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RESEARCH ARTICLE

STUDY OF MORBIDITY PATTERN AMONG MIGRANT WORKERS IN A COASTAL CITY OF KARNATAKA

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ABSTRACT

Background: Knowledge about the health status of migrants is often limited due to lack of data. This is because migrants are often excluded from surveys. Immigrants from disease-endemic areas settle in urban slums with highly vector-receptive and unprotected housing, introducing new and drug-resistant strains.

Aims and objectives: 1. Study of Morbidity Pattern among Migrant Workers

Material and Methods: Migrant population in coastal city was the study population. Study duration: From December 2015 to April 2016.Study design: Cross sectional study. Subjects of this study included migrant population located in 3 different areas of coastal city. Clinical examination was done at the site of camp**.** Pretested questionnaire was used to collect data by interview method.

Results and Discussion: A total 300 migrant workers were included in the study, of this 75.33%were male workers and 24.67% were female workers. 39.33%of the workers belonged to the age group of 21-30 years. Amongst the migrants workers, musculoskeletal symptoms ranked 1st in 43.33% subjects. 22.66% migrants had skin problem followed by fever which was seen in 20.66% migrants. Other important illness seen in the migrants were gastrointestinal problems (9%) respiratory problems (8%) and urinary tract infections (6.66%).Only 6% of the migrants had complained of having malaria. Injuries were seen in 3.3% migrants.

Conclusion: This study has shown the pattern of health problems amongst migrant workers, which can contribute to further development of health promotion strategies for migrant workers.

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INTRODUCTION

Migration is a process of social change during which a person moves from one cultural setting to another in order to settle for a longer period of time or permanently (Syed and Vangen, 2003). Reasons for migration can be divided into push factors (driving the individual out of the country of origin) and pull factors (attracting the individual towards the recipient country). Push factors includewar, poverty, hunger etc., while pull factors include employment opportunities and political and religious freedom (Mygind *et al*., 2006; Carta *et al*., 2005). These factors affect both the nature of the migration and the migrants health (Bhugra, 2004). Knowledge about the health status of migrants is often limited due to lack of data. This is because migrants are often excluded from surveys. There may be several reasons for this, including insufficient knowledge of the language, lack of professional interpreters, and greater costs when conducting surveys and interviews among migrants. In addition, there are difficulties in engaging migrants in these surveys. This may be due to the migrants' feelings of less trust with the surrounding society and its institutions. Migrants often live in a social context where new social, political and language realities result in great demands on their coping skills and adaptability (Mygind *et al*., 2006; Hjelde, 2004). The workers' living conditions are poor with denial of basic amenities to maintain the standard of living, making them prone to health problems. The construction sites create breeding grounds for various vectors and the unprotected labourers act as potential baits. In addition, immigrants from disease-endemic areas settle in urban slums with highly vector-receptive and unprotected housing, introducing new and drug-resistant strains. (Maria Kristiansen *et al*., 2007) In this quest, a cross-sectional study was planned in the construction sites in the city of Mangalore to study the baseline socio-demographic profile and morbidity pattern of migrant workers.

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MATERIALS AND METHODS

Source of data: Study population: Migrant population in Mangalore City limits in different places. 1. Shaktinagar 2.Bhengre 3.MRPL construction site. Study duration: From December 2015 to April 2016.Study design: Cross sectional study. Sample size: 300. Inclusion criteria: Migrant workers of Mangalore city not residing for more than 3 years were included. Exclusion criteria: Resident labourers of Mangalore city.

Method of collection of data: Informed written consent was obtained by explaining the study subjects about the method of study, outcome and possible intervention. Assurance to the subject about confidentiality of the subject's data was ensured. A pre-tested semi structured questionnaire was used for collection of data. Data was collected by interview cumclinical examination at the work site.

RESULTS

Table 1 Socio- Demographic Distribution

In the above table, out of the total 300 migrant workers, 226(75.33%) were male workers and 74 (24.67%) were female workers Majority of the migrant workers160 (53.33%) were Hindus by religion, followed by Muslims 104 (34.67%).170 (56.67%) were married and 130 (43.33%) of them were unmarried. Majority of the workers had completed primary education (46.67%)

Table 1. Sociodemographic distribution among study subjects

Socio-demographic factors	Number (N=300)	Percentage %
1.Sex		
Male	226	75.33
Female	74	24.67
2.Religion		
Hindu	160	53.33
Muslim	104	34.67
Christian	20	06.67
Others	16	05.33
3.Marital status		
Married	170	56.67
Unmarried	130	43.33
4.Education		
Illiterate	90	30
Primary	140	46.67
Secondary	38	12.67
Higher Secondary	22	07.33
Graduate	10	3.33

Table 2. Age group distribution of the study subjects (N=300)

Age group	Number	Percentage
10- 20	34	11.33
21- 30	118	39.33
31- 40	92	30.67
41- 50	46	15.33
More than 50	10	03.33
Total	**300**	**100**

Table 2 Out of 300 migrantsexamined, 188 (39.33%) workers belonged to the age group of 21-30 years and 92 (30.67%) workers belonged to the age group of 31-40 years. The youngest migrant worker was 10 years of age and the oldest was 68 years in age.

