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UTILIZATION OF REPRODUCTIVE HEALTH SERVICES BY WOMEN LIVING IN SLUMS

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Abstract: *The study on utilization of reproductive health services by the women in slums of Delhi made an effort to scientifically present the detailed account of the level of knowledge and attitude of the women regarding reproductive health issues, and identify the barriers to reproductive health service use among women in slums. The paper also highlighted the existing reproductive health care service delivery system under the government hospital. The study found that there is a lack of knowledge among women regarding various reproductive health issues. Women's reproductive health is inextricably woven with social and cultural factors that influence all aspects of their life, and it has consequences not only for the women themselves but also for the well being of their family. This study would help the social workers in understanding the issues related to the pattern of service utilization in the area of reproductive health.*

Key words: *reproductive health, women, health services*

INTRODUCTION

Women face reproductive morbidity and mortality due to complications of pregnancy, childbirth, unsafe abortions, reproductive tract infections, sexually transmitted infections, effects of harmful contraceptives. The foundations for the reproductive health of women are laid in childhood and adolescence, and are influenced by many factors such as poor nutrition, low level of education or illiteracy, poverty, unhygienic living conditions and several socio-cultural taboos. All the above mentioned factors cause reproductive health problems and a 'culture of silence', due to which women found themselves unable to demand for reproductive health information and services. Underlying poor reproductive health among Indian women is their poor overall status on the one hand and an inadequate delivery system to cater to the needs of secluded, shy and devalued women on the other. Fully achieving the Millennium Development Goal 5 (hence forth refer to as MDG 5) target of reducing by three quarters, between 1990 and 2015, the maternal mortality ratio remains a challenging task; it is the area of least progress among all the MDGs.

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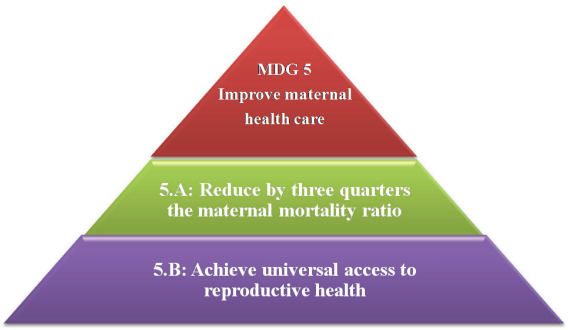

Figure 1: Millennium Development Goal 5

The International Conference on Population and Development (ICPD) Programme of Action (PoA) offered a starting point for MDG 5, as its Chapter VIII gives specific recommendations on how to narrow the gap between 1990 MMRs and the 2015 Targets. These include the promotion of prenatal care, postnatal care, childbirth care, maternal nutrition programmes, adequate delivery assistance, obstetric emergencies, attention to abortion complications, and family-planning services (IISD, 1999).

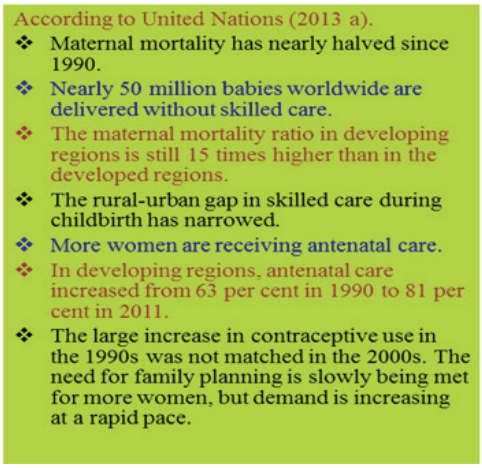

Figure 2: Facts sheet on Millennium Development Goal 5

Measuring progress on Millennium Development Goal 5 on maternal health requires measuring the Maternal Mortality Ratio (MMR), which is indispensable, but difficult to measure accurately, and often unreliable. As the deaths from childbirth not attended by health care staff are often not reported, and women who return home from a hospital or health centre and die or fall ill later from complications are often not represented in national statistics. While the Millennium Development Goals are focused on developing countries, it is important to keep in mind that preventable maternal morbidity and mortality also affects specific, often marginalized, populations in developed nations (United Nations, 2013 b). In many situations women is considered marginalized, for women living in slum, there are added risks, lack of awareness about hygiene, low levels of education, low social status, and the stigma about gynecological problems may result

not only in higher actual morbidity, but also lower treatment rates when sick, thereby resulting in a greater effective burden of ill health among women.

