11

IMPROVING HEALTH AND WELL-BEING OF MIGRANTS IN INDIA

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I. Internal Migration in India – Context and Scale

Internal labour migration is a complex reality in India. Triggered by degenerating rural livelihoods and climate variability, millions of Indians are choosing to migrate to cities in search of secure employment. The magnitude of this movement has been increasing steadily every decade. Although the census definition of migration captures a broader movement, a disaggregation of the census data shows that in 2011 about 51 million migrants migrated for work (Tumbe 2023).

Over time, this movement has become more long distance with an increase in interstate mobility. States such as Uttar Pradesh (UP), Uttarakhand, Bihar, Rajasthan, Odisha, West Bengal, and Jharkhand with low HDI outcomes and a surplus of labour are its primary suppliers. On the other hand, Maharashtra, Gujarat, Kerala, Haryana, Punjab, and Tamil Nadu, epicentres of economic progress, attract a large number of workers (Srivastava 2011).

Migrant workers, estimated about 350 million, form one of the biggest segments within India's large informal sector workforce. Most such workers migrate seasonally and keep moving between their villages of origin and cities of work, a pattern referred to as seasonal and circular. A disproportionate number of seasonal migrants hail from marginalised communities like SCs, STs, and religious minorities (National Commission for Enterprises in the Unorganised Sector 2007). Increasingly, millions of women are also undertaking migration and engage in severely exploitative work streams.

Many of these labour-migrants operate in the absence of written contracts and are often outside the ambit of social protection schemes. Devoid of critical skills, information, and bargaining power, they get caught in exploitative

DOI: 10.4324/9781003664314-13
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labour arrangements that force them to work in low-end, low-value, hazardous work environments. Increasing informality of work, exclusionary urban policies, and weakening processes of social dialogue and collective bargaining have further compromised the conditions of migrant workers in the economy. Several such fragilities were sharply amplified during the COVID-related lockdowns in 2020 when the media was replete with images of lakhs of migrant workers walking back to their villages on foot.

Despite the large numbers that underlie this phenomenon, India's social policies continue to be plagued by a 'sedentary bias'. Because of their constant mobility, both between their villages and the cities, between several different workplaces and across different cities, they lose access to entitlements often tied to a single place of domicile. They struggle to access basic public provisioning such as subsidised food, fuel, health, and education, and even immunisation of children.

Political exclusion of migrants is another significant challenge. Many studies and anecdotal evidence point out that a large number of migrants cannot cast their votes or participate in elections because of mobility. Serious citizenship issues arise as the state machinery does not allow the portability of this basic entitlement (Srivastava 2020). This phenomenon is also inadequately captured by large-scale data collection exercises of the government, such as the census and national sample survey (NSS), which are constrained by methodological and definitional flaws. Cumulatively, these interconnected issues deepen the systemic vulnerability faced by migrant communities, making them more susceptible to health and well-being issues.

II. What Affects the Health and Well-Being of Labour-Migrants and Their Families?

Based on our own experience of working with high migrant communities, we have identified four critical factors that affect the health and well-being of migrants. These are nutrition, occupation, housing, and gender dynamics. In the following sections, we describe each factor in some detail.

Nutrition

While nutrition is vital for maintaining health and well-being, migrants often struggle with nutritional insecurity in both their source and destination regions. At the source, small land sizes, scarcity of water, and absence of alternative livelihoods cause economic distress. The meagre incomes from seasonal and unskilled jobs at the destinations are inadequate to pull these households out of poverty (Sharma *et al.* 2014) and subsequently impact their household food security. A study by Mohan *et al.* (2016) conducted in rural, high migration communities of southern Rajasthan revealed a significant lack

of availability of nutritious food. While most households had some cereals (87%), over half (56%) had no pulses and about a quarter (26%) had no cooking oil at home.

Most mothers reported consuming some form of staple (roti), but their access to essential components of a balanced diet like pulses and vegetables was considerably lower. It was not surprising that over half of the total children studied (695) were stunted and underweight, while about half of their mothers were undernourished.

Among migrants themselves, poor nutritional status has been observed at various instances. Surveys conducted by *Aajeevika* Bureau, a public service organisation that works to protect the rights and well-being of migrant workers, between 2015 and 2018 revealed high levels of malnutrition across various work sites. Among factory workers in Ahmedabad (*n* = 407), 46% were underweight and 13% overweight or obese. Among construction workers in Ahmedabad (*n* = 200), 42% underweight, 6% severely underweight, and 2% severely underweight. In Surat, 17% of power loom workers (*n* = 65) were underweight, while 29% were overweight or obese. Similarly, workers in recycling units in Mumbai (*n* = 51) were 33% underweight and 17% overweight or obese.

The nutritional status of women migrant workers is also precarious. A study by Ravindranath and Iannotti (2019) conducted across five construction sites in Ahmedabad found a significant proportion (47%) of women migrant workers in the sample (*N* = 55) underweight (including four pregnant women) or suffering from low BMI (M = 18.36, SD = 1.7) (Table 11.1).

Table created by author using data from Ravindranath and Iannotti (2019). 'Maternal health and access to healthcare among migrant workers engaged in informal construction work, Ahmedabad, India' (Version 1, Research Square).

Since many migrant workers move with their entire families, the children also experience vulnerability to nutrition insecurity. Findings of a study conducted in Ahmedabad revealed that undernutrition was highly prevalent among the children of migrant construction workers (Ravindranath *et al.* 2019). In a sample of 113

TABLE 11.1 Malnutrition among Women at Construction Sites in Ahmedabad City

Classification	*BMI (kg/m²)*	*Total Sample (N = 55)*
Normal range	18.50–24.99	29 (53%)
Underweight (<18.5)		
Mild thinness	17.00–18.49	13 (24%)
Moderate thinness	16.00–16.99	8 (14%)
Severe thinness	<16.00	5 (9%)

Note: BMI categories as per WHO norms.