Table 3. Morbidity pattern of the Study population (N=300)

Morbidity Pattern	Number	Percentage
Fever	62	20.67
Skin problem	68	22.67
Musculoskeletal problem	130	43.33
Gastrointestinal problem	27	09.0
Respiratory problem	24	08.0
Urinary tract infection	20	06.6
Malaria	18	06.0
Injury	10	03.3
Others	14	08.0

Note: Few subjects had more than one morbidity.

In morbidity amongst the migrants, musculoskeletal symptoms ranked first, 130 (43.33%) of300 study population. 68 (22.66%) migrants had skin problem followed by fever which was seen in 62 (20.66%) migrants. Other important illness seen in the migrants were gastrointestinal problem (9%), respiratory problem (8%) and urinary tract infection (6.66%).Only 18 (6%) of the 300 migrants had malaria. Injuries were seen in 10(3.3%) migrants. Other morbidities included Eye problems, Hypertension, Menstrual problems and Headache.

DISCUSSION

A total 300 migrant workers were included in the present study. Of this, 226(75.33%) were male workers & 74(24.67%) were female workers.170 (56.67%) of the migrant workers were married. Majority of the migrant workers 160(53.33%) were Hindus by religion followed by Muslims 104 (34.67%). 188 (39.33%) of the workers belonged to the age group of 21-30 years, the youngest migrant worker was 10 years of age and the oldest was 68 years in age. Regarding morbidity pattern in this study, 43.33% subjects had musculoskeletal problems like aches, pulls, tendinitis, etc. This is probably due to improperphysical activity during manuallabour and un-ergonomic practices at the work place. Similar study done by Mohopatra (2002), also reported that 40% of the migrant workers suffered from musculoskeletal disorders affecting various joints and muscles ranging from neck to foot. In the present study 62 (20.33%) out of 300 migrants had fever. Study done by Adsul *et al*. (2011) also showed that the highest morbidity (23.11%) at the construction site was due to acute febrile illness. Out of these, 20.71% workers had suspected malaria. In the present study 6% workers had malaria. Reason for malaria at construction sites may be due to favourable conditions for mosquito breeding sites offered by construction site environment and the unprotected workers acting as baits. In this study, Skin problems such as fungal infection, contact dermatitis, and eczematous rash were found in 22.66 % of the workers. Contact with cement and lime may have led to irritant dermatitis. Inadequate bathing besides handling of various construction related materials like paints, corrosives, and detergents, waste at construction site may have also attributed to these skin conditions amongst these labourers. Unhygienic cooking and eating practices could have contributed to gastrointestinal problem such as loose motions, abdominal pain, constipation, and loss of appetite which was found in 09% of the migrant workers in the present study. Study doneby

Adsul BB[8] also showed that 4.41% worker had gastrointestinal problems as workers were exposed to chemical agents, parasitic agents, or infective agents at the work place and at the place of their residence. In this study, 8 % of workers had various respiratory infections. Gurav *et al*. (2005) have reported respiratory problems in 4.86% of workers. The respiratory problem in this study may be due to higher exposure to dust during the working hours and post-working hours as most of the workers living accommodations were located within the construction site. In the present study 6.6% of them complained of a urinary tract infection. This raises the suspicion of sexually transmitted infections in them; which requires further study.

It was found that 3.3 % migrant workers were having some form of injury while working at the construction site. Construction industry is known for high incidence of accidents. According to Ramsay (1983) the risk of accidents increases with extremes of temperature. Age, sex, personal habits (such as working under the influence of alcohol), personality traits (risk-taking behaviour), and physical and mental state of the worker play an important role in the occurrence of accidents. (Gupta and Mahajan, 2003) In a study by Shah and Mehta, (Shah and Mehta, 2009) the prevalence of injuries was 25.42%, and the reason for the low prevalence in this study can be attributed due to more of mechanization at work place and on-site periodic safety induction training given by the construction company employing them.

Other important illness seen in the migrant workers was eye problem in 8 (2.6%) of the labourers. Eye conditions were mainly related to conjunctivitis with a potential risk to spread and foreign bodies due to dusty working conditions. Hypertension was diagnosed in 3 of the migrant workers. Mean number of days lost due to illness among the migrant workers were 2 to 3 days. This is important in considering the fact that their daily wages would be deducted if they did not work. It was found that to avoid financial loss, the migrant workers get back to their work without recovering fully from their illness, prolonging their sickness & spreading it to co-workers. This further predisposes them for increasing their morbidity status in future.

Conclusion

This study has shown the pattern of health problems among stmigrant workers, which can contribute to further development of health promotion strategies for migrant workers. The benefits to the construction company are to have a healthy workforce to achieve its targets and goals of the project as well as opting for the Occupational Health and Safety Assessment Series certification.

Public–private partnership can act as a model to decrease morbidity and mortality at construction site among migrant workers.

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