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Inter-State Migration, Footloose Labour and Accessibility to Health Care: An Exploration among Metro Workers of a Camp in Bengaluru

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Abstract & Keywords: The neoliberal political economy that India adopted in 1991 has brought in huge Foreign Direct Investments, which has led to a perceptible increase in the number of migrants in the major cities of India due to various structural reasons in their place of origin and rapid developmental activities in the cities. Bengaluru has the second largest migrant population after Mumbai, and as per the labour department of the government of Karnataka; there are more than 65 lakh migrant workers in Karnataka, who are involved in various developmental projects, including the metro railway project in Bangalore. Even though the Karnataka Building and Other Construction Workers Welfare Board (KBOCWWB) offers certain social security, including health care for registered migrants, they must wait more than a year to get these benefits. With privatisation and increased out-of-pocket expenditure for health related issues, the migrants face a major hurdle in surviving at the migrated workplaces. Many of them are unaware of welfare boards, and the number of migrants who are registered with them is very small. This paper aims to understand the accessibility of health facilities for migrant workers working in the Bengaluru Metro Project. This research will understand the legal, economic and psychological aspects related to the health status of migrant workers through qualitative study. The study used in-depth interviews to elicit responses from selected inter-state migrant workers to understand their access towards health facilities. The thematic analysis of the interview transcripts revealed a substantive gap in workers' access to health facilities. The unregulated working conditions have added more stress to the workers, and due to poverty and unemployment back home, these hurdles are not forcing them to go back. More awareness creating interventions from the government can transform their lives.

Key Words: Migration; Footloose Labour; Metro Train Constructions Workers; Health Care; Social Work; Health Awareness

Historically, human migration has been part of larger social change and development processes. According to its required needs, the development processes attract skilled, semi-skilled and unskilled labour forces in regional, national and international domains. From a capability development approach, Amartya Sen (1999) theorised migration as an important function in expressing people’s capabilities and aspirations. According to World Migration Report 2022, around 3.6 percent of the population, which is 281 million people, are international migrants in 2020, which has increased from 153 million in 1990 (McAuliffe & Triandafyllidou, 2022). The neo-liberal political economy has accentuated the human

migration process within and among the countries. The neoliberal order has minimised the role of social justice and slowly transformed the welfare state into a 'competition state' (Joppke, 2021; Laruffa, 2022). Even though India adopted a "Mixed Economy" policy after independence with a stronger state role and private sector participation, in 1991, it officially adopted a neoliberal political economy. Neoliberalism believes that liberating individual entrepreneurial skills and freedom can strengthen human wellbeing. This can be materialised in an institutional framework that encourages free trade and the free market. To recover from the weak economy, neoliberalism prescribed various conditionalities to achieve a larger goal of reducing the fiscal deficit (Chandrasekhar & Ghose, 2000). This path of reducing fiscal deficit has resulted in state withdrawal from many sectors, primarily social sectors (Sethuraman, 2015). This, in turn, had a major impact on many welfare policies which protected the migrant labourers and their families.

This paper attempted to understand the status of inter-state migrant workers under the present neoliberal regime in India. The withdrawal of the welfare state and emergence of the market has played a significant role in aligning every sector of the economy including the health sector. Further, with the coming in of more private capital for infrastructural development projects, the enclaves of development have attracted more migrant workers, who were deprived of their livelihood back in their home states. We discussed such an increase in inter-state migration trend after adoption of neoliberal political economy in India. In this context, this study has highlighted various aspects related to health such as nutrition, awareness, access, working conditions and psychological impact that emerged as prominent themes from the in-depth interviews conducted among inter-state migrant workers in the Bangalore metro project.