TABLE 11.2 Malnutrition among Children Under Five in Ahmedabad City

Prevalence of Undernutrition (%)			
Age in Months	*Stunting*	*Underweight*	*Wasting*
0–5 (*N* = 7)	42.9	42.9	14.3
6–11 (*N* = 15)	46.7	53.3	33.3
12 –23 (*N* = 30)	46.7	46.7	20.0
24–35 (*N* = 25)	40.0	52.0	8.0
36–47 (*N* = 18)	27.8	33.3	5.6
48–60 (*N* = 36)	38.9	61.1	38.9
All age groups (*N* = 131)	40.5	50.4	22.1

Note: Table created by author using data from Ravindranath et al. (2019). 'Nutrition among Children of Migrant Construction Workers in Ahmedabad, India'. *International Journal for Equity in Health*. 18(143).

children, half were underweight, slightly less than half were stunted, and one in five experienced wasting (Table 11.2).

COVID-19 Effect

The COVID pandemic, subsequent lockdown, and halting of employment and incomes affected almost the entire country, with those working in the informal sector affected the most. Lack of food created panic and unrest after lockdown announcement. Fragility of the communities was visible clearly, with numerous families having no food to eat. Grains from the previous harvest were used up, the crop was not ready, food supplies from the public distribution system (PDS) did not reach, and other sources of income were abruptly halted.

Basic Healthcare Services (BHS), a not-for-profit organisation that provides health and nutrition services in rural, high migration communities in south Rajasthan, conducted a survey to ascertain food availability in rural, tribal communities in southern Rajasthan who rely predominantly on outward migration for sustenance. Telephonic interviews of 211 men and women were conducted (Saxena *et al.* 2020).

While cereals such as wheat and maize were available in most households, pulses were available in only 65% of households, with 43% having only one type. Additionally, 78% reported having one or more vegetables, but this dropped to 34% when lower nutritional value vegetables like onions, potatoes, green chilies, and garlic were excluded. Less than half (49%) reported having milk.

Challenges like remote market locations, pandemic restrictions, and supply chain disruptions contributed to price hikes and limited cash flow. This

often forced families to barter their harvest and subsist on a primarily cereal-based diet with minimal variety.

Children too were severely affected as childhood malnutrition levels increased substantially compared to pre-pandemic times. Mothers of children enrolled in the *phulwaris*, day-care centres, run by BHS, as the children became much weaker than before. The mothers had to go for work in the fields and needed a place to keep their children. Similarly, at the phulwaris we run at construction sites in Ahmedabad for children from migrant families, we saw the number of children attending the centres almost doubling following the pandemic, with older school-going children also attending the crèches in hope of two meals a day.

In summary, the COVID-19 pandemic worsened the nutrition security among migrant workers and their families, both in their villages where they came from and in the cities where they found work.

III. Work and Health – Occupational Safety and Health of Migrant Workers

Migrant workers are pervasively engaged in hazardous work sectors, largely vacated by local workers. Migrants, often belonging to marginalised social groups bereft of social capital and networks in cities, take up precarious work that subject them to grave risks of injury, accidents, and long-term health disorders.

Workers are subject to several types of occupational safety concerns, depending on the work sectors and contexts. For instance, fire hazards are one of the most fatal accidents with a very high incidence, especially in sectors such as chemicals (Kaushal 2021), recycling, garments, and heavy engineering. In settings such as the power looms, where the machinery is outdated with limited safety features, serious injury and even death by electrocution are common. The automobile sector sees a high incidence of limb loss and amputations on account of power press injuries (Safe in India 2021). Over and above these accidents, exposure to hazardous work conditions also results in deadly diseases, such as silicosis, tuberculosis, and other forms of respiratory illnesses, among workers (Jain & Sahoo 2019).

Despite the alarming regularity with which we hear of such accidents, there is no systematic data capturing the scale at which they happen. For instance, data from the Directorate General Factory Advice Service and Labour Institutes (DG-FASLI) show that 3,331 deaths were recorded between 2018 and 2020 in Indian factories (Paliath 2023). Experience and anecdotal evidence from the ground suggests that these are severe under-estimates, since most of these data are of registered factories that employ a small portion of workforce in India. Such data remain unavailable for the informal sector, which employs a large majority of workers.

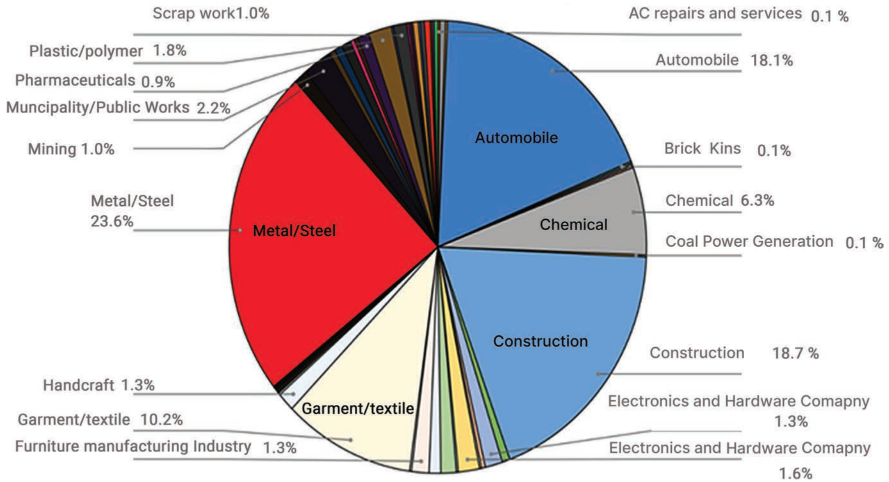


FIGURE 11.1 Sectors where accidents/injuries have been recorded on the e-log.

