Chapter 14
Health Beyond Borders: Migration and Precarity in South Asia

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14.1 Introduction

In 2020, COVID-19 disrupted all forms of human mobility through the closing of national borders and halting of travel worldwide. However, the impact of the pandemic and policy responses to it wasn't equal across populations and regions – in resource-poor contexts in South Asia, the ban on movement within countries and across national borders and suspension of transport at short notice left millions of migrants stranded. For instance, the closure of the Nepal-India border left hundreds of workers returning to Nepal stuck in crowded temporary shelters at the border (Down to Earth, 2020b). Covid-19 also disrupted migration patterns, increasing the risk of concentrated outbreaks in areas of return, a majority of which were ill-equipped to offer even general care (Kapilashrami et al., 2020). Nearly 117,145 undocumented Afghans returned from Iran and Pakistan in the first 2 weeks of March 2020 alone (IOM, 2021).

When the pandemic struck, sectors such as tourism, construction, and service sectors, which employ millions of migrant workers, closed overnight. By early May 2020, 30% of families in Sri Lanka and Bangladesh engaged in these sectors had lost all their income (UNICEF, 2021). In India, closure of work sites and eviction forced 10.4 million domestic migrant workers to return to their home states (Down To Earth, 2020a); many undertook weeks-long journeys on foot, with no provision for their food, shelter and health. As reports emerged on their state of hunger and assaults, it became clear that the physical and mental health impacts of the lockdown would be "potentially worse than the threat of the virus itself."

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S. I. Rajan (ed.), *Migration in South Asia*, IMISCOE Research Series,
https://doi.org/10.1007/978-3-031-34194-6_14

(Kapilashrami et al., 2020; Kapilashrami and John, 2023). Furthermore, targeted sanitising and quarantining measures in countries like India stripped low-income internal migrants of their civil and political rights making them "subjects of charity, objects of (mis)governance and bodies of disease and stigma" (Deeksha in Samaddar, 2020:124).

Even before the pandemic, the framing of migrants as disease-carriers has long been central to public policy discourses (e.g. as target groups for HIV/AIDS interventions), mainstream media portrayals (John & Kapilashrami, 2020) and scholarship (with disproportionate focus on infectious diseases and migrants' health). Responses to the pandemic merely intensified these views. However, the pandemic simultaneously made visible migrants, and the precarious conditions in which they live, work and move. Low-wage migrant workers in South Asia frequently find themselves caught in a cycle of precarity that spans contexts of destination and origin as both are characterised by poverty, informality and insecurity of work. Precarious work often goes hand in hand with intermittent access to basic services (Babu et al., 2017), widespread discrimination and ill-treatment (Sharma et al., 2021; Samaddar, 2020), combined with an inability to demand rights and justice, and poorer health outcomes (Kusuma & Babu, 2018).

This chapter presents an overview of the health status and healthcare access of low-income migrants, including internally displaced people (IDP) and refugees, in South Asia. We draw on the findings of a scoping review (Munn et al., 2018) of literature on migrants' health and determinants to examine how their health is linked to their social, work and political lives. This scoping review is part of a larger body of work undertaken by the research team of the Migration Health South Asia (MiHSA) network to examine the volume, scope, nature and trends in migration health research in South Asia. Authors utilised the Scopus database to retrieve documents in peer-reviewed journals from 2000 to 2019 using the search words "health" along with several migrant categories (e.g. IDP, internal migrants, refugees, asylum seekers, migrant workers, labour migrants). We extended the scope of the review by undertaking a further rapid review of literature from 2019 to 2021 on the health of migrants in South Asia as well as South Asians migrating to regions like the Gulf Cooperation Council (GCC) Countries and Singapore. Within this literature, we analysed discussion on the factors and processes that underlie poor healthcare access and outcomes.[1]

14.2 Migration in South Asia

Rural to urban migration and forced displacement from conflicts, persecution, disasters and neoliberal economic development projects have a long history in South Asia. In 2019 alone, the region reported 498,000 new IDPs fleeing conflicts

