LIVING CONDITIONS, HEALTH AND OTHER ENTITLEMENT OF MIGRANT WORKERS IN KERALA: A STUDY IN MALAPPURAM DISTRICT

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DECLARATION

Date: 20 /07/2018

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“…we never had land;
after coming here I bought one bigha land
and I built my own house there.
Now my family is happy there.
Kerala changed my life.”

Kamal, Migrant worker form West Bengal

To

the migrant workers of the world

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ABBREVIATIONS

AABY	AamAdmiBimaYojana
APL	Above Poverty Line
BOWCA	The Building and Other Construction Workers (Regulation of Employment and Conditions of Services) Act
BPL	Below Poverty Line
CDS	Centre for Development Studies
CHIAK	Comprehensive Health Insurance Agency of Kerala
CHIS	Comprehensive Health Insurance Scheme
CPWD	Central Public Work Department
DML	Domestic Migrant worker
GDP	Gross Domestic Product
Govt.	Government
HDI	Human Development Index
ID	Identity Document
ILO	International Labour Organization
IOM	International Organization for Migration
ISMSK	Interstate Migrant Workers in Kerala
IT	Information Technology
KBOCWWFB	Kerala Building And Other Construction Worker Welfare Board
KSACS	Kerala State AIDS Control Society
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
NCEUS	National Commission Enterprises in Unorganised Sector
NCR	National Capital Region
NHAI	National Highway Authority Of India
NSS	National Sample Survey

NSSO	National Sample Survey Organisation
OBC	Other Backward Class
PWD	Public Work Department
RSBY	RashtriyaSwasthyaBimaYojana
SAARC	South Asian Association for Regional Cooperation
SC	Scheduled Caste
ST	Scheduled Tribe
UHC	Universal Health Coverage
UNDP	United Nation Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UWSSA	Unorganised Workers Social Security Act
WHO	World Health Organization

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CHAPTER 1

INTRODUCTION

Migration is a phenomenon that draws the growth of the humanity since old age era. In modern period it is mostly considered as a livelihood strategy of the marginalised groups in the world, and it provides many opportunities for the survival of the people in different aspects. Migration, in fact, is mainly a component of the social and economic development of the globalised world. In 2015, almost 244 million populations migrated globally, which accountedfor 3.3 percent of the global population.The vast majority of the people in the world do not cross the borders of countries. In fact, more massive level migrations happen within the countries. In India there are 326 million internal migrants or 28.5 percent of the population are moving within the countryitself for their livelihood. Migrations in India are of two types; long term and short term or seasonal/circular migration.United Nations Educational Scientific and Cultural Organisation (UNESCO)defines "Long-term migration, resulting in the relocation of an individual or household... [s]hort-term or seasonal/circular migration, involving back and forth movement between a source and destination" (UNESCO, 2013).

The International Organisation of Migration (IOM,2004) says that "the movement of a person or group of a person, either across an international border, or within a state is a population movement, encompassing any movement of people whether its length, composition, and causes; it includes the migration of refugees, displaced persons, economic migration and persons migrating for other purposes, like marriage and the family reunification".IOM (2018)defines the migrants as:

> "a migrant is any person who is moving or has moved across an international border or within the state away from his/ her habitual place or residence regardless 1) the person legal status; 2) whether the movement is voluntary or involuntary;3) what the causes of the movement are of; 4) what the length it stays"

Migrants and migrant-related issues has been the concern of IOM which works in agreement with relevant states and with the migrants who are in need of international migration services[1] (ibid).

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[1]iom.int/who-is-a-migrant

TheIOM (2018) further defines labour migration as:

> "...the movement of aperson from one state to another, or withintheir own country of residence, for employment. Labour migration is addressed the mostin their laws. Also, some states have taken anactive role in regulating outward labour migration and seeking opportunities for their nation in other countries" (ibid).

According to UNESCO, when the distribution of resources as well as opportunities become unequal, migration definitly is a natural outcome (UNESCO, 2013). The neo-liberal policies has escalated the migration of young people (ibid). Social, economic, political and demographic conditions are also factors contributing to it. There are multiple deprivations faced by the youth while they migrate sometimes even leading to conflict situations (ibid). It should be noted that both domestic and international policies have hardly considered the issues related to youth migration (ibid.).

Migration is a process of social change during which people move from one cultural setting to another to settle for a longer period or permanently (Sayedet al, 2003).Being a non-native population, migrant people are vulnerable and exposed to many problems. Mostly in health; they experience several health problems because of the decreased awareness about local health facility and social protection schemes. Migrants face lots of challenges, which affect their health, particularly in the setting of the destination and during the migration, they face legal, social, cultural, economic and communication barriers. It makes inequities regarding the health conditions between the host and migrant community. Most of the time,themigrants are negatively affected by the imbalances which make them even weaker. Health of an individual is determined not just by the individual but also by social-economic factors, interventions and access to social and health services (WHO**,** 2008)**.**The migrant workers face different challenges in health and also in accessing health and social services. These challenges are intensified by the lower social and economic positions as well as irregular status of migrants[2]. This undocumented people also face these issues because of the nature of the work they are involved in. Their work nature is dangerous and degrading as it is exposed to occupational hazards and also because of the lack of health insurances. Some categories of the migrant labours with legal entitlement are more comfortable in accessing the services even they felt barriers in "language and cultural differences as well as institutional and structural obstacles" (ibid).

[2]Migration that take place outside the regulatory norms of sender, transit and receiver states

Various researchers have pinpointed the positive and negative effects of migration concerning its influence on the social, cultural and economic domains of the area where a large number of people seek their fortunes. They all shed new light on the complicated relationship between migration and health issues. Still, there is an urgent need to take cognizant of lack of consistency in various reports in understanding the correlation between migration and health in depth.

Types of migration

Migration is mainly classifiedas international and internal migration. The migration across an international border is different from the movement across the administrative boundary within a country. Based on the duration of migration it can be termed as long term or short term migration (IOM, 2004). According to International Organization for Migration,

> "[i]nternational migration is the movement of persons who leave their country of origin or the country of habitual residence, to establish themselves either permanently or temporarily in another country,[and] internal migration is the movement of people from one area of a country to another, for the purpose or with the effect of establishing a new residence" (ibid).

The internal migration, or the movement of the population within the boundaries of the country, is essential for the valuable insight it may provide regarding the social and economic forces responsible for such movements, and in respect of the resulting population redistribution (Rele,1969).

Reason for Migration

There are certain reasons why the people decide to migrate within the country or outside the country. Environmental factorslikeclimateand natural disasters and political factors includingwar,moreopportunity,better earnings for work, and better living conditions, are working as the motive for migration. Cultural reasons such as religious freedom or better opportunities for education also act as a factor for migration. Apart from these, economic reasons such as better employment wage also lead to migration. Due to globalisation,sustaining national economies has brought in exponential demand for workers from the other countries. They are called as "economic migrants". Generally this group of migrants are those individuals from poor developing countries who choose to migrate hoping for sufficient income tosurvive (James and Mathew, 2016). There are pull

and push factors (Ravenstein,1889 cited in James,2016) which lead to migration. Pull factors include the reasons for migrating to a place as in certain desirable factors such as a better climate, food supply, or liberty (ibid).

The major pull factors which lead to migration arebetter living conditions,better job opportunities, education, political and religious freedom, enjoyment, better medical care, security, attractive climates, industry, family links, better chances of marrying and such other positive factors(ibid).Push factors can be said as the reasons for emigrating (leaving a place) because of difficulties such as food shortage, war, floodetc. The major push factors which lead to migration are the unavailability of jobs, inadequate living conditions, desertification,few opportunities, political fear or persecution, famine or drought, forced labour or slavery,loss of wealth, inadequate medical care, death threats ,natural disasters, poor housing , desire for more political or religious freedom, pollution, discrimination , landlord/tenant issues, reduced chances of marrying,bullying, war, such other negative factors and condemned housing (ibid).

Migration in India

Migration in India is nothing new a phenomenon and in fact historical accounts clearly depicts that people in India had moved searching for job as response to environmental shocks and stress and also to escape political conflict and religious persecution. However, better transport networks, better communications, new economic opportunities and conflict over natural resources have created increased levels of mobility (UNDP, 2009)**.**Internal migration is vital and essential component of the social and economic life of a country. Migrants constitute a floating and invisible population, alternating between source and destination areas and remaining on the periphery of the society. According to Census of India (2001), internal migrants constitute a large 309 million people, which was about 28% of the total population. More recent reports revealed by the NSSO (2007-08) report shows that, there isabout 326 million migrants in India, that is nearly 30 percent of the total population. Almost 70 percent oftotal migrants are women (ibid). It is estimated that contribution of migrantsis not less than 10 percent to the country's Gross Domestic Product (GDP), which goes unnoticed (UNDP,2009).

Internal migration in India is an indication of the unequal distribution of development programmes. Here, established industrial pockets get their due whereas the rural areas

remain underdeveloped and overlooked. Additionally, cities grow and rural lands are being urbanised in the name of development leaving the inhabitants homeless. The traditional jobs like farming have proven non-profitable and insufficient to meet the growing demands. Poverty,increasing unemployment, environmental degradation, population pressure, natural resourcesdepletion,etc.limit the livelihood options and have forced people to find new arenas for livelihood (Akinola, 2014). Several other factors like repayment of debts, financing the education and marriage of dependents also cannot be ignored (Akinola, 2014). Mohammad Akram (2014) says

> "...there is an urgent need to control the push factors of migration. Poverty and lack of productive employment are two most important determinants of out-migration in India. Out-migration of the poor, unskilled and uneducated population not only perpetuates their economic deprivation but also causes loss of their cultural and social capitals. Together they cause exclusion and marginalisation" (Akram, 2014).

Migration to Kerala

Kerala is experiencing an heavy influx of migrant workers into the States' emerging urban areas and its peri-urban hinterland(James and Mathew,2016). The shortage of skilled and unskilled labour due to high education levels and emigration from the state to Gulf countries by the Kerala population, make Kerala an attractive destination for workers from the north, central and north-eastern India (James and Mathew,2016). High wages, good environmental conditions and overall development in the state like education and health care make it an attractive destination for migrants.

Migration to Gulf countries has made a change in the life of the people in Kerala. The income from Gulf remittances has caused widespread changes in Kerala's economic development. In the recent years Kerala is witnessing large inflow of migrant labourers from different parts of the country(James and Mathew,2016). The large scale of immigration and the flow of remittances have resulted in unprecedented economic changes in Indian economy especially in the labour market, consumption, saving, investment, income distribution and regional development. Large scale infrastructural development in the state, like housing, has attracted large number of construction workers.

The migration of Keralites to Gulf countries has created a shortage of unskilled workers in Kerala which further leads to an increase in wages. It promoted the migration of

construction and unskilled workers to Kerala from other states like Tamil Nadu, West Bengal, Orissa, Assam, Uttar Pradesh, and Bihar. Poor economic condition and living standard of the migrating communitiesin these states have been identified as the reason for this type of migration.

The state of Kerala with a population of 34 million (Census, 2011) enjoys one of the best health indicators in India. There are about 25 lakhs domestic migrant labourers in the state of Kerala today, with an annual arrival rate of 2.35 lakhs (Narayana et al, 2013). For the past few years, migrated labourers have been in high demand in Kerala due to their comparatively high wage and scarcity of native workers for skilled labour. The inflow of large numbers of north Indian people has created highly vulnerable informal sector against an organised labour force in Kerala that has developed through years of agitation. This unorganised majority of imported labourers lack sufficient social securityregarding health, shelter and education(Narayana et al, 2013;James and Mathew,2016). The gruesome environment they live and lack of access to governmental support has turned out to a severe problem that needsseriousattention.

Labour Mobility in Kerala

There is a definite pattern of labour mobility in Kerala because of the emigration and internal migration to Kerala. Large-scale migration of Keralites to Gulf countries (emigration)is living abroad in 2014 is estimated to be about 24.05 lakhs, up from 22.8 lakhs in 2011, 21.9 lakhs in 2008, 18.4 lakhs in 2003 and 13.6 lakhs 1998 (Zachariah and Rajan, 2014) and a steady flow of migrants from another state to Kerala (internal migration) characterise the labour mobility which is observable in Kerala. While in the case of labour mobility within the state, large-scale occupational mobility, specifically horizontal mobility in the informal sector can be identified. The higher wage rate and employment availability in certain sectors like services and construction industry drew a large number of workers from another sector like agriculture, leading tohigh horizontal labour mobility in the state. The absence of organised labour in the informal sector, except in a few occupations like construction workers, street vendors, Marine Fishing,Hospitality, Sand Mining, Laterite Mining etc. made occupational mobility free from restrictions.While the organized workers like head load workers restrict the entry into these occupations through trade union membership**.**Overall, lack of employment

security, underemployment and vast deprivation of local informal workers in the state (Nandu,2015).

Emigration from the state takes out a considerable portion of semi-skilled and unskilled workers from various occupations. In addition to this, the withdrawal of workers from different occupations due to affluence resulting from remittance has also contributed to the shortage of labour force at least in some occupations. Along with this labour shortage, the rapid expansion took place in hotels and restaurants, which gave an opportunity for the workers from other states to get employment. Studies show that emigration has led to increase in wage rates in the state. Apart from that, emigration has also caused for the large-scale replacement migration in Kerala. The higher level of education in the state also pulls back the educated youth from engaging in certain unskilled or semi-skilled work. However, such works are largely preferred by the migrant workers from other states. The rapid urbanisation taking place in the state is also another reason for attracting migrant workers to the state(Nandu, 2015).

Moses and Rajan (2012) arguehow migrant workers are mostly isolated from the local community. Lacking local language skills, and often confined to the worksite, these workers face difficulty in learning about the rights afforded to them in Kerala, or about the level of prevailing wages and protections. This difficulty in accessing such measures due to different factors results in the exploitation of migrant workers. In fact, they are unable to argue for higher wages and are also unaware of the protection measures enjoyed by the local workers. For many of the migrants who are unaware of the local labour market the relative standards of comparison,wages and working conditions offered in their home labour markets, far awa**y**(ibid)**.**

The in-migrants in Kerala constitute about 7 percent of the total population of the state (Sankari, 2017). In the particular situation, the Kerala Government has devised a social security net for migrant workers. They have been outside the ambit of most of the welfare schemes. The particular scheme is first of its kind in the country where migrant workers are not only living without any legal rights access, on the other hand the essential services like identity documents, social rights or housing are also lacking.They face multiple challenges with regard to vast differences ofculture and languagein the country (ibid). These facts question the very idea of social inclusivity. As per Sankari (2017) “Kerala

offering to provide social protection and medical care to migrants is a small revolution in a profoundly neoliberal country further marked by its oppressive caste system".

Migrant workers and health in Kerala

As a result of the large-scaleemigration,tothe Gulf countries, the socio-economic status of the people in Kerala have gone higher,and this created an uncertainty in the informal sector. Large-scale emigration to Gulf countries from the state started in the 1970s; reached its peak in the 1990s and the trend continues(Narayanaet al, 2013). Though a large number of semi-skilled and unskilled workers, especially among the educated youth, have the advantage of the emerging employment opportunities in the state, Higher education level and the affluence of families derived from Gulf remittance have led the youth to not engage in semi-skilled or unskilled work. Simultaneously, the large-scale migration has led to the fall in fertility rate in the state. This along with the rapid urbanisation of Kerala has created demand for the unskilled and semiskilled workers locally, thereby attracting domestic migrant labours (DML) in a large number**.** DML are employed in almost all sectors and occupation in the state and are well integrated with the state economy (Narayana et al, 2013)**.**

A migrant labourer in the state confronts many problems in accessing public health care services provided for them. This is mainly due to the language and cultural differences. The situation becomes worse during the monsoon, which is also a time of the annual outbreak of contagious diseases in the state. It has much to do with the standards of hygiene set and followed by a community. The efforts on the part of the authority to maintain hygiene have been unsuccessful owing to the high density of people in almost all area and poor sense of cleanliness of people (Chatterjee, 2016).

The large inflow of in-migrant labours from different parts of the country especially from the states like Assam, West Bengal, Bihar, Chattisgarh, Odisha and Tamil Nadu (Government of Kerala, 2015)[3]. Majority of them are belonging to the semiskilledand unskilled works, and a large proportion works in the construction sector (Government of Kerala, 2015). A robust database with details on the migrant labours working in Kerala is currently absent. Even then, some pilot studies and media reports have revealed that more

[3]Govt of Kerala, 2015

than twenty-five lakhs in migrant labourers hailing from different parts of India are working in the unorganised sector (Government of Kerala, 2015).

Multiple studies and researches have addressed definitive issues on immigrant labour and issues related to migrant labours. Exhaustive studies on health, working and living conditions of the in-migrant labours in Kerala have appeared to be inadequate. In this context, the researcher would like to study how the living and working conditions of the migrant labours create obstacles for them to attain the health services which are available and how these obstacles put them in vulnerable conditions. Above all, the research would also like to look into how the state is making the policies and schemes in consideration of the migrant workers.

The high number of migrant labourers and their attitude towards the accession of health care services add to aggravating the already ill-managed system. Availing health service at health centres and hospitals also seems quite a difficult task for them due to communication problems. The odd behaviour and the culture which is alien to the natives create intermittent clashes that break the harmony in the state. The natives have started looking at the migrants with suspicious eyes as more and more cases of theft, murder and illegal trades are reported against them. Migrants have started to be seen as an intruder though their service in different sectors is essential to keep the state move forward and to maintain the economic stability. The higher inflow of the migrant workers to Kerala influences the state economically, socially and politically. In such a situation, a government must intervene with several welfare measures and policies and implement them to keep the harmony in the society intact. The government of Kerala already took such measures in 2010, which was a social security scheme for the migrant workers. Kerala was the first state to provide benefits to the jobseekerswho come from outside of the state[4] (Businessline,2015), though the statement is highly debatable.

The Police Department of the State in co-ordination with other Departments,have started audits of in-migrant workers in cities ofThiruvananthapuram and Ernakulam through which biometric details have been 'captured',and identity card hasbeen issued(The Hindu,2016). In 2016, a new insurance scheme called 'Awaas' was launched to provide social security measures for the migrant workers and also to act as their database and registry. This has implications on crimes involving migrant workers which has been on

[4]The Hindu businessline, 2015

the rise as per the Police Reports, along with the incrasing migrant population[5]. Currently Kerala offers free health care to all the migrant workers. The State is planning legislation to address the migrant labours issue with the "The Kerala workers social security bill"[6].First official labour camp is openedin the Palakkad district for the inter-state migrants. The camp would accommodate about 1500 workers. Similar camps will be established other districts the next phase. The Labour Department is alsoplanning to start Kiosks and call centres for people who are proficient in Hindi to interact with and understand the problems of the labours. Migrant Suraksha project is getting implemented across Kerala under the guidance of the Kerala State AIDS Control Society (KSACS) among migrant labourers since 2009. The main aim is to detect HIV positive cases among and also to create awareness, and health card also has been issued (Government of Kerala, 2015; The Hindu, 2016)[7]. Many private institutions and foundations have their Migrant Suraksha project and conduct free medical camps which aim to improve the living conditions of the migrant workers in the state[8]. In 2017, Kerala government announced a health insurance scheme, named 'Aawaz'[9] (Government of Kerala, 2017).

In this pretext, the current research is looking into the living and working conditions of the migrant labourers in the State of Kerala. The research attempts to elaborate on the multiple access issues faced by the migrant workers in attaining health care in Kerala and also tries to throw light on factors contributing the same. The research has also attempted to understand how the State has been trying to address these multiple issues.

[5]Ndtv.com,2016.
[6]Economic Times.com,2015.
[7]The Hindu, 2016.
[8]The Hindu.com,2016
[9] Tele Sur.com,2017.

CHAPTER 2

MIGRANT LABOURERS IN CONSTRUCTION SECTOR IN KERALA AND HEALTH AND SOCIAL PROTECTION SCHEMES: A REVIEW

The available literatures existingin the subjects help us to understand the knowledge and they provide the requisite background for the study and make the researcher aware of the issue. It also helps us to find the gap that exists in the area of study. In this chapter an attempt has been made to review the migrant labourers working in the informal sector especially in construction sector and their health and social protection schemes in India in general and Kerala, in particular.

Migration is a phenomenon that draws the growth of the humanity since time unknown. In the modern times, it is mostly considered as a livelihood strategy of the marginalized groups in the world and it provides many opportunities for the survival of the people in different aspects. IOM (International organization for migrants) describes “migration as the movement of a person or group of persons, either across an international border or with in a state. It is a population movement, encompassing any kind of movement of people whatever its length, composition, and causes; it includes migration of refugees, displaced persons, economic migrants, and persons moving for other purposes, including family reunification.”(IOM, 2011). Migration is any kind of movement of people from one place to another. It may be as a group or individual movement. 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 legal status; (2) whether the movement is voluntary or involuntary; (3) what are the causes for the migration are; or (4) what the length of stay is.” Most of the migrants used to move to seek their better living opportunities[10].

“Migration means crossing the boundary of a political or administrative unit for a certain minimum period” (Boyaleet al, 1998 as cited in Castles, 2000). Thus migration is not only the movement from one place to another but also it has some political view which is

[10]iom.int/key-migration-terms

crossing border of the one administrative unit. There are two types of migration internal migration and international migration.

According to IOM, International migration is defined as the movement of "persons who leave their country of origin or country of habitual residences, to establish themselves either permanently or temporarily in another country. An international frontier is therefore crossed" (IOM, 2011).The movement from one country to another for temporarily or permanently due to different reasons. While internal migration is the movement within the country. Internal migration is defined as "a movement of people from one area of a country to another area of the same country for the purpose of or with the effect of establishing a new residence. This migration may be temporary or permanent" (IOM, 2011). Internal migrants move but remain within their country of the origin (ibid).Internal migration can span great distance and bring together different people (Castles, 2000)**.**

"Migration is an important livelihood strategy for many and has been shown to have economic benefits" (Karan, 2003 as cited in Borhade, 2011)**.** Movement done for seeking labour is known as labour migration. IOM (2018) defines"labour migration is the movement of persons from one state to another, or within their own residence, for the purpose of employment".Labour migration is commonly a temporary migration. The labourers work in a different country than their own. It will usually contractual arrangement enforced and organised by governments, employers or both at times with a limitation in the period and nature of the employment as well as on the rights and responsibility of the migrants (Urquiaet al*,* 2011).

Migrant worker's movement are historical phenomenon and have broad implications. Most labour migration is motivated by the search for survival and the most common cause for migration is income disparity, along with disparity in employment and social well-being between differing regions (Hugo, 1998 as cited in Castles, 2000); **"**as well asgrowth of informal economy and the consequent migration from rural to urban, urban to urban and from backward and underdeveloped to advanced and developed regions" (Acharya& Reddy, 2016). Labour migration is the after effect of the socio political consequences and economic under development. But historical context of development has reflected that even development also led to migration which has been accelerated by development policies of the government. Most of the migrants are poor, with no land

owning and mostly belonging to lower "social ladder" in terms of caste and/or tribal identity and from economically backward regions (ibid). In addition to developmental processes, difference in demographic aspects as in fertility, age structure, mortality and growth of labour force are also important for migration (Hugo, 1998 as cited in Castles, 2000).

Migration in India and Kerala

The enormous populations of Asia within a vast extent of area make it difficult to consideras a single entity. Asia includes, India and China, the two most populated countries in the world, whose diasporas of approximately 25 million and 40 million respectively are almost and each equivalent to the total populations of many sizeable states(Arnold 2012: p.195). The urge to migrate is affected by a number of factors that influence both permanent migration and circular migration including regional inequality, under employment in rural areas, the development of labour intensive industries, as well as civil upheavals and wars. There are high levels of internal migration from rural to urban areas in India.

India has a long and complex migration history. During the nineteenth century India established communities in a range of countries across the world. Indian independence in 1947 came with the partition of British India into India and Pakistan, which led to massive migrations of Muslim from India to Pakistan and Hindus and Sikhs from Pakistan to India from 1947 to 1950. Around 12 million to 18 million people suffered from violence due to rival migration which resulted in 200,000 to 1 million deaths. Internal migration in search of better work opportunities involves millions of Indians, possibly as many as 20 million at any given time, most of whom will be temporary migrant working in such as field as construction, agriculture and manufacturing (Arnold, 2012: p. 212).

Kundu and Gupta's (1996) study on Migration, Urbanisation and Regional Inequality is something important when talk about the development dynamics of a country like India. They noted that the regional disparity is going up in terms of various other economic indicators as well. The interstate disparity in monthly (per capita) consumption expenditure has increased from 1 1.1 per cent in 1973-74 to 17.3 in 1992, as per the data available from the National Sample Surveys. Similarly, the disparities in case of other

infrastructural facilities and basic amenities like power consumption, transport system, health services etc.are also going up. They also mentioned that some social dimensions like incidence of poverty, population growth, infant mortality rates, the disparity has gone up.

An analysis on the pattern of migration in urban centres has studied by Kundu and Sarangi in 2007. The study which is based on the National Sample Survey's report on the employment and unemployment states that at macro level economic deprivation is not a major factor that contributes to the migration of people from rural to urban. It reports that the rural to urban migration is seen in the economically well off families also. When it comes to the household level it can say as the pattern of migration is diverse depends on the socio economic status of the family. There was another surprising result of the study that the migrants are better off in the urban area than in the non-migrants of the place.

A District level analysis of rural to urban migration in has done by Mitra and Murayama (2009) using Census Data 2001. In their study they have given a specific importance to migration and health. It says that the migration to urban areas from rural areas areexcessive than the resources available. Considering the sanitation, drinking water and health care facilities are even scarce enough to meet the needs of urban population. The native urban population always have better access to this scarce resource than the migrated population which lead them continue to be in poor health condition. They state that, there are several long-duration migrants who continue to live in both income and health poverty and migration has certainly not paid them in terms of health facilities.

According to Bhagat&Mohanty (2009), urbanisation is crucially linked to migration. He included net migration to urban areas as one of the major components of urban growth. Migration has 20 per cent contribution towards the urban growth. The author also predicts the future of urban migration that the urban to urban migration is likely to accelerate due to labour market demand, but this would not have any impact on urban growth.

Keshri and Bhagat (2010) have done a study on Temporary and Seasonal Migration in India. The Unit Level Data of 55th round of National Sample Survey formed the base of this particular study. The results showed that temporary migration is very high in the state of Kerala with a rate of 16 – 20 per thousand and the rates are higher among men compared women.The caste group is found to be a significant predictor of seasonal

migration as scheduled tribes are two times more likely to migrate seasonally compared to SCs, OBCs and other caste groups. They also observe a positive and significant association between permanent migration status and temporary migration. Apparently people from the Central Region are more likely to migrate temporarily followed by the Southern Region compared to other regions.

Marmot (2005), talks about the inequalities in health between the countries. The author necessarily pointed out that the factors like dirty water, low calorie food or poor antenatal care is not the reasons why the health inequalities exists between countries. The social determinants of health inequality are crucial here. It is very important to check whether the policy decisions of the country on health are having desired impact when it is implemented. There is nothing that the high income or developed countries shows better indicators of health. The author quoted an example of Kerala and China having a good health indicators despite of low income that some other higher income countries. Also he highlighting in his work that, reducing social inequalities in health, and thus meeting human needs, is an issue of social justice.

Maiti (2008) conducted a study on workload assessment among female construction workers of Mumbai. It highlighted the health risk factors the respondents are facing as a construction worker. The researcher noted that the workers are at the risk of slipping, experiencing excessive workload, falling from top etc. due to the poor safety measures followed in the construction industry in India. Also workers had to handle more load than recommended by NIOSH per day without having sufficient rest. The study recommends for a redesign of workplace and work methodology for a proper safety and health security of construction workers.

Bhagat (2011) studied on the pattern of urbanisation in India based on Census data. Analysing the trends from 1961 to 2011, it shows that there is an exponential growth in the urban population. The population grew from 78.94 million to 377.10 million in 2011. According to him the population growth is due to these three components; the natural increase, net rural-urban classification and rural-to-urban migration.

Moorin et al (2006) studied on health related migration with an aim to determine whether the incidences of serious diseases are related to intra-state migration. The study was done in Australia using the data extracted from Western Australia Electoral Rolls in different

years and hospital morbidity data. The results reveal that there was a reduction in endocentric migration among rural population and also people from remote location, following the onset of serious disease except in the case of mental disorders. The persons are unable to migrate following the onset of disease despite their increased need for treatment is due to their low economic means. In the case of exocentric migration, the studies indicate that the disease has no relative effect. The study defined serious disease as ‘any disease that cause significant disruption to people’s lives due to either severity or requirement for multiple tertiary care visits for treatment.

Moses and Rajan (2012) points out several regards of the labour market and internal migration to Kerala. The state of Kerala is known for its achievement in delivering a comparatively high level of human development as in low infant mortality rates and population growth and High level of literacy and long life expectancy, despite a relatively low level of per capita income (Sandra brook et al, 2007 as cited in Moses and Rajan, 2012: p.2). Moreover, Kerala has experienced very high level of emigration to middle east and abroad, and this emigration has generated both wealth and opportunities at home. Consequently, Kerala can attract inter-state migrants from across the country, lured by the promises of the well paying jobs compared to their home states.

Migrant labours in informal or unorganised sector

Labour migrations in India are dominated in the informal sector. In India, 90 per cent of the families earn their livelihood from the informal sector and these sectors contribute two fifths to the GDP of the country (Kansara and Hill**,** 2017). Following the international guidelines on the concept of informal sector, the National Commission for Enterprises in the Unorganised Sector (NCEUS) adopted the following definition of the ‘Unorganized sector’**:** “The unorganized sector consists of all unincorporated private enterprises owned by individuals or households engaged in the sale and production of goods and services operated on a proprietary or partnership basis and with less than 10 total workers” (Kannan&Papola,2007: p.323)**.**

India has one of the largest populations of the poor in the world. According to World Bank poverty statistic, 32.7 percent of population in India lives on less than 1.25$ a day”. Much of these poor belong to disadvantaged communities that are largely concentrated in the resource poor regions (cited in Srivastava&Sutradhar 2016). The areas mentioned are

mainly comprised by the rain fed parts as Central and Eastern India. These areas continue with a low productivity in agriculture sector, and the same acts as the most critical push factor. Seasonal migration has emerged as an important livelihood strategy for much the rural poor. The largest migration is aimed towards the construction sector (Srivastava&Sutradhar, 2016).

"Unorganized workers consist of those working in the unorganized enterprises or households, excluding regular workers with social security benefits and workers in the formal sector without any employment/ social security benefits provided by the employers" (Kannan&Papola,2007). Unni (2005),emphasises on the heterogeneity of the workers in the informal sector in India; as in those entering the particular sector have multiple reason for the same. The entry can be voluntary and otherwise. A segment of employees who are pushedout the formal sector may be forced to work in the informal sector. Lack of unemployment insurance in India adds to this scenario (ibid).

