

REPORT

FEMALE MIGRANTS IN INDIA

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Executive Summary

There has been an increasing feminization of internal labour migration in most developing countries over the past few decades [1–9]. Although the reason for internal migration among female migrants, as reported by existing secondary sources in India, is predominantly marriage, there has been an increase in migration for economic reasons [10–14]. While the only major data sources on migration in India (the Census and National Sample Survey [NSS]), provide information on various dimensions of migration, they fail to provide detailed information on the health-related vulnerabilities of migrants. National Family Health Survey (NFHS) of India too has only a proxy indicator to capture the migration status of the respondent, making migration-focussed analysis of health indicators difficult. Further, a few small-scale surveys were conducted to understand the mechanism of male migration, almost no primary study has been conducted on internal female migrants in India [15, 16]. Women migrants are more likely to be vulnerable than their male counterparts in destination areas with regard to health, physical safety and financial means. The Population Council conducted an exploratory study on internal female migrants in Delhi and Mumbai to better understand their socio-economic and health related vulnerabilities.

The study entailed a cross-sectional bio-behavioural survey in Delhi and Mumbai. Women aged 18 years or older, who had migrated and were currently working in either of the two study sites, irrespective of their primary reason for migration, were recruited for the study. A total of 1000 female migrants were interviewed for the study. This comprised of 499 respondents from Delhi and 501 from Mumbai.

KEY FINDINGS

Most female migrants worked as domestic workers in the households

More than half of female migrants worked as domestic workers in households (Delhi: 47.3%; Mumbai: 54.9%); 18.4% were engaged in tailoring/handicrafts; and 11.8% were working in factories. Shop-keeping and other petty business was also reported (8.2%). Very few of the respondents (5.9%) were engaged in formal-sector jobs such as teaching, nursing, and community health. On average, female migrants were earning about 4,655 INR per month.

Better economic opportunities was the most commonly reported reason for migration

Better income (67%) and better work opportunities (60%) were the most frequently reported pull factors, followed by having well-settled relatives in Delhi/Mumbai (29.7%) and family movement (17.9%). The most frequently cited reason pushing respondents to migrate were reported as 'no money in the household' (54.2%), followed by being dissatisfied with the work they did at home (43.6%), and lack of employment in their home districts (15%).

Access to social and financial entitlements between migrants in Delhi and Mumbai are significantly different

About half the female migrants in Mumbai had a bank account in contrast to one-fifth of the Delhi migrants. However, the bank account holders in Delhi were more likely to utilize it for saving or setting aside money compared to their counterparts in Mumbai. Use of informal channels for saving money was very low in both sites (about 12%). Female migrants in Delhi were more likely to save money by keeping it with themselves than their counterparts in Mumbai (53.3% vs. 22%; $p < 0.001$). More than half of the female migrants had access to most of the social security schemes/cards.

High prevalence of anaemia and low body mass index

Anaemia was frequently observed among the migrant women. In Mumbai, 62.2% of the female migrants were moderately anaemic and 9.9% were severely anaemic, while in Delhi, 38.9% were moderately or severely anaemic. Overall, 10.6% of the female migrants were found to have blood pressure readings suggestive of

hypertension, the proportion being higher (17.7%) in Mumbai. Further, based on the body-mass-index, 39.2% women in Mumbai and 17.6% in Delhi were found to be obese.

Diabetes was the most frequently reported non-communicable disease (NCD)

Diabetes was self-reported by more than a fifth of the migrants in Delhi (21.2%) and about one-tenth in Mumbai (9.4%). Further, hypertension was self-reported by 3.2% of migrants in Delhi and 8.6% in Mumbai. Health care seeking behaviour was high as most migrants sought treatment for NCDs (90.8%), and most used public health care facilities (76.5%).

Abnormal vaginal discharge was the most frequently reported RTI/STI symptom

In the last six months, female migrants in Mumbai were more likely to report symptoms of reproductive tract infections (RTI) or sexually transmitted infections (STI) (36.3% vs. 14.8%; $p < 0.001$) and treatment seeking behaviour (57.2% vs. 19.4%; $p < 0.001$) compared to migrants in Delhi. The most commonly reported symptoms related to RTI/STI was abnormal vaginal discharge (Delhi: 10% and Mumbai: 20.2%), followed by painful or burning urination (Mumbai: 18.2% vs. Delhi: 4.8%). Problems of sexual dysfunction, such as loss of sexual desire or sexual dissatisfaction, were more commonly reported among the migrants in Mumbai.

Access to ANC services between migrants in Delhi and Mumbai were significantly different

Attendance at Antenatal clinics (ANC) was reasonably high (82.1%) for the most recent pregnancy among young migrant women (aged ≤ 25 years) in Mumbai, but relatively low (67.3%) among those in Delhi. Of those who attended ANC clinics, the majority were registered in the public facilities. Although few women reported pregnancy-related complications, more than 80% sought treatment in government hospitals. Further, institutional delivery was higher among the young migrant women in both the cities (Delhi: 76.4% & Mumbai: 77.6%).

Spousal abuse more common among migrants in Delhi

High prevalence of spousal abuse, which included both verbal (65.1%) and physical abuse (32.6%), was reported by women at both the study sites. Reporting of both types of abuse was higher in Delhi. More than 70% of the women in Delhi and around 45% in Mumbai reported having a violent argument with their husband in the past six months.

RECOMMENDATIONS

- Creating enabling environment for potential female migrants: Migration information and support centres in high out-migration districts and high in-migration destination sites could be established to support and facilitate independent migration for women.
- Ensuring adequate representation of women in the implementation of National Rural Employment Guaranty Scheme (NREGS) and linking it to skill development to improve income generation activities in their home districts would serve to reduce the need to migrate.
- Improving awareness of social protection schemes and financial entitlements in migrant settlements would improve access to these services.
- Improving awareness of the availability of low-cost public health care services and introducing behaviour change interventions directed at disease prevention would benefit both the migrant and the larger community in low-income high-density neighbourhoods.
- Individual and community level interventions such as individual/couple counselling and referral to appropriate physical and mental health and legal services would address spousal abuse among migrants and the general community.

