International Journal of Community Medicine and Public Health
Rao AS. Int J Community Med Public Health. 2026 Aug;13(8):4273-4280
https://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040
DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20262702

Original Research Article

Intersecting gender and migrant status disadvantages in the experiences of women construction workers: consequences for health and healthcare

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Received: 24 April 2026
Revised: 11 July 2026
Accepted: 15 July 2026

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ABSTRACT

Background: Temporary migrants are the backbone of India's urban construction industry. This form of migration is driven by a range of socio-economic factors. In cities, such migrants live and work in challenging conditions for low wages, with few social and legal protections, and with limited access to social welfare programmes. Little is known about temporary migrant women, whose numbers and economic contributions are likely underestimated. Evidence suggests that disadvantages associated with temporary migrant status and gender impose significant barriers on health and healthcare seeking, but few studies have focused on this marginalized population.
Methods: Ethnographic fieldwork was conducted over a period of 8 months in two temporary migrant settlements on the outskirts of Bengaluru, India, and in-depth interviews were conducted with 18 women construction workers. Intersectional and Social Determinants of Health frameworks were utilized to better understand the influence of temporary migrant status and gender.
Results: Analysis showed links between social determinants of health (labour, income, living conditions) and health and healthcare seeking. Disadvantaging factors associated with both temporary migrant status and gender - lower wages, repetitive labour, lack of protection, precarious employment, and impermanent housing - contributed independently and interactively to poor health; however, temporary migrant women construction workers perceived limited options to address their health concerns. Their concerns extended beyond poor physical health to encompass emotional and psychological dimensions.
Conclusions: The challenges and needs of temporary migrant populations will increase as their numbers grow, suggesting that migration and gender concerns need to be integrated into broader health systems and policies.

Keywords: Construction, Gender, Intersection, Social determinants of health, Temporary migrant

INTRODUCTION

One in three Indians, or about 450 million residents, is an internal migrant.[1] An estimated 15-100 million are temporary migrants, who move periodically between their home and destination.[2-4] Temporary migration is typically engaged in as part of a family poverty mitigation strategy in response to the decline of rural livelihoods[5]. Compared to long-term migrants, temporary migrants are disadvantaged in terms of caste, income, education, and land ownership. Temporary migrant labour is often one of 3Ds (dangerous, dirty, difficult, and in the Indian context, frequently demeaning), involves few protections, and pays lower wages.[5,6] The number of temporary migrant women may be underestimated, as their labour is masked by its 'casualized' nature.[4,5,7]

To understand the influence of temporariness and gender, the current study was approached using an intersectional framework, which suggests that disadvantages do not operate independently, but intersect with each other in

complex ways to produce profound inequalities, and a social determinants of health framework, wherein attention is paid to the larger social and economic contexts and living and working conditions in which health is produced, including income, social protection, social inclusion/exclusion, education, employment, job insecurity, working conditions, housing, and access to health facilities.[8,9] These two frameworks are linked by evidence that gender and migrant status are influential social determinants of health and healthcare access.[10,11]

Literature review

Temporary migration and health

The health consequences of rural-to-urban migration are mediated by social, political, and economic disadvantage and moderated by factors such as duration of migration, reason for migration (forced, distress, choice), background (gender, education, income), and the role of remittances.[12] Migration can benefit health if associated with improved incomes, housing, nutrition, access to health facilities, and health information; evidence suggests that long-term rural-to-urban migration leads to an improvement in some health outcomes.[13] However, as temporary migrants rarely stay long enough to accrue these benefits, health risks may outweigh potential benefits.

