single men compared with those consisting primarily of families. Children of migrant workers experience a six-fold risk of mistreatment than children in the general population. 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 over time[15,177,183,186].

Current policies in India

Although India does not have a comprehensive policy on internal migration, fragmented policies for the protection of migrants do exist. Table 4 summarizes programme and policy measures in India for internal migrant populations.[197]

Table 4: Existing Policies and Programmes to Address Migrant's Health and Social Security Needs in India[87,112–119]

Existing Polices/Programmes to address migrant's health and social security needs	Responsible Government Institution	Supporting Institutions
No comprehensive policy on internal migration. Comprehensive migration support program piloted for tribal migrants in Maharashtra state during 2013-16, to be soon extended in other tribal states of India.	National Commission for Scheduled Tribes, Ministry of Tribal Affairs, New Delhi & Maharashtra State Tribal development department	UNDP, India Disha Foundation (NGO)
Interstate Migrant Workers Act 1979 provides comprehensive protection and welfare services to inter-state migrant workers.	Ministry of Labour and Employment	International Labour Organization World Bank
Integrated Child Development Scheme provides health care services to migrant women, children and adolescents at destination cities.	Ministry of Women and Child Welfare	World Bank
Portable National health insurance program 'Rashtriya Swasthya Bima Yojana	Earlier Ministry of Labour and Employment, recently it has shifted to Ministry of Health and Family Welfare	GIZ – Deutsche Gesellschaft für Internationale Zusammenarbeit. (earlier The German Organisation for Technical Cooperation (GTZ)
National urban health mission 2013 plans to cover migrants in the health programs.	Ministry of Health and Family Welfare	N.A
Bihar, Jharkhand and Rajasthan states have made provision for registration of out-migration at source area.	State Labour Department	N. A

Summary and discussion

International human rights law guarantees every individual right to free movement within a territory of the country[198], a commitment legally binding on all parties to the International Covenant on Civil and Political Rights. International law also provides for the basic right to highest attainable standard of health to citizens. This right, along with principle of non-discrimination, implies a clear right to access core minimum set of health services for all including internal migrants who move within their own country.

The literature review suggests that internal migration is widespread and the number of people who moved across the major zonal demarcations within their countries was nearly four times more than those who moved internationally. While internal migration is an important in LMICs, the review shows the internal migration is on decline in H&UMICs countries like the USA, Japan etc.

Despite the important role internal migrants play in development and growth of economy of the country the review indicated that not much has been done to specifically address the problems faced by internal migrants. Existing health policies of different countries do not emphasize the health problems specific to internal migrants. The review suggests that the majority of H&UMICs have policies for international migrants, refugees, and internally displaced people in place but do not have policies related internal migrants. Perhaps this could be due to the decline in H&UMICs. Another explanation that could be given for the non-existence of specific policies for internal migrants in H&UMICs could be that these countries have better health systems which are less strained and have optimum resources to ensure that the internal migrants do not face health problems as those faced by internal migrants in lesser developed countries. However, there are no empirical data to suggest this.

In terms of policy with respect to welfare and health issues of internal migrants, LMICs are in the early stages of development. However, the magnitude of internal migration is such that governments have begun to realize that internal migrants cannot be ignored as it would ultimately affect the destination community and health outcome indicators of the nation.

The interplay between migration and health involves a range of factors and determinants. Therefore a multi-sectoral, coordinated and interactive policy approach is required to manage the issue related to improve the health of migrants. Existing policy measures for internal migrants are few and far between compared to international migration, though the magnitude and socio-economic development outcomes of internal migration are more or equal to international migration.

Policy measures related to migration include, security, labour, trade, enforcement and international aid laws. Health policy related to migration was traditionally viewed in terms of a threat to public health resulting in screening, monitoring quarantine, communicable disease control as in case of pandemic flu. More recently, health policy for migrants encompasses a right based approach which recognizes migrants' special vulnerability to interpersonal and occupational hazards, social exclusion, and discrimination and the importance of universal access and culturally competent health care services.

Policy measures for internal migrants have been taken in some countries like China, and Vietnam where the magnitude of internal migration is such that the plight of internal migrants cannot be ignored as it will ultimately affect the destination community and health outcome indicators of the nation. Some countries such as Mongolia and Cameroon have introduced innovative policy measures to deliver affordable, accessible and quality health care to internal migrants. Others such

as Sri Lanka and Thailand have developed comprehensive migration policies for both internal and international migrants, while some countries such as Philippines and Malaysia have a few programmes in place such as health insurance for international as well internal migrants[20,59,60,63,65,103–105,199]

In some countries, the governments have attempted to address the problems of internal migrants. For example, in Singapore, the Government provides protection to Male Construction Workers (MCWs) under its Employment Act and Workers' Compensation Act and also provides services to upgrade the skills of MCWs and provide better housing facilities. However, no such policies have been formulated for female domestic workers[149]. Few countries have developed migrant friendly policies directed at improving their access to healthcare for example in Argentina, the employers for rural workers have to contribute a fixed percentage of workers' salaries towards a special fund that covers social benefits programmes including health insurance providing social protection as well as healthcare access[150]. Over 78% of the Latin American and Caribbean (LAC) population lived in urban areas in 2007. LAC, which includes few upper middle-income groups. The LAC governments have recently shown a strong political commitment at central government level for legal and regulatory reforms with respect to land policy, programmes to regularize land tenure and social inclusion policies, locally driven initiatives linked to social programmes in partnership with local community organizations, and programmes focused on engaging the private sector, as another source of support for the upgrading of slums[200].

According WHO[160], though the approaches are fragmented, a number of national and international agencies, including non-governmental agencies are finding ways to improve aspects of health and access to health services for migrants. These approaches run parallel to national health systems

and depend on external funding and lack sustainability. Some countries have also worked towards contributory social security schemes, employer based health insurances or tax based schemes, for migrants. For example, Brazil, Spain and Portugal have adopted a policy of equal access to coverage for all migrants irrespective of their legal status. Some initiatives are led by trade unions and employees. For instance, in Argentina, employers for rural workers contribute a percentage of workers' salaries towards a special fund that covers social benefits In line with these provisions and WHA resolution[134], H&UMICs have started working on policies for migrants, but they are particularly focused on international migrants, and has less priorities for internal migrants. e.g. Bio-mosaic software developed by the United States of America, The 'Migrant Health: Key infectious diseases affecting migrant populations in the EU/EEA' project launched by the European Centre for Disease Prevention and Control (ECDC), and the National Health Institute Doutor Ricardo Jorge, comprehensive healthcare strategy for migrants developed by Mexico, policy for allowing undocumented migrants to access medical care in France including health insurance[36,37,158,201].

Evidence indicates that resources are rarely directed at mobile and displaced populations and their needs are not addressed in national strategies. Several countries have adopted a range of policies for migrant health. However, most policies are not evidence-based leading to inappropriate and ineffective measures. One of the main challenges is that existing health policies in a range of countries do not identify the specific issues related to the health of internal migrants. A range of determinants interact to determine the impact of migration on health. Hence a multi-sectoral, coordinated and interactive policy approach is required to manage the issues related to the health of migrants. What is needed are separate, focused policy measures aimed at the accessibility,

affordability and continuity of health services to internal migrants in context of their mobility and vulnerable living and working conditions[3,5,202,203].

The review demonstrated very clearly that India is facing migration challenges and has increasing need to formulate and implement policies to improve migrants' health. Currently, India has **few or no policies** or programmes targeting internal migrant issues and this segment of the population still faces exclusion from the various mainstream programmes. 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 taken a back seat[5,51].

The literature review has helped to identify the gaps in terms of policy with respect to welfare and health issues of internal migrants in different countries. Few policy gaps can be identified specifically from the piecemeal policy efforts as below;

- Overall, the government policies and institutional measures are limited by the sustained perception of the governments that free migration is harmful to development and needs to be controlled by restriction on the movement of citizens. This perception influences the direction of policy measures for internal migrants. The system lacks a comprehensive approach based on rights, entitlements and inclusion.
- In most of LMICs where migration health policies exist, they operate in isolation and therefore not very effective.
- There is a disconnect between practice and policy. Migration policies need to be compatible with health-promoting strategies for migrants based on a public health approach. An important

gap noticed in most countries is that the policy measures are not backed by the requisite research and evidence, leading to less effective measures.

- Evidence indicates that resources are rarely being directed at mobile and displaced populations and their needs are not addressed in national strategies and action frameworks. As a result, though national programmes have expanded their service areas, efforts to reach remote, and hard-to-reach populations like internal migrants has not been successful.
- The major obstacle in access to health care is the high cost of health care, high out of pocket expenses due to lack of coverage by health insurance schemes. The insurance schemes available are linked with the residency status and not easily transferable from one area to another, Migrants therefore do not qualify for public insurance and assistance programmes. Hence, fragmented insurance schemes with restricted transferability are not very useful. Further, policy development is required for a national transfer mechanism, which will help migrants to get the benefit of the welfare schemes, insurance and uninterrupted health care when mobile due to job demands.

  Innovation and electronic records, single unique identification numbers linked with insurance and social welfare schemes would permit better administrative integration and delivery. This initiative faces technical barriers as establishing a nation-wide medical record system and linking to existing insurance systems in different cities is complex.
- Further, the policies overlook the human cost both of migrants and their families. Policies lack comprehensive programmes for social protection for rural-urban migrants.
- Another major gap is in the form of implementation and regulation of laws, policies and programmes. The problem is that the governments do not have a strong institutional mechanism to enforce the laws for the employers, and the workers themselves do not have sufficient knowledge of the laws and rights, while the channels to raise their concerns are

severely limited. For implementation, the major policy gap is uncoordinated approach which is reflected in un-integrated implementation by local governments and other stakeholders.

The Indian context

The review has demonstrated the magnitude and variety of internal migration flows in India, as well as the problems associated with them. This reiterates the need to address the issues of migrants by streamlining the existing policy mechanisms to cater to their varied needs. India has **few or no structural policies** or programmes targeting the migrant issues in totality. There is a need to modify the existing policy structures and programmes so that the needs of this marginalized group are accommodated in the various national policies and programmes. The **development of a comprehensive migration policy** would be an important step forwards, it could ensure collection of data on migration, portability of the available health and other social security programmes, as well as their convergence at source and destination level, at both inter and intrastate level.

Since review has shown clearly importance of addressing migrants' health/social needs and absence of comprehensive policy framework for migrant's health needs the need for further research in this area is highlighted.

Few key areas where internal migrant specific policies are required include policies for protection of rights; on recruitment agencies, agents and other related business to avoid exploitation; sufficient and safe channels of transmission of remittance; migrant friendly healthcare services; removing linguistic and cultural barriers; documentation of internal migrants and enhancement of surveillance & information systems to ensure utilisation of disaggregated data for taking appropriate initiatives; lack of political initiatives; strengthening of existing health systems and healthcare manpower wherever necessary; proper identification or listing of slums and their development. Almost majority of H&UMICs are actively engaged in taking some or other

initiatives to address migrants' health needs. UN's agency International organisation for migration seems to be leading agency worldwide, that provides active technical support to governments of respective countries, but largely focussed on international migrants[54,136,158,160,163].

CHAPTER 3

CROSS-SECTIONAL SURVEY EXPLORING THE SOCIO-DEMOGRAPHIC CHARACTERISTICS, HEALTH CARE PROVISION AND BARRIERS TO ACCESS OF HEALTHCARE OF INTERNAL MIGRANTS IN NASHIK, MAHARASHTRA, INDIA

INTRODUCTION

In order to formulate and implement policies to improve migrants' health, it is important to gain an understanding of internal migration in India. For this it would be important to get a picture of who the migrants are, where they migrate from, what their demographic profile is, what problems they face when they migrate including access to health care. This chapter describes a descriptive study exploring the socio-demographic profile of migrants, challenges and barriers faced by migrants in accessing health care including maternal and child health care and the availability of appropriate health facilities and appropriate care to the migrant population.

In order to gain an understanding of internal migration and migrant's health a questionnaire survey was undertaken in Nashik city of Maharashtra state. This city is an important area where migrants come from different parts of the country to undertake a range of employment. The survey was to understand who the migrants are, where they come from, and their demographic profile, problems they face when they are in city including access to social and health care, and access to appropriate services.

Aims:

The aim of the study was to understand the factors (individual community/system level) affecting the migrant's access to healthcare services

Oobjectives of the study were:

- To understand the demographic and socio-economic characteristics of the migrant communities.
    a. Migration history/duration of migration
    b. Age/gender/educational/occupational/religious/ethnic composition

- To assess the felt healthcare needs, utilization and perceived relevance of available healthcare services by migrants including mother and child health care (MCH)

- To gain an understanding of the migrants' assessment of quality of healthcare
- To identify barriers to access to and utilization of healthcare services

METHODS

An interviewer-administered questionnaire, using random sampling was undertaken among the migrant population in Nashik.

Study area: Why Nashik?

The study was undertaken in Nashik city in Maharashtra state of India, situated at a distance of 200 km from Mumbai (capital of the state). The city is an ancient place of pilgrimage in India and is an important and vibrant urban conurbation of northern Maharashtra. The city experiences substantial in- migration from all over the country because of the employment opportunities. It is considered as one of the most rapidly growing industrial cities in Maharashtra with an Information Technology park, wine park zone, and educational institutions. There are 174 medium and large industrial units, 6 five-star industrial development corporations, 10 co-operative industrial estates and 7 sugar factories in the district.

The opportunities in Nashik attract skilled and semi-skilled migrants. Nashik's population is 2.21 million[166], of which the migrant population constitutes 20%, including from within the state of Maharashtra and the neighbouring states of Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh and Gujarat. Rapid industrialization, agriculture growth and the booming construction industry has resulted in increased migration and subsequent increase in urban poverty. There are 104 government authorised slums in Nashik where 25,036 households reside. Nashik has a large number of seasonal migrant workers. There are approximately 30 temporary 'halt points' of migrants who reside without any basic amenities, this population is approximately 200,000

(Information from NGO Disha Foundation working on migrants issues). Seasonal migrants are generally engaged as daily wage labourers in the informal economy i.e. agriculture and construction sector. See figure 8 and 9 for location of Nashik on India map and Maharashtra map

Figure 8: Maharashtra's Location on The Map of India

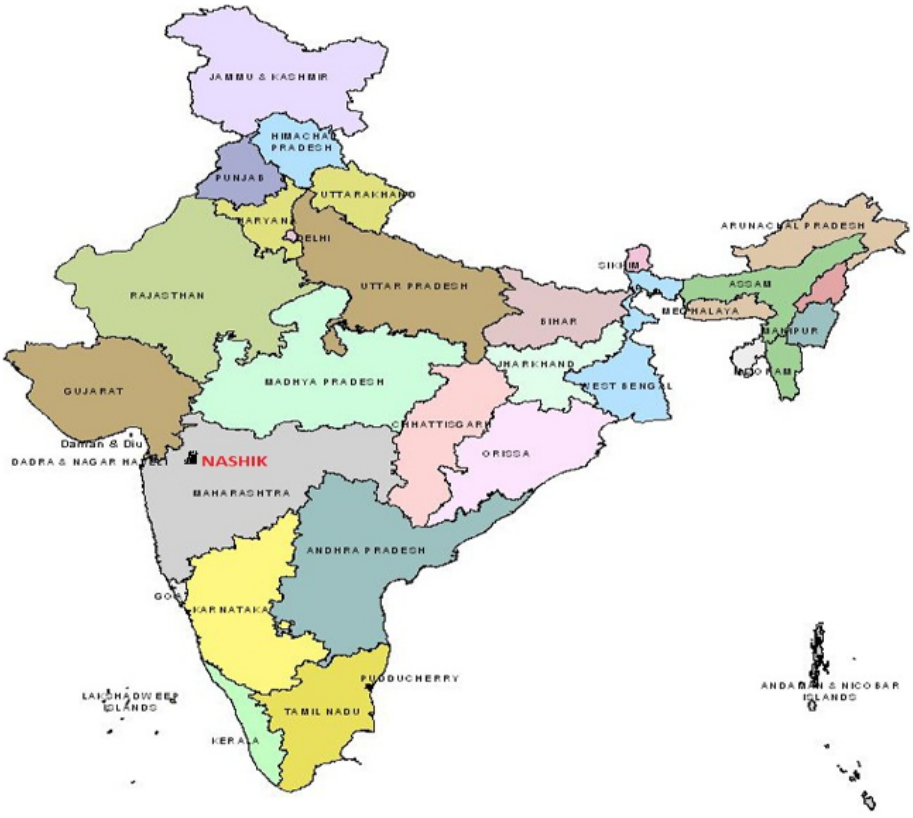


Figure 9: Nashik on Maharashtra Map



Source: www.mapsofindia.com

Nashik Municipal Corporation (NMC) is the main provider of the health service delivery system in Nashik. NMC provides healthcare through 5 major hospitals, 6 maternity hospitals, 7 dispensaries through Reproductive and Child Health Programme, 9 urban health centre with support of Central government (7 NMC, 1 civil hospital, and 1 Red Cross hospital). Mobile health schemes which includes around 4 mobile health dispensaries/vans at provide primary healthcare services to the communities living in the slums.

Definition of Study population: 'Migration' and 'Migrants'

Movements which resulted in change of the usual place of residence of the individuals were treated as migration. The study population was defined as 'Migrant households that had migrated to Nashik city within the last 10 years, but not less than 30 days'. The Census of India[166] and National Sample Survey[33] deemed six months as the minimum period of stay in a place but the minimum stay period was reduced to a month for this survey to capture seasonal/circular migrants. Individuals who migrated to Nashik city and currently lived in the urban slums or slum like temporary settlements/camps, were also included in this study. Migrants living in newer slums/non-notified slums were considered eligible to be included in the clusters. Those, who gave verbal informed consent to participate in the study were included.

Sampling

A questionnaire survey was conducted through face-to-face interviews of migrants. Random sampling was used for selecting the migrant households. Households of eligible migrants were identified from various clusters in the city. Attempts were made to identify migrant's locations particularly from newer slums, 'de-notified' slums and camps, where newcomers usually reside. Snow-balling technique was used during the pilot survey to identify such habitations. The required sample size of quantitative data was calculated according to the formula (Lwanga and Lemeshow

1991)[204]. Taking the prevalence of utilization of government healthcare service of 15% (rate based on an ongoing study in Delhi-personal communication with the researcher Kusuma) with 10% relative precision and 95% confidence interval, and considering the design effect (DEFF) of 1.7 as cluster sampling is adopted, and factoring in a 5% non-response rate, the sample size of 3886 was calculated. As the response rate to be interviewed for the survey the sample was a total of 4002 interviews.

For MCH care, the survey was conducted through face-to-face interviews of migrant women, using random sampling. The selection criteria were 'migrant women who delivered their babies in Nashik in the last 2 years'. A total of 298 women were interviewed.

Designing and Pre-testing of questionnaire

The Indian Council of Medical Research, New Delhi decided to undertake a multi-centre study on people's access and health system's responsiveness in fast-growing smaller cities. A team of researchers was brought together from several cities (I was the lead researcher from the city of Nashik) to develop a questionnaire to collect data on the socio economic, demographic details of the migrants (including their education, marital status, religion, employment, income, etc.) their access to government health care including MCH and their views on the quality of care provided. Pre-testing of the questionnaire was done with migrants working in three different sectors - construction sites, furniture workshops and agriculture which helped to initiate interaction with migrant community, completing the questionnaire and check if any amendments or if any new questions were needed. Following piloting the questionnaire was refined and the English version was translated into Marathi to be used in Nashik.

Process of data collection

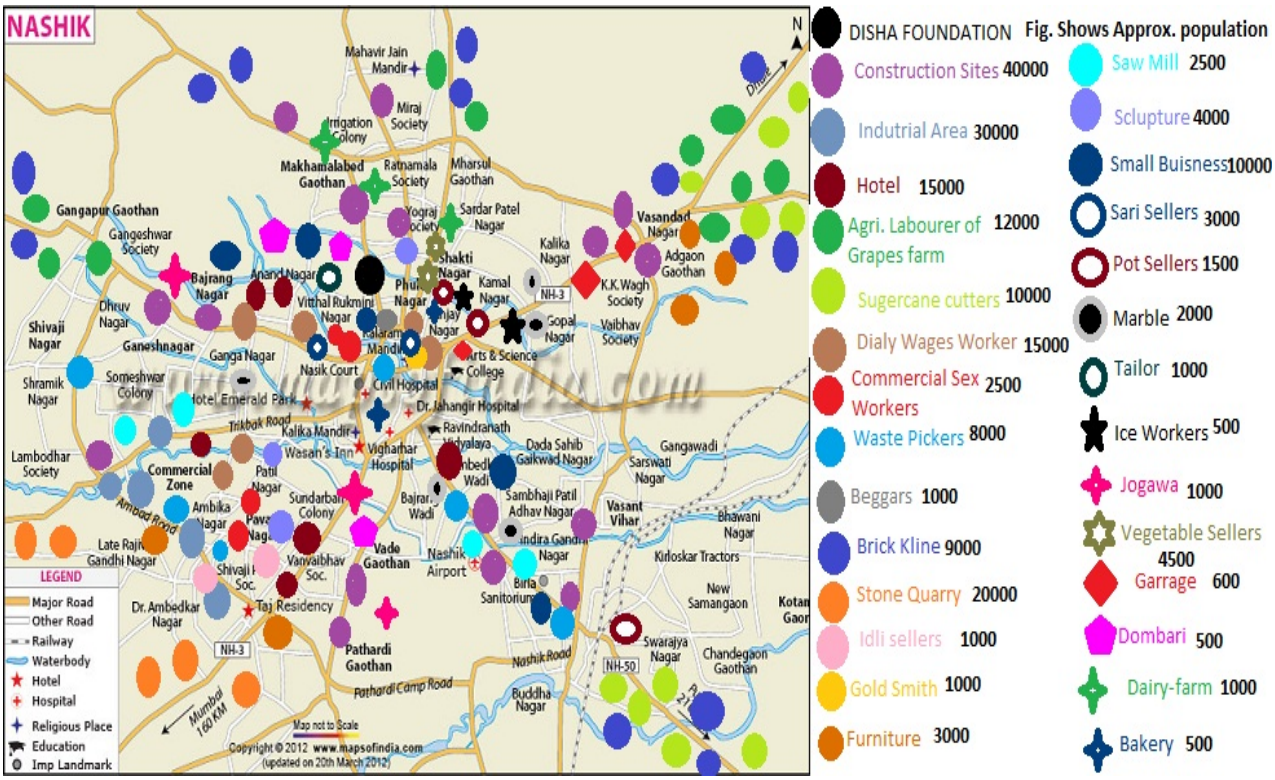
A team of 4 interviewers was recruited to administer the survey in Nashik, they were selected on the basis of their social science educational background, previous experience on conducting health research, and experience in working with migrant communities. Their selection was done with support of local NGO working in migration and the health sector in Nashik. Induction and training was given by me to the team on the objectives of study, methods and the collection of data. An additional training was organized for team with a local Obstetrician to enable them to understand MCH i.e. ANC care, immunization details etc. (which was included in questionnaire for mother and child health survey, see questionnaire in appendix 1)

Identification of the working sites

Mapping of migrants' sites was done in Nasik city of unauthorized slums, migrants' halt points, open spaces and work sites. Various sources were used for the identification of migrants; this included visits to the sites, discussion with various migrant key informants, NGOs working with migrants, migrant's employers in different sectors, municipal corporation, government health personnel's etc. Thirty sectors were identified where migrants were engaged as workers/labourers across Nashik city (as shown in figure 10). A major challenge was to locate and identify widely dispersed migrants, who met the defined criteria. Hence, it was decided to identify certain high concentration clusters where around 15-20% of the households were newer migrants. Initially, the interviewers visited several slums, slum like areas, open spaces, resettlement colonies, habitations along the railway tracks and fly-over bridges, where people set up temporary tents and huts to live, and newer habitations near the existing slums, habitations on or near the foot paths, road side, and construction work sites. Information regarding how long people have been staying in this area,

and are there any people who joined recently i.e., within the last 10 years was gathered through talking informally with the residents and community leaders. Migrant's locations to be considered for inclusion were identified and care was taken to include clusters from all parts of the city. The participants were randomly chosen using random generation of numbers, based on their availability to spare time roughly 40 minutes to respond to questionnaire.

Figure 10: Migrants' Locations in Nashik City by Type of Sector (Work)



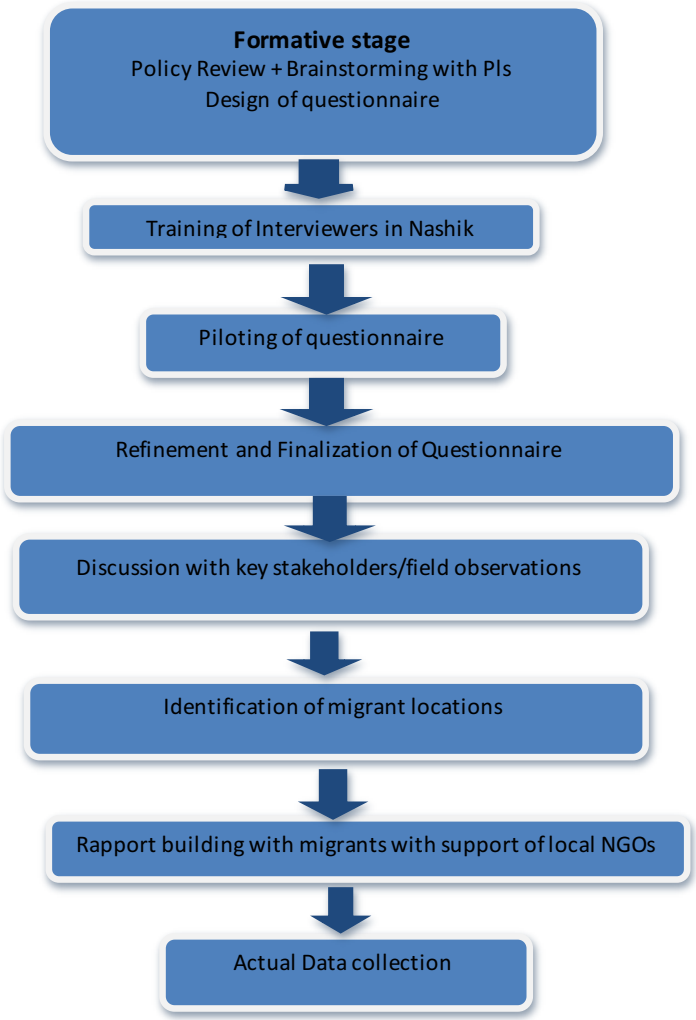
**Approximate population of migrant's in each sector is indicated in the figure.*

Data Collection

After refining questionnaire, data collection was undertaken through some rapport-building activities with support of local NGOs, such as regular community visits, mobilization, and awareness programmers/health check-up camps, which helped to establish good rapport with migrant community. Respondents were selected randomly, based on their interest and willingness

to participate in the study, their convenience to spare approximately 40 minutes to respond to the questionnaire, and their language skills either Hindi or Marathi to answer questions. Migrant were excluded from data collection whose language was not Hindi or Marathi. Data collection happened during August 2013-April 2014. See figure 11 for the processes followed during data collection.

Figure 11: Flowchart of Sequence of Data Collection



Challenges faced during the data collection of the study

- Data collection had to be done in alignment with working hours of migrants in 30 different sectors. The workers leave their house early in the morning and come back to their residence

late at night from work. The interviewers had to schedule their timing either early morning between 8-9 am or after 7 pm, and on Wednesdays since it is payment day and weekly off in labour markets.

- Language barriers: Nashik experiences intrastate and interstate migration. Migrants from South India, or Odisha did not understand either Hindi or Marathi since they were not Hindi/Marathi speakers.
- Bias of the migrant community due to regional issues raised by political parties such as Maharashtra Navnirman Sena and Shiv Sena affected their response to the study, as they are hesitant to give the details about their citizenship.
- Migrants' employers like contractors did not allow their migrant employees to participate in study as they feared that researchers might educate migrants about their rights and empower workers to unite and make demands.

- Expectation of the migrant community for immediate support i.e. access to doctors or support for them to access social security services.

RESEARCHER INTERVIEWING MIGRANT WORKERS IN A STONE QUARRY	RESEARCHER INTERVIEWING MIGRANT WORKERS, A GROUP DISCUSSION BEFORE THE INTERVIEW
	

Photo credit: Anjali Borhade

Data Analysis

Statistical analysis was conducted using SPSS (version 22, IBM Inc.). Bi-variate comparisons of data were done between intra and interstate migrants using Chi-square and Fisher Exact tests (if the value in cells was ≤ 5) to obtain *P*-values (α = 0.05). Based on these multivariate models were created using unconditional logistic regression to obtain odds ratios (ORs) and 95% confidence intervals (CIs).

Measures

Migrants' were categorized according to their state of origin as (i) Maharashtra (Intrastate) and (ii) Non- Maharashtra (Interstate). Maharashtra migrants were defined as those who lived in Maharashtra state including any block or district, and whose native language is Marathi; Non-Maharashtra migrants were defined as migrants who were from out of Maharashtra state and whose local language was other than Marathi.

Access to general health care

The outcome variables related to availability of medical care, services provided by the government health worker, source of medical care, etc. were included. Socio-economic and demographic characteristics were considered as independent variables.

Individual level independent variables were respondent's age (categorized as 1 = below 20 years, 2 = 21–30 years, 3 = 31–40 years, 4 = 41–50 years; 5= above 50 years), social class (1 = scheduled caste, 2 = scheduled tribe, 3 = other backward castes, 4 = uncategorized castes), Family income (1 = below Rs.5000, 2 = Rs 5001–Rs. 8000, 3 = Rs. 8001–Rs.12000; 4= above Rs.12000), Education (Primary = Class 1-5; Upper Primary = Class 6-8; Secondary = Graduate & More= Above Class 12), Possession of Ration and Voter card(1 = Yes, 2= No), Health worker informs about govt. Programmes(1= Yes; 2= No; 3= Sometimes), Possession of medical care/health insurance

coverage(1= Yes; 2= No), Availability of basic amenities at health facility(1= Yes; 2= No; 3= Don't Know), Heath systems responsiveness(1= Always; 2= Usually; 3= Sometimes; 4= Never)

Access to mother and child health care

The outcome variables considered were odds of a mother receiving ANC and likelihood of a mother delivering the child at a health facility. Socio-economic and demographic characteristics were considered as independent variables. Individual level independent variables were respondent's (mother's) age (categorized as 1 = below 20 years, 2 = 21–30 years, 3 = 31–40 years, 4 = 41–50 years; 5= above 50 years), age at first delivery (1 = delivered at or when younger than 18 years; 2 = delivered at 19 years or later), last delivery place (1 = home; 2 = Institution), last delivery type (1 = Caesarean, 2 = Normal) and parity (1 = one pregnancy;2 = two pregnancies, 3 = three or more pregnancies); social class (1 = scheduled caste, 2 = scheduled tribe, 3 = other backward castes, 4 = uncategorized castes).

RESULTS

Results are divided into two categories-

1. Migrants and access to health care,
2. Migrant women and their access to mother and child health care

1. RESULTS- MIGRANTS AND ACCESS TO HEALTH CARE

1.1 Demographic characteristics of the Interstate and Intrastate Migrants, Nashik

Table 5 summarizes the socio-economic and demographic characteristics of the study population. A total of 4002 migrants were surveyed, out of which 2357 were intrastate migrants i.e. from within Maharashtra and 1645 were interstate migrants i.e. from the various states of India other than Maharashtra.

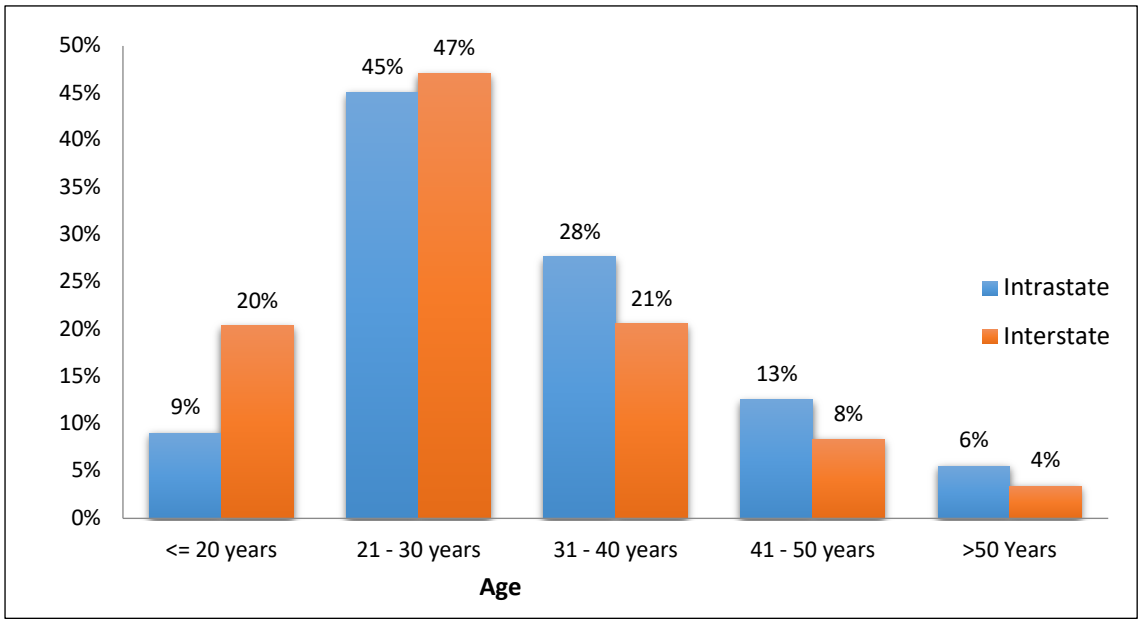
Table 5: Basic Demographics of Interstate and Intrastate Migrants, Nashik.

Basic Demographics and Living Status	Total	Origin		*P*-value
		Maharashtra	Non-Maharashtra	
N	**4002**	**2357**	**1645**	
Age	**4002**			
<= 20 years	549	214 (9.1)	335 (20.4)	<0.001
21 - 30 years	1837	1062 (45.1)	775 (47.1)	
31 - 40 years	993	654 (27.7)	339 (20.6)	
41 - 50 years	435	296 (12.6)	139 (8.4)	
>50 Years	188	131 (5.6)	57 (3.5)	
Gender	**4002**			
Male	2742	1440 (61.1)	1302 (79.1)	<0.001
Female	1260	917 (38.9)	343 (20.9)	
Caste/ Social Category	**4002**			
ST	1565	1106 (46.9)	459 (27.9)	<0.001
SC	754	588 (24.9)	166 (10.1)	
OBC	1079	444 (18.8)	635 (38.6)	
Others	604	219 (9.3)	385 (23.4)	
Religion	**4002**			
Hindu	3835	2341 (99.3)	1494 (90.8)	<0.001
Muslim	150	10 (0.4)	140 (8.5)	
Sikh	6	1 (0.0)	5 (0.3)	
Christian	11	5 (0.2)	6 (0.4)	
Education	**2348**			
Primary	665	381 (30.6)	284 (25.7)	<0.001
Upper Primary	672	294 (23.6)	378 (34.2)	
Secondary	882	472 (37.9)	410 (37.1)	
Graduate & More	129	97 (7.8)	32 (2.9)	
Family Income	**4002**			
<5000	1281	642 (27.2)	639 (38.8)	<0.001
5001-8000	1473	903 (38.3)	570 (34.7)	
8001-12000	918	611 (25.9)	307 (18.7)	
>12000	330	201 (8.5)	129 (7.8)	
Occupation	**4002**			
Daily Wage labourer	2783	1727 (73.3)	1056 (64.2)	<0.001
Not working	177	121 (5.1)	56 (3.4)	
Others (self-employed)	1042	509 (21.6)	533 (32.4)	

*P-values are calculated using Chi-square test or Fisher-exact test (if number in any cell of table is <5)

The age composition of migrants, both in the intrastate and interstate groups showed that majority of migrants were less than 30 years of age. (21 to 30 years - 45.9%; $P< 0.001$). More than 50% of the migrant population was male and below 30 years old. There were more young interstate migrants (20% below 20 years and 47% between 21 to 30), as within Maharashtra there was significant but lower proportion of those who migrated beyond 30 years of age as well (27% in 30-40 years) (see figure 12). Majority of migrants had completed their primary and secondary education (primary 30% & 25%, secondary 37%; $P< 0.00$). Most of them were working as daily wage labourer (Intrastate 73% Interstate 64%; $P< 0.001$) and earning monthly between Rs 5000-8000 (Intrastate 38% Interstate 34%;$P< 0.001$).

Figure 12: Age Group of Study Population

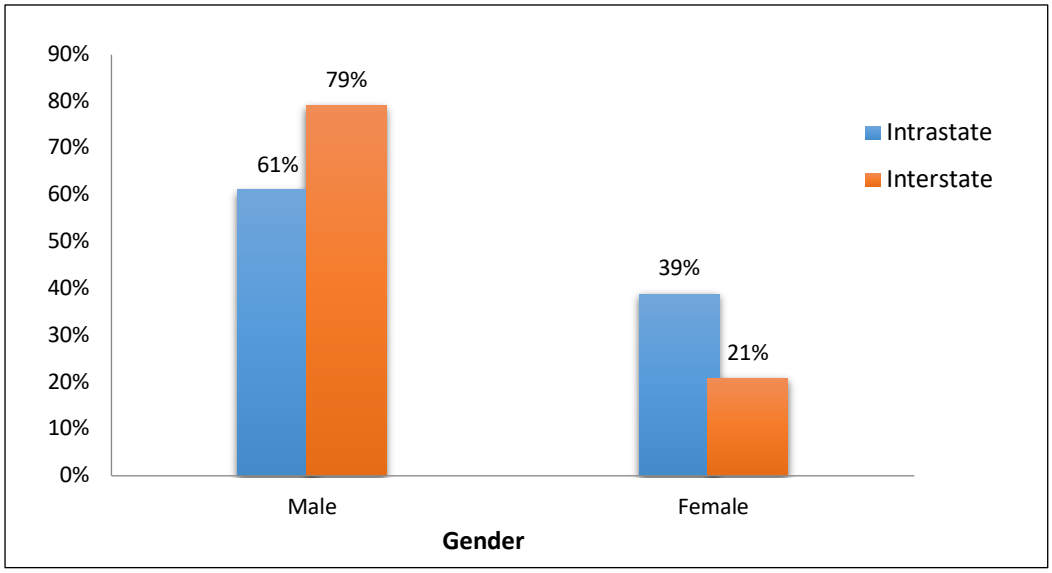


Gender

61% of intrastate migrants were male compared to 79% from outside Maharashtra. Reasons for their migration (see table 5). 97% of those questioned said it is for livelihood and better income.

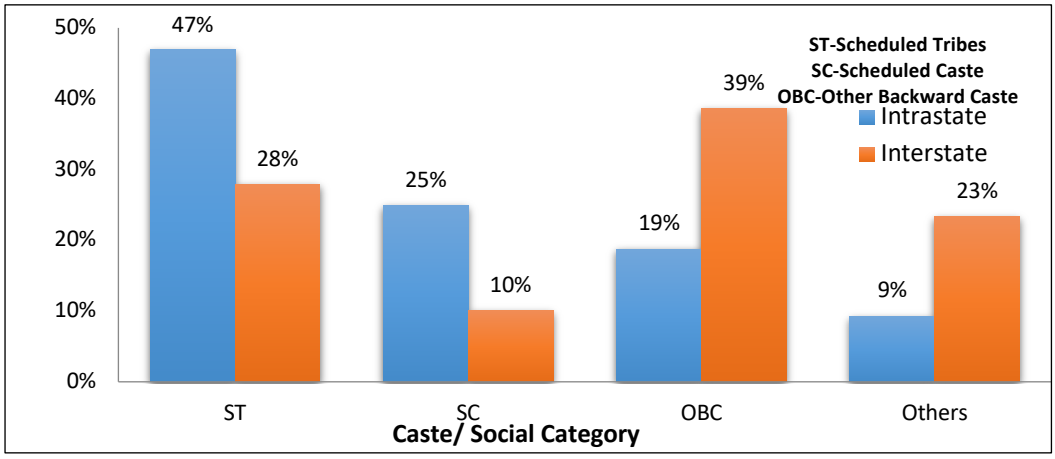
Females appeared to migrate less for livelihood especially when migration was interstate, 21% as against 39% of intrastate migrants.

Figure 13: Gender of Study Population



Social categories

Figure 14: Caste/Social Category among Study Population



47% of the intrastate migrants belonged to scheduled tribes category while among interstate migrants there were OBC's (39%) and scheduled tribes (28%) *(P*<0.001) (see figure 14). There

was not much difference in the religious composition, as both groups were mainly Hindus, 99% in intrastate and 90.8% in interstate migrants (P<0.001).

