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Methodology Article

Health Challenges or Risks, and Services for Child Migrants in India

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Abstract

Until recently, most of the literature on migration focused on adults, and rarely have migrant children's perspectives been heard. The number of children migrating alone has increased. Child migrants (below the age of 18) accounted for 12% of the total migrant population. Given their unique physiology, children under 18, particularly those who are very young, are more susceptible to health risks. Despite the significant health risks, health services are generally unavailable or inaccessible to child migrants, and private health services are often too costly, which places health services beyond their reach. This article examines the health risks of child migrants globally, with a special focus on child migrants in India, and identifies the barriers to them accessing health services. However, there is a lack of information on migrants in general, leading to a gap in the data on the health issues of child migrants. To understand this issue, I have reviewed a range of articles and documents, which have helped to identify these gaps in the literature. In addition, the research found that in India, health services are provided based on identity documents linked to place of origin, excluding migrant children from these essential services. Accordingly, it is recommended that public health services are delinked from place of origin requirements and that more data is collected on migrant child and their health issues.

Keywords

Migrant Children, Migration, Risks, Health, Global, India

1. Introduction

Migration has always been a characteristic of human society, one that has, and will probably always be, fraught with health challenges [42]. Today, it remains the main way in which people escape climatic, social, political, agricultural and economic threats, seeking alternative life options elsewhere [20]. The growing phenomenon of unofficial and, hence, unrecorded migration poses an obstacle to understanding the real pace and scope of contemporary movement and all the ways in which population movement affects health and healthcare [26]. The speed of contemporary migration, the number of people involved, and the fact that people are often moving from parts of the world with very distinct health conditions and disease profiles inevitably carry with them implications for the health and healthcare of those who move and those who receive them [65].

Migration exposes individuals and groups in many settings to health risks. Despite this, many remain excluded from the benefits of health and healthcare [29]. Migration to urban areas not

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only affects the health of adults, but also the health of children, in an adverse manner [23]. Children are one of the most vulnerable groups affected by migration, and children who migrate without their parents are an extremely vulnerable group [38]. The migration of children to the streets is a well-known phenomenon in many countries, leading to many health risks [69].

India, being a diverse nation, has witnessed successive waves of migration, resulting in an increasing number of children and adolescents migrating [36]. While globally, child migrants (below the age of 18) accounted for 12% of the total migrant population [77]; in India, according to UNICEF, this proportion is much higher, with child migrants making up an estimated 20% of internal migrants (i.e., 92.95 million) [10]. In addition, migration discussions often overlook children from migrant families in India with low income [13]. Hence, it has been difficult to provide a comprehensive picture of the situation of migrants, particularly of migrant street children, partly because they often live under the radar and outside social norms, and sometimes even outside the law [67].

Unofficial migration may be an even more important process than official migration in terms of how it affects health [3]. As noted by the World Health Organization (WHO), some data on the health of child migrants is routinely collected by countries, but these data tend not to be concentrated around health [2]. Comprehensive and reliable data are critical for informing further research and policies related to migrant health [52]. The absence of official estimates is the foremost lacuna and poses a roadblock to the delivery of critical services and programmes in India, such as the Integrated Child Development Services (ICDS), which are not available to migrants [55].

This article attempts to capture the health risks of child migrants, with a particular focus on migrant children in India. It investigates the following question: *What are the potential health issues faced by child migrants, particularly in India, and what are the barriers to them accessing health services?*

2. Methodology

2.1. Methods and Materials

To answer the research question, peer-reviewed literature with themes related to health and child migrants, including the accessibility of health services to child migrants, both globally as well as in India, were assessed. Approximately, 20 journal articles were read related to themes such as migration, children and health risks. The peer-reviewed literature was accessed through electronic searchable sites (PubMed, ProMED, and others) using standard search strategies for literature related to migrants, mobile populations, and health risks. In addition, 10 publicly available reports from international and national organisations and agencies were accessed for information on migrants, mobile populations, and health.

