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RESEARCH ARTICLE

EPISTEMOLOGY IN MIGRANT COMMUNITY FOR BETTER HEALTH OUTCOMES IN PRIMARY HEALTH CARE OF NORTH INDIA - A CASE STUDY

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Abstract

The migrant community often lacks health care access due to poor health knowledge. Epistemology deals with the nature and scope of knowledge. Epistemology links the migrant community to the health system with adequate knowledge to accept the health-seeking behavior in lifestyle. Objective: To assess the salutogenic health promotion model in primary health care for the migrant population. Methods: A qualitative analysis of the migrant community was conducted in a family with an antenatal case as the index case. The epistemological salutogenic health model of General Resistance Resources (GRR) and Sense of Coherence (SOC) were applied. A health promotion model was devised following the GRR and SOC. A health system intervention was also planned to improve health indicators. Results: The family had a better approach to health and preparedness towards the institutional delivery of the child. The children were immunized with appropriate documentation. The success story of the family turned the migrant community to act as a social support group for positive health. There were improvements in the health indicators of the urban slum improved. Conclusion: Using epistemology aspects and a salutogenic health promotion model bridged the gaps in the health system with the migrant community. The migrant community is often ignorant about their health but with appropriate health promotion models, their health needs can be addressed.

Introduction:-

Epistemology is a multifaceted term that is concerned with the nature, possibilities, and scope of knowledge that may lead to acceptance of an innovation or a change in individuals, communities, and society.[1] (Watve M, 2017; Anderson 2016) Knowledge is one of the roots of the belief system of an individual, society, or community. The belief system forms an integral part of the decision-making process for health-seeking behavior. Poor health-seeking behavior and access to health care have been observed in the migrant community, despite immense improvement in the health system in developing countries like India. It may be due to multiple factors influencing their behavior such as poor community participation, lack of awareness, frequent migration, loss of daily income to illiteracy, myths about immunization, and poor socioeconomic status.[6](Shung et al 2016), 8,[9,10,11](Grudywetal, 2018; Singh et al 2018; Singh et al 2012;)[7](Smith et al 2015)

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The adaption of the health system for the migrant community has become an urgent need due to the rise in tourism. The international migrant community has seen an enormous increment to 258 million in 2017 from 220 million in 2010, worldwide.[3](United Nations, 2017)Additionally, an economic survey conducted in India estimated inter-state migration of nearly 9 million annually between 2011 and 2016.[4]The internal migrants in the country are also reported to a humongous load of 139 million. [5](Government of India, 2018; RGI, 2019)

It is hypothesized that health system gaps can be addressed by understanding the Epistemology aspects of the community. Our case study focuses upon Antonovsky'sSalutogenisis model which is based on the dynamic continuum of health and illness. It focuses on the factors that guide the community factors towards positive health and risk factors that cause the disease. The salutogenic model stands for GeneralizedResistanceResources(GRR) and Sense of Coherence(SOC). GRR signifies "a property of a person, a collective or a situation which, as evidence or logic has indicated, facilitates successful coping with the inherent stressors of human existence". SOC is defined as "the ability to understand the overall situation and the capacity to use available resources." There are three integral domains of SOCare comprehensibility (the sense of one's own life as ordered and understandable); manageability (the perception of available resources and skills to manage stressors); and meaningfulness (the overall sense that life is filled with meaning and purpose). 10,11(Sorionenetal , 2016; Golebiewski et al , 2017)

Our case study focuses builds a salutogenic health promotion model in the migrant community to increase awareness about the internal and external factors influencing the individual, health system & surroundings, further enhancing their ability and improving health. These programs are focused not only on minimizing (disease) risks, but also on strengthening the existing coping mechanisms of each participant, hence guiding them towards the path of positive health.

Community Setting

This qualitative analysis conducted in an urban slum near a tertiary care hospital, Sector 12, Chandigarh, having a population of around 400 with one antenatal, 40 under 5 children, and 9 unimmunized children. There was one temporary Anganwadi center in the area.

For our case study, we focused on a family with an antenatal case (pregnant woman).

