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An Analysis of Health Issues and Challenges among Urban Migrant Population in Kerala

Ajith Kumar S

Abstract: ***Background: Urbanisation and migration are interconnected. As per Census 2011, 31.16% of the Indian population was urban, whereas in Kerala, 47.72% of the total population was urban. A study conducted by Gulati Institute of Finance and Taxation showed that there were 25 million migrant labourers in Kerala. The migrant labourers were facing various problems both health related and non health related. The objective of the study was to analyze the health problems, disease pattern, health care seeking behaviour and health care utilization amongst the urban in-migrant population of Kerala.***
Methods: It was a cross sectional descriptive study conducted among a sample of 1217 migrant labourers from the Ernakulam district of Kerala. The study followed a 30 cluster sampling method. Only those respondents having length of stay in Kerala at least six months were included in the study. The Crosstabs procedure forms two-way and multi-way tables and provided a variety of tests and measures of association for two-way tables. A binary logistic regression was done to outline the predictors of health seeking in facilities for migrant workers
Findings: The study found that majority of migrant workers were belonged to backward communities, males married and engaged in construction work. The state of origin of the migrant workers were, West Bengal (35%), Odisha (19%), Tamil Nadu (16%), Assam (14%) and Uttar Pradesh, Bihar. Majority of the respondents had been staying in Kerala for duration between one to six years. Accidents and injuries, skin problems and Non communicable diseases were major health problems among the migrant workers. The logistic regression analysis showed possession of health insurance, monthly income, state of origin and easy connectivity to health facilities are positive predictors for health care seeking for migrant labourers.
Conclusion: The present study revealed migrant workers were suffering from many illness like Accidents and injuries, NCD, skin problems etc. Improve the awareness of health issues among the migrant workers, through IEC and BCC. The existing health insurance needs to be strengthened.
Keywords: Migrant labourers, Disease problems, Health care seeking.

I. INTRODUCTION

A. Background

We live in a world which is becoming increasingly urban. Urbanisation is defined in demographic terms, as the increasing share of population that is living in rural areas. Migration is driving much of the increasing urbanisation, making cities more diverse place in which to live [1].The world is urbanizing with significant changes in the living standards, life styles social behaviour and health of the present and the future generations The term urbanization means “to make a rural area or nation more industrialized or urban or to cause the migration of rural dwellers in to cities” [2]. Over 54 % of the world’s population lives in urban areas in 2014. By 2050, the urban population is expected to grow around 6.4 billion.[1]. In India, the urban population has shown an increase from 25.52 % in 2001 to 31.16% in 2011. In Kerala, 47.72 % of the total population are urban in 2011, as compared to 25.96% in 2001 census and it is likely to increase in the future. Kerala positioned 19th in terms of the level of urbanisation as per 2001 census was ranked in 9th in 2011. Ernakulum (68.1%) is the most urbanised district and Wayanad (3.9%) is the least urbanised in the state. The infrastructure facilities available for the population in general do not much differ between the rural and urban especially in the case of access to educational and health care [3]. Migration is a form of mobility, as defined by Yadlapllay Kusuma and others, in which people change their residential location across the defined administrative boundaries for a variety of reasons, which may be involuntary or voluntary, or a mixture of both [4]. In Kerala, the inflow of migrant labourers from different parts of the country is increasing due to more opportunities for employment and higher wages. Most of the migrant workers, to seek employment elsewhere because of comparatively low level of wages, lack of employment opportunities and the seasonal nature employment in the agricultural sector [5]. Poor economic conditions, getting better employment, meeting household expenditure, to accumulate savings, repaying debt, financing education and marriage of dependents etc were some other reasons for migration [6]. Nimble O. J and A. V. Chinnasamy argued that poverty and caste discrimination were the main reason for migration among the Dalit women in Delhi [7].

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According to a study conducted by Gulati Institute of Finance and Taxation, there were over 25 lakhs domestic migrant labourers in Kerala from other parts of the country (D. Narayana 2013). The study also found that the number of newly arriving migrant labourers in Kerala each year was around 2, 35,000 [5].

