HEALTH, HYGIENE AND PSYCHOLOGICAL WELL-BEING OF INTERSTATE MIGRANT WOMEN LABORERS IN KERALA

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Abstract

Interstate migrant women workers constitute a vulnerable segment of Kerala's labour force, facing multiple challenges related to health, hygiene, and psychological well-being. Separation from family, unfamiliar social environments and long working hours often lead to stress, anxiety, and emotional insecurity. Inadequate sanitation, poor housing conditions, and limited access to gender-sensitive healthcare further aggravate their vulnerability. This study examines the living conditions, hygiene facilities, and access to healthcare services of interstate migrant women labourers in Kerala using primary data collected from 150 respondents in Thiruvananthapuram district. The study employs chi-square tests to assess the effectiveness of facilities and variations in healthcare access. The findings reveal significant inadequacies in sanitation, menstrual hygiene, and healthcare awareness, indicating the need for policy reforms, improved employer accountability, and targeted government interventions to ensure dignity, safety, and well-being of migrant women workers.

Keywords:- Interstate Migration, Women Workers, Health and Hygiene, Psychological Well-being, Labour Welfare.

In recent years, Kerala has witnessed a large number of migrant labor inflows from different parts of India, mainly from West Bengal, Assam, Bihar, Odisha, Utter Pradesh and Tamilnadu. The contribution of migrant workers to the economy is huge but remains poor in return for their security and wellbeing especially among women labors. Women migrated labors in Kerala are engaging in many fields like construction works, hotels, beauty salons, textiles, plantation works and fish peeling.

Most of the migrant women labors are depending their male member in family they are facing a lot of discriminations from the family, moreover from the employer and

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customers too. There is lack of strong government control for protecting the rights and interest of migrated women in Kerala. The differences in values, customs, languages and food habits in Kerala create problems of adjustment among women migrant labors. As the migrant women labors are far from their home place they may face psychological issues like loneliness, emotional deprivation, anxiety, stress and depression. The female migrant labors in Kerala are struggling to integrate with socially and culturally as the language, customs, rituals, attitude of people are different from theirs. In the case of women migrants' critical health issues are there because of long working hours, issues associated with pregnancy and maternity health, poor living and working conditions, lack of toilets and bath facilities badly affect the efficiency of women migrant workers. Economic issues relating to poor wages, lack of better employment packages, absence of allowances, bonuses and fringe benefits are another major challenges facing by the women interstate migrants in Kerala. So it is essential to conduct a study covering all these major challenges facing by the interstate migrant women labors in Kerala.

Review of Literature

Parida and Raman (2013) conducted a comprehensive study on in-migration and informal employment in Kerala and found that migrant workers, particularly women, remain outside the ambit of labour protection and welfare schemes. Their study highlighted poor housing conditions, absence of social security, and vulnerability to exploitation as major challenges.

James (2016) examined the social integration of migrant workers in Kerala and observed that migrant women experience greater cultural alienation and social exclusion compared to men due to language barriers and gender-based discrimination. The study also noted that lack of community support networks intensifies psychological stress among migrant women.

Kumar and Pramod (2016) studied the psychological problems of migrant labourers in Kerala and found high prevalence of anxiety, depression, and emotional distress, especially among women workers. Their findings indicated that poor living environments and lack of healthcare access significantly affect mental health.

Shajeena (2020) in her study on interstate migrant workers in Kerala revealed that women migrants face inadequate housing, unsafe working conditions, and poor access to reproductive and general healthcare services. The study emphasized the need for gender-responsive labour policies.

The review clearly indicates that although migrant women play a crucial role in Kerala's economy, they continue to suffer from poor health, hygiene, and psychological well-being, thereby justifying the need for the present study.

Objectives of the Study

1. To assess the effectiveness of living conditions and hygiene facilities available to interstate migrant women labourers in Kerala.

2. To evaluate the adequacy of access to health care and hygiene services among interstate migrant women labourers in Kerala.