Reproductive health issues includes pregnancy, child birth and post partum care, breast feeding, maternal and infant nutrition, infertility services, sexual behavior, Reproductive Tract Infections/ Sexually Transmitted Infections (hence forth refer to as RTIs / STIs) and Human Immuno-deficiency Virus/ Acquired Immune Deficiency Syndrome (hence forth refer to as HIV/AIDS) services, reproductive rights and freedom and women's status and empowerment. There is an increasing thinking in the scientific community about the need to give stress on maternal health, in essence their reproductive health problems. The Reproductive and Child Health (RCH) program aims at integrating all interventions of fertility regulation and maternal and child health with reproductive health of both men and women. Although the reproductive health concept is not new, as the programs related to women's health did exist before, but they were available as vertical programs namely, Family Planning Program, Mother Health Care program (as a part of Family Welfare Program), TT immunization Program (part of Immunization Program) , Dais Training Program…etc. In 1992 the Child survival and Safe Motherhood Program integrated all the schemes for better compliance. The component of this program are early registration of pregnancy, to provide minimum three antenatal check- ups, universal coverage of all pregnant women with TT immunization, advice on food , nutrition, and rest, detection of high risk pregnancies and prompt referral, clean deliveries by trained personnel, birth spacing, and promotion of institutional deliveries. The current Reproductive and Child Health Program (RCH) has integrated these services and the major interventions which are obstetric care, Medical Termination of Pregnancy and Prevention of RTIs and STIs.

The success of a health system rests on ensuring that health facilities, goods, and services are available, accessible, acceptable, and of good quality on a non-discriminatory basis. MDG 5 does not explicitly capture the importance of expanding and strengthening health systems, and addressing women's rights and empowerment and gender equality as critical components of progress. Overlooking discriminatory practices and the importance of placing special focus on the needs of rural, poor, migrant, and displaced populations has been a blockage to progress on improving maternal health. Maternal and child health (MCH) centers are functioning to cater to the needs of slum dwellers in Delhi. The main strategy of this project are as follows: increase MCH services, improve the quality of MCH services through training of health staff, mothers and other women groups, improve utilization of services by generating community participation, and improve socioeconomic status of women. In urban areas, municipal health departments are mainly responsible for providing preventive and curative health services. The activities of MCH have been run by Municipal Corporation of Delhi.

There are multiple slum clusters in Delhi (approximately 1080 slums cluster spread over eight zones) (Sundar and Sharma, 2002) with localized communities where most of the women are illiterate, and dependent on their husband for their health related decision making. The slum population in Delhi city is growing very fast. While no

reliable recent estimate of slum population in the city is available, it is estimated that about one- fifth of the city's population lives in slums. In the absence of an adequate health care system, the women in slums continue to suffer. There is a need to understand the health problems affecting this group of people and to know their treatment patterns for the same so as to design more appropriate and sensitive health services. It has been noticed that women frequently lack understanding of the dangers of pregnancy to the health of both mother and the child. Reproductive health needs of the women are poorly understood and ill served and little information available in terms of the slum women's reproductive health needs and problems.

In this context, the researcher had taken the initiative to carry out descriptive study to look after the women's reproductive health issues in an urban slum of Delhi, including the knowledge, attitude and the context within which they arise and also identified the barriers to reproductive health use among women in urban slum area. The study also highlighted the existing reproductive health care structure, process and services provided by a government hospital.