To locate relevant literature, a methodical and transparent approach was used, to enable replicability [66]. This involved a thorough 30 systematic search addressing the review questions, with clear criteria for inclusion in the review [66]. This were supplemented by hand-searches on Google Scholar and through snowballing techniques, by reviewing the reference lists of articles already identified for inclusion [25, 64].

Establishing inclusion and exclusion criteria is a standard, required practice when designing high-quality research protocols. It involves identifying the criteria that has been used to determine which research studies will be included and excluded. The inclusion and exclusion criteria must be decided before you start the review. Inclusion criteria is everything a study must have to be included [83]. Exclusion criteria are the factors that would make a study ineligible to be included. Inclusion and exclusion criteria, were formulated to ensure that articles included were most relevant to the literature review questions [80]. These were designed prior to beginning the search and slightly adapted at the initial phases of the process, to include further criteria that was not initially considered by the author.

Certain search terms were also used. Consideration was given to the scope and breath of the literature review when planning the search. The researcher aimed to retrieve a broad range of studies, which could be refined according to the inclusion criteria. Search terms were devised based on key areas relevant to the review questions [12, 28]. These included keywords related to ‘children’, ‘migrants’, ‘India’ and ‘health’. The researcher refined results by applying filters such as ‘healthcare’ and ‘health services’ which helped focus on articles specifically addressing the health challenges and risks faced by migrant children.

A balance of specific inclusion and exclusion criteria is paramount. For some systematic reviews, there may already be a large pre-existing body of literature. Therefore, having explicit exclusion criteria from the beginning allows those conducting the screening process an efficient workflow [4, 61].

The websites of organisations and agencies—such as the World Health Organization, International Organisation for Migration (IOM), International Labour Organization (ILO), other United Nations (UN) agencies, the World Bank, Centres for Disease Control and Prevention (Atlanta, USA), European Centres for Disease Prevention and Control, Health Protection Agency (UK), and others—were canvased and read in detail relating to health concerns and outcomes, globally as well as India. As the article involved no direct contact with individuals or included any personal medical information, research ethics approval was not sought.

Once the relevant publications were identified, they were an analysed by varying degrees. The most common method was thematic analysis[1] e.g., [22, 59, 73].

1 Thematic analysis is a method used to analyse qualitative data. It involves the identification and reporting of patterns in a data set, which are then interpreted for their inherent meaning (Liebenberg et al., 2020; Zammit & Xu, 2020).

2.2. Scope

This article has looked at children who have migrated both with family members and children who migrated alone due to peer pressures, for work or just due to family breakdown [40]. The scope would include the time period for the studies included in the literature review; global and India; children (under 18); looked at health of migrant children and access to healthcare.

2.3. Terminology

This study looked primary at child migrants.[2] IOM defines a child as, "every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier". Similarly, a migrant child is defined as, "Any person below the age of 18, who is moving or has moved across an international border or within a State with or without their family, away from their habitual place of residence regardless of: the child's legal status; whether the movement is voluntary or involuntary; what are the causes of the movement; what the length of the stay" [38].

2.4. Limitations

Despite performing a targeted search, all searches were limited to articles in English, from peer-reviewed journals [25]. While recognising the limitations of only using peer-reviewed articles in terms of publication bias, this was deemed necessary to ensure a high level of quality of the literature included in the review. Additional limiters were applied to the Web of Science and Scopus search to ensure relevant results, due to the large number of disciplines covered [7]. Moreover, through the process of considering the findings in the context of existing literature, the researcher noticed that children's accounts did not include much detail on the health risks and challenges by child migrants. In fact, it was observed that few research based articles and journals looked at the health concerns, risks and challenges faced by migrant children [48].