Note: Figure created by the author from Rajan *et al.* (2020). Precarious employment in power looms. In *Handbook of Internal Migration in India* (1st ed., p. 642). SAGE Publications Pvt Ltd.

An alternative data tool e-log, recently set up by Work Fair and Free Foundation to capture and establish the incidence of occupational accidents and injuries recorded about 670 cases in the industrial hubs of Gujarat (38%), Maharashtra (38%), and Rajasthan (20%), in which 1,273 workers were victims of various injuries and accidents. Most victims were between 20 and 40 years of age, largely migrant workers (Srinivasan & Niveditha 2024). Of the 670 cases recorded across 47 sectors, most were from the automobile, metal/steel, construction, and chemical industries (Figure 11.1).

HIGH INCIDENCE OF SILICOSIS IN THE STONE CARVING SECTOR – EVIDENCE FROM PINDWARA

In several districts of Rajasthan, large numbers of people are engaged in stone-carving as an occupation. For instance, in Pindwara block of Sirohi district, it is estimated that about 8000 people, largely young men, are employed in 248 factories in this occupation. Similar numbers are engaged in stone-carving in several other districts of Rajasthan, such as Dungarpur, Pali, Jodhpur, Karauli, and Bharatpur. According to a study conducted by Aajeevika Bureau and Kotra Adivasi Sansthan in 2017, the prevalence of those exposed was found to

be 9%, while in unexposed workers engaged in other occupations, the prevalence was 0.18%, thus indicating a prevalence 50 times more in stone-carvers than in those in other occupations. An assessment of stone-carving units of Pindwara by the National Pollution Control Board also reported that workers in these units are exposed to high respirable silica and are suffering from silicosis (Akolkar 31 July 2017).

Survey statistics also point to an alarmingly high death toll among stone-carving workers who are victims of silicosis. In just 11 panchayats surveyed, 275 workers have died in the last 3 years, preceding the survey, reporting sustained cough, breathlessness, and other symptoms of advanced silicosis. Crude death rate in Pindwara among working age men was also found to be 4.5 times higher than state average, which indicates high mortality.

An audiometry test done with power loom workers in Surat, mostly migrants from Odisha, revealed 94% of the workers had some form of hearing loss (Varma 2023). Noise-induced hearing loss (NIHL) found in 35% of workers was a direct consequence of their long unprotected exposure to extremely high levels of noise that emanated in the power looms. While normal conversation is at around 35 dB, these power looms generated noise between 110 and 114 dB, where workers work for 12 hours without ear protection.

Several structural drivers contribute to this disproportionate exposure to occupational risks migrant workers endure. Intense fragmentation of work because of high production pressures in global supply chains has resulted in the accelerating incidence of occupational safety and health (OSH) risks and long-term illnesses. Poor work conditions lead to failing health of workers, resulting in a high circulation of casualised workforce. Also, a poor investment in safety training or skilling increases their propensity to accidents.

Smaller units employing migrant workers in large numbers operate at a survivalist level and often lack the experience or the expertise to install adequate safety architecture. After COVID, an increasing casualisation of wage relations has seen workers moving from daily-waged arrangements to piece rates for job works. This has resulted in a scenario of long work hours needed to earn the same amount of wages, thus resulting in exhaustion and further risks. Piece-based wage relations also obliterate the employer–employee relationship, making it difficult for workers to mobilise and demand for safer conditions at work. This is further complicated because of marginalised communities, such as *Dalit* and *Adivasi* workers and women engaged in disproportionately hazardous work, whose ability to demand safety is constrained.

The current legal and policy architecture surrounding labour regulations also lends itself to exclusion. Thresholds for registration under safety

provisions are kept small. Only units employing over 10 workers are required to register themselves under various safety provisions. Several units avoid these obligations by registering themselves under less stringent acts, such as the Shops and Establishments Act, rather than Factories Act, where the safety mandates are much higher.

Housing and Health

In the absence of decent incomes, a vast majority of the informally employed migrant workers take up suboptimal housing arrangements in urban areas. These arrangements are often in temporary shelters, open spaces, work sites, or densely packed rooms/halls in urban slums. With varying degrees of access to safe drinking water and sanitation facilities, migrant workers persist in subhuman living conditions, exposing themselves to different kinds of health risks, especially infectious diseases such as dengue, malaria, diarrhoea, and tuberculosis.

Several studies have pointed out that urban settlements or peripheries with a marked presence of migrant workers are outside the ambit of urban governance policies and city planning processes. A large majority of migrant settlements are unrecognised in city-based enumeration exercises, which deprives them of access to basic public provisioning by a huge margin (Desai 2017). Thus, migrant settlements suffer from a glaring absence of basic infrastructure and urban amenities of water and sewerage lines and regular arrangements for garbage disposal.

Consider the following migrant testimonies from Surat that attest to suboptimal public provisioning in migrant settlements: *We have been living here for the last few years. All these years, we have had issues with the water supply and gutter line. Few days back the water was contaminated. It was water from the gutter. We couldn't even use it in the toilets* (by women migrant workers from Raigad district of Maharashtra engaged in 'dhaga' cutting work in Surat). *The gutter line overflows all the time. The toilet pipelines are leaking and deteriorating. We are forced to do all the maintenance work at our own expense. We complained at the commissioner's office multiple times, but nobody ever responded* (Pappubhai, resident of Kosad Awas in Amroli, Surat). Living in dense numbers in congested mess halls and rented rooms is also a common feature of migrant workers in cities. Crammed, ill-ventilated, dimly lit spaces that also house a small bathing area are usual characteristics of migrant living.

