Utilization of Maternal and Child health services and health seeking behaviour among women in an urban Slum of Delhi

A dissertation submitted in partial fulfillment of the requirements for the award of

Post-Graduate Diploma in Health and Hospital Management

by

Alok Kumar
PG/11/006

International Institute of Health Management Research
New Delhi -110075

May, 2013

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VIMARSH
DEVELOPMENT SOLUTIONS

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Certificate of Internship Completion

Date: 29/04/13

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Mr. Alok Kumar has successfully completed his 3 months internship in our organization from February 04, 2013 to April 29, 2013. During this period he has worked on **"Utilization of Maternal and Child health services and Health seeking behavior among Women in an Urban slum of Delhi"** as a part of team under my guidance at Vimarsh Development Solutions. His work has been satisfactory during this tenure.

We wish him/her good luck for his/her future assignments

Mr. Udit Bhandari
Director, Vimarsh

Certificate of Approval

The following dissertation titled "**Utilization of Maternal and Child health services and health seeking behavior among women in an urban Slum of Delhi**" is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

Name	Signature
DR. SHER SINGH KASHYOTIA	
DR. NITISH DOGRA	

Certificate from Dissertation Advisory Committee

This is to certify that **Mr. Alok Kumar**, a graduate student of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. He is submitting this dissertation titled **"Utilization of Maternal and Child health services and Health seeking behavior among Women in an urban slum of Delhi"** in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management**.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

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Date : 29/04/13

FEEDBACK FORM

Name of the Student: Alok Kumar

Dissertation Organisation: Vimarsh Development Solutions

Area of Dissertation: Utilization of Maternal and Child health services and Health seeking behavior among women in an Urban Slum of Delhi

Attendance: Excellent

Objectives achieved: All the set objectives were fulfilled on time.

Deliverables: Proposal writing
Interaction with experts
Monitoring of field workers.

Strengths: Alok is hardworking and has impressive analytical skills He has good communication skills and is keen to learn new things.

Suggestions for Improvement: He should be more flexible.

VIMARSH THE CONSULTANCY GROUP

Signature of the Officer-in-Charge/ Organisation Mentor (Dissertation)

Date: 29/04/13
Place: New Delhi

Abstract

The objective of the study was to determine the awareness and practices regarding Maternal, neonatal and child health services among eligible women of age 15-49 years (who have given birth in last two years) in an urban slum in Delhi. A total of 204 eligible women were interviewed. Systematic random sampling technique was used and survey questionnaire tool was used to gather data on ANC, delivery, PNC, Newborn care and care related to sick children. The obtained data was analyzed in SPSS 17.

Out of 204 women interviewed, 49 percent were illiterate and their median age was 24 years. Seventy five percent of women registered for ANC but only 37 percent women received ANC during their first trimester of pregnancy. Around 45 percent of the deliveries were home deliveries. Out of these home deliveries 96 percent of the deliveries were conducted by Traditional Birth attendants. Majority of institutional deliveries were conducted in public health facilities (93%). Only 51 percent of women interviewed visited any health facility for postnatal checkup. Twenty two percent children were not weighed after their birth at all. A significant 12.3 percent of children were breastfed only on the next day of their birth. Twenty percent of the children that were born were not fed colostrum. Within first three days of their birth, 30.4 percent were given plain water/ sugar water/ honey or any food other than mother's own milk. Around 34 percent of Children had fallen sick within last 15 days of the interview. Out of which 13.7 percent, 25 percent and 23 percent children suffered from Diarrhea, Acute respiratory infections and fever respectively during last 15 days of delivery. Fifty percent children who suffered from diarrhea were given lesser fluids to drink than usual during diarrhea. Only 32 percent of children who suffered from diarrhea were given ORS.

There is a low level of awareness among the community women regarding Antenatal checkup, institutional deliveries, birth preparedness and Post natal care among women. The main reason for not going for antenatal checkup was that they did not face any complications. Similarly, Post natal checkup was not received because either the facility was far or it was not considered necessary. The distance of health facility is an important determinant in utilization of maternal and child health services among women. Also there is a need to create awareness regarding management of childhood illnesses.

ACKNOWLEDGEMENT

I would like to acknowledge and extend my heartfelt gratitude to the EHI International and Vimarsh Development Solutions, especially to Mr. Deepak Bhandari for providing me the opportunity to work and learn in the esteemed institute.

I wish to express my deep sense of gratitude to my mentor Mr. Udit Bhandari, Director, Vimarsh for his vital encouragement and support. Suriti Sachdeva, Anamika and Kshma for their valuable inputs, understanding and assistance. They were kind enough to give valuable time whenever required.

