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Original Research Article

Mothers on the move: a mixed methods exploration of maternal and child healthcare access among migrant women in Bengaluru

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ABSTRACT

Background: Migrants in India face unique challenges in accessing maternal and child health (MCH) services. This study assessed the usage pattern and determinants of MCH services among migrant women in the Sarjapur PHC area of Bengaluru urban district, Karnataka.

Methods: A mixed-methods study was conducted between December 2023 and June 2024. Quantitative data was collected from 100 eligible migrant women using a semi-structured questionnaire. Adequate utilization was defined based on 8 indicators (ANC visits, IFA adherence, institutional delivery, PNC, immunization, family planning, Anganwadi enrolment, health worker contact); meeting ≥6 criteria was considered adequate. Statistical analysis was performed using chi-square and logistic regression. Qualitative data was gathered through 3 FGDs and 4 key informant interviews and analysed thematically.

Results: 74% of migrant women had adequate MCH utilization. Institutional delivery (90%) and immunization (88%) had the highest uptake, while IFA adherence (64%) and postnatal care (72%) lagged behind. Key predictors of adequate utilization included literacy (AOR 4.10, p=0.012), gainful employment (AOR 2.85, p=0.046), and South Indian origin (AOR 2.76, p=0.032). Qualitative findings highlighted the role of frontline workers, peer influence and familiarity with services as facilitators, while language barriers, time constraints and poor awareness were key barriers.

Conclusions: Despite relatively high overall utilization, migrant women, particularly those from north India, face systemic barriers. Targeted outreach, flexible service delivery and culturally sensitive strategies are needed to improve equity in MCH access.

Keywords: Health care utilization, Maternal-child health services, Migrants

INTRODUCTION

According to the International Organization for Migration (IOM), migration is defined as the movement of persons away from their usual place of residence, either across an international border or within a state, regardless of legal status or underlying reasons.[1] Migration- both internal and international- continues to shape population dynamics and pose significant public health challenges globally. Between 1990 and 2020, the global population increased from 5.3 to 7.8 billion, while the number of migrants rose from 153 million (2.9%) to 281 million (3.6%). Of these, approximately 48% were women and an estimated 36 million were children.[2] Migration is especially prominent in low- and middle- income countries, where individuals move in search of employment, safety or improved living conditions.[3]

India has one of the largest populations of internal migrants in the world. According to the 2011 Census, approximately 450 million individuals or nearly 37% of the population, were internal migrants.[4] More recent estimates suggest that around 400 million people (28.9%) migrate seasonally, often moving from rural to urban areas for work in jobs like construction, domestic labor, and manufacturing industries.[5] Women constitute a

substantial part of this migrant workforce, often employed in informal, low-paying jobs with minimal social protection.[6] Migrant women and children are particularly vulnerable in terms of healthcare access.

In the south Indian state of Karnataka, and particularly in Bengaluru, internal migration has increased substantially in recent years. The city's expanding construction, garment and service industry has attracted large numbers of migrant workers. It is estimated that around 42% of Bengaluru's population consists of migrants, many of whom live in informal settlements or peri-urban areas with inconsistent access to healthcare services.[4,7]

Access to healthcare services is recognized as a universal right and is reinforced by the Sustainable Development Goals (SDG-3), which seeks to ensure healthy lives and wellbeing for all.[8] In alignment, the government of India has adopted Universal Health Coverage as a guiding principle, implementing schemes such as National Health Mission, Ayushman Bharat and Janani Suraksha Yojana to expand affordable and equitable care. These policies aim to address health needs across populations, including vulnerable groups.[9]

Migrant women and children represent a particularly vulnerable population. Maternal and child health (MCH) services are essential, time sensitive and potentially lifesaving interventions, yet their utilization remains inconsistent. Studying these challenges in peri-urban Bengaluru, where rural and urban health systems intersect, can offer valuable insights into how healthcare delivery can be adapted to meet the needs of mobile populations. Therefore, this study was conducted to assess the utilization of maternal and child health services among migrant women in Sarjapur PHC area and to identify the facilitators and barriers influencing access to care.

METHODS

A mixed methods study was conducted from December 2023 to June 2024 in selected villages under the Sarjapur PHC, Bengaluru Urban district, Karnataka. The study population comprised migrant women aged 18-49 years who had been residing at their current address for a minimum duration of 6 months. Eligible participants included those who were either currently pregnant or had at least one child aged 0-5 years. Ethical approval for the study was obtained from the Institutional Ethics Committee.