METHODOLOGY:

In order to accomplish the objective of the study, approach to triangulation of both qualitative and quantitative research methods was adopted. The design of the study was descriptive. Area of the study was Shalimar Bagh slums, Delhi. There were six slums in the Shalimar Bagh locality. Health care services were provided by Maternal and Child Health Centre. Respondents of the study were women in the reproductive age group (15-45 yrs) and health care providers available at maternal and child health centre. Non- probability method of purposive sampling has been used to select the community. Women were selected by using probability method of stratified random sampling. To select a Sample size of 60 women in the reproductive age group (15-45 years), the researcher stratified the women in the three groups on the basis of age: 15-25 years, 25-35 years, and 35-45 years. The source list of each slum population were obtained from the survey records of Auxiliary Nurse Midwives (ANMs) and authenticity of data have been checked through electoral rolls for each constituency. The researcher then prepared lists of women in the reproductive age group. The list comprised with total population size i.e. 1127 women in the age group of 15-45 years. Then a proportionate random sample of 20 women was selected from within each stratum. Four groups of women were selected for the purpose of focus group discussions using non- probability method of purposive sampling. 17 health care providers were selected using non-probability method of purposive sampling. The data was collected using Interview schedule and focus group discussion schedule with the women and interview guide with the health care providers. Secondary data was also collected through internal as well external sources. Both qualitative and quantitative analysis of data has been done.

FINDINGS

The research talked about the women living in the slum or the disadvantaged group

of the urban population who have little or no access to organized health care services provided by government hospitals and health centers where outreach services of the government institutions are inadequate to meet the needs of the slum women. The respondents (women) of the study mainly belonged to the Hindu (53) and Muslim community. Average monthly income of household was reported to be Rs.2937.40/-. Three-fourth of the women were housewives. Many of the women (38) were illiterate, and some of them (12) attained the primary level of education.

Antenatal Care: Women get antenatal care services either by visiting health care facilities or during community visits made by the health workers. Many of the women (26) did not utilize antenatal care, among those who have utilized (34) these services some of them (15) received it during community visits made by Auxiliary Nurse Midwives (ANM). Women who were not using antenatal care (ANC) services in slums reported that they did not perceive antenatal care to be beneficial to their health, or the health of their unborn child.

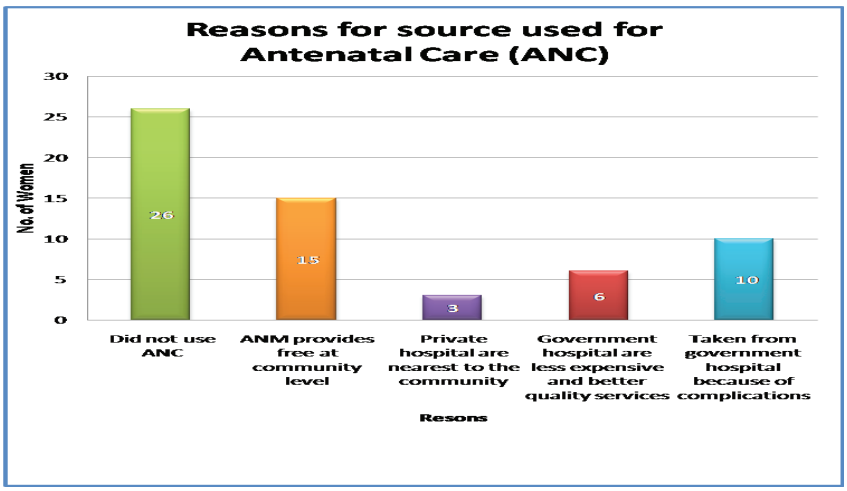

Figure 3: Reasons for source used for accessing Antenatal Care

Respondents indicated that as pregnancy is a natural state there was no need to seek medical care and that such care should only be sought if an obvious problem arises. The common reasons cited for not using ANC services were lack of awareness regarding availability of health care facility, not been allowed to visit hospital by family members, or because they were planning to go to their native place for their delivery. Among those who have utilized ANC services (34), 21 respondents preferred government health care facility and reasons cited were that they were less expensive and better quality of services, was provided free at community level. The main reason reported by women (3) for choosing private hospital was it being the 'nearest facility' whereas government health care services outside the locality, where 'time & travel' costs are higher.