Neoliberalism and Labour

The neoliberal political economy, along with reemphasising the "Laissez-faire" principle of liberalism, demands the state to create a market in those areas where there is a scope for the market. Inequality, being a functional component of this political economy, focuses more on absolute poverty than relative poverty for the bare minimum survival of workers (Peet, 1975). This leads to cheap labour and insecurity at the workplace. As the International Labour Organisation (ILO) highlighted, the labour insecurity of workers increased to 1530 million in 2009 with low pay and extreme poverty (Wise, 2015). Migrants' health is negotiated with the positive narrative of a neoliberal political economy by insisting on upward mobility. However, the lack of labour protections, social security and an insecure labour environment has made migrants vulnerable (Dutta, 2021). Informalisation of the workforce has been another important feature of neoliberalism. In 1999-2000, around 37.8 percent of informal workers in the organised sector rose to 54.4 percent in 2011-12, according to the 68th round of NSSO. Of the total employed people, the informality reached around 99 percent in 2017-18 (Jha & Prasad, 2020). The informalisation has expanded the scope for more internal migration of workers in search of better opportunities due to a lack of job security. This has led to more inter-state migration in the Indian context, which will be explored further.

Inter-State Migration in India

Internal migration within the country signifies disparity among the regions within the country with regard to their developmental indicators. People from underdeveloped regions move towards developed regions in search of opportunities. According to the Census (2011), there are around 450 million internal migrants, which is 45 percent more than the numbers in the 2001 Census. More migrant populations are from the states of Uttar Pradesh, Bihar, Madhya

Pradesh and Rajasthan, and most of them move towards Delhi, Kerala, Maharashtra, Gujarat and Tamil Nadu (Khan & Arokkiaraj, 2021). Various factors, including poverty, unemployment, and declining agricultural growth, were exacerbated after the economic liberalisation in 1991 and contributed to more inter-migration from rural to urban areas (Mitra & Murayama, 2008). According to Mahapatro (2013), there has been a change in the migration pattern due to the development of the IT sector in Karnataka, and there has been a decline in migration towards the states of Punjab, Haryana, and Maharashtra.

Inter-State migrants are vulnerable to various health related issues as the new environment without proper facilities creates insecurity among them. The majority of them belong to underprivileged classes, working as contract labourers in factories, metro projects, and other related construction work. employers overlook their right to various legally mandated facilities. Due to a lack of basic amenities such as water and sanitation, they are vulnerable to health hazards in the work environment and susceptible to diseases (Krishna & Raj, 2022). UNESCO report "Social Inclusion of Internal Migrants in India" (2013) highlights the poor health indicators for migrant women and children who are vulnerable to all forms of violence. Further, due to costly private healthcare, lack of leisure time due to workload, distance to healthcare facilities, lack of transportation facilities, and delay in accessing government health services, the healthcare utilisation by migrants remains very poor compared to others (Borhade, 2012).

The Unique Identification Authority of India (UIDAI) signed a Memorandum of Understanding (MoU) in 2010 with the Coalition of Organisations for the Security of Migrant Workers (COSMW) to create more awareness for accessing many social security services provided by the government of India through Aadhar enabled applications (UIDAI, 2010). However, in many situations, the migrants are stamped as 'outsiders', and local ethnic, linguistic and religious lines of division play a role in their exclusion and discrimination. According to Bhagat (2011), various aspects like political and administrative processes and market mechanisms create a divide between the migrants and locals. Such complexities in accessing various services from the government create a major hurdle for migrant workers in accessing health services in the host state.

Overview of the health challenges

According to the Health Dossier, the healthcare record of the state of Karnataka is quite impressive, especially with patient services indices such as the In-Patient Department ratio of 124.3 (National average - 62.6) and Out-Patient Department ratio of 1734.5 (National average - 1337.1) (GoI, 2021). Even the recent praise by the Chairman of the National Medical Commission (NMC) on surpassing the WHO mandate of a 1:1000 Doctor-Patient ratio and achieving almost 2:1000 Doctor-Patient ratio (The Hindu, 2024) stands as testimony to the status of health care in the state of Karnataka. Despite these numbers, most of the inter-state migrant workers, the focus of this study, are not even registered as migrant labourers and thereby technically are not even considered under the official population of the above-mentioned statistics.

