Fact Finding Report

Reproductive and Child Health Amongst Brick Kiln Workers

Fact finding report By

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Contents

Abbreviations

ANC	Ante Natal Care
ASHA	Accredited Social Health Activist
DLHS	District Level Household Survey
ICDS	Integrated Child Development Scheme
JSSK	JananiShishuSamrakshaKaryakram
JSY	JananiSurakshaYojana
MoHWF	Ministry of Health and Family Welfare
NFHS	National Family Health Survey
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
PDS	Public Distribution System
PNC	Post Natal Care
RCH	Reproductive and Child Health
WHO	World Health Organisation

Introduction

India's brick kiln industry contributes about 3 billion to the country's economy every year with an estimated demand of 120 billion bricks per year[5]. There are about 50,000 brick kilns all over India employing on an average 100 workers per unit[6]. Brick kiln industry in India probably employs the largest unpaid women work force in the world. Not underpaid but unpaid altogether[9].Brick kiln workers are mainly the rural migrant labour which is amongst the most neglected sections of the society.In Rajasthan, as elsewhere in the country, migrant labour forms the backbone of the brick kiln industry[7]. The kilns are located in the city outskirts and require large number of resident labour force[7]. This labour is sourced from different areas within the state and also from various other states like UP, Chhattisgarh, and Bihar. The process of brick making is characterized by division of labour based on a sequence of specialized activities starting from moulding of raw bricks to firing them and then finally loading them into trucks for supply. All the work is hard labour. Living in the kiln fields, these labourers are like captive workers for their contractors and kiln owners. Long working hours, poor work conditions and an absence of basic facilities are all indicators of exploitation. Given the nature of work, injuries to brick head loaders and to those involved in kiln firing are commonplace. However, even first aid facility is seldom available at the work sites. When paid a piece-rate, the labourers also try to load and carry as many bricks as possible at a time, increasing the probability of accidents[10]. Any medical expenses or hospitalization charges incurred by injured labourers are initially paid for by the mate, but later on adjusted from their wages. Such unforeseen expenses can eat into 20 per cent of the season's earnings of a labourer, not including the number of work-days lost due to forced rest[10].

In India nearly 40% and in Rajasthan 10 % of total population are considered migrant, yet migration is poorly understood and not prioritized in government policy[1,8]. Seasonal migrants represent a particularly vulnerable category of people who come from the poorest sectors of society, often from scheduled castes and scheduled tribes[1]. As seasonal migrants move between their home and work locations, continuity of care is interrupted and the portability of benefits denied[1]. Working under what are often exploitative or slave-like

conditions, they are systematically excluded from social services, as existing policies have largely failed to provide protection to this population, especially with regard to state-provided services such as healthcare[1].

The special predicament of these seasonal migrant laborers is that their movements are not tracked. This population is never acknowledged in any of the government conducted surveys and remains largely hidden. Health surveys such as National Family Health Survey (NFHS), and the District Level Household Survey (DLHS) did not consider migration as a variable affecting the health status in general, and maternal health in particular[2]. They are neither counted in their source state nor in the destination state and hence lack access to any public service like education, health, infant care or PDS.In health sector maternal and child health is largely influenced by social determinants. Circular migration affects health service utilization and thus the health status of women and children who are most vulnerable. Efforts by the government in increasing access to maternal health have been unequal and many such migrant women still lack access to basic maternal health care[3]. WHO recommends that pregnant women should receive focussed antenatal care as it is an important determinant of safe delivery[4]. But still due to lower compliance of IFA tablets, the problem of anaemia remains largely unaddressed among most of thepregnant women working at brick klins. Next, poor access to basic health care due to socioeconomic disparities is associated with worse healthcare utilization and health outcomes[2]. Women in brick kilns were living in a medically underserved region and faced barriers to health care access such as inaccessible transportation. There was no special effort from public health system to reach out to migrants[2]. In such a situation migrant rely on unregulated private providers for basic health care[2].

