Chapter-5

Findings, Conclusions and Recommendations

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FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the final findings and conclusion of this study as well as some solutions for the identified problems, and finally way forward at the end of the chapter.

Maternal health outcomes resulted from dramatic inequalities between and within countries and societies that cannot be attributed to biological differences. It further pointed out the characteristics of individual women like age, number of pregnancies and education level play an important role in determining whether they seek appropriate services, but the underlying factors influencing health behavior operate at inter-related levels of social influence, family and peers, the community in which women live and the health system available to them, wider cultural norms, the legal and policy environment and overarching governance structures (UNDP, 2011).

Maternal mortality is on higher side in the developing countries than developed ones, e.g. Maternal Mortality Ratio (MMR) of developing countries is 230 per 100,000 live births while 16 per 100,000 in developed countries in 2013.This disparity is also found within the countries, and also between women with high and low income and between women living in rural and urban areas (WHO, 2013). All the studies on maternal health or reproductive health revealed that, the main causes of the maternal morbidity and mortality are preventable (WHO, 2012) all these arguments opine that the poor reproductive health outcomes are somewhere related to the vulnerability of the population.

Despite of many national and international commitments like, 1994 International Conference on Population and Development (ICPD), 1996 International Conference on Women, in Beijing, Millennium development Goals (MDG), the ground reality is that a large number of women in developing countries do not have access to maternal and child health services, nor have proper knowledge about the HIV and other STIs. Many of them cannot get to, or afford, high-quality care due to various factors

(demographic, socio-economic, cultural and programmatic factors). Cultural customs and beliefs can also prevent women from understanding the importance of health services, and from seeking them, taken the case of migrant women in the words of Shaokang et al. (2002) that, *"Migrant women's unawareness of maternal health service, together with their vulnerable living status, influences their utilization of maternal health care"*, they may also be vulnerable towards HIV infection for many reasons including low perceived vulnerability of HIV infection, limited access to health care and health awareness, and low levels of education (Ford et al., 2007; Smith et al., 2003). Therefore, *"tailored maternal health education and accessible services are in demands for the migrant population"* (Shaokang, 2002), including comprehensive knowledge and education on HIV /AIDS, sexual behavior and modern contraceptive methods.

5.2 Major Findings of the Study

5.2.1: Demographic and Socio Economic Profile of the Respondents

"The factors that affect health may include inherent factors and extrinsic factors. Inherent factors comprise age, ethnic origin, and genetic makeup or inherited education, nutrition, habits, and sex; extrinsic factors include social class, occupation, habitat and environment. Among the extrinsic factors, social-economic factors play an important role in affecting the people's health in contemporary society" (Milio, 1986; Chiu, 2002).

5.2.1.1: Age of the Migrants

- The study intentionally picks the respondents from the reproductive age group, and so the distribution of the age of respondents lying between 15-45 years of age span and that happens to be vulnerable age also from various angles.
- Majority of the migrant women (respondent of the study) are from the age group of 26-35 years.
- Next major respondents belong to 15-25 years of age group.
- The least number of respondents belong to 36-45 years of age group.

5.2.1.2: Religious and Caste Status of Migrant

- Maximum respondents belong to Muslim community followed by Hindu community and both communities are majorly represented by OBCs, the least representation is from Christian community which has only SC/ST representation.
- OBC is the dominant group as far as caste based distribution is concerned while the upper caste has slightly more representation than SC/ST group.
- Christian respondents belong to either SC or ST group only. All ST migrated from Jharkhand belonging to *Munda* tribal community and SC is *Harijans* converted to Christianity.
- Among Muslims all the respondents are Sunnis and the major group among them is of OBC followed by upper castes like *Pathan, Sheikh, Chaudhary* etc.
- Among Hindus, the group in again dominated by OBC like Muslims followed by upper caste which exists in small percentage.

5.2.1.3: Education Status of the Migrants

- A huge majority of women (respondents) are illiterate (86%), which is much higher than the national average, (overall 34.54% women are illiterate in India, census 2011) and only very few of them are educated to different levels.
- In entire sample size of 200 females of this study only two have reached the graduate level. Very few had *Madarsa* education at the primary level.
- Upper caste respondent both from the Hindu and Muslim community are educated mainly beyond fifth standard and all the metric and graduate women belong to the upper caste with only one exceptional case from the lower class who has studied till tenth standard.

5.2.1.4. Occupational Status of the Migrants

- Migrant women in Aligarh are majorly housewives doing household work and whose husbands are the breadwinner of the family.
- The second largest group of respondents are self employed, self employed here signifies, women are those who opened some basic shops or selling some items from their home, many of the self employed women are busy in

Appliqué or Patch work, they get just rupees 10-20 in preparing one *kurta or Pajama* (depending upon the work).

- Few of the self employed women are engaged in making some small parts of metal hardware and locks industry working from their home. There are also some women who make some earning from preparing batashe (a local sweet prepared from boiled sugar syrup) and sell them to the wholesalers.
- Under the daily wager category which is the third major group of women, they are mainly the labourers at construction site and few of them are the daily wager in some factories or small scale industry.
- The fourth main group is of women working as maids in the houses and the women who are working as a house maids are the ones who migrated earlier, none of them is here for less than two years.

