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Health Needs, Health Seeking Behaviour of Interstate Migrants and Health System Response: A Case study

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ABSTRACT: Health needs and health seeking behaviour of interstate migrants are an area of priority because the migration is changing into a standard development within the globalized world. The increased pressure on the general public health system to produce quality health care to the guest population is often does not reach the bottom level.

The researchers have conducted a cross sectional study by taking eighty sample population from West Bengal working in construction sector in Calicut district. They were asked about the health needs, health seeking behaviour and also the system's response to that. The self-reported answers were qualitatively analysed and information is presented.

The linguistic and other cultural barriers and previous experiences with the health service providers at Kerala have influenced the health seeking behaviour of the population in utilizing the services from primary health centres. They make cost benefit analysis before accessing different health care providers and often skip PHC due to the time clash. Another factor is that the chemists and private clinics are functioning at a time which is convenient to the migrant population whereas the timing of PHC functioning is a barrier in accessing the services.

Keywords: Health, Needs, Inter State Migration, Migrants, Health System, Response

1. INTRODUCTION

Internal migration is an expected phenomenon in countries where the labour forces are distributed oddly. The push factors and pull factors influence this labour force to go in search of jobs that pay them better. As this group is permanently or temporarily moving within and between states in India, their participation in the socio-economic and political life of India is also neglected. Thus they remained as invisible population for a long time. The existing policies and programmes were insufficient to meet the needs of the population. Thus the vulnerabilities of the internal migrants are remained like an open Pandora's Box.

As migration is a hardbound reality in the context of India, a plethora of issues associated with the interstate migrants is a matter of debate. This is indeed true with the case of the health needs of the population and the response of the health system towards addressing it. The 4th Global Forum on Migration and Development recognized the importance of migrants' health and recommended for cost effective health care models for various types of migration scenarios" (International Organization for Migration, 2013).

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From time in memorial, people went on searching for new lands, resource because they were in pursuit of healthier economic conditions and safe environment. It is continuing still and internal and external migrations are thus common in the atlas. In the case of India, many people have seen Kerala as a safer destination which led to the influx of interstate migrants to Kerala. Considering the statistics on internal migration in India, the attraction of migrants towards the Kerala state and their flow clearly indicates that the state became a 'gulf' for the labour force. The Kerala state stands with a migrant population of 25 lakhs which accounts for 8% of the total population of Kerala (International Organization for Migration, 2013). So the role of public health system in providing cost effective, quality health care to this working population is essential.

2. Interstate migrants, health seeking behaviour and health system response

Interstate migrants are the population who move within the country in search of means of living. According g to the Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act, 1979, inter-State migrant workman means any person who is recruited by or through a contractor in one State under an agreement or other arrangement for employment in an establishment in another State, whether with or without the knowledge of the principal employer in relation to such establishment (Narayana D, Venkiteswaran, Joseph, MP, 2013). Kerala witnessed a surge in the number of domestic migrant workers across primary and secondary sectors of economy. They are constituted an essential; component in each developmental and other projects. Their absence often creates news as the industry is shut for days due to the absence of workers.

The migrant worker travels far for selling his labour power where there is a labour shortage. He/she manage to get a job and remain there until he/she is required (Berger& Mohr, 1989). Departing from the native area and landing in a totally new area places them in vulnerabilities. In the new place, they are disadvantaged in comparison to the native population. They lack social goods, education and health which all impede their integration into the local population (Chatterjee, C.B., 2006). Bustamante (2011) points out that "migrants are inherently vulnerable as subjects of human rights from the time they leave home to initiate their migration (Bustamante, J.A., 2011)." Varennes (2003) states that the population are living in host states where they may not have mastery over the native language, are unfamiliar with the functioning of legal system and administration, disconnected from traditional support and family networks, exposed to a society with new and entirely different ways of life or cultures, the situation can leave them confused and upset (Varennes , 2003). In this powerless situation, they are prone to much vulnerability.

The vulnerabilities related to the health migrants are manifold. Inter-State Migrant Survey in Kerala by CDS-ISMSK reveals how migrant workers are largely isolated from the local community due to language and other cultural barriers (J.W. Mosses & S.I. Rajam, 2012). The recent study initiated by Government of Kerala in 2013 reveal about the status of domestic migrant labour in Kerala. The living conditions of this population is characterized by crowded rooms with poor water supply and sanitation facilities without proper space for cooking, bathing, lack of safety measures at work site, no welfare entitlements etc (Narayana D, Venkiteswaran, Joseph, MP, 2013). Due to restrictions in portability of entitlements, the inter-state migrants are not able to make use of the provisions of from central and state governments they had accessed prior to migration (Kumar,

N.A., 2011). Accessing the provisions of the Rashtriya Swasthya Bhima Yojana (RSBY), government provided health insurance by the migrant population is reportedly zero at Perumbavoor Taluk hospital, Ernakulam, Kerala, where there is a higher concentration of migrant population in its working area (Kumar, N.A., 2011). The limitations to access health care due to language barriers, lack of time, lack of knowledge about the public provisioning of health care etc. exacerbates their vulnerability (Kumar, N.A., 2011). Above all, the absence of strong social support created the psychosocial distress and has an adverse effect on the migrant labourers' mental health (Rogaly B, et al., 2002).