In this survey migrants belonged to different origin states. 63% were from within Maharashtra, other states were UP (10%), Bihar (4.8%), Gujarat (4.4%) and Bengal (3.7%). 59% spoke Marathi as the Maharashtra group formed a high proportion of the sample. Among the inter-state migrants, the common languages were Hindi (18%), Bhojpuri (4%), Gujarati (4%), Bengali (4%) and Tamil (1%).

Housing

Both intra and interstate migrants resided mostly in migrant camps (Table 6), the percentage being greater among interstate group (71%). The greater concentration of these migrants were in non-notified slums, the residence in notified slums being minimal (0.7-1%).40% of both the groups lived in kutcha houses and partially kutcha structures which are mainly formed with mud or tin sheds. The non- Maharashtra migrants were also more dependent on kerosene for fuel. See pictures 1 to 13 for living and working situations of study population.

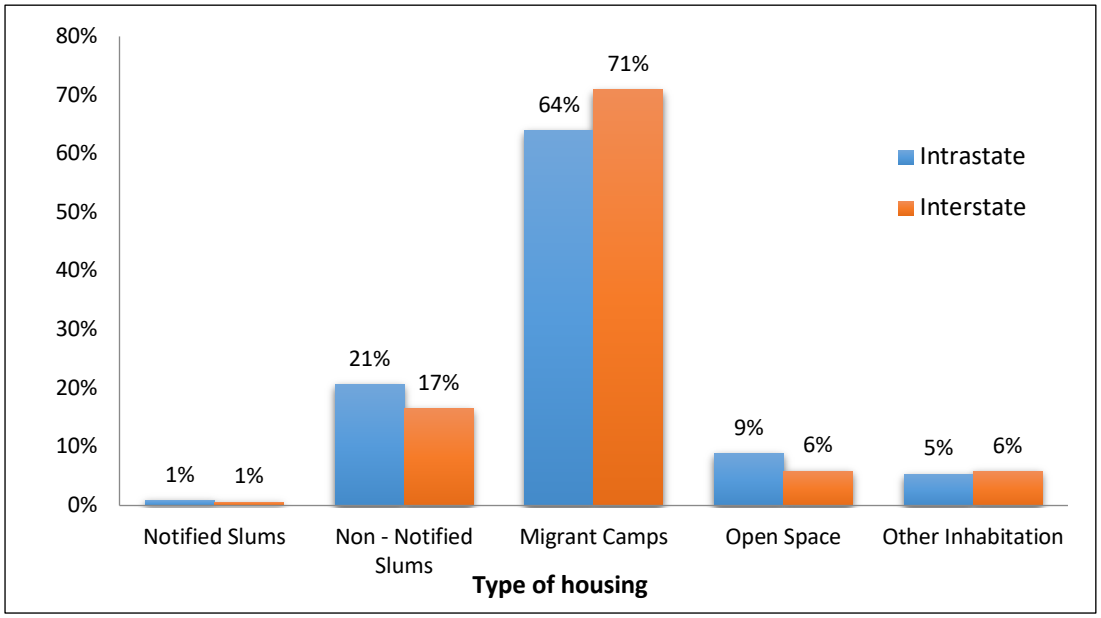
Table 6: Housing Characteristics of Interstate and Intrastate Migrants, Nashik.

Housing Characteristics	Total	Origin		*P*-value
		Maharashtra	Non-Maharashtra	
N	**4002**	**2357**	**1645**	
Type of Slum	**4002**			
Notified Slums	35	24 (1.0)	11 (0.7)	<0.001
Non - Notified Slums	760	488 (20.7)	272 (16.5)	
Migrant Camps	2675	1508 (64.0)	1167 (70.9)	
Open Space	307	209 (8.9)	98 (6.0)	
Other Inhabitation	225	128 (5.4)	97 (5.9)	
Type of House	**4002**			
Squatter hut	733	527 (22.4)	206 (12.5)	<0.001
Katcha house	1664	984 (41.7)	680 (41.3)	

Semi pucca house	954	499 (21.2)	455 (27.7)	
Pucca house	395	197 (8.4)	198 (12.0)	
Open space	256	150 (6.4)	106 (6.4)	
House Ownership	**4002**			
Own house	264	197 (8.4)	67 (4.1)	<0.001
Rented	1048	601 (25.5)	447 (27.2)	
Free	2690	1559 (66.1)	1131 (68.8)	
Number of Rooms	**4002**			
1 room	3217	1928 (81.8)	1289 (78.4)	<0.001
2 rooms	710	404 (17.1)	306 (18.6)	
3 rooms	55	17 (0.7)	38 (2.3)	
4 or more rooms	20	8 (0.3)	12 (0.7)	
Separate Kitchen	**4002**			
Yes	726	390 (16.5)	336 (20.4)	0.002
No	3276	1967 (83.5)	1309 (79.6)	
Kitchen Place	**3276**			
In living room	2735	1623 (82.5)	1112 (85.0)	0.002
Open space	414	249 (12.7)	165 (12.6)	
Others	127	95 (4.8)	32 (2.4)	

*P-values are calculated using Chi-square test or Fisher-exact test (if number in any cell of table is <5)

Figure 15: Accommodation Type



Accommodation of Migrants - the Study Population in Nashik

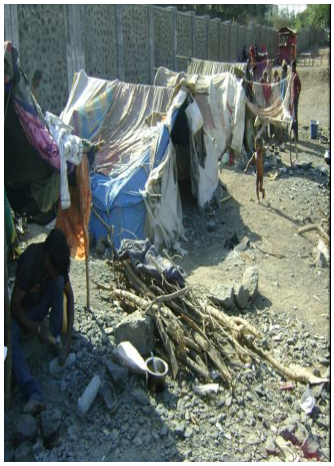
MIGRANTS LIVING ON OPEN SPACE IN NASHIK- HALT POINT-SATPUR AREA



MIGRANT'S LIVING ON OPEN SPACE IN NASHIK- HALT POINT-GANGAPUR AREA



MIGRANTS IN UNOFFICIAL SLUM AREA IN NASHIK



MIGRANT'S IN TEMPORARY SHELTER AT BRICKKILN SITE



TEMPORARY SHELTER OF MIGRANTS



CROWDED LIVING IN MIGRANTS CAMP- TYPICALLY 8-10 MEN IN ONE SMALL ROOM



Photo credit: Anjali Borhade

Access to Basic Amenities

Table 7 summarizes access to basic civic amenities amongst the migrants. 48% of intrastate and 44% of interstate migrant households did not have a private source of potable water and were dependent on public taps. Only 13% (intrastate) and 25% (interstate) migrants had piped water at

home. Sanitation facilities were poor as more than 85% of the intrastate migrants did not have separate toilets and 61% used open fields for defecation). However, more number of interstate migrants had separate toilets, 50% used community toilets. Although, migrant households had metered electricity connection (40-57%), 60% of the households were without sewers, highlighting the unhygienic living conditions the migrants lived in.

Table 7: Access to Basic Amenities of Interstate and Intrastate Migrants, Nashik.

Access to Basic Amenities	Total	Origin		*P*-value
		Maharashtra	Non-Maharashtra	
N	**4002**	**2357**	**1645**	
Cooking Fuel	**4002**			
Gas	609	350 (14.8)	259 (15.7)	<0.001
Hearth	2032	1410 (59.8)	622 (37.8)	
Kerosine	1179	480 (20.4)	699 (42.5)	
Others	182	117 (5.0)	65 (4.0)	
Source of Portable Water	**4002**			
Piped water in the house	710	306 (13.0)	404 (24.6)	<0.001
Hand pump	619	293 (12.4)	326 (19.8)	
Public tap	1858	1138 (48.3)	720 (43.8)	
Tanker truck	48	43 (1.8)	5 (0.3)	
Others	767	577 (24.5)	190 (11.6)	
Separate Toilet	**4002**			
Yes	744	338 (14.3)	406 (24.7)	<0.001
No	3258	2019 (85.7)	1239 (75.3)	
Place of Defecation	**3258**			
Community toilet	1379	766 (37.9)	613 (49.5)	<0.001
Mobile toilets	12	7 (0.3)	5 (0.4)	
Open fields	1867	1246 (61.7)	621 (50.1)	
Drainage	**4002**			
Open drain	256	126 (5.3)	130 (7.9)	<0.001
Closed drain	1691	873 (37.0)	818 (49.7)	
No drainage	2055	1358 (57.6)	697 (42.4)	
Electricity Connection	**4002**			
Metered Connection	2756	1466 (62.2)	1290 (78.4)	<0.001
Drawn from street lights	119	64 (2.7)	55 (3.3)	
No Electricity	1127	827 (35.1)	300 (18.2)	
Possession of Ration Card	**4002**			

Yes	578	411 (17.4)	167 (10.2)	<0.001
No	3424	1946 (82.6)	1478 (89.8)	
Type of Ration Card	**578**			
Have that meant for BPL	329	243 (59.1)	86 (51.5)	0.238
Have that meant for APL	242	163 (39.7)	79 (47.3)	
Have other type of card	7	5 (1.2)	2 (1.2)	
Possession of voter ID	**4002**			
Have voter ID	733	490 (20.8)	243 (14.8)	<0.001
No voter ID	3269	1867 (79.2)	1402 (85.2)	

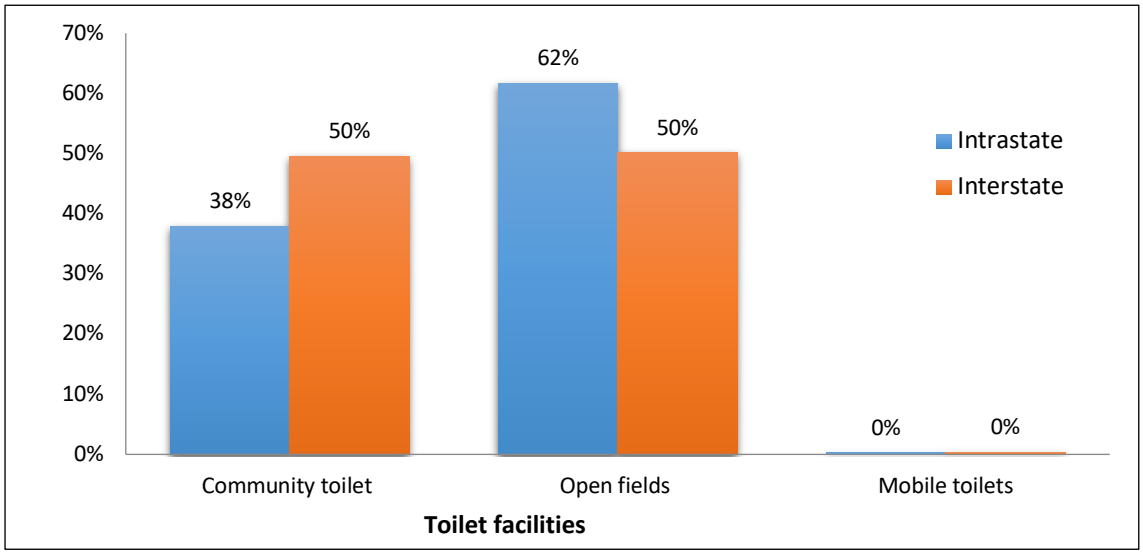
*P-values are calculated using Chi-square test or Fisher-exact test (if number in any cell of table is <5)

FACILITIES AT MIGRANT'S CAMP PROVIDED BY EMPLOYER AT CONSTRUCTION SITE IN NASHIK



Photo credit: Anjali Borhade

Figure 16: Toilet Facilities



Possession of local identification papers:

Both intra and interstate migrants were at a disadvantage if they did not possess PDS ration cards (83% and 90% respectively). Proof of identification is necessary to access basic necessities and 80% of intrastate migrants did not possess appropriate ID and the proportion was higher in the interstate group, 85%.

Figure 17: Possession of Type of Ration Card Among Those Who have Ration Cards

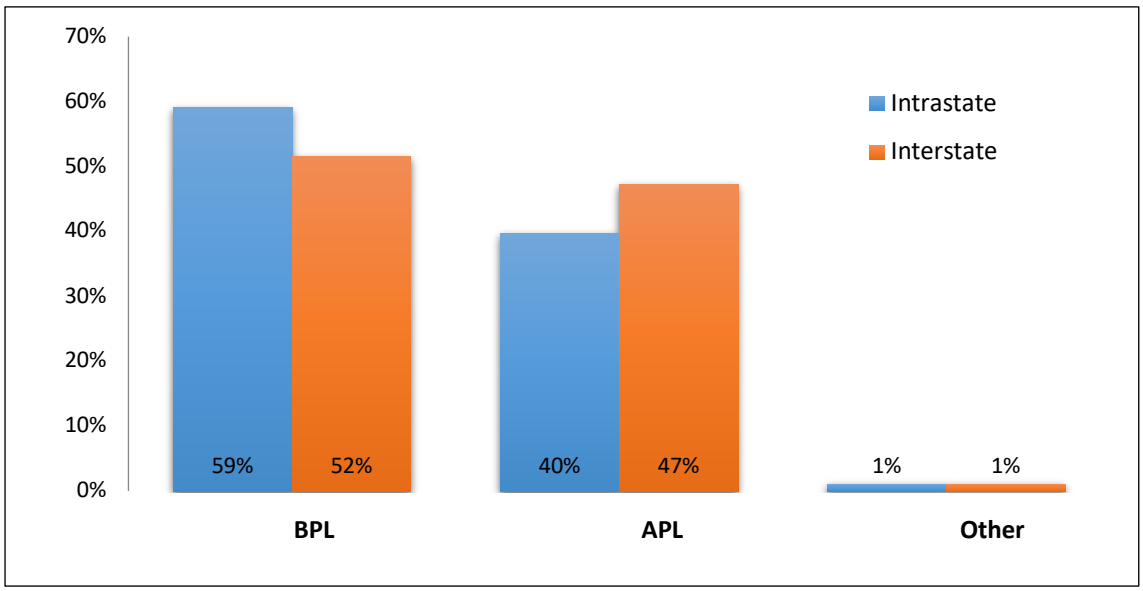
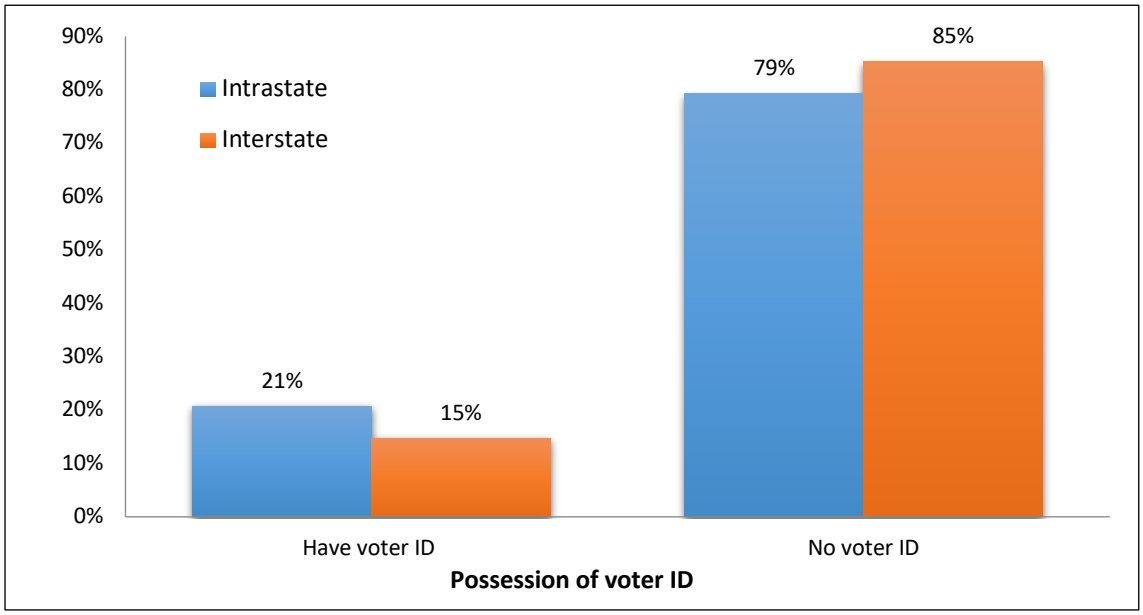


Figure 18: Possession of Voter Card



Social Networks in Urban Environment

Social networking is important to get settled in a new city. The study suggests that more than 60% migrants had relatives living in the same locality and a reference before coming to the city. Only 11% of intrastate migrants had access to a radio or read newspapers, whereas 18% of interstate migrants had radios and 12% read newspaper.

The data shows that 75% of intrastate and 73% interstate migrants did not have any civil society organizations where they lived. However, membership of community based organizations such as local Ganesh Mandal (religious organizations), was high – 46% and 30% in intra and interstate respectively. See table 8 for details.

Table 8: Social Networking amongst Interstate and Intrastate Migrants, Nashik

Social Networking	Total	Origin		*P*-value
		Maharashtra	Non-Maharashtra	
N	**4002**	**2357**	**1645**	
Social Networks	**4002**			
Have relatives in the city				
Yes	2599	1601 (67.9)	998 (60.7)	<0.001
No	1403	756 (32.1)	647 (39.3)	
Relatives lives	**2599**			
In same locality	2007	1188 (74.2)	819 (82.1)	<0.001
In other locality	592	413 (25.8)	179 (17.9)	
Have people in the locality from their native place	**4002**			
Yes	2413	1430 (60.7)	983 (59.8)	0.583
No	1589	927 (39.3)	662 (40.2)	
Community Based Organization	**4002**			
Yes	401	209 (8.9)	192 (11.7)	0.009
No	2965	1757 (74.5)	1208 (73.4)	
Don't Know	636	391 (16.6)	245 (14.9)	
Member of any CBO	**401**			
Yes	154	96 (45.9)	58 (30.2)	0.002
No	247	113 (54.1)	134 (69.8)	
Communication Channel				
TV : Possesses TV	**4002**			
Yes	1155	701 (29.7)	454 (27.6)	0.151
No	2847	1656 (70.3)	1191 (72.4)	
Radio : Possesses Radio	**4002**			
Yes	537	240 (10.2)	297 (18.1)	
No	3465	2117 (89.8)	1348 (81.9)	<0.001

Newspaper	**4002**			
Yes	445	249 (10.6)	196 (11.9)	0.198
No	3557	2108 (89.4)	1449 (88.1)	

*P-values are calculated using Chi-square test or Fisher-exact test (if number in any cell of table is <5)

1.2 RESULTS- ACCESS TO HEALTH CARE

Access to governmental health services among migrants is in Table 9. For most migrants (83% intrastate; 89% interstate) government health workers had never visited them with the most likely source of medical care for most migrants being a private doctor or hospital (84% intrastate and 88% interstate migrants). Slightly more intrastate migrants accessed government health facilities (12% vs. 8%; $P = 0.0013$). 95% migrants did not have any health insurance coverage. Walking to a health facility was most common among migrants with interstate migrants using public transport to access health facilities more than intrastate migrants (37.6% vs. 23.1%; $P = 0.014$). Among the 3629 respondents who reported reasons for not visiting a government health facility, majority (54.1%) reported bad quality of health services.

Table 9: Access to Government Health Services among Inter-State/ Intra State Migrants, Nashik

Access to Government Health Services	Total	Origin of Migrants		*P*-value
		Maharashtra	Non-Maharashtra	
N	**4002**	**2357**	**1645**	
Government health workers' services				
Government Health Workers' visit to the slum/area	**4002**			
Visited		289 (12)	117 (7)	
Never		1967 (83.5)	1461 (88.8)	<0.001
Don't know		101 (4.3)	67 (4.1)	
Whether health worker informs about govt. Programmes	**406**			
Yes		87 (30.1)	29 (24.8)	
No		174 (60.2)	80 (68.4)	0.290
Sometime		28 (9.7)	8 (6.8)	
Possession of medical care/health insurance coverage	**4002**			
Yes		108 (4.6)	86 (5.2)	0.389
No coverage		2249 (95.4)	1559 (94.8)	
Availability of medical care				
Usual source of medical care	**4002**			
Private doctor (qualified)/ Private hospital		1982 (84)	1445 (88)	
Unqualified practitioner		67 (3)	49 (3.0)	
Govt. health facility/ NGO/Trust hospital/ Other systems of medicine		285 (12)	135(8)	0.0013
Didn't have any usual source of care		23 (1.0)	16 (1.0)	
Travel to see govt. healthcare providers	**374**			
By walk		163 (58.0)	38 (40.9)	
By public transport		65 (23.1)	35 (37.6)	
By rickshaw/auto/cab		51 (18.1)	18 (19.4)	0.014
By own vehicle		2 (0.7)	1 (1.1)	
Others		0 (0.0)	1 (1.1)	
Reasons for not availing services from government health facility	**3629**			
Bad Behaviour of Staff	35	24 (1.2)	11 (0.7)	
Bad Health services	1963	1070 (51.5)	893 (57.5)	
Distance	932	613 (29.5)	319 (20.6)	<0.001
No Free Medicine	11	2 (0.1)	9 (0.6)	
No Need felt yet	197	112 (5.4)	85 (5.5)	
Other Issue with Centre	218	116 (5.6)	102 (6.6)	

Time Problem	273	140 (6.7)	133 (8.6)

*P-values are calculated using Chi-square test or Fisher-exact test (if number in any cell of table is ≤ 5)

Figure 19: Whether Government Heath Workers Visit the Locations of Study Population

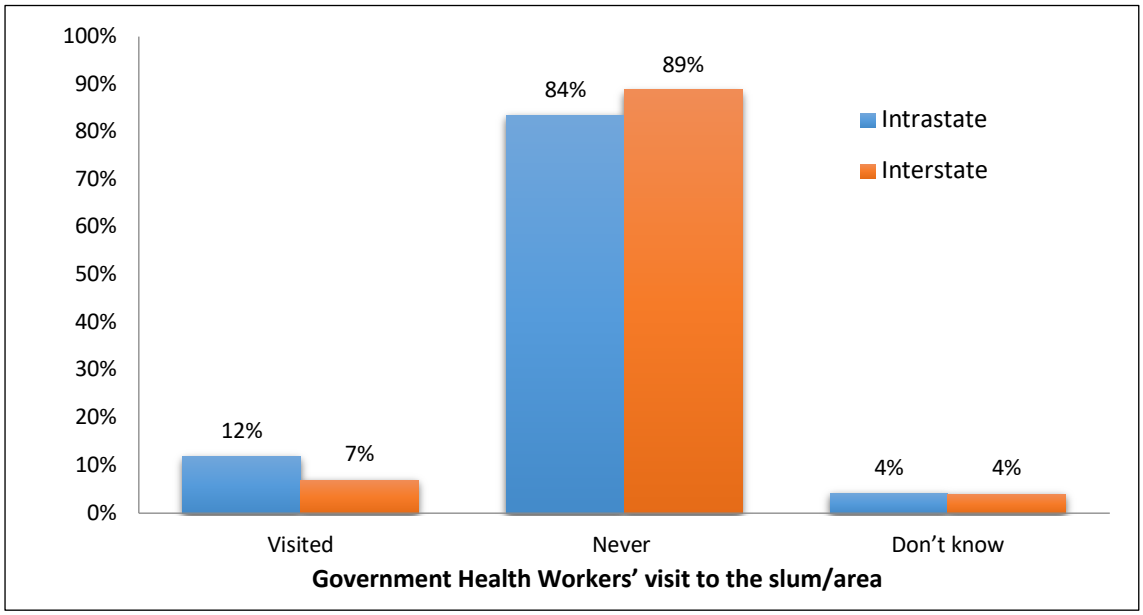


Figure 20: Possession of Medical Care/Health Insurance Coverage

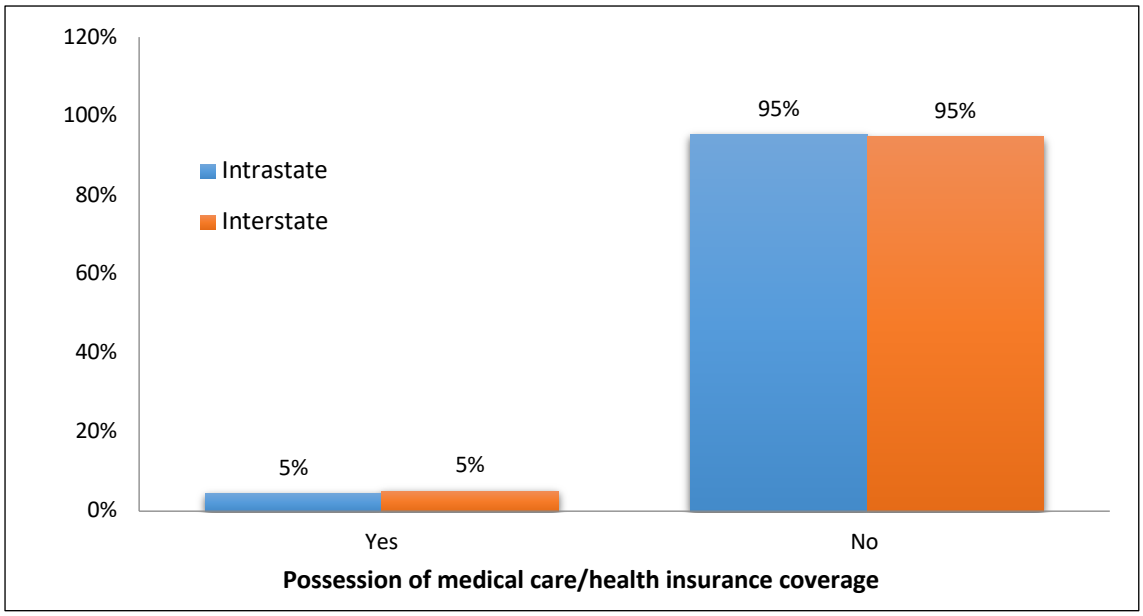
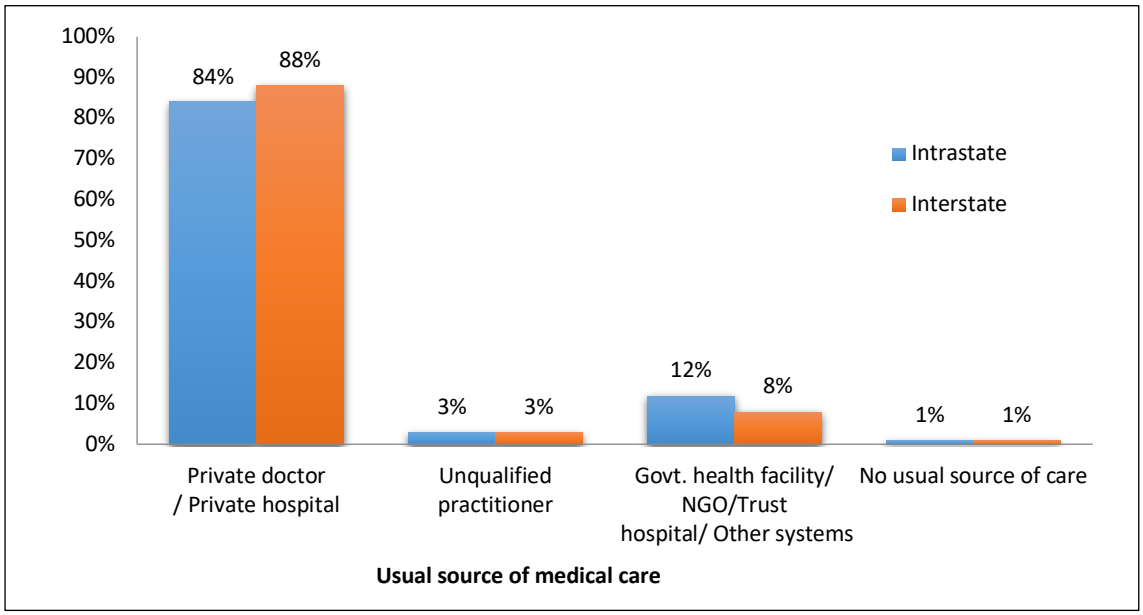


Figure 21: Source of Medical Care



1.3 QUALITY OF HEALTH SERVICES

The questionnaire assessed the quality of health services at the health facilities visited by the migrants (see Table 10). Majority of the migrants did not have any complaints about the various aspects that make up quality of health services at the facilities visited by them. A few notable issues were healthcare providers listened more carefully to intrastate migrants (71.1% vs. 65.2%; $P = 0.072$) and the explanations were more comprehensible to intrastate migrants (70.4% vs. 66.3%; $P = 0.001$). There was not any notable discrimination due to any particular cause among the migrants in the health facilities they visited (see Table 11).

Table 10: Quality of Health Care Services among Inter-State and Intra State Migrants, Nashik.

Quality of Health Access	Total	Origin of migrants		*P*-value
		Maharashtra	Non-Maharashtra	
N	**4002**	**2357**	**1645**	
Availability of basic amenities at health facility				
Availability of drinking water at health facility	**372**			
Yes	335	248 (88.6)	87 (94.6)	
No	4	4 (1.4)	0 (0.0)	0.200
Don't know	33	28 (10.0)	5 (5.4)	
Issues related to treatment at government health facility/difficulty and other issues in getting treatment				
Availability of free drugs/medicines at govt. health facility	**372**			
Yes	269	197 (70.4)	72 (78.3)	
No	45	36 (12.9)	9 (9.8)	0.337
Sometimes	58	47 (16.8)	11 (12.0)	
Heath systems responsiveness as reported by the respondents				
Treated with dignity	**372**			
Always	251	183 (65.4)	68 (73.9)	
Usually	69	57 (20.4)	12 (13.0)	0.207
Sometimes	35	25 (8.9)	10 (10.9)	
Never	17	15 (5.4)	2 (2.2)	
Privacy	**372**			
Always	239	178 (63.6)	61 (66.3)	
Usually	79	61 (21.8)	18 (19.6)	0.967
Sometimes	42	32 (11.4)	10 (10.9)	
Never	12	9 (3.2)	3 (3.3)	
Whether the healthcare provider listened carefully	**372**			
Always	259	199 (71.1)	60 (65.2)	
Usually	60	47 (16.8)	13 (14.1)	0.072
Sometimes	38	22 (7.9)	16 (17.4)	
Never	15	12 (4.3)	3 (3.3)	
How often healthcare providers explain things in a way you could understand?	**372**			
Always	258	197 (70.4)	61 (66.3)	
Usually	62	54 (19.3)	8 (8.7)	0.001
Sometimes	38	22 (7.9)	16 (17.4)	
Never	14	7 (2.5)	7 (7.6)	

*P-values are calculated using Chi-square test or Fisher-exact test (if number in any cell of table is ≤ 5)

Table 11: Perceived Discriminating Behaviour of Health Care Providers Due to Socioeconomic / Migration Status towards Migrants in Nashik

Perceived Discriminating Factors	Total	Origin of migrants		*P*-value
		Maharashtra	Non-Maharashtra	
N	**4002**	**2357**	**1645**	
Perceived discrimination due to your language	**4002**			
Yes	54	22 (0.9)	32 (1.9)	
No	2294	1309 (55.5)	985 (59.9)	<0.001
Can't say	1654	1026 (43.5)	628 (38.2)	
Perceived discrimination due to migrant status	**4002**			
Yes	103	64 (2.7)	39 (2.4)	
No	2239	1261 (53.5)	978 (59.5)	0.001
Can't say	1660	1032 (43.8)	628 (38.2)	
Perceived discrimination because you are poor/lack money	**4002**			
Yes	119	94 (4.0)	25 (1.5)	
No	2228	1235 (52.4)	993 (60.4)	<0.001
Can't say	1655	1028 (43.6)	627 (38.1)	
Perceived discrimination due to your place of origin	**4002**			
Yes	40	24 (1.0)	16 (1.0)	
No	2312	1309 (55.5)	1003 (61.0)	0.003
Can't say	1650	1024 (43.4)	626 (38.1)	
Perceived discrimination due to gender	**4002**			
Yes	23	21 (0.9)	2 (0.1)	
No	2330	1310 (55.6)	1020 (62.0)	<0.001
Can't say	1649	1026 (43.5)	623 (37.9)	

*P-values are calculated using Chi-square test or Fisher-exact test (if number in any cell of table is ≤ 5)

Figure 22: Reasons for Not Availing Government Health Services

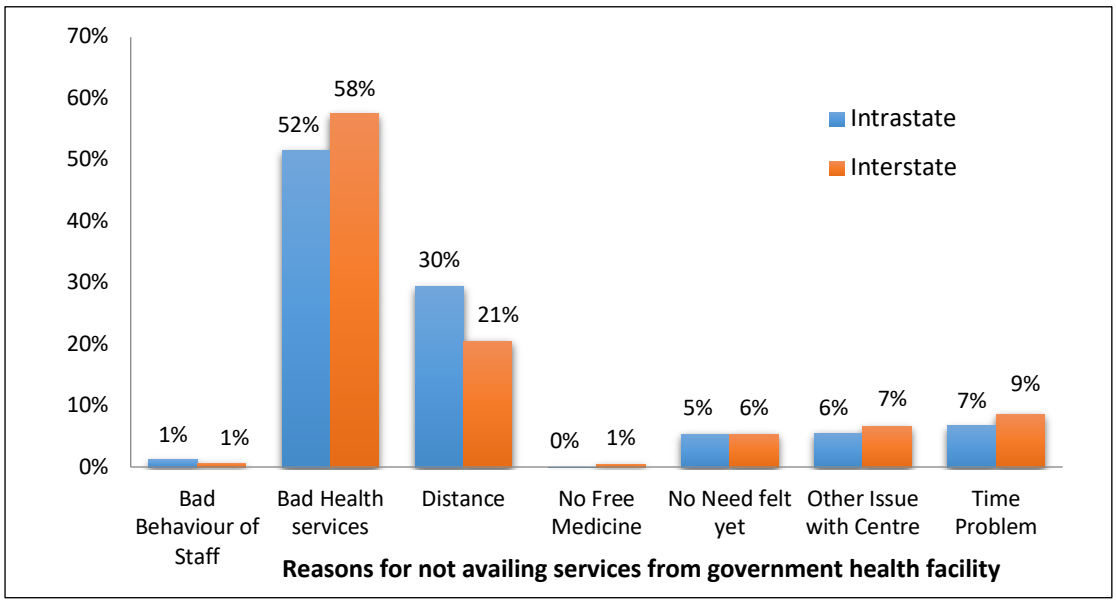


Table 12 includes the results of the logistic regression model comparing interstate and intrastate migrants in Nashik. Interstate migrants were less likely to be female (OR = 0.53; 95% CI = 0.45 – 0.62), more likely to belong to OBC/others category, more likely to live in a migrant camp (OR = 1.44; 95% CI = 1.06 – 1.97), more likely to access private healthcare (OR = 1.2; 95% CI = 0.93 – 1.56), less likely to be visited by health workers and more likely to be disrespected due to language (OR = 2.69; 95% CI = 1.40 – 5.19).

Table 12: Logistic Regression Comparing Migrants from Within Maharashtra with Those from Outside Maharashtra With Respect to Various Factors Related to Access to Care in Nashik

Variable	Un-Adjusted OR (95% CI)	*P*-value	Adjusted OR* (95% CI)	*P*-value
Age	0.97 (0.96, 0.97)	<0.001	0.97 (0.96, 0.97)	<0.001
Gender				
Female	0.41 (0.36, 0.48)	<0.001	0.53 (0.45, 0.62)	<0.001
Male	1		Reference Group	
Social Category				
ST	0.24 (0.19, 0.29)	<0.001	0.20 (0.16, 0.25)	<0.001
SC	0.16 (0.13, 0.20)	<0.001	0.17 (0.13, 0.22)	<0.001
OBC	0.81 (0.66, 1.00)	0.049	0.71 (0.57, 0.88)	0.002
Others	1		Reference Group	
Slum Type				
Migrant camp	1.02 (0.78, 1.34)	0.881	1.44 (1.06, 1.97)	0.021
Non-notified slum	0.74 (0.54, 0.99)	0.047	0.86 (0.61, 1.21)	0.389
Notified slum	0.60 (0.28, 1.29)	0.195	0.75 (0.32, 1.75)	0.511
Open space	0.62 (0.43, 0.88)	0.008	1.18 (0.79, 1.76)	0.419
Others	1		Reference Group	
Source of Healthcare				
Private	0.97 (0.77, 1.21)	0.779	1.20 (0.93, 1.56)	0.161
Government	0.54 (0.38, 0.77)	0.001	0.83 (0.54, 1.27)	0.380
Others	1		Reference Group	
Reason for Not Availing Government services				
Bad Health services	0.99 (0.73, 1.35)	0.974	0.90 (0.64, 1.27)	0.555
Distance	0.60 (0.43, 0.82)	0.002	0.72 (0.50, 1.03)	0.070
Other Issue with Centre	0.67 (0.48, 0.93)	0.017	0.74 (0.50, 1.07)	0.111
Time Problem	1.30 (0.89, 1.91)	0.169	1.31 (0.85, 2.00)	0.219
No Need felt yet	1		Reference Group	
Health Workers Visit Area				
Once in a year	1.35 (0.55, 3.32)	0.517	0.61 (0.22, 1.71)	0.352
Once in 6 months	0.09 (0.01, 0.71)	0.022	0.06 (0.01, 0.52)	0.010
Once in 3 months	0.20 (0.08, 0.50)	0.000	0.26 (0.10, 0.68)	0.006
Once in a month	0.69 (0.48, 0.99)	0.043	0.53 (0.35, 0.80)	0.002
Never	1.10 (0.83, 1.47)	0.512	0.69 (0.50, 0.96)	0.029
Don’t know	1		Reference Group	
Disrespect Due to Language				
Yes	2.38 (1.37, 4.13)	0.002	2.69 (1.40, 5.19)	0.003
No	1.23 (1.08, 1.40)	0.002	1.02 (0.88, 1.19)	0.768
Can't Say	1		Reference Group	

*Adjusted for all variables in this table.

2. RESULTS- MIGRANT WOMENS' ACCESS TO MOTHER AND CHILD HEALTH CARE

Demographics

Table 13 consists of the results of comparison socio-demographic factors between migrant women (total = 298) from intrastate (n = 176) and interstate (n = 122). The age composition of migrant women, both in the intrastate and interstate groups showed that majority of women were less than 30 years. (21 to 30 years - 73%). Majority of migrant women had completed their primary education (intrastate 41%, interstate 28%). Most of them were working as daily wage labourers (Intrastate 69% Interstate 73%) and earning a monthly income between Rs 5000-8000 per month (Intrastate 39% Interstate 37%).

