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REFLECTIONS

Challenges of dealing with migrant brick kiln workers

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Abstract

Brick kilns in rural India exemplify extreme poverty and exploitation, as seasonal migrant labourers work long hours for minimal pay, living in cramped, poorly ventilated dwellings. Children often begin working at a young age, with irregular or no schooling. Access to healthcare is severely limited, with maternal care, immunisation, and disease screening being sporadic and follow-up rare. Poor nutrition and widespread substance use further compromise health. Lacking identification or permanent addresses, these families are excluded from social welfare schemes. This situation reflects a profound human rights crisis, requiring enforcement of labour laws, provision of health and nutrition services, child welfare support, and measures to protect dignity and well-being.

Keywords: *brick kilns, marginalised community, migrant workers, labour rights*

A drive through rural Haryana offers a view of tall chimneys, surrounded by rows of neatly stacked bricks in the midst of green fields. From a distance, brick kilns appear serene, until you step into the compound where 200–250 labourers toil through extreme weather to power India's construction industry. With rapidly rising urbanisation, brick kilns reveal a story of poverty, neglect, child exploitation, and systemic invisibility. These kilns operate from October until the onset of the monsoon, with activity peaking during the summer months. Staffed by migrant labourers from Chhattisgarh, Bihar, Rajasthan, Bihar and West Bengal [1,2] — the workers travel seasonally with their families, finding themselves in Jharkhand in one year and the southern parts of India in the next. The official age of the working population ranges from 17 to 60 years, though unofficially, children begin working much earlier. About 80% of the workers belong to a scheduled caste or tribe [1,2].

In one such kiln in Jhajjar, Haryana, a couple live with their five daughters and one son in a cramped, makeshift brick room — one in a row of similar dwellings. In the dark, single-room space, measuring no more than 100-150 square feet, a baby crawls on the floor while his eldest sister Priya (name changed) sits outside on a *charpai* at 11 am, eating her staple meal of rice and potatoes. The room has no light, no ventilation, a single small fan, and serves as the bedroom, living room, and kitchen, all in one. The economic condition of this population is poor, with workers being paid 50 paise for the manufacture of one brick. This involves processing the clay into moulds, sun-drying them, and then baking them at high temperatures in the kiln. Even with long working hours, this family of eight barely manages to earn ₹5,000 to ₹6,000 every fortnight during dry weather and if it rains — they are given a basic sustenance allowance of ₹2,500.

Basic provisions are available in small, independently run shops set up near the brick kilns. The diet of most families is limited, primarily consisting of wheat, rice and tubers [2]. Vegetables are rare, and fruits are virtually absent from their plates [2]. There is widespread malnutrition among children raised in these kilns [3]. Tobacco and *bidi* use is rampant and even children as young as 10 are seen using these, despite laws prohibiting its sale to minors. In many cases, parents themselves provide these to their children. Alcohol is often prioritised over food; many workers go to bed hungry but intoxicated. "Just yesterday, three or four men were completely knocked out — *marne ke haalat mein* — after drinking," recounts the local headman. There are no savings. Whatever little they earn is spent quickly, mostly on basic necessities, addictions, or survival. Their lives are so harsh that even well-intentioned efforts to eliminate alcohol and tobacco would be challenging to implement. As one local health worker puts it, "We can't just take these away — how else will they make their lives tolerable? There is hardly any difference in the way the labourers in these camps and animals are treated."

This tragic story becomes even more disconcerting when we examine access to healthcare. The district hospital in Jhajjar attempts to send medical teams on a rotational basis to the various brick kilns in the area. However, these visits are irregular and often insufficient to meet the community's needs. While the teams conduct tuberculosis screening, basic check-ups, and occasional immunisation drives, the overall coverage remains poor, and follow-up care is non-existent. Maternal healthcare is also severely inadequate. Despite efforts at outreach, most women do not receive proper antenatal care and only arrive at the local primary health centre when they are already in labour — often with no prior medical records or identification. A study from Faridabad showed that only 23% had institutional deliveries [1].

While working as a primary care doctor in a village in Faridabad district, I came across a 30-year-old woman in her fourth pregnancy who arrived in active labour, with no history of antenatal check-ups, no identity documents, and no known medical background. The family did not even have a mobile for communication. It was only after the delivery that routine tests for pregnant women were conducted, including HIV, for which she and her husband were positive. The newborn was started on antiretroviral

(ART) prophylaxis, and the couple was counselled by PHC doctors, nurses, and counsellors from the local ART centre. Yet, five days after delivery, they migrated away from the kiln, were untraceable and lost to the healthcare system. The follow-up and treatment of the family members, and protection of the child against vertical transmission of HIV is now improbable. This is the precise danger of informal, migrant labour clusters: a population that falls through every safety net simply because they are never counted in the health system.

Education in brick kilns is as inconsistent as healthcare services. Priya's five school-age siblings attend a make-shift, open-air school held under a tree by volunteers from a local Christian organisation. In the 40 brick kilns in the area, only about half permit children to attend these classes. They may be considered fortunate to have some form of education even though there is no formal curriculum, no seating, and all age groups are combined into one class, their learning unstructured and just symbolic. In the neighbouring district of Faridabad, one would not find such a facility at all. Children simply do not go to school. 17-year-old Priya had studied in her village until Class 8; but being the eldest of her siblings, she dropped out of school to take on domestic and childcare responsibilities. She also works in the brick kiln to contribute to family income. Her story is not an exception — it is the norm.

This issue is beyond poverty; this is fundamentally an issue of human rights. These families are denied access to education, consistent healthcare, social protection, humane living conditions and basic dignity. They remain outside the reach of government schemes that require identification, a permanent address, or digital literacy. The workers and their families should have Aadhar IDs which enable linkage with social welfare schemes. From a healthcare perspective, it is imperative that regular camps be conducted for antenatal care, immunisation services, and routine screening and treatment of common conditions. Efforts should also be initiated for community-based awareness and early prevention of substance use, along with establishing linkages to de-addiction services for those in need. Nutritional support should be strengthened including linkage to Anganwadi services, the mid-day meal programme and Anaemia Mukt Bharat, particularly for children, adolescents and women of reproductive age [3]. A diet limited to cereals and potatoes leads to nutritional deficits and adds to the rising burden of non-communicable diseases. It is essential that more variety be available to the workers, either directly through employers or in attached grocery shops. Prolonged exposure to dust and smoke increases the risk of respiratory [4] or heat related illnesses [5], and provision of protective gear such as masks, gloves, goggles, and boots is essential to reduce inhalation and injury. Regular screening for respiratory disorders, including tuberculosis, should be incorporated into health camps. When national health programmes already cover all essential health services to enlisted population through Ayushman Arogya Mandirs located in the same area or village, a system to include migrant labourers must be put in place.

India has laws to protect inter-state migrant workers and to abolish bonded labour, such as the Minimum Wages Act, 1948 or the Child and Adolescent Labour (Prohibition and Regulation) Act, 1986 [6]. But laws without enforcement become mere decorations. There are no routine inspections, no centralised registry of kiln workers, and no integration with child welfare services — only smoke, heat, and silence. It is easy to drive past a distant chimney and forget what fuels it. The cost of every brick laid in our cities is a child without an education, a pregnant mother without access to healthcare and a worker who drinks himself to sleep. Until we abolish this hidden suffering, the houses we build will continue to stand on fractured human lives.

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