Received: 30 January 2024 | Revised: 29 February 2024 | Accepted: 31 March 2024

Unequal Inaccessibility in Health Services Reason for Rural Migration: An Application of Lee's Push Pull Theory

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Abstract

Rural-to-urban migration has been a growing phenomenon in recent years in Nepal. Federal Democratic Republic Nepal is combating the unequal distribution of resources, power and opportunities induced by a unitary and centralized government in the past. The aim of restructuring the state was to eliminate the uneven distribution of services, power and resources distribution in terms of region. Now, Nepal is implementing three levels of governments- federal, provincial, and local government to eliminate existing inequalities and to make powerful local areas. In this sense, rural-urban migration is not a growing phenomenon but is now a reverse situation. Local governments are developing in the local areas, the local people are migrating to cities. So, the objective of this paper is to apply the push-pull theory of migration and interlink Lee's theory and the distribution of health services in rural areas including Diprung Chuichumma Rural Municipality, Khotang. It is based on the positivistic phiolosophy and its apprach is deductive approach. The causes of rural-to-urban migration are both push-pull factors. Unequal inaccessibility in health services between rural and urban areas is the main reason for migration.

Keywords: Health services, rural-to-urban migration, unequal inaccessibility, push-pull theory, negative fators, positive factors.

Introduction

In Nepal, there are many disparities between rural and urban structures in providing state services and facilities. Health is considered a fundamental right, but many inequalities have been persisting between rural and urban areas in terms of health facilities and services provided by the state. A vivid example looks like this: There are many disparities found in health indicators between rural and urban areas. The fertility rate is 2.9 in rural areas, compared to 2.0 in urban areas. The use of modern methods of family planning among married women in rural areas is 41% slightly lower than the users of urban areas (44%). Maternal health and child health indicators are lower in rural areas than in urban areas. Child mortality (deaths per 1000 live births) is higher in rural areas than in urban areas. Neonatal mortality is 26 in rural areas, compared to 16 in urban areas. Infant mortality in rural areas is

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1.36 times higher than in urban areas. Similarly, under-five mortality is higher in rural areas (44) than in urban areas (34) (Ministry of Health, 2016).

It is found that highly unequal distribution of health-related human resources between urban and rural areas. The main causes are cities offering doctors better income, more opportunities for career development, better infrastructure, and more social amenities than rural areas (Chen et al., 2004). Nepal has historically structured rural-urban unequal inaccessibility in health sectors. The urgent problem in rural areas is the unequal distribution of manpower. Urban areas have experienced doctors but rural areas lack basic medicines in Nepal (Ailuogwemhe et al., 2005). It leads to the rural-to-urban migration phenomenon in Nepal.

Migration and the availability of healthcare facilities and services are interrelated issues. Low availability of healthcare facilities can promote migration. In this regard, Suwal (2014) concluded that the rural-to-urban migration phenomenon occurs at a higher rate at the national level. Rural people have to face more problems in obtaining health services facilities than urban people. They have higher travel burdens and higher costs than urban dwellers when taking health care services (Probst et al., 2001). There is a differences in treatment travel expense between rural and urban dewellers. The cost burden of medical travel in rural areas was higher than in cities. The cost of traveling for treatment at night time in rual areas is more (Akinlotan et al., 2021). Rural residents have faced a greater risk for health problems compared to residents of metropolitan and central core areas (Auchincloss, 2002). There is a compulsion to live in rural areas at a high risk of health. People are looking for opportunities to reduce high risk of health. It attracts urban-centric migration and people start migrating from rural areas to urban areas.

Rural and urban areas can be seen from the uneven migration phensomenon. Migration from rural areas to cities in developing countries is a worldwide trend. Selod & Shilpi (2021) indicated that the rural-to-urban migration phenomena are more concerned on the internal or national level, also less occurs at the international level. The rural-urban migration phenomenon occurs higher rate in developing countries than in developed countries (Selod & Shilpi, 2021). Rural-urban migration is both proactive and reactive migration but its main causes are the push and pull factors of the origin place and destination place.

Healthcare facilities and services are the major factors of origin and destination places to determine migration decision-making. It also describes the Lee migration theory, analysis of the existing health facilities and services of the Diprung Chuichumma Rural Municipality, Khotang, and lastly, interlinks the health

care facilities and services to Lee's push-pull theory of migration. The aim of this paper is to link the unequal inaccessibility of healthcare facilities and rural to urban migration by applying Lee's migration theory.

