View Point

# Migrants to Urban India: Need for Public Health Action

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Migration is an integral part of population dynamics. According to the National Sample Survey 2007-08, the number of migrant households per 1000 households in India was 33 in urban areas.[1] Two-thirds of the households migrated for employment-related reasons. Another 21% of the households migrated for study purposes. Other reasons for migration of households include forced migration (natural disaster, social/political problem, and displacement by development projects), acquisition of own flat/house, housing problems, health care, postretirement, marriage, and so on.[1]

Migrant population, being a non-native population, is vulnerable and is exposed to many health problems. Most of the health problems of migrants are ascribed to their migration to urban areas, decreased awareness about local health facility, inability to cope with psychological stress, unhealthy sexual practices, and frequent migration. Other factors are: food insecurity, climate, and other environmental hazards.

Stress among migrants arises from displacement, insertion into new areas, and reinsertion into the former environment. Poor working condition, poor living condition, lack of job security, meagre salary, inability to fulfil their own needs, exploitation by contractors are the other factors which also contribute to stress. Many of them resort to drinking habits, further having negative impact on their health. Alcohol intake also leads to mental problems and domestic violence. Despite the fact that they are the ones who need the health services most, they are unable to utilize the available health services. Most of them rely on unqualified medical practitioners and spend huge proportion of their earnings in seeking health care services.[2]

Migration to urban areas not only affects the health of adults, but also the health of children in an adverse manner. This fact is evident from the relation between migration and child mortality, and this has been shown in a study which has used data from the National Family Health Survey-3.[3] Undernutrition and low immunization coverage is also responsible for child mortality.[4]

Undernutrition is a major problem among migrant population, especially among women and children as was shown in a study done in Mumbai. Migrant population is a disadvantaged section of society. They have low access to government food-security scheme due to nonavailability of their local identity cards.[4]

In comparison to the general population, immunization coverage rate is low among migrants and lowest among the recently migrated population.[5] Determinants for immunization coverage are: age of mother, educational qualification, use of health care services, occupation and income of head of household, and the visits by health worker.[5] In a study from Northern India, it was shown that the proportion of fully immunized children against the seven vaccine-preventable diseases was 60% in settled migrants, and only 39.7% among recently migrated population.[5] Fully immunized children were low among recently migrated population. One study had shown very low immunization coverage among children of slums in Orissa. About 25% of children had not received even a single dose of vaccine and none of the children in the community was fully immunized.[6]

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Antenatal and delivery care services is another area of concern among the migrant population. It had been shown in a study done among construction workers in Punjab, that three or more than three antenatal check-ups were received by only 10.5%.[7] Almost three-fourths of migrant women did not receive even a single dose of tetanus. Most of the migrant women were delivered at home and only few were attended by traditional birth attendants. This shows the poor level of health care available to pregnant women.[8] According to a study which used data from the National Family Health Surveys, 1992-93 and 2005-06, there has been a decline in safe delivery care among poor migrant women.[8]

Migrant populations are at risk of developing human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) because of high prevalence of behavioral risk factors. They are not only themselves at risk of developing HIV/AIDS, but also form an important link in transmission of HIV to their native home village.[9] Qualitative and quantitative studies done in Southern and Eastern India have given various reasons for migrant population being at increased risk of HIV and sexually transmitted infection which includes low condom usage, multiple partners, frequent visits to female sex workers, cheaper sex, pre- and extramarital relationship, use of drug and alcohol before the sexual act, use of pornographic material, and so on.[10] Alcohol use, among migrant populations, has been found to be associated with high-risk sexual behavior.[11] Two-third of migrant population consumes alcohol prior to sexual act, thus increasing the chances of inconsistent condom use and hence increasing the chances to acquire HIV infection.[12]

Migrant population, especially seasonally migrant population, is vulnerable to malaria. The reason for this vulnerability is favourable climatic condition for mosquitoes, like collection of water. A study from Gujarat showed a high rate of infection among all age groups but prevalence was higher among <14 year age group, as compared to adults.[13] Significant proportion of population that is >50% was found to be infected with *Plasmodium falciparum*.[13]