Table 13: Socio-Demographic Profile of Migrant Women in Study Area of Nashik

Variables	Variable Categories	Maharashtra	Non-Maharashtra	*P*-value
N		176	122	
Age	21-30	130 (73.9)	89 (73.0)	
	31-40	18 (10.2)	15 (12.3)	
	41-50	6 (3.4)	1 (0.8)	0.516
	< 20	22 (12.5)	17 (13.9)	
	> 50	0 (0.0)	0 (0.0)	
Education	Primary	46 (41.4)	21 (28.0)	
	Upper Primary	26 (23.4)	33 (44.0)	0.028
	Secondary	36 (32.4)	20 (26.7)	
	Graduate & More	3 (2.7)	1 (1.3)	
Income	<5000	56 (31.8)	43 (35.2)	
	5001-8000	69 (39.2)	46 (37.7)	0.381
	8001-12000	42 (23.9)	22 (18.0)	
	>12000	9 (5.1)	11 (9.0)	
Occupation	Daily Wage labourer	122 (69.3)	89 (73.0)	
	Not working	28 (15.9)	8 (6.6)	0.035
	Others	26 (14.8)	25 (20.5)	
Religion	Hindu	173 (98.3)	108 (88.5)	0.003
	Muslim	2 (1.1)	11 (9.0)	
	Sikh	0 (0.0)	2 (1.6)	

	Christian	1 (0.6)	1 (0.8)	
Caste	SC	48 (27.3)	14 (11.5)	<0.001
	ST	95 (54.0)	43 (35.2)	
	OBC	28 (15.9)	46 (37.7)	
	Others	5 (2.8)	19 (15.6)	

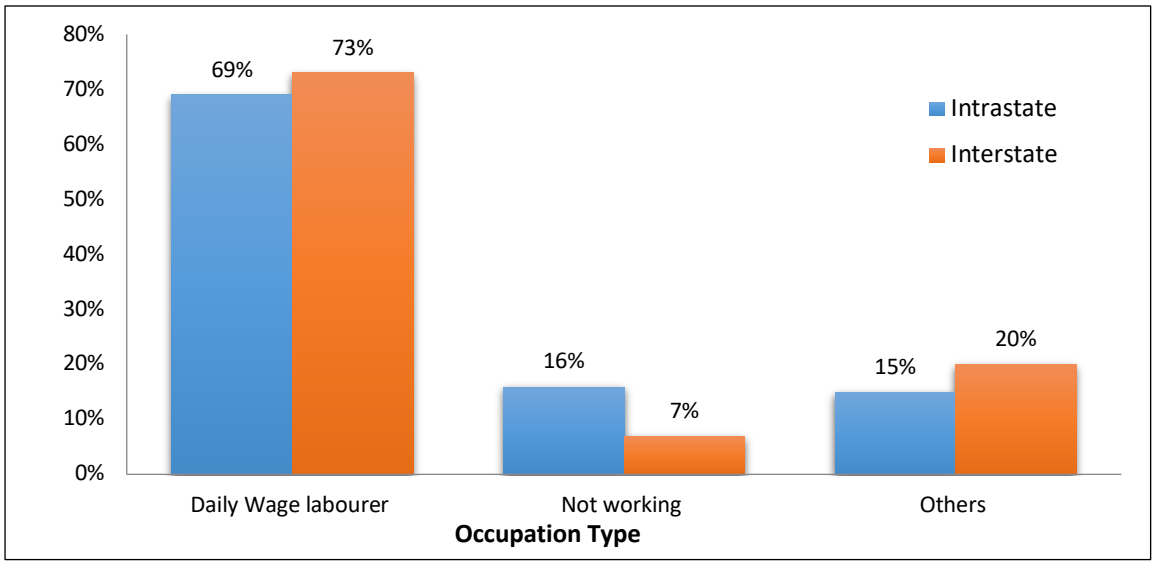
*P-values are calculated using Chi-square test or Fisher-exact test (if number in any cell of table is ≤ 5)

MIGRANT WOMAN WORKING IN A BRICK KILN



Photo credit: Anjali Borhade

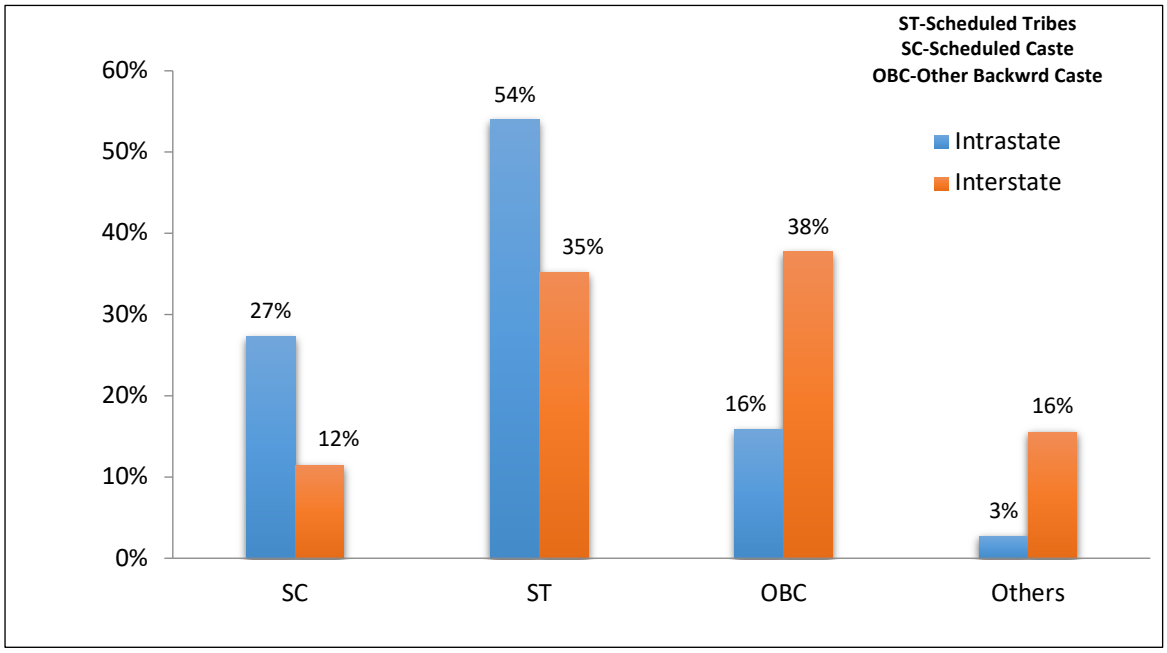
Figure 23: Occupation Type



Social categories

Among intrastate women, 54% belonged to scheduled tribe category, and 27% belonged to scheduled caste category; while among interstate migrants there were OBCs (37%) and scheduled tribe (35%) *(P*<0.001). There is hardly any difference in the religious composition, as both groups were mainly Hindus, 98% in intrastate and 88% in interstate migrants (*P*<0.003).

Figure 24: Caste/Social Category



Housing Characteristics

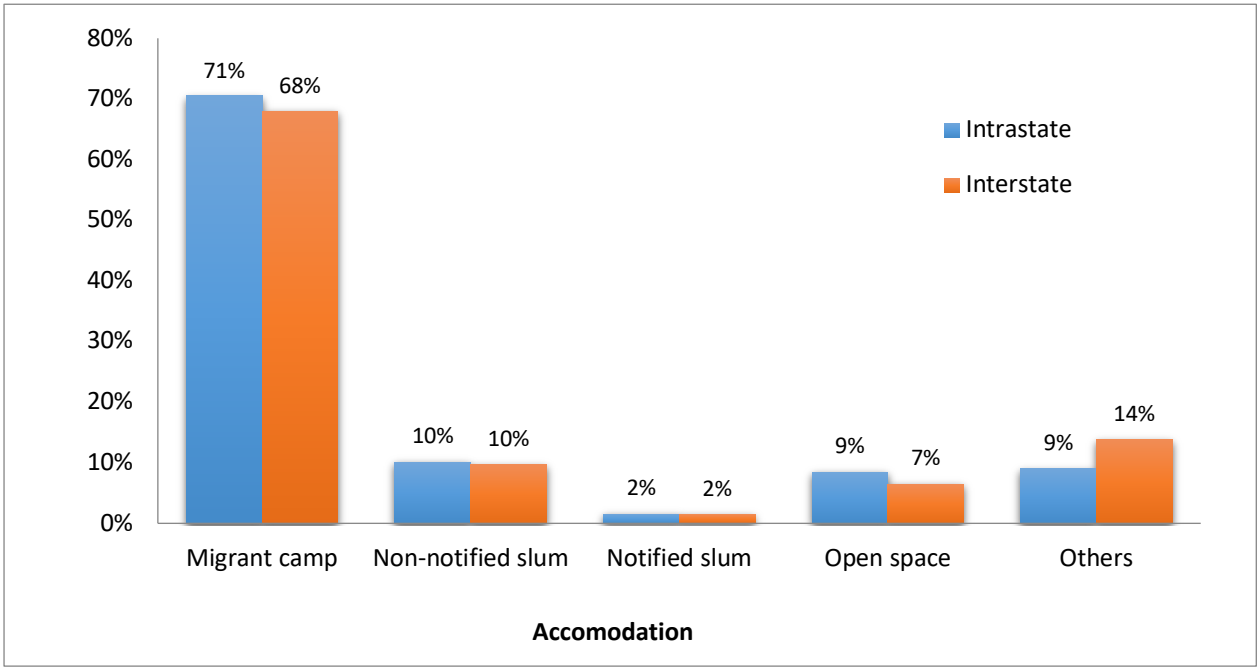
Both intra and interstate migrant women resided mostly in-migrant camps (Intrastate 70% Interstate (68%) (see Table 14), the percentage being greater among intrastate group (70%). 51% of intrastate and 46% of interstate women lived in kutcha houses, while 24% intrastate, and 21% interstate women lived in squatter hut.

Table 14: Housing Type and Access to Basic Amenities among Migrant Women in Study Area

Variables	Variable Categories	Maharashtra	Non-Maharashtra	*P*-value
N		176	122	
House type	Katcha	91 (51.7)	57 (46.7)	
	Open space	11 (6.2)	10 (8.2)	
	Pucca	10 (5.7)	3 (2.5)	0.148
	Semi Pucca	21 (11.9)	26 (21.3)	
	Squatter hut	43 (24.4)	26 (21.3)	
Slum type	Migrant camp	124 (70.5)	83 (68.0)	
	Non-notified slum	18 (10.2)	12 (9.8)	
	Notified slum	3 (1.7)	2 (1.6)	0.743
	Open space	15 (8.5)	8 (6.6)	
	Others	16 (9.1)	17 (13.9)	
Source of Portable Water	Piped water in house	29 (16.5)	29 (23.8)	
	Hand pump	31 (17.6)	29 (23.8)	
	Public tap	72 (40.9)	46 (37.7)	0.071
	Tanker truck	4 (2.3)	0 (0.0)	
	Others	40 (22.7)	18 (14.8)	
Defecation place	Community toilet	61 (41.5)	42 (41.6)	
	Mobile toilets	0 (0.0)	0 (0.0)	1
	Open field	86 (58.5)	59 (58.4)	
Drainage	Closed drain	62 (35.2)	43 (35.2)	
	No drain	97 (55.1)	64 (52.5)	0.756
	Open drain	17 (9.7)	15 (12.3)	
Voter ID	No	136 (77.3)	96 (78.7)	0.883
	Yes	40 (22.7)	26 (21.3)	
Ration Card	No	143 (81.3)	111 (91.0)	0.031
	Yes	33 (18.7)	11 (9.0)	
Ration Card Type	Other Type of Card	143 (81.2)	111 (91.0)	0.031
	Meant For APL	33 (18.8)	11 (9.0)	

*P-values are calculated using Chi-square test or Fisher-exact test (if number in any cell of table is ≤ 5)

Figure 25: Type of Accommodation



Access to Basic Amenities

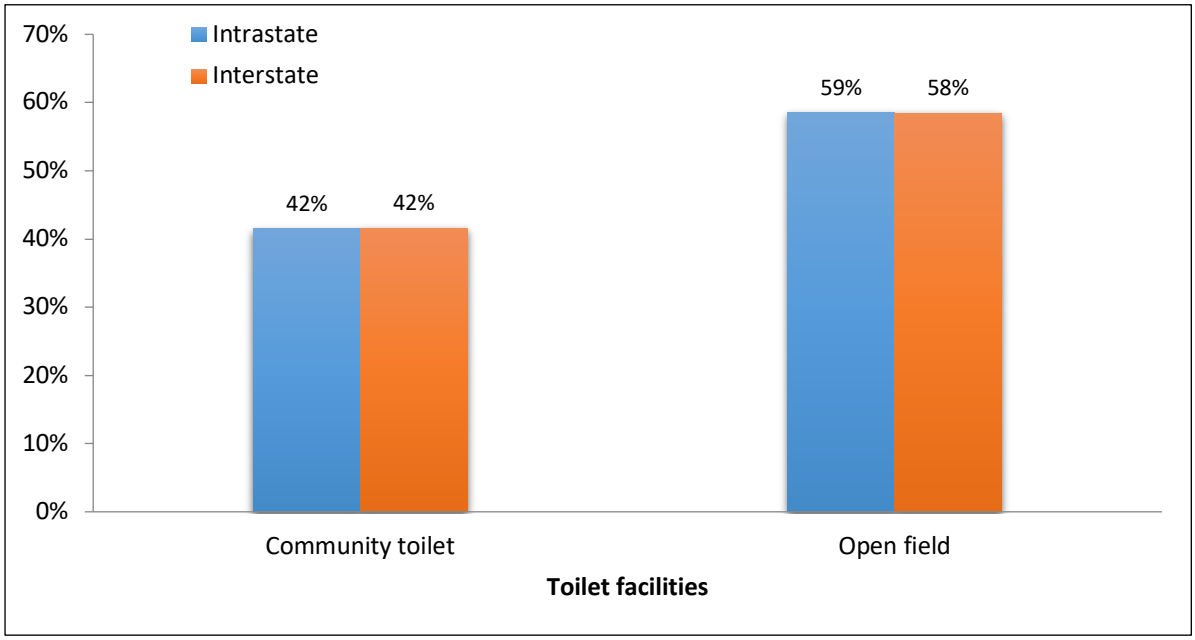
Table 14 summarizes access to basic civic amenities amongst study population. 48% of intrastate and 44% of interstate migrant women's households did not have a private source of potable water and were dependent on public taps. Only 16% (intrastate) and 23% (interstate) migrants had piped water at home. Basic sanitation facilities were poor - 41% migrant women had access to community toilets and 58% used open fields in both groups. No notable difference was found between the two categories of migrants with respect to age, house type, area of living etc.

MIGRANT WOMEN IN STONE QUARRY- NO PLACE TO RELAX DURING LUNCH BREAK



Photo credit: Anjali Borhade

Figure 26: Toilet Facilities



Possession of local identification

Both intra & interstate migrants were at a disadvantage of not possessing PDS ration cards (81% and 91 % respectively). Voter card is considered as important proof of identification and necessary to access basic necessities; 77% of intrastate, and 78% interstate women did not possess such ID.

2.2 MIGRANT WOMEN'S' ACCESS TO MCH CARE

In terms of access to MCH services among the two categories of migrant women (see Table 15) a higher proportion of migrant women from interstate had either one child or more than two children (P = 0.0009). Majority of women from both groups were not aware about existing MCH programmes, especially the availability of transport for pregnant women.

LACTATING MIGRANT MOTHERS WHO PARTICIPATED IN THE STUDY



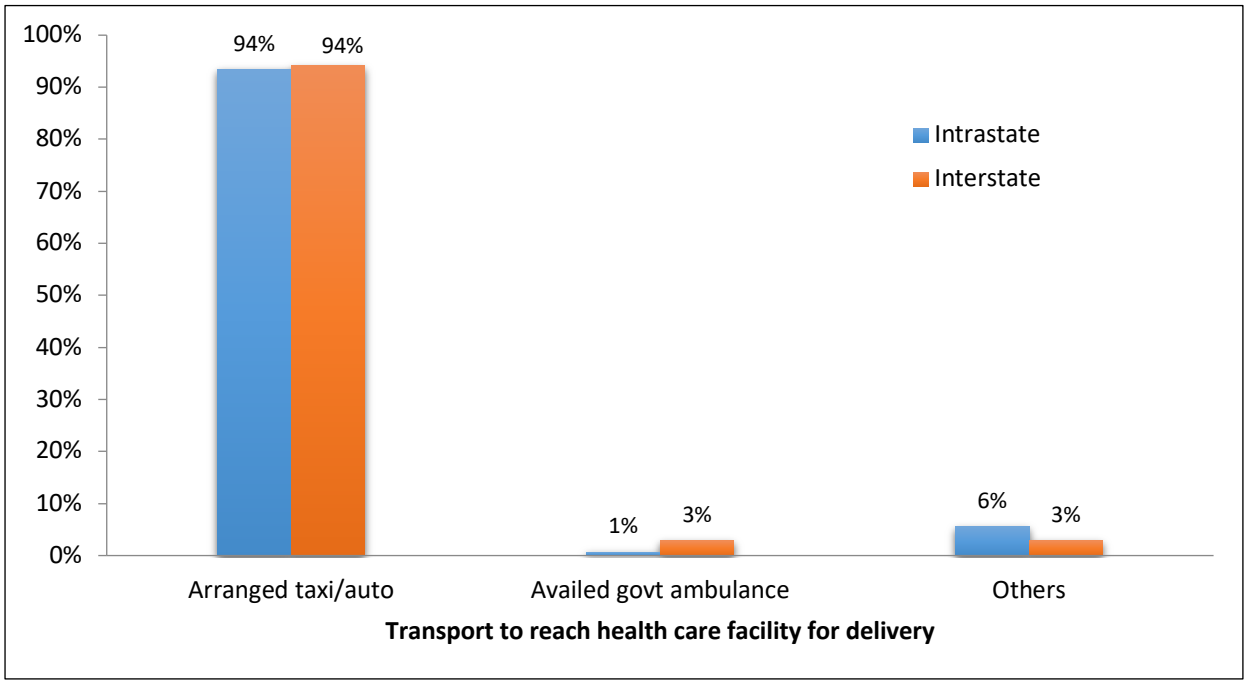
Photo credit: Anjali Borhade

Table 15: Access to Mother and Child Health Care Services among Migrant Women in Study Area of Nashik

Variables	Variable Categories	Maharashtra	Non-Maharashtra	*P*-value
Number of pregnancies	1	83 (47.2)	74 (60.7)	0.0009
	2	67 (38.1)	22 (18.0)	
	>2	26(15%)	26(21%)	
Age of first pregnancy	<= 18	58(32%)	35(29%)	0.598
	>18	126(68%)	87(71%)	
Last delivery place	Home	61 (34.7)	55 (45.1)	0.09
	Institution	115 (65.3)	67 (54.9)	
Last delivery type	Caesarean	7 (4.0)	4 (3.3)	0.998
	Normal delivery	169 (96.0)	118 (96.7)	
Last delivery stay	In both places	4 (2.3)	3 (2.5)	0.066
	In native place	111 (63.1)	92 (75.4)	
	In the city	61 (34.7)	27 (22.1)	
ANC	No	10 (5.7)	21 (17.2)	0.003
	Yes	166 (94.3)	101 (82.8)	
Source of ANC	Government	113(68%)	51(50%)	0.01
	Private	28(17%)	31(31%)	
	Others	25(15%)	19(19%)	
IFA received during ANC	No	14 (8.0)	22 (18.0)	0.015
	Yes	162 (92.0)	100 (82.0)	
Number of IFA received	< 60	141(87%)	90(90%)	0.471
	>= 60	21(13%)	10(10%)	
Tests performed during ANC (ALL)	No	97(9%)	141(19%)	0.0001
	Yes	959(91%)	585(81%)	
Information about anaemia during ANC	No	172 (97.7)	112 (92.6)	0.064
	Yes	4 (2.3)	9 (7.4)	
Other test during ANC	HIV	2 (66.7)	0 (0.0)	1
	Ultrasonography	1 (33.3)	1 (100.0)	
Getting TT injection during ANC	No	9 (5.1)	16 (13.2)	0.024
	Yes	167 (94.9)	105 (86.8)	

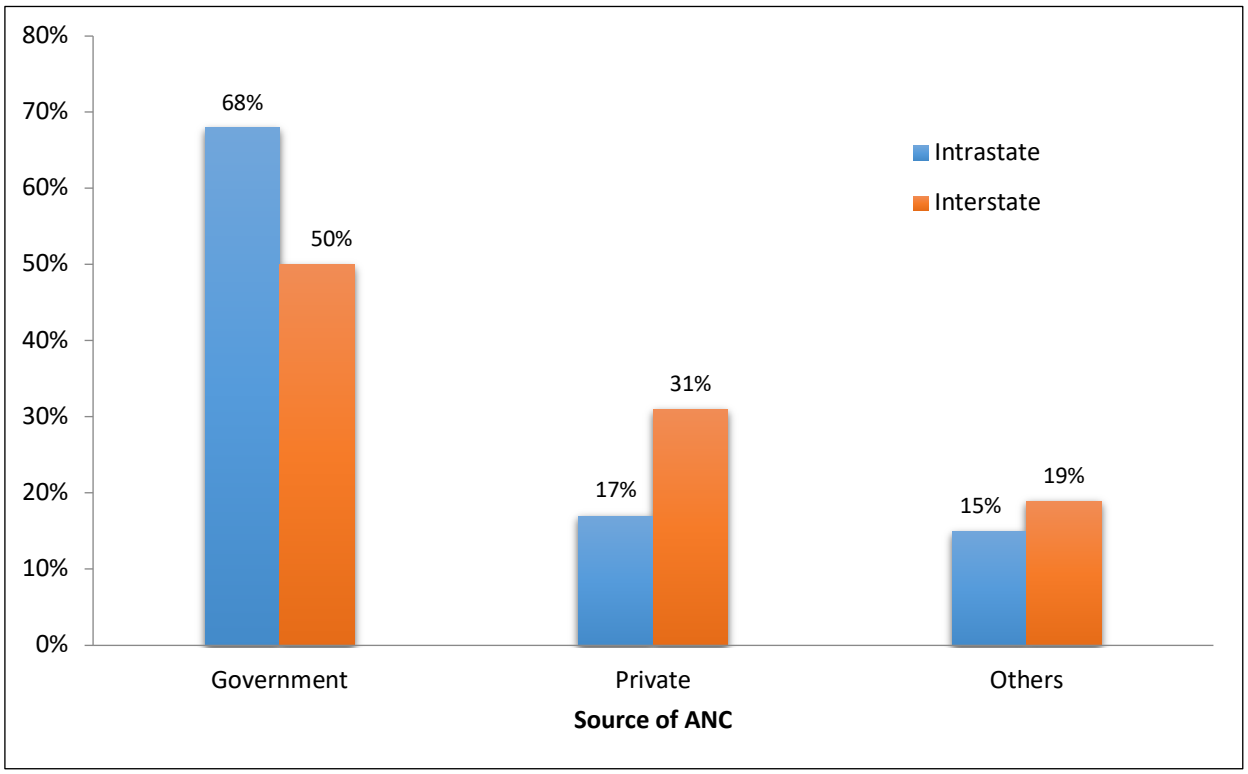
*P-values are calculated using Chi-square test or Fisher-exact test (if number in any cell of table is ≤ 5)

Figure 27: Awareness Among Study Population about the Government's Free Transport to Reach Health Facility for Delivery



Higher proportion of intrastate migrant women has availed antenatal care (ANC) compared to interstate migrant women (94.3% vs. 82.8%; *P* = 0.003). More intrastate migrant women had government facilities as their source of ANC (68% vs. 50%) while for most interstate women the source was private healthcare facilities (31% vs. 17%) (*P* = 0.01). More intrastate migrant women received iron and folic acid (IFA) compared to interstate migrant women (92% vs. 82%; *P* = 0.015). Also, more intrastate migrant women underwent all ANC tests compared to interstate women (91% vs. 81%; *P* = 0.0001) and received anti-tetanus injections (94.9% vs. 86.8%; *P* = 0.024).

Figure 28: ANC Source



Migrant women's perspective on quality of MCH care

On comparing the responses on quality of MCH services between intra and interstate migrant women (see Table 16), the notable information was that the preferred place for ANC check-up for intrastate migrant women was government health facilities (56.8% vs. 36.9%) while for interstate women it was home (44.3% vs. 29.5%) ($P = 0.022$). This trend was similar for preferred place of normal delivery. Intrastate women preferred government hospitals (53.8% vs. 35.3%) while interstate women preferred home (44.5% vs. 31.6%) ($P = 0.019$). Also, a higher proportion of interstate women reported that dignity was not maintained during delivery (43.4% vs. 29.5%; $P = 0.02$).

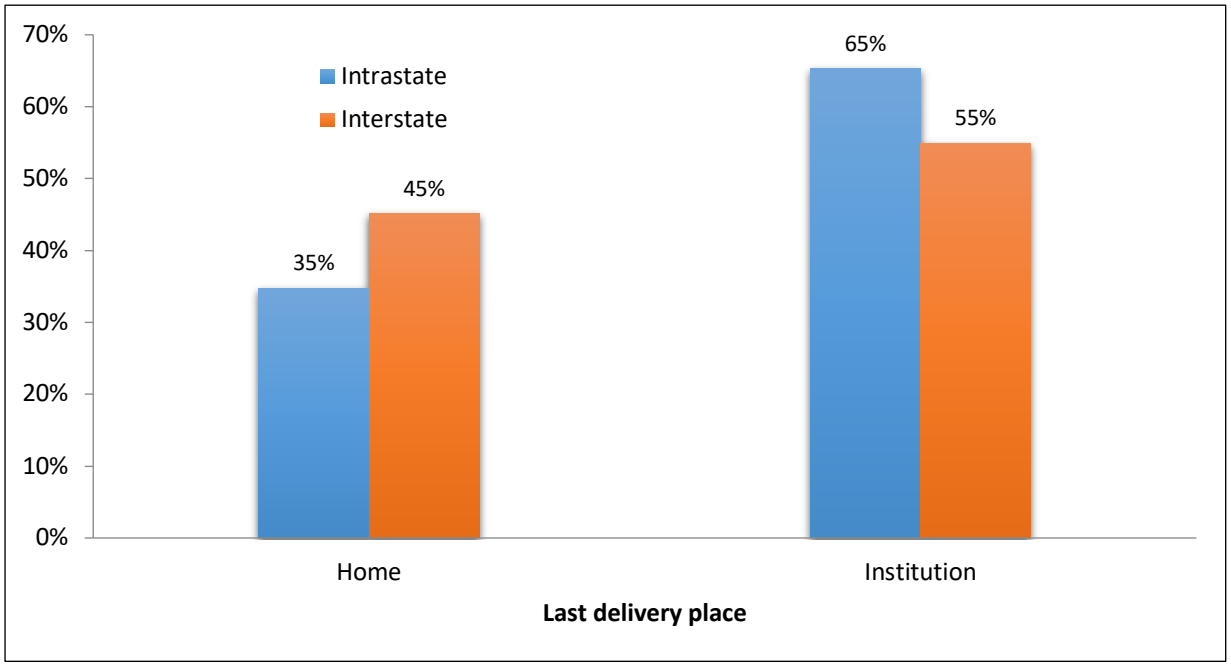
Table 16: Quality of Maternal and Child Health Care Services in Nashik

Variables	Variable Categories	Maharashtra	Non-Maharashtra	*P*-value
ANC wait time in minutes	<30	43(26%)	26(25%)	0.855
	>=30	124(74%)	79(75%)	
ANC waiting time is ok or not	It is bit more	12 (7.2)	9 (8.6)	0.315
	Too much waiting	16 (9.6)	16 (15.2)	
	Waiting time is ok	139 (83.2)	80 (76.2)	
ANC check-up time in minutes	<30	117(71%)	62(62%)	0.115
	>=30	47(29%)	38(38%)	
Time for ANC check-up is satisfactory or not	Not satisfied	84 (50)	57 (54%)	0.643
	Can't say	18 (10.8)	8 (7.6)	
	Satisfied	65 (38.9)	40 (38.1)	
Choice of health care provider for ANC check-up	A doctor	134 (80.2)	80 (76.2)	0.189
	A nurse	31 (18.6)	20 (19.0)	
	Others	2 (1.2)	5 (5)	
Dignity maintained during ANC	Always	149 (89.2)	98 (93.3)	0.422
	Never	2 (1.2)	0 (0.0)	
	Sometimes	2 (1.2)	2 (1.9)	
	Usually	14 (8.4)	5 (4.8)	
Preferred place for ANC check-up	Govt. hospital	100 (56.8)	45(36.9)	0.022
	Home	52 (29.5)	54(44.3)	
	Private. Hospital	24 (13.6)	23(18.9)	
Place of normal delivery	Govt. hospital	92 (53.8)	42 (35.3)	0.019
	Home	54 (31.6)	53 (44.5)	
	Non-governmental health facility	25(15%)	24(20%)	
Conveyance to reach health care facility for delivery	Arranged taxi/auto	116 (93.5)	64 (94.1)	0.374
	Availed govt ambulance	1 (0.8)	2 (2.9)	
	Others	7 (5.6)	2 (2.9)	

Promptness of hospital in delivery	With a lot of delay	1 (0.8)	0 (0.0)	0.19
	With some delay	1 (0.8)	3 (4.4)	
	Yes, I was attended immediately	122 (98.4)	65 (95.6)	
Hospital was clean or not during delivery	Clean	148 (84.1)	95 (77.9)	0.238
	Not clean	1 (0.6)	0 (0.0)	
	Somewhat clean	27 (15.3)	27 (22.1)	
Dignity maintained during delivery	No	52 (29.5)	53 (43.4)	0.02
	To some extent	5 (2.8)	6 (4.9)	
	Yes	119 (67.6)	63 (51.6)	
Health worker visited for postpartum care or not	No	144 (81.8)	107 (87.7)	0.227
	Yes	32 (18.2)	15 (12.3)	
Health worker gave postpartum care advice or not	No	41 (23.3)	38 (31.1)	0.169
	Yes	135 (76.7)	84 (68.9)	

*P-values are calculated using Chi-square test or Fisher-exact test (if number in any cell of table is ≤ 5)

Figure 29: Place of Last Delivery



Utilization of Immunization Services

On comparing utilization of immunization services for children of intrastate women and interstate women (see Table 17) there were no notable differences between the two categories. Majority of the children received immunization. Majority of mothers were aware of the immunization services.

Table 17: Utilization of Immunization Services among Migrant Women in Study Area of Nashik

Variables	Variable Categories	Maharashtra	Non-Maharashtra	*P*-value
Where the child parents approached for vaccination	Govt hospital	53 (31.7)	25 (22.5)	0.212
	Nearby health facility	79(47.3%)	60(54.1)	
	Others	35(21)	26(23)	
Awareness of child mother regarding vaccination	No	8 (4.6)	10 (8.3)	0.289
	Yes	167 (95.4)	111 (91.7)	
Child have vaccination card or not	Given but not found	5 (2.9)	2 (1.7)	0.592
	No	14 (8.0)	13 (10.7)	
	Yes	156 (89.1)	106 (87.6)	
Child received BCG at the time of birth	No	20 (11.4)	20 (16.5)	0.276
	Yes	155 (88.6)	101 (83.5)	
Child received OPV at the time of birth	No	20 (11.4)	21 (17.4)	0.201
	Yes	155 (88.6)	100 (82.6)	
Child received HEPB at the time of birth	No	20 (11.4)	22 (18.2)	0.142
	Yes	155 (88.6)	99 (81.8)	
Child received DPT1/OPV1/HEPB1 in first month	No	51(10%)	42(12%)	0.374
	Yes	474(90%)	321(88%)	
Child received DPT2/OPV2/HEPB2 in second month	No	63(12%)	52(14%)	0.310
	Yes	462(88%)	311(86%)	

Child received DPT3/OPV3/HEPB3 in third month	No	87(17%)	67(18%)	0.465
	Yes	438(83%)	296(82%)	
Child received measles	No	58 (33.1)	53 (43.8)	0.082
	Yes	117 (66.9)	68 (56.2)	
Child received VIT_A	No	58 (33.1)	54 (44.6)	0.06
	Yes	117 (66.9)	67 (55.4)	

*P-values are calculated using Chi-square test or Fisher-exact test (if number in any cell of table is ≤ 5)

Figure 30: Mother's Awareness Regarding Vaccination

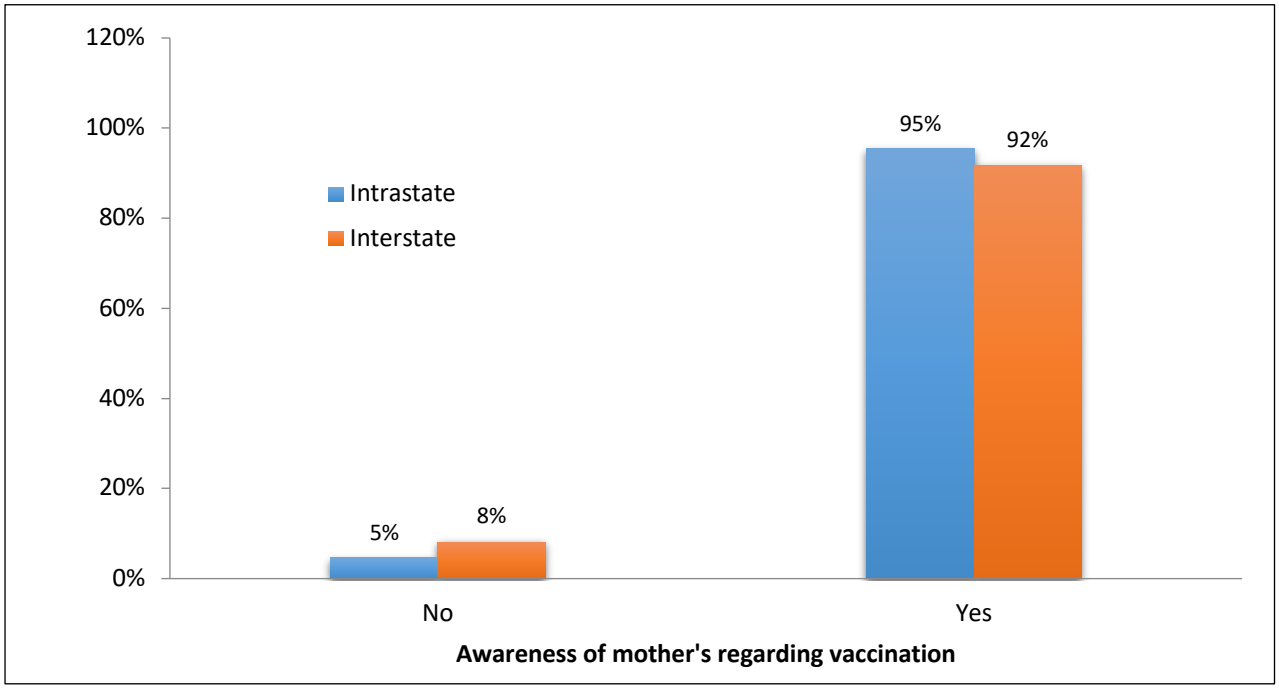


Table 18 depicts results of the multivariate logistic regression comparing intrastate and interstate migrant women. There was a lower likelihood of OBC (OR = 0.08; 95% CI = 0.03, 0.26) and ST (OR = 0.07; 95% CI = 0.02, 0.23) populations compared to other social groups among interstate migrant women. Also, interstate women had a lower likelihood of receiving ANC compared to intrastate women (OR = 0.24; 95% CI = 0.08, 0.74).

Table 18: Logistic Regression Comparing Migrant Women from Within Maharashtra with Those from Outside Maharashtra With Respect to Various Factors in Nashik

Variable	Un-Adjusted OR (95% CI)	*P*-value	Adjusted OR* (95% CI)	*P*-value
Age	1.01 (0.97, 1.06)	0.541	0.99 (0.94, 1.05)	0.770
Social Category				
ST	0.12 (0.04, 0.34)	<0.001	0.08 (0.03, 0.26)	<0.001
SC	0.07 (0.02, 0.24)	<0.001	0.07 (0.02, 0.23)	<0.001
OBC	0.43 (0.15, 1.28)	0.132	0.37 (0.12, 1.16)	0.091
Others	1		Reference Group	
Slum Type				
Migrant camp	0.63 (0.30, 1.32)	0.219	0.93 (0.40, 2.17)	0.865
Non-notified slum	063 (0.23, 1.71)	0.361	0.92 (0.29, 2.85)	0.887
Notified slum	0.63 (0.09, 4.25)	0.633	2.13 (0.28, 15.89)	0.459
Open space	0.50 (0.17, 1.50)	0.218	0.82 (0.23, 2.93)	0.764
Others	1		Reference Group	
Defecation Place				
Open field	0.95 (0.49, 1.82)	0.871	1.19 (0.55, 2.58)	0.659
Community toilet	0.95 (0.48, 1.89)	0.885	0.96 (0.44, 2.11)	0.923
Others	1		Reference Group	
ANC				
Yes	0.29 (0.13, 0.64)	0.002	0.24 (0.08, 0.74)	0.013
No	1		Reference Group	
IFA received during ANC				
Yes	0.39 (0.19, 0.80)	0.010	1.02 (0.34, 3.02)	0.976
No	1		Reference Group	
Delivery				
Institution	0.65 (0.40, 1.03)	0.070	0.77 (0.44, 1.36)	0.376
Home	1		Reference Group	

*Adjusted for all variables in this table.

DISCUSSION

Migrants and their access to health care

The results show that migrants to Nashik city were mainly young males and had primarily migrated to earn their livelihood, and usually worked as labourers in the informal sector (mainly construction, catering, etc.). The survey showed that interstate migration was higher among scheduled tribe (ST) population followed by scheduled caste (SC), while a higher proportion of other backward caste (OBC) social groups were migrating to Nashik from other states.The results identified that STs formed a high proportion of the migrants and this appears to correlate other studies highlighting the issue of distressed ST migration[31,175]. This needs further examination, specifically in Maharashtra where the rates seemed higher for Nashik. Maharashtra is an economically advanced state and therefore local people from weaker social groups found livelihood opportunities within the state, while people migrating from lesser developed states such as Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan were more likely to belong to relatively stronger social groups (still weak but not as weak as SCs or STs). This provides some credence to the hypothesis that there might be an inherent inequity even within migration in that the very weak sections of migrants have only enough resources to migrate within the state while relatively better of social sections can have resources to migrate outside the state. This is an observation that needs to be further verified in future studies and other settings.

Studies have shown that large scale migration from rural to urban areas had resulted in increased pressure on housing and public resources in Indian cities[205]. The results appeared to reinforce this as the majority of migrants lived in slums which were non-notified and non- regularized or open spaces. They had no access to sewer drains, piped water and had congested and poorly ventilated houses with only unclean fuel like kerosene available for cooking and no access to toilets which posed serious health hazards for this group. Such poor-quality accommodation does not come

under either rented/owned category, but are illegally occupied free residences. Most of these houses consists of a single room with no separate kitchens and no clean fuels. There were no significant differences in living condition of intra and interstate migrants in this study and both categories of migrants were living in poor circumstances. These findings are consistent with other studies[177,196,206].

Both intra & interstate migrants were at a disadvantage of not possessing public distribution services (PDS) ration cards (83% and 90 % respectively). The Below Poverty Line (BPL) PDS ration card gives additional subsidies to the poor to obtain food grains and other essential commodities. Data shows that more intrastate migrants had managed to get a BPL ration card, than the interstate migrants. Despite the poor socio-economic profile, many interstate migrants were excluded from the BPL category. This deprives them of the BPL benefits, which they are entitled to. The basic means of food security were compromised as the migrants did not have ration cards and were unable to access PDS shops to get subsidized rice, wheat, etc. These findings are consistent with previous studies[30,169].

In India, local proof of identification (ID) is necessary to access basic necessities or services (such as access to rented housing, PDS services, electricity, hospitalization in government hospitals, education etc.) Study shows that 80% of intrastate migrants did not possess such ID and the proportion was higher in the interstate group, 85%, which means they were not eligible to access the basic services in Nashik city.

They did appear to have a strong social network in Nashik in the form of relatives and village acquaintances which appeared to be the key factor in their decision to migrate. Interaction with the outside world through newspapers, television etc. was limited. Non-government organizations/ community based organizations were also conspicuous by their absence in these areas.

The question whether there is presence of any community based organization in their locality, revealed that migrant localities lacked any presence of civil society organizations/non-governmental organizations to support and facilitate their integration and access as 75% of intrastate and 73 % interstate migrants did not have any civil society organizations where they lived. However, membership of community based organizations such as local Ganesh Mandal, was high – 46% and 30% in intra and interstate respectively. This may have been due to a misunderstanding of the term 'community based organizations' as membership of socio-religious local groups such as Ganapati Mandals where migrants participate in was the reason why the proportion of positive response to this question was high.

The survey has highlighted issues related to migration status, language barriers, lack of appropriate information and accessibility to social care and the paucity of organizations to support the migrants and ensure their rights, which acted as barriers to improve the conditions of the migrant population. Thus, it is important to review the policies for migrant protection and ensure appropriate interventions are put in place to improve the living conditions and support provided to them.

The utilization of government healthcare services by both intra and interstate migrants was low. Most migrant workers preferred private healthcare facilities over government facilities with distance to government health facility being cited as one of the main reasons. This is quite possible since most migrants lived in migrant camps (~67%) which are often away from main areas of the city where government health facilities are located. Thus accessing government health facilities even if the cost of healthcare might be lower, is not feasible for migrants. These findings are consistent with other studies, which concluded that migration led to diversified vulnerability among internal migrants[15,177,206]. The common determinants of health risks among migrants are the motivational factors and occupation related factors. In addition the living conditions of

migrants' affect their health, these factors are inter-correlated[16,81,82,134]. The survey also demonstrated that most interstate migrant workers preferred private health facility over government facility, compared to intrastate migrants due to language barriers and lack of good treatment by doctors. It demonstrated that state specific identity had added to the vulnerability of interstate migrants, which was one of the reasons for lack of access to government health care. These findings are consistent with other studies, which demonstrated that vulnerability of the migrants arise because of living in a place which is different in culture, language, social settings from their native place and the loss of the traditional support system they enjoyed before migration.[15,16,81,207]

The results demonstrated that government health workers had never visited the locations of most migrants indicating lack of proactive efforts in the health system towards migrants' health. These finding are consistent with the studies which show that behaviour of the healthcare staff towards the poor and disadvantaged is one of the deterring factors; bias against the migrants may translate into health providers' neglect, which in turn perpetuates poor migrant health.[147,183,206]

Majority of migrants did not have any complaints about the various aspects that make up quality of health services at the facilities visited by them. A few notable issues were healthcare providers listened more carefully to intrastate migrants. It demonstrated health providers' discrimination towards interstate migrants possibly due to language barriers. There was not any notable discrimination due to any specific cause among the migrants in the health facilities they visited.