The migration labour and the patterns of recruitment as explained in Mosse et al (2005) study, show that there are broadly three systems of recruitment, andit involves varying degrees of dependence and exploitation. They are a) Opportunistic migrant who travels to nearby towns and cities, where the recruitment is as daily wage labourers through informal urban labour market, or *nakas*; b) peoplehaving direct contacts with builders/contractors travel in groups, who are usually kin groups, along with younger woman, often comprised of affine relations, "a practise of which serves to protect the core patrilineage from the divisiveness of unequal and individualised migration earning" (and gives women more liberty than among their marital kin)" and; c) migrant are mobilised in their own villages by gang leaders/brokers or '*mukkadams'*- Former labourers turned supervisors and villages money lenders a few of whom have settled in town-who negotiate with contractors/employers arrange cash advances and long term work (Mosse et al, 2005).

Mosse et al(2005) in the study argue that livelihood and outcome of labour migration can be differentiated into two: firstly, one from relatively better off households with some minimum food security. Here young men take turn to migrate opportunistically as individuals for interrupted periods to maximise cash earning in order to manage the inter year fluctuation in farming, to meet the need for investment (in wells, house-building,

marriages, etc) or to repay loans. Secondly, one is from poor households whole families migrate for long periods for survival, and are tied into relationships of dependence.

Labour migration is irreversibly a part of the lives and livelihood of many of the migration poorest section of the rural India. Labour migration is not just a means to cope with below subsistence agriculture and debt. “Migration is a route of upward social and economic mobility: but for the vast majority migrations not only perpetuates debt and dependence, but expose the poorest to extreme hardship and cruel exploitation” (Mosseet al, 2005).

Socio cultural changes and vulnerability among migrants

The labour migration movement bring changes in their life. Labour migration for anyone is a change in residence, a shift in employment and shift in social relation (Piche, 2013). The main change is shift in the employment. In destination**,** workers have poor living and working conditions, lack of citizenship rights, entitlements and voice. There are lower than the legal minimum. However at the cost of hardship, low consumption levels, and possibly smaller working life span, they manage to save a good portion of employment for longer duration as well as receive higher wages than non migrants. Their remittances are used to boost consumption, the condition of residential housing, expenditure on children’s education and selective investment in other assets (Srivastava&Sutradhar,2016).

Mosse et al (2005) earlier studies on *adivasi* migration revealed that migration is a complex phenomenon is which successful migrants secured incomes and status in the community through investment in land and symbolic capital, in which women found new freedoms and in which age hierarchies were challenged.

Even people are migrated the links between migrant community and area of origin may persist over generations. Remittances fall off and home visits may decline in frequency, but familial and cultural links remain. People stay in touch with their area of origin, and may seek marriage partners there (Castles,2000).

Though migrant workers maintain poor standard of living at destination, they manage to save some of their earning which they remit to their families at the source area to stabilize and the better their conditions of living. Such remittance sent by the migrant workers may

even influence the pattern of the growth and developing in the source areas. The impact on the source area may occur through a number of channels, which include changes in labour market, income assets and how the remittance earned through migration is spent by migrant households. Some of the less direct ways through which migration impact the source area include changes in attitudes and destination make migrant labour more assertive in their demand for better conditions and better wages even in the local labour market (Srivastava, &Sutradhar,2016).

The political participation of the migrant labours from rural areas working in urban areas has been limited and hence they are unable to participate in the planning and governing process which eventually intensifies their political vulnerability and their alienation from the social and political life (Chatterjee,2006).

The migration brings lots of changes in migrant people. All types of migration lead to social and cultural change (Castles, 2000). The migration process often becomes complex as the migrants hail from diverse societies with differing socio-cultural and political practices. Immobility in occupational status limits social profile of migrant labourers. At least for a few generations migrant labourers preserve some traits of their cultural identity (e.g. language). The policies of multiculturalism has accompanied along with the granting of permanent settlement, where government has recognized the cultural particularity of migrant labourers rather than attempting for cultural assimilation into receiving population. But where pluralism is unwelcomed by the Government by perceiving it as a threat for national identity and unity, it is the migrant labourers from ethnic minorities who have been significantly marginalized (ibid.).

Migration brings forth socio-cultural changes. Any attempts to suppress such transformations give way toconflict and racism, while those communities and societies which emphasises on participatory approach to comprehend and regulate these changes is expected to have positive outcomes (Castles, 2000). The changes also make some vulnerability among the migrant labours.The migrant workers travel far for selling their labour power where ever there is a shortage. They manage to get jobs and remain there until he /she is required (Berger& Mohr, 1998 cited in Sithara and Sebastian, 2017). Departing from the native area and landing in a totally new area places them in a vulnerable situation. In the new place, they are disadvantaged in comparison to the native population. They lack social goods; education and health, which all impede their

integration into the local population (Sithara and Sebastian, 2017).Chatterjee, (2006) argue that

> "migratory movements characterised by increased quantitative growth and qualitative differentiation along the lines of migratory patterns, nature of migrants, their quality and final destination have facilitated a differentiated development pattern creating spaces of vulnerability"(Chatterjee, 2006).

Chatterjee identifies vulnerability as

> "Vulnerability can be understood as a state of being exposed to susceptibility to danger or abuse. It comprises of weakness of physical and mental strength, defenceless, unprotectedness, fragility and exposure to undesirable conditions/ factors. In addition to the health environment in the place of origin, transits and destination (including diseases prevalence), they include patterns of mobility (regular, circular, seasonal, etc.) which define the conditions of journey and their impact on health; the status of migrants in destination areas that determines their access to health and social services; and familiarity with the culture and language of the host community. Vulnerability is a relative term. Similarly, factors leading to vulnerability are varied and relative. In the case of migrants, the common factor that justifies their vulnerability is perhaps the fact that their origin differs from their present residence. The difference is not merely limited to the experience of the change of space but extends to other experiences of differences of culture, language and people. The vulnerability which is primarily premised on the alien status of the migrant gets complicated by the combination of factors at the area of destination. Limited choice and reduced capacity to negotiate results in increased discrimination in life chances. The migrantis considered an 'outsider' " (ibid: 3).

Chatterjee (2006) argues that the vulnerability of migrants depends on various factors from legal status to its overall environment and he considers the legal status of migrants in host area as one of the key factors for hurdles to health services. The discussion on health and human rights issues of migrant population is the most pertinent issue to be discussed. It is important to note that "the mass exodus of poor population from the areas of origin to the area of the destination for economic and socio-political reasons internally and undocumented or irregular migration from outside the country" (ibid: 4). The undocumented or irregular migration from accessing social services, including health care also becomes an important aspect to be studied. Sometimes health coverage to migrants is neglected by employers as they are hired in an unpredictable domestic and international environment. Hence, migrant labour force often becomes cheaper than the native labour force. These biases have been used as an excuse to limiting integration, inferior care to the migrants. This restricts and perpetuates the social mobility of migrants.

Living and working condition of the migrant labours.

The migrant labourers who are at the bottom level of construction and other modern industries face alienation, worst working and living conditions (NCEUS, 2007).Acharya&Reddy (2016) says that lack of proper water, toilet facilities and electricity still remains even though the ownership of the assets has improved (Acharya&Reddy, 2016).Lack of proper working conditions and absence of social security is still prevailing and it has been noted that the accident rate among the construction workers in India is higher. Of the every thousandconstruction workers injured, one hundred and sixty five workers are from India (ILO, 2002 as cited in Acharya& Reddy, 2016). Poor living conditions leads to various health issues, which is a function of their choice of occupation as well as standard of living (Sunder et al, 2000, Ray 1993, as cited in Chatterjee,2006). This harms the migrants and increases the chances of them being prone to infectious diseases. Apart from providing basic amenities employers are reluctant to take up other responsibilities of migrant workers and their family (Srivastava&Sutradhar,2016). The weak economic background of migrant labourers force them to live in deteriorated living conditions like rented shabby dwelling, tents or on site settlements(ibid). Labours laws are hardly followed, so that working hours are extended more than eight hours. And even when workers work overtime not even the minimum wages are paid (ibid)

Chatterjee quotes Breman for depicting this situation

> "Globalisation and the associated casualisation of work ironically have favoured the migrants who are absorbed in all forms of low paying, low or unskilled jobs with higher prospects of potential health hazards. Employers prefer to employ migrant labour with lower wages and they are steadily replacing local labourers" (Breman, 1994, as cited in Chatterjee,2006).

Also, the sustainability of migrant labourers in the urban industrial system in India is affected by their mobile existence (ibid).Moses and Rajan (2012:p.9) observes: "if workers are isolated from the surrounding community, it is more difficult for them to find out the local wage, rights and support systems available to them. When language barriers are high, or when the workers are physically isolated from the surrounding population, then the changes of abuse and exploitation increase."

The CDS-ISMSK (2012) survey data reveals how migrant workers are mostly isolated from the local community. Lacking local language skills, and often limited to the worksite, these workers will have complexity in learning about the privileges afforded to them. This ignorance allows workers to be exploited, in that they can be kept unaware of the fact that local workers are enjoying higher wages and more protection (Moses and Rajan, 2012).

Health condition of the Migrant labours

Migration is a public health challenge and in particular settings the benefits of healthcare can remain exclusionary.Health is important when the people used to move from one place to another. There would be change in migrant's health status.

WHO defines (WHO, 2014) 'health' as" the state of complete physical, mental and social well being and merely the absence of disease or infirmity". Health is affected by many influential factors, those factors known as determinates of health. These factors can make an impact on people and community positively or negatively. According to WHO, "the determinants of health include the social and economic environment, the physical environment and the person's individual characteristics and behaviours" (WHO, 2014).

Cultivation, manufacturing, fish processing, transportation and construction and quarry works are the major occupations that attract migrant labourers. Internal labour migrantslive in deteriorated living conditions being away from their family and society and even facing occupational hazards. Further they face exclusion from mainstream programmes like those on education and health. This leads to poor health status of migrants (Borhade, 2011).

Among the informal migrant workers pain in the neck, skin diseases, chest pain,stomach pain,diarrhoea,weight loss, tiredness,lack of appetite, hair loss, giddiness, swelling of limbs and hands, cold-cough and fever, eye problems are the commonly reported health problems(Jayaranjan, 2000, as cited in Chatterjee&Borhade,2011). Women migrant labourers are vulnerable to reproductive tract,anaemia, infections and violence (Borhade, 2011). Several maternal and child health indicators are reported to be on hike. As cited by Bhorade (2011) "…the lack of availability of caretakers when hospitalized,higher expenses at private health care institutions and ill-natured treatment at government hospitals are some reasons why migrant women labourers prefer home

deliveries"(National Urban Health Mission, 2008, as cited in Bhorade, 2011). Among migrants,respiratory infections, infectious diseases, hepatitis, malaria, typhoid fever are found in higher rates (Chatterjee,2006).

IOM (2016) explains;

> "…social determinants of health that can impact the health and wellbeing of individuals and communities. The migration process can expose migrants to health risks, such as perilous journeys, psychosocial stresses and abuses, nutritional deficiencies and changes in lifestyle, exposure to infectious diseases, limited access to prevention and quality health care, or interrupted care" (IOM, 2016).

On the other hand migration betters the living condition by enhancing the socio-economic status, enabling an escape from violence and persecution, betters the educational access and even increases the purchasing power particularly for the left-behind family due to better remittances. Migrants also contribute to the developmentof countries of origin, transit, and destination with their intellectual, cultural, human and financial capital as well as through their active participation in the form of physical labour to the society. Being in good health is a prerequisite to being a productive contributor to the social and economic of society. But that health prosperity depends on the health system of destination place too. A large proportion of workers in the informal sector are illiterate, poor and vulnerable (Mahal, 2014). Their working and living conditions are unhygienic with deficit health care benefits, without paid leaves, pensions, maternity benefits and similar supports (Khansara and Hill, 2017). Illness, hospitalization and acute need for medical care are one among the most major insecurities of these workers (Donfouet and Mahieu, 2012;Gosh, 2010 as cited in Khnasara and Hill, 2017).

Health inequalities result from a broad set of social, economic and political conditions which influence the level and distribution of health within a population. Health inequalities which results from unequal distribution of primary social goods, resources and power also constitutes the social determinants of health (Balrajan et al, 2011).

"The migration decisions are made not just by individuals they often represent family strategies to maximise income and survival chances" (Hugo, 1994, as cited in Castles 2000). Policies of the government on immigration also lead to strong reactions of the population. Immigration takes place at the same place at the same time as economic restructuring and far reaching social change. People whose lives are already in a changing

mode that too in an unpredictable way often causesinsecurity to the new migrants. Migration and minorities are seen as a danger to living standards, life style and social cohesion (ibid).

Public health threats arise in the migrant population when diseases are communicable and infected persons move or migrate. Different types of migration causes multiple vulnerability among labourers. The common possible determinants of health risks among migrants are the motivational factors, occupational factors and the environment related factors. The factors that increase the health risks and health outcome either directly or indirectly are not exclusive (Chatterjee, 2006).

The most obvious challenge is to integrate the needs of both host and migrate population. One side there is responsibility to protect the host community from the threat disease and take care of their healthcare needs, on the other side migrant have health and welfare priorities that are associated with their basic human right, including the right to health (ibid.).

Social Protection for Migrants

Labour migration is a process of skill formation. Many migrants bring their relatives, friends and co-villagers once they have firmly established in urban areas. Some of migrant also upgrade their skill level and learn two and more skill (Deshinker and Akter 2009; Bhagat, 2014 cited in Bhagat, 2017). Migrants contribute in the development but when the people moving across certain boundaries is costly, especially if these boundaries reflect differences in societal characteristics such as cultures, laws and institutions (Belot and Edverveen, 2012 cited in Kone et al, 2018)

Internal migrants in India, the group is permanently or temporarily moving within and between states, their participation in the socio-economic and political life is also neglected. Thus they remain as invisible population for a long time. The existing policies and programmes were insufficient to meet the needs of the population. Thus, the vulnerabilities of the internal migrants remain like an open pandora box (Sithara and Sebastian A, 2017).

Labour Laws

The Indian state is the guardian of citizen rights and in principle offers protection to migrant construction workers through central and state legislation**.** There was abundance of legal protection inter, the alia under the Minimum Wages Act (1948), the Contract Labour System (Regulation & Abolition Act, 1970), the Bonded Labour System (Abolition) Act(1975); and for women under the Equal Remuneration Act (1976), the Construction Worker Act (or the Factories Act 1996) These laws include; the Workers Men Compensation Act 1923; the Payment of Wages Act 1936; the Child Labour (prohibition & regulation) Act, 1986; the Bonded Labour Act 1952; Parliament passed the Interstate Migrant Workmen (Regulation and Condition of services) Act 1979(Mosseet al, 2005;Chatterjee,2006) specifically to deal with malpractices associated with recruitment and employment of workers who migrate across state boundaries as well as through moves towards Indian ratification of the ILOs new convention on Child labour, moreover Trade Union Act(1926). These legislations contained the provision relating not only to wages, but also health and safety and injury (protective clothing), insurance/compensation for accident and injury, and the right to shelter and child care (Mosseet al, 2005). "The Indian constitution contains basic provisions relating to the conditions of employment, non-discrimination, right to work for example Article 23(1), Article 39, Article 42, and Article 43 which are applicable for all workers including migrant workers within the country. Migrant labourers' are covered under almost all labourers' laws and policies" (Chatterjee,2006).

Migrants and human rights have to be conceived from the prevailing contradiction within as well as across the countries, between voluntary and skilled migrants at one end of the poor and unskilled migrant population destined to be excluded and obscured from the fabric of the host societies. In India, internal migration of poor labourers, their rights have remained elusive. Available studies clearly show that human rights are generally not well protected in informal sector employment. Most migrant workers are not able to avail themselves the existing schemes coming under the national policy (ibid). Policy makers have the tendency to perceive migration as a 'problem', causing threat to economic and social. There have been minimal or even no provisions for the disadvantaged poor migrant, who are facing insecurity in their migrated location (ibid.)

“Migrants health extends to the underlying determinants including adequate nutrition, housing, healthy environment, and occupational conditions, access to health related education and information as well as access to health care and education” (WHO, 2004).

“Social security is defined as a provision of protection for individuals and households, to ensure their health income especially in case of old age unemployment, sickness, invalidity, work injury, maternity or loss of a sole earning member” (Singh et al, 2015). Thus social security can help reduction of poverty and inequality and therefore support inclusive growth through enhancing human capital and productivity. The need of such highly subsidised programs arises in India because 90% of workers in India earn their livelihood in the unorganised sector, which lacks social security schemes. (Singh et al, 2015).

NCEUS explains:

> “unorganised sector work force does not enjoy social protection as employment security, work security and social security. In that spirit of extending social security to the unorganised sector and keeping mind long term demographic trends which indicates a rapidly ageing population and non declining unorganised sector work force, the government of India passed Unorganised Workers Social Security Act(UWSSA) in 2008” (NCEUS, 2008).

This Act is to provide minimum level of social protection which would enable the migrant workers to bear income and health related shocks, stay away of poverty and ultimately lead a better lives (ibid).In the concerns of the health of the migrant labours, Ghosh (2010) highlighted the fact that “the major burden of disease among the poor was acute illness and this needs to be treated on an outpatient basis only”. Therefore, health insurance package that will compensate such loses is more desirable among the poor (ibid).

Health insurance penetration in India is very low. The economic status of the households emerged as the dominant factor in explaining health insurance enrolments differentials in both urban and rural regions (Chakrabarthi and Shankar, 2015). Bawa and Ruchita (2011) also showed in their study that the middle and lower income groups preferred government-sponsored health insurance schemes rather than the private health insurance schemes due to the perception of higher risk and lower trust.

Low public expenditure on health care when compared to developing and emerged economies and high out of pocket care expenditure force the government to focus on the alternative health care financing, which could mitigate the financial loss due to ill health among the poor and the informal sector. Although in India already national health insurance like RahtriyaSwasthyaBimaYojana (RSBY) for informal sector workers is there but its penetration has not reached up to the level of desired benefits (Bawa and Ruchita ,2011).

Labour Welfare in Kerala

The Labour department in Kerala takes initiatives to render good service to the employees and ensure the welfare of them. Kerala government runs 16 welfare boards and they take care of the requirements of the labourers in the state. The remarkable progress in the lives of head load workers of Kerala since 1985 is an outstanding achievement of the boards.

Following are some Important Welfare amenities run by the Department.

(1) Unorganised Daily Waged Employees Distress Relief Fund:

The scheme came in to being in 2007-08. It is applicable to all daily wage workers who are not enrolled in any other welfare scheme. The scheme provides a financial assistance of Rs.2000 in the event of an accident at work site. Labour department is the custodian of the scheme.

(2) Kerala Unorganized Retired Workers Pension Fund Scheme:

The schemes were designed to reach to the traditional teachers who impart preliminary education to the rural students. The teachers who attained 60 years of age when the scheme was put into effect, ie, 01.08.2008, the workers who came under Kerala Artisans and Skilled Workers Welfare Scheme 1991 and any other category which the government adds to the list later. The scheme provides a monthly pension on attaining the age of 60.

(3) RashtriyaSwasthyaBhimaYojana (RSBY):

Social health protection programmes such as India’s health insurance scheme, RSBY are increasingly seen as “a key component of a social protection approach to reduce poverty

and improve health status" (Sabharwal et al, 2014). Moreover, attention has recently been given to the indirect economic and social benefits of social protection prompted through principles of solidarity and equity to support economic productivity, empowerment and social outcome more broadly (ibid.)

RSBY health insurance scheme was initiated by Indian Ministry of Labour and Employment in 2008. The main objective of the scheme is to provide health insurance to households living below the poverty line with the aim of "protecting poor households from major health shocks which push them into poverty and indebtedness. Beneficiary households can access inpatient treatment costing up to rupees 30000 per year for five members of the households by paying 30 rupees as an annual registration"[11] (RSBY, 2018).

RSBY was launched in 2008 and was initially target only the below poverty line (BPL) households, but it expanded to cover other defined categories of unorganised workers, covering: street vendors, beedi workers, MNREGA workers. Domestic workers, building and other construction workers registered with welfare board, licensed railway porters, sanitation workers, mineworkers, rag pickers, rickshaw pullers, auto/tax drivers (ibid).

RSBY offers an insurance coverage of Rs. 30000 to a five member family of a BPL worker in the unorganised sector. Central and state governments are parties in the scheme and implement the scheme together. Currently, Central government pays 60% and the states take care of the remaining 40% of the annual premium decided through tendering. As per the latest data, 33 lakh families are part of the scheme and another 3.77 families may soon be added to the list. The scheme is implemented via Comprehensive Health Insurance Agency (CHIAK).[12]

(4) Comprehensive Health Insurance Scheme (CHIS and CHIS PLUS):

CHIS scheme was introduced to give support to non-RSBY workers. The beneficiaries of the scheme are divided into two categories: (a) all belong to the BPL list of the state government but do not come under the definition of poor by Planning Commission and (b) APL families that do not belong to either State government list or the list compiled by

[11] rsby.gov.in
[12] Govt of Kerala, 2015.

Planning Commission. The department expects an addition of 2.29 lakhs families in 2016-17. CHIS PLUS provides a financial assistance of 70000 for some diseases.

(5) AamAdmiBhimaYojana (AABY):

AABY scheme delivers insurance coverage for 48 categories of households in the country. Instituted by the Government of India, the insurance is provided to either the head of landless families or to the single employer in a family. The central and state governments share the premium amount of Rs. 200 equally among them. The insurance cover comprises the payment ofRs. 30000 for natural death, 75000 for accident death, Rs. 75000 for permanent disability, and 37,500 for partial disabilities. The scheme also extends scholarship worth Rs.100 for two children or Rs.200 for one child.

Other welfare schemes like, the Kerala Small Plantation Welfare Scheme, Kerala Head Load workers (Attached, Unattached and Scattered) Scheme, Kerala Migrant Workers Welfare Scheme, Kerala Automobile Workshop Workers Welfare Scheme, Kerala Auto rickshaw Workers Welfare Scheme, Artisan Workers Welfare Scheme, Kerala Domestic Workers Welfare Fund Scheme, Kerala Laundry Workers Welfare Scheme, Kerala Barber and Beautician Welfare Scheme, Kerala Temple Workers Welfare Scheme etc. are also introduced through this department.

Welfare Schemes for Migrant Workers in Kerala

Kerala launched a new welfare scheme titled 'Inter State Migrant Welfare Scheme' on May 1, 2010 in connection with its celebration of International Day of Workers. The new scheme was aimed at providing certain benefits in the event of casualty. As per the scheme, Migrant workers get a membership card on joining the scheme. Every member will be thereafter eligible for health care assistance not exceeding 25000 per year if he cannot take work owing to serious injury or disease. In normal cases, the worker is entitled to receive 100 rupees per day, up to maximum of 2000 rupees at a single go. The scheme also provides a pension of 1000/ year for those maintain their registration for three years continuously and the overall pension benefit falls between Rs. 10000 to Rs. 25000 per person. Besides, the government ensures an ex gratia payment of 50000 if a member dies during work and 10000 in the event of natural death. The amount will be paid to the dependants of the deceased. The government also thoughtfully included a provision of Rs. 5000 to Rs.15000 (considering the distance to place of domicile of the

migrant) for transporting the body of the deceased to their home town. Rupees 3000 per annum is also earmarked in the scheme for the education of migrant children who pursue studies beyond Class X (Haseena, 2015).

Kerala Construction Workers Welfare Fund Board is entrusted with the task of implementing the scheme. A migrant worker may join the scheme by paying Rs. 30 rupees annually. While, the Board will set aside double that amount in every migrant's name. The board manages the cost by inflicting CESS on employers and the government will also provide it with fund to plug the gap. In addition, Inter State Workmen (Regulation of Employment and Conditions of Service) Act also provides a welfare fund package for migrants. An advisory committee headed by the state labour commissioner and comprising trade union representatives will monitor the functioning of the scheme (Haseena, 2015).

Though the scheme is indeed a good model for other states to follow, it has shortcomings entrenched in it. The major problem perceived in the draft of the scheme is its range. It disappointingly restricts the beneficiary's number to half a million when the total count is much more that. More than that, only 18000 migrants have so far registered in the scheme, which emphasizes the need to strengthen the functioning of the agencies concerned and give proper awareness to the migrants (Haseena, 2015).

Problems Faced by Migrant Labours Availing Social Protection Schemes

Migrant workers predominate in the lower income labour market with higher risks of exposure to unsafe working conditions (Pasclae,2003 as cited in Chatterjee, 2006). “Internal migrants among the poor labourers the susceptibility to health problems stems from their peripheral socio economic existence in the host areas. Since they are absorbed in the informal economy they exist as undocumented labour in most cases and fall outside the coverage of the labour welfare schemes and hence the employer does not provide them their due” (ibid). Migrant labours avail themselves of curative care but they fall outside the coverage of preventive care largely due to their fluidity of movement caused by the uncertainty of employment.

The large number of workers involved in the construction sector the seasonal/temporary migrants are under counted in the data and are invisible in policy discourse (Chatterjee, 2006) The normal social security provisions, including special Act legislated to safeguard

the interest of the workers engaged in the sector such as BOWCA (Building and Other Construction Workers (Regulation of Employment and Condition of Service) Act, 1996) in case of India, are the either poorly implemented or nonexistent. Knowledge among the workers about their legal labour related entitlement is very low (Srivastava&Sutradhar, 2016).

The Building Workers CESS

The Government of India introduced the Building and Other Construction Workers CESS Act in 1996 to raise fund to help function welfare boards constituted in all states in accordance with the building and other construction workers act of 1996.

Purpose of the Boards

According to the Act, every state is required to set up BOCW welfare board to ensure that workers get assistance. Workers who registered themselves with the board may get fund under various schemes offered by the boards. Boards in each state offer different schemes and distribute the collected money on demand. The welfare board in Kerala is called Kerala Building and Other Construction Workers' Welfare Fund Board.

The board plays key role in the life of a worker by providing him benefits such as pension, medical expense, marriage assistance, education expenses, housing loan etc. It was August 1996 the government of India passed Building and other Construction Workers' (Regulation s of employment and Conditions of Service)Act of 1996. In compliance with the act, "Kerala Building and Other Construction Workers' Welfare Fund Board" came into effect on 1st September 1998.

The Act mandates that every registered member should deposit 20 rupee per month and every employer is liable to pay 1% of the total cost of construction if the total estimate exceeds 10 lakhs to the welfare board

Following are the important features of KBOCWWFB:

1. It is aimed at bestowing social security and ensuring welfare assistance to the workers
2. It is body that has representatives of workers, employers and government as stakeholders in which government deals with policy matters

3. Chief executive (secretary) is in charge of the office and appointed by Govt.
4. Contribution of employees and employers is mandatory
5. Government does not provide any financial assistance

The welfare boards extend support to all employees working in the construction field. Skilled semi skilled or unskilled, supervisory, technical and clerical workers can access to the benefits from after registration.

Welfare Boards

As of March 2017, 2.58 crore workers registered with boards across India. As per state wise data, with 32.14 lakh enrollments Uttar Pradesh stands top on the list of registration followed by west Bengal with 28.81 lakh. Madhya Pradesh has 26.53 lakh people registered with board. States including Tamil Nadu Andhra Pradesh, Rajastan. Karnataka and Chattisgarh have recorded more than 10 lakhs of registration. Registration in six other states fall between 5lakhs and10 lakhs. Bihar, Gujarat and Jharkhand exhibit poor performance in terms of its registration. Small states like goa, Nagaland and Meghalaya have less than 10000 workers registered. Labour Ministry claims that the registration number has gone up to 2.8 crore according to latest data (Ministry of Labour and Employment, 2017).

The CESS Collected in the last 20 Years

The state and local governments are given the task of CESS collection and deposit it with welfare boards. It is estimated that the total CESS collection in the last 20 years amounts to 32632.90 crore as per the report submitted by Government of India to the committee. The committee supposes that many of the organizations have been omitted and data given only correspond to the activities of State agencies like the Railways/NHAI/PWD/CPWD alone. The gap in collection and records, in the committee's view, owes to lack of a proper system. Many states are understood to have constituted years after the commencement of fund collection. Committee sought details of such state and exact data from Government of India(Ministry of Labour and Employment, 2017)

The data accessed by the standing committee reveals that Rs 7516.52 has been spent by welfare boards for the last 20 years which makes up 23% of the total fund. Only 6 states have utilized more than half of their fund. Kerala's performance in releasing fund is

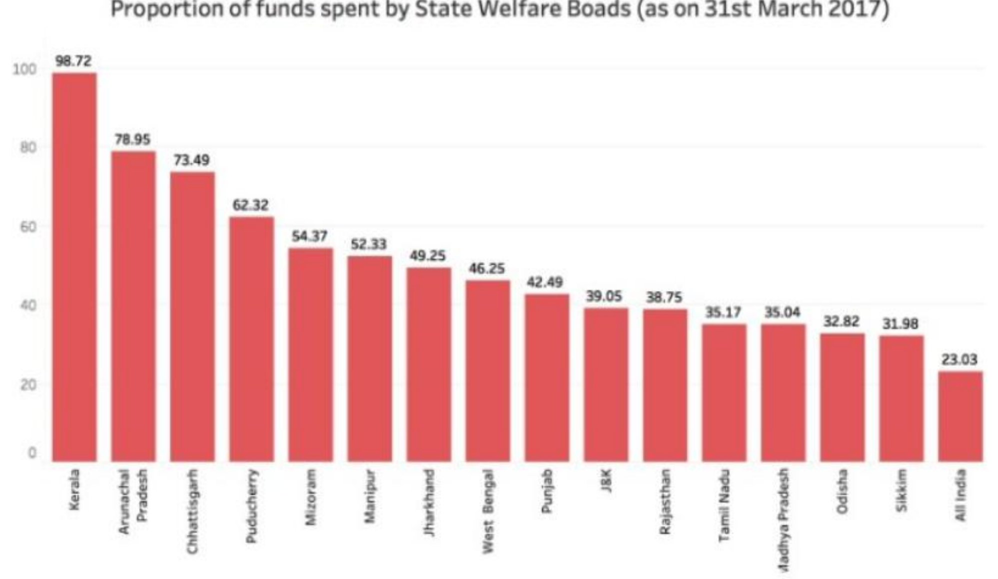
splendid. It has made use of 99 % of the total fund received and the only state which crossed the threshold of 90%. Latest data released by Labour secretary state that the CESS collection has reached 37,482 crore and expenditure has become 9491 crores as of 30th June 2017. The further details of data are unavailable(ibid).