Introduction

There has been an increasing feminization of internal labour migration in most developing countries over the past few decades [1–9]. Although the reason for migration among female migrants as reported by existing secondary sources in India is predominantly marriage, there has been an increase in migration for economic reasons [10–14]. Data on female migrants, as also on their male counterparts, are limited in India. Although small surveys were conducted to understand the mechanism of male migration, almost no primary study has been done on internal female migrants in India [15, 16]. Research done so far has used data from secondary sources like the Census and National Sample Survey (NSS) [3, 17, 18]. These studies highlight the need to study female migration as an important component of labour migration. Women migrants are likely to be more vulnerable than their male counterparts in destination areas with regard to health, physical safety and financial means. While the only major data sources on migration in India, the Census and NSS, provide information on various dimensions of migration, they do not provide detailed information on the health-related vulnerabilities of male or female migrants. The National Family Health Survey (NFHS) also has only a proxy indicator to capture the migration status of the respondent, making migration-focussed analysis on health indicators difficult.

Objectives

The Population Council conducted an exploratory study on internal female migrants in Delhi and Mumbai to better understand their socio-economic and health related vulnerabilities. The specific objectives were:

1. To examine patterns and reasons for migration among economically active internal female migrants in India.
2. To explore economic, social, cultural and health vulnerabilities among female migrants in India.

Methodology

As a part of the initial study design, the eligible participants included females who had migrated primarily for work purposes. However, qualitative interviews with key stakeholders indicated that most of the migrant women living in low income high density settlements of the big cities migrate primarily due to the employment opportunities for their husbands and not themselves — associational migration. Once they reach cities, women do engage in low-wage jobs in the unorganized sector to bring home additional income.

We conducted the bio-behavioural survey in low-income and high-density settlement areas of Naraina Vihar and Wazirpur in Delhi, and Andheri, Rafiq Nagar and Wadala in Mumbai. In the selected sites, all the households with eligible participants were listed and approached for participation in the study. Women who had migrated and were currently working, irrespective of their primary reason for migration, were recruited for the study using simple random sampling.

A total of 1000 female migrants participated in the bio-behavioural survey. This comprised of 499 respondents from Delhi and 501 from Mumbai.

Inclusion criteria:

- Age 18 years and above
- Native inhabitants of any rural area of India except Delhi and Mumbai

- Currently living in Delhi or Mumbai
- Residing in study sites for at least 6 months prior to the survey
- Currently employed in Delhi/Mumbai.

Exclusion criteria:

- Individuals who are cognitively impaired
- Individuals in very poor health who cannot be interviewed

Data collection was done through CSPro-based questionnaires using mini laptops. Following the survey, height, weight, haemoglobin and blood pressure (BP) readings were recorded by trained female research staff. Test results were noted by the interviewer on the survey form. The interviewer then notified the individual of her test results and provided information on locally available health services, if required. Informed consent was obtained from all participants prior to the interview. The study was approved by the Population Council's Institutional Review Board in New York. All analyses were conducted using STATA version 13.1 (College Station, Texas). Comparative analyses were conducted between the female migrants by their location of residence. Pearson's chi-square test for categorical variables and Student's t-test of means for continuous variables were used.

Findings

SOCIO-DEMOGRAPHIC BACKGROUND

The mean age of female migrants was 29.2 years (Table 1). Female migrants in Mumbai were older than those in Delhi (33.3 years vs. 25.1 years; $p < 0.001$). A fair proportion of migrants were uneducated (39.2%), and less than a fifth (16.2%) had completed secondary-level education. Most of them followed the Hindu faith (67%), less than a third were Muslim (29.7%); there were significant differences in the religious distribution across the two cities. Respondents in Mumbai were mostly currently married (83.2%), whereas those in Delhi were mostly single/never married (48.1%). They were typically living with their family, either a husband (61.3%) or other family members such as their parents or relatives (34.6%). A few lived alone or with friends (4.1%).

Table 1: Socio-demographic background of the internal female migrants in Delhi and Numbai, India, 2014

	Location			p-value
	Total % (n)	Delhi % (n)	Mumbai % (n)	
Number of respondents	1000	499	501	
Age				
Mean (SD)	29.2 (9.0)	25.1 (7.0)	33.3 (8.8)	<0.001
Median (IQR)	28 (22-35)	22 (20-29)	32 (26-38)	
Education				
No or non-formal education	39.2 (392)	44.7 (223)	33.7 (169)	<0.001
Primary or below (completed year 1-4)	12.5 (125)	12.6 (63)	12.4 (62)	
Below secondary (completed years 5-9)	32.1 (321)	24.8 (124)	39.3 (197)	
Secondary or above (completed years 10 or above)	16.2 (162)	17.8 (89)	14.6 (73)	
Religion				
Hindu	67.0 (670)	81.4 (406)	52.7 (264)	<0.001
Muslim	29.7 (297)	14.8 (74)	44.5 (223)	
Others	3.3 (33)	3.8 (19)	2.8 (14/501)	
Marital status				
Currently married	63.6 (636)	43.9 (219)	83.2 (417)	< 0.001
Separated/Divorced/Widowed	10.8 (108)	8.0 (40)	13.6 (68)	
Never married	25.6 (256)	48.1 (240)	3.2 (16)	
Living with				
Husband	61.3 (613)	42.7 (213)	79.8 (400)	< 0.001
Other family members	34.6 (346)	53.5 (267)	15.8 (79)	
Alone or with friends	4.1 (41)	3.8 (19)	4.4 (22)	

SD: Standard deviation; IQR: Inter-quartile range.

MIGRATION HISTORY

Study participants in Mumbai were relatively older inhabitants of the city as compared to those in Delhi; the mean duration of stay at the current place of residence was 12.7 years in Mumbai and 7.5 years in Delhi (Table 2). Female migrants in Delhi and Mumbai came from different regions of India. A classification of the states of origin by destination sites shows that most were short-distance migrants. They appear to have migrated to the nearest big city since most of them came from within the same state, adjacent states, or nearby states. In Mumbai, the respondents were mostly within-state migrants (47.1% from Maharashtra). The proportion of migrants from southern states like Andhra Pradesh, Karnataka, Kerala and Tamil Nadu was much higher in Mumbai than in Delhi (12.2% vs. 2%). The majority of female migrants in Delhi were from northern states like Uttar Pradesh (40%), Bihar (32.9%), and other states like Uttarakhand, Chandigarh, Punjab, Haryana, Jharkhand, Himachal Pradesh, Rajasthan and Gujarat (18.7% combined).