National health insurance schemes like Rashtriya Swasthya Bima Yojana (RSBY) in 2008, which was later subsumed by Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) in 2018 by the Ministry of Labour and Employment, Government of India, covers economically weaker sections including migrants. This scheme covers roughly 40% of the population, mainly focusing on the unorganised sectors, and the benefits are portable across

the country (Angell et al., 2019; Malhi et al., 2020). Despite being covered by national health insurance schemes, studies show that out-of-pocket (OOP) health expenditures are significantly high. According to Sriram and Khan (2020), OOP expenses incurred by poor Indian citizens are 62.6 percent of the total health expenditure. This number is higher than the base reference for financial catastrophe defined (at or exceeding 40% of household expenditure in a year) by Xu et al. (2007). This expenditure can also be incurred at a relatively smaller amount periodically for outpatients. This scheme covers only hospitalisation, excluding post-hospitalisation and outpatient expenses (GoI, 2023a; Sriram & Khan, 2020), increasing the economic burden on low-income people. The available national-level schemes generally come into action only when serious health issues require hospitalisation, and any expenses incurred due to seasonal and occupational recurring health issues will have to be borne by the individuals themselves. But many times, these health schemes do not reach the intended beneficiaries due to various reasons as follows;

Barriers to Healthcare Access

Social discrimination and lack of knowledge about the eligibility and entitlement of healthcare coverage among migrant workers and service providers are the major reasons for limited access to healthcare in the migrated location (Ang et al., 2020; Ramana et al., 2023). Further, occupational, social, and environmental factors also lead to injuries, respiratory problems, and malnutrition, compromising the health of migrant workers (Dodd et al., 2017). It is primarily the lack of social protection (legal and health) in the workplace that increases the vulnerability of migrant workers. The absence or lack of audit on the legal and health protection of migrant workers leads to wage discrimination, poor living conditions, long working hours, and occupational injuries, contributing significantly to the health problems of migrant workers (Jayaram & Varma, 2020; Kumar & Gopalakrishnan, 2020; Regmi et al., 2019).

Ensuring affordable access to healthcare for economically poor population, including migrant workers, is the government's primary obligation. The participation of inter-state migrant workers in major developmental projects is significant, as they form a sizable share of the state's workforce (Bhoi et al., 2022; Dodd et al., 2017; Jayaram & Varma, 2020; Suresh et al., 2020). Jayaram and Varma (2020) identified wage discrimination against migrant construction workers, highlighting an average loss of a month's wage in a year due to wage fraud[1]. Due to inadequate wages, meeting basic requirements like access to healthcare becomes challenging. Unless the illness is severe, there is a lack of interest in seeking healthcare support, and self-medication is very prevalent among this population (Bhoi et al., 2022; Kumar & Gopalakrishnan, 2020). A study by Dash and Mohanty (2019) indicates that untreated health issues or not seeking medical attention at the right time increases the incidence of chronic diseases, further exacerbating their health conditions and the duration of hospitalisation (Sriram & Khan, 2020). Communication using the local language, the high cost of private healthcare, conflicting work schedules, inadequate healthcare practitioners available at the worksite, lack of information, and lack of trust in government healthcare services (Bhoi et al., 2022; Krishna & Raj, 2022; Kusuma & Babu, 2018) are some of the important barriers to low utilisation and access to healthcare. Notably, a study by Loganathan et al. (2019) shows that communication difficulty (language) in the host state of the migrant

[1] A type of fraud that occurs when employers do not pay their employees according to the law

worker leads to medication errors as it may hinder accurate understanding of the prescribed medication.

