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Research Article

Perspectives of Migrant Link Workers on Strengthening the Provision of Maternal and Child Healthcare Services for Female Migrants

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The vulnerable population of migrant women face increased challenges in the areas of maternal and child health. The recruitment of Migrant Link Workers (MLWs) in Ernakulam district, Kerala, is a first of its kind initiative wherein resourceful migrants identified from within the migrant community with lived experiences of migration themselves, serve as health activists working closely with frontline healthcare workers to cater to the migrant community. This study employed a phenomenological research design to explore the perspectives of MLWs on their role in strengthening the provision of maternal and child health services to female migrants in the district. Four broad themes emerged namely (1) collaborating with local healthcare workers to enhance services; (2) accountability towards the migrant community; (3) competencies and core strengths; and (4) challenges in engaging the migrant community. In conclusion, the efforts of MLWs have enhanced the delivery of maternal and child immunization services by strongly supplementing the services of local frontline healthcare workers.

Keywords
Maternal and child health, child immunization, Migrant link workers, Kerala, India, Female migrants, task shifting and task sharing

INTRODUCTION

Maternal health is a vital aspect of public health (Leung, 2023; WHO), whose importance is grounded in its significant influence not only for the well-being of the mother but also for the child, family, and the broader community (Leung, 2023). Accessing maternity care services in a continuum of care approach is key towards the reduction of maternal and neonatal morbidity and mortality; it comprises care provided to women during pregnancy, childbirth, and the postpartum period in a comprehensive and integrated manner by a skilled provider (Tamang, 2017; Wang and Hong, 2015). The UNDESA reports an increased number of

maternal deaths during pregnancy and childbirth (2020) due to reasons that are preventable (WHO) through timely interventions by skilled health professionals as well as educating community members (Gliozheni and Gliozheni, 2020). Further, most maternal deaths occur in sensitive and humanitarian settings of which Sub-Saharan Africa and Southern Asia together constitute the majority of the global total in 2017 (WHO; Gliozheni and Gliozheni, 2020).

Another equally critical area is the health of children, and the role of immunization in promoting their health. Immunization has led to a drastic reduction in cases of vaccine preventable diseases that were once considered fatal, thereby helping children to grow and develop healthily (Mohamdeen). Their importance in promoting children's health presents them as key components of primary health care and an undeniable human right that strengthen the global health scenario. Vaccines are most effective when administered to children in a timely and age appropriate manner in the prescribed dosage when children are most prone to certain diseases (Singh). A child who remains non-vaccinated or does not get vaccinated on time remains vulnerable with increased chances of infections that are otherwise preventable (Smith, 2023). Despite the known benefits of vaccination for children and larger communities, low vaccination coverage rates still persist in countries indicated by a 2022 data from the WHO which stated that 14.3 million infants missed receiving their first dose of the DTP vaccine. Additionally, 6.2 million infants are only partially vaccinated. Most low- and middle-income counties are a long way from achieving universal coverage of children's vaccines (Summan et al., 2022) of which nearly 60% reside in countries of Africa and Asia, among the total of 20.5 million affected children (WHO).

Maternal Health and Child Immunization Scenario in India

In India, several inequities exist between and within states in relation to maternal health services used and maternal deaths (Hamal et al., 2020). Although the overall maternal deaths have reduced significantly over the years in the country, the situation of the poorer states still needs to be improved, with greater focus on the rural and tribal areas (Meh et al., 2022). With regard to immunization for children, reasons for not accessing immunization services as cited by communities included demand-side issues as being the major cause, such as not feeling the need of vaccination stemming from a lack of awareness, not knowing about vaccines or where to go for vaccination; inconvenient timings; fear of side-effects and adverse event following immunization (United Nations Children's Fund [UNICEF], 2010).

