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Maternal Migration From Urban Slums & It's Impact On Health Outcomes: A Cross-Sectional Observational Study Done In Noida

[1]Dr Anshul Chamoli, [2]Dr Shiva Singh, [3]Dr Shweta Arora

[1]MPH Student, Dr. B R Ambedkar University, Agra, Uttar Pradesh, India

[2] Project Manager, 1000 Days - MCH, Doctor For You, Noida, Uttar Pradesh India

[3]Director CSR TB program Monitoring and evaluation -Project Development, Doctors For You, Noida, Uttar Pradesh India

Abstract

Background: Migration during pregnancy is most common among females, due to cultural, structural or social arrangement. Migrant pregnant women generally face barriers in accessing healthcare services in their migrated locations. This leads to poor health outcomes.

Objective: The objective of this study is to find out the role of migration on the health among the pregnant women migrating from urban slums of district Gautam Buddha Nagar in Uttar Pradesh during pregnancy & to explore the challenges & barriers faced by them.

Methodology: This is a qualitative study with a cross-sectional observational design. Data were collected through informal telephone interviews and face-to-face interviews. The sample comprised registered pregnant women who received periodic visits and counseling.

Results: Maximum number of migrated pregnant women were multiparous & belonged to the age group 18-30 years. Majority of them responded to the lack of human resource & services in their migrated locations. Most of them revealed that ANC (Antenatal Care) & PNC (postnatal care) visits were not made to their households. They faced challenges while accessing healthcare. Lack of awareness regarding importance of taking scheduled vaccinations, promoting early & exclusive breastfeeding was seen. Not being registered in their migrated locations prevented them from accessing supplementary nutrition.

Conclusion: Present study finds that migrated pregnant women face real obstacles & are not able to enjoy their full health potential. They miss out on important components of ANC & PNC. The clash & overlap between AWCs (Anganwadi Centers) due to migration prevents them from getting benefit of supplementary nutrition. Their new-born infants also miss out on vaccinations. All of this has serious implications on maternal & child's health. Therefore, it is suggested that states should recognize migrants as a vulnerable group and adopt inclusive strategies to ensure their access to healthcare services., which will result in better health outcomes.

Keywords - Maternal migration, migrants, health outcomes, urban slums, Noida

1 INTRODUCTION

Noida city is part of India's National Capital Region (NCR) and is less than 25 km from New Delhi, the national capital. Noida is emerging as one of the best metropolitan cities. ABP News even ranked it "Best City for Housing" in 2015. [1]

With the establishment of NOIDA city in 1976, hundreds of small-scale factories were established in Noida. Due to these developments, the demand for workers suddenly rose in Noida. Hence Noida, as a result of in-migration, saw an influx of migrants in the early 1990s from the various parts of Uttar Pradesh and other states, including Bihar, Madhya Pradesh, and West Bengal. When they arrived in Noida, there were not enough authorized colonies to live in, and if there were some, these poor migrants were not in a position to afford the rent. So, it was a natural step to live in a slum and survive.

"A slum is a compact settlement with a collection of poorly built tenements, mostly of temporary nature, crowded together usually with inadequate sanitary and drinking water facilities in unhygienic conditions" (NSSO, 2014). According to the 2011 Census, 2613 slums reported from cities and towns account for 12.92 million slum households across the country. In total, 65.49 million people occupied these slum households (NSSO, 2014). As per Centre of Indian Trade Unions (CITU) and other people's groups, Noida's slums are home to nearly 30,000 households.

Slums are inhabited by the poverty-stricken population of the country. They generally do not have access to quality education and affordable health services. It is because of the cheap housing option that people resort to slums. The income levels of slum dwellers are such which do not allow them to buy land elsewhere. [2]

Slum dwellers are marred by the integral and structural problems of slums. Slum dwellers face poor sanitation & hygiene, poor health, and socio-economic backwardness, apart from getting marginalized, ostracised, and discriminated against.

Females dwelling in these slums have come mostly to look for jobs in urban areas, or with their husbands after marriage. When they are pregnant, they prefer to migrate temporarily to their mother's house, & return back after child is delivered. But sometimes, the migration is for good, & they never return back to their urban settlements.

Females during pregnancy are faced with the double burden of their pregnancy journey & household chores. In urban slums, women going out for work also adds to this list. Therefore, it becomes essential to take special care of pregnant women. But in slum areas, lack of facilities, physical barrier & cultural barriers prevent them from achieving their full health potential.

The "First 1000 Days", begin right from the conception & goes up to when the child reaches her second birthday. The "First 1000 Days" are a period of rapid physical growth and accelerated mental development and offers a unique opportunity to build lifelong health and intelligence. Since the baby in the womb is dependent on the mother for nutrition as well as mental, physical and emotional growth. Therefore, whatever parents do in the first 1000 days makes a difference to the rest of their baby's life.

