

## **6.0: Introduction**

The present chapter explains the summary and conclusion of the study. This chapter is broadly divided into four parts. The existing health policy available pertaining to child health in international, national and state level discussed in part one. In part two, overall summary of the findings of the study is presented. Testing of hypothesis is presented in part three of this chapter. In part four, the study conclude with some suggestions for policy implications keeping in mind the gap between existing policy level and the summary findings of the study.

This study has undertaken to explore the impacts of mobility on those who do not move i.e., the left behind family members. Impacts at place of origin can be seen on income, consumption, education, health and broader cultural and social prospects. However, these impacts are mostly favorable, but the concern that communities lose out when people move needs to be explored. Our review of the evidence suggests that impacts are complex, context specific and subject to change over time. The nature and extent of impacts depend on who moves, how they fare abroad and their proclivity to stay connected, which may find expression in flows of money, knowledge and ideas, and in the stated intention to return at some date in the future (HDR, 2009).

## **6.1: Existing Health Policy pertaining to child health**

To achieve sustainable and attainable child health status across the globe, efforts have been made to have comprehensive goals and target bound declarations at international, national and at various provincial levels keeping their needs, urgency and requirements. The declaration made by the international community i.e., the Millennium Development Goal (MDG) to achieve the sustainable child health status is discussed below.

## **6.1.1: Initiatives at International Level**

### **6.1.1.1: Millennium Development Goals (MDG)**

In September, 2000 the United Nations declared in its Millennium Declaration, representing leaders from 189 nations, embraced a vision for a world with collaborative approach of both the developing and developed countries, for the betterment of all, particularly the most disadvantaged groups. The vision was transformed into eight Millennium Development Goals, consisted 18 targets and forty-eight indicators to provide a framework by which progress could be measured. The Millennium Declaration document, in its goal four stated to reduce child mortality and under-five mortality rate by two thirds between period of 1990 and 2015.

## **6.1.2: Initiatives at National Level**

A series of attempt has been made by Government of India at the national level to achieve child health goals with declaration of some policy and programmes. Among them, the very popular ones are: National Population Policy (NPP)-2000, National Health Policy (NHP)-2002, and National Rural Health Mission (NRHM)-2005.

### **6.1.2.1: National Population Policy-2000**

Inadequate care, asphyxia during birth, premature birth, low birth weight, acute respiratory infections, diarrhoea, vaccine preventable diseases, malnutrition and deficiencies of nutrients, including vitamin 'A' are major causes of high mortality and morbidity among infants and children below five years of age in India. Urgent attention is required in policy level to curb high morbidity and mortality. In view of this, Government of India has declared a policy at the national level in the year 2000. Thus, a National Technical Committee is set up included all range of health practitioner, academician and programmer for developing quality improvement activities with monitoring schedules and suggestions for facilitating provision of continuing medical and nursing education to all peri-natal health care providers with prescribing peri-natal audit norms. More on, to achieve objectives, the baby friendly hospital initiative (BFHI) extended to all hospitals and clinics up to sub centre levels. Essential equipments for the newborn were provided at sub-centre levels. Programmes for Safe Motherhood, Universal Immunization, Child

Survival and Oral Rehydration have been combined into an Integrated Reproductive and Child Health Programme, which also includes promoting management of STIs and RTIs to achieve the wider goals (NPP-2000).

#### **6.1.2.2: National Health Policy-2002**

Public health initiatives over the years have contributed significantly to the improvement of the health indices in the country. Despite the impressive public health gains the morbidity and mortality levels in the country are still unacceptably high. These unsatisfactory health indices are, in turn, an indication of the limited success of the public health system in meeting the preventive and curative requirements of the general population. In order to achieve the wider goal of '*Health for All*', which was declared in the then health conference in 1983, and further in 2002 the national government declared a National Health Policy. The policy concerned about the child health in the public health domain that the persistent incidence of macro and micro nutrient deficiencies, especially among women and children particularly in girl child, has the multiplier effect through the birth of low birth weight babies and serious ramifications of the consequential mental and physical retarded growth. Among the number of factors, inhibit to access to the existing public health facilities contributing to low health status, social, cultural and economic factors. Thus, the policy recognizes the catalytic role of empowered women in improving the overall health standards of the children (NHP-2002).