The antenatal case belonged to a Hindu nuclear family that had shifted from Moradabad, Uttar Pradesh nearly 6 months back. The family belonged to Upper Lower Socioeconomic status as per the modified Kuppuswamy scale 2018.13(Saleem, 2018)The family was headed by a 28 years old laborer with a 26 yrs. old pregnant wife and two female children of ages 4yr and 3yr. The antenatal case was a 26 yr old married woman with a Period of Gestation (POG) 24 weeks, 3rd gravida, and 2 live births. Her menses started at the age of 14 years with a 4/30-day cycle, regular moderate flow, mild dysmenorrhea, and using a **simple cloth.** She was a non-smoker and non-alcoholic. She had a non-significant family and personal history with no history of any abortions or stillbirths. She still uses **traditional cooking ways**, **practices open defecation,** and has **poor hygienic conditions.**

1.Issue: Shortage of logistics for migrants leads to loss of faith in the health system

She had her Last Menstrual Period on 20 April 2018 upon which she visited the civil dispensary for a urine pregnancy test. After confirmation of pregnancy, the head of the family decided to continue the pregnancy in preference of a male child. She was registered with the health system but due to logistic shortage in the health system, the Maternal and Child Protection (MCP) card was not made.

She said "Humara Pregnancy ka card bhinahinbanaya, kyunki hum bahar se aayehain" (Our MCP card was not made as we come from outside)

2. Issue: Poor Communication with migrant patients put patients at risk

In the first trimester, an ultrasound(USG) at a private clinic reported a gestational sac of 10 weeks with positive Foetal Cardiac Activity. None of the other investigations or intake of folic acid was reported by her. In the second trimester, she was started on Iron Folic Acid and calcium tablets. Due to nausea and vomiting, after a few tablets, she stopped the intake of the tablets. Level II USG showed a single live intrauterine live child with POG at 22 weeks and 2 days, low lying placenta covering internal os(placenta previa), but the case had no information about it. Hemoglobin was reported as 11.3gm%. However, on questioning she said

"Ultrasound dekha kuch parchi pelikha par ye bhi nahin bataya ki wo theek hai ya nahin(they checked the ultrasound report but did not tell that everything is all right) "

"Khoonke test karate rahtehai par batatekuchnahinhain(they take the blood but do not tell anything) "

3. Issue: Poor socioeconmic status with migrant patients limits their access to health care

On asking about the other routine investigations, she had a notion that it will cost money and a lot of time will be wasted. Although she goes to a civil dispensary for a checkup whenever her husband takes her but she did not feel satisfied.

4. Issue: Loss of faith in the health system makes migrants ignorant and leads to poor health-seeking behavior

The female children of 4 yrs. and 3 yrs. had no documentation of any immunization. The presence of BCG scar helped in concluding BCG immunization. However, in a continued conversation with the mother, she had told that "only two injections are enough in villages" and it is just a waste of the laborers' wages. Furthermore, she added that the child cries a lot after the injection. It was also found that she didn't have information about the schedule of the immunization or any of the government schemes and was frequently sent back home as she didn't visit on immunization days.