The overall impact of migration on health is negative.[11,14] Many migrants live in crowded and unsanitary conditions, leading to an increased risk for communicable (tuberculosis, HIV/AIDS) and non-communicable (diabetes, obesity, cardiovascular illness) diseases.[14-16] Migrant women have limited access to antenatal care, institutional delivery, and post-natal care, with severe consequences for maternal and neonatal health.[17,18] Migrant children have low rates of immunization and are at greater risk for acute respiratory infections, diarrhoea, stunting, and mortality.[19,20] Migrant women and children are at greater risk of experiencing violence or abuse.[21] Migration can have a significant impact on mental health and well-being.[22,23] Many have an inadequate awareness of health risks and entitlements, and limited contact with public health facilities due to lack of identification documents, and cultural, linguistic, financial, distance, and time barriers.[14,24]

Gender, migration and health

Temporariness intersects with gender to produce particularly negative health consequences for migrant women. Women migrants have poor health outcomes resulting from heavy physical labour, lack of safety and protective gear, and poor access to sanitation facilities.[25,26] They encounter gender-based issues at the worksite (wage discrimination, sexual harassment) and residence (the 'second shift' of household labour), which can also impact health. Furthermore, women migrants may lack the financial and cultural independence to seek healthcare.[26-28]

Research gaps

Migration research has focused on labour and economic causes and consequences of migration (remittances, skill development), usually associated with male migrant; it overlooks concerns around health, education, and gender equality, and has a limited understanding of gender-specific migration experiences.[4,29,30] Much of the existing research on migrant health does not distinguish between temporary and long-term migrants. The goal of the study was to examine the impact of temporariness and gender, the intersection of these two factors, and the links between labour, economics, and the conditions in which health is produced.

METHODS

An ethnographic approach, which requires the researcher to be immersed in the everyday lives of the community of interest, was taken to examine the lives of temporary migrant women migrant workers. It combines participant observation with in-depth interviews, informal conversations, and extensive field notes to generate rich, contextual insights into how people make sense of their lives and to understand how sociocultural, economic, and structural factors shape their experiences and actions. The study was approved by the Institutional Ethics Committee at the Indian Institute of Public Health, Bengaluru (Approval No. IIPHHB/TRCIEC/170/2019).

Study population

Temporary migrant women typically travel with their families, and travel shorter distances, unlike their male counterparts.[28] In this study, the focus was on families from North-East Karnataka, which has limited agricultural activity due to a hot climate, low levels of rainfall, and poor soil. The population suffers from socio-economic and livelihood vulnerability, which has contributed to a high rate of out-migration.[31] The focus was on construction workers, as construction work is the largest single-sector source of employment for temporary migrants[2] and women comprise around 15% of temporary migrant construction workers.[4] It is estimated that Bengaluru employs about 1.5 million workers.[32]

Fieldwork

Ethnographic fieldwork was conducted between July 2019 and March 2020, in two peri-urban field sites, populated largely by migrant construction workers. Each site consisted of a cluster of 5-6 migrant settlements, which were similar in terms of the composition, road access, appearance and layout. Access was facilitated by two local non-profit organizations that provide services to migrant populations. Visits were made to the field sites to become familiar with the area and residents, at different times and on multiple days of the week, so that it suited the schedules of the participants. Extensive field notes were maintained on life and conditions in the settlements.

In-depth interviews

Fieldwork was supplemented with in-depth interviews with participants who met the following inclusion criteria: that they were women, had moved between origin and destination within the previous year, and were engaged in construction work. As this was an ethnographic study, sample sizes were not calculated in advance. Interviews covered topics such as experiences of migration, work, income, health, and healthcare seeking in the last year. The conduct of interviews was cut short by the onset of the COVID-19 pandemic, but by this point in the study process, thematic saturation had been reached. Ultimately, a total of 18 interviews were conducted.

The interviews were accompanied by observations at participant homes and communities. The field sites did not offer convenient spaces to conduct the interviews in private; family members and neighbours usually joined in the interviews, although the men usually left when the conversations turned towards women's health. Despite privacy concerns, the women were agreeable and even seemed to prefer it; often, the others provided additional insights. Written informed consent (or witnessed thumbprints) and permission to audio record was sought from participants, and verbal assent from others present. The interviews averaged 30 minutes, and were conducted in Kannada, the local language.