The migrant status itself and the deprivation in terms of the social determinants of health put the interstate migrants in a risky position. The health system response to address the health needs of the migrant population is reportedly late in many locations.in the case of Kerala, the public health system could not foresee and prepare itself to the needs of the migrant population. Its lack of preparedness was revealed when the migrant labourers brought out epidemics which were eliminated once (Akinola, A.B. et al., 2014). As the UN conventions speak of the right of migrants to health, the government system is requisite to provide healthcare starting from the primary health care level. The present cross sectional study has look into the congruence between health needs of migrants and the health system response.

3. Methodology

The researchers has conducted a cross sectional study among interstate migrants in Calicut district. 80 samples were randomly incorporated in the study. All samples were employed in the construction field. The data was collected using questionnaire, interview schedule and focused group discussions. The data collection taken one month duration and they were met during lunch breaks. The data has both quantitatively and qualitatively been analysed and presented here.

Basic profile of the sample

Table No. 1

Sl No.	Items	Categories	%
1	Age wise distribution	18-25	48.75%
		26-35	38.75%
		36-45	12.50%
2	Education wise distribution	Below SSLC	38.75%
		SSLC	28.75%
		Higher Secondary	26.25%
		Degree	6.25%
3	Native State	West Bengal	100%
4	Purpose of stay in Kerala	Employment	100%
5	Period of stay in Kerala	Below six months	13.8%
		six months to one year	21.3%
		One year to five year	48.8%
		Five to ten years	8.8%
		Above 10 years	7.5%

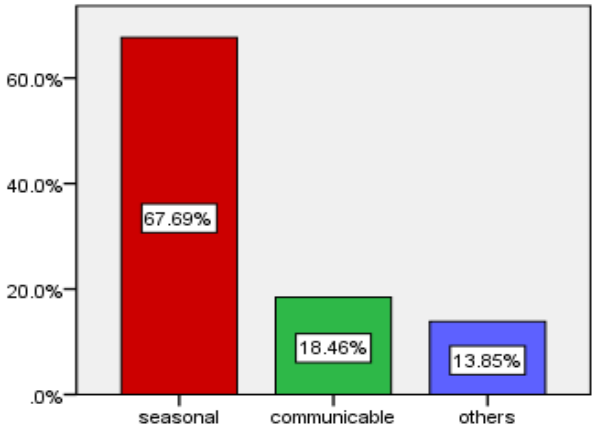
The basic profile of the respondents gives key information that all the samples were from West Bengal (100%) and they are scattered into three age group, in which half of them are youngsters with the age of 18-25 years. The education level also comparable low one third of them did not completed matriculation and another one third is with a qualification of secondary school certificate. The 64% of the sample population is familiar with the state through many years of stay and almost half of the sample population is staying in Kerala for the last one to five years

Figure No. 1

4. Major findings

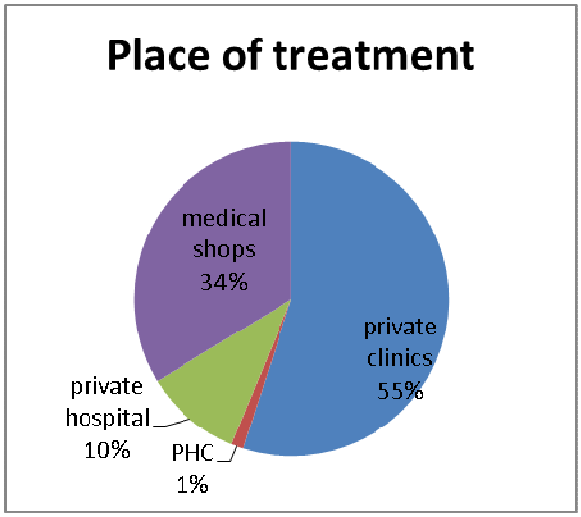
Table No. 2

Any disease/ symptoms of disease for the Past Three Months		
Responds	Frequency	Percentage
Yes	27	33.8
No	16	20.0
some times	37	46.3
Total	80	100.0