Epistemological aspects

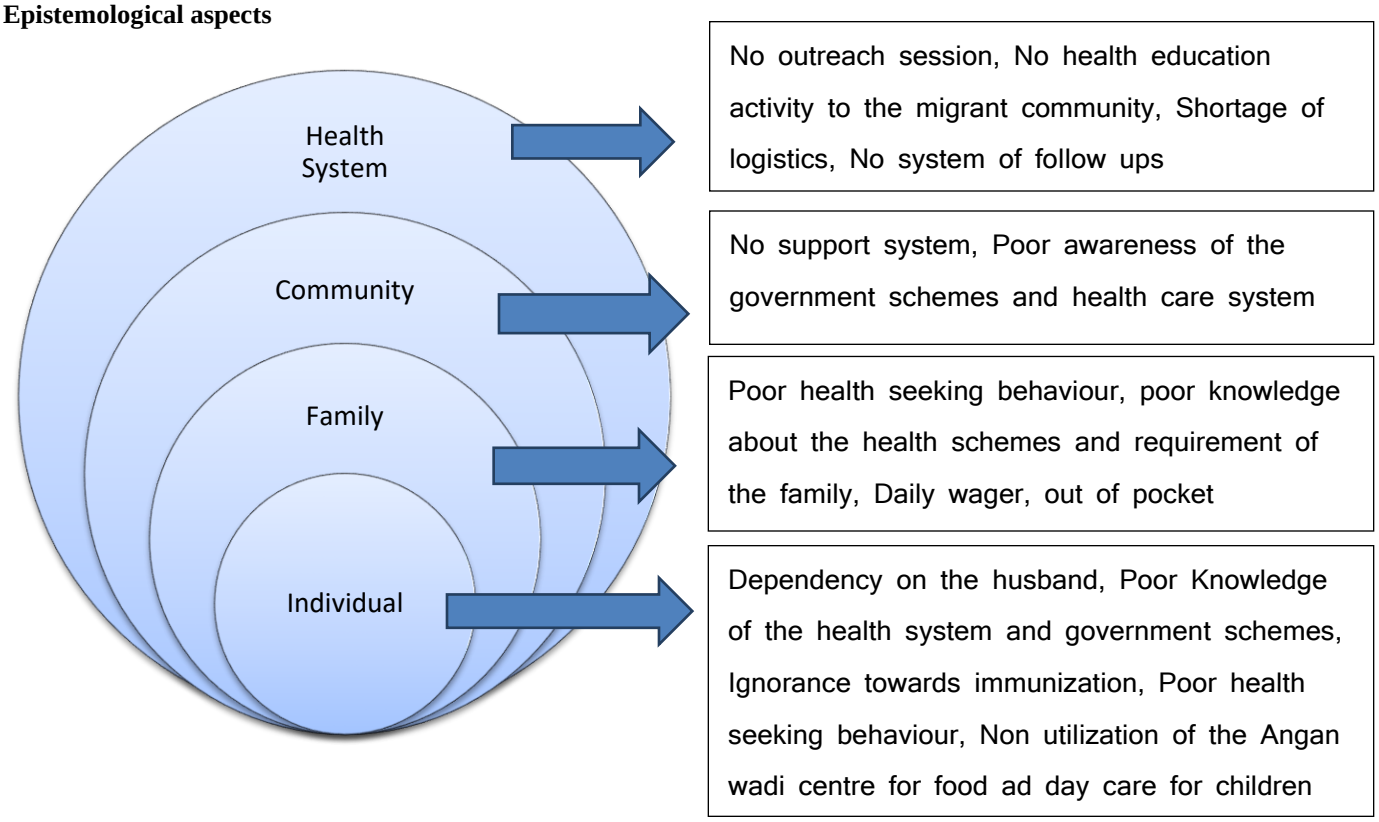

Figure 1:- Epistemological aspects related to the health and health system in the migrant community.

Intervention

The intervention was planned in two steps – a health promotion model for the family and community and a health system strengthening intervention.

Health Promotion Model: Our resident (first author) devised a health promotion model that was based on improving the awareness of the migrant family about the self, health system, and utilizing the resources in hand. The health promotion model consisted of four aspects. The first aspect worked upon the self-abilities of the family individuals. It aimed to improve their self-esteem and encourage them to ask questions. The second aspect was to recognition of the community restraint resources. It also aimed at the identification of social support groups and identification of themselves as contributors to society. Further, the sources of economic help were delineated to help during the economic crisis. The third aspect was to help identify how the family could contribute to their community in further identifying the restraint resources. The fourth was to promote women's health with short, medium, and long-term future goals e.g. family planning.

Health system intervention: The health system issues were addressed with a collaborative meeting between the health officials and public health activists. The outreach sessions for the migrant community were requested every month, with field visits of the health workers. The shortage of logistics and Health education activities was warranted by the officials.

Results:-

The major GRR were money, social support, ego, poor self-esteem, and poor knowledge about the health system. (Figure-1)During the implementation of the health promotion model, empathically the family was addressed on their illiteracy status and gave them hope in educating their children for better socio-economic growth of the family. In order to improve their self-esteem, they were asked to find out if they had qualities that would benefit the community. The gender equality notion was imparted across the family with the importance of a healthy child than the only male child.