5.2.1.5 Average Income and Expenditure Status of the Migrants

- It has been found that half of the surveyed migrant women's average family income is around Rs 4001-6000,
- Next by the group whose income is between Rs 2001-4000.
- There are few families whose income is around Rs 6001-8000 but it is the smallest group.
- In majority, earning is less than or equal to monthly expenditure, which shows that economically they are on the deficit side.

This poor economic situation puts the migrants in vulnerable situation. In general women take minimum for themselves out of the total expenditures, in such circumstances it become very obvious , that why majority delivered at home ,without any ANC and PNC.

Kincaid (2000) & Su et al. (2007) opine that, "*the income of the family itself may affect maternal health outcomes. A family with low income may be constrained in being able to pay for health service fees, transport to facilities, or health-related resources that incur additional expense (e.g., nutritious food, contraceptive supplies or condoms, some biomedical tests)*".

5.2 .2 Living Conditions and available Facilities

Ray (1993) has also pointed out that, "*the poor living conditions such as lack of proper water supply, poor drainage system and unhealthy practices and deplorable sanitary conditions expose the migrants to various kinds of health risks predetermined by their standard of living and their choice of occupation*".

5.2.2.1 Housing Status

- Majority of the migrant families have their own houses in form of *katcha* houses, squatter huts and tents etc (squatter hut are made up of polysheets/Tarpaulin, bamboos and mud).
- Second is the rented group living mainly in *pucca* and semi *pucca* houses.
- The last group lives free of cost under construction buildings, and also as care takers in houses which are vacant especially in garages or as gatekeeper/watchman.
- Maximum of the houses have single room followed by two rooms and very few have more than two rooms.
- Study revealed that majority of the houses do not have separate kitchen and only small percentage have separate kitchen in name sake only like preparing food under shed.
- Many migrant women prepare their food either in the courtyard or outside the home (where more than one family living together).
- In some houses it is observed that women prepare food inside the room and that is the only room of the house.
- Majority of surveyed migrant women uses Hearth (Cow dung cakes/Coal/Wood) as a fuel for cooking and within this category majority of them prepare food in open kitchens, in courtyard or outside the house followed by Gas and Kerosene users.
- Migrant women who use gas cylinder for the cooking purpose are mainly of small sizes which they get refilled at higher rates from black market and out of all gas users only three respondents have proper gas connection, whoever uses gas they prepare their food inside the room or few have separate kitchen.

5.2.2.2 Water and Sanitation

- Majority of the migrant women use public hand pumps/municipality taps.
- The next group of respondents uses personal hand pumps.
- Few respondents get water through buying it on monthly basis, or few getting it free from the neighbour.

5.2.2.3 Place of Defecation

- More than half of the respondents use their personal toilets for defecation.
- Second category of the group, go out in open fields to relieve themselves.
- Lastly very few uses community toilets.

Except very few none of the personnel toilet has flush system and are used without doors. For screening purpose rags or sacks are used and only very few have proper toilet system.

5.2.2.4 Usual Course of Medical Care

- Private practitioners (unqualified) are visited by most of the respondents mostly like Hakeem, Jarrah etc. because of easy availability of them in those areas where migrants live.
- Second largest group seeks help from private practitioner (qualified) when there is some health problem.
- Govt health centres are visited by some migrants if the location of it is not far and also when the problem is serious.
- A very small percentage of migrants take medicines in consultation with medicine shop keeper, Para medical practitioner and medical representatives etc.

5.2.3 Migration

5.2.3.1 Native Place Status of the Migrants

- The majority which is half of the number of respondents coming from the different districts of Uttar Pradesh like Badayun, Bulandshahar, Agra, Kasganj, Hardoi, Hathrus, Dibai. Except few most of these districts are

adjoining districts of Aligarh like Bulandshahr, Badayun etc. together constitute the maximum Inter district migration to Aligarh.

- Second largest group of migrants is of interstate category. Interstate migrants are mainly from the Bihar followed by migrants from West Bengal, Jharkhand, M.P, and Orissa. A good amount of interstate migration from Bhagalpur and Sharsa district of Bihar to Aligarh also took place (some 20-25 years ago) and as, the study is focused on the new migrants (span of 6 months to the 8 years) so this huge migrant population has been excluded.
- The third group of migrants is categorized as intra district migrants. It is the migration from the same district that mainly constitutes the rural – urban migration (short distance migration). During the study it is found that large influx of the intra district migration occurred from villages during the 1992 communal riots (out of the scope area of the study).

5.2.3.2 Years of Migration to that Particular Place

- It is found in the study that maximum number of migrants migrated to Aligarh between the last 5-8 years.
- Second largest group of migrants is of those who came 3-5 years back.
- Next by those who are here for last 1-3 years.
- The last group of migrants is here for not more than 1 year.
- Some of the migrants (belong to the last group) from MP have divided the year between Aligarh and their native place, stay eight months here and the rest of the months of the year at their native place, this is the fixed pattern they follow and the place of their dwelling in Aligarh is also fixed (this particular community is needed to study in detail).

5.2.3.3 Reason for Migration

- The major part of migrant women population came here along with their husband (associated migration) for the most common reason i.e. for better livelihood.
- Second major group of migrant women is of those who migrated after their marriage. NSSO 2007–2008 also given the marriage as the prominent reason for the female migration.