The results also showed the lack of awareness of the various health schemes which demonstrates the need for the government to educate and inform migrants about various health issues and available services. This will help many of the government health schemes in reaching out to the lower strata of the society for more effective coverage.

Migrant women and their access to MCH health care

The results show that the utilization of government maternal healthcare services was low among migrant women, these findings are consistent with other studies.[15,87,91,208] However, the results identify that state citizenship status is strongly linked with access to MCH services particularly, among interstate migrants, since they have a low utilization rate compared to the intrastate migrants. Interstate migrant women had delivered at home much more than intrastate migrant women. India's national average of institutional deliveries are 66%, while urban Maharashtra's average is 84%.[209] The institutional delivery among both groups was low, but comparatively lower among interstate migrant women, and is far below the national and state average. One of the factors which reflected this was dignity during delivery. Interstate migrant women indicated that dignity wasn't maintained during delivery compared to intrastate migrant women. The above clearly demonstrated the lack of inclusiveness in the health system possibly due to language or cultural barriers interstate migrant women did not prefer hospitals.

Although a high proportion of both type of migrant women reported to have ANC care with the health systems either private or government, the data on accessing the various components of ANC reveal that the care was largely inadequate for interstate migrant women. Intrastate migrants had better ANC, visited government facilities more for ANC and delivery, received more iron and foliate. However, more interstate migrant women had home delivery, inferior ANC and reduced access to government facilities. This lower service utilization among interstate could be attributed to both individual- and health system-level factors. It demonstrated that the existing urban health welfare programme did not cater for the migrants in general and interstate migrants in particular for MCH services.

The majority of migrant women of both groups were not aware of the government support during delivery such as free transport services. A significant proportion of interstate migrant women accessing ANC from nearby private healthcare providers implied that they were not acquainted with the government health system in the new urban environment. Thus, migrants, particularly interstate migrants, are at the risk of not accessing government maternal healthcare services. Migrants usually arrive in urban areas to improve their livelihood opportunities, it appears interstate migration itself is a major risk factor related to migration status, language barriers, and discrimination at health system which hampers their access to health. It might also be applicable to intrastate migrants as they are not familiar with the local health system at the destination location. These results are consistent with the other studies[91]

On comparing utilization of immunization services for children of intrastate and interstate migrant women, there were no notable differences between the two categories. The majority of children received immunization and the majority of women were aware of the immunization services. It could be due to the various measures, programmes and incentives in place to ensure comprehensive immunization cover to include every child in India, irrespective of their residential status[210].

CONCLUSION

It became evident from the above analyses that migration resulted in poor living condition with poor civic amenities. Migrants were vulnerable to multiple health hazards due to poor and unhygienic living conditions and a lack of knowledge and information resulted in poor utilization of the health facilities available.

Results demonstrate that both intra and inter-state migrants are fairly similar in their socio-economic profile, and availability of health care, but interstate migrants appear to be less able to

access hospital delivery, ANC and government health facilities. The interstate (non-Maharashtrian) migrants faced discrimination at health facilities due to language barriers highlighting the case rapid and effective interventions. These findings question the inclusiveness of the health system of the state, and demonstrates the need to initiate specific efforts to make health services more inclusive to all groups irrespective of their migration status.

In India, health is the responsibility of the state (state governments are responsible for implementation of national and state level health policies and programmes for their citizens within their state) but taking into account mobile status of migrants whether interstate or intrastate, it is crucial to ensure flexibility. Universal access to health care would be a proactive step towards it. Migrant friendly approaches will need to be included and integrated in existing policies. The results have implications towards the newly launched national urban health mission in India in 2013, which has mandate to address health inequities among urban poor groups in urban areas. Currently the mission does not have specific plans to reach out to migrant populations to offer health care including mother and child health services. Results indicate the need to create a migrant friendly service delivery framework within the existing programmes like the National Urban Health Mission; such as strong information education and communication (IEC) campaign to increase awareness among migrants about their right to health and access to health care services, mapping of urban migrants and collection of appropriate data for better coverage, universal outreach to all migrant's location in cities for health/MCH services, and electronic tracking to allow migrants access to health and social care entitlements outside their own state would go a long way. To improve access. Universal access to health care would be most suitable strategy for migrants, since results had shown existing universal immunization programme has been very effective to reach this hard to reach group as the results demonstrated that the majority of them were aware and accessed the services effectively.

Long term strategies are needed to improve living and work conditions for migrants. It needs to get integrated in other broader policies of the government of India such as 'Smart City' initiatives that plans to develop citizen friendly and sustainable cities. To achieve this cross-ministerial partnership would be crucial with the health ministry developing comprehensive policy frameworks to address the diverse needs of migrants. Since maternal and child health has been of concern and interest in India, it is important to pay special attention to groups such as the migrants, so that they are accommodated into the existing MCH programmes, and contribute to achieve SDG3 targets at national level. The results could be generalized to other states of India, and also to other emerging economies where similar internal migration exists due to urbanization.

The migrant's survey helped to understand their demographic profile, the barriers they face while accessing government health services, and the gaps in existing health programmes. Efforts to develop more inclusive and migrant friendly health programmes and policies are vital. The survey was conducted only in one city of India, it is not clear to what extent the results can be generalised to other cities of India. Based on these findings, a qualitative study was conducted to understand perspectives of programme and policy implementers who are responsible for migrant's health and other social welfare needs in India; such as officials of Ministry of health and family welfare, Ministry of labour and employment, agencies who are helping the Indian government to formulate policies such as the International Labour Organization.

CHAPTER FOUR

"If You Are a Migrant You Are Actually Nobody's Baby."

EXPLORING VIEWS OF POLICY MAKERS AND STAKEHOLDERS ON THE POLICIES FOR MIGRANTS' HEALTH IN INDIA: QUALITATIVE STUDY

INTRODUCTION

The results from third chapter showed that the internal migrants were a vulnerable group who missed out on the most basic health, mother and child health services and welfare programmes provided by the state. It was clear that migrants were vulnerable and are exposed to a range of health hazards due to poor living conditions and lack of knowledge and information resulting in poor utilization of health facilities available. The interstate (non- Maharashtrian) migrants faced discrimination at health system level due to language barriers, and hence were worse off than the intrastate migrants, identifying the need for a quick and effective interventions to be put in place.

The results of second and third chapter showed that due to India's federal and state structure, health is a state subject, the state citizenship criteria excludes migrants from the health and social security policies. However, the mobile status of migrants means there is a need, earlier chapters recommended the need to build portability of health, social services and universal access to health care.

It was important to investigate further to understand perspectives of policy makers and other relevant stakeholders about migration and health issues, policies for migrants, initiatives taken and their successes and challenges, to ensure the introduction and implementation of progressive policies in the migration and health sector. A qualitative study was undertaken to explore the views of policy makers and stakeholders in India on the policies to improve the health and social situation of internal migrants and the implementation of these policies. Participants of the study were policy makers and implementers mainly in health and labour ministries, officials of World Health Organization (WHO), International Labour Organization (ILO), and International Organization for Migration (IOM) who are responsible for development and implementation of

health care delivery system in cities. Researchers who are engaged into migration and health research, as well civil societies working on migrant's issues were also included.

AIM

The aim of the study was to understand the views of policy makers and related stakeholders in India on migration and health issues, existing policies and its implementation related to improve the health and social condition of internal migrants.

METHODOLOGY

Study Participants

Recruitment of participants, exclusion/inclusion criterion

The study was conducted in India during March 2014 – December 2016. Data was collected via qualitative methods mainly in-depth interviews. The participants of the study were policy makers and implementers mainly in health and labour ministries, officials of World Health Organization (WHO), International Labour Organization (ILO), and International Organization for Migration (IOM) who are responsible for development and implementation of health care delivery systems in cities. Researchers who are engaged in migration and health research, as well civil societies working on migrant's issues were also included. Selection of participants was done on the basis of information available after literature review, such as policies available for migrants and responsible person for planning and implementation of these policies, particular researchers who have been engaged in the migration related research, or NGOs having specific interventions for migrants. A list of all such potential participants was prepared. Direct contacts were made with the chosen participants via emails and phone calls, and those who agreed to participate in the study, were included. The participants who were willing to participate in the study and did not have any

official reservations or constraints to share relevant information were included in the study. Those who expressed reservations were excluded from the study. 8 policy makers, 4 researchers and 5 civil society representatives and 4 key officials from ILO, WHO, IOM were included in the study.

METHOD

In-depth interviews (IDIs) and focus group discussion (FGD) using interview guides were used. Interview topic guides with open-ended questions were used. The topic guide in English was piloted and refined for final use. The topic guide had questions on the "Volume and situation of internal migrants", "vulnerability and challenges of migrants" and "Existing policies for migrants' health and social security needs" "challenges and suggestions" for better inclusion of migrants in health and social security policies. (See interview guide, and other communication tools used during study from appendix 2-5)

Data Collection, Transcription and Translation

The IDIs of the 8 policy makers, 4 researchers and 5 civil society activists and 4 key officials of WHO, ILO, IOM were conducted at a place that was convenient to them. Since, migration and health is a specialised topic, selection of participants depended on the information available, the availability of participants, and their willingness to participate in the study. On average, each interview took 30-45 minutes. Interviews were audio and video recorded for those who gave consent and note-taking was used for the others. No more than two interviews were conducted on the same day to ensure data quality. Each interview was given a code to maintain anonymity and participants' confidentiality.

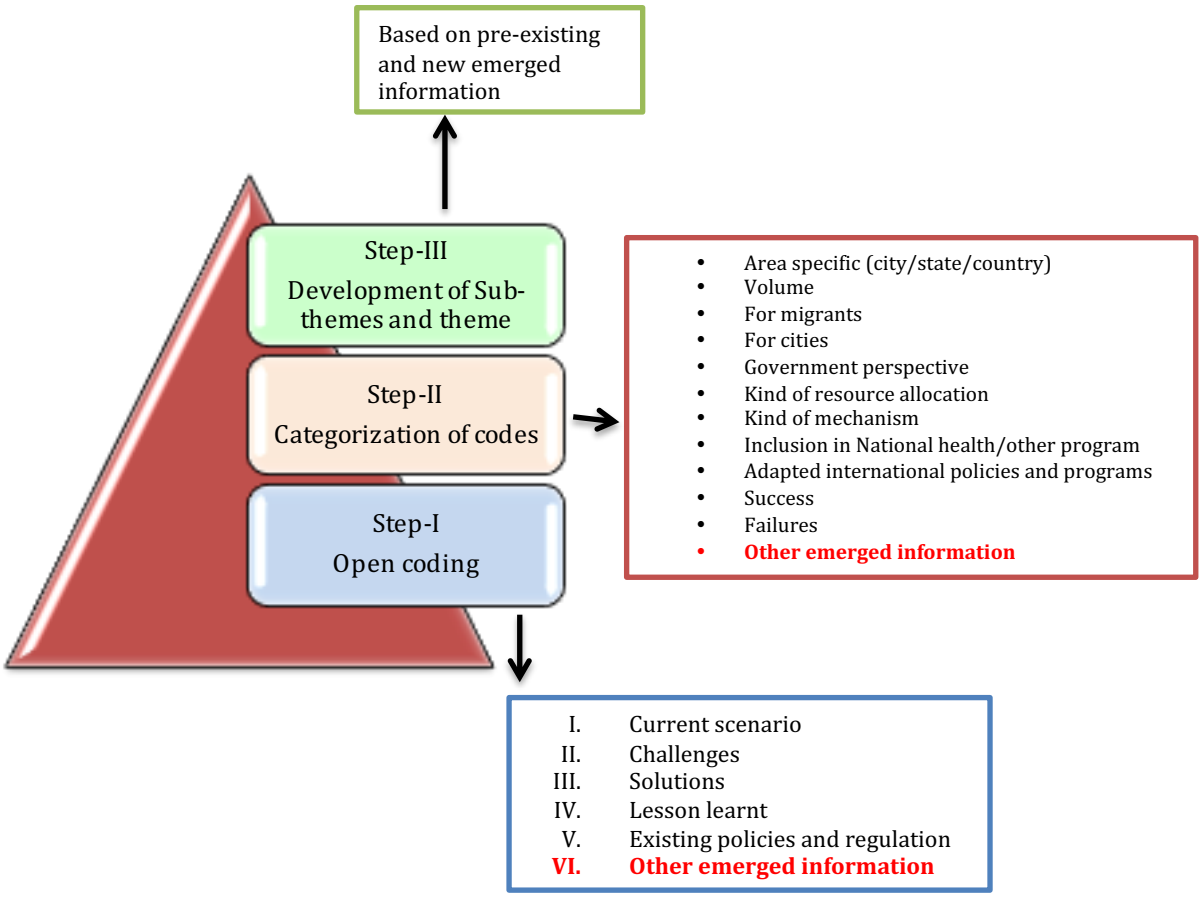
Data Coding and Analysis

All interviews were transcribed verbatim to produce the initial set of transcripts. These transcripts were crosschecked against the original recordings to produce the final set of transcripts. The finalised transcripts were coded using the software package Atlas ti 7.2®, utilizing a reflexive and inductive approach to allow codes and categories to emerge from within the data. The initial list of codes that were generated as the data became available was compared with newer codes that emerged enabling refinement of the coding framework utilised to guide the coding process. The coding framework was used to guide the coding of all the data that was collected.

To check data coding, an independent researcher was involved to code four randomly selected interview transcripts (one from each category of participants). The independent researcher had prior knowledge and experience in qualitative data analysis and was oriented about the study objectives. The results were compared and discussed.

The following section presents the study findings drawn from this joint analysis of findings from all categories of participants.

Figure 31: Data Analysis Process



Ethical Considerations

Signed consent was obtained from all participants prior to data collection and after explaining the nature of the study in detail as well as answering any questions that any of the participants had. The study received ethical approval from the Medical Sciences Inter Divisional Research Ethics Committee, Research Services, and University of Oxford (see their letter number MSD-IDREC-C1-2014-011). Ethical approval also sought from PHFI's Institutional Ethics Committee vide letter number TRC-IEC-192/13. (See all ethics approvals in appendix 6-8)

RESULTS

The following major themes as described below emerged:

SITUATION OF MIGRANTS IN INDIA- LACK OF INFORMATION ON ACTUAL SITUATION

There was no official estimate of data on migrants, in any existing government data source. This was mainly because there was no consistent definition of migrants. The official data was from the Census and National Sample Survey which gave an estimate of around 30 million, but research studies estimated around 100 million.

Need for Migration Specific Data and Disaggregated Data on Service Usage

Further, it was pointed out that there is a need for deeper understanding of the data that was collected and the type of data that was being collected; merely having statistics that describe the flow of migrants alone, is not useful for developing effective policies. Migration specific disaggregated data will be important for policymaking and also to monitor utilisation of services by migrants

"I think we need deeper work not just collecting statistics or data about what type of services are being accessed by whom but actually talking to people and trying to understand what it is that they actually want when they say that they want to be in good health… what does good health mean to them, what type of service they are trying to access, why and what's the kind of element of necessity there, what's the element of kind of status there and what's the element of sort of… what's it called… commoditisation of the whole thing."

Expert, Migration

ISSUES OF MIGRANTS

Some key issues of migrants emerged from the interviews such as registration of migrants at destination areas, lack of co-ordination among interstate government,

Registration of Migrants in Destination States

Lack of a full proof mechanism for registration of migrants and access to such data in destination states are key challenges. This problem is compounded by the fact that many illegal agents operate in bringing migrants to work in different sectors such as at constructions sites, brick kilns etc. and they prefer not to register any migrants. Though there are legal requirements and labour laws for registration of contractors or employers and the workers they employ, there are no mechanisms to monitor them.

While efforts have been taken in this regard in pilot projects, this issue continues to plague the provision of social security schemes and other safety nets for migrants in their destination states.

"One of the major problems we face with regard to migrants is the lack of proper documentation with regard to them."

Senior policy maker, Government of India

Accessing Government Schemes across States

The next important challenge was the portability of services and lack of documentation

Portability of IDs across states

Important challenges to migrants were portability of services and its connection with state specific identification. Most migrants have access to at least some form of registration in the form of government IDs in their home state. However, given the federal nature of India, each state is free to frame its own laws and regulations when it comes to the implementation of various social security measures especially those that are initiated by the local government (state government). Hence, even if a migrant has some sort of identification that they have obtained in their home state for example a ration card or a voter ID card, it may not help them in obtaining services in their

destination state if the ID that they possess is not recognized as valid for accessing services in that particular state/region. With the launch of the AADHAR card in India (which ensures unique identification number for every citizen of India), there were initial discussions and some policy level initiatives to have the AADHAR card as a unique portable ID across the various states.

"Practically migrants are not considered citizens of destination states if they do not have local official identity. AADHAR card is only hope currently. It should be taken as an opportunity to develop portability of public services linked with AADHAR number."

Senior Policy Maker, Ministry of Labour and Employment, Government of India

Lack of Documentation

The next issue with accessing government schemes in destination states is the problem of proper documentation. Even if migrants have some form of registration, issues with the quality of the documentation tend to create problems when it comes to registering them or providing services at the destination state. Coupled with the fact that languages can vary from one state to another, lack of documentation or the quality of it, even if some form of documentation exists, is a serious barrier to availing government services in destination states.

"Even if you have the documentation, how do you match it; the names are wrong, the names in the BPL card is different from the name in other card, the spellings are wrong, address are… so it's very difficult."

Senior Policy maker, Government of India

"We had a separate database which we tried to use. Didn't work... Manually you have to sit and correct and verify and how do we do it manually also; we don't know the person, photographs are not there. It is simply impossible."

Senior ILO official

Lack of Political Capital for action on migrants

Negative attitudes towards migrants

Some of the key informants who participated in this study pointed out that while senior policy makers and programme managers might be sensitive to the necessity of ensuring safe migration and providing services for migrants in their destination states, this need not be the case with younger officers who are tasked with implementing various programmes. Many continue to consider migration as a negative phenomenon that needs to be reversed or stopped. Migrants are also seen as a drain on the resources that would have otherwise been utilized by the local population.

One senior officer from the health ministry said that the provision of proper services to migrants is sometimes seen as a magnet for more migration that a destination state might not want.

"What about the human resources for health for delivery of these services to these increased number of population because of migration… increased population… increased population meaning there might be more pressure on the human resource in terms of delivery of health services, in terms of receipt of health service and then the third aspect of it is the supply of medicines and drugs and all that and that would be another aspect of the migration which will actually imply on how it will affect… how migration will affect the population…"

Senior Policy maker, Ministry of Health and Family Welfare

A civil society member who had been working with migrants in urban centres in India for many years also stressed the importance of getting all stakeholders involved in providing services for migrants to promote understanding the value of migrants to the local community.

"Bring these diverse stakeholders together so that they understand the needs of the urban vulnerable population, they understand the phenomena of migration, they also understand that these migrants are not useless people and that they are actually contributing to the city. So all the buildings that the Corporation is building are being built by some of these people and so... it is their responsibility to respond to their needs.

Senior Civil Society representative

Lack of Health Focus…. Migrant's Health Focus

Migrants' rights are generally overseen by Ministry of Labour in India, as it is the nodal ministry for labour welfare. Most schemes that are currently being implemented for migrants are done by the Department of Labour. The Health department's role is limited and peripheral. Even with newly introduced national health policy in India, there is a lack of specific focus on migrants and their issues. While discussing the issue of migrant's health, a key policy maker from the department of health said that migrants could make use of facilities that are available for the general public as there was nothing that prevented them from accessing the same.

"*Recently as you are aware that the government has launched and it has approved in 2013 the National Urban Health Mission Programme which is part of the overall National Health Mission Program, there are certain specific provision which are now catering to the slum population now wherever these migrants… so called hidden migrants are staying will perhaps be not perhaps not always be in the same proportion well in the neighbourhoods but one of these populations which are you know slum populations you know we have these interventions."*

Senior policy maker, Ministry of health and Family Welfare

Talking of the actual situation faced by migrants when it came to ensuring their health and well-being one of the participant who participated in the study remarked that in reality migrants are on their own when it came to their health

"*So overall for the migrant's health in India, migrants have to take care of their own health literally."*

Senior Official, International Labour Organisation

Another participant who a senior academic working on issues related to migrants has acknowledged that health only got peripheral attention among policies and programmes seeking to provide services for migrants. He emphasized that it was important that social provision of health care services specifically focused on migrants and their families are important precisely

because migrants were not in a position to take care of their health. Additionally, their mobile nature made it difficult to track and provide them with services as well as gave rise to specific situations and needs that are different from the general population. Hence, in the absence of a specific programme that seeks to ensure provision of health services for migrants, most migrants get left out.

"Health is somewhat submerged in migrant you know within migrant concern and therefore it really becomes important in policy to you know to focus on it because you know migrants themselves are not looking at their health it is something that they think will trickle down from the fact that they get employment or you know they get better economic and they become better you know eh better economic opportunities which are the kind of main drivers of migration which will then kind of you know translate into better health care and better wellbeing. So health itself is not something that is focused on by migrants themselves…. For me then that's really very important if that's the case that therefore it is important for policy to focus on health issues. You can't leave it to the migrants themselves to think about all of this. There has to be social provision of services. In fact in all the new programs that are coming up say for instance now maternal and child health like the Janani Suraksha Yojna for instance then you need a specific component that focuses on migrants because you know…. Because I don't think that it is… you need eh this because the migrant's needs are different and you have to have a specifically different kind of category so that you are able to think about what their maternal needs are."

Migration Researcher and Expert

INNOVATIONS

Quite a number of innovations for providing services for migrants have been piloted in different states in India. This is especially true of those states who have a high volume of migrants, some of them are described compiled from all interviews.

Interstate Migration Initiative between Andhra Pradesh and Odisha- Collaboration between Governments

There are some good pilots of state collaboration to address interstate migration, mainly in Odisha and Andhra Pradesh. Odisha being source state, and Andhra Pradesh being destination state, both states have signed Memorandum of Understanding (MoU) for interstate collaboration to ensure

migrants rights and welfare, as a part of MOU, they have initiated registration of migration, registration of contractors who bring migrants in to work in the construction and brick kiln industry. The project has developed portability of education for migrant's children. In Andhra Pradesh schools are being held for brick kiln worker's children in their own mother tongue (Odiya). Portability of PDS has also been piloted, subsidized food grains provided through the PDS system in India is available at specific shops that are located near the residence of a family. Accessing the PDS system usually involves having a card that is issued for the purpose (ration card).

There is access to health services at worksites specifically for migrants via health outreach. ASHAs visiting brick kilns to ensure that children of brick kiln workers are immunized and other health services that are provided for them. They have also piloted Rashtriya Swasthya Bima Yojana (RBSY) the national health insurance scheme for migrants for out-patient use. Links were made with National AIDS Control Programme for prevention and treatment of HIV/AIDS among migrants. A key barrier in providing services for migrants in their destination states was that states did not collaborate between themselves, but now situation is changing. The International Labour Organization has played a co-ordinator's role in this pilot.

"Earlier Andhra and Odisha would not talk to each other but now they at least pick up the phone and talk, and even if they talked before, the talk would not be a pleasant talk, it'll be more like a blame talk, but now they look for solutions. They've really worked; they've come a far way and... the Labour Commissioners talk; the Nodal officers talk. So, it's like the true convergence

Senior ILO official

"Even if we have registrations the states need to collaborate between themselves to make it work efficiently."

Senior policy maker, GOI

Emergency services and other support in Jharkhand

The Jharkhand state' labour department has introduced an initiative of Red and Green cards for migrants in Jharkhand that is loaded with a range of services including life insurance, emergency support services etc. They have also started a migration support centre in Delhi, which is major destination of migrants. However, all this has only a limited focus on the health of migrants, and their overall approach is to stop migration.

"If migration can help them to earn better it's okay, but if its distress migration, we want our workers to stay back in our state, especially young girls, and we have many welfare packages for them to return back, we also run huge campaign for it".

Senior official, Ministry of Labour, Jharkhand

Special Initiative for Tribal Migrants in Maharashtra

Maharashtra state has piloted portability of PDS ration cards, for intrastate migrants as well a migration support programme for tribal migrants in one district of the state. The programme includes co-ordination among various departments such as health, education, labour, and other departments that support tribal migrants in a targeted manner at source areas. The programme also is engaged in developing specific skills to ensure better agricultural and forest conservation, etc. so distress migration can be minimized. In addition, the tribal department has also developed a programme to support tribal migrants in cities when they migrate, mainly to provide seamless access to education, health, housing, legal support to minimise their distress during the migration period. The Tribal Ministry is nodal agency and this programme is targeted only at tribal intrastate migrants. However, it has set up a co-ordination framework at state level with a clear role for each ministry.

"We know migration can't be stopped, but we also don't want to promote migration. Hence, we support our tribal migrants temporarily to access basic services in the city, but we will mainly focus to strengthen their livelihood at their village level for those who want to remain in the village. We need to work with range of other government departments - labour, health, education, skills and so on. This is very new approach we have adopted; our officers are getting accommodative about it."

Senior Official, State Tribal Development Department, Maharashtra State of India

Gujarat Initiative for Migrants

Gujrat is a pioneer state for developing special services for migrants in relation to vector borne diseases as well primary health and MCH services. Special mechanisms are set up to address vector borne disease among migrant construction workers. Vector borne disease control programmes have started a mandatory registration of workers by their employers and they have issued them with a health card; every worker must be screened for malaria or other vector borne diseases and if found positive, their treatment should be started and documented on the card. Unless registration is done and the health card is completed the employer is not allowed to hire the worker. If the worker is found not to possess the card there is penalty of Rs 1000 per worker levied on the employer. The programme officials inspect all construction sites once in every two months. The response from the employers has improved over a period of time, particularly after an outbreak of Dengue in a few sites. This helped the employers understand the importance of this initiative.

"We had a hard time, construction companies were very difficult stakeholders to work with, and they didn't allow our health workers to enter their premises. Finally, we had to approach the district Collector, he issued an official notice to these companies, which made our entry easy to these sites for health intervention"

Senior official, Vector Borne Diseases Control Programme, Gujarat State of India

Gujarat state had India's first urban health programme, to address health needs of the urban population. The senior official of their urban health society said that had they had initiated a rapid mapping of all migrants in the city every month, and they provide this group MCH and other health care through outreach activities at all migrant locations such as unofficial slums, footpaths, residential camps provided by construction companies or industries for their migrant worker employees. They do not discriminate between local and migrant groups in the outreach services.

"*We know that if we exclude migrants from coverage of these basic health care facilities, these health problems like Malaria, or related to MCH are not going to end, it will come back, and we will never achieve health goals for our cities, so it's wise to include migrants for these services".*

Senior official, Gujarat Urban Health Society, Ministry of Health

Initiative of Ministry of Labour - Amendment in Interstate Migrant Worker Act 1979

A senior official of Ministry of Labour and Employment talked about their initiative towards introducing an amendment in the only piece of law available for interstate migrant workers in India. The Ministry had set up a working group to make necessary amendments in the law to make it more inclusive for all types of migrant workers, inducing inter and intrastate in the informal sector to ensure their labour rights. The group had submitted their key recommendations to the Ministry.

"We had set up a group to make amendments in Interstate Migrant Worker Act 1979. The act is not being implemented due to many technical flaws… we are in process to make it more inclusive and user friendly to protect labour and human rights of migrant workers".

Senior official, Ministry of Labour and Employment

UN's Taskforce for Migration and Development

A senior representative of the UN agency in India related that in 2012 they formed an internal taskforce on migration and development for India. Different UN agencies have specific roles to play in the taskforce - United Nations Educational Scientific and Cultural Organization(

UNESCO) is responsible for the education of migrants, World Health Organization (WHO) looks after the health of migrants, International Labour Organisation have the responsibility for social security for migrants, United Nation's Development Programme (UNDP) and The United Nation's Population Fund (UNFPA) looking at different aspects such as water sanitation and living conditions of the migrants in India. The task force had done an early assessment and a brief was provided to the government. The Task Force is hopeful that government will use the brief as a background for the urban health missions and other departments that work with urban health mission. However, so far, the implementation has not been put in place.

"..we had UN task force in the migration in health ..not only health but migration in general to look at…we had done early assessments and a brief provided to the government, ..probably urban health mission work is still in the process…we haven't seen the implementation in the concrete term yet, we haven't have the proper documentation of the process…..so how does it implement in any state or in country is not known ..as far as I know Andhra Pradesh have started having their own plan within the state but it's not for migrants, it's general urban health per se.. migration would be next big thing to address in India".

Senior UN representative, India

There are some good pilots in few states for migrant's health and social security, but concern was raised by a senior migration expert that all these pilots lack comprehensive databases or resources to look at the impact the interventions have had on migrants especially on their health and well-being. It is not known what interventions worked and what did not work which is a key barrier to designing appropriate interventions.

"I feel there is an incredible level of ignorance or lack of awareness of what's already been tried and tested and like I know I am repeating myself but I just feel that in order to make effective policies you have to have some understanding of what's been tried before and without that you can't really make anything possible."

Migration Researcher and Expert

CHALLENGES AND POSSIBLE SUGGESTIONS

Policies for Migrant's Health and Social Security Needs: Lack of a Migrant Centred Policy

The participants pointed out that India does have different labour laws that protects different types of workers including migrants; India also has an Interstate Migrant Workers Act 1979 for the protection of interstate migrants but all these laws are not implemented due to employers' apathy, lack of political will and migrant's lack of awareness. The Federal Labour ministry is in the process of making the necessary amendments in the act that can cover all types of migrant workers of India. Most of the innovations and programmes that are aimed at providing services to migrants are currently limited to states which have a high volume of their citizens who migrate in search of jobs to other states. However, there is a need for a national migrant policy that addresses these issues at the source, while in transit and at the destination in order to ensure that all migration is safe. The absence of such a policy/regulatory framework is a key gap that currently exists in India.

"What we need is a national framework that takes care of these issues at the source, transit and destination."

Senior Policy Maker, Ministry of Labour, Government Of India

Speaking of the importance of having a national policy for migrants one of the participants pointed out that the presence of such a policy conveys a clear intent that the government is keen on acting in a coordinated manner to address the issues faced by migrants

"the advantage of doing that is that it is a statement of intent you know it is a statement which shows that the government is going to take a sort of co-ordinated uh approach to migration management where you know different parts of the government and different parts of the administration at least are on the same page."

Migration Researcher and Expert

Lack of Cross Learning and Sharing of Data

Talking of the current situation, one of the key participants said that at present there is a clear lack of sharing of information and lack of synergy between various departments that are involved in implementing programmes that are aimed at migrants. This they felt led to duplication of efforts and waste of time and resources

"there is no cross learning there is no learning from experience or sharing information about what was good, what was bad, what worked what didn't work, what can be up scaled you know there is no actual accumulated experience and knowledge from those experiments and eh some happened at a very localised level like eh another thing that I heard about eh was in X for e.g. ummm I think one of the collectors there decided that he should send teachers with migrating families so that the children could be educated in their language so going from Madhya Pradesh to Maharashtra say send eh Hindi speaking teacher with the kids so that when they get there they have somebody to teach them the same language…Again you know we don't know what happened to this initiative why did it stop was it a success, was it a failure, what can we learn from that because without that learning we can't actually do anything nationwide you know we can't have any up scaling or replication so that's one big issue."

Migration Researcher and Expert

Need to Increase Awareness about Migrants among the General Public

In general, the outlook of the local population towards migrants has been negative. Hence, increasing awareness about the positive role played by migrants in a local economy (such as construction of houses, provision of specific services etc. for the local population), it was pointed out, would help to initiate action at the policy level for taking positive action for the welfare of migrants.

"Public opinion is extremely important in galvanising all of this so we need that in India and we don't have it, your average Indian citizen ummm I hate to say is very indifferent to the plight of the urban poor and the poor rural migrant, until and unless people start to feel that it is outrageous to see babies crawling around in dirt and you know, pregnant women carrying loads of bricks you know without any protection I don't know anything is going to change."

Migration Researcher and Expert

Universal Health Coverage for Migrants

A majority of the participants were of the opinion that universal health coverage has to be implemented as part of addressing the health of migrants as quite often those who migrate face a major financial burden related to paying for health services.

"…like for example, in case of emergency even though you are not migrants if you have emergency accident somewhere so cannot be carried back to the residence where you have registered and where you have rights to access the health services …you have to use facility at the time of incidence when it occurred…so your life can be safe …and other service providers have to have referral system of information so it means the country should have a good health system ..or a good health information system…good referral system…a good package of health benefits that can be provided universally and inclusively regardless of where you have registered, regardless of your migration status. This is too the process…but that's one of the feature that we need to work out …"

Senior official, WHO, India

DISCUSSION

Migrants play an important and constructive role in the economy and development of their destination state. This aspect needs to be highlighted, not just among the general public but also through advocacy with policy makers and programme managers. One of the key issues that migrants face is that they are away from their home state and can be considered a drain on the resources of the destination state. This attitude towards migrants does not exist just among local population who might feel that migrants are taking away their jobs and are not welcome in their area, but also among programme managers and policy makers who might consider migrants to be unwelcome visitors who need to be sent back to their homes. Further, migrants do not have any political capital and hence, are not considered as important enough by the political classes to consider making adequate investments in and provide them with services

The results show that inclusion of migrants is imperative in all plans of Universal Health Coverage (UHC) and for UHC to work. This finding is very consistent with WHO's mandate[211] which states

that WHO cannot achieve Sustainable Development Goal 3.8 on universal health coverage unless the health needs of refugees and migrants are met. It also states that the access of refugees and migrants to quality for health services is of paramount importance for a rights-based health system, global health security and for public efforts aimed at reducing health inequities.

India is embarking on an ambitious target of achieving UHC for all citizens. Everybody will be entitled to comprehensive health security in the country. It will be obligatory on the part of the State to provide adequate food, appropriate medical care, safe drinking water, proper sanitation, education and health-related information for good health. The State will be responsible for ensuring and guaranteeing UHC for its citizens. A High Level Expert Group (HLEG) on Universal Health Coverage (UHC) was constituted by the Planning Commission of India in October 2010, with the mandate to develop a framework for providing easily accessible and affordable health care to all Indians[212,213]. Migrant's health should be at the centre of universal health coverage, taking into account their mobility, volume and the vulnerabilities they face.

Results also indicate the need for a national migration policy; India does not have a comprehensive policy on internal migration, but few policies are available in some states for the protection of migrants. The Indian constitution[214] contains basic provision relating to the conditions of employment, non-discrimination, 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 existing labour laws as discussed in literature review. However, they are widely disregarded by employers and intermediaries because of a lack of political will to implement them, and unawareness among illiterate migrants of their rights as workers[51,173]. The only legal protection for interstate migrants is available via 'The Interstate Migrant Worker Act', it has been in force since 1979, and has the potential to address interstate

migration issues, but it is not implemented due to lack of awareness among migrants as well NGOs, and the lack of incentive among politicians and government officials dealing with this group. It is crucial to activate and implement the available laws to address migrants' issues related to the exclusion of services[114].

India has ratified the International Labour Organization's conventions but is neither a signatory or ratified the [9]Convention of Migrant Workers (CMW), which provides the formal sanction for protection of the migrants. Similarly, [10]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, including health are not protected.

However, within national health programmes and policies, currently, there is little related to the health of migrant workers[51]. Some important policies such as the National Health Policy 2017[167] aim to achieve an acceptable standard of health amongst the general population, and promote equitable access to public health services across the social and geographical area of the country. Similarly, the National Population Policy 2000[168] affirms the commitment of the government to voluntarily and through informed choice and consent of citizens, while accessing reproductive and

[9] 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.

[10] 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.

health care services, are enabled to access appropriate family planning services. The newly launched National Urban Health Mission[87] ensures health equity among the urban poor population, but it does not have a migration specific approach. The qualitative study has shown clearly that all these health policies do not have specific strategies or priorities to address migrant's health needs. it also illustrates that as migrants have special needs, an overarching policy umbrella will not help them to access health or social services. There has to be a migrant specific focus and strategies to reach out to this vulnerable group.

The qualitative study has also highlighted shown some important pilot programmes for migrants in a few states. Currently, most of the migrant healthcare is in the non-governmental sector (wherever such organizations exist). The existing central government guidelines allow all migrant children to benefit from nutritional supplementation under the Integrated Child Development Scheme (ICDS) at destination cities irrespective of whether they are registered in the area. 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 these facilities. However, it has not been very successful. Taking into account India's large ICDS programme, successful implementation of this guideline has huge potential to make a positive impact on mother and child health issues of migrants[115].

Similarly, Public Distribution System (PDS) has issued a Government Resolution, 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[169]. Similar initiatives are made for brick kiln migrant workers in Andhra Pradesh and Odisha with the support of the state and local

government bodies and co-ordination of the International Labour Organization. However, this needs the continuing support of the government and NGOs. Such initiatives need to be scaled up in other areas. Some currently functioning programmes like the National AIDS Control Programme have a mandate to provide outreach services[187]. This programme has adopted an outreach approach and tracking system for HIV/AIDS prevention and treatment for a few categories of the migrant population viz. truckers, sex workers and construction workers in India. The qualitative study indicated the importance of evaluating such programmes, and draw lessons for replicability and scaling up of other public health outreach interventions for migrants.

Other initiatives such as in Jharkhand are mainly towards controlling the migration, with very limited focus on health. The Maharashtra tribal department's initiative seems the most comprehensive migration support programme with a strong commitment of the department. They plan to set up a state level migration research and resource centre to continue the initiative, they have also obtained the budget allocation for this initiative. The UN's taskforce on migration is good start, though nothing has been implemented so far, but it is encouraging to note that migration issues has been integrated into the agenda of the UN in India.

The study has highlighted some key challenges in addressing migrants' health issues in India. The study showed that one of the serious constraints in framing an effective policy response to internal migration is lack of credible data on migration. Currently none of the official surveys capture migration specific data. All study participants, including policy makers, researchers and those from civil societies were of the same opinion about this aspect.

Another challenge which was mainly indicated by policy makers was the absence of a national identification mechanism, that can provide one single data source of all citizens across India, that can be useful for tracking migrants and their access to public services and can create portability of

services. A system of unique identification number (AADHAR)[215] that is being introduced presently could provide the solution to overcome this problem in India. There is a pilot done by Unique Identification Authority of India (UIDAI)[216] with an NGO to enrol migrant workers for the registration. Efforts were also made to explore if the AADHAR number can be linked with easy access to health, food security and other basic services. During pilot, migrants were enrolled, but nothing further was done to build the portability of services[180]. The Indian government's ambition to enrol every citizen of India and link all services/bank accounts/cell phone numbers to AADHAR, AADHAR still has a great potential to create portability of services.

SUGGESTIONS FOR POLICY AND PROGRAMMES ESPECIALLY FOR HEALTH

The study has provided some suggestions, mainly for policy and programmes to ensure migrants health and wellbeing, as outlined below:

Universal Access to Public Health Services and portability of Social Security

Make all services accessible and available for local population open to migrants. This would ensure that migrants are able to access quality health care services at their destinations and lead healthy lives. Such universal access to the public health system will also ensure that migrants do not access non-licensed practitioners and quacks and that the state is able to ensure that essential services such as immunisation and other maternal and child care services are provided whether a migrant is in their home state or a destination state. Special provision of such services in existing programmes such as National Urban Health Mission would be crucial.

Include out-patient services in the RSBY scheme

Most migrants are in need of out-patient rather than in-patient schemes. The RSBY scheme, which is only national insurance scheme, funds health care expenditure that requires hospitalisation. This means migrants access out-patient services from non-registered providers who are available in their neighbourhood. Hence, providing them with only in-patient services only covers a small proportion of their health care requirements. RSBY's OPD usage would be very useful for migrants. Since this scheme is under revision by the Ministry of Health, it may be suitable to modify the coverage and benefits to migrants.

National registry with portable IDs and documentation

AADHAR number can be linked with the registration of migrants. There should be national level database of migrants, not just in terms of their numbers, but also disaggregated data on utilisation of health and social security services. There should be a consistent definition of migrants across all databases.

Home and destination states need to collaborate to provide services

A proper institutional mechanism needs to be built that can define the role of federal as well state governments, for effective and active co-ordination among these bodies to ensure portability of social security services and migrants' rights.

Convergence of various departments to provide services and social security measures for migrants

Convergence of schemes mainly ICDS, education, health and livelihood is very crucial, different responsible departments need to come together for creating a single point for access to these services across states for migrants

Draft a national policy with specific schemes to provide social security schemes for migrants in their destination states

A national comprehensive policy is important, that can act as an umbrella to include the above mentioned institutional mechanisms, as well as role of federal and state governments.