Fact finding Team and Respondents

Fact Finding Team

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Respondents

1. Main supervisor (*munshiji*) of the brick kiln
2. Two co-supervisors
3. Abihdan wife of Noor Mohammed
4. Amarjahan wife of Ishayak
5. Mulkaan wife of Mubin Khan
6. Saabrun wife of Ikraar

Objectives and Methodology

Objectives

The fact finding was carried out at a few brick kilns in Ajmer and Bhilwara in the month of October to assess the situation of reproductive health amongst brick kiln workers and reach of reproductive public health services to women in the target group.

The team visited the brick kilns to specifically find out the health-related problems of pregnant women as well as health related services that are denied to them.

The team also tried to find the scenario about immunisation of children of workers.

Methodology

1.Visits to brick kilns

2. Interaction with brick kiln workers

3. Interaction with brick kiln supervisors

KeyFindings

Total number of households present at brick kilns was 903. Going from past trends, it is expected that 10 percent of the respondents are single male migrants while the rest have

migrated with their family. The questions on reproductive health have been addressed only to family migrants and not single male ones.

All the workers were seasonal migrants. Nearly one third of these households were intra state migrants primarily from the districts of Ajmer and Nagaur. Rest were inter-state migrants primarily from UP, Chhattisgarh, and Bihar. Majority of the workers are from Scheduled Castes followed by Other Backward castes and Scheduled Tribe.

During Survey around Seventy-two women reported as lactating or pregnant. Out of these women around 45 were lactating and 27 were pregnant women. Thus, on average every brick kiln has more than three lactating or pregnant women.

24 women responded to question on Mamta card. Out of these only seven women reported that they are having Mamta Card.Remaining 17women did not have Mamta Card and they weren't registered.Most of the pregnant women at worksite did not get proper health check-up, as they did not have information about nearby health centers and also no ASHA (Accredited Social Health Activist) worker visited the worksites.

Around 24 women respondedto question on whether they had Ante Natal Check-up (ANC). Only half of them had a pre-natal check-up. The women who had the check-up were further asked about the place that where they had the check-up. Out of the nine women who responded, six had the check up at a Government hospital and two at a private hospital. One woman reported being checked at the brick kiln.Further our team asked them about place of delivery. 33 women responded this question and out of these women 22 reported having their delivery at the Government hospital and remaining one third women reported having their delivery at the brick kiln/home itself. Then team asked them about maternity benefit that how many of them had received this benefit (benefits of JananiSurakshaYojana – JSY). 32 women responded to the question and out of these only 10 had received maternity benefit of Rs. 1,400. Remaining 22 had not received any benefits.

Almost half the children were reported not to have received any immunisation. For those who reported being immunised, all were immunised at the Government hospital except one child and that was reported as immunisation being done at the brick kiln. 60 % children living at brick kiln have not received poliodrops. Most of the women shared that they have

some problem regarding reproductive health like white discharge and irregularities in period.

So, it can be said that reach of reproductive and child health public services at brick kilns is severally limited.

It is likely that the limited reach of RCH services that is reported has taken place at the homes of the women. The outreach of public health services at brick kilns is almost non-existent.

Long working hours, poor working conditions and an absence of basic facilities like toilets, safe drinking water and no crèche or rest room for them, make their condition more vulnerable. There is distress in the migration too as the working conditions in the work site are no better. Meagre payment, lack of healthcare facilities and PDS facilities at destination place affect the migrants negatively.

Cases

All four women in the cases highlighted below work at Bharat brick kiln which is located at Loha village near Shrinagar in Ajmer district

Case 1: Mrs Abhidan wife of Mr Noor Mohammad

Age:37 years

Address: Agra, Uttar Pradesh

Problems:

1. Mamta card not formed
2. ANC check-up not done

Mrs Abhidan wife of Mr Noor Mohammad belongs to a poor family. She is living in a small village. She is working at Brick kiln so that she can take care of her family. She has 5 children and is now six months pregnant. She said she didn't get any type of health services. Her Mamta card wasn't formed yet and her ANC check-up wasn't done. Due to unavailability of

health services nearby, she has to avail these services from Bengali or *JholaChaap* doctors (unqualified doctors or quacks).

There are no toilet and bathroom facilities in the kiln.