Several Indian states such as Assam, Uttar Pradesh (UP), Madhya Pradesh (MP), Chhattisgarh, Odisha, Bihar, Rajasthan, Haryana, Punjab and West Bengal recorded a high number of maternal deaths (Deol, 2022). Several of these states have also recorded a poor performance in terms of children's health and immunization such as Bihar, MP, UP, Rajasthan and Assam (UNICEF). Vaccination rates were also found to be lower in infants with mothers having no or less literacy and in families with inadequate women empowerment (Mathew, 2012).

The southern state of Kerala has made great strides in the areas of both maternal health and its childrens' health status and welfare (Ministry of Health and Family Welfare, 2022; Deol, 2022; Rajpal et al., 2023; Health issues India). The state has effectively delivered maternal and child immunization services through the National Health Mission, responsible for advancing health of mothers and their children as well as ensuring their survival. Among its various goals are included improved universal availability of and access to quality public health care and services for people including reproductive, maternal and child health; and immunization in a way that is equitable, affordable and ensures quality. Specific emphasis is laid on reaching out to those residing in rural areas, the poor, women and children.

Maternal and Child Health in the Context of Inter-State Migration in India

Inter-state or internal migration as a phenomenon has been on the rise in India, wherein sending states experience out migration of people to states that have better work opportunities, wages and living conditions. Sending states including UP and Bihar were characterized as being thickly populated and less urbanized, while states that received migrants such as Maharashtra, Delhi and Kerala were seen as more urbanized and industrialized (Raj, 2023).

The state of Kerala has been witnessing a large inflow of migrants from several east Indian states that face unemployment and low wage issues (Parida and Raman, 2021; Peter and Narendran, 2017) due to reasons such as favourable wages, relatively better living and working conditions and social acceptance (Peter and Narendran, 2017). Migrants including women have moved to the state to live and work (Peter et al., 2020). Ernakulam district in Kerala accounts for the largest number of migrants in the state (Parida and Raman, 2021). Women who migrate with their spouses either join the workforce at the lowest levels or stay at home to take care of their families. Reaching out to these vulnerable women is often challenging as they have very limited exposure to the local language and culture, possessing poor knowledge, attitude and practices in health by virtue of hailing from conservative backgrounds or states with poor health infrastructure (Santalahti et al., 2020). Also, migrant women may have additional needs such as economic, that may compete with healthcare (World Health Organization Regional Office for Europe, 2018). These can have negative implications such as maternal and infant deaths, home deliveries that can prove to be fatal (Patel et al., 2021; Ou et al., 2021), and susceptibility of children on account of non-immunization (Anderson, 2014).

The Migrant Link Worker Model of Care

It is in this context that the recruitment and work of Migrant Link Workers, hereafter referred to as MLWs, becomes significant. The recruitment of MLWs in Ernakulam district a first of its kind initiative wherein resourceful migrants identified from within the migrant community as health activists work closely with the frontline healthcare workers to serve the community, specifically focussing on the vulnerable group of migrants.

MLWs are persons with lived experiences of migration journey themselves and mostly hail from the states from which several migrants along with their families have migrated to Kerala in the recent past. Their leadership and multi- lingual communication skills enable the dissemination of health-related awareness and information among migrants and connect them to services in their own language (Peter et al., 2020). The initiative is powered by the State Government that acts as an enabler, with the involvement of the district administration and various departments including legal, health, police, excise, Childline as well as civil society organizations that work with migrants. Among their various roles, the MLWs work closely with the local healthcare system in enhancing the maternal and child health and immunization status situation among migrants.

Theoretical Framework

The institution of the MLWs as a means to improve the maternal and child health and immunization status among migrants can be viewed as an instance of task shifting and task sharing in healthcare, which has proven effective for vulnerable communities in low- and middle-income countries in combatting the issue of shortage of human resources in health and deliver several health services effectively (Adejumo et al., 2024; Mbouamba Yankam et al., 2023). Within the task shifting and sharing strategy, their institution also dually serves as an example of a culturally sensitive intervention through which the heath conditions of migrant women and children are improved. Hence, the application of task shifting and sharing when applied to the case of MLWs also helps towards the larger achievement of the SDG goal of ensuring healthy lives and promote well-being for all by increasing access to maternal and child health among migrants.

