**SKILLS FOR FREEDOM**

**Newsletter from India**

**No: 15 July: 2016**

This electronic newsletter from **PEACE TRUST, INDIA** is addressed to NGO's, Social Activists, Media, Opinion makers, Leaders and Bureaucrats for improving their understanding on skilling the youth for gainful employment and addressing social issues like modern slavery, child labour, migrant labour, un-employability of youth. We also send this to people who we believe are involved in improving the migrant worker's conditions. You are welcome to unsubscribe yourself, if you so choose.

**-EDITOR**

Peace Trust is a Non Government Organization working on Child Labour and Bonded Labour issues since 1984. It has also focused on Migrant workers rights issue since 1999.

* Peace Trust’s Skills for Freedom is the only solution to end Modern Slavery in Tamil Nadu. It is a joint effort for enhancing the employment opportunities of rural youth in Dindigul, Karur, Tiruppur Districts.
* Reduce the risk for Young Workers - Beginning of this month Peace Trust has launched a new Initiative to "Support School Education, Health Protection, Livelihood Development and Skill Training for Gainful Employment among Vulnerable Young Population in Dindigul District".
* SPSC Vocational Education & Employment Facilitation Centre provides access to vocational education and employment facilitation for rural poor youth in Nagapattinam, Thiruvarur District Tamil Nadu and Karaikal District, Puducherry.
* Peace Trust also provides training for Quality Teacher Education and gainful employment to young women from resource poor families in Dindigul and Karur District.

The views expressed are not of the donors but a compilation of field realities for the purpose of sharing and action.

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**MIGRANTS**

**PUBLIC HEALTH IMPERATIVES**

***The head of ICMR speaks about the health challenges facing the country, and the importance of data-driven policy making.***

***BY AKSHAI JAIN***

Dr. Soumya Swaminathan is a slight woman with a shock of wavy white hair and a manner as easy with a smile as it is with interrogation. At the helm of all medical research in the country, she’s also the head of the Indian Council of Medical Research (ICMR) and the Department of Health Research in the Ministry of Health and Family Welfare.

Detailed and critical research is, she believes, key to formulating healthcare policy and evaluating the benefits of current programmes. It can do for healthcare what her father M.S. Swaminathan’s crops did for Indian agriculture.

In the midst of answering phone calls, signing files, and meeting officials, she outlines some of the many questions that we need to be asking.

**Healthcare and public health in India seem to be at a crossroads, and in some ways our situation is unique. We have a high burden of both communicable diseases (like malaria) and non-communicable diseases (like diabetes, cancer, cardiovascular diseases). The burden of non-communicable diseases is increasing rapidly in both urban and rural areas. Government health spending however seems to have plateaued, but the amount people spend on private healthcare has increased. Where are we headed? Going forward how do you see the role of the government versus the private sector?**

I think this is an important question. I feel that the government has to take the primary responsibility for providing healthcare, especially primary healthcare. There is no doubt that the private sector will play a big role. Their involvement might increase, and we might see more public-private partnerships—of which varied models are being tried out. But the responsibility for oversight and governance will continue to lie with the government. Even if we enter into public-private partnerships for running government health facilities or laboratories we will have to be in charge of the supervision and quality control. We will need to ensure that what is needed is being provided and the quality and the cost of the services is as per what had been decided.

Primary healthcare is envisaged to be a large component of preventive and promotive healthcare—which needs to be strengthened. Even the prime minister is talking about wellness. We have to start addressing lifestyle issues, improve screening for common ailments, blood pressure, diabetes, cancer and so on. The role of providing preventive and promotive healthcare (like running large immunisation campaigns or screening programmes) is again primarily that of the government. The government’s immunisation programme currently provides ten vaccines (the private sector provides many more, but those are only available to those who can afford them). The number of vaccines does need to be increased, but we have to compare the benefits of different approaches and do detailed cost-benefit analysis on issues like this.

To address behavioural and lifestyle challenges we’ll have to start large awareness campaigns. In some of these cases, like alcohol and tobacco-related health issues, policy interventions would need to be made by the government. This could be in the form of a ‘sin tax’ which some countries have used to fund treatment of alcohol and tobacco-related diseases.

**Non-communicable diseases are increasingly rapidly in urban and in rural India. In a survey of 86 villages in Maharashtra’s Gadchiroli district, Dr Abhay and Rani Bang found that stroke, a lifestyle disease, is the most frequent cause of death in the area. Fourteen per cent of deaths in these villages occur due to stroke. Places like this seem to going through an “epidemiological” transition. As you’ve already mentioned this is an area where preventive and promotive healthcare is important (these issues needs a “bio-social” as opposed to a “bio-medical” approach). How are these interventions, approaches going to be designed?**

According to WHO’s Global Burden of Disease studies the top risk factors in India (that lead to disease) are high blood pressure, high blood sugar and indoor and outdoor air pollution, in that order. Indoor air pollution is chronic in rural areas where women still used solid fuels to cook indoors.

Hypertension and blood sugar require behavioural changes and lifestyle modifications. Planning these interventions will require a lot of research in the area of social delivery—we need to look at people’s practices, their risk behaviours, why they’re doing certain things. These will help us design the most effective strategies for bringing about behavioural change. They will help us address questions like— at what age, what level are community programmes more effective? Are peer groups better than a doctor?

We have to do many more studies. Right now, out of the total healthcare expenditure only a very small proportion is going to public health research and within public health research a tiny proportion goes to health economics—looking at socio-behavioural patterns, cost effectiveness, etc. We need to expand the capacity to do the kind of research that will inform policy. I think ICMR’s priorities now are really going to be in the area of implementation research—we have a lot of tools that are being developed in medical colleges and research institutes across the country that have not found their way into practice or policy. We need to bridge that gap between knowledge and action.

**Could you give some examples of the kind of tools that you’re talking about?**

I’m talking about a test for, let’s say, blood sugar, or one of the infectious diseases—kala azar or dengue. How do we get this into the healthcare programme? There is a company in India that has developed a TB diagnostic test that is supposedly as good as international WHO-approved tests. Our job at ICMR is to help with the validation of indigenous products like these, and to work with the entrepreneurs to improve them. We’d like to give the health ministry a range of products that are made in India, and are a fraction of the cost of imported ones—which is what will convince them to buy these things. I’m trying to position ICMR as a knowledge partner that works with businesses.