[1] See 'Pandemic, precarity and health of migrants in South Asia: Mapping multiple dimensions of precarity and pathways to states of health and well-being' paper for more developed methodology for review.

and violence (IDMC, 2020). The region also hosts one of the highest refugee populations in the world, including more than 700,000 Rohingya refugees in Bangladesh (UNHCR, 2019) and 1.4 million Afghan refugees in Pakistan. Mobility patterns in South Asia are however defined primarily by temporary migration of low-wage migrant labourers within national borders (inter-state as well as rural-urban intra-state) as well as across countries in the region, brokered by middlemen and recruitment agencies (World Bank, 2020). In India, there's an estimated 100 million internal migrants (Economic Survey of India, 2017) and a million Nepalis who migrate on a circular basis for work (World Bank, 2020). South Asians also constitute the largest expatriate population in the Gulf Cooperation Council (GCC) countries (Jain & Oommen, 2017).

South Asian economies benefit extensively from migrants' labour. Internal migrant workers in India, for example, contribute 10% of the country's Gross domestic product (GDP) (Deshingkar, 2020), forming the backbone of various sectors, including construction, domestic work, agriculture, garment, mining, among others. In Nepal, around 30% of the country's GDP comes through remittances, mostly from the Gulf States and Malaysia (Sharma, 2018), while in Pakistan and Bangladesh, these figures stand at 7.9% and 5.8% respectively (World Bank, 2020).

14.3 Migrants' Health and Its Determination

The conditions in which migrants work, live and travel influence their health and well-being. In our scoping review, we identified three overlapping determinants of migrants' health in South Asia – work conditions, intersecting social inequalities, and migrant status and associated restrictive governance. We describe these below alongside an examination of the pathways through which these determinants affect health and the corresponding states of ill-health they produce.

14.3.1 Migrants' Work and Health

Low-income migrants in South Asia populate the informal economy, which accounts for nearly 80% of total employment in the region (ILO, 2018). The informal sector is characterised by precarious employment, exploitative employment practices, poor remuneration and social protection, and hazardous conditions created as national labour markets became globalised and incorporated in a neoliberal capitalist economic structure.

In our review, studies examining the health of migrant workers in the construction sector in India (Adsul et al., 2011) and the garment/textile sectors in Bangladesh and Sri Lanka (Solinap et al., 2019; Senarath et al., 2016) report that a majority develop respiratory problems, jaundice, gastro-intestinal illnesses, kidney ailments and musculo-skeletal problems. These effects were attributed to dangerous working

conditions and poor safety standards observed. For example, the authors observed that these migrant workers worked long hours without protection or adequate training – in the construction sector, they routinely suffered from falls and, in the garment and textile sectors, workers struggled with health conditions caused by repetitive tasks and difficult sustained postures. A survey of repeat migrants[2] in India (LSHTM, 2018) reported 83% worked in dusty, smoke-filled rooms with inadequate ventilation, 42% worked without safety gear, and a quarter were in contact with potentially infectious and dangerous materials on a daily basis. Working in hazardous conditions like these can cause injuries and illness that result in long-term disabilities, which may in turn force the children of these workers into entering similarly hazardous work (LSHTM, 2018). Another study among internal migrants in India found that those with a history of migration is twice as likely to have diabetes, hypertension and cardiac complaints compared to those with no history of migration (Hameed et al., 2013). The authors identified employment-related stressors as a risk factor. Exploitative employment terms and conditions, such as longer work hours without break and inability to change one's place of work or to take leave, can also result in poor physical health. Studies on the work conditions of Nepali migrants in the Gulf States note that working long hours in the sun were significantly associated with dehydration and heat stroke (Simkhada et al., 2018; Pradhan et al., 2019). Albeit limited, studies also report association with poor mental health. For instance, Akhter et al. (2017) studied women migrant workers in the Bangladesh's garment sector and found that a majority of them suffer from anxiety, stress, restlessness and thoughts of suicide due to the work burden, exacerbated by separation from their children and family support. In all three studies, researchers found that migrant workers' access to health-care was limited by their long work hours and minimal or absence of medical services at the workplace. Lack of contracts and social protection measures, which is common to the unorganized sector in South Asian countries, can also limit access to employee benefits such as health care or sick leave (Bhattacharyya & Korinek, 2007).