Table 2: Migration history of the internal female migrants in Delhi and Mumbai, India, 2014

	Location			p-value
	Total % (n)	Delhi % (n)	Mumbai % (n)	
Number of respondents	999	498	501	
Duration of stay at the present place (in years)				
Mean (SD)	10.1 (7.9)	7.5 (6.6)	12.7 (8.2)	<0.001
Median (IQR)	8 (4–15)	5 (3–10)	10 (7–18)	<0.001
Native state				
Uttar Pradesh	33.1 (331)	40.0 (199)	26.3 (132)	<0.001
Bihar	19.1 (191)	32.9 (164)	5.4 (27)	
Other northern states ¹	10.9 (109)	18.7 (93)	3.2 (16)	
Maharashtra	23.7 (237)	0.2 (1)	47.1 (236)	
Southern states ²	7.1 (71)	2.0 (10)	12.2 (61)	
Other states ³	6.0 (60)	6.2 (31)	5.8 (29)	
Age at first migration				
Mean (SD)	18.8 (4.5)	17.6 (3.7)	20.0 (4.9)	<0.001
Median (IQR)	18 (16–20)	18 (16–20)	19 (17–21)	
Length of time since first migration				
Less than 5 years	28.9 (289)	42.8 (213)	15.2 (76)	<0.001
5-9 years	27.2 (272)	29.3 (146)	25.1 (126)	
10-14 years	16.9 (169)	12.4 (62)	21.4 (107)	
15-19 years	11.5 (115)	6.8 (34)	16.2 (81)	
20 years or more	15.4 (154)	8.6 (43)	22.2 (111)	
Reason for migration				
Job/Work related	47.8 (477)	51.6 (257)	44.0 (220)	<0.001
Marriage (moved with husband)	38.3 (382)	30.9 (154)	45.6 (228)	
Family movement	11.0 (110)	16.1 (8)	6.0 (30)	
Other reasons	2.9 (29)	1.4 (7)	4.4 (22)	
Employment before migration				
Not employed	76.1 (759)	80.5 (401)	71.6 (358)	<0.001
Agricultural work	13.6 (136)	7.0 (35)	20.2 (101)	
Non-agricultural work	10.3 (103)	12.4 (62)	8.2 (41)	

SD: Standard deviation; IQR: Inter-quartile range.

¹ Other northern states include Uttarakhand, Chandigarh, Punjab, Haryana, Jharkhand, Himachal Pradesh, Rajasthan and Gujarat.

² Southern states include Andhra Pradesh, Karnataka, Kerala and Tamil Nadu.

³ Other states include West Bengal, Orissa, Assam, Madhya Pradesh, Chhattisgarh and Goa.

The mean age at first migration was higher for the respondents in Mumbai compared to those in Delhi (20.0 years vs. 17.6 years; $p < 0.001$). The duration of time since first migration was also significantly higher for the migrants in Mumbai, as about 60% of them had migrated to Mumbai more than 10 years back. In contrast, Delhi had more recent migrants, as more than 42% of the respondents had migrated to Delhi in the past five years. A high proportion of our study participants reported job or work-related reasons for their first migration (47.8%). Migration due to marriage (38.3%) was the second most frequently cited reason. Some moved with their family (11%), and the remaining cited other reasons (2.9%) such as medical treatment and children's education. The majority of the women were not employed before migrating (76.1%). Those, who were employed prior to migrating out of their home district, had worked mostly in the agriculture sector in Mumbai (20.2%) and in the non-agriculture sector in Delhi (12.4%).

ECONOMIC ACTIVITIES

As seen in Table 3, about half of female migrants worked as domestic workers in households (Delhi: 47.3%; Mumbai: 54.9%), 18.4% were engaged in tailoring/handicrafts and 11.8% were working in factories (with a much larger proportion in Delhi as compared with Mumbai). Shop-keeping and other petty business was also reported (8.2%). Very few respondents (5.9%) were engaged in formal-sector jobs such as teaching, nursing, and community health.

Table 3: Economic activities of the internal female migrants in Delhi and Mumbai, India, 2014

	Location			p-value
	Total % (n)	Delhi % (n)	Mumbai % (n)	
Number of respondents	998	497	501	
Occupation				
Domestic labour	51.1 (510)	47.3 (235)	54.9 (275)	<0.001
Factory labour	11.8 (118)	17.9 (89)	5.8 (29)	
Other wage labour	2.7 (27)	4.2 (21)	1.2 (6)	
Tailoring/handicraft work	18.4 (184)	11.1 (55)	25.7 (129)	
Shop-keeping/petty business	8.2 (82)	10.5 (52)	6.0 (30)	
Formal-sector jobs	5.9 (59)	6.2 (31)	5.6 (28)	
Others	1.8 (18)	2.8 (14)	0.8 (4)	
Monthly income in INR				
Mean (SD)	4,655.19 (2403.13)	5,755.53 (1684.61)	3,563.62 (2510.54)	<0.001
Median (IQR)	5,000 (3000–6000)	6,000 (4500–7000)	3,000 (1500–5000)	
Number of months employed in the last year				
Less than 12 months	35.3 (353)	27.5 (137)	43.1 (216)	<0.001
All 12 months	64.7 (647)	72.5 (362)	56.9 (285)	
Number of working days per week (mean, SD)	6.6 (0.8)	6.7 (0.5)	6.5 (0.9)	<0.001
Number of working hours per day (mean, SD)	6.3 (2.0)	6.8 (1.6)	5.9 (2.2)	<0.001
Frequently called to work beyond work hours				
Yes	31.3 (312)	40.2 (200)	22.4 (112)	<0.001
No	68.7 (686)	59.8 (297)	77.6 (389)	
Get paid for overtime work				
Yes	32.1 (320)	32.8 (163)	31.3 (157)	0.621
No	67.9 (678)	67.2 (334)	68.7 (344)	

SD: Standard deviation; IQR: Inter-quartile range.

On an average, female migrants reported earnings of about 4,655 INR per month; respondents in Delhi earned more than those in Mumbai (INR 5,755.53 vs. INR 3,563.62; $p < 0.001$). As shown in Table 4, migrants in Delhi reported higher wages across all occupational categories. Respondents in Delhi worked more days per week (6.7 days vs. 6.5 days; $p < 0.001$) and more hours per day (6.8 hours vs. 5.9 hours; $p < 0.001$) than those in Mumbai (Table 3). Workers in Delhi were also more likely to work beyond working hours (40.2% vs. 22.4%; $p < 0.001$), while non-payment for overtime work was equally common in both cities (Delhi: 67.2%; Mumbai: 68.7%).