Case 2: Mrs Amarjahan wife of Mr Ishayak

Age: 27 years

Address: Village Amroha, TahsilLaharpur, Dist. Sitapur, Uttar Pradesh

Problems:

1. She is anemic, weak and having dermal problems like itching but still not getting health services at Brick klin

Figure 1 - Amarjahan

Mrs Amarjahan wife of Mr Ishayak belongs to a poor family. They have very small land which is around 2 beegha. They are working at Brick kiln so that she can take care of her family. Now she is 6 months pregnant and this will be her first delivery. She said she didn't get any type of health services at brick kiln. For Mamta card and for immunization she went to the government hospital which is near to the Brick kiln. She also visited Janana hospital, Ajmer for her health check-up. Now she is very weak and has dermal problem also so it is very difficult for her to visit a govt hospital or any hospital away from the kiln.

There are no toilet and bathroom facilities in the kiln.

Case 3: Mrs Mulkaan wife of Mr Mubin khan

Age:27 years

Address: Village Mohdipur, TahsilKesarganj, Dist. Sitapur, Uttarpardesh

Problems:

1. Her child didn't get vaccination
2. She is having a problem of white discharge

Mrs Mulkaan wife and her husband Mr Mubin khan are from a small village in Uttar Pradesh. Their economic condition is not so good. They have very small land which is around 4 beegha. They are working at Brick kiln so that they can take care of their family. Now she has a seven-month-old child. She said during her pregnancy period she didn't get any type of health or immunization services. Even her Mamta card wasn't formed. Due to unavailability of health services her child didn't get vaccination.

She also informed about other women who are suffering from other problems such as lack of toilet and bathroom facilities at brick kiln which will lead to infection and cause many diseases.

Case 4: Mrs Saabrun wife of Mr Ikraar

Age:25 years

Address: Village Amora, TahsilLaharpur, Dist. Sitapur, Uttarpardesh

Problems:

1. Her child didn't get vaccination
2. She is having a problem of white discharge

Figure 2 - Saabrun

Mrs Saabrun wife of Mr MrIkraaris from a small village. Economically their condition is not so good. They have very small land which is around 2 beegha. They are working at Brick kiln so that they can take care of her family. She said during her pregnancy period she didn't get any type health services. Because of this two of her children died before her delivery. Even her Mamta card wasn't formed as well as she didn't get immunization services also.

Toilet and bathroom facilities are not available at brick kiln so they have to defecate in the open and this will cause so many communicable diseases and infections. Even they have a problem during periods also because they use the same cloths again and again due to unavailability of sanitary pads which will lead to vaginal infection and cause white discharge from vagina.

Guidelines and Guarantees

→ National Health Mission

In 2013, the Centre Government launched the National Health Mission (NHM) as an umbrella program with two main prongs: The National Rural Health Mission (NRHM), first launched in 2005, and the National Urban Health Mission (NUHM). The purpose of these schemes is to improve health infrastructure and health outcomes in India's rural and urban areas. A major focus of the NRHM is improving maternal and infant health, which is revealed in the NRHM Service Guarantees. Reducing the maternal and infant mortality is a key goal for Reproductive and Child Health Programme under the National Rural Health Mission (NRHM). Several initiatives have been launched by the Ministry of Health and Family Welfare (MOHFW) under the Mission including JananiSurakshaYojana (JSY), a key intervention that has resulted in phenomenal growth in institutional deliveries with more than one crore women being benefited from the scheme annually. JSY was launched to promote institutional deliveries so that skilled attendance at birth is available and women and new born can be saved from pregnancy related deaths. However, even though institutional delivery has increased significantly, out of pocket expenses being incurred by pregnant women and their families are significantly high. Another initiative is JananiShishuSamrakshanKaryakram (JSSK) which is aimed at providing cashless institutional delivery.

a) JananiSurakshaYojana (JSY):

Since its implementation in 2005, the JSY scheme has aimed to reduce maternal and neonatal mortality by providing women with conditional cash assistance for registering their pregnancies and choosing institutional delivery. All women are eligible for JSY benefits, regardless of their age or number of children. To receive JSY benefits, women must present a JSY card and a referral slip from an Accredited Social Health Activist (ASHA), Auxiliary

Nurse Midwife (ANM), or Medical Officer (MO). JSY guidelines specify that a woman's state of residency (not the state in which she delivers) determines the amount of the JSY cash benefit. Therefore, even though many women in India return to their mother's home to deliver, which may be located in another state, these women must be given a JSY payment at the rate of their own home state.