CONCLUSION

The study has shown that migration is an emerging and important issue in India that needs policy level attention to ensure health and overall wellbeing of migrants. Currently, India has no structural policies or programmes targeting migrant issues comprehensively in spite of significant volume of migration. This segment of the population faces exclusion from the various mainstream programmes. Taking into account the mobility patterns of migrants, universal access to health and social security would be a positive step in improving the health of migrants. There is a need to modify the existing policy structures and programmes so the needs of this marginalized group are accommodated for in the various national policies. Effective implementation of the available programmes at source and destination, at inter and intrastate level would be important to improve the status of migrants' health. Interstate collaboration is required among government departments, to assess and subsequently tackle occupational risks and their health and social consequences before, during and after migrants' period of work. 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 and the general public needs to be achieved. The provision of basic services would require better coordination among departments located in different sectors and different areas. The federal government has a major role to play in the process including promoting an alliance among key health service providers and their respective departments, their capacity building, and resource allocation.

The qualitative study has shown key challenges around migration in India and possible solutions. Lack of data, state specific programmatic policies and lack of co-ordination among states are key challenges that need to be addressed the unique and pressing needs of migrants. However, there are some promising pilots in a few states, key lessons can be learnt from these pilots for solutions such as building migration specific disaggregated data within existing government data sources, construct portability of social security services across states, and universal access to health and social services.

In next chapter, I attempt to understand the situation in other countries on similar issues of migration, policy measures taken so far and their successes and challenges. It was done via site visits and interviews of key policy makers, researchers and civil societies in Sir Lanka, Vietnam, Philippines and China. Based on these comparisons, results are analysed to draw transferable and practical lessons for India to develop policy recommendations to address health and social security needs of migrants.

CHAPTER FIVE

PRO-MIGRANT POLICY RESPONSE: LEARNING FROM OTHER ASIAN COUNTRIES

UNDERSTANDING POLICY LEVEL RESPONSE IN SRI LANKA, PHILIPPINES, CHINA AND VIET NAM

A QUALITATIVE STUDY

INTRODUCTION

The results from fourth chapter showed that migration is emerging as an important issue in India which needs policy level attention that can ensure health and wellbeing of migrants. Currently, India has no structural policies or programmes targeting the migrant issues comprehensively in spite of unprecedented migration, hence, this population faces exclusion from the various mainstream programmes. The qualitative study has shown key challenges around migration in India; lack of migration specific data, state specific programmatic policies and lack of co-ordination among states to cater to the unique needs of migrants.

it was important understand the situation in other Asian countries mainly Sri Lanka, Vietnam, Philippines and China where similar migration is prevalent (as identified by the literature review), policy measures taken so far in these countries and their successes and challenges. A Qualitative study was undertaken, participants of the study were policy makers and implementers mainly in health and labour ministries, officials of World Health Organization (WHO), International Labour Organization (ILO), and International Organization for Migration (IOM) who are responsible for the development and implementation of health care delivery system in cities. Researchers in migration and health research, as well as civil societies working on migrant's issues were also included.

Based on the comparisons of initiatives taken in these countries, results are analysed to draw transferable and practical lesson for India to inform policy recommendations to address health and social security needs of migrants.

AIM

The aim of the study was to gain an understanding of internal migration, views of policy makers and related stakeholders in China, Viet Nam, Sri Lanka, and Philippines on migration and health issues, their existing policies and its implementation related to health and social needs of internal migrants.

METHODOLOGY

STUDY PARTICIPANTS

Recruitment of participants, exclusion/inclusion criterion

The study was conducted in China, Sir Lanka, Viet Nam, and Philippines during March 2014 – December 2016. Data was collected via qualitative methods mainly in-depth interviews of participants. Main participants of the study were policy makers and implementers mainly in health and labour ministries, officials of World Health Organization (WHO), International Labour Organization (ILO), and International Organization for Migration (IOM), Migrant's Trade Union Leaders who are responsible for development and implementation of health care delivery system in cities. Researchers who were engaged in migration and health research, as well civil societies working on migrant's issues were also included, such as policies available for migrants and responsible person for planning and implementation of these policies, particular researchers who have been engaged in the migration related research, or NGOs having specific interventions for migrants. A list of all such potential participants was prepared. Direct contacts were made with the chosen participants via emails and phone calls, and those who agreed to participate in the study, were included. The participants who were willing to participate in the study and did not have any official reservations or constraints to share relevant information were included in the study. Those

who expressed reservations were excluded from the study.6 policy makers, 4 key officials from WHO/ILO/IOM, 5 researchers and 6 civil society representatives were included in the study

METHOD

In-depth interviews (IDIs) and focus group discussions using interview guides were used with participants. Interview topic guides with open – ended questions were used. The topic guide in English was piloted and refined for final use. The topic guide had questions on the "Volume and situation of internal migrants", "vulnerability and challenges of migrants" and "Existing policies for migrants' health and social security needs" "challenges and suggestions" for better inclusion of migrants in health and social security policies. The interview guide is enclosed (Appendix 4).

Data Collection, Transcription and Translation

The IDIs of 6 policy makers, 4 key officials from WHO/ILO/IOM, 5 researchers and 6 civil society representatives were conducted at a capital city or the biggest city of respective country that was convenient to them. Interviews were conducted in Beijing, China, Hanoi, Viet Nam, Manila, Philippines and Colombo, Sri Lanka. Since, migration and health is a specialised topic, selection of participants was entirely dependent on the information available from the literature review, availability of participants, and their willingness to participate in the study. On average, each interview took 45-60 minutes. Interviews were audio and video recorded for those who gave consent and note-taking was used for the others. No more than two interviews were conducted on the same day to ensure data quality. Each interview was given a code to maintain anonymity and participants' confidentiality.

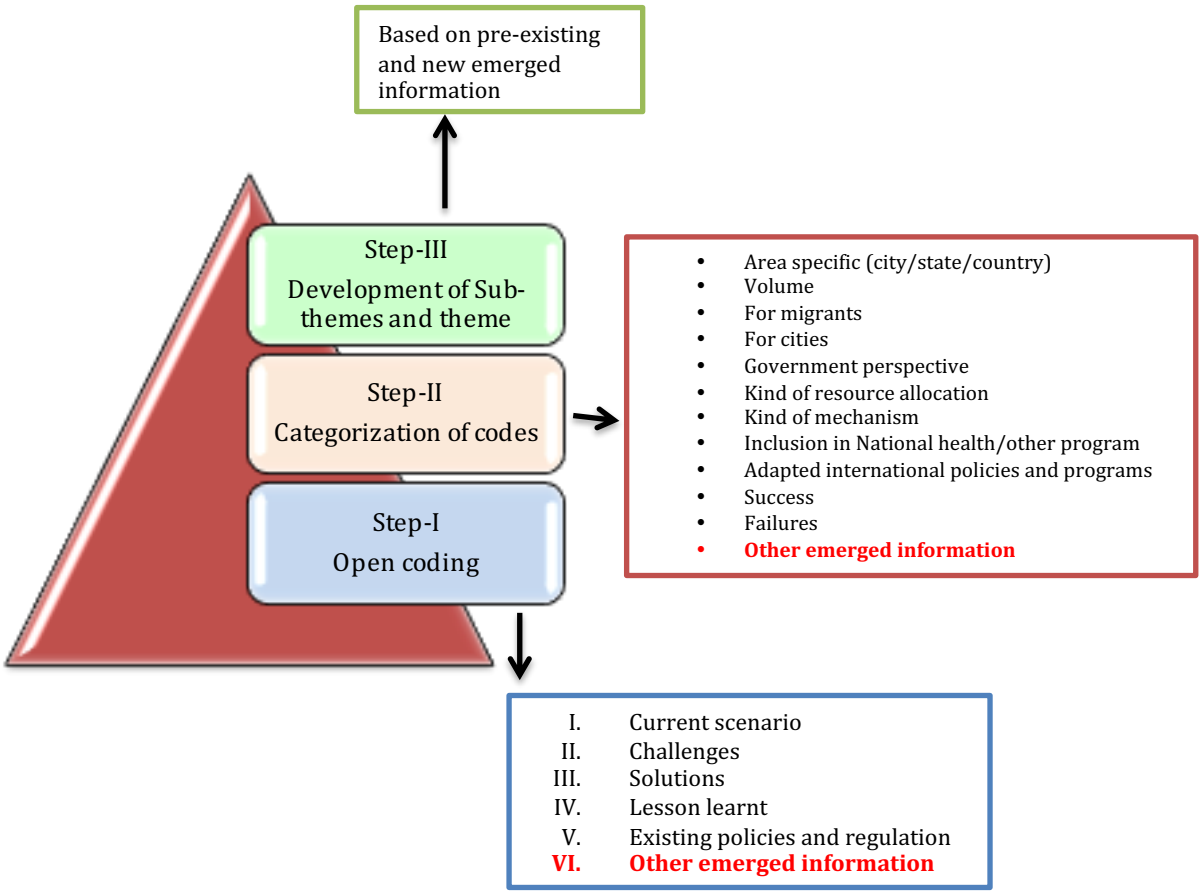
Data Coding and Analysis

All interviews were transcribed verbatim to produce the initial set of transcripts. These transcripts were crosschecked against the original recordings to produce the final set of transcripts. The finalised transcripts were coded using the software package Atlas ti 7.2®, utilizing a reflexive and inductive approach to allow codes and categories to emerge from within the data. The initial list of codes that were generated as the data became available was compared with newer codes that emerged enabling refinement of the coding framework utilised to guide the coding process. The coding framework was used to guide the coding of the data collected.

To check data coding, an independent researcher coded four randomly selected interview transcripts (one from each category of participants). The independent researcher had prior knowledge and experience in qualitative data analysis and was familiar with the study objectives. The results were compared and discussed.

The following section presents the study findings drawn from this joint analysis of findings from all categories of participants.

Figure 32: Data Analysis Process



Ethical Considerations

Signed consent was obtained from all participants prior to data collection and after explaining the nature of the study in detail as well as answering any questions that any of the participants had. The study received ethical approval from the Medical Sciences Inter Divisional Research Ethics Committee, Research Services, University of Oxford (letter number MSD-IDREC-C1-2014-011). Ethical approval also sought from PHFI's Institutional Ethics Committee vide letter number TRC-IEC-192/13 (See appendix 6-8)

RESULTS

Volume of Migration

The study participants said that migration is a growing phenomenon in their respective countries. According to them, migration was an undeniable reality in their countries. Study participants broadly divided migrants into two categories; internal and external.

Internal Migrants

These included migrants and their families who had migrated from rural areas to urban areas in search of better job opportunities within their country. The majority of migrants in most countries in the region were in this category. Internal migrants primarily worked in low level/blue collared jobs such as construction sites, brick kilns etc. and in general were not covered by any comprehensive social protection schemes or health insurance. In some countries, the owners where these workers were employed were expected to provide them with some form of social security such as insurance. However, these were sporadic and monitoring was practically non-existent. Internal migrants also include those who are internally displaced due to various issues such as natural calamities, riots etc. and hence, more vulnerable.

External Migrants

These were primarily citizens of a country who had relocated to another country in search of better job opportunities and living conditions. Both in the Philippines and Sri Lanka there were large numbers of individuals who had migrated from their country to other parts of the globe and were primarily highly skilled workers such as nurses. In such cases, the ministry of external affairs in the home country provided services such as pre-departure briefing, health screening and provision of other services for the migrants.

The response of the participants was recorded mainly on the internal migration.

Internal migration has been essential component of Vietnam since the '*doi moi'* economic reforms. The inter-provincial migrants increased both in absolute and relative terms in Viet Nam. The Vietnam, 2015 census data indicated that nearly 19.7% of the total population migrated internally.

"We had provided technical support to Vietnam government to conduct migration census in Vietnam in 2004 and in 2015. First in terms of the proportion of migration in Vietnam the finding also shows that during the last five years for every one hundredth person of Vietnam there will be 20 migrants"

Migration Census National Co-ordinator, UNFPA, Vietnam

Urban population in Philippines grew 4 times while rural population only doubled in last decade; Migration to urban areas still continues to be predominantly female According to Census of Population and housing 2010, 2.9 million Filipinos migrated between 2005 and 2010.

"Oh it is in millions… it would run in millions… only in terms of urban development the number of affected population would run in millions. But in terms of disaster of course disasters in the Philippines are all around the islands so if we have seven thousand one hundred islands in the Philippines then the extent maybe twenty five percent or thirty per cent of these islands are seriously affected by disasters."

Migration Researcher, Philippines

According to the Migration Population Development report 2016, (National Bureau of Statistics of China), roughly 18% of the population of China are migrants. Around 247[5] million Chinese people have migrated to cities from Chinese rural to urban areas for livelihood.

"In China the internal migration is many… talking about the population movement from rich urban areas in China so they went to the cities for better job opportunities and conditions and this happened since mid-1980s and by the end of 2015 the number of migrants have raised to 247 million which is more than the nations, one sixth of the nation's total population."

Migration researcher, Beijing, China

The majority of the migration in Sri Lanka happened during the separatist conflict for safety. But labour migration was on the rise for livelihood from rural to urban areas. According to 2001 census, nearly 20% of total population had internally migrated.

"We had been serious about migration specific data, since we aimed to formulate national migration policy".

Senior official, Ministry of Health, Sri Lanka

Issues faced by Migrants

The participants highlighted two key issues migrants faced during their migration period; lack of proper registration and access to basic amenities.

1. Lack of proper registration systems

China has a household registration system that is linked to the home town of the migrant (source area). This entitles the migrant to receive services in the province/area where the registration has been done but not in another province. Given this situation many migrants cannot access government services such as health care and education in other provinces in China

"Well they have less, they have much less access to public services in the cities and the reason is because we have the household registration system in China which is the hukou so you know in the cities they do not have the urban hukou that is why they are not entitled to the same level of welfare and services in the city so for example education for children, so in early years their children cannot go to public school or they have to pay very high for their children to public schools, in recent years the policy has been improving, they have been trying to accommodate these migrant children into the public school but still there are large group of migrant's children who do not go to public school and there are migrant children schools established for these migrant children to receive education in the cities especially the large cities, but there is also a wave of policies that close these kind of migrant children schools. So the education for migrant children in the urban cities is an issue at the present time."

Migration Researcher, Beijing, China

The same issue was reported as a barrier to accessing health care for migrants in Vietnam.

"Because in Vietnam with the system of household registration, that is the obstacle for the migrant to access the health service."

Migration Researcher, Vietnam

The exception to this was Sri Lanka where health care was universal and there was no requirement for local registration for a citizen to access healthcare anywhere in the country.

'We have universal health care as well migration policy in place, it works complimentary to each other, and makes sure that migrants are not excluded from health services during their mobility"

Senior official, Ministry of Health, Sri Lanka

2. Poor Facilities at the Destination

Participants said that migrants face poor living and housing conditions. Most migrants who move from rural areas and their hometowns to urban areas do so in the hope of attaining a better quality of life through the greater opportunities that are usually available in large cities. However, the civic infrastructure and support services such as drinking water, sanitation etc. that are available in the places where migrants congregate are abysmally poor. This was more or less similar in the all the countries of the study.

"When they… when they came there… when they came in to that location there was not even potable water… no potable water… they don't have proper sewage system although they have access to power… electricity but of course the main problem is any livelihood eh… no source of income for them that is the most… the major problem of the community."

Migration researcher, Philippines

"In China, when people migrate to urban areas, they have to live in slum areas with very poor basic amenities. Their employers are supposed to provide them decent housing, but it depends on if they have legal work contract, if not then they really face poor conditions"

Migration researcher, Beijing, China

"Due to our registration system, migrants can't claim permanent housing or water connections at destination location if they possess the same at their hometown. Hence they suffer for basic amenities in cities".

Asian Parliamentarian Committee Member, and Public Health Researcher, Vietnam

Challenges

Key challenges that were highlighted by the participants were; lack of data, lack of integrated action across departments and negative attitudes of native population towards migrants.

Lack of migration specific data

Lack of comprehensive data on migrants was cited as a key impediment in crafting policies that are relevant for them. Participants from China and Vietnam said they had migration census, but migration specific disaggregated data was not available. This was a complex issue since many local governments weren't positive towards migrants coupled with the fact that many migrants are outside formal registration processes in their destinations compounding the problem.

Inter-sectoral co-ordination

Addressing the needs of migrants generally involves inter-sectoral/ministerial action. This was especially true with regard to internal migrants as migrants outside the country were considered the responsibility of the ministry of external affairs in each country. Some efforts for example in Philippines were being made to resolve the situation.

"we saw that the migration in health network is a separate area for synergy for collaboration so there will be projects that would be sponsored by say the overseas worker's welfare administration and then the DOH from health then they will be from the DHA from the foreign affairs, office of the undersecretary for migrant workers affair so there will be collaboration so that's included in the plan the strategic plan and we have identified the strategic areas…"

Senior official, Ministry of Health, Philippines

The success story has been in Sri Lanka where inter sectoral coordination has been successful and separate officers have been identified and appointed to ensure that this happens and migrants do

not face any difficulties in accessing health and social welfare services. Another important point made by the Sri Lankan participant was the fact that given the nature of migration the coordination mechanism needs to be at a senior level in the political/governance structure. This was felt would enable greater coordination across ministries that are relevant for providing services to migrants.

"While there are different policy actions that we would do… but we think that may be… considering its contribution to sustainable development that there should be a higher placed body which looks at migration related challenges of health… so that necessarily could be the ministry of health or it could be the President."

Senior official, Ministry of Health, Sri Lanka

Negative attitudes of local residents towards migrants

Conflicts between local residents and migrants was highlighted as a key challenge that needs to be addressed. The negative attitude of local residents to migrants has been identified as a key barrier in two countries- Philippines and China. Local residents consider migrants as sources of crime and as taking away resources and services that would otherwise be available to the local residents such as water, sanitation, jobs etc. This leads to a hostile situation for migrants which makes them further vulnerable

"Most of the people around this community are actually not very friendly with them because they thought eh… these relocated families are either thieves or robbers. so the trust is not there… No trust between the relocated community and the native community."

Migration Researcher, Philippines

A civil society representative from China described this as being a global phenomenon that needs to be addressed when we addressing issues to make migration safer.

"The core issue is the prejudice and discrimination and that exists in whole human history… umm my experience for working with migrant workers has been 19 years. Had been travelling to both India and the United States, I've noticed the same trouble of prejudice and discrimination exists in those countries… and the nature is the same."

NGO Representative, China

Policies /Innovations available for migrants in study areas

Migration- Policies being left out or not being specifically included

It became clear from the study that, in general, national policies that are meant to provide services and support specifically for migrants are non-existent in China and Vietnam, since they are strongly linked with the registration system. Exceptions to these are the Philippines and Sri Lanka where specific policies had been developed to address issues arising from migrants and high-level political engagement with migrants was present.

Initiatives in China

Study participants from China said that the Chinese leadership during the period 2000-2004, made serious efforts to fundamentally review the official approach to labour migration. Several policy initiatives to free the labour market across China and guarantee more equitable opportunities for migrant labourers were undertaken in this period categorized into the following sections

Policy Initiatives to reform the existing system

Steps have been initiated to reform *Hukou* System in March, 2001 and China started an experimental reform of the residence registration system in more than 20,000 small towns. Mega cities such as Shanghai and Beijing have adopted a 'soft' policy of "widening the gate, raising the price", under which the number of rural labourers for permanent residence status was less restrictive. In early 2002, the State Council issued Document No 2 which stated that rural migrants should be encouraged to migrate to urban areas. More importantly, the document set out four new policy principles: fair treatment, reasonable guidance, management improvement, and better service. In January 2003, the State Council Office's No. 1 Document brought together a unified framework which entails policy decision to abolish any excessive and unfair restrictions on rural labourers seeking either temporary or permanent employment in urban areas, ensuring that proper

legal procedures are applied when employing rural labourers, including proper work contracts and the timely payment of wages, improving the working and living conditions for rural migrant labourers, especially women, including health care, safety at work and social security and enhancing the proper management of migrant population by providing for their employment, health care, education for children, family planning and legal aid

Education for children of migrants

In September 2003, the State Council promulgated a document to improve basic education services for the children of migrants in cities, which was jointly drafted by six related ministries. The document specified that urban governments and their public schools must be responsible for the education of migrants' children. Migrant run schools is an example of efforts by community to empower themselves.

Social Insurance Programmes

Social insurance programmes- URBAN FIVE - includes insurance for basic healthcare, elderly pensions, unemployment insurance, occupational injury insurance and maternity benefits for working mothers. These urban five programs are mandatory and a range of urban organizations and corporations have to adhere to them. Ministry of Labour mandated employers and enterprises to provide for work related injury and accident insurance for migrant workers, especially in high risk industries, such as construction and mining. Other than these, insurance schemes to provide financial help and to reduce out of pocket expenses functioning in China are New Rural Cooperative Medical Scheme which covers about 87% of the population, Medical Assistance Program, Urban Residence Basic Insurance Scheme. The salient features of health insurance schemes prevalent in China are summarized below-

In general, NCMS and migrant health insurance permit little flexibility for migrants to transfer their health insurance between rural and urban areas because both are subsidized partly by local governments with variable capacity for support. Institutional barriers that stop migrants from transferring their scheme is due to differences in financial status between different areas, making it hard to navigate through the health insurance systems when they move

Training and Education Programmes for internal migrants

The government has ensured skill training and information on applicable laws and regulations to rural migrants for a reasonable fee. A National Plan jointly drafted by 6 ministries was launched to provide training to rural migrants. A Sunshine Project as part of National Plan was launched in 2004 to train and instruct new rural migrants in the sending areas, especially the identified poor areas. Residential community forms are an important method for transmitting information and improving awareness. The NGOs have also been incorporated to provide training and education to migrants. Research has found strong association between migrant's knowledge and health.

Health policy measures

In January 2004, the Ministry of Health issued a document to improve health protection, control the incidence of and improve the diagnosis and treatment of occupational illnesses among migrant workers, this includes improved access to emergency services and preventive care to deal with occupational diseases. Local policies are being piloted in different cities to meet the challenges of tuberculosis, sexually transmitted diseases and maternal health. For e.g. special schemes provide subsidies to migrant women to be able to deliver their babies in public hospitals in Shanghai

Community participation and the concept of Alternative clinics

Community based health care is promoted by establishing small hospitals and clinics in residential communities to provide preventive services and treatment for common diseases. The Alternative clinics are set up by migrants themselves. "Zhejiang Village" is a migrant community of about 100, 000 migrants located in southern Beijing. Most migrants in the community access their daily health services from clinics set up by their fellow migrants from Zhejiang. Since so many people migrated from rural areas in southern Zhejiang, local doctors there lost their clients and some moved to Beijing to set up clinics. They lack formal license from the government. But, migrants prefer these clinics compared to formal hospitals in Beijing, because they are convenient to visit, cheaper, and most importantly, the doctors are more familiar with the patients' lifestyle and providers understand their problems better. These clinics can be used for migrant management and to foster closer relationships with migrants. Such clinics need to be encouraged as catering for migrants and other urban poor.

Special and Pilot Projects

UNESCO and its project "Together with Migrants" has been piloted in 8 sites in China. Local NGOs play an important role to improve the welfare of migrants. In the Chinese context two types of local NGOs are concerned with internal migration. One type is grassroots and community-based, and seeks financial and public support from, international donors, the media and other interested parties, to enable them to work directly with migrant labourers. The others consist of mass organization and social actors, such as, women's federations, trade unions, voluntary organizations and associations, which, on the one hand, maintain a close relationship with the government and, on the other, enjoy a certain latitude in their routine work and project activities.

The Shenzhen Women Worker's Centre runs a "Women's Health Express", a minibus that visits factory sites throughout the Pearl River delta. It is equipped with a small library, facilities for playing videos, and exhibition boards with information on health and rights. Mechanisms to ensure empowerment of migrants include trade unions, NGOs and civil society.

Initiatives to stop exploitation and trafficking of women migrants

Steps taken to prevent exploitation and sexual abuse of women migrants include raising awareness of dangers (sexual exploitation, HIV-AIDS, trafficking) among the source population; efforts to reduce school dropouts; promote employers to provide jobs for women; bilateral cooperation between sending and receiving provinces for employment of migrant workers, managed migration and arrangements for accessing social services for migrants in distress.

Challenges in access to Social Security in China

The study participants from China explained that in China, migrants' access to health and social security is linked to the job contract. The social security card is provided to migrants by their employers, if they have work contract, they are entitled to pensions, industrial residence, healthcare, maternity leave and also the employment pension. National data showed only 17% of the migrants had such a social security card, it means more than 80% of migrants are working without any job contracts, and they were considered as illegal citizens of the city, and hence, not covered under any social security, including access to health care. This population is largely dependent on the expensive private medical care, hence, face high out of pocket expenses.

"if you have social security card that means you can go to a specific hospital or clinic then you get free of charge treatment, if you do some operation then they will give you concession of certain percentage of amount … some of migrants, if they don't have money they just neglect their health,

they just drink lot of water… according to the Chinese culture if one drink lot of water then get cured and it helps them to recover…"

Migration researcher, Beijing, China

Migration census in Viet Nam

The study participants from Vietnam said that in Vietnam efforts are made specifically to build a database on internal migration by collecting data on characteristics, facts and figures on internal migration in 2004 and in 2015. The census provided robust evidence on the magnitude of internal migration in Vietnam since the economic reforms. It also emphasized the need for infrastructure development and public service to manage issues related to the migrant population. This lead to the need of mainstreaming migration in the National Poverty Alleviation program, need to develop coordination between sending and receiving community, improving access of migrants to basic services and low-cost housing, health insurance and abolition of household registration system which acts as a barrier to accessing basic and health services. The collaboration with NGOs was also emphasized for the welfare of internal migrants. Earlier, the Vietnam migration survey conducted in 2004 and 2015 led by the General Statistical Office, Vietnam and United Nations Population Fund made specific recommendations related to special attention to migrant women particularly in the age group of 44-59 years; necessity to strengthen IEC activities, promotion of education, special emphasis on reproductive health care and family planning needs of migrants and measures to improve information, education and communication campaigns about health. It is highlighted that in order to protect the health of migrants, it is necessary to formulate comprehensive measures and not only the development of medical systems. In particular, special attention needs to be paid to water, sanitation and housing for migrants. Hence both the surveys have laid the foundation for steps to be initiated by the government. In recent years, the Government has given some recognition to the particular vulnerability of migrant and mobile populations to HIV infections. At the sub-national level, there is also some growing recognition

of migrant's HIV vulnerability, with some provincial and local authorities partnering with donors to implement HIV prevention activities which specifically target migrant workers. This is a positive first step towards addressing the particular vulnerability of mobile and migrant populations. However, the bigger challenge ahead is to ensure that in practice, HIV prevention, treatment and care are consistently available to migrant and mobile populations across Viet Nam.

Portable Health Insurance in Philippines

A senior official of Philippines Health Insurance Corporation said that Philippines had come up with the portability of insurance programme for their internal as well international migrants. The National Health Insurance Program was established to provide health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of Philippines which would be expanded progressively to constitute one universal health insurance programme for the entire population.

"We are a country of islands, we often face storms, and our people get displaced very frequently. Taking into account this problem and also high migration to urban areas, we had developed portable health insurance for our people, which they can access anywhere in the country. Similarly, we also offer same insurance to our people who are migrated to other countries"

Senior official, Philippines Health Insurance Corporation

Migration Health Policy in Sri Lanka

A senior official from Ministry of Health, Sri Lanka said that in 2013 Sri Lanka adopted the National Migration Health Policy providing for the health care and equitable services to the migrants in Sri Lanka. The Policy was developed by the Ministry of Health in recognition and promotion of the Right to Health for internal, in bound and out bound migrants and their families left behind in Sri Lanka. The policy is targeted at all men and women migrants, during the whole migration process with the aim of improving migrant's access to health care and promoting their

well-being which will ultimately contribute to productive and healthy working environments. It aimed at engaging all relevant sectors and agencies that are responsible to ensure the health of the migrants throughout the migration cycle through a coordinated multi-sectoral, multi-agency approach. It is expected that this would lead to the enhancement of the benefits of out-bound, internal and in-bound migration on the economy and society by promoting the beneficial aspects of migration and minimizing the negative health impacts, integrating migrant health care into development, public health care and social welfare goals of Sri Lanka, and working towards the realization and protection of human rights in the process of migration.

Other than the national migration policy, Sri Lanka has initiated Social Welfare schemes for migrants and their families like Videsh Rakiya, social insurance scheme which covers illness expenses, disability, death, death of dependents and funeral expenses.

"It was a major challenge to bring everyone on board and ensure political will… people change, so we had to start fresh dialogues with concerned new authorities… But finally, we are there… our comprehensive migration health policy is in place. We had very scientific approach to formulate the policy, we started with migration data, multiple consultation with different stakeholders and so on…."

Senior official, Ministry of Health, Sri Lanka

DISCUSSION

The study showed that internal migration is on the rise in these countries. China is unique, where a number of changes have occurred simultaneously, all creating more movement of people. These include market liberalization and the spread of export oriented manufacturing and the removal of employment and movement controls. The internal migration trend in China shows that roughly 18% of the total population of China are migrants. Around 247 million Chinese people have migrated to cities from Chinese rural areas.[59] About half of these movements are inter-provincial,

from under- developed parts of the country to the east coast, and the remaining are intra-provincial movements within the eastern provinces. Majority of these movements are circular in nature, which retain strong links with their rural families. They are also termed as the floating population in China. The majority of the migrants are aged between 16 and 35 years[1,18].

Internal migration has been essential component of Vietnam since the '*doi moi'* economic reforms. In Vietnam, the 2015 census data indicated that nearly 19.7% of the total population migrated internally[60]. The migration to urban areas was mainly to Hanoi and Ho Chi Minh City and the nature of migration was permanent. However, it is to be noted that the census did not capture seasonal and temporary migration in Vietnam, most of which is to industrial zone[8]. Evidence indicates that labour migrants account for a large proportion of workers engaged in the service sector mainly in retail trade, transportation, domestic and personal services. The emerging trend was increase in the number of female worker migrants relative to males. Excessive concentration of population in a few cities combined with inadequate infrastructure is resulting in over urbanization in Vietnam with a portion of the urban population not having access to basic amenities like hygienic toilets and clean drinking water[8,10].

Internal migration data from Philippines indicate that urban population grew 4 times while rural population only doubled during 1060-2000; Migration to urban areas continues to be predominantly female. According to Census of Population and Housing 2010, 2.9 million Filipinos migrated between 2005-2010[62].

Migration in Sri Lanka largely happened during the separatist conflict for safety. But labour migration was on the rise for livelihood from rural to urban areas. According to the 2001 census, nearly 20% of the population had internally migrated, however no migration specific disaggregated data was available[66].

It was noted that all the countries that participated in the study were in the early stages of development. It was noted that governments were being to realise that the internal migration was on rise and cannot be neglected and measures were required to redress these issues. Some measures have been taken and some challenges faced by them are being addressed. Overall, the government policies and measures are limited by the perception of the governments that free migration is harmful to development and needs to be controlled by restricting the movement of citizens. This perception changes the direction of policy measures taken for internal migrants. Such an approach has been identified as the major barrier to developing appropriate policies in China and Vietnam as household registration system forms the basis of social, health and economic policies for internal migrants. The system lacks a comprehensive approach based on rights, entitlements and inclusion. In many cases, as in China and Vietnam, health and education are supposed to be accessed in their home provinces. When a migrant or his family leaves their home town in search of better prospects, they risk losing out on these services. While administratively migrants are supposed to integrate into the social system of their destinations and the process of registering and obtaining services this is not always the case especially, if there are no appropriate services catering to migrants in their destinations. Research shows that the rural–urban migration in China resulted in health problems due to existing rural-urban dualism due to prevalent registration system which prevented rural population from benefiting from state facilities[12,69]. The new urban care system adopted in 1994 does not cover migrant workers not registered with the government. Further, frequent mobility and localized medical care funds makes the inclusion of migrants in the formal health care system difficult. There exists an unbalanced relationship between the government, employer and migrant worker - the local governments promote increasing profit of private enterprises by providing cheap labour and do not emphasize on providing better facilities for the welfare of the workers. The existence of cheap, migrant labour is

in the interest of the government to boost foreign investment, land rates and income level of local people. It was identified that the main barrier in health care access by migrants was household the registration system, lack of insurance system and high cost of health care particularly, primary health care leading to high out of pocket expenses[12,73,217,218].

The study identified the need for migration specific data for developing evidence based policy. It was noticed that Viet Nam and China initiated migration census, but an important gap noticed was that the policy measures were not backed by the requisite research and evidence, leading to less effective measures, since none of the countries had migration specific disaggregated data pertaining to migrant's access to health or social security services

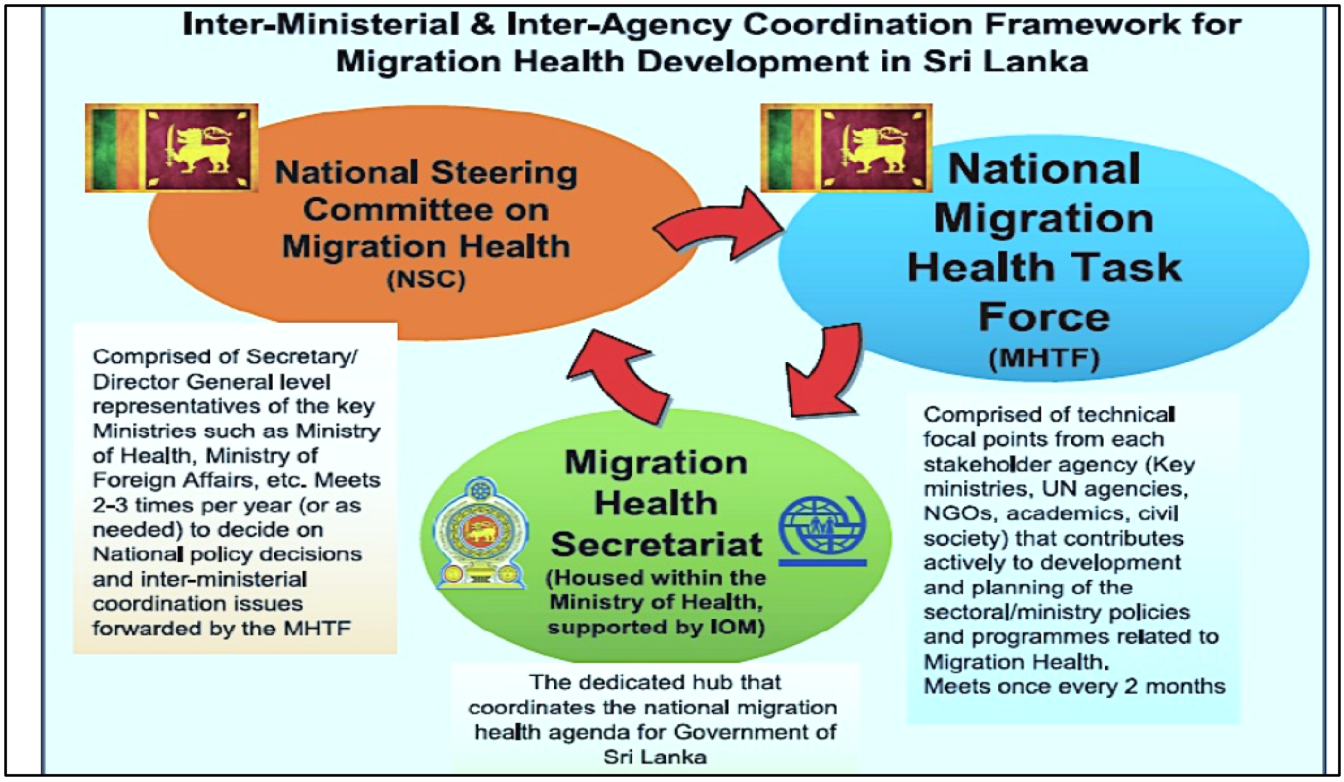
The major obstacle in access to health care is its economic cost, compounded by the high cost of health care, high out of pocket expenses due to lack of coverage by health insurance schemes. There appears to be discriminatory access to sick pay and health insurance among migrants' due to lack of portability. The insurance schemes available in the countries like China were linked with the residency status and not easily transferable from one area to another, migrants therefore, do not qualify for public insurance and assistance programmes. Hence, fragmented insurance schemes with restricted transferability were not very useful. The study identified need for policy development for a national transfer mechanism which will help migrants to get the benefit of the welfare schemes, insurance and uninterrupted health care even when they are mobile due to job demands. Philippines has set up a model that can be help to inform national portable insurance available to any citizen anywhere in the country[125].

Implementation of policies and programmes and regulation of laws in favour of migrants are hampered by the absence of robust institutional mechanism to enforce the laws and the workers lack sufficient knowledge of the laws and rights, while the channels to raise their concerns are severely limited. Another barrier is the uncoordinated approach which is reflected in un-integrated implementation by local governments and other stakeholders. Where migration health policies exist, they operate in isolation at national levels. Though many policy measures exist they lack a policy framework coordinating and linking all efforts rather than functions in fragmented manner, resulting in minimal impact. These policy gaps need to be plugged by different government agencies as government intervention is still the most powerful measure in regulating social, economic and health aspect of migrants. Sri Lanka has a good example of formulating National Migration Policy and has set up a strong institutional mechanism for effective implementation of the policy for migrants. In recognizing the multi-disciplinary nature in addressing health issues stemming from various migration flows, a participatory, inter-sectoral 'whole–of-government' approach was adopted by the government of Sri Lanka (GoSL) to advance the national migration health policy process. Key milestones on the journey of Sri Lanka's policy development process were established by the ministry of health (MOH) in 2009. The policy formulae and intervention framework were guided in a large part by the evidence generated through a National Research Agenda commissioned by the Inter-Ministerial committee in 2010, with technical cooperation from IOM. An inter-ministerial coordination mechanism was established with technical and financial support from IOM, with the ministry of Health (MOH) playing a coordinating role to galvanize the migration health agenda. The inter-ministerial and inter-agency coordination framework that comprises three elements: A secretariat to drive coordination, a National Migration Health taskforce (MHTF) to drive technical cooperation, and a National Steering Committee (NSC) to drive legal and executive level action were put in place. The MHTF also enabled input

from civil society, non- governmental sector, academic and intergovernmental organizations for the policy formulation[220].

Through this coordinated framework, the GoSL was also able to proactively respond to emerging migration health related challenges such as the health services provision for returning refugees and the assessment of resident visa applicants to the country. A key formative step was the establishment of a dedicated Migration Health Secretariat/ Unit by the Ministry of Health within the Directorate of Policy and Planning with the ongoing technical and financial support of IOM. The unit's role is critical as it acts as a dynamic coordination node to support the administrative and management functions of the policy development process, coordinate MHTF and NSC meetings, facilitate monitoring and implementation of the inter-Ministerial action plan; develop a repository /knowledge hub for all relevant technical papers and planning documents and ensure future sustainability and respond to emerging migration health related issues[105].

Figure 33: Inter-Ministerial and Inter-Agency Co-Ordination Framework for Migration Health Policy in Sri Lanka



Sri Lankan migration policy model is worth exploring and could be used in other countries.

CONCLUSION

The study has shown that the internal migration is an essential corollary of rapid inequitable growth and development apparent in countries which participated in the study - Sri Lanka, Philippines, China and Vietnam. It became evident from the study that the impact of the migration process is on the economic, social and health aspects of the migrants. As far as health is concerned, migrants are bearing the brunt in form of worse health outcomes in respect of maternal and child health, prevalence of communicable diseases, vulnerable mental health and higher risk to accidents and occupational hazards. Migration as a process acts as the social determinant of the health status of migrants and has a negative impact due to poor living and working conditions to which the migrants are exposed due to their socio-economic status. Further, mobility in itself worsens the

already precarious health of the migrants as it leads to discontinuing medication and minimal utilization of health services at new destinations.

These aspects of internal migration impacting on the health and well-being of migrants have been noticed by the governments of countries participating in the study. China and Vietnam have household registration system which forms the basis of social, health and economic policies for internal migrants. China has fragmented policies to address migrant's health and social security needs such as health insurance and education for children, employment training as outlined above. However, the system lacks a comprehensive approach based on rights, entitlements and inclusion. Sri Lanka and Philippines recognize that the rights based approach needs to be adopted to manage internal migration to facilitate inclusive growth and development. Philippines have launched portable national health insurance to ensure universal health care for every citizen of the country. While Sri Lanka has taken significant steps to formulate their National Migration Health policy. It is clear that multi-sectoral and coordinated policy measures and strategies are vital to deal with the issues of internal migrants as right to health also includes the underlying preconditions of health - an adequate supply of safe food, nutrition and housing, access to safe drinking water and adequate sanitation, safe and healthy working conditions, and access to health-related education and information. The right to health also includes a range of socio-economic factors crucial to the achievement of health. For effective implementation of policy measures, migrants, community, civil society and NGOs should collectively participate, supported by the health professionals.

