

Migration, poverty and people's access to health care: In Ludhiana City: A policy brief

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Abstract

The urban poor and migrants live in slums, devoid of essential services like clean water, sanitation and health care. Primary health care services do not reach them, leaving them dependent on unqualified private practitioners. Most of the Millennium Development Goals (MDG) could not be achieved in India, and globally we have the Sustainable Development Goals (SDG) to be achieved by 2030. To make an impact in this arena, the vulnerable and under-served populations must be targeted for priority care within the national primary health care framework. In the context of the limitations faced by the governmental health services to provide for the migrants, a partnership between various stakeholders is essential to address the challenges. Such an intervention is proposed to be initiated and implemented in the slums of Ludhiana, in a phased manner.

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Context and importance of the problem

One of three urban people live in slums. The urban poor live in most challenging conditions in ramshackle dwelling and overcrowded settlements, and suffer exclusion from essential services like health, clean water, sanitation, education, electricity etc. The challenge of inclusion of urban poor was stated directly in the Millennium Development Goals (MDG), Target 7C "to halve the proportion of the population without sustainable access to safe drinking water and basic sanitation by 2015" and Target 7D to "achieve significant improvement in the lives of at least 100 million slum dwellers by 2020." An UN report confirmed that the MDGs 1, 4 and 5 related with

poverty reduction, child mortality reduction and maternal health improvement are difficult unless urban poor are given priority.¹

Unlike in rural areas, the primary health care system is not well-organized in the urban areas. This is reflected in the shortage of resources, facilities and implementation mechanisms for health in urban slums where the poor and migrants live. People consider the availability of essential elements such as doctors, medicines, trust, etc. as prerequisites to the credibility of health services. Lower levels of immunization lead to more frequent outbreaks of vaccine-preventable diseases in communities that are already more vulnerable owing to high population density and a continuous influx of new infectious agents. This increase in disease creates additional reliance on healthcare, which in India is largely private and requires out-of-pocket expenditures which lead to financial strain on already poor families. Childhood vaccines hold tremendous promise in reducing many infectious diseases, including diphtheria, hepatitis B, and measles.²

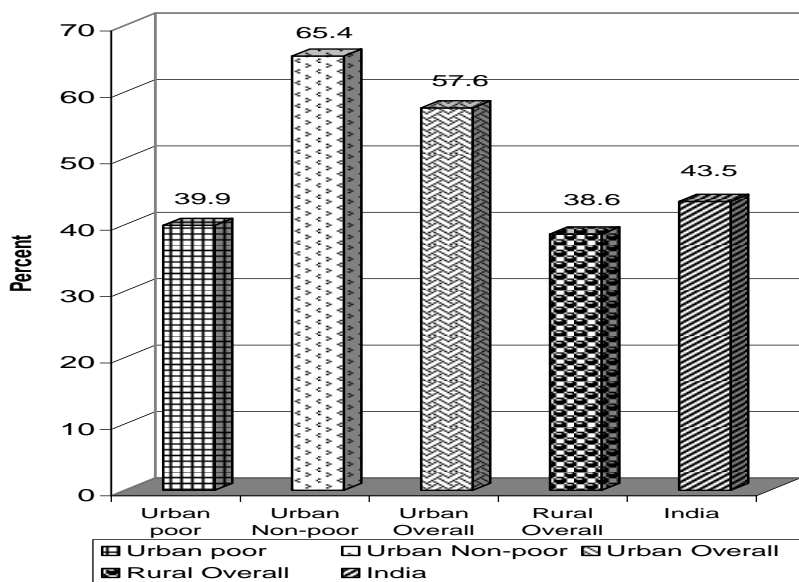


Fig. 1: Children aged 12-23 months receiving complete vaccination

Only 40% of the children from urban poor households receive all the recommended vaccinations.

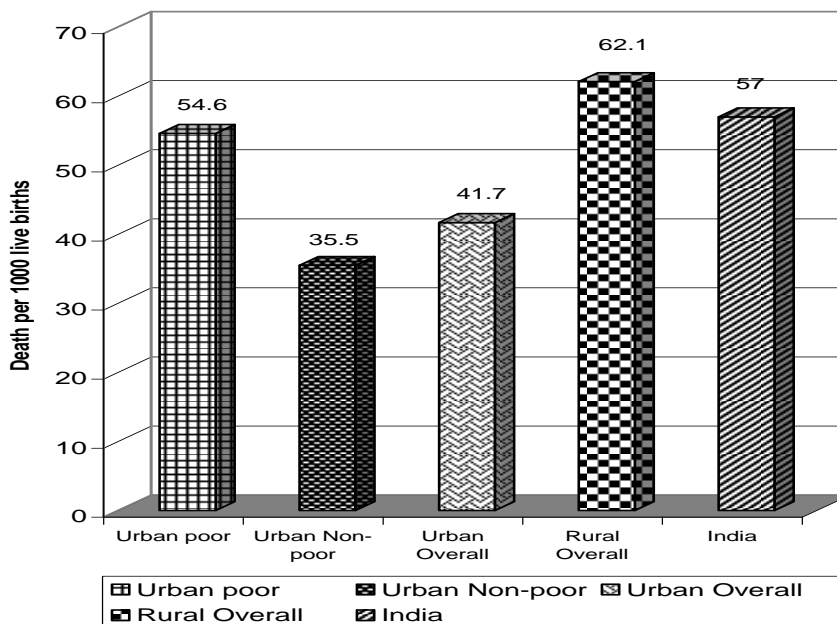


Fig. 2: Infant Mortality Rate

Lack of access to health care, poor behaviors, nutrition and poor environmental conditions all contribute to high infant and child mortality in slums. Near 100,000 babies die before reaching their fifth birthday

Approaches and Results: 3947 migrant households in 30 newer slum clusters of Ludhiana were surveyed to assess the availability, accessibility and utilization of healthcare services to them, and identify key points to develop an intervention for improvement.