Migrant population is also exposed to increased risk of developing cardiovascular diseases due to high prevalence of risk factors.[14] Significant correlation was found between duration of migration and waist size, waist to hip ratio and systolic blood pressure. It suggests that their chances of developing cardiovascular disease increases with duration of stay; the factors responsible for this are socioeconomic status, obesity, and lifestyle. Studies have shown a high prevalence of hypertension among migrant population.[15]

Migrant population constitutes a large proportion of population in urban areas. They also suffer from large number of health problems. Further, they are not able to utilize the existing health services. Some of their problems can be tackled by providing them health education about services available. Health care systems should include this vulnerable group of our countrymen in their priority area. Specific attention is needed to educate poor-migrant women about the benefits of timely and proper utilization of antenatal and delivery care services. Interventions are needed to control obesity and to decrease the magnitude of noncommunicable diseases in this stratum. Malaria surveillance and control is required in areas where migrant population is living. Promotion of condom use should be done at their place of work, as well as in their native place. Programs should be framed for helping them to quit alcohol. Interventions should be aimed at decreasing their loneliness and isolation. Health care interventions for migrants to urban areas of India have to align carefully with their needs, not only to target the prevalent conditions, but also to be accessible and available to them at a time which does not compromise their daily efforts to earn a livelihood.

## References


1. Migration in India, 2007-2008, Ministry of Statistics & Programme Implementation. Government of India, June 2010. Available from: http://www.mospi.nic.in/Mospi_New/upload/533_final.pdf [Last accessed on 2013 Aug 9].
2. Babu BV, Swain BK, Mishra S, Kar SK. Primary healthcare services among a migrant indigenous population living in an eastern Indian city. J Immigr Minor Health 2010;12:53-9.
3. Stephenson R, Matthews Z, McDonald JW. The impact of rural-urban migration on under-two mortality in India. J Biosoc Sci 2003;35:15-31.
4. Choudhary N, Parthasarathy D. Is migration status a determinant of urban nutrition insecurity? Empirical evidence from Mumbai city, India. J Biosoc Sci 2009;41:583-605.
5. Kusuma YS, Kumari R, Pandav CS, Gupta SK. Migration and immunization: Determinants of childhood immunization uptake among socioeconomically disadvantaged migrants in Delhi, India. Trop Med Int Health 2010;15:1326-32.
6. Swain BK, Mishra S. Immunization coverage among migrant tribal children in slums of Orissa. Indian Pediatr 2006;43:1011-3.
7. Abrol A, Kalia M, Gupta B, Sekhon A. Maternal health indicators among migrant women construction workers. Indian J Community Med 2008;33:276-7.
8. Singh PK, Rai RK, Singh L. Examining the effect of household wealth and migration status on safe delivery care in urban India, 1992-2006. PLoS One 2012;7:e44901.
9. Saggurti N, Mahapatra B, Swain SN, Jain AK. Male migration and risky sexual behavior in rural India: Is the place of origin critical for HIV prevention programs? BMC Public Health 2011;11 Suppl 6:S6.
10. Mishra S, Swain BK, Babu BV. Sexual risk behaviour among migrant tribals living in urban slums of an eastern Indian city: Implications on the spread of HIV. Coll Anthropol 2008:32:1-4.
11. Rao N, Jeyaseelan L, Joy A, Kumar VS, Thenmozhi M, Acharya S. Factors associated with high-risk behaviour among migrants in the state of Maharashtra, India. J Biosoc Sci 2013;45:627-41.

12. Verma RK, Saggurti N, Singh AK, Swain SN. Alcohol and sexual risk behavior among migrant female sex workers and male workers in districts with high in-migration from four high HIV prevalence states in India. AIDS Behav 2010;14 Suppl 1:S31-9.
13. Srivastava HC, Chandrashekar P, Kurien G, Sreehari U, Yadav RS. Malaria in seasonal migrant population in Southern Gujarat, India. Trop Biomed 2011;28:638-45.
14. Ebrahim S, Kinra S, Bowen L, Andersen E, Ben-Shlomo Y, Lyngdoh T, *et al*, Indian Migration Study group. The effect of rural-to-urban migration on obesity and diabetes in India: A cross-sectional study. PLoS Med 2010;7:e1000268.
15. Kusuma Y, Gupta S, Pandav C. Migration and hypertension: A cross-sectional study among neo-migrants and settled-migrants in Delhi, India. Asia Pac J Public Health 2009;2:497-507.

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