We need to do the studies that bridge the policy-action gap. So before I ask industry to collaborate on pneumococcal vaccines, I first need to know the exact burden of pneumococcal pneumonia among children in India. I also need to know whether introducing a vaccine will bring down deaths.

We have good surveillance systems for a few diseases. For rotavirus-induced diarrhoea we have data from different parts of the country for the last 4-5 years. So within a year we will be able to gauge the impact of the recently introduced indigenous rotavirus vaccine.

Another example is the human papillomavirus (HPV) vaccine for cervical cancer in women. This vaccine has got a lot of bad press recently because of the Supreme Court case on the HPV vaccine trial, so a lot of time has been lost. We have data on the prevalence of HPV in women of different age groups. Data from the vaccine trials would have helped us compare its benefits with those from a screening program for cervical cancer. At what cost does a vaccine like this become beneficial? With this information in hand we can spur industry, telling them the price point at which the vaccine would work.

These are some of the areas we’re working on. We’re trying to also do something similar with TB and nutrition. We’ve collaborated with Tata Trusts to introduce nutritional supplements for TB patients in Odisha in an effort to reduce drug resistance in patients. We’re trying it in a couple of districts before we take the results to the health ministry.

Implementation research of this nature needs resources—that is why the government needs to put in more resources into health research. This research will help us understand and predict outcomes. It will shorten the process of introducing new effective treatments. We have a lot of ideas, but are not able to fund everything.

**You’ve talked about implementation research being one of your priorities. Given that the funds are very tight, what are some of the other priorities for ICMR in the next few years?**

I can answer that in a couple of ways—one is that we’re actually trying to prepare a strategy document for ICMR where we develop a framework that will make it easier for us to prioritise.

Other than that we have developed a few different priority areas: evidence to policy is one of our key priorities; setting up data systems and data repositories is another. We have vast amounts of data, we do survey after survey. But is this data being utilised optimally to drive interventions, in the formulation of policy? Are we making it available to the people who need to use it?

Leveraging traditional knowledge or medicine is another area—I think there’s a lot of untapped potential there. We need to create systems to validate ayurvedic treatments using clinical trials; discover new medicines from herbs and bring them into the mainstream drug development process.

The last area is building capacity for health and biomedical research. Given how few researchers we have right now, this will be an investment in our future. We need to build capacity in science and technology in general, but obviously for ICMR the focus will be on medical research.

In terms of health budget we need the full budget to be able to deliver all the programmes. In the TB programme, for example, we’ve been able to get only half of what was envisaged in the 2012-17 five-year plan. So it has not been able to deliver what it had originally proposed to do. The same has happened in the case of other programmes.

The allocation for health research is less than 1 per cent of the healthcare budget. So we’re not able to work fast or efficiently.

***You’re the medical editorial policy director at the journal*Nature*. What is your opinion of India’s current medical research output?***

I think we have a long way to go because medical research is given low priority. If you look all of science and technology, our overall research output is very low if you benchmark it against China or other western countries. But if you look at medical research, that is an even tinier percentage of overall research being carried out.

A recent paper by Dr. Samiran Nundy and his colleagues showed that research output from most medical colleges in India was zero. Five institutions (AIIMS, PGMIR Chandigarh being among them) in the country accounted for 80-90 per cent of the output even though we have nearly 400 medical colleges. Most of these colleges do not produce even a single paper. We need to start with medical students, inculcating a spirit of scientific enquiry in them, giving them exposure to research methods. Faculty members of our medical colleges need to start doing research apart from teaching.

Funds are of course tight, but we also need to build the capacity to use existing resources allocated for research optimally. If we focus on this in the next ten years we’ll be able to improve quality.

***You’ve mentioned that we have a lot of data. But how reliable and systematic is this data?***

You’re right. We have to judge the quality of this data—but we also have a lot of data that is well collected, standardised. We have ICMR surveys, National Family Health Survey (NHFS) data, other multi-centric studies, and 40 years of data on nutrition from the National Nutrition Monitoring Bureau (NNMB).

***The bedrock of health is nutrition. India’s figures are abysmal: nutrition data from across 28 states and Delhi, shows that 38.7 per cent of children under 5 in India are stunted (a measure of chronic under-nutrition), 19.8 per cent are wasted (acute under-nutrition). India’s average annual rate of decline for under-five stunting, between 2006-2014 has been 2.3 per cent per year, much better than the 1.2 per cent the country saw during 1992 and 2006. However, India still lags behind neighbours and even some sub-Saharan countries. Nepal has an average annual decline rate of 3.3 per cent per year, and Bangladesh matches that of India.***

***Despite this, 40 years after being established, the NNMB has been shut down by the Union Health Ministry. This bureau, under ICMR, had been critical in informing the government’s poverty alleviation interventions with periodic assessments of nutrient deficiency among tribal communities, pregnant women, adolescents and the elderly in India. How are we going to keep track of the nutritional intakes of vulnerable populations?***

This is something we’re discussing. We’re trying to see if we can mobilise resources outside government. We’re also talking to the Registrar-General of India to see what kind of (replacement) surveys might be useful, since we don’t want to repeat what other surveys might be doing. It is important that we convince the government to reinstitute some sort of nutritional survey because otherwise we’re not going to have any data to benchmark our initiatives against—we won’t know which areas need more attention, whether we’re making progress.

We’re soon going to have a meeting where we’re calling all stakeholders, national and international, to try to come up with a single national survey that collects data for all parameters. We will also try to come up with a model to identify research questions based on this data.

***You’d also mentioned a national system for collecting data on non-communicable diseases…***

That will be part of this single survey.

***Who is going to be administering this survey?***

That is again something that needs to be discussed. What we need to try and do is to harmonise all existing surveys, which are currently not comparable because some of them use different definitions. We need to create one survey platform.

**There is a wide agriculture-nutrition disconnect in India. The crops that are grown most commonly and receive the maximum support from the government are not the most nutritious. Economics rather than nutritional requirements dictates what crops are grown. Are genetically modified, fortified, crops like Golden rice a solution to this? What else can be done to bridge this?**

That is just one way of intervening—the interventions can be at many levels. Currently people are eating a cereal-rich diet low in vitamins and micronutrients. GM rice can of course provide some of these, as can zinc-fortified milk. GM crops are just one way of doing this, bio-fortification (breeding crops to increase their nutritional value) is equally effective.