Table 4: Differences in average income of the female migrants by occupational categories in Delhi and Mumbai, India, 2014

Occupational categories	Total	Delhi	Mumbai
	Mean (SD)	Mean (SD)	Mean (SD)
Domestic labour	5090.39 (2157.23)	5863.4 (1460.75)	4429.82 (2423.26)
Factory labour	6095.76 (1586.29)	6544.94 (1169.31)	4717.24 (1899.45)
Other wage labour	5151.85 (1951.21)	5547.62 (1283.6)	3766.67 (3201.04)
Tailoring/handicraft work	2254.89 (1774.99)	4020 (971.52)	1502.33 (1482.11)
Shop-keeping/petty business	4693.9 (2200.75)	5548.08 (1777.47)	3213.33 (2096.59)
Formal jobs	5162.29 (3109.06)	6822.58 (2769.2)	3324.11 (2361.14)
Others	4833.33 (1571.81)	4464.29 (1447.34)	6125 (1436.14)

LIVING CONDITIONS AND REASONS FOR MIGRATION

Since our study sites were located in low-income, high-density settlements in the two cities, the overall living conditions were poor. Overall, 44.4% of the female migrants reported residing in their own house (Table 5); this was higher in Mumbai than Delhi (51.5% vs. 37.3%; $p < 0.001$). A similar proportion (43.5%) lived in rented accommodation, while the rest lived with friends or relatives (12.1%). More than 40% of the respondents had piped water facilities. A higher percentage in Delhi reported accessing drinking water from public sources than those in Mumbai (56.7% vs. 39.9%). The majority of participants did not purify water before drinking (81.8%); although significantly more respondents from Mumbai reported purified water compared to those in Delhi (34.9% vs. 1.4%; $p < 0.001$). The use of public flush toilet facilities was considerably higher among migrants in Mumbai (93.4%) compared to those in Delhi (43.3%). A sizeable proportion of the female migrants in Delhi (47.1%) reported going to nearby open spaces or railway tracks.

Table 5: Living condition of the internal female migrants in Delhi and Mumbai, India, 2014

	Location			p-value
	Total % (n)	Delhi % (n)	Mumbai % (n)	
Number of respondents	1000	499	501	
Nature of the current residence				
Own house	44.4 (444)	37.3 (186)	51.5 (258)	< 0.001
Rented house	43.5 (435)	41.3 (206)	45.7 (229)	
Friends/relatives	12.1 (121)	21.4 (107)	2.8 (14)	
Source of drinking water				
Piped water into dwelling	42.7 (427)	41.9 (209)	43.5 (218)	< 0.001
Public tap	48.3 (483)	56.7 (283)	39.9 (200)	
Public tube-well	7.7 (77)	0.2 (1)	15.2 (76)	
Other	1.3 (13)	1.2 (6)	1.4 (7)	
Purifies the water before drinking				
No	81.8 (818)	98.6 (492)	65.1 (326)	< 0.001
Some purification done	18.2 (182)	1.4 (7)	34.9 (175)	
Toilet facility used				
Private flush toilet	6.3 (63)	6.2 (31)	6.4 (32)	< 0.001
Private pit latrine	1.4 (14)	2.8 (14)	–	
Public flush toilet	68.4 (684)	43.3 (216)	93.4 (468)	
Public pit latrine	0.3 (3)	0.6 (3)	–	
Open space (field, railway track)	23.6 (236)	47.1 (235)	0.2 (1)	

Pull and Push factors influencing migration

Respondents were asked to report the reason for migrating to Delhi/Mumbai. Multiple responses were allowed. A similar pattern of responses was observed in both cities. Better income (67%) and better work opportunities (60%) were the most frequently reported pull factors, followed by having well-settled relatives in Delhi/Mumbai (29.7%) and family movement (17.9%). Similarly, push factors for migrating out of their native states were explored among the female migrants. The most frequently cited reason to migrate was 'no money in the household' (54.2%), followed by dissatisfaction with work they did at home (43.6%), and lack of employment in their home districts (15%). Political instability and environmental conditions such as droughts/floods or debt at home were infrequently reported [data not shown].

FINANCIAL SECURITY AND ACCESS TO SERVICES

Financial security of female migrants was assessed through their access to financial services and entitlement to social security schemes (Table 6). There were significant differences between the female migrants in the two cities. About half the migrants in Mumbai had a bank account in contrast to only one-fifth of the migrants in Delhi. Interestingly, among those who had a bank account, 92.5% of Delhi female migrants used it for saving money in the past 12 months compared to only 33.9% of those in Mumbai. Use of informal channels for saving money was very low in both cities (about 12%). Female migrants in Delhi were more likely to save money by keeping it with themselves than their counterparts in Mumbai (53.3% vs. 22%; $p < 0.001$). Migrants in Delhi were also well prepared for financial emergencies, as 60.5% of them had saved money for emergencies in the past six months, compared to 13.8% of those in Mumbai.

Overall, more than half of the female migrants had accessed social security schemes and possessed residential and other identity proof. However, access was higher among those in Mumbai. More female migrants in Mumbai had a ration card (62.9% vs. 45.3%), voter-ID card (67.1% vs. 62.3%) and Aadhar card¹ (74.7% vs. 58.5%) compared to migrants in Delhi. The largest difference was observed with possession of PAN cards – 67.9% of the Mumbai migrants had them compared with 6.8% of Delhi migrants. More than half of migrants had a gas connection and almost all had mobile phones.

¹ Aadhar is a biometric identity card issued by the Unique Identification Authority of India on behalf of the government, and is available to anyone residing in India to establish a unique identity (not citizenship) to access services such as bank accounts, mobile phone or gas connection.

Table 6: Financial security and access to services among the internal female migrants in Delhi and Mumbai, India, 2014

	Location			p-value
	Total % (n)	Mumbai % (n)	Delhi % (n)	
Number of respondents	1000	499	501	
Has a bank account				
Yes	35.5 (355)	21.4 (107)	49.5 (248)	< 0.001
No	64.5 (645)	78.6 (392)	50.5 (253)	
Saved/set aside money using a <u>bank account</u> in past 12 months¹				
Yes	51.5 (183)	92.5 (99)	33.9 (84)	< 0.001
No	48.5 (172)	7.5 (8)	66.1 (164)	
Saved/ set aside money using <u>informal saving club</u> or with a person outside family in past 12 months				
Yes	12.1 (121)	12.2 (61)	12.0 (60)	0.904
No	87.9 (879)	87.8 (438)	88.0 (441)	
Saved/set aside money with <u>herself</u> in past 12 months				
Yes	37.6 (376)	53.3 (266)	22.0 (110)	<0.001
No	62.4 (624)	46.7 (233)	78.0 (391)	
Saved money for emergencies in the past six months				
Yes	37.1 (371)	60.5 (302)	13.8 (69)	<0.001
No	62.9 (629)	39.5 (197)	86.2 (432)	
Access to social security schemes/financial services²				
Ration card (low income category)	54.1 (541)	45.3 (226)	62.9 (315)	
Voter ID card	64.7 (647)	62.3 (311)	67.1 (336)	
Aadhar card	66.6 (666)	58.5 (292)	74.7 (374)	
PAN card	37.4 (374)	6.8 (34)	67.9 (340)	
Gas connection	51.8 (518)	44.5 (222)	59.1 (296)	
Land patta	18.8 (188)	0.2 (1)	37.3 (187)	
Passport	2.7 (27)	0.2 (1)	5.2 (26)	
Health insurance card	5.5 (55)	0.2 (1)	10.8 (54)	
Life insurance	7.0 (70)	1.0 (5)	13.0 (65)	
Birth certificate for children ³	56.6 (326)	79.5 (151)	45.3 (175)	
Marriage certificate ⁴	10.8 (74)	2.2 (5)	15.2 (69)	
Mobile phone	94.4 (944)	99.4 (496)	89.4 (448)	