Piecemeal efforts driven by any one department or ministry rarely works, adoption of a comprehensive 'whole' approach seems more promising. It is clear from the experience and lessons learned in Sri Lanka that a right based; multi-sectoral and coordinated policy measures and

strategies appear to be the most promising way forward to manage internal migration and issues of migrant health.

Lessons for India

The focus of all interventions and policies in India, so far, is not to improve access to public services for internal migrants. A large proportion of the migrants are not entitled to basic services as access is linked to place of residence and residential status. The pro-poor measures need to be focused on both backward regions, source areas and destination areas, which means broadening the safety net coverage to target the poorest through housing, sanitation, health and nutrition schemes.

Lessons can be learnt from existing micro projects of the countries interviewed and adapted to ensure that policies reflect local realities and is acceptable by the communities in India. For example, migration census can be initiated in India as it is in China and Viet Nam. Perhaps, India could take this a step further and build migration specific disaggregated data needs based on the access to health and social security services to enhance the monitoring mechanisms, this can be done by incorporating migration specific variables in the existing surveys - national family and health survey, labour and employment survey, national sample survey and census.

Taking into account the mobility of migrants and state specific health services that are linked with residential status, India needs portability of health insurance across states, that can provide universal access to health care across the country. National portable health insurance can be adapted from Philippines existing health insurance model.

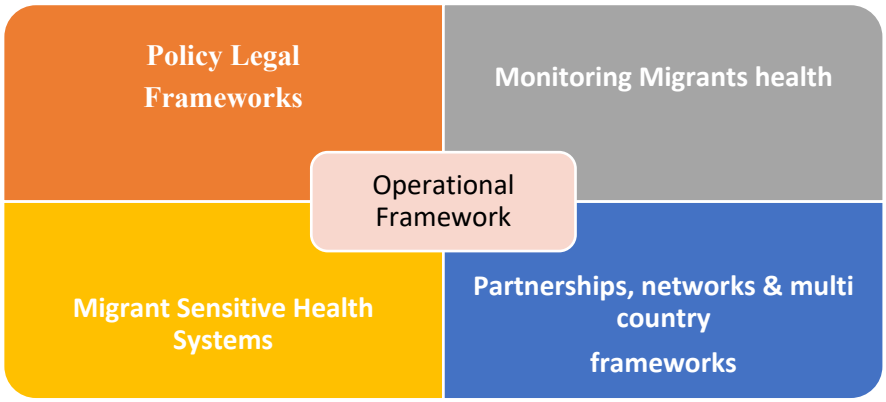
Looking at policy examples of China, Vietnam, Philippines, and also within India it is clear that piecemeal efforts driven by single departments or ministries rarely works for migrants, since migrants have unique and pressing needs. The only way to overcome the unique problems and issues of internal migrants in India is to adopt the 'Right to Health' principles as it includes the underlying preconditions of health. If managed appropriately, internal migration can be the tool for poverty reduction. They are an important group contributing to the economic development of the nations by working in precarious conditions and need to get equitable recompense.

Recommendations which may be adapted in the Indian Context

1. Policies and strategies

India has a lot to learn from all participating countries in the study. The policy framework can be derived from policy initiatives in Sri Lanka, Philippines, Vietnam and China as outlined below: The possible policy framework is based on the 61st World Health Assembly's Resolution[134] on migrant health and strategies are devised to attain those broad objectives suited to Indian context.

Operational Framework: Key Priorities



Recommended strategies to attain key priorities of migrants' health

- Promote evidence based policies it is essential that national level migration specific disaggregated data is included in existing government data sources mainly census, national sample survey, and family health survey
- Develop a Migrant Sensitive Health Policy, considering the vulnerabilities and offering tailored solutions and incorporating a public health approach to improve the health of migrants and promote equal access regardless of status
- Establish a focal point of coordination with a specific nodal authority responsible for coordinating the different policy sectors - health, urban development, housing, water, labour laws, unique identification authority of India etc to result in coordinated and non-

conflicting policies between different sectors with respect to welfare of internal migrants. This will avoid duplication of efforts and wastage of both human and financial resources.

- Devise a portable national health insurance policy to provide financial support to migrants for their health expenditure and reduce out of pocket expenses
- Extend social protection and improve social security for all migrants

I. Migrant sensitive health systems

- Ensure that health services are delivered to migrants in a culturally and linguistically appropriate way and enforce laws and regulations against discrimination
- Adopt measures to enhance the ability of health systems to deliver migrant inclusive services and programmes in a comprehensive, coordinated, and financially sustainable manner
- Enhance the continuity and quality of care received by migrants in all settings, including the private and voluntary sectors.
- Develop capacity in the health and relevant non-health workforce to understand and address health issues associated with migration.
- Strengthen special health programmes for communicable diseases like TB, malaria, similarly for migrants similar to what is already available in India for STI/HIV/AIDS
- Effective implementation of the available programmes for migrants to improve the health status of migrants. This could include initiating or reinforcing migrant-friendly public health services, and creating a greater awareness about those services among migrants, onsite mobile health services or providing special assistance to migrants in regular health services, etc.

- Devise tools using information technology to ensure continuity of services for of migrants moving from different states
- Encourage community participation and outreach services to reach mobile internal migrants and organise partnership with private employers.
- Promote involvement of local governments in the implementation of programmes for migrants

II. Monitoring Migrants Health

- Disease surveillance tailored to migrants' health problems
- Supporting the appropriate disaggregation and analyses of migrant health information
- Use the evidence from monitoring migrant health to formulate evidence-based polices for equitable access to health and social security
- Gather appropriate data and foster specific research to contribute to evidence-based decision-making and monitoring of the impact of policies and programs

III. Partnerships and Networks

- Harness the capacity of existing networks to promote the internal migrant health agenda
- Facilitate a network of different regions of the country on migration, especially in sending and receiving communities to develop programmes for migrants at sending areas to support the host community.
- Facilitate networks of different states of the country to share experience and examples of good practice

The qualitative study has shown that, as in India, internal migration is an emerging issue in the countries participated in the study. However, the respective governments of these countries have begun to realize that internal migrants cannot be ignored as it would ultimately affect the destination community and health outcome indicators of the nation. The study has demonstrated that India has specific lessons to be learnt from these countries such as; migration census can be initiated in India likewise China and Viet Nam, National portable health insurance can be adapted from Philippines's existing health insurance model, and comprehensive 'whole government approach can be adapted from Sri Lanka to formulate right based; multi-sectoral and coordinated policy for migrant's health.

The next and final chapter will discuss key findings of literature review, quantitative survey on migrant's access to health, and findings of qualitative study in India on perspectives of the policy makers and other relevant stakeholders on migrant's health and policy initiatives, challenges and success. The chapter will also propose some recommendations for improving the health of internal migrants in Indian and suggest further areas of research in this area.

CHAPTER SIX

SUMMARY, DISCUSSION AND CONCLUSIONS

SUMMARY OF FINDINGS

This DPhil research was focused on understanding and critically analysing the extent of internal migration, the impact of migration on health and the existing policies related to internal migration in India. The research also explored what mechanisms selected Asian countries have developed to address migrant's health needs. Three important dimensions were explored in relation to access to health and social security programmes among migrant - 'Vulnerabilities', 'Issues faced by migrants', and 'Existing Mechanisms, Challenges and Successes' at policy level. Views of relevant stakeholders on evidence based policy framework for migrant's health were also explored.

This research determined that internal migration occurs in all parts of world, it is growth engine of development and it is here to stay. However, in spite of the important role the internal migrants play in development and economic growth of the country concerned this group of migrants are vulnerable due to exploitation from lack of appropriate facilities, economic hardships, etc. which impact on their health and well-being and very little is being done to support and protect this group of people.

Firstly, a literature review was undertaken to understand the circumstances in low, middle, high and upper middle-income countries in terms of volume of internal migration, issues of migrants, and the existing policy environment to support migrant's health and social security needs. The review (Chapter 2) indicated that while international migration in many H&UMICs was highlighted and initiatives had been taken to ensure the rights of international migrants this was not the case for internal migrants. Internal migrants, who were moving within their own country and contributed to the country's economic development were neglected by their governments/policy makers. The review also demonstrated that internal migration was on decline in H&UMICs - USA, Japan etc. and this may be one of the reasons that internal migration was not

considered an issue in these countries. Another explanation for the non-existence of specific policies for internal migrants in H&UMICs could be that these countries had better health systems and have optimum resources to ensure that the internal migrants have appropriate and good health and social care as the rest of the citizens unlike the conditions faced by internal migrants in less developed countries. However, there is empirical data to or make these comparisons.

The literature review showed that internal migration is growing concern in LMICs which are in the early stages of their development in terms of policy with respect to welfare and health issues of internal migrants. It was observed that the policy measures on migration include, security, labour, trade, enforcement and international aid laws, while rarely including health policy for migrants[12,72,73]. Moreover, the existing policy measures for internal migrants are minimal compared to international migration, though the magnitude and socio-economic development outcomes of internal migration are either equal or greater than international migration. The review identified that some countries have developed innovative policy measures to deliver affordable, accessible and good quality health care to internal migrants, examples include Mongolia and Cameroon. In addition, few countries such as Sri Lanka and Thailand have developed comprehensive migration policies for both internal and international migrants, and some countries such as China and Vietnam have migration specific census, but access to public services is linked to registration system. Philippines and Malaysia have health insurance for international as well internal migrants. It was observed that the existing health policies of different nations do not emphasise the unique needs and issues specific to internal migrants, which warrant separate, focused policy measures targeted at accessibility, affordability and continuity of health services related to their mobile situation and vulnerable living and working conditions. The literature review also demonstrated that fragmented efforts driven by any one department or ministry rarely worked, and the adoption of a comprehensive approach seems more promising. It became clear

from the lessons learned from these countries that a right based; multi-sectoral and coordinated policies and strategies may be the best way forward to manage the issues faced by internal migrants.

The literature review demonstrated that internal migration for livelihood is rising in India, and certain social groups such as scheduled tribes (STs) and scheduled caste (SCs), are migrating to escape from poverty with STs being the dominant group among the categories followed by SCs and other backward castes (OBCs). The review showed that India is facing challenges due to internal migration and has an increasing need to develop and implement policies to improve migrants' health. Currently, India has a few fragmented policies and programmes for migrants, but there are no structured policies or programmes targeting migrant issues and this segment of the population still faces exclusion from various mainstream programmes. There is a need to modify the existing policy structures and programmes so the needs of this marginalized group are incorporated in the various national policies and programmes.

Chapter three was based on a quantitative survey, which described vulnerabilities of intra and interstate migrants and their access to health services in one of the fastest developing cities of India, Nashik in Maharashtra, in one of the highly urbanised states of India (Maharashtra). The chapter described the poor socio-demographic profile of migrants and their vulnerabilities due to their migration status. It was clear that migration among STs/SCs/OBCs was high with STs forming a large proportion. The findings also highlighted migrant's inability to access general health and maternal and child health care due to lack of awareness, migrant specific health programmes, and discrimination by the health system due to their migration status. The survey also highlighted that interstate migrants were more vulnerable in terms of access to health and social security programmes compared to intrastate workers, due to the linking of such programmes

with state specific identity in India. This demonstrated the emerging need to initiate universal access to health and social security programmes in India, and the need to build portability of these services for better inclusion of migrants. The Aadhar card and number, a biometric-based identity card which has been made popular in India for many years could be a tool to ensure universal access and portability.

Chapter four was based on a qualitative study, which demonstrated clearly that India was facing challenges related to internal migration and had an increasing need to formulate and implement policies to improve migrants' health. Interviews of key policy makes, implementers, researchers and members of civil societies made it very clear that currently, India has no structured policies or programmes targeting migrant issues comprehensively in spite of large volume of migration. This meant that this segment of the population faces exclusion from the various mainstream programmes. The qualitative study has highlighted the key challenges related to migration in India and possible solutions that can be drawn from some of the initiatives in a few states. Lack of migration specific data, state specific programmes/policies which are linked with state citizenship, and lack of a federal structure are some of the key challenges to cater to the unique and pressing needs of migrants. However, there are some promising pilots in a few states such as the interstate collaboration between Andhra Pradesh and Odisha, a comprehensive support programme for tribal migrants in Maharashtra, the urban health programme for migrants in Gujarat by the urban health society, department of health, Gujarat. The only national level initiative identified was the amendment of the interstate migrant workers 1979 proposed by Ministry of Labour and Employment, which has the potential to ensure health and human rights to all migrant workers of India, is in process, but it has not been taken forward yet. The key learning that can be drawn from these pilots include the importance of gathering migration specific disaggregated data within the

existing government data sources, construct portability of social security services across states, and universal access to health and social services.

The fifth chapter described a qualitative study focused on learning from other Asian countries mainly Sri Lanka, Philippines, China and Vietnam. The study showed that internal migration is a consequence of rapid inequitable growth and development. It became evident from the study that the impact of the migration process is on the economic, social and health aspects of the migrants. As far as health is concerned, migrants are bearing the brunt in the form of worse health outcomes with respect to maternal and child health, increased prevalence of communicable diseases, mental health issues and a higher risk of accidents and occupational diseases. Migration as a process acts as one of the social determinant of the health of migrants and has a negative impact due to unhygienic and poor living and working conditions to which the migrants are exposed due to their socio-economic status. Further, mobility in itself worsens already existing health problems of the migrants as it leads to discontinuing medication and utilization of health services at the new destination. These determinants and the impact linked with internal migration were noticed by the governments of countries that participated in this study. China and Vietnam have household registration systems (ho khau) which forms the basis of social, health and economic policies for internal migrants.[182] China has fragmented policies to address migrant's health and social security needs such as health insurance, education for children, and employment skills training as highlighted in the chapter. However, the system lacks a comprehensive approach based on rights, entitlements and inclusion.

Sri Lanka and Philippines have recognized that a right based approach to manage internal migration should be adopted for all-inclusive growth and development. Philippines has launched a portable national health insurance to ensure universal health care for every citizen of the country

and Sri Lanka has taken significant steps to develop a National Migration Health policy. The general consensus was that multi-sectoral and coordinated policy measures and strategies are the best way forward to manage problems and issues of internal migrants as right to health also includes the underlying preconditions of health: an adequate supply of safe food, nutrition and housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and access to health-related education and information. Moreover, the right to health embraces a wide variety of socio-economic factors indispensable to the achievement of health. Further, for effective implementation of policy measures, it was thought that migrants, community, civil society and NGOs should collectively participate, supported by the health professionals and others involved to be more sensitive and aware to the issues of internal migrants. It is clear from the lessons from Sri Lanka that a right based, multi-sectoral and coordinated policy measures and strategies is an important step forward to manage issues of migrant health.

The fifth chapter has highlighted specific lessons that can be learnt from these countries to be adapted to the Indian context. Examples include the introduction of a migration census could be initiated in India similar to China and Vietnam, a system of national portable health insurance could be adapted from the Philippines's existing health insurance model, and comprehensive 'whole government approach' adapted from Sri Lanka. This could inform the development of a relevant right based, multi-sectoral and coordinated policy to be developed to improve migrant's health in India.

DISCUSSION

Migration – a global perspective

Insights from Global Initiatives by UN Agencies

Besides India and other Asian countries, efforts were made to understand global policy initiatives for migrant's health taken by UN agencies such as World Health Organization (WHO) and International Organization for Migration (IOM).

Resetting the Agenda of Migrant Health

Acknowledging the inherent connection between migration and health, WHO Member States adopted the 2008 World Health Assembly (WHA) Resolution on the health of migrants (WHA.61.17)[134]. The resolution paved the way for the 2010 Global Consultation on Migrant Health[160] in Madrid, Spain which was co-organized by IOM, WHO and the Government of Spain and defined an operational framework to guide Member States and stakeholders in implementing the strategies of the resolution. This Operational Framework reaffirmed the need for adopting a rights-based, equity-driven, health system strengthening, multi-sectoral approach in addressing health and migration and identified four priority areas for action, namely: monitoring of migrants' health; policy and legal frameworks; migrant-sensitive health systems; and, partnerships, networks and multi country frameworks. Yet while awareness and recognition of the urgency to adapt policies and programmes, across sectors, to the health challenges brought by global human mobility is on the rise, the adaptation and development of necessary technical and policy instruments remains slow.

Governments are faced with the challenge of integrating the health needs of migrants into national plans, policies and strategies across sectors, responding to the call to 'leave no one behind' and

achieve Universal Health Coverage (UHC), stated by the 2030 Sustainable Development Goals (SDGs). Coordinated efforts are needed to ensure that migrant health is addressed without discrimination throughout the migration cycle, as are efforts to adapt and strengthen the resilience of local health systems in light of more diverse population health profiles. Addressing the health needs of migrants and affected local populations reduces long-term health and social costs, facilitates integration and contributes to social and economic development.

At the 106th IOM Council in November 2015, a *High-level Panel on Migration, Human Mobility and Global Health* was organized. During the Session, the President of the Democratic Socialist Republic of Sri Lanka, His Excellency Maithripala Sirisena, offered to host a Global Consultation on migrant health. In addition, during the 69th World Health Assembly in May 2016, a Technical Briefing session was dedicated to the topic of '*Migration and Health*'. WHO Member States also debated and took note of the Secretariat report on '*Promoting the Health of Migrants*' (WHA A69/27).

In September 2016, during the UN General Assembly Summit on Large Movements of Refugees and Migrants, IOM, WHO and UNHCR co-organized a *Side Event on Health in the Context of Migration and Forced Displacemen*t, which was sponsored by the Governments of Sri Lanka and Italy. These activities illustrate that migration and health is a topic of interest for many governments and requires a dedicated and in-depth discussion to redefine the global agenda, taking stock of current trends and perspectives.

The UN General Assembly Summit on Large Movements of Refugees and Migrants has created a unique opportunity for the global community to forge a greater consensus on managing the world's movements of migrants and refugees. It also set in motion the development of a roadmap to a

Global Compact [11](United Nation's initiative to encourage businesses worldwide to adopt sustainable and socially responsible policies, and to report on their implementation) for Safe, Orderly and Regular Migration and a Global Compact for Refugees. The Global Consultation was an important milestone to ensure adequate reflection of the health of migrants within the Global Compacts.

The 2nd Global Consultation on Migrant Health

"Leaving No One Behind: A Call for Action to Ensure Migrant's Health and Wellbeing"

In response to the renewed international attention to the topic, IOM, WHO and the Government of the Democratic Socialist Republic of Sri Lanka jointly organised the 2nd Global Consultation on Migrant Health to offer Member States and partners a meaningful platform for multi-sectoral dialogue and political commitment to enhance the health of migrants.

The Director of IOM's Migration Health Division Dr. Davide Mosca made a statement during the consultation

"Migrant health must be looked at as a global agenda and the SDGs should be interpreted by linking the call to facilitate orderly, safe and responsible migration and mobility of people (SDG 10.7) with the achievement of universal health coverage (SDG 3.8). This can only be realised through the implementation of well-managed and coordinated migration policies, which include financial risk protection and equal access to quality health services."

The Colombo statement was adopted on the closing day of the 2nd Global Consultation on Migrant Health. Demonstrating the high-level commitment to migrant health, the President of Sri Lanka, H. E. Maithripala Sirisena, IOM Regional Director for Asia and the Pacific, Dr. Nenette Motus,

[11] UN Global compact, information available on https://www.unglobalcompact.org

WHO Regional Director for South East Asia, Dr. Poonam Khetrapal Singh and senior government representatives from over 40 countries participated in the meeting.

The Colombo Statement called for mainstreaming migrant health into key national, regional and international agendas and promote international solidarity for equitable migrant health policies, a shared research agenda and the development of global frameworks to ensure migrant health is protected. It was decided that the momentum generated by the global consultation will carry forward to the 70th World Health Assembly (WHA) in May 2017, where 194 countries deliberated on priority actions to protect the migrants' right to health and wellbeing. The Resolution on "Promoting the Health of Refugees and Migrants" was endorsed on Monday 29 May 2017 during the 70th WHA. This resolution is an important step towards ensuring health is adequately addressed in global compact for refugees, and the global compact for safe, regular and orderly migration[221,222].

Why India is an important stakeholder in Global Migration Scenario?

Migration for livelihood is a growing phenomenon in India. Migration in India is rising rapid rising, both international as well internal migration. Approximately 29% of India's population is migrating within the country. According to the estimates from the National Sample Survey data in India, over US$3.846 billion was sent by international migrants and US$7.485 billion by internal migrants in 2007/2008 as remittances[40,42]. This suggests that migration can play an important role in poverty reduction and economic development. The migrant population is normally missed out at source and destination from most social welfare development programmes, such as livelihood, education, health, insurance, legal protection etc. Hence positive facilitation of safe migration should be specially emphasized which includes access to basic public services mainly health, education and livelihood. Safe and skilled migration is the motto of the Indian government in

relation to India's international migrants and support programmes[223,224] have been set up by the ministry of foreign affairs for international migrants but the same supportive approach is missing for internal migrants.

Prime Minister Modi's government's ambitious 'Skill India Mission'[225] and 'Make in India'[226] programmes have created newer opportunities for young people in semi urban and urban areas, and even at an international level and this environment has been instrumental in facilitating and increasing migration. India being Asia's largest and most influential labour sending county[224,227], has a greater role to play on these issues at an international level. India is facing migration challenges and has an increasing need to develop and implement strategies to improve migrants' condition both internal and cross border. Currently, India has very little or no structured policies or programmes targeting migrant's issues in a holistic manner. The Indian government must ensure coherence between national and international policies for migration and development. It can learn from the policies and programmes from countries like Sri Lanka, and adapt them to the Indian context. There is a need to modify the existing policy structure and programmes so the needs of this marginalized group are accommodated in the various national programmes, including health and other social protection. Development of a comprehensive National Migration Policy would be proactive step towards it that can ensure health and welfare of those who migrate. After all, migrants are a key group contributing to the economic development of the India by working in precarious conditions and need to benefit equitably from the fruits of growth as other sections of the society.

Migration and SDGs links in the Indian context

The Sustainable Development Goals (SDGs) recognize the importance and interrelation between health and migration indirectly[55,228]. It is time to recall the Stockholm Agenda[229] in the Indian context, which says "migrants' remittances are neither an answer to development nor an appropriate policy for poverty reduction." The SDG discussions must specifically include migrants and migration for sustainable development. *Migrant health in India must be looked at as a global agenda and the SDGs should be interpreted by linking the call to facilitate safe migration (SDG 10.7) with the achievement of universal health coverage (SDG 3.8) and also with other SDGs.* For health, as for other sectors, migrants face specific challenges that must be addressed if India has to meet the Global aspiration to 'leave no one behind' The evidence suggest a number of issues which need to be tackled to ensure that migration contributes to, and does not undermine, the achievement of the SDGs. SDGs and possible migrant specific indicators in the Indian context could be achieved as described in table 19 below:

Table 19: Sustainable Development Goals (SDGs) And Possible Indicators In Terms of Internal Migration In India (Adapted From IOM 2014)[230]

SDGs	**Possible Migrant Specific Indicators in India (Adapted from IOM, 2014)**
Goal 1. End poverty in all its forms everywhere	• Number of public and private banks that have started providing access to financial services and safe remittance services for migrants. • Number of financial institutions that are participating in regional and national labour mobility and trade in service agreements • Reduce the average cost of sending remittances to less than 5% of the value of national remittance transactions, extending to all migration corridors in India • Reduce the proportion of migrants who pay more than one month's wages as recruitment costs **Cover people who are poor and vulnerable with social protection systems** • Proportion of socially excluded groups of migrants covered by universal social protection systems before and

	during migration at source and destination states (irrespective of their state specific citizenship status) • Proportion of migrant workers having access to transfer mechanisms for social benefits earned in destination locations and back to the place of origin
Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture	• Number of migrant children having access to nutritious food before and during the migration • Proportion of migrants having access to food security services offered by public distribution system at destination level such as seamless supply of food grain at ration shops before and during the migration period. **To ensure sustainable agriculture for migrant farmers:** • Proportion of migrant farmers (rural and tribal) who have equitable access to agriculture development programs to strengthen their agriculture and make it more productive for at least for 8 months of the year (As major agriculture of India is rain fed) • Proportion of rural and tribal farmers who are trained for sustainable agriculture and marketing of goods.
Goal 3. Ensure healthy lives and promote well-being for all at all ages	• Proportion of migrants (and dependents residing in the destination locations) who have universal and equal access to preventative and curative health services mainly mother and child health, tuberculosis, malaria, neglected tropical diseases and priority non-communicable diseases • Disaggregated data of migrants in terms of gender, age, migration status (circular/short term/permanent), type of migrant (type of professions, skilled/semi-skilled, unskilled) and by specific disease [e.g. HIV/AIDS, Tuberculosis, Malaria, Mother and Child Health, neglected tropical diseases and priority non-communicable Diseases]; by policy topic [e.g. insurance, financing, Universal Health Care] • Number of migrant's friendly health programs initiated • Proportion of health professionals recruited at different tiers to address the special health needs of migrants • "Tracking strategies" developed for improving migrants' health outcomes. • % of remittances used for health purposes by migrants'
Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all	• Proportion of migrant children with access to pre-school education • Proportion of migrant children with access to primary school education • Proportion of migrant children with access to secondary school education • Proportion of migrant children who attain equivalent qualifications and grades as compared with native born

	children
Goal 5. Achieve gender equality and empower all women and girls	• Gender disaggregated statistics on total number of identified victims of human trafficking and exploitation within India • Disaggregated statistic of migrants and identified victims of gender- based violence, including human trafficking • Mechanisms to offer special assistance for victims of trafficking and exploitation • Business sectors screening their supply chains for forced labour, especially child labour
Goal 6. Ensure availability and sustainable management of water and sanitation for all	• Proportion of migrants with access to potable drinking water and sanitation facilities at destination cities during their migration period
Goal 7. Ensure access to affordable, reliable, sustainable and modern energy for all	• Proportion of migrants with universal access to modern energy services
Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all	• Proportion of migrants employed in the informal economy • Proportion of migrants having access to equal and safe working conditions • Share of new jobs created in migrant- associated businesses, and migrant supported enterprises • Proportion of migrants covered by portability of social security benefits • Proportion of migrant workers enjoy equal wages for equal work • Proportion of young people who receive skills development training and have access to better employment • Proportion of young people who have access to vocational and skills training, and/or whose prior work experience or training is recognized • Proportion of migrant remittances transferred using formal channels • Proportion of migrant remittance senders and receivers with access to other financial services • Financial literacy rate of senders and receivers of remittances • Proportion of new businesses created through migrant remittances • Proportion of new Micro, Small and Medium Enterprises (SMEs) created by migrants
Goal 11. Make cities and human settlements inclusive, safe, resilient and sustainable	• Migrant inclusive city planning: • Proportion of migrants provided with appropriate housing and basic entitlements in cities • Availability of public services to migrants in cities without state specific identity

Goal 13. Take urgent action to combat climate change and its impacts*	• Number of initiatives to restore forests and water that can combat climate change and its negative impacts on agriculture, which leads to distress livelihood migration among rural and tribal farmers.
Goal 17. Strengthen the means of implementation and revitalize the global partnership for sustainable development	• Number of businesses reporting on screening their supply chains, screening for forced labour and exploitation, especially child labour • Number of recruitment agencies and companies that employ ethical recruitment practices systems that protect human and labour rights of migrants and that facilitate recognition of qualifications and portability of pensions and other social benefits • Existence and effectiveness of existing frameworks to reduce distress migration for livelihood within certain states

RECOMMENDATIONS

Recommendations are proposed in two categories; i) Recommendations to address health needs of migrants, ii) Broad recommendations to address various social determinants of migrant's health at policy level

i) RECOMMENDATIONS TO ADDRESS HEALTH NEEDS OF MIGRANTS:

A. Need for improved definition of migrants

An improved definition of the internal migrant population and its subcategories are necessary to enable appropriate data collection and more accurate measurement of health indicators, healthcare utilization and health outcomes within this group.

B. Data collection of internal migration at a countrywide level

One of the main constraints in framing an effective policy for internal migration is the lack of data. It is recommended to incorporate separate category of migrants in the sample selection process of National Family Health Survey (NFHS). Migration specific variables are

recommended in NFHS such as migration duration and residential status (anytime, between 1 month to 12 months), length of stay, and access to diseases specific health services and family welfare services. These variables are not captured in the current survey, it can help to generate data of migrants and also monitor their access to health care.

B. Healthcare Delivery

Health care utilization rates among migrants are often found to be poor. Migrant populations often cannot access the services/programmes due to their migration status, timings of their work and distance to services. Ministry of Health and Family Welfare could work towards creating migrant friendly health services through the following strategies:

1. Universal coverage of all health programmes including insurance for migrants before and during migration period.
2. Provide mobile health cards to migrants that can be utilized both at source and destination in any state, it can devise "Tracking strategies" for improving health outcomes of migrant, which can be linked with unique identification number.
3. Rashtriya Swasthya Bima Yojana (RSBY) should be applicable to BPL and non-BPL families of migrants.
4. Special outreach services (via existing human resource such as the ASHA worker) for migrants at their locations in cities which are not covered routinely such as construction, sites, agriculture sites, footpaths, opens spaces etc. mainly for a for preventive and curative treatment. Current front-line workers in National Urban Health Mission could undertake such outreach activities
5. The onsite mobile health services for providing special assistance to migrants would be useful.

6. Health services should provide professional interpretation services in multi-lingual encounters for interstate migrants to overcome language barriers.
7. Besides public health centres and urban health centres, Employment State Insurance (ESI) hospitals and their health centres should be made accessible to migrant workers.

C. Addressing basic needs of migrants

This would be a crucial step to address the important determinants affecting the health status of migrants. This could include:

- improving living and working conditions
- enabling the provision of low cost and good quality food options for migrant workers
- setting up of Migrant Resource/Assistance centres at the major source and destination locations which provide information and advice on available public services including health and education.

E. Capacity building

It would be important to build capacity in this area, this could include:

- Promoting collaboration among different government sectors, donor agencies, and agencies working on migration to develop and implement appropriate health polices/programmes.
- Building partnerships with NGOs working at source and destination to raise awareness among migrants to become more knowledgeable and stay updated about the available support and services.

It would also be being important to learn lessons from existing initiatives by NGOs, governments and others and build networks so good practice could be shared and collaborative work to improve the health of migrants could be facilitated.

F. Research

Encouraging research related to various aspects of migrant health and evaluating interventions in place would contribute to the evidence-base in this area. This would contribute to developing and implementing effective and efficient policies and interventions based on evidence.

G. Advocacy

While labour laws may exist to protect workers, governments may not have robust institutional mechanisms to enforce the laws on the employers, and the workers themselves may not have sufficient knowledge of the laws and their rights. There is a need to advocate for strengthening the existing programmes for migrants specially convergence of the programmes at source and destination with respective government departments and ensuring enforcement of appropriate laws.

ii) **BROAD RECOMMENDATIONS TO ADDRESS MIGRATION ISSUE AT POLICY LEVEL**

Comprehensive policy recommendations were developed to address migrant's health issues from lessons learnt from policy interventions at international, national and state levels of co-operation between the state and non-state actors. A blueprint was drawn for a national policy, keeping the federal structure as the base of the policy making body, this includes the overall objective of inclusive growth and protection of human and labour rights of migrant workers in India. As proposed previously[5], the policy framework will be divided into two sections;

1. Policies to support migrants during migration period across states.
2. Development policies for sending and receiving states of migration

1. **Policies to Support Migrants' During Migration Period.**

These recommendations are expected to generate; institutional mechanisms for migrants' access to health and social security services across the states, bridge data gaps to promote generation of migration specific disaggregated data, developing migrant friendly universal access to health and developing portability of social security programmes for migrants mainly education, food security, basic entitlements and legal support for migrants across state borders.

I. Creating an Institutional Mechanism for Migrants Access to Health and Social Security across State Borders.

No institutional mechanism is presently available to offer access to basic health care and social security services to migrants at destination locations, since they are operated by state administration and linked to state citizenship. Hence the 'mobility card' or migration certificate is recommended which can be linked with a unique identification number. The card can be issued by the local panchayat before migration, which can be accepted by respective government agencies to offer their programmes to migrants in different states. The Ministry of Panchayat Raj Institution (MoPRI) is the recommended nodal ministry for this purpose. To extend the benefits of programmes and policies, it is recommended that the MoPRI consider implementing the following recommendations in a targeted manner:

1. Ensure panchayat level registration of the labour contractors who recruit migrants for jobs
2. Initiate a mandatory registration of people who migrate for livelihood. The registration should be done at panchayat level before they migrate
3. This data can be useful at village, block, district and state level to improved planning and implementation of rural and tribal welfare schemes targeted appropriately at migrating families.

II. Building Migration Specific Disaggregated Data

It is recommended to include migration specific data in the existing government data sources such as the regular surveys conducted by specific ministries and the national census. As the data presently collected does not include important aspects of India's internal migration patterns the following strategies are recommended:

i. To adopt improved and consistent definition of migrant populations and its subcategories for a more accurate assessment of health and social security programmes
ii. To ensure that data on seasonal and circular migrant is captured as they are generally missed out from the various surveys due to their mobility.
iii. Incorporation of migration specific variables in the existing surveys

The above-mentioned strategies will support the collection of national level migration specific data, without the need to create separate mechanism for separate migration surveys. This data can be very useful for planning, implementation and monitoring of various health and social security programmes for migrants. Existing survey and recommendations for migration specific disaggregated data are summarized as below

Table 20: Existing Surveys in India and Recommendations

Existing Survey in India	Governing Bodies	Recommendations
The National Family Health Survey (NFHS): a large-scale, multi-round survey conducted in a representative sample of households throughout India. Three rounds of the survey have been conducted since the first survey in 1992-93. The survey provides information on: • Fertility infant and child mortality • The practice of family planning • Maternal and child health • Reproductive health • Nutrition and anaemia • Utilization and quality of health and family planning services. Each successive round of the NFHS has two specific goals: 1) To provide essential data on health and family welfare needed by the Ministry of Health and Family Welfare and other agencies for policy and programme purposes, 2) To provide information on important emerging health and family welfare issues.	Ministry of Health and Family Welfare: National Family Health Survey (NFHS)	It is recommended to incorporate separate category of migrants in the sample selection process of NFHS. Migration specific variables are recommended in NFHS such as migration duration and residential status (anytime, between 1 month to 12 months), length of stay, and access to diseases specific health services and family welfare services. These variables are not captured in the current survey.
Census: The **population enumeration survey in every 10 years**, the survey is generally conducted between 9 and 28 February.	Ministry of Home Affairs, Registrar General of India	It is recommended to adapt special methodology to capture migrants at destination locations, since in this period, majority of migrants are not available at their native places due to migration, and hence missed out from the enumeration

National Sample Survey: A large scale sample surveys in diverse fields on All India basis. Primarily data are collected through nation-wide household surveys on various socio-economic subjects, Annual Survey of Industries (ASI), etc. The surveys is are carried out once in 5 years on: • Consumer Expenditure • Employment – Unemployment • Social Consumption (Health, Education etc.), Manufacturing Enterprises • Service Sector Enterprises	Ministry of Statistics and Programme Implementation	A special round of National Sample Survey is highly recommended to capture statistics of migrant population working in all sectors of informal economy as labourers. Their even shortest migration duration period should also be captured which ranges between one to two weeks-one year. The suggested variables should include in the survey questionnaire are- their migration reasons, their length of migration, skills and main occupation during their migration, income, and access to various social security programs during migration, impact of migration at source as well at destination areas. These variables are not captured in the currently in the national sample survey.
Employment-unemployment household level national survey, the first survey was conducted in 2010, and latest survey was done in 2014.	Ministry of Labour and Employment, Labour Bureau, Chandigarh	It is recommended to include special variable of 'Migration' short time and long-time (ranging from one month to 12 months), the employment and wages situation of migrants working in all categories of informal sector in the upcoming employment survey. This information can be useful for improving their employment status, including skill building and linkages to access various social security benefits. These variables are not currently captured in the employment survey.

III. Constructing Portability of Social Security Services

The need for portable social security measures is vital for migrants in India mainly for food security, education, housing, skills training and legal assistance. Recommendations for the respective ministries are outlined below:

A. Ministry of Consumer Affairs, Food and Public Distribution

There is a need to create provisions of low cost and good quality food options for migrant workers, making the Public Distribution System (PDS) portable will enable migrant workers both within a State and also across State borders (similar to the Maharashtra state model for intrastate migrants) would be very useful.

B. Ministry of Women and Child Development

1. According to the Supreme Court guideline for Integrated Child Development Service (ICDS), all migrants' families should get a receipt from their source area ICDS Anganwadi, which can be submitted at Anganwadi at the destination. According, to this guideline all migrant children, women and adolescent girls can avail the benefit of Anganwadi services (nutrition for children, immunization, anaemia control for mothers and adolescent girls) at the destination level, irrespective of their migration and BPL/non-BPL status.

   It is recommended that this should be implemented for migrants at destination locations across all states.

2. It is recommended that migrant women and children should be included in available national schemes at destination areas specially the child protection and welfare schemes, Women empowerment schemes, Child Development Schemes and other schemes of WCD.

C. Ministry of Urban Development

The Ministry of Urban Development is responsible for decent housing and living conditions in semi urban and urban areas for urban poor population. Priority should be given to migrants in cities for access to temporary shelters / basic amnesties set up by local bodies (such centres are established urban local bodies according to the Supreme Court guidelines of 24*7 shelters for the urban homeless and poor populations).

D. Ministry of Human Resource Development, Department of School Education and Literacy

According to the '**Right to Education Act'** inclusion of migrant children in education at various destinations in cities and small towns where they migrate must be available.

Migrant children in the different locations of cities/ towns like construction sites, open spaces, railway platforms and other workplaces where migrants are engaged as labour should be identified. Necessary outreach from the education department should also be considered.

Interstate migrant children may face language barriers, hence local language teachers should be arranged while developing mechanisms for mainstreaming migrant children in education. Ministry of Human Resource Development, Department of School Education and Literacy could also devise a system of portability of enrolment as this will then help in reducing dropout rate.

E. Ministry of Labour and Employment

1. Special migration facilitation centres to support migrant workers in terms of access to construction welfare board, and other similar labour welfare programs at destination locations should be set up.

F. National co-ordination systems to track movement of inter and intra state migrant workers, to target them for benefits of various social security scheme (including data linked with AADHAR) need to be established

G. Ministry of Skill Development & Entrepreneurship

1. Migrant men, women and young people should be included in various skill building training and apprenticeship initiatives specially in the sectors where they work as unskilled workers mainly construction, agriculture, hotel, hospitality, transport, etc.
2. Special mechanism should be developed to reach out to young migrant for skill development at village and cities level where they migrate for their livelihood such as large-scale awareness campaigns, engaging potential employers of tribal migrants etc. as these young people are generally missed out from various skill development programmes

H. National Legal Services Authority (NALSA): To create efficient legal support for migrant workers

Migrants have diverse needs for legal aid and support due to their mobility, lack of awareness of their rights. They generally face exploitation at the workplace in terms of wages, accident compensation, sexual harassment etc. It is recommended that the National Legal Services Authority (NALSA), which is available in every district and state in India, extend their support towards fast tracking legal response for cases of trafficking, minimum wage violation, abuse and accidents at the workplace and also to create cadre of paralegals among migrants which can strengthen the capacity of migrants to access their rights and entitlements before and during their migration. An example of good practice is the model initiated by

NALSA's Maharashtra state chapter, Tribal Development Department, and the NGO Disha foundation in Nasik district since 2014. In past year, NALSA and Disha Foundation have trained 50 young migrants as paralegals who are working to resolve various legal cases at the community level. NALSA has also set up a 'Grievances Handling Cell' at the 'Migration Resource Center' of the Disha Foundation, where migrants can register their cases. The cell has a panel of 3

lawyers and it is headed by district judge; the cases are resolved within a period of between 2 weeks to 1 month. This initiative has proved very helpful for more than 5000+ migrants over a period of 2 years in terms of legal awareness. The same model could be replicated in other parts of the country with support from the local NGOs.

Governance

In relation to policy initiatives for migrants, the proposed governance structure is as below

Nodal Ministry

Since, migrants mainly work in the informal sector, the implementation of policies should be done under the guidance of the nodal ministry for labour rights, i.e. Ministry of Labour and Employment (MoLE). A special unit should be set up at MoLE and work closely with other ministries such as Ministry of Health and Family Welfare, Ministry of Tribal Affairs, Ministry of Rural Development, Ministry of Women and Child Welfare, Ministry of Urban Development, urban local bodies, etc. for effective convergence with state policies.