- The third main group is of those women who have come here for their employment mainly at construction site, they come here as contract labourers through contractor like women from Jharkhand as well as women from adjacent districts, (usually along with their families).
- The next group is of those females who came here because of some social and political pressures like safety of life in their native place as it is communally sensitive place or a place where law and order problem is rife,(along with their families).
- The remaining numbers of migrants are here for various reasons like health facilities, education of their children or natural calamity happened at their native place.
- All these three reasons have almost same small number of migrants in each category. It has been observed in the study that migration for education of children is usually done by those who are relatively better financially.
- Migration on the account of natural calamity is mainly from those places where natural calamity is a recurring problem especially from annual flood prone places (e.g. Bhagalpur district of Bihar).
- Dearth of health facilities and services also compel people to migrate especially from adjoining areas.
- Few migrant families migrated as the result of chain reaction. Earlier migrated families to Aligarh acted as pull factors in the host area for those belong to their own family and native area.

5.2.4 Maternal Health

"Low utilization rates for maternal health services are caused by a range of factors: distance from health services; cost, including the direct fees as well as the cost of transportation, drugs and supplies; multiple demands on women's time; and women's lack of decision-making power within the family. The poor quality of services, including poor treatment by health providers, also makes some women reluctant to use services" (AbouZahr, 1997).

5.2.4.1.1 Age at Marriage

- This study is clearly the microcosm of the country as far as age is marriage is concerned, it shows that maximum numbers of respondents get married between age of 15-19 years which is considered very early age marriage and most of the migrant women got married before the legal age of marriage as per law.
- Very few numbers of migrant women got married at the age of 20 and above.

The age of migration and age at marriage both lie in the same age group and that is also the productive age, physically and sexually.

5.2.4.1.2 Number of Children

- Majority of migrant women do not have more than two children.
- Next major group of women have three children.
- Women who have more than three children are lesser in number than those who have less than three children.

Most of the women are young and still have good number of years ahead to bear more children.

5.2.4.1.3 No of Still Birth

- The number of still births among migrant women is quite low only very few had it once only.

5.2.4.1.4 No of Abortion

- The findings reveal that maximum of migrant women had no history of abortion and approximately one third of them had it once or twice.

5.2.4.2 History of Last Delivery

This section deals with the history and status of the last delivery of the respondents.

5.2.4.2.1 Place of Last Delivery

- The place of last delivery for majority of respondents is the host place as maximum number of respondents migrated during last 1-8 years and corollary to this delivered at the host place.

- Number of respondents also preferred their native place for delivery as they are more confident about delivering there and maximum of them are from adjacent districts as it is easier for them to travel back to their native place during delivery.

5.2.4.2.2 Antenatal Check -up

- Maximum numbers of migrant women do not go through the antenatal checkups.
- There are also substantial numbers of women who have gone through these checkups although they are less than half of the number of respondents.
- The number of ANCs is more than the number of institutionalized deliveries because many of the respondents have ANC but they prefer home at the time of delivery especially when they come to know that everything is fine and nothing to worry about.
- It is also revealed from this study, that the women who didn't go for ANC are mainly those who delivered at home.
- In most of the cases it is observed that the highest level of care was taken during the first pregnancy.

In this survey the number of women who have ANC, is very low comparing with a study conducted by Agarwal, in 2007, in urban slum in Delhi, that most women,76% in his survey received antenatal care while this study in Aligarh shows that only 40% migrant women(respondents) received antenatal care.

5.2.4.2.3 Reason for Not Going for Antenatal Check- up

There are three major reasons which outweigh other reasons of not taking up ANC; they are-

- Unawareness about ANC (General perception- *khan jana ahota hai ?Kab jana hota hai?kyoun jayen?* Where to go? When to go? Why to go? etc.).
- No need or importance of ANC and (General perception-*sab karne wala upper wala hai* everything in the hand of God).
- Problem of no one to accompany.

- There are other minor reasons also like no time, transportation problem, and financial difficulties etc which have also contributed to staying away from ANC.
- There are some unexpected reasons which came forth like if no ANC during last pregnancy than why during current pregnancy, losing a day's wage if time is devoted to check up, apprehensions about the procedure of check up, etc. Grossman, K. (1990), also claimed that *"health services themselves often are 'the problem' when they are inappropriate, poorly delivered, inaccessible or insensitive to the cultural imperatives of time and place".*
- More than half (53%) of the respondents shun ANC because of their behavioural and attitudinal problems, many migrant women are not going for the ante natal care as they are not aware about it as Case Study No.-2 reveals that, she was not concerned about the risky signs when she actually need assistance and believe that this is all natural and expected in pregnancy like swollen feet, hand, and face, nausea (even excessive).

5.2.4.2.4 ANC Service Availed through

- Maximum services of ANC are avail through Govt./Maternity hospital.
- Next by the local practitioner both qualified and unqualified.
- ANC service has also been availed through Govt. Health centres and NGO/Trust hospitals but their use is low among migrant women.
- Mobile clinics are also preferred but it comes last in preference.

5.2.4.2.5 First Time Check Up of Pregnancy

- Maximum number of migrant women who went for ANC took the check-up somewhere between 3-5 months.
- Next number of women comes under the category who took check-up between 6-8 months of pregnancy.
- The number of a woman who took check-up in the initial two months or in the last month of their pregnancy is low.
- Therefore, we can infer that maximum number of females who went for ANC took the check up between 3 to 8 months of pregnancy.