Where existent, legislative measures to protect migrants' health are poorly enforced. For example, in India, internal migrant workers are protected by the Building and Other Construction Workers (Regulation of Employment and Conditions of Services) Act 1996 and the Unorganized Workers' Social Security Act 2008, which provide social security benefits for work-related injuries, sicknesses, maternity, and pension for those above 60 years (Ministry of Law & Justice, 2018). In addition, the Workmen Compensation Act of 1923 provides a list of diseases which, if contracted by the employee, will be considered an occupational disease liable for compensation (NCEUS, 2007). However, a survey by Aajeevika Bureau (2014) across three employment sectors in Rajasthan found that migrants are routinely blamed for accidents and are immediately laid off. In the rare instances where employers paid for basic medical treatment, the amount was deducted from

[2] A term used by authors to refer to a mode of migration undertaken by the poorest and most illiterate sections in rural India.

the workers' monthly wages. Contractors and employers refuse liability for deaths, and families rarely receive compensation (Prayas, 2009). Poor enforcement of regulations is also reported in other countries in the South and South East Asia region, including Myanmar (Tanaka et al., 2015) and Cambodia (Oka, 2010). Other barriers to healthcare access reported in the above studies include language and cultural differences, discriminatory attitude by healthcare workers, and fear of job loss (Simkhada et al., 2018; Pradhan et al., 2019; Akhter et al., 2017; Bhattacharyya & Korinek, 2007).

14.3.2 Social Inequalities and Health

Attention to social divisions (based on gender, nationality, caste, ethnicity, among others) and structural conditions associated with these (e.g. poor housing, food insecurity, lack of education and other opportunities) is critical for migrants' health in South Asia, where they represent diverse caste, ethnic/indigenous groups, and class. Class relations, defined by rigid hierarchies of social structures like caste and tribe, steer patterns of labour migration, which, in turn, influence the health and wellbeing of migrants and their families. Albeit limited studies explicitly examine these inequalities and their effects on migrants' health, there is evidence to suggest inequalities determining migrant health and their differential health experiences across migrant groups. A study in the Indian state of Rajasthan, tribal status was found to be strongly related to poor nutritional outcomes and being a tribal from a high outmigration area adds to the vulnerabilities faced by these families (Mohan et al., 2016). In a study of seasonal migrants in three Indian states, Shah and Lerche (2020) found the low-caste and tribal migrant labour from central and eastern India to be the most exploited migrant workforce. These populations take up work that local populations, including marginalised groups, were moving away from. Within the migrant groups under study, there was a qualitative difference between the working and living conditions of *Adivasis* (tribal) and *Dalits (historically marginalized 'untouchable' caste)*, and that of other backward castes and Muslims; with the former relying exclusively on piecemeal daily wages. Almost all these workers had contracted malaria at one point or the other in destination states and incurred mounting debts in meeting their medical expenses. Most of the health expenses went to treatments by *Shamans* and medicine from quacks.

Gender emerged as a critical determinant of mobility and work and the resulting differences in health risks and vulnerabilities. Mazumdar et al. (2013) reports a distinctive gendered pattern in migration across India – most women migrants are in the paid domestic and garment sectors, and male migrants dominate services and industries. While this increases men's risk to accidents and injuries from heavy machinery work, women migrants face a double burden of occupational hazards along with gender-based discrimination (including wage differences), sexual harassment, and lack of privacy for sanitation (Tiwary & Gangopadhyay, 2011). This pattern is also visible at the community level – In Bangladesh's Cox Bazar, for example,

women and girls among Rohingya refugees were found to be at high risk of multidimensional gender-based violence at the household and community level, exacerbated by displacement (UNHCR et al., 2020). Transgender people in this community were worse affected as they, in addition to these risks, also had to circumvent social exclusion and discrimination based on their gender, which impeded access to even basic healthcare services.