The bottom line though is that people need to get a balanced diet. What most people get in the public distribution system (PDS) is what they can afford to eat. They can’t afford fruits and vegetables. NMMB surveys show that the intake of fruit and vegetable in the Indian diet is less than 5 per cent of recommended dietary amounts.

So you have to improve the basket of things available in the PDS. Crops like millets are not available now because farmers are not growing them. They don’t grow them since there’s no assured market, and so millets are expensive. If the government assures a minimum support price for them farmers might start growing them. We also need to figure out how to include locally available foods—like the leaves of the drumstick plant and other wild leaves—in our diet. In parallel, the fortification of rice, wheat, oil and milk should also be explored.

People also need to be educated on health. Even those who can afford to eat well don’t know what a healthy diet is, they eat too much carbohydrate, oil, salt and sugar.

***We’ve talked a bit about data; and about the lack of detailed epidemiological studies in India. Apart from rotavirus and HPV are there any other diseases for which we’ve got adequate data?***

We have studies like the INDIAB or India Diabetes study, a national prevalence survey for diabetes, hypertension and pre-diabetes. It is the largest survey in the world and has covered all the states and union territories. So far we’ve got data for 17 states, the remaining are in progress. This study allows us to compare prevalence rates between rural and urban areas, highly urbanised states and more backward states, etc. We will be able to benchmark progress of the national program against non-communicable diseases (over the next 5-7 years) against this data.

***Is all this data in the public domain?***

The first stage of the INDIAB Study is done. We had a dissemination meeting in April 2016, and the data is in the public domain. But I do find that a lot of our data is not publicly available. For example there was a large study supported by ICMR that looked at bone health—bone mineral density, vitamin D levels—in about 2,000 adults from across the country. It was an extremely well conducted study, but the data from it was not made available. We’re now analysing it, but this is something that should have been done long ago. We need to be more responsible with data.

ICMR is also trying to come up with a data sharing policy. That again is an area where you need a policy; you want to be open and transparent, and at the same time there might be intellectual property issues or concerns like protecting investigators, etc. that you have to keep in mind. International agencies now make it mandatory for researchers (using public money) to put their data in the public domain.

**Mental health is a largely ignored area in India. Is this something that ICMR is going to be addressing and how?**

I got interested recently when I attended a high level meeting in Washington. Mental health accounts for a large proportion of disability around the world. Depression, anxiety, suicide rate are increasing in young adults—these are critical areas that need to be addressed. We’re planning to have a consultation on identifying priority areas where implementation research is needed to be able to implement interventions at the community level.

We obviously don’t have enough psychiatrists in the country, so we need to think of different approaches. Who else can help at the community level? A handful of NGOs working in this area have been able to use community workers to identify mental health issues and be part of the follow-up care. They’ve experimented with different models to deal with a range of disorders—from schizophrenia to depression. A huge amount of work is needed in this area.

***You’ve been quoted in a recent news report saying that “In the last three years, drug testing and registration has suffered due to strict norms”. You’ve also mentioned that under the new rules that the government is coming out with—fresh clinical trials related to drug policies, strategies to administer drugs for particular diseases and combination of drug therapies will be cleared by local ethics committees and wouldn’t need to go through the Drug Controller- General of India (DCGI). Isn’t there a great risk of misuse here?***

I wasn’t talking about a blanket relaxation of regulations. What I meant was that we need to make them a little more rational. You can’t club all clinical trials together in one box. A trial of a new drug molecule is very different from that of a treatment protocol that combines two drugs that have already been individually approved for use. The risks here are very different.

The idea here is to free capacity for people to do high level clinical trials in institutes that have good ethics committees, evaluate trial protocols, and make sure that all norms are being followed. The Drug Controller-General of India (DCGI) needs to be free to focus on regulatory trials—of new drugs, etc.

Our current set of rules has led to a situation where delays often make research irrelevant. In global trials for example, Indian investigators can often not take part because by the time they get permission to go ahead with the trails, other countries have very often already finished enrolling. At the end of the day it’s Indian patients who suffer.

Take the case of a new drug, bedaquiline, for TB. By the time permission was granted for a trial in India other countries had already recruited patients so we ended up recruiting only five patients, two from Delhi and three from Chennai. That’s all the experience—five patients—that we have in India for this important new drug. When the drug company in question comes to us for registration our first question is—how do we know this drug works since you didn’t recruit enough Indian patients in your trial?There are many other cases where clinical trials are unnecessary. The dosage of antibiotics does not depend on ethnicity: an American needs the same dose as an Indian. So why do we need to do these repeat trials?These are old rules, some of them kneejerk reactions, that we need to rationalise. We have to differentiate between different types of clinical trials, and not subject everyone to the same scrutiny.

**Some critics believe rates for under-nutrition in India are highly exaggerated. They blame this on the application of a uniform WHO-specified height to decide whether or not a child of a given age and gender is stunted. And similarly, a uniform WHO-specified weight to decide whether or not the child is underweight, regardless of race, socio-cultural background, geographical location or time or vegetarian versus meat diet. Any failure to meet the standard is attributed to malnutrition and the child classified as malnourished.**

**Arvind Panagariya, one of these critics, maintains that this leads to glaring statistical inconsistencies in comparisons between India and Africa. India’s infant mortality rates are much lower yet rates of under-nutrition and stunting are much higher. Comparing Kerala with Senegal, the former has a life expectancy of 74 years while the latter is 62, yet we are told Kerala has a higher proportion of stunted and under-weight children than Senegal. Do you agree?**

WHO standards are fine; they included communities from all over the world including India. The criteria was birth circumstance, i.e. children who were not limited by birth or the environment. In India you can see the difference between children born into different environments (food, water). That shows the differences are not genetic. I don’t believe in this theory that we are genetically small and that we should change our standards.

**So there are other reasons for the anomalies that are pointed out. Do we know what they are?**

We are getting closer—there is lots of work going on. One of the interesting new things we’re doing is looking at the microbiomes of people living in slums (the human microbiome is the aggregate of microorganisms that resides on and in skin, saliva and mucus and in the gastrointestinal tracts). We’ve found very early differences in the enteric (intestinal) passage colonisation by pathogens and bacteria. What we’re realising is that just giving extra nutrition is not going to work, neither is just replacing dirty water with clean water. You have to take care of sanitation, drinking water and nutrition starting from pregnancy and early childhood.