Hypotheses

H0a: There is no significant effectiveness in living conditions & hygiene facilities (responses are evenly distributed).

H1a: There is significant ineffectiveness in living conditions & hygiene facilities (responses differ significantly).

H0b: There is no significant difference between the perceived access to health care & hygiene services and the expected adequate level among interstate migrant female labourers.

H1b: There is a significant difference between the perceived access to health care & hygiene services and the expected adequate level among interstate migrant female labourers.

Statement of the Problem

Despite their growing contribution to Kerala's labour market, interstate migrant women workers continue to experience serious challenges related to health, hygiene, living conditions, and psychological well-being. They often live in overcrowded accommodations with inadequate sanitation, limited access to clean drinking water, and poor menstrual hygiene facilities. Language barriers, lack of awareness, and discrimination restrict their ability to access healthcare services effectively. These conditions not only affect their physical health but also lead to emotional distress, anxiety, and reduced quality of life. However, systematic empirical studies focusing specifically on the health, hygiene, and psychological well-being of interstate migrant women workers in Kerala remain limited. Hence, the present study seeks to examine the effectiveness of living conditions and healthcare facilities available to this vulnerable group.

Scope of the Study

The study focuses on interstate migrant women workers employed in various sectors such as construction, fish processing, plantations, textiles, hospitality, and beauty services in Thiruvananthapuram district of Kerala. It examines their living conditions, hygiene facilities, and access to healthcare services, including women-specific health needs. The study also analyses variations in perceptions regarding healthcare accessibility and sanitation facilities. However, the study is confined to selected respondents and does not include male migrant workers or other districts of Kerala.

Significance of the Study

This study is significant both academically and socially. Academically, it contributes to the limited literature on interstate migrant women workers by providing empirical evidence on their health, hygiene, and psychological well-being. It also enriches migration and labour studies with a gender-specific perspective. From a practical perspective, the findings provide valuable insights for policymakers, labour departments, and employers to design better welfare

schemes, housing facilities, healthcare access, and workplace safety measures for migrant women. Socially, the study highlights the hardships faced by a marginalized group and helps create awareness about the need for dignity, equity, and human rights for interstate migrant women workers in Kerala.

Research Methodology

This study employs a descriptive research design, utilizing both primary and secondary data for a comprehensive analysis. Primary data were collected from interstate migrant women workers from Tamil Nadu, Assam, Odisha, Jharkhand, and West Bengal who are employed in sectors such as plantations, fish processing, textiles, construction, hospitality and beauty services. Data collection was conducted using a structured interview schedule. Secondary data were sourced from relevant journals, books, and government reports on migrant labor issues. According to a study conducted by the Kerala Institute of Labor and Employment (KILE) titled Interstate Migrant Workers in Kerala: A Study on Their Work and Life (2020), a significant proportion of women migrant workers in Kerala originate from Tamil Nadu, Assam, Odisha, Jharkhand, and West Bengal, primarily engaged in the aforementioned sectors. The study population comprises 213,090 women migrant workers across Kerala from these states. For research feasibility, a sample of 150 migrant workers from Thiruvananthapuram district has been selected using a convenient sampling method. This approach ensures a focused analysis of the challenges faced by interstate migrant women workers in Kerala.

Data Analysis

An analysis of the personal profile of the respondents (Table 1) reveals that a majority of the migrant women labourers belong to the age group of 31–40 years (36.6%). With respect to their state of origin, most of them are from West Bengal (38.66%). An examination of their educational background shows that the largest proportion has only lower primary education. Considering their marital status, it is evident that most of the respondents are single (41%). Further, an assessment of their living arrangements in Kerala indicates that a majority reside in employer-provided group housing (52%).

