Review

Migrant Construction Workers Health Seeking Behavior in India- Literature Review

[1]*Ajoke B. Akinola,* [2]*Anil Kumar Indira Krishna*

[1]*Department of Public Health, Faculty of Allied Health Sciences, Achievers University, Owo, Ondo state, Nigeria*
[2]*School of Public Health, SRM University, Kancheepuram District, Tamil Nadu India*

Corresponding author: Ajoke B. Akinola, Department of Public Health, Faculty of Allied Health Sciences, Achievers University, Owo, Ondo state, Nigeria. achieverspublichealth@gmail.com; +2349033512206

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Abstract

Background: Migrant construction workers are contributing economically to the nation's development but their health seeking behavior has been a public health challenge. In the process are susceptible to different health problems from work fatalities, injuries, environment and higher risk of diseases and sickness.

Method: Searches were conducted from inception to date, November 2021. Search engines like PMC, and Google scholar was used. Twenty-one studies were included in the review. Study finds that Ignorance, discrimination, self-defeat, work-related health risks, deteriorating working condition and living, to mention few deepens their health seeking behaviour.

Conclusion: Amelioration of society (social inclusion, networks, educators), Equity on scarce resources, cultural (community participation), environmental (violence) togetherness through government and other nongovernmental organizations should be addressed. Necessary to protect, cure, prevent and promote health seeking behavior of construction migrant population.

Key words: Health seeking behavior, Construction migrants, Vulnerability

How to cite this article

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INTRODUCTION

Globally, the estimated number of migrants is close to One Billion out of which 740 internal and 214 international according to World Health Organization (WHO). This has increased to 232 million going by the WHO and United Nations Populations Fund (UNFPA) in 2013. The word migration has been a multifaceted and cumbersome issue with about 30 to 40 million undocumented migrants.[1] This has been unparalleled within India, from 1971 census, there were 167, which has risen over the years in 2005 to over 400million.[2] According to India, census 2001 record, about 42.1 million were interstate migrant.[3]

Reports from the human development research paper 2009/13, construction sector deploys close to about 40 million workers going by the unions estimate.[4] Interestingly, the Indian constitution provides freedom to the citizens for unregistered migrants when moving within the country,[5] which turns it into a dynamic one. With many migrating for different reasons, attracting both skilled (carpenter, masons, plumbers) and unskilled workers while increasing intra and interstate travel. Based on the National Aids Control Program, (NACO) report, migration cannot be overlooked as about one-third of the people in 2001 census are migrants. In the unorganized sector, construction tops the list in India after agriculture.

This puts the country on top of the list in the worlds accident rate among construction workers.[6] For instance, the International Labor Organization (ILO) reports that 165 of every 1000 workers are injured on their job, severally they often pay for their food, fuel and medical expenses whenever injured at work.

In Tamilnadu state, construction workers are next to factory workers in terms of employment and majority of them are migrant laborers. The migrant labor contribution to economic (migrant laborer contributing 10% to the National GDP) and to the social life in the region is remarkable. According to R. Poongodi, migrant construction workers are employed up to 40million construction jobs[4,7] especially when more women are involved in the sector. On the overall basis, they constitute more than one third in the construction industry.

The women worker carries loads of bricks, cement, stones and water, sift them to the masons, some also do plaster and their wages are less when compared to the male workers[6] which makes them more vulnerable compared to the male counterpart. During this rigorous activity, the majority of human migrants are subjected to different health hazards. With little or no available and accessible health care, linguistic barriers, limited to HIV prevention care and cultural problems. Also, in terms of coping with traditions and practices to mention few.[8]

Health seeking behavior is the combination of remedial actions that person/s undertake to correct perceived ill health by Ward, Mertens and Thomas in 1996. Health seeking behavior is initiated with signs, symptoms and or morbidity/mortality definition as a result of which a plan for prompt treatment action is devised. Risk factors influencing migrants' health seeking behavioral pattern by Chatterjee, Chandrima B in a study are but not limited to government (policies, community participation), employer related (insurance coverage, reproductive health care for women and coverage), health sector (preventive health networks, approach, coverage, cost), personal factors (social support groups, health beliefs and treatment seeking behavior) impact the health risk.[9] Barriers to treatment may be: Place and distance to facility, Hesitant (avoid male doctors have internal examinations for them), non-familiarity with health systems, diagnosis and treatment long process, travel details to health care provider place, constant mobility, cost of medical care and attitude of the treatment provider (vulnerability, power differentials, leading to exploitation) according to Gopichandran Vijayaprasad who studied the determinant of trust in health care in the southern part of the country[22] this puts the migrant in a more tight corner. In exploring these actions, it will unveil information on how best services can meet the needs of the vulnerable population. The purpose of this study is to explore the health seeking behavior of construction migrant workers in the country. Health seeking behavior of the group cannot be over emphasized as their research is limited in this area.