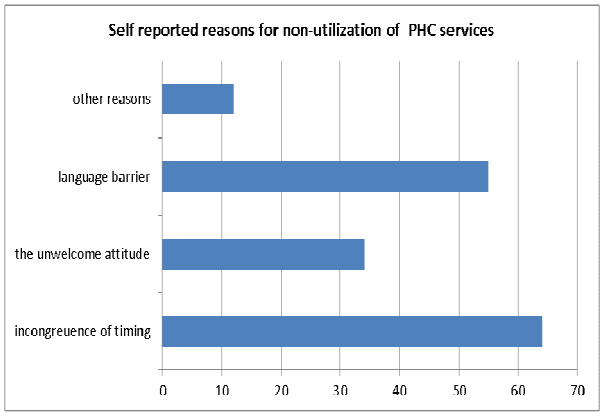
The above table and graph show the disease morbidity of the sample population. About 80% has reported about any incidences of diseases or symptoms of diseases. Those who are laid down with diseases reported that it was seasonal diseases (67.69%). Also they reported the presence of communicable diseases and other diseases. They engaged mainly in wok at construction sites. So their job is invariably associated with more occupational hazards than other jobs. Most of them are living in temporary shacks or sheds near the work site. So the disease-proneness is evident from the self-reported cases.

Figure No. 2



The pie diagram represents the choice made by the sample population for availing the health care services. 55% choose private clinics and 34% for drug store. The status of PHC in their health seeking services remains unimportant. When they are found with any symptoms of diseases, they prefer private clinics or drug stores even though it incurs out of pocket expenditure. Adding to it, the researchers asked questions about the knowledge of the workers about the location of the PHC. Only 63% are aware and out of it, only 1% has made a visit for the treatment. **Figure no.3**

The next level of questions connected to their non-utilization of health care services from the PHC was intrigued and the figure no. 3 reveals the self-reported reasons. The working hours of PHC and the working hours of the migrant labourers are same. At the onset of diseases, these migrants often goes to nearby drug stores to subside the symptoms. So they do not lose a working day and the wage. If they are found with



severe weakness due to illness, they approach clinics because they are been accompanied by fellow workers only before or after the work. So they try to find out clinics which offer services after their working hours. Again, their previous experiences at PHC also avert them and go for other service providers.

The sample population were not aware of the services been provided by the PHC and Gram Panchayat. They reported about an awareness programme which has conducted within last one year. But they do not remember about the contents or the purpose of the meeting. So they are unaware about the situation and dissatisfied on the situation.

An interesting finding is about the health seeking behaviour of these sample population at their native state. It was found that 89% contact PHC as the first point of health care facility in their home state whereas their behaviour is changed in the present living area due to the perceived barriers.

The researchers have visited the PHC and Gram Panchayat regarding the services provided for the health needs of the domestic migrant labourers. The system has got no clear information about the status and the total number of the population within the panchayat. They reported about having conducted health awareness through distributing pamphlets. But the sample population does not remember about such a pamphlet. So it is clear that there is a gap between the health needs of the migrant population and the response of health system and local self-government institution.

5. Discussion

The present study explore into the missing link between the health needs, health seeking behavior of the interstate migrants and system's response to it. Ackernocht (1947) has rightly pointed out disease and its treatment is only in the abstract purely biological process. Actually, such facts as whether a person gets sick at all. What kind of disease he acquires and what kind of treatment he receives depend largely upon social factors (Ackernocht, 1947). There is a deep contradiction exist at the system level towards the health needs of the migrant population. On the one hand there is a significant population (8%) in Kerala who are vulnerable in the arrived land. On the other hand, there is health system which is equipped for catering the needs of the population. But the access and utilization of the services by the vulnerable group is not happening at ground level. There are several reasons which can be attributed to it.

The integration with local culture is the first issue. Learning the language of the new land is essential to integrate with the new culture. As Jonathon W. Moses and S. Irudaya Rajan (2012) mentioned in their study, the migrants are from West Bengal and they have Bengali as their mother tongue and Hindi as the second option for communication in other areas of India. While coming to South India, these languages are not familiar to the local culture. The difficulty associated with Malayalam language also makes the people more isolated. Even though, the Keratites are familiar with colloquial Hindi due to the interaction with migrants, the acceptance of 'Bhai-log' to local culture happen only when they learn Malayalam and converse in it. Thus the migrants are isolated from the community life and its various elements. As health and health care institutions are also a part of these community life, the migrants often end up with drug stores and private clinics rather than looking into the public health care institutions and other social

determinants of health.