Based on the above literature, it is evident that migrant workers do not get access to appropriate health care facilities in their place of work for various reasons. Ignorance, being in a vulnerable position, contractor negligence, language and communication hurdles are some of the significant issues that create a hurdle in accessing health facilities. The majority of metro workers coming from outside Karnataka, they face similar kinds of problems. Very few studies have looked at various aspects of metro workers, but not on the accessibility and affordability of health facilities. This study is an attempt to understand their concerns related to health from different disciplinary perspectives.

Metro Project: A Brief

Bengaluru is the capital city of Karnataka state in southern India, with a population of 96,21,551 (GoI, 2023b), of which 91 percent live in urban localities. Driven by work opportunities, the city has become the destination for many inter-state migrants. Bangalore Metro, popularly known as "Namma Metro" was established in 2005 as a special-purpose vehicle and jointly managed by the Government of India and the State Government of Karnataka. Bangalore Metro Rail Corporation Limited (BMRCL) is a joint venture entrusted with implementing and operating the 'Namma Metro' Project. The metro service covers 73.81 KM, covering an East-West corridor of 43.49 km from Whitefield (Kadugodi) in the east to Challaghatta in the west; and a North-South corridor of 30.32 km from Nagasandra in the North to Silk Institute in the South. Namma Metro is India's first metro rail project commissioned with 750V DC Third Rail Traction on Standard Gauge (BMRCL, 2023). The metro line involves both elevated and underground passages, which poses a challenging work environment for construction workers.

METHODOLOGY

The study's primary objective is to understand the accessibility to health care services through the perspectives of the inter-state migrant construction workers of the Bangalore Metro project. These perspectives are developed through social interactions among migrant workers who cohabit at common workplaces and in their dwellings. Therefore, it would be apt to situate this study using the Social Constructivist research paradigm (Creswell, 2007). The existence of this reality is understood from the ontological stance of subtle idealism, and the epistemological stance is fixed as interpretivism (Ritchie et al., 2013). Grounded Theory is selected as the appropriate approach to collate these perspectives into a cogent theoretical framework (Frost, 2011).

Method

Within the qualitative methodological framework, the study used interview schedules with open-ended questions to get details from the migrant workers working on the metro construction project on Bannerghatta Road, Bangalore. The field researchers initially developed a rapport with the migrant workers through frequent interactions. Later, after gaining the confidence of the respondents, they gathered data based on open-ended questions in their schedule from the etic approach.

Sample

The population of the study was comprised of inter-state migrant construction workers enrolled in contractual labour for the erection of the Bangalore Metro Rail project. Most of

these migrant labourers are from central India. The sample for this study was collected from the Hulimavu labour colony of the Bangalore Metro project off the Bannerghatta road. Non-probability snowball sampling was used to identify the respondents for the study. Since the labour camps were not freely accessible, as the contractors have made certain restrictions, the respondents were interviewed when they were outside their labour camps. In total, 18 migrant workers were identified using a convenience sampling technique and interviewed. The interviews were conducted in Hindi and then translated into English before transcription.

Data Analyses

The transcripts were read repeatedly to identify the essence emerging from the data. Categories were made based on the identified similarities and differences. Further, coding and labelling were done in line with the constant comparison method of qualitative data analysis (Charmaz, 2006). The analyses were interspersed with the actual data excerpts from the interview transcripts to add more credibility to the claims made by the researchers. All these excerpts were cited as R followed by a number (E.g. R3, R12, etc.), which denotes the Respondent number.

RESULTS AND DISCUSSION

Health aspect

Nutrition, a far cry

The interviews show that the company provides food three times a day for the workers by employing a permanent cook. Since, in such arrangements, a significant part of workers' salaries is deducted towards food expenses, a lot of workers cook on their own. Given the amount of physically exhausting work they put in daily, the protein requirement and a balanced diet are a distant dream for most metro workers. Their work timings are not fixed, as many days they have to work at night to complete the project due to traffic and frequent disturbances from the public in the daytime. Such erratic work timings deprive them of the opportunity to concentrate and cook properly, which in turn affects their health conditions over time. Those who avail the food from the company kitchen also complained of routine fixed food variety, quality, and taste without much variation or improvement. The company kitchen contractors focus more on making a profit than providing healthy food for these metro workers who are involved in physically demanding tasks. The workers' awareness of protein and other requirements is insufficient as they are more focused on the work and the money they can earn within the contract period. The contractors utilised such a situation in their favour by not providing quality food, as there was no explicit demand from the workers.