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METHODOLOGY

This research aimed at exploring the health seeking behavior of construction migrant workers. This study was conducted from inception to date, November 2021. Search engines like PMC (medical search headings were used (MeSH) for PubMeD) resulted into 392, and Google scholar (title was entered in the search engine, at any time, sorted by relevance, included patients, and citations. Advance option was used to further capture the keywords "migrant construction workers" applying the exact phrases, 718; added the health seeking behavior gave 503). The terms used in PMC are migration "health seeking behavior and construction worker" with terms ("transients and migrants"[MeSH Terms] OR ("transients"[All Fields] AND "migrants"[All Fields]) OR "transients and migrants"[All Fields] OR "migrant"[All Fields]) AND Construction[All Fields] AND ("occupational groups"[MeSH Terms] OR ("occupational"[All Fields]

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AND "groups"[All Fields]) OR "occupational groups"[All Fields] OR "workers"[All Fields]) AND ("health"[MeSH Terms] OR "health"[All Fields]) AND Seeking[All Fields] AND ("behaviour"[All Fields] OR "behavior"[MeSH Terms] OR "behavior"[All Fields]) AND ("india"[MeSH Terms] OR "india" [All Fields].

Twenty-one studies were included in the review, after thorough screening for articles that did not match the search keywords. The search included both primary and secondary studies from both peer reviewed articles and literatures relevant to the given context was selected from abstract and full text articles as shown in Table 1: Citation summary. To ensure rigor in this review, news reports (in print or web based) were excluded, since the information they provide vary generally in place, time, source and require specific procedure for analysis.[10]

DISCUSSION

To improve on construction migrant populations' health seeking behavior, problems, barrier, factors associated, and impact cannot be over emphasized. Many studies have shown that there are different health hazards that this group of people, male, female and children face at the point of duty.[11] Very little research has been studied on the health seeking behavior of the population. On migrant's health seeking behavior, S. Pramanik and S. Chackrabarti studied on the health problem migrant construction workers are facing using Neutrosophic Cognitive Map (NCM), to see causal relationship[12] and impact of problem but there was no clarity on their health seeking behavior. Jatrana Santosh and Suresh Kumar Sangwan examined the health experiences of female construction migrant worker in North India. Although, there was an improvement after migration, they pointed on the societal environment within which the behaviour occurs, which needs to be worked upon.

In the marginalized communities where there is poor access to health care and living condition deteriorating, Gopichandran Vijayaprasad, and Satish Kumar Chetlapalli identified some factors not limited to perceived competence assurance of treatment. Irrespective of their ability to pay, approach of doctor, economic factors and awareness of health could raise trust level in health care[13] and may improve migrants' health care seeking pattern. MacKian Sara reviewed that health seeking behavior of migrant is not just a one-off isolated event but a multi-step event like.[14] The lens need be broadened like other determinants of health, policy directives, population health, inequality reduction, improvement of social injustice, should be built upon.

This is necessary, in order to move to a more holistic dimension, which will automatically improve migrants' attitude towards their health care. Globalization and health in 2009 reported that in India, internal migrant had poorer health seeking behavior than their non-migrant counterparts which was attributed to behavioral risk factors, lack of health facility knowledge, cultural and linguistic barriers, although there were some safety net program in place for migrants by the Governor of the Reserve Bank of India to mitigate and reverse their vulnerability, which is commendable, however there are broad gaps plaguing their health seeking behavior[15].