Rogers et al. (2021) in their mixed method study in Australia report the effectiveness of cross-cultural worker services who were appointed to enable women and their families from cross border migrant and refugee backgrounds access health and community-based services through the continuum of pregnancy to the early parenting period. The cross-cultural workers model was found to meet the needs of migrant and refugee women by reducing barriers to healthcare access, thereby producing positive health outcomes. The WHO Regional Office for Europe in its technical guidance report on 'Improving the health care of pregnant refugee and migrant women and new-born children' points out to issues in providing healthcare to mothers and newborns, arising from lack of interpretation services to ensure good communications in healthcare facilities, as well as person-centred preventive care that is culturally sensitive. A systematic review conducted by Redden et al. (2021) to examine the effectiveness of interventions directed to international migrant women settling in Western countries that may directly or indirectly affect their reproductive health, found that the migrant women's reproductive health was most positively affected by those interventions that adapted to meet the cultural and linguistic contexts of the particular migrant group, in focusing on disease prevention activities.

Rationale for the Study

Existing studies on the importance of cross-cultural workers and their importance in delivering timely interventions for improving mother and child health are more in the context of international migration. Limited literature exists in the area of internal migration. Moreover, studies offering perspectives of the cross-cultural workers themselves are sparse especially in the Indian context, which is marked by large amounts of internal migration. Hence, this study fills this gap by looking at the novel case of the institution of the MLW model of care, as well as attempts to gain an in depth understanding on their perspectives about their role in strengthening the provision of maternal and child health services to female migrants in the district, thereby leading to better health outcomes among the internal migrant community.

METHODOLOGY

Research Design

The study employed a phenomenological design in order to gain an in-depth understanding on the perspectives of MLWs instituted under a welfare project for interstate migrants, on how their work strengthens the provision of health services in the sphere of maternal and child health for migrant women.

Sample Recruitment and Data Collection

Semi- structured interviews were carried out with five MLWs comprising four females and one male to gather their detailed perspectives about their role in strengthening maternal and child health for migrant women (Creswell, 2013; Creswell, 1998 as cited in Sharma et al., 2024), at which point data saturation was attained. The participants were recruited in a purposive manner, based on i.) their involvement for at least a minimum duration of six months in the project, and ii.) having extensive experiences of working with migrant women.

MLWs were contacted individually for the research purpose and having obtained their verbal consent, the interviews were audio recorded and transcribed in order to identify similar patterns and arrive at themes. The interviews were conducted during 2023 and 2024 as part of a larger mixed methods study on the sexual and reproductive of internal female migrant workers.

Interviews were conducted in Hindi and Malayalam languages based on the preference of the link workers; each interview lasted about 25–30 minutes. In addition, the authors were also part of select MLW field cum home visits with the migrant women community, which allowed a greater understanding of their work and interventions made. Lastly, secondary literature that provided a fair understanding of the timeline and structure of the constitution of the MLW system, its salient features along with some of the key work done by the link workers was also reviewed.

Ethical Considerations

The study was approved by the Rajagiri Institutional Ethics Committee (RCSS/IEC/008/2020 dated 7 December 2020). Pseudonyms were assigned to ensure confidentiality of participants. Access to the audio files was only permitted for the research

team. Any information that revealed the identity of the participants were removed from the transcripts.

Data Analysis

Following data collection, generation of codes and thematic analysis was done by both authors using Braun and Clarke's thematic analysis method (Byrne, 2022). The six-phase process in the analysis included familiarisation with the data; generation of initial codes; generating themes; review of potential themes; defining and naming theme and lastly, producing the report.

FINDINGS

The process of thematic analysis led to the identification of four major themes. These are 1) Collaborating with local healthcare workers to enhance services; 2) Accountability towards the migrant community; 3) Competencies and core strengths and 4) Challenges in engaging the migrant community.