The analysis of the working sector distribution (Table 2) reveals that migrant women workers are predominantly employed in beauty salons (25.33 per cent), hotels and restaurants (22.66 per cent), and fish processing units (18 per cent), indicating their concentration in gendered, labour-intensive and service-oriented sectors. Only a smaller proportion works in construction (10 per cent) and plantation activities (9.33 per cent). Regarding earnings, most respondents fall within the ₹ 10,000 – ₹ 15,000 monthly wage bracket (40.66 per cent), followed by ₹ 5,000– ₹ 10,000 (34.66 per cent), showing that a major share of workers receive low to moderate income, with very few earning above ₹ 20,000 (2.66 per cent). The mode of wage payment indicates that cash payments (54.66 per cent) are more common than bank transfers (45.33 per cent), reflecting

Table 1

Personal Profile of the Respondents

Variable	Category	Frequency	Percentage
Age	21-30	12	8
	31-40	55	36.6
	41-50	36	24
	51-60	27	18
	61-70	11	7.3
	71-80	9	6
State of Origin	Tamil Nadu	8	5.33
	Assam	36	24
	Odisha	25	16.6
	Jharkhand	23	15.33
	West Bengal	58	38.66
Educational Qualification	LP	59	39.33
	UP	38	25.33
	HS	30	20
	HSS	22	21.33
	Graduation	1	0.66
Marital Status	Single	62	41.33
	Married	54	36
	Widowed/Divorced	34	22.66
Family type in Kerala	Lives alone	22	14.66
	Lives with spouse	36	24
	With spouse & children	12	8
	With employer-provided group housing	78	52
	With relatives/others	2	1.33

Source: Primary Data

informal labour practices and limited financial inclusion.

An alarming trend emerges from wage-timeliness data, where only 8 per cent reported receiving wages *always* on time, while a high 38 per cent stated that wages are *never* paid on time. Another 30 per cent receive wages *sometimes*, suggesting widespread wage delay and financial insecurity. Analysis of benefits received shows a severe lack of social protection; while accommodation (52 per cent) and food (44.66 per cent) are commonly provided, other essential benefits such as overtime pay (0.66 per cent), paid leave (0.66 per cent), maternity leave (0.66 per cent), and health insurance (1.33 per cent) are almost absent. This highlights significant gaps in employer responsibility and labour welfare measures. Overall, the findings

Table 2

Work Profile of Respondents

Variable	Category	Frequency	Percentage
Working Sector	Construction Plantation	15	10
	Fish processing	14	9.33
	Hotel/restaurant Beauty	27	18
	salon Textile/garment	34	22.66
		38	25.33
		22	14.66
Monthly Wage	0-5000	18	12
	5000-10000	52	34.66
	10000-15000	61	40.66
	15000-20000	15	10
	Above 20000	4	2.66
Mode of Payment	Cash	82	54.66
	Bank transfer	68	45.33
Are wages paid on time	Always	12	8
	Mostly	36	24
	Sometimes	45	30
	Never	57	38
Do you receive any benefits	Overtime pay	1	0.66
	Food provided	67	44.66
	Accommodation Paid	78	52
	leave	1	0.66
	Maternity leave Health	1	0.66
	insurance	2	1.33

Source: Primary Data

indicate that interstate migrant women workers in Kerala continue to face low wages, high wage-payment irregularities, limited formal financial access, and minimal employment benefits, reflecting their vulnerability within the labour market.

Hypothesis

H0: There is no significant effectiveness in living conditions & hygiene facilities (responses are evenly distributed).

H1: There is significant ineffectiveness in living conditions & hygiene facilities (responses differ significantly).

Living Conditions & Hygiene Facilities

Expected Frequency (E)

A standard research assumption:

If facilities were "effective", **expected responses would be equal across items**.