With this mission in mind, the 1000 Days' project has been started by Doctors For You in October, 2023. One most important factor that remains unaddressed in most of the studies is Migration. No study has been done so far which takes care of the effect of migration on health of pregnant women.

This study is done to see the effect of their migration on health outcomes during this crucial phase of pregnancy.

2 RATIONALE:

The poor migrants usually settle in unauthorized slums or settlements. The migrant health is found in a disadvantageous position due to poor access to healthcare services. Female migration is common in India. Women make up 83% of India's permanent internal migrants, and 84% of those are marriage migrants [3]. Women also migrate for other reasons such as economic opportunity; however, economic migration only represents 1.1% of women's migration. Migration for women has unique individual opportunities and costs, including specific health vulnerabilities and needs, when compared to men, including around pregnancy and childbirth. [4] Much of the research in India is suggestive that pregnant women migrants are less likely to meet key components of the perinatal continuum of care, including meeting the recommended number of antenatal care visits, delivering in a facility, and receiving postnatal care, when compared to non-migrant women. [5]

3 AIM

The aim of this study is to understand the role of migration on health of pregnant women residing in urban slums of district Gautam Buddha Nagar in Uttar Pradesh, India.

4 OBJECTIVES

i) To understand the role of migration on the health among the pregnant women living in urban area.
ii) To explore the challenges & barriers of receiving healthcare facilities among pregnant women who have migrated from urban slums.
iii) To assess the impact of these barriers on maternal health outcomes.

5 METHODOLOGY

It is a qualitative study aiming to understand individual experiences and views. Study design used is cross-sectional observational. Methods of data collection included telephonic informal interviews & face to face interviews.

The sample included registered pregnant women, who were being visited & counselled on a periodic basis.

- **Operational definition**

The National Sample Survey Organization 2008 [6] defined migrant as "A household member whose last usual place of residence (UPR) any time in the past was different from the present place of enumeration was considered as a migrant member in a household."

- **Conceptual definition**

In our study, we have defined migrant as population who have migrated from their urban settlements to any other place for delivery.

- **Inclusion criteria**

Pregnant women residing in slums of district Gautam Buddha Nagar in Noida (sector 8, 9 & 10), who were registered in 1000 days project & had migrated to their villages/mother's home for delivery were included in the study. Those who gave consent were included in the study.

- **Exclusion criteria**

Pregnant women who were registered, but had not migrated were excluded. Those who were not able to give consent because of lack of cooperation of husband & family were excluded from the study. Also, pregnant women not registered under the project were excluded.

6 DATA COLLECTION

- **Informal interviews**

Informal interviews were conducted telephonically with pregnant women who had permanently migrated to their villages and were not planning to return to their urban settlements.

- **Face to face interviews**

Face-to-face interviews were conducted at the homes of pregnant women in their slum households. These interviews were conducted with women who had migrated temporarily and returned to their urban settlements after delivery. Open-ended questions were asked, such as:

- ✓ "How often did the Accredited Social Health Activists (ASHAs)/Anganwadi Workers (AWWs) come for postnatal care (PNC) visits?",
- ✓ "What all services were covered by Anganwadis?",
- ✓ "How much knowledge do you have regarding breastfeeding of infants?",
- ✓ "What all dietary recommendations had been given to you by AWWs?",
- ✓ "Whether Iron folic acid (IFA) & calcium were provided by PHCs (Primary Health Centre) & whether you were counselled for regular consumption by AWWs?",
- ✓ "What schedule was given to you regarding vaccination?
- ✓ "What all challenges did you face in your village/mother's home regarding access to Maternal and Child Health (MCH) services?"

With the consent of each participant, interviews were audio taped. Field notes were made, when required. Each interview lasted for 35–40 min. After each interview, the key points were summarized by the interviewer and verified as a way of participant validation. Questions asked of the respondents were related to the problems faced by the pregnant women at the destination, availability of the healthcare services, nutritional intake of pregnant women & utilization of maternal healthcare services. Confidentiality about participants' details was strictly maintained. They were also informed of their liberty to withdraw from the study anytime.

7 RESULTS

Some pregnant women migrated to their mothers' home. Some others migrated to their village as they had come to urban area for breadwinning. A majority of women were in the age group of 18–30 years. Nearly half of the mothers experienced more than 3 pregnancies and only few were primiparous. Reasons for migration varied. One pregnant woman said, "It's my first baby so I want to have it at my mothers' house." Another woman said, "I was not getting any work here in Noida, so I migrated back to my native village.". One said, "Government had broken down my slum household & provided us with new accommodation in sector 122, therefore I migrated there." One other responded, "I went back to my mother's home because my husband's family asked me to go as his family did not want to take care of recently delivered mother & the child." Most common reason given by many pregnant women was, "I will not have to do as much work at my maternal place after the birth of my child."