¹ Those who had a bank account. ² Multiple responses possible. ³ Those who reported having children. ⁴ Those who were married.

HEALTH STATUS

Biomarker measurements

The study collected biomarker measurements from study participants. Height, weight, blood pressure and haemoglobin assessments were undertaken. 10.6% of the female migrants were found to have blood pressure readings suggestive of hypertension (Table 7). This proportion was higher (17.7%) among the migrants in Mumbai. Hypertension was defined as readings above 140/90 mmHg per the WHO definition. Anaemia was frequently observed among the female migrants; a higher proportion of migrants in Mumbai were anaemic than those in Delhi. As per NFHS definition, anaemia was considered mild in cases where haemoglobin level was between 10.0–10.9 g/dl, moderate where it was between 7.0–9.9 g/dl and severe where it was less than 7.0 g/dl [19]. In Mumbai, 62.2% of the female migrants were moderately anaemic and 9.9% were severely anaemic, while in Delhi, 38.9% were moderately or severely anaemic. Body-mass-index (BMI) was calculated based on the measured height and weight of the respondent. WHO defines obesity as a BMI level equal to or greater than 25. In Mumbai, 39.2% of the female migrants were obese as compared to 17.6% of their counterparts in Delhi. The proportion of underweight women was low (<10%).

Table 7: Bio-marker measurements among internal female migrants in Delhi and Mumbai, India 2014

	Location			p-value
	Total % (n)	Mumbai % (n)	Delhi % (n)	
Blood pressure¹				
Low	31.5 (297/943)	23.6 (109/462)	39.1 (188/481)	<0.001
Normal	57.9 (546/943)	73.2 (338/462)	43.2 (208/481)	
High	10.6 (100/943)	3.2 (15/462)	17.7 (85/481)	
Haemoglobin level²				
Normal	20.7 (133/641)	30.1 (99/329)	10.9 (34/312)	<0.001
Mild anaemia	24.2 (155/641)	31.0 (102/329)	17.0 (53/312)	
Moderate anaemia	49.9 (320/641)	38.3 (126/329)	62.2 (194/312)	
Severe anaemia	5.1 (33/641)	0.6 (2/329)	9.9 (31/312)	
Mean (SD)	9.6 (1.5)	10.1 (1.2)	9.2 (1.6)	<0.001
Body mass index³ [weight in kg/(height in meter)²]				
Underweight	7.7 (73/950)	5.2 (24/465)	10.1 (49/485)	<0.001
Normal	63.7 (605/950)	77.2 (359/465)	50.7 (246/485)	
Overweight	28.6 (272/950)	17.6 (82/465)	39.2 (190/485)	

¹ Blood pressure: Low: 110/70 mmHg; Normal: 110/70-140/90 mmHg; High: >140/90 mmHg.

² Haemoglobin: Normal: Hb>11.0 g/dl; Mild anaemia: Hb= 10.0-10.9 g/dl; Moderate: Hb 9.9-7.0 g/dl; Severe: <7.0 g/dl,

³ BMI: Underweight: <18.5; Normal: 18.5-24.99; Overweight: >25.0

Self-reported disease history

Respondents were also asked to report about non-communicable diseases (NCD) and symptoms of RTI/STIs experienced in the past six months (Table 8). Diabetes was the most frequently self-reported NCD; 21.2% of the migrants in Delhi and 9.4% in Mumbai reported it. Hypertension was self-reported by 3.2% of migrants in Delhi and 8.6% in Mumbai. The majority of migrants who reported any NCD sought treatment for it (90.8%), and most used public health care facilities (76.5%). The self-reported use of public health facilities was higher in Delhi compared to Mumbai. In both cities, the most commonly reported symptom of RTI/STI was abnormal vaginal discharge (Delhi: 10% and Mumbai: 20.2%), followed by painful or burning urination (Mumbai: 18.2% vs. Delhi: 4.8%). Overall, female migrants in Mumbai were more likely to report symptoms of RTI/STI (31.7% vs. 12.4%; p<0.001) than in Delhi. Problems of sexual dysfunction, such as loss of sexual desire or sexual dissatisfaction, were more commonly reported by the migrants in Mumbai. Self-reported TB disease was infrequent.

Psychological health of the migrants was assessed using the standard scoring system based on the general health questionnaire (GHQ) [20]. A tenth of the migrants in both the cities showed evidence of psychological distress (10.6%); and 8.4% had scores suggestive of severe psychological distress.

Table 8: Self-reported disease history in past six months among the internal female migrants in Delhi and Mumbai, India, 2014

	Location			p-value
	Total % (n)	Mumbai % (n)	Delhi % (n)	
Number of respondents	1000	499	501	
Non-communicable diseases¹				
Diabetes	15.3 (153)	21.2 (106)	9.4 (47)	
Hypertension	5.9 (59)	3.2 (16)	8.6 (43)	
Cancer	1.1 (11)	1.0 (5)	1.2 (6)	
Had any of the above non-communicable disease	20.6 (206)	23.4 (117)	17.8 (89)	0.026
Sought treatment for at least one problem ²	90.8 (187)	95.7 (112)	84.3 (75)	0.005
Public facility used for treatment ³	76.5 (143)	92.9 (104)	52.0 (39)	<0.001
Problems related to RTI/STI¹				
Vaginal sore or ulcer	2.3 (23)	1.2 (6)	3.4 (17)	
Pain/burning during urination	11.5 (115)	4.8 (24)	18.2 (91)	
Abnormal vaginal discharge	15.1 (151)	10.0 (50)	20.2 (101)	
Had any of the above RTI/STI problems	22.1 (221)	12.4 (62)	31.7 (159)	< 0.001
Sought treatment for at least one problem ²	46.6 (103)	19.4 (12)	57.2 (91)	< 0.001
Public facility used for treatment ³	54.4 (56)	75.0 (9)	51.6 (47)	0.127
Sexual dysfunction ⁴	6.4 (64)	2.6 (13)	10.2 (51)	
Self-reported and symptomatic TB¹				
Suffered with TB	1.3 (13)	2.0 (10)	0.6 (3)	0.050
Sought treatment for TB ²	92.3 (12)	100.0 (10)	66.7 (2)	0.057
Public facility used for treatment ³	100.0 (12)	100.0 (10)	100.0 (2)	0.000
Psychological health				
Score based on general health questionnaire				
Normal (0–15)	81.0 (810)	81.0 (404)	81.0 (406)	0.215
Evidence of distress (16–20)	10.6 (106)	9.4 (47)	11.8 (59)	
Severe problem and psychological distress (>20)	8.4 (84)	9.6 (48)	7.2 (36)	