The impact of gender inequalities on migrant workers' health is mediated by other aspects of their position in social hierarchies. Mazumdar et al. (2013) found that a majority of migrant women workers from historically and socially disadvantaged communities (*Adivasis* and *Dalits*) are more concentrated in short-term and circular migration – generally involving hard manual labour. Studies from India have shown that women engaged in such sectors suffer from multiple occupation health hazards such as body ache, sunstroke, skin irritation, and poor maternal health, and experience harassment, poor housing facilities, and depression (Bhattacharyya & Korinek, 2007; Jatrana & Sangwan, 2004).

14.3.3 'Migrant' Identity, Transience and Health

Vulnerabilities associated with and arising from the status of 'being a migrant' is shown to impact on migrants' health. Studies associate these vulnerabilities primarily with the transient nature of migrants' social and economic lives that translate into a range of domains; namely, lack of documentation as well as information about their entitlements and location of healthcare facilities, non-portability of entitlements (such as health insurance); thus impeding their access to healthcare and resulting in poorer outcomes (Babu et al., 2017; Borhade, 2011). Even where elements of welfare, such as education and health, are framed as universal and grounded in rights-based legal frameworks, providing proof of domicile/residence is a prerequisite to access a majority of schemes, especially those run by the state. For example, Nepali migrants in India, most of whom work as daily-wage labourers, struggle to access healthcare services in India without an *Aadhar* card (an Indian identification card linked to individual biometrics) (Adhikary et al., 2020). Such exclusion is also evident among interstate migrants (Lone et al., 2021). Employers also try to cut cost by hiring migrants in an irregular situation to avoid providing health coverage. The Aajeevika Bureau survey (2014) in India found that a majority of migrant workers were unable to avail full benefits under various state legislations as they were rarely registered officially by contractors or employers. As a result of this during Covid-19, the severely delayed furlough schemes and benefits that were offered to factory worker failed to reach internal migrants who suffered job losses.

Research on immunization patterns in rural–urban migrant populations in India (Kusuma et al., 2010) revealed isolation faced by migrant families in a new sociocultural environment as a key reason for lower vaccination uptake among recently migrated and temporary migrant families. The temporariness and the 'outsider' status to a locality exposes them to widespread abuse and ill-treatment from local

residents, landlords, authorities “that comes with their work but rarely ends with compensation and justice” (Sharma et al., 2021). The ‘outsider’ status also drives the perception of migrant workforce being ‘disposable’. This was evident in the early days of the pandemic-related lockdown in 2020 in Qatar, where migrant workers from Nepal were deported under the pretext of Covid-19 testing, after being detained with inadequate food or water in overcrowded quarters (Budhathoki, 2020). While governments in GCC countries provided financial relief to businesses to maintain workers’ salaries and jobs, foreign workers were excluded from these programmes, and from overall Covid-19 policy responses (UNICEF, 2021). Many in low-skilled employment in construction, retail, and other labour-intensive occupations continued to stay in overcrowded living conditions, even as public health messaging emphasised strict physical distancing; areas subsequently recognised as Covid-19 hotspot (Cornwell, 2020).