#### **6.1.2.3: National Rural Health Mission-2005**

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission in the year 2005. Moreover, to carry out necessary architectural correction in the basic health care delivery system with a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water constituted the core agenda of this mission. The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children (NRHM, 2005).

### **6.1.3: Initiatives at Odisha State Level**

Despite gradual improvement in health status over many years, preventable mortality and morbidity in Odisha are still remarkably high in statistics. The root causes of poor health status continue to be poverty, social deprivation, lower levels of literacy, inefficient health systems and infrastructure for health care and control of diseases, particularly communicable diseases. Moreover, socio-cultural inequities and barriers, insufficient assertion and demand for health care, inadequate regional imbalances of service outlets and poor quality of health care reduce access to and effectiveness of public services are also undertaken. Realizing the importance of the health care investment Government of Odisha has setup its own goal to improve the health of the people. Further, to equitable access the good quality of health care Government of Odisha declared two policies in this field that are **Health Vision 2010** in 2001 and **State Integrated Health Policy 2002**.

#### **6.1.3.1: Health Vision 2010 pertinent to child health status**

The Government of Odisha through numerous programmes in the health sector seeks to provide adequate, qualitative, preventive and curative health care to the people of the state. In order to ensure health care services to all, particularly to the disadvantaged and vulnerable groups like scheduled tribes, scheduled castes, gender, old person, children, disabled and other backward classes Government of Odisha declared Health Vision 2010. It also aims to provide affordable quality health care to the people of the state to ensure greater access to primary health care by bringing medical institutions as close to the people as possible or through mobile health units (Vision, 2010). More on the vision declares on risk protection against major communicable diseases, injuries, all ailments of women and children, with particular reference to conditions associated with pregnancy and childbirth. This will be achieved through a combine of service and financing options.

#### **6.1.3.2: State Integrated Health Policy 2002**

The policy document is a guiding document providing a framework for the integral development of the health sector in Odisha to meet its stated social goals and objectives. As we know investing for the health and wellbeing of children is investing for the future. The state already has several health interventions for children through the various programmes such as Reproductive Child Health (RCH) programme, the Infant Mortality

Rate (IMR) reduction strategy, and the Integrated Child Development Services (ICDS). Despite the various programmes adopted for better child health care Odisha recorded the highest infant and child mortality rate states among the states of India. Innovative efforts to reach out of schoolchildren, working children and street children will be made through Self help Groups (SHGs), NGOs, women's groups and children's groups. The coverage and quality of the Integrated Child Development Services (ICDS) with regards to nutrition and child health care are expanded and improved in collaboration with other departments. Despite these, the state performance in health realm is distressed with widespread under-nutrition and anemia among children, leading to stunted growth and development, and other health related problems. To ensure the better functioning of all programmes directed at improving health of the children the state declared a time bound goals in the integrated health policy documents. These are listed in appendix Table 4 (**see appendix Table 4**).

## **6.2: Summary findings of the study**

Let us sum up the empirical evidences with regards to the impact of internal rural-urban out migration on health status of left behind family members in general and child health in particular in rural Odisha. It is found that the internal migration has magnificent impact on the health status of left behind families through migrant remittances. Further, the empirical evidence suggests that internal migration not only improves the financial or social stature of migrants and their left behind families but also on health status of left behind family members. Moreover, the improvement of health made not only through migrant remittances but also with transforming health knowledge, idea, practice and health information to origin and changing the health care practices among migrant households at source areas. Hence, the overall improvement of health status of the migrant members is envisaged over non-migrant members.

