A Study on the Sexual & Reproductive Health Risks of Rural Migrant Women in Mysore, Karnataka, India

By,

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1. Introduction

Globalization over the past two decades has caused rapid growth in India's economy, a phenomenon noted by India's place in the top five major emerging national economies alongside Brazil, Russia, China, and South Africa. One consequence of this rapid advance is the development of infrastructure in Indian cities, and as a result construction workers are in high demand. This demand for manual labor has created a portal through which rural migrants enter large cities in India, resulting in the creation of pockets of individuals at high risk for health problems due to their employment and living conditions. Despite the attempt of the Indian government to make healthcare accessible to both rural and urban populations, the nomadic lifestyle of migrant workers makes it so that they do not fall into either of these categories, and therefore they tend to be neglected from health service outreach programs. Migrant workers are particularly prone to the contraction of sexually transmitted diseases and poor family planning due to their mobile lifestyle and lack of awareness about safe sex practices and reproductive decision making.

Within the migrant worker population, female migrants are an important point of interest. Much of the attention on migrant worker health lies around males, yet a closer interest in women is necessary; as the population of India grows rapidly every year, maternal and child health should be a priority. Although females naturally have a longer life expectancy at birth, India is one of the few countries where the life expectancy of a man and woman are about the same. The below life expectancy of women in India is a reflection of their standing in society. They typically lack autonomy, independence, and are generally the non preferred gender of children.

As a result, they are at a disadvantage in maintaining good health and receiving adequate care. It is for this reason that the health of migrant women is a priority to be studied.

The purpose of this study is to get a better understanding of the reproductive health risks that rural migrant women face due to their lifestyle conditions. A questionnaire was created in order to gauge the knowledge, attitudes, behavior, and practices of rural migrant women surrounding reproductive health and family planning. The questionnaire also entails about details regarding the migration status, as to later create a link between specific migrant conditions (time of travel, inter-state vs. outer-state migration, connection to home) that may place women at especially high risk. This questionnaire has been administered to as many migrant women as funds and resources allow in the allotted time period of this project. This study will help the TI-Migrant Project to develop a proposal which addresses the issues migrant women face in order to improve the quality of their reproductive life.

2. Methods

23 women were sampled from migrant camps in the district of Mysore, Karnataka. The questionnaires were translated from English to Kannada. The TI-Migrant project counselors traveled to migrant camps in Mysore and administered the questionnaires in Kannada. The results were then translated to English and input as data points for this study.

3. Results

3.1 Sexual Debut & Age of First Pregnancy

23 out of 23 women had sex for the first time at or under the age of 18, four of which (17%) doing so under the age of 16. All respondents denied having had premarital or extramarital sex. As for first pregnancies, 22 out of 23 of the women had their first pregnancy at or under the age of 20, meaning that 95.7% of the women surveyed have carried out at least one teenage pregnancy.

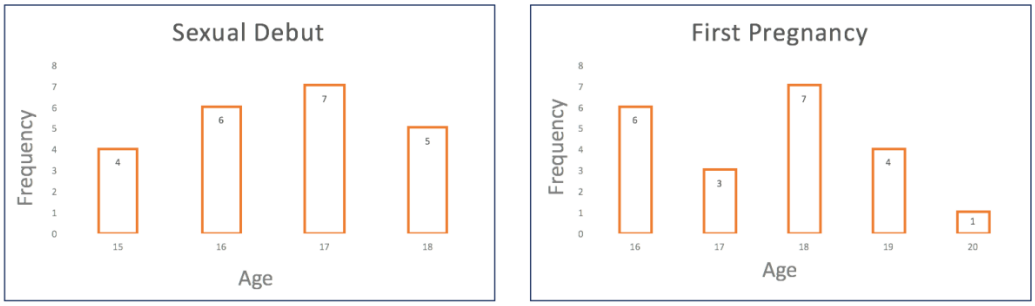

Fig 1. Histogram of ages at sexual debut and first pregnancy

3.2 Contraception Usage

When asked if condoms were useful, 15 out of 23 women reported “no”. Out of the other eight women surveyed, four women said they considered condoms useful, while the other four said they didn’t know. Four out of 23 women reported actually using condoms.