My study would have been incomplete without the extended support I have received from the field investigators who I worked with for primary data collection in the field. I am highly indebt to the community of the slum for giving me their precious time to carry out my study in the district. My sincere gratitude to Dr. Vikrant Bhardwaj for his cooperation, support and guidance during the fieldwork.

I express my sincere thanks and gratitude to my mentor Dr. Preetha G S Assist. Professor at IIHMR Delhi, She was always supportive to me and gave her valuable feedbacks whenever I required them.

It is a great pleasure to thank my beloved parents for their blessings, my friends for their support and wishes which helped me write my report successfully. Special and heartfelt thanks to my sisters, Rashmi and Abha for being a constant source of support. Without their inspiration and encouragement this study could not have been completed.

However, I accept the sole responsibility for any possible error of omission and would be extremely grateful to the readers of this project report if they bring such mistakes to my notice.

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List of Abbreviations

ANM	Auxiliary Nurse Midwife
ANC	Antenatal Care/Checkup
ASHA	Accredited Social Health Activist
CHC	Community Health Center
GoI	Government of India
LHV	Lady Health Visitor
MOHFW	Ministry of Health and Family Welfare
MPW	Multi Purpose Worker
PNC	Postnatal Care
PHC	Primary Health Center
SPSS	Statistical Package for Social Sciences
UHC	Urban Health Center

Part I: Internship Report

1.1 Profile of the Organization

EHI International (formerly known as EPOS Health India Pvt.) undertakes research studies in the Health and Nutrition Sector. It has vast client experience with deep expertise in undertaking research and evaluation studies, training of the health care providers, large scale surveys, research, policy, systems and capacity development for organizations and health care providers in private and public sectors throughout India and other parts of the developing world. Closely working with all our clients, we develop their capacities while developing effective and sustainable solutions together for their success.

Since its inception in 1999, EHI International has developed and sharpened its competencies assuming a leadership role in professional health consulting and management through successful execution of more than 116 projects and more than 9 projects currently under implementation for client organizations such as Registrar General of India, National Building Construction Corporation, Uttar Pradesh Project, International Finance Corporation, Infrastructure Leasing & Financial Services, Infrastructure Development Finance Company Limited, Ministry of Health & Family Welfare (Govt. of India), DFID, World Bank, GTZ, EC, KfW, UNICEF, UNOPS, MOPAN, OXFAM, CIDA, Aga Khan Health Services, The Commonwealth Secretariat and several State Government Health Departments such as Uttar Pradesh, Haryana, Himachal Pradesh, Madhya Pradesh, Punjab, Rajasthan, Tamil Nadu, Uttaranchal, West Bengal, Bihar, Jammu and Kashmir, Mizoram, Meghalaya and Gujarat.

Its group entity Vimarsh began by specializing in research and documentation in the Health and Family Welfare sector and has since 1992 expanded and diversified to specialize in programme / project evaluation, demographic surveys, large scale surveys, operations research, project preparation and project implementation.

Vimarsh provides services for qualitative and quantitative research, management and implementation of projects related to health, nutrition, elementary education, rural development, forestry, poverty alleviation, livelihoods, micro-enterprise development and

water and sanitation. Over the years we have developed expertise in qualitative and quantitative research especially management of large surveys, project planning & management, institutional development, monitoring & evaluation, human resource development & capacity building at different levels.

1.2 My involvement

- **Prepared technical proposals for various studies like**
  - ✓ End Line Assessment of EU-EMEP Supported Project "Improving Reproductive and Sexual Health of Young People in three countries" for MAMTA
  - ✓ "Evaluation of KAVAL Voucher scheme" for State Innovations in Family Planning Services Agency
  - ✓ "Oxfam- End line evaluation of Western India Program-Natural Resource Management"
  - ✓ "Evaluation of Integrated Low cost Sanitation Scheme" for Ministry of Housing and Urban Poverty Alleviation

- **Prepared Expression of Interest for various studies like**
  - ✓ Expression of Interest (EoI) for Consulting Services for Development and Printing of IEC/BCC Materials for Malaria Control
  - ✓ Expression of Interest for appointment of Monitoring and Verification Agency for Karnataka Health systems Development and Reforms
  - ✓ Expression of Interest (EoI) for Hiring of services for conducting Mid-line review of Capacity building initiatives under ISGP Project, Service Delivery and Governance in Project Gram Panchayats in West Bengal

- **Prepared Survey tools – Quantitative and Qualitative tools for**
  - ✓ Evaluation Of Comprehensive Child Survival Programme (CCSP) under NRHM, Uttar Pradesh for State Innovations in Family Planning Services Agency