Women account to about 97% Nepalese migrant construction workers experienced several health problems and injuries although one-third of respondent was provided health insurance. Lack of leave for illness, cost and fear of losing their job was reported as barrier to seeking health service there.[16]

In Southern India, Kerala, kudos to the state government, for the intervention action plans on interstate migrant labor. Sreejini Jaya worked on contributing factors to the health seeking behaviour as a result of an increase in the influx of construction workers in the state. About 44% poor health seeking pattern was noticed among the younger age, health facility and their employer were contributing factors. Suggested policy intervention to come to the rescue for a more migrant-friendly health system[5]. In addition to the policy recommendation, registration of migrants from and to migrated area is needed. For proper documentation by their employer to enable provision and extension of resources. Chatterjee, Chandrima B indicates that it is their human right to access health and health service, but stigmatization and discrimination is the order of the day.[9]

Leading to self-defeat and intensifies migrants' problem of health seeking behavior. Although the Indian constitution, article 43, applicable for migrants in the country, identified some gaps. According to the study like gross underestimation of internal migrants and human rights are not well protected in the informal sector like construction. Most of the law are on paper, lacks implementation and follow-up by concerned authorities as a result of the helplessness, ignorance, and desperation of migrants.[9] Kusuma et al., studied treatment seeking behavior in hypertension in Delhi state, 41% of disadvantaged migrants were aware of their status and 5% controlled it.[17] Which indicated a lack of awareness on the health of the population and has become a common problem. In the access to maternal health care and institutional delivery, migrants use the services less than the settled migrants, 37% received ANC, 53% of deliveries took place at home and post-natal care was grossly abandoned.[20]

In neighboring Thailand, Naing, Tinzar et. al., reported construction migrant not well documented for TB

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symptoms. Indicated self-medication pronounced, inappropriate drugs used, and they were least likely to visit health care center for illness.[19] Active surveillance and health education suggested to better TB control.

Implications

Ethics and moral values

Moral complexity is an issue of contention in this study such as undocumented work. The expressions employed in different studies reveals diverse perspectives from researchers. Voice from non-status migrants 'construction migrants' is absent in many studies, which attests to the fear of this vulnerable population, but some researchers' values, who discuss the issues, but not with or on behalf of the migrants. Another sub theme of concern, the social/moral space, in which undocumented migrant work. That may not belong to the same sphere of rights and responsibilities that most citizens (and researchers) experience. This means that some social locations are governed by exploitations that may not be mediated by the countries policies and guidelines. Suggesting that careful ethical consideration is deserved by this minor population. Researchers should fully implement and monitor a framework for social justice to avoid migrant crisis.[25-27]

Gender variations

There are variations, despite clear indications on migrant women, more vulnerable, to poor social and health conditions. Migration and gender status continue to be independently conceptualized. Which the literature does not address, the operational situations of undocumented status uniquely affect gender health and well-being.[20] Even though, constitution guarantees equal rights, yet discrimination is deeply rooted amongst non-status women. Poor personal communication with health care providers in Toronto, suggest that substance abuse is higher among the migrant men and the women experience depression.[7, 20] Therefore, gender-based analysis for future research is needed to facilitate better understanding to providing solution to diverse effect to their health seeking pattern. Since women are faced with balancing multi facet activities, from job, with traditional family and social expectations[21] exploring their health seeking pattern would be an advantage.

The construction migrants' children untold story

When the families of migrants are not documented little wonder will the children born to the construction migrant families are mostly undocumented. Their health status and how they get treated for ailments and basic amenities are still under scrutiny as a result of their migrant status. In particular, research on the completed fertility of migrants is almost totally absent. Hence, a ripple effect continues to grow, and this area of study warrants further investigation.

Institutions and health regulatory bodies

To mobilize, create outreach programs for the marginalized by institutions, concerned health bodies like university/college Institutions, public health professionals, medical professionals, psychologist and so on. This should include Research into intervention plans to understand migrant workers in the construction sector, intra and interstate wise, which will reveal things that are plaguing the sector like, providing insights into the organization of migrant workers,[24] promoting behavioral change towards health problem and health seeking pattern to promote, curative and preventive health. Through adoption of positive and safer practice to preventing all manner of diseases, illness and injuries. There is a need to Sensitizing and encouraging community participation to improving on the behavioral change. Through BCC programs, especially for women in terms of maternal and reproductive health issues. To provide education and awareness programs conducted in association with their employers and contractors. Encouraging supporting organizations like the civil societies, human rights and voluntary organizations. Together with the government at all levels to come together to better construction migrant lives.