Once enteric dysfunction gets established in these children (a disease called enteropathy) they don’t seem to be able to absorb nutrients, which is I think one of the reasons why our iron and folic acid programmes don’t work. Contrary to belief the problem is not worms—the government is deworming children twice a year, but many randomised controlled trials have shown deworming doesn’t really have an impact.

It’s critical that we do impact evaluations of our programmes. We’ve spent a lot of time and money on them, but if after 15 years of running the iron and folic acid programme our rates of anaemia are unchanged, what exactly is happening? Ironically, the government is now starting the National Iron Plus initiative, moving into younger age groups—children under two. In India we’re not doing enough impact evaluations and follow up studies.

**There is very little drug R&D in India. Why do you think this is the case?**

Some companies are now investing in drugs. Sun Pharma recently signed a MoU with the International Centre for Genetic Engineering and Biotechnology (ICGEB), Delhi, to develop a new dengue drug.

**You’re also working with them on a malaria eradication project in Madhya Pradesh. What are the desired outcomes of that? Is it to develop new drugs?**

The malaria project is to demonstrate that a particular strategy could work to eliminate malaria from an entire district. India is committed to eliminating malaria by 2027, so this project is an effort to implement focused interventions in one place to see what works and what changes need to be made in our malaria eradication programme. Our MoU with Sun Pharma is a fairly broad one that also includes drug development, but there’s nothing specific on the cards right now.

**Are there other diseases where you’re looking for partnerships?**

Depending on our interest, we’re open to partnerships with the private sector. There has to be private support for research, too. You asked why there’s little private R&D in India—that’s something you’ve got to ask the industry. Maybe they’re just happy selling generics.

**You’ve done a lot of work on TB, especially paediatric TB. India has reduced TB rates only slowly.  The multi-country Sentinel Project on drug-resistant TB, which you’ve been involved with, has found that in India drug-resistant TB prevalence in adults and children is about the same. Unfortunately the tests used on adults are inaccurate for children and people with HIV. There’s a lot to be done on the TB front. How is ICMR handling the TB epidemic?**

First we need a national prevalence survey to give an estimate of the true burden. We need to move quickly on research priorities like diagnostics, shortening treatments by using a combination of newer drugs and coming up with a universal treatment regimen. Currently we first have to test drug sensitivity and then determine treatment. We need to work towards a combination of drugs that will work regardless. Then there are adjunct therapies that can be used to stimulate immunity to improve treatment outcomes. We also need to tackle conditions like TB meningitis in children.

**You’ve also talked about eradicating measles…**

It is one of the diseases targeted for elimination, so ICMR will support the government like it did for polio, by providing evidence and research, doing environmental surveillance and transmission research. We’re formulating a plan with the Health Ministry.

**In a paper you wrote in The Lancet you talk about steps the government is taking to tackle antibiotic resistance—recording of patient details, establishment of a National Programme on Antimicrobial Surveillance in ten laboratories at academic centres, etc. This sounds like a very large and ambitious plan. What is its current status?**

It’s ongoing. The surveillance has started in four hospital laboratories, and we’re in the process of extending it to ten.

**Genomics is the current buzzword. How relevant is it to India? Are we better off using our limited resources on more urgent needs like primary healthcare?**

It’s difficult to prioritise. Genetic studies have a significant role to play in understanding disease causation, pathology and transmission. Within genetics there’s host genetics and microbial genetics. In TB for example, microbial genetics studies are important—they can tell us about why there’s more drug resistance in certain parts of the country, they can tell us about transmission habits, and can help with early detection of drug resistance and so on.

Host genetics studies are relevant in diseases like cancer and non-communicable diseases because they can actually guide treatment, give you a better understanding, and help develop new therapies. So I think given our limited resources we need to focus on ones that are most important for us.

**If you were to do an M.S. Swaminathan on Indian healthcare what would that be?**

I think our biggest challenging is improving primary healthcare. We should come up with a model that is cost effective, makes sense in our own context and focuses on promotive and preventive healthcare. I think this would go a long way in reducing the disease burden, otherwise we’re going to have to invest increasingly more in tertiary care.

**But we’re spending nearly Rs 5,000 crore on establishing three new AIIMS in Maharashtra, West Bengal and Andhra Pradesh…**

There’s a need for that. The government is setting them up to address current requirements. It’s also why the government is setting up the dialysis centers. But we should really be looking at how to prevent chronic disease rather than focusing on how many patients we can provide dialysis to.

We have to do the tertiary care, take care of people who’re sick, but we need to invest much more heavily in preventing the causes of these disabilities, whether it’s diabetes, hypertension, or chronic fatigue.

**You’re the second woman director of the ICMR in its 100-year history. Is this evidence of an increasing role of women in Indian science?**

I hope it’s a pointer to more equality in the future. Every third director should be a woman. I think that’s likely to happen, too.

**KERALA TO BRING OVER 25 LAKH MIGRANTS UNDER INSURANCE COVERAGE**

The scheme, titled 'Awas', would not only ensure social security to the migrant workers but also act as their database and registry, he told the state assembly noting that the number of crimes involving them were also on the rise along with their population.

The LDF government in Kerala is planning to launch a comprehensive insurance scheme for more than 25 lakh migrant labourers in the state which would also serve as a database of them, Chief Minister Pinarayi Vijayan said today.

The scheme, titled ‘Awas’, would not only ensure social security to the migrant workers but also act as their database and registry, he told the state assembly noting that the number of crimes involving them were also on the rise along with their population.

“The Labour Department is mulling implementation of an insurance scheme, Awas, for them. Besides ensuring them safety and security, we can complete their registration also as part of that,” Vijayan said, adding a residence mapping would be held to collect their exact whereabouts and other details.

He was replying to a Calling Attention by Congress member V P Sajeendran to the challenges and social problems reportedly being faced by the state due to the growing number of migrant labourers and their “increased involvement” in crimes.

Detailing the government’s other welfare plans for the migrants, Vijayan said the government was planning to carry out periodical medical camps at the labour units to keep a tab on the health status of the migrants, in view of complaints about the reporting of many fatal diseases among them.

Quoting a study conducted by the Gulati Institute of Finance and Taxation (GIFT) in 2013, he said there were 25 lakh migrant labourers working in the state and their number surely had gone further up in the last three years.