- ✓ Evaluation Of Accredited Social Health Activists (ASHA) under NRHM, Uttar Pradesh for State Innovations in Family Planning Services Agency

1.3 Managerial Tasks Performed

Since I am working as a Research Associate in a Public Health Consulting firm, my work is providing technical assistance rather than managing processes. I am actively involved in writing technical proposals and drafting budgets for the same. This includes developing approach and methodology for a study, designing tools required under the study, developing the entire work plan and inputs of various experts involved under the study. The detailed description of work plan and person days and preparing the draft budget considering various activities under the study is also my responsibility. Other work also include finalizing the experts for a particular study, the finalization of team and follow up with different experts for their consents and updating them on various proceedings. When the proposal is awarded, my area of involvement include desk research, training of field workers and coordinators, finalization of tools in consultation with the client and monitoring of field activity. I also provide my inputs in report writing

1.4 Reflective learning during Internship duration

- Team work – Since preparing a quality research proposal requires various inputs from people with expertise in their respective fields, I have to coordinate with all of them. Since all of them belong to different level of hierarchy, I have learnt how to work in a team.
- Meeting the deadlines – Since EHI-Vimarsh bid together in number of opportunities (as high as 12-13 per month), the deadlines are taken seriously here. I complete my work in time and submit them before the deadline
- Multitasking – Since preparation of a proposal requires all the activities from conducting desk review, developing methodology, rapport building with the client, following up with the experts and preparing the budget for the study, I have learnt to do multiple tasks.

- Negotiating skills – My work also includes interaction with experts and convincing them to get involved in the projects. This has helped me develop my negotiating skills
- Widening my domain – Since I write proposals for Natural resource management, Livelihood, capacity building and in other areas related to social sector, it has helped me widen my knowledge related to sectors other than health sector also

Part II : Dissertation on "Utilization of Maternal and Child health services and health seeking behaviour among women in an urban Slum of Delhi"

Chapter 1: Introduction

1.1 Background of the Study

The urban population of India is one of the largest in the world. According to the Census 2011, urban India has 37 percent of its national population and is expected to rise to 46 percent by 2021. [1] The unprecedented growth in urban population can be attributed to large extent to the migration of rural poor to these cities. With hope of better means of livelihood, they migrate to urban areas where they have to pick up lowly paid jobs since they have no education or skill. With their meager income, they are forced to live in Slums.

Globally, slums have been recognized as neglected communities with limited access to services. They are often characterized by deficient access to safe drinking water and sanitation, poor drainage system, excessive open sewers, amount of uncontrolled rubbish, poor lightening and above all severe over-crowding. Poverty, unemployment, illiteracy, polluted environment and uncontrolled population growth together present a big threat to the health of slum dwellers. [2, 3]

The growth of slum areas and concentration of the poor people in the slums is a rather depressing aspect of urbanization. Majority of the people who live there belong to lower socio-economic classes and have migrated to the city with the hope of better means of livelihood. [4] Having basically no education, skill and work experience, they have no choice in the competitive job market and pick up lowly paid jobs such as construction laborer, domestic servants, casual factory workers and petty trading business. With their meager income, they are forced to live in slum areas in the most unsanitary and unhygienic conditions, and are carrying out their existence with the barest necessities of life. [5] Even if people have some money, they do not invest it in house improvement, because of its temporary status or illegal occupation of the public lands and constant threat of eviction. Therefore, the housing of the slum dwellers is of lowest quality.

1.2 Problem Statement

Poor housing conditions, overcrowded environment, poor sanitation, occupational hazards, group rivalries and clashes, stressful conditions together with lack of open space for children's recreation etc. are detrimental to the health of people in the slums. In terms of health services also, their access is very restricted. In India, despite the supposed proximity of urban poor to urban health facilities, their access to them is severely restricted or limited. The inadequacy of urban health delivery system, ineffective outreach and weak referral system limits the access of urban poor to health care services. Social exclusion, lack of information and assistance at secondary and tertiary hospitals makes them unfamiliar to the modern environment of hospitals thus further restricting their access to treatment facilities. Lack of economic resources inhibits and limits their access to available private facilities.

There is a need for special attention to be paid to integrate all interventions of maternal and child health with reproductive health in urban areas. This has become crucial because of the rapid urbanization and the resultant mass scale migration of the rural poor to urban areas. In the cities, they live in slums in unhygienic and unsanitary conditions with virtually no access to basic amenities like safe drinking water and toilets and which are the breeding grounds for diseases that endanger the health of its residents. In the absence of an adequate health care system, the urban poor of India, particularly the women, continue to suffer. In fact their health is neglected the most. Insecurity related to regular income, food, shelter, access to healthcare and other essential services, along with poverty and difficult physical and social environments, such as exploitation and abuse in the treatment of women, have an adverse impact on the health of the urban poor women.