Statement of the Problem

One can read a lot in the newspapers about the people of rural areas migrating towards the city. Such news can be seen and heard being communicated prominently in the mass media. Academic studies related to migration are being researched such as CEDA (1973) concluded that the cause of Hill to Tarai migration is the push factors. The push factors in the hill were lack of infrastructure development, lack of health facilities, and lack of employment opportunities. The pull factors in Tarai were less active. Kansakar (1974) found that the causes of Hill-to-Tarai migration were the economic disparities between the Hill and Tarai. The push factor of the hill was very strong for making migration decisions. Further Kansakar classified to pull factors were rapid growth of population, low agricultural productivity and inefficiency of land etc. Pull factors were the presence of health facilities and the low price of land in Chitwan. CEDA and Kanskar indicate that the health facilities are the pull factors of Hill-to-Tarai migration, but ignoring the poor conditions of health facilities may be the push factors of the origin place.

Another research concluded that insufficient agricultural land, rural debt, and social stigma were the main causes of migration. The fertile land of the Tarai, the government resettlement program, physical facilities, and relative networks were pull factors of the Hill to Tarai migration (Dahal, 2011). Dahal does not give attention to the push factors like health care facilities. It may be a major factor for rural-to-urban migration. Nepal's government has been making policies and plans in this regard. However, migration to cities due to uneven expansion of access to health services has not been studied in depth. So this study is more relevant at this time.

Tarai became the major destination for Hill people, and the flow of Hill people to Tarai was highly dominant in internal migration. The causes of migration differ in terms of types of migration. The cause of internal migration is agriculture. In contrast, the cause of international migration is service. The geographical structures are constraints and facilitators of development, high elevation regions are less developed than lower-elevation regions in Nepal. The development ranking of the region directly influences the migration pattern. There is a positive relationship between the development regions and migration. The Tarai region has a higher development ranking than hills and mountains. So the Hill-to-Tarai migration rate is high (Gurung, 2001).

Urban migration is increasing rapidly in Nepal. In 1981, there were 23 municipalities with 6.4 percent of the country's total population. Between 1991 and 2011, the number of municipalities remained unchanged at 58, but the share of the population living in municipalities increased significantly from 13.9 to 17.1 per cent (Sharma, 2014). Human incapacity leads to poverty. Illness hinders income generation, ill health hinders public participation. In the same way, ill health creates obstacles in education, politics, religion, and economic sectors, constraining them from grasping every opportunity and use of resources. This increases poverty. Therefore, the saying that health is wealth becomes meaningful. The unequal distribution of healthcare institutions and insufficient human resources contribute to urban-centric migration. It needs intensive study to link Lee's migration push-pull migration theory. There are insufficient studies on the linking of theoretical and empirical research.

Nepal Demographic Health Survey (2016) reported that 47 per cent households of the total households have at least one person who migrated in the past 10 years. The male migration percentage is 33 in the past year. Nearly 80 per cent of males migrated for work (Ministry of Health, 2016).

The definition of a village has been changing now. Migration processes may have changed the definition of a village. Macfarlane (2002) found that the inhabitants of Thak village are change. There is found children, elderly people, blacksmith and tailors. Thak village is changing into a place where old people, disabled and poor people live. There are only old men and women waiting at home (Macfarlane, 2002). It is difficult to meet young people in the village. It is difficult to admit sufficient students in school. Although the roads, electricity and other infrastructure have reached the village, the process of entering the local towns. Many studies show that the main reason for migration is the lack of a source of income in the village. Many studies show income generation plans for reducing rural-to-urban migration. Income-generating programs like commercial fishing, and opening homestays cannot stop the migration in rural areas.