Policy improvement

Indeed, the system is commendable for allowing free movement of citizens within the country. The India judiciary comes to rescue migrants, makes pronouncements fill the gaps of justice but policy makers and rulers completely ignore the reality. Legislation may be inefficient, they do so because regulatory systems are overstretched, resource inadequately structured and crunched.[6] States need to be sincere as this is lacking since this sector are not organized, no documentation of migrants sufficiently to lobby and form pressure group/association/union. There is a lack of support from the civil society. There is the need for policy intervention to come to rescue for a more migrant-friendly health system.[5, 23] In addition to the policy recommendation, registration of migrants from and to migrated area for proper documentation by their employer is needed. This is to enable provision, the extension of resources, reduction of disease burden and improved health seeking behavior in states and country at large. Altogether, results to amazing experiences if the sector is organized. Including services like training programs, workshops, awareness campaigns and much more. It would be lot easier for the government to

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address any problem not only from the health perspective. Although, efforts were sought but might not be strong enough to tackle the hideous and genuine issues of construction migrant labourers' health seeking pattern to curb disease rate increase. Voluntary and nongovernmental organizations need be encouraged on the issues of migrant workers.

Proposed Framework for Strengthening HSB among Migrant Construction Workers

Addressing the health-seeking behavior of migrant construction workers requires acknowledging the ethical, social, and structural complexities that shape their lives. Many migrants remain undocumented, which excludes them from legal protections, social benefits, and health systems. This invisibility creates moral tension, as their labor supports economic development while their well-being is neglected. Ethical principles of equity and social justice demand that policymakers and researchers prioritize the needs of these marginalized workers. Without integrating their voices and lived experiences into research, policies risk perpetuating structural violence and social exclusion. Migrants often work in settings governed more by informal exploitation than by protective labor policies, and this underscores the urgent need for a rights-based framework that protects health as a human right rather than a privilege. [1-3]

Institutions and Health Regulatory Bodies

Institutional engagement is central to improving migrants' health outcomes. Universities, public health institutions, and professional bodies can drive evidence-based interventions through research, surveillance, and community outreach. These institutions should collaborate with local health departments and non-governmental organizations to design culturally sensitive education and behavior change communication programmes targeting migrant communities.[4] Capacity building of frontline health workers, especially on occupational health and migrants' rights, is crucial to reduce discrimination and build trust. Involving civil society groups, human rights advocates, and trade unions can enhance accountability and create safe platforms for migrants to report grievances. These institutional partnerships can also advocate for employer compliance with occupational health standards, strengthening enforcement mechanisms and ensuring preventive and curative care reach this population.[5]

Policy framework

Improving the health-seeking behavior of migrant construction workers requires an integrated policy framework anchored in the Social Determinants of Health (SDH) and the Migrant-Sensitive Health Systems Framework (MSHSF) of the World Health Organization.[6-8] These frameworks emphasize that health outcomes are shaped by social, economic, and political structures. Such as housing, employment, education, and access to care. A critical first step is the systematic registration and documentation of migrant workers at both sending and receiving locations. This would allow governments to allocate resources equitably, plan targeted health interventions, and ensure inclusion in national health insurance and social protection schemes. [9]

Legal frameworks, including enforcement of the Employment & Conditions of Service Act, 1996, must be strengthened to secure safe working conditions, occupational health services, and medical insurance coverage. Community participation should be integrated into programme design to enhance cultural appropriateness and ownership. Building peer-support networks and migrant worker associations can empower workers to demand their rights, access care, and promote safer workplace practices.[10] These actions collectively operationalize the SDH and MSHSF principles by addressing the root causes of poor health-seeking behavior and reducing structural vulnerability.

Policy Improvement

Despite constitutional provisions supporting free movement, the health rights of internal migrants remain poorly protected due to fragmented policies and weak enforcement. Regulatory systems are often overstretched, and civil society support is minimal, leaving migrants without organized representation or bargaining power.[11] A migrant-friendly health system demands comprehensive reforms: mandatory registration of migrant workers, integration of migrant health into national health policies, and monitoring of employer compliance with occupational health standards. Political commitment is essential to ensure sustainable funding, human resources, and intersectoral coordination. Legislative enforcement also requires attention. Existing laws such as the Employment & Conditions of Service Act, 1996 should be operationalized with regular inspections, penalties for non-compliance, and grievance redress systems to protect workers' health and safety.[5] Employers must be mandated to provide orientation on workplace hazards, training on occupational safety, and access to preventive and curative health services. Policy reforms should further include mandatory health insurance coverage for all registered migrant workers and their families.[6] Strengthening labor inspection systems, establishing labor cells at state level, and creating panchayat-based migrant databases could enhance oversight.[12]