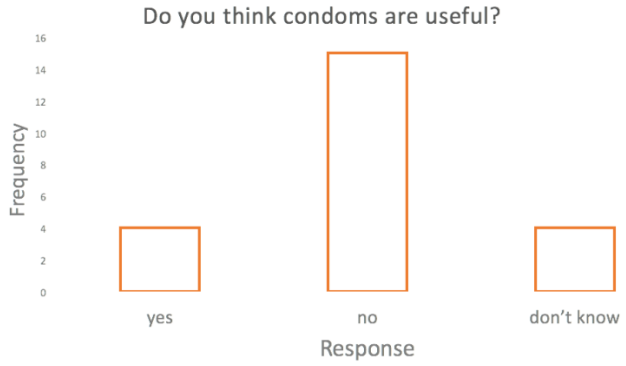

Fig 2. Responses reflecting behaviors surrounding the usefulness of condoms

3.3 Awareness of Resources

78.3% of women surveyed are unaware of where to find family planning resources near them. When asked whether women frequent hospitals or medical shops in order to treat reproductive health issues, 39.1% reported having visited a hospital between 1 and 2 times. Alternatively, 82.6% of women reported visiting a medical shop for reproductive health issues, a little under half (42.9%) reporting having visited one over four times. Out of the 14 women responding “yes” to having experienced symptoms of an STI, 6 of them felt as though a medical shop would be the best place to seek treatment. Zero out of 23 women reported ever having planned their pregnancies.

3.4 Pre-Natal & Post-Natal Care

Zero out of 23 of the women reported ever receiving pre-natal or post-natal care.

3.5 Institutional Delivery Rate

Between 23 women, 57 live births were reported, 51 of which were delivered in an institution. Of the other six delivered in-home, 3 of them came from one mother of 6.

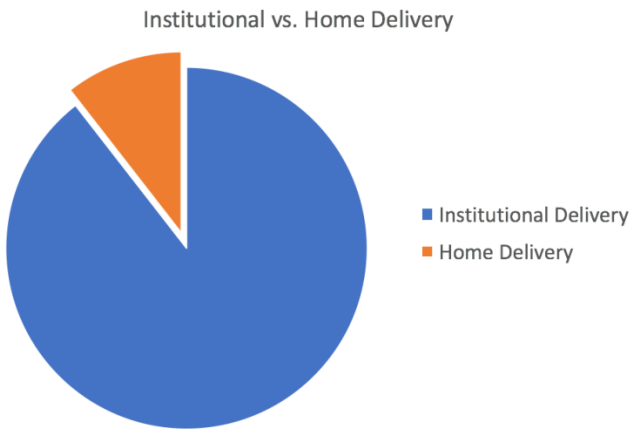

Fig 3. Statistics of institutional delivery rate versus home deliveries

3.6 Economic Independence & Autonomy

All women surveyed report traveling with their husbands to migrant camps. However, of the 23 women surveyed, 21 women report working in migrant construction sites in order to earn their own money as well. That said, 17 of those 21 women (81%) said that they do not feel economically independent, despite earning their own wages. When asked whose decision it should be to visit a healthcare center for reproductive health issues, eleven out of the 23 women reported that it was their husband's decision. Five out of 23 responded that they would not visit a healthcare center, and only three replied saying that they felt it was their own decision.