Expected life expectancy, maternal and child mortality rate, child mortality rate disability, access to health facilities, treatment methods, nutritional status etc. help to understand health development. Considering the right to health in Article 35 of the Constitution of Nepal, various plans and programs related to health can be carried out by using the authority given by section 102 of the Local Government Act 2074 to manage various problems related to the health of citizens within the local areas. The average life expectancy of Nepalese was 55 years in 1994, which is gradually improving. iIlliteracy, poverty, low availability of drinking water, lack of food security, and low availability of treatment services can be considered as the causes of low life expectancy (UNDP, 2001). The difference in the place

of residence makes a difference in life expectancy. It seems that the average life expectancy of the Himalayan region is seven years less than that of the Tarai region. Infant mortality is higher in rural areas than in urban areas. Similarly, the statistics of the Ministry of Health (1997) show that the probability of death of infants in the Himalayan region is twice that of other regions.

In Nepal, the maternal mortality rate is high due to the traditional way of giving birth. Maternal death occurs due to a lack of health care during pregnancy, childbirth and after birth. It seems that the residents of this rural municipality rely on the use of a home medicine system, weed and herbs in case of illness and general treatment. Around the year 1985, community women's health volunteers were created to bring health awareness to the villages. It seems to have increased access to health in the village. After 1990, after the government of Nepal took a policy to expand government health institutions at the level of village development committees, health sub-posts were established in villages, 6 to 8 village development centers. Now sub-health posts have been converted into health posts. However, not sufficient studies were done at the local level.

Although the fundamental right to get basic health services free of charge is given in the constitution, the health sector is becoming profit-oriented. There is a compulsion to get treatment only by paying a lot of fees. Improvements are needed to provide quality and accessible access to government hospitals. According to the list of single and common rights of the constitution, the federal, provincial and local governments have been given the responsibility of health services. The responsibility of the local level in the health sector is becoming intensive. Looking at the data on health development, the health status of Nepal appears to be in a critical state. Nepal Demographic Health Survey reported that the infant mortality rate per thousand live births is 32, the neonatal mortality rate is 21, the under-five mortality rate is 39, and the maternal mortality rate is 239 per thousand live births. The total fertility rate is 2.3 per woman. There are many challenges and problems to establishing equitable access for citizens in all areas of health (Ministry of Health, 2016).

It has not been possible to manage skilled human resources for public health. There is a lack of modern equipment and specialized doctors in government health institutions, and they are not able to solve communicable and non-communicable diseases. Some children are suffering from malnutrition. Malnutrition in more than one-third of children under five years of age and women of reproductive age group, and private sector health services becoming more expensive are the major problems and challenges in the health sector.

The local government is the closest and the first body to expand access to local government services in making health services accessible and quality. Its effectiveness and accountability increase universal access to free basic health services. At the local level, the status of Ayurveda, natural and other medical systems has been studied. Hospitals with basic emergency surgery and laboratories are not being built at the local level. There is a situation of not being able to organize the medicine provided free of charge by the government of Nepal. Lack of a primary health center in this rural municipality, a lack of specialist medical services, a lack of equipment in the birthing center, a lack of physical structure, the widespread problem of uterine prolapse, a lack of disability-friendly health services, lack of adolescent-friendly health services and there are problems such as lack of manpower needed for epidemic prevention. There are fewer studies on the role of local government in expanding healthcare facilities and services to reduce rural-to-urban migration. Above the research gaps, this paper tries to find out the answer the following research questions:

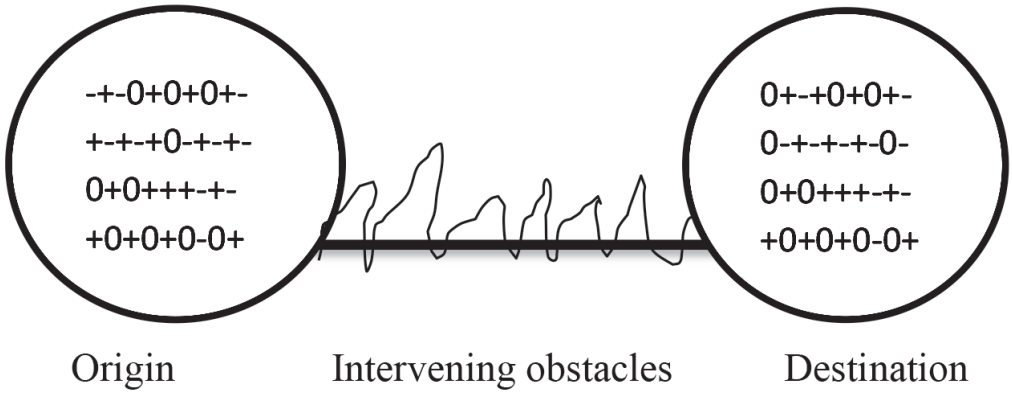
- What are the existing situation of health care facilities and services of Diprung Chuichumma Rural Municipality?
- What is the interlinkage between the existing situation of healthcare facilities and services and rural-to-urban migration?

