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Existing practices and barriers to access of MCH services – a case study of residential urban slums of district Mohali, Punjab, India

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ABSTRACT

Maternal mortality and morbidity continues to be high despite the existence of national programs for improving maternal and child health in India. Though urban India has a relatively strong health and nutrition infrastructure - there is marked inequitable distribution of service availability and utilization between the rich and poor, between the settled urban population and the marginalized slum dwellers. So the present study intends to assess the utilization of maternal health services by women residing in urban slum areas of district Mohali, Punjab. A cross – sectional descriptive study was carried out and a total of 164 respondents were interviewed using a semi-structured questionnaire by door to door survey. As many as 77% of the respondents received Antenatal care, out of which 59% completed 3 visits of ANC .23% of the women did not receive even 1 ANC check up. 49% women in the slums delivered their child at home,81% of these deliveries were conducted by trained dai while 19% of the women delivered their child without any SBA. The major reason for not opting for an institutional delivery as stated by 53% of women was that, "they did not feel it necessary" while 20% blamed the non cooperative hospital staff. About 89% of the women eligible for JSY did not receive any Cash Incentives. 40% women revealed that it was due to the non filling of JSY card by ANM's that they were not able to avail monetary benefits under the scheme. Postnatal care was not sought by 77% of the women. Only 57% of the child received all vaccinations up to their present age. The present study found that poor sense of need and on top of it, the providers poor attitude were the main reasons for not utilizing health care facilities.

Keywords: Urban slums, Utilization, ANC, Intranatal, PNC, Barrier

INTRODUCTION

A country's overall development is incomplete without participation of all the sexes equally; women constitute a major chunk of the work force these days in every nation. A woman requires special attention during 15-44 years of her life since she gets matured sexually and socially, gets married, conceives and gives birth to children during this phase[1].The process of childbearing needs to be given special attention, as it affects the overall health, especially the reproductive health of the woman, as well as health of her new born. Moreover, the place where delivery takes place is an important aspect of reproductive health care, quality of care received by the mother and the newborn baby depends upon the place of delivery.

India is witnessing an explosive growth in population living in urban areas, and it is estimated that nearly 30 percent of India's population or about 300 million people live in towns and cities[2] .The Country has witnessed around 8 percent growth in GDP in the last couple of years and has planned to achieve a target of over 9 percent growth by the end of 11th plan period[3]. Census 2011 lists 7,935 towns in India, the number of towns has increased by 2,774

since the last Census (2001)[4]. With over 575 million people, India will have 41 percent of its population living in cities and towns by 2030[5]. Currently urban population of India is about 377 million, out of which 97 million people belongs to urban poor population (Census 2011)[6]. There has been a growth of 17.8 million in urban slum population of India during the last decade, according to a government committee formed to create a 'reliable statistical model' of enumerating people living in such areas[7]. There are about 49000 slums in India.[8] The level of urban poverty in India is increasing, while rural poverty is decreasing. Given the difficulty of accurately estimating the size of the poor and slum populations residing in urban areas, it is also difficult to assess the health and nutritional status of such populations. The subject of slum welfare is immensely important, yet until recently it was largely ignored. Most people are simply unaware of the gravity of the slum problems. The details of the problem are frequently unknown, because so often the poorest communities within an urban population are unmapped and hence are unknown to officialdom. Moreover, when morbidity statistics are collected, those for the poorest tend to be grossly under recorded and seem to be a conspiracy of silence about health and welfare of the inhabitants of those lucky slums that succeed in getting official recognition. The review of literature on the health care utilization shows that urban health is still a less researched area in the context of its complexities. Different studies done across the country revealed that, among the urban population, slum dwellers have higher rate of morbidity prevalence and their living condition is extremely poor. Although uniformly disadvantaged, the urban poor cannot be treated as homogenous entities; there exist important socio demographic variations within the urban poor population in relation to their use of services and the barriers faced in service utilization. Though urban India has a relatively strong health and nutrition infrastructure - with public sector investments coming from central, state, and local bodies as well as a vast private sector - there is marked inequitable distribution of service availability and utilization between the rich and poor, between the settled urban population and the marginalized slum dwellers. So Attention to vulnerable communities in the slums is needed from a public health perspective, and pregnant females and children constitute the major "high risk" group.