1.3 Rationale of the Study

In India, there have been limited efforts to study the health of individuals especially women living in slums. Of the few studies that exist, most have reported considerable differences in the situation of reproductive and child health between slum and non-slum areas. An understanding of those aspects of women's health that are affected by their childbearing role, their utilization of already available health services, their treatment patterns and barriers to this utilization is therefore required to design appropriate approach to their health needs.

Data on the above mentioned issues needs to be made available easily and quickly to provide a feedback to the policy makers for immediate remedial measures. Keeping these aspects in mind, a rapid community based survey was employed. The design of this rapid assessment approximates that of a large scale survey but without the luxury of time to provide a "snapshot" of women's practices regarding maternal and child health in urban slum settings.

1.4 Review of Literature

Urbanization has led to increased productivity and economic diversification, but also deprivation, poverty and marginalization. The slum population not only suffers from marginalization and poverty but also from inequitable distribution of public services like health and education. [6] While growth of towns and cities is indispensable to modern society, the equity gap is widening day by day. This is adversely affecting the slum population and bringing about social exclusion

In general, the health seeking behavior is directly related to the ability to pay. The poor people do not seek treatment unless they have no other choice left. [7] In few ways, the urban poor also share similar characteristics. The situation with respect to women's health in the urban slums is even worse. Their health is neglected the most. Insecurity related to regular income, food, shelter, access to health care and other essential services, along with poverty and difficult physical and social environments, such as exploitation and abuse in the treatment of women, have an adverse impact on the health of the urban poor women. [5]

The utilization of maternal and child health services is affected by a range of factors, socioeconomic and cultural, such as women's status in the household and society, their educational and economic status, accessibility of facility (distance, transport) and availability and quality of care (availability of staff and equipment in the health facility). [8] The entire cycle of care an expectant mother and her newborn should receive like Antenatal checkup, delivery, postnatal checkup, newborn care and care seeking related to childhood diseases and self is also influenced by the decisions made by other family members. [9]

Few similar studies that have been carried out suggest that the main reason for low utilization was lack of knowledge about the services offered, which may in turn be attributed to the high level of illiteracy and lower accessibility of health facilities. [10] The proportion of deliveries assisted by skilled attendants is generally lower among the women from slum areas. This could be due to lack of availability, poor access, or inability to afford the services of skilled attendants. The proportion of home delivery has been higher among women from slum areas. The low utilization of delivery facilities by slum women has also been reported in previous studies. [11, 12]

Few studies also revealed that the dependence of slum women on the public health system for reproductive health services is high. [13] This is encouraging but it is widely recognized that urban health facilities are marred by inadequate medical and nonmedical manpower. Previous reports have suggested that only about 77% of the Urban Family Welfare Centers and Urban Health Posts are fully functional. [14]

1.5 Objectives of the study

General Objective

To determine the awareness and practices regarding Maternal, neonatal and child health services among eligible women of age 15-49 years (who have given birth in last two years) in an urban slum in Delhi.

Specific Objectives

1. To assess the utilization of Maternal and child health services among the eligible women in the slum.
2. To study the care seeking behavior among eligible women during pregnancy, delivery of child, newborn care and during illness of their child.

Chapter 2: Data and Methods

2.1 Study Design

This is a cross sectional descriptive study. A key feature of this study is that it is aimed at understanding those aspects of women's health that are affected by their childbearing role especially in urban slum settings since they are marginalized and have not been given due importance in past. Such data needs to be made available easily and quickly to provide a feedback to the policy makers for immediate remedial measures. Keeping these aspects in mind, a rapid community based survey was employed. The design of this rapid assessment approximates that of a large scale survey but without the luxury of time to provide a "snapshot" of women's health in urban slum settings. This study was carried out in a slum of Central Delhi.

2.2 Sampling Frame and calculation of Sample Size

The sampling universe was all the women of age 15-49 years of this particular slum, who have given birth in last two years. Before the study began, listing of households and eligible women for this slum was conducted. All households were arranged and numbered in geographically consecutive manner. A total of 473 eligible women were listed in the slum area with their households. Assuming the frequency of outcome to be 50 percent (since we are not considering incidence of any disease 'p = 0.5'), the sample size was calculated for 95% confidence limits and came out to be 212 eligible women. However, out of 212 eligible females, interviews could be conducted only with 204 women due to non-response and unavailability.