Research Methods

This paper is based on the positivistic philosophy and its approach is deductive approach. Descriptive research design is applied for the application of Lee's migration theory. The justification for using the descriptive framework is that migration from rural areas to urban areas due to unequal inaccessibility of health care servicies and facilities. The existing situation of health care facilities and services of Diprung Chuichumma Rural Municipality have been described from the secondary source of data that is the record of Rural Municipality office. The data have been generated from reviewed previous studies related to migration and expansion of health services and facilities. Lee's push-pull theory has been described to study rural-to-urban migration.

Lee'e Push Pull Theory of Migration: The Theoretical Foundation

Everett Lee criticized Ravenstein's law of migration and developed the push-pull theory of migration in 1966. He introduced four factors that decide to migrate and the process of migration. These factors are associated with the place of origin, factors associated with the place of destination, intervening obstacles, and personal factors (Lee, 1966).



He defined that the push factor is related to the origin place and it is a reason to move from a particular country or place. The pull factor is related to the destination place and it is the reason to come to a particular place. An intervening obstacle is difficulties and obstacles in the way of migration. Geographical barriers, political barriers, cultural barriers, and social barriers etc. are intervening obstacles. Personal factors are personal sensitivities, intelligence, awareness, and knowledge of the situation at the destination (Lee, 1966).

He proposed that both origin and destination places have three factors, which are positive, negative and neutral. These are shown as + sign, - sign and 0 sign respectively. The positive factors of the origin place tend to hold people within it and attract people from other areas to the destination place. Negative factors of the origin place tend to migrate from it and repel people to the destination place. 0 sign is neutral, to which people are essentially indifferent (Lee, 1966).

The individual evaluates the positive, negative, and natural factors of the areas of origin and destination. Hence this assessment is influenced by the stage of the individual's life cycle. An individual who has lived in a place for a long time may over-value positive factors and under-value negative factors. Similarly, different constraints may simultaneously lead to incorrect evaluation of the positive and negative aspects of the destination (Lee, 1966).

He argued that push factors can be divided into economic, political, cultural, environmental factors etc. The economic push factors are a lack of employment, crop failure, lack of fertile land, lack of food and shelter, low level of standard of living, poverty etc. The political push factors are war, tyranny, lack of civil rights, unfair legal system, lack of government tolerance etc. The social factors lack of health care, lack of health services and facilities, lack of educational opportunities, social injustice and discrimination, lack of religious tolerance etc.

Among the social factors, the most important influencing factor is the availability of health services. Everyone wants to be disease free, and wants to live more. Therefore, if there is a lack of health care facilities, people leave their native places and migrate elsewhere. Health service facilities include the expansion of hospital, availability of doctors, diagnostic laboratories, equipment, surgery services, bed arrangements, availability of medicines, availability of blood banks, availability of oxygen, etc. According to Lee, these health-related services and facilities are the push factor of the origin place and pull factors of the destination place influencing rural-to-urban migration. So, the expansion of health services in Diprung Chuichumma Rural Municipality has been explained in the next section.

Health Facilities and Services of Diprung Chuichumma Rural Municipality

This section examines the condition of the health sector of Diprung Chuichumma Rural Municipality and the development made in the health sector of the rural municipality. The presence of healthcare providers determines access to healthcare. Therefore, the health service infrastructure in the rural municipality is explained in the table below.

Table 1

Details of health infrastructure for providing health services

Serial No.	Health infrastructure and services	Numbers
1	Health post	7
2	Community Health Unit	1
3	Birthing Center	3
4	Women Health Volunteers	89
5	Vaccination center	9
6	Bed Numbers	9
7	Clinic	9
8	Sub-health post	1
Total		**128**

Source: Diprung Chuichumma Rural Municipality, 2075

The data obtained from the survey shows that the condition of Diprung Chuichumma Rural Municipality can be considered satisfactory in terms of access to primary health facilities. From the point of view of health-related infrastructure, there is an impression that it is easy to get primary health facilities at the local level.