> Either we cook or the cooking man comes and serves us food on time here that is the only good thing 3 times a day. (R2)
>
> Dal, rice, sabji. Chicken on Sundays. Sometimes fish and egg. (R12)
>
> We get non veg 3 days a week and we pay for the inputs from our pocket however there is a company-hired cook who cooks for us three times a day. (R14)

Kachan and others (2012) identified that the lack of adherence to the dietary recommendations that are required to prevent diseases such as cardiovascular diseases, hypertension, and metabolic syndrome is found to be more common among blue-collar workers than white-collar workers.

Gateway to Health

The legal framework for migrant workers insists on many social security aspects, including proper health facilities for the workers and their families. Wherever the contractors are intermediaries between the workers and the principal employer, these basic provisions are violated with impunity. According to Ang et al. (2020) and Ramana et al. (2023), a lack of awareness regarding health related support systems among workers is one of the important reasons for not demanding their health rights at the workplace. According to 'The Occupational Safety, Health and Working Conditions Code 2020', ensure that no charge is levied on any employee in respect of anything done or provided for maintenance of safety and health at the workplace, including conduct of medical examination and investigation for the purpose of detecting occupational diseases. All the workers undergo a basic medical examination during induction, and they are provided with a medical card upon which they shall procure medicines from the colony itself for small ailments such as headaches or colds. However, there is no evidence of complete regular health checkups for all employees. Even when the employer brings any doctor for a medical checkup, according to the labourers, that is more ritualistic than done with real intent. For any major health ailments, the employer does not support, and particularly the sub contractors do not provide the mandatory support as said by the law.

> I have a medical card that the company which I work for has given me and I get medicines if required. (R6)

There is an ambulance on standby for any emergency. In case of any major emergency, the workers are taken to nearby government hospitals for treatment. The employer also has an association with a local hospital in case of any minor emergencies.

> The company has a tie-up with a local hospital, and we get treated there if anything happens to us. (R6)

Visiting a local government hospital takes one whole day, and not all employees get the benefit of paid sick leave in such situations. To avoid such pay cuts, the employees prefer to do some self-medication and try to solve the issue. This may, over a period of time, affect their health as the root causes of medical ailment are not addressed. A study by Dash and Mohanty (2019) provides evidence of such deterioration of health conditions due to the failure to treat the ailment at the initial stages.

> There is an ambulance of the company that takes us to the hospital. (R14)

> Even if someone gets injured at this point then we worker brothers only help that person. (R7)

> If we get a fever or something we have to manage ourselves but if people get injured while working then the company pays for treatment. (R13)

Sick, yet kicking

The responses of the workers do not give clarity on the provision of and availing of sick leaves. Some of the workers claimed that they get paid if the leave is available for medical

purposes. However, there is another section of the workers who claim they shall only get paid for the hours of work that they have clocked in.

> You can get sick leave and paid for the day if you are not feeling well. There are also some medicines available for like pain or headache. (R13)

> If I put in a sick leave I get paid for the day as well. If I take a leave for non-medical reason then I don't get paid. (R14)

Policy UnAwareness

With regard to the government policies on health, there is an abysmally low awareness among migrant workers. Out of the 18 migrant workers interviewed, only one gave an affirmative response for the Ayushman Bharat card. He, too, insisted that he got it from his native state out of his own volition and neither the company nor the government of the migrated state took any initiative towards promoting it.