Figure 1: Construction Workers Registered with State Welfare Boards

Source:factly.in/labour-welfare.

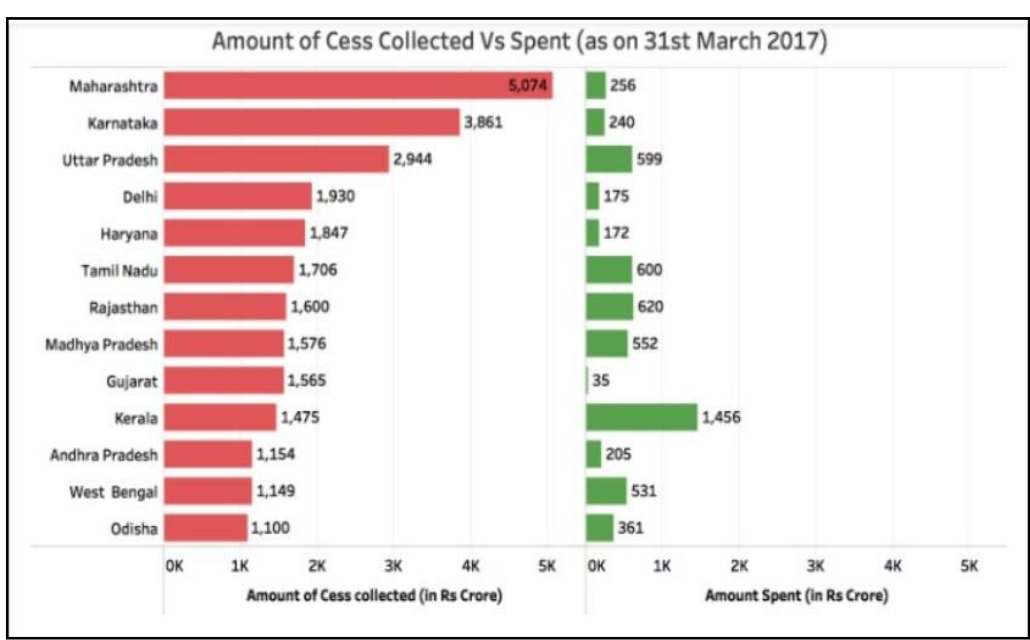
It should be noted that the states that have collected highest amount of CESS fund are the states have spent less. Maharashta tops the list in terms of poor spending. It spent only 5 % of the whopping 5074 crore collected. Next to Maharashtra it is Karnataka that collected as much as 3861crores but used only 6% of it. The following are the states which spent less than half of their fund:Uttar Pradesh (20%), Delhi (9%), Haryana (9%), Tamil Nadu (35%), Rajasthan (39%), Madhya Pradesh (35%). The first 13 states contributed more than 82% in terms of CESS collection but they released only 21% of the total amount put together.

Figure 2: Funds Spend by State Welfare Boards



Source:factly.in/labour-welfare

Figure 3: Amount of CESS Collected and Spend



Source:factly.in/labour-welfare.

Recently Kerala collected 2841.34 lakhs in 2017 and 23958.97 lakhs in 2018. The contributions of Malappuram district in the cess fund during these years are 138.04 lakhs and 264.57 respectively.

Migrant Workers and Identity proofs

Most migrant workers lack government identity documents and do not have any local entitlement to the government services and welfare programmes that require proof of identity. Though, the workers are provided ID cards at times, the main purpose of such cards is to only help site mangers to manage the security of the sites and control the passage of individual through them(ibid).

Only a few migrant workers have the proof of identity, depriving them of access to entitlements at the destination. Workers maintain a “very low standard of living and they are not able to save remit and use their remittance to improve their conditions of housing in the native areas” (ibid.). Neither the state nor the employers appear willing to bear and subsidize part of the costs through appropriate policies and investment in necessary infrastructure. However, the government appears unwilling or not capable enough to formulate appropriate labour and social policies and enforcement the interest of the migrant workers (ibid).

The data gap has held back rights protection and research based policy making. “Methodological hurdles involving the inappropriateness of the use of conventional methods of data collection which cannot easily be adapted to situations involving illegality, where people fear to report abuse, further complicated the process of estimating the number of international migrants” (Chatterjee,2006).Ensuring legal, social and human rights to migrants has been difficult, “the rights based approach to migration has indeed expanded the scope of understanding migration as an indispensable process in the scheme of globalization and identified migrants as an important part in the process of development” (ibid). Major impediment to policy making on migrants both internal and international has been the lack of the information on types of violation, the places where they occur and their characteristics (ibid).

The literacy gap in health insurance was the main barrier for the low insurance uptake in the country (Gosh &Mondal, 2011 cited in the Kansara& Hill, 2017). The lack of proper understanding of the concept of the health insurance was the main barrier for the low

enrolment of the health insurance (Bending &Thankom, 2011 as cited in Kansara& Hill, 2017). Shiva Kumar(2013) proved that the awareness of health insurance schemes positively affects the decision to subscribe for it.

According to Bawa&Ruchita (2011) "...among the informal groups, availability of subsidized government health care inversely affects their decision to enrol for health insurance". The individual to whom, subsidized government health care was available are less willing to enrol for health insurance. But if the "health insurance policies were linked to government hospitals, this raises the probability to enrol for it. Result shows that people preferred to join government schemes" (Bawa&Ruchita,2011). Those who are not aware are more willing to enrol for health insurance. Findings of the study are opposed by research that awareness increases the willing to join for health insurance.

CHAPTER 3

METHODOLOGY

This chapter primarily deals with the research methods and settings and the various sources and tools of data collection and the varied experiences of the researcher. This research is qualitative in nature.

Statement of the Problem

In Kerala, there is an uncertainty in informal sector and slow growth of formal sector. The high educational status and political awareness in the state evolved in the form of a large scale emigration to Gulf countries. Large scale emigration to gulf countries from the state started in the 1970s; reached at its peak in the 1990s and the trend continues. Though a large number of semi-skilled and unskilled workers have the advantage of the emerging employment opportunities in the state, especially among the educated youth. Higher education level and the affluence of families derived from Gulf remittance have led the local youth not to engage in semi-skilled or unskilled work. Simultaneously, the large scale migration has led to the fall in fertility rates in state. This along with rapid urbanization of Kerala has created demand for the unskilled and semiskilled workers locally, thereby attracting domestic migrant labours (DML) in large number (Narayana et al, 2013) from other states of the country. DML are employed in almost all sectors and occupation in the state and are well integrated with the state economy (Narayana et al, 2013).

The large inflow of in-migrant labours are from different parts of the country especially from the states like West Bengal, Assam, Chathisgarh, Bihar, Odisha, Tamil Nadu etc. Majority of them, belong to the unskilled or semiskilled workers, who mainly work in the construction sector which experience relative shortage of labour supply in the domestic labour market. A robust data base on the migrant labours working in Kerala is absent. Even then some pilot studies and media reports have revealed that more than twenty five lakhs of in migrant labours hailing from different parts of India are working in the unorganized sector.

A migrant labourer in the state confronts many problems in accessing public health care services provided for them. This is mainly due to the working and living conditions of the

migrant labourers. The situation becomes worse during the monsoon, which is also a time of annual outbreak of contagious diseases in the state. It has much to do with the standards of hygiene set and followed by a community. The efforts on the part of the authorities to maintain hygiene have been unsuccessful owing to the high density of people in almost all area and poor sense of cleanliness of people**.**

The international, national and the region specific studies exhibit various information aboutthe in-migrant workers and the related issues. But these exhaustive studies on health, working and living conditions of the in-migrant labours in Kerala appeared to be inadequate. It is in this context that this research would be an enquiry into the living and working conditions of the migrant workers in Kerala and the resulting implications on their health. Further the entitlements which these workers should receive with regard to health especially the accessibility to the recently introduced Aawaz scheme will also form a major part of this study.

Conceptualization

Migration is a result of various circumstances. Although unemployment seems to be the apparent reason in most cases, unemployment arises from various other factors including being landless, underdevelopment in the locality, and exploitations at multiple levels. People get attracted to a place where they are endowed with more facilities and income. Places with high infrastructural activities may accommodate more people, even unskilled or semi-skilled labourers.

There are many factors responsible for migration. Underdevelopment, low level of urbanization and industrialisation and poor infrastructure on one hand and poor skills and educational attainment, poor health, unemployment,landlessness and social problems like social identity based atrocities are all factors that force people to out migrate. These are called push factors that squeeze people out of their place of origin. Thus people move from one place to another in search of better opportunities which include employment opportunities and services like basic health, education and social security. So people immigrate to the areas where these facilities are available especially industrialised areas where infrastructure development generates demand for migration and work opportunities mostly in construction sites (Acharya& Reddy, 2016).

The structural inequalities faced by the migrants in these sites of migration have significant impact on overall health and well-being. The secretariat of the World health organization (WHO, 2008) reported that the fundamental health needs of the migrants are not sufficiently met; therefore they raised concern with regard to equity, social cohesion and inclusiveness. The report highlighted that, for their part, low skilled and seasonal workers are often concentrated in sectors and occupations with high levels of health risks.

In the context of Kerala, the migrant workers are arriving from other states to seek better employment opportunities and livelihoods. Being outsiders in the community they face vulnerabilities in the society particularly with regard to health. Sithara& Sebastian (2017) point out that there is a deep contradiction that exists at the level of the system towards the health needs of the migrant population. The migrant workers form a significant population in Kerala which is almost 8 percent of the total population in Kerala. It's a grave question as to whether the current health system in the state is equipped to cater to the needs of this added population. But it's evident that there is gross underutilization of the health services due to various factors like lack of access and other barriers by the migrant workers.

There are potential barriers to the use of the health services among the ethnic minorities especially in migrants(Scheppers et al, 2006). Migration creates a situation where migrant labourers are forced to live in unhealthy and unfavourable conditions which include poor accommodation. A person migrates out of their conditions. Health care is a natural right of every individual but still these ethnic minorities confront different barriers in utilising and accessing the health services mainly due to their socio economic vulnerabilities like the migrant workers in this case. The study shows that potential barriers occurred at three different levels mainly at the patient level, provider level and system level. The barriers at the patient level are related to the patient characteristics: demographic variables, social structure variables, health beliefs and attitudes, personal enabling resources, community enabling resources, perceived illness and personal health practices. The barriers at provider level are related to the provider characteristics: skills and attitudes. The barriers at system level are related to the system characteristics: the organisation of the health care system. There are many barriers of which some are tied to ethnic minorities. The barriers are connected to a particular situation of the individual patient and subject to constant adjustment. This is very relevant in the case of migrant labourers in terms of health

accessibility (ibid.). To reduce the barriers to access the health care services and to make the migrants included as the part of the health system the states needs to provide social security schemes for them.

Based on the 1952 convention 102- the social security(minimum standards convention)- the ILO has been defined as the protection which society provides for its member through a series of public measures: 1) To offset the absence or reduction of income from work are resulting from various contingencies (notably sickness, maternity, employment injury, unemployment, invalidity, old age and death of the bread winner); 2) To provide people with health care and; 3) To provide benefits for families with children.

The various social protection mechanisms for workers identified and assessed by the ILO reported schemes are mainly of two categories. First one is to maintain the earning capacity of the labourer and another provides income security to the worker after end of the working career. One of the main aim of these schemes is to maintain health as access to health care enables the worker to maintain health and hence the earning capacity. This may be provided by the government or through voluntary schemes including what are known as micro-insurance schemes for health care. Further social protection helps during periods of incapacity which enables workers to avoid a loss in income either due to sickness, or disability resulting from employment injury or other unforeseen events, both in the short and long term through replacement benefits (Canagarajah&Sethuraman, 2001).

There is entitlement to enjoy the social protection and health insurance schemes. Bollini and Siem (1995) say that the migrant and ethnic group, particularly those who are disadvantaged, have reduced access to health care services. They encounter not only economic barriers, but also administrative, linguistic and cultural ones. The poor health outcomes observed are linked to the lower entitlement for migrants and ethnic group in the receiving countries. The authors further said that “not only are they exposed to poor working and living conditions, which are per se determinants of poor health, but they also have reduced access to health care for a number of political, administrative and cultural reasons which are not necessarily present for the native population and which vary in different societies and for different groups” (ibid: p.825).

Migrant workers in unorganised sector are among the vulnerable communities in India. In last survey conducted by NSSO In the year of the 2009-2010, announced that there are 46.5 crore unorganized labour in our country. Out of those greater part 43.7 crore are unorganized sector and 2.8 crore labour from the organized sector. There are various labour force are in unorganized sectors like agricultural and allied service; in those classifications; by far most of workers that means 52 percent are engaged in agriculture sectors and rest of the labours are from non- agricultural service like construction work, House hold work, beedi workers , mechanical and industrial works. The maximum numbers of the migrate labour belong to socially deprived section and they are encountered with their daily life like they normally work in deplorable working conditions and living with unhygienic conditions that make them susceptible to suffer from various types of contaminated as well as occupational diseases. And this issue does not inclusive in the existing policies and programs in India. There are government laws towards migrant labours relating to the health and hygiene which is applying or both organized and unorganized sector as well,

1) Work men compensation Act, 1923.
2) Payment of wage act ,1936
3) Minimum Wage Act ,1948
4) Bonded Labour Act ,1976
5) Contract Labour (Regulation and Abolition Act), 1970
6) Interstate Migrant Workmen (Regulation of Employment and Condition of Service) Act (1979)
7) Child Labour (Prohibition and Condition of Service Act), 1986
8) Building and other Construction works (Regulation of Employment condition of service Act) 1996
9) Unorganised Workers Social Security Act (2008)
10) RashtriyaSwasthyaBimaYojana (RSBY).

Despite having few relating to health and hygiene, (as discussed above) almost all migrant labourers are the still the most underprivileged population, who are habituated to get deprived from the facilities of health care service and social security (Chatterjee, 2016).

Table 1: State-Wise Indicators

States	Kerala	West Bengal	Assam	Odisha	Tamil Nadu
Population	3,34,06,061	9,12,76,115	3,12,05,576	4,19,74,452	7,21,38,958
HDI- Rank among states in India (2011)	1	9	12	19	6
Literacy rate (%)	94	76.26	72.19	72.87	80.33
Sex Ratio (2011)	1084	950	958	979	995
Infant Mortality rate (2011)	12	32	55	57	22
Life expectancy at birth (2011-12)	74	64.9	58.9	59.6	64.6
Per capita Income at current price to 2011-12 (Rs)	83725	55864	33633	46150	89050

Source: *Census, 2011, Sample Registration System, Office of the Registrar General, India.*

In Kerala is acclaimed nationally and internationally with respect to the social security and welfare measures it has extended for many years the policy of government of Kerala. The State has the highest ranking in the case of the most of the development indicators such as literacy rate, sex ration, infant mortality rate and life expectancy at birth, this development pattern has attracted migrant labourers from various states to Kerala. Major determinates of migration of labours to Kerala are compulsion from Rural indebtness, growing un employment, poor income from agriculture in home state, pressure of large size of the family, catalytic role of recruitment agents, positive role of social network of migrants, high wage rate in Kerala and the preference of employers in Kerala for migrant labourers who are ready to work at low wage rate. The main reason behind migration is the employment consideration and the bleak employment prospect in the local labour

markets. The difference in the economic opportunities between home states and Kerala is pushing the movement of labour.

The migrant workers in Kerala are confronted with wide range of the problems. These include poor quality of the Accommodation, Long working hours, limited access to health care services, social exclusion, poor social interaction and lack of integration with the local community, poor access to available schemes and services and non-provisioning of Entitlement of Government Schemes.

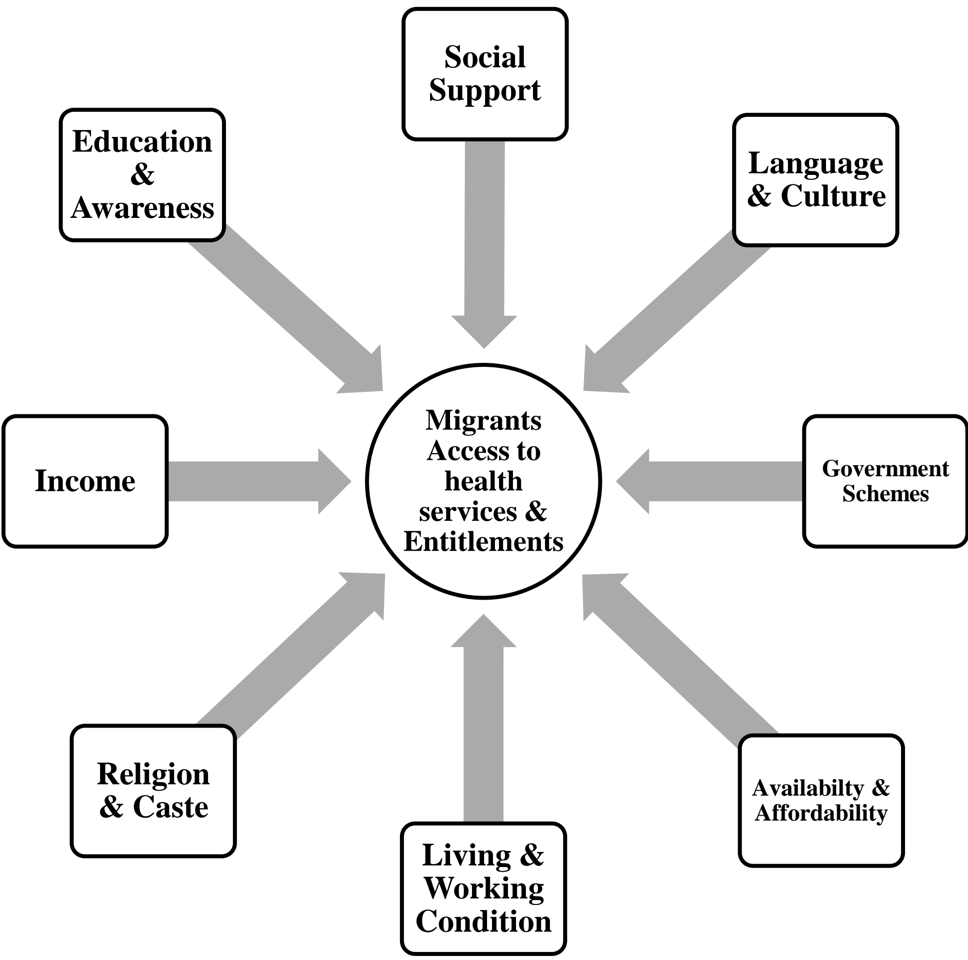
In this problem the lack of access of services and entitlement for migrant workers is serious one. Both employers migrant and government institutions at state level or national level do not pay any attention in providing welfare measure to migrant labours. Hence their entitlement are not properly utilized or availed for migrant labours inn Kerala. There is lack of awareness about the existing legal and social security schemes. It is the non provisioning of entitlements and non- probability of benefits provided by central and home state are what create problems for migrants.

Conceptual Framework

The major focus of this study would be on the access to various health services and entitlements to the migrant workers in Kerala. Further the impediments or barriers in accessing these services will also be explored in this study.

Migrants in this study comprises of all the male interstate workers employed in small or medium construction industry in EranadTaluk in Malappuram district in Kerala aged between 17 to 59 years. The health services would constitute both public and private services available to these workers in Kerala. Entitlements to these workers were mainly limited to the social security schemes like RSBY, Aawaz and BOWCA (Building and Other construction workers Act, 1996). Thus this study is looking at the living and working conditions and other major barriers to access the health services and entitlements by these migrant workers.

Figure 4: Conceptual Framework



There most important indicator here would be the living and working conditions of the migrant worker. Living conditions would comprise of the habitat of the migrant worker and the environment that surrounds it which would include the facilities like water, sanitation, climate, food and other arrangements that would impact the health of the worker. The working conditions includes the place of work, nature, duration, and the safety measures available to the workers and the health risks associated with this work to the migrant workers. Thus living and working conditions are most important as it serves as the background for understanding the reasons which hinder the utilisation of health services and also which acts as barriers in accessing the entitlements.

Further the economic conditions of the migrant workers are directly dependent on the nature of work. The living conditions are dependent on the income and it also impacts the

health services they access when in need. A fare share of the income also is send as remittances back home.

Social factors like religion and caste acts as barriers to accessing services and entitlements. Further language or the place of birth can also serve as impediments to the same as these cultural factors often alienate people or marginalise them among the mainstream society. The services made available should also be culturally acceptable to the people in need. Thus it can also serve as a barrier. Education and awareness can in some way control this barrier to a certain extent.

Above all the availability of the services is the most important and once the services are available then the question of affordability arises. This depends on the financial capability of the migrant worker. The availability of services and entitlements doesn't always ensure its utilisation. Governments have come up with schemes and services to improve this conditions but only proper awareness can help in making these facilities more acceptable and increase the utilisation. Social support thus plays a major part in this regard.

Thus all the above mentioned factors are interrelated and would give a clear understanding of the material conditions of the migrant workers and also would thus enable to understand the causes which stems from those conditions which acts as barriers in accessing services and entitlements related to health and also living a life with dignity.

Research questions

The migration of labourers is a widely explored area. It becomes important to understand the reasons that facilitate migration of workers to Kerala? Further the major sectors in which these labours are accommodated and in addition to these the barriers they face in adapting to the new environment. The conceptualization of the problem has raised questions related to barriers in accessing the health services and health schemes (entitlements) among migrant labours in the informal sector in the study area. The border questions are:

a) How does socioeconomic status of migrants labours act as a facilitator or inhibitor in accessing health services and protection schemes entitled for them in Kerala. What are the major areas and barriers which have implication for migrant labourers in accessing assigned entitlements?

b) Are the challenges faced by migrant labour a two way process? What are the issues faced by health care providers in addressing health care needs of the migrant labourers?

c) The role of 'Aawaz' insurance and other entitlements in addressing the barriers faced in accessing the health services?

Objectives

The study tries to identify the barriers to access the health services and health entitlement among the migrant workers in the ErandTaluk, Malappuram district. Specific objective of the study are-

1. To study the socio economic status of the migrant workers.
2. Tostudythe barriers faced by Migrant workers in accessing the health services in Kerala.
3. To understand issues faced by the health care providers in addressing the health provision to migrant workers.
4. To identify the areas where interstate migrant workers are lacking in accessibility to entitlements and social welfare schemes.
5. To understand role of 'Aawaz' health insurance in addressing entitlements issues faced by migrants workers.

Research design

This study is primarily qualitative. Flick (2009:96) says that "Qualitative research is of specific relevance to the study of social relations; due to the fact of the pluralisation of life worlds". For the study both secondary and primary data were collected. Primary Data for the Study was collected through case study and in-depth interviews using interview guides for the participants. Secondary data sources include articles published in journal, media reports, Government order and reports, books etc. A pilot study was conducted before the actual field work to assess the feasibility of the study and also to understand the working and living conditions of the respondents (Migrant labour) in the study area.

Rationale for the selection of study setting

Kerala is known all over the world for the achievement in the sphere of human development at extremely low levels of per capita income. But Malappuram district with large population in the state lag behind in various social indicators including health. The district secured least rank in the HDI ranking in 2011 among all the districts in Kerala. Similarly the lack of infrastructural facilities in the region has again put the district at a position with least availability of health care institutions. During 2001 the district was ranked last in the index of doctor per lakh population and nurses per lakh population. Further in the case of the bed per lakh population the district was ranked last among all the other districts. In case of hospitals per one lakh population the district was placed 13 out of the total 14 districts. However there is rapid development of private health institutions (mostly big and medium allopathic institutions) inMalappuram district (Nandu, 2015). This is due to the influence of Emigrants to Gulf from the district.

EranadTaluk exhibits one of the highest (5th in position) emigration rates from the state. Among 1000 people who emigrate out of the state, 97 people are from EranadTaluk(Zachariah, 2003).The large scale emigration lead to shortage of labour force in certain occupations and further the affluence of remittance lead the members of emigrant households to stay unemployed for a long time. This has resulted in the increased the wage rate and lead to migration from other states. Large presence of the migrant labour is found in the rural area of the Taluk (Nandu, 2015). The backwardness of the region especially in health status and other service delivery and rapid growth and presence of the migrant labour in the region is the major reason for the selection of EranadTaluk as the study area.

Figure 5: Map of Malappuram District

Sampling

The Migrant labours in EranadTaluk of Malappuram district are the subjects of the study. Purposive sampling method was used for the selections of the respondents. Purposive sampling helps to identify and select the information rich cases for the most proper utilization of available resources (Etikan et al, 2016). It involves identification and selection of individual or groups of individual that are proficient and well informed with a phenomenon of interest (Cresswell& Clark as cited in Etikan et al,2016). The samples for the study were decided to be selected from the male migrant labours who were employed in the small or medium construction works. Construction work has been cited as one of the most exploitative work for a migrant labour and it employs a major share of the

migrant working population in the state. Three contractors were selected at random from three different areas in the study area who provided employment to the migrant workers in EranadTaluk and purposive sampling was used to find the samples. Thus purposive sampling was used to identify the samples required for the study by keeping the inclusion criteria of being employed in a medium or small scale construction work for not less than 2 years and age criteria (17 to 59 years). A total of 16 samples (migrant labours) are taken for the study. Consent was taken from the respondents for data collection. Further interview was taken from 20 key informants in the study area. The names of the participants and identity were kept confidential and thus pseudo names have been used in this study.

Participants

Participants for the study include the people who had migrated from other states (Hindi speaking and Non Hindi Speaking states) of the country to Kerala. The criteria to choose the participants were that they should be working in Kerala for a time period of not less than 2 years. Help of translators were taken for the translation and conducting interviews with migrant labourer. Further 20 interviews with key informants were also conducted which included four doctors (two from a public hospital and two from a private hospital), four nurses (two from a public hospital and two from a private hospital) , District medical officer and Deputy Medical Officer, Labour officer, Assistant Labour officer and Field Officer with the labour department, four health inspectors (two from rural area which includes the Taluk hospital and two from the urban area within the study area) , Health superintendent of a municipality within the study area were interviewed personally and two officers (a Deputy officer and a Field officer) of Building and other construction workers welfare board were interviewed by means of telephone.

Sources of Data Collection

Primary Sources

Case study, as method of research, is used in this study. "Case study research scientifically investigates into a real-life phenomenon in-depth and within its environmental context… such a case can be an individual, a group, an organization, an event, a problem, or an anomaly" (Buroway, 2009; Stake, 2005; Yin, 2014 as cited in Ridder, 2017). This method was used to understand the barriers in utilizing the health

services and in enrolment to the health insurance scheme for the migrant labours in an in-depth manner.

Informal and in-depth interviews, observations, Telephonic interviews were used as the techniques of data collection. Various tools like semi structured interview guides and interview schedules were used for collecting information from the participants. The entire interviews with the migrant labours were conducted in Hindi and were recorded in audio format. Then they were later translated and transcribed into English. Field notes were also kept as a part of recording the findings.

Preliminary analysis began at the time of the translation. The observation and quotes were marked. The transcribed data were categorized based on themes which were associated with the experience in accessibility of health care services and the process of the entitlement enrolment for the government health insurance scheme.

Secondary Sources

Various documents, reports, publications of the central, state and local governments were studied.Several libraries and documentation centres were visited and data associated to migration in general were collected. Books, e-books, magazines, journals and news letters were evaluated both in English and Malayalam. Reports prepared by research scholars and universities were studied briefly.

Research Settings

Malappuram is one among the 14 districts in the state of Kerala in India. As per the census India 2011,Malappuram has a population of 41, 12, 920 of which 19, 60,328 are males and 21, 52,529 are females. The sex ratio is around 1098 compared to 1084 which is average of Kerala State. The literacy rate of the district is 80.51% of which 81.94% males are literate, and 79.62% females are literate. The total area of Malappuram is 3554 sq.km with a population of 1157 per sq.km. Out of total population, 55.82% population live in urban areas, and 44.18% live in rural areas. There are 7.5% scheduled castes (SC) and 0.56% scheduled Tribe (ST) of the total population in Malappuram District (Census, 2011). In Malappuram, there issixsub-district(Taluk/Tehsil), among them Tirur is the most populous tehsil with a population of about 9.3 lakh, andPonnani is the least populous Taluk with 3.8 lakh population. Among the working population in

Malappuramdistrict out of the total population, 1062,424 were engaged in work activities. 80.2% of workers were engaged in main works while 19.8% were involved in the marginal activity (Census, 2011).

EranadTaluk is one among the six Tehsils in Malappuram district. It comprises of 33 villages (subdivision) with a total population of the 910,978 as per the census (2011). Out of the total population, 34.7% live in the urban areas while 65.3% live in the rural areas. The total literacy rate of Taluk is 94.6%. Out of the totalpopulation, 72.29% are Muslims while 26.17% are Hindus. Caste-wise distribution shows that Scheduled Caste (SC) constitutes 9.3%, while scheduled Tribe (ST) constitute only 0.4% of the total population in EranadTaluk. The sex ratio of the EranadTaluk is 1052. Thus for every 1000 men, there are 1052 females in Taluk area (Census, 2011).

Out of the total population, 241,252 are engaged in work activities. 77.1%of workers are employed and are earning for more than six months while 22% are involved in the marginal activity providing a livelihood for less than 6 Months. Of 241,252 workers engaged in Main work, 11,111 are cultivators while 21,421are Agricultural Labour (ibid).

Table 2: Demographic Details of EranadTaluk

Ernad Population Facts

Number of Households	1,78,209
Population	9,10,978
Male Population	4,43,977 (48.74%)
Female Population	4,67,001 (51.26%)
Children Population	1,30,000
Area	703.85 km2
Population density/km2	1,294
Sex-ratio	1052
Literacy	81.12%
Male Literacy	82.24%
Female Literacy	80.05%
Scheduled Tribes (ST) %	0.38%
Scheduled Caste (SC) %	9.33%

Source:Census,2011

Table 3: Occupational Details of EranadTaluk

	Total	Male	Female
Main Workers	186,106	165,563	20,543
Cultivators	11,111	10,521	590
Agriculture Labourer	21,421	19,274	2,147
Household Industries	2,350	2,020	330
Other Workers	151,224	133,748	17,476
Marginal Workers	55,146	40,944	14,202
Non Working	669,726	237,470	432,256

Source:Census,2011

There are difficulties in estimating the exact number of migrant workers in Malappuram district. The study done by Narayana et al (2013) for Labour and Rehabilitation Department, Govt. of Kerala estimated that there are 2.5 lakh migrant workers in the Malappuram district. Due to their floatingnature there is a lack of exact data of interstate migrant workers in the district and Taluk.