Skilled human resources related to health influence the expansion of health access. Therefore, in the table below, the situation of human resources in the health institutions of Diprung Chuichumma Rural Municipality is given.

Table 2

Details of the health workforce in the Rural Municipality

Name and address	Number of health workers employed				Total
	Health Assistant	Assistant Health Worker	Auxiliary Nurse and Midwife	other	
Health Post, Yamkha	0	2	3	1	6
Health Post, Dandagaon	1	2	1	1	5
Health Post, Chhorambu	0	2	2	1	5
Health Post, Batase	1	2	2	1	6
Sub-health Post Sapteshawri Chhitapokhari	0	2	2	1	5
Health Post Chhitapokhari	0	2	2	1	5
Health Post Temma	1	2	1	1	5
Total		14	13	7	37
3					

Source: Diprung Chuichumma Rural Municipality, 2075

Looking at the distribution of working health workers, it seems that there is a lack of skilled manpower. In case of lack of manpower, it is necessary to look at the situation of filling the approved posts. In the table below, details about health institutions, vacancies and services are given.

Table 3

Health institutions, vacancy fulfilled status and service-related details

Name and Address	Approved Posts	Status of Vacancy	Maternity Services	Family Planning	Immunization Services	Counseling Services	Safe Motherhood Services
Health Post, Yamkha	6	5	Yes	Yes	Yes	Yes	Yes
Health Post, Dandagaon	6	3	Yes	Yes	Yes	Yes	Yes
Health Post, Chhorambu	6	5	No	Yes	Yes	Yes	Yes
Health Post, Batase	6	6	No	Yes	Yes	Yes	Yes
Sub-health Post Sapteshawri Chhitapokhari	3	5	Yes	Yes	Yes	Yes	Yes
Health Post Chhitapokhari	6	4	No	Yes	Yes	Yes	Yes
Health Post Temma	6	5	No	Yes	Yes	Yes	Yes
Total	**39**	**33**					

Source: Diprung Chuichumma Rural Municipality, 2075

According to the data of the Health Branch, the status of various vaccination services provided to children in Diprung Chuichumma Rural Municipality is given in the table below.

Table 4

Village level vaccination details in Diprung Chuichumma Rural Municipality

Ward no.	Number of children to be vaccinated by type of vaccine				
	BCG	Pentavalent	Polio III	Measles Rubella	Japanese encephalitis
1	75	75	75	75	75
2	43	43	43	43	43

3	47	47	47	47	47
4	43	43	43	43	43
5	46	46	46	46	46
6	28	28	28	28	28
7	58	58	58	58	58
Total	**340**	**406**	**411**	**345**	**357**

Source: Diprung Chuichumma Rural Municipality, 2075

Looking at this table, it has been found that 340 children have received the BCG vaccine, 406 children have received the pentavalent vaccine, 411 children have received the polio III vaccine, 345 children have received the measles-rubella vaccine and 573 children have received the Japanese encephalitis vaccine. According to the available data, out of 1992 children, 1859 children (93.32 percent) have received the various types of vaccination services mentioned above, while 6.68 percent of the children have not yet received the vaccination services.

According to UNICEF 1986, many people in Nepal are suffering from the problem of micro-nutrition and vitamin deficiency. The problem of iron deficiency is seen in pregnant women. Iodine deficiency is found in abundance in the people living in this Himalayan region. Due to lack of iodine, one has to face problems like goiter, and lethargy. 40 per cent of people suffer from goiter due to iodine deficiency (UNICEF, 1996).

In Diprung Chuichumma Rural Municipality, some people suffer from infectious and chronic diseases such as diarrhea, fever, gastric, whooping cough, cancer and pressure. The types of major diseases that appeared in the family members are presented in the table below.

