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Health service utilization among migrant mothers of under-five children in Shivamogga district of Karnataka

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Abstract

Introduction: Migrant mothers residing in the slum area always underutilize the health services rendered by the government. **Objective:** The objective of this study was to assess the health services utilization for children among migrant mothers of under-five children. **Method:** A cross-sectional descriptive survey approach was used for this study. The study was conducted among 320 mothers from selected migrant areas of Shivamogga District of Karnataka. **Results:** Results revealed that the majority (99.1%) of the mothers had utilized hospital services for delivery. Around 82.2% of the mothers were aware of Janani Suraksha Yojana. However, 57.5% of the mothers have not received cash incentives from the government after delivery under Janani Suraksha Yojana. Findings of the study also revealed that 55% of mothers have enrolled for Bhagyalakshmi Scheme and 71.2% of the mothers have received a Madilu Kit. It was evident from the study findings that 99.3% of mothers immunized their children and 84.3% of children above three years were going to Anganwadi. This indicated that still, many migrants were not able to access some of the government schemes. So, there is a need to build cognizance among migrant mothers on the government's welfare and health awareness schemes. Also, available services should be made more accessible to the migrant population.

Keywords: health service utilization, migrants, migrant mothers, under-five children.

Introduction

Migration is becoming easier and faster in the modern world today. For many reasons, people frequently switch from one location to another for finding better work, schooling, housing etc. (World Economic Forum, 2017). Human migration is gaining momentum day by day due to the complexity of human life and rapidly evolving social and economic conditions. According to

the 2017 International Migration Survey, the number of migrants is growing rapidly. In 2017, there were 258 million international migrants compared to 173 million in 2000. India has also been estimated to be the largest birthplace for most migrants around the world (United Nations, 2017).

In general, migrants are identified as residents outside their place of origin or their last residence (International Organization for Migration, 2019). In India, internal labour migrants are the pockets of a neglected population whose development indicators are alarming (Nitika, Lohiya, Nongkynrih, & Gupta, 2014). Internal migration refers to a move from one area (a province, district or municipality) to another within one country (National Sample Survey Office, 2010). Non-availability of employment opportunities in backward regions, natural calamities, better living conditions and poor economic conditions are driving forces for internal labour migration (Manmeet et al., 2015).

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The poor migrants are employed in numerous activities like vendors, daily wage workers and domestic servants and live in slums (Zulu *et al.*, 2011). People often migrate from rural to urban areas within a country or from less developed to more developed countries for better life opportunities but may remain outside the range of health services (World Health Organization, 2019). According to the 2001 census, around 307 million people migrated from their birthplace. Of these, 84.2% migrated from one place to another within the state and the others migrated from outside the region (Office of the Registrar General & Census Commissioner, 2011).

It is assumed that migrants in low-income households prefer to live near the workplace. A study conducted in Delhi showed that most of the households in the slums underneath the poverty line migrated from other states (Kumar & Aggarwal, 2003). The three key features of slum settlements that contribute to the poor health outcomes are: poor environmental conditions and infrastructure; limited access to services due to lack of income to pay for treatment and preventive services; and dependence on poor quality and mostly informal and unregulated health services that are not suited to meet health needs of slum dwellers (Zulu *et al.*, 2011). Because of the temporary settlements, the migrant population has limited access to welfare and government health schemes and services which results in underutilization. Expensive private health services, work pattern, work timings of the migrants and distance, are other factors hindering the accessibility to the health services (Borhade & Anjali, 2011).

Reduction of maternal and infant mortality and morbidity was one of the key indicators for tracking the achievement of the Millennium Development Goals. It also reflects the quality of health services implemented and utilized in any country (Manmeet *et al.*, 2015). In a quest to reduce the maternal, neonatal and under-five deaths, Government of India and Government of Karnataka (one of the states in India) launched many beneficiary schemes like Janani Suraksha Yojana to promote institutional delivery (The institutional deliveries are ensured by giving incentives to antenatal women) (National Health Portal, 2015), supplying Madilu Kit (a kit which contains all necessary and basic items for mother and baby after delivery) at

hospitals (Government of Karnataka, 2007), Universal immunization program, ICDS (Integrated Child Development Scheme) program and Bhagyalakshmi scheme (the primary objective of this scheme is to encourage the birth of girl children and to improve the status of them in society by providing financial assistance).