Quantitative component

Sample size

The sample size was calculated using the formula:

$n=z^2pq/d^2 = 1.96\times1.96\times50\times50/10\times10=97$, rounded to 100

Assuming 50% prevalence for maximum variability, a 95% confidence interval, and 10% absolute prevalence, the final sample size was taken to be 100 participants.

The study used a convenience sampling method, and data was collected through face-to-face interviews using a pretested semi structured questionnaire. The questionnaire was designed to capture key components of MCH service utilization. A composite variable was created to assess adequate MCH utilization based on eight core indicators drawn from the National Family Health Survey-5 (NFHS-5) and the Government of India's RMNCHA+N strategy.[10,11]

These indicators included: four or more antenatal care visits, iron and folic acid (IFA) consumption for at least 100 days during pregnancy, institutional delivery, postnatal checkup within 2-7 days of delivery, child fully immunized for age, current use of any family planning method, enrollment of children in Anganwadi centers and at least one home visit by a frontline health worker such as ASHA or ANM. Participants fulfilling at least 6 out of the 8 criteria were classified as having adequate utilization of MCH services. Data was analyzed using Jamovi software. Descriptive statistics such as means and percentages were calculated, and associations between variables were tested using the Chi-square test, with p values <0.05 considered significant.

Qualitative component

The qualitative component of the study involved three focus group discussions (FGD) with a total of 28 migrant women and four key informant interviews (KII) with frontline health workers, including ASHA worker, ANM, Anganwadi worker, and the medical officer at the primary health centre. A predesigned topic guide, translated to local languages was used. The guide included open-ended questions exploring participants' understanding and experiences of maternal and child health services, such as awareness and knowledge of MCH services available in the area, perceived barriers to access, quality and acceptability of care and enabling factors. Questions for key informants focused on their perspectives and challenges in delivering services to these migrant populations. Data collection continued till thematic saturation was achieved. All qualitative data was translated into English, manually coded and analyzed thematically. Emerging themes and subthemes were examined to explore the perceptions, barriers and facilitators influencing MCH service utilization among migrant women.

RESULTS

Quantitative findings

The study included 100 migrant women residing in the Sarjapur PHC area, Bengaluru urban district. The mean age of participants was 24.8±3.6 years, and the majority

were Hindu (91%). The average duration of residence in the area was 2.4±1.6 years. Educational attainment was low, with 42% reporting no formal schooling and an additional 13% having less than primary level education. Most participants were from lower socioeconomic strata, with 37% categorized as lower middle class and 28% as lower class according to the modified BG Prasad classification. The most common occupations included daily wage labor (46%) and domestic work (34%). Most husbands were employed as construction laborers in nearby areas, and 74% had educational attainment only up to the primary school level.

Table 1: Association between sociodemographic factors and maternal and child health (MCH) service utilization among migrant women (n=100).

Variables	Category	Adequate MCH utilization (%)	Inadequate MCH utilization (%)	Chi square value	P value
Religion	Hindu	72 (79.1)	19 (20.9)	0.74	0.38
	Muslim	6 (66.7)	3 (33.3)		
Education	Illiterate	33 (68.8)	15 (31.2)	9.0006	0.0026*
	Literate	48 (92.3)	4 (7.7)		
Socioeconomic status	Middle class	31 (88.6)	4 (11.4)	2.78	0.24
	Lower middle class	27 (73.0)	10 (27.0)		
	Lower class	22 (78.6)	6 (21.4)		
Occupation	Gainfully employed	74 (90.2)	8 (9.8)	4.23	0.0395*
	Not employed	13 (72.2)	5 (27.8)		
Type of family	Nuclear	71 (92.2)	6 (7.8)	1.81	0.17
	Non-nuclear	19 (82.6)	4 (17.4)		
Parity	1-2 children	63 (87.5)	9 (12.5)	7.05	0.0078*
	≥3 children	18 (64.3)	10 (35.7)		
Duration of migration	<2 years	42 (76.4)	13 (23.6)	1.70	0.19
	≥2 years	39 (86.7)	6 (13.3)		
Place of origin	North India	53 (81.5)	12 (18.5)	4.89	0.0268*
	South India	34 (97.1)	1 (2.9)		

Chi square test was used to assess association between independent variables and MCH service utilization. p <0.05 was considered statistically significant. Percentages are row wise and indicate the proportion of women with adequate or inadequate MCH utilization within each category. *Statistically significant at p<0.05.