Natal Care: A greater cause of concern was the fact that a large number of women have undergone home deliveries which were attended by untrained Dai.

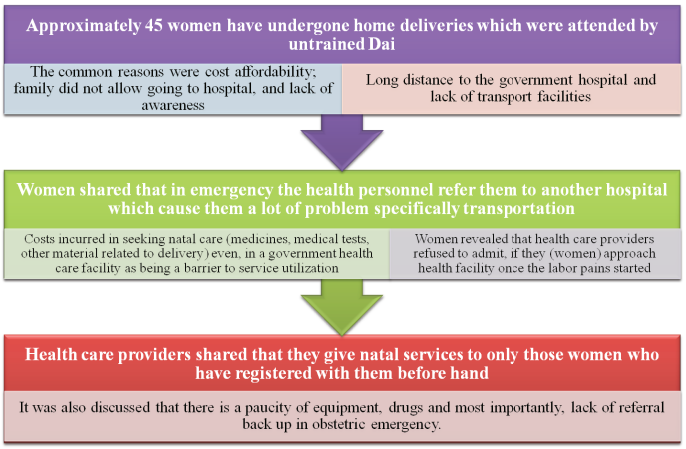

Figure 4: Views on Natal Care Services

The users were of the view that all the above mentioned factors lead to people losing faith in government health system.

Post Natal Care: Very few women did not have any health problem after delivery. It was noted that of those who did have some health problem (50), many of them (34) did not take any treatment.

Safe Abortion/Medical Termination of Pregnancy: It was found that very few women (15) had never sought pregnancy termination while others (45) had sought the medical termination of pregnancy. It was noted that all the women who sought abortion, had always availed services from a safe health facility, the government health facility (23) and the private (22). It was also found that women did not consult any traditional practitioner or dais. Those who had sought abortion, various reasons mentioned by women (23) for availing government health services.

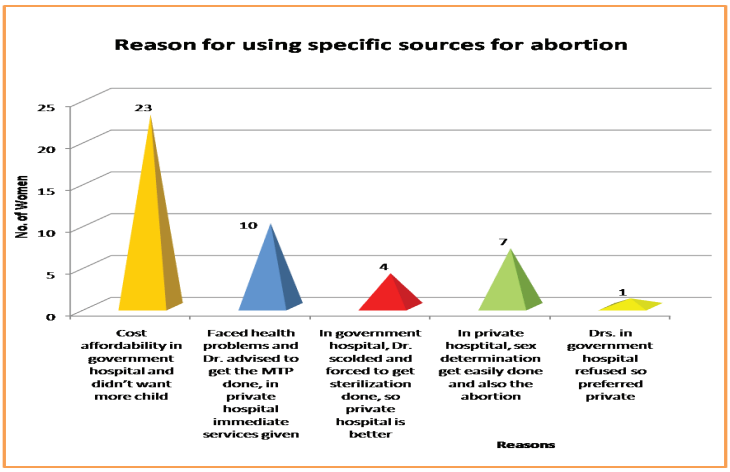

Figure 5: Reasons for using specific sources for seeking abortion

An interesting point has also been revealed by women that they selected the government hospital for abortion because of their poor economic status and also because they thought government services were free. However, after coming to the hospital they realized that services were not free. Because women often had to pay for medicines and required to make repeated visit before an abortion was performed. It was reported that women who had sought an abortion, many of them (20) had not experienced any health problem after the abortion. The remaining women (25) faced one or the other health problem.

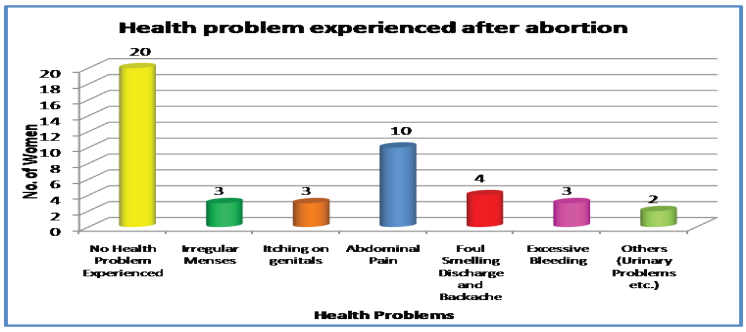

Figure 6: Post abortion reproductive morbidity

It indicated that post-abortion care and follow-up needed improvement. Post-abortion health seeking behavior was also very poor.