3. Findings

3.1. Potential Health Issues Faced by Child Migrants, Particularly in India

Migrants, as a non-native population, are exposed to tend to experience health problems [73]. Many of these problems can be ascribed to their migration to urban areas, decreased awareness about the health facilities in the new location, inability to cope with psychological stress, unhealthy sexual practices, and frequent migration, as well as food insecurity, climate, and other environmental hazards. Migrants, including in India, also face health inequities due to discrimination, social exclusion, legal status, gender inequalities, poor living and working conditions, language barriers, lack of information and absence of healthcare financing [70].

Child migrants, as a group, are considered more vulnerable than adults, as children are not yet fully developed [34]. Migration exposes children to various risks and vulnerabilities. In the PhD study titled *Exploring the Lived Experiences of Migrant Street Children in Delhi: Understanding Gender and Space in Street Situation*, [44] explored the experiences of migrant street children in Delhi, India, including the reasons for their migration, their lives on the streets, and their exit from the streets, as well as the impact of gender and space in street situations. The study found, among other things, that migrant street children are generally unable to access health and education services, putting them at great risk and adding to their vulnerability [49]. This is supported by other research, which highlights that migrant children are at risk of missing out on most developmental aspects, including regarding health [58].

A child's stage of growth, strength, and development affects their specific degree of vulnerability, thereby affecting their health [57]. The National Commission for Protection of Child Rights (NCPCR), [3] an Indian statutory body established under the Commission for Protection of Child Rights Act, 2005, sets out the common risks for children according to their age groups:

1) Children of 0–6 years: The common risks include being deprived of health, nutrition, and pre-school education. They can lack a birth certificate, immunisation, and access to health facilities, resulting in acute malnourishment, sickness, and mortality. They can also lack access to childcare centres, crèches, safe drinking water, sanitation, and so forth.
2) Children of 6–14 years: The common risks include school dropout, or having no access to school, leading to involvement in other activities, such as working with members of their family, which can lead to health hazards, exploitation, and abuse.
3) Children of 14–18 years: The common risks include being out-of-school and constituting an active labour force. This age group is at risk of drug abuse and sexual exploitation. Adolescent girls are vulnerable to sexual exploitation and being pushed into the sex trade, early marriage, and pregnancy.

These risks are heightened for migrant children.

Migration impacts on children observed differently, according to their age, class and gender [11, 46]. Given their unique physiology, children under 18, particularly those who are very young, are more susceptible to temperature extremes affecting their health than adults, who are better able to survive [63].

2 The terms migrant child/children or child migrant are used interchangeably in this article.

3 The NCPCR is a government body established in March 2007 under the Commissions for Protection of Child Rights (CPCR) Act 2005 to ensure that all laws, policies, and programmes are in tune with child rights perspective as in the Constitution of India and also UNCRC.

Poor health also makes children less resilient to conditions on their migration journeys [49]. Migrant children, however, are not a homogeneous cohort; therefore, their health needs and outcomes vary significantly based on a multitude of factors, including country of origin, socioeconomic status, migration and asylum-seeking experiences, and the health-care system in their host country [74].

Generally, migrant children are reported to have high rates of infectious diseases such as influenza, hepatitis B and C, and tuberculosis, as well as intestinal and skin infections [5]. They also have a high prevalence of anaemia, haemoglobinopathies, vitamin D deficiency and nutritional problems ranging from wasting and stunting to obesity [39]. Higher rates of communicable diseases are often the result of lack of availability or inaccessibility of vaccination programmes through disruption in their home countries or during their migration journeys [76]. Dental problems are also common among refugee and migrant children [78].

Among child migrants, those living on the streets are extremely vulnerable to health risks. Living on the streets can lead to a violation of the fundamental rights of children, which include the right to education, health, nourishment, entertainment, safeguarding, and proper growth [87]. Furthermore, children living on the streets are often exposed to emotional, physical, and sexual exploitation, which extinguishes their idea and hope of a 'safe and secure childhood'.