Table 5

Details of major diseases seen in the Diprung Chuichumma Rural Municipality

S. N.	Name of Diseases	S. N.	Name of Diseases
1	Diarrhea	19	Diabetes
2	Fever	20	Blood pressure
3	Allergic itching disease	21	Stomach related disease
4	Wounds	22	Asthma
5	Rheumatic disease	23	Uric Acid

6	Breathing disease	24	Cancer
7	Gastric	25	Thyroid
8	Back pain	26	Neurological disease
9	Legs binding	27	Uterine related disease
10	Bone joints pain	28	Bone fractures
11	Tonsils	29	Mental illness
12	Common Colds	30	Jaundice
13	Headache	31	Typhoid
14	Fungal infection	32	Pneumonia
15	Eye-ripening	33	Chickenpox
16	T.B.	34	Viral Infections
17	Leech infection	35	Herpes zoster
18	Toothache	36	Scabies

Source: Diprung Chuichumma Rural Municipality, 2075

In this rural municipality, the condition of chronic illness of family members has been presented. According to this, the number of patients with diseases related to blood pressure, and heart disease is seen to be high, while patients with diabetes, cancer and kidney-related diseases are also found to be significant.

Table 6

Details of major diseases seen in the Diprung Chuichumma Rural Municipality

S.N.	Diseases	Sex	Ward No.							T otal
			1	2	3	4	5	6	7	
1	Tuberculosis	Female	1	1	4	0	0	0	3	9
		Male	0	1	2	3	1	1	3	11
2	Cancer	Female	2	2	3	1	1	3	6	18
		Male	0	1	2	1	1	1	3	9
3	HIV AIDS	Female	0	0	0	1	0	0	0	1
		Male	0	0	0	1	0	0	0	1
4	Diabetes	Female	0	3	4	7	0	1	8	23
		Male	1	8	10	5	0	0	4	28
5	Blood Pressure	Female	13	15	11	1	2	5	17	64
		Male	10	15	14	0	2	4	41	86

6	Cardiovascular diseases	Female	2	10	5	3	1	3	16	40
		Male	3	5	6	1	2	2	5	24
7	Renal Disease	Female	2	1	2	0	0	1	2	8
		Male	1	2	5	1	1	1	4	15
8	Malnutrition	Female	0	1	0	0	1	0	0	2
		Male	0	1	0	0	1	0	0	2
9	Other	Female	0	8	3	0	0	0	0	11
		Male	10	46	4	1	2	2	10	75

Source: Diprung Chuichumma Rural Municipality, 2075

Safe motherhood shows the conditions of health services in the Rural Municipality. Child mortality rate, maternal mortality rate etc. are influenced by safe motherhood. In the table below, details are given based on the temporary means of family planning.

Table 7

Details of those who use the temporary means of family planning in the Rural Municipality

Ward No.	User of the temporary means of family planning		Total
	Male	Female	
1	0	0	0
2	0	217	217
3	50	84	134
4	47	126	173
5	0	0	0
6	0	0	0
7	39	101	140
Total	136	528	664

Source: Diprung Chuichumma Rural Municipality, 2075

Policies and programs related to health services in rural villages

In the policies and programs of Diprung Chuichumma Rural Municipality of 2077/078, it seems that health-related policies have been made clear. It has been mentioned that the Rural Health Service Act will be implemented effectively. It seems that the policy of appointing one MBBS doctor has been adopted, but so far

this has not been implemented. It seems that a policy has been taken to upgrade sub-health centers within the rural municipality and convert them into health centers. It seems that a policy has been taken to train local health workers through subject expert doctors for the prevention of prolapse, vaginal discharge, and uterine problems among women suffering from chronic diseases.

Diprung Chuichumma Rural Municipality formulated the first periodic plan in 2076. It seems that the plan has been formulated keeping various indicators related to health in the plan. Which is given in the table below.

Table 8

Details of those who use the temporary means of family planning in the rural municipality

Indicators	Base year F.Y. 2075/76	Target F.Y. 2078/79	Target F.Y. 2080/81
Number of first visits to health post when sick	52	60	80
Pregnant women within the Rural Municipality who give birth in a health institution	76	180	290
Diarrhea infection rate (per thousand)	5.49%	3.25%	1%
Respiratory Infection Rate (per thousand)	10.98%	6.36%	2%
Health workers working in health institutions	29	39	39
Rate of use of contraceptive methods	34	60	74
Children with all types of vaccinations	69	75	85
Number of families having health insurance	185	3752	3752