In industrial areas that also double up as worksite housing for migrant workers, garbage collection arrangements are abysmally poor. Such areas fall through the cracks of urban, labour, and industrial governance ecosystems, with migrant communities having to pay the heavy price of ad hoc and poor-quality access to basic amenities, while being at the beck and call of the employer round the clock.

Compounded impact of long working hours, strenuous working conditions, crowded living spaces, and poor nutrition usually leave migrant workers highly vulnerable to diseases such as tuberculosis. Severe lack of hygiene in their living areas also expose them to seasonal, communicable diseases such as dengue, malaria, and cholera. Challenges in navigating complex health systems in urban spaces render them incapable of accessing good quality, reasonably priced healthcare, which adversely affects their return to well-being and good health.

Gender, Work, and Health

Increasing rural distress has triggered migration of women in greater numbers, along with their families, alongside a smaller percentage who migrate on their own. Anecdotal evidence from the ground suggests that the number of women migrating is likely to have increased post-COVID.

Migrant women face numerous gender-based challenges at the destination regions. These challenges include, among others, discrimination in labour markets, vulnerabilities in living spaces, and a lack of access to public spaces (ILO *et al.* 2020). After putting in long work hours at the work sites, where they are not remunerated independently or are severely under-remunerated, they have to come back to their heavily congested living spaces in the evenings and perform functions of social reproduction that involves undertaking several gender-based tasks such as cooking, cleaning, and tending to children. Every time they move in search of work, they are forced to reproduce the household in very frugal conditions. Thus, women migrant workers absorb the compounded effects of a hostile city and poor work conditions with their bodies and minds.

Several migrant women, especially those residing on open settlements and pavements, have highly limited access to basic public services. For instance, studies of migrant women construction workers in Ahmedabad have shown that they must wake up as early as 3:30 in the morning to undertake open defecation before the city wakes up, since they don't have another way of accessing toilets. 'Women on average were walking an additional 3 km, spending one hour daily accessing toilets. They faced the immense stress that they might not be able to find a toilet or may be delayed in returning to their families. An additional very significant source of stress was that the women and girls may not find time and opportunity to access a toilet for the next 12 hours (ibid.)'.

Access to childcare facilities is another aspect where migrant workers receive negligible support from the state or the employers. Women do not have support systems to enable childcare along with their back-breaking work. Women are routinely prevented from taking breaks to breastfeed infants, which also has a severe effect on the early health and nutrition of

their children. Lack of access to healthcare during pregnancy or sickness is a natural course of life for migrant women workers (ibid.) They must resort to private clinics when they are sick since public facilities are very hard to navigate and would require their husbands also to take time off to accompany them to the hospitals. When very sick, they end up returning to their villages to more familiar pastures.

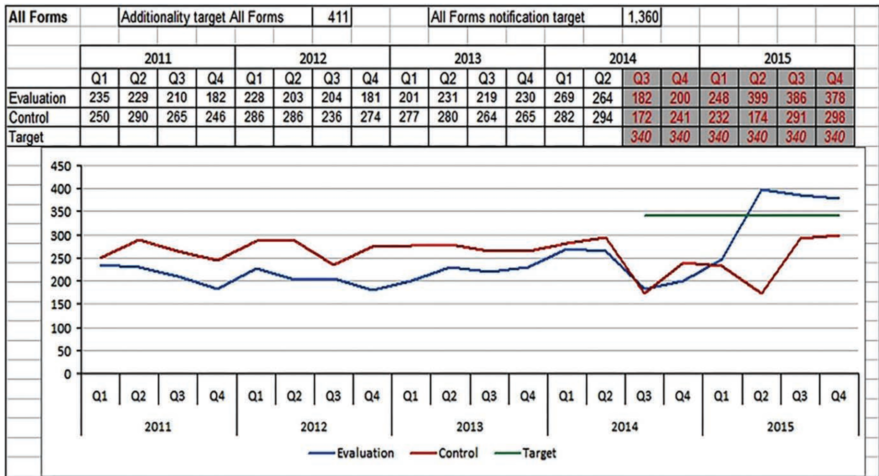
Migrant women also find it challenging to access antenatal healthcare. Accredited social health activists (ASHAs) and *Anganwadi* (childcare centre) workers are not incentivised to bring migrant families, especially those living in open spaces, on roadside pavements, and at work sites. ASHA workers receive their incentives regularly upon immunising children and pregnant women. This incentive system ends up being misaligned with migrant women and children who are constantly on the move (Thomas *et al.* 2020). Thus, unattended deliveries at the workplace, miscarriages, reproductive health issues, and poor pre- and postnatal care are common on construction sites (Jayaram *et al.* 2019).

IV. Case of Tuberculosis among Labour-Migrants – Convergence of Unsafe Work, Undernutrition, Poor Housing, and Unresponsive Services

Migrant workers are often undernourished, work in unsafe occupations, and reside in crowded and unhealthy spaces. All these factors converge together to cause a high risk of contracting tuberculosis (TB), which spreads rapidly to other co-workers and co-inhabitants due to the highly congested work and living arrangements. Work settings, as in the garment and construction industries, further intensify the risk of the disease by damage to their lungs by smoke, fine dust, lack of ventilation, and other pollutants. Crucially, delayed detection and difficulties in completing treatment due to inconsistency or interruptions significantly increase their vulnerability.

In 2011, through a network of migrant volunteers and a migrant support centre, Aajeevika Bureau, implemented a series of interventions aimed at early detection and management of TB among migrant populations. Volunteers raised awareness, conducted screening camps within factories and residential areas, and educated factory management on tuberculosis among the migrants and its impact on the productivity of workers.