Migrant children can also be exposed to what are known as 'vulnerability chains' or 'triggers', i.e., where the existence of one vulnerability can spark another [37, 33]. For instance, children may turn to irregular work and crime to obtain money to support their family or continue their journey, increasing their vulnerability thereby affecting their health.

3.2. Barriers to Migrant Children Accessing Health Services

Healthcare is routinely disrupted or halted when children and families move or spend extended periods in different city/country [60, 71]. Children on the move may have additional health, nutrition and protection needs due to the physical and emotional stress of migration. Moreover, access to health services for children on the move and their families can also be hindered by prohibitive costs and exclusion from health insurance and other social protection schemes, as well as by psychosocial disorders such as post-traumatic stress disorder and other mental health conditions stemming from the major disruption to child lives, trauma, abuse or violence during their migratory journey [16, 17].

Migrant children on the move and their families can also face barriers due to poor health literacy and lack of awareness of healthcare rights [30]. This is particularly relevant when information is not available in a language or format that is understandable or via channels used and trusted by migrant children and their families. In addition, discriminatory attitudes towards migrant children, particularly migrant street children, can prevent them from attempting to access services and prevent service delivery personal from providing services [44].

Despite a high prevalence of many serious diseases and health issues, migrant children are less likely to access healthcare services in host countries than local children, including preventive services, primary healthcare and dental care [85]. Language skills and familiarity with the culture of the host community play an important role in determining health access [47]. In addition, public health services are often not available or accessible to migrant children and private health services can be too costly, which places health services beyond the reach of many child migrants [54].

At present, health programmes for migrants have been limited in number, scale, and positive impact on child migrants and their health [60]. In addition, the services provided to child migrants are often not integrated, leading to migrant children 'falling through the cracks' and not receiving services or having to negotiate complicated arrangements.

Lack of medical records is another practical barrier to child migrants' ability to access healthcare. There is also a need for proper interpreters to be available to child migrants. Child migrants often rely on social workers, foster parents and other trusted adults for interpretation and mediation during interactions with medical and/or health staff [84]. Compounding the lack of health services and programmes for migrants, child migrants are often unaware of the dangers and consequences of migration, so that they are unable to protect themselves [47, 21].

3.3. Migration and Health Related-legislation and Policies in India

The Constitution of India is the supreme law of the country. It provides fundamental rights and directive principles to its citizens, including children and migrants [24]. The fundamental rights contained in the Indian Constitution require all needs of children to be met and their rights protected [72, 85]. These rights, which are applicable to its citizens (including children), include the right to equality, the protection of life and liberty, and the right against exploitation (see Articles 14, 15, 16, 17, 21, and 21A of the Constitution of India, Government of India, [24]).

India is also a signatory to the United Nations Convention on the Rights of the Child (UNCRC), to which it has been signatory [41]. Countries that have ratified the UNCRC are bound by international law to ensure that it is implemented [51]. India has also ratified the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution, and Child Pornography as well as the Optional Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women, and Children, supplementing the United Nations Convention against Transnational Organized Crime. Hence, India acknowledges and recognises the universal rights of children, including the children in need of care and protection (CNCP), such as child migrants [81].

Furthermore, in India, the National Commission for Protection of Child Rights (NCPCR) is constituted under the Juvenile Justice (Care and Protection of Children) Act, 2015, a statutory body under the Commissions for Protection of Child Rights (CPCR) Act, 2005, an Act of Parliament (December 2005), and is under the administrative control of the Ministry of Women and Child Development, Government of India. The Commission's mandate is to ensure that all laws, policies, programmes, and administrative mechanisms are in consonance with children's rights, as enshrined in the Constitution of India and also by the UN [32].