Statelessness continues to characterize the lives of million in South Asia. Worldwide, studies report that this leads to social and biopolitical exclusion, which often translates into adverse living and working conditions, poverty, the perpetual fear of arrest and deportation, chronic stress, and other factors that interact to heighten vulnerability to illness and injury (Berk et al., 2000; Fassin, 2008; Willen, 2005). Such biopolitical exclusion became apparent in India as migration became highly politicsed with contemporary political developments. In 2015, the Supreme Court of India directed Assam, a North Eastern state that shares a border with Bangladesh, to update its National Register of Citizens by requiring people to produce documents of ancestry in order to be enlisted as Indian citizens. The final list of “citizens”, published on August 31, 2019, excluded nearly 19 lakh residents of Assam, many of whom belonged to economically vulnerable sections with no documents to prove their nativity (Karmakar, 2019). During Covid-19, these populations struggled to access healthcare over lack of documentation and fear of deportation, while those in detention centers weren’t given access to work or appropriate healthcare and were kept in cramped quarters (COVID-19 Emergency Statelessness Fund Consortium, 2021). Even where formally recognised as citizens, migrants are often treated de facto as non-citizens (Mander & Sahgal, 2008), invisible to planners and public policy makers in destination cities.

Migrants are also subjected to surveillance based on their sociability, guided by the temporariness of their livelihood, and perceived disposability. Assumptions underpin frames of threat to security (national or local area) as well as to public health, as migrant bodies are deemed as carrier of infections (Samaddar, 2020; John & Kapilashrami, 2020). The pandemic crisis, Samaddar (2020: 62) observes, effectively transformed a labour migrant from a “productive body” providing capital to families and communities to a “body of disease”. This notion prompted selective quarantining measures and state actions to disinfect migrants, ostracization and vigilantism of return migrants during COVID, as well as deportations following routine screenings for other infectious diseases. In the GCC countries, which hosts 15 million migrants from South Asia, migrants are subjected to compulsory periodic medical examinations and face deportation without diagnosis and treatment, if found to be HIV positive (Wickramage & Mosca, 2014).

14.4 Discussion

The conditions in which migrants move, live, and work carry exceptional risks to their physical and mental well-being (Zimmerman et al., 2011). This chapter contributes to a deeper understanding of the different determinants of migrants' health, which reflect conditions of precarity, and how these in-turn affect healthcare entitlements and well-being. We take stock of the limited regional evidence on the health of migrants – internal and international – and identify how these relate to the different aspects of precariousness and marginality that defines their lives.

The concept of precarity has received much attention in recent scholarship. Rooted in the analysis of a set of labour conditions, the term denotes the "social positioning of insecurity and hierarchization, which accompanies the processes of Othering" (Puar, 2012: 165). Viajar (2018) in her study of migrant domestic workers in Malaysia, explores three dimensions of precarity – the devaluation of their work which reproduces the "productive-reproductive and formal-informal labour dichotomies" (Work-based precarity); deportability of migrants (Status-based precarity); non-recognition of domestic work which prevents workers from enjoying labour rights such as fair wages (National-based precarity). Viajar observed these dimensions engender and reproduce disempowerment, disposability and exclusion of migrant workers. Drawing on our findings, we build on this framework in relation to migrants' health, identifying the process of social determination, i.e. pathways through which states of ill-health are produced among migrants.

Judith Butler explains precarity denotes a "politically induced condition in which certain populations suffer from failing social and economic networks of support and become differentially exposed to injury, violence and death" (Butler, 2009: 25). Precarity has been examined largely in relation to labour conditions, thus overlooking dimensions of precarity exercised in the socio-cultural and political lives of migrants (e.g. othering in communities, omissions in public policy and planning, everyday violence outside their workspace).

Our examination of the determinants of migrants' health examined in migration health literature in South Asia revealed reveals three broad dimensions of precarity: (i) *Work-based*, concerned with insecure, hazardous and disempowering work conditions, (ii) *Social position-based,* pertaining to exclusion resulting from the intersecting multiple oppressions faced by low-income migrants, (iii) *Status-based*, derived from vulnerabilities arising from the mobile and transient nature of their lives and livelihoods, as well as illegality or inferiority framed in formal policies and informal governance procedures that disenfranchise migrants.