Majority have the tendency to go for the check-ups after first trimester and it reduces with the consequent months.

5.2.4.2.6 Number of Ante Natal Care

- As far as number of times ANC is taken, out of those who went for ANC half of them took it 1 to 2 times only.
- Followed by one fourth of them who took it 3 to 4 times. and
- The remaining respondents took it more than four times including those who are called by doctors owing to complications and need more checkups.

The government recommends for 3 compulsory ANC (DLHS) and our survey reveals only one fourth are following the recommended norm.

5.2.4.2.7 Necessary Checkups

- It has been found from the survey that females who have ANC out of all the number of listed and recommended tests, the test which is taken up by maximum number of respondents is the abdominal test and naturally it is the oldest test and most commonly performed both by qualified and non qualified practitioners.
- As far as other tests are concerned the percentage varies on the basis of the doctor's qualification and recommendation as well as on the basis of the place of check up. It has been found after the discussion with the respondents that ultra sound test is mostly recommended by private practitioners.

Even though the percentage of the respondents having ANC is low still the recommended tests are not being done properly and sincerely which is not a good sign definitely

5.2.4.2.8 Number of Iron and Folic Acid (IFA) Tablets Consumption

- The study reveals that the consumption of iron and folic acid tablet is not prevalent among migrant women only one fourth consumes among the entire sample size. This is also proofed by the analysis of the cases.

- Among all the consumers of the tablets majority consumes not even 30 tablets through their pregnancy which is very much less than the recommended consumption.
- The next consumer group which comes in the range of 31-100 tablets, within this group maximum of the women consume all the 100 tabs for 90 days.
- In the last group which comes in the range of 100-200 tablets the number of consumers are equal to the 31-100 tabs group, in this last group all the females have consumed at least 100 tabs and most of the females in this group are strongly advised by the doctors because they are anaemic.

5.2.4.2.9 Source of IFA Tablets

- Health workers are the main source of getting IFA tabs for migrant women.
- Next by Government health centres/maternity hospitals.
- Other sources are private practitioner (qualified) and mobile clinics but they are not as major as those mentioned before.

5.2.4.2.10 Consumption of Nutritious Food

- The encouraging sign which the study reveals is that consumption of nutritious food is there although the amount of food and frequency varies widely but non consumers are very few out of total.

5.2.4.2.11 Use of Tetanus Toxoid Injection

- The study reveals that significant numbers of females have taken it but there are still many who deprived themselves from having it. This study shows that 40% migrant women were unprotected against the Tetanus, whereas other study conducted by Agarwal (2007) in urban slum in Delhi, showed only17% migrant women were unprotected against tetanus.
- There is one more group of women who have this injection only after delivery because of unawareness and it is not of much use after delivery.

5.2.4.2.12 Type of Delivery

- It is found that majority of women have normal (Vaginal) delivery.

- Only few have caesarean delivery. Majority of caesarean deliveries took place at private hospitals/clinics and just two were done at Government Hospital.

5.2.4.2.13 Place of Normal Delivery

- Maximum numbers of normal deliveries are done at home. Home is still the preferred place for normal deliveries among migrant women.
- Next by Government hospitals.
- Than by private clinics.

A study by Ray (1993) showed that practices of delivery at home in slums were found to be 34.7%, while the results of this study shows a little higher trend of the home based deliveries which is 57.50 %.

5.2.4.2.14 Assistance during Delivery

- As home is the most preferred place, maximum of deliveries are assisted by untrained *Dais*.
- The next most preferred places are Govt. Hospitals and private clinics where doctors and nurses carry out the delivery.
- In several cases elderly lady or mother/mother in law assisted the delivery (as in case Study No.05) at home.

According to Borhade (2012) *"many urban migrant women prefer having home childbirths in India"* which is also the finding of this study.

5.2.4.2.14.1 Use of Safe Delivery Kit

- The respondents covered in the case studies shared about the use of safe delivery kit at the time of delivery at home, they informed that when the nurse (trained *Dai*) comes for the delivery at home than they use all the safety articles (sterilized Blade, thread, clean cloths, soap etc) for the delivery.
- In the case of untrained *Dai,* they do not use any such safety kit. These untrained *Dai* demand less than what a trained *Dai*/Nurse ask for.

Alisjahbana (1993) has suggested that that *"the special attention is given to the practice of traditional birth attendants, who are considered a risk due to a lack of training and hygienic equipment"*.

- Researcher further find that the rate of delivery from unsafe mode to safe mode has gone up as the duration of stay increases i.e. who migrated earlier they have more chances to deliver at hospital than through trained nurse than by untrained *Dai* at home as the duration of migration reduces (delivery at hospital is considered to be the safest and delivery done by untrained *Dai* is considered to be least safe). In some cases financial condition plays role in deciding upon the mode of delivery.