Source: Diprung Chuichumma Rural Municipality, 2076

The main objective of the Periodic Plan of Diprung Chuichumma Rural Municipality is to increase the availability and quality of quality and basic health services and facilities. The strategies and actions of this periodical plan are gradually expanding health institutions and services, increasing the quality of health services, ensuring access to health services, expanding public awareness about health,

etc. Conducting awareness campaigns on child marriage, birth control, family planning, maternal and child welfare to increase public awareness, increasing public awareness on hygiene and nutritious food, reducing malnutrition and disease incidence, building human health, raising public awareness on communicable and non-communicable diseases that are more problematic, yoga, meditation as an alternative There are strategies like spreading the word about treatment. Under the strategy to expand health institutions and services, establish at least village-level hospitals in appropriate locations and provide health service facilities, make birthing services effective at all health posts, reduce maternal mortality and infant mortality to zero, and provide at least all types of medicines, equipment and skilled manpower to improve the capacity of health posts. Making arrangements to make health service facilities agile, identifying suitable locations and establishing primary health centers, arranging necessary medical equipment in every school with medical personnel and arranging regular health changes for students, community hospitals that meet the prescribed standards, health clinics and drug stores in different locations of the municipality based on need are operating.

As part of the strategy to ensure access to health services, expanding health services by providing health check-ups and other facilities by conducting maternity camps in areas, communities and settlements where health services are not available for senior citizens and due to various reasons, expanding free and safe delivery services and health services before and after delivery. Incentive programs will be conducted to provide 100 percent maternity services from health institutions, maternal and child health services, immunization services, safe motherhood and family planning services will be expanded and strengthened, and all medicines provided free of charge by the government will be classified according to the needs of the rural municipality at all times. Creating an accessible environment, ensuring skilled obstetricians and other human resources in health institutions, creating an environment where services can be obtained 24 hours a day, effectively deploying health insurance, expanding access to health services in the poor and backward classes, regions and communities, mobile hospitals and community health Units, village clinics will be increased, Dalits, extremely poor and citizens over 70 years of age will be provided with free health check-up and treatment from village health posts, hospitals, and menstrual health management programs and raising public awareness against superstitions related to menstruation, etc.

Interlinkage between the Existing Situation of Healthcare Services and Rural Migration

Diprung Chuichumma Rural Municipality can be considered satisfactory in terms of access to primary health facilities, but not advanced facilities and services. There is no hospital, except for health posts and sub-health posts. According to Lee,

it is the push factor and the negative factors of the Diprung Chuichumma Rural Municipality influencing the rural-to-urban migration.

There is a lack of skilled manpower for the primary health services. There is also insufficient manpower to provide basic health services. Health Assistant, Assistant Health worker and ANM are serving there. They provide only basic health care for the rural people. For the treatment of major diseases, one should go to the best hospitals in the city. Therefore, Lee's theory of the push factor is becoming the stronger and dominant factor in rural migration.

Some common diseases such as fever, common colds, wounds, gastric, diarrhea etc. can be treated only by local health institutions. But the main diseases seen at this local level like cancer, high Blood pressure diabetes Stomach related diseases, asthma, uric acid, rheumatic, thyroid, neurological disease, mental illness, viral infections, bone joint pain, leg binding etc. have to go to the city hospital for treatment. Treatment of these diseases is not possible in rural health facilities. Therefore, they are forced to migrate to urban areas due to treatment.

Medicines for these diseases are also difficult to get in the village. Because there are only medicines available for common diseases. If you live in a village, you have to send medicine to someone from the city and ask for it. In this way, the attractiveness of living in a village house starts to decrease. Instead, the attraction towards the city to settle down begins to increase. According to Lee, it is a negative sign of origin place. The origin place cannot hold people when negative factors are abundant. Negative factors of the origin place tend to migrate from it (Lee, 1966).

Diprung Chichumma Rural Municipality does not have diagnostic laboratories and equipment for various diseases. The patient should go to the city hospital for regular check-ups of diseases like thyroid, diabetes, uric acid, etc. Similarly, during the treatment of some diseases, regular follow-up visits to the doctor are required. For this, the patient has to travel to the city from time to time. Due to this, the attraction towards the city increases tends to rural migration. But people have so many obstacles in the migration journey based on Lee. Whoever clears the obstacles to the migratory journey succeeds in migrating to the urban areas.