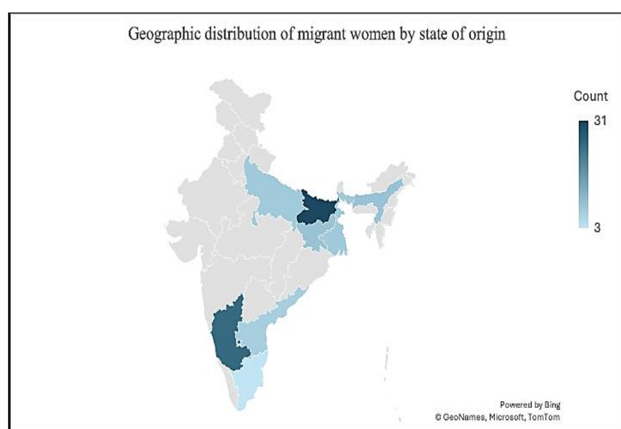

Figure 1: State wise distribution of migrant women (n=100).

In terms of region of origin, 65% of participants had migrated from North and Eastern Indian states such as Uttar Pradesh, Bihar, Jharkhand, West Bengal, Odisha and Assam. The remaining 35% were from other parts of South India, including other parts of Karnataka, Andhra Pradesh, Telangana and Tamil Nadu. Languages spoken at home reflected this diversity, with participants speaking Hindi, Bengali, Odia, Kannada, Telugu and Tamil (Figure 1).

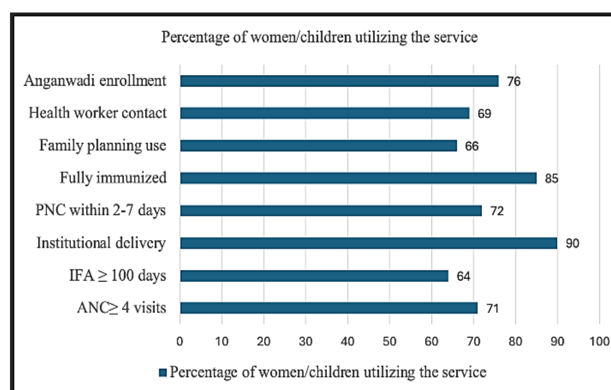

Figure 2: Self reported utilization of MCH services among the participants (n=100).

Among the women, nine were currently pregnant, and six had delivered in the past 1 year. Of these, only three women had delivered in the Sarjapur PHC area, indicating that many still preferred going to their native areas for childbirth. All women with recent pregnancies

possessed a Mother and Child Tracking System (MCTS) card or Thaayi card (Mother and Child Protection Card). Among under-five children, 26 had no immunization card or written record. All participants had Aadhar card, but none possessed a ration card.

Utilization of maternal and child services was assessed using a composite scoring method, and 74% adequate utilisation were classified as having adequate utilization. Figure 2 presents the self-reported utilization of MCH services, showing the highest uptake for institutional delivery and relatively lower coverage for IFA consumption and contact with health workers.

Chi-square analysis revealed statistically significant associations between education (p=0.0026), occupation (p=0.0395), parity (p=0.00078), and place of origin (p=0.0268) with MCH service utilization (Table 1). Literate women were significantly more likely to have adequate utilization (90.2%) as compared to illiterate women (68.8%). Similarly, those who were gainfully employed had higher service utilization (90.2%) than unemployed women (72.2%). Women with lower parity (1-2 children) had better utilization (87.5%) compared to those with 3 or more children (64.3%). Women from South India had better women from south india had better SERVICE utilization (97.1%) compared to their north Indian counterparts (81.5%).

A multivariate logistic regression model (Table 2) identified literacy (AOR- 4.10, p=0.012), gainful employment (AOR- 2.85, p=0.046) and South Indian origin (AOR- 2.76, p=0.032) as independent predictors of adequate utilization. Duration of migration, family type and socioeconomic status were not significant in the adjusted model.

Table 2: Predictors of adequate maternal and child health service utilization among the study population (n=100).

Variables	Category (reference)	AOR (95% CI)	P value
Education	Literate versus illiterate	4.10 (1.36-12.37)	0.012*
Occupation	Gainfully employed versus not employed	2.85 (1.02-7.92)	0.046*
Parity	1-2 children versus ≥3	3.52 (0.98-10.45)	0.243
Place of origin	South India versus North	2.76 (1.09-6.98)	0.032*
Duration of migration	≥2 years versus <2 years	1.92 (0.77-4.77)	0.158
Type of family	Nuclear versus other types	1.63 (0.52-5.15)	0.402
Socioeconomic status	Middle class versus lower SES	1.94 (0.68-5.49)	0.217

AOR- Adjusted odds ratio, CI- confidence interval. P<0.05 was considered statistically significant. *Statistically significant at p<0.05.