2.3 Sampling technique

A systematic random sample design was adopted to draw sample since the list had the details of households along with the eligible women arranged and numbered in geographically consecutive manner. Let the number of eligible women in the slum be "N". The sampling interval "k" was determined as k=N/212. Here the sampling interval k was 2 (approx)

- A random number between 1 to k was selected. Let the number so selected is **"r".**

- The remaining 211 random numbers associated with the selection were **r+k, r+2k, r+3k……r+212k.**
- The sample comprised of eligible women at serial numbers **r, r+k, r+2k, r+3k……r+212k.**
- In a household if there was eligible women age 15-49 years, who has given birth in last two years, the same was selected for detailed data collection. If an eligible woman was not available or will be asked whether there is any women satisfying the eligibility criteria the same will be selected, if not the process will continue till eligible women found in the nearby household following the right hand rule.
- This method of selection of eligible women was followed for all the 212 random numbers selected.

Here we took r = 2. The samples thus were 4^{th}, 6^{th}, 8^{th} and so on till we covered 212 samples.

2.4 Study Tools

The Study Tool that was developed to gather data was Survey Questionnaire and interview schedule was the technique used. The questionnaire was pre-tested on the field before the study started on 25 different samples. The questionnaire has following components and indicators on which the data was collected.

- **Background characteristics** like name, age, educational qualification, occupation and other such details
- **Antenatal care, care during delivery and post natal care** which will include questions on ANC visits, reasons for not going for ANC, questions related to birth plan, questions on PNC
- **New born and child health** which will include questions on child rearing practices, infant and young feeding practices, immunization of child
- **Childhood illnesses and treatment seeking behavior** which will have questions on common illnesses in young children, the management of these illnesses and their treatment practices.

(The original questionnaire is attached in the Annexure 1)

2.5 Data analysis

The data was analyzed in SPSS v. 17.0 statistical package and MS excel was used to make charts and tables.

Chapter 3: Result and Findings

Table 1: Socio – demographic Characteristics of 204 eligible females

Age	Range - 17-40 years
	Median - 24 years
Education	49 % have no schooling and are illiterate
	30 % are either primary or middle pass
Religion	85.3% Hindus
	11.3% Muslims
	2% Parsi
	1% Sikh
	0.5% Christian
Employment	87.3% are Home makers
	11.8% are domestic workers or maid
Parity	Range - 1-8 children
	Median - 2 children

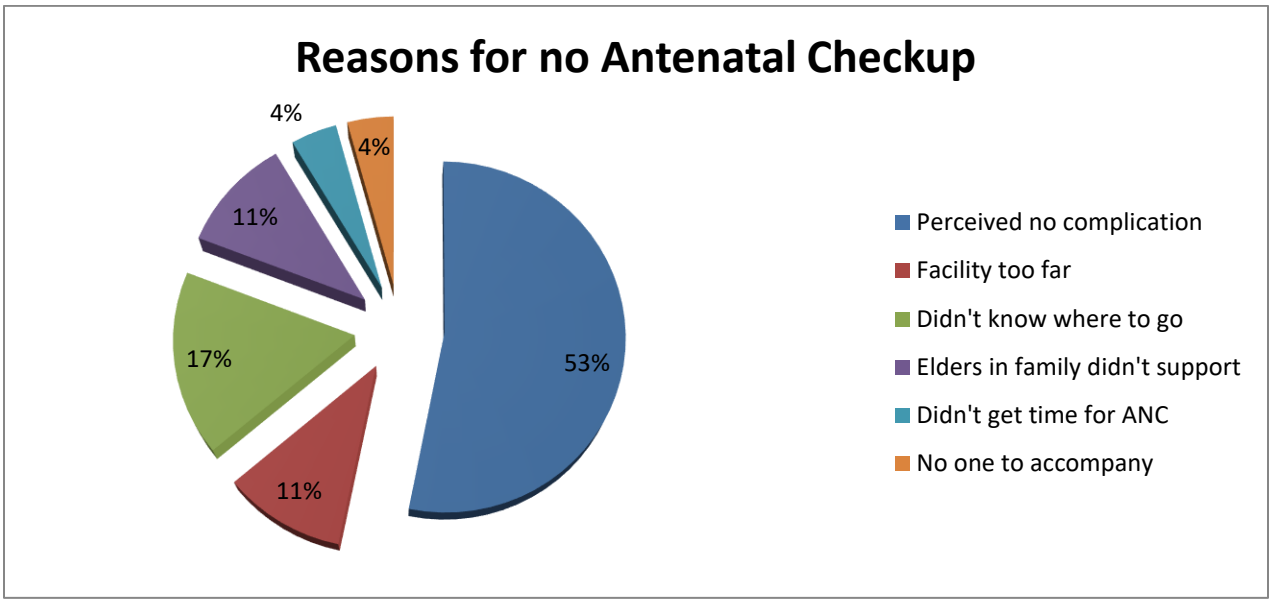
The women interviewed fall in the age group of 17 years to 40 years. As evident from the table around half of the women interviewed are illiterate and a majority of these women are home makers. The parity varies from one to eight children.

