

SOCIO-DEMOGRAPHIC AND HEALTHCARE SERVICES UTILIZATION PATTERN AMONG THE POOR MIGRANTS IN IMPHAL, MANIPUR: A CROSS SECTIONAL STUDYSingh K. B¹, M. Shyami², Priscilla K³**HOW TO CITE THIS ARTICLE:**

Singh K. B, M. Shyami, Priscilla K. "Socio-Demographic and Healthcare Services Utilization Pattern among the Poor Migrants in Imphal, Manipur: A Cross Sectional Study". Journal of Evolution of Medical and Dental Sciences 2014; Vol. 3, Issue 30, July 28; Page: 8468-8476, DOI: 10.14260/jemds/2014/3072

ABSTRACT: With the on-going National Rural Health Mission the healthcare sector in the rural areas are becoming relatively better well-organized than the urban areas. This affects the poorer section of the urban community who cannot afford costly treatment in private-run health facilities. To prepare an effective health-plan for this population under the up-coming National Health Mission, it is imperative to study the socio-demographic and healthcare utilization pattern among the urban poor. The study was taken up in Imphal, the capital of Manipur State in 2012. Both quantitative data (3844 poor migrant households) and qualitative data were collected. There was no identified slum area in Imphal. Majority of the cross-State migrants were from Bihar. Migration was mainly for economic reasons. Most of the migrants (92%) lived in rented houses out of which 63% were katcha houses. 67% of the migrant households lived in a single room. Main fuel for cooking was LPG. Main sources of water for drinking were house-hold tap and tanker-trucks. None of the houses had own latrines. Closed drainage system was present for a few households (8%) only. TV/Radio which was possessed by all the households was the main source of information. The usual source of medical care was from the two teaching medical institutions existing in the State. Other public healthcare facilities were accessed only by a few. Transportation to access the health facilities was to be arranged by self. Out of the pocket expenditure was the usual mode of expenditure for meeting expenses during times of seeking healthcare. Home-visit by healthcare workers was a rare phenomenon except during Intensified Pulse Polio Campaigns and for Routine immunization services. Very few (<1%) received free medicines from the health facilities. The main reason for not accessing government healthcare facilities was long waiting time. There was hardly any discrimination because of being a migrant. Nearly half of the women had 3 or more ANC visits. Home-visits by government health workers for ANC and PNC services were almost non-existent. Institutional delivery rate was 86% with delivery by Caesarean section being 20%. Fully immunized rate among children was 49%.

KEYWORDS: Poor migrant, Healthcare utilization, Socio-demography.

INTRODUCTION: With the implementation of National Rural Health Mission, the healthcare services in the rural areas are becoming more organized. However, the healthcare services in the urban areas through under-staffed municipalities, costly private health institutions and ill-equipped Urban Health Centres still remain an issue.^{1,2}

Moreover, the poorer sections of the urban population notably the migrants who migrated mainly of economic reasons cannot readily access the costly private health institutions and still remain vulnerable to malnutrition and other ill-health. Also because of their alien status, they may face discrimination by the healthcare providers.^{3,4}

ORIGINAL ARTICLE

For effective planning and implementation of the up-coming National Health Mission (Rural plus Urban), it is important to know the socio-demographic pattern as well as the existing healthcare utilization pattern among the poor migrants.³ There is hardly any publication regarding this issue in the State of Manipur. The present study was taken up to probe in this area.

Study Methodology: The study was done during the period from May to October 2012 in Imphal, which is the capital of Manipur State. The area was so selected because it was the area having the densest population of migrants in the State. Both the districts in Imphal viz., Imphal East and Imphal West were included in the study. Individuals who migrated to Imphal and currently been living there for a period of 30 days to 10 years were included as the study subjects, the head of families being the key informants.

It was anticipated that if the duration was extended, richer people who came for a few days could have been included which would defeat the purpose of the study. Also, people who have migrated before 10 years would be almost like a citizen of the area. A sample size of 3886 households was calculated based on an assumed healthcare service utilization rate of 15%, an allowable error of 10%, 95% confidence interval with a design effect of 1.7 and 5% non-response rate.