The stark reality

- 40% -no electric supply
- 57% - no drainage
- 65%-no toilet on premises
- 96.2% -no ration card
- 96.9% -no voter card
- 96.7%- never used any Govt Health Facility

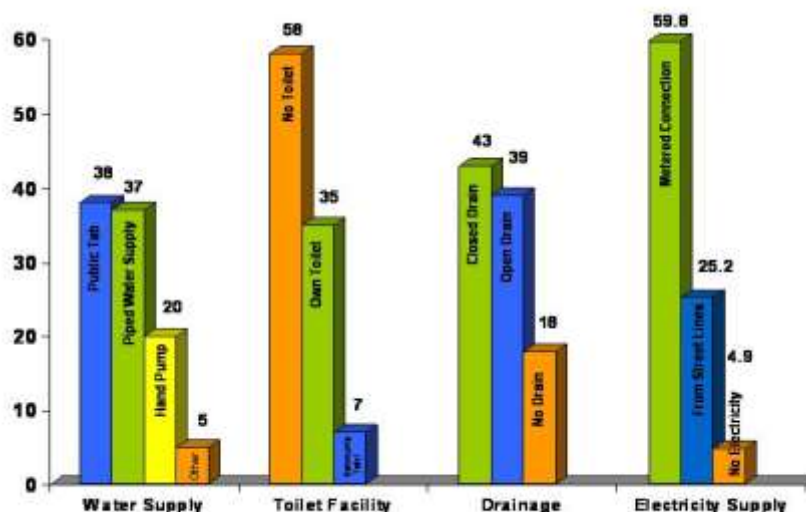
Most of the migrants in Ludhiana hailed from U.P (48.5%) followed by Bihar (40.8%), with the commonest reason for migration being for better earning (98.2%). Usual source of health care by the migrants was by unqualified practitioner (58.5%) followed by private qualified doctor (37.6%). 65.4% of them were unaware of any Government Health Facility (GHF) nearby. Long waiting time was the commonest problem cited (42.7%) by those who had availed government health services. Problems of accessibility, including long distances to the nearest clinic, scarce public transport and time taken to access the health services continued to be major barriers. Issues related to affordability in terms of treatment costs and loss of income due to visits to clinics, costs of drugs, etc. were

MCH services

- 56.0% -no ANC received
- 71.1%- no IFA tablets
- 29.7% -no Tetanus toxoid
- Routine Immunization (complete) coverage in 12-23 months old children- 12.2%

also major obstacles. 67.2% households were visited by a government health worker, but mostly for Pulse Polio immunization (96.8%). Only 17.8% of them were visited by the health worker during the pregnancy. The primary immunization coverage in 12-23 month olds were BCG: 65%, DPT (3 doses): 50%, OPV (3 doses): 51%, Hepatitis-B (3 doses): 23%, & Measles vaccine: 20%.

Ludhiana slums: household facilities (2012-13)



Ludhiana Migrants (2012-13)	Maternal Care	India (2007-08) ⁴
ANC (4+ visits)	51.0	24.6
ANC (at least 1 visit)	76.4	44.0
TT coverage	76.0	70.3
Received IFA tablets	65.1	28.9
Institutional deliveries	38.7	27.8

Inadequate water supply and poor sanitary conditions can have a deleterious impact on household outcomes. Poor sanitary conditions and poor water quality lead to sickness, cause diarrhea and other water borne diseases. India still loses about 0.4 to 0.5 million children under age five each year due to diarrhea.³

Conclusions

Government health services, including essential MCH services, are largely not reaching the migrant in Ludhiana, leaving them dependent on private/unqualified providers. With advocacy and added awareness about different government health centers, their programmes and services provided by our team to the slum communities adopted by us, an overwhelming response for seeking appropriate health-care by the community has been observed. Moreover in 7 out of 10 slum areas, the government has been able to provide both manpower (ANM and Doctor) and materials once a week within 3 months of the intervention phase. 1710 vaccine doses have been given to 1267 missed children and 215 antenatal women have been provided services in previously 6 unreached migrant slum areas of Ludhiana. Under the Rajiv Awas Yojna, 3000 EWS flats have been built to re-settle slum-dwellers, the houses to be allotted in the name of the female member of the household.

Administered during the first few years of life, vaccines are largely considered to be one of the most cost-effective instruments for reducing child morbidity and mortality² and are thus considered excellent tools for achieving the fourth Millennium Development Goal (MDG4), which calls "for a two-thirds reduction in child mortality during the period 1990 -2015."

Implications and Recommendations

As India failed to meet its MDG targets on maternal and child health, in future, the more vulnerable and unreached sections of the population, like the migrants, need to be targeted for priority services within the framework of the country's primary health care services. In order to address these challenges, partnership with government and non-governmental providers to bring about sustainable improvements in health in underserved urban

settlements is recommended. It is envisaged to develop and implement an interventional package by combining the approaches of inclusive partnership and community mobilization. The focus should be on promotive and preventive care by sensitization of providers towards the special needs of the migrants, facilitating access to identified facilities and extending civic amenities to them. It is proposed that one day a week would be fixed for a particular migrant slum, in which MCH services, particularly routine immunization to be provided to the migrants, as part of outreach activity of government health worker of the nearest center who should guide and help the migrant population by increasing their knowledge and awareness of health problems and access to services available, thus improving their health care seeking behavior. This activity can be later scaled up to other areas in the wake of the National Health Mission.

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