Theme 1: Collaborating with Local Healthcare Workers to Enhance Services

The MLWs have been assigned one block each in the district and are expected to work closely with all the frontline workers of the wards in the block as and when the need arises. Hence, they supplement the efforts of the local healthcare workers and work in a way that there is continuous flow of information between them, while plugging any gaps to overcome the limitations of the existing systems if any.

> In my area, there are 49 ASHA workers and I am the only MLW. So, the ratio is 49:1. I get calls often from different places in my area when health workers are unable to communicate due to language barrier with the pregnant migrant women who sometimes do not even know about their last menstrual period and how many months pregnant they are. So then I go personally and meet them, get information from them in their own language, which I then share with the ASHA workers for their records and further intervention. (MLW 3)

Sub-theme 1.1: Providing Relevant Information in a Timely Manner

The work of link workers entails providing accurate and relevant health information to the migrant community in a timely manner so that they can obtain health services due them, which very often they are unaware of including those on immunization services and antenatal care such as vaccination days, antenatal check-up days, free of cost scanning services etc.

> We go to migrant mothers with infants and inform them about the vaccines their child must take at 6 weeks, 3 months, 6 months etc. The women only know that vaccine needs to be taken at 5 years for their child, but are unaware of the different vaccines and any other details. We ensure they get the right information at the right time and also that they act on it. (MLW 1)

MLWs provide information on various schemes and benefits related to maternal health and child health which the migrant women can avail, especially if they are new in an area.

> We inform migrant mothers that their children are entitled to get food at the Anganwadi, and also about the financial benefit they are entitled to in case of a first-time pregnancy. (MLW4)

In working closely with the healthcare workers, the link workers communicate effectively on the needs of the migrant women related to obtaining immunization card for their children, or antenatal care for themselves. This is often achieved by them personally accompanying the ASHA workers in cases where a situational analysis of female migrants may be needed and where communication is difficult due to the latter's inability to understand their language. In some cases, MLWs visit an area first and then provide information to ASHA workers on new women and children who may have come into a particular ward to stay and work and may need maternal or child health services.

In the course of their work with pregnant women, MLWs who are males despite being able to communicate effectively with the women, gather information and do follow-ups always in the presence of ASHA workers, without whom the migrant women may be uncomfortable in revealing information to a male.

Sub-theme 1.2: Active Follow-Up and Personal Care Tracking

The MLWs do constant and rigorous follow ups with female migrants who may be pregnant, new mothers and for their children. This is mostly done by means of field visits to homes of migrants as well as regular phone calls to the women in the event of the link workers' inability to visit them. They keep track of the dates for check-ups for women or immunization for the children and provide reminders to those concerned, persuading the women to go.

> We call up migrant mothers and remind them on their child's vaccine dates and which health centre or Government hospital they must go to, to get the services. (MLW 2)

Follow ups are done even post the doctor visits to understand the status of the women and inform accordingly to the ASHA workers for them to plan the next steps.

Theme 2: Accountability towards the Migrant Community

MLWs being one from among the migrant community are people who at the same time have secured themselves better positions in their own right by virtue of their hard work and qualities possessed. and become a voice for the migrants at various platforms, raising their concerns to the rightful authorities for solutions. As such, being someone from among the migrants, they are more understanding and empathetic towards the situations of migrants and therefore make themselves approachable by the former. In other words, the link workers possess the ability to meet migrants where they are as well as at a time and place convenient for them, followed by a process of handholding.

> We, link workers always remain available, accessible and approachable for the needs of female migrants especially in the context of the care they must receive in their pregnancy, or for their children. (MLW 1)

> We share our numbers with everyone and even tell house numbers to pass on our numbers to any female migrants who may need. We tell the women that they can call us at any point for any help. (MLW 2)

Sub-theme 2.1: Being Approachable to the Migrant Community

In many cases, MLWs support female migrants who are completely unaware of

navigating the healthcare system or are new to the area by accompanying them for hospital visits and voicing their concerns with the medical personnel.