¹ Current condition: had condition in past 6 months.

² Of those who had the problem in last 6 months.

³ Rest used private health facilities.

⁴ Sexual dysfunction comprised sexual dissatisfaction and loss of sexual desire.

MATERNAL AND CHILD HEALTH, AND USE OF FAMILY PLANNING

We collected information on marital history, fertility, family planning and maternal and child health related issues from the ever-married women migrants (Table 9). Average age at marriage for the ever-married respondents was 17.7 years. On an average, they had 1.3 living girls and 1.3 living boys. More female migrants in Delhi experienced child deaths than those in Mumbai (34.2% vs. 10.8%; $p < 0.001$). A high proportion of women reported that they did not want to have any more children. Among them, unmet need for contraception was high, as 25.1% reported not using any contraception. The most popular family planning method reported was female sterilization in both cities (Delhi: 36.8%; Mumbai: 50.5%).

Indicators for maternal and child health care service utilization have been computed for younger women (aged 25 years or less) so as to restrict the analysis to those for whom the most recent pregnancy and delivery would have taken place in Delhi/Mumbai. Self-reported antenatal check-up (ANC) attendance for the most recent pregnancy was reasonably high (82.1%) among migrant women in Mumbai. In contrast, ANC attendance was low (67.3%; $p = 0.059$) among migrant women in Delhi. Of those who attended ANC clinics, the majority had used public health

facilities (Delhi: 100.0%, Mumbai: 76.4%). The same women were asked about their experience of complications during the most recent pregnancy. About 10% in both places reported having experienced complications, and most of them had sought treatment in government hospitals. About three quarters of women in Delhi (74.6%) received iron folic tablets in their last pregnancy, compared to 67.2% in Mumbai. Institutional delivery was a little higher among the migrant women in Mumbai compared to those in Delhi (77.6% vs. 76.4%; NS). There was a marked difference in the practice of exclusive breastfeeding for first six months between the migrants of two cities (Mumbai: 77.6%, Delhi: 20.0%).

Few respondents reported having a child less than one year of age. Among these infants, diarrhoea (46.7%), fever (50%) and cough (40%) were prevalent in the last two weeks.

Table 9: Maternal and child health, and use of family planning among the internal female migrants in Delhi and Mumbai, India, 2014

	Location			p-value
	Total	Delhi	Mumbai	
	% (n)	% (n)	% (n)	
Marital and fertility history, and use of family planning				
Number of respondents	636	219	417	
Age at marriage				
Mean (SD)	17.7 (2.6)	17.7 (2.0)	17.8 (2.9)	0.601
Median (IQR)	18 (16-19)	18 (16-19)	18 (16-19)	
Number of living children				
Girls: Mean (SD)	1.3 (1.1)	1.4 (1.2)	1.3 (1.0)	0.455
Boys: Mean (SD)	1.3 (1.1)	1.2 (1.0)	1.4 (1.1)	0.043
If any child died after birth				
Yes	18.9 (120)	34.2 (75)	10.8 (45)	< 0.001
No	81.1 (516)	65.8 (144)	89.2 (372)	
Future intention to have children				
Have (a/another) child	20.0 (127)	22.8 (50)	18.5 (77)	< 0.001
No more/none	70.1 (446)	53.4 (117)	78.9 (329)	
Undecided/Don't know	9.9 (63)	23.7 (52)	2.6 (11)	
Current contraceptive use¹				
Not using	25.1 (112)	13.7 (16)	29.2 (96)	< 0.001
Female sterilization	46.9 (209)	36.8 (43)	50.5 (166)	
IUD	12.3 (55)	35.9 (42)	4.0 (13)	
Pills	5.4 (24)	–	7.3 (24)	
Condom	4.0 (18)	2.6 (3)	4.6 (15)	
Other methods	6.3 (28)	11.1 (13)	4.6 (15)	
Maternal health				
Number of respondents ²	122	55	67	
Attended ANC during the most recent pregnancy				
Yes	75.4 (92)	67.3 (37)	82.1 (55)	0.059
No	24.6 (30)	32.7 (18)	17.9 (12)	
Place of antenatal check-up				
Public hospital/clinic	85.9 (79)	100.0 (37)	76.4 (42)	0.001
Private doctor/clinic	14.1 (13)	0.0 (0)	23.6 (13)	
Experienced pregnancy complication				
Yes	9.0 (11)	10.9 (6)	7.5 (5)	0.508
No	91.0 (111)	89.1 (49)	92.5 (62)	

Sought treatment for pregnancy complication³				
Yes, in government hospital	81.8 (9)	83.3 (5)	80.0 (4)	0.887
Yes, in private hospital	18.2 (2)	16.7 (1)	20.0 (1)	
Received iron folic acid tablets during last pregnancy				
Yes	70.5 (86)	74.6 (41)	67.2 (45)	0.374
No	29.5 (36)	25.5 (14)	32.8 (22)	
Place of delivery for the most recent child				
Home	23.0 (28)	23.6 (13)	22.4 (15)	0.001
Public medical institute	65.6 (80)	76.4 (42)	56.7 (38)	
Private medical institute	11.5 (14)	0.0 (0)	20.9 (14)	
Duration of exclusive breastfeeding for the most recent child				
6 months or more	51.6 (63)	20.0 (11)	77.6 (52)	< 0.001
Less than 6 months	48.4 (59)	80.0 (44)	22.4 (15)	
Child health				
Number of respondents	744	259	485	
Have a child less than one year of age				
Yes	4.0 (30)	3.5 (9)	4.3 (21)	0.572
No	96.0 (714)	96.5 (250)	95.7 (464)	
In past 2 weeks, child has suffered from⁴				
Diarrhoea	46.7 (14)	66.7 (6)	38.1 (8)	
Fever	50.0 (15)	33.3 (3)	57.1 (12)	
Cough	40.0 (12)	22.2 (2)	47.6 (10)	
Chest pain/breathing problem	10.0 (3)	22.2 (2)	4.8 (1)	

¹ Among those who don't want any more child; ² Women aged 25 years or below. ³ Of those who experienced pregnancy complications; ⁴ Multiple responses possible.