Figure 11.2 explains the impact of the intervention. The blue line indicates the evaluation group – two TB units where the intervention was implemented. The red line indicates the control group. We can see that the city had similar incidence of TB across both the groups. Interestingly, with active case finding and other series of interventions, the incidence of TB increased in the evaluation group. This shows around 200 per 100,000 population of



All Forms | Additionality target All Forms 411 | All Forms notification target 1,360

	2011				2012				2013				2014				2015			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Evaluation	235	229	210	182	228	203	204	181	201	231	219	230	269	264	182	200	248	399	386	378
Control	250	290	265	246	286	286	236	274	277	280	264	265	282	294	172	241	232	174	291	298
Target															340	340	340	340	340	340

FIGURE 11.2 Tuberculosis among labour-migrants in Ahmedabad city.

Note: The figure was taken from the Grantee Annual Narrative Report for the Project that Aajeevika Bureau and BHS implemented in Ahmedabad called Stooping TB among Migrants in Ahmedabad City, India, supported by TB partnerships. Submitted in April 2016.

TB patients were undetected. They were either not able to reach the health system or vice versa (India Aajeevika Bureau (AB), 2010).

Adherence is another major hurdle for migrant TB patients. Various factors can be attributed to this, such as limited access to correct TB-related information, social stigma and discrimination, lack of awareness of entitlement to health services, and low health-related spending capacity proportionate to household income, as well as migrant-unfriendly health services. All these lead to reluctance in seeking care or adhering to treatment.

Delayed detection followed by irregular, incomplete TB treatment puts the migrant population at high risk. Migrants' difficult life causes them to constantly juggle between the need to work in the city (at the destination) and travel back to villages (at the source) to fulfil responsibilities. This back and forth, coupled with limited social support, long working hours, unfamiliarity with the health systems in the city, and the urgent need to earn a living (inadequate financial resources), makes it difficult for them to seek care during early symptoms and continue treatment subsequently.

V. Policy Responses for Improving Health and Well-Being of Migrants

Integrated Child Development Services

The existing central government guidelines allow all migrant children to avail of nutritional supplementation under the Integrated Child Development

Scheme (ICDS) at destination cities, irrespective of whether they are registered in the area. As a result, all migrant children can benefit from Anganwadi services in or near where the migrants reside. Pregnant women can also avail of antenatal and postpartum care through Anganwadis, which are linked to government health services. Adolescent girls can be given treatment for anaemia at the Anganwadi centres (AWCs) and, in addition, be provided life skills and sex education through ICDS programmes.

An empirical study by CMS Social across six states – West Bengal, Maharashtra, Gujarat, Delhi, Punjab, and Karnataka – reported that while 75% households used to send their children to AWCs at their native place, only a little more than one-fourth send at their destination. While the AWC coverage of children was better in Gujarat with 52% children, it was only 15% in Delhi and 18% in West Bengal. In Delhi, the coverage was only 12% among the children of short-term migrants. Although the average distance of AWCs is about 1 kilometre from the place of residence, two-thirds of the migrant population is not availing the services of the AWC at the destination. It is mentioned that the absence of domicile documents deprives young children from migrant families of early childcare services, such as vaccinations and essential nutrition available to the local population through the ICDS.

Another study in Tamil Nadu reported that out of 176 children aged below 6 years, only 11 children had access to AWCs. Overall, only 6.3% of the children in their sample migrant families had access to AWCs (Vidhyasagar & Shyamalanachiyar 2020).

Ayushman Bharat PMJAY

Pradhan Mantri Jan Arogya Yojana (PMJAY) was launched in 2018. It is the largest health assurance scheme in the world, aiming to provide health cover of INR 5 lakhs per family per year for secondary and tertiary care hospitalisation to over 120 million poor and vulnerable families. The households included are based on the deprivation and occupational criteria of Socio-Economic Caste Census 2011 (SECC 2011) for rural and urban areas, respectively (Department of Rural Development n.d.).

In the wake of the COVID-19 pandemic in June 2020, when issues of migrant workers came to light, PMJAY benefits were extended to migrant workers, a population especially at risk. The National Health Authority (NHA) also launched a multistate radio campaign to raise awareness of this provision. It was believed that the portability feature of the scheme would enable migrant workers to access healthcare services across different states. A survey (Prakash *et al.* 2022) among migrant populations residing in Hyderabad found that less than 1% of the total respondents had an AB-PMJAY card, while 55% did not have it (but were aware about the scheme). The remaining 44% were unaware of the AB-PMJAY scheme, indicating a serious lack of awareness about it and its benefits among slum populations.

Another study by John *et al.* (2020) showed, e.g., the level of reach of AB-PMJAY (Gujarat – 3.25%, Haryana – 3.5%, and Maharashtra – 3%) to be abysmally low. Complex registration processes and a lack of outreach to women and children are some constraints in accessing the benefits of this scheme.

National Health Policy

The National Health Policy 2017 aims at universal health and well-being yet falls short in addressing the specific needs of migrants. While the policy prioritises urban slum dwellers and other vulnerable groups, it does not explicitly acknowledge the unique health challenges by migrant populations. Furthermore, it lacks concrete plans to ensure migrants receive the healthcare they deserve.

India's National Urban Health Mission (NUHM), a part of the National Health Mission (NHM), acknowledges the healthcare challenges faced by internal migrants living in urban areas. The NUHM recognises them as a vulnerable population. The 2023 NUHM framework outlines a four-tiered system of urban health facilities (Urban Primary Health Centres (UPHCs), Urban Health and Family Welfare Centres (UHWCs), Urban Community Health Centre (UCHC), and specialist UPHC), aiming to provide comprehensive primary and secondary care to all urban residents, including outreach programmes focused on preventive healthcare.