Qualitative findings

Thematic analysis of interviews revealed key facilitators and barriers influencing the utilization of MCH services among migrant women (Figure 3).

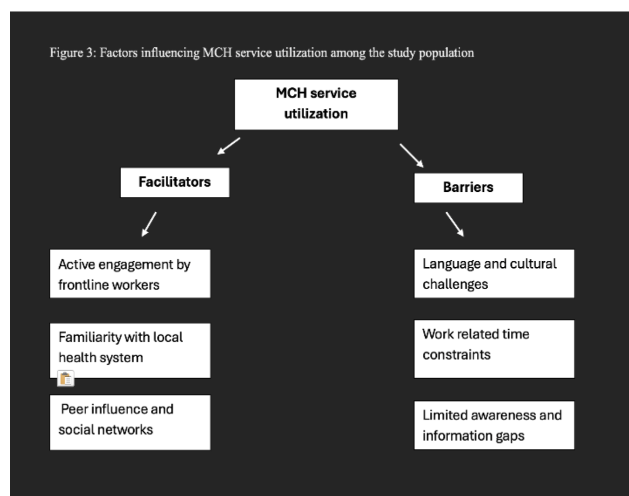

Figure 3: Factors influencing MCH service utilization among the study population.

Facilitators

Active engagement by frontline health workers

Many participants emphasized the role of ASHAs and Anganwadi workers in raising awareness and guiding them through available services. These workers were often the first point of contact for newly migrated families.

"*The Anganwadi Didi explained to us about the importance of it… Take home rations are also given."*– Migrant woman from DT Sandra village.

Familiarity with health services

Women reported that over time, as they become more familiar with the functioning of the local health system- including service days and locations- they felt more confident in accessing these services regularly. Migrant women from South India were generally more familiar with the language and healthcare systems. several of them acted as informal mediators and helped others navigate the services and communicate with health workers.

"Initially the women are unsure, but once they know the immunization days and the staff, they start coming regularly, without needing reminders." -ANM from Sarjapur

Peer encouragement and shared experiences

Word of mouth and positive testimonials from neighbors or relatives helped overcome the initial hesitation about public health services. Several participants were influenced by others' experiences of respectful care.

"My neighbour- she said the staff were kind and helpful. That's why I feel more comfortable going there for my children" - Migrant woman from Mugaluru village

"When I first missed my monthly (period), I did not know what to do, which doctor is good. Then she (my neighbor) introduced me to ASHA- who gave me a pregnancy kit and asked me to come on Thursday for checkup." - Migrant woman from Thindlu village

Barriers

Language and cultural barriers

Communication difficulties due to unfamiliarity with Kannada were frequently cited by both migrant women and health workers.in many cases, women struggled to understand health information or instructions at facilities. This often necessitated the involvement of a third person- usually a neighbor or family member- to interpret, which sometimes led to delays or missed services. Interestingly, children were often quicker to pick up the local language and were occasionally relied upon to translate basic information.

"Have to always find someone else who speaks their language to tell them vaccination dates." -ASHA from Mugaluru village

Time constraints and long waiting hours

Women working as daily wage earners and housemaids expressed frustration about the long waiting times at public facilities, which often resulted in a full day's loss of income. As a result, some preferred to delay or altogether avoid seeking care unless absolutely necessary.

"The waiting time at government hospital is too long, we can't return to work after checkup" -Migrant woman from Thindlu village

Limited understanding of entitlements and services

Several participants, particularly those with limited formal education or recent migrants, lacked awareness about the range of maternal and child services they were entitled to- such as the number of ANC visits recommended, availability of postnatal care or free nutritional supplements.

"We didn't know we had to go for checkups even if there were no problems." -Pregnant woman from Marangere village

DISCUSSION

The findings of this study indicate that while a substantial proportion (74%) of migrant women utilized MCH services adequately, notable disparities persist. These were primarily influenced by key sociodemographic factors such as maternal education, employment status and region of origin. A detailed comparison with NFHS estimates from Karnataka highlights important service delivery gaps. These migrant women, despite living in peri-urban areas with relatively good health infrastructure, continue to face barriers that limit their access to timely and comprehensive care, suggesting that systemic and contextual factors- rather than mere availability- play a pivotal role in the utilization pattern of services.