MATERIALS AND METHODS

A cross- sectional descriptive study was conducted in the 6 residential urban slums of District Mohali, Punjab, India, namely Udham Singh Colony, Amar Colony, Ambedkar Colony, Balmiki Colony, Madanpura slums and Verka chowk, between months of April 2012 to May 2012. The estimated number of households/ Jhuggies in these slums as per district records was 3296. These slums have been in existence for the last 10 years with an approximate population of 18000. All married women in the age group of 15-45 years who were either pregnant at the time of interview or had delivered within the last 3 years were included in the study. A total of 515 such women were identified in these slums and 164 women were selected by random sampling technique and interviewed by door to door survey. The pretested semi structured questionnaire was used by investigators for interview. Multiple visits were made for contacting all eligible respondents in the slums. A list of ANM's who look after these slums were obtained from the Civil Surgeon Office and their help was sought to identify the women. For these slums, there is no separate ANM appointed by the State Government and these ANM's are catering about 25000 – 30000 population each. The respondents were orally explained the purpose of the study, verbal consent was taken and the females were interviewed in detail about socio-demographic profile, their reproductive behavior and intentions, details of antenatal care, delivery, postnatal care, attitude and level of satisfaction towards various maternity and child health schemes like Janani Suraksha Yojana, family planning methods, child immunization and perceived barriers for non-utilization of maternal health-care services. Data analysis was done with the help of MS Access, excel, SPSS 16 & SAS 9.2.1. The data was tabulated in terms of frequency distribution of different variables. Chi-square test of significance was employed for testing associations. P_<0.05 was considered for statistical significance.

RESULTS AND FINDINGS

Socioeconomic and Demographic Profile: Findings show that, among the164 mothers interviewed, 58.5% belong to the age group of 20 to 25 years, followed by 31.7 % in the age group of 25 to 30 years .Greater proportion (66.5%) of the women were illiterate. Most (86%) of the study participants were housewives. More percentage (74%) of the women belongs to low socioeconomic class.

Table 1 Socio Demographic Characteristics of Respondents (N=164)

Characteristics	Frequency	Percent (%)
AGE (years)		
< 20	11	6.7
20-25	96	58.5
25-30	52	31.7
>30	5	3.0
EDUCATION		
Illiterate	109	66.5
Till 5th	25	15.2
Till 8th	12	7.3
Till 10th	11	6.7
Till 12th	6	3.7
Graduate	1	0.6
OCCUPATION		
Housewife	141	86
Employed	23	14
FAMILY INCOME		
Below 1000	1	0.6
1000-5000	121	73.7
5000-10000	37	22.6
>10000	5	3.0
Total	164	

Maternal Child Health Practices: The practices include Antenatal, Intranatal and postnatal services as well as immunization coverage of children. Out of the 164 respondents, 83 (50.6%) were registered by the ANMs but only 38 (46%) got registered in 1st trimester. In total 127 mothers (77.4%) received ANC services, 43 (52%) completed 3 ANC visits. Further folic acid tablets were distributed to 117 women i.e. 71.3% and 126 (76.8%) received complete Tetanus Toxoid immunization.