The study also aims to understand the accessibility issues related to the social protection- Aawaz health insurance scheme for the migrant labours. Under this insurance scheme, there were total 1.5 lakhs Biometric cards were distributed among the Migrant labors till February 2018. In Malappuram District, a total of 9964 Biometric cards were distributed of which 9764 were for Males, and 195 and 5 for females and third gender respectively (minister-labour.kerala.gov.in). This shows that there is a large number of male migrants without families and only very few women migrate with their husbands for work to Kerala.

Data Analysis

The whole research process makes use of a relatively large amount of data collected. The collected data from in-depth interview was translated and transcribed first and analyzed through the variousdomains. Those data were quite messy and comprised mainly ofquestionnaires, field and observational notes and interview notes. The data collected from the field were complemented by various other secondary sources such as press

articles, reports from governmental and non-governmental agencies and material provided by migrant organizations and communities. It took a lot of time and effort to analyze the data to produce meaningful results and to answer the research questions as satisfactory as possible. Data was read and studied, and then they were segmented and coded according to the themes. The whole process of data analysis was conducted manually.

Experiences and Challenges faced in the field

Field work has been an integral part of this study to get valid information in the place of assumptions. It was carried out from the second week of November 2017 to the first week of January 2018. The study comprises of 16 in-depth interviews with migrant labourers and 20 informal interviews with doctors, nurses, labour officer and field officers from Labour department, and Health Superintendent and Junior Health Inspectors from the health and Local Self Government department. Interviews are quite informative and provide sufficient data to meet the objectives of the research being conducted.

My first attempt to meet and talk to the migrants in the Manjeri town area was a failure. When approached for contacts, they were friendly thinkingI was there to employ them. Knowing my purpose, they turned indifferent and did not give their number. It happened again and two more workers denied access to them. From this experience, I understood that migrant workers could not be approached directly and a contractor's help was indispensable.

The following day, I met a friend of mine, who is in construction sector. He took me to a labourer's quarters in the evening. It was a poorly maintained double-storied commercial building situated in the outskirts of the town. The premises were not clean and the rooms too. I could only see two newcomers who came just 2 months ago. They were shy to open up and I left them for the time being to come back again to meet others who, I presumed, were taking overtime.

After two days, I went to the same place. When I reached there, one person who could be of any help to me was about to leave the place. From him, I understood that 8 people were living in that small space in which four came to Kerala only recently. They were mostly coolie workers and not in touch with construction work. His friends were employed in road construction. Without detailing much, he left me abruptly.

After this incident, I decided to meet another friend Mr.Dileep whose is an architect by profession. He introduced me two contractors who undertake works of residential buildings. Under those two contractors, 5 construction works had been progressing in EranadTaluk and they employed 32 workers in which migrants formed the majority. I visited one of the working sites near Malappuram with Mr.Dileep, managed by a contractor named Mr.Sundar. Mr.Dileep introduced me to the workers and we spent a lot of time with them and had lunch with them. Before we left, I disclosed my purpose of visit to them and a worker named Kamal extended his support wholeheartedly. He stayed with four friends at the work site itself. We left them after collecting contact details.

I returned to the site the following day. I reached there afternoon and saw the 5 migrant workers engaged in plastering the wall. Only two of them wore gloves and boots while mixing sand and cement. Others kept theirs aside and were exposed to the chemicals. Their work ended around 6 pm. After taking a short bath from water tank and changing dress, they joined me for tea from a nearby shop. Some of them bought GudkaPanmasala and beedi. Finishing tea, we got back to work site for talk.

The workers stayed in one of the rooms of the building. The floor was dusty with cement and metal jelly. They kept all belongings including dress and food items, did cooking and slept in that untidy little space. While two of them were engaged in cooking, I started interview with the experienced migrant worker, Mr.Kamal. He has been in Kerala for more than 10 years, and can understand and communicate in Malayalam. I had my questionnaire ready with me. To my questions, he gave replies without any hesitation. He talked of his past life in West Bengal and Bengaluru and what he felt about Kerala. His talk touched different topics such as work, working conditions, wages, health, Kerala people, food, climate, and government schemes for them. It went on about one and half hours till he got tired. Then, I took leave thanking him. I visited the place in the next three days and made efforts to maintain the rapport with them.

Meanwhile, I decided to contact labour officer in Civil Station in Malappuram headquarters during free hours. My effort to take an appointment with the Labour Officer failed as he was on a long leave. Instead, I met Deputy Labour Officer who was given the charge of District Officer at his office with my friend Mr.Ranjith. We were allotted around 30 minutes as many others were waiting outside to meet him. The officer gave us a brief structure of Aawaz Insurance Schemes and directed to a field officer for more

information. Field officer was kind-hearted and friendly. He spoke to us in detail and cleared our doubts amidst his busy work schedule. He shared the difficulties inherent in the process of enrolment and barriers they were struggling to overcome. Lack of a common language to converse with and cultural differences are stumbling blocks in communicating with migrants. Other factors that make their job hard were unavailability of migrants during office hours and their movement from one place to another.

The next day, I went to the construction site with Ranjith. He is fluent in Hindi and I sought his help to interact with the migrants effectively. The purpose of the study, structure and questionnaire were briefed to him in advance. Mr. Nadir was my next participant. He was shy and afraid of the repercussions of the interview. Mr. Kamal came to my help and convinced Nadir that he would not be in trouble. Kamal was like a guardian for his friends. It was Kamal who arranged interviews with Akram, Hakeem, Tajudheen and Nadir by convincing them in the following days.

In the meantime, I visited a labour camp in Melmuri near Malappuram where enrolment campaign of Aawaz health insurance scheme was organised by Labour department. Field officer was present there. The programme was held in a site for hospital. Entry to the site was restricted and my friend and I were granted permission only after consultation with security personnels. I noticed that builders were very particular about security and security cameras had been installed for surveillance and safety. Enrolment took place in a temporary shed that worked as an office near the site. Migrants stood obediently in queue for enrolment. The queue became long when more people joined taking break from the on-going work. Inside the office room, we saw IT professionals from 'Smart IT Service', an outsourcing agency that was hired for collecting biometric data. Collecting data was not an easy task as some of them did not have proper ID with them. Some others even were not able to understand Hindi. In such cases, help of Hindi-speaking migrant was necessary. We tried to get permission to talk to migrant in vain. It was against the order of the contractor and staff denied us the permission.

With the help of Kamal, I was able to locate a few other migrants living in Chemmankadav, 4 Kms from Malappuram town. These people were employed by a contractor named Haris. They were ready for the interview when I met them at their residence. I found them very friendly and co-operative. As soon as we began, the owner of the building rushed in and interrupted the interview. He insisted on getting permission

from local authorities before we proceed. The reason he became nervous and angry was a police search occured a few months ago for a migrant who was allegedly involved in a crime. I completed interview from a nearby tea shop. They were sorry for the unfortunate incident.

I set aside the next day exclusively for meeting Medical staff at Government Medical College, Manjeri. My intention was to get information regarding their experience in treating migrants and to know how they managed to communicate with them. Meeting with two doctors and two nurses did not take long since they were in the thick of duty. What they unanimously expressed was the problem of communicating with migrants. It is of great importance in determining the disease of the patients. Apart from that, in most cases, migrants who took treatment that includes operation in case of serious injury, came without any standby person. As a result, nurses had to render additional service to them.

It was from Jouhar Ali, a friend of mine, I got to know about Razaq, a construction worker-turned-tea seller in Manjeri. Razaq runs a small tea shop near his home. He found a bride from Manjeri and settled there a few years ago. He shared his life's journey and experience in Kerala as a migrant labourer. He also took small construction contracts and employed a few. Razaq knew Malayalam and introduced Sayed, Jamal, Kadir, and Aminul to me. I talked to them and collected information pertaining to my study.

In the following day, I met another contractor Koya through Dileep. Koya gave me the contact of Sudan, a migrant from West Bengal and Sudan introduced his friends Sanjay, Prakat and Ram to me when I met him at his residence in Kootilangadi. From their words, I could read the issues that they had been facing like discrimination and isolation. They knew that all these issues stem from language difference and stark contrast in culture. Still, deprivation at home made them survive here. They were satisfied in the sense that they could manage their requirements well now.

In the meantime, Kamal informed me of an addition of 2 new workers in his team. Both, namely Arumugam and Venkitesh, were from Tamilnadu and lived together. Arumugam had long been here and knew Malayalam well. He was social and active among people. I interviewed both and spent time with them to observe their work and daily routine after getting consent from the contractor.

I stayed there from evening till next day evening. There were 7 workers who occupied two rooms in the building; Kamal, Akram, Nadir, Hakeem and Tajuddheen in one room and Arumugam and Venkitesh in another. They all took bath after work. Some went out for tea and bought beedi, vegetables, curry powder and fish, whileArumugam and Venkitesh had food at a hotel. While two of the Bengali group began cooking, I glanced through the room. The rooms were dusty with concrete materials and cement. Dust occupied even in the luggage and dresses kept in a corner. They used water from a nearby well for cooking. During this time, others in the room were busy calling friends and family. Having had their dinner, all of them turned to mobile phones for watching movies and making calls. It was usual that they spent their majority of free time on phone. They lay down on a mat on the dusty floor for sleep.

In the other room, Arumugan and his nephew Venkitesh had been drinking and kept on talking about their job, family and other things. Venkitesh became emotional and started crying due to separation from family. Arumugan calmed him down and they fell asleep by 10 pm.

Next morning, all woke up before 7am. Two of them took bath. Despite the availability of running water toilet was not clean. Bengali group managed with yesterday's leftovers and rice and sabzi they prepared afresh. Meanwhile, Arumugam and Venkitesh had their breakfast at a hotel. They said that they cooked rarely.

Their work commenced at 9 am with the arrival of contractor, architect and supervisor. Being the main masons in the team, Arumugam and Kamal were given the instructions by supervisor in relation to the amount of work to be completed by evening. The main masons divided the team distributed the work to their co-workers. Arumugam and Venkitesh did concreting of the floor , whereas others occupied themselves in plastering work. Two of the workers were seen mixing the concrete and distributing materials to others and three of them were doing plastering. All of them were exposed to concrete materials without any safety materials such as mask, shoe or gloves. At 11am, work came to a halt for tea. They resumed work after 15 minutes and continued till 1.30. In between, one of the worker cooked the lunch for the co-workers. Arumugan and Venketesh went to hotel for their lunch. They returned to work at 2.30 after the lunch and a short nap and work lasted till 6 pm. After that, they took rest for half an hour before taking evening bath.

I came to know that wages were usually on every weekend. Workers would send home a major portion of it through bank on weekends. It was understood that a few had the knowledge about government schemes and programs for them and none of them registered themselves under the welfare board.

I had a plan to meet Labour Officer, Medical officer, deputy medical officer and assistant labour officer in person in the coming day. District Medical Officer was on hectic work and she could spare only a little time for me. She and her team were on the run to control and prevent seasonal outbreak of contagious diseases during monsoon. Cleaning drives, medical camps for migrants and awareness campaigns were organised by health department in different parts of the districts for this. Health inspection in migrants' dwellings was a routine incident as a part of this. I noticed that there was little communication between the Health and Labour departments. Health department did have access to the data collected by Labour department for Aawaz enrolment and was not a party in the scheme despite the fact that Aawaz offered free medical treatment in government and empanelled private hospitals that come under the purview of Health department.

The fact that Health department has nothing to do with Aawaz scheme surprised me. Since health consciousness and prospects of the migrants form a part of my study, I took myself to municipality to conduct the interview of one Health Superintendent and two Junior Health Inspectors. They said that their duty was to maintain hygiene in the municipal area. There had been medical camps and awareness drives in every nook and corner of the municipality. I was not surprised to hear that they found dealing with migrants a hard task. Lack of access to them, their details and language were the main obstacles experienced by them.

Health inspectors from Taluk hospital too admitted language as a grave issue while dealing with migrant. In addition to that, they felt that migrants were less co-operative in their attitude. Lack of exact data regarding number of migrants in an area and their place of living took the matter beyond their capacity.

In the last leg of my field work, I scheduled a meeting with my friend Dr. Ashraf who runs a private clinic in Makkaraparambu, 6 Kms from Malappuram town. According to him, there was a high rise in the number of cases from migrant community during

monsoon. He observed that a good majority of them he treated suffered also from skin diseases, which, he thought, where the products of lack of hygiene. Two nurses interviewed were more concerned about not having a common language to talk to them. Dr. Ashraf too agreed with that point undoubtedly.

The field work narrated above offered several challenges to me beginning from arranging a meeting with migrant workers, collecting the required data to documenting them systematically. It took me a while to take off the work as where to begin with was unknown. My first attempts to get information were a failure. But, I did not give up and tried again with the help of my acquaintances in the construction field. I learned a lesson then that a migrant is always under the control of the contractor and he will talk only if he gets permission from the employer; van unwritten rule strictly followed by each migrant.

Once got access to them, I made most of it by talking to them, being with them and observing them keenly. Language had been a severe problem which I managed to surpass with the help of a translator. I was lucky enough to meet a few migrants who were good at Malayalam. I used them to get the words of other migrants who had little knowledge of Hindi translated into Malayalam or Hindi.

Besides language, non-cooperation of the migrants was also a stumbling block in the beginning stage. Some of them were really afraid about the purpose and after-effects of my enquiries. Routine police inspections and moral policing by some local might have been the reasons behind their silence. I took a lot of pain to convince them to provide me with the information I sought. Even after their consent data collection progressed slowly owing to their work schedule.

Meetings with labour and health officials were also not smooth. I had to visit the offices several time before I got an appointment. While labour officials were busy with the Aawaz enrolment, Health officials were working on disease-prevention programmes. However, I could manage to talk to them and obtain the data required for my research.

Ethical Concern

The study began after getting ethical clearance from the Centre of Social Medicine and Community Health of Jawaharlal Nehru University. Informed verbal consent was taken from all respondents after providing information regarding the study. Respondents were

informed about the possible risks and benefits of participation, and their participation is purely on voluntary basis. The confidentiality of the data collected is maintained even after the study was over and the information leading to the identification of respondents are removed from the study report. The data collected are kept with the researcher and will be used only for academic purpose.

Limitations of the Study

The main limitation of the study is the unavailability of the recent statistical data about the interstate migrant workers. The recent data available are mainly the 2001 census and the 2007-2008 National sample survey (NSS). Both provide broad information while 2011 census data not yet available in public domain. The exact number of the migrant workers is not available with any of state government departments. Another limitation of the study is that there are chances of recall bias and hesitance to share the life events of migrant labours due to their privacy issues and the short period of the interaction with migrant labours may not have been sufficient for capturing their entire life history.

The study mainly focuses on the living and working situation, barriers to health care accessibility and health care entitlement in Kerala as experienced by a migrant. The study does not intend to focus on the aspects of behaviour and mental health of the migrant workers. The researcher faced the continuous lack of availability and cooperation of the migrant workers during the field data collection because of their floating nature and work schedule. The study mainly focused on the male migrant labours who were involved in construction work either under the small scale contractors or not under any. The study didn’t take response from female migrant workers and the male migrant workers who were under big contractors or contracting companies. Another limitations of the study is the short duration of interview with higher officials like district level officers due to their work schedule.

CHAPTER 4

THE SOCIOECONOMIC STATUS OF MIGRANT LABOURS IN ERANAD

In the recent times, there is a trend in the employment sector of Kerala which has created an inrush of labourers from other states of the country because of high wages, work opportunities and social harmony. The number of the inter-state migrant labourers is estimated to be more than 25 lakhs with an annual arrival rate of 2.35 lakhs (Narayana&Venkateswara, 2013). In Kerala, the inter-state migrant labourers are hired in various domains of areas such as construction, manufacturing, hotel and agriculture. Among them, 60% of the migrant labours depend on the constructionsector for their livelihood.[13]

This chapter primarilydeals with the socioeconomic status of the migrant labourers and its implications in their lives. The participants of the study are fromin EranadTaluk of Malappuram district of Kerala. In this research, the socioeconomic status indicates an individual's position in society which includes a combination of variables including their occupation, education and income. Thereby, in this study, the analysis of the scoio-economic factorsof the migrant labourers are of utmost importance in understanding their position in the society and its implications while they avail the resources.

Figure 6: Percentage of Inter-State Migrant Workers in Kerala

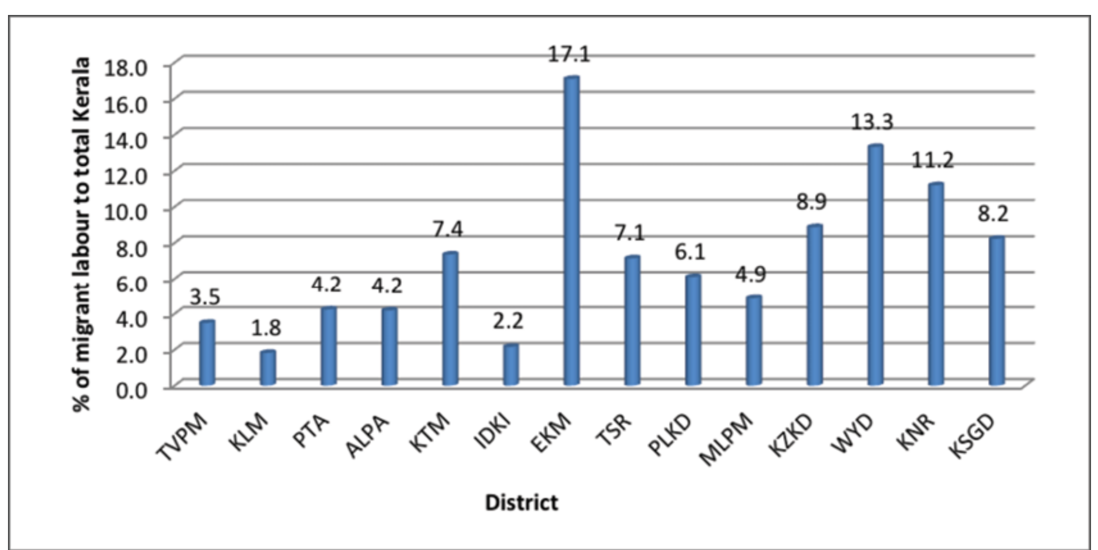
Source: Labour Commissionerate, Government of Kerala ,2016.

The Figure 5, illustrates the proportion of inter-state migrant labours from different states in Kerala during the year of 2016 (Government of Kerala, 2016); As per the report of

[13]kerala.gov.in/migration

Government of Kerala, Labour Commisionate the highest porportionof inmigrants in Kerala are from West Bengal comprising 46%; followed by Assam with 15%and third from Odisha 11 % (Ibid).

Figure 7: District-Wise migrant Workers in Kerala (%)



Source: Labour Commissionerate, Government of Kerala,2016.

Codes:TVPM–Thiruvananthapuram; KLM–Kollam; PTA–Pathanamthitta; ALPA–Alappuzha; KTM– Kottayam; IDKI – Idukki; EKM – Ernakulam; TSR – Thrissur; PLKD – Palakkad; MLPM –Malappuram; KZKD–Kozhikode; WYD–Wayanad; KNR–Kannur; KSGD-Kasargod

The above figure shows the total migrant labours percentage of distribution in various districts of Kerala. In that case,Ernakulam district employs the highest 17% of the total migrant workforce followed by Wayanad with 13%. Malappuram district where the survey for this study is conducted shares 4.9% of the total migrated population in the state.

From the data mentioned it is clear that in-migration from multiple states are happening to Kerala as well as all the districts are having labourers from other states working in the corresponding districts with varying proportions. With this overview the next section of the chapter looks into details of the social profile of the 16 study participants from

Malappuram district who works in the construction sector which is the largest job providing sector for the inter-state in-migrants.

Profile of the Respondents

The study emphases on 16 inter-state male migrant labourers who work fordifferentconstructionsitesunder the supervision of individualsmall-scale contractors. The table no 3 below is the illustration of therespondent'ssocial profile, were their age, religious identity, caste category, marital status, education, income, State of Origin and duration of stay in Kerala are the identified particulars.

Table 4: Socio-Economic Profile of Study Participants

S. No	Respondent's Name	Age	Religion	Category	Marital Status	Education Status	Income	Migrated from	Duration of Stay
1	Arumugam	45	HINDU	SC	Married	4th std.	20000	Tamil Nadu	15 years
2	Hakeem	28	MUSLIM	OBC	Married	12th std.	18000	West Bengal	7 years
3	Kamal	36	MUSLIM	OBC	Married	4th std.	20000	West Bengal	12 years
4	Akram	22	MUSLIM	OBC	Unmarried	12th std.	17500	West Bengal	4 years
5	Nadir	26	MUSLIM	OBC	Unmarried	8th std.	18000	West Bengal	6 years
6	Sayed	34	MUSLIM	OBC	Married	3rd std	20000	Assam	8 years
7	Razaq	36	MUSLIM	OBC	Married	8th std.	20000	Assam	8 years

8	Jamal	23	MUSLIM	OBC	Unmarried	7^{th}std	20000	Assam	7 years
9	Venkatesh	28	HINDU	SC	Married	10th std.	18000	Tamil Nadu	5 years
10	Tajudheen	29	MUSLIM	OBC	Married	4^{th}std.	20000	West Bengal	12 years
11	Kadir	17	MUSLIM	OBC	Unmarried	9th std.	17000	Assam	2 years
12	Aminul	25	MUSLIM	OBC	Unmarried	7^{th}std	17500	Assam	3 years
13	Ram	21	HINDU	ST	Unmarried	6^{th}std	17000	Odisha	3 years
14	Sudan Barman	26	HINDU	SC	Unmarried	9th std.	20000	West Bengal	6 years
15	Sanjay Barman	19	HINDU	SC	Unmarried	10^{th}std	17500	West Bengal	3years
16	Prakat	27	HINDU	ST	Married	4^{th}std.	18000	Odisha	8 years

Source: Fieldwork, 2017

In EranadTaluk male workers are predominant in the construction sector in comparison to males, of which only less than 10 percent among total labourers are comprised of woman (Government of Kerala, 2016). During the fieldwork, it was a difficult task tolocate women in the construction field. Due to this reason, the prime respondents for the study are males who fall in between 17 to 60 years of age. Out of the 16 migrant labourers, twelve ranges between the age group of 17 to 30, three labourers in between 30 to 40 and one labour is aged more than 40. The larger proportion of the labourers working in the sector of construction are of the age group 20 to 40 which cannot be generalised with a

sample of 16; whereas enquiry with multiple contractors has emphasised the fact that the age group preferred is also the same as the works involved usually required high physical labour. In a lifetime it is their most promising period, and due to poverty and monetary concerns,these individuals are forced to leave their loved ones and community behind in search of a job.

The religion-wise distribution of the workers shows that ten labourers are Muslims and are the only OBC category participants among them. The remaining six labourers are Hindus, of which four belong to scheduled caste and two scheduled tribe category, notable that all hindus are from socio-economically backward. It is also notable the study districts are highly preferred by the Muslim participants as Malappuram is a district with highest proportion of Muslims in the population and few among the Muslim participants were finding it easier for them to mingle with the community being a Muslim and were able to relate themselves to the surrounding religiously. Eight of the total respondents are married and the rest unmarried. Among the eight married labourers, four labourers have children. But none of the migrant workers is staying with the families; their families are back in their homeland. Out of 16 respondents, nine workers have a joint family system which to an extent supports the separated family members emotionally.While seven people are from nuclear families, during the interaction they all shared their concerns about their family members left all alone in the respective hometowns.

Case study method was chosen to conduct the research, among 16 case studies, selected five cases which explains the multiplicity and nuances of lives of the migrant workers in Kerala are elaborated in the following section.

Case study - 1

Arumugan

Arumugam is a 45-year-old migrant worker who is from Neyyarmalai of Salem district in Tamil Nadu. He has a medium size physiquewith6 feet height. He studied till 4th standard and dropped schooling due to the severe financial constraints at home. Arumugan'smother and father passed away years before; got married before the age of 20 and have two children. He has two sisters, who are married off and currently living with their husbands'. It was 15 years ago,he first came to Kerala, and before shifting to Malappuraminitially he was working as a daily wager in Thrissur and Palakkad districts.

For the past eight years,Arumugan is working in Malappuram under a construction contractor. Now due to his efficiency in the field, he can earn rupees upto800-900 per day. With these earnings, he is able to manage his food and accommodation and above that, he is ale to send an amout of 12000 to 14000 rupees per month to his home back in Tamil Nadu. The main feature attracted Arumugan to work in Kerala is the states comparatively high pay scale for its marginal labourers.

He states:

> *"...pay is significantly low in Tamil Nadu, and sometimes it is challenging to get a job.Everything in my place depends on various factors; climate, water, rain everything... But in Kerala, it is easy to find job and pay is high here."*

Arumugan increasing age was causing deprivation in his working capacity as per the participant. He used to load 300-400 bricks per day in his during his 20s and 30s, whereas, now he is able to carry a maximum of 150 bricks per day.

During the past 15 years, Arumugan has spent large part of his life in Kerala, and he very rarely he used to visit his home, which is a common factor among most the participants. Migration has disconnected him from his home, its environment, relatives and friends. In reparation of it, Arumugam has made Kerala a new home and struck a chord with local population. During this small period, he has earned respect here by acquiring good communication skills and working capacity. With the money he earned, he could not only maintain his family but also improve the living condition to a great extent. He modified his house and married off his two sisters within the short span of time. The education of his daughter is the most important factor driving him to stay back in Kerala away from his family and loved ones.

He lives in a single room in Malappuram town with one of his relatives. The room has water supply and toilet facilities. They take food at hotels as the owner does not let them cook inside the room. Taking food from hotels has increased the daily expenses of Arumugan a lot, which makes him work overtime even during Sundays, which ultimately affects his health as he is not getting enough rest most of the time. Initially, they found it difficult to follow the food habits in Kerala and later they grew used to it.

Arumugan reminds of his past life as farmer at home and how hard a life it had been. Continuous financial stress forced him to give up farming and migrate to greener

pastures. He was a man with no experience in construction activities when he migrated to Kerala. He felt discomfort at job sites especially by safety equipments. He avoided safety measures for comfort in the beginning, but started using them after his colleagues met with injuries. Injuries and diseases mean loss of income and additional expense at hospitals and for medicine.

Additional expense in any regard is a painful thing for migrants. They avoid such a situation at any cost. Arumugan explains how he normally does when he gets ill. He, like most of his co-workers, will consult a doctor or take medicine on their own if he feels not well. Medical shops in Kerala that does a doctor's job for uncomplicated illness help him save consultation fee and time. By doing so, Arumugan can perhaps save one working day. Although cheaper, Government hospitals are not normally preferred in less serious cases. But, Government hospital is a first preference rather than private centres in case of serious diseases that require admission to a hospital. Sometimes, they travel back to take treatment and rest to reduce expenditure. According to him, government hospitals in Tamil Nadu are comparatively cost-effective and easy to access. In Kerala, unmanageable crowd deters migrants from approaching the hospitals. Moreover, Arumugam has several experiences of discrimination in social spaces such as hospitals to talk about, in which locals condescend to him.

Arumugam is a firm believer of God and makes regular offering to Village deity, a speciality in Tamil Nadu villages, to ward off all the bad things. He believes that the Village Deity has been guarding him all these years away from home so that he is still able to work well.

When Arumugan was enquired about not registering in insurance schemes, he mentioned reluctantly in his local language that '*kadavulkappathiduve'* which meant 'God will save us in difficulties'. Despite having lived in Kerala and acquired language skills to communicate with the people, Arumugan is yet to enrol in any of the schemes offered by government of Kerala for the benefit of the migrants. He possesses all the valid ID proofs and documents to make him eligible for the schemes. Yet, ignorance delays it. When probed again during the second meeting with Arumagan, from his words, it is understood that the discrimination that he faces can be a reason behind this and he will be grateful if somebody could help him get the benefits from the government.

Case study 2

Sudan Barman

Sudan Barman is a 26-year-old unmarried male hailing from Cooch Bihar, West Bengal. He is slim and has 5.5" height. He always chews tobacco. He belongs to the joint family of a father, a mother, two elder brothers and their wives and two kids. He came to Kerala in 2012 in search of a better and stable job. His student-life ended with and he took a job on a farm only to discover later that what he earned was insufficient. He migrated due to the indebtedness of his family. His family has two *bhiga*landand they were leasing two more *bhiga*. In that land they used to cultivate mustard and for the cultivation his family bought loan from local money lender. Due to flood his family had a loss of everything andthey couldn't pay back the money. That became burden after that. So, Sudan and his brother came to Keralato earn more and repay the money.

At that time, Sudan was invited to Kerala by an old friend of him with an assurance that he could make a lot of money in Kerala. His friend took him to a place called Mundakodu in Malappuram district and later Sudan found work in different places in the construction sector. Four years ago, the wage in Kerala was below 500-600 rupees per day. Now he earns 800-900 per day in accordance with the nature of job. It is almost double the wages paid at home. Moreover, He could save about 12000-15000 rupees usually and not less than 10000 even in the difficult time.

According to Sudan, high wages in Kerala have helped improve the living conditions of his family. In the beginning, language, culture, people, places and everything concerning to Kerala was alien to him and he felt lost. Added to it, the family and people he left behind is too far to go back to frequently. Gradually, Sudan got accustomed to the nature and environment of Kerala and its people. At present, He is over-joyous about the better life he has presented to his family after coming to Kerala.

Sudan Burman's a day of work starts about 9 in the morning. Breakfast is usually taken at hotels and includes Roti and egg or Channa curry as rarely does he get time to cook food in the morning. Around 11 am, house owners provide him with tea and snacks. Burman's lunch comprises Rice, *Sabji* and any vegetable or fish curry. In evenings, he gets tea again. Dinner dishes are prepared by himself in the room. He usually makes rice, *Sabji*, and vegetable or *daal*curry. Fish and Chicken find a place in his menu once in a week

and Mutton twice in a month. Burman like any of friends from his part of the country prefers cooking to taking food at hotels in Kerala. It is because they do not like the flavour of ingredients such as coconut oil and tamarind.

According to Burman, the local people have been kind to him though there are exceptional cases of moral policing. He shares incidents of intimidation and questioning from some people. But they form only a minority and all others are good towards him and his people. Burman's working hours span from 9 am to 5 pm on normal days and during summer, the working time is between 6 am and 2pm. After work, He retires to room in Kootilangadi, 2 Kms away from Malappuram and joins with friends for evening chat and cooking. Burman shares his room with two others. He uses water from the municipal water supply for cooking. In the building where he resides there is only one toilet available for 10-12 people living there.

Burman is a person who is all the more concerned about his health. He understands that he can continue here only till he works hard. Hence, he cares much about the health but not without checking expenditure on that. He prefers to go to Co-Operative hospital in Malappuramso as to avoid the exploitation at private clinics. Self medication and Ayurvedic medicine are other means of treatments he is inclined to. A year ago, he was admittedin a government hospital due to fever. It was his contractor who came for his help, took care of all communication for him and settled the bills. Burman has been unable to do offering at temples nearby as a part of his belief to get rid of diseases because the priests here do not understand Hindi.