Antenatal Care

An encouraging 75 percent of women registered for ANC. The average month of pregnancy at which ANC was received was 5^{th} month. Ideally, there should be at least one ANC visit during the first trimester of pregnancy but here only 37 percent of those women who had ANC received it during their first trimester. Moreover only 25.2 percent had full Antenatal Checkup. Majority (92.5 percent) of women received ANC from any Government source.

Twenty five percent women did not receive any Antenatal Checkup. The main reason for not receiving ANC was that they perceived no complications (55.6%) followed by 17 percent of women who did not know where to go for ANC. A significant percentage of women (11%) said that their family did not allow them to go for ANC and another 11 percent women said that the facility was too far. Other reasons stated were that there was no one to accompany and they did not get time to go for Antenatal checkup. The following chart signifies the same.

Chart 1: Reasons for not receiving ANC



It is interesting to note that 93.6 percent of interviewed women said that Anganwadi centre or ICDS centre is located in their locality. However, only 57.6 percent women had ever received any service from the centre.

Birth Preparedness and Delivery

The community women had low levels of awareness about the birth plan. Following table shows the components of the birth plan and percentage of women who had planned these components in advance.

Table 2: Components of Birth Plan planned in advance by the interviewed women

S.no.	Components of Birth Plan	% of women who planned
1	Decided place of delivery in advance	3.3
2	Saved/Arranged money for delivery	9.9
3	Arranged transportation to go to facility	3.3
4	Fixed and informed Dai/SBA in case of home delivery	6.6
5	Arranged delivery kit	7.7
6	Kept clean cloth to dry and wrap the baby	13.2

It is clear from the table that the importance of Birth preparedness has not been realized by the community women. The low percentage of women who had planned the above mentioned components reflect that the awareness about birth plan is low and has not been given due importance.

Only 55.4 percent of deliveries were conducted in an institution. Out of these institutional deliveries majority (93%) were conducted in government facilities. Rest 44.6 percent deliveries were conducted at home. Around 96 percent of these home deliveries were conducted by Traditional Birth Attendants or dais.

Postnatal care

Only 51 percent of women interviewed visited any health facility for postnatal checkup. Out of which 73 percent women received postnatal checkup within 48 hours of delivery. The main source of postnatal care was a Public health facility (among 81.7% women).

The remaining 49 percent women who did not go to any health facility for PNC stated the main reason for not having PNC was that they did not face any problem. The following table depicts the main reasons for not going for postnatal checkup.

Table 3: Reasons for not receiving postnatal checkup

Reason(s) for not receiving PNC	% of Women
No Problem Faced (%)	75.0
Considered Not Necessary (%)	14.0
Elders In Family Did not Considered Necessary (%)	8.0
Social Taboo (%)	5.0
Elder women Were Examining (%)	2.0
ANM/USHA Did Not Come Home For Check Up (%)	2.0
Health Facility was Too Far (%)	9.0
PNC Cost Too Much (%)	2.0

The main reasons for not having postnatal checkup were that no problems were faced (75%) after delivery of the child followed by 14 percent women who did not consider PNC as necessary. Other reasons that affected utilization of PNC were that the health facility was too far (9%) and elders in the family did not consider that PNC is necessary.

Newborn and Child care

Twenty two percent children were not weighed after their birth at all. A significant 12.3 percent of children were breastfed only on the next day of their birth. Twenty percent of the children that were born were not fed Colostrum. Within first three days of their birth, 30.4 percent were given plain water/ sugar water/ honey or any food other than mother's own milk.

The average age at which other food is given to the baby was 3 months. Even after availability of Anganwadi or ICDS centre in the area, only 66.7 percent mothers received services from these centers.

Around 10 percent of children never received any vaccination. The main reason for not receiving vaccination was lack of knowledge about vaccination.