The migrant were vulnerable groups and were disadvantaged relative to the native population. They had often a low socio economic status with no access to health care [8]. It had been seen that, migrant labourers face a large number of problems, such as longer working hours, lower wages as compared to local workers. They usually live in slum like localities and live with poor sanitation and poor access to safe drinking water. High density of population, overcrowding, lack of safe drinking water, poor sanitation, and lack of provision for health facilitates poor health care access etc., make them susceptible to infectious diseases, respiratory problems, skin problems etc. Use of tobacco and alcohol are high among the migrants [9]. The risk factors for Cardiovascular disease, Cancer, were also common among them. They suffer from many diseases like fever, respiratory infection and suspected malaria [10].

B. Rationale

There are several national and international studies regarding the health and migration, health issues and migrant labourers etc which were realized from the literature review. Some studies were related with the health problems, which are common among the migrant labourers while some are related with socio economic demographic issues. However, there are very little studies studies about both and health problems health seeking bahviour and coverage of health services in Kerala ; this study is hence proposed and it is expected that the findings of this study will be helpful in strategic planning of health services for migrant labourers.

II. LITERATURE REVIEW

Simon J. L. Massey and Nick Parr conducted research on Australia's migrant population's socioeconomic characteristics (Simon J. L. Massey and Nick Parr, 2012). Five socioeconomic statuses were identified and compared in the study: labour force participation, unemployment, income, educational attainment, and occupational status. The most obvious difference was that migrants had significantly more education, particularly at the university level [10].

Jessica Heckert (Jessica Heckert, 2015) conducted a survey to investigate internal migration among Haitian adolescents aged 10 to 24, to make a comparison the characteristics of young migrants with educational and labour motivations and to identify factors related to family financial assistance to youth migrants. According to the survey, as people became older, schooling and labour movement became more common. The rate of educational migration was higher among those born outside of the capital and those who were first enrolled in school on time.

Labour migration was associated with late school enrolment and differed little by birth region [11].

Warren Dodd and co-workers (.Warren Dodd, et. al. 2017) undertook an exploratory mixed method stud in Tamil Nadu's Krishangiri District to determine the drivers of internal migrants' health and their impact on migrants' health outcomes. According to the study, which used semi structured interviews and a survey, the mean age of the workers was 48 years old. Just 3.6 percent of them had received any formal schooling. More than half (53.3 percent) of those polled said at least one member of their family was a migrant. More than a quarter of the migrants were found to have health issues, according to the report. The majority of them experienced problems with their tissues, infective or parasitic disorders, or skin concerns [12].

Pramod R. Regmi and colleagues (Pramod R. Regmi et al., 2019) used focus group discussions and in-depth interviews to analyse the lifestyle and health care access of Nepali migrants in Nagpur and Mumbai, India. Five themes were identified: housing, lifetime/networking/risk-taking behaviour, employment environment, help from local organisations, and health service consumption. The study discovered that Nepali migrant workers' socioeconomic status was reflected in their inadequate housing and working conditions, putting them at a higher risk of getting a variety of diseases. The study emphasised the importance of the awareness of public health, with a focus on alcohol and cigarette usage restrictions [13].

A study conducted by Yadlapalli S. Kusuma, Chandrakant S. Pandav, and Bontha V. Babu (Yadlapalli S. Kusuma, et. al., 2014) to present the socio-economic profile of the socioeconomically disadvantaged migrants with a sample of 10530 living in Delhi The study found that the main reason for migration was earning a livelihood, followed by better earnings. The study also found that a major proportion of the poor migrants were engaged as temporary wage/casual labour, with low-paid and low-earning jobs in the informal sector. Migrants frequently lived in outdated, unsanitary conditions with a severe shortage of essential facilities (water supply, sanitation, and access to social services). Vulnerable socioeconomic classes, such as scheduled castes and other backward castes, were frequently used to symbolise impoverished migrants [14].

A mixed method study conducted by Dr. Anoop Khanna, found that a large majority of the population belonged to Scheduled Castes (39 percent) and Other Backward Castes (41 percent). Nearly three-fourths belonged to Hindu religion, while one-fourth belonged to Islam. Around 46 percent of the respondents were staying the locality for last more than 6 years. A large proportion of households had migrated from Bihar, Uttar Pradesh, and West Bengal. These three states together contributed to nearly 27 percent of the total migration in Jaipur. Nearly 27 percent of the participants reported illness over past 6 months, and all of them reported some spending for the treatment of such illness.[15].

Nimble and Chinnaswamy (2020) undertook a cross-sectional analysis to determine the determinants causing Dalit women's migration, the financial distress caused by health care spending by Dalit migrant women, and to provide cost-effective measures for lowering health care expenditure. According to the study, poverty and caste prejudice were determined to be the primary drivers of migration. The study also discovered that providing Dalit women with better, more cost-effective health care will improve their quality of life [7].

With a sample of 166 migrant workers, Dilip Saikia (Dilip Saikia2015) conducted a study using survey data to analyse the economic situations of migrant workers in the Trivandrum District of Kerala. The study showed that majority of migrant works were in the younger age, their average age was 26.42 with about 57.8% of them were below 25 years. The study also demonstrated that all the samples selected were males, majority of them were unmarried and 96.4 were Hindus. The study further showed that Scheduled caste dominated sample while 32% of them did know their caste. Majority of them were worked in the informal sector out of which most of them in the construction field [16].

Manmeet Kaur, Sukhbir Singh, and others (Manmeet Kaur et al. 2015) conducted a study using a semi-structured interview with 208 female samples to determine the socioeconomic and health system determinants that may affect migrants' use of health services. The study discovered that 60% of the samples were migrated, with the remainder being village residents. The majority of the migrants lived in slums, while villages had a higher number of native women. The study also found that the mean age was 25 and 26 for migrant and native populations, respectively. The study further demonstrated that migrant workers had higher education levels than natives [17].

III. METHODOLOGY

It was a cross sectional descriptive study, conducted in the urban migrant population of the Kerala state in India. The Target population was the people in the urban migrant population.

The study proposed to address the health problems, health seeking bahviour and in the heterogeneous urban and migrant population in the state. In Kerala since private sector is very strong in the urban areas how this population responds to public health care services in the state.

There is no comprehensive strategy for addressing the problems of this population. The research tries to fill the gaps. It is also expected that the findings of the research may help to reformulate the existing draft health policy of the state.

A. Research Questions

The following are the research questions;

1) What are the socioeconomic and demographic factors that affect the health status of the urban migrant population in the state?

2) What are critical problems in terms of health and non-health factors and their effect on health care seeking of urban in migrant people in Kerala?

B. Aim and Objectives

1) *General:* The main aim of the study was to analyze the socioeconomic and demographic status and the health problems, disease pattern and their impact on health care seeking among the urban in-migrant population of Kerala.

2) *Specific objectives*

a) The assess the socio demographic and economic status and their impact on health seeking of the urban migrant workers of Kerala

b) To assess the health problems and their impact on health seeking of the urban in-migrant population of Kerala.

3) *Study design:* A cross sectional descriptive study

4) *Study Population*: Out of the 14 districts in Kerala, one district selected based on the percentage of urban and migrant population (Ernakulum).

The study was conducted at Ernakulum District of Kerala, South India. Ernakulum District is the most urbanized District and the Domestic Migrant Labourers were largest in this District, hence selected for the study. The study followed the 30-cluster sampling method. A multistage sampling technique was used. .

A pre designed semi structured schedule having open and close ended questions was used for the collection of primary data. In addition, secondary data from various sources such Health Services, Health Facility etc., will be for getting the information regarding the existing facilities, availability accessibility and effectiveness of the health services facility for addressing the issues of the target respondents.

Data were entered and analysis was carried out in SPSS. The data collected through the survey was analysed and presented through contingency tables and figures. Appropriate statistical analysis such as logistic regression chi square values etc were used to fulfil the objectives.

IV. RESULTS

A. *Socio Economic And Demographic Characteristics Of The Urban Migrant Workers*

This section describes the background characteristics, including demographic profile, socio economic characteristics of the urban migrant workers in Kerala. The socio economic and demographic characteristics are widely considered as the major determinants of health.

Table 1 below captures the major background characteristics of the respondents.

The vast majority of the respondents (95% and above) of the study were in the age category of 19-64 years and were males. More than 72% of them have education status up to 5th standard. No one had education beyond secondary level.

With regard to religion, there was an equal distribution of Hindus and Muslims (49% each) among the respondents with others constituting less than 2%.

Three-fourths (75.9%) of the respondents belonged to OBC or the Scheduled tribes or castes. More than 70% of the respondents were construction workers. Majority of the migrant labourers were married and more than one fourth (26.1%) of the respondents were single.

There was only a very small proportion of the urban migrant workers were divorced or widowed. More than three fourth (79.5%) of the urban migrant workers said they earned a monthly income above 16000. Only 3% said they owned a house. More than three fourth (76.7%) of the respondents said they did not own any assets.

Majority of the migrant workers were from West Bengal (35.2%), followed by Odisha (19.3%) Tamil Nadu (15.9 %) and Assam (13.6 %).

The migrant workers from Uttar Pradesh, Bihar, Delhi and Gujarat together constituted about 13.6 % of the sample

Table: 1.Socio economic and demographic characteristics of the urban migrant workers

Socio-economic & Demographic characteristic (N=1217)	Number N=1217	Percentage
Age		
Up to 18	41	3.4
19 and above	1176	96.6
Sex		
Male	1154	94.9
Female	62	5.1
Education		
Up to 5th Standard	978	72.1
Above 5th standard	339	27.9
Religion		
Hindu	595	48.9
Muslim	603	49.5

Others	15	1.2
Don't know	3	0.2
Caste category		
General and OBC	601	49.4
Scheduled Caste and Scheduled Tribe	314	25.8
Don't Know	302	24.8
Occupation		
Construction	880	72.3
Carpentry	10	0.8
Restaurant	129	11.0
Fishing	14	1.2
Street Vendor	11	0.9
Others	168	12.9
Marital Status		
Single	318	26.1
Married	880	72.3
Separated	12	1.0
Others	5	0.6
Monthly Family Income		
Less than 16000	226	18.6
16000 and above	990	81.3
Ownership of House		
No house	28	2.3
Own house	39	3.2
Rented	1026	84.3
Mortgaged	4	0.3
Staying without rent	119	9.8
Ownership of Assets		
No Asset	934	76.7
Inherited Wealth	68	5.6
Savings	173	14.2
Own house	42	3.5
Length of migration		
Up to 3 years	483	39.7
3-6 years	547	44.9
More than 6 years	287	15.4
State of origin		
Assam	166	13.6
Bihar	75	6.2
Orissa	235	19.3
Tamil Nadu	193	15.9
West Bengal	428	35.2
Others	120	9.9

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B. Disease problems

This section demonstrates the major disease problems faced by the urban migrant workers in the state.

The self reported health problems of the urban migrant workers are shown in the table 4.2. The study shows that majority of the migrant workers had disease problems. Accidents and Injuries (51.6.9% of the reported cases), Skin problems (30%) and Non communicable diseases (7.1%) were the major health problems identified from the survey.

Table No. 4.2.Self reported disease problems among the urban migrant workers in Kerala

Disease Problem (N=665)	Number	Percentage
Non communicable diseases	46	7.1
Skin Problems	195	30.0
Accidents & Injuries	335	51.6
Others	73	11.3
Total	649	100

V. DISCUSSION

There were several studies previous conducted, which had shown that majority of the migrant workers were in the productive age group (8, 10 21, 27, 28, 33). The present study found that 90% of the migrant works in Kerala were in the age group of 16-64 Years. The study revealed that majority of the migrant workers was males. Male dominates the migrant workers coming from different parts of the country to Kerala. They came to Kerala for economic benefits to protect financially to their families. Hence most of them were working group and male dominated.

In many studies, it was shown that educational status of the migrant workers were very low and most of them were illiterate (10, 31, 33,).This study also identified that the educational status of the migrant workers was also very poor. Majority of the migrant workers had educational status up to secondary levels of education. An interesting fact, identified from the study that, no one had above secondary level of education.

A. Socio- Economic And Demographic Characteristics

Many studies among migrant workers had highlighted that the major religious groups were Hindus and Muslims dominated. The present study also found that migrant labourers often represented by backwards classes. A study conducted by Anoop Khanna(34), Yadlapally(33), Nimble and Channaswamy(35) and Dilip Saikia(36) had found that majority of the population belongs to SC and backward class. The present study also identified this. However, in the study, almost equal proportion of the respondents constituted Hindus and Muslims. Three fourth of the migrant workers belonged to OBC Category. This study also authenticated that majority of the migrant workers were in the lower caste. However, this study found that, only 1.6% of the migrant workers were from the Scheduled Caste Category, while 24.3% of them were Scheduled Tribe. Most of the Scheduled Tribe migrant workers were from the state of Tamil Nadu

Majority of migrant workers get monthly income above 16000..This income was much higher than those getting in their state of origin. Therefore, the study revealed that the workers from different parts of the country were migrated to Kerala for better earnings. Majority of them were living in rented building and a small proportion was living with their friends or relatives without rent.

The study also found that majority of them had no assets. Nearly one sixth of the migrant workers had inherited wealth and savings, while a very small proportion hade own house in their state of origin.

Majority of the migrant workers were engaged in the construction workers. In the study it was found that more than 70% of migrant workers were engaged in the construction sector. Almost all the states, people coming from other states were engaged in construction field. The people engaged in street vending were mainly from Delhi. A small proportion of the workers were engaged in Fishing, where majority of them were from the state of Tamil Nadu.

The study found that majority of the migrant workers was married. But only a small proportion was divorced. All states except Assam and Uttar Pradesh, majority of them were married. The study further found that more of the widowed migrant workers were from the state of Tamil Nadu

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A very large majority of the migrant did not have any assets. However, a few had inherited wealth and savings, but their savings were more than inherited wealth. There were only a very small proportion of them had own house in their state of origin. Almost all the migrant workers from Assam, had no assets. In Delhi West Bengal and Bihar, where, 80% of them had no assets.

Most of the migrant workers were staying in rented house or staying without rent. As far as the State of Tamil Nadu was concerned more than 90% of them were staying in rented house. Staying without rent were more in state of Assam, Odisha , West Bengal and Uttar Pradesh.

The male migrant labourers dominated the females. However, more female migrants were from the state of Tamil Nadu. In the states of Assam, Bihar, Odisha, West Bengal and Uttar Pradesh, almost all of the migrant workers were males. Thus it was evidenced from the literature review that males migrant dominates in migration.

Hindus and muslins were the important religious groups among the migrant workers. In many states Hindus were dominated. They were Tamil Nadu, Odisha Bihar and Assam. The states where Muslims dominated were West Bengal Uttar Pradesh Delhi and Gujarat. In our study, the proportion of Hindus and Muslims were more or less same. However, many studies reviewed from the literature survey, that Hindus were dominated by Muslims. more than 80% of the migrant labourers in Kerala from west Bengal were Muslims. But in the state less than 30% of the population were Muslims. Thus it is realised from the study that whether these Muslim migrant labourers were really from the Muslim population of West Bengal or somewhere else. Further research is required in this area.

Table No.5.1. Association between background characterises and health care seeking of migrant workers

Characteristic	Health care seeking		$\chi 2$	ρ value.
	Yes	No		
Age			1.034	.309
18 and less	80.4	19.6		
Above 18	72.4	26.6		
Gender			7.397	.019
Male	74.4	25.6		
Female	58.3	41.7		
Education status			20.199	.000
Up to 5th Standard	70.1	29.9		
Above 5th standard	83.1	16.9		
Religion			6.163	.104
Hindu	70.6	29.4		
Muslim	76.4	23.6		
Others	75.0	25.0		
Don't Know	100.0	00		
Caste			2.427	.119
General and OBC	77.7	22.3		
SC/ST	72.9	27.1		
Occupation			11.223	.047
Construction	75.5	24.5		
Carpentry	90.0	10.0		
Restaurant	71.5	28.5		
Fishing	85.7	14.3		
Street Vending	54.5	45.5		
Others	102	53		

State of origin				51.775	.000
Assam	67.5	32.5			
Bihar	79.7	20.3			
Orissa	74.7	25.3			
Tamil Nadu	67.4	32.6			
West Bengal	79.8	20.2			
Others	63.4	36.6			
Length of migration				68.641	.000
Up to 3 years	62.1	37.9			
4 to 6 years	76.9	23.1			
Above 6 years	92.5	7.5			

The table above (Table No. 5.1) summarizes the various parameters that seemed to have had an influence on their healthcare seeking. It can be seen that education above 5th class was a significant association on health care seeking. Similarly, the state of origin played a significant role in whether the migrants sought care or not. The longer the length of migration, the longer was the chance that the migrants sought health care. The statistical analysis shows that the parameters such as age religion and caste have no significant association on health care seeking.

Table No.5.2. Association between socioeconomic characterises and health care seeking of migrant workers

Socio economic characteristic (N=1217)	Health care seeking		$\chi 2$	ρ value.
	Yes	No		
Marital Status			21.999	.000
Single	66.6	33.4		
Married	76.5	23.5		
Separated	33.3	66.7		
Others	85.7	14.3		
Monthly income			20.349	.000
< 16000	61.0	39.0		
>15999	76.3	23.7		
Ownership of assets			6.902	.075
No assets	72.1	27.9		
Inherited wealth	84.4	15.6		
Savings	78.2	21.8		
Ownership of house	71.1	28.9		
Ownership of house			37.078	.000
No house	25.0	75.0		
Own house	86.8	13.2		
Rented	74.9	25.1		
Mortgaged	100	0.0		
Staying without rent	73.7	26.3		

The table No. 5.2 shows the association between socioeconomic characteristics with the health care seeking of the migrant workers. The variables such as marital status, monthly income and ownership of houses of the migrant workers have significant role the health care seeking of the migrant workers. The study showed that the higher the level of income of the migrant workers. The longer was the chance to seek health care.

Table No.5.3. Association between background characterises and disease problems of migrant workers

Variables	Disease Problems				
	Non Communicbale	Skin Problem	Accidents & injuries	Others	Total
State of origin					
Assam	8.5	33.8	42.3	15.5	71
Bihar	11.8	35.3	47.1	5.9	34
Orissa	6.0	25.3	60.0	8.7	150
Tamil Nadu	8.3	28.1	46.3	17.4	121
West Bengal	5.6	32.0	54.5	7.8	231
Others	10.7	35.7	39.3	14.3	56
Income Status					
Less than 16000	6.3	48.1	41.8	3.8	79
16000 and more	8.1	31.8	59.5	0.6	516
Education status					
Up to 5th std	8.4	31.6	59.3	0.7	440
Above 5th std	6.4	40.4	50.6	2.6	156
Religion					
Hindu	9.8	30.0	59.3	1.0	307
Muslim	6.0	37.0	55.9	1.1	281
Others	0.0	100	0.0	0.0	5
Caste					
General & OBC	6.5	37.6	55.2	0.7	279
SC/ST	10.3	27.4	61.7	0.6	175
Occupation					
Construction	7.7.	32.7	58.9	0.7	440
Carpentry	0.0	0.0	100	0.0	4
Restaurant	5.4	35.1	59.5	0.0	74
Fishing	16.7	16.7	66.6	0.0	6
Street Vending	0.0	33.3	66.7	0.0	6
Others	14.3	44.4	39.7	1.6	63
Length of migration					
Up to 3years	4.1	41.2	54.7	0.0	194
4 to 6 years	2.6	12.9	84.2	0.3	650
Above 6 years	8.8	15.1	74.5	1.6	251

The above table (table No. 5.3.) shows the significant association between the back ground characteristics with the disease problems of the migrant workers. All the variables have statistically significant relation with accidents and injuries. However, the background characteristics do not have significant role the disease of skin problems. But, the length of migration of the migrant workers has a significant relation with Non communicable diseases. The variables like state of origin and religion have statistically significant with other diseases.

Table No .5.4. Association between behavioural characterises and disease problems of migrant workers

Variables	Disease Problems				
	Non Communicable	Skin Problem	Accidents & injurie	Others	Total
Smoking					
Yes	7.0	29.7	53.0	10.3	474
No	7.4	32.4	46.8	13.3	188
Alcohol Consumption					
Yes	6.3	27.0	55.6	11.1	189
No	7.4	31.9	49.6	11.2	474

The table No. 5.4 show the relationship between smoking habits and alcohol consumption with diseases problems. The statistical analysis shows that there is no significant association with the disease problems of the migrant workers in terms of their behavioural characteristics such as smoking and alcohol consumption.

Table No.5.5. Association between disease problems and health care seeking of migrant workers

Disease Problems	Health care seeking			$\chi 2$	ρ value.
	Yes	No	Total		
Non communicable	84.8	15.2	46	2.455	.117
Skin Problems	74.9	25.1	195	.198	.656
Accident & Injuries	80.9	19.7	335	10.799	.001
Other	69.9	30.1	73	1.219	.269

The table No. 5.5 highlights the association between disease problems and health care seeking of the migrant workers. The statistical analysis shows that the accidents and injuires have a significant relation with health care seeking of the migrant workers . however all other disease problems does not have any statistically significant association with the health care seeking.
A logistic regression model was generated to identify predictors for health seeking of migrant labourers in local health facilities. The predictor variables which were shown to be significant (Chi Square) were included in the model; they were possession of health insurance, marital status, education, monthly income in INR, ownership of house, state of origin, length of migration, availability of easy transport to health facilities, distance of health facilities from home. The combined impact of predictor variables which were significant by Chi Square is explained in the model summary below.

Table: 5.6. Model Summary

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
1	281.889[a]	.069	.196

In the model summary with the -2 Log Likelihood statistics of 281.889, it is clear that the model does not predict the likelihood of dependent variable well and that about 10-20% of the variation in dependent variable can be predicted by predictor variables.

Table :5.7. Hosemer and Lemeshow test (Model diagnostic)

Step	Chi-square	df	Sig.
1	5.797	8	.670

A p value of 0.670 which is greater than 0.05 and is hence insignificant denotes that the logistic regression model is a good fit.

Table :5.7 Results of Binary Logistic Regression model

	B	S.E.	Wald	df	Sig.	Exp(B)
Availability of Health Insurance- Yes	-1.196	.356	11.273	1	**.001***	.303
Distance of health facility from home - < 3 km	.088	.349	.063	1	.802	1.092
Ownership of house - Yes	.139	.695	.040	1	.841	1.149
Health problem – Accidents and injuries	-.279	.436	.409	1	.523	.756
Length of migration			.850	2	.654	
< 3 years	.460	.504	.832	1	.362	1.583
4-6 years	.331	.475	.485	1	.486	1.392
>6 years						
Education - More than 5th class	-.424	.402	1.115	1	.291	.654
Income – 16000 or more per month	-.919	.393	5.479	1	**.019***	.399
State of origin			17.465	5	**.004***	
Assam	-.333	.494	.454	1	.501	.717
Bihar	-1.616	.475	11.592	1	**.001**	.199
Orissa	-.128	.528	.059	1	.808	.880
Tamil Nadu	.727	.784	.861	1	.353	2.070
Others	.659	.691	.908	1	.341	1.932
West Bengal						
Easy access of facility by transport - Yes	-1.421	.692	4.220	1	**.040***	.241

From the above regression model, it can be seen that possession of health insurance, monthly income, state of origin and easy connectivity to health facilities are positive predictors for health care seeking for migrant labourers.

VI. CONCLUSION

The present study revealed migrant workers were suffering form many illness like Accidents and injuries, NCD, skin problems etc. Improve the awareness of health issues among the migrant workers, through IEC and BCC. The existing health insurance needs to be strengthened.

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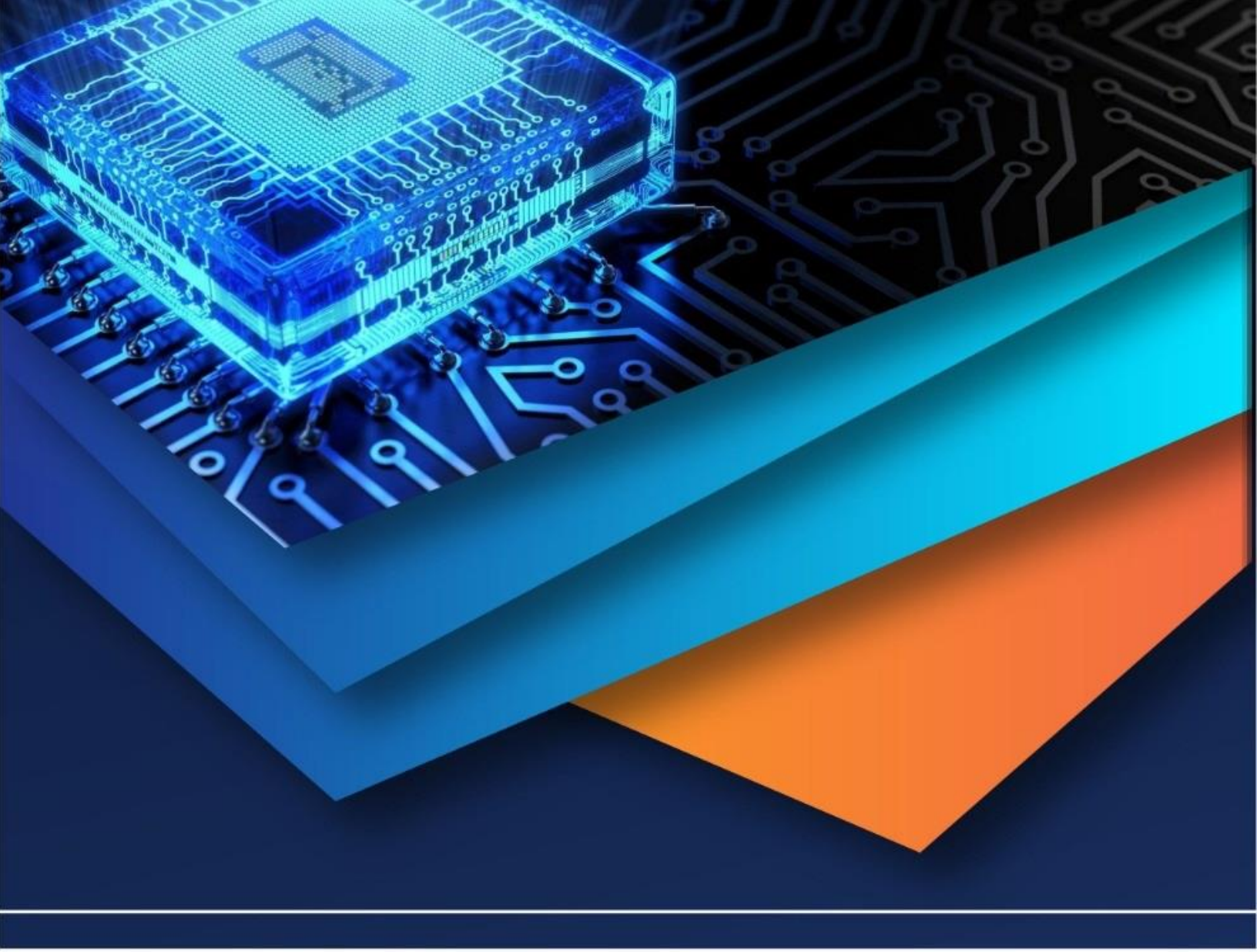

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