Burman remembers his initial fear for heights. Now it has significantly gone down. Moreover, safety measures taken care of by the contractors bolster his confidence while working at heights. In his opinion, the working environment in Kerala is not exploitive in naturethough occasional shouts are thrown at them by supervisors to accelerate the speed of the work. He felt that the people of Kerala are generally good and not greedy like his native people who fight for money. In public facilities too, Kerala stands far ahead of his native town. Tarred road is a luxury for them and transportation a difficult task.

Climate is also a reason why Burman remains in Kerala. Kerala is endowed with a balanced climate conducive to construction activities. In Cooch Bihar, the temperature varies in great degrees and climate is at its extremes in all seasons.

Burman has aadhar card and identity card in his possession. His ration card is with the family. He had been a beneficiary of BimaYojana while at home. As of now, he has not enrolled in any schemes here and filled up enrolment papers with the help of contraction to avail government health insurance scheme. Waiting for the approval from the agencies, he is in the hope that government support will be of great help to him to meet additional expenditures.

Case study 3

Kamal Hassan

Kamal Hassan hailing from Burdwan district of West Bengal left home for Kerala 12 years ago. He is 36 years old now. He belongs to a family of mother, two brothers and a sister. His father abandoned his family when he was only 11. He dropped education after 4th grade and joined his mother in the fields to help his family. At the age of 17, being the elder son, he took up responsibility of family and moved to Bangalore mediated by an agent for construction work, where he earned 200 per day. Later, he was informed of better job prospects in Kerala and he, at 24 now, migrated to Kerala. He has been working in Kerala as mason for 12 years and gained skill in plastering. His daily income amounts to 850 rupees in contrast with 400 rupees he may have received at home. In farming, a day's work brings only 300 rupees.

Kamal's life is overturned after coming to Kerala. He has been able to save 15000 rupees per month that have changed the situations at home. He has put up new concrete house in place of a mud shackle, married off his sister and brothers and found out a partner for himself. At present, he is content with his family and his two children. Kamal visits home every year and spend two months before rejoining for work.

It was in Thrissur district Kamal was first assigned to a work. Then, he moved to Malappuram. He loves the peaceful environment in Kerala and good nature of local people. He lives with 4 others in a single room. But the conditions in Kerala are better than in Bangalore. Here, he gets time to watch films with friends. He is a habitual smoker but stays away from alcohol or any other forms of drugs.

Kamal is a skilled mason and gets regular work. He has only good experiences to share about the places he worked in Kerala. Nowhere has he felt he has been side-lined or

discriminated against. Health is a matter of great concern to him. He takes medicine from a chemist shop whenever he feels ill or rather consults a doctor in serious diseases. In hospitals, he has been undergone discriminatory treatment and exploitation. One such incident occurred at a private hospital when he sought treatment for stomach pain. Tests were carried out only for minting money from him and the next day, he was perfectly alright without medicines prescribed.

Case study 4

Ram

Ram comes from Odisha and is just 21 years old. Having lost his father, he takes care of his mother and a sister is married off. Their property had been confiscated forcefully by a local money lender for not paying back the money they borrowed from him for his sister's marriage. They moved to a house of a relative. When agricultural labour became insufficient to pay back the debts, Ram migrated first to Banglore and then to Kerala.

Arrival in Kerala has changed the face of his family. He is able to save 10000 rupees a month and repay half the loan amount by now. He earns 700 per day on an average. To him, Demonetisation has been a blow because construction activities came to a standstill and job opportunities fell drastically.

Ram arrived here five years ago with no proficiency in either Malayalam or Hindi. He has gone through several hardships owing to this. He is taken as a yet another Bengali and called Bengali *Bhai* derogatorily by local people. To Malayalees, all Bengali and similar language speaking people are Bengalis only. Even in such an adverse situation, he was able to get work and save good share of money for the family.

Ram says that he was very slow to interact with the native people because of the fear triggered by the lynching of migrant by a group of people. The news spread through WhatsAppandpeople like him were terrified by the incident. He was also scared of the visits of the officials and police at their living places. According to him, culture and language hold Keralites and his people apart. He does not like chappathi baked with coconut oil. To avoid coconut oil, he cooks roti, chaval, dal and sabji for himself.

In the past 3 years, Ram got ill several times, especially during monsoon and once he was admitted to a government hospital for 4 days. He paid the money for his treatment at that time. In another incident, his friend met with an accident in the worksite and his legs got fractured. Their contractor helped them in paying the bills for operation then. Ram is of the opinion that Medical service is excellent here nevertheless the high cost incurred. He relies mostly on Co-Operative hospital in need of detailed consultation with a doctor. Otherwise, he will neglect the small disturbances and discomforts in the fear of losing wages. The practice of wearing amulet powered by *Manthras* from local *sanyasins* or temples to keep diseases and hard luck at bay is difficult to continue here as the worship system is totally different here.

He stays in a room with two others in which one is his cousin. They cook food using pipe water and the house has toilet facility. Ram works under Sundar (name changed) the contractor and gets work everyday, especially at residential building. His initial fear of heights has gradually reduced. He is happy that potable water is supplied at the site. More than that, worker show unity irrespective of all the differences they are born with to make the working environment a place of friendship and happiness.

Case Study 5

Razaq.

Razaq, 36 years old man of Assam origin, migrated to Kerala 8 years ago. His parents died earlier leaving three sisters and two brothers with him. His schooling was blocked when he was in 8th standard due to poverty. Part time job in a hotel in Guwahati along with schooling did not help him much so that he left for Kerala to make money. He served a small stint as a cleaner in a hotel in Calicut. Later, he worked at different construction sites in Northern Malabar before got settled in Manjeri 4 years ago. After working under a contractor for a period of time, Razaq started taking subcontracts.

In his second year in Malappuram, Razaq fell down from the terrace during work and his left leg got fractured. Since he had no money or helpers to look after him, he was sent home by the contractor. It took 8 months of rest to recover and he got back to continue with the same contractor. He says that he was not aware of the any government schemes or insurance for them.

Razaq is a religious person and attends Friday *Namaz* and religious festivals without fail. Because of this, he is connected to the people. People like him for his extraordinary skill at cooking. Last year, he married a native woman he fell in love with at a work site with the consent of her family. Now he stays with her in rented room in her place.

He mastered the skill in cooking during his stint at hotels in Assam and Kerala. Encouraged by Malayalee co-workers who enjoyed his preparation, Razaq opened eatery shop with the help of friends. The eatery sells tea and north Indian snacks earning him fair amount of money. Along with that, he undertakes small sub contracts and employs some migrants.

Police and other officials conducted raid in his labour camp and there were some inhabitant with no valid ID or with fake ID. The incidents alerted him and he became very conscious of the documents. He has Identity card, Aadhar card and driving license and he keeps them always with him to police interferences.

Razaq's service is sought in case of any tussle between local people and migrants. He is able to solve the issues between them. It was Razaq who settled a recent fight between a migrant and an auto driver over fare. He wields a great influence among migrant workers in the area.

Social status of the migrant labour

Educational status of the migrant labour

Education is one of the major measurements of the human development. Educational status determines the work opportunities and status of the migrants in the host society. Also, the education status gives opportunities to the labourers to find jobs that pay more than what is paid for an uneducated even though every job has its own dignity. All the migrant labours has received education. The educational profile of the participants ranges from primary education to matriculation (plus two). There are 5 people who gotonly primary education and three got upper primary education;whereas, six went to high school, and two gained seniors secondary education. This part looks into the educational status and changes in job opportunities of the migrant labours.

The respondent Arumugam who is 45 year old person hailing from Tamil Nadu having 15 year vast experience in Kerala. He is highly skilled mason worked and lived in various places in Kerala mainly in northern parts. Arumugam said

> *"I studied till 4th grade. I got married at 20. I have two children; one boy, and a girl. My motherandfather areno more. I came to Kerala 15 years ago… four years ago, to Malappuram. Since then I have been working here in the construction sector under one contractor."*

Arumugam is a main mason working in construction sector under various contractors in Kerala. He got only primary education, and since last year he has been working as mason without any changes in his job profile. Low Educational status and lack of job opportunities leads to the migration to the Kerala.

Whereas another 28-year-old respondent Hakeem a resident of West Bengal who is currently working in Eranad Taluk of Malappuram district as construction worker states that:

> "*I did my schooling till 12th standard, and later on began to help myfather in the field. After two years it is from my uncle, I came to know about the job Opportunites in Kerala and the good pay. So I decidedto come here for a betterliving.For the past seven years, I have been working as aconstruction worker in Kerala."*

Even after completing the secondary education due to poverty he was not able to continue his studies and was forced to work with his father in the agricultural fields. From his words, it is clear that even people who live in the other tip of India are aware of the employmentopportunities in Kerala. The significant fact attracts the migrant labourers is the wage. In otherparts of India especially in the northernside, the pay is very less for the marginallabourers. He further adds:

> "*Now I can speak Malayalam, and with the help of a Malayalifriend, I got a job in one of the finest hotels in Kozhikode. Since the food and accommodation are free, I can save more money. It happened because of this job honestly… my studies helped me to get this job.*"

Hakeem came to Kerala as a construction worker, but his educational qualification aided him to pursue a career with better pay and living condition.Thisinfers that the migrant labourers can geta less physical stressfull job in Kerala if they are educationally qualified. In Kerala, there is a general understanding that most of the inter-state migrant labourers are construction workers or are engaged in works which are more hazardous and

physically more stressful. But this statement of Hakeem proves it erroneous, if you have advanced skill and technology with a suitable educational qualification then in Kerala the workers can get other jobs, which in the process will help them to earn more money and thereby to build their living condition better.

Another respondent from Burdwan in West Bengal is Kamala a well-built- tall person who is a construction worker living in different parts Kerala for more than a decade. Compared to other migrant labours fluently he can speak Malayalam. He says:

> "*I started working when I was 12, and now I am 36-years-old. I dropped out of schoolwhen I was in my 4th grade. My parents were not able to support me at that time. So, I started working to support them. I have five siblings, and I am the second eldest in the family. So,financially it is my responsibility to take care of them. For some reason or the other, I was unable to continue my education. But it is a promise to myself that I will provide a good education to my child.*"

This statement by the respondent shows another essential feature of the migrant labourers.The workers are migrating to other states due to their poor living conditions at home. The hardships in their family have forced them to look for a job which in due course of time had led them to dropped out of schools. But they are aware of the importance of education and are determined to provide proper education to their younger ones.

Akram who is living in Kerala for the past four years is one of the youngest respondents from West Medinipur in West Bengal. He is working as a construction site helper, he says:

> *"Iam 22-years-old and continued my studies till 12th standard. I do enrol as a graduate student in a college, but due to some reasons, I couldn't complete mycourse. I had to drop out of my college and started working as a salesman in my native town. For that job my salary was meagre, and I needed to make some quick money as soon as possible. And it was through one of my friends I came to know that in Kerala the wages are comparatively better, so I just came here. Now here I am a construction worker can get 800 rupeesperday. With the help of that money I am doing a distance graduation course."*

Some workers are forced to leave their dreams and hope to get a good pay even the job condition is adverse. But they are not ready to give up their passion for studies. Akram is one such example.

Most of the respondents commented that it is the better wage system in Kerala attracted them to migrate. While analysing the educational condition of the migrated labours,one narrative derived that workers with less educational qualification are entitled to continue the same job for many years. But respondents with higher educational qualification are promoted to other jobs with higher pay and more facilities. The commonest factor among most of the participants in the study is that debt was an important cause which has pushed them to migrate to Kerala parting themselves away from their loved ones. On the other hand the economic constraints faced during their early ages of life forced many of the participants to discontinue their studies. Only two out of the 16 participants has attained higher secondary education, of which one participant has achieved a change in the status of the work he has been doing and the other one is trying to continue his higher education through distant education facilities. While Akram was trying to attain higher education through distant education, he emphasises the fact that the job which he was doing back home was of a sales man, but the wages in comparison to the construction sector he is working now was much lesser back home. Almost all participants reflected on their misfortune of discontinuing education but were particular about making sure that their children get proper education as mentioned in the narrative by Arumughan and Kamal during his case study.

Social life of the migrant labours

Socialisation is an important factor for an outsider in his new environment. The language, culture and other factors make the migrant labours more vulnerable and feel being excluded. But most participants of the study have shared a different opinion about their socialisation with host community. Arumugan45-year-old migrant worker from Salem district in Tamil Nadu, one of the eldest participants, says:

> "*…this is my 15th year in Kerala. I worked in different places. Only a few times was I offended by the local people otherwise they are good… I have good friends here and they helped me once financially. Most of the Malayali people know Tamil and so I am able to talk with them easily… before 5 years I was able to bargain my wage compared to Bengalis who could not… because I know Malayalam.*"

The fifteen-year experienced respondents say that language is one of the primary determinants of socialisations. Since he is good at the locallanguage, he can bargain for a better wage and couldcommunicate with the local community. Thereby he is capable of developing a sense of camaraderie with the locals.

Another respondent is a staunch sportsman, the 26-year-oldNadir who also havean athletic body, according to him:

> "*Onweekend days I used to play football with my friends in the local area. Thereby I madesome good friends from the field. Now I have lots of Malayali friends. They used to invite me tofunctions at their home.*"

Nadir used to play football every weekend close to his apartment; it is a placewhere he makes friends, most of his friends are natives. From college students, shop owners to government officers, the list goes on. The respondents have stated that sports and other recreational activities are some of the other aspects which promote social integration among the migrant labourers and the native community.

A34-year-oldrespondent from Nagaon district of Assam, Sayed said that:

> "*For the past eight years after work for namaz, every evening and Friday afternoon I used to go to the masjid for Juma. Thus in the community, I am a familiar face also people in this locality often used to invite me for their religious functions, without any hesitation, I used to participate in most of the functions organised by the masjid.*"

From Sayed'swords, it is clear that religious beliefs and practices are another factorwhich contribute towards socialisation. His eight years of bond with the natives in the communityadvances due to his affiliation with the masjid. During the study, threerespondentsmade the same statement that their religious practiceshave helped them to integrate with the community.

Razaq, another respondent who came to Kerala in search of a job is now a permanent resident. Eight years beforehe came to Kerala and worked in different parts of the state is finally settled in Kerala. Also with the support of the community and little savings from his previous job as a construction worker, he had started a small eatery shop in the locality. He said:

> *"I came here eight years ago and started my career asaconstruction worker. I like cooking, and sometimes I used to cook at the worksite. Some of my colleague from Kerala liked my Bengali food. Because of their encouragement, my passion for cooking increased. Then two years later, I started my eatery shop with the help of those colleagues. Now I am settled here and got married to a Malayali girl; she is a native of Manjeri."*

The above cases describe that how language, culture, peer groups and religionhas becomea helping factor in the integration of migrant labourers in Kerala. Arumugamfrom

Tamilnaducan communicate in Malayalamwhich in the due process benefited him to bargain for higher wages with the contractors. Due to his language fluency in some work sites he is competent to demand more wage compared to other migrant workers. But in the case of Nadir, it was peer group, and for Razaq it is his religious identity and beliefs. Therefore, contact with the local people has led to the assimilation of various attributes of the locality that in turn made social integration a possible reality in Kerala.

Language was found to be one among the most critical barrier in socialisation of the inter-state in-migrants in Kerala. All the migrants in the study are actually from non-Hindi speaking states of India. But on the other hand while in Kerala, Hindi is used among the locals and migrants for communicating largely. Many a time both the people do not know Hindi. Over the period of time they have been learning Hindi on one side and the migrant people starts learning the local language of Malayalam. The way in which Hindi is homogenised as the language of migrants has to be considered seriously while considering socialisation of the migrants.

The othering of migrants especially those who are involved in manual labour by calling them 'Bengalis' is a general phenomenon in the area, which is also an identity issue faced by the migrants. Ram from Odisha says

> "*…they call us Bengalis. I am not from Bengal. Still they call us Bengali. They are making fun of us. They are making of us… even in hospital they call me Bengali bhai. I feel uncomfortable."*

New migrants are facing ostracisation in multiple ways as in people looking at them doubtfully especially during the initial days were concerns of the participants. They are worried about even incidents of lynching at times.

Hence multiple factors cause hindrances in socialising for these interstate migrants especially during the initial days. The participants acknowledge the fact that good socialisation happens mostly with the local inhabitants and they are happy with the way Keralites mingle with them and help them over the period of time as discussed in the initial part of the session.

Economic status of the Migrant labour

Income of migrant workers from construction work

Better and consistent wages is one among the most important factor that attracts in-migrants to Kerala. High requirement of workforce in the unskilled sector and high payment for the job compared to their own home place have pulled them in to Kerala. Field study warrants that the economic status of the migrants improved after their being in Kerala.

Jamal is just 23-years-old and is coming from Nagaon district of Assam. For the past seven years, he is working in the construction field and earns 900 rupees per day. His stopped his schooling after 7thstandardand came to Kerala for the first time at the age of sixteen. He adds:

> *"As a Mason depending upon the work, I am earning 900 rupees per day, but in our hometown, we get only 450 to 550 rupees maximum for the same work we do here. In Kerala, we are getting more compared to any other place. Every month, I send 12000 rupees to my family. It may go upto 15000 and sometimes only 10000…depends on work…"*

Jamal gives a clear picture of the wage difference in both the states for the same type of job. Per day most of the experienced migrant labourers earn up to 900 rupees and send 10000 to 12000 per month on an average after their individual expenses. And very skilled workers are able toearn 20000 rupees per month depend on the work they get.

Another respondent is 28-year-old Venkatesh, from Tamilnaduthe nearest state of Kerala, he is always concerned about his family. He says:

> *"After coming here I could manage the 'kaasuprachnam' (financial problems) at home. I am sending more than 12000 every month to home…am able to look after my family now(he smiled). I am the only son in the family.i take care of them and they are happy…that's my happiness. I am sad staying away from them. Now my wife is there to look after them... I will always take care of my family. I want my parents to take rest properly.Family is everything.Sometime my wage is not enough at times… but my contractor helps."*

Compared to other respondents to this migrant labourer, the family is his strength. He can overcome any odds in his worksite because of this strength. One of the commoninferences from the cases mentioned above is that; the workers are coming to Kerala due to some particular factors. Most common is the higher pay but other than that

well-being of the family members, education of the children are some of the other aspects.

Tajudeen, one of the respondents fromDibrugarh district, Assam is 29 years old married man. He came to Kerala and is working in the construction sector since he was17 year old. Tajudheen shared the same opinion like Jamal and Venketesh.Tajudeen said that

> "*I came to Kerala 12 years back, when I was 17 years old. Since that time I was working in the construction sector. Mainly, I do plastering. Here we are mainly for this job. In our village, I used to work in the paddy fields. Here I am getting 850 per day but at home I would hardly get 400 rupees. Farming would give only 300. Now I am able to send home average 15000 per month. They are happy out there. So I am herehappy*."

With more than one decade being a migrant labourer in Kerala, Tajudeen gives the comparison of the jobs and wages in his place of origin and host place. In Kerala Tajudeenis earning 20000 rupees on an average per month from the construction work with 12 year experience. He is skilled worker and able to send in around 15000 per month to home after his living expenditure in Kerala. The loss of the jobs, less wages in agriculture sector and better employment opportunities are main motivations for in-migration in India.

The study reveals that most of the migrant labourers constitute the productive age group of 18 to 35 years and are males. The migrants, mostly, belong to the socially and economically deprived section such as scheduled caste, scheduled tribe, and other backward class community. The loss of traditional jobs and low wages are known to have push factor which made them migrate to Kerala. The participant's educational profile is ranging from lower primary to class twelfth. The labourers earn 700 to 900 per day and send home remittance worth 12000 to 15000 per month. The remittances change their family as well as the community situation in home town.

Indebtedness and land holding of the migrant labours

The main motives of the migrant labourers are economic improvement and repayment of the debt due to various reasons: Indebtedness due to dowry, illness, and agricultural loans. This debt burden and low wages compel the labours to migrate places like Kerala where the wagesare better. Among participants, ten workers migrated due to the debt of family in their native places.

Most of the migrant don’t have lands. From their responses it is understood that there are 8 people who possess land property in their respective places. Three of them bought their own land post migration period. In that 4 of them have 1 to 50 *bhiga* lands, three of them have 50 to 100 *bhiga* land and only one has above 100 *bhiga* of land. Remaining 8 people don’t own any land property.

One of the participants Sanjay revealed about the indebtedness situation due to the agricultural loss and that become a push factor to migrate to Kerala. Sanjay is 19 year old person, living with his brother Sudan in near to Malappuram town. Sanjay migrated to Kerala only 3 year before and he is working in construction sector to repay the money. Sanjay said,

> “*…family has 2 bhiga land and we leased 2 more bhiga in Mekhliganj. In that we used to cultivate mustard and we bought loan from local money lender. Due to flood we lost everything and we couldn’t pay back the money. That became burden after that… me and my brother came here to earn more and repay the money”.*

In 2009 there is flood in Cooch Behar district in West Bengal. In that flood Sanjays Family faced loss in Cultivation and that leads them into Migration to Kerala .Itclearly shows that the how the debt became a reason for the migration. Loss of job and loss in agriculture sector also become reason for the migration.

The indebtedness push workers to migrate to different places to repay the money and get the free the indebtedness. Prakat is 29 year old labour from Bargarh District in Odisha has another story to share,

> “*…we don’t own any land...we used to go for work in a farm field in Kharamal. There, wage was less as 70 -100 rupees. Three years before my father got paralysed... for hospital and other expenditures I couldn’t pay money... so I borrowed money from the farm owner. I couldn’t repay even after three year. To clear those loans, I came here*.”

Prakat is migrated to Kerala due to low wages in his place and indebtedness because of the health expenditure of his father. The Health expenditure makes many of the deprived sections more vulnerable economically. Most of the migrants seek livelihood in other places due to debt.

But in some other cases after the migration changes the destiny of the migrant workers who are marginalised. Migration is a process that may uplift the status economically. Kamal said *“Before my family did not have any land…after coming here I bought 20*

decimal land... and I built my own house there. My family is happy there. Kerala changed my life." Before coming here his father abandoned his family, so as elder sibling he have to take care and support so since his 12 year age working in field. Poor economic condition pushed him to become a migrant labour. Here the migration changed the life of the labour. Everyone dreams of own place and home in India. Like Kamal's, many lives changed because of the migration.

Occupation, working and living condition of the migrant's workers

Occupational status of migrants

Loss of jobs, low wages, family debt, failure of agricultural crops are main push factor to seek job opportunities in India and at the same side better wages, sustainable job opportunities, peaceful social atmosphere become the pull factors drawing people to Kerala from other states. Migrant worker Prakat hailing from Odisha said

> "*Before coming here, I used to work in farms. And the wage was very less that time. Then my neighbour told me about opportunities in Kerala. I came here 8 years before and since that time I have been working in house construction. Now, I am working as a mason and earning a fair amount of wage under my contractor."*

Prakat is belonged scheduled tribe and he is from Bargarh District in Odisha before migrating to Kerala he used to work in the field for 70-100 rupees per day. The neighbour of him become source information about the job opportunities in Kerala and he moved to the Kerala. Now he is earning 800- 900 per day and able to send 12000 to 15000 per month. The low wage in agriculture sector and information about better job opportunities and wages helped to pursue the job in Kerala.

Another respondent is 25 years old Aminul is coming from Nagaon district in Assam. He did the schooling till 7th class and discontinued due to the family economic crisis. He migrated to Kerala before 3 years. Aminul said,

> *"One of my friends advised me to go to Kerala where I could find job and enough money. That friend worked here in Kerala that time and I came with him. Before that I worked in the fields in Kaliabor for low wages 300 rupees and that was not helpful to meet the family's economic needs and I didn't get enough money from that job. Main reason for coming here was the lack of job availability in the home town and also some economic problems in the family. When I came here, I used to go to any job which was available then. After one year I started working in house construction. Currently I am working under one contractor*".

Aminul worked for 300 rupees in his home place in Assam. The money he earned out there is to not enough to meet the family End. Now he is able to earn 750 per day for the work in construction in Kerala. Family Friends neighbours and family members are the main sources of the information about the jobs and network for the migrant labourers. The family debt is the reason of this participant migration from his home place.

Another migrant worker hailing from Odisha , his name is Ram and he able to earn 700 rupees per day. He is worked in Bangalore before moving to Kerala.

Ram said that

> *"Before coming here, I worked in a construction company in Bangalore.the working conditions were challenging and scary there. One of my friends told me about cable work here in Kerala. So I joined him and came here. After cable work contract, I started working in house construction sector here as mason and conditions here are better than other places".*

Due to unsafe working condition he moved from Bangalore to Kerala.Through the network of the friends and family, the migrant labourers are able to find better opportunities for them. Here the working conditions of the former place are pathetic according to the participant and that is the main motivation for him to change the job.

Construction sector is one of the largest unorganised sectors that absorbs major share of the migrant workers in Kerala. While most of the construction jobs are categorised as skilled and semi-skilled, most of the labourers are involved in the semi-skilled or unskilled works. The payment for the semi-skilled work starts from 600 rupees to 1000 rupees with extra payment for extra work time. This wages are moderately high in Kerala, according to labourers who did the same jobs in different parts of the country.

Working and living condition of the migrant labour

Most migrant labourers live in groups in rented buildings or rooms. A single room is often shared by 5 to 8 people and rent per person ranges from 500 to 800 per month. Some of the workers live in the work site itself. Toilets are common for most rented buildings and they cook separately within the room itself. Most of the room are congested with out any proper ventilation. The condition of the workers who are staying in working sites is quite unsafe. Continuous contact with harmful contents like cement and metals makes them unhealthy living condition

Moreover, the safety measures in working site are mostly found only in records. In their view, the working conditions in construction sector especially in small constructions like house construction are comparatively better. Protective measures are not taken seriously by the contractors and in most cases, the required standards are only superficially maintained so as to get the clearance from authorities. Situations like continuous contacts with cement and other construction materials make them quite vulnerable to diseases.

The respondent Aminul, 25 year old from Assam and living in Kerala more than 3years in Kerala said about the living place,

> "*…we are living in rented room near Malappuram. For each person we have to pay 600 rupees per month and five people are living in my room. Two of them went for leave… we are used to cooking in our room itself. Two toilets and two bath rooms are here for four rooms. We used water from the pipe connection and we use the same water for bathing and cooking.*"

Each Migrant worker has to pay minimum 500 rupees for the room rent. In one room there will be minimum 3 people live. Moreover they have to cook in the room itself. Overcrowd and cooking in the roomitself make the migrant worker living condition become hardship. This amply shows the average living condition of the migrant labourer in Kerala. Another respondent Kamal who has lived almost 12 years and have vast experience in Kerala said

> "*Rooms are congested... in one room, 5 of us are living although the space is not enough for more two persons. In the same room we have to cook and sleep and we sleep on the floor itself... we don't have any other options because we have to save the money."*

For saving money the migrant labours usually share the room. Here Kamal said about the living situation. This answer shows that the migrant workers live in an overfilled room even though the rooms are good. They sleep on the same floor on which they cook.

Another respondent Jamal is young but spend his 7 years in Kerala and he revealed that they used live in the construction work itself to save the money. Jamal said

> "*…you can see how we are living here. Most of the time we live in the work site itself. We don't have any problem for that and we don't have to pay the money to our contractor nor the owner of the building. At the same time, we are giving the security for the construction equipment and building materials. A few times we have to work at night also. So it is better to live in the work site itself... we sleep on the floor itself and cook in the same place."*

Here these words show that migrant workers are used to live in the work site also. The main reason behind this is that they don’t have to pay extra money towards the room rent and they can save some amount.

As same as living places congested, the work condition also hard for the migrant workers. The continues exposure to the building materials and dusts make migrant workers affected by physical injury and other hardships, one of the respondentArumugam said,

> *“We rarely use any gloves or any other protective measures when we work in the construction site. Because some time that kind of things are so disturbance for me… I have rashes and itching on my legs and a hand, which, I think, is the result of over exposure to cement.*”

Here the participant doesn’t care about the safety measures because of the personal choice. But he himself is conscious about the concrete substances causing diseases. Another respondent Tajudeen shared,

> “*…when I started working in this field. Initially I was frightened because of the height. So I used to tie the rope around my waist. Then working in heights has become a routine. Still, I wear rope, if the work is at more than two floors above.”*

Here the migrant worker is aware of the safety measures in a working site and their usage. Most of them use safety objects only if they feel there is more risk like falling from height.

According to migrant workers, working conditions in small constructions field are better when compared to big constructions sector. Safety measures are not well maintained but most labourers prefer to wear and use the protective measures as and when they feel so. Living condition is still a problem for the labours due to congestion in many rented rooms. They are more susceptible to various kinds of diseases.

The chapter elaborated on the socio-economic profile of the participants who were 16 male migrant workers working in construction sector, who migrated from the states of West Bengal, Odisha, Assam and Tamil Nadu. The chapter also discussed multiple factors that led to migration. The chapter has addressed certain critical nuances of the changing lives of migrants in the state of Kerala during their post migratory phase of life. Ten of the respondents belong to Muslim and others to Hindu community. Eight of them are married, but none of them are living with family in Kerala. The first section of the

chapter analyses the social status, economic status, working and living condition of the Migrant workers.

The social status includes the educational status and socialization of the migrant labourers with the local community in Kerala. Their profiles state that five people received primary education, three got upper primary education, six went to high school and only 2 gained senior secondary education. The responses of the participant reveal that those who attained a better education can get jobs in various sectors from construction to hospitality. There are plenty of job opportunities for migrant workers in Kerala in different sector. But social integration is a very slow and difficult process. When the difference in language and culture distances migrants from the Keralites, a few things like participation in religious rituals and sports activities help them integrate to the local community.

Majority of the respondents moved to Kerala in the hope to payback the debt that system of dowry, illness and agriculture have inflicted on them. Better wages and social conditions in Kerala are other attracting factors. In Kerala most of them earn minimum 700 rupees per day and saves average 10000 rupees per month for the family. Migrants mostly live in clusters in a single congested room or at work sites and cook food in the same place. Sanitation facilities are not sufficient and hygiene is a problem.

The works the migrants are exposed to involve danger and risk and the working and living environment is seen to be dirty enough to spread diseases. Migrants habitually live a secluded life and do not come in contact with natives regularly. The narratives as well as themes explored in the current chapter points towards the fact that homogenising all inter-state migrants as one category in highly inappropriate; whereas certain generalisations can be made out on the other side. Higher wages and better working conditions with savings to look after their families are the common factor making them migrate to Kerala. In-spite of facing multiple difficulties during different phases, they are able to find a space of their own in the society over the period of time and socialise. With this understanding the following chapter tries to understand the barriers the participants face to access healthcare services in Kerala. The following chapter will also try to understand the issues faced by the healthcare providers in addressing the health issues of migrant workers.