Childhood mortality and Treatment seeking behavior of Mother and Child

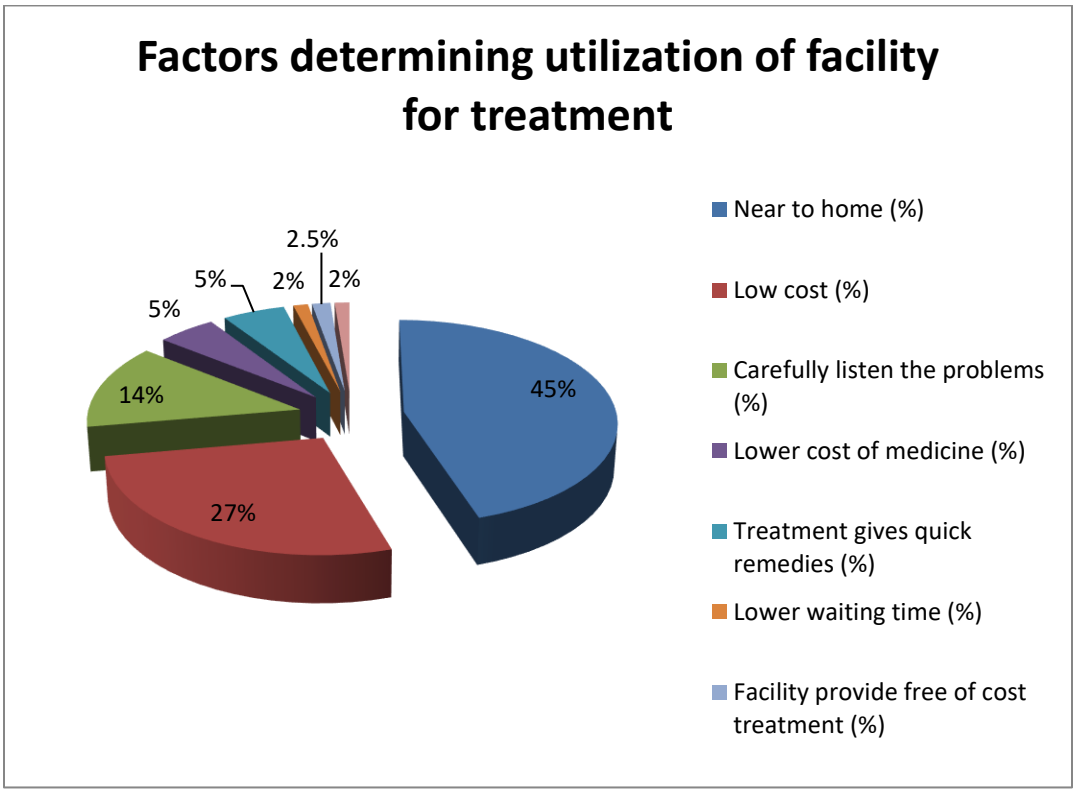
Around 34 percent of Children had fallen sick within last 15 days of the interview. Out of which 13.7 percent, 25 percent and 23 percent children suffered from Diarrhea, Acute respiratory infections and fever respectively during last 15 days of delivery. Fifty percent children who suffered from diarrhea were given lesser fluids to drink than usual during diarrhea. Only 32 percent of children who suffered from diarrhea were given ORS. Both public and private facilities were equally utilized for treatment.

Thirty two percent of mothers who fell sick did not seek any treatment. Among the women who sought treatment utilized both public and private facilities equally. The factors that determine utilization of health facility for treatment of disease are shown in Chart 2. The major determinants of health seeking behavior are as follows:

- Distance of the health facility from home – 45 percent of women responded that they would visit a facility if it is near to their homes. In the Post natal care section also, majority of women who did not go for PNC stated the reason that the facility was too far.
- Cost of treatment – 27 percent of women respondents said low cost of treatment encourages them to utilized a particular facility because the cost of treatment was less
- Fourteen percent women said that they went to a health facility because the provider listened to their problems carefully

- Lower cost of medicine was a major determinant of going to a health facility for 5 percent of respondents
- Five percent women said that they prefer treatment at a particular facility because the treatment provides quick relief
- A minor percentage of respondents also said that lesser waiting time and free of cost treatment would encourage them to avail treatment from a facility.

Chart 2: Factors determining utilization of health facilities for treatment of disease



Chapter 4: Discussion

The median age of the respondents is 24 years. Around half of women that were interviewed were illiterate. Lot of studies have revealed the fact that education of mothers have a direct bearing on their reproductive health, their health seeking behavior, their fertility patterns, parity and so on.

It was encouraging to note that around three-fourth of women had registered for Antenatal checkup. But the average month of pregnancy at which ANC was received was 5^{th} month of the pregnancy. Ideally, there should be at least one ANC visit during the first trimester. Only 37 percent women had their first ANC during their first trimester. If the ANC takes place during first trimester, the expectant mother is more likely to deliver safely.

Among the women who did not go for Antenatal checkup, the main reason stated for not doing so was that they did not perceive any complication (55.6 %). Seventeen percent women did not know where they should go for ANC. Clearly there is a lack of awareness about antenatal check up and its significance among the community women. Eleven percent women said that their family did not allow them to go. The decision making power still remains with in-laws or husband in the family. Despite the availability of Anganwadi centre or ICDS centre, only 57.6 percent women had ever received any service from these centres. It may be possible that women are not aware of the services provided at Anganwadi centre or ICDS centre.