> Many female migrants are unaware of the whats and the hows of antenatal care. Hence, we support them by personally accompanying them to the hospitals for their check-ups till a point that they become comfortable with the system. (MLW 4)

MLWs frequently make home visits to migrant women with the aim of building a rapport with them. This may often not be possible in the case of healthcare workers due to their many other responsibilities. Additionally, they also share a strong rapport with key members of the local community.

> We go into the homes of female migrants regularly and after a good 15 minutes or so of asking about their general well-being, they feel comfortable to share information, even that which is sensitive, with us link workers. They then begin calling us for any help or information they may need, such as the immunization of their which may be due. Sometimes, their homes may be situated in very interior or remote areas which no one else may access. (MLW 1)

Sub-theme 2.2: Adopting a Humane Approach

The humane and non-judgemental approach adopted by all MLWs gives a sense of assurance to migrant women that they are heard and their needs are taken care of. These needs are then effectively communicated by the MLWs to the relevant authorities for necessary action.

MLWs also work closely with migrants by casting out all fear from them, being one among them. Often times, the presence and approach of local healthcare workers may instil fear and suspicion in the minds of migrants when they are asked to share their personal information.

> Female migrants who are pregnant and have no education or exposure may feel intimidated of ASHAs when they see them in a group during daytime when their husbands are away at work. (MLW 3)

> Fear of local healthcare workers due to language barriers leads to pregnant migrants refusing to go for any medical check-ups or even reveal that they are pregnant. They simply refuse saying they will go to their native states and do the needful. This fear is removed and confidence given by MLWs so that the women then talk openly and even become receptive to the information given to them. (MLW 4)

Theme 3: Competencies and Core Strengths

MLWs possess a unique combination of lived experience, community insight, and professional competence, enabling them to bridge gaps between migrant families and the health system. Many had already been informally supporting migrants before their formal appointment, which strengthened their trust with the community and local health workers.

> Even before working as a MLW, I have been living in Kerala since the last 20 years. I shared a good rapport with the ASHA in my area. I also used to help several migrant workers living in my area with their health-related concerns, directing them to public health centres where they could avail services for free, sometimes even accompanying them to health centres, and even helping pregnant women. Seeing this, the ASHA works in my area recommended my name for the position of MLW and also informed me of such a position with the NHM. (MLW 3)

MLWs also employ strong negotiation and communication skills, persuading women to access maternal and child health services, which has helped reduce home deliveries and improved immunization coverage. They creatively use technology and social media to disseminate health information and maintain contact with migrant women.

> I had created a WhatsApp group adding all migrant women into it and told them to share numbers of women seeking maternal and child health services information who they may know. There were a lot of women who were part of it and benefitted from the information shared. (MLW 1)

Sub-theme 3.1: The Language Advantage

MLWs' ability to speak migrants' native languages, along with reasonable proficiency in Malayalam, immediately puts women at ease, fostering cooperation and trust. Communicating in familiar languages, combined with attentive listening, removes feelings of othering and promotes a sense of belonging, encouraging women to proactively seek maternal and child health services.

> Migrant women as soon as they hear someone speak in their own language are instantly put to ease. They then become cooperative and willing to do whatever is asked of them. (MLW 5)

> Because the woman knew I genuinely intended to help her and I understood her language and her concerns, she used to call me regularly even after she left, asking me from time to time what vaccine is due for her child and eventually connecting me with the local ASHA worker there. (MLW 1)

Sub-theme 3.2: Proactive Engagement and Problem-Solving

MLWs through their solution-oriented approach are focussed on mitigating issues of migrant women. They are vigilant in monitoring pregnancies, accompanying women to health facilities, and ensuring continuity of care.

> I convinced a pregnant migrant lady who was simply not willing to seek antenatal care, by stating the risks involved in doing so unlike the common practices in her home state. Eventually, she agreed and had a hospital delivery. (MLW 4)

MLWs in many cases intervene in areas that are beyond the ones assigned to them when urgent needs arise, demonstrating adaptability and commitment to ensuring that women and children access all entitled health services.