The finding of the study indicates that majority of the migrants are belonging to prime working age group (20-30), completed education up to secondary school, middle category of standard of living index and the poorest wealth quintile. More on majority of migrants belong to Other Back Ward Categories (OBC) category. Most of them are small and marginal farmers. The size of the migrant households is a large three member's

family. As the migrants are migrating at the prime working age of their life, hence it creates a shortage of labour force at the origin particularly during the time of seedling and harvesting. Although, agriculture is the main occupation of the area but insufficient of land for cultivation, low agricultural production and higher wages at destination are main pull factors responsible for migration in rural Odisha. Most of the migrants of rural Odisha are working as unskilled workers in the textile industries of Surat in Gujarat and construction and allied sectors of metropolitan city Mumbai.

Even if the migrants are engaged as unskilled manual labour in the unorganized sector their earning is quite high i.e., 8,874 rupees per month. Out of this around rupees, 3,205 are spending towards consumption expenditure at destination and rupees 3,836 sending as remittances to origin. In order to understand the economic impact of the internal migrants the study administrated a schedule of questionnaire in the study area. The finding suggests that the earning of the migrant labourer is around three hundred rupees per day, which is more than the daily wage rate prescribed by the government of Odisha. If we assume other factors as constant the remittance to their family is quite high. Nonetheless, the spending at destination is also high. It may due to the impact of peer group pressure, urbanite and urban lifestyle on the spending pattern of single rural migrants at destination. The study also found that family requirement at origin and children well-being are the major reasons for remitting money by migrants in rural Odisha. Majority of migrants used the informal sources (Friends, relatives and unregistered money transfer agents etc.) for remitting money to origin. The probable reason may be the lack of exposure to the financial institutions owing to low education status, rigid financial mechanism and easy accessible to the non-formal systems at destination and origin.

The study found that migrants' marital status, household possession of land, number of persons per household, migrants' monthly income and consumption expenditure at destination are the core determinants of the migrants' remittances in rural Odisha. It is prudent to say that ever-married person would be more responsible than never married. Hence, the burden of marriage and family may force the migrants to send more. On the one hand household possession of land and their requirement for agricultural investment would be high and on the other hand the aspiration of the migrants to get the share of

parental property (if the individual is living in joint family) determines the decision on remittances. The requirement and responsibility of joint family system compels the migrants to send more as compared to nuclear families. It is fact that amount of sending money depends on the consumption expenditure at destination and on income. The suffering of the child during last two weeks of the survey very often shapes the migrants' remittance in rural Odisha. More on, future health status of an individual is unpredictable and it is more in the case of child health. The expenditure incurred due to health care is unpredictable and unavoidable. Hence, to meet the unavoidable and emergency situation the migrants are remitting more. As we know and many past studies exhibit that, the poor people migrate to free from economic exclusion. However, our finding suggests that none of the economic variables viz., wealth quintile and standard of living play dominant role to determine migrant remittance.

The empirical evidence suggests that increasing migrants' remittances raises the household's monthly health expenditure and lessens burdens of disease in households. The increasing household's monthly health expenditure make-out significant changes in health status of left behind family members over non-migrant counterparts at origin. The study also found that increasing migrant remittances increase the frequency of nutrition food intake among the left behind family members such as milk, cord, bean, green-leaf, meat etc., as a result their nutritional status improved, leads to a low incidences of various diseases. The increasing remittances from migrants enable household to spend more on health care both in protective and curative thematic area. As a protective measure expenses are made for coverage in the health insurances and nutritional food intake and in curative measure; the household spends in medical expenses. The result is the improvement of the health status. The finding of the study suggests that increasing investment in health insurance, consumption on nutritional food intake and medical expenses reduces the incidences of disease burden and mortality.

