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A cross sectional study on health seeking behavior of migrant workers: Bangalore city

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ABSTRACT

Background: Global migrant population is 214 million people, which accounts for approximately 3% of world population. As per 2001 census 307.2 million people, which is 30% population in India were migrants as reported by place of birth, of which 42.1 million were interstate migrants in India. Migrant populations as being a non-native population, are vulnerable and are exposed to many health problems. Most of the health problems of migrants are ascribed to their migration to urban areas, decreased awareness about local health facility, inability to cope with psychological stress, unhealthy sexual practices, and frequent travelling. The objective of the study was to assess the health seeking behavior of the migrant worker in Bengaluru.

Methods: This is a cross sectional, exploratory and community based study. The study was conducted in the field practice area of department of Community Medicine of Dr. B. R. Ambedkar Medical College and Hospital, Bengaluru. Total study subjects were 295 were selected by convenient sampling method. The study was conducted between May 2017 to June 2017. Data regarding health seeking behaviour was collected using semi structured questionnaire.

Results: Migrants were from different states of our country. 25.7% were from other districts of Karnataka, 58.3% of them belonged to high risk occupation and 41.7% to low risk. Around 85% of the migrants discussed their health problem, 59% of them preferred home remedy as a first priority for their illness & 41% preferred private hospitals for major illness. Around 52.9% of study subjects waited for more than 3days before seeking health care.

Conclusions: The health seeking behaviour was poor and delay in seeking healthcare during their illness.

Keywords: Health seeking behaviour, Migrants

INTRODUCTION

Migration is an integral part of population dynamics. International Organization for Migration [IOM], has defined migration as a process of moving, either across an international border, or within a state. Human development report on human mobility and development estimates the total global migrant population at 214 million people, which accounts for approximately 3% of world population.¹

As per 2001 census 307.2 million people or about 30% of the 1028.6 million populations in India were migrants as reported by place of birth, of which 42.1 million were interstate migrants in India. Migration rate in urban area per 1000 households in India is 33. Among many reasons of migration 2/3rd of migrants migrate from one place for another for employment. 21% of migration is for studies. Other reasons for migration of households include forced migration (natural disaster, social/political problem, and displacement by development projects), acquisition of

own flat/house, housing problems, health care postretirement, marriage etc.²⁻⁴

Migrant populations as being a non-native population, are vulnerable and are exposed to many health problems. Most of the health problems of migrants are ascribed to their migration to urban areas, decreased awareness about local health facility, inability to cope with psychological stress, unhealthy sexual practices, and frequent travelling. Other factors are: food insecurity, climate, and other environmental hazards.⁵

Bengaluru, which is considered unique among the Indian cities, has its own history of migration with the dimensions of outward, inward and return migration. There is a higher influx of labor migration to Bengaluru city is seen in last 10-15 years, as there is increase of activities in the infrastructure and construction sectors. People migrate to have more opportunities in life but when the poorest migrate, in the context of limited resources and choices they often face conditions of vulnerability to high risk on health and life. Migrant labourers have limited protection on health, safety, security and face problems of availing it. The study was undertaken to assess health seeking behaviour of the migrant workers in the field practice area of Dr. B. R. Ambedkar Medical College.

METHODS

This is a cross sectional, exploratory and community based study. The study was conducted in the field practice area of Department of Community Medicine of Dr. B. R. Ambedkar Medical College and Hospital, Bengaluru. Total study subjects in the present study are 295 and subjects were selected by convenient sampling method. Study was initiated after obtaining approval from institutional ethics committee. The study was conducted between 25th May 2017 to 15th June 2017. The subjects interviewed were from various occupations like labourers, factory workers, painters, drivers, sellers & vendors, carpenters, plumbers and electricians etc. Data collected using pretested semi structured was questionnaire after explaining them the importance of the study. They were interviewed at their work place and some of them at their shelter/residence. The study subjects were interviewed at their work place between 10 AM to 1 PM and between 4 PM to 6 PM at their residence.

For analysis purpose we have classified the occupations into high risk and low risk.

High risk: Threat to life or disability. It includes labourers, factory workers, painters, drivers, electricians.

Low risk: Threat to health status. It includes sellers and vendors, carpenters, plumbers.

Data was analyzed using frequencies, percentages and chi square test using SPSS 18.0 version.

RESULTS

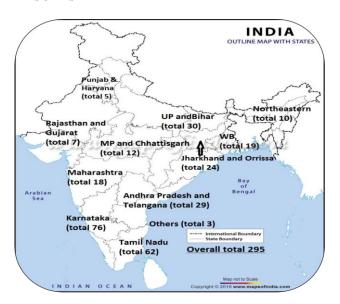


Figure 1: Distribution of the study subjects based on the states from which they have migrated.

Figure 1 shows the pattern of migrants to Bangalore urban area. Out of 295 migrants, 25.8% (76) were from other districts of Karnataka and 74.2% (219) were from outside Karnataka.

Table 1 shows majority of study subjects were in the age group of 15-35 years accounting for` 80.9% and the proportion was same in males and females. Among 295 study subjects 88.8% had schooling. Around 62.7% (168) of the total study subjects were staying in the rented houses and 34.2% in the working compounds or sheds. Around 16.9% were staying with their blood relatives (including spouses) and 78.3% were living alone at the place of migration. Migrants who were staying with blood relatives were more among females compared to males. Out of 295 study subjects 25.1% were having the BPL cards which are only functional in their respective states.

Table 2 shows 58.3% of the total study subjects were engaged in high risk work and they were more among males (61.8%) compared to females (38.6%). Among the total study subjects 84.1% were living at migrated place from more than one year and 68.1% of them were working for 7-10 hours per day. Out of 295 study subjects 74.2% had 4 to 6 days of rest per month. There was significant association in type of occupation, duration of migration, working hours per day among males and females but there was no significant association between males and females in terms of rest days per month.

Table 1: Socio demographic characteristics of study subjects.

Socio demographic characteristics		Male, N (N=251) (%)	Female, N (N=44) (%)	Total N (N=295) (%)
Age group in years	15-25	78(31)	16(36.3)	94(31.8)
	26-35	128(50.9)	17(38.6)	145(49.1)
	36-45	27(10.7)	7(16)	34(11.5)
	46-60	18(7.4)	4(9.1)	22(7.4)
Schooling	No Schooling	20(7.9)	13(29.5)	33(11.1)
	Schooling	231(92.1)	31(70.5)	262(88.9)
Place of Residence	Own house	8(3.2)	1(2.3)	9(3.1)
	Rented house	155(61.8)	13(68.2)	168(62.7)
	Working compound	88(35)	13(29.5)	101(34.2)
Roommates at place of residence	Blood relatives	21(8.3)	29(65.9)	50(16.9)
	Friends	9(3.6)	5(11.4)	14(4.8)
	Others	221(88.1)	10(22.7)	231(78.3)
BPL card possession	Yes	59(23.5)	15(34.1)	74(25.1)
	No	192(76.5)	29(65.9)	221(74.9)

Numbers in parenthesis indicates percentage.

Table 2: Distribution of the study subjects based on occupation, duration of migration, working hours and rest days/month.

Occupational characteristics		Male, N (N=251) (%)	Female, N (N=44) (%)	Total N (N=295) (%)
Type of occupation	High risk	155 (61.8)	17 (38.6)	172 (58.3)
	Low risk	96 (38.3)	27 (61.4)	123 (41.7)
Duration of migration	<1 year	31 (12.4)	16 (36.4)	47 (15.9)
	>1 year	220 (87.7)	28 (63.6)	248 (84.1)
Working hours	< 6 hours	5 (2.0)	8 (18.2)	13 (5.2)
	7- 10 hours	171 (68.1)	30 (68.2)	201 (68.1)
	>10 hours	75 (29.9)	6 (13.6)	81 (27.8)
Rest days per month	1-3	66 (26.3)	9 (20.5)	75 (25.8)
	4-8	185 (73.7)	35 (79.6)	220 (74.2)

Numbers in parenthesis indicates percentage.

Private health u of ■ Female (N=44) Govt. ■ Male (N=251) Over the counter drugs nedicatic No (self Yes Delay in days before > 3 treatment 1 to 3 18.2 < 1 Practice of home remedy illness No for 77.3 Yes problem No n of health 17.1 93.2 Yes 82.9 0 20 40 60 80 100 Percentages (%)

Figure 2: Distribution of study subjects based on health seeking behaviour.

Characteristics of Preference of health facility Home remedy P value P value occupation Govt (%) Private (%) Yes (%) No (%) High risk 109 (57.7) 62 (59.0) 86 (49.7) 85 (70.2) Type of 0.81 0.00 occupation 80 (42.3) 43 (41.0) 87 (50.3) 36 (29.8) Low risk 1 to 3 52 (62.7) 62 (63.3) 11 (28.9) 21(39.6) Rest days per 0.00 0.00 32 (60.4) month 4 to 8 27 (71.1) 32 (39.6) 36 (36.7) <6 12 (6.3) 1 (0.9) 8 (4.6) 5 (4.1) Work hours per day 7 to 10 137 (72.5) 64 (60.4) 0.00 118 (67.8) 83 (68.6) 0.97 > 1040 (21.2) 41 (38.7) 48 (27.6) 33 (27.3)

Table 3: Factors effecting health seeking behaviour of migrant workers.

Numbers in parenthesis indicates percentage.

Figure 2 shows around 84.4% of study subjects discussed their health problems with others and it was almost equal among both sexes. More than 50% of the study subjects practised home remedy for their illness. Around 81% of them delayed seeking health care for their illness by 1 to 3 days whereas very few (9.5%) received health care within one day. Among 295 study subjects 57.3% (169) practiced self medication for their illness and it was more among females (65.8%) compared to males (55.8%).

Table 3 shows occupational characteristics affecting health seeking behaviour of study subjects. There was no significant association between type of occupation with preference of health facility and working hours per day with use of home remedy for their illness (p>0.05). There was significant association between rest days per month, work hours per day with preference of health facility and also between type of occupation, rest days per month with use of home remedy for illness (p<0.05).

DISCUSSION

In our study male study subjects were more (85%) compared to females which was similar in other study by Mitra et al.⁶ A study by Rajesh et al among rural agricultural migrants had 55.7% males and 44.3% females. Around 54% preferred health care facility for their illness (48% government and 28% private hospital).⁷

In a technical report by European centre for disease prevention and control about 87.6 percent of migrants were working in high risk occupation and in our study 58.3% were working in high risk occupation and males were more compared to females in such occupation. In our study half of the study subjects depended on home remedies for their illness and it was 77.3% and 55.8% among males and females respectively. More than 50% of migrants depended on government services for their illness and over the counter drugs. There was no much difference between males and females. In a study by Surabhi et al 28.6% and 22.3% of study subjects were dependent on over the counter drugs and government hospital respectively for their illness which is different to the observational in our study.

A study on Tamil Migrants in Kochi, the health seeking behaviour varies from seeking health care from private hospitals to medical shops to government hospitals to not taking any treatment. Linguistic difficulties and temporary nature of stay also affected the health seeking behaviour. Drug stores/on the counter drugs were identified as main source of health care outside home for majority of migrants. The important factor determining the choices of health care are the belief and perceptions of illness causation. A study by Saikia in Kerala found poor patterns of health care seeking; and the main reason for poor health seeking behaviour was lower socio economic status.

Noncompliance to treatment, non utilisation of preventive services, poor access to health services, social, personal, economic, cultural, political and experimental factors were found to be the reasons for poor health seeking behaviour. ¹²⁻¹⁴ In other study language barriers, lack of time and lack of knowledge about the healthcare by govt. etc were some of the reasons for poor health seeking behaviour. ¹⁵ A study by Sreejini around 28.6% preferred over the counter drugs for their illness, 47.1% and 22.3% preferred government and private hospital respectively. Socio economic status and duration of migration had an impact on their health seeking behaviour. ¹⁶

In our study, study subjects utilized govt. services more than private services that rules out the possibility of poor health seeking behaviour due to of lack of knowledge of available services. Most of the migrants preferred on the counter drugs and home remedy as their first choice, this could be due to their working hours and accessibility to their services from their work place, due to their perception about health care or their affordability etc.

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Institutional Ethics Committee

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