As the migrant population are non-native population, they are vulnerable and are exposed to many health problems. Migration to urban areas affects both the health of adults as well as children. Under-nutrition and low immunization coverage are common problems and also responsible for child mortality. The circumstances of children of migrant population experience the same difficult living conditions that their parents endure (Nitika, Lohiya, Nongkynrih, & Gupta, 2014). The immunization coverage rate is found to be low among the migrants (Geddani *et al.*, 2018). A low percentage of migrant mothers received antenatal and delivery services (Abrol, Meenu, Gupta, & Sekhon, 2008).

Thus, with all the literature support and being closely associated with community activities, the researchers were interested to conduct this study with the main objective to understand the health service utilization of migrant mothers in terms going for institutional delivery, and utilization of schemes like Janani Suraksha Yojana, Bhagyalakshmi scheme, Madilu kit, Universal immunization programme and ICDS programme.

Material and Methods

A cross-sectional descriptive survey was carried out among migrant mothers of under-five children from different migrant areas of Shivamogga District of Karnataka state. Two slums were selected using simple random sampling technique and purposive sampling technique was used to select the mothers from the selected slums. The sample size for the study was 320 based on pilot study findings.

A survey was conducted using the semi-structured validated questionnaires. Socio-demographic profile was used to collect the background information of the respondents and a semi-structured interview schedule was developed to collect the information on health service utilization among migrant mothers. The areas included under this questionnaire were utilization of

government services like institutional delivery, Janani Suraksha Yojana, Bhagyalakshmi Scheme for girl children, Madilu Kit scheme, Universal Immunization Programme, ICDS program and utilization of Primary Health Care (PHC)/Sub centre/government hospital services. The tool was submitted to seven experts to establish content validity. All the items in the tool rated 100% agreement but for four items grammatical corrections were given by the validators. One question on the immunization schedule was modified based on new immunization schedule according to expert's suggestions. There was no scoring for the items in the tool. Thus, the final tool had 28 items. Reliability of the tool was established by the test-retest method. All items reliability was seen in terms of the agreement. There was 100% agreement for all the items.

Data collection

Ethical clearance was obtained from the Institutional Ethics Committee. Administrative permission to conduct the study was obtained from concerned authorities. The mothers of six months to five-year-old children from the selected migrant area and those who were willing to participate in the study were included in the study.

A good rapport was established with the migrant mothers before administering the tool and informed consent was obtained from each migrant mother after explaining the purpose of the study. The researcher conducted face to face interview by visiting the migrant mothers at their houses. Demographic details of the mothers were collected by using demographic proforma followed by a semi-structured interview schedule on health service utilization.

Approximate time spent with each mother was approximately 20-25 min. After the interview, the researcher acknowledged and appreciated for their participation and cooperation by individual thanking.

Data were analyzed using SPSS version 16. Sample characteristics and health service utilization for children among migrant mothers, were described by descriptive statistics.

Results

The results revealed that majority 84.4% of the mothers were housewives (Figure 1).