However, the effectiveness of these facilities for migrants remains limited. A 2020 study by Santalahti *et al.* (2020) on migrant construction workers in Karnataka highlights several barriers, such as financial constraints, distance and transportation to facilities, lack of awareness about facilities, and clash between work hours and facility timings, among various others.

Employees' State Insurance Corporation

The Employees' State Insurance Corporation (ESIC) is a social security programme in India that provides health insurance to millions of workers and their families. Although a vital programme, a large number of workers are unfortunately missing out on these benefits.

There are two main reasons for this. Firstly, employers often neglect to register their workers for ESIC, although they deduct the employee contribution from their wages. This leaves the workers without health insurance coverage, a big disadvantage particularly when they get injured on the job. Secondly, workers in the informal sector, a large part of the Indian economy, are not covered by the scheme at all.

The problem is significant. A Safe in India (SII) 2023 report found that a large majority of injured workers in two Indian states (68% in Haryana and

85% in Maharashtra) received their ESIC identification card after their accidents, instead of their first day of employment. This suggests a much larger number of workers may not be registered for ESIC at all.

VI. Actions to Improve the Health and Well-Being of Labour-Migrants

Nutrition Security at Source and Destination

Public distribution system: The PDS in India is well-positioned to offer a critical form of assistance to poor migrant households. A large body of evidence reflects on the important contribution it is increasingly making towards food security and poverty reduction in different parts of the country (Chatterjee 2014; Drèze & Khera 2013; Khera, 2011; Sen & Himanshu 2013). With appropriate reforms, the PDS has served well to supplement our food security goals across Odisha, Himachal Pradesh, and Rajasthan, among others. It points to the real potential of the PDS in supporting the efforts of nutrition security by diversifying its food basket to include pulses, oil, and other millets such as ragi and *bajra*. In some states, progress has been on both fronts; e.g., Karnataka and Odisha have been giving ragi through the PDS (Paliath 2024). In Tamil Nadu and Himachal Pradesh, dals and oil have been provided for years, but the union government has yet to adopt or replicate their models on a national scale.

State-run canteens: State-run canteens have emerged as vital resources for food security among urban migrants in India. Many migrants, especially those living alone, lack cooking facilities or the time to prepare meals. These canteens address this gap by providing affordable, hot, and often subsidised meals.

A canteen survey by Khera (2024) conducted in three states – Tamil Nadu's Amma Unavagams, Karnataka's Indira canteens, and Rajasthan's Indira *Rasois* (kitchen) – revealed that these canteens serve a diverse range of people like working professionals, migrant labourers, students, and the elderly. The study found the canteens offer hygienic, affordable, and homely food for whom hunger and destitution are chronic problems and for those with transient issues.

Many migrants consume irregular and often unhealthy meals because of long working hours and limited cooking facilities. By offering meals at heavily subsidised rates or even for free, community cuisine ensures that migrants, who often live on meagre incomes, access nutritious food without straining their budgets.

Beyond providing sustenance, these canteens foster a sense of community and inclusivity. By bringing together people from different socio-economic backgrounds, they contribute to a more equitable society.

While state-run canteens have made significant strides in providing food security, improving menu options is crucial. Incorporating nutritious foods like eggs, yogurt, buttermilk, fresh vegetables, and diverse grains is essential. By prioritising nutrition, these canteens can effectively compete with often unhealthy street food options.

Furthermore, sustained government funding is necessary to establish canteens as a cornerstone of India's social safety net. This investment can ensure consistent meal availability, create employment opportunities, and promote a stronger sense of community.

Community-based creches for children: Community-based crèches, both source and destination that provide childcare, nutrition, and a stimulating environment for children, can offer a solution to the problem of care in terms of resources and in transforming unsuitable habits and attitudes around child malnutrition.

This argument is based on our own experience of managing such crèches (phulwaris) in predominantly tribal, high migration areas of southern Rajasthan over the last 11 years. Children enrolled in the phulwaris show a marked improvement of their nutritional status, with levels of wasting coming down significantly. This has also been observed across other day-care centres in the country (Gope *et al.* 2019) (Figure 11.3).

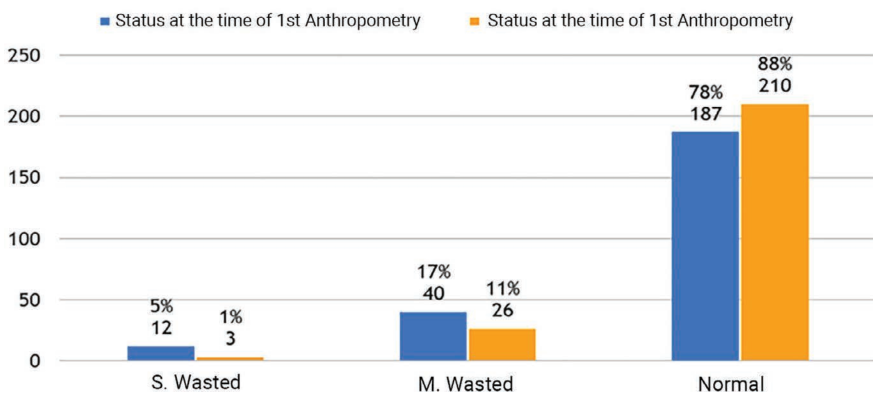


FIGURE 11.3 Change in nutritional status of phulwari children from before to after enrolment.