Sub-theme 3.3: Familiarity with the Migrants' Home-State Culture and Practices

Being from the migrant community, MLWs understand the cultural norms and common healthcare practices of migrants' home states. This contextual knowledge enables them to interpret behaviours sensitively and approach pregnant women tactfully, aligning health interventions with women's expectations and practices.

Theme 4: Challenges in Engaging the Migrant Community

Migrant Link Workers (MLWs) encountered several challenges while delivering maternal and child health (MCH) services to the migrant population. These challenges primarily stemmed from the transient nature of migrant life and the socio-cultural attitudes influencing healthcare-seeking behaviour. Despite these constraints,

MLWs often employed persuasive communication and negotiation skills to encourage service utilization among migrant women.

Sub-theme 4.1: Mobility and Disruption in Continuity of Care

A major challenge consistently reported by MLWs was the frequent movement of migrant families, which disrupted the continuity of maternal and child health services. Once registered for antenatal care or child immunization, many women relocated or changed contact information, making follow-up difficult. This transient pattern hindered the provision of consistent care throughout pregnancy and early childhood.

> Many times, it happens that once the pregnant women are registered for providing them necessary services, the family change their place of accommodation as well as their contact number. Hence, it becomes difficulty to find or contact them and this disrupts the continuity of services that could have been provided to the women. Unfortunately, there is no solution as yet to this problem. (MLW 5)

Sub-theme 4.2: Socio-cultural and Health Seeking Barriers

MLWs also faced challenges arising from socio-cultural norms, beliefs, and attitudes among migrant women and their families. These included the reluctance to use family planning methods, hesitation to seek antenatal care, and apprehensions about immunization. Such attitudes were often rooted in experiences and practices from their home states, economic insecurities, and fears of losing daily wages.

> Parents fear that immunization will lead to fever in their children for three days which in turn will prevent them from going for work and hence lose out on wages for those days. At other times, they leave for their village, or cite reasons such as not having immunization card or not remembering the vaccine that was taken last. (MLW 2)

> Migrant women show hesitation to seek antenatal care citing it as an uncommon practice in their native states to frequently seek medical care in case of a pregnancy. They see it as a waste of time to go to the doctor and say that antenatal services in their states are better. (MLW 1)

In response, MLWs used persuasive communication and culturally sensitive engagement to address misconceptions and motivate women toward safe healthcare practices.

Thus, MLWs navigate a complex field shaped by mobility-induced service disruption and socio-cultural resistance to healthcare. Their efforts to build trust and influence behaviour play a critical role in ensuring maternal and child health service delivery among migrant communities. Figure 1 presents a graphical representation of the emergent themes and sub-themes.

DISCUSSION

This study which aimed to gain an in-depth understanding on the perspectives of MLWs on their role in strengthening existing maternal and child health (immunization) services for migrant women and children in Ernakulam district yielded four broad themes namely: (1) Collaborating with local healthcare workers to enhance services; (2) Accountability towards the migrant