However, despite India's strong commitment to upholding children's rights, in practice, migrant children face many barriers to receiving their basic rights. In particular, migrant children face discrimination routinely due to their inability to access birth registration and identification documents [9]. Their lack of legal identity means that they are unable to access welfare, education, and healthcare services, thus leaving them without access to any form of protection [20, 83]. The absence of proof of identity for migrants can result in the denial of such rights or even complete exclusion. Furthermore, the absence of residential address evidence for these identification systems creates additional difficulties for them in gaining access to these systems [43].

4. Discussion

Under the Convention on the Rights of the Child, every member State has a responsibility to ensure the right to health of all children in a country, regardless of their citizenship, nationality, or legal status [86, 45]. The interaction between health and migration is a complex and dynamic one [35]. The type of work migrants are expected to perform, the physical and housing conditions that are generally available to them, the access (perceived or real) they have to health and social services, and the extent to which they are able to remain in contact with family are important determinants of health and wellbeing [14]. Language skills and familiarity with the new culture also play an important role in determining health access [47].

Furthermore, child migrants are often unable to access existing public and private health services, as discussed in previous section [54]. The effects of migration on children are diverse, and there are numerous health concerns that require attention. In India, this is made even more difficult by bureaucratic obstacles requiring people to access health services in their place of origin [19]. Given this, many researchers have acknowledged the need to examine migration as a social determinant of health [18].

However, much of this deliberation has occurred in the context of international migration, in particular with respect to the movement of people from developing to developed countries and has rarely considered child migration in developed nations such as India [53]. This is despite the fact that some of the most prominent international migration corridors exist between developing countries and that there are three times as many child migrants in India than there are international migrants [1, 68]. As with all people, migrants carry the health 'footprints' of the countries and social environments they come from and, since, in general, economically motivated migrants tend to move from poorer to economically more developed countries (or regions), a proportion of them can be expected to carry health profiles associated with poverty [50].

Thus, the obvious solution to these problems is to provide migrants, and particularly migrant children, with health services [54]. In particular, health interventions for child migrants in urban areas of India have to align carefully with their needs, not only target the prevalent conditions, but also be accessible and available to them [74]. It is also important to ensure that health services are child and migrant friendly [44]. To ensure the wellbeing of migrant children, policy perspectives must be re-evaluated and a greater emphasis must be placed on policy implementation [2].

To effectively include child migrants, services need to be available to them wherever they are. They also need to be tailored to their age and culture, making use of young community health workers from migrant communities. In order to reach children with essential services, it is necessary for governments to invest in national and local education and healthcare systems so that they meet the needs of migrant children [15, 82]. Caregivers, parents, community members, and teachers all have a huge role to play in this. An increased focus is needed on the role and support of local community representatives in promoting integration and social cohesion through thoughtful urban planning and the effective provision of basic services, including health and education, to newcomers [44].

At a global level, for the government to develop effective policies that reflect an integrated approach to migrants' health, it must be informed by sufficient data [84]. Policies and programmes on the health of child migrants need to be informed by empirical evidence and information that captures the voices of both children and adults. There should also be a mechanism that brings all of the relevant parts of government and civil society together to achieve one goal, that is to reduce the risks to health of child migrants by providing health access in an organised integrated way [44].

Hence, it is essential to enrol street children in a biometrics-based identification system, such as Aadhar[4], to facilitate the integration of these children into education, healthcare, and even temporary shelter care [3, 56]. Having a comprehensive understanding of the distribution of street children at the state and district levels through biometrics is essential to improving service delivery to these children, particularly those in night

4 Aadhaar is a unique identification system in India. It provides residents with a 12-digit identification number issued by the Unique Identification Authority of India (UIDAI).

shelters, to guarantee their safety and security. Moreover, biometric identification can assist in the implementation of an integrated programme to track children who have migrated to urban areas or run away from their rural homes and families back to their native villages in other states. Identifying the locations of their origin could help in undertaking a thorough analysis of their situation and facilitate positive changes to reduce their vulnerability, potentially even removing them from street situations [75]. This can also guarantee that supplementary benefits such as healthcare, training, and education are accessible to them through targeted programmes, allowing them to be self-sufficient and integrated into mainstream society [8].