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In addition, targeted orientation on health risks, rights awareness, and preventive practices should be provided by employers. Collaborative partnerships among government agencies, civil society, trade unions, and community organizations. Community engagement must also form part of the framework. Empowering migrant workers through peer-support networks, trade unions, and community-based organizations can improve awareness of rights, promote preventive health practices, and create safe spaces for reporting workplace hazards.[7] Such collective structures enhance workers' agency and reduce the social isolation that often discourages health service utilization. By integrating legal protections, institutional support, and community participation, this framework can address the root causes of poor health-seeking behavior and reduce the vulnerability of migrant construction workers in India. They are crucial to mobilize resources and counteract stigma.[13] Policy reforms must be underpinned by rigorous data collection and research on migrant health behaviors to close evidence gaps. Without these systemic changes, efforts to improve health-seeking behavior will remain fragmented, insufficient and unsustainable to reduce the health inequities.

In conclusion, their helplessness, social exclusion, little or no access to health services and legal rights to mention few, are basic ethical concerns necessary to promote and protect the vulnerable.[25- 27] The problem is huge and requires the effort (coordination and cooperation) of all concerned bodies, Trade unions. To date, there are no sustainable efforts to promote or provide access to services to this population, there are human rights, may be time for Migrant Workers Rights. To this effect, the knowledge, insights, and recommendations herein, will function as a steppingstone for critically addressing the complex issues surrounding not having proper documentation and health seeking behavior of construction migrant workers in India.

Strengths and Limitations of the Study

This study contributes meaningfully to the evidence base on the health-seeking behaviour of migrant construction workers, a population that remains underrepresented in mainstream health research and policy discourse in India. One of its key strengths lies in its use of a multidimensional analytical lens grounded in the Social Determinants of Health (SDH) and Migrant-Sensitive Health Systems Framework (MSHSF). This allowed for a nuanced examination of how structural factors, Such as housing, income insecurity, occupational risk, and legal exclusion. Shapes health behaviours, rather than reducing them to individual choices alone.[1,2] Such an approach offers a more comprehensive understanding of the systemic barriers that must be addressed to improve health outcomes in this group.

Another strength is the critical synthesis of existing literature spanning public health, labour policy, and migration studies, which provided an interdisciplinary perspective. This cross-sectoral integration makes the findings more relevant to policymakers and practitioners seeking to design context-specific interventions.[3] The study also highlighted gaps in regulatory enforcement and data systems, thereby pointing to concrete policy entry points that can enhance accountability for migrant health.[4]

However, the study has certain limitations that must be acknowledged. The reliance on secondary literature and policy documents may have introduced selection bias, as available evidence disproportionately reflects formal or urban settings while underreporting the experiences of undocumented or circular migrants.[5] Furthermore, the absence of primary data limited the ability to capture lived experiences, cultural beliefs, and trust dynamics that directly influence health-seeking behaviours. This reduces the depth of insight into gendered or psychosocial dimensions of care access.[6] Additionally, much of the evidence came from heterogeneous studies using varied methodologies, which constrained direct comparison and synthesis of outcomes. Finally, given the cross-sectional nature of most included data, causal inferences about the relationship between migration and health-seeking behaviour could not be established.[7]

Despite these limitations, the study provides an essential foundation for further research and policy action. It underscores the need for future studies that combine epidemiological data with ethnographic and participatory approaches to more accurately reflect the complex realities of migrant workers' health needs.

Recommendations for Future Research

Future research should move beyond descriptive assessments and aim to generate deeper empirical insights into the structural and psychosocial determinants of health-seeking behaviour among migrant construction workers. First, there is a need for longitudinal studies that track health behaviours and outcomes over time to better understand how migration trajectories, employment conditions, and social integration influence access to care.[1,2] Such designs would help establish causal relationships, which are often obscured in the predominantly cross-sectional evidence currently available.