Data analysis

Interviews were translated and transcribed into English and analysed using a thematic analysis approach.[33] This analytical approach required the author to become familiar with the data and review notes taken during fieldwork, following which codes were extracted. These codes were examined and sorted into categories, which were then built up into overarching themes. These themes were revised and refined with subsequent readings of the transcripts until a larger 'story' was identified.[33] Observational notes provided supplemental and contextual information. Analysis was conducted using Dedoose qualitative analysis software.

Site description

Settlements

The settlements ranged in size, averaging 30-40 homes. In some settlements, the residents were connected by shared characteristics (family ties, native place), and others had been organized by the *maestris* (sub-contractors) who had facilitated migration and employment. Settlements were poorly lit and infested with vermin and generally lacked toilets and bathing facilities. Residents built enclosed 3 ft by 3 ft spaces out of available materials for bathing. Residents would urinate or defecate on the borders of the settlement (separate areas for men and women), using trees or bushes for privacy. Due to lack of drainage, stagnant water was common, and rubbish collected at the borders of the settlement.

Homes

Each home was approximately 10 by 14 ft. The homes were built of materials such as bamboo, wood, bricks, tarpaulin, and vinyl or corrugated sheets. The floors were made of packed earth, poured concrete, or discarded tiles. The houses did not have windows or other ventilation. Some homes had indoor packed earth stoves, and others had outdoor stoves made of stacked bricks. None of the houses had electricity or water, and residents relied on solar lamps and water that they collected and stored from a variety of sources.

RESULTS

Socio-demographic characteristics

The participants ranged in age from 20-50 years (M=31.5) (see Table 1 for details of sociodemographic characteristics). They lived with families ranging in size from 2-14 members (M=4.9), and except one, had accompanied their husbands. All but two participants had children, ranging in age from infancy to adulthood. Only four women were educated beyond primary school (M=3.2 years of schooling), and all were members of disadvantaged castes. Some had migrated recently, and others had first come nearly two decades ago (M=6.6 years). They reported returning to their native place 3 or 4 times in a year for a period of 2-4 weeks.

Reasons for migration

The migrants migrated due to limited income-earning employment opportunities in their native place. Few families had significant assets in terms of land, livestock, or equipment. Many had taken loans for agriculture, house construction, and medical expenses, and had come with a maestri to earn an income and pay back loans. As some women described,

At our native place, our family could barely earn 100 rupees, so we came here. Now we built a house over there. We got our daughter married. Our owner gives us loan without any interest. So instead of our hometown, we work hard here and visit our hometown occasionally. (Dharini, 43, Raichur district).

We don't have anything either here or there. Even if we go back to our native place, we have to do the same coolie [daily wage] work and earn. But there, they pay very less coolie for the work which is not enough. So, we stay here. If we go, we stay for 15-20 days and then we come back. (Kartika, 50, Chitradurga district).

Labour

All the women engaged in unskilled construction labour

as part of a *maestri*-organized 'gang.' They built roads, buildings, and drains, for private and public employers. They worked six days a week, 8-9 hours a day, although occasionally shifts extended beyond 12 hours. The labourers had little control over the location, work, or hours. Women who did not belong to a regular work 'gang' were employed inconsistently, as *maestris* preferentially employed men. At these times, some of the women worked other jobs (dishwashing, housework):

Sometimes, we don't get work. [Every] 1 or 2 weeks, we sit at home. If someone calls us for housekeeping work, if they give 200 or 300, we go for that. We never say we won't do this kind of work. (Kamakshi, 27, Ballari District).

We have to tell people we are looking for work. If someone calls us, then we have a livelihood. Otherwise, we have to be at home. (Seshamma, 38, Yadgir District).

On construction sites, women's work consisted of transporting materials such as cement, stones, and sand; older or pregnant women performed lighter duties, such as sweeping or watering. Construction sites were often hot, dusty, and dangerous, but few women were provided protective gear, such as reflective vests, helmets, or footwear; they were warned that they were responsible for their own safety. As construction sites usually did not include sanitation facilities, the women preferred to take care of their needs before or after their shift.