CHAPTER 5

BARRIERS TO ACCESS HEALTH CARE SERVICES IN KERALA

Migration is considered as a livelihood strategy. People migrate for a better life, education and protection from hazardous situations. However this would be different, when deprived people migrate; often having to face more vulnerabilities(UNDP, 2009). Derose et al(2007) pointed out that "vulnerability is shaped by many factors including social marginalization and lack of socio-economic and societal resources." The migrant populations who are underprivileged face difficulties due to various reasons in the host society. They face difficulty in different domains of their life. Studies like that of Ajith Kumar (2011, p.5) describes how "vulnerability of the migrant arises because of living in a place which is different in culture, language, social locations, no legal protection, lack of entitlements, different consumption habits from their native place and the loss of the traditional support system they enjoyed before migration" (Kumar, 2011). The study draws out how these dissimilarities influence their daily life when people move from one social location to another.

Migrants are treated as minoritiesin the host society in comparison to the local population. Certain studies that deal with the question of ethnic disparity(Betancourt, 2003) thatdeal with migrant labourer's access to health sector show that members of minority groups suffer disproportionately in comparison to the majority host population due to their socio economic disadvantages, lower level of education and suffer more from diseases and other health conditions. The study further points out that migrant labourers work in environments with much higher occupational hazards than the majority population.

Migrants face several structural and individual level factors in the destination society that have been linked to either facilitating the receipt of high-quality care or becoming potential barriers to receiving such care in health(Regina *et.al*). These factors do not operate in isolation but in clusters (e.g. income, minority status, gender, distance to health care providers etc.) working together to determine one's access to health care (Regina *et.al*). There are certain other barriers to the access of health care for migrants like communication style and attitude of health personnel that greatly affect the quality of services (Elzbieta*et al,* 2016). Ahluwalia (2016) elaborates further on the situation describing how multiple barriers as in lack of knowledge mainly about public health

provisions, longer waiting time at the available health care facility, distance of the facility, inconvenient working hoursalong with unavailability of drugs and medications act as further deterrents to health care services for migrant workers. In this purview, the following sections discuss the access issues faced by the migrant workers in Kerala in accessing healthcare facilities.

Difference between the Kerala workers and Inter-state Migrants in Kerala

There is a significant difference in the aspect of 'vulnerability' between the Keralite workers and migrant interstate workers and the major problem faced by the migrant worker in Kerala is the non-accessibility to health care. There are several government and non-governmental organizations however trying to address this problem with targeted interventions. This chapter deals with the main barriers faced by migrants workers to access health care services and also the obstacles faced by health service personnel's to provide service to migrant workers in Kerala.

Language barriers to access the health care service

India is a multi-lingual country and embodies a number of languages and cultures. The 2011 census of India states that, there are 122 languages spoken by Indian people. Among these are 22 major languages each spoken predominantly in differentregions. The division of the country into states in 1956 was done on the basis of these linguistic boundaries.Narayan says that "each state has numerous minority groups whose mother tongue may differ from the official language of the state" (Narayan, 2013). Each language has a number of dialects and regional variations which might not always be mutually understandable (Narayan, 2013). These variations not only acts as hindrance to the migrant workers in their access to health sector but also as affects communication among migrants from various regions and had also posed great difficulty to the researcher during the course of the study while collecting data from various sections of labourers.

Varennes states that "living in host states where they (migrant) may not master the official language(s), are unfamiliar with the workings of the legal system and administration, detached from traditional support and family networks, exposed to a society with ways of life or cultures they may find at times alien and may face trials that can leave them disoriented and disturbed" (Varannes as cited in Ajith 2011, p.5). The migrant workers in Kerala travel a long distance to reach the destination in search of

employment opportunities. The dominant spoken language and social settings are unfamiliar to almost all of them and these language barriers create obstacles when they approach health care facilities. Works like that of Malsumi further draws out how language and cultural differences also may become a possible source of bias in self-assessed health comparison between ethnic groups (Malsumi et al., 2010). These studies points out that most of interstate migrant workers have felt these alienations in their new environment and are very evident when it comes to health sector. These language barriers are greatly responsible for serious ignorance among migrant workers about local health facilities and health care treatment.

The narratives below are examples of how language acts as a barrier to health care services among migrant labourers. It's about a soft spoken and shy workerSayed (name changed) who has been working in Kerala for 8 years, who has worked and travelled across the state but still faces a lot of difficulties due to language:

> "*After four months of my arrival here in last year- I caught a severe fever. My friend and I went to the hospital. However, I was not able to tell my pain and problems to the doctor because the doctor was not able to understand what I was saying. Somehow we managed and the doctor gave me medicine. However, after one week I was forced to go home*."

This narrative of Sayed gives a picture of how language acts as a potential barrier creating problems in communication between migrant patients and doctors and affects access to healthcare. The study shows how these are common incidents in the lives of migrant workers and draws our attention to how severe illness compels them to go back home at least for a period of time till they recover in several cases.

Another respondent Aminul went with Sayed to doctor last year and he further adds:

> "*bhayya, that was funny...(laughing)... I went to a doctor for my fever check up for the first time here. We communicated through gestures. Because the doctor did not understand what Sayed said and I did not get what the doctor said. Finally, one person came and helped me. But that is not always possible.*"

Several other narratives from different labourers thus show how communication in almost all the cases is similar, strained and incomplete without the assistance of a translator (most often the case). Furthermore, certain instances show how this difficulties in communication often leads to misunderstanding and wrong diagnosis despite the efficiency of the health service system. The only way many a time, the migrant workers

can communicate are solely through gestures, which may not suffice for proper diagnoses and to measure the gravity of the health condition of the patient.

Lack of proper communication can create hindrance between the migrant worker and health care provider. The miscommunication is problematic when they seek treatment and also for the health service personal, here one respondent Akram expressed that:

> "*I am very conscious about my health conditions because, without that I cannot work and earn properly. I used to take rest if I have weakness or illness. Perhaps I feel very tired or ill. Then I used to go medical shop and take medicine. If it did not work, I would go to the doctor. Here I feel awkward to talk to a doctor. Because most of the doctors do not know Hindi or Bengali, and I don't know Malayalam.*"

Akram studied up to 12th standard and is pursuing graduation course through distance mode. His case shows how even the relatively more educated, have limited knowledge on proper healthcare measures and procedures or are forced to ignore them. Language becomes a barrier and thus their inability to convey their problems to doctors leads to self-medication in many cases.

The lack of knowledge and inability to understand or communicate in the local languages often leads to the exploitation of migrants also. Several migrant workers stated that they are charged extra for the treatment from private clinics. One such example is of a respondent called Prakat from Odisha who gave the following narrative;

> "*Once I got cheated by one person in the clinic. I got an injury in the workplace and me and my friend went to a clinic which is nearby. The doctor was inside the room and a person sitting outside asked me to pay the fees. I and my friend did not understand how much the fee was and I paid 300 rupees. However, later I came to know the actual fees is only rupees 200.*"

The private clinics in the state misuse lack of awareness on the information about the health facilities available to migrants. The migrants are already deprived and the exploitation makes them further vulnerable.

Health professionals also face various difficulties while providing service to migrants with language being the main barrier for the service provider in Kerala. The main medium of communication in the state is Malayalam and only a few of the health professionals are able to communicate with migrant labourers in Hindi. There has been a massive influx of migrants to Kerala and the health sector has been facing the problem of

communication when it comes especially to the labourers. The lack of proper communication in health service can create a barrier to beneficiaries in using the service. A review of barriers experienced by minority groups, when using health care services noted that verbal and nonverbal communication style and different factors related to the general patient approach are all important to avoid feeling of discrimination, racism and stigmatization (Elzbieta et al, 2016). The situation is no different for health service providers too. Narayanan (2013) says that "it's not unusual for an Indian Doctor to encounter 4-5 different language during a single day at the clinic, especially if he/she is practising in an urban area. While most of the doctors in India eventually end up with a functional knowledge of more frequently encountered languages, it is becoming increasingly difficult to communicate in all languages one encounters in an Indian clinic." In India most of the doctors are interacting in different languages with different patients in urban settings. The arrival of large number of migrant labourers into Kerala created a situation of multi-lingual interaction between provider and beneficiaries in health sector. The study has revealed that the staff at health care centre often face difficulties, when dealing with a migrant owing to the language barrier.

Doctor Kevin (name changed) from Isha Clinic in Malpuuram, narrates a working experience he has while dealing with migrant workers;

> *"...still language is one of the main problems. I know Hindi, but other health professionals who are working here are not experts in Hindi. Some of them can handle them. But that is not enough while giving treatment. It is problematic."*

Majority of the health service providers in Kerala are not able to communicate with migrant labours due to linguistic differences. Most of the health professionals in Kerala are not trained or adept at interacting with patients in different languages especially in Hindi and are totally inept in other Indian language. This linguistic barrier becomes a major obstacle for providing proper healthcare, conducting diagnosis or even prescribing medicines.

Another narrative from a doctor at a different private clinic highlights the same problem in communication;

> "*…communication in Hindi is not difficult for me. But difficulty is there while communicating with those migrant workers who can't speak Hindi. That is problematic during the consultation and treatment time.*"

Both doctors said that they face problems while attempting to communicate with patients who are migrants even though they have a good command over Hindi language. This is because, there is a section of migrants who come from states like Orissa, Assam, Bengal and other states who don't know Hindi. Situation is no different in government hospitals as shown by the narrative by a doctor in medical college, Manjeri with more than 10 year experience:

> *"Main barrier is language. Not all migrant labourers speak Hindi. They may be odiya or Bengali. But I am not an expert in that. So, I have to communicate with help of a third person or non-verbally. That has limitation for taking their case history and problems. That is big barrier for us."*

Since labourers speak mainly their mother tongue Odiya, Bengali and Assamese, doctors from Kerala find it difficult to grasp and propose a diagnosis. The situation is such that doctors at many instances have to guess ailments by communication done through nonverbal gestures which is problematic and might cause complications or difficulties in some cases. One nurse said, that the same problem arises in providing services too;

> "*…for me, language is main problem. It is difficult to talk with them and understand their problem and their needs. This is the case not only with patients but also with their Attendants in the hospital."*

Attendance are also important factors during the treatment time of patients in hospitals, hence the communication with bystanders is also important for service providers.

An improper means of communication such as non-verbal communication may even have disastrous effects. The cost of medical negligence due to miscommunication would be very high. Here another doctor from a Private clinic says: "*Once I noticed there is miscommunication between the nurse and the patient who is migrant at the time of treatment. Luckily, I noticed that and corrected*."

Another Private doctor said that

> "*While we treat migrants, we do the service with an extra consciousness because while taking the details of the patients there are chances of miscommunication due to language differences...*"

Miscommunication due to language not only creates barriers, but also affects the quality of service of the health institutions to migrants in Kerala.

Cultural barriers to access the health care service

People share common culture and no individual can live without it. Culture helps to manage daily lives because people who share the same culture attach similar meanings to the same thing (Indira,2015). Cultural difference between two communities can often lead to imbalances and often certain difficulties in the society and a multicultural environment can quickly create problems related to unfair treatment or discrimination. (Santoso, 2010). Cultural differences, prejudices, and stereotypical perceptions and othering many a times leads to migrant labours being discriminated against and at certain times to exclusion from the local population. The case is in health sector is reflective of this larger situation and the discriminatory conditions faced by these workers are the same. Acculturation into a new health care system is a complex process because of specific barriers of perceived access and satisfaction with existing services (Elzbieta et al*,* 2016).

There is lack of social integration between the interstate migrant workers and the local Keralite population because of various factors like language, food anonymity, social distance, lack of positive attitude from Keralites towards the migrant labours are few among them. Moreover the research has revealed that a minority of the migrants have felt bias and varying degrees of differential treatment from the local community. Cultural dissimilarities between the migrant workers and local people are evident in daily lives and day to day conversations between both sections and many a times reflected through disparities in wages given to both communities. The excerpt below is an example of the situation;

> *"They(Keralites) call us (migrant workers) bhais or Bengalis. I am not a Bengali. But still they call me Bengali bhai. Even in hospital the people call us like that. They are making fun of us... I feel uncomfortable."*

The daily conversation between the migrant worker and members of the host society generally creates a feeling of exclusion in the migrants. A respondent Sayed elaborates

"When I came for the first time, I suffered a lot because I did not speak Malayalam. That is biggest problem I faced here. While talking with doctors we continuously felt hesitant. We also felt the discrimination, because, sometimes we have to wait more time than local people to meet the doctors".

Discrimination is another social issue which troubles the migrants often. They are side-lined by the local people who take advantage of being the native in many situations.

The following narrative from a worker called Arumugam who even though coming from the nearest state Tamilnadu, living in Kerala for more than 15 years and having achieved proficiency in Malayalam language was posed more as a complaint to the researcher and draws our attention to the discriminatory environment faced by migrant labourers:

"*my friends and I feel offended sometimes when we go to the hospitals. The people there used to neglect us. Sometimes we are totally ignored by them. I don't know what their problem with us is but, this kind of act is sad*".

Several other participants revealed that they often felt discriminated and had gone through many similar situations and in many cases went on to helplessly state that *"they did not even know the reason for which they were treated this way"* The apparent discrimination felt by the migrants points to the fact that culture exerts a great influence on people's attitude. The researcher in the course of the study also found that the intensity of discrimination is much higher in private hospitals and also in situations of medical emergency because of unaffordable healthcare charges and the reluctance on the part of medical personnel in the private sector to take the responsibility of migrant workers.

Financial barriers to access the health service

People are often forced to migrate due to lack of opportunities to improve financial situation at their home state and Kerala which offers the highest wage to migrant workers not only among Indian states but in comparison even to SAARC countries (Sobhana. 2012) draws a large number of migrant labourers striving for better economic opportunities.

The financial position of migrant workers in Kerala are far better than of those working in other states, however access to health care services remains an issue for them owing to its financial cost in comparison to the income they earn. Several of the respondents said that many of the migrant workers are often not able to continue treatment after their first consultation because of high charges and that the financial cost disproportionate to the

salary they earn is the primary barrier to health care accessibility. This situation may seem paradoxical as Kerala ranks first in health sector among Indian states and is known for being one of the cheapest provider of healthcare providers. It is this anomaly that the study will go on to deal with in the coming section.

The research has revealed that different sections of migrant workers make use of both public and private healthcare services in varying degrees owing to varying factors which are discussed below.

A section of the respondents revealed that a few of them approach public health service institutions rather than private services because the fees and other costs for treatment are less in the government hospitals. Hakeemshares;

> "*I findhospital charges are high in Kerala, but the treatment is good. In my hometown Katwa, hospital charges are low but the treatment is not very good. If something happens at the workplace we would go to the local doctor or else cooperative hospital in Malappuram. We prefer the cooperative hospital in Malappuram because in private hospitals the cost is high and in government and other public hospitals the fee is less."*

In the opinion of these respondent's, the quality of treatment is high in cooperative and government hospitals, whereas you get similar services but at much highercosts in private sector when compared to government hospitals. One of the youngest respondents Sanjay is conscious about the expenditures. Sanjay migrated to Kerala before 3 years and is working now as a labourer:

> "*In private clinics we must give 200 rupees at least for consultancy. But in facilities like cooperative hospitals, we give only 80 rupees consultancy fee to the doctor. And with that slip we can consult again within a few days they won't ask to pay again. That's why we prefer government hospitals."*

Private clinics and hospitals charge fee without any regulation. The migrant workers hailing from deprived economic background are not able to meet the health charges incurred at the private clinics. 80 rupees for consultation is a good deal for them so they opt for co-operative hospitals. Another respondent Jamal has been living in Kerala for almost 7 year so far as a migrant labourer.

He used to stay in the work sites with his friends in Kerala and gave the following narrative;

> *"My friends used to go to private clinics here. They say that consultation fee is high. I do not know about private clinics here because I never went there. In the cooperative hospital, we are getting good treatment".*

Migrant workers get the information from their co-workers and friends who are working in Kerala. Friends, family and co-workers are the main network source of information in key areas including the health sector. Here the participant's friends informed him that private clinics are costly compared to the public institution and he opted for public hospitals instead of private clinics.

The following narrative of Kamal is a story of exploitation that arose out of the lack of an informed social network:

> *"...5 years before I went to the hospital for stomach ache. The doctor checked me and suggested me to take some tests. I spent more than 4000 rupees for that. Later, I took medicine through a different consultation and felt okay. But I lost 4000 rupees and a working day".*

The study through interactions with many respondents in the field reveals that a lack of awareness in health treatment and services is a cause of the exploitation of the migrant labourers. Kamal further added that

> "*that time (5 year before) I was not familiar with the places here in Malappuram. I didn't know about the cooperative hospital and government Taluk hospital in Malappuram town.*"

Like Kamal, except for a small section of the respondents mentioned above most of the migrant workers are not aware about the health facilities and low cost medical institutions in Kerala. Subsequently many of them opt for the available health services which is near by them rather looking for the affordability or cost effectiveness showing how social networks is a major factor in access to healthcare.

The study reveals that except for a small section of workers mentioned above, most of the respondents pointed out that many workers are forced to choose private establishments due to bigger crowds and longer queues in public hospitals. Furthermore the thought of losing a day's wage serves as the added reason for choosing private services over the public facilities and the choice remains the same most of the time until and unless the health condition becomes serious and they are left with no other choice. Arumugam thus talks about this situation;

"I mostly used to go to any nearby clinic because the queue will be much longer in government hospitals and I end up losing wages of one of my working days. I used to consult at a private clinics nearby. It is more expensive compared to government hospitals but I go there as I don't want to waste a day's wage".

This scenario poses a grave situation for many migrant labourer in certain cases where high user charges and referrals to conduct different kind of medical tests often deter the migrants from taking any kind of medical treatment. An example of this situation is brought to the fore through the following excerpt;

"The hospitals and clinics are very clean and neat here both in public and private hospitals and all kind of medical tests are available. The only thing I feel bad about is that the medical fees and other charges are very high here. So, sometimes I won't go for the test because I felt that is useless for me".

Private clinics in Kerala charge high rates and most of the time migrant workers find it unaffordable to seek the medical tests and treatment. Though they earn roughly 12000 per month, a lion's share of their income is sent home. Some private medical clinics and labs exploit migrant workers as shown through Kamal's case discussed above and recommend unnecessary medical tests and medicines resulting in high fees discouraging many from taking any further treatment and leading to involuntary negligence of medical situations at future instances. Thus, the situation has to be seen and analysed in relation to the next part of the study on the migrant worker's lack of health information.

Lack of health information and Health literacy

Lack of Health literacy and information about health services can create obstacles to access health care services for the migrants as is evident from the multiple cases discussed above. The availability of health services is high in Kerala and with the model in the state having a health sector even comparable to many developed countries in the world. Even in the period between 1980's- 1990 when, Kerala had been among the economic backward states, its health sector model boasted of low cost health care service, universal accessibility and availability even to the deprived sections of the society (archive.india.gov.in). However, these achievements cannot be a justification for the discrimination faced by a section of migrant population. The narrative from a respondent Tajudheen highlights this issue;

> "*That time I don't know anything, where to go or whom to ask. Whenever I feel pain on my leg. I will use home remedy. Then it became unbearable. Finally, I told my contractor and he took me to the Government hospital.*"

The participant said that he is unaware of the availability of the services nearby. The lack of knowledge about locality and health services forced him to depend on home remedies. And the local people and the experienced migrant co-workers and contractors are only the source of information about the local places and the services available.

It is not only the knowledge about the service availability, but also the lack of information about the disease and other health problems that combine to create obstacles or delay the accessibility to the treatment. One of the participant Aminulsays :

> "*Last year I got chikungunia and I didn't know anything about the disease. First I felt body pain especially in joints and was extremely tired. My condition deteriorated, I thought it was because of the overtime work and fever. Then after 3 days my condition became worse. Then my friends took me to the hospital and from there we came to know that this fever is called chikungunia. I was hearing it for the first time in my life.*"

Here the participant has no awareness about the disease or the symptoms. There are few other instances where respondents talk about a situation where he doesn't have any idea about the disease he is ailing from and they come to know even about the existence of this kind of the diseases for the first time. It validates the view that health literacy is also an important factor in the accessibility of the services.

Work time, distance and transport availability

Another major issue faced by migrants hindering their access to health care services is their working hours which coincides with the outpatient timings of hospitals. A migrant labourer working in the construction sector generally works from early morning till evening for a minimum of 8 hours and often end up doing extra time to finish their work depending on the contracts in which they are employed by. Hence, most of the health services become inaccessible to the migrant labourers due to unsuitable timings and it is only on Sundays that they get an off.

Venkatesh elaborates on this situation:

“We won’t get time to go to hospital. We have work from morning 8 to evening 6pm or 7pm. On some days there will be overtime work too, and we don't get any time. Only on Sundays do we get an off-day and outpatient section won't open on Sundays”.

Long working hours six days a week and the outpatient department being closed on Sundays mean that migrant workers aren’t able to go to the hospital and consult any doctor. This leads to a situation where they have to choose high cost private clinics instead of public health institutes. Another respondent Sudan thus sums up:

“*Every day we have to work. Sometimes on Sunday too. That depends on the contract of the work. We have to complete the work within that time. In between, going to hospital and taking treatment is difficult. But I will go when I need to go. But that day I have to take off and I will lose my wage”.*

Majority of the migrant workers don’t want to lose their wages even for a single day. Hence, they postpone the consultation for a later period. Taking one day off means losing money ranging from 600 to 1000 and it is more than what a migrant can afford.

Another important factor is the proximity of the health care centres. Health care institutions that are located far away from the migrant worker are not preferred by them generally. Kadir, one of the young and less experienced workers among the respondents from Assam explains this with his experience:

“I worked in one building construction site in a rubber plantation one year ago. We used to stay there near the site itself at that time. One day one of my co-workers got an injury on the shoulder during work. There was no bus or auto there. Nor was there any doctor or clinic nearby. Finally the place owner had to come with his own vehicle and take him to the hospital.”

Migrant workers who are working in the isolated areas or hilly regions have much lesser access to health institution. There are two main reasons for it: one is the distance from their place or residence or workplace to health institutions and the second being the lack of transportation facilities at the location.

Sanjay, another respondent talks about how the distance and unavailability of affordable transportation facilities prevent workers from visiting health institutions.

> *"Before 6 months we lived in a place that is 45 minutes from town. There is only one bus every hour. The auto charge is high. Because of the distance we won't go to the hospital unless it is an absolute emergency."*

Majority of the migrant workers in the district stay in the outskirts of the town or nearest villages in the town to reduce living costs and in such cases distance and transportation facilities serve as major reasons affecting accessibility of health services.

Lack of Attendants for by-standing

Migrant's access to or their willingness to access the health services of the state is often determined by the want of an attendant to go along with them or to look after them when they are sick. Migrant labourers in Kerala who often come to the state alone in search of jobs often face this problem. This lack of an attendant or companionship of any family member and friends who are all working in jobs with long arduous working hours often suffer from negligence in situations where they suffer from diseases or medical conditions and are devoid of any medical care.A respondent Akram who has been living in Kerala for 4 years in Malappuram recounts an experience;

> *"One of my friends used to work with us 2 years before. He was tired and coughed all the time. Then after a short while he started to spit blood. We were afraid and took him to a doctor. After tests and diagnosis we came to know that he had TB. Then he had to leave for his village, otherwise what he will do here, because nobody here can look after him".*

Akram's statement is a testimony to the poor health literacy and underlines that migrants gets very little support as they stay so far away from their family.

Razaq shares how the bystander issue affected his health condition;

> *"...3 years before I fell down from the terrace during work, my left leg got fractured, I didn't have money that time. The situation become worse after my being admitted to the hospital because I didn't have anyone with me for support in the hospital. After one week, my contractor sent me home."*

Majority of the hospitalized migrant workers aren't be able to continue their treatment in the healthcare institution after a few days due to the lack support system, especially the lack of peer support and Attendant in hospitals or at their place of residence(in many cases not possible due to the working conditions and hours of the friends). Hence, they end up leaving the state and return to their home to continue with treatment. The lack of

the social support is thus a barrier for the migrants to access health care services in Kerala.

Lack of cooperation and Time

The migrant workers in Kerala are not integrated well into the local community due to their outsider identity. Key informants to the present study like health inspectors who are from the host population but engage with migrant workers on a regular basis states that this lack of integration is evident in the health camps and programs which are meant for them. One health inspector puts it thus;

> "*…they won't cooperate with the programs because of fear. They always like to be isolated from the local community… Most of them won't communicate in Hindi with us. If they need anything they will talk, but if we ask them, about health they won't communicate properly even in Hindi."*

Some of the migrant workers hesitate even to talk to the health inspectors and don't even share information regarding health due to fear and a lack of comfort reflecting the lack of assimilation into the host community.

A health inspector elaborates on how they attempt to make contact and draw information:

> "*We try to reach them from the contractor's base and also through non-contractors. Through contractors we get to labourers under them. But through non-contractors bases, we get less or we won't get much people due to their floating nature and their working time"*

Health inspectors who are working at the grass root level say that migrant labourers who are not under big contractors are scattered. They are unable to reach and provide service to them. Their working time of the migrant workers is also a problematic factor. Health inspectors in districts, work during evenings in an attempt to check and collect sample because of this. The health inspector further says that:

> "*…we would collect sample in the evening because of the labourers who are available only at that time. But half of them are alcoholic and we can't do anything about that. However we regularly conduct night health camp in the pockets where the community is scattered. Frequently, we are identifying the infectious diseases from them. Once we identified three filariasis, one TB and one Malaria case through these health camps. But what happens is that after two days none of them were there. We have to face many issues like these."*

Health inspectors work and reach out to the grass root level. The officials of the Kerala health department identified infectious diseases from the field frequently, but they failed to do follow up due to the floating nature and second time availability of the identified migrant workers.

The problems in providing services for the migrant populations are not restricted to only language and time, there are other issues too. A nurse points out one such issue;

> "*sometime newspaper reports and some activists would level some allegations against us. The actual reason behind denying treatment would be money. Though we are ready to extend our service and support, they don't have money to pay and it is true we cannot pay for them from our hands. However, news reports and activists will state that we denied the treatment and blame us.*"

Here, nurses say that migrants do not often have enough money to take treatment recommended to them. Moreover, Health care institutions cannot extend completely free check-up and treatment. Misinformed news reports and activists also create difficulties at certain times. Exaggerated news and over interference on the part of them put the service providers in trouble and demoralise those to a great extent and it also builds a wall between the migrants and service providers in certain situations.

Migrant labourers face various barriers in accessing health care services. The main barriers are the language differences and the cultural differences. The migrants face difficulty in accessing health care services due to the communication barriers with both private and public health service personnels. Along with the language difference, the cultural variation between workers and local community leads to the unequal accessibility in health care.

The chapter has discussed the narratives of the participants in detail about the access issues faced by the migrant workers in construction sector. The issues were tried to understand from a two way perspective; which are of the issues faced by the participants in accessing the health care services as well as the problems and difficulties faced by the healthcare providers. The participants themselves reflect often about the difference they feel about Keralites and themselves while accessing healthcare. The study brings out issues of discrimination faced by the participants while accessing health care. Language barriers were identified as one among the most critical factor affecting access. Most of the migrants are coming from non-Hindi speaking states, and the mode of communication is

mostly Hindi in Kerala with the migrants. While accessing health care, communication is very vital for explaining and expressing their discomforts, illness and problems faced to the heath personnel and on the other hand the health personnel also find it difficult to understand their issues as well as to communicate them about their diseases and treatment requirements. Many a times there are extreme situations where they have to communicate through gestures even. The migrants who have gained proficiency in Malayalam explicitly has advantage over migrants who doesn't know Malayalam.

Cultural differences contribute to access issues faced by the migrant workers in Kerala. There is a tendency of homogenizing migrants as a single entity and a very typical example is mentioning them as 'Bengali' in genaral. The participants in the study have explicitly shared their dissatisfaction and disappointment of such homogenization. They feel ostracized in the community due to these differences. While accessing hospitals the participants are even pushed back in the queue and such discrimination is making them vulnerable and they feel stigmatized while accessing health care.

Financial stability and consistent job opportunity is the most important pull factor for migrants coming to Kerala. In health care access financial burden caused due to out-of-pocket expenses is a serious concern of the migrant labourers. Accessing public health institutions are preferred over private institutions for health care issues, but the long waiting time, compromising wages, travel time, transportation issues and similar factors hinder the migrants from accessing public institutions. The concerns of discriminations and barriers of language add to this. On the other hand, the participant also has evidently expressed their gratitude towards multiple health personnel who were courteous and caring towards their concerns while providing health care. In this context, many a time they have to approach private clinics and institutions for health care needs. Most of the participants were highly satisfied with both public and private health care provisions and they often compared with their situations prevailing in their home state. But the high cost of the health services in Kerala made health care services unaffordable for migrant labours. Lack of awareness and health information set grounds for them to be exploited by private and other service providers. The long work time and lack of other social support make them more vulnerable in their living conditions.

The chapter throw light to multiple issues faced by the migrant labourers in Kerala while accessing health care. It is evident from the discussion that while understanding health

access these multiple factors cannot be singled out and their intersections has to be given primacy in bringing out nuances. Considering the high number of interstate in-migrants which is approximated to be more than 25 lakhs in Kerala as per official records (Government of Kerala, 2015) which is also acknowledged as an underestimation, the current government has started multiple new initiatives for addressing health issues of migrant workers in Kerala. Building a complete data base comprising the details of the interstate migrants in Kerala, provisioning of identity cards and providing health insurance and other entitlements are few among them. The following chapter tries to bring out the issues faced by interstate migrant workers in accessing entitlements. In the purview of the data analysed in chapter four and five, the following chapter tries to understand the issues contributing to lack of access to entitlements and the role of Aawaz health insurance scheme in addressing access to entitlement issues faced by the migrant labourers.