5.2.4.2.15 Money Spent on Delivery

- Majority of the respondents spend between Rs. 501-1500 on delivery. This is the average expenditure incurred on delivery at home as maximum numbers of deliveries are done at home. The average charge of *Dai* for one delivery varies from Rs. 500-to Rs. 1000 depending upon gender as well as the area or locality or the financial status of couple.
- In cases where family is poor local *Dai* takes between Rs.100- Rs. 500 which is the second major range of expenditure as per the study.
- Expenditure which is higher than Rs.2000 and going above Rs.10000 falls in the category where there are some complications or the birth is caesarean. These deliveries are mainly taking place at Govt. hospitals or private hospitals.
- Just very few have zero expenditure deliveries, where the deliveries are done by the mother/mother in law or by the elderly lady (case study No. 05) at home, in few cases delivery are taken place by self, which was also considered to be free or with very minimal afterward expenditure.

5.2.4.2.16 Incentive and Amount for Delivery

As per Janani Suraksha Yojna (JSY) scheme in India, poor women delivering at Govt. Hospitals are entitled to receive Rs.1400 for rural background and Rs. 1000 if she is from urban area.

- Out of total women delivering at Govt. hospitals maximum of them received delivery incentive but there are some cases where incentives are not claimed because of various reasons.
- Out of total recipients/ beneficiaries maximum of them received Rs. 1000 as incentives. The reason for majority of them getting Rs.1000 is that

maximum migrants are living on the periphery of the city, which might come under the rural administration therefore entitled for Rs. 1000 only.

- Some of them received Rs.1400 as incentives.

5.2.4.2.17 Complications during Pregnancy and After Delivery

- The study is pointing towards two common problems faced by majority of the females are swelling and nausea during pregnancy.
- There is a small fortune group of females who faced no complications during pregnancy.
- Females do suffer complications during pregnancy but fail to acknowledge it as a problem.
- There are few cases of complications during delivery, of various natures like; prolong labour, few had no pain, problem of delayed placenta delivery water discharge severe bleeding and pretended labour etc.

5.2.4.2.18 Medical Checkups after Delivery (Post Natal Care)

- The results of post natal checkups reveals that majority of migrant women stayed away from the checkups the most probable reason could be that maximum of the deliveries were normal and usually normal deliveries do not require much medical attention post natal.
- The study reveals the various reasons of skipping PNC, as majority of migrant females consider it as unimportant or and many not aware about it.
- The remaining migrant females have other reasons of not going for PNC in varying numbers like no time, financial problem, transportation inconvenience, physician's bad attitude etc.

In the survey Post natal complications does not find to be prevailing among migrant women as the group of fortunate females has grown by many folds as compared to females who faced complications post natal. The probable reason for this desirable situation is that most of the females delivered naturally and this method is given preference especially in Govt. Hospitals as it does not entail post natal complications and not because migrant females are serious about PNC.

It has been revealed in the research that, ANC is taken relatively more seriously in comparison to PNC, because after delivery they (majority of the respondents) and their families do not considered it as an important measure of mother's health.

One of the case study (Case Study No.08), who faced the complications of Prolapsed Uterus, and was unaware regarding the services from where to seek checkups.

5.2.4.2.19 Consumption of Nutritious Food during Post Natal Period

- There is a slight improvement in the consumption of nutritious food post-natal if we compare with the results of pre-natal although non-consumers remain the same more or less.

5.2.4.2.20 IFA Tablets after Delivery

- The consumption of the IFA tablets falls after delivery as compared to before delivery as they ignore the fact that it is recommended post delivery also and after.

5.2.5 Contraception

5.2.5.1 Use of Contraception

- One or the other type of contraception has been used by majority of migrant women but the consistency of usage has not come out during the survey.
- Condom is the most preferred type of contraption followed by OCPs and IUCDs. The majority users of condom are not consistent with its use and only few users use it every time. The dual purpose/protection characteristic is not known to majority of respondents i.e. it stops pregnancy as well as the transfer of STD. Similar findings were came from "EMPHASIS project" conducted with the Bangladeshi migrants coming to India, also showed that among migrants, condom use was primarily used to avoid pregnancy and rarely used to prevent HIV or STIs. Knowledge about the purpose of using condoms among all respondents was very low.
- Some respondents use emergency pills or permanent methods like Female Sterilization (FST) and Non Scalpel Vasectomy (NSV) but they are very few.

5.2.5.2 Place of getting Information (Modern Contraception)

- Majority of respondents get the information about contraceptive methods at the host place.

5.2.6 Migration and HIV/AIDS

5.2.6.1 Awareness about HIV/AIDS

- The awareness level about HIV/AIDS is very low among migrant women and which is not a good sign.
- Only very few are able to recall and called it as (dirty disease).
- Majority believed that HIV transmits through having sexual relationship with the prostitutes.

5.2.6.2 Source of Awareness about HIV/AID

- There are two main sources of awareness first is radio and the next one is television. There are other sources but their contribution as per the study is quite low as compared to radio and telly.
- Other sources include family members, banners and pamphlets, Govt hospitals at the time of ANC, community workers/Health Workers working for NGOs and GOs etc.
- It is quite surprising that none of the respondent come to know through news paper, as majority of the respondents is illiterate.

5.2.6.3 Place of getting Information (HIV/AIDS)

- Host place ranks highest as the place of getting information as compared to native place or last place of residence.

5.2.6.4 Level of Awareness about HIV/AIDS

- Out of total number of respondents who are aware about AIDS maximum of the respondents don't know about deadliness of this virus, they are unsure about its killing nature.
- Quite a good number of respondents are sure about its incurability.
- There are also few respondents who consider it as curable.