After long days of construction work, all the women had to do a 'second-shift' at home, including cooking, cleaning, laundry, and childcare.

I have to wash the dishes, collect firewood, then cook and eat. Then again at night, I have to wash everything and wake up early in the morning to cook and pack the food. (Dharini, 43, Raichur District).

We can't rest at all. We have to empty the garbage, do a puja, wash the utensils. Then I have to make some rice and curry to eat. (Parvati, 35, Haveri District).

Table 1: Participant characteristics.

Participant no.	Age	No. of years of education	Caste	Native place	No. of family members	No. of years since initial migration
1	43	0	SC	Raichur	4	10
2	35	0	BC	Raichur	6	4
3	50	0	OBC	Chitradurga	14	15
4	35	1	OBC	Haveri	2	5
5	37	6	OBC	Koppal	2	1
6	27	12	OBC	Ballari	5	7
7	35	2	SC	Ballari	4	4
8	27	3	SC	Ballari	5	8
9	20	6	SC	Ballari	2	2
10	26	2	BC	Ballari	2	0.8
11	28	2	BC	Koppal	4	1.5
12	33	2	SC	Raichur	5	4.5
13	38	4	SC	Yadgir	3	2
14	20	7	SC	Raichur	4	17
15	30	0	SC	Raichur	3	6
16	38	0	SC	Yadgir	12	18
17	22	5	SC	Yadgir	6	1.5
18	25	5	ST	Yadgir	3	12

Economic concerns

Women's daily wages (Rs. 250-400) were uniformly lower than men's wages (Rs. 360-500), even when they did similar work. All the labourers received their wages weekly, in cash, but the women had little control over how that money was utilized - they were given some money to manage the household, but the remainder was sent to support family members living in the native place, and towards the repayment of loans. Most of the women knew little about the loans - when it was taken, total amount, amount repaid, interest rates, etc.

They (husband) will know about it. They only tell us that it is there, we don't know how much. (Kamala, 20, Raichur District).

Sometimes, part of the wages was withheld by the *maestri* for safety, payment for services (water, electricity) or towards the repayment of a loan taken from the *maestri* himself.

We would've taken advance for food, so all those costs will be deducted from the salary and the rest will be paid to us. Sometimes, the wages are fully deducted and nothing is paid for that day. (Malati, 35, Raichur District).

We only take 2000 rupees per week and leave the rest with the maestri. Because if the money is with us, we might spend it on something. (Suchitra, 28, Koppal District).

Living conditions

The living conditions in the settlements were poor for all residents - crowded, dirty, and lacking facilities (electricity, water, fuel, sanitation) - but women most suffered the consequences. They cooked using firewood in smoky, poorly ventilated spaces. The women were predominantly responsible for collecting water and were often seen carrying heavy buckets and pots of water, and faced challenges because of their 'outsider' status:

[The locals] tell us that we come from some other place and try to take their water. They fight with us. (Bhagyamma, 38, Yadgir District).

The poorly illuminated settlements were unsafe for women. Perhaps most dangerous was the absence of bathrooms and toilets, which required women to relieve themselves in public and often unsafe conditions – in the dark, in vermin-infested areas, and at risk of harassment or sexual assault. They took the following measures for safety:

We go in the night or early in the morning. We go when it's dark so that people can't see. If we can't do it at that time, we have to find bushes or a tree and go there. We can't do anything about it. (Kamakshi, 27, Ballari District).

Even while going to the toilet, some 2-3-4 of us go together. All drunk people. It's difficult here. (Bhagyamma, 38, Yadgir District).

Health and healthcare seeking

Nearly all the women described fatigue, exhaustion, or general aches, which they handled with the aid of balms and painkillers purchased at pharmacies. Only for specific complaints, such as coughs or fevers, did they visit a private clinic.

Sometimes when the pain is too much, I take a tablet. Otherwise, we have to keep working. (Rani, 26, Ballari District).

If something hurts, we go to the pharmacy, get medicines and eat. If it does not reduce, then we go to the doctor. (Malati, 35, Raichur District).