Mixed-methods and participatory approaches are also recommended to complement quantitative surveillance

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with qualitative insights into workers lived experiences, cultural beliefs, and perceptions of the health system.[3] This could reveal how trust, stigma, and workplace hierarchies shape decision-making about when and where to seek care. Including the voices of female workers and informal labourer. Groups often underrepresented in research, would enhance the equity orientation of future studies.[4]

Moreover, implementation research is needed to evaluate the effectiveness and scalability of migrant-sensitive health interventions. For example, future studies could assess the impact of mobile health clinics, occupational health insurance schemes, and multilingual health education programmes on service utilization and health outcomes.[5,6] Comparative studies across different states and migration corridors would also shed light on how variations in labour governance, health infrastructure, and urban policy shape migrant health behaviours.[7]

Finally, building collaborative research platforms that engage government agencies, academic institutions, civil society, and migrant worker organizations is critical to ensure that evidence informs real-time policy decisions. Such multisectoral partnerships can strengthen the translation of research findings into actionable strategies and contribute to sustainable improvements in migrant workers' health and wellbeing.[8]

CONCLUSION

This study highlights the urgent need to address the structural determinants influencing health-seeking behaviour among migrant construction workers in India. It demonstrates that poor access to health care is not merely the result of individual-level factors but is deeply rooted in precarious working conditions, inadequate social protection, and weak institutional accountability. Applying the Social Determinants of Health (SDH) and Migrant-Sensitive Health Systems Framework (MSHSF) underscores the importance of integrating health interventions with broader labour, housing, and social welfare policies to promote equity and inclusion. To improve outcomes, policies must go beyond fragmented and reactive responses to establish a coherent framework that recognises migrant workers as a core part of the public health system. This requires stronger legislative enforcement, intersectoral coordination, and the development of migrant-sensitive health services supported by adequate financing and trained personnel. Community-based participation, accurate data systems, and employer accountability are also critical to ensure that workers can access preventive and curative services without fear of discrimination or financial hardship. While the study was limited by its reliance on secondary data and the absence of primary qualitative insights, it provides an essential foundation for evidence-based policymaking. Future research should adopt longitudinal, participatory, and implementation-focused approaches to better capture the complexities of migrant health needs and to evaluate scalable interventions. By embedding equity principles in health policy and practice, India can advance towards a more inclusive health system that protects and promotes the wellbeing of its vast internal migrant workforce.

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Table 1: Citation Summary

Citation and topic	Type of study	Method	Result/Findings/Outcome
Shivalli S, Pai S, Akshaya KM, D'Souza N. Construction site workers' malaria knowledge and treatment-seeking pattern in a highly endemic urban area of India [published correction appears in Malar J. 2016;15(1):415]. Malar J. 2016; 15:168. Published 2016 Mar 16. doi:10.1186/s12936-016-1229-2	Original research study	cross-sectional study. Random selection of 9 cites in Mangaluru. Sample size 132 with semi-structured interviews. 119 workers participated in the survey.	1. Only less than 12% could explain the preventive measures 2. Male workers (AdjOR 7.21, 95 % CI 2.3–22.9) and those with self-stated malaria within 1 year (AdjOR 11.21, 95 % CI 2.38–52.8) showed favorable treatment-seeking pattern. 3. Female workers ($\beta = -0.281$, $p = 0.001$), self-stated malaria within 1 year ($\beta = 0.276$, $p < 0.001$) 4. Urgent need of intensifying and streamlining of ongoing malaria prevention activities for migrant construction site workers in Mangaluru, India. 5. Ethical concerns and fairness towards gender should be high lightened and intensified through programme implementation for successful health and treatment seeking behavior.
Census of India (2001). Migration Tables DI, D1 (Appendix), D2 and D3 Tables. New Delhi. Registrar General and Census Commissioner, India	Research study: Housing listings e.t.c	Secondary data: Census highlights	Population of internal migrants
Deshingkar, Priya, and Shaheen Akter. "Migration and human development in India." (2009).	Research study Working paper	UNDP Report: Field evidence, Primary and Secondary data	1. Migrant laborers live and work in extremely difficult and dangerous conditions 2. Risk of non-recognition at the policy level and faulty implementation of labor laws. 3. Nearly all sectors employ migrant workers (including children) through a complex system of contractors and agents who are well-positioned to exploit illiterate and poor workers 4. The lack of data and the laxity in implementing and monitoring labor laws indicate gaps of political commitment towards migrant (women and children) 5. Change policy level to support migrant reduce vulnerability and improve access to education, housing and health programs Without this recognition and action such large population with continue to be excluded and Millennium Development Goals will remain unfulfilled
Jaya Sreejini. Factors associated with Health seeking behaviour and Self-reported morbidity pattern among the Interstate migrant labourers in Thiruvananthapuram district. Trivandrum.2013.	Research Dissertation	Cross Sectional survey, 283 Interstate Migrant Labourers, Multistage cluster Sampling	1. Overall morbidity profile of the migrants was poor 2. Poor pattern of health care seeking Adverse health habits: lack of migrant friendly places