CHAPTER 6

ACCESS TO ENTITLEMENTS AND 'AAWAZ' HEALTH INSURANCE SCHEME IN KERALA

Introduction

Internal migrants are a particularly vulnerable group, often living in unsafe and unregistered housings, more likely to be working in the informal sector doing irregular and dangerous jobs and earning lower income than Keralites. The condition in which migrants live and work is far below the minimum standards enjoyed by Keralites and adversely affects their health. It is the state's responsibility to take care of them, which indirectly would also help to safeguard the health of the natives too. Studies (Hopkins et al, 2016) point out that "High levels of vulnerability and need for social protection, evidence suggests internal migrants are at high risk of exclusion from social protection programmes and represent one of the hard to hard groups, they may face additional challenges and risk being excluded as a result of a combination of factors, including the ways in which social protection design and implementation practices interact with migrant-specific characteristics". Higher vulnerability leads to the exclusion of migrant labourers from the host society, wherein they actually need proper social protection. This lack of accessibility to social protection schemes makes them more susceptible to face further challenges in society. The lack of documentation of migrants becomes a further hurdle in making social protection measures effective especially in health sector. Deepa (2014) through her study draws out that the local administrative bodies should maintain details of the migrants in the respective places by ensuring their registration strictly which in turn can help the administrative body to issue health care and health insurance policies.

Government of India implemented the scheme called RastriyaSwastyaBimaYojana (RSBY) in 2007. RSBY is an ambitious public health insurance scheme for the poor, aimed to improve the quality of health service available to them by making it more lucrative for private and public hospitals to provide care. This is done by allowing the hospital to bill an insurance company for the cost of the treatment, providing both health services to the poor and help the hospital to generate revenue. The government would make the scheme nearly free for beneficiaries by subsidising the annual premium. The scheme would also utilise Smart Card Technology for the identification (Rajasekhar et al, 2011).

In-migration to Kerala maybe considered a social, political and heath challenge because of the need to provide everyone with access to quality health services adhering to the concept of universal health coverage. Narayana(2013) in his study about the domestic migrant labourers (DML) in Kerala has suggested that Government of Kerala should design a Kerala State Insurance Scheme Specially targeting DML most of whom maybe above poverty line. The study suggests that the scheme maybe on contributory basis utilising subsidies from the Government of Kerala. It also suggest that the Government of India may also be encouraged to contribute to the scheme and the health scheme be limited to those who register as per certain recommendations.

The government of Kerala implemented a health insurance scheme called *Aawaz*to give a medical security to the workers employed in dangerous conditions and to provide free treatment to migrant labourers. Uma and Satheesh(2016) in their study defines the health scheme called Aawaz as a health insurance scheme planned to be implement in the state by the year 2017 for 40,00,000 domestic migrant labours who have been working in different sectors in Kerala. It aims at providing health care assistance and free medical facilities to each registered worker. The initiative plans to collect information about domestic migrant workers and provide an identity card to each worker who gets registered.

The previous chapter had discussed the main barriers faced by the migrant workers to access the health service in general and the barriers for health workers to provide the service to the interstate migrants in Kerala. The coming section will mainly focus on the obstacles faced by migrant workers to enrol in the Aawaz insurance scheme and the issues faced by the government official in this process.

Lack of knowledge about health care entitlements

It is obvious that lack of knowledge about health services, schemes and policies of the government often distance people from health institutions. With regard to migrant community, linguistic and cultural elements add to the failures of the system available. A way to counter this is to equip them with the necessary knowledge about the schemes by issuing entitlements. Entitlements makes people more aware of their rights in a new place and paves way for social inclusion. The central government insurance scheme RastriyaSawsthyaBhimaYojana(RSBY) provides its cardholders an insurance coverage which can be obtained after registration in an allied scheme in their place of work.

Unfortunately, the migrants leave the card at home and come to the state as uninsured persons in their place of work. This fact shifts the focus from non-availability of the services onto the problem of ignorance. If registered under welfare boards, each migrant is eligible to get the insurance offered in the RSBY scheme when a situation arises. Sometimes, joint family structure compels them to leave the card for the use of other members and this absence of a health insurance policy exposes them to several risks.

The field study conducted by the research reveals that, only six out of the sixteen participants interviewed have enrolled in the Aawaz Scheme. The remaining ten were unaware about the scheme and the following excerpt taken from a conversation with one of these participants Ram sums up this situation;"*I have voter id card, Aadhar card with me if you want to see I can show you. What card you're asking about…health card...? No. I don't have anything like that*."

The participant has no information about a scheme that provides health card even though he possesses Voter ID and an Aadhar card, which are essential for identification. Another participant who has lived in Kerala for more than 8 years, Sayed asks similar questions:"*No brother, I didn't hear anything like that. Nor anybody told me. Is it government card? What will I benefit from that card? Where I can get it from?"*

These responses are an indication of the reason behind low enrolment rates of migrant workers in this scheme. The former only shows complete ignorant of it whereas, the latter though unaware is eager to know about it. Ignorance of the beneficiary, apprehensions of the community to reach to the public services and failure of the system to plug the disturbing information gap make the access of the scheme difficult.

Aawaz is a scheme which on paper strives to ensure accountability and provide redresal for all the grievances and casualties that occur to migrants. It mainly focuses on the construction labourer because they are more vulnerable to dangerous situations. But, many beneficiaries who work at construction sites have not heard of such a scheme. It can be deduced that migrants' connect with the host society is minimal and/or the officials who are in charge of the scheme are yet to reach out to the beneficiaries. It is evident that inefficient dissemination of information leading to lack of awareness leads to many eligible people being omitted.

It is a common misconception that migrants in Kerala have already enrolled themselves in at least one health scheme either at the central or state level. However, only a few of them have RSBY cards in their family. This is evident from the narrative of a respondent called Aminul:

> "*I have Voter card, Aadhar card and ration card. I do not have insurance or anything like that. But I wish I could take insurance scheme for me and family. But I don't know who I should approach for that."*

Majority of the respondents gave a similar account as Aminul as having no knowledge of how and where to apply for the schemes. This informs the gap in the dissemination of information about the insurance schemes and draws our attention to the lack of any security in their life. However, there are a few among the respondents who had got their names registered in RSBY schemes before they even migrated from their native states. Sudan puts it this way:

> *"I have voter identity card, Aadhar card, ration card and other things. Back home we used to get Bimayojana and other things but here, we didn't get anything like that till recently. Our contractor filled out a form for us, for some government health insurance programme and through that we came to know we would get free treatment for one year. That is all I know about this. We think that this kind of government programme is good and helpful for us. Now we do not own any kind of card for health treatment but if this program starts we hope it will help us. Nonetheless, back home we have bimayojana card for family."*

It is clear from the informant that he is newly registered to the Aawaz scheme and he got to know about it through his contractor. Though a beneficiary of RSBY, he gets no benefit as he left the card at home for the family and now foresees a better life for himself too with the enrolment in the state insurance scheme.

t is important that the information regarding the welfare schemes reach the beneficiaries and another participant Prakatshows why:

> "*We aren't much knowledgeable about any government welfare schemes for us. Nobody informed us of any kind of programs here or back in my home town. I'm not aware of any kind of health programs over here or if they are available to me here, I feel happy because I had felt this is needed for us many a times."*

The participant expresses his concern as well as desire of being able to enrol in a health insurance scheme and at the same time vividly shows the shortcomings of the system and its implementation.

RSBY and Issues of Usage in Kerala

An RSBY entitlement offers the client Rs.30000 per annum for treatment and is valid across India and is considered to be a great asset to migrants who seek jobs in distant places. Many cardholders on the contrary cannot make use of the card in reality as most of them leave it home for their family. Sanjay elaborates: *"I have card at my home... I know I can use it here... but problem is that all my family has one card... so it is better to keep it there..."*

An insurance card kept at home is like having no cards at all and they are forced into abstinence from treatment due to financial constraints, high cost of healthcare medical services and poverty. The problem stems from the nature of RSBY which is issued to a family in joint ownership and to protect the interests of the family, migrants prefer to keep it at home. A participant Sudan thus states

> *"My family has Bimayojana card. It is useful in government hospitals. Some private hospitals refused to accept it. Card is for my family also. Hence, I thought they can use it. If I bring it here what will they do?"*

This is an opinion shared by all of the respondents in the study and reflects a larger common interest within the community to put one's family members before themselves by keeping their RSBY card home. These narratives show how the RSBY scheme fails many a times in delivering on one of its primary purposes of safeguarding the labourer employed in arduous environments. It also tells us how private hospitals in many of their native states refuse to accept it and deny treatment citing technical problems. Conversations with the workers revealed that the major technical issues alluded to by these hospitals is the lapse in payment of hospital expenditure by way of reimbursement from the insurance company. Respondents like Kamal draw our attention to another aspect of this scheme that is problematic:

> *"Yeah… Bimayojana card we have at home... I heard I can use that here... for that I need a registration or something like that... don't know about that...that's why I am not using it here."*

Mr. Kamal thus, has not been able to use his RSBY card here solely because he hasn't registered with the Welfare board for the unorganised sector. There is in fact an option of portability - to get the benefits of RSBY legally. A consumer through this facility can

make use of his card from another location using portability option built into it. There is a provision in the scheme that enables the consumer to register it with whichever state welfare boards they wish registration under the welfare board is mandatory to avail the benefits of the scheme and some migrant workers ignorant about these technicalities and/or how to carry out these procedures are left with no other choice but to forego it. The following narrative by Aminul is another example of the migrant workers inability to deal with these technicalities:"*I brought the card here. But they said I did not register in some board... and I can't use the card...so I couldn't use it...I took the card back to my home and returned it to my family*."

The participant in this case even though aware to a certain extent about the facilities, complaints about still not being able to register his RSBY card in Kerala owing to technical issues and shows how structural and bureaucratic complications become an overwhelming barrier for them.

In a nutshell, migrants who have RSBY card in their name and are eligible to get insurance benefit face difficulty to use it in multiple ways. It is common in the character of the migrants to leave RSBY cards at home so that their families get the benefit. Secondly, an ignorant migrant is poorly connected to the new world and lacks basic information like how and where to get enrolled and make use of the provisions within the schemes designed for them. Finally, barriers can be in the form of bureaucratic complications and red-tapism ingrained in the system. A combination of these factors prevents the migrants from exercising their fundamental rights in the host society.

Aawaz Insurance Scheme

The scheme of Aawaz is implemented by Labour Department of Government of Kerala by registering the beneficiaries under the scheme; and Health Department of Government of Kerala by providing the health care services to the inter-state migrants registered under the scheme (Government of Kerala, 2016, para. 2 &Government of Kerala, 2017, para, 4). 'Aawaz' is a first of its kind health insurance scheme introduced by the state of Kerala and the target of the scheme is identification of migrant labourers living in Kerala and to provide them a free health insurance cover of 15000 per annum in government hospital and empanelled private hospitals. Moreover, a migrant is entitled to receive a life insurance cover of 2 lakhs according to this scheme (Government of Kerala, 2017, para. 1). A detailed exploration of the Government orders and documents related to the work

plan and implementation of the scheme were explored in detail to understand the technical aspects of the scheme. The scheme is intended to bring in registry a with complete details of all inter-state migrants under one database, issuing identity card for every migrants for identification purposes, official purposes and for bringing them under schemes for multiple entitlements and also to provide the above mentioned health insurance benefits (Government of Kerala, 2016, Government of Kerala, 2017). Multiple technicalities are involved in the registration process as well as in getting the benefits of the scheme to the beneficiaries. The following sections of the chapter discuss the issues related to registration, other technicalities and access issues related to attaining entitlements and the scheme benefits. Before getting into the elaborations of the same it is critical to understand certain key points about the scheme which the researcher try to throw light on, which are (1) The current scheme was proposed initially and was ratified by the Cabinet and Legislature in 2016 Nobv; (2) The estimated number of migrants are above 25 lakhs in Kerala; (3) Only one lakh migrants are currently registered under the scheme; (4) The insurance companies which would provide the insurance is not yet confirmed and the negotiations are continuing (5) Government has started giving the beneficiaries the benefits from January 2018 and (6) As the Insurance provider is not yet been confirmed, the Government has allotted a separate fund from the 2017 budget with special sanction for providing benefits until the Insurance Company is confirmed.

Perception of migrants towards the Aawaz insurance scheme

As a part of the implementation of the scheme numerous identification and data collection drives have been conducted at various sites and biometrics details of the migrants are obtained before issuing the card to each beneficiary. The migrant labourers have positively responded to the insurance scheme. One of the respondents a migrant labourer called Razaqsettled in Kerala, married from Malappuram District and running an eatery shop along and doing construction work thus speaks about the scheme;

> *"These kinds of schemes are good for us. I felt the need for these kinds of health programs. We came here for work and have staying here for a long time. Hence, I think these kinds of programs support us."*

The response reflects migrants perception about this scheme designed completely for them. Similar responses from several responses make it clear that they are happy and grateful for the recognition they receive in an alien state. Migrant labourers are an apprehensive community badly in need of a mechanism to protect their lives. The

response therefore is an acknowledgement of the efforts taken by the state government for non-natives.

Health of the inhabitants of a region should be an area of supreme importance to the government irrespective of them being a native or non-native. Government policies and determination in its implementation may have a lasting impact upon the health standards and culture of its people. 'Aawaz' is multi-pronged in the sense that it brings the migrant community into the fold of governance with proper documentation, helps reduce the burden of expensive medical service and most importantly helps to take them into the mainstream from the periphery they were always in. It is to be noted that an insurance policy envisaged protecting the lives here acts also as a means of social inclusion and justice.

An experience from a 21 year old participant Ram who has suffered from severe illness on multiple times and having been admitted to the hospital for several days expresses the following opinion;

> *"Last year one of my friends met with an accident at the work site and his leg got fractured. We didn't have enough money with us for his operation. Somehow, we managed. So, these kinds of schemes are actually a support for us."*

The statement clearly reveals the apprehensions of a migrant labour. A good majority of migrants are prone to accidents due to the risky nature of jobs at construction sites. Nonetheless, the pressure of circumstances forces them to continue with the job. 'Aawaz' is an answer to several of their issues. The scheme not only saves a lot of money spent on treatment and medication but also encourages a reluctant patient to visit hospitals. Thus, 'Aawaz' helps to alleviate financial burden to a good extent, the chief reason for many to migrate.

Another participant Nadir who came to Kerala 6 years and already having certain entitlements like Aadhar and voter id card expresses the following view on Aawaz scheme;

> *"We are coming far away from home and working in construction sector here. If anything happens to us here, none will be there to look after the family back home. So, such a government scheme is a hope for us... what do I have to do to join in this scheme?"*

Most of the migrant respondents expressed deep concerns about their lives and the future of their family if they were to lose their lives in Kerala while working. Construction

activities are hazardous working environments and include a lot of risks. Quite often, labourers risk their life hoping for a better life in the future. The concern expressed by the participant throws light on how difficult the lives of migrants are on one hand and how ignorant they are about the schemes entirely designed for them on the other. The motive of the Aawaz insurance scheme is inclusion and better integration of migrant workers within Kerala society and the willingness to join the scheme is a proof of their longing it.

Lack of Awareness and distance to the Aawaz registration offices

Introduced into a new environment, language and culture - a migrant enters into an unknown territory where he takes time to adapt as everything he/she is familiar is replaced with a new social system. As a result many of the new migrants become victims of their ignorance in the host society in various ways.

The study has already discussed in the above sections how certain insurance schemes envisaged for the well-being of the migrants go unnoticed by them. The 'Aawaz' scheme also suffers the same plight even after rigorous and widespread campaign organised by the Kerala governments' department of Labour. Campaigns are done through officers visiting the labour camps in person, through social circles and pamphlets emphasising on the need for documentation and the necessity to enrol in the scheme. However, many of the migrant labourers still fall outside the purview of the scheme due to the lack of efficient information dissemination where all details about the scheme are not explained. The narrative from a participant Razaq is an example:

He said,

> *"But I do not know where I can approach for this scheme. Two weeks before officers came and told me about the office at Malappuram town. There are a lot of government offices. Where exactly do I have to go?"*

This situation is an example of how, despite information being provided to the beneficiary- lack of proper details or explanation about the procedures leads to the workers not being able to locate the offices concerned to continue the rest of the process. Migrants find it difficult to identify geographical locations and offices owing to their lack of language proficiency and complications in the paper work too becomes a hurdle in many cases.

Another participant Kamal expresses these concerns:

> *"I am interested to join this scheme. What should I do for it? I have my Aadhar card now. The previous day they had asked me to come with Aadhar card to office. But the problem is that, I do not know where the location of the office for this scheme is? They said it is in the office at Malappuram."*

These instances show the helplessness faced by the migrant workers and reflects the lack of support from the host population. They get little help even from their contractors in dealing with official procedures.

Another major problem workers face in enrolment to Aawaz scheme is the constant shift in workplaces. Kadir a recent migrant, working in construction sites thus explains his situation:

> *"The officers asked me to come to his office for the registration for the scheme. But I am staying in another place now and not in Malappuram. I just came here to help my friend in the contract work. Anyway, I have decided to register in that. So, where should I go to register, here or near to where I reside?"*

Migrant workers in Kerala are a highly mobile community and have to travel widely across the state for jobs. Short span of work in a place, continuous travel and unawareness about the concerned offices in different location deter them from the registration process time and again. Nadir a 26 year old migrant worker from West Bengal talks about this situation:

> "*The officers informed me about this scheme at my work site. I have to go to the office for registration. Which means that I have to go to town and I can't take leave because of the contract. Sunday also we are working and the office is so far from here. Let's see."*

According to the participant, they get no holidays and taking leave is not entertained by the contractor and the distance between enrolment office and work sites requires a day's leave to visit the office. This statement shows how that lack of awareness is not the lone problem faced by the migrants.

Exploitation from mediator

Ignorance invariably leads to exploitation. In the case of migrants, mediators who are mainly contractors take advantage of the situation to make money. Sudan pointing out the machinations of the contractor says: *"my contractor asked 5000 rupees from each one of*

us for this. He said he will get 15000 rupees ka free treatment yearly in government hospitals and other private hospitals and 2 lakh insurance for us".

The contractors exploit the ignorance of their workers by demanding a large sum of money in the name of free policy. It indicates an urgent need to educate the migrants.

Another participant, 17 year old Kadir, is a migrant labourer, who came from Assam to Kerala in search of work. Kadir elucidating the role played by the contractor says:

> "*…5000 rupees is required for the insurance paper work. He (contractor) said he will take care of all the requirements. We don't have to run for paper work. The Contractor said, he will do everything. I just have to go and givesphoto of my eyes with the identity card. At least, we are getting free treatment from hospitals. That is good."*

From Kadir's words, it is clear that an outsider's help is inevitable to procure paper work for the policy. They are ready to pay money for the contractor's intervention and support, as it may help save many days' wages if they have had go to offices on their own. The factors leading to normalisation of corruption involved in the implementation of the scheme are already mentioned. When 'ignorance' becomes a source for exploitation, it is the responsibility of the government agencies to take cognisance of the matter seriously and spring up with corrective measures to avoid this situation in future. A participant Sanjay, shares the same view. He says: *"My brother used to take care of everything. He said we have to give some money to contractor for the health insurance. I don't have any idea about this."* Beneficiaries like Sanjay inevitably fall prey to greedy contractors. This also brings forth the need and reminds us of the lack of support system. The root of all problems faced by the migrants is poor language skills.

Socio cultural problems.

As noted before, linguistic and cultural differences of migrants are key issues which require an urgent perusal. It is natural that the natives are apprehensive about strangers. Withdrawn into one's own community, migrants keep a distance from the local community, apprehensive of the attitude of people around them. Akram allaying his reasons for reluctance says: *"I don't feel like talking to them about myself. They look at me with doubt even after I disclose my details, as if I did something wrong."* Migration is uprooting and placing oneself as a stranger in new environment. Social integration may occur very slowly and has a rocky path to tread. Language, culture and social behaviour cause mayhem for the migrants. Adaptation is as much a painful task as winning trust is a

matter of long term co-existence. Migrants in Kerala too are victims of these differences. They often feel discriminated against and offended by the host society's unwelcoming attitude. They often prefer to live in groups and maintain their distance from others. Being minority and underprivileged, migrants face grave inequalities and labelling. Prejudices and rumours work against them and widen the gap.

The reflection of visible neglect and non-cooperation from the local people reflects in the living conditions of the migrated communities. They puts them in disadvantageous conditions amidst lot of problems. These sentiments are echoed by one of the participant Venketesh where he says

> "*I have a voter ID and an Aadhar, then why do I need another card. They are asking for thumb impression and Iris scan of the eye. If they do need these details, they are already available in the Aadhar card, why another card for the health programs?...frequently, someone comes to the quarters…2 months before, police came... after that people from municipality office came. What wrong did we do? I don't know. We came here for our job".*

This brings to our attention, security concerns of the migrants. They complain of repeated visits by the police, for enquiry. Aadhar card bearers suggest authorities to use their unique number to get access to their data instead of multiple visits by the police and other authorities in the name of data collection. This shows that data collection is being conducted at multiple-levels and with the help of police. It becomes an annoyance and a cause of distress for the migrants. This also hints the lack of trust on the community.

Lack of mutual trust between guests and the host has generated fear psychosis amongst some people and they refuse to divulge details in view of unwarranted incidences. The information provided is sometimes maliciously used to disseminate fake news. This adds fuel to the fire. One of the participants Ram said

> "*I am afraid to tell the truth because a few months ago, I saw a video on Whats app, where few people trashed one guy and he died. The message is intended to make people hate us, but I didn't feel like that. Most of them are cordial and courteous. There are a few people here whose approach is somewhat rude… after I saw the video I became a little bit conscious. Last month government officers came here and I was terrified but they came to inform us about the insurance scheme. I wanted to enrol in that. If treatment and medicine are free of cost, who will say no to that."*

The respondent was anxious and shared his angst over the misinformation spread through social media. It is dangerous as local people having prepossession and ill-informed notions that migrants are instinctively criminal, target the migrant for every other small

incidents. These uncomfortable circumstances make them detached from the society they live now. It further delays the ambitious social integration programme attached to the social protective measures adopted by the government. Flawed perception, widely circulated, creates disturbing ripples in the society to the extent, making people feel insecure in the state.

Labour department officials

It is not just the migrants who are perplexed but officers too. They have initiated a herculean task, of locating the migrants and collecting the data as a part of the insurance scheme. Labour department officials are currently authorised to collect details of the migrants in the state and issue health card. They too are faced with challenges in the process. Assistant labour officer explaining the problems says:

> "*…there are two types of migrant workers in construction sector. Some are under big contractors (large scale contractors) and others who take subcontracts (minor contractors) who work independently and earn money through their negotiations. From big contractors, collecting data of labourers is not a big issue, whereas collecting data of minor construction labourers is problematic, they are mobile and we have no mechanism to monitor that. We don't possess accurate data of the migrant workers"*

Labour officer's words explicate the gravity of problems in documenting the migrant labour force currently working in the state. Large-scale contractors keep a permanent working force and it is easy to obtain details and keep a track on them with the help of the contractors. In contrast, freelance construction workers are itinerant in nature and travel across the region for jobs. It is difficult to locate them or procure their details. Since they leave the site immediately after the completion of current job, tracking the migrant worker is not easy.

The District labour officer further adds: *"Contractors do not give exact numbers and information of the migrant workers, they hide details from labour department to overcome the legal issues"*. In light of the comment made by the labour officer on contractors, it could be said that, contractors also play a significant role in data collection. According to him, it is possible for a contractor to hide the exact number of workers and their details from the authorities if they desire. The intention behind it could be to prevail over the legal matters associated with keeping workers. Officials are helpless and are forced to accept the details provided, as there is no other mechanism present to validate.

The Field officer from the labour department said that,

> *"Migrant workers are the people who are scattered and floating in nature. Collecting details from them is very difficult. For Aawaz enrolment process we have to go in the evening and that is difficult. After 5 we don't have official duty, but we go to the migrant labourer's resident place and approach them, but by 6 clock half of them might get drunk."*

Officials who are in continuous touch with the migrants are of the view that 'most of them are scattered and hard to reach out'. Data collection can only be conducted in the evening as that is the only time they are available, for which the officials have to work overtime. These efforts also often turn futile as the migrants are intoxicated by the time officials locate them. This forces the officials to repeatedly visit the beneficiary, to obtain the details required. Considering the massive number of migrants and inadequate staff, data collection and enrolment is a case of despair for the department.

Identity proof issues

Enrolment in government's schemes can only be carried out by furnishing valid proof. Aadhar card, voter ID and ration card are accepted in the verification process for enrolment. Authorities depend and demand Aadhar card, as it has biometric details of the applicant. Since the intention behind 'Aawaz' scheme is proper documentation of the migrants in the state, data collection process for this scheme is of immense significance.

Migrant workers who hail from different states across the country, many may not have all the required identity proofs with them. The assistant labour officer succinctly describes:

> "A s*ection of the migrant workers do not have identity card. Without any identity card, enrolling in the insurance scheme is not possible. Some of them have identity cards but not an original one. Some show identity cards with same credentials such as date of birth, place etc. but with a different name, they are not applicable to enrol in the insurance scheme."*

Lack of original documents is a recurring problem in the identification process. Some possess fake identification cards, which are not acceptable and they cannot enrol in the scheme. The Assistant labour officer expressing concern says: "*Fake identity cards are there. There are illegal migrants from Bangladesh. They do not have any proper identification card. Most of them keep fake identity card but they cannot enrol".* Officers have found some illegal migrants from Bangladesh in guise of Indian migrants. They often possess a fake identity. The scheme is for Indian citizens and therefore, they cannot

apply. Identification is a process laden with the risk of faking. Migrants with fake identity cause a great distress to officials and are a threat to the security of the country as well.

Language issues

A field officer from labour department detailing the problems associated with communication says:

> "*They can't speak to us because of the language barrier, so we need a translator. We also seek help from the owner of the building where they reside or the main mason who can communicate with us. If nobody is available, it is very difficult to explain and make them understand about the scheme/program and get the required details from them*."

The statement underlines the fact that language is a great obstacle for communication. The labourers who are not proficient in either Hindi or Malayalam make the matter worse for the officials. In such cases, the officials seek assistance of owner or the head of that migrants group, to talk to them. A translator's help if needed is sometimes sought as a last resort.

The field officer relaying the difficulties and concerns says:

> *"The migrants are hesitant to talk with us. Even if they are proficient in Hindi they don't talk with us. There is some kind of fear of the government officials griping them. Most of them are not comfortable to meet us."*

Migrant labourer's reluctance to open up, as mentioned in the statement, does not arise only from lack of proficiency in a language. It springs from an unknown fear of the officials who quiz them. The result of this is miscommunication and inadequate data. The field office from labour department continued:

> *"Talking in Tamil is not a problem. But while talking to people from Hindi belt they become scared and talk in a mixed language rather than proper Hindi. It is very difficult to make them understand the benefits of the Aawaz insurance scheme*."

According to the officials their conversation with the Tamil migrants is not problematic but communicating with the migrants from north and north eastern states is a tough task. Ultimately, it is the migrant labour who suffers as they are not able to understand benefits of the scheme and are at loss.

Work time issues

A normal migrant works more than their native counterpart and is free only after 5 pm in the evening. The official time of the office ends at 5pm. Hence, officers are not able to get the details during their office hours. In order to collect data, the officials work overtime and try to meet the migrants at 6pm, at their residences.

A filed officer says:

> "*After evening 6 only, most of the migrant workers are available as they become free only by that time. At times they work overtime, in that situation, they are not available and we won't be able to get details from them. Working hours is very big issue."* He further adds: *"Only Sunday they don't work and we also have off on Sundays. Sometimes, we cancel the off day and go for collecting details from them, otherwise it would be incomplete as they won't be available."*

The officials puts in their effort to collect data even on Sundays, the only off day for both of them. During weekdays, it is difficult to locate the migrants and are available only in the late evenings. The Assistant labour official recollects the difficulties in data collection:

> *"It's a bit difficult for the collection of data. One of the main aims of this scheme is collection of details, of all the migrant workers, but collecting details from the scattered migrants is very difficult as they don't stay at one place regularly. Some of them would stay in work site, especially construction workers. Day time we won't be able to trace them, so we have to go in the evening time."*

The labour official reveals various issues which crop up during data collection and enrolment of migrants. The official time of work varies for the official and the migrants and the officials have to work overtime to complete their task. They sometimes conduct multiple visits to certain residential places to ensure that they meet all migrants living there. Altogether, enrolment in the ambitious Aawaz scheme is riddled with complex issues. The officials who are entrusted with the task have to go extra mile to meet the goal, which may occur gradually.

The migrant labours in Kerala is vulnerable in their working and living conditions due to their migratory status. The vulnerability is visible in the utilisation and accessibility of health care services in Kerala. Most of them are unable to use the available health resources in Kerala properly. The existing welfare measures like RSBY and Cess fund under Building and other Construction Worker's Act and the Welfare Board Schemes

have not reached to them primarily due to the lack of awareness about schemes. In terms of RSBY, portability of the scheme from their respective States to Kerala is posing multiple unresolved technical issues.

The Aawaz health insurance by Government of Kerala has brought about a shift in the existing scenario with migrants getting more conscious about entitlements. The scheme is aimed at providing the free health insurance cover of 15000 per annum for the registered migrant labour in Kerala. Factors such as language, culture and work time of the migrants cause a significant slow-down in the functioning of the system.

CHAPTER 7

DISCUSSION AND CONCLUSION

Introduction

Migrant workers seeking employment in Kerala from states like west Bengal, Bihar, Orissa, Chhattisgarh, and Jharkhand, and also from southern state from Tamil Nadu, are Increasing. This stream of migration to Kerala is because of the existence of better working conditions and prevailing high wage rates. In general for these workers, many of them being on contract labour, are subjected to economic exploitation by getting low wages sometimes below subsistence level across the country. Across the country, the contract system of employment is increasing and so much so in the state of Kerala. Compared to migrant workers from outside the state, the local workers are well organised and succeed in getting decent wages and working conditions (*Government of Kerala*,2015). Therefore, the state labour department initiated a number of programs aiming at improving awareness among all the migrant workers as well as promoting their health and living conditions. This study focused on the factors pushing the migrants from their host states to Kerala and how they have been living and adapting to working in Kerala. It also focusses on different benefits and entitlements they are supposed to get and the barriers to access them, like the Government health insurance scheme called 'Aawaz' for the Migrant labourers. The study is conducted among male migrant workers in the construction sector in EranadTaluk in Malappuram district. For the data accumulation, the working and living condition and issues in access to health care services and schemes are studied.

The study tries to identify the barriers to access the health services and health entitlement among the migrant workers in the EranadTaluk, Malappuram district. Specific objective of the study are-

1. To study the socio economic status of the migrant workers.
2. To study the barriers faced by Migrant workers in accessing the health services in Kerala.
3. To understand issues faced by the health care providers in addressing the health provision to migrant workers.

4. To identify the areas where interstate migrant workers are lacking in accessibility to entitlements and social welfare schemes.
5. To understand role of 'Aawaz' health insurance in addressing entitlements issues faced by migrants workers.