> We took the initiative of making the ayushman card. The company didn't provide us with any sort of information on that. (R4)

But for a few migrant workers, others have not even registered themselves with the labour welfare board of the state. During the induction, everyone has undergone medical examination and a medical card is provided, which at the most functions like an identity card and for availing medical supplies from the nearby medical stores where the company has a tie-up.

> We do get an Identity card that has got a seal of approval from the government. (R13)

> I don't have a migrant worker card. (R15)

Working conditions
Work in eternity

The analysis of the data revealed that invariably the construction workers continue their work for 12 long hours.

> I work 12-hour shifts (R13)

> The work will end around somewhere at 8PM and i started at 8AM in the morning. (R7)

Most of the workers are paid on an hourly basis and this is the primary reason which drives them to work for longer hours.

> There are also people working longer hours here than 12 and they get paid overtime for that. (R13)

> For every extra hour worked, I get paid accordingly. (R16)

There is a need to sensitise them towards the importance of proper rest for the recuperation of the body for the next day's strenuous manual work. The ill effects of pushing the body too much during a young age shall not be physically sustainable in the long run.

Research study on migrant workers by Jayaram & Varma (2020), Kumar & Gopalakrishnan

(2020) and Regmi et al. (2019) highlights the long working hours and their impact on the health conditions of migrant workers. The hierarchy of contractors involved in the project has created differential rights for workers working under different contractors. All the workers do not have similar rights with regard to leaves, benefits and allowances. In the State of Punjab and Others. v. Jagjit Singh and Others (2016) the supreme court insisted on equal treatment of all employees who do similar work with equal benefits, including wages. Here, we have observed that workers under some of the subcontractors were denied their rights and benefits compared to other workers under different contractors.

Safety Measures

Unanimously, all the workers agreed that their safety and security at the construction site were of paramount importance. There are Safety Supervisors who constantly monitor them and ensure that they are wearing all the safety gear. Since it is an elevated corridor construction site, it is mandatory for all workers to wear the harness.

However, some of the workers who had worked abroad had concerns about the quality of the safety gear provided by the company. Further, a few workers mentioned that despite repeated instructions and warnings from the supervisors, they do not pay attention and act with a complacent attitude.

> I use a harness provided by the company. (R14)
>
> There is a safety supervisor who checks whether everyone is wearing proper safety gear or not. (R16)
>
> Everything is done here with safety. We are given instructions on how to do everything. If we don't work with safety, we are scolded too by the supervisors (R18)
>
> we won’t get all those amenities like that of abu dhabi like shoes, Glasses, proper harness. (R2)
>
> Supervisor also being in power does not instruct us properly that what all measures can you take. (R4)
>
> We only ignore him and it is our mistake too that we don't work properly therefore accidents occur. (R4)

There is a clear scope for the Social workers to intervene and create an attitude and behavioural change among these migrant construction workers to not take the safety measures lightly at any cost.

Unmindful Impact: A Psychological Perspective
Leisure, a luxury!

The fact that they are paid on an hourly basis and the constant rush to make the most out of the opportunity, invariably most of the workers have the tendency to work on Sundays as well. Though it is not a compulsion, the voluntary work done on holidays is not considered on par with overtime payment as mandated by the law.

> There are no chances for holidays as such. (R2)

> I am a contract worker and I only get paid for the days I have worked. (R6)

There were a few inconsistencies in the claims itself with respect to the holidays, which might be the difference between the workers who are directly in contract with the construction company and those who have been subcontracted through other agencies to the company.

> Yes, diwali holiday was there and for chhath. (R17)

This is clearly depriving the workers of their leisure time for engaging in activities that shall promote their psychological wellbeing. All work and no play might get them more salary but definitely at the expense of their physical and mental health. The lack of awareness about at what cost they are earning that extra money is the reason for them to be exploited with(out) their consent.