Total positive responses =

12 + 19 + 24 + 21 + 22 + 28 + 15 + 9 = **150**

Expected per item = Total ÷ 8 =

150 / 8 = **18.75**

Formula:

$$\chi^2 = \frac{\Sigma(O-E)^2}{E}$$

χ2=2.43+0.003+1.48+0.27+0.55+4.56+0.75+5.07,

χ2=**15.12**\chi^2 , **15.12**χ2=**15.12**

df = categories – 1 = 8 – 1 = **7**

At 5% significance level, df = 7 →

χcritical2=14.067\chi^2_{critical}

= 14.067χcritical2=14.067

Decision

χcalculated2(15.12)>χcritical2(14.067)

Result: Reject the Null Hypothesis (H0) and Accept the Alternative Hypothesis (H1)

The chi-square test indicates that the distribution of satisfaction across various living and hygiene indicators is not uniform. Since the calculated chi-square value (15.12) is greater than the critical value (14.067), the null hypothesis is rejected, confirming that the living and hygiene conditions provided to migrant women are statistically inadequate**.**

The lowest observed responses were recorded for menstrual hygiene (9), adequate living space (12), and waste disposal (15). These facilities are essential for women's dignity, health, and safety. Poor menstrual hygiene infrastructure exposes women to infections and psychological stress, while overcrowded living spaces increase vulnerability and disease transmission. Although ventilation and drinking water scored relatively higher,

Table 3

Observed Responses on Living Conditions & Hygiene Facilities

Indicator	Observed Frequency (O)
Adequate living space	12
Clean accommodation	19
Clean drinking water	24
Clean toilet	21
Separate women's toilet	22
Ventilation & lighting	28
Waste disposal facility	15
Menstrual hygiene facility	9
Total	**150**

Source: Primary Data

Table 4

Chi-Square Test for Living Conditions & Hygiene Facilities

Indicator	O	E (18.75)	$(O - E)^2 / E$
Adequate living space	12	18.75	2.43
Clean accommodation	19	18.75	0.003
Clean drinking water	24	18.75	1.48
Clean toilet	21	18.75	0.27
Separate women's toilet	22	18.75	0.55
Ventilation & lighting	28	18.75	4.56
Waste disposal	15	18.75	0.75
Menstrual hygiene	9	18.75	5.07
Total χ^2			**15.12**

Source: Primary Data

these alone cannot compensate for deficiencies in sanitation and gender-specific facilities.

Thus, the results clearly show that the existing accommodation and hygiene arrangements fail to meet the basic standards of well-being for interstate migrant women.

Hypothesis

H0b: There is no significant difference between the perceived access to health care & hygiene services and the expected adequate level among interstate migrant female labourers.

H1b: There is a significant difference between the perceived access to health care & hygiene services and the expected adequate level among interstate migrant female labourers.

$\chi 2=61.28$ $df=n-1=9-1=8$

Decision Rule

At 5% level,

Critical value for df=8 → 15.51

Since:

61.28>15.5161.28 > 15.5161.28>15.51

Result: The Chi-Square value is significant, and hence **reject H0 and accept alternate hypothesis.**

The perceptions towards access to healthcare are **not uniform,** there are **strong variations.** It is evident those healthcare services are affordable and that women-specific health services are available to migrant women employees.

Table-5

Calculation Summary onAccess to Health Care & Hygiene Services

Statements	O	E	$(O - E)^2 / E$
I can easily access a health care centre when I need medical help.	22	16.67	1.70
I am able to communicate with healthcare providers despite language differences.	2	16.67	12.91
The health services available to me are affordable.	35	16.67	20.14
I receive respectful and non-discriminatory treatment in health facilities.	12	16.67	1.31
I have sufficient knowledge about where to go for medical treatment in Kerala.	3	16.67	11.20
My workplace provides adequate first aid or health support.	10	16.67	2.67
I receive proper information about vaccinations, maternal health and check-ups.	14	16.67	0.43
Women-specific healthcare services are easily available to me.	28	16.67	7.68
Government provides sufficient support for women's health needs.	24	16.67	3.24

Source: Primary Data

Government support is found to be adequate, and health centres are generally accessible. However, effective communication with healthcare providers remains a major concern due to the lack of awareness of the local language. Knowledge about where and how to access appropriate treatment is very poor among the respondents. Additionally, most workplaces do not provide basic first-aid facilities, which further aggravates health and hygiene issues.This means migrant women experience **unequal and inconsistent access** to healthcare services.