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Citation and topic	Type of study	Method	Result/Findings/Outcome
Sudhershan Rao Sarde: MIGRATION IN INDIA TRADE UNION PERSPECTIVE IN THE CONTEXT OF NEO LIBERAL GLOBALISATION, Regional Representative, IMF-SARO, New Delhi	Discussion paper	n/a	1. Problems of migrant huge 2. Trade Unions and Social actor's cooperation Required Policy and Government intervention needed
R. Poongodi. Socio Economic Characteristics of Women Construction Workers in Tamilnadu – Some Evidences | Sep 2012 •	Research paper	Primary data: Random sample of 50women construction workers	1. Women not only face insecurity at work but also paid lower wages 2. Minimum wages and other legislations are violated for women Faced with multifaceted work and discriminated
Chatterjee, Chandrima B. Identities in motion: migration and health in India. Mumbai: Centre for enquiry into health and allied themes, 2006.	Discursion paper	n/a	1. Organizational reform/institutional development 2. Primary health service provision for migrants/refugees 3. Behavioral change of health providers and health seekers Research (collecting evidence on migrant's health)
Adsul BB et. al. Health problems among migrant construction workers: A unique public-private partnership project. 2011.	Research Project	Primary data: Cross-sectional study, sample size 1337 construction workers	1. Morbidity profile was Malaria fever, Respiratory infections, hypertension, tobacco and alcohol usage was highest among others. 2. Need for Behavioural Change Communication to address the vector born disease and lifestyle diseases like alcohol, hypertension, injury prevention Active surveillance of fever cases to reduce incidence of man-made malaria by supervisor in charge. Towards having a healthy work force through PPP (public private partnership)
Pramanik, Surapati, and Sourendranath Chackrabarti. "A Study on Problems of Construction Workers in West Bengal	Research study	Primary data using Neutrosophic Cognitive Maps, among 100 construction workers	1. Construction worker worked for hours, staying away from home have effects not limited to: bad habits, misunderstanding, physical health problems Implement "Regulation of Employment & Conditions of Service Act, 1996 to protect the rights of construction workers and government should provide them education regarding their profession in order to avoid professional hazards.
MacKian, Sara. "A review of health seeking behaviour: problems and prospects. "UK (2003)	Review	n/a	1. Solution to resource and constrain is to understand why and how people do what they do 2. Health seeking behaviour is not just a one off isolated event, result of an evolving mix of social, personal, cultural and experiential factors like woman's decision to attend a particular health care facility is the composite result of personal need, social forces, the actions of health care providers, the location of services, the unofficial practices of doctors, and in some contexts has very little to do with physical facilities at a particular service point

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			3. lens needs to be broadened to other determinants of health, including policy directives to enhance population health, reduce inequality and improve social justice
Todrys, Katherine Wiltenburg, and Joseph J. Amon. "Within but without human rights and access to HIV prevention and treatment for internal migrants (2009)	Research	n/a	1. Social protection and health care systems need to keep pace with the reality of internal migration. 2. In the face of HIV and other transmissible diseases, serving internal migrants is a public health imperative. 3. Targeted HIV prevention programs and the elimination of restrictive residence-based eligibility criteria are also necessary to ensuring internal migrants' equal rights to HIV prevention and treatment Government take account of the health needs, human rights, and development goals of internal migrants will be critical to better supporting the next generation of the economy's workers.
Joshi, Suresh, Padam Simkhada, and Gordon J. Prescott. "Health problems of Nepalese migrants working in three Gulf countries."(2011)	Research study	Primary date; Cross sectional survey, 408 construction migrants	1. Injuries or accidents at work 2. One third of the respondents were provided with insurance for health services by their employer 3. Lack of leave for illness, cost and fear of losing their job were the barriers to accessing health care services Employers should provide orientation on possible health risks and appropriate training for preventive measures and all necessary access to health care services to all their workers.
Kusuma, Yadlapalli et. al "Treatment seeking behaviour in hypertension: factors associated with awareness and medication among socioeconomically disadvantaged migrants in Delhi, India." (2013).		Cross sectional study	1. Hypertension has become a common problem less than average of the population are aware of their status The health education and awareness campaigns along with facilities such as blood pressure screening and hypertension treatment through primary health care system are essential.
Kusuma, Y. S., et al.Migration and access to maternal healthcare: determinants of adequate antenatal care Delhi, (2013)	Research study	Primary data: Cross-sectional survey, 809 rural-urban migrant mothers	1. Migrant women, particularly recent migrants, are at the risk of not receiving adequate maternal healthcare. Because migration is a continuing phenomenon, measures to mitigate disadvantage need to be taken in the healthcare system
Naing, Tinzar, et. al. "Migrant workers' occupation and healthcare-seeking preferences for TB-suspicious symptoms and other health problems: a survey among immigrant workers. Thailand."(2012)	Research study	614 migrant workers	1. Self-medication and inappropriate drugs used is the mode of health care seeking 2. Accessing and Choice of health facility is influenced by occupation, lifestyle and socio-economic condition Utilization of facility can be improved by overcoming barriers like complete registration coverage and better provision of health care information