Family Planning Services: The average family size was 4-6 members per household. In case of level of knowledge of the family planning services, except for one respondent, almost all of them have heard of the contraceptive methods. Health care providers were major source of learning about family planning services.

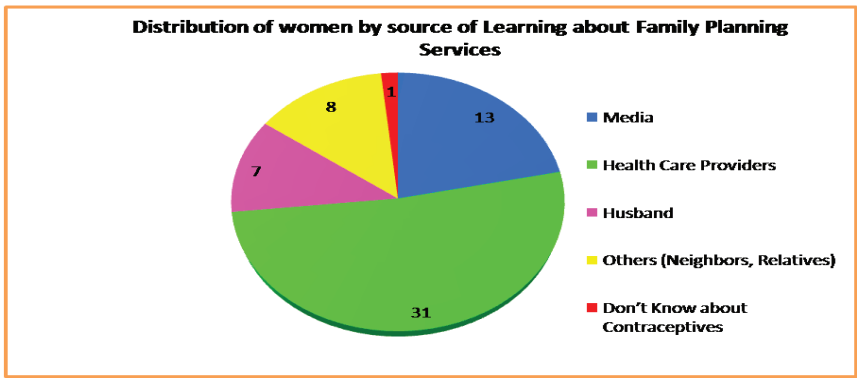

Figure 7: Source of learning about Family Planning Services

The current practice of contraception among the sample women reveals that 40 women were found to be using some method of contraception (including natural methods). Many reasons mentioned for non-usage of contraception.

Table 1: Reasons for non-usage of contraception

S. No.	Reason	No. of Women
1	Husband does not favour	8
2	Need More Chidren	4
3	Need One Son	3
4	Against Religious Belief	2
5	Lack of Awareness About Existing FP Method	2
6	Fear of Side Effects	1
	Total	20

The women were asked to shed light on some of the drawbacks of family planning services provided by government hospitals. They cited that locations of health care facilities were not in convenience (5), careless attitude of health care providers because of which they have to stand in long queues (23), more time wastage (5), staff shortage as there was no doctor and transportation available at night (5), health care providers scolded them badly and forced them to get sterilized (4), either the medicines were not given or rarely given (11), poor quality of services (3). With the introduction of newly launched intra uterine copper devices (IUCD) with the safe use for ten years, a great change has been noticed among the women on the usage of IUCD as compared to sterilization and other contraceptive methods.

Prevention and Treatment of Reproductive Tract Infections /Sexually Transmitted Infections (RTIs/STIs): It was noted that significant number of women (45) did not know about the mode of transmission of RTIs. About cure of RTIs, some of the women (10) responded it was curable and rests (2) said it was not curable. However, a considerable number of women (48) did not know whether it was curable or not. Similar to the findings about RTIs, even findings on STIs gives a picture that women in reproductive age group, tend to be largely ignorant of sexually transmitted infections, their modes or transmission and prevention, and the extent to which they could be life threatening. A large number of women (57) had experienced one or the other reproductive health problem. Information was collected from women on some common symptoms of RTIs and STIs experienced by them.