We apply balm over our legs and then sleep. Because what else to do? (Seshamma, 38, Yadgir District).

As a visit to a private clinic cost (>Rs. 500, including consultation, tests, and medicines) exceeded a day's wages, they tried to avoid them. Care seeking, whether from a pharmacy or a clinic, was usually in the company of husbands. One particularly disadvantaged participant drew links between their labour, living conditions, and health:

It's very hard to live here. Lot of problems. There's no electricity, no water, nothing. And whatever we earn we give to the hospital because we eventually fall sick doing this kind of work. We cook with firewood. The soot is all over us, our clothes. There's a lot of smoke inside the house too. (Seshamma, 38, Yadgir District).

Public healthcare facilities were not located nearby, and in any case, the women did not feel that providers treated them well.

They don't care for poor people like us… they tell us to come tomorrow or the day after. They keep misleading us. [They say] that the doctor is not there. Madam is not there. Some machine is not working for the blood tests. This is how they fool us. What if we die waiting 2-3 days for the doctor to come? We are fine going to the private hospitals even if we have to borrow money. (Seshamma, 38, Yadgir District).

They had almost no contact with any public health facility or health workers. If they required any long-term treatment, they preferred to visit the public healthcare facility in their native place.

These doctors are not like the ones in our native place. Here, we have to go twice to get alright. In our hometown, we go just once and we get alright. Here we don't seem to feel fine even after taking all the medicines. (Rani, 26, Ballari District).

Regardless of how they felt, the women rarely skipped work, as they could not afford to miss a day's wages, and because they feared that the *maestri* would drop workers who were repeatedly absent. They had grown accustomed to the fatigue and aches; these issues were simply part of their daily life and did not merit any attention.

Work is difficult… but we have to work hard. If they ask us to lift a stone, we have to lift a stone. We have to separate the gravel, we have to carry the sand… Only then they will pay us. Will they give for nothing?" (Dharini, 43, Raichur District).

DISCUSSION

During fieldwork, all migrant community members complained about the indignities they faced every day and their limited ability to change their circumstances:

We have to work, we have to do everything they say. They give us too much work. We get tired of work, but we still have to work and come back. If we talk back, they start fighting. If they say something and we talk back a little, they scold us. They tell us not to come to work. They ask us to go work elsewhere and not to come here. They won't pay us. Just fights (Male resident).

Consistent with what is known about temporary migrants, study participants had low levels of education, income and asset ownership, and low social status driven by caste. They had migrated from underserved rural areas to compensate for the lack of income-earning opportunities.[31] Living and working in urban areas may have mitigated some disadvantages, but they persisted across factors such as income, labour, working conditions, living conditions, and access to health services.[3,5]

Women were particularly disadvantaged. For instance, while construction work was challenging for both men and women, women suffered lower wages, poorer working conditions, longer working days, and limited water or sanitation facilities.[26] All temporary migrants lived in rudimentary settlements that lacked water, electricity, and sanitation facilities, but women's experiences of these conditions led to severe and differential health consequences, widening the gap between men's and women's disadvantage.[11,14] Cooking in poorly ventilated spaces increased the risk of respiratory illnesses, and water collection was physically exhausting and led to conflict with locals. The absence of toilets exposed women to the risk of harassment and sexual assault; as a result, women urinated infrequently, increasing their chances of developing infections. At home, they carried the 'second shift' of household work, including childcare, cooking, cleaning, and laundry.[27] The link between labour, economics, and health is evident in the current study, as the women's long days of underpaid and unpaid work resulted in exhaustion and pain, for which they had limited treatment options.[25]

A lack of money was one barrier, as women made lower wages, had little control over their income, and limited knowledge of their economic situation. They had limited financial or social independence to seek healthcare. Iyer et al have described how "women tend to have poorer access to, and control over, resources within households… gendered divisions of labour leave them with little time or opportunity for health seeking.[34] In low income settings, not only is non-treatment higher among women than among men, but women are more likely to self-treat, or to receive treatment from informal health providers" (p. 18).