Majority of the pregnant women responded the lack of human resource & services in the facilities in their migrated locations. ANC visits were not made to their households. There was no one to promote behavioural change in their villages. Because of lack of awareness, women often tended to listen to their family & neighbors, neglecting their own health. One pregnant woman even responded, "I have been told to do household chores while bending to promote normal vaginal delivery."

Pregnant women also didn't go for their ultrasound. They hesitated because of lack of financial support. Hardly did they know about Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) which envisages to improve the quality and coverage of Antenatal Care (ANC) including diagnostics and counselling services as part of the Reproductive Maternal Neonatal Child and Adolescent Health (RMNCH+A) Strategy. So that they can avail free Ultrasound Sonography (USG).

They revealed that no PNC visits were made in their residences. Immediate breastfeeding within 1 hour of delivery in case of vaginal birth & within 48 hours of delivery in case of Caesarian section was not initiated by Auxiliary Nurse and Midwifes (ANMs). No information was provided by health workers (ASHA/AWWs) about exclusive breastfeeding that has to be done till 6 months of age. "Instead, the majority of the infants were given a prelacteal feed, which included ghutti, honey, jaggery, butter, ghee, sugar, goat's milk, cow's milk, buffalo's milk, and boiled water."

One-woman mother said, "In our culture, 1st feed of honey is given by child's aunt (bua) & then only breastfeeding can be initiated by mother." The significant reason for giving honey is baby's voice becomes soft. Another woman revealed, "We give first feed of ghutti to our newborns because it helps in boosting their immunity." According to one woman, "We don't give colostrum to infants because it's impure & dirty." One woman revealed, "It is considered auspicious to give something sweet to a newborn, so we feed them jaggery and ghee."

No one provided them any information about how they have to take care of their nutritional requirements. One major challenge they experienced was exclusion on the grounds that they were not natives of that village, & so no Anganwadi took interest in providing them MCH services.

All of this contributed to poor health outcomes: like Low-birth weight infants, Malnourished babies having less cognitive ability facing frequent episodes of diarrhea & achieving delayed developmental milestones.

Most of the pregnant women preferred home delivery compared to institutional delivery. One pregnant woman gave reason, “I don’t want to stand in long queues in this condition(pregnancy), it’s convenient for me to get baby delivered at home.” They found it’s troublesome to wait for long hours in public facilities & can’t afford private facilities, so chose the easiest way out, i.e. home delivery done by midwives. They thought that home delivery is safe for them, because getting hospitalized for delivery might result in surgery (C-section). They also avoided visiting any public or private healthcare facility due to the expenses they would have to bear. They were not aware that institutional delivery is covered under Janani Suraksha Yojana, where free institutional delivery is done in public facilities, amenity is provided & also incentive is given to pregnant women who opt for institutional delivery.

Pregnant women having lower educational attainment mostly end up following certain misconceptions. Their cultural beliefs & misbeliefs prevented them from doing healthy practices. Lack of knowledge led to mothers being ignorant of their health, which in turn affected their child’s health too. Also, inaccessibility to health services from public providers further worsened the situation because they were not in a condition to afford private treatment/health services.

Regarding the free ambulance services provided by the government, only few were aware of such services and hardly any utilized the government ambulance services.

8 DISCUSSION:

The decision to give birth for the first time in one's native place can be attributed to several factors. Firstly, the first pregnancy is a unique and significant experience, and there is typically greater familial support available in one's native environment. Additionally, it is a cultural tradition for a woman's natal family to take responsibility for her first childbirth.

The present study migrants are characterized by younger ages, lacked knowledge, bounded by misbeliefs. Whatever cultural practices they followed, as a part of society’s norms, many a times proved harmful for them & their infants’ health. Mothers, due to lack of knowledge & experience were not able to initiate breastfeeding by themselves. Mostly they preferred giving prelacteal feed to their newborn, which is again deeply rooted in their culture. Evidence gathered by the WHO indicates that use of prelacteal supplements without any medical indication is associated with early termination of breastfeeding.[7] Among Hindu and Muslim families, provision of prelacteal feeds can be a traditional ceremonial practice that includes a range of items such as honey and clarified butter.[8] Proper counselling of pregnant mothers can support them & their family members in having appropriate information on the risks of providing prelacteal supplementation. In a cross-sectional study, it was found that exclusively breastfed infants (0–6 months) had significantly higher length-for-age and weight-for-age compared to those who were not exclusively breastfed.[9]

The healthcare providers faced the main problem that as these women moved to their native place during the pregnancy time, it is difficult for them to trace and maintain their health records. Thus, the migrants miss many ANC (antenatal care) visits. Without adequate ANC services, pregnant women struggle to recognize signs of pregnancy-related complications, resulting in delays in seeking quality care when needed. Insufficient ANC increases the risk of adverse pregnancy outcomes and maternal mortality.