SD: Standard deviation; IQR: Inter-quartile range.

SPOUSAL ABUSE

Currently married women were asked whether they were verbally/physically abused by their husbands (Table 10). A sizeable proportion of female migrants reported experiences of verbal abuse, (65.1%), and physical abuse (32.6%). Reporting of both verbal and physical abuse was higher in Delhi. More than 70% of women in Delhi and around 45% in Mumbai reported that they had a violent argument with husband in the past six months. In more than 30% of the cases, the argument was started by the husband. 47% of women in Delhi and 11.3% in Mumbai reported that the husband was drunk at the time of the last argument.

Table 10: Verbal/physical abuse by husband among the currently married internal migrant women in Delhi and Mumbai, India, 2014

	Location			p-value
	Total % (n)	Mumbai % (n)	Delhi % (n)	
Number of respondents	636	219	417	
Husband ever showed anger/yelled/shouted at her				
Yes	65.1 (410)	73.6 (159)	60.6 (251)	0.004
No	34.9 (220)	26.4 (57)	39.4 (163)	
Frequency of shouting in past 12 months¹				
Often	16.8 (70)	12.3 (20)	19.7 (50)	0.075
Sometimes	79.6 (331)	85.2 (138)	76 (193)	
Not at all	3.6 (15)	2.5 (4)	4.3 (11)	
Husband ever slapped/punched/kicked her				
Yes	32.6 (207)	38.8 (85)	29.4 (122)	0.033
No	67.4 (427)	61.2 (134)	70.6 (293)	
Frequency of slapping in past 12 months¹				
Often	17.2 (36)	14.1 (12)	19.4 (24)	0.001
Sometimes	75.6 (158)	85.9 (73)	68.5 (85)	
Not at all	7.2 (15)	–	12.1 (15)	
Husband ever used weapon or sharp instruments to hurt her				
Yes	3.1 (20)	1.8 (4)	3.8 (16)	0.294
No	96.9 (615)	98.2 (215)	96.2 (400)	
Frequency of using weapon in past 12 months¹				
Often	33.3 (7)	25.0 (1)	35.3 (6)	0.654
Sometimes	57.1 (12)	75.0 (3)	52.9 (9)	
Not at all	9.5 (2)	–	11.8 (2)	
Frequency of violent arguments with husband in last 6 months				
Daily	1.3 (8)	0.5 (1)	1.7 (7)	< 0.001
Once per week or more	6.8 (43)	7.8 (17)	6.2 (26)	
Once per month or more	7.2 (46)	12.8 (28)	4.3 (18)	
Rarely	33 (210)	41.1 (90)	28.8 (120)	
Only once	5.8 (37)	9.1 (20)	4.1 (17)	
Never	45.9 (292)	28.8 (63)	54.9 (229)	
Who initiated the last such incident				
Husband	31.8 (202)	35.2 (77)	30 (125)	< 0.001
Herself	19.3 (123)	11.9 (26)	23.3 (97)	
Parents	0.9 (6)	1.4 (3)	0.7 (3)	
Can't remember	34.6 (220)	26.5 (58)	38.8 (162)	
Others	13.4 (85)	25.1 (55)	7.2 (30)	
Husband was drunk during the last such incident				
Yes	23.6 (150)	47.0 (103)	11.3 (47)	< 0.001
No	76.4 (485)	53.0 (116)	88.7 (369)	

¹ Of those who said “yes” in the previous variable.

Conclusions

This is one of the few studies to explore migration and social, economic and health related behaviours of internal female migrants in India. We reached women in the lower socio-economic group, who had migrated from various parts of the country and were currently living and working in Delhi and Mumbai. Most female migration is believed to be associated with the spouse's movement. This study furthered our understanding of the reasons for migration beyond marriage and the pattern of female migration from small villages and towns to metropolitan cities of India. It also provides information, hitherto unavailable, on health-related vulnerabilities of social and financial entitlements, and service utilization by female migrants. We present the results separately for the two cities so as to understand the differences in the characteristics of migrants and patterns of migration between the two sites.

Internal female migrants in India were fairly young, especially those in Delhi. Their educational attainment was very poor. The proportion of currently married women was much higher in Mumbai, while migrants were mostly unmarried in Delhi. They were typically living with their family, which included husband or other family members such as parents or relatives.

Female migrants in Delhi and Mumbai came from different parts of India. A classification of the states of origin by destination sites shows that most were short-distance migrants. They appear to migrate to the nearest big city. This is in line with Zipf's law of migration [21] that states that the volume of migration is inversely proportionate to the distance between origin and destination. Age at first migration was much higher for the respondents in Mumbai compared to those in Delhi. Also, the study-participants in Mumbai were relatively older inhabitants of the city compared to migrants in Delhi. Though marriage as a reason for migration was frequently reported, migration for job/work opportunities was the most commonly cited reason. Considering that marriages in India are largely patrilocal [22], marriage-related migration has traditionally been the single most important reason for migration of females. It is possible, that the frequent reporting of economic reasons for migration in our study could be because of the study eligibility criteria of being currently employed. Nonetheless, this finding is in line with recent studies where a shift towards economic reasons for migration was observed among the female migrants in India [10, 23]. This was also reflected in women's reporting of better income and work opportunities as pull factors for migration while push factors indicated that their migration was mostly poverty driven, evident from the most frequently cited reasons – no money in the household, dissatisfaction with the work they did at home and lack of employment in their home districts.

The majority of female migrants were engaged in informal-sector jobs. Half of them were domestic workers. Other occupations reported were tailoring/handicraft work, factory work, shop-keeping and other petty business. As expected in a low income setting, very few participants were engaged in formal-sector jobs. Despite comparable costs of living in the two metropolitan cities, the average income was higher in Delhi than Mumbai even within similar job profiles. Also, average working hours and days were greater in Delhi. Non-payment for overtime work was equally common in both cities.