The general health care education was imparted with non-usage of simple cloth and usage of government sanitary pads was demonstrated. They addressed harmful practices like open defecation and were motivated to use community toilets. Further, she was advised for regular antenatal follow-up, and bed rest and was educated about danger signs during pregnancy. She informed me about the emergency number and on the occasion of initiation of labor. She was also advised to get tested for a glucose tolerance test and to repeat the ultrasound. She was also educated about the importance of immunization and was motivated to get the child vaccinated. She was informed about the condition of "placenta previa" and motivated to keep a positive attitude towards pregnancy. She was also counseled on family planning methods as well. The family was motivated for institutional delivery and immunization as per schedule. Further, the neighbors were encouraged to provide social support and manage her kids during the time she goes for checkups. Health education regarding dietary habits, personal hygiene and sanitation, and immunization and national programs was also provided.

After 4 weekly visits, the antenatal case felt better prepared for institutional delivery and confident to call upon an ambulance in absence of her husband. The neighbors started supporting the family during the checkups. They initiated the use of community toilets. The children were immunized with up-to-date immunization cards. With the successful intervention at the family level, the family became a knowledge hub for the migrant community residing there. The migrant family was well informed of the Government schemes and the benefits that could be availed at the health facility if required. The outreach session was implemented and the immunization of the migrant community was now complete and regular follow-up was being done.

Discussion:-

Epistemology has found its utility in health settings with self-care, professional care, and involving the community leading to a holistic approach to health. The salutogenic health promotion model for a migrant family in primary health care enabled us to address the major GRRwith provision of social support, increased self-esteem, and appropriate knowledge about the health system. The health promotion model worked upon the belief system of the migrant family to improve their health-seeking behavior.

There have been only a few studies that demonstrated the use of epistemologically appropriate health promotion models in migrant community.[18](Murge et al, 2016)) Our case study demonstrated how understanding the epistemological aspects can bring about change in the mental psychology of the family as well as the community. There is also evidence to support the existence of positive health effects of salutogenic approaches. (Álvarez ÓS, et al 2020)

Our case study also focused on the health system gaps that were common challenges faced by low and middle-income countries.[15-17](Zukifietal, 2020, Lue et al, 2020; Aewohetal, 2016)Studies have also reported that health-seeking behavior among migrants remained dismal synergized with illiteracy and poverty.16,17(Lue et al, 2020; Aewohetal, 2016)However, it was quite evident in our case study that despite similar limiting factors the health seeking behavior improved in the family after intervention with the salutogenic health promotion model. The prevalent belief system of loss of wage over health needs to be addressed with compassion and strategic communication. [18](Kimani-Murage etal ,2016)Our case study depicted that there was a poor connect of the health workers to the field is one of the reasons for missing out on the migrant populations. Some studies report poor management of the patient load in the health care facilities that made the patients reluctant to come to health care

facilities.20,21(Sun etal2017;Meng et al, 2015) The health workers should not be afraid to report adverse events and a felt need to stop blame culture in health profession keeping accountability in place.[11]

Poor free services must reach the migrant population. In India, maternal and child health are covered by free health care services such as Janani Shishu Suraksha Karyakaram (JSSK), Janani Suraksha Yojana (JSY), Ambulance service, Pradhan Mantri SurakshitMatritva Abhiyan (PMSMA), Pradhan Mantri Matru Vandana Yojana (PMMVY), food supplementation at Anganwadi and Ayushman Bharat.22,23 Further a feedback mechanism has also been devised with an initiative such as "MeraAspataal" by the government of India through SMS, Web portal, and mobile app which help the government to take appropriate decisions for enhancing the quality of healthcare delivery across public facilities.24 Hence, more research is required in health system strengthening to address the needs of migrant communities.

Conclusion:-

Knowledge is the stepping stone for change of beliefs and decision-making. The salutogenic health promotion model of health promotion in the migrant population helped to address the needs at the grass root level for better access to health care facilities. The health system needs to regain the faith of the migrant community with adequate and appropriate health communication skills. The facilitation of the public health activists and health care workers with the health promotion activity is a must reach so that the people can make informed decisions with an understanding of the government schemes and avail their benefits.

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