Source: Created by authors

We do not, however, see such improvement in children going to AWCs (Dixit *et al*. 2018), and there are at least three reasons for the same: high energy and protein content of food offered in the phulwaris compared to the AWCs; phulwaris functioning for full day (8 hours) and not half day as AWCs do; and enrolling children 6 months onwards. The AWCs enrol children aged 3 years and above, by which time malnutrition has already set in.

Safe and Affordable Housing for the Migrant Workers/Families in Cities

Given the extent of housing issues faced by migrant workers in urban destinations, several non-profit organisations and government institutions have piloted and attained varied degrees of success with housing models and solutions on the ground. Worker hostels and dormitories have been a dominant mode of housing set up by non-profits working with migrant communities. ShelterSquare Foundation with the support of Aajeevika Bureau has recently set up a dedicated hostel facility aimed at providing dignified accommodation and food to approximately 200 workers in the power-loom industry in Surat. A core strength of the model is that its management and outreach are led by workers themselves through the Pravasi Shramik Suraksha Manch (PSSM), a migrant workers' union promoted by Aajeevika Bureau.

Other state-run facilities, such as the Apna Ghar in Kanjikode, an industrial area in Palakkad district of Kerala, have been built exclusively for migrant workers. The facility contains dormitory rooms, kitchens, bathrooms, dining halls, and cloth-drying areas. Built by Bhavanam Foundation, the housing authority in Kerala, it offers a chance for employers to reserve spots for workers employed by them. Similarly, *Ren Baseras*, built under the ambit of the National Urban Livelihood Mission, offers spaces for migrant workers as night shelters, beneficial for seasonal workers who otherwise live in open spaces in the city. It helps them save on rent for a family accommodation too. However, some of the state-run housing facilities have been under criticism for the ghettoisation and surveillance of migrant workers in such spaces. Ren Baseras also provide gender-segregated living spaces not conducive for family accommodation.

The Affordable Rental Housing Complex (ARHC) Scheme, the only housing scheme exclusively announced for migrant workers, launched in the wake of COVID, is also plagued with several issues. Conceived as a model to ensure the supply of adequate rental housing units for migrants in cities, both through repurposing vacant units in government housing projects and through public–private partnership (PPP) models to develop a new supply of housing stock, the scheme has seen a sluggish pace of implementation. The economics of the scheme also do not cater to vulnerable migrant workers, effecting monthly rents as high as INR 5,000 (Varma 2023).

Ensuring decent housing for migrant workers and including them in the policy imagination for urban governance architecture related to basic public provisioning are an overarching imperative the state must prioritise. Within that, recognition of migrant settlements in city-based enumeration exercises would be of utmost importance so that basic urban amenities such as water and sanitation are available to migrant workers. It is also important to integrate provision of housing to migrant workers with childcare, education, and health facilities. Regulation of rents as a proportion of minimum wages, especially in migrant-dense settlements, will also go a long way in migrants having access to decent housing in cities.

Making Workplace Safe

Our experience with Aajeevika Bureau and Work Fair and Free Foundation suggests that combining several different interventions is imperative to address the issue of risks and hazardous work effectively. For instance, undertaking safety audits among diverse informal work contexts has proved extremely useful in identifying specific hazards on the work sites. Such exercises have been carried out in a participatory manner with the active engagement of skilled and experienced worker leaders and safety experts who can pinpoint specific points that can pose risks to workers. We have undertaken this across sectors, such as construction and power looms, where the frequency of accidents has been found to be high.

Such exercises have been rolled out within the broad scope of action of worker unions and collectives whose on-ground presence and intimate knowledge of the work settings have proved tremendously useful in ensuring the effectiveness of such exercises. This has also proved to be strong in building worker conscientisation regarding the otherwise normalised issue of worker safety. Our learnings suggest that this needs to be combined with direct delivery of technical inputs in the form of safety trainings by experts, such as in the domain of fire and industrial safety, with a special focus on prevention and mitigation. We are also building on insights from these experiences to establish model work sites in collaboration with employers, often emphasising on the business rationale of investing in basic safety measures to avoid accidents and for a higher payout for worker compensation in the event of accidents.

Another instance of a powerful on-ground intervention is SII, which facilitates compensation through ESIC. Focusing on prominent automobile clusters across the National Capital Region (NCR), and more recently in Pune, SII has set out a high-impact example of ESIC facilitation, ensuring that thousands of injured workers employed in the automobile supply chains can claim medical relief, treatment, disability benefits, and pensions. SII runs worker assistance centres that advice workers of their ESIC benefits and helps

them obtain compensation when they are injured. They also raise awareness about workplace safety and ESIC services through media campaigns. Their efforts have already helped thousands of workers access healthcare and compensation.

As mentioned in the above section, Work Fair and Free has set up a data architecture that will help collect the alarming frequency with which accidents and injuries happen in informal workplaces. The tool has already successfully registered over 650 workplace accidents from three states – Gujarat, Maharashtra, and Rajasthan – and holds immense potential of scaling-up across the country. We believe that this can be an effective tool in battling the data darkness around occupational risks and injury in the country today.

Migrant-Responsive Health Services

AMRIT Clinics: Migrant-Responsive Healthcare among High Migration Communities

BHS is a not-for-profit organisation, driven by the vision of a world where marginalised and vulnerable communities lead a healthy life with dignity. The communities BHS serves lie at the intersection of *high impoverishment*, *critical dependence on migration*, and *lack of access to healthcare*. Faced with high disease burden, indebtedness, and low productivity, families left behind by migrants cannot negotiate healthcare and other social security entitlements (Basic Healthcare Services n.d.).

BHS runs a network of six not-for-profit primary healthcare clinics in remote, rural, and high migration communities in Udaipur district in South Rajasthan, India. Called AMRIT Clinics, they provide promotive and preventive care to these communities. Among the patients seeking care at the clinics, 90% are from migrant families.