The study also found that migrant households have better health knowledge and information over non-migrant counterparts. The migrant households are translating the knowledge and information into practice to reduce the incidence of various diseases. For

instance using toilet soap and treating drinking water reduce the incidences of communicable diseases like diarrhoea and pneumonia, which found significant difference the morbidity pattern. Many qualitative findings of the study indicate that due to migration their awareness and level of health knowledge increases. These practices change the outcomes of the migrant households over non-migrant counterparts. Further, the level of woman empowerment and decision making is high among migrant families than non-migrant families. Of course, many past studies have already proved that women in migrant households are more empowered and decision maker than non-migrant households. Moreover, women empowerment and autonomy indicators significantly determine the health status of children.

The conclusion of the presented study is corroborated by past studies. To substantiate the quantitative findings of the study we quote one of the qualitative findings To substantiate the quantitative argument the study quote one of the qualitative finding [*“ Bidesibadi jibaru amagama re lokakanara chalicalana, arthika, swastya and sikyara khetrare bipula matrare labhabanaa hoichi. Ahi subidha kebala takanka madhyare simitanahi annyana gaama lokankara madhya bahuta subbidha heuchi. Purbaru ama gaama re besi loka roga re maruthile karanna tannka pakahre pasia nathila chikichha heba pain jadiba kichhi loka pakare paisa thila kintu semananka ate sabu kathha janna nathila abama jaddi ba janna thila swatstya seba painni ki ahi subhidha nathila jemiti ajkalli achhi. Bartamana ama gaana ra besi loka baharaku jai paisa patra bahuta kameile tennu semane abe bahuta subidha re achhanti. Tike kichhi roga hele tanka ghara pila kimba bada loka manaku turanta medical jauchhanti abama upachara karuchhanti”*]. In English. Due to migration the life style of the people has changed. The process of migration not enhances the income level of migrant households but also their education and health status. More on he has categorically explained that before migration the household members are unable to access and utilize the health facilities because in lack of resources and awareness. Although few households had ability to pay but their limitation was their awareness of facilities. However, at present it has corrected in our village due to migrant remittances specially focus on child emergency medical situation.



*Moreover, the benefit accrued from migrant not only restricts with mover household members but also it percolates other household members in our village].*

The impact of migration process, i.e., remittances is a multidimensional effect at the source region. The empirical finding indicates that household receiving more remittances the health status of the left behind members is better in comparison to household receiving less remittances. Further, the study also suggests that migrant household members are better in their health status as compared to non-migrant counterparts. Besides, the migration process, the other factors are also playing unique role to shape the health status of population. However, the role of the migration cannot undermine based on the empirical findings. The finding suggests that children in the migrant households have better nutritional standard as compared to the non-migrant households. It also suggests that the children of the migrant families are less prone to any diseases or morbidity and mortality as compared to the non-migrant households. Further, the study gears-up with empirical findings that households are receiving more remittances and spending more in health, through directly in a medical care and indirectly in a nutritional food intake; as a result the children are better in their nutritional status. Hence, migration is considered as positive indicator of development in rural Odisha.

Finally, we can understand with empirical evidence that migration improves the financial or social stature of migrant and their left behind family members. This also improves the health status of the left behind family members, particularly among children, not only through migrant remittances but also with transforming health knowledge and health information, and changing the health care practices among migrant households. The empirical evidence also suggests those increasing migrants' remittances that push the household's monthly health expenditure and lessen the burden of disease among migrant households. The increasing household's monthly health expenditure brings-out significant changes in health status of left behind family members over non-migrant counterparts.