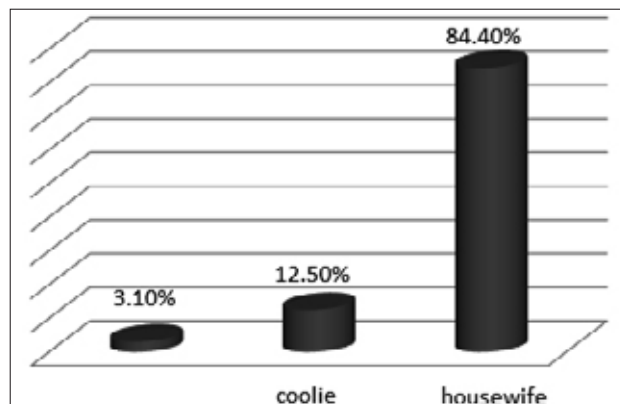


Figure 1: Frequency and percentage distribution of the occupation of mothers

It was evident from the study that 168 (52.5%) were having two children, majority 179 (55.9%) of the children were in the age group of 3-5 years, 189 (59.1%) children were male, most, 178 (55.6%) of the children's birth order was second which is depicted in table 1.

Table 1:

Frequency and Percentage Distribution of Characteristics of Children

N=320

Sample characteristics	Frequency	Percentage (%)
Age in year		
0.6-1 year	64	20
1.1-3 year	77	24.1
3.1-5 year	179	55.9
Gender		
Male	189	59.1
Female	131	40.9
Birth order		
1	70	21.9
2	178	55.6
3	51	15.9
4	21	6.6

Table 2 depicts that more than half 186 (58.1%) of the families were Muslims, around 60% of the family had a monthly income of INR 5,001-10,000. In the study, most of the family members were having Aadhar Card (301, 94.06%), which is a unique identification number issued by the Unique Identification Authority of India (UIDAI).

Table 2:
Frequency and Percentage Distribution of Family Characteristics

N=320		
Sample characteristics	Frequency	Percentage [%]
Religion		
Hindu	134	41.9
Muslim	186	58.1
Caste/Tribe (n= 134)		
Schedule caste	31	23.2
Schedule tribes	78	58.3
Other backward classes	17	12.6
General	8	5.9
Monthly family income (Rs.)		
Less than 5000	74	23.1
5001-10000	193	60.3
10000-15000	37	11.6
Above 15000	16	5
Number of members in the family		
3-5	198	61.9
6-8	111	34.7
8-10	11	3.4
Type of diet		
Vegetarian	8	2.5
Mixed diet.	312	97.5
Nearest health services available		
Govt. hospital/PHC	320	100
Private hospital/clinic	0	0
Nearest school available		
Govt. School/anganwadi	320	100
Private school	0	0
*Identity card present among family members	301	94.06
Aadhar Card	258	80.65
Ration Card	276	86.25
Voter ID		

*multiple responses

Utilization of health services was assessed based on the utilization of schemes like institutional delivery, utilization of Janani Suraksha Yojana and Bhagyalakshmi scheme for girl children, utilization of Madilu Kit and utilization of Universal Immunization Program Services.

Table 3 depicts that 317(99.1%) of the mothers had their delivery at private/government hospital and for one (0.9%) trained health professionals conducted the delivery. Majority of the mothers were aware of Janani Suraksha Yojana 263 (82.2%) and 184 (57.5%) mothers did not receive cash incentives from the government after delivery under Janani Suraksha Yojana. One of the reasons for not receiving benefit from Janani

Suraksha Yojana was that they had more than two children. As per the scheme, mothers are eligible for a cash incentive of INR 700/- for normal deliveries and INR 1,500/- for caesarean section. 97(71.3%) mothers received less than INR 1000. This total amount may not reach to the beneficiaries due to various reasons which they were also not able to express. ASHA/ANM worker did not visit most of them after delivery at least once 193 (60.3%)

Table 3:

Utilization of Janani Suraksha Yojana

N=320		
Utilization of Janani Suraksha Yojana	Frequency	Percentage (%)
Awareness of scheme		
Janani Suraksha Yojana		
Yes	263	82.2
No	57	17.8
Received cash incentive from Govt. after delivery under Janani Suraksha Yojana		
Yes	136	42.5
No	184	57.5
Amount of cash incentive received from Govt. after delivery under Janani Suraksha Yojana (n=136)		
Below 1000	97	71.3
1000-1500	39	28.7
Visits by ANM/ASHA worker at least once after delivery		
Yes	127	39.7
No	193	60.3

Study results also revealed that only 72 (55%) subjects enrolled their girl children for Bhagyalakshmi scheme by the government

The reasons for not enrolling are, having more than two children, not having a valid identity card and some of them felt that the procedure to apply was very complicated.