JSY BENEFIT FOR INSTITUTIONAL DELIVERIES

(in Rupees)

Rural				*Urban*		
Category of States	Assistance to mother	Assistance to ASHA	Total	Assistance Mother	Assistance to ASHA	Total
LPS*	1400	600	2000	1000	400	1400
HPS**	700	600	1300	600	400	1000

* Low Performing States (LPS) include Assam, Bihar, Chhattisgarh, Jammu & Kashmir, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh, and Uttaranchal.

** High Performing States (HPS) include all states that are not LPS.

b) JananiShishuSurakshaKaryakram (JSSK):

Through the NHM, the government also coordinates the JSSK scheme, which the Government launched in June 2011 as a means of eliminating out-of-pocket expenses incurred by pregnant women and sick new-born, which are "without doubt, a major barrier" for pregnant women and children, many of whom "die on account of poor access to health facilities." Therefore, the JSSK scheme provides that pregnant women seeking institutional delivery and sick new-borns until 30 days after birth are entitled to absolutely free care in all government health facilities. JSSK services are available to all women who deliver in government health facilities, regardless of age, number of children, or economic status. These free JSSK services include delivery (including Caesarean section), medicines, consumables, essential diagnostics, blood transfusions, nutritious meals (up to 3 days for normal delivery and 7 days for Caesarean section), free transportation to and from the facility (and between facilities in cases of referral), and exemption from all user charges.

The JSSK scheme provides essentially the same free services to sick new-borns that are available to pregnant women.

→Convention on the Elimination of all forms of Discrimination against Women (CEDAW)

As per Article 16(e) of the Convention on the Elimination of all forms of Discrimination against Women (CEDAW), to which India is a signatory, men and women have a right to decide freely and responsibly on the number of children to have, the space between children and the information and means to enable them to exercise these rights. The International Conference Population and Development, 1994, also declares that reproductive health care programmes must provide the widest range of services so that couples have the means to freely decide on the number of children to have, the space between children.

→United Nations Convention on the Rights of the Child

India is a signatory to this convention according to which all decisions concerning children will be taken keeping the best interest of the child in mind; the child is entitled to the right to health and health care and the state should ensure health care services.

→Integrated Child Development Scheme (ICDS)

The ICDS which is one of the largest child care services in the world, mandates that through anganwadis every child's health and nutrition are ensured. Anganwadis are meant to ensure that all children receive immunisation shots, weight check, nutritious food and regular monitoring of the child's growth indicators from birth till the age of five.

→Right to Education

As per this act passed in 2009, all Indian children in the age group of 6-14 years have the right to free and compulsory education.

→'**adequate means of livelihood**' as enshrined in Article 39 of the Indian Constitution mandates that all Indian citizens have a right to earn a decent livelihood to maintain themselves and their families in dignity

→ Minimum Wages Act 1948

According to the Act of Indian Parliament, workers must receive a 'living wage' (as defined by the Indian Constitution) to ensure basic standard of living including good health,

education, dignity and provide for contingencies. Payment of wages below minimum wages amounts to forced labour. Besides, there are several rights for workers such as right to form unions, sick leave, casual leave, special rights for women such as paid maternity leave, crèche facility for children, etc.

→All above guarantees are needed for a person to exercise the **right toLife of Dignity** as laid down in Article 21 of the Indian Constitution

Violations of Rights

- None of the women detailed in the cases above has received any kind of health service from the Anganwadi or any public health facility. This is in violation of service rules of anganwadis that stipulate that they muct register every pregnant/lactating woman in their area and provide ANC, PNC and health & nutrition services to children. Mamta card, (the Mother and Child Protection Card) is an important tool for monitoring the health status of mothers and new born children. By not providing these cards, the women have been denied an important health service and thus deprived of their right to Health
- None of the women have received benefits under JSY or JSSK. They have been denied this service in spite of being extremely poor and much in need of cash incentives such as these
- Abhidan's right to information has been violated as she did not have information on spacing of children; a poor woman, she can hardly afford to care for five children and she is now pregnant with the sixth child. Had she received proper counselling and information she could have planned her family size in a better manner. CEDAW, to which India is a signatory, also states that couples must have the information and the means to plan their family size, gap between children, etc.
- The children of these women have not received immunisation services, which is violation of their right to health. It is a violation of the convention of the rights of the Child, (to which India is a signatory) that states that the state shall always act in the best interests of the child and shall ensure health rights of the child