5.2.6.5 Mode of Spread of HIV/AIDS

- The total number of respondents who are aware about HIV/AIDS, every one of them is aware about unsafe sexual contact transmission of this virus.
- When asked about other modes of spread like through infected blood, through infected needles and blades and mother to child, maximum of respondents are unaware or not sure about these modes of spread.
- There are few respondents who are aware about these other three modes of spread at least awareness level about the mode of spread is not zero.

5.2.6.6 HIV Test during Pregnancy

- Maximum numbers of the respondents are not sure whether they have HIV testing during pregnancy or not.
- The remaining respondents are divided between those who are confirmed about having it and not having it, although the numbers of respondents who do not have it are higher than who have it.

5.3 Conclusion

The study finds that the socio-economic condition of the poor migrants (respondents) is almost similar across all religious groups be it Hindus, Muslims or Christians with negligible differences. Majority of migrants living in periphery of Aligarh are from the OBC caste in both the Hindu and Muslim communities, than from the Schedule caste or from the Upper caste and the least number of migrants belong to the Schedule Tribe. Majority of the women are from the active age group in all senses, this is the age when one is more physically fit and productive as well as sexually more pronounced therefore rending them more vulnerable.

It has been found that quite high percentage of migrant women are uneducated, Upper caste respondents both from the Hindu and Muslim community are relatively better educated that is mainly beyond fifth standards and all the post metric and graduate women belong to the upper caste only. Little less than half of the migrant women are house wives and the remaining are involved into various occupations like maids, daily laborer, engaged in embroidery etc. the self employed category is the largest earning group among the working females. In general their earning is less than the monthly

expenditure, which shows that economically they are not in favorable condition, the housing condition of the majority of them is very poor without basic amenities like drinking water, toilet facilities, separate ventilated kitchen and less polluting fuel for cooking food etc. and maximum of them are living in single room houses.

Majority of the respondents do not have voter ID card or ration card and non possession of which deprives them from claiming Govt. benefits for the downtrodden. During the time of general illness majority prefer to go to the unqualified private practitioner owing to reasons like close proximity, non seriousness about health etc. despite of Aligarh's good health infrastructure with good number of govt. hospitals including health posts and health camps/mobile clinics etc.

Migrants have been categorized into three categories of interstate which is mainly dominated by migrants from Bihar followed by other states like MP, West Bengal, Jharkhand and Orissa. Second category of migrants is of inter district mainly dominated by migrants from adjoining districts of Aligarh like Bulandshehar, Badaun etc. On the basis of the personal observation and the findings from the data collected explains that majority of the migrants who migrated from the Bihar and MP are relatively old settlers (5 to 8 years) as compared to other respondents and majority of the newer migrants are divided between intra and inter district migrants and few from the Orissa and West Bengal. Female migrants particularly from Orissa have come only after their marriage. Livelihood finds itself as a dominating reason for migration among migrants in this study which is in accordance with NSSO 2007–2008 on migration, data reveals that the livelihood is the main migration reason among the males and marriage is the main among female, this survey has also revealed the similar results. The main reason of female migration in this study is associated with their husbands who have come here in search of better prospects.

Migrations of females because of marriage, livelihood for self as well as for family have significant number of respondents. There are other reasons also for migration like social and political pressures, education of children, natural calamities and migration for better health facilities.

It has been observed in the survey that the presence of known person in the host area plays the anchor role in bringing a new migrant in the host area. The known person can be from a native place, friend or some relative close or distant one.

In the survey majority of female migrants get married till they reach the age of nineteen years and within this group most of them are married even before they reach the marriageable age of eighteen years for females as prescribed by Indian Law, exposing them to health risks as they are not fully mature and child bearing capacity is low. Majority of migrant females have up to three children but there are still significant number of females respondents who have more than three children. The worrying point is that majority of female respondents are below 35 years of age which give them quite good number of years ahead to become pregnant again which not only burdens them with pregnancy but also increases the size of the family.

The study reveals that health during and after pregnancy is not given much needed attention as the data collected suggests. If we talk of Ante Natal Care more than half of the respondents pay no heed to the importance of it during pregnancy, they mainly think it is not necessary or they are not aware about it. Those who go for ANC prefer local practitioner (Qualified as well as Unqualified) or Govt./Maternity hospital, they go between 3rd to 8th month of pregnancy and getting the check up done between one to four times during their pregnancy. More number of visits for ANC is either because of awareness about one's health or recommendation by doctor on the account of some complication. The number of respondents who have ANC check-ups is mainly because of the city's better health facilities like mobile clinics, and health camps etc and not because of their behavior only. Out of series of test done during ANC abdominal examination which is also the most basic one is performed on majority of females who visited for ANC, IFA tablet consumption is very poor both before delivery and further falls after delivery and the main sources of these tablets are Govt./Maternity hospital and health worker, although majority do not consume nutritious food during pregnancy but it is seen during the survey the increase in the number of consumers of nutritious food after delivery which is not in the case of IFA tablet consumption. In case of TT injection which is highly recommended in Pre natal stage, here too the score is not very good although more than half of the respondents have taken it at least once before or after delivery put together.