Findings

- A majority of migrant women live in overcrowded, employer-provided housing with inadequate sanitation.
- Menstrual hygiene facilities and waste disposal systems are severely lacking.
- Wage irregularities and lack of benefits further worsen health insecurity.
- Although healthcare services are affordable, women face major barriers due to language problems and lack of awareness.
- Workplace health support, maternity care information, and first-aid services are almost absent.

- Healthcare access is unequal, leaving many women dependent on chance rather than entitlement.

Suggestions

1. ***Gender-Sensitive Housing Facilities***: Employers and contractors employing migrant women should be mandated to provide gender-sensitive housing facilities. This includes separate and hygienic toilets for women, adequate living space, proper waste disposal mechanisms, and access to menstrual hygiene facilities such as sanitary napkin disposal units. The Kerala Labour Department should issue clear housing guidelines and make these facilities a compulsory requirement for labour registration and license renewal. Such measures will significantly improve personal hygiene, dignity, and overall health outcomes of migrant women workers.

2. Establishment of Multilingual Health Information Centres: Health Information Centres or helpdesks should be set up in migrant-dense areas such as labour camps, industrial zones, and urban settlements. These centres must function in multiple languages commonly spoken by migrant women and provide guidance regarding nearby government hospitals, maternity services, immunisation schedules, and emergency care facilities. Local self-governments, in collaboration with the Health Department and NGOs, can manage these centres to ensure outreach and regular updating of information.

3. Strengthening Workplace Health Support Systems: Every employer engaging migrant women should be legally required to provide basic first-aid facilities at the workplace. In addition, periodic medical camps focusing on general health, reproductive health, and occupational hazards should be organised in coordination with primary health centres. Employers should also ensure maternity-related support such as paid leave, rest periods, and referrals to public health facilities. These steps will reduce workplace health risks and enhance women's productivity and well-being.

4. Language Support Mechanisms in Hospitals: To address communication barriers, government hospitals in migrant-receiving districts should appoint trained translators or migrant health facilitators familiar with the languages of migrant workers. These facilitators can assist women during registration, consultation, and follow-up treatment. This intervention will improve diagnosis accuracy, treatment compliance, and patient satisfaction, particularly in maternity and emergency cases.

5. Regular and Strict Labour Inspections: The Kerala Labour Department should strengthen inspection mechanisms by conducting regular and surprise inspections of migrant housing and work sites. These inspections should specifically assess health, hygiene, sanitation, and safety standards. Non-compliance must attract penalties, while compliant employers can be incentivised through recognition or certification. This enforcement will ensure that health and

safety norms are not merely advisory but effectively implemented.

6. Introduction of Digital Health Cards for Migrant Women: The state government should introduce a digital health card system for migrant women employees that records basic medical history, immunisation details, maternity benefits, and access to public health schemes. This portable health ID can be linked to existing public health platforms and used across districts, ensuring continuity of care even when migrants change locations. Such a system will enhance inclusivity and improve monitoring of migrant women's health status.

Conclusion

The overall findings of the study reveal that interstate migrant women workers in Kerala continue to face significant inadequacies in both their living conditions and access to healthcare and hygiene services. The chi-square analysis on living conditions showed statistically significant dissatisfaction, particularly in areas such as menstrual hygiene, adequate living space, and proper waste disposal, indicating that basic sanitation and residential facilities remain far below acceptable standards. Similarly, the perception analysis of healthcare access shows clear gaps in language-friendly services, awareness of treatment options, respectful medical interaction, workplace health support, and information on women-specific healthcare. Although some facilities such as affordability of services and availability of reproductive healthcare scored moderately higher, the overall pattern reflects inconsistent and insufficient health and hygiene support. Taken together, the results indicate that the current infrastructure and service delivery mechanisms fail to meet the essential needs of migrant women, demonstrating an urgent requirement for policy intervention, improved monitoring, culturally sensitive communication, and gender-responsive health and sanitation facilities to enhance their overall well-being and quality of life.

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