Therefore, it is evident that access to identification documents is essential for obtaining public services and plays a critical role in enabling participation in mainstream society. Many migrant children, particularly children who were born on the streets, do not possess a birth certificate, which is a crucial document to avail schemes and benefits. The lack of a birth certificate or transfer certificate leads to difficulties in enrolling in school. The lack of permanent residence leads to further obstacles in applying for government documents. Thus, a collective effort by governments, communities and the private sector is critical to providing quality health services for children [31].

5. Conclusion

In recent years, the field of migration and health has received considerable attention globally [87]. There is greater recognition today that while migration provides opportunities for social and economic mobility, it also has adverse impacts on the physical and mental wellbeing of migrants [57]. Children migrants are a particularly vulnerable subset of migrants [34]. Around the world, countries and national governments are recognising the right of migrant children to health, education and safety [4] The right to health is one of the core rights of children under the Convention on the Rights of the Child [43].

Good health is essential to give all children the best start in life, develop their full potential and prevent problems in later life [27]. When able to access routine immunization, nutrition and health services, children can survive and thrive, even when far from their home [86]. Hence, it is important that countries integrate all migrants, regardless of their status into the public health system as soon as possible [62]. Furthermore, restricting access over long periods is likely to increase the long-term costs associated with late intervention [35].

Child migrants, particularly in India, generally have high rates of infections and communicable diseases; vitamin deficiencies and nutritional problems; as well as dental problems. They also face health challenges stemming from unsafe sexual practices, as well as dangerous living and working environments. Compounding this, in India, health services are provided based identity documents linked to place of origin, excluding migrant children from these essential services [80].

To improve the health of child migrants, integrated health policies must be formulated using a coordinated approach involving caregivers, parents, community members, and teachers [44]. Systematic actions that support migrant health improvement access to health services, and those that address the specific vulnerabilities of certain migrant populations such as children, will assist nations in developing programmes to meet current and future demands [6]. Policymakers must be attuned to these differences in the needs of various migrant populations and sub-groups, including children, to design effective interventions and strategically position resources.

Efforts to address this problem are hindered by, among other things, a lack of data on migrants, in general, and child migrants, in particular. According to the literature, there has been almost no systematic effort to estimate the total number of child migrants in India. Therefore, a necessary first step is collecting the data on migrants to inform targeted actions [52]. Timely, reliable and accurate data is vital to inform evidence-based policies and programmes that not only protect children on the move, but also uphold the rights of all migrants [2].

In addition, the system of providing services such as health and education in India should be adjusted to provide services to children regardless of registration in their place of origin. This requires a legislative change by central and state governments. Together with this, service providers need to be educated by governments to change discriminatory attitudes and behaviour towards street children. Local community members (parents, caregivers, community members, and teachers) should be supported by stakeholders to integrate migrants and promote social cohesion, including the effective provision of basic services to newcomers. Migrant street children should be engage in the provision of services and dialogue between children and local authorities facilitated [76, 79].

Thus, this article attempted to contribute to improving the wellbeing of migrant children, who are part of society by capturing the health risks of child migrants. It made attempts to answer the questions as proposed in the article as it is believed that these children like any other child should be given the chance to flourish and reach their potential. It is hoped that the findings of this article will inform policies and programmes for migrant children, as well as inspire further research into this area.

Abbreviations

WHO	World Health Organisation
ICDS	Integrated Child Development
IOM	International Organisation for Migration
ILO	International Labour Organization
UN	United Nations
NCPCR	National Commission for Protection of Child Rights
UIDAI	Unique Identification Authority of India

Author Contributions

Yukti Lamba: Writing – original draft, Writing – review & editing, Visualization, Validation

Conflicts of Interest

The researchers declares no conflicts of interest.

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