### **6.3: Testing the Hypothesis:**

1. It is observed from the present study that the migrant households are better off in economic status as compared to non-migrant households. Further, the study also establishes the fact that the spending pattern of migrant households vis-à-vis non-migrant households on health care in general and child health care in particular akin to the our hypothesis (29% of migrant households as compared to 12% of non-migrant households belonging to high standard of living index). Hence, the contention of the first hypothesis appears to be valid.
2. The empirical investigation of the study well establishes the fact that increasing remittances from migrants enables them to spend more on health care, health insurance and nutritional food intake. All these expenses reduce the incidences of disease burden and child mortality. For instances; around (14.3) percent of household spending 500 rupees per month as their health expenditure receiving 2,000 rupees as monthly remittances in contrast to 31.8% of household in same spending category receiving 5,000 as monthly remittances. This proves our second hypothesis that the health expenditure of migrant households is determined by migrants' remittances.
3. Many qualitative findings of the study indicate that due to migration the awareness and level of health knowledge of migrant households' increases over time. The practice of certain modern hygienic methods, viz., use of toilet soap, boiled filter water, shoes in latrine, phenyl for cleaning of floor, etc. reduce the incidences of communicable diseases like diarrhoea and pneumonia. This has a salutary effect on the child health and morbidity pattern. All these establish the hypothesis that 'health status of children of migrant households is better off in comparison to non-migrant households'. For example, 56.5% of migrant household's children suffered from at least one disease during last two weeks prior to the survey as compared to 62% of non-migrant households' children.
4. The fourth hypothesis of the study is 'migrant household are more aware about health conscious, health knowledge and health information over non-migrant households'. Sufficient evidence is not found in our empirical research to establish this fact. To answer certain health related questions both the migrants and non-migrants have approximately equal response. Hence, fourth hypothesis is partially valid.

5. In the present study only health aspect of the migrant household is studied. No attempt has been made to examine the effect of migrants' remittances on other aspects of the left behind families. In course of data collection we have gathered some idea about the impact of migration on human capital, but these things cannot be established in a concrete manner. However, argument of Micheal Grossman (1972) i.e., health may be viewed as human capital and based on our findings; we may argue that migration has potential to impact on human capital. Thus the hypothesis five which assured 'migrants' households are better off in their human capital (health) as compared to their non-migrant counterparts' which is also established from our analysis.

#### **6.4: Conclusion and Policy Implication**

The study has undertaken the task of evaluating the impacts of migration on the left behind family members. In many developing countries, like ours, both the internal and international movement is a household strategy aimed at improving not only the mover's prospects but also the extended family as well. To support the move the family expects the financial remittances which can be used to meet the major financial investments as well as immediate consumption needs (HDR, 2009). More on the flow of remittance in terms of money are vital in improving the livelihoods of millions of people in developing countries. Many empirical studies have confirmed the positive contribution of international and internal remittances to household welfare viz., nutrition, food, health and living conditions in places of origin (Yang, 2009). The finding of the past studies on migration highlights the greatest impact at household level with regards to income, consumption, education and health.

However, people often believe that impact of migration on destination is negative. The fear is that newcomers may grab jobs entitles more burden on public services, create social tensions and even increase criminality at destination. Many evidences suggest that these popular concerns are exaggerated and often unfounded. Hence, theses perceptions need a careful investigation to formulate policy decision. Studies also suggest the possibility of creating virtuous circle through policy measures that enhance and broaden the benefits of mobility. This would increase migrants' economic and social contributions to both destination and origin communities.

Numbers of past analysis have shown that large gains to human development would flow from improved policies towards movers. These would benefit all groups affected by migration. However, a bold vision is needed to realize these gains. A vision that embraces reform because of its potential pay-offs, while recognizing the underlying challenges and constraints. Hence, the findings suggest that migration is a substitute not an alternative for the overall development.

The basic objective of the present study revolves around ‘the relationship between flow of remittances from internal rural-urban out migration and its impact on health status of left-behind family members in general and child health in particular’. The empirical evidence corroborates our view that households receiving more remittances are in a better position as compared to their low remittances receiving counterparts. Although the study has its own limitation on selection of the sample population (as only economic migrants are included in the sample) yet the empirical evidence suggests that with the increase of migrant remittance, the household’s monthly health care expenditure pushes up so also better health outcomes of the left-behind family members at the place of origin. This implies that migrant remittance has a positive impact on the health status of the migrant family members in general and child health in particular. This assertion is based on a simple axiom that migrant remittances are necessarily used towards the achievement of better health status of the migrant family. Hence, the prospect of better health status of the left-behind families hinges on two important determinants. These are: 1) the amount of remittance received by the household from the migrants 2) the desire and willingness of the family to utilize these remittances towards the health expenditure. If a congenial atmosphere is created to direct the above mentioned factors in right direction we will certainly expect desired result.

