

Migration: Disease Burden, Health Care Access and Challenges Ahead

Dr. B.V. Babu

Health Systems Research Division
Indian Council of Medical Research
New Delhi



- Migration represents an important livelihood diversification strategy for many in the world's poorest nations
- Internal migration is of considerable importance in several countries including India - developments perspective
- Migrants' health received a considerable recognition during the last few years and is marked by the World Health Assembly (WHA)'s resolution on migrants' health.
- The 61st World Health Assembly acknowledged that the health of migrants is an important public health matter and recognized the need for WHO to consider the health needs of migrants in the framework of the broader agenda on migration and development.
- Emphasized the need for additional data on migrants' health and their access to health care in order to substantiate evidence-based policies (World Health Assembly Resolution 16.17, 2008).



Work-related injuries/illnesses

- Risk of injuries is high
 - Due to nature of work
 - Unhygienic/dangerous working conditions
- Usually employers does not follow safety measures to avoid accidents
- Compulsion of migrants to work in such situations – poverty



Non-communicable diseases

- High prevalence of hypertension (15-25% in Delhi migrants; 18% in Hyderabad migrants)
- Indian Migration Study – BP, lipid and fasting glucose levels are higher among migrant men than rural men.
- Reasons – modernization/acclulturation, livelihood insecurity/stress during adjustment process



HIV and other infections

- Risk of several infectious diseases (like TB, hepatitis, dengue, pneumonia, cholera, etc.), which spreads easily in highly concentrated migrant pockets.
- Risk-prone behaviour
 - HIV, STIs
- Malaria – transmission – effects both populations
- Hygiene related infections
 - Respiratory infections, diarrhoea



Nutritional problems

- Both problems of malnutrition
- Overweight/obesity- 49.6% (males); 56.5% (females)
- However, the migrant people were consuming <50% of recommended dietary allowance (RDA) of many micronutrients.
- Attributable to modernisation



Maternal and child health

- 2 categories of migrant families
 - Migrants live in city by leaving women & children in rural areas
 - Migrants live in the city with families
- Several implications
- Low status of women
 - Doubly disadvantaged
- Vulnerable to violence and abuse
- Lack of accessibility redressal system
- Women who do not migrate at high risk of HIV/STIs
- Children accompanying workplace - expose to risk

Low health care coverage

- Health insurance
 - Only 10.6% of migrants covered by some insurance
 - Mostly at their native place
 - Mostly RSBY, followed by ESI or CGHS
- Availability of Govt. health facilities
 - Some Govt. facilities – 39.6%
 - Unqualified practitioners – 69.5%
 - Qualified practitioners – 26%
- Utilization of govt. facilities – 35%



Healthcare Access and Utilization

- Accessibility and utilization of healthcare services are compromised
 - Lack of familiarity
 - Financial/structural/linguistic barriers
 - Exclusion policies/practices
 - Discriminatory treatment of healthcare staff
 - Lack of migrant- specific plans at facility level and preparedness



Lack of Healthcare Access

- After migrating, people could not cope with the urban system and becoming vulnerable in the new environment.
- Vulnerability - state of being exposed to or susceptibility to neglect or abuse.
- Migrants are disadvantaged compared to the native population regarding health care and other services.
- Poverty and livelihood insecurity is crucial among migrants due to high cost of services and cash dependency in cities.



Lack of primary health care

- The PHC system is not structured and organized in urban areas, unlike rural areas.
- The local urban administration, i.e., municipality is expected to provide both preventive and curative services to the urban population.
- However, the infrastructure and manpower of municipalities are not sufficient to cater to the needs of the growing urban population, particularly the migrant influx.
- Lack of funds and political will are other reasons for insufficient healthcare by urban administration, specifically to migrants.



Examples: Access to primary health care

- Fully immunization by 6 VPDS:
64% in migrants vs. 83% among Delhi children
- Among Bhuba migrants: Accessing:
 - Govt. facility – 19.2%
 - Pvt. Doctor – 72.7%



Areas for improvement (to be explored)

- Migrant sensitive health system
 - Responsiveness of the government towards growing population
 - Specific policy for identifying, notifying and providing basic amenities and welfare services
 - Awareness on migrants' health
 - Health workforce
 - Emphasis on primary health care



Areas for improvement (to be explored)

- Understanding barriers in providing service
 - Cultural and structural barriers
 - Information / linguistic barriers
- Community participation/partnership approach/community-institutional support



ICMR multi-centric interventional study on Migration, poverty and access to healthcare

- **6 metros/big cities:** Bangalore, Delhi, Hyderabad, Kolkata, Lucknow and Mumbai
- **7 smaller cities:** Aligarh, Bhubaneswar, Imphal, Jaipur, Ludhiana, Nasik and Visakhapatnam

Aim:

To develop and test a supportive strategy of healthcare, which would achieve the desired levels of accessibility and delivery of health care services to migrant living in Indian cities.



Focus in Formative Research

- Migrants' healthcare access in the vulnerability context and livelihood insecurity
 - 5 dimensions of Access – Availability, Accessibility, Adequacy, Affordability, Acceptability



Focus in Formative Research

- Health system's responsiveness towards migrants health
 - **Themes:** Autonomy, Communication, Confidentiality, Dignity, Choice, Quality basic amenities, Prompt attention, Access to family and community support
 - Difficulties/bottleneck in delivery services
 - Exploring govt. processes
 - Understanding 'exclusion' process