Migrant-friendly features of the clinics include the following:

Deep location within the high migration communities: The clinics are located within high migration communities, of which 60–70% households have at least one male family member migrated to a city for livelihood. The close proximity and affordability of the clinics make them convenient for migrant families, especially women and elders, to seek care.

Response to needs of high migrant populations: The clinics progressively developed the capacity to manage health needs – diagnosis and treatment of tuberculosis, silicosis, reproductive tract infections, HIV, etc. – of the migrant populations. Within these, the clinics deal with specific needs of the migrants. As an example, many migrants who suffer from tuberculosis cannot stay back in the village for the entire duration of treatment and must return to the city in between for earnings. Such patients are

encouraged to stay back for the intensive phase and provided medicines for a longer duration, coinciding with their plans of return.

Similarly, partners of men who migrate singly and who return home only seasonally rarely prefer oral contraceptives that need to be taken daily. For them, longer-term contraceptive choices, such as injectables or intrauterine devices (IUDs), or emergency contraceptives are offered.

Women providers: In most families, it is the man who migrates leaving behind the woman, children, and the elders. Women often are most comfortable seeking care from women providers, and, therefore, by design, clinics are staffed by women nurses from similar communities, many of whom have also faced the effect of migration in their families. They are better able to serve these communities.

Mohalla Clinics: Migrant-Responsive Healthcare in Cities

'Mohalla' clinics have emerged as a crucial lifeline for the migrant population in Delhi. These clinics offer free primary healthcare services, including consultations, medications, and diagnostics, addressing a critical gap in healthcare access for a community often facing financial and geographic barriers. They are strategically in areas the urban poor communities reside and, hence, enhance the availability and accessibility of healthcare services for the underserved. To accommodate daily wage earners' schedule, many clinics operate extended hours, reducing the time and cost associated with seeking medical care.

The clinics staff a doctor, a nurse, a pharmacist, and a laboratory technician, with a few variations across clinics, and provide a defined package of services. Despite facing challenges during the COVID-19 pandemic, these clinics remained operational, providing crucial primary care services when larger hospitals were overwhelmed. They played a vital role in delivering outpatient care, testing for COVID-19, and serving as accessible healthcare points for the public during the crisis.

While the full impact of Mohalla clinics on the health of poor migrants is still being assessed, evidence suggests positive outcomes. These clinics have been shown to increase utilisation of healthcare services, reduce out-of-pocket expenses, and improve patient satisfaction (Akhtar & Ramkumar 2023).

A study by Sethi *et al.* (2020) involving 493 women across 25 urban poor settlements with Mohalla clinics found that the clinics' proximity to homes significantly improved women's access to healthcare. This is attributed to reduced travel time, costs, and constraints imposed by patriarchal norms on women's mobility. Notably, 78% respondents who had visited a clinic expressed satisfaction and a willingness to continue using the service. However, challenges such as language barriers, lack of awareness, and limited

specialised care options remain obstacles to full accessibility for migrant communities (Lahariya 2020).

Migrant-Responsive Care for Tuberculosis in Cities

Based on our experience of implementing a TB control project among migrants in Ahmedabad, we have developed the following insights on elements of a migrant-responsive TB detection and treatment programme:

Partnership with organisations working with migrant populations: It is not easy to build trust and relationship with this population because of their exclusion in the city. It is useful to have partnerships with organisations working with the migrants for a long time and having credibility among them.

Focusing on most vulnerable migrants: Within the labour migrant populations, those who have *contractual low-end jobs, those who are recent migrants, and single male migrants* are more likely to have a higher prevalence of the disease and are more likely to have missed interventions focusing on migrants in general. Camps in smaller factories and outreach case detection activities in neighbourhoods with recent migrants are likely to provide a higher yield than camps in big factories (where employment is more formal and working conditions somewhat better).

Engage peer volunteers, key informants, and private provider: Intensive outreach activities through these channels is likely to lead to a much higher yield than household visits. Such an approach is also likely to be much more sustainable. Such an approach is likely to be most useful *when combined with a migrant-friendly drop-in centre*, where referred suspects could be counselled and supported during flexible hours, and their sputum collected and transported. Such a space also helps in following up the patients and ensuring compliance.

Early detection and support services at source villages: Since the migration to cities like Ahmedabad is often by single males and is seasonal, they move between the villages and city often. There is a need to strengthen the early detection and management services in the source villages and improve the linkage between the source and destination.

Providing cooked food helps improve compliance and promotes recovery in the most vulnerable: We encountered a subset of patients (~20%) who had little to eat because of advanced disease and loss of job. Providing cooked food at the doorstep led to a high compliance and recovery in almost all these patients. We believe that this approach should be integrated in programmes that aim to address TB among labour-migrants.

VII. Conclusions

Migration, often circular and seasonal, is a lived reality for millions of people, often the most marginalised. While, on the one hand, migration offers an opportunity to come out of vulnerability, it also creates circumstances highly adverse for the health and well-being of the migrants and their families. The intersection of four factors – inadequate nutrition, poor housing, hazardous occupations, and lack of migrant-responsive healthcare – is responsible for the poor health of the migrants. Health, housing, and nutrition policies and schemes are either blind to the needs of the migrants or are insufficiently implemented to reach the most vulnerable.

There are examples of policies, programmes, and models that are migrant responsive in each of these domains of healthcare, housing, occupational safety, and nutrition, some of which are presented here. It is now imperative on policymakers, programme managers, civil society, and industries to take these examples to scale and make inclusive spaces for living, healthcare, and work for all migrants. There is also an urgent need for a policy on migrant health. Till that time, health for all will remain a rhetoric.

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