It was also targeted to collect Maternal and Child Health (MCH) specific information from mothers who had children aged less than one year and living in the households selected for collecting general information. All wards in the two districts were covered till the desired sample size was achieved. Two pre-tested questionnaires were used by a team of trained investigators for collecting (i) general household information from heads of households and (ii) MCH specific information from eligible mothers.

Ethical approval was obtained from the Institutional Ethical Committee, Regional Institute of Medical Sciences (RIMS), Imphal. Written informed consent was taken from the key informants. Data collected were continuously checked, entered and analysed by using SPSS 20.0. Incidents in which the interviewee did not want to answer all questions were encountered during the survey.

These incomplete data sets were excluded from the analysis. In addition to the aforementioned quantitative data, qualitative data were also collected through six Focussed Group Discussions (3 Women groups, 3 Men groups). The qualitative data were analysed on continuous basis by using Atlas ti software.

RESULT: Completed general household data sets could be collected from 3844 households and MCH specific data sets from 191 eligible mothers. Men (2165) outnumbered the women (1679) by 13% and persons of the active age of 21-50 years (3486) comprised 91% of the total population. Most of the migrants (28%) have been residing in the area for 2-4 years followed by 6-8 year (22%) 4-6 years (21%), <2 year (19%) and 8-10 years (10%). Imphal did not have any notified slums or migrant camps.

ORIGINAL ARTICLE

Characteristics	No. of persons (%)
Sex distribution	
• Males	2165 (56.32)
• Females	1679 (43.78)
Age distribution	
• 21-50 years	3486 (90.69)
Duration of migration	
• < 2 years	722 (18.78)
• 2-4 years	1084 (28.19)
• 4-6 years	808 (21.03)
• 6-8 years	841 (21.89)
• 8-10 years	389 (10.11)
Caste	
• General	2316 (60.25)
• Scheduled tribe	1038 (27.00)
• Schedule caste	221 (5.75)
• Others	269 (7.00)
Religion	
• Hindus	2576 (67.02)
• Christian	1030 (26.80)
• Islam & others	238 (6.10)

Table 1: General characteristics of the study population

Very few were found to be staying in open space. Majority of the migrants (60%) belonged to general category followed by ST (27%), SC (6%) and others. The religion-wise composition was Hindus (67%), Christian (26%), Islam (4%) and others.

Household characteristics	No. of households (%)
Living in katcha houses	2431 (63.23)
Living in rented houses	3531 (91.87)
Living in a single room	2572 (66.90)
Having separate kitchen	916 (23.84)
LPG as main fuel for cooking	1939 (50.45)
Household tap as main source of drinking water	1353 (35.22)
Having own toilets	0 (0.00)
Having proper drainage	311 (8.10)
Electricity connection	3762 (97.87)

Table 2: Living condition of the migrant households

63% of the migrants lived in Katcha houses followed by Semi-pucca houses (20%), Pucca houses (15%), squatter hut (2%). 92% were found to be staying in rented houses, whereas 5% lived

ORIGINAL ARTICLE

in their own houses. 67% of the houses had only one room followed by two-rooms (25%), three or more rooms (8%). A separate kitchen was found only in 24% of the houses. Main fuel for cooking used was gas stove (50%) followed by hearth (38%).

The main sources of drinking water were Household-tap water (35%), Public tap water (29%) and Tanker-truck (18%) and Hand-pump (11%). Almost one-third of the new migrants depended to Tanker-trucks compared to older migrant (2% or below dependence). None of the houses had own toilets. Majority of them (97%) used means other than mobile toilet or community toilet for defecation. Only 8% of the houses had closed drainage system. 6% did not have any drainage system. 98% of the houses had electricity connection out of which 96% were metered ones.

Only 4% of the families had ration card. Voter ID card was possessed by 42% of the respondents which was similar irrespective of the migration period. 66% of the migrants were from the study state whereas the remaining was cross- state migrants (Bihar-22%, UP-3%, WB-2% and other states and Nepal). The main reasons for migration were for better earning (55%), children's education (8%). Most of the migrants came without anybody's facilitation (38%). In other cases, relatives and villagers of their parent villages facilitated them (25% and 22% respectively).

The major languages being spoken currently were Manipuri (62%), Bhojpuri (14%), Bengali (9%) and Hindi (6%). Out of all the cross- State migrants, 36% of them used to speak the local language whereas 14% still continued to talk in their mother tongue only.