“The increasing inflow of migrant labourers poses a great challenge to the state. The number of crimes, they are involved, are also on the rise along with their total number. Besides gruesome murders, they are also allegedly involved in burglary and theft,” he said and referred to the recent rape and brutal murder of a Dalit law student in Perumbavoor.

However, it was difficult to place restrictions on their entry into the state, he said, adding that police, labour contractors and owners of rented houses were given strict directions to keep the registry of migrant labourers in their respective areas.

Police were also keeping an eye on the criminal background of migrant labourers and whether any terror elements had infiltrated among them, he said.

The Chief Minister also added that majority of migrant labourers were coming to Kerala in search of better wages and peaceful environ and the government was committed to ensure them security and hygiene.

**TAMIL NADU NOW HOME TO 1 MILLION MIGRANT WORKERS: STUDY**

Tamil Nadu is home to more than a million migrant workers, a government-commissioned survey has found.

The just-concluded survey conducted by a private consultant on behalf of the state labour department shows that a majority of the 10.67 lakh migrant workers in the state are unskilled workers. About 27% are employed in the manufacturing sector, 14% in textile industries and 11.41% in the construction sector. The numbers may be under-reported, say social workers, but the data will help them get healthcare and other benefits.

Experts say relatively better wages and employment opportunities in TN draw workers from West Bengal, Odisha, Bihar, Jharkhand and Assam. Bernard D'Sami, a faculty member of Loyola Institute of Social Science Training and Research attributes the demographic change to special economic zones.

"Migration has been so much that Hindi and Bengali have become languages of communication in urban areas. Workers from West Bengal have proved their skill in laying granite floors, while those from northeastern states are sought after for security and hospitality services," he said.

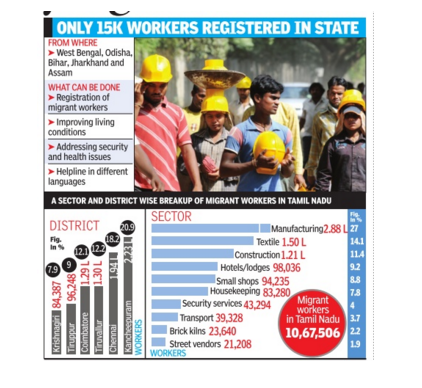
In the construction sector, activists complain, several migrant workers are not registered under the Tamil Nadu Construction Workers Welfare Board, leaving them at the mercy of builders and contractors. A senior official in the labour department said the survey was but a beginning. "This will help us keep a tab on the working and living conditions of migrant labours across the state," he said.

According to the migrant worker survey, 20.9% of migrant workers in Tamil Nadu live in Kancheepuram district. Most of them work in manufacturing companies. Kancheepuram has units including Ford, Hyundai, BMW and Nissan where several migrant workers are working. The top three districts -- Kancheepuram, Chennai and Tiruvallur -- house 51.3% of the migrant worker population. Real estate projects and the metro rail work have attracted migrant labour.

The second maximum number of jobs are offered by textile and allied industries which emply 1.5 lakh workers, evidently why Coimbatore has 12.1% and Tirupur has 9% of the state's migrant population.

Unorganised Workers Federation advisor V Geetha said the survey figures were surprisingly less. "It does not appear to have covered all the migrant population in the state. The number of workers in the construction sector must be more," she said. There have been several complaints from migrant labours on delay and non-payment of wages. "It's unfortunate that most children of migrant workers do not get formal education. Most of them were badly affected by the recent floods, but did not get any compensation."

According to the 2011 census, Tamil Nadu has a population of 7.12 crore. The state that attracts workers has also been seeing outward migration of its working class. A recent study conducted by the Centre for Development Studies (CDS), Thiruvananthapuram, along with Loyola Institute of Social Science Training and Research, and Rajiv Gandhi National Institute of Youth Development, Sriperumbudur found that one out of every 10 households in TN, especially those along the coast, has its members in countries such as Singapore, Saudi Arabia, the UAE, Malaysia, Kuwait, Muscat, Doha, the US, and Bahrain.



**GOVT MOOTS ID CARDS FOR MIGRANT LABOURERS**

THIRUVANANTHAPURAM: Following the repeated instances of the involvement of migrant labourers in criminal activities and the difficulty in tracking them down, the government mooted a plan to issue identity cards for the migrant work force in the state, whose number is estimated to be 25 lakhs.

"The government is keen on issuing identity cards for the migrant work force in the state. The department is going ahead with the idea and we are working on the nuances of the project," said additional chief secretary (labour and skills) Tom Jose.

According to sources in the labour department, the idea is to announce a health insurance scheme for the labourers so that they volunteer to enrol their names, and thereby get added in the database of the government. The details of the plan will be announced in the budget session of the assembly which will begin on Friday, it is reliably learnt.

The department is aiming to improve the living conditions of the labour camps where the migrant workers from other states are lodged. Most of these labour camps are run in dilapidated buildings and unhygienic conditions which are breeding grounds for many diseases.

The department is at present considering what type of identity cards should be provided - whether it should be with a micro-chip having multiple data encrypted in it, in which case, the government will have to undertake a laborious task including conducting the background check of the labourers at their native location, detecting their blood groups etc. The police have also suggested incorporating the criminal records, if any, of each labourer being enrolled under the scheme. The police gave this suggestion after it came to light that a migrant labourer is the main accused in the sensational murder of a dalit girl at Perumbavoor.

According to the police, the biggest headache is the lack of comprehensive database of the labourers, who are mostly a floating population. "There is a seasonal variation in the numbers of the migrant labourers - from 17 lakhs to 25 lakhs" police sources said.

In 2014, the state intelligence department had submitted a proposal to the state government to consider a legislation for the welfare and regulation of migrant labourers. "The police cannot monitor them separately per se as it is their constitutional right to come to this state and work here. But the labour department can launch welfare measures for them, and it can also be a way of monitoring them," intelligence department sources said.

**KERALA TO INTRODUCE INSURANCE SCHEME FOR 2.5 MN MIGRANT LABOURERS**

Thiruvananthapuram, July 18 (IANS) The Kerala government is to begin an insurance scheme for the over 2.5 million migrant labourers, mostly from West Bengal, Bihar and the northeast, who work in the state, Chief Minister Pinarayi Vijayan said on Monday.