Quite a good majority of females have normal delivery during their last pregnancy and the most preferred place of delivery for them is home than Govt. hospitals or Private clinics which also shows that institutionalized deliveries needed to be promoted further, it is also been observed that the number of ANCs are higher than

institutionalized deliveries because during ANC if everything comes out to be normal than respondents do not feel the need for institutionalized delivery. As most of the deliveries have taken place at home, therefore these deliveries are mainly assisted by untrained *dais* which are usually preferred for the home deliveries as they do not charge much and are easy to call. The other reasons for delivering at home are that migrant families are apprehensive about hospital's environment and procedure as well as behavior of the staff. They prefer it mostly when there are complications which cannot be handled at home. The most common range of expenditure on delivery is from Rs. 501 to Rs. 1500, the major portion of which usually involves service charge of dai and other essential things needed during delivery. Higher expenditure is done when delivery takes place at hospitals through caesarean section. As per JSY there is a provision of incentive for those who deliver at Govt. hospital or health center, those respondents who preferred Govt. hospitals for delivery received the incentive except few who on various account do not receive the incentive.

Majority of the respondents faced various complications during pregnancy and the most common ones are swelling and nausea. It is very interesting to note that most of the complications are not taken seriously by the pregnant females as they think it is a part of any pregnancy so not to worry about them much. Complications after delivery have not been found with most of the respondents because maximum numbers of deliveries were normal and usually normal deliveries do not pose complication after birth. Post natal care is given the same treatment by majority of respondents as Ante natal care and even a more non sincere attitude towards it, again mainly for the same reasons for which they give a miss to ANC, that is unawareness and not considering it to be important.

The survey has revealed that majority of respondents have used one modern method of family planning or contraceptive but regularity of its use is not maintained on every occasion. The most preferred one is condom and apart from it there are other methods like OCP and IUCD which are also been adopted by respondents. Respondents use condoms as birth control method but majority of them are not aware about its other purpose of obstructing transfer of STD. In an analysis of NFHS -3 by Mishra (2014) revealed that about 40.4% of migrants women were using modern contraception methods, while this study finding is little better in terms of contraceptive usage, which is around 72% migrant women are the users of modern contraceptive methods. The

credit goes to the Urban Health Initiaves and their associated NGOs, who rigorously work for the contraceptive marketing, and make it available for the all slum dwellers as well as to all poor urban dwellers, including those who Lives in suburbs.

Host place plays important role providing information to migrants about contraceptives and HIV/AIDS because Aligarh is a city where communication is better than rural or semi rural areas. Although majority of respondents are not aware about HIV/AIDS and its lethality, but those who are aware about HIV/AIDS, do not know about all the modes of spread except unsafe sexual contact which is known to all who are aware about HIV/AIDS. Television and radio have come out to be the most effective modes of communication, majority of respondents are not sure whether they were tested or not for HIV during pregnancy, which also shows their lack of concern and awareness about HIV/AIDS.

5.3.1 Few generalizations based on the study are as follows:-

5.3.1.1 What makes migrant women's maternal health vulnerable?

- Illiteracy
- Early age of marriage
- Low socioeconomic status
- Indifferent attitude towards their health condition
- Lack of ANC checkups
- Lack of IFA intake
- Less prevalence of TT injection
- Lack of preparedness
- Lack of institutionalized delivery
- More deliveries by untrained *Dai* (Easily available Dai are not trained, who are trained demands more)
- Indifferent attitude towards the PNC

- Relatively poor nutritional condition (Believe that only expensive foods are nutritional).
- Average prevalence of contraceptives
- Unawareness regarding the health facilities

5.3.1.2 What makes migrant women vulnerable to HIV/AIDS?

- Illiteracy
- Low socioeconomic status
- Indifferent attitude towards their health condition
- Lack of ANC checkups
- Unsafe sex (low use of condom)
- Unawareness regarding the HIV
- Lack of knowledge about the mode of spread of HIV
- Not aware about the HIV testing

Overall migrant women in Aligarh do not score well on the health parameters, because of-:

5.3.1.3.1 Personal and Social Problems- They are living in a relatively poor conditions, majority have financial crisis, fear of medical instruments and environment, lack of control and poor say in the reproductive health issues.

5.3.1.3.2 Problem related to the Unawareness- Majority of the migrants are illiterate, although they used the modern methods of the contraceptives but are not much aware about the importance of Condom for its dual purpose, very poorly informed about the HIV/AIDS, not much aware about the ANC, and institutionalized deliveries etc.

Few new migrant women are even not aware about the place for medical services.

5.3.1.3.3 Problem related to Unavailability of Resource- Living on the outer fringe or road side, far from the medical services, usually services are available near the major population concentration, so difficulty in emergencies. (Case study No.04).

5.3.1.3.4 Attitudinal Problem- Reproductive health and personal health is not much of their concerned. ANC is not of much importance. IFA tablets are not at all taken seriously (53% of the respondents are not going for the ANC because of their behavioral and attitudinal reasons), PNC is not of their concern.

5.3.1.3.5 Situational Problem- Less informed in new environment and culture, sometime language barrier (like the respondents from Orissa, Case No.05).

5.3.1.3.6 Problem related to the Welfare Policies- Urban Health Initiatives (UHI), not working in the areas like Razanagar because of its rural status, and Urban Health Training centre (UHTC) is not providing the health cards to the migrants who are living just adjacent to them because of their policies (observed during the survey).