The remaining 50% used to speak in both languages. 18% of the families had relatives in Imphal out of which more than half of them had relatives in the same locality. 21% of the families were aware of local Community-Based Organizations (CBOs), but only 2% of them were members of those CBOs. All the households possessed TV or radio. The main sources of knowing what was happening in the city were through co-worker migrants (31%), radio (23%), TV (22%) and local newspapers (16%).

Characteristics	No. of study participants (%)
Aware of home visits	1029 (26.78)
Main activities on home visit	
• IPPI	3809 (99.10)
• Routine immunization	2690 (69.98)
Satisfied with the services provided	1585 (41.24)

Table 3: Perception on Home visits by government health workers

73% of the study participants were not aware of any home-visit made by government health workers. Less than 1% of all the households got a home-visit per month. The services provided by the health workers during the home-visits, as reported by the study participants were Pulse Polio Immunization (99%), Routine Immunization services (70%), Giving health related advices (6%), Family Planning (5%) and PNC services (3%). Surprisingly, 41% of the study participants were satisfied with their works.

30 of the study participants were hospitalized for illnesses in the last one year. Two-third of them spent Rs. 5000 or above. Friends/relatives helped in one-fifth of them; otherwise they had to spend from their own pocket. Another 371 persons reported of seeking out-patient medical care in

ORIGINAL ARTICLE

the last one year for which they had to spend Rs. 500-3000. In 5% of these cases friend/relatives helped them. For the remaining cases, they had to spend from their own pocket.

Characteristics	No. of patients (%)
Place for seeking healthcare	
• RIMS & JNIMS	234 (58.31)
• Private doctors at home	104 (25.87)
• Private health facilities	33 (8.21)
• UHCs	25 (6.23)
• Others	5 (1.25)
Rickshaws as main means of transport while seeking healthcare	306 (76.32)
Doctors examining patients	372 (92.88)
Spending Rs. 5000 or more during hospitalization	20 (65.76)
Got free medicines	3 (0.87)
Perceptions	
• Waiting time too long	117 (45.21)
• Amenity for drinking water	62 (23.94)
• Clean surrounding	31 (11.92)
• Privacy maintained	72 (27.97)
• Delayed treatment due to lack of money	45 (17.20)
• Discrimination because of migrant status	5 (1.94)

Table 4: Healthcare services availed by 401 migrant-patients who sought treatment in last one year and perception of 259 migrant-patients who visited government health facilities

The usual source of medical care were the two teaching-medical institutions (RIMS and JNIMS) (58%), private doctors at doctors' home (26%) and private health facilities (8%). The usual means of transportation to the health facilities was through cycle-rickshaws/auto-rickshaws (76%) followed by public transportation system (12%). In 90% of the cases, they could reach their destined places within one hour. After reaching the health facilities 93% of them got examined by doctors, the remaining being examined by other health staffs. Less than 1% of them got free medicines. There was not much problem because of their migrant status.

The main perception on government health facilities were too long waiting time (45%), perceived improper treatment (6%) and inconvenience of the service timing (4%). Only one-fourth of the study participants who had family members attend government health facilities were aware of the amenity of drinking water in the facility. 70% of them were satisfied with the waiting arrangement. Only 12% reported of the place being clean, 44% reported of being tolerable and the other 44% reported of dirty surrounding

Only 20% of the persons reported of being treated with dignity at the government health facilities whenever they went there. Complete privacy was provided in only 28% of cases. 17% reported of delay in getting further medical care. 12% said they were refused further treatment because they could not afford it. 67% reported of being listened to by the health providers. 94% were happy with the explanations made by the health providers. But only 54% was happy with the time

ORIGINAL ARTICLE

given to ask questions. Only 2% of the study subjects felt that these problems were because they were new to the place.

Out of the 191 live births that occurred in the selected households in the last two years 86% of them took place in the present city they were residing. 74% of all the deliveries were institutional delivery, which is not bad. 20% of them were through Caesarean section, which is on the higher side. 88% of the pregnant women stayed in the same city during their pregnancy and had ante-natal check-ups.