Special units should be created to perform the following functions:

- Collection, management and collation of migration data
- Operation of migration resource centres created in the high migration zones within the country
- Operation of inter-state migration management bodies such as the migrant workers' cell instituted within state labour departments
- Operation of National Labour Helpline
- Linking migrant workers and their households with existing government schemes

- Incorporate mechanisms that monitor the provision of appropriate work for migrants and enable them to access legal provisions for social protection.
- Set up national and sub-regional social dialogue mechanisms to address migrant labour issues.
- Promote equality of opportunity by strengthening gender-specific approaches to policies and activities concerning labour migration particularly, in recognition of the increasing feminization of labour migration. Facilitate technical co-operation activities with international agencies, including ILO, IOM, WHO, UNAIDS.

Formation of inter-state migration management bodies

Given the high rate of migration across certain corridors such as eastern Uttar Pradesh - Mumbai, Bihar – NCR Delhi, Western Odisha– Andhra Pradesh, Rajasthan-Gujarat, Orissa-Gujarat etc. there is a need to institute processes involving labour departments of both source and destination states. A migrant worker cell should be established within each state's labour department which specifically addresses issues concerning migrant workers. A labour officer from the source state can be deputed to the destination to look into matters concerning migrant workers and work collectively with labour officers at the destination. *Example:* Bihar state government has experimented with deputing a Joint Labour Commissioner at Bihar Bhavan in Delhi to address needs of migrant workers from Bihar in Delhi

Inter-sectoral convergence

There are a number of government programmes and policies, which need to converge for the for their effective utilization by the migrant community. Various ministries should be part of this convergences such as the Ministry of Rural Development, Ministry of Tribal Development,

Ministry of Women and Child Welfare, Ministry of Health and family welfare, Ministry of Urban Development, urban local bodies, etc. Policies should promote building national capacity to manage labour migration by developing national labour policies and legislation consistent with overall population policy, and government structures to manage labour migration. The latter should include the creation of focal points within relevant ministries to handle labour migration issues, and establish institutional mechanisms for enhanced co-operation between government authorities, worker organizations, employer associations and civil societies.

IV. Development polices for sending and receiving states of migration

1. Inclusive urban development policies:

The constitution of India gives citizens right to travel, reside and carry out any trade, profession or business in any part of the country, this right can be undermined by governments and urban bodies, which do not implement enabling development policies and measures. Current urban policies do not promote this leading to increase costs of migration for the poor and the anti-migrant rhetoric is becoming more strident in many states and urban metropolitan areas.

Migration should be acknowledged as an integral part of development. Government policies should not hinder but should seek to facilitate internal migration. It should form an essential part of city planning and the city-development agenda should seek to include and integrate migrants politically, economically, socially, culturally and spatially. There should be integration with other existing policies such as the Twelfth Five Year Plan, JNNURM, and City Development Plans, which should recognize the value of migration in very explicit terms and address migrants' concerns and their rights unequivocally. The centre, states and urban bodies need to pursue coherent urban development policies to include migration.

2. Development policies in sending states of migration:

To alleviate distress migration policy initiatives, have to aim for a more pro-poor development strategy in the sending areas/states of migration that can strengthen the livelihood base in these areas. These should be in the form of agriculture, land and water management, improved infrastructure and the creation of non-farm employment and self-employment. These strategies need to be accompanied by changes that improve the access for the poor to land, social and physical infrastructure, and include governance mechanisms. This is a long-term plan, meanwhile policies should promote the role of panchayats to aid migrant workers residing in their sending area. They should maintain a database of migrant workers through a 'migration register' and issue identity cards and pass books to them before migration. Further, panchayats should initiate migration management and governance including training, placement and social security benefit assurance for migrants before and during migration. With growing IT-based communication, it should become possible for panchayats or NGOs play this role. Overall India needs better integration of urban and rural policies towards improving the conditions of rural migration to urban areas.

Study Limitation and Challenges

This study used a mixed methods approach; literature review, quantitative survey, qualitative interviews and site visits to understand successes and challenges in the implementation of migration and health policies India and other countries.

The quantitative study had certain limitations. It did not provide information about the migration process, whether migration had been helpful economically, and the specific problems faced by migrants other than access to basic services and social welfare programmes. Due to limitations of time and resources no information was collected about various health problems faced by the study

population, or their level of awareness about the common diseases such as tuberculosis, malaria or occupational diseases. The study was specifically designed to collect information on basic demographics, and access to general health care and maternal and child care among disadvantaged migrants in one city of India.

The qualitative interviews were conducted till saturation was reached. The selection of relevant participants for the study was a key challenge, since it was mainly focused on the policies for migrants, as it is a specialized sector, there were only a limited pool of participants to select from and not many options were available in India and in other countries. To overcome this challenge, contacts were made with government offices in India as well Indian offices of international agencies mainly WHO, ILO, IOM etc., who were instrumental in identifying and establishing contacts in the selected countries. In a few cases, the policy makers were not able to share information since it was too early for them to comment on new or emerging policy developments. In countries like China and Vietnam, language was the main barrier and local English speaking translators were hired for Chinese to English and Vietnamese to English translations, with support from the academic contacts.

Despite these limitations, the study has strengths such as a representative and large sample size, well designed methodology, low non-response rate, and data collected from representative samples using a pre-tested questionnaires by trained interviewers. The results of the study may be generalized to other states in India, and also to other emerging economies where similar internal migration exists due to urbanization, though it is not clear to what extent these results can be generalised to varying extents depending on local conditions.

Many of the broader policy suggestions emerged out of the investigator's own role as a NGO advocate and may not be easily demonstrated as purely evidence based, and may have scope for investigator bias.

Study Contribution

The study adds to the existing literature on internal migration and the development of policies in India, and other low, middle, high and upper middle-income countries. The literature review was presented at a Lancet conference and published as an abstract in The Lancet. The World Health Organization, South East Asia Regional Office has supported the review and is planning to adopt the subsequently developed policy brief for its member states (see Appendix 9). Some key findings of the study are published as a chapter in three different books (See Appendix 10 – Achievements during DPhil, including list of publications.)

The study contributes to a more in-depth understanding of migrants' issues related to health, and the social determinants that need to be addressed, and the existing policies and interventions its successes and challenges in India and some Asian countries - China, Sri Lanka, Vietnam and Philippines. It may help the federal, state governments, researchers and civil societies in these countries to gain an in-depth insight into policy implementation. As migration and health is a cross-cutting issue in most of the LMICs, the results may be useful for policy makers, planners, practitioners, and academics from health as well other disciplines for gaining an understanding of the issues related to migrant's health, social security and related policies.

Areas for Future Research

A study on the evaluation of health and other developments policies for STs and SCs in India would be useful to understand the gaps in the implementation of these policies and its impact on migration among these groups compared to other social groups. Pilot studies that examine the

universal health coverage and portability of social security among migrants is also a future area of research. Pilot studies on the challenges and barriers of introducing and implementing convergence and inter sectoral co-ordination among health and other ministries and its impact are also other research areas.

CONCLUSION

The study has identified the gaps in terms of policy with respect to welfare and health issues of internal migrants in India, China, Sri Lanka, Philippines and Vietnam. Government policies and institutional measures are limited as governments perceive that unrestricted migration is harmful to development and needs to be controlled by restricting the movement of citizens. This perception has an impact on policies developed for internal migrants. This results in the system lacking a comprehensive approach, based on rights, entitlements and inclusion as identified in India, China and Vietnam. Most LMICs, including India, where migration health policies exist, they operate in isolation at national levels and is usually not very effective. There is a disconnect between practice and policy; migration policies need to be compatible with health-promoting strategies for migrants based on a public health approach. An important gap noticed in most countries including India is that policy measures are not backed by appropriate research and evidence, leading to less effective measures. Evidence indicates that resources are rarely being directed at mobile and displaced populations and their needs are not addressed in national strategies and frameworks. As a result, though national programmes have expanded their service areas, efforts to reach remote, and hard-to-reach populations like internal migrants have not been successful. The major obstacle in access to health care is its economic cost, compounded by the high cost of health care, high out of pocket expenses due to lack of coverage by health insurance schemes. The insurance schemes available are linked with residency status and not easily transferable from one area to another, migrants therefore do not qualify for public insurance and assistance programmes. Hence fragmented

insurance schemes with restricted transferability are not very useful. Further policy development is required for a national transfer mechanism, which will help migrants to get the benefit of the welfare schemes, insurance and uninterrupted health care even when mobile due to their work.

The research indicates that innovations including electronic records, single unique identification numbers linked with insurance and social welfare schemes would allow better administrative integration and delivery. Currently a system of unique identification number (AADHAR) may be the tool to overcome this problem in India. A pilot is currently being undertaken by the Unique Identification Authority of India (UIDAI) with an NGO to enrol migrant workers for the registration. Efforts were also made to explore if the AADHAR number can be linked with easy access to health, food security and other basic services. During the pilot, migrants were enrolled, but this did not go on to develop and build portability of services. The Indian government's ambition is to enrol every citizen of India and link all services/bank accounts/mobile phone numbers to AADHAR, AADHAR may still have the potential to create portability of services.

Further, the policies overlook the human cost both to migrants and their families. Policies lack comprehensive programmes for social protection for rural-urban migrants. Social protection policies are viewed as charity and not as long-term investment in human capability and development. Implementation and regulation of laws, policies and programs is another major challenge. Governments do not have strong institutional mechanisms to enforce the laws and the workers themselves do not have sufficient knowledge of the laws and rights, and have very limited channels to raise their concerns. One of the issues is the uncoordinated approach which is reflected in a fragmented implementation process by local governments and other stakeholders. Government intervention is still the most powerful tool in regulating social, economic and health aspect of migrants.

The study was able to draw policy lessons for the Indian context, from its own pilots and also from other countries. Lack of migration specific data, state specific programmes/policies which are linked with state citizenship, and lack of a federal structure are the key challenges to provide for the unique and pressing needs of migrants in India. However, there are some promising pilots in a few states. The research has shown that inclusion of migrants is imperative in all plans of Universal Health Coverage (UHC) and for UHC to work. This is consistent with WHO's mandate which states that WHO cannot achieve Sustainable Development Goal 3.8 on universal health coverage unless the health needs of refugees and migrants are met. India is embarking on an ambitious target of achieving UHC for all citizens. The State government will be responsible for ensuring and guaranteeing UHC for its citizens. Migrants' health should be at the centre of universal health coverage plan, taking into account their mobility, volume and the vulnerabilities they face.

The recommendations made in study are pragmatic and can be taken by the Indian government to formulate a comprehensive migration policy which can act as an overarching strategy to protect the rights and welfare of internal and cross border migrants of India. This will ensure inclusive growth for India as it aims to achieve the SDGs and ensure India's place as a global economic leader in the future.

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APPENDICES

APPENDIX 1: QUESTIONNAIRE OF MIGRANT'S ACCESS TO HEALTH CARE IN NASIK AND OTHER CITIES OF INDIA

Time:	H H M M	ID No.							
Institute, City									
ICMR National Task Force Project on Migrants' Healthcare									
S.No.	***Question***	***Responses***	***Code***						
1.	Name of the city:	11. Aligarh 12. Bhubaneswar 13. Imphal 14. Jaipur 15. Ludhiana 16. Nasik 17. Visakhapatnam							
2.	Name of the slum:								
3.	Type of slum:	1. Notified slum 2. Non-notified slum 3. Migrant-camp 4. Open space 77. Others (specify)							
4.	Name of the respondent:								
5.	Gender:	1. Male 2. Female							
6.	Age:	_____ Yrs.							
7.	Name of the head of the household: _____								
8.	Address: Area: _____ H.No.: _____ Ward No.:_____ Street No.: _____ Land mark, if any: _____								
9.	What is your caste/tribe? _____ (*Take the instant response and categorize later*)	1. ST 2. SC 3. OBC 4. Others							
10.	What religion/faith do you follow?	1. Hindu 2. Islam 3. Sikh 4. Christian 77. Others (specify)							
11.	Type of house:	1. Squatter hut 2. Katcha 3. Semi pucca 4. Pucca 5. Open space							

12.	House ownership:	1. Own 2. Rented 3. Free	
13.	How many rooms are there in the house?	_____ rooms	
14.	Is the kitchen separate? If Yes, skip Q.15	1. Yes 2. No	
15.	If No, where is the cooking place located?	1. In living room 2. Open space 77. Others (specify)	

For questions with # mark, multiple responses are possible.
If any question is **not relevant/not applicable**, the code "**99**" may be recorded against that question.

16.	What fuel is used for cooking?	1. Gas 2. Hearth (wood/ coal/cowdung cakes) 3. Kerosine 77. Others (specify)	
17.	From where do you fetch potable water?	1. Piped water into the house 2. Hand pump 3. Public tap 4. Tanker-truck 77. Others (specify)	
18.	Does the house have a separate toilet? If Yes, skip Q.19	1. Yes 2. No	
19.	If No, where do the household members go for defecation?	1. Community toilet 2. Mobile toilets 3. Open field 77. Others (specify)	
20.	How is the drainage around the house?	1. Open drain 2. Closed drain 3. No drainage	
21.	Does the house have electricity?	1. Yes, metered connection 2. Drawn from the street lines 3. No connection	
22.	Does your household have a ration card? If No, skip Q.23	1. Yes 2. No	
23.	If Yes, what is the colour of the card? (*See the card colour and categorise*)	1. That meant for BPL	

		2. That meant for APL 77. Others (specify)	
24.	Do you have voter ID card?	1.Yes 2. No	
25.	What was the last place of residence of the head of the household?		
26.	What is your native place?	Village/town: _____ District: _____ State: _____	
27.	When did your head of the household migrate to this city?	_____ years	
28.	What are the reasons for migration of head of household? # _____ _____ _____ _____ (*Take the instant response and categorize later*)	1. For livelihood/ better earnings 2. Social and political pressure 3. Natural calamities 4. Healthcare 5. Education of children 77. Others (specify)	
29.	Who brought/helped your household to come to this city? #	1. Relatives 2. Villagers 3. Contractor 4. Agencies 5. Self 77. Others (specify)	
30.	How often you go to your native place? If Never, skip Q.31 & 32	1. Once in a month 2. Once in three months 3. Once in six months 4. Once in a year 5. Once in more than a year 6. Never	
31.	Approximate periods of stay during the year in the city and native place?		
32.	What are the reasons for this stay in the native place?		
33.	In which language(s) you speak at home?		
34.	In which language(s) you speak with local people?		
35.	Do you have any relatives in this city? If No, skip Q.36	1. Yes 2. No	
36.	If Yes, where do they live?	1. In the same locality	

		2. Other locality	
37.	Any of the people living here belong to your native place?	1. Yes 2. No	
38.	Are there any community based organizations in your area? If No/Don't Know, skip Q.39 & 40	1. Yes 2. No 88. Don't know	
39.	If yes, what type of organizations are they? #	1. Self help group 2. Slum welfare society 3. Youth Club 4. Mahila Mandal 77. Other (specify) 88. Don't know	
40.	If yes, are you a member of any community based organization?	1. Yes 2. No	
41.	Do you have TV?	1. Yes 2. No	
42.	Do you have Radio?	1. Yes 2. No	
43.	Do you read Newspaper? Or have it read to you (by colleagues, friends,etc.)	1. Yes 2. No	
44.	How do you generally come to know about things happening in the city? #	1. TV 2. Radio 3. News paper 4. Neighbours/ co-workers 5. Through Announcements 77. Others (specify)	

Q.No. 45: Details of the household members and illness experiences (NOT pregnancy/delivery related)									
S. No.	Name (original family members of the respondents)	Gender (1=male; 2=female)	Age in years	Relation to head of the household*	Present place of residence (1=present city; 2=native place)	Education (Number of years of school/college	Marital status (1=married; 2=un-married; 3=separated/divorcee; 4=widow/wid	Occupation**	Income per month
1.	*Present interviewee*								
2.									
3.									
4.									
5.									
6.									
7.									

*1=husband; 2=wife; 3=son; 4=daughter; 5=daughter-in-law; 6=son-in-law; 7=father; 8=mother; 77=others (specify)

**1=Permanent employee (government); 2=Permanent employee (private); 3=temporary salaried employee; 4=temporary waged employee; 5=small business; 6=daily wage labourer; 7= home maker; 8=currently not working; 77=others

Contd..,

Q.No. 45 *Continued*: Details of the household members and illness experiences (NOT pregnancy/delivery related)										
S. No.	Name	Whether suffered from any illness over the past 6 months (Yes/No), if yes, what is the <u>most</u> recent illness & its duration If No, skip next two columns	How much did you spend for treating this illness?	How did you arrange for this money?* #	Whether hospitalized over the past one year (Yes/No), if yes, illness & duration of stay of recent hospitalisatio If No, skip next two columns	How much did you spend for treating this illness?	How did you arrange for this money?* #	Does any member suffer from chronic illness (Yes/No), if yes, what is it? If No, skip next two columns	How much did you spend <u>in a month</u> for treating this illness?	How did you arrange for this money?* #
1.										
2.										
3.										
4.										
5.										
6.										

*1=Current income of any household member ; 2=Savings; 3=Payment of reimbursement from a health insurance plan; 4=Reimbursement by the employer;
5= Sold items (furniture/jewellery); 6=Contributed by relatives or friends; 7=Borrowed from others; 8=The service is provided free of cost; 77=Others

Questions on Healthcare Access and Responsiveness

46.	Does a govt. health worker visit your area/juggi? If response is 5 or 88, skip Q.47-51	1. At least once in a month 2. At least once in three months 3. At least once in six months 4. Once in a year 5. Never 88. Don't know	
47.	Do the health workers visit your house?	1. Yes 2. No	
48.	What services are provided by the govt. health worker?		
	a) Antenatal care services	1. Yes 2. No 88. Don't know	
	b) Immunization services	1. Yes 2. No 88. Don't know	
	c) Postpartum care	1. Yes 2. No 88. Don't know	
	d) Family planning services	1. Yes 2. No 88. Don't know	
	e) IEC/health education/health advice	1. Yes 2. No 88. Don't know	
	f) Pulse polio	1. Yes 2. No 88. Don't know	
	g) Any other (specify) _____	1. Yes 2. No	
49.	Are the services provided by the govt. health worker satisfactory?	1. Not satisfied 2. Somewhat satisfied 3. Satisfied 4. Very much satisfied	
50.	Do the health workers inform you, when there are any govt. health activities (like immunization to children, pulse polio, antenatal care, etc.)?	1. Yes 2. No 3. Sometimes	
51.	What type of healthcare services do you expect from health worker?		
52.	What is your usual source of medical care? (Please take only ONE response)	1. Private doctor (qualified) 2. local practitioner (unqualified)	

		3. Govt. Health centre/hospital 4. Private hospital/ nursing home 5. Traditional/spiritual healer 6. Others systems of medicine (Ayur/ Homeo/Unani) 77. Others (specify) 8. Didn't have any regular source/usual provider	
53.	Do you currently have medical care coverage (health insurance)? If No, skip Q. 54	1. Yes 2. No	
54.	If yes, from which of the following do you obtain your health insurance? #	1. Employees State Insurance (ESI) hopital 2. RSBY/ State Govt. sponsored scheme 3. Central Govt. Health Scheme (CGHS) 4. From your employer (_____) 5. Private insurance 6. Any other (specify):	
55.	What are the health facilities that are available in your locality? # _____ _____ _____ (*Mention the name of the facility as told by the respondent and categorize later*)	1. None 2. Govt. hospital/ district hospital 3. Medical college hospital 4. Dispensary 5. Mobile clinic 6. Hospital run by NGO/charitable trusts/religious organizations 7. Local practitioner (unqualified) 8. Private hospital 9. Private practitioner 10. Ayurvedic 11. Homeopathic 12. Unani 13. Traditional healer 77. Others (specify)	
56.	Which government health facility you or your family members use in case of illness? (*Write the name*) If None, skip Q. 57 & 58		

57.	How frequently you or your family members avail this govt. health facility from this health facility?	1. Always 2. Most of the times 3. Some times	
58.	For what type of illnesses/conditions do you or your family member use this facility?		
59.	Skip Q. 59 & 60, if response to Q. 56 is not 'None' If not availed, what are the reasons for not availing services from government health facility?		
60.	If not availed, where do you go for availing the health services?		
61.	Skip Q. 61-85, if response to Q. 56 is 'None' When did you or your family last visit any govt. health facility in the city?	1. During last one month 2. 2-3 months 3. 4-6 months 4. 6-12 months 5. more than one year 6. Never	
62.	How do you normally travel to see your healthcare provider?	1. Walk 2. By public transport 3. By rickshaw/auto rickshaw/cab 4. By own vehicle 77. Others (specify)	
63.	How long does it take you to travel to your healthcare provider?	_____ hours, _____ mins.	
64.	What services did you receive at govt. health facility? #	1. Examined by doctor 2. Examined by nurse or other staff 3. Received medicines 4. Diagnostic tests 5. Education/counseling/information 6. referred to another hospital 7. admitted as inpatient 77. Others (specify)	
65.	What problems did you face at the govt. health facility? #	1. No problem 2. lack/non availability of money 3. The health facility is far away 4. Had to wait for longer duration 5. Did not receive medicines	

		6. Did not receive diagnostic tests 7. Delay in getting test reports 8. Not seen by the doctor 9. Behavior of the service provider 77. Others (specify)	
66.	What are the working hours of this health facility? If Don't know, skip Q. a, b; 67 & 68	1. Knew the timings 88. Don't Know	
	a) Opening hours		
	b) Closing hours		
67.	Are these timings convenient for you? If response is 1 or 2, skip Q. 68	1. Very much convenient 2. Convenient 3. Somewhat convenient 4. Not at all convenient	
68.	If the response is '3' or '4', what do you suggest regarding working hours of the facility?		
69.	Is drinking water available in the premises of the health facility?	1. Yes 2. No 88. Don't Know	
70.	Does waiting space exist in the health facility and what about waiting space?	1. Yes, space available with sitting arrangement 2. Space available, but no chairs/benches 3. Insufficient space 4. No specified space 88. Don't know	
71.	Are there toilets available for patients in the premises of the health facility?	1. Yes 2. No 88. Don't Know	
72.	How do you rate the cleanliness of the health facility like clean toilets/premises?	1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad	
73.	Whether the prescribed drugs/medicines are given free of cost at health facility?	1. Yes 2. No 3. Sometimes	
74.	During the past illness episode, have you had difficulty getting medical treatment from government facility? (recent illness episode in last 6 months for which you visited health facility for yourself or any of your family members)	1. Yes 2. No	

75.	When you sought healthcare, how often doctors, nurses, or other healthcare providers treat you with dignity?	1. Always 2. Usually 3. Sometimes 4. Never	
76.	During the past 6 months, how often were your physical examinations and treatments done in a way that your privacy was respected?	1. Always 2. Usually 3. Sometimes 4. Never	
77.	During the last 6 months, were you able to get the prescribed medicines free from health facility?	1. Got all medicines 2. Got some medicines 3. Did not get any	
78.	During the past illness, did you have delay in obtaining further care such as inpatient admission, surgery, tests, etc. at health facility?	1. Yes 2. No 3. Some times	
79.	How do you think that above mentioned problems are because of you are newer to the city?	1. Yes 2. No 3. Some times	
80.	During the past 6 months, how often did doctors, nurses or other healthcare providers listen carefully to you?	1. Always 2. Usually 3. Sometimes 4. Never	
81.	How often did doctors, nurses or other healthcare providers, explain things in a way you could understand?	1. Always 2. Usually 3. Sometimes 4. Never	
82.	How often did doctors, nurses or other healthcare providers, give you time to ask questions about your health problem or treatment?	1. Always 2. Usually 3. Sometimes 4. Never	
83.	In the past six months, did the doctor ever discuss with you regarding various treatment options?	1. Always 2. Usually 3. Sometimes 4. Never	
84.	When you sought healthcare from government during last 6 months, whether the doctor explained what treatment he is giving and did the doctor ever asked you whether the that treatment is acceptable to you?	1. Always 2. Usually 3. Sometimes 4. Never	
85.	Do you think whatever information you shared with the doctor/other health care providers was kept secret?	1. Always 2. Usually 3. Sometimes 4. Never 1. Don't know/cant say	
86.	In the last 6 months, were you ever turned back (denied) govt. healthcare because you could not afford it?	1. Yes 2. No 3. Sometimes	
87.	Did you ever availed services of private health care providers during last 6 months?	1. Yes 2. No	

88.	Over the last 6 months, was it difficult to avail the services at government health facility compared to other services?	2. Never a problem 3. Some times 4. Always 5. Not applicable- Never tried	
89.	When you or your family member(s) severely sick, any one come forward to help you to get treatment/medicines If No, skip Q. 90	1. Yes 2. No	
90.	If yes, who comes first?		
91.	In the past, did you feel that you are disrespected by the govt. healthcare providers for any of the following reasons:		
	a) Because of your caste/class	1. Yes 2. No 3. Can't say	
	b) Because of your physical appearance	1. Yes 2. No 3. Can't say	
	c) Because of your language	1. Yes 2. No 3. Can't say	
	d) Because of your migrant status	1. Yes 2. No 3. Can't say	
	e) Because you are poor/ lack of money	1. Yes 2. No 3. Can't say	
	f) Because of your place of origin	1. Yes 2. No 3. Can't say	
	g) Because you are male/female	1. Yes 2. No 3. Can't say	
	h) Because of another reason: (Specify)	_____	
92.	For you and your family what are the most important things that you want from government health system? (*Record responses as told by the respondent in that order*)	1. 2. 3. 4. 5. 6.	

Questions for Mothers on Antenatal and Obstetric Care and Childhood Immunization

(If the respondent is woman having a child less than 2 years of age)

93. Obstetric history:

Pregnancy	Live birth (1)/ Still birth (2)/ Abortion (3)	Gender (1=male; 2=female)	Surviving (1) / Dead (2)	Age (if dead, age at death)	Age of mother at delivery	Place of delivery (home (1)/ Institution (2))	Nornal delivery (1) /Cesarean (2)	Where did you live at time of delivery Vill (1) /city (2)
1								
2								
3								
4								
5								

Important: The pregnancy/delivery refers to the most recent one, that is ended as delivery.

94.	Where were you during your last pregnancy (which ended as delivery)? If response is 1 or 2, skip Q. 95	1. In this city 2. In native place 3. Both	
95.	If Both, note down the period (pregnancy months) of stay at each place	a. At current city	
		b. At Native place	
96.	When you were pregnant, did you go for an antenatal check-up? If Yes, skip Q. 97	1. Yes 2. No	
97.	If No, why didn't you go for any antenatal check-up?		
98.	Skip Q. 98 -101, if response to Q. 96 is 'No' If Yes, from where did you seek ANC? #	1. Nearby government health facility (specify) 2. Mobile clinic 3. Health worker 4. Maternity hospital 5. Qualified private practitioner 6. Tertiary/specialised govt. hospital (specify) 7. local practitioner (unqualified)	

		8. NGO/Trust hospital 9. Dai 77. Others (specify)	
99.	In which month of your pregnancy, did you go for check-up for the first time?		
100.	How many times did you go for antenatal check-up during the last pregnancy?		
101.	Who advised you to go for antenatal check-up? #	1. None/self 2. Husband 3. Other family members (specify) 4. Health worker 5. Anganwadi worker 77. Others (specify)	
102.	When you were pregnant, did health worker or any other health personnel visit you at home for an antenatal check-up? If No, skip Q. 103	1. Yes 2. No	
103.	If yes, how many months pregnant were you when a health worker first visited you?		
104.	Were you given iron and folic acid tablets during this pregnancy? If No, skip Q. 105-107	1. Yes 2. No	
105.	If yes, how many tablets did you receive?		
106.	Did you consume the tablets?	1. Consumed all tablets 2. Consumed some tablets (mention the no. of tablets consumed) 3. Did not consume any	
107.	If did not or partially consume the IFA tablets, please tell me the reason for not consuming all the tablets?		
108.	Did you receive the following tests during your pregnancy		
	a) Weight measurement	1. Yes 2. No	
	b) Height measurement	1. Yes 2. No	
	c) Blood Pressure check-up	1. Yes 2. No	
	d) Urine test	1. Yes 2. No	
	e) Abdominal examination	1. Yes 2. No	
	f) Haemoglobin	1. Yes 2. No	
109.	Have been told that you were anaemic during pregnancy? If No, skip Q. 110	1. Yes 2. No	
110.	If yes, have you been given any treatment?	1. Yes	

		2. No	
111.	Have you been given any other advises like on diet, rest, etc? If No, skip Q. 112	1. Yes 2. No	
112.	If yes, details		
113.	Were there any other tests done during pregnancy? If No, skip Q. 114	1. Yes 2. No	
114.	If yes, can you tell me what those were?		
115.	When you were pregnant, were you given any TT injection in the arm to prevent you and the baby from getting tetanus? If No, skip Q. 116	1. Yes 2. No	
116.	If yes, during this pregnancy, how many times did you get this injection?		
117.	How long do you usually have to wait at the hospital before being seen by a doctor/nurse/ANM who provides you antenatal care?	_____ hrs. _____ min.	
118.	Are you happy with the time you normally have to wait?	1. The waiting time is okay/just right 2. It's a bit more 3. Too much waiting	
119.	How much time do you usually spend with the antenatal care provider at each visit?	_____ mins.	
120.	Do you have enough time with the antenatal care provider during your check-ups, or would you prefer	1. A lot more time 2. A little more time 3. Time is about right 4. Can't say	
121.	If you had a choice, for antenatal check-ups, would you prefer to be attended by	1. A doctor 2. A nurse 3. A midwife 4. A combination 5. No preference	
122.	What is your opinion on the information you received about looking after yourself during the pregnancy?	1. Not enough 2. As much as you wanted 3. Too much 4. No information received 5. Don't remember	
123.	When you sought antenatal care, how do you feel about how often that doctors/ nurses treat you with dignity?	1. Always 2. Usually 3. Sometimes 4. Never	
124.	Were the physical examinations and treatments done in a way that your privacy was respected?	1. Always 2. Usually 3. Sometimes 4. Never	
125.	Did you plan in advance where to deliver the child?	1. Yes 2. No 3. Felt unnecessary	

126.	Did you plan in advance for the birth attendant?	1. Planned for doctor 2. Planned for ANM/Nurse 3. Planned for Dai 4. Planned for mother/mother-in-law 5. Didn't plan 6. Felt unnecessary	
127.	Did you plan in advance how to reach the health facility where you planned to deliver the child?	1. Yes 2. No 3. Felt unnecessary	
128.	Did you plan in advance for any person to accompany you while going for delivery?	1. Yes, husband 2. Yes, other family member 3. Yes, neighbours 4. Did not plan 5. Felt unnecessary	
129.	Were you aware that free government transport facility to take you to hospital in emergency in delivery?	1. Yes 2. No	
130.	How much money did you save specifically for the purpose of delivery	Rs. _____	
131.	Was your delivery normal or caesarean? If response is 1 or 2, skip Q.132, 133	1. Normal 2. Forceps 3. Caesarean	
132.	If caesarean, where did you undergo?	1. Nearby health facility 2. Private clinic 3. Govt. hospital 77. Others (specify)	
133.	Did the doctor or any other care givers discuss with you/your family member regarding caesarean?	1. Yes, doctor has discussed regarding caesarean and decision was taken in consultation with me /family member 2. Doctor informed caesarean has to be done, but decision has been taken by the doctor 3. Did not inform anything but performed caesarean	
134.	Skip Q. 134 & 135, if response to Q 131 is 3 If normal delivery, where did your delivery?	1. Nearby health facility (specify) 2. Govt. hospital 3. Private clinic (specify) 4. Home	

		5. NGO/Trust hospitals 77. Others (specify)	
135.	If normal, who assisted with delivery?	1. Doctor 2. Nurse/midwife/health worker 3. Dai 4. Mother/mother-in-law 5. Elderly lady 77. Others (specify):	
136.	What is your preferred place of delivery?	1. Home 2. Govt. hospital 3. Private hospital	
137.	Skip Q. 137-140, if it is hospital delivery/cesarean How did you reach the health facility for delivery?	1. Availed govt. ambulance 2. Availed private ambulance service 3. Arranged taxi/autorikshaw 77. Others (specify)	
138.	When you reach the hospital for delivery, did you receive prompt attention by the healthcare providers	1. Yes, I was attended immediately 2. With some delay 3. With a lot of delay 4. Did not receive any attention 88. Don't know	
139.	How do you rate the cleanliness of the labour room/delivery space?	1. Clean 2. Somewhat clean 3. Not clean	
140.	During your stay in health facility for delivery, did the hospital allow your family members/relatives to be with you / be by your side during pains and after delivery?	1. Yes, they were allowed 2. No, they were not allowed	
141.	How much money did you spend for this delivery/Caesarean?		
142.	Did you receive any money/incentive for having delivery in health facility? If No, skip Q.143	1. Yes 2. No	
143.	If yes, how much?		
144.	When you are in health facility for delivery, whether doctors, nurses, or other healthcare providers treat you with dignity?	1. Yes 2. To some extent 3. No	
145.	Ask Q. 139, if it is Home Delivery Were there any complications during the delivery? #	1. None 2. Pretermed labour 3. Heavy bleeding 4. Prolonged labour 5. Delayed placenta delivery 77. Others (specify)	

146.	Did any health worker/personnel visit your home after delivery? If No, skip Q.147 & 148	1. Yes 2. No	
147.	If yes, after how many days after delivery, she/he visited you at home?		
148.	How many times?		
149.	Were there any complications after delivery? If No, skip Q.150-151	1. Yes 2. No	
150.	If yes, what were they?		
151.	How were the complications managed?		
152.	Did you get any advise after delivery regarding	1. Yes 2. No	
	a) Family planning	1. Yes 2. No	
	b) Breast feeding	1. Yes 2. No	
	c) Immunization of child	1. Yes 2. No	
	d) Any other (specify)	1. Yes 2. No	
153.	How do you rate the post partum care received by you that was given by the health worker?	1. Very good 2. Good 3. It's okay 4. Bad 5. Very bad	
154.	What is your opinion on the information you received about breast feeding	1. Not enough 2. As much as you wanted 3. Too much 4. No information received 5. Don't remember	
155.	What is your opinion on the information you received about contraception for spacing or for no more children?	1. Not enough 2. As much as you wanted 3. Too much 4. Did not receive any 5. Don't remember	
156.	Were you told about how to recognize and proceed about any of the following serious problems that can happen in pregnancy?		
	a) Any bleeding P/V during pregnancy, and heavy (>500 ml) vaginal bleeding during and following delivery	1. Yes 2. No	
	b) Severe headache with blurred vision	1. Yes 2. No	
	c) Convulsions or loss of consciousness	1. Yes 2. No	
	d) Prolonged labour (labour lasting for more than 12 hours)	1. Yes 2. No	

	e) Cases with leaking P/V	1. Yes 2. No	
	f) High fever with or without abdominal pain	1. Yes 2. No	
	g) Decreased or absent foetal movements	1. Yes 2. No	

Questions On Immunization (for child < 2 years age)

Reference child 1 (Name: _____)

157.	Age of the reference child 1	_____ months	
158.	Gender of the reference child 1	1. Male 2. Female	
159.	Place of stay of the reference child during first year of life If response is 1 or 2, skip Q. 160 & 161	1. Present city 2. Native place 3. Both	
160.	If both, period of stay (child's age in months) in present city	_____ months	
161.	If both, period of stay (child's age in months) in native place	_____ months	
162.	Are you aware that child should be given some vaccines to prevent certain diseases?	1. Yes 2. No	
163.	Generally, whom did you approach for giving vaccines to your child? #	1. Nearby health facility (specify) 2. Mobile clinic 3. Health worker 4. Qualified private practitioner 5. Govt. hospital (specify) 6. Local practitioner 7. Dai 77. Others (specify)	
164.	Do you have the vaccine card for this child? [Investigator has to see it] If 'Not given, skip Q. 165	1. Yes 2. Not given 3. Given but not found	
165.	If yes, who has given it to you?	1. Nearby health facility (specify) 2. Mobile clinic 3. Health worker 4. Qualified private practitioner 5. Govt. hospital 6. Local practitioner 7. NGO/trust hospital 8. Dai 77. Others (specify) 88. Don't know	
166.	Did the child receive the following vaccines? *[Investigator: tick in the box appropriately]*		
a.	BCG at birth	1. Yes	

		2. No	
b.	OPV-0	1. Yes 2. No	
c.	Hepatitis B-0	1. Yes 2. No	
d.	DPT-1 (1 ½ month)	1. Yes 2. No	
e.	OPV-1(1 ½ month)	1. Yes 2. No	
f.	Hepatitis B-1 (1 ½ month)	1. Yes 2. No 3. Not in the program	
g.	DPT-2 (2 ½ month)	1. Yes 2. No	
h.	OPV-2(2 ½ month)	1. Yes 2. No	
i.	Hepatitis B-2 (2 ½ month)	1. Yes 2. No 3. Not in the program	
j.	DPT-3 (3 ½ month)	1. Yes 2. No	
k.	OPV-3(3 ½ month)	1. Yes 2. No	
l.	Hepatitis B-3 (3 ½ month)	1. Yes 2. No 3. Not in the program	
m.	Measles (9-12 months)	1. Yes 2. No	
n.	Vit-A (below 1 year)	1. Yes 2. No	
167.	If child is not immunized either totally or partially, what are the reasons?		
168.	Did you face any difficulty/problem in getting the child immunized?		

Reference child 2 (Name: _____)

169.	Age of the reference child 1	_____ months	
170.	Gender of the reference child 1	1. Male 2. Female	
171.	Place of stay of the reference child during first year of life If response is 1 or 2, skip Q. 172 & 173	1. Present city 2. Native place 3. Both	
172.	If both, period of stay (child's age in months) in present city	_____ months	

173.	If both, period of stay (child's age in months) in native place	_____ months	
174.	Do you have the vaccine card for this child? [Investigator has to see it] If 'Not given, skip Q. 175	4. Yes 5. Not given 6. Given but not found	
175.	If yes, who has given it to you?	1. Nearby health facility (specify) 2. Mobile clinic 3. Health worker 4. Qualified private practitioner 5. Govt. hospital 6. Local practitioner 7. NGO/trust hospital 8. Dai 78. Others (specify) 89. Don't know	
176.	Did the child receive the following vaccines? *[Investigator: tick in the box appropriately]*		
a.	BCG at birth	1. Yes 2. No	
b.	OPV-0	1. Yes 2. No	
c.	Hepatitis B-0	1. Yes 2. No	
d.	DPT-1 (1 ½ month)	1. Yes 2. No	
e.	OPV-1(1 ½ month)	1. Yes 2. No	
f.	Hepatitis B-1 (1 ½ month)	1. Yes 2. No 3. Not in the program	
g.	DPT-2 (2 ½ month)	1. Yes 2. No	
h.	OPV-2(2 ½ month)	1. Yes 2. No	
i.	Hepatitis B-2 (2 ½ month)	1. Yes 2. No 3. Not in the program	
j.	DPT-3 (3 ½ month)	1. Yes 2. No	
k.	OPV-3(3 ½ month)	1. Yes 2. No	
l.	Hepatitis B-3 (3 ½ month)	1. Yes 2. No 3. Not in the program	
m.	Measles (9-12 months)	1. Yes 2. No	

n.	Vit-A (below 1 year)	1. Yes 2. No	
177.	If child is not immunized either totally or partially, what are the reasons?		
178.	Did you face any difficulty/problem in getting the child immunized?		

Outcome of the interview	1. Completed 2. Incomplete 3. Refused		
Reason for refusal/ incompleteness:			
Initials of the interviewer:		Date:	

APPENDIX 2 : LETTER OF INVITATION TO THE STUDY PARTICIPANTS

Department of Population Health, University of Oxford, Rosemary Rue Building, Old Road Campus, Headington, Oxford OX3 7LF

Letter of Invitation to Participants

Challenges and Plausible Solutions for Ensuring Health of Urban Migrants as a Part of India's Agenda for Sustainable Urban Growth Story

PhD Research Project, Department of Population Health, University of Oxford, UK
Principal Investigator: Anjali Borhade
Supervisor: Dr Premila Webster, University of Oxford

Dear XXXX

Greetings!

My name is Anjali Bhaskar Borhade; I am writing you to request to participate in my PhD research titled 'Challenges and Plausible Solutions for Ensuring Health of Urban Migrants as a Part of India's Agenda for Sustainable Urban Growth Story' I'm working with Public Health Foundation of India as an Associate Professor, and currently I am on study leave for undertaking PhD at Department of Population Health, Oxford University, UK.