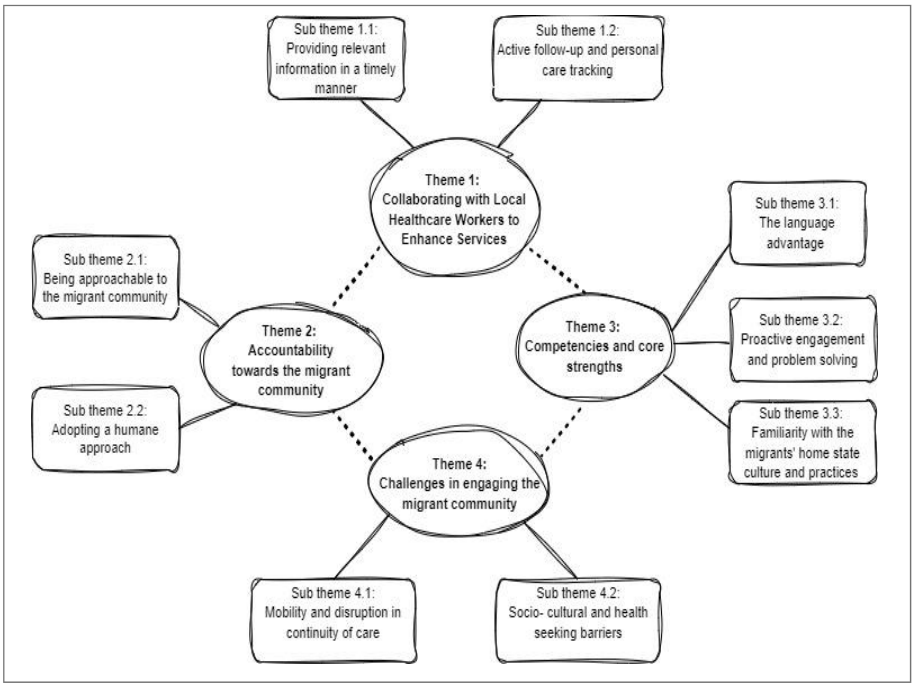

Figure 1: Themes and Sub-themes

community; (3) Competencies and core strengths and (4) Challenges in engaging the migrant community. The role of MLWs is an example of an innovative mechanism in public health by means of introducing culturally appropriate interventions to improve health and well-being of migrant women and their children. The support extended by the MLWs chosen from among the community itself who already possess certain qualities and are trained to gain more skills has led to immense increase in utilization of maternal and child health services, thereby showing positive health outcomes in both spheres. According to the Tulane University school of public health and tropical medicine (2021), cultural competence in health care is concerned with 'delivering effective, quality care to patients who have diverse beliefs, attitudes, values, and behaviours'. This practice requires systems to customize health care according to cultural and linguistic contexts of patients, and also understanding the potential impact that cultural differences can have on healthcare delivery. One step towards building cultural competence in delivering healthcare involves building teams with healthcare professionals who echo the diversity of the patients served. Diverse teams possess a wide range of cultural knowledge from which team members can benefit. This enables them to respond with empathy to the unique cultural needs of patients. Equally important is language accessibility. Barriers in this regard can hinder the precise description of symptoms as well as diagnosis. The present study is consistent

with the abovesaid points as the institution and work of the MLWs reinforces cultural sensitivity and language compatibility in the healthcare delivery process which has led to an uptake of maternal health and child immunization services among the migrants, who may otherwise remain invisible in mainstream systems of service delivery.

In a study that aimed at understanding the effect of culture-based intervention to improve the satisfaction and quality of life for elderly people in social welfare institution wherein the intervention included critical elements of their ethnic culture, it was found that that their average of life satisfaction and quality of life increased post the intervention (Sabri et al., 2019). Another study based on designing a culturally sensitive intervention in Canada (Murdoch-Flowers et al., 2019) for diabetes prevention showed how culturally-based health promotion can bring about healthy changes addressing the mental, physical, spiritual and social dimensions of a holistic concept of health. In an article that reviewed factors affecting implementation of culturally-appropriate maternity care services (Jones et al., 2017), it was seen that findings such as accessibility and person-centred, respectful care along the continuum of care through pregnancy until after birth also held true in the context of the present study, seen through perspectives of MLWs.

MLWs worked closely with local heath workers in providing services by eliminating language barriers faced by the health workers. This is consistent with a study of 2018 of health workers using the services of interpreters to provide sexual and reproductive health services to migrant and refugee women (Mengesha et al., 2018), where they state how language prevents the women from effectively availing services. Another point highlighted by a male MLW about women not opening up to him about their health status also is confirmed in the study. In a study of 2022 (Vu et al., 2022), most healthcare providers stated using the services of interpreters who also helped refugee women navigate the health system. This was associated with many benefits, such as a strong patient- interpreter relationship, which in turn helps with follow-ups and comprehensive care.