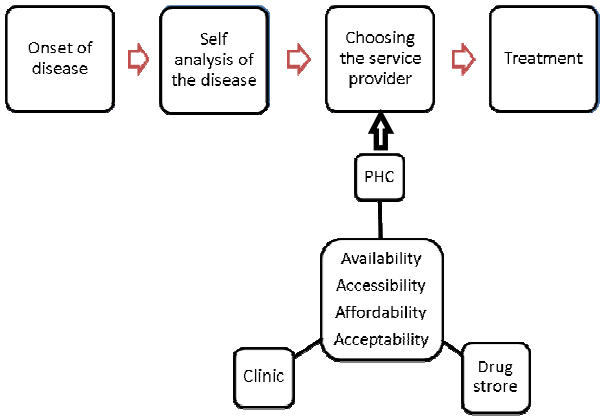
Secondly, the time is another crucial factor. The working hours of outpatient services in PHC are 9.00 am to 1.00 pm and 2.00 pm to 4.00 pm. The sample population work from 8 am to 5 pm in the evening. The system and the client have got same working hours and there is little chance to have their interaction at the health centre. Again Sunday is holiday for both the parties and the chances of getting acquainted are lesser. So the convenience of the labourers favours the private clinics or drug stores. A study in Nigeria also reports that the limited open hours of the primary health centre poses a barrier to the clients whose work nature clashes with the timing of the PHC (Musah K. Toyin & Kayode O.O, 2014).

The health seeking patterns of the migrants are very poor. They preferred the drug store on the onset of symptoms and if it does not work, they go for private clinics which are running in the late evening. A study by Dr. Sreejini J also reports about the prevalence of poor patterns of health seeking behaviour among the migrant population (Sreejini J., 2012). They develop such pattern because do not want to lose their work and wage. They depend on the drug stores on the onset of symptoms of diseases.

Under such conditions, the health system response is pivotal in addressing the health needs and influencing the health seeking behaviour of the migrant population. Without having the knowledge of the factors that influence their health seeking behaviour, no change process can be initiated (D. Maneze et al., 2015). So the absence of a culturally sensitive public health system stands as barrier in catering the health of diverse population. The health care providers at bottom level are not trained to meet the needs of the interstate migrant population in a culturally sensitive way. The migrants, thus, feels the system as unfriendly and do not approach the public health care facilities due to the unwelcoming attitude. Also due to the communication problem, the service provider-client interaction is occurring very little. Empirical evidence (Cooper & Roter. 2003, Saha, S. et al., 2003; Schmid Mast M et al., 2007, Rivers, Desiree Avia, 2007; PL Hutchinson, M. Do, S Agha, 2011) reveals the role of effective provider-client interaction and the resultant change in accessing and utilizing health services. When such an effective interpersonal communication between health worker and client is not happening, the client will search for other service providers.

The situation under the study can be graphically represented as follows:

Figure No.4



Here the client, on the onset of a disease, makes self-analysis about his situation. Based on the

perceived threat, he/she decide to think about accessing a service provider. Here the client makes cost-benefit analysis in terms of availability, accessibility, affordability and acceptability. Along with it, the prior experiences with the service provider also influences the decision making process. Often, the availability of PHC services at the onset of a disease is not occurred because the distance to nearest chemist or clinic is lesser than that of the PHC. Accessing it within the service delivery timing is a difficult for the migrant labourers as it clashes with their working timing. Regarding affordability, the client makes a cost benefit analysis among the severity of disease, the monetary loss due to absence at work, the out of pocket expenditure at chemist shop or private clinic. At the end, they find that utilizing the service of the chemist shop or clinic at their comfortable timing has more benefit than losing a day's job and pay for accessing the PHC services. This decision is unconsciously supported by the other linguistic and cultural barriers.

6. Recommendations

Inclusive planning of health service delivery is necessary to serve the health of migrant workers. Accordingly, the health system has to revamp its service in an inclusive and culturally sensitive way. So the researchers are recommending the following points of action:

- Provide Migrant friendly PHC services, especially in terms of the time schedule of work.
- General or disease specific health and medical camps for the migrants at work site.
- Training the health personnel at Health centres with essential language skills to deal with the migrant population.
- Develop risk register at PHC level for the diseases surveillance among migrant population.
- Collaborative efforts by local self-government bodies and health system to develop measures for the right to health of the migrants.

7. Conclusion

The research study was concentrating on the health needs, health seeking behaviour and the corresponding response from the part of health system. There exist gap in addressing the health needs of the migrants by the local healthcare facilities. The cultural and other barriers avert the behaviour of the population and make them depend on chemists or private clinics. Thus change is essential. It not for saving the out of pocket expenditure alone, but for re-tuning affordable, available, accessible and acceptable public health care for the guest population who significantly contribute to Kerala economy.

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