Examining work as a determinant of migrants' health, we reveal how restrictive contracts and terms of employment, poor wages and work conditions create insecurity and disempowered states of being. While migrants exercise agency in the choices they make and the daily negotiations in their workspace, this is within a rather restrictive environment created by the neoliberal Market-State complex that actively functions to dispossess them of their social-economic rights. Ferguson and McNally (2014) view this as a deliberate strategy to keep them vulnerable and

controllable as they become "cheap labour" and thereby profitable. Their disempowered state precludes them from being able to negotiate safer workspaces leaving them stuck in precarious jobs for their entire work-life span, exposed to different health risks and occupational hazards, and abuse without compensation or recourse to justice. The precarity they face at work is exacerbated by insecure legal and residential status (Piper et al., 2017), and results in poor mental and physical health.

A second determinant of mental health, and dimension of precarity identified is social inequalities deriving from diverse identities and aspects of social location (e.g. gender, nationality, ethnicity, caste, geography, class) that characterise migrants in South Asia. These factors interact to create and reinforce a social hierarchy on the basis of which some migrant groups cluster in low-dignity and insecure work and face greater 'othering' and exclusion. Social and biopolitical exclusion often translates into adverse living and working conditions, poverty, the perpetual fear of arrest (and/or deportation), resulting in chronic stress and heightened vulnerability to illness and injuries. Systematic exclusion also results in erosion of trust in public services (including health) resulting in lower uptake of preventive interventions such as immunisation, and avoidance of healthcare (Kusuma & Sivakami, 2017). Kapilashrami and Hankivsky (2018) remind us that migrants are not a homogenous group with uniform health and healthcare seeking experiences, and framing them as such masks differential risks and precarities resulting from migrants' unique social position at different stages of their journeys. Studying this multi-dimensional socio-economic ordering can provide valuable insights into how different axes of power intersect with each other to place migrants in different situations of discrimination and disadvantage as well as advantage and leverage, potentially guiding more targeted and effective health policies (Kapilashrami & Hankivsky, 2018).

A third dimension relates to the status of 'being a migrant' and its effects on health. The effects of migrant identity on health are constituted via two pathways. First, displacement/dislocation and (re)adjustment in a new environment can cause significant psychological stress, which is aggravated by the insecure and exploitative nature of their livelihoods as well as ill-treatment by employers and authorities. Even internal migrants often refer to their destination states as 'foreign' (Rogaly et al., 2002), and struggle to access elementary citizenship rights and entitlements (Sharma et al., 2021). The resulting insecurity and stress has been associated with substance abuse, domestic violence and physical and mental health problems (Borhade, 2011, Mander & Sahgal, 2008). While these vulnerabilities are common to other marginalised groups (e.g. urban poor), the precarity linked to mobility and migrant status produces excess burden on health. Second, the transient nature of migrants' social and economic lives, and the attached 'non' or 'inferior' citizen status exposes them to alienation and othering from the society and reinforces their disposability. Active vilification from media and pathologizing in health policy discourses (as seen in the case of COVID, and pervious pandemics) makes them particularly prone to abuse, violence and subjects of invasive interventions. This disposability not only affects their physical and mental health but erodes trust in public services, thereby limiting their interaction with health systems and uptake of services.

In conclusion, the pandemic was a wake-up call of sorts for governments in South Asia as it exposed the structural neglect and violence faced by mobile populations in origin and destination contexts, and centre-staged policy concerns around their social protection. Policy and media discourses in South Asia have tended to frame the sudden public visibility of migrants during the enforced lockdown as a 'migrant crisis'. Having taken stock of the evidence on migrants' health and its determinants we argue that this is a 'development and governance' crisis that failed to account for and redress the multiple systematic production of precarity that puts migrants at great risk of poor health in destination contexts. While there's mounting scholarship on migration in South Asia, migrants' health continues to be a neglected area, in research and policy. Notably, epidemiological studies that report on migrants' health status, tend to be stripped off an analysis of the socio-economic and political determinants and the pathways through which their health states are produced. In addressing these gaps for more migration-aware and migrant-sensitive public policy response, we call for more nuanced analysis of differences within differently situated migrant groups, and an explicit adoption of an intersectional lens.

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