There are three birthing centers in the Diprung Chuichumma Rural Municipality. There are no available surgery services, blood banks and oxygen gas, but manage only normal delivery cases. Health posts cannot handle complicated pregnancy cases. Complicated pregnant women may die if they do not receive treatment immediately. Some pregnant women have died prematurely due to a lack of maternity services. The main reason for this is living in villages, where there is a lack of hospitals that provide good maternity services. Complicated pregnant women can only be saved if they are rushed to a city hospital for delivery. They should be

immediately rescued by helicopter and taken to a city hospital. According to Lee, these health-related services and facilities are the push factor of the origin place and pull factors of the destination place influencing rural-to-urban migration. So, the poor condition of healthcare services in Diprung Chuichumma Rural Municipality is accelerating rural-to-urban migration.

There are three maternity centers in Diprung Chuchumma Rural Municipality. There are no surgical services available, no blood banks and no oxygen gas, although normal delivery cases can be managed. Health posts cannot handle complicated pregnancy cases. Pregnant women can die if they do not receive treatment immediately. Some pregnant women have died prematurely due to a lack of maternity services. The main reason for this is living in villages, where there is a lack of hospitals providing good maternity services. Complicated pregnant women can only be saved if they are taken to well-equipped hospitals in the city for delivery. They should be immediately rescued by helicopter and taken to the city hospital. According to Lee, these health-related services and facilities are the place of origin and the bridge factors of destination that influence rural-to-urban migration. However, due to the poor condition of health services in Diprung Chuchumma Rural Municipality, migration from villages to cities has increased.

There are three maternity centers in Diprung Chuchumma Rural Municipality. There are no availability of surgical services, no blood banks and no oxygen gas, although normal delivery cases can be managed. Health posts cannot handle complicated pregnancy cases. Pregnant women can die if they do not receive treatment immediately. Some pregnant women have died prematurely due to a lack of maternity services. The main reason for this is living in villages, where there is a lack of hospitals providing good maternity services. Complicated pregnant women can only be saved if they are taken to well-equipped hospitals in urban areas for delivery. They should be immediately rescued by helicopter and taken to the city hospital. According to Lee, these health-related services and facilities are the push factors of origin and the pull factors of destination that influence rural-to-urban migration. Hence, due to the poor condition of health services in Diprung Chuichumma Rural Municipality, migration from rural to urban has increased.

Conclusion

Historically, the unitary and central state system had been producing and reproducing inequality and disparities between rural and urban areas in terms of the expansion of state services and facilities. Although, the state system has changed, its remnants can still be easily found. As rural areas faced urban-centric development and urban-biased activities, rural residents migrated to urban areas. This trend has been increasing for a long time. It is still increasing now. The village is becoming empty. Village houses are not inhabited. Big locks are hanging. The agricultural

lands are becoming barren. Villages are becoming places where only the elderly and the disabled live. The potential for development in rural areas is increasing but people are migrating to urban areas. The current federal democratic republic system is practicing local-level government. Political power has reached the rural areas.

The local government is the closest and the first body to expand access to local government services. Hence, physical infrastructure is being built in rural areas. Especially, the motorable road tracks are opened. In the health sector, health service infrastructures have also been built. However, rural people are migrating to the cities. The expansion of the service facilities of the motorway seems to have made it easier to move towards the cities. Young people are migrating from villages to cities.

Local government could not reduce rural-urban migration, but it is growing now. If it continues to grow in this way, it may become a myth that Nepal is a country of villages. Therefore, it seems that the local government should make policy and legal arrangements to minimize migration from rural areas to urban areas. The federal government and the state government should run hospitals with the same facilities as in the city. No one should have to migrate to the city for the sake of medicine and treatment. The compulsion of village people to migrate to cities for survival should be removed. Arrangements should be made at MBBS Doctor at Health Post. Necessary laboratory, equipment and technicians should be arranged for disease diagnosis. Arrangements should be made for complicated cases of pregnant women to give birth easily in the village.

Lee's belief that migration can be minimized by removing the negative aspects of the place of origin can be applied here. According to him, if the above-mentioned actions are taken, the factors affecting the rural areas will be reduced and the migration from the villages to the cities will be reduced. Based on the above-mentioned theoretical and empirical facts, it can be concluded that if health services are extended to villages like cities, one of the migrations caused by health services can be prevented.

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