The present study revealed that MLWs being from the migrant community had a contextual understanding of practices in the home states of migrants, which helped to add perspective and understanding to the behaviours of migrant women related to uptake of health services. This is consistent with a study that used the services of aboriginal interpreters and aimed to assess patient experiences of hospitalisation to identify strategies to improve equity in health care for aboriginal patients (Mithen et al., 2021). The study found that patients attached importance to the fact that the aboriginal interpreters had spent time in remote aboriginal communities, which gave some interpreters confidence that he had genuine understanding of the needs of aboriginal people living in remote communities and urban communities. Further, aboriginal interpreters explained that being of the same cultural background as their clients made them the only professional the patients can truly relate to. Interpreters 'walked in two worlds' and are thus uniquely positioned to understand perspectives of migrant women as well as the local healthcare system.

Reflections on the Sustainability of the MLW Model

As the MLW model of care has enhanced the provision of maternal and child health services for the migrant community, sustaining the model must be considered. Towards this, initiatives of such a nature must be embedded into the state health budgets rather than these remaining project or external donor driven, which may often be the case of community-based health worker programmes (Scott et al., 2018). Accounting for these personnel in state health expenditures will ensure the smooth implementation of aspects such as training or remuneration of personnel involved in the long term, thereby improving effectiveness of such programmes, as seen from similar instances of large-scale community health worker programmes in Africa and Asia (Masis et al., 2021). This can ultimately result in universal health coverage for all communities including the ones that are underserved. Further, clearly defining the role of MLWs within the hierarchy of healthcare workers is another step in ensuring the sustainability of this cadre. In this context, excessive workload due to a smaller number of workers in the cadre as well as existing ones performing many tasks that are not health oriented, can lead to severe burnout. To this may be added a lack of clear career progression. Sustainability calls for sufficient number of personnel with clear allocation of tasks a well as opportunities or career advancement.

Implications for Research and Policy

This study offers implications for research and policy. From a research perspective, the study offers a possibility for longitudinal research to capture the long-term effectiveness of the services provided by the MLWs from a multi stakeholder view. Additionally, an opportunity exists for developing detailed case studies on the extent to which service users from the migrant community have had positive health outcomes as a result of the interventions of the MLWs. These can build the case for replicating the best practices towards increased healthcare access for internal migrants in various other locations in the state and country, which are marked by significant amounts of interstate migration in the recent years.

At a policy level, there must be provisions for recruiting of more such workers from the community with lived migration experiences and the resultant rich cross-cultural understanding of the home and host state practices and systems that they carry with themselves. Also, strengthening the already existing workers by defining their roles clearly as well as incentivising their work can make their contributions more effective by enabling them to identify more vulnerable communities through a focussed approach. Finally, aligning the efforts of MLWs with other departments such as labour, housing and social protection can enhance the effectiveness of their interventions, thereby necessitating the need for inter-sectoral coordination for service delivery. These can help improve outcomes for the migrant communities, not just in the area of health but the many other crucial areas such as education, work, quality of life and overall well-being.

CONCLUSION

The MLWs network being a unique feature of the Ernakulam district healthcare system, their presence and work has enhanced the delivery of maternal and child immunization services by strongly supplementing the services of local frontline healthcare workers operating in the district. The emergent themes illustrate clearly on how their work solidifies the provision of maternal and child health services towards female migrants in the district, thereby leading to better health outcomes in the domain. Thus, it is apt to state that the work of MLWs ensure that the vulnerable section of migrant women is not left behind and receive quality services similar to the local community in an equitable manner.

As a limitation, the study did not include the perspectives of the various stakeholders such as senior authorities, medical personnel, other frontline health workers and migrant service users. Including these may have provided a more comprehensive understanding on the extent to which the migrant community have gained from the services of the MLWs.

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Declaration of Conflicting Interest

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