My PhD research is focused on understanding urban labour migration and health programs/policies in India and abroad, mainly in Asian countries – Japan, China and Vietnam, and developed economies of Europe. Research will compare these emerging and developed economies in terms of their initiatives to address migrant's health needs, and transferable lessons will be drawn for India to develop primary health care mechanism for urban migrants. I'm planning to use secondary data (existing available quantitative data). I'll collect primary data using qualitative methods. Please find attached summary document of research for your information. I'll be happy to answer your queries or concerns if any related to my study.

If you are interested to participate, I request you to kindly send your confirmation at the earliest on phone (+44 740-588-7720 (UK) / +91 9650806259 (India)) or email anjali.borhade@wolfson.ox.ac.uk
Once I get your confirmation, we can schedule your interview upon your convenience.

Looking forward to your response,

Thanking you

Best wishes



Anjali Borhade
PhD Researcher

APPENDIX 3: CONSENT FORM FOR THE PARTICIPANTS

Department of Population Health, University of Oxford, Rosemary Rue Building, Old Road Campus, Headington, Oxford OX3 7LF

University of Oxford

Central University Research Ethics Committee

Consent Form of a Research Participant

Name of Research Project: Challenges and Plausible Solutions for Ensuring Health of Urban Migrants as a Part of India's Agenda for Sustainable Urban Growth Story

CUREC Number……

Principal Investigator: Anjali Borhade, PhD researcher, Department of Population Health, University of Oxford, UK

I understand that I am participating in a study being conducted Ms Anjali Borhade, PhD researcher, Department of Population Health, University of Oxford, UK. I have been informed that this study has been reviewed by, and received ethics clearance through the University of Oxford Central University Research Ethics Committee.

I have been informed by the researcher that the research is focused on understanding urban labour migration and health programs/policies in India and abroad, mainly in Asian countries – Japan, China and Vietnam, and developed economies of Europe, USA, Canada, Mexico and Braizil. Research will compare these emerging and developed economies in terms of their initiatives to address migrant's health needs, and transferable lessons will be drawn for India to develop primary health care mechanism for urban migrants. I am aware that researcher has approached me due to my current official position in the relevant sector in my state/country.

I confirm that the purpose of the research and my participation in this research project has been fully explained to me.

I understand that this will involve an interview with me about my role in formulation and implementation of polices and programmes for urban migrants, state of urban migration, and lessons and challenges while addressing migrants' primary care health needs.

I understand that my interview will be audio and video taped, and I have my consent for it.

I acknowledge that any information, photographs, or recording taken of me will not be owned by me.

I understand that my participation in this research project and the information provided by me may be shared in public domain in any medium in any part of the world.

I understand that the information I'll provide to researcher will be included in her PhD thesis.

I understand that on successful submission of the thesis by researcher, it will deposited both in print and online in the Oxford University's archives, to facilitate its use in future research. The thesis will be published with open access. I will be able to freely access the thesis via open access

I understand that I may withdraw my consent at any time during my participation in the research project and that I do not have to give a reason for my decision. I acknowledge that such withdrawal of my consent will not prejudice my participation in this research project. I also understand that if I have any concerns regarding this research, the *procedure to address the same is explained to me by the researcher.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to participate as a subject in this study

Signed……..(Participant)

Print Name……..(Participant)

Witnessed by……..(Researcher)

Print name……Anjali Borhade……..(Researcher)

Researcher: Anjali Borhade, PhD student, Department of Public Health University of Oxford, UK. Email: anjali.borhade@wolfson.ox.ac.uk

Date……

***Procedure for raising concerns and making a complaint**

If you have a concern about any aspect of this project, please speak to researcher Ms. Anjali Borhade (cell numbers are +44 740-588-7720 (UK), and +91 9650806259 (India)) or her supervisor Dr Premila Webster (+44 777 -134-7984),who will do her best to answer your query. The researcher should acknowledge your concern within 10 working days and give you an indication of how she intends to deal with it. If you remain unhappy or wish to make a formal complaint, please contact the chair of the Research Ethics Committee at the University of Oxford (Chair, Medical Sciences Inter-Divisional Research Ethics Committee; Email: ethics@medsci.ox.ac.uk; Address: Medical Sciences Divisional Office, Level 3 John Radcliffe Hospital, Oxford, OX3 9DU, UK). The chair will seek to resolve the matter in a reasonably expeditious manner.

APPENDIX 4: INTERVIEW GUIDE FOR QUALITATIVE STUDY

Checklist for Qualitative Interview

Challenges and Plausible Solutions for Ensuring Health of Urban Migrants as a Part of India's Agenda for Sustainable Urban Growth Story

PhD Research Project, Department of Public Health, University of Oxford, UK

Funded by: PHFI-UKC Wellcome Trust Capacity Building Programme (WTP)

Principal Investigator: Anjali Borhade
Supervisor: Dr Premila Webster, University of Oxford , and Dr Dileep Mavlankar, PHFI.

Key points	Possible questions to be used in interview
Migration status in the state/country	Urban migration scenario/ Volume of migration/issues arising out of migration for migrants and for cities/perspective of government towards migration
Challenges of urban migration	Challenges for administration/governance while addressing health and other needs of urban migrants.
Solutions to address migrants needs -	Solutions to address health and other needs of migrants in cities via various programs and policies mechanisms (including health and other social protection)
Lessons learnt from programs for migrants health needs	Lessons learnt while formulations and implementing programs and policies for urban migrants; success and failure stories
The existing policies and regulations with regard to healthcare and social protection to migrants	• Existing programs and policies to address the health needs of the migrants. • Resource allocation for programs for the urban migrants including budget and Human resource allocation. • State co-ordination policies for budget allocation for migrants. • Inclusion of migrants specifically in various National Health/other programs. • Adaptation of International policies/programmes related to internal migration

Questions to be used during interviews:

1. What is urban internal labour migration scenario in your country? (Specified with country name)

2. What is volume of migration in the country?

3. What are issues arising out of migration?
   - For migrants and
   - For cities

4. Please share perspective of government towards migration. (Whether its good/bad for development, what needs to be done to channelize migration etc)

5. Please tell me about existing programs and policies to address the health needs of the migrants in your country/state.

6. Is there any solutions/initiatives you have initiated to address health and other needs of migrants in cities (for ex- via various programs and policies mechanisms - including health and other social protection). Please share.

7. What kind of Resource allocation is made for programs for the urban migrants (including budget and Human resource allocation)

8. What kind of mechanism has developed for state co-ordination during formulation and implementation of policies – mainly for budget allocation for migrants?

9. How you have made inclusion of migrants specifically in various National Health/other programs.

10. Please share if you have adapted any International policies/programmes related to internal migration while formulating these policies in your country.

11. What kind of governance Challenges administration face while addressing health and other needs of urban migrants? (Including departmental co-ordination, implementation etc)

12. Can you please share the lessons you learnt while formulations and implementing programs and policies for urban migrants?

13. Please share success and failures during these processes.

APPENDIX 5: OPT OUT FORM FOR PARTICIPANTS

Department of Population Health, University of Oxford, Rosemary Rue Building, Old Road Campus, Headington, Oxford OX3 7LF

OPT OUT FORM

Challenges and Plausible Solutions for Ensuring Health of Urban Migrants as a Part of India's Agenda for Sustainable Urban Growth Story

PhD Research Project, Department of Population Health, University of Oxford, UK

Principal Investigator: Anjali Borhade
Supervisor: Dr Premila Webster, University of Oxford

If you **DO NOT** want to participate in the research, (Challenges **and Plausible Solutions for Ensuring Health of Urban Migrants as a Part of India's Agenda for Sustainable Urban Growth Story)** PhD research project at the Department of Population Health, University of Oxford, please fill out the form below and return it to the school or Principal Investigator. If we do not receive an opt-out form from you, you may be contacted to take part in this study, as described in the accompanying information sheet.

I, the undersigned, AM NOT willing to take part in the above study.

Name _____

Name of the office: _____

Signature: _____ Date:_____

Name of researcher: Anjali Borhade, PhD student, Department of Public Health University of Oxford, UK. Email: anjali.borhade@wolfson.ox.ac.uk

APPENDIX 6: MSD ETHICS APPROVAL

MEDICAL SCIENCES INTER DIVISIONAL RESEARCH ETHICS COMMITTEE
Research Services, University of Oxford

University Offices, Wellington Square, Oxford, OX1 2JD
Tel: +44(0)1865 616577 Fax: +44(0)1865 280467
ethics@medsci.ox.ac.uk http://www.medsci.ox.ac.uk

UNIVERSITY OF OXFORD

CONFIDENTIAL

Ref: MSD-IDREC-C1-2014-011

24th January 2014

Ms. Anjali Borhade
c/o Courses Administrator
Department of Public Health
University of Oxford
Rosemary Rue Building
Old Road Campus
Headington
Oxford, OX3 7LF

Dear Anjali

CUREC checklist

I am writing to acknowledge receipt of your CUREC-1 form for your project: **Challenges and Plausible Solutions for Ensuring Health of Urban Migrants as a Part of India's Agenda for Sustainable Urban Growth Story**

On the basis of the information you have provided this has now been approved by the Medical Sciences IDREC **subject to:**

a) **it is your responsibility to comply with the requirements for administering any tests or questionnaires and if in doubt to contact the publisher of those tests or questionnaires.**

The reference number for this project is **MSD-IDREC-C1-2014-011** and is valid for a period of **24** months from the CUREC 1 approval date, 20th January 2014. Please may I remind you that your project may be reviewed at some stage during an annual audit of projects.

Amendments

Should you at some stage alter some of the techniques or procedures then you should first undertake a checklist (CUREC-1) to see whether these changes alter the ethics of the research. If these remain the same then the committee will require notification of the changes to lodge with the project. If they do not remain the same then you may need to complete a CUREC-2 form and undergo further scrutiny by the committee.

Please do not hesitate to contact me if you have any queries about this.

Yours sincerely



Gill Halstead
Research Ethics Co-ordinator, Medical Sciences

APPENDIX 7: MSD AMMENDED ETHICS APPROVAL FOR VIDEO RECORDING OF INTERVIEWS

MEDICAL SCIENCES INTER DIVISIONAL RESEARCH ETHICS COMMITTEE
Research Services, University of Oxford

University Offices, Wellington Square, Oxford, OX1 2JD
Tel: +44(0)1865 616577 Fax: +44(0)1865 280467
ethics@medsci.ox.ac.uk http://www.medsci.ox.ac.uk

CONFIDENTIAL

Ms Anjali Borhade
Nuffield Department of Population Health
University of Oxford
Old Road Campus
Headington
Oxford

4th December 2014

Dear Anjali

MSD-IDREC-C1-2014-011: Challenges and Plausible Solutions for Ensuring Health of Urban Migrants as a Part of India's Agenda for Sustainable Urban Growth Story

Thank you for submitting a request for amendments to the above project.

I am pleased to confirm that your requests to:

- video interviews with participants
- extend the project end date until 31st December 2016

have been approved.

Please do not hesitate to contact me if you have any queries about this.

Yours sincerely

Gill Halstead
Research Ethics Co-ordinator, Medical Sciences

APPENDIX 8: ETHICS APPROVAL OF PHFI ETHICS COMMITTEE

PUBLIC HEALTH FOUNDATION OF INDIA

Institutional Ethics Committee

Public Health Foundation of India

ISID, 4, Institutional Area, Vasant Kunj, New Delhi - 110 070

Communication of Decision of the IEC[1]
Form II

TRC-IEC No:	**TRC-IEC-192/13**	**Date:**	**December 2, 2013**		
Project Title:	Challenges and plausible solutions for ensuring health of urban migrants as a part of India's agenda for sustainable urban growth story				
Principal Investigator:	Anjali Borhade [WTP PhD Scholar]				
Review	**Full review**	☐	**Expedited review**	☒	
Date of review:	**NA**	**(DD/MM/YYYY)**			
Date of previous review:	**NA**	***(in case of re-submitted applications)* (DD/MM/YYYY)**			
Decision of the IEC:	**Approval** ☒	**Study can begin** ☒	**Resubmission**	☐	
	Conditional Approval ☐		**Study cannot begin**	☐	
Requirements to be fulfilled in case of conditional approval:	**Not applicable**				
Suggested alterations in case of resubmission:	**Not applicable**				
In case of approval, *recommended for a period of :*	3.5 years				
Comments:	The PI needs to send a copy of the IRB approval from Oxford University to the IEC secretariat. PI is a Wellcome Trust Capacity Building Programme PhD student at Oxford University UK mentor: Dr. Premila Webster (Oxford University) Indian mentor: Dr. Dileep Mavlankar (IIPH-Gandhinagar)				

Please note: Beginning of the research based on this approval implies acceptance of the following conditions:

1. *PI will inform the Secretariat of the start date of the study.*
2. *The PI will inform the IEC in case of any adverse events.*
3. *The PI will inform the TRC (Technical Review Committee) and IEC in case of any change of study procedure (including- changes in the informed consent form, recruitment procedure, potential research participant information), site and investigator.*
4. *The PI will inform the TRC – IEC Secretariat on termination of the study and submit a final report within 3 months of completion of the study.*
5. *Members of the IEC have the right to monitor the study with prior intimation.*
6. *Progress report to be submitted to the TRC-IEC Secretariat every 6 months from the date of start of study.*
7. *This permission is only for the period mentioned above.*

INSTITUTIONAL ETHICS COMMITTEE
APPROVED
CHAIRMAN / MEMBER SECRETARY
PUBLIC HEALTH FOUNDATION OF INDIA

Prof. Ramanan Laxminarayan
Name and signature of Member Secretary

[1] Adapted from the ICMR form: available at http://www.icmr.nic.in/bioethics/Communication%20of%20Decision%20of%20the%20IEC.doc

APPENDIX 9: WHO POLICY BRIEF

POLICY BRIEF

Migration and Health: A Policy Review to Support Inter-Sectoral Actions and Joint-Policy Interventions in Low and Middle Income Countries Across Regions

Anjali Borhade[a,b] Subhojit Dey[b], Anita Tripathi[b,c]
Dileep Mavalankar[d], Premila Webster[a]

Executive Summary

This policy brief provides an overview of internal labour migration in low and middle-income countries (LMICs). It outlines the factors affecting the health of migrants and policies and initiatives in low and middle-income countries (LMICs) to address health issues. It also outlines how Sustainable Development Goals (SDGs) relate to migration. Based on the evidence the brief proposes recommendations that can mitigate health problems related to internal migration and address health inequity in this vulnerable population.

The scale of internal labour migration

Internal Migration in some LMICs – what is known from the literature?

Migration of persons within national borders is far greater than migration across international borders. According to the UNDP Human Development Report1 in 2009 the number of people who moved across the major zonal demarcations within their countries was nearly four times larger (740 million) than those who moved internationally (214 million). In Asia, Africa and Latin America, approximately 40 per cent of urban growth results from internal migration from rural to urban areas[2].

Estimate of internal migration in selected countries

The table below presents some data on the scale from the available literature

Country	Estimate of internal migrants	Source	Comments
India	30 million[3]	National Sample Survey 2006-07	Micro-level studies suggests the estimate close to 100-120 million[4]
China	247 million[5]	Migrant population development report 2016	18% of total population are migrants
Vietnam	19.7% of the total population[6]	Population and Housing census 2015	Among total migrants aged between 15 and 59 years, 52.4% are women, consolidating the outcome of "female migration"
Bangladesh	13.5 million[7]	Population and housing census 2011	The rate of internal migration in 2011 was 9.7 per 1007
Philippines	2.9 million Filipinos migrated from 2005 to 2010[8]	Census of population and housing 2010	Between 1960-2000, the urban population grew 4 times while rural population only doubled

[a] Nuffield Department of Population Health, Oxford University, Oxford, UK,
[b] Indian Institute of Public Health-Delhi, Public Health Foundation of India, Gurgaon, Haryana, India,
[c] Ministry of Health and Family Welfare, New Delhi, India,
[d] Indian Institute of Public Health-Gandhinagar, Gandhinagar, Gujarat, India.

Funding Source
Wellcome Trust Capacity Strengthening Strategic Award to the Public Health Foundation of India and a consortium of UK universities
World Health Organization, South-East Asia Regional Office, New Delhi, India

Country	Estimate of internal migrants	Source	Comments
Mongolia	20.7% of the total population[9]	Census 2000	Rapid migration from rural to urban areas, currently, 60% of the total population live in urban areas.
Sub-Saharan countries	Estimated 50-80% of rural households have at least one migrant member[10]	Macro studies	No government data available
Cameroon	Mobility index estimated 32.5% migrants[11]	Government data	The socioeconomic migration and social migration are predominant with 64 % and 21.6 % respectively of migratory flux towards the cities
Sri Lanka	20% of the total population (2001)[12]	Government data	Major migration during the separatist conflict for safety, labour migration on high rise for livelihood from rural to urban areas. However, no specific data is available.
Ghana	40% of the total population[13]	Government data	Out of it, 70% of population migrates for livelihood.

Internal migration and its impact on health

Internal labour migration has become an important livelihood strategy for many poor people worldwide.[13] There is mounting evidence through micro-studies and surveys that internal migration can reduce poverty, inequality and contributes to overall economic growth and development.[14] However, this marginalized population faces exclusion from the various existing mainstream programmes such as education and health. This leads to poor health and can have significant public heath implications specifically in relation to infectious and occupational diseases[15].

Factors that impact on the health of migrants[16]

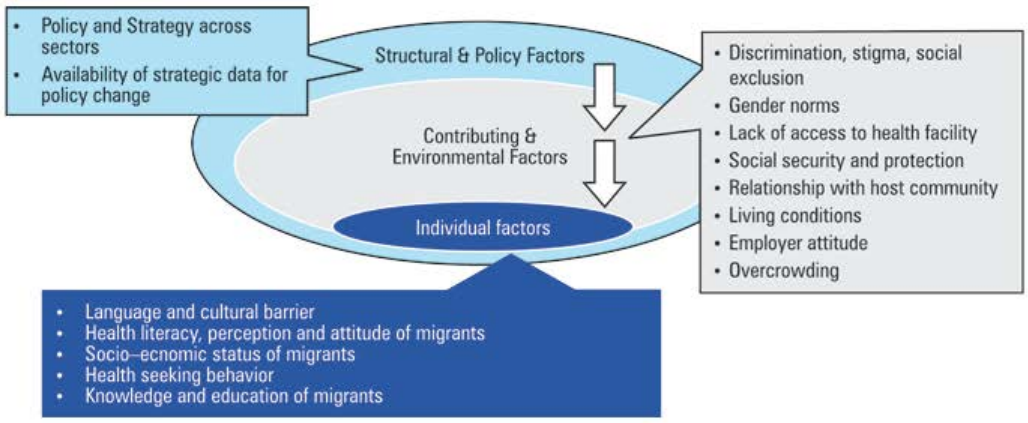
Migrants are often exposed to difficult and unsafe conditions, face occupational hazards, live in poor conditions and are without their supportive family and societal structure[15]

The following are some of the factors that impact on the health of the migrants:

- Overcrowding living conditions which enable increased transmission of infectious diseases
- Poor nutritional status (consequent lowered immunity)
- Inadequate clean water to allow personal hygiene
- Poor environmental sanitation
- Inadequate or no shelter without sanitation facilities.

The diagram below summarizes the determinants that impact on the health of the migrants

Figure 117: Factors affecting migrant's health



Migrants are particularly vulnerable to the following[18]

- Morbidity related to occupational exposures such as dermatitis, heat stress, respiratory diseases, musculoskeletal disorders and traumatic injuries. Exposure to pesticides or chemicals in pregnant women contribute to an increased risk of spontaneous abortion, premature delivery, foetal malformation, etc.
- Lack of proper water supply, poor drainage system, poor sanitary conditions render them more susceptible to infectious diseases, such as malaria, hepatitis, typhoid fever, etc.
- They are approximately 6 times more likely to have tuberculosis than the general population. Evidence shows that migration is an important factor for TB treatment default.
- Studies show that migrant workers are more susceptible to HIV/AIDS. Prevalence of HIV/AIDS among male migrants is 0.55 % compared to 0.29 % among non-migrants. They may have little or no access to HIV information, prevention (condoms, STI management), and health services.
- Migrant workers are 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.
- Migrants appear to have a higher proportion of reproductive health problems, dental diseases, cancer, poor child health and social and mental health problems.
- Migrant women have lower antenatal care coverage, higher prevalence of anaemia, reproductive tract infections and violence against women.
- Children of migrant workers experience a six fold greater risk of physical abuse compared to children in the general population.
- Migrant children suffer from malnutrition and lack of immunization as their parents move frequently for employment .
- Migrants are subject to stress related to job uncertainty, poverty, social and geographic isolation, poor housing, intergenerational conflicts, separation from family, lack of recreation, and health, shelter and safety concerns. This could result in relationship problems, substance abuse, domestic violence, and psychiatric illness.
- Studies show increased alcohol consumption and risky sexual behaviour in communities of predominantly single men compared with those consisting primarily of families.
- Prolonged stay at destination cities leads to an increased risk of psychiatric disorders; this 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

Population mobility is an underlying factor in the emergence of public health threats and risks. These risks are often related, but not limited, to transmissible pathogens. Mobile populations can link zones of disease emergence to low prevalence or non-endemic areas through rapid or high-volume movements. For example in the 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 of drug resistance TB due to default in treatment due to migration.

Health Policy related to Internal Migrants in LMICs – issues and challenges

IIn terms of policy with respect to welfare and health issues of internal migrants, LMICs are in the early stages of development. However, the magnitude of internal migration is such that governments have begun to realize that internal migrants cannot be ignored as it would ultimately affect the destination community and health outcome indicators of the nation.

Policies related to migration include, security, labour, trade, enforcement and international aid laws but rarely include health policy for migrants. Health policy related to migration was traditionally viewed in terms of a threat to public health resulting in screening, monitoring quarantine, communicable disease control as in case of pandemic flu. More recently, health policy for migrants encompasses a rights based approach which recognizes migrants special vulnerability to interpersonal and occupational hazards, social exclusion, and discrimination and the importance of universal access and culturally competent health care services.[19,20]

Evidence indicates that resources are rarely directed at mobile and displaced populations and their needs are not addressed in national strategies[14,20]. As a result, though national programmes have expanded their service areas, efforts to reach remote, and hard-to-reach populations like internal migrants have not been successful.[14,19,20]

Several countries have adopted a range of policies for migrant health. Appendix 1 provides details of existing policies. However, most policies are not evidence-based leading to inappropriate and ineffective measures.[14,19,21] One of the main challenges is that existing health policies in a range of countries does not identify the specific issues related to the health of internal migrants. A range of determinants (Fig. 1) interact to determine the impact of migration on health. Hence a multi-sectoral, coordinated and interactive policy approach is required to manage the issues related to the health of migrants.[19] What is needed are separate, focused policy measures aimed at the accessibility, affordability and continuity of health services to internal migrants in context of their mobility and vulnerable living and working conditions. (See annexure- Innovations in LMICs for Migrants Health)

Sustainable Development Goals (SDG)s seen through the internal migration lens

There are several SDGs - Goals 3 (health), 4 (education), 5 (gender equality), 8 (decent work) where the migrants rights are often not fully realised, due to legal, social, economic, linguistic and cultural barriers. In addition, achieving goals 10 (reducing inequalities), 11 (sustainable cities), 13 (climate action), 16 (peaceful societies) and 17 (partnerships) are also dependant on ensuring the needs of this marginalised population are addressed through appropriate local, national and international policies.

Moving the policy discourse on migrant health: From 'Piecemeal' efforts to 'Whole Government Approach'

Internal migration is emerging as a major livelihood strategy among the poor in LMICs. Some LMICs have already taken significant steps in terms of policy with respect to welfare and health issues of internal migrants. Examples include countries like Sri Lanka, Cameroon, Thailand and Ghana have developed comprehensive policies to address internal migration. While countries like China, India, DRC Congo, Vietnam, address migrant health through fragmented policies. A few countries like Mongolia and Cameroon have come up with innovative policy measures to deliver affordable, accessible and quality health care to internal migrants. However it seems piecemeal efforts driven by single departments or ministries rarely work. Evidence from the literature suggests that right based, multi-sectoral and co-ordinated policy measures and strategies are needed to manage internal migration and issues of migrant health.[19]

Strategies to improve the health of migrants that appear to work at a national level include:

- Formation of a nodal agency and focal point for welfare of internal migrants responsible for coordinating the various relevant departments, and promoting migrant-sensitive health policies through a comprehensive national migration health policy.[22,23]
- Formation of a database on internal migrants and development of an effective tracking system to counter their mobility. This could help to co-ordinate the assessment of the migrants health and social security needs and identify gaps in service delivery to meet their diverse needs.[19,24]
- Building migration specific disaggregated data such as residential status, length of stay, and access to diseases specific health services would be crucial.
- Universal coverage of health and social security programmes (social insurance, education, livelihood training, and housing) is crucial for migrants to get seamless access before and during their migration.[19,25] Convergence of the existing programmes at source and destination levels will ensure better response to needs of marginalized migrants.

Annexure

Table 1: Existing Policies to address Health and Social Security Needs of Internal Migrants in LMICs

Country	Existing Programmes and Policy Measures	Responsible Agencies	Supporting Institutions
*Sri Lanka	Sri Lanka National Migration Health Policy for internal and international migrants, adopted evidence-based and multi-stakeholder approach for promotion of the right to health. Special programs launched for migrants: • Language and culture sensitive health services offered for psychological and reproductive health • Insurance and other social welfare schemes • Retirement Scholarship scheme for children of migrants • Four subsidized loan types offered to migrants for housing, self employment, basic amenities and pre departure[22]	Ministry of Health Co-ordination with Thirteen key government ministries	International Organization for Migration World Health Organization
**China	• No comprehensive migration policy exists. Reform of Hukou system for registration of urban and rural migrants • Extension of Rural Cooperative Medical System Social Insurance Program • NGOs involvement in health care of migrants • Establishing alternative clinics set up by migrants themselves • Education & training to migrant population • Empowering migrants through trade unions, Improving the working & living conditions for rural migrants; Providing skills, training and information on applicable law • Local policies are being piloted in different cities of China with focus on tuberculosis, sexually transmitted disease and maternal health[26,27,28]	Ministry of Public Security Ministry of Health Ministry of Labour	International organization for migration World Health Organization International Labour Organization Local NGOs and Trade unions
**India	No comprehensive policy on internal migration Comprehensive migration support program piloted for tribal migrants in Maharashtra state during 2013-16, to be soon extended in other tribal areas of India[29].	National Commission for Scheduled Tribes, Ministry of Tribal Affairs, New Delhi & Maharashtra State Tribal development department	UNDP, India Disha Foundation (NGO)
	Interstate Migrant Workers Act 1979 provides comprehensive protection and welfare services to inter-state migrant workers.[30]	Ministry of Labour and Employment	International Labour Organization World Bank
	Integrated Child Development Scheme provides health care services to migrant women, children and adolescents at destination cities.[31]	Ministry of Women and Child Welfare	World Bank
	Portable National Health Insurance program 'Rashtriya Swastha Bima Yojana'[32]	Earlier Ministry of Labour and Employment, recently it has moved to Ministry of Health and Family Welfare	The Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH (GIZ)
	National Urban Health Mission 2013 plans to cover migrants in the health programs.[33]	Ministry of Health and Family Welfare	
	Jharkhand and Rajsthan states have made provision for registration of out-migration at source areas.[34,35]	State Labour Department	

Country	Existing Programmes and Policy Measures	Responsible Agencies	Supporting Institutions
**Vietnam	No comprehensive migration policy exists. Vietnam internal migration survey conducted in 2004 and 2015 to build national level data on migration. The survey led to the need of mainstreaming migration in the National Poverty Alleviation Programme, develop coordination between sending and receiving communities, improving access of migrants to basic services and low cost housing, health insurance and abolition of household registration system 'doi moi' which acts as a barrier in accessing basic and health services.[5]	General Statistical Office, Vietnam Ministry of Planning and Investment (MPI)	United Nations Population Fund World Bank
*Thailand	National Migration Policy exists but does not focus on internal migrants. Policy focuses on holistic and multi-sectoral approach for improving health of migrants laying emphasis on social and environmental determinants Universal coverage of health security was introduced through social security and universal coverage schemes (UCS) Good Practices includes involvement of migrants as community health workers, migrant friendly health services, establishment of six migrant health posts.[36]	Ministry of Health	World Health Organization International Organization for Migration
**Mongolia	No comprehensive migration policy exists. Reach Every District (RED) strategy adopted for outreach to cover mobile and unregistered remote migrant population for improved access to immunization, maternal and child health and other health services.[37,38]	Ministry of Health	World Health Organization
**Philippines'	• No comprehensive migration policy exists. Presence of a legal framework for protection of migrants and Internally Displaced Persons • Special initiatives for migration and HIV • Portable national health insurance.[39,40]	Ministry of Health Philippine Health Insurance Corporation	World Health Organization International Organization for Migration
**Malaysia	• No comprehensive migration policies exist • Mandatory HIV Testing, Emphasis on accessibility to health care services in terms of physical, economic and information criteria • Vision of Malaysian government is to provide equitable, affordable, efficient, technologically appropriate and consumer friendly health system • Health care accessibility is available 24 hours at minimal cost. Free of cost services for treatment of infectious disease • Appropriate housing and basic amenities to migrants is ensured under Minimum Standard of Housing and Amenities Act 1990.[41,42]	Ministry of Health	World Health Organization International Labour Organization

Country	Existing Programmes and Policy Measures	Responsible Agencies	Supporting Institutions
*Cameroon	No comprehensive migration policy exists. Creation of a National institution for set up of proactive governance of internal migration (F-PGIM), with the goal of transforming internal migration into an engine of balanced national development and equitable and sustainable human development Efforts are being made to establish a National Center for the integrated monitoring of internal migration, emphasis on promoting community health by creating health and sanitation committees in urban neighbourhoods, health training programs for city dwellers in techniques of primary health care at the neighbourhood level.[43]	Ministry of Territorial Administration with several other ministries.	African, Caribbean and Pacific (ACP) Observatory on Migration European Union UNFPA International Organization for Migration IOM Development Fund
*Ghana	Recent Creation of a National Migration Bureau (NMB) an inter-ministerial committee later renamed as Migration Unit (MU), task is to formulate National Migration Policy to mainstream migration into development plans National Population Policy 1994 recognizes that instead of stopping migration, it is important to monitor and manage migration Ghana's Poverty Reduction Strategy (GPRS) also focuses on reducing poverty among migrants particularly labourers[44]	Ministry of Interior Inter-ministerial Migration Unit team	International Organization for Migration
**Democratic Republic of Congo (DRC)	No comprehensive migration policy exists. But efforts are made by National Government to incorporate migrant health into its overall programs and policies associated with the reform Strategy of the Ministry of Public Health; Health strategy of DRC for migrants 2013-2017 highlights migration health as one of principal intervention method, public health approach adopted to the health of migrants, by ensuring their health rights, avoiding health disparity in health status by providing accessible, available, acceptable and quality health care[45]	Ministry of Health, Immigration, labor and social welfare	International Organization for Migration World Health Organization UN agencies (UNICEF, UNFPA, UNAIDS, UNHCR) Local civil societies and academia
International conventions, and policy commitments	• The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 2001 • Declaration of Commitment on HIV/AIDS, which calls for "national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrant and mobile workers" and also includes refugees and internally displaced persons • The Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, and the Protocol against the Smuggling of Migrants by Land, Sea and Air • The World Health Assembly Resolution on Health of Migrants.	United Nations Human rights, Office of the High Commissioner United Nations General Assembly Special Session United Nationals office on Drugs and Crime World Health Organization	National governments of respective countries

*Countries that have initiated comprehensive policies for migrants' health
** Countries that have adopted piecemeal/fragmented polices for migrants' health

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APPENDIX 10: DPHIL STUDY OUTCOMES AND ACHIEVEMENTS

Achievements during DPhil

Anjali Borhade, Nuffield Department of population Health, University of Oxford, UK

Published paper- Books chapters in Book

Borhade A, Zhang M. Challenges and Solutions of Food Security among Seasonal Migrants: The Case of Seasonal Migration in India. In: Xu Q, Jordan LP, editors. Migrant Workers: Social Identity, Occupational Challenges and Health Practices. New York, USA, Nova Publishers; 2016. p. 115-23.

Borhade A. Internal Migration in Contemporary India. In: Mishra DK, editor. Internal Labour Migration in India: Emerging Needs of Comprehensive National Migration Policy. New Delhi, India, Sage Publications; 2016. p. 291-236

Babu BV, **Borhade A**, Kusuma YS. Extended Case Study: A Mixed-Methods Approach to Understanding Internal Migrant Access to Health Care and the Health System's Response in India. In: Schenker MB, Castañeda X, Rodriguez-Lainz A, editors: Migration and Health: A Research Methods Handbook. California, USA: University of California Press; 2014. p. 484-98.

Borhade A, Dey S, Tripathi A, Mavalankar D, Webster P. Migration and health: a review of policies and initiatives in low and middle-income countries. *Lancet* 2016; 389 (S26): 26. Available on http://dx.doi.org/10.1016/S01406736(16)322620

Babu et al, Living conditions of internal labour migrants; a nationwide study in 13 Indian cities, Int. J. Migration and Border Studies, Vol. 3, No. 4, 2017

Submitted papers for Publications

Borhade A, Dey S, Tripathi A, Shrivastava P, Mavalankar D, Webster P. Migration and health: a policy review to support intersectoral actions and joint policy interventions in low- and middle-income countries (LMICs), November 2016 WHO South East Asia Regional Office, New Delhi

Borhade A, Dey, Mavalankar D, Webster P, **Socio-Economic Profile of Inter-state and Intra-State Urban Migrants: A Case study of Nashik, Maharashtra,** Special Issue on "Understanding Migration Patterns and Migrant Experiences in Asia" for the journal 'Environment and Urbanization ASIA, Sage Publications'' October 2016

Borhade A, Dey, Mavalankar D, Webster P, **The Saga of Livelihood Migration Among Tribals in Nashik District, Maharashtra, India,** Special Issue on "Understanding Migration Patterns and Migrant Experiences in Asia" for the journal 'Environment and Urbanization ASIA, Sage Publications'' October 2016

Poster / Paper Presentation / Speaker / Resource Person

Invited as scholar in Global Network of scholars on migrant and health, set up by International Organization for Migration, Geneva, attended first meeting of network in September 2017 in Colombo, Sri Lanka

Participated as an expert in second global consultation on migrants' health, Organised by Ministry of Health, Sri Lanka, International Organisation for Migration and World Health Organisation, Colombo, February 2017

Borhade A, Dey S, Tripathi A, Shrivastava P, Mavalankar D, Webster P. Migration and health: a policy review to support intersectoral actions and joint policy interventions in low- and middle-income countries (LMICs). **Poster Presentation** Pubic Health Science Conference, organised by The Lancet, 28 November 2016, Cardiff, UK

Borhade A, Dey S, Mavlankar D, Webster P. Cross-Sectional Survey of Internal Migrants in Nasik, India to Determine their Socio-Demographic Profile and Access to and Utilisation of Healthcare Services. **Oral presentation** at 2nd International Conference on Public Health, 28-29 July 2016, Colombo, Sri Lanka.

Borhade A, Panel Speaker in 'Health in Megacities' for 'Global forum for health' organised by Ministry of Health and Ministry of Science and technology has organized in Manila during 24-28 August 2015.

Borhade A, Dey S, Tripathi A, Shrivastava P, Mavalankar D, Webster P. Migration and health: a policy review to support intersectoral actions and joint policy interventions in low- and middle-income countries (LMICs). **Poster Presentation** at 5th Annual Public Health Foundation of India Research Symposium, 11 - 13 March 2015, New Delhi, India.

Contribution in Policy Development Initiatives

1. Technical Advisor, National Commission for Scheduled Tribes, Government of India (Letter attached at the end)

National Commission for Scheduled Tribes (NCST), Government of India has developed comprehensive policy recommendations to address issues of internal tribal migrants in India. I've provided technical support to the NCST in entire process. These

recommendations ensure multi-sectoral approach and engagement of various government ministries.

These recommendations have defined-

1. Detail outline of flagship livelihood migration support program in all tribal states of India
2. Specific engagement of 12 different key line ministries at national level, for mainstreaming migrant's rights into their existing mandate.
3. Budget allocation by state and federal government for this initiative

Key outcomes of these recommendations are expected to generate-

1. State specific migration support program
2. Migration specific disaggregated data by National Sample Survey, Health and Family Welfare Survey, Employment Survey by Labour Ministry and Census of India.
3. Developing Portability of social security programs for migrants
4. Developing universal access to health, education and basic entitlements for migrants across state borders.

2. Ministry of Tribal Affairs and UNDP, India:

I'm in process to provide technical support to Ministry of Tribal Affairs 'Government of India and UNDP (partnership) to develop workable intervention plan based on the above recommendations for all tribal states of India.

3. Policy Brief development for WHO and member states

Based on my literature review, WHO SEARO office has suggested to develop a policy brief that can be referred to WHO's members states, on 'Migration and health: a policy review to support inter-sectoral actions and joint policy interventions in low- and middle-income countries (LMICs)'.

Letter of Appointment as an Advisor to the National Commission of Scheduled Tribes (NCST), Government of India

No 55/1/NCST/2016 – Adm

सत्यमेव जयते

भारत सरकार
Government of India
राष्ट्रीय अनुसूचित जनजाति आयोग
National Commission for Scheduled Tribes

छठी मंजिल, बी विंग, लोकनायक भवन
खान मार्किट, नई दिल्ली – 110003
6th Floor, 'B' Wing, Lok Nayak Bhawan,
Khan Market, New Delhi - 110003
Dated 31.5.2016

To,
Ms. Anjali Borhade
Founder Director, Disha Foundation
Associate Professor,
Indian Institute of Public Health, Delhi

Sub: Appointment as honorary Advisor at National Commission for Scheduled Tribes

Dear Ms. Borhade

1. National Commission of Scheduled Tribes has appointed you as honorary advisor for developing policy framework to strengthen existing policies to ensure social protection and welfare of tribal population in India.

2. No remuneration, stipend, TA/ DA, transport or residential facility will be provided by the commission during this assignment.

3. The period of this position will be from 1st June 2016 to 31st May 2017

We look forward to work with you and seek your technical inputs and expertise in this noble work.

Yours Truly,

(K.D Bhansor) Mrs
Director

Tel.: 011-24657271, 011-24615012, Fax: 011-24624628, 011-24624191, Toll Free 1800117777

NCST's letter of recommendations to address tribal migration in India

NO. K-11/Cont./Maharashtra/2/2015

सत्यमेव जयते

भारत सरकार
Government of India
राष्ट्रीय अनुसूचित जनजाति आयोग
National Commission for Scheduled Tribes

छठी मंजिल, बी विंग, लोकनायक भवन
खान मार्किट, नई दिल्ली – 110003
6th Floor, 'B' Wing, Lok Nayak Bhawan,
Khan Market, New Delhi - 110003
Dated 31/5/16

To

The Secretary
Ministry of Tribal Affairs
'A' Wing, Shashtri Bhavan,
New Delhi

Subject: Comprehensive policy framework to address distress tribal migration in all Tribal States of India

Sir,

I am directed to forward comprehensive policy framework to address distress tribal migration in all tribal states of India.

1. Since past one year, NCST has investigated into the matter of tribal labour migration for livelihood. It has ben noticed that tribal migration for livelihood is very high from less developed states to developed states of India. These poor tribal workers face multiple exclusions from various social protection programs and polices, which makes them more vulnerable and it affects their overall socio-economic status.

2. NCST has conducted a study in collaboration with a pioneer NGO Disha Foundation, working in migration sector. NCST has noticed through this study that national and regional data of migrating tribal families are almost similar, the development indicators are worse among ST population leading to highest urban migration of ST households. When ST households migrate to urban areas, these indictors do not improve much compared to other social groups. This clearly indicates the lack of access of ST households to various entitlements even in urban areas. Hence, there is an urgent need to provide special attention to migrant tribal population both at rural and urban areas to improve their development indicators. Overall, migration management (facilitation) approach should be more pragmatic at both source and destination locations.

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3. NCST has developed comprehensive policy recommendations based on technical inputs from Maharashtra Tribal department, Disha Foundation, and available various policies to address labour migration in India. These recommendations ensure multi-sectoral approach and engagement of various government ministries.

4. It is strongly recommended that Ministry of Tribal Affairs should co-ordinate with different ministries for successful implementation of the suggested recommendations at national and state level

5. This has been approved in the Commission's meeting number 84th dated on 25th May 2016.

Action taken in this matter may kindly be sent to the Commission at an early date.

Yours Sincerely,

(K. D Bhansor)Mrs.
Director

Encl: Comprehensive policy framework to address distress tribal migration in all Tribal States of India

CC:

Ms. Anjali Borhade, Founder Director, Disha Foundation, Nasik/Associate Professor, Indian Institute of Public Health, Delhi