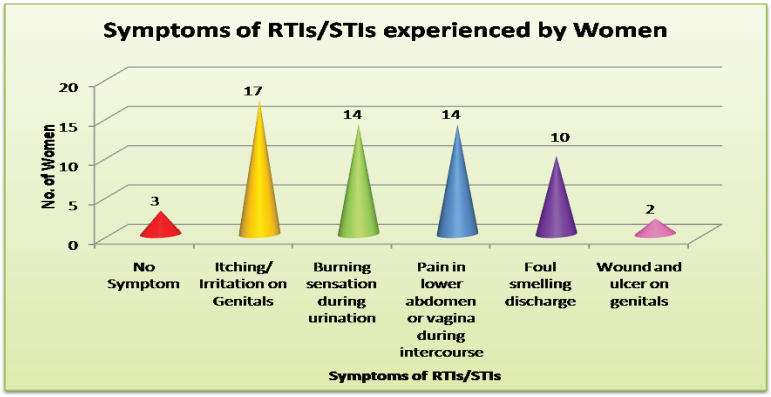

Figure 8: Symptoms of RTIs/STIs experienced by Women

Above mentioned data indicated persistence of the reproductive morbidity among a very large proportion of women in urban slums. The management of such health problems assumes great importance since still a very large proportion of women (41) had not sought any treatment for their health problem. Women were asked to report whether their husband has certain reproductive health problem or not. It was found that they did not know about the same. This clearly indicates the communication gaps existing between husband and wife. Treatment seeking behavior with regards to RTIs/ STIs among men found to be very poor. A small number of them (15) were seeking treatment for RTIs/STIs experienced by them.

Reproductive Health Care Services through an Integrated Approach : Reproductive health services were provided by Maternal and Child Health Centre under overall control of Municipal Corporation of Delhi (MCD). Reproductive health care service delivery system rests on a well-conceived infrastructure to make reproductive health care available to slum dwellers, with female workers (Basti Sevikas), the Auxiliary Nurse Midwife (ANM), the Medical officer in-charge, who has the overall responsibility for providing integrated reproductive health services to the slum dwellers and other qualified personnel and finally the government hospitals at the apex of the edifice.

Reproductive health services provided by the government health facility: The reproductive health services most widely available at health care facility were antenatal care, and family planning. However, reproductive health services need to address far more than these two. Health care providers revealed that most of the antenatal visits women did late in pregnancy. Emergency obstetric care was virtually non-existent. Even health facility had no means for transporting women to the nearest referral hospital, No resident doctor and a driver (on ambulance) were available at night.

Staff shortages: There was a serious shortfall of skilled staff at the field level with appropriate technical skills. The providers mentioned that they are simply frustrated by what they see as the poor condition of government health facilities. They expressed concern about vague job descriptions which they say force them to take on extra work for which they are not qualified, equipped or remunerated. Health care providers were unanimously critical of the lack of services for staff working in this health facility.

Shortage of supplies: Health facilities were lacking in basic maternity equipment, in equipment for delivery, as well as in basic consumable supplies such as syringes, needles and gloves, essential medicines, rings for laparoscopic sterilization.

Lack of transport facilities: Lack of transport has resulted in inadequate monitoring and supervision, termination of basic outreach services and lack of effective referral systems. Health workers reported that the majority of patients with obstetric complications come in by rickshaw, often over long distances. Shortages of adequate transport have had a major impact on both the quality and accessibility of existing services.

In-training provision for better service delivery: Many weaknesses in provider (ANMs and Basti Sevika) competence attributed to poor or non-existent training, cited

by the medical officers. In addition to this, providers expressed concern at the lack of refresher, in-services or, on-the-job training. While higher level authorities suggest that many of these problems have already been identified and that efforts are currently underway to resolve them within the framework of the RCH program.

Beneficiaries access to complete and accurate information about health care services: No guidance and counseling have been given to the patients who seek reproductive health care services. When asked by the researcher why further information was not offered, providers responded, " *If they ask, we tell them; if not, we don't*".

Skills in interpersonal communication and counseling: During interview almost all the health care providers pointed out the deficient interpersonal communication and counseling skills exists in the health care delivery system. It has been noticed that the superior staff blamed the subordinates having deficient interpersonal communication and counseling skills.

Regular monitoring and supervision of performance: Health care providers also revealed about inadequate monitoring and supervision. Almost all the providers were well aware of the public sector norms recommending that supervisory visit be carried out on a quarterly basis but, even one annual visit is probably more than the reproductive health care facilities can ever expect to receive.