Services availed	No. of eligible mothers (%)
No. of ANC	
• At least once	167 (87.32)
• 3 or more	83 (43.46)
Place of ANC	
• Govt. Health facilities	127 (76.01)
• Home-visit by health workers	5 (2.99)
Received IFA tablets	85 (44.50)
Received TT	95 (49.74)
Perceptions on ANC services	
• Satisfied with the waiting time	63 (32.98)
• Adequate information provided	159 (83.25)
Institutional delivery	165 (86.39)
Proportion of Caesarean sections	33(20.00)
Rs. 4000/- to 6000/- spent for delivery	136 (71.20)
PNC on home-visit by health workers	4 (2.09)
Fully immunized children	94 (49.21)

Table 5: Details on MCH services as reported by 191 eligible mothers and their perception on it

87% of all the pregnant women got checked-up at least once during their ante-natal period, the usual place of visit at the govt. health facilities (76%). Only 3% of these pregnant women got ANC during health workers' health visit. Half of the women received 3 ANC services. 45% got IFA tablets, but only one-eighth of them consumed all the IFA given, the common reasons being not liking the taste, gastric problems, pre-conceived idea that medicines should not be taken during pregnancy. Half of all the pregnant women got Tetanus Toxoid injection.

The other services provided during ANC in addition to physical examination were weight measurement (98%), BP check-up (98%), urine test (98%), Hb test (95%), advice on good food and rest (37%), ultrasonography (19%), HIV testing (29%). 38% of the women got examined within 30 minutes of reaching the place. Others had to wait more; 13 had to wait for more than 2 hours. One-third of the women were satisfied with the waiting time. 83% got enough information from the health provider regarding dos' and don'ts during pregnancy.

52% of the families having pregnant women kept a saving of Rs. 9, 000/- and above for delivery purposes. 86% of the deliveries were institutional deliveries. 20% of the all deliveries were through Caesarean section, 55% of them being performed in government health facilities. The

ORIGINAL ARTICLE

preferred choices of delivery by the families were government health facilities (43%), home (35%) and private health facilities (22%). At the government health facility, prompt treatment was reportedly given to 61% of cases, 5% complaining of not getting any attention at all. 66% of the cases were happy with the cleanliness of the labour rooms. Family members were allowed to be by the side of the pregnant women during pains and after delivery in 57%. Majority of the women (71%) had to spent Rs. 4, 000/- to 6, 000/- during pregnancy except for 7% who had to spent more than Rs. 10, 000/-. There was no case in which no expenditure was made during delivery. The main advices got by the women after delivery were on Immunization of child (57%), family planning (53%) and exclusive breastfeeding (24%).

After delivery in only 2% of cases, health workers came for home-visit for providing post-natal care. 9% had some post-natal complications, out of which 71% did nothing for it.

The main places the families accessed for children's immunization were government health facilities (56%), health workers (16%) and private practitioner (13%). 49% of the children were fully immunized against the six vaccine preventable diseases.

The figure reduced to 31% if Hepatitis B, too was accounted. The main reasons for not immunizing at all or partially immunized were: not aware of full immunization schedule (25%), went to parent village (14%), not aware of vaccination (10%), not a felt need (8%), long waiting time (8%), no time to spare (4%), and reluctance to take out child outside (4%).

DISCUSSION & CONCLUSION: It may be concluded that in the State of Manipur, the migrants were different from migrants in other States of the country in the sense that they could afford rented houses. Hence the basic amenities availed by them were comparable to the owners of the houses in the urban area. While assessing healthcare services there was no discrimination in because of being a migrant.⁵ The qualitative data, too, supported this. But poverty, yes, as 12% of the study subjects was refused further treatment since they could not afford it. This is seen better as compared to other studies.^{2,5} Hence, while formulating a health policy in the urban area, due importance need to be given considering the healthcare deprivation of the poorer section. The services provided need to be affordable by them.

The two teaching medical institutions (Regional Institute of Medical Sciences and Jawaharlal Nehru Institute of Medical Sciences) and other private health institutions may be good enough for giving therapeutic care in the urban area. But promotive and preventive healthcare services provided by the government health facilities were hardly available in the urban area (Less than half of children fully immunized against the six vaccine preventable diseases, only 3% of all the pregnant women having ANC through home-visit and 2% for PNC) is a critical issue regarding the above mentioned areas.