This study is primarily qualitative. For the study both secondary and primary data were collected. Primary Data for the Study was collected through case study and in-depth interviews using interview guides for the participants. Secondary data sources include articles published in journal, media reports, Government order and reports, books etc. The Migrant labours in EranadTaluk of Malappuram district are the subjects of the study. A total of 16 samples (migrant labours) are taken for the study. Further interview was taken from 20 key informants in the study area. Thus purposive sampling was used to identify the samples required for the study by keeping the inclusion criteria of being employed in a medium or small scale construction work for not less than 2 years and age criteria (17 to 59 years).

Further 20 interviews with key informants were also conducted which included four doctors (two from a public hospital and two from a private hospital), four nurses (two from a public hospital and two from a private hospital) , District medical officer and Deputy Medical Officer, Labour officer, Assistant Labour officer and Field Officer with the labour department, four health inspectors (two from rural area which includes the Taluk hospital and two from the urban area within the study area) , Health superintendent of a municipality within the study area were interviewed personally and two officers (a Deputy officer and a Field officer) of Building and other construction workers welfare board were interviewed by means of telephone..

Socio-Economic Profile of the Migrant Workers

In this study, out of 16 migrant case studies conducted, 12 people fall between the age categories of 17 to 30 years. This shows that, most of the migrant workers are young and able bodied and are able to do hard physical work. Their education status ranges from the primary education to senior secondary schooling. Even little better educational status, like secondary and higher secondary schooling helps them change their occupation for better earnings and status.

Majority of them are school drop-outs due to economic issues in their family. The study finds that majority of the migrants falls under the Muslim community in the study area. 10 out of the 16 labours are Muslims and other 6 belong to Hindu community, in which 4 of them are scheduled caste and 2 of them belong to scheduled tribe. Most of the migrant labourers earn around 700 to 900 rupees per day as compared to Rs. 350 or 450 in other states. Even though there are minimum wages given for each states some of the studies in these states (Acharya& Reddy, 2016) shows that they are not even given minimum wages and there is no place for equal wages for men and women. Very important aspect of migration is the push factors, of landlessness, poverty, unemployment and lack of educational and health services in the host states and the pull factors being the employment opportunities, better living conditions, educational and health services. Most important aspect of migration is to send remittances to family who are left behind to take care of their marginal lands, family and old parents. In most cases the labour is able to send some amount as remittances, In this study the respondents shared that they send remittances of 12000 to 15000 rupees per month to their respective places. Important point to mention here is that most of the migrant labours use the banking services for their economic transactions in their everyday life and also to send the remittances.

This study also analyse the social integration of the labour from other states into the Kerala culture, provided they have been staying for long. Interacting with the local people, learning local language and working in the occupations, where there is a team work made some of them integrate well.

Socialisation, living and working condition of Migrant labours

The study finds that the socialisation of the migrant labourers is less due to the cultural and language difference but there are a few cases which show that the migrant labour who have more lived- experience in the local community and have learned the local language have been more integrated with the local people. Peer group interaction, sports and recreational activities, same religious beliefs and practices are helping factors for integration of migrant labours in the region. Some of the migrant labourers are settled in Kerala to seek the better employment opportunities and health and education for their family and children.

Emile Durkheim (1895) studied how societies maintained the social integration after traditional bonds were replaced by modern economic relations. Durkheim believed that

society exerted a powerful force on individuals. People's norms, beliefs and values make up collective consciousness or shared way of understanding and behaving in the world. According to Durkheim, the collective consciousness binds individuals together and creates social integration (cited in James L & Mathews D, 2016). In the present study, the labour coming from one state also shows collectiveconsciousness, and integrates them due to similar social situations, background and the similar aspirations with which they migrate to different states. Literature also shows, the migration is patterned and also kinship plays an important role in bringing their relatives to the urban centres.

Most of the migrant labourers responded that the main motivation behind the migration is the better job and wage opportunities in Kerala and they felt the need of the economic improvisation of their families. Half of the respondents shared the indebtedness due to the dowry, illness, and agricultural loans were the reasons for migration. Only a few of them are holding their own land and houses back home. The loss of traditional jobs, low wages, family debts, failure of the agricultural crops are the main push factors, while better wages, sustainable job opportunities and peaceful social atmosphere act as pull factors for the labour migration. The main source of information about the job opportunities are friends and family members and the neighbours of the migrants.

The irony of migration to urban centers is that they aspire to improve their living standards, however, studies have shown that their living conditions, like housing, cleaner air and environment, cost of living back home is comparatively better than urban enters where they migrate (Achrya and Reddy year,2016, IIDS, 2018). They often end up in crowded places, slums and *JuggiJopri* clusters where they live in closed, without ventilation rooms, shared by the whole family or many men staying together, further lack of water and sanitation facilities.

In this study it was found that most of the migrant workers live in shared rented rooms near or in the outskirts of the main town areas. The rooms are congested and occupied by 5 to 6 persons in one room and cooking is also done in the same room. The availability of the water and toilet facilities is not sufficient in some places. Some of the labourers stay in the worksite itself to save their money. The availability of fresh and potable water and toilet facilities are not proper. These living conditions make the migrant workers more prone to diseases. The working conditions in the construction sites of smaller buildings and houses are not harmful compared to big constructions sites, and also safety measures

are not properly maintained. Most of the workers do not care about the need of the safety. They use the protective measures when they feel so. They find the protective gear like helmets, gloves and boots, hampering their work, so they prefer working without wearing them. Though they are conscious of the risks and hazards of not using the gear, still they sometimes neglect them. The respondents also shared diseases they have acquired, especially skin allergies, due to non-usage of protective gears.

Accessibility issues to Health services.

All these factors discussed above have an influence on the health and well-being of the migrant labourers. They face issues while accessing health care services. There are multiple factors like language, culture, economic, health literacy, work time, distance to health institution, transport availability which are directly influencing the accessibility of the health services by the migrant workers.

Language is a major barrier for migrant workers in Kerala in order to access health care services. Most of the migrant workers revealed that seriously injured or ill persons among them prefer to go back to their home town to continue their treatment rather than continuing it in Kerala. The lack of local language skill is causinga hindrance in the communication between the health service personnel and migrant workers and this influence the quality of treatment negatively. Even educated migrant workers are hesitant to communicate with health service personnel and sometimes they are forced to use self-medication due to lack of information about the health care. The lack of local language skill is also causing economic exploitation of migrant workers. Private clinics and labs charge extra money for services due to the lack of awareness among the migrant labours. Language is a barrier for health care for professionals also. Most of the health service personnel face communication issues with migrant workers. The majority of health staffs in Kerala communicate with patients in local language; Malayalam. But the massive influx of migrant workers to the state has created issues in the health service sector. The communication barrier can cause the quality of the service and even medical negligence.

Like language, culture has a great influence on migrant workers. The differences in culture and language cause a reduced social integration between the migrants and the local people. Minor sections of the migrants have felt biases from the local community. It is clearly evident in the work sector. There is wage difference between the migrant workers and local workers. The local workers are getting more wage compared to

migrants for the same job. The cultural difference makes the migrant workers feel discriminated against in health institutions. According to the migrant workers, they have to wait more time to consult the doctors compared to the local people. The discrimination is high in private hospitals at the time of emergency treatment. A few of the private health institution show reluctance to admit or give treatment to migrant labours due to the fear of responsibility issues in absence of relatives and friends of the patient. Another reason is the higher cost of emergency treatment. The perception and inability to pay the medical bill also makes the migrant labours experience discrimination in accessing the health care services.

Most migrant workers have achieved better economical position after migrating to Kerala. But accessing health care is an unresolved issue for them due to the higher medical service cost in Kerala. Most of them are not willing to continue their treatment after the first consultation because of the unaffordable costs. The migrant workers use both public and private services. However, they are mostly willing to use the public services but overcrowded public hospitals and huge queue deter them from using the services. It is because none of the migrant workers ever wants to lose their one day wages. They prefer the public health institution because of the less consultation fees.

Another issue is lack of awareness of the health services and the locality. By reason of lack of information about affordable health service provider near by the migrant workers are forced to depend up on the home remedies. Not only the information about the health services but also the lack of knowledge about the illness or health problem is also creating barriers to proper utilization of the health services. Like lack of information about health services, the working time distances, and transport availability are also creating hurdles to reach the health services for the migrant workers. The outpatient timings in hospitals clash with working time of the migrants. Since most of the labourers are not willing to lose one working day, it leads them to choose private health services, even though they do not prefer to go there. Another issue is the lack of support of the accompanying persons for care. Most of migrant labourers do not prefer to continue their inpatient treatment in Kerala due to the lack of support of a caregiver either from the family or friends, as they too are busy with their own daily labour. Mostly migrant labours have migrated alone and not with their family . The cost of the treatment is another reason for discontinuing the treatment, they are thus forced to leave the state and continue their treatment in their native places.

‘Aawaz’ health insurance scheme and issues to get the entitlement

Migration stream to Kerala had created social, political and health challenges before the society. Keeping the barriers to health services for the migrant workers, the State is responsible to fulfil the needs and provide adequate quality services according to concept of Universal Health Coverage (UHC) and also the declaration of Health for all. Thus, the Kerala government implemented ‘Aawaz’ health insurance scheme with the aim of providing health care assistance and free medical facilities to each registered workers.

Most of the migrant workers responded to scheme very positively because majority of them work in construction site, and they are vulnerable to various kind of diseases and injuries. So they hope this scheme will be useful for reducing their health expenditure. Construction work is quite hazardous and risky. Migrant labours take risks while working at the site. So they hope that the scheme will be helpful for their family, if they lose their life while working.

The motive behind ‘Aawaz’ health insurance scheme is the better integration of the migrant workers to the health system. But most of the beneficiaries are not aware about the schemes in Kerala. They are not able to subscribe to the available schemes like RSBY at national level because of the lack of information about the portability, structural barriers and they are compelled to leave the entitlement for the use of other family members in their native place.

The lack of awareness among migrants about the scheme shows that there is a gap in information dissemination. Lack of local language skill and unknown territory make the migrant become the victims of the ignorance in the host society. Despite the information provided to the beneficiary the migrants are not able to find the enrolment offices to continue the rest of the process of registration.

Not only the lack of information but also the distance between their work place and their living places and the registration offices demand a days’ leave from work, which they are not willing to do. This creates problem with the availability of entitlement. Lack of awareness is creating exploitation by mediators in the name of enrolment process. Lack of awareness is used as a tool by few small contractors to exploit the migrant labours economically in the name of paper works for the enrolment process in Aawaz scheme.

The mandatory enrolment of workers in this scheme by contractors is only used for registration (on paper), but they are not made aware of the scheme and their entitlements.

Majority of the migrants are highly mobile. They travel and work across the state. Short span of work in a place and continuous journey and lack of awareness about the places deter their enrolment process sine die. A section of migrant labourers, who are alienated because of the cultural and local language differences, makes them keep a distance from the local community and authorities. Repeated checking by police and local body officials makes them annoyed and cause fear among them towards the system. It makes migrant workers to back off from enrolling in the health insurance scheme.

The implementing authority of 'Aawaz' scheme is the labour department. Instead of the language and cultural issue the officials in the department face other obstacles in the enrolment process of migrant workers into the scheme. According to them, the data collection of migrant labours is quiet a difficult task for them because most of the freelance construction workers are itinerant in nature and travel widely to seek their job. So it is difficult to locate them and get their details. Even then data collection can only be possible in the evening time as that is the only time they are available. For this the officials have to do over time work with inadequate facilities.

The intention behind Aawaz scheme relies on the proper documentation of the migrant workers in the state. The migrant workers who hail from the other states and may not have all the identity proof with them to meet the enrolment criteria. Not only the lack of valid identity proofs but also the fake identity cards are causing the obstacles in accessing Aawaz entitlements.

Conclusion

Braveman and Gruskin (2003) in their article highlight the importance of considering 'health inequity' in the place of 'health inequality' and explaining the concept. According to them equity is the term that stand equal to social justice or fairness and is linked to human rights. Defining the concept of health inequity, it projects the disparities in access and availability of health opportunities between different groups in the social hierarchy. Health inequities put the disadvantaged group into further disadvantage due to the distributional injustice. This definition stands important when it comes to the matter of analysing health of different social groups and their rights to be healthy.

The study reveals socio-economic changes in the lives of migrant labourers in the State of Kerala over the years after migration. It is understood that the principal reason for the migration boom towards Kerala is an economic crisis. The huge difference in wages between their native place and Kerala is the primary impetus to make migrants opt for Kerala as their preferred destination. Another important area covered in the discussion is social integration. Understanding migrants' life with the totally 'new' community is of great significance for the study, which might have multiple policy implications.

The study identified major barriers for health service providers to provide with necessary health services and migrant community to access them. The main barriers are lack of awareness, language, cultural issues among migrants about the services provided for their welfare and the entitlement awarded to them for the accessibility. Mostly, an undocumented migrant is at a disadvantaged position in accessing the health services and other social protection schemes for them.

The study takes a serious look at the factors that may cause problems to migrants living in Kerala. While the Government of Kerala implements plans to improve the status of the migrants and offers them welfare schemes for their well-being, a good section is not able to get the benefit of them. The work culture, they follow sometimes bar them from bothering about one's own life and health. Language is a definitive barrier. But apathy to the initiatives by the government or lack of awareness is a more serious one. Migrants settled at one place get the government benefits like any other natives.

In the matter of social integration, in some places, migrants are treated less equal to the natives. They are mere workforce than human beings and often find themselves in a crisis when there is a theft or murder. Their settlement is the main target of the police in the hunt for illegal drugs. Language and culture play a vital role in building relationship among people. Since the natives and migrants are mutually dependent, both communities are forced to learn the language of the other, but cultural habits put them at different poles. Locals in Kerala have learned Hindi and migrants Malayalam bit by bit thereby increasing their affinity towards each other. But culture seems to be a too a turbulent river to cross as it often contains many unknown things within.

From the facts mentioned above, it must be noted that the reasons for poor conditions of the migrants do not arise from any institutional failure altogether. The migrants themselves stay away from the socialising process and are not bothered to get help from

the government. This may be due to the poor education they received at home. The only aim of their arrival here is to survive at any cost, and they are ready to suffer inordinate pains to make money. Multiple factors affect the health and access of migrant labourers in Kerala to services and entitlements which were discussed in detail in the research. The current initiatives of safety nets like, Aawaz insurance scheme is definitely admirable. But, on the other, it has to be critically viewed whether such initiatives are actually attending to matter with proper understanding of the nuances.

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APPENDICES

Interview Guide for Participants

Interview guide to study barriers to health care services due to working and living conditions of migrant workers and among local unorganized sector workers and domestic migrant workers in Eranad block of Malappuram district.

Interview guide No: _______________ Date: ______________

- **Individual and household details**

  1. Name, Age, Sex, religion, education, marital status , Occupation, Income
  2. Details of family members

- **Migration details**

  1. Destination region and reason for migration
  2. Effect of migration in socio economic condition
  3. Changes in health care utilization after migration

- **Living and working details.**

  1. Living conditions: place, room, availability of water and sanitation facilities, type of foods, changes in food habits.
  2. Opportunities and challenges in after coming to the this place.
  3. Responses and interactions with local communities.
  4. What about the climate conditions of this place
  5. How is the working conditions, opportunities and challenges.
  6. What are the differences you felt from local people in terms of working conditions?

7. What are main problems you identified in the working and living conditions, and how these things affect your health?

- **Illness details**

1. Origin of illness
2. Symptoms at origin
3. Who identified the illness?
4. How do you confirm the illness?
5. Severity of illness from beginning
6. Details of rest taken
7. Do you face any difficulty in doing day to day activity due to the illness
8. Stress due to illness
9. Does the illness affect your employment?

- **Preference to public or private sector**

1. Which care provider do you consult?
2. Reason for choosing the provider
3. What was your priority while choosing the provider?

- **Availability of public and private sector facilities**

1. During the time of illness, is it possible for you to avail public / private care services
2. Whether public or private care providers are more accessible for you
3. Which sector is more affordable for you?
4. Do you approach the same provider whom you consulted one year before?
5. if not, reason for changing provider

- **Quality of services in public and private sector**

1. In which sector do you think a better quality service is available?

2. Are you satisfied with their service and expertise in the

3. Which sector lets you take decisions on treatment- public or private?

4. Which institution is better in terms of its hospitality?

- **Other major health providers approached**

1. Which are the other major providers you approached for treatment?

2. Reason for approaching them

- **Socio-cultural aspects of the of health care seeking**

1. Any preference to doctor or institution affiliated to particular religion or caste

2. Do you prefer to approach a male or female doctor?

3. Do you resort to any religious practices to cure the illness?

- **Obstacles to accessing the health care**

1. How is your living condition a barrier to avail health care services?

2. How do your language and cultural differences affect your access to health services

3. Have you faced any discrimination from health care providers?

- **Pathway of health care utilization**

1. Immediate response to the illness

2. Whether done any self treatment

3. At which stage of illness, do you approach a doctor for treatment.

4. Any delay in treatment seeking

5. If discontinued treatment at any stage, reason for discontinuing

- **Entitlement details**

1.What are the welfare schemes you are aware of

2.What are the welfare schemes you have enrolled in.

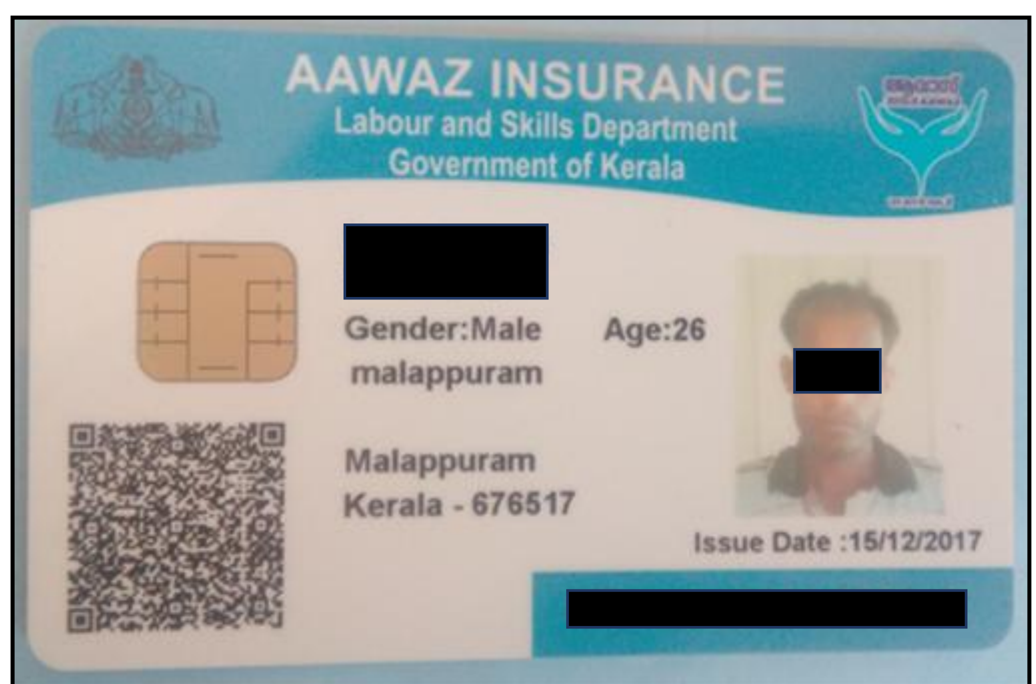
3.Do you get any benefits from those schemes?.

4.what are the challenges you faced in getting those benefits.

5.how are these schemes helpful to maintain your health.

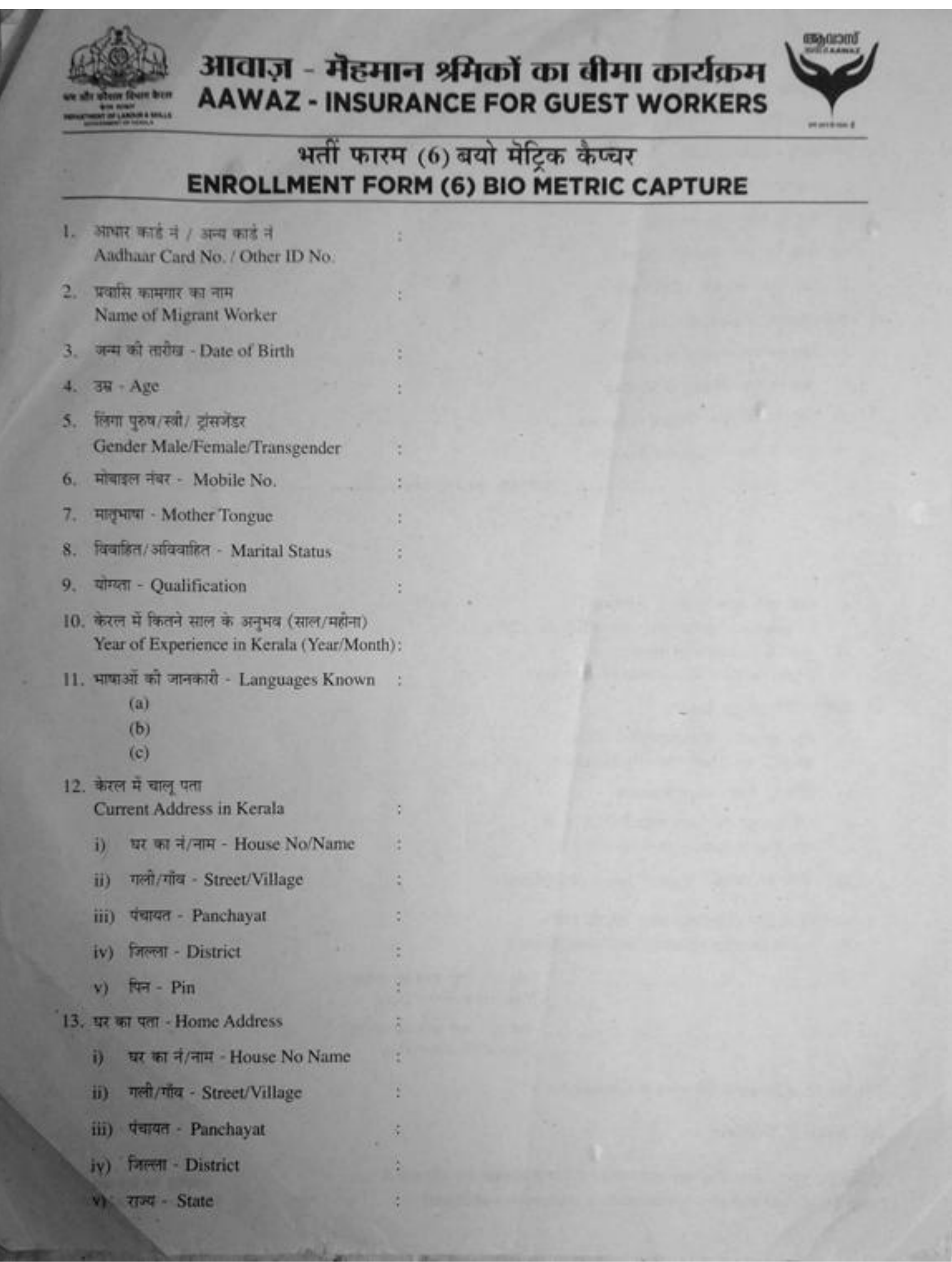
6.what is your suggestion to improve the schemes made for you.

Aawaz Insurance Card



Registration Process of Aawaz Scheme

Aawaz Insurance Scheme Enrolment Form



आवाज़ - मेहमान श्रमिकों का बीमा कार्यक्रम

AAWAZ - INSURANCE FOR GUEST WORKERS

भर्ती फारम (6) बयो मेट्रिक केप्चर

ENROLLMENT FORM (6) BIO METRIC CAPTURE

1. आधार कार्ड नं / अन्य कार्ड नं Aadhaar Card No. / Other ID No. :
2. प्रवासि कामगार का नाम Name of Migrant Worker :
3. जन्म की तारीख - Date of Birth :
4. उम्र - Age :
5. लिंगा पुरुष/स्त्री/ ट्रांसजेंडर Gender Male/Female/Transgender :
6. मोबाइल नंबर - Mobile No. :
7. मातृभाषा - Mother Tongue :
8. विवाहित/अविवाहित - Marital Status :
9. योग्यता - Qualification :
10. केरल में कितने साल के अनुभव (साल/महीना) Year of Experience in Kerala (Year/Month):
11. भाषाओं की जानकारी - Languages Known :
    (a)
    (b)
    (c)
12. केरल में चालू पता Current Address in Kerala :
    i) घर का नं/नाम - House No/Name :
    ii) गली/गाँव - Street/Village :
    iii) पंचायत - Panchayat :
    iv) जिल्ला - District :
    v) पिन - Pin :
13. घर का पता - Home Address :
    i) घर का नं/नाम - House No Name :
    ii) गली/गाँव - Street/Village :
    iii) पंचायत - Panchayat :
    iv) जिल्ला - District :
    v) राज्य - State :

vi) डाक घर - Post Office :

vii) नज़दीक के पुलीस स्टेषन Near by Police Station :

viii) पिन - Pin :

14. बैंक विवरण - Bank Details

i) बैंक खाता नं - Bank Account No. :

ii) बैंक का नाम - Bank name :

iii) शाखा का नाम - Branch Name :

iv) आई. ऐफ. एस. कोड - IFS Code :

15. परिवार विवरण - Family Details

i) पिता का नाम - Name of Father :

ii) माता का नाम - Name of Mother :

iii) पति/पत्नी का नाम - Name of Spouse :

iv) बच्चों के नाम - Name of Children :

a) नाम - Name.................................. पुरुष/स्त्री - Male/Female.................... आयु - Age............

b)

c)

16. a) बच्चे अगर केरल में पढते हैं ? (हॉ/नहीं)
Childrens, whether studying in Kerala - (Y/N)

b) जवाब हॉ है तो स्कूल का पता दें
If yes, mention the address of the school :

17. मज़दूरी ब्यौरा - Wage Details

a) वेतन का प्रकार (दैनिक/साप्ताहिक/मासिक)
Wage Type (Daily/Weekly/Monthly) :

b) वेतन की रकम Wage Amount :

c) यदि आप इस वक्त काम करता हैं ? (हॉ / नहीं)
Whether presently working ? (Y / N) :

d) नौकरी का स्वभाव - Type of Job & designation :

18. दस्तावेज़ों के सबूत (रेशन कार्ड/वोटर आई.डी. आदि)
Proof of documents (Ration Card/Voter ID etc.)

i) .... नंबर और जारी करने की तारीख
Number & Issue Date

ii) .... नंबर और जारी करने की तारीख
Number & Issue Date

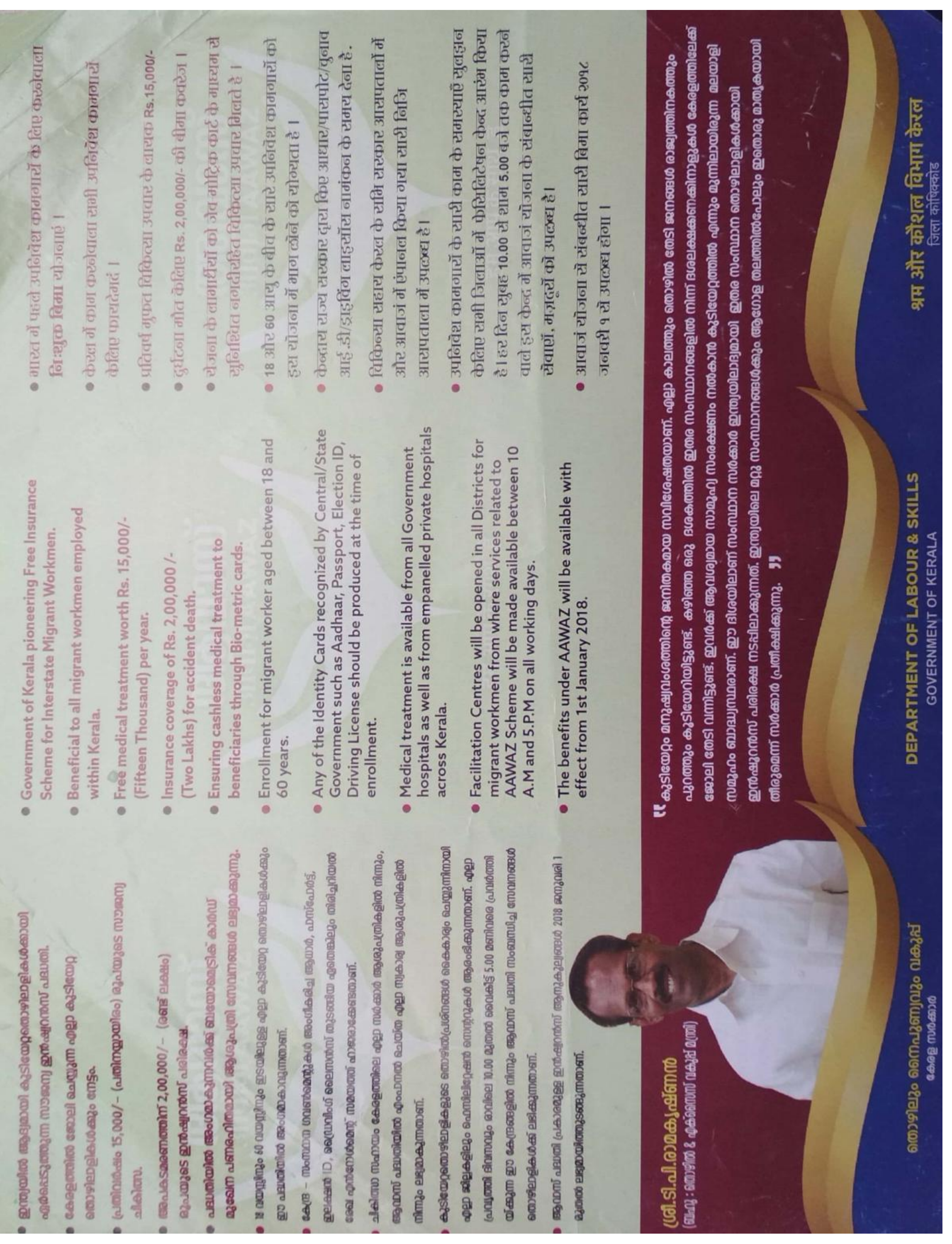
19. Name of Nearest Relative & Contact No :

20. Name of Nominee :

मैं इसकेद्वारा घोषणा करता हूं की सारे ऊपर बयानें और विषयों बिलकुल सच और सही हैं
I here by declare that above statements & contents are absolutely [illegible]

कामगार का हस्ताक्षर
Signature of Worker

IEC Pamphlet



GOVT. OF KERALA
AAWAZ
हम आपके साथ हैं
1800 42 555 214
0471 2557756
155 214
DLO(E) MALAPPURAM
0483 2734814, 8547655273