The study revealed that out of 164 respondents who delivered a baby, 81 (49.3%) reported of home delivery, deliveries conducted by SBA in total were 66, in which; only 03 deliveries were conducted by government trained SBAs and the rest, i.e. 63 deliveries (77%) were conducted by some unknown

private SBA as reported by respondents. Moreover, the study reflected that still 19% deliveries were unsafe, as they were conducted without any SBA assistance, at home. Out of the 164 respondents that we interviewed, 102 were found eligible for the JSY scheme benefit, but only 12 mothers received financial assistance under JSY.PNC services were availed by only 37 women, i.e. 22.5%.On interviewing the mothers about the vaccinations received by their children below 5 years of age, it was found that 56.7 % had received complete immunization upto the present age. Research reflected that the dropout rate of (DPT+polio) vaccine was highest i.e. 76% followed by that of Measles (67%)

Table 2 Utilization of Antenatal, natal, Postnatal and Immunization services (N=164)

Characteristics	Frequency	Percent (%)
Registration during 1st trimester (n=83)	38	46
3 ANC Visits (n=83)	43	52
Home Delivery{SBA private} (n=81)	63	77
Home Delivery{SBA Government} (n=81)	03	04
Home Delivery { Non SBA} (n=81)	15	19
Utilization of JSY scheme (n=102)	12	12
Dropout rate DPT+POLIO vaccination (n=71)	55	76
Dropout rate of Measles vaccine (n=71)	48	67

Characteristics	Frequency	Percent (%)
Registered Antenatal Mothers	83	50.6
Received ANC services	127	77.4
Injection Tetanus Toxoid 2 doses	126	76.8
Folic acid Tablets received	117	71.3
Institutional Delivery	83	50.6
Home Delivery	81	49.3
Postnatal check up	37	22.5
Complete immunization coverage up to present age	93	56.7

The major barriers to utilization of MCH services by the respondents are described in the underlying table. On questioning the respondents about the reasons for preferring home delivery over institutional delivery, 53% said that, 'they do not feel it's necessary to deliver at a hospital' further, 42 % revealed that, ' non cooperative hospital staff ' was the reason behind not preferring institutional delivery. It was also found that, in 33 % cases 'husband was not at home' to take the pregnant women to institution.

As mentioned in the earlier tables, out of the 164 respondents, only 12 received financial assistance under JSY scheme. Reasons furnished by the rest of the 90 respondents were as follows, 40 % told that 'JSY card was not issued' by the ANMs, 'non cooperation of the hospital staff' (24%). 'Paper work not completed upto time' and 'do not know' were the reasons reported by 20% and 16% respectively.

Greater proportion (78%) mothers said that 'lack of information' was the reason for not getting their children vaccinated. 36% thought 'it was not necessary' and 21% revealed that 'immunization card was lost/left at home state where child was born'.

Table 3 Major factors affecting utilization of Maternal Child Health Services

Major Factors	Percentage
Reason for home delivery (n=81)	
Long distance to facility	6 %
Family didn't allow	9 %
Unavailability of Transport	5 %
Better service at home	6 %
Long waiting time at hospital	8 %
Don't feel necessary	53 %
Non co-operative hospital staff	42 %
Husband not at home	33 %
Others	7 %
Reason for not getting money under JSY scheme (n=90)	
JSY cards not issued by ANM's	40 %
Hospital staff non cooperative	24 %
Paper work not completed upto time	20%
Don't know	16 %
Reason stated by mothers for not getting their child vaccinated (n=71)	
Lack of information	78%
Don't feel necessary	36%
Child was ill	8%
Priority to work	1%
Immunization card lost/ Left at home state where child was born	21%
Other	1%

On performing bivariate analysis, significant association was found between the mothers registered by ANMs and those who received ANC, number of ANC visits, place of delivery, cash benefits under JSY scheme, received PNC and number of PNC visits with the help of chi-square test. Very High association was observed when correlated with received ANC services (x^2 =0.000), number of ANC visits (x^2 = 0.001), received PNC (x^2 =0.006).