CONCLUSION

The study focused on government health care delivery system but whenever respondents were asked about preference for health care services, they started making comparisons between government and private health care services. The analyses under each component showed that government health care facility have a slight edge over private health facilities. Respondents of the study identified the poor quality of services offered at government institutions to be a motivating factor for delivering at home. Thus the quality of services provided by government health care facilities in the area requires further investigation. Further intervention is also required to establish the types of care provided during an antenatal care consultation to establish the feasibility of using these visits to encourage women, particularly those with high-risk pregnancies, to be linked with a trained attendant for her delivery. Emergency obstetric services should be available at all the health care facility. If there is need of referral to other hospital, transportation should be available all the time (day and night). The women who do not approach health care facility for postnatal care, it can be suggested that home visits should be encouraged as part of postpartum care in order to identify reproductive morbidity after delivery.

Hence, for safe motherhood there is a need of counseling of pregnant women and her family members (husband/ mother-in-law) that antenatal care is essential. The health system needs to support traditional birth attendants with proper training. There is also a need of strengthen maternity care services by ensuring timely detection, management and referral of complicated pregnancy, delivery and post delivery complications,

screening for RTIs/STIs during the antenatal period in order to prevent maternal morbidity and mortality and support for family planning services, and ensure safe delivery services at MCH Centre. The health centres should ensure access to timely emergency obstetric services and provide adequate communication, skilled personnel, facilities and transportation systems, especially to women belonging to slums, keeping in mind their poor economic conditions.

As analysis showed that all the women who sought abortion, had always availed services from a safe health facility i.e. government and private, but the difference is very slight. Non-use of contraception rather than contraceptive failure was reported to be the chief reason by a number of women seeking abortion. The reasons cited for not using contraceptives by women ranged from fear of some methods, lack of awareness about existing family planning method, husband's objection to use, and certain health concerns. This indicates gap between knowledge and use of contraception, knowledge was usually based on information received through the health outreach activities of the programme but not on the basis of actual lived experiences of people, the knowledge did not translate into actual practice. As a result, complications resulting from unsafe abortion constitute major source of reproductive mortality and morbidity. It necessitates to improve quality of services in government health care facility by proper monitoring of MTP services and training of health care providers at various levels. There is a need for provision of counselling for woman and her husband in order to access effective contraception so that abortion can be avoided because of unmet need of family planning.

Analysis of findings reflects that there are various patterns, which influences the utilization of family planning services. These include knowledge of location of health care facilities, and other supply sources, their proximity, the attitude of family planning personnel and the suitability of timings and other hospital procedures. There are many myths and misconceptions prevail in the community regarding contraception like women cited that, IUDs can reach to throat and can cause death. It has been observed that the health care providers rarely referred to the side effects associated with the method being provided like, in the case of injectable methods, where disruption of menstrual bleeding is known to be a major factor contributing to method discontinuation and creates various myths and misconception in the mind of users and community at large. All this strongly gives an impetus on training programmes for providers on client-provider relations and on reproductive health counselling should be developed. There is a need to emphasize more on spacing methods such as pills, condoms and injectable devices effective for long period (5 or 10 years), which would be helpful in improving maternal and child health. Findings above clearly indicates that male involvement is weak and needs to be more actively sought in terms of their participation as adoption of family planning method, depend on inter-spousal consultation.

Analysis of data revealed that a large number of women were still unaware of the infections and diseases related reproductive system. A significant number of women were still unaware whether the RTIs/STIs are curable or not, their modes or transmission and prevention, and the extent to which they are life threatening. This reflects the

ignorance of women towards their reproductive health and also dissatisfying patterns to seek treatment for reproductive morbidity. It has been revealed that males do not come forward for treatment. As a result the same women come over and over again for treatment. It could be the reason for poor follow-up among women who come for RTIs/STIs treatment. In order to ensure better utilization of reproductive health services, male participation or male-shared involvement in reproductive health is of utmost importance. It also highlights the need to educate women regarding the symptoms and consequences of RTIs/STIs. There is a need of routine inclusion of RTIs/STIs screening in antