# **Case Report**

DOI: 10.5455/2394-6040.ijcmph20150214

# Public health activism: success story of overcoming barriers to health care faced by a migrant family

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**Received:** 22 November 2014 **Accepted:** 10 January 2015

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## **ABSTRACT**

This is a case study from a village in Haryana. A migrant family from another state was working in poultry farm. Family had six children. Youngest was girl infant with grade IV malnutrition and unimmunised. This family was denied immunisation, registration to Anganwari centre, and there were issues of child labour. With public health activism, all these problems were solved. This case study demonstrates that if there is strong commitment and confidence among public health practitioners, they can overcome most of the barriers. Such Public Health Activism should be promoted.

**Keywords:** Migrant, ICDS, Child health, Malnutrition, Immunisation, Child labour, Public health, Clinico psychosocial case

# INTRODUCTION

As per millennium development goals, international community is committed to reduce malnutrition, eradicate extreme hunger and poverty, achieve universal primary education and improve maternal and child health. Equitable distribution and easy access of health services is of core importance to fulfill the commitments. It determines health-related behaviour and decision-making and further wellbeing of the families. Various behaviour change theories also emphasize that many factors influence the health behviour. However, none of these theories inform us that how to activate all these conditions and influence the health seeking behavior of a family.

We report the case study, where public health activism was used to break all the barriers and inculcate positive change not only in the behaviour of the family but also of the health service provider and the employer of the family in question.

# **CASE REPORT**

# Study area

The department of authors runs weekly half day clinic in a village of North Haryana. It has catchment population of about 5000, a quarter of which belong to the lower socioeconomic group. Among them significant numbers of migrant people are working in the poultry farms in and around the village. Resident doctors of community medicine who are undertaking the postgraduate course in community medicine runs the clinic on rotational basis, under the supervision of a senior resident (who is already postgraduate in community medicine) and a faculty member. The case in question was taken up by the junior

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resident as family case and was presented as 'clinicopsychosocial case' at departmental academic forum.

## The case: trigger point for initiating investigation

A case of severe malnutrition was brought to our notice in the first week of July 2014 when a lady, who was mother of six children including an infant, came to the OPD to enquire whether they were eligible for treatment; as they are migratory population? We were awestruck by the fact that someone is doubtful about the fundamental rights to get treatment, even so many years after independence! We decided that we would visit the family to obtain further details

#### The family visit

Next day, along with the health worker, one of the authors (SB), visited the residence of the lady. As she was residing in the quarters given by the poultry farm owners, initially the manager of the poultry farm was hesitant and did not allow us to visit the house. However, lady and her other children came along with their mother to us.

# The housing

We realized that the locality had a cluster of people belonging to the same caste. There were closely packed quarters with very little free space and litter was found in front of the houses. Her house was pucca, 8 feet by 6 feet. The quarters had a common water supply and a common sanitary latrine (though they were not using due to cultural practices). There was obvious overcrowding where 8 members were sharing a room with no lighting and ventilation. They were using wood for cooking inside the house and a suffocative smell of smoke was coming from the room.

#### Child labour

Entire family including children, was working as egg collector in that farm. On asking about child labour, firstly the farm manager denied that there is any child labour in practice. After taking him into confidence he told child labour is cheap. Children are given Rs. 100 per day per child, whereas adults demand Rs. 200 per day. And for their small size, children can easily enter the cages and easily collect the eggs. Children also do extra duties without any overtime.

The manager told that if he send them to Anganwadi, then who will work for them? Asking about crèche in the farm, he told he has no idea about that. Regarding poor housing conditions he replied that he cannot do more because it is his masters concern; he is doing only master's job. Though sanitary latrine was there but all workers of Uttar Pradesh (U.P.) prefer open defecation practices.

#### The case

Initially, the well-being of both the mother and the youngest child was enquired.

Physical examination of the infant revealed that the 1-year-old child weighed 5 kg and was doing well, though she was very hungry. She was only taking milk (cow and breast milk). She had Grade IV malnutrition and was unimmunized. The child was born in Lutpura village, Etawa, U.P. and it was a case of home delivery. They had come here six months back.

# Barriers to health care seeking

We asked, why she had not attended OPD; her husband replied that they did not have the time to go to the OPD, as eggs are loaded (in the trucks) in the morning, and in the evening the OPD used to close. They are daily labour. If they become absent, then they will lose the daily wages. When asked about the low weight of the child, she smiled and told that all other siblings were like this child and after some time they all become normal.

Though, initially they had visited Anganwadi centre of village, but they got disappointed with the behavior of the staff. Routine immunization was not given and they were asked to bring the documents of U.P. to get any service. Even enrollment of the other under five children was not done.

#### **Contraception**

Regarding multiparity, the husband replied that they have only one male child out of 6 and one got aborted. For poverty alleviation male child is necessary in a family. Regarding vasectomy he replied that he will lose his potency if he gets operated. For his wife, he told that who will take care of their 6 children during the period of operation.