Table 4 Association between Number of mothers registered by ANM (n=83) and other indicators

Characteristics	No./Percentage	Chi-square
Received ANC		
Yes	78	.000
No	5	
No. of ANC visits		
>3 visits	17	
<3 visits	61	.001
None	5	
Place of Delivery		
Govt Institution	41	
Private Institution	4	.029
Home-SBA (private)	34	
Home-SBA (govt)	0	
Home- Non SBA	4	
Cash benefits under JSY scheme		
Yes	6	.017
No	77	
Received PNC		
Yes	27	.006
No	56	
No. of PNC visits		
>3 visits	2	
<3 visits	25	.025
None	56	
Total	**83**	

DISCUSSION

Maternal mortality is the outcome of a complex web of causal factors that include social, economic, educational, political and cultural causes as well as issues such as gender inequity, state of physical infrastructure, geographic terrain and the health system. Through this study, researchers found that only half of the respondents (83 out of 164) got registered by the ANMs, moreover only 38 out of them (46%) got registered in the first trimester of pregnancy. Time of registration plays a very important role in evaluating the services from the supply side. In the current study, 127 women (77.4%) availed the ANC services .No doubt the rate

of ANC service utilization was good but it was also found that, only 52% mothers received complete three ANC checkups.

Number of institutional and home deliveries was almost same but a shocking fact was reflected by the study, that, only 4% home deliveries were done with the help of a government trained SBA, around 77% were conducted by some unknown private SBA whose whereabouts and credentials were not known to any government health staff of that area. And rest of the home deliveries were conducted without assistance from any SBA.

It was evident that despite the JSY scheme being in full swing, un-institutional and unsafe deliveries were still taking place in these slums. The major reason, stated by 53 % women for choosing home delivery was, that they did not feel the need to go to a Health institution as they were not facing any complications before or during pregnancy. The second most common reason stated (by 42% women) was 'Non cooperative attitude of the hospital staff', the respondents told the researchers that they were mistreated and insulted by the staff as and did not understand the local language as well. In 33 % cases, the husband of the respondent was not at home to take her to the hospital when the labour pain started.

Out of all the eligible women ,only 12% got JSY benefit, the reasons varied from person to person ,but the most substantial being, "Non-issuing of JSY cards by the ANM's"(40%), followed by ,again, non cooperative hospital staff (24%).

In comparison to the ANC utilization, PNC utilization was found to be very low (22.5%).On probing the reasons for this disparity, it came to light, that, it was a common practice amongst women in these slums to go to their home states of Uttar Pradesh and Bihar for delivering the baby. Tracking the mothers after they come back from their home states was a roadblock in providing PNC services.

Due to the very same reason, the immunization coverage for children below 5 years of age was found to be 56.7%. Furthermore, the dropout rate of (DPT+polio) vaccine was highest (76%) followed by Measles at 67%. Likewise it was found that, by the time, child turns 9 months, and most of the mothers either forgot when to get their child vaccinated next or lost / misplaced the immunization cards.

Lastly, the research paper tries to establish an association between the number of women registered with the ANM and the provision, utilization of services like ANC, PNC, place of delivery, number of ANC visits and financial benefit under JSY scheme .It was found that there was a very high statistical significance associated with all of them, values form Chi Square test came out to be far less than 0.05.Thus, it could be inferred that registration plays a very prominent and important role from both the provider side and the consumer side for availing MCH services.

CONCLUSION

Utilization of healthcare services is poor in urban slums even though physical accessibility is present. Social and cultural barriers are more common in slums where healthcare services are not reachable. Home deliveries and unsafe deliveries are still widely prevalent in slums. Skilled birth attendants are not reaching to those who need them the most. Accessibility to healthcare services of slum population must be taken into account in the district health planning process. Healthcare services need to be scaled up so that ante-natal services and skilled birth attendants are available for all. The health education component of care can bring about changes in attitude and practice. This component should be strengthened in the healthcare delivery system. Health workers need to be trained regularly and motivated about the essential gynecological and obstetric care. Female literacy drives should also stress on adolescent girls awareness regarding health, legal age of marriage and future motherhood. Mothers and pregnant women's queries and doubts should be judiciously addressed during antenatal check up days, in immunization clinics, mothers group meeting in anganwadi and during the home visits by health workers. Dedicated joint effort, both by the community as well as health staffs is essential for the achievement of MDG-5.

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