Approximately half of the deliveries conducted (44.6 %) were domiciliary/home deliveries. Out of which, 96 percent of the deliveries were conducted by Traditional birth attendants or Dais. Majority of the women do not have any knowledge on Birth preparedness and components of birth plan. The importance of birth plan has not been realized. The counselling on these aspects needs to be provided by the community health workers.

Half of the women did not visit any health facility for Post natal check up. The main reason for not receiving any Post natal check up was that they did not face any problem after delivery. A significant 14 percent of women did not consider PNC as necessary. There is again a lack of awareness among women regarding Postnatal Checkup and its importance. It is also evident that the health is neglected unless the problem aggravates to an extent that treatment is the only option left.

A drawback of home deliveries is that in most of the cases, the baby doesn't receive essential newborn care. In this study, 22 percent children were not weighed at all and 12.3 percent of children were breastfed only on the next day of their birth. It was sad to note that 20 percent of the children which were born were not fed colostrum. Colostrum contains antibodies from the mother is essential for the development of innate immunity in the baby. Some communities in India still discard colostrum due to lack of knowledge. It was also noted that within first three days of their birth, 30.4 percent of the newborns were given plain water/ sugar water/ honey or any food other than mother's own milk. Moreover, the average age at which food other than mother's milk was given to the baby was 3 months. Ideally, for first six months exclusive breastfeeding should be done.

Around 10 percent children never received any vaccination. The main reason for not receiving any vaccination was lack of knowledge about immunization. This seems to indicate that the outreach activities related to immunization is poor in this area, so every time the same children are missed.

In 83 percent of the cases where the children suffered from diarrhea, acute respiratory infections or fever during the last 15 days some kind of treatment was sought. The utilization of Public health facilities as well as private health facilities was equal. It was shocking to learn that 50 percent of the children who suffered from diarrhea were given lesser fluids to drink during diarrhea. This practice should be reversed as during diarrhea the body loses fluid at a rapid rate. More fluid should be administered to the children suffering from diarrhea. Only 32 percent of children suffering from diarrhea received ORS. This clearly indicates that there is lack of knowledge regarding management of diarrhea at home.

When women were interviewed about their health seeking behavior, it was found that 32 percent of women who fell sick did not seek any treatment at all. Distance of the health facility from home is an important determinant of health seeking behavior among these women. Forty five percent of the women agreed that they were more likely to visit a health facility if it was near to their homes. Twenty seven percent of women respondents said low cost of treatment encourages them to utilize a particular facility because the cost of treatment was less. Fourteen percent women said that they went to a health facility because the provider listened to their problems carefully. Lower cost of medicine was a major determinant of going to a health facility for 5

percent of respondents. Another 5 percent women said that they preferred treatment at a particular facility because the treatment provides quick relief. A minor percentage of respondents also said that lower waiting time and free of cost treatment would encourage them to avail treatment from a facility.

Chapter 5: Conclusion and Recommendations

The common perception of health providers is that a slum is generally excluded from general population in terms of access to health services. But this is not the condition here. In fact the utilization of maternal and child health services is not very bad. This also may be due to intervention programs being run by agencies in this area. However, in almost all services, the fact which came forth was that the facilities are far. The community is more biased towards using government health facilities. This may be due to their lower ability to pay. Most of the home deliveries are conducted by dais. It seems that there is an unavailability of skilled birth attendant. There also is a need of proper counseling on birth preparedness and making birth plan since half of the deliveries are conducted at home. The Postnatal checkup in case the delivery is conducted at home is very unlikely since the health facilities are situated far away from home. The lack of knowledge and low level of awareness related to Newborn care practices and management of diseases is reflected by the fact exclusive breastfeeding is not followed for first six months. Similarly, the importance of colostrum is not realized. The following recommendations are proposed on the basis of above mentioned findings

1. Provisioning of Community health workers if not existent, who provide counseling to the community women on various issues like Proper time for Antenatal checkup, institutional delivery, postnatal care and management of childhood diseases at home. If these health workers exist, proper monitoring of these health workers should be done to ensure awareness
2. Training of traditional birth attendants since half of the delivery are conducted at home. Delivery kits should be made available to the expectant mothers
3. More public health facilities with trained personnel and medical doctors should be created since government health facilities are preferred
4. Public private partnership with organizations must be done if maintenance of government is an issue
5. Health education should be provided and behavior change communication can be done to educate the community

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