5.3.1.3.7 Positive outcome of the Migration

Migrant women who migrated earlier are better off than the later ones, shows that as the time passes in the host area their awareness (related to every aspects) enhances and so their situation. More chances of enjoying modern amenities, availability of the better health facilities, more sources of information.

According to the analysis of this research, many migrant women get informed regarding the modern method of the contraceptive as well as of HIV/AIDS in the host area, so migration is also advantageous in terms of getting new information.

5.4 Suggestions

An integrated and holistic approach is required to address the multifaceted challenge of the internal migrants. The main challenge is to reach out to this most vulnerable population, (especially, who are living in the periphery of the city or in scattered manner). It requires the coordination between the different stakeholders of the society along with the related departments and ministries to ensure the universal access to affordable healthcare.

Good and safe motherhood programs need to be complemented by a wider continuum of care that starts with access to family planning, Antenatal services, Post-partum support, and treatment of co-morbidities such as nutritional deficiencies and HIV, these all should be provided under the maternal Health package.

There are some suggestions for:

5.4.1 Migrant community

- It is suggestive to the community to develop the network as early as possible (from disorganized to organized) as social networks are important not only for their intrinsic value but also because of the accessibility of additional resources through the development of relationships that allow people to meet their needs.

5.4.2 Policy Makers and Service Providers (Govt. or Non Governmental)

- Govt. should provide migrants inclusive health care policies, as well as improving migrants' access to government services and welfare programmes that can improve the quality of life of migrants. This will in turn lay the foundations for a more inclusive and integrated society and balance economic prosperity and social diversity. Need is to bridge the gap between the migrant population and the public health system.
- Policy should be need based not the area based (as discussed in **5.3.1.3.6).**
- Train at least one volunteer from the migrant community in the Home Based Life Saving Skills (HBLS) along with the primary health care to help in the emergencies, who covers 30-50 families from the migrant community and provided some remuneration.
- Government should improve and promote the community based approach (use of outreach services to reach people at their doorsteps,). There is need to increase the coverage and number of mobile clinics, to cater the health needs of the migrants and other poor population living in the suburbs.
- Jannani Suraksha Yojna (JSY) program should provide money to the pregnant women even at the time of ANC (as an aspect of birth preparedness) to promote ANC, along with the remuneration which is given for the institutionalised delivery. Like in Bangladesh, where the vouchers are given to

attend the ANC along with the institutionalized delivery. Ahmed et al. (2011), conducted an intervention study in Bangladesh, in communities in which pregnant women were given vouchers that could be used as payment in local health facilities. Overall, the study reveals that, the voucher scheme doubled the uptake of antenatal care, and increased the skilled attendance by 3.6 times and prevalence of delivery within a facility by 2.5 times.

- Micro insurance should be made available to them, improving health insurance coverage for migrants, which will likely benefit their maternal Health.
- To prevent delays in health seeking, to promote protection and to increase the preparedness it is important to impart the health education, especially on the issues of maternal health, correct and comprehensive knowledge on the mode of spread of STDs specifically on HIV, and use of contraceptive knowledge should be the part of health education through Information Education Communication (IEC) tools.
- Female condom needed to be promoted (as to provide more freedom to women to control on their reproductive life).

5.4.3 Social workers

- **BCC:** Use of Behavior change communication (BCC) to change the attitude of the poor migrants towards their own health needs and benefits.
- **IEC:** To improve community awareness on ANC, institutionalized/safe and hygienic deliveries, to promote contraceptive acceptance and to create awareness for HIV and its mode of transmission, Information, Education and Communication (IEC) activities has to be designed and used through community campaign and mass media like local television channel, radio and local newspapers, local rallies, puppet shows, Nukkad Natak (Street Plays), pamphlets, neighbourhood meetings, chauraha meetings and there are many more IEC tools which could be used to communicate the correct health knowledge.
- **Right Based Approach:** as discussed in Chapter 1, Section 1.7 (Rights of Migrants)

- **Faith Based Approach:** Social worker could apply Faith Based /Religious approach to create awareness and sensitization towards the reproductive health (Maternal Health and HIV) in the underprivileged communities like poor migrants as Green (2001) has found in his study the positive impact of the FBA/FBO in overall decline of HIV infection rate, in Uganda.
- **Integrated Approach:** the health of rural-urban migrants not only concerns urban residents, but is also closely linked to the long-term and sustainable development of the whole society, so more holistic and comprehensive attention is needed in partnership with different stakeholders, like, community leaders, civil societies NGOs, cooperatives, private health sector, and other agencies, they all have to play a major role in achieving the policy objectives.
- Social worker has many roles to perform in bringing a healthy living to the migrant population, like mediator, educator, facilitator, mobilizer etc.

5.5 Way Forward

This research is focused on impact of migration on maternal health outcomes among the migrant women and their awareness regarding the HIV/AIDS. Future studies could focus on the impact of migration on other specific aspects of the reproductive health like contraceptive prevalence, the cultural believes of migrant women on pregnancy and delivery related issues, nutritional intake of the migrant women. Some of the specific and unique migrant communities have been discussed in this study; their dynamics could also be taken up by the future researcher.