"Even though there are rules in the state that all migrant labourers should register with the police station nearest to their residence, it's not getting the desired results and hence we will soon introduce a new insurance scheme and through this we will be able to get all the details of the migrant labourers who are in the state," said Vijayan while replying to a calling attention motion moved by Congress legislator V.P. Sajeendran.

He said the last time a survey was undertaken to estimate the number of migrant labourers in the state was in 2013, and it was found that there were an estimated 2.5 million migrant labourers working in Kerala who came from various other states.

"Today those numbers are even higher and as their numbers are increasing, so are the cases registered against them. While 90 per cent of these labourers are here to eke out a living, the rest are those with a criminal record in their home state and that is repeated here. Since we do not have proper registration programmes, we expect all migrant labourers to enroll themselves in the proposed insurance scheme as through it we will be able to get a proper registration of these labourers," said Vijayan.

The migrant labourers are mostly from West Bengal, Bihar and some northeastern states. Ever since the arrest of an Assamese -- Ameerul Hassan -- in the murder of a Dalit law student in April at Perumbavoor in Ernakulam district, there has been an increased demand from various quarters to register the migrant labourers.

Sajeendran observed that of the 24,000 casual labourers engaged by the Cochin Refineries at their new project, around 10,000 were migrant labourers. "And just as we the Keralites who are there in good numbers in other states of the country and abroad and are treated with respect, we also should give the migrant labourers a decent standard of basic amenities," he said.

Vijayan agreed that the migrant labourers have now become an integral part of the Kerala society and hence, as the host, "we have a duty towards them also".

"It has come to our notice that they have serious health issues and to ensure that they have good medical support, we will organise special medical camps at their labour camps. We will also ensure that they have all the basic sanitation facilities at the labour camps," added Vijayan.

**MIGRANT WORKER AWARDED LIFE TERM FOR RAPING TODDLER**

Dharbendra and the minor boy were playing with the girl and later the girl started to cry. He had gone into hiding The district Mahila court issued a non-bailable warrant against him and Podanur police arrested him from Bihar a few weeks ago. On Wednesday, the judge G Raja sentenced Dharbendra to life imprisonment and imposed a fine of 1,000. Dharbendra was lodged at Coimbatore central prison.The special public prosecutor R Sarojini appeared on behalf of the victim girl and demanded the court punish Dharbendra severely. Dharbendra often visited his neighbour's house and used to play with his neighbour's two-year-old daughter.On August 7, 2010, the mother of the minor girl had gone to her back yard to collect washed clothes.

Coimbatore: A migrant labourer from Bihar was sentenced to life imprisonment by the district Mahila court here on Wednesday for raping a two-year-old girl at Mullai Nagar near Podanur in August 2010.His accomplice, a 15-year-old boy was earlier arrested for raping the minor girl and the case trial was pending before the juvenile justice board.Dharbendra, 28, and a 15-year-old boy, were working as daily wage labourers, staying in a rental house at Mullai Nagar near Podanur in 2010. Dharbendra often visited his neighbour's house and used to play with his neighbour's two-year-old daughter.On August 7, 2010, the mother of the minor girl had gone to her back yard to collect washed clothes. Dharbendra and the minor boy were playing with the girl and later the girl started to cry.

The duo left the girl in front of the house and fled.When the mother picked up her child, she found her daughter had suffered bleeding injuries. Immediately she informed her husband and took the child to a nearby hospital where doctors confirmed that the girl was sexually assaulted.She lodged a complaint with Podanur police who registered a case and arrested Dharbendra and the minor boy for sexually assaulting the girl.Dharbendra was remanded to judicial custody and he was lodged at Coimbatore central prison. The 15-year-old boy was sent to the remand home for juveniles

**TIRUPUR’S MIGRANT POPULACE PROVIDES A CAMOUFLAGE FOR ANTI-SOCIAL ELEMENTS**

Tirupur: Tirupur may keep proving its moniker of being the dollar city of the state by ramping up the forex revenue it earns for the country every year. Along with this, the town’s notoriety has also grown as a den of anti-socials.

After Maoists, it is now the turn of a suspect with ISIS links to have found a refuge in this western Tamil Nadu town.

For years, anti-social elements from across the state would come to Tirupur to camouflage themselves among the lakhs of migrants living in the dingy lanes of the town to work as labourers. In fact, Tirupur was a staple in the checklist of police from across the state whenever they were on the hunt for a suspect. Not just hardened criminals, even thieves and eloped couples would land in Tirupur, get a job in one of the hundreds of garment units and live among a sea of migrants. “For a desperate employer, it is impossible to verify the antecedents of all applicants. Most migrants don’t know Tamil which makes it difficult to probe. We don’t insist on identity proofs as seldom do people from interior villages of a backward state possess ration cards or voter ID cards,” said an owner of a medium-scale garment unit.

A recruitment agent who often travels to Bihar or Odisha scouting for workers says they do a character verification by checking with other labourers from the same or nearby village.” But it is not foolproof,” he said.

Soon after the arrest of Maoist Rupesh, Tirupur police instructed all garment units to collect the complete biodata of all their migrant workers. But the instruction was followed more in breach. A state government survey released in 2016 says Tirupur has 9% of the 10 lakh migrant population living in the state. “Even if we track the migrant workers, there is no mechanism to keep tabs of their relatives and friends who stay here,” says a police officer.

Senior police officers say one way to prevent Tirupur from turning a safe haven for extremists is to scale up the intelligence mechanism.

Retired additional deputy commissioner of police A S Nandakumar says there was very little information-sharing between various intelligence wings. “Number one, there should be better inter-state intelligence sharing and two, the sharing should be timely,” he said.

**CHILD LABOUR**

**SEVEN CHILD LABOURERS RESCUED**

Trichy: A joint operation of Child Line and the Mannargudi police rescued a minor bonded labourer and 7 child labourers near Mannargudi on Tuesday.

As part of the 'Operation Smile' campaign, the team carried out a search at Kamalapuram on Tuesday. Finding an 8-year-old boy herding sheep, the team made enquiries and found that he was forced into shepherding after discontinuing his studies after second standard. His parents had sold him to a sheep owner for Rs 30,000 to pay back their debts. Similarly, 7 other teens, all under the age of 17, were rescued from two eateries.

All those rescued were taken to the all women's police station at Mannargudi and their parents called. They were warned against forcing their children into labour and allowed to take them along after counselling.