#### The intervention

Nutrition: One of the author (SB) gave dietary advice to her and personally purchased some food for the malnourished child as an emergency measure, and followed up on weekly basis. The father was told regarding enrollment of the child in the Anganwadi and other members of the community were also told regarding availability of health services and Anganwadi services.

Immunization: During the OPD session the mother met us again and told that health workers are not ready for immunization of the child due to malnutrition. First author (SB) personally met the anganwadi worker to understand the reasons for the same. It was observed that AWW (who is partly paid voluntary worker essential acting as coordinator and is responsible for food and nutrition and preschool education of the children 0-6

years of age) and ANM (who is the health worker of the area with technical skills to give vaccines), were apprehensive that if any problem occurs to that child, who will take the responsibility. After long debate it was finalized that the author (SB), will give the first vaccine and if any emergency occurs he will do the necessary referral and follow up in the PGI, which is a tertiary care institute. On the scheduled date the child was vaccinated successfully and no problem was there.

Anganwadi enrolment: The Anganwadi worker was reluctant to register the eight children of that farm because they have no identification card. After further questioning they told that if they enter this child in their record, higher officials will scold them. Regarding other children they told that it is very difficult for them to maintain the register as they are migratory population. After active involvement by the author (SB), at last, eight children were enrolled. Now they are getting food as well as primary education.

#### Outcomes

- 1. Follow up of the child showed that child has now gained weight. Now she is in grade 2 (previously grade 4). She is now immunized up to date.
- 2. After this practical experience, the health workers are now confident enough to give vaccine to malnourished children.
- Higher officials convinced the Anganwadi workers, that they will not ask any question or give negative marks to them for reporting any malnourished/high risk cases.
- 4. The children of this family are no more child labour, because they are getting food from Anganwadi.
- 5. The family was convinced for family planning and checkup has been done for haemoglobin.
- 6. Manager promised us regarding improvement in sanitation and no more appointment of child labour.

#### **DISCUSSION**

India has committed itself for achieving millennium developmental goals. The government has rolled out several strategies like promotion of institutional deliveries through monetary incentives and health system strengthening to improve maternal and child-health indicators. ICDS is working for preschool education and other services.<sup>3</sup> But unfortunately migrant population are deprived from these services. The migrants are disadvantaged groups as they are poor, uneducated and they also do not have social support with them. They are unaware about the available services. Govt. health service providers also do not reach them in routine situations as this population is not registered with them.

Through this case study, we attempted to understand the barriers of accessing primary health care as well as primary education to the migrant population. In a country like India, where migrant population constitutes large numbers and as they are vulnerable groups, we have to provide all primary services for betterment of our country. Mere absence of local identity should not deprive them from government services.

The study emphasizes that there is need to break down the barriers for the sake of migrant population and giving them proper care at primary level so that we can decrease the cases of malnutrition, improve enrollment in Anganwadi, stop child labour and also improve maternal as well as child health with the existing settings.

Many barriers emerged from this study. Firstly, lack of local identity has emerged as an important barrier that prevents entry to the health and ICDS system. Though the ICDS guidelines says that if an immunization card is there, then the migrant population can be enrolled in Anganwadi anywhere in India and if the people have lost the card then the worker should check the scar mark of that child and immunize, and if nothing is available then the worker have to restart the immunization course according to the age. It seems there is utter confusion about the guidelines. Thus each district should draw its own area specific strategy which is very simple to follow, and puts responsibility of the population enrolment on the service providers, as well as employers, where such migrant labour is employed. Secondly, reluctance on the part of AWWs to register such population with them should be addressed through periodic office circulars and clear instructions during all possible personal interactions with AWWs and their supervisors.

Thirdly, lack of confidence among the immunization providers about giving vaccine to malnourished babies should be addressed through continued education sessions during routine monthly meetings. If required, such workers should be sent for special training on this. Fourth, the fear of higher officials for reporting any complication was also reported. Health workers don't want to mention the real case scenario (severe malnutrition) due to fear of the higher officials. They don't want red mark in their work book which is important for their promotion. It can be diluted by supportive but firm supervision and leadership.

Another issue is about child labour. North India is largely dependent on U.P. for labour, where poverty and illiteracy are more. So these migrant labours are exploited more by these kind of people by giving minimum facility to them and by ignoring laws regularly. Work and living environment is also grossly substandard without any protective gears. This can only be addressed by strict enforcement by administrative authorities.

Thus this case study demonstrates that if there is strong commitment and confidence among public health practitioners, they can overcome most of the barriers. Such public health activism should be promoted.

Funding: No funding sources Conflict of interest: None declared Ethical approval: Not required

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DOI: 10.5455/2394-6040.ijcmph20150214

Cite this article as: Bhattacharya S, Trusty K, Aggarwal AK. Public health activism: success story of overcoming barriers to health care faced by a migrant family. Int J Community Med Public Health 2015;2:71-4.