Migrated pregnant women themselves revealed that delivered babies were not given appropriate attention by health workers. Even if the baby was underweight, free meals were not provided by AWWs because they were not officially registered in their natal villages. Also, it is difficult to enroll women temporarily at their natal homes in supplementary food programs (provided by the government to pregnant women and newborns). Furthermore, they have no idea that iron folic acid & calcium has to be taken during & after pregnancy. They lacked information that IFA & calcium is provided free of cost in all public facilities.

Women lacked knowledge about the nutritional services provided by Anganwadi Centers (AWCs). Even if their infant was malnourished, they couldn't do much because they didn't know that double ration is provided by AWCs for malnourished children.

It is more likely that the recent-migrants may not be covered in census due to various factors such as their location of habitation, indicative of non-inclusive nature or exclusion of vulnerable population such as the poor migrants.

According to Hagan (1998) migrants lack social networking. This limits their access to knowledge & awareness regarding available MCH services & how to effectively utilize them.

Educated women are more likely to be aware about danger signs of pregnancy & are often not easily convinced by society to follow misbeliefs. Investing in education yields long-term benefits in various aspects of life, including health. The impact of maternal literacy on a family's health-seeking behavior is clearly illustrated by the observation that in India, states such as Kerala and Tamil Nadu, where female literacy rates are high, also demonstrate significantly lower rates of infant and maternal mortality. [10], [11]

Therefore, it is primarily the state's responsibility to ensure and promote improved educational opportunities for all, with a specific focus on girls' education as outlined in the fourth Sustainable Development Goal (SDG-4).

Regarding transportation to health facilities, people often rely on auto rickshaws rather than government-provided ambulance services. One possible reason for this preference may stem from a lack of awareness about the availability and extent of ambulance services.

The health system needs to focus on the ground level implementation issues involving various cadres of service providers (ASHA, AWW, ANMs) and whether the service provision is implemented as designed. Strengthening the outreach services would be helpful in increasing the ANC utilization, which in turn increase the chances of skilled birth attendance.

The migrant population are new to the area, so they are less aware about the exact location of the government health centers. In addition, they lacked community support and had lower communication with health workers. This further increased their physical & social distance from all these MCH services, which can be a significant contributory factor in poor health outcomes of migrant mothers & their infants. In order to reduce the equity gap in maternal health services, marginalized women need more access to health services. This can only be achieved by active engagement of outreach workers.

According to Gardner and Blackburn (1996) there is an increasing concern about migrant women having less access to reproductive health information and services than non-migrants. Also, it has been observed that

there is no migrant specific program available right now. Hence, the study population needs migration specific health education program.

The present study migrant women are living in compromised conditions in the background of low educational attainment and lack of community feeling owing to migration. They heavily relied on government healthcare sources and thus the government sector remains the major provider. Due to the impact of poverty and social inequality on access to healthcare, there is a crucial need to enhance the quality of government services to be more accessible and user-friendly. Recent migrants are particularly at risk of missing out on these services, highlighting the importance for health systems to recognize migrants as a vulnerable group and adopt inclusive strategies to ensure their access to healthcare services.

9 CONCLUSION:

Migration has the potential to disrupt the continuum of care. It has been found to occur mostly in 3rd trimester and in the late postpartum period, which are the most critical periods for the health of the mother and baby. Women migrated as they believed that they would receive better and more supportive care at their natal homes. This study highlights several challenges faced by migrant pregnant women regarding maternal and child health in their native places. Migrants often return to their hometowns for their first childbirth due to cultural traditions and familial support. However, this relocation presents significant barriers, including limited access to antenatal care (ANC), resulting in missed visits and increased risks during pregnancy.

Cultural practices such as providing prelacteal feeds and inadequate breastfeeding support contribute to health risks for infants. Furthermore, migrants' lack of knowledge about available health services, including free nutritional supplements like iron folic acid and calcium, exacerbates maternal and child health issues.

Social and economic factors also play crucial roles, as migrants may not be officially registered in their native villages, impacting their access to essential healthcare and government welfare programs. Educational disparities and social isolation further hinder their ability to seek appropriate care.

The healthcare system's challenges include inadequate outreach and awareness about services among migrant communities, leading to underutilization of healthcare facilities. There is a clear call for tailored health education programs and improved service delivery to address these disparities and ensure equitable access to maternal and child health services for migrant women.

In conclusion, addressing these systemic gaps requires a multifaceted approach that includes enhancing educational opportunities, improving healthcare accessibility, and implementing migrant-specific health programs. This approach aims to mitigate the adverse health outcomes faced by migrant women and their infants, promoting better maternal and child health across diverse socio-economic contexts.

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