**CHILDREN ALLOWED TO WORK WITH FAMILY UNDER CHILD LABOUR BILL AMENDMENT**

The amendment continues to prohibit the employment of children below 14 years of age in any “profession” and has increased the penalties for violators.

The Rajya Sabha on Tuesday passed a Bill that allows children below 14 to engage in “home-based work” with their families after school hours, or help their families in fields or forest gathering. It amended a 1986 law that prohibits child labour.

The amendment also allows children between 14 and 18, newly defined as ‘adolescents’, to work or be employed in other professions as well, except in “any of the hazardous occupations or processes” that have been listed in the law.

The amendment continues to prohibit the employment of children below 14 years of age in any “profession” and has increased the penalties for violators. Employers of children can be jailed for six months to two years or be fined Rs 20,000 to Rs 50,000 or both. The original 1986 law provided for imprisonment between three months and one year and a fine of Rs 10,000 to Rs 20,000.

**BONDED LABOUR**

**GOVT TO SOON CARRY OUT SURVEY ON BONDED LABOUR**

New Delhi, Jun 18 () The government will soon conduct a nation-wide survey to ascertain the number of bonded labourers in India.

This is significant in light of findings by Australian Rights group Walk Free Foundation, which claimed India has the highest number of people globally trapped in modern slavery.

"The government will soon conduct a country-wide survey to know the number of bonded labourers," Labour Minister Bandaru Dattatreya told reporters here.

Elaborating, Labour Secretary Shankar Aggarwal said: "We are yet to decide on the time of the survey and which agency will do it, but there is a thought that the states should do the survey in their respective areas."

Calling into question the 2016 Global Slavery Index released by the Foundation, Dattatreya said: "They say there are about 1.8 crore bonded labourers, but they don't say where they got these figures from."According to the slavery index, India has the dubious distinction of having the highest number of people globally in modern slavery, with 18.35 million victims of forced labour, ranging from prostitution to begging.

"There are NGOs that are working against the interest of India and are trying to defame the country. Their data are wrong," the minister said.Dattatreya also spoke of the recent International Labour Conference (ILC) in Geneva in Switzerland, where discussions were held with the member countries on labour laws concerning global supply chain and outsourcing.

"We have said India will take a stand only after thorough consultation on this issue and the Labour Ministry will soon discuss it with the Ministry of External Affairs, the MSME and Commerce ministries," Dattatreya said.

India will host the meeting of BRICS labour ministers in Hyderabad next month.He also added that International Labour Organisation (ILO) DG Guy Ryder will be visiting India on July 9-11 and meeting several ministers and officials. Stay updated on the go with Times of India News App. Click here to download it for your device.

**2,216 BONDED LABOURERS RESCUED LAST FISCAL IN UP: DATTATREYA**

New Delhi, Jul 18 () As many as 2,216 bonded labourers were rescued and rehabilitated in Uttar Pradesh last fiscal, Parliament was informed today.

During 2015-16, 2,216 bonded labourers were released and rehabilitated in Uttar Pradesh, Labour Minister Bandaru Dattatreya said in a written reply to the Lok Sabha.

According to the statement, no bonded labourers rescued and rehabilitated during the current financial year.

In 2014-15, 853 bonded labourers were rescued and rehabilitated in the Chhattisgarh. Similarly, in 2013-14, 1,800 bonded labourers were released and rehabilitated in Uttar Pradesh while the number of such workers was 150 in Rajasthan and 28 in Odisha.

The Bonded Labour System has been abolished by law throughout the country with effect from October 25, 1975 under the Bonded Labour System (Abolition) Ordinance which was replaced by the Bonded Labour System (Abolition) Act, 1976.

The minister said that instances of prevalence of bonded labour system are noticed now and then even after its abolition.

In order to assist the states to rehabilitate the identified and released bonded labourers, a Centrally Sponsored Plan Scheme for Rehabilitation of Bonded Labour is in operation since May, 1978.The government has revamped the scheme with effect from May 17, 2016. The revamped scheme is known as 'Central Sector Scheme for Rehabilitation of Bonded Labourer, 2016'.

The revised scheme is a Central Sector Scheme. The State Government is not required to pay any matching contribution for the purpose of cash rehabilitation assistance.The financial assistance has been increased from Rs 20,000 to one lakh per adult male beneficiary, Rs 2 lakh for child labour & women and Rs 3 lakh to trans-genders, or woman or children rescued from ostensible sexual exploitation. These cash benefit is additional to other land and housing elements etc.

The amount of assistance for survey of bonded labourers is Rs 4.50 lakh per district. The release of rehabilitation assistance has been linked with conviction of the accused. Stay updated on the go with Times of India News App. Click here to download it for your device.

**FOUR RESCUED FROM BONDED LABOUR IN HOSKOTE, OWNER AND SONS CHARGED**

BENGALURU: Suffering through bonded labour for over 10 years, three minors and an adult were rescued from a vegetable farm in Hoskote on Saturday, July 16. The four victims, hailing from Krishnagiri in Tamil Nadu and Ramanagara in Karnataka were trafficked by the farm owner and his five sons who had paid the parents of the four an advance at the time of trafficking, ranging from Rs 20,000 to Rs 60,000.

The oldest, 25 years of age, was bought by the farmer ten years ago and the rest of them, aged 16, 15 and 14 were trafficked, seven, four and five years ago, respectively. Once brought to the farm, the four youngsters were forced to work as per the weightage of advance paid to the parents.

On Saturday, the victims were rescued by the Bangalore Rural District Administration and local police, along with the International Justice Mission (IJM). A case has been registered against the farm owner and his sons at the Hoskote Police Station under IPC 370 (Trafficking of Persons), bonded labour act and child labour act.

"It is a serious crime that the youngsters were used as bonded labourers at this vegetable farm in Hoskote," said, GB Chandrashekara, Tahsildhar of Hoskote who was in charge of the rescue. "The government of Karnataka takes these cases very seriously and we will conduct raids on any farm or factory that we suspect uses bonded labour. In this case, the owner of the farm faces serious human trafficking charges which carries a minimum sentence of 10 years. The labourers have been given release certificates by the Assistant Commissioner of Bangalore Rural District, MK Jagadesh and they will be rehabilitated."