The data in the Table 4 reveals that 72.2% of mothers were aware of Madilu Kit and 228 mothers (71.2%) have received Madilu Kit by the government hospital but 173 (75.9%) of them have received only 10-15 items.

Table 4:
Frequency and percentage of awareness and utilization of Madilu Kit by the mothers

N=320		
Madilu Kit	Frequency	Percentage (%)
Awareness regarding Madilu Kit		
Yes	231	72.2
No	89	27.8
Received Madilu kit from Govt. hospital		
Yes	228	71.2
No	92	28.8
Number of items received in Madilu Kit (n=228)		
Below 10	6	2.6
10-15	173	75.9
16-19	49	21.5

The study findings also depict that all the children were immunized immediately after birth and 318 (99.37%) of them immunized their children regularly either at PHC/Sub centre/government hospital. Only 55% of the children were only receiving vitamin A prophylaxis. It was also found that 288 (98%) subjects have received nutritional supplements from anganwadi. Most of the children above three years were going to anganwadi (151, 84.36%), majority of the mothers received nutrition education from anganwadi worker/Auxillary Nurse and Midwife (ANM) (288, 90%), none of the subjects received any medication from anganwadi worker/ANM (320, 100%) and weight of 288 (90%) children was monitored regularly at anganwadi centre.

Discussion

The health of migrants attracts considerable global interest. There are always disparities in the use of health services among migrants compared to native people (Shaaban, Morais, & Peleteiro, 2019).

In the present study, it was evident that 57.5% of the mothers did not receive cash incentives from the government after delivery under Janani Suraksha Yojana, 55% of the migrant mothers have enrolled their girl children under Bhagyalakshmi scheme and 71.2% of the subjects have received Madilu Kit after delivery. Most of them verbalized that the procedures for getting the benefits were very complicated. Similar findings

are reported in a cross-sectional survey which was conducted at Bangalore, India among postnatal mothers where 78.3% were aware of Janani Suraksha Yojana scheme and 82.9% had received cash assistance under the scheme (Reddy, Kishore, Viswanatha, Ranganath, & Shanmugapriya, 2016).

All the children of the migrant mothers were immunized immediately after birth, and a majority of them immunized their children regularly at PHC/Sub centre/government hospital by the vaccines which are supplied by the government according to the age. Similar findings recording the lack of complete immunization coverage were reported among migrant workers from other parts of the country. Immunization coverage is less among the migrant population compared to the general population (Kusuma, Kumar, Pandav, & Gupta, 2010). There was a study conducted among Urban South Indian population which showed that the coverage of optional vaccines was very less (Manthiram et al., 2014) which is similar to the present study in which, none of the mothers immunized their children with optional vaccines.

ICDS program, which focuses on children's nutrition, was availed by the majority. Nutritional supplements distributed at Anganwadi centres promote the holistic development of the children (Bhagat, Choudhari, Baviskar, & Mudey, 2015). In the present study, it was found that 90 percent of the children were receiving the nutritional supplements, 84.36% of the children below three years were going to Anganwadi. The reason for the lack of 100% coverage in this area has to be investigated.

As per the study results, many mothers inspite of having access to the health services, did not utilize or access, due to lack of identification document. A systematic review revealed that health care access has to be improved for the migrants. Further, it stated that an urban health care system should have robust migrant sensitive health care system (Kusuma, Kumar, Pandav, & Gupta, 2010).

The study was limited to selected migrant areas of a particular district in Karnataka state of India which the researchers could access only the migrants and who were available during the time of data collection. Covering the migrant population from different

districts could have revealed more data on the healthcare utilization pattern of migrant mothers of under-five children. Future research covering a larger sample and comparison between the native and migrant population could be explored.

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