41% of the households being satisfied with meagre services through home -visits by health workers may be explained by the fact that the study participants are not aware of the basic health facilities they ought to get as compared to other studies.^{6,7} Urban health institutions having health workers to visit the families regularly for providing basic healthcare services including preventive and promotive healthcare is a must. These health institutions may be structured so that there is complete community participation in its management.

Unlike in this studies, health institution function better in other places where migrant could feel better than in this study group.⁸ Link workers selected by from the community by the community

ORIGINAL ARTICLE

working on voluntary basis for mobilizing the community may have a role in spreading awareness and mobilizing the needy. Re-structuring the urban health facilities and making available a strong functioning government health centres in the urban areas is also needed. Health centres having similar organizational structure as that of rural areas may also be considered for urban areas. The population norm for these to be established centres may be made as double of their rural counterparts as the population density is more in urban areas.

The other option is to let each of the 6-7 ANMs currently posted in the already existing Urban Health Centres be allocated a geographical area of about 1000 population and give fortnightly home-visits to each household in her allocated area as done in other studies.^{9,10} In addition, the MOs of the UHCs may provide extended clinic service to each of the allocated areas on a weekly basis so that all the areas allocated to the ANMs are at least on quarterly basis.

Similar studies may be taken up in other States of the country so that the States may come up with State specific effective urban health plans.

REFERENCES:

1. Petros Galanis, Panayiota Sourtzi, Thalia Bellali, Mamas Theodorou, Ioanna Karamitri, Olga Siskou. Public health services knowledge and utilization among immigrants in Greece: a cross-sectional study. *BMC Health Services Research* 2013, 13:350.
2. Caswell A. Immigrants and Health Care: Mounting Problems. *Ann Intern Med.* 1995; 122 (4): 309-310.
3. Tazuko Shibusawa, Ada C. Mui. Health Status and Health Services Utilization among Older Asian Indian Immigrants. *J Immigr Minor Health* 2010, 12:527-533.
4. Muenning P, Fahs MC. Health status and hospital utilization of recent immigrants to New York City. *Prev Med* 2002, 35: 225-231.
5. Prashant Kumar Singh, Rajesh Kumar Rai, Lucky Singh. Examining the Effect of Household Wealth and Migration Status on Safe Delivery Care in Urban India, 1992–2006. *PLoS ONE* 7(9): e44901.
6. Su Liu, Catherine X. J. Hu, Selene Mak. Comparison of Health Status and Health Care Services Utilization between Migrants and Natives of the Same Ethnic Origin—the Case of Hong Kong. *Int J Environ Res Public Health.* Feb 2013; 10 (2): 606–622.
7. Derose KP, Escarce JJ, Lurie N. Immigrants and health care: sources of vulnerability. *Health Aff (Millwood).* 2007 Sep-Oct; 26(5):1258-68.
8. Singh PK, Rai RK, Alagarajan M, Singh L (2012) Determinants of maternity care services utilization among married adolescents in rural India. *PLoS ONE* 7: e31666. doi: 10.1371/journal.pone.0031666
9. Navaneetham K, Dharmalingam A (2002) Utilization of maternal health care services in southern India. *Social Science and Medicine* 55: 1849–1869. doi: 10.1016/s0277-9536 (01) 00313-6.
10. Hemant Mahajan, Bhuwan Sharma. Utilization of Maternal and Child Health Care Services by Primigravida Females in Urban and Rural Areas of India. Hindawi Publishing Corporation *ISRN Preventive Medicine.* 2014, Article ID 123918, 10 pages. <http://dx.doi.org/10.1155/2014/123918>.

ORIGINAL ARTICLE

AUTHORS:

1. Singh K. B.
2. M. Shyami
3. Priscilla K.

PARTICULARS OF CONTRIBUTORS:

1. Assistant Professor, Department of Community Medicine, JNIMS, Imphal.
2. Assistant Professor, Department of Community Medicine, JNIMS, Imphal.
3. Assistant Professor, Department of Community Medicine, JNIMS, Imphal.

NAME ADDRESS EMAIL ID OF THE CORRESPONDING AUTHOR:

Dr. H. Kulabidhu Singh,
Department of Community Medicine,
JNIMS, Imphal-795005.
Email: kb_heisnam@rediffmail.com

Date of Submission: 10/07/2014.

Date of Peer Review: 11/07/2014.

Date of Acceptance: 17/07/2014.

Date of Publishing: 25/07/2014.