"Giving advances to labourers or their families and restricting the freedom of the labourer based on the advance is also illegal according to the Bonded Labour (Abolition) Act which attracts a maximum sentence of three years," said Sashmeeta Mulmi, Director of Government Engagement, IJM.

"We suffered at the farm and we were desperate to leave," recalled the 18 year old rescued victim. "We were not given any time to rest even if we were sick and we were beaten if we spoke to each other or for small mistakes. Four months ago after I was beaten badly I escaped from the farm and went home but the owner's son came to my village and brought me back. For a week it was okay but then they started beating me again."

Working seven days a week from 6 am to 8 pm, tending to carrots, beetroots, cauliflower and roses, the last few years had been a harrowing experience for the four of them. Inhaling pesticides everyday caused respiratory problems as well. Living in the cow shed and being fed stale leftovers through the day, these boys would often also have to lift heavy shipments that came to the farm. All of this, for Rs 10 a week apart from the advance given to their parents.

Even if we consider the advance the labourers received as a yearly wage, they were grossly underpaid," said an official at IJM. "The minimum wage for an agricultural worker in the state of Karnataka is Rs 288.66 per day for eight hours of work. The labourers in this case were forced to work much more than the prescribed hours and severely underpaid. More importantly, their freedom of movement was restricted and they were exploited making the owner culpable of human trafficking and bonded labour crimes among others."

**IMPLEMENT ACT TO ERADICATE BONDED LABOUR EFFECTIVELY, SAYS DC**

MANGALURU: Deputy Commissioner A B Ibrahim on Thursday directed officials to implement the Bonded Labour System (Abolition) Act, 1976. Chairing a district level awareness committee on the abolition of bonded labour on Thursday, he said committees have been set up under the Act at the district level with DC as chairman and at the sub-division levels in Puttur and Mangaluru respectively with the assistant commissioners in Puttur and Mangaluru heading the same.

Ibrahim directed the officials of labour department to hold awareness regarding the Act to various non-government organisations and social workers. The department should be at the forefront of identifying cases of bonded labour and take steps to rehabilitate such persons, if any, DC said. Bonded labour system is inhuman and cooperation of all is needed to eradicate it, and stakeholders too should have due information about the import and significance of the act, he added.

The Act makes provision to provide a rehabilitation package of Rs 1 lakh to those rehabilitated from the practice of bonded labour, DC said. The district incidentally last recorded mass case of bonded labour on December 1, 2010 when Robust intelligence gathering by Bangalore-based NGO International Justice Mission helped DK district administration free 22 bonded labourers, one child bonded labourer and their 16 dependents from a stone quarry at Vittla in Bantwal taluk.

Revenue officials and DK Police raided the quarry and rescued workers who worked for measly salary of Rs 100-150 a week, and lived in stone sheds. It was referral client who was on an aftercare programme with the NGO, who alerted them to these labourers working in the quarry. These labourers and their families hail from Krishnagiri, Mysuru and Chamarajnagar districts. Kumar, additional DC, Vedamurthy, Addl SP, D R Ashok, assistant commissioner were present.

**MOU SIGNED WITH TATA MOTORS FOR TECHNICAL AUTOMOBILE TRAINING**

Peace Private ITI and SPSC VEEF Industrial School have signed a MoU with TATA Motors for the ongoing program of providing technical and vocational training. They provide practical training to the students and allow training at any of their plants / Service Centers / Workshop run by their dealers for either commercial vehicles or passenger’s cars. They also conduct an annual “Train the trainer” program for the instructions of automated related trade from Peace Private ITI.

Tata Motors also provide free of cost tools for demonstration of the technology involved in motor vehicles and such other learning aids in its discretion.

The successful students may apply to the dealerships of Tata Motors or company for employment and they might consider offering employment them on merits.

Dr. J. Paul Baskar, Chairman Peace Trust signed MoU at SKIP House in Bangalore on 15th July, 2016. Mr. Stanley, General Secretary and Fr. Jose Podimattam, Chairman of SKIP were present.

**MIGRANT WORKERS RIGHT COALITION (MWRC) MEETING**

The Migrant Workers Right Coalition (MWRC) meeting is conducted in Chennai on 28th June, 2016. The President of Thamizhaga Kattada Thozhilalargal Madhiya Sangam (TKTMS) Mr. Pon Kumar, Dr. J. Paul Baskar, Chairman, Peace Trust, Dindigul, Sister. Valarmathi, Coordinator, National Domestic Workers Movement, Chennai, Prof. Dr. Bernad D’samy, Director, Arunodhaya Migrant Initiatives, Chennai, Mr.K.Gopal Reddy, Former Project Coordinator, BWI SA/PO, Mr.S.Sivasomasundaram, President, Meetpu Trust, Madurai have participated in the meeting. The following issues were discussed in the meeting.

* Ways for Effective functioning of MRC
* Strengthening of MRC by admitting new partners
* Find out the ways to bring pressure on the government for new Emigration Act (Amendments)

The following conclusions were taken after the discussion.

* MWRC’s constructive activity
* Merging right and deserved organizations.
* MRC must act as a government agency
* To set new law for migrant and to submit a request regarding this to Honorable Prime Minister
* A Conference meeting in Madurai
* To link with overseas Tamil organizations
* To get permission from a Member of Parliament to be as an adviser of MWRC.
* To create administrative implementation under Mr. Pon Kumar, President of TKTMS and other foundation members of TKTMS.

**APPEAL SUBMITTED TO HON. PRIME MINISTER REGARDING MIGRANTS SUFFEREING IN OMEN AND TRANSPORTATION OF MR. SARAVANAN’S MORTAL**

An appeal was submitted to Honorable Prime Minister Mr. Narendra Modi regarding the repatriation of stranded 14 migrant domestic workers from Omen who are being physically and mentally tortured by extracting 18 hours of work without providing proper food and shelter. They are all been sent from Madurai through agent. An appeal was also submitted regarding the transportation of Mr. Saravanan’s mortal who has met an accident in the campus of the company on 02.06.2016, admitted in SAIF hospital and died in 03.06.2016. His mortal still remains there even after two weeks. A request application was submitted to Prime minister regarding this through Migrant Workers Rights Coalition (MWRC) on 17th July, 2016.

The Madurai Bench of Chennai High Court Justice Sasitharan dictated the police to file FIR against agents who have sent these women to Omen. Advocate Naguvanan represented the worker.