Hence, with the support of our investigation we propose the following two sets of policy suggestions towards the achievement of defined objective of the dissertation. These are: Migrant Friendly and Remittance Enhancing Measures and Health Awareness Creating Measures.

### **Migrant Friendly and Remittance Enhancing Measures:**

Migrants are always considered as vulnerable group both at destination and at origin. On account of abject poverty and repeated natural calamities, the people of Ganjam are compelled to migrate. They are in dire need of employment to free from poverty trap. Poverty is the main cause for malnourishment, which deteriorates the health status of the poor. Malnourishment is the major cause of morbidity and mortality. To reduce the malnourishment of children among study population the empirical evidence suggests that provision of adequate nutritional food is essential. This needs increasing consumption expenditure of household on nutritional food particularly for children. Therefore, migrant remittance is a viable option to increase the consumption expenditure at sending region to reduce the malnourishment and promote the health status of children. Further, the findings of the study suggest that increasing out of pocket expenditure in health simply alters the thousands of lives in numerous ways. These are: 1) increasing access to health facility reduces the number of diseases and mortality, 2) investment in protective health measures through more investment in nutritional food intake, 3) investment in health insurance. Thus, investment towards health is the most important determinant of health outcome (this is supported by MDG declaration and NRHM documents). Therefore, effort should be made to scale up the migrant remittances towards health investment domains. Policy should be directed to make comprehensive mechanism for reducing the administrative cost of remittance so that the left behind family members will receive more.

One seminal factor in this regard is the exploitation of migrants. We should have a note in this aspect. Very often, the intermediaries like migrant mafias, Dalals and opportunistic groups are exploiting the illiterate, innocent and simple rural migrant labourers. These labourers have been taken far away from their origin and exploited which act as a dis-motive factor at origin for further migration. Migrants feel their life is at stake, although the fears about migrants are exaggerated by print and electronic media. So, all information related to labour laws, working hours and workers right etc. should be available at both the origin and destination. Public awareness should be created with the dissemination of these facts through mass media for the betterment of employers and

employees. We may cite Chinese ‘Hukou’ system here, under which each migrant is registered or have work permit before moving the cities. As a result, the movement of labourer would be easy and able to create a national labour market. Better networking such as, transportation and communication system between sending and receiving region would be able to increase not only the number of migrants but also remittances. All these require a strong political will and committed attitude of the bureaucracy to enforce strict regulation for the protection of the interest of the migrants. Therefore, local committees should be appointed and empowered with the support of government to take affirmative action in favour of migrants and punitive action against migrant mafias, Dalals and opportunistic groups.

### **Health Awareness Creating Measures**

Remittance alone cannot change the situation much. Unless the mind set up of the left behind families are changed health status of the family and child health remains the same. Hence, remittance does not operate in isolation. It should be accompanied with other socio-economic measures, like health awareness and health consciousness measures. Promotion of health insurance, hand-washing and treating drinking water reduces the morbidity and mortality. The finding of the study also suggests that health knowledge, information, women empowerment and decision making lessen the household disease prevalence in study area. Hence, effort should be to promote these steps to have a positive impact on health outcome of the left-behind family of the migrants.

The goal of better health outcome of the migrant family can be achieved through intensified public action, better management of resources, changes in social attitude and cooperation of the people. Therefore, it is envisaged that a synergized interaction between Government, Non-Governmental Organisation (NGO) and people is essential. All the stakeholders should play their due role. Government as the major partner formulates policy and fill the gap of ‘out of pocket expenditure’, NGOs act as the facilitators but the real player is the ‘people’. In the present study the family of the migrant. Hence, the active participation of all these agents represents the hallmark of the success.

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