As per the Code of Wages, 2019, the employer should provide for a day of rest in every period of seven days and they should provide remuneration in respect of such days of rest. Further, it insists that the payment for work on a day of rest should be at a rate not less than the overtime rate. However, most of the respondents interviewed were not provided with paid weekly holiday violating the labour law.

For Home, from away

The entire labour colony from where the participants were selected and interviewed is only for the males on a sharing basis. Irrespective of their marital status and the large family back home, they stay in forced bachelorhood and isolation for an unduly extended time.

> I have a mother, a wife, and my son of 3 years. (R4)

> 5 members, mom and dad and 2 brothers. (R11)

> There are my parents, my two brothers, wife and 2 kids. (R14)

Thomas, Liu, and Umberson (2017) have clearly highlighted the significance of the impact that marital, intergenerational, and sibling relationships have on one's wellbeing. Though they are allowed to travel once a year to their native, fully funded by the company, we could not find consensus among all the workers on this facility. Staying away from ailing parents and young children is clearly having an impact on the psychological wellbeing of these workers.

> If I work for six months, the contractor gives me a ticket to go home. He pays the money. (R12)

> I will be going home after another 6 months as going and coming back once a year is paid by the company. (R16)

> My son is studying in Patna. That's why I am working so hard for my family to provide him the education he needs. (R7)

Haunting Insecurity

As migrant workers are not aware of their basic rights, entitlements, and the stipulations of the Constitution of India, they are mired in the uncertainties about the future. The lack of proper medical insurance and social security net is constantly keeping them in a sense of insecurity, greatly affecting their psychological capital and inhibiting the realisation of their potential.

> We further wish that nothing should happen to any of us because we won't be able to handle the cost here in bangalore. (R2)

Jung, Lim, and Chi (2020) have highlighted that the lack of rewards and organisational justice would negatively impact the safety behaviour of construction workers. The fear that in case of any untoward incident, the company may not support them, especially among the workers enrolled through contractors, shall lead to detrimental results. The need of the hour is to clear any existence of discriminatory treatment among the workers and create awareness about the facilities available to them.

1 CONCLUSIONS AND RECOMMENDATIONS

The overall analysis of the responses from inter-state migrant workers of the Metro construction project shows various shortcomings at the implementation level of various welfare measures, including health related among the inter-state migrant workers. This gives a lot of scope for intervention in creating more awareness among employers and employees for a better and healthier working environment. The study shows that the workers involved in heavy weight lifting work, do not meet the daily nutritional requirements. Since all the workers are residing in the labour colony, the employer employs them at work at any time according to the demand of the work. This has deprived them of regular sleep and rest. The contractors do not make any active effort in creating awareness regarding healthcare facilities and benefits the employer. The working conditions are further creating more stress on the workers, which has a perceptible psychological impact on their overall well-being.

The following are some of the key intervention points for strengthening the workers' welfare measures related to the health and working environment of metro workers in Bengaluru;

- Regular health awareness workshops for workers, supervisors, and contractors emphasising cleanliness and its benefits, appropriate nutritional intake of food, regular health camps, regular health checkups and visits to nearby hospitals which have tie-ups with BMRCL.
- Policy awareness should be made for contractors, supervisors, and employees regarding wages, paid holidays, working hours, and various government-mandated social security protections.
- Psychological counselling sessions should be conducted regularly as all the metro construction workers have travelled away from family members and do not frequently visit their families due to tightly scheduled work.
- Social workers shall interact with migrant workers to develop a mutually agreed upon standard operating procedure to ensure a safe work environment.

- Social workers, in coordination with the contractors, shall constantly monitor and evaluate the wellbeing of migrant workers. The same shall be prepared as reports and shared with contractors, employers, and other stakeholders.

- They shall engage in creating awareness through client-specific approaches like street plays, songs, etc.

- Local language orientation can make the relations better. Further, a coordination committee representing both sides can act as a buffer zone to avoid any kind of miscommunication.

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