Women sought care only for illness or when it threatened their livelihoods. They had limited contact with public health services, due to challenges related to time, distance, transportation, lost wages, and most importantly, trust.[26] Healthcare seeking was further shaped by their temporariness, as women preferred to seek long-term care in the native place, where they had the support of family members, and where public health facilities were familiar and accessible.

Despite the many barriers to their health and well-being, however, few women spoke spontaneously about their health concerns; even after prompting, they spoke in broad, non-specific terms. They may have been reluctant to share their concerns with a stranger, but the predominant reason was that they simply did not feel there was any point to raising these issues. Their concerns about their health were exceeded by worries about children, loan repayment, unstable work opportunities, risk of eviction, and more generally, about whether their lot in life would improve:

We are not interested in living here. We are only worried about when the loan will be repaid and when we will return home. I think about it in the morning as soon as I wake up and at night. I can't sleep properly because I keep worrying. When will we repay it? We have left behind our small kids. How can they grow up with someone else for so long? So I am always thinking about it. (Rani, 26, Ballari District).

If we save enough, then we will go back to our native. Why should we stay here? Until we earn enough, we have to be here… At some point, we want to go back. (Malati, 35, Raichur District).

The study describes the marginal and precarious existence of temporary migrants but attempts to expand social welfare and education schemes to reach these populations have met with limited success.[6] Legislation that addresses migrant worker rights (Interstate Migrant Worker Act, 1979) or occupations dominated by migrants (Building and Other Construction Workers Act, 1996) focus on formal employment at large worksites; these laws have limited relevance for temporary migrants, who are recruited and contracted through informal labour networks and are unlikely to be unionized. These laws make no provisions for women, who tend to have particularly limited knowledge about or willingness to get organized.[35] In general, laws and policies related to migration are centred around labour, economic, and law enforcement concerns rather than health and well-being.[21]

Although acknowledged by successive governments to be a vulnerable group, the failure or inability of the state to address the conditions of this mobile population has led to an underclass of disadvantaged citizens. The fact that migrants continue to migrate and work despite these conditions speaks to their lack of options.[6] Nevertheless, most of the families maintained a strong connection to their native place as "…circular migration enables the fulfilment of aspirations and objectives which largely remain rurally rooted - the paying off of agricultural loans; the marking of lifecycle events; getting one's children married; and in their most basic form, the

sustenance of one's family".[35]

Demographic trends suggest that the rate of temporary migration is increasing in India, even as that of permanent migration has slowed down.[29] As the challenges and needs of this population continue to grow, migration concerns need to be integrated into broader health systems.[14] Although the present study was limited to Bengaluru, the findings will find application in large urban centres throughout India, many of whom depend on a significant yet vulnerable temporary migrant presence to fuel their growth.

The study has some limitations: first, the study sites and populations may not be representative of other temporary migrant settlements and communities; second, although appropriate for an ethnographic approach which prioritizes depth over breadth, the sample size limited the ability to capture the full diversity of experiences among temporary migrant women; third, the lack of privacy may have hindered discussions around sensitive topics; and finally, the onset of the COVID-19 pandemic curtailed the possibility of additional observations and interviews which may have further enriched the findings.

CONCLUSION

This study demonstrates the need for studies that distinguish between temporary and permanent migrants and reiterates the need for gender-specific migration research. Women construction workers are multiply disadvantaged by both gender and temporary migrant status, with consequences for labour, income, health, and healthcare access. Health and other social welfare interventions must contend with the impact of temporariness and gender, and the intersection of these two factors, in their design and implementation. Targeted health interventions, with consideration of their specific vulnerabilities, must be developed to meet the needs of migrants.

Funding: Financial support was provided by the Azim Premji University
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee of the Indian Institute of Public Health (Bengaluru), Public Health Foundation of India

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Cite this article as: Rao AS. Intersecting gender and migrant status disadvantages in the experiences of women construction workers: consequences for health and healthcare. Int J Community Med Public Health 2026;13:4273-80.