- The Children's Right to Education has been denied by the state as well as their employers as the women are not in a position to send their children to school
- Saabrun's children's right to Life itself has been violated as two of her children died before birth because Saabrun did not receive adequate ANC
- The women workers' right to livelihood has been violated as they receive meagre wages that doesn't allow them to provide a decent, dignified and comfortable lives to themselves and their families. They cannot afford proper health care or education for children on the wages that they receive
- The employers have also violated the Minimum Wages Act by paying the workers a wage that is below the 'living wage'. Several other provisions in the law that provide for dignity and comfort of workers have been violated such as – maternity benefits and paid leave for women, sick leave, medical insurance, safety at working place, regulation of working hours, adequate drinking water & clean toilets, crèche facilities for children of workers, provident fund and other such social security schemes.
- The women's right to health has been denied at their work places as well as by the state that has not reached out to them with health services.
- The denial of the Right to Health amounts to denial of Right to Life of dignity as enshrined in the Indian Constitution.

Recommendations

Migrant labours who work at brick kiln are mostly deprived of medical care. Since brick kilns are usually away from the city or village, the people have to travel quite a distance to reach the nearby medical facility. They are mostly unaware of various schemes mandated under the guidelines that safeguard right to health. Specific recommendations related to the health of the women mentioned in the cases are:

- Ensure that the women are immediately provided incentives under JSY and other maternity benefit schemes where eligible
- Ensure that the children are immediately registered in anganwadis for provision of nutrition and immunization. Make sure that the children receive their shots immediately.

- Ensure that their children are not denied the right to education; make sure that the women's children are enrolled in schools
- Ensure that the women receive PNC soon after delivery; make sure that their Mamta cards are formed quickly so that their own and their children's health can be monitored regularly.

The State should take this issue as a high priority to provide ANM's and ASHA workers for the brick kilns. State must strengthen the monitoring of the working of the ASHAs and ANMs at the brick kilns. It should be strictly monitored whether the ANMs and ASHAs have registered pregnant women at their nearest Anganwadicentre or not.

Anganwadis and PHCs must be senstitised to the health care needs of brick kiln workers in their vicinity; rather than wait for the workers to approach them, health workers must be encouraged and incentivized to seek out such workers, register them and provide regular care.

The State should make it a point to spread awareness about JSSK and JSY schemes, especially at the brick kilns. The brick kiln workers are migrants from nearby states who are often unaware about the benefits available to them especially since they do not belong to the place where they work. Special awareness camps must be held at brick kilns as also health outreach camps so that the workers can avail these services.

Ensure that schools identify and enroll children of brick kiln workers in their vicinity.

Wherever necessary initiate legal action against brick kiln owners to ensure payment of minimum wages to workers.

Conclusion

It can be said that reach of reproductive and child health public services at brick kilns is severally limited. Less than one third pregnant women reported having a Mamta Card. Only half the pregnant women reported having had pre-natal check-up. One third women reported having delivery outside the Government hospital. Less than one third women received the cash benefits provided to women whose delivery is conducted at the Government hospital. It seems that all the women who had delivery at the Government hospital did not receive cash benefits probably because of their migrant status.

The children have also not been covered fully. Only half the children reported being immunised. What is very surprising that even polio drops have not been administered to all the children.

Added to these is the fact that these women do not have hygienic working conditions – there are not toilet or drinking water facilities, no crèches for children. They all suffer from other ailments such as skin ailments, vaginal discharge, lack of sanitary products,

Brick kiln workers are already vulnerable –being as they are migrant workers. Denial of health services forces them to seek health care from quacks which places them in further danger. Sometimes they are also constrained to seek health from expensive private sources, which causes indebtedness.

It is likely that the limited reach of RCH services that is reported has taken place at the homes of the women. The outreach of public health services at brick kilns is almost non-existent. In order to ensure the health rights of these vulnerable communities, it is absolutely essential for governments to provide free and good quality health care facilities within easy reach of the brick kiln workers.

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