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Calavita K. Gender, migration, and law: Crossing borders and bridging disciplines.2006	Discussion paper	n/a	1. A focus on the complex ways in which gender, race, immigration, and law interact potentially advances our understanding of immigrants' experiences, and of broader theories of gender and migration. This literature's focus on the intersection of class, race, and gender, and the role of law and the state in constituting them, complicates considerably the picture of women's subordination and the nature of their multiple marginalities
Oxman-Martinez J, et al. Intersection of Canadian Policy Parameters Affecting Women with Precarious Immigration Status: A Baseline for Understanding Barriers to Health. 2011	Discursion paper	n/a	1. Women who are disadvantaged raises question to gender disparity and access to equitable health These direct and secondary policy barriers intersect with each other and with socio-cultural barriers arising from the migrant's socio-economic and ethno-cultural background to undermine equitable access to health for immigrant women living in Canada.
Gopichandran V, and Satish K C. Dimensions and Determinants of Trust in Health Care in Resource Poor Settings– (2013)	Research study	Primary data: 35 In-depth Interviews	1. Perceived competence, assurance of treatment irrespective of ability to pay or at any time of the day, patients' willingness to accept drawbacks in health care, loyalty to the physician and respect for the physician. Comfort with the physician and health facility, personal involvement of the doctor with the patient, and so on were identified as factors determining the levels of trust by respondents
International Organization for Migration. World Migration Report. Communicating effectively about migration. (2011)	Discussion paper	n/a	1. The chapter has highlighted several good examples of how governments, civil society, international organizations and the media have worked towards promoting a balanced image of migrants and their contributions, locally or in the media, dispelling migration myths through information campaigns and giving migrants a voice in telling their experiences through new media. However, for these and other initiatives to have a consistent impact on public perceptions and attitudes, they need to be scaled up, adjusted to fit local contexts and, most importantly, be supported by strong political will as part of a long-term strategy.
Tirukkovalluri SS, Arumugam B, Gunasekharan N, Suganya E, Ponsuba TA, S D. Social determinants in access to tobacco prevention and cessation support services among migrant construction workers in Urban Chennai, India. J Family Med Prim Care. 2020;9(4):1991-1998. Published 2020 Apr 30. doi: 10.4103/jfmpc.jfmpc_1072_19	Cross-sectional study-community based design	GATS survey, migrants working across 13 construction sites, Chennai, May–September 2019	1. 338 (98%) were currently using tobacco. 2. About tobacco ill-effects on health (84.6%), 3. Only 110 migrants (34.9%) considered quitting Tobacco prevention and cessation support services may be a promising strategy to reduce health harms of tobacco intake

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Supplementary Information An assessment of migrant worker health and safety risks - HSE 2006	Research Study	Primary data: In depth interviews of 200 migrant's worker	1. Support organizations like community organizations providing to be source of advice and guidance 2. Building Unions along with the Lewishham college to be running a training centre for migrant construction workers at Canary Wharf. 3. The Portuguese Workers' Association runs a surgery for Portuguese workers at the TUC Partnerships, in which worker consultation and involvement in health and safety procedures is encouraged, has been set up. There are regular visits and training by an advisor, who also works closely with the employer. This has been a successful initiative, with the health and safety standards of several employers, especially SMEs, improving dramatically, according to those interviewed

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