Overall living conditions were poor. This could be because our study sites were located in low-income, high-density settlements. However, there was a difference in the hygiene practices between the two cities. More respondents from Mumbai reported purifying the water before drinking compared to those in Delhi. Though use of public toilet facilities was reported in both the cities, a sizeable proportion in Delhi practiced open defecation. Further, the poor socio-economic status of migrants was reflected in the lack of access to basic financial services and social security schemes; access was higher among women in Mumbai attributable to their better educational profile or being natives of southern states which are known to have better uptake of such services [19].

Health-related vulnerabilities were observed based on selected disease profiles. A high proportion of migrants in Mumbai had blood pressure readings suggestive of hypertension, and a sizeable proportion was obese. Moderate or severe anaemia was observed among more than half of female migrants. Diabetes was commonly reported by the migrants in Delhi, whereas both diabetes and hypertension were reported by migrants in Mumbai. Symptoms related to RTI/STIs were more common among the migrants in Mumbai. The most commonly reported problems were sexual dysfunction, pain/burning during urination and abnormal vaginal discharge. Though treatment-seeking for non-communicable diseases was very high, it was lower for symptoms

related to RTI/STI. A considerable proportion of women migrants showed evidence of psychological distress, which could possibly be because of the stress of earning a living in addition to managing the household chores and trying to assimilate in a socio-culturally different environment.

Higher ANC attendance, more institutional delivery and higher proportions giving exclusive breast-feeding for six months (for most recent birth) among young migrants (<25 years of age) in Mumbai compared to those in Delhi indicate higher level of awareness among the former. Further, female migrants in Delhi experienced more child deaths than those in Mumbai. Better maternal and child health indicators in Mumbai are in tune with findings from NFHS 3 that show higher uptake of ANC services and institutional delivery in the southern states from where the majority of female migrants in Mumbai came. In contrast, migrant women in Delhi belonged to the northern states which are known to have adverse MCH indicators [19]. Diarrhoea, fever and cough were the commonly reported infant health problems. Unmet need for family planning was high among these women. The most popular method of contraception was female sterilization.

Verbal/physical abuse by husband was a commonly reported problem among the currently married women. Many of the women reported verbal/physical abuse in the last one year. Married migrant women are possibly more vulnerable as they live in unfamiliar surroundings without the social support of their natal or in-law families. We did not seek information on verbal or physical abuse in the community or workplace which is a limitation.

Recommendations

1. Creating an enabling environment for potential female migrants: Migration information and support centres should be established at both origin and destination sites

We observed a high proportion of women reporting economic reasons for their migration, indicating increasing feminization of migration for work opportunities. Thus, a well-organized support system for potential female migrants can facilitate their independent migration. Also, awareness campaigns at various levels would be helpful for the migrants for knowing the situation and types of work and facilities available at the destination. Migration information and support centres at some destination sites with high in-migration rates and at origin sites with high out-migration rates should be established.

2. Ensuring adequate representation of women in the implementation of National Rural Employment Guaranty Act (NREGA) and linking it to skill development

A shift from unemployment in areas of origin to informal sector jobs in urban destination areas was observed. This shift may be seen in the wider context of falling levels of economic security in rural areas. Although the implementation of National Rural Employment Guaranty Scheme (NREGS) in many states of India has resulted in an overall increase in employment in rural areas, and has decelerated the urbanization process to some extent [24], it is mostly benefitting men [25]; there is a need to emphasize greater involvement of women in the workforce. To reduce the pressure of migration to urban areas implementation of NREGA needs to be continuous and inclusive and linked to skill development in rural areas under the new national skill development programme.

3. Efficient allocation of labour skills at the destination sites

Due to low educational levels and poor/nonexistent skill sets, a large number of migrant women engage in domestic work. While this may be safer option as women work part time in nearby high-income settlements, it may be worthwhile to establish centres to train these women in home based income generating activities like tailoring, handicrafts or cottage industry. This would help in diversifying the available job opportunities for these women by an efficient allocation of skills leading to a more efficient labour market.

4. Improving awareness of social protection schemes and financial entitlements in migrant settlements

Internal female migrants reported limited access to financial services and social protection schemes in destination cities. They should be made aware of their legal entitlements and provided full access to them. Since access to such services is particularly low in Delhi, awareness campaigns to emphasize easy access, availability and benefits of such schemes should be promoted in migrant settlements in Delhi.

5. Improving awareness and provision of low-cost health care services

Certain groups of female migrants showed specific disease patterns. Anaemia, hypertension and obesity were prevalent among the migrants in Mumbai. Diabetes was prevalent among the female migrants in Delhi. Anaemia was observed among more than half of female migrants. Although symptoms related to RTI/STI were commonly reported, treatment-seeking for these problems was low and unmet family planning needs were moderately high. This indicates the need for targeted IEC (Information Education and Communication) campaigns and behaviour change interventions to create awareness about preventable diseases and to provide information on locally available low-cost public health care services. These interventions would benefit the larger community in these low-income high-density neighbourhoods.

6. Individual and community level interventions to address spousal violence

Study findings show a high prevalence of verbal and physical abuse of the female migrants by their husbands. Since spousal abuse can often lead to poor physical and psychological health, the NGOs working in migrant settlement areas should organize peer support groups or one-on-one/couple counselling sessions to address spousal violence. If required, the NGOs should provide physical, mental, emotional and legal support or referral to appropriate services.

7. Increasing awareness of psychological health

Poor psychological health among the female migrants is also an area of concern, and there is a need to create awareness about common symptoms of psychological ailments such as depression and anxiety. This would enable these women to identify the symptoms and access necessary medical help without feeling stigmatized. Medical treatment for psychological disorders is available free of cost at most government tertiary care health facilities.

8. Protection of migrants rights by the government

Female migrants were observed to receive various wages for the same kind of occupation across cities. Although the same labour laws are applicable to women throughout the country, there is little opportunity to seek justice or compensation against violation of contracts and rights for migrants in the destination. Innovative mechanisms should be developed by the government to protect the female migrants' rights, as they are the most vulnerable members of the labour force. Awareness campaigns that include migrants' rights should be launched.

9. Further research on feminization of migration and discrimination of migrants

Focused research on migration, including both female and male migrants, would be helpful in understanding the gender dimension of migration. The current exploratory study, having collected information only from female migrants, is unable to comment on whether the problems identified in this study are applicable to all internal migrants. Similarly, the problems related to low wage levels, job insecurity, poor living conditions, poor health, and limited access to social, financial and health services are common in the lower socio-economic sections of the population. To determine whether migrants are adversely placed within that sector, a comparative study between male and female migrants and non-migrants is recommended.

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