Institutional delivery (90%) and child immunization were the most widely accessed services, reflecting strong public health infrastructure in the area and in alignment with NFHS-5 Karnataka data, which reports institutional delivery coverage at 96.2% and full immunization at 86.5% for children aged 12-23 months.[12] However, other components showed lower utilization: IFA adherence was 64% (versus 40.9% in NFHS-5 Karnataka) and only 72% of the migrant women received post-natal care within two days (versus 87.4%).[13] Family planning usage (66%) was slightly below state average (68%), while ANC coverage was comparable (70%).[12]

Anganwadi enrolment among migrant children (76%) was slightly lower than Karnataka's average (80%).[12] Qualitative findings suggested that frontline workers played a key role in encouraging uptake of services like take-home rations and pre-school education, indicating strong community engagement.

From an equity perspective, the fact that 22% of migrant women did not achieve adequate MCH utilization points to a gap in the service delivery. Similar findings have been observed by Gawde et al. who reported lower uptake of ANC and institutional deliveries among internal migrants in Mumbai, largely due to systemic and contextual constraints.[13] Importantly, this gap appears to stem not from availability of services but more from barriers in accessibility, awareness and culture appropriateness. Devasenapathy et al and Rautela et al similarly found that mobility, lack of formal documentation, and exclusion from local beneficiary lists contributed to inequities in maternal health service use among migrants.[14,15]

In our study, literate women were significantly more likely to use MCH services, echoing national findings from Johri et al., who noted that maternal health literacy strongly correlates with child immunization status.[16]

Employment status presented a more complex picture. Quantitatively, gainfully employed women were more likely to use MCH services adequately. However, qualitative data showed that long waiting times and fear of lost wages often caused daily wage earners and domestic workers to skip or delay visits, resulting in apparent contradiction. This emphasizes the concept of 'time poverty' where employed women, although economically empowered, struggle to balance work responsibilities with service access.[17] Studies from urban slums in Mumbai and Delhi have similarly reported that women in informal jobs tend to prioritize income over preventive care, especially when services are time-intensive.[17,18]

Place of origin emerged as another critical determinant: women from north India had lower MCH utilization than South Indian migrants, likely due to language barriers and limited social support. Similar disparities have been described by Kusuma et al and Siddaiah et al, who documented how limited access to healthcare services, along with socio-cultural factors and low awareness, affects the utilization of maternal health services among migrant women.[19-21]

The qualitative component of this study underscored the pivotal role of frontline health workers. ASHAs and Anganwadi staff were frequently described as approachable, informative and supportive, serving as essential links between migrant women and the formal health system. Peer networks also played a key role with word-of-mouth testimonials encouraging hesitant users to engage with public services. These findings are also highlighted in a WHO- supported article by Cornetto et al, which emphasizes that strong policy and system support for community health worker programmes significantly improves maternal and child health outcomes, especially in underserved populations.[22]

International literature supports these findings. For example, Doocy et al in Jordan and Mishori et al in the United States of America, have shown that tailored, inclusive models are necessary for improving health access among migrant groups.[23,24] In the Indian context, studies by Borhade and Dasgupta further emphasize that despite national programmes, migrants face denial of access due to systemic exclusion, poor awareness and lack of portability of benefits.[25,26]

There are several important policy implications based on these findings. First, national health programs must be inclusive of migrants and the unique challenges they face in accessing healthcare. Second, practical service delivery strategies such as extended working hours, weekend clinics, fast track queues and multilingual counselling can reduce barriers and enhance accessibility for working women and linguistically diverse groups. Finally, using national digital health platforms like Ayushman Bharat and the ABHA (Ayushman Bharat Health Account) system can support continuity of care by enabling portable health records, especially beneficial for mobile populations.[27]

Future research must focus on scalable innovations for improving MCH access among migrant families and on monitoring integration across the health system. Policy frameworks must recognize that integration, and not just infrastructure is essential to achieving equitable health outcomes for migrant communities.

Strengths of the study include its mixed-methods approach, engagement with a hard-to-reach migrant population, and strong community cooperation. Limitations include limited generalizability due to the single-site design and potential recall bias in self-reported data.

CONCLUSION

This mixed-methods study found that 74% of migrant women in the Sarjapur PHC area of Bengaluru accessed maternal and child health (MCH) services adequately. Utilization was highest for institutional delivery and immunization, while gaps persisted in IFA adherence, family planning, and postnatal care. Education, employment status, and place of origin were significantly associated with utilization. Migrants from north India and Nepal had lower odds of adequate use, likely due to language barriers, unfamiliarity with the health system, and weaker community ties. Qualitative findings highlighted the positive role of frontline workers and peer networks, alongside barriers like long waiting times and poor service awareness.

To improve equity in MCH access among migrant women, we recommend targeted multilingual outreach, flexible service hours for working women, and culturally sensitive care. Recognizing migrants as a priority group in urban health planning, while leveraging frontline worker support and peer networks, will be essential to closing the existing service utilization gap.

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