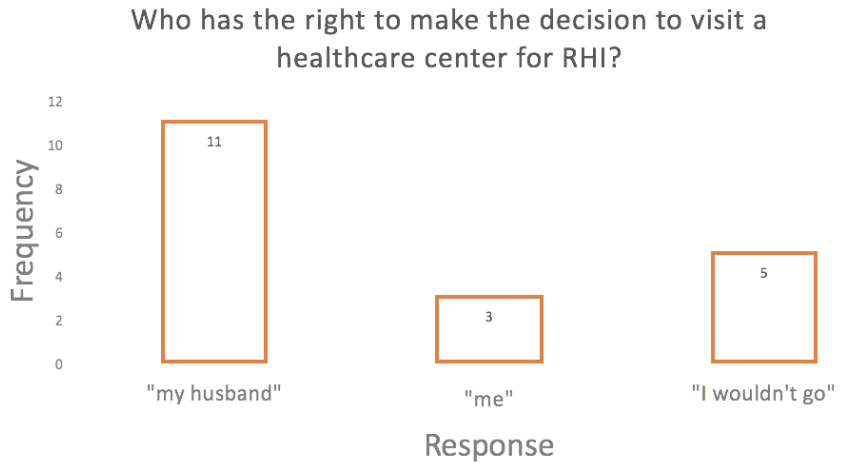

Fig 4. Responses reflecting the attitudes surrounding health autonomy

4. Conclusions

Rural migrant women are prone to an early sexual debut as well as early, high risk pregnancies. Attitudes surrounding contraceptive usage generally reflect a lack of faith and lack of belief that they are useful. Contraception usage is extremely low among rural migrant women.

In regards to seeking care, rural migrant women seem to have a preference to medical shops as opposed to hospitals, likely because of the long wait times in government hospitals and the expenses at private hospitals. Rural migrant women are extremely unlikely to seek pre-natal and post-natal care. Despite disparities in other areas of reproductive health, rural migrant women exhibit high rates of institutional delivery, possibly a product of National Health Mission's Janani Suraksha Yojana program. Rural women lack autonomy on a fundamental scale, reflected in their economic independence and attitudes about reproductive decision-making.

5. Recommendations

Perhaps the most attainable solution to the deficiencies evident in this report is increasing access to pre-natal and post-natal care. The TI-Migrant project has the advantage of pre-existing stable relationships between migrant workers and counselors; through this relationship, women can be informed of the health value of receiving natal care from a doctor throughout the course of and after their pregnancy. There seems to be a lack of belief that natal care is necessarily or helpful to women, so I suggest creating an educational campaign regarding the benefits of natal care. In an intervention to improving migrant healthcare in Mumbai[1], Gawde et al. increased the awareness of migrants about health conditions that may put them at risk using educational materials that were displayed at prominent locations within the community, at community festive events, and community self-help groups. Although there are a lack of general meeting spaces for migrants in Mysore, the counselors can bring educational materials to field visits and distribute them to migrants for the same effect.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4644792/pdf/fpubh-03-00255.pdf

Another apparent issue is the knowledge of services available to migrant workers regarding reproductive health. A similar material distribution system was used in the study in Mumbai, where Pamphlets distributed that outlined a schedule of services offered as well as location of each service offered. The schedules were translated into Hindi as well. If similar documents could be generated that are specific to Mysore, women would be able to know where and when they can consult medical care. An additional idea would be to include on the pamphlet means of transportation both to and from the medical centers available.

A larger and more pressing issue found in the population of rural migrant females is the lack of autonomy and independence they feel from their husbands. This problem is less easily solved with a pamphlet, as the lack of independence from husband and families is deep rooted in Indian gender culture and history. That said, a way of empowering women could be grouping them in ways where they empower each other. Female support groups discussing the work-home life balance would allow both women to voice their feelings and concerns as well as counselors to understand ways in which they could target small parts of womens' lives that could potentially be separated from their husbands and children. In a study on female migrants in China[2], researchers discuss the positive impacts of female groups, saying that they create a sense of empowerment that "not only influence[s] individual women but also function through the tightly-knitted rural social network to develop others' individual agency and collective agency of female kin. Creating an environment where women see themselves for their value separate from home life may greatly increase the chances that they feel the right to (a) spend their own money, and (b) make reproductive health decisions without consulting their husbands.

[2] https://www.files.ethz.ch/isn/137972/WP79.pdf

These recommendations are small solutions to kinks in the chain of events of a female's life that ultimately lead to poor reproductive health. Because female health in India is intrinsically linked to their status in society, there are larger, more socio-cultural causes to reproductive health issues that may be difficult to solve with interventions. That said, the beginning of this data collection yields few insights into places where intervention is possible. Above all, it is recommended to continue data collection on this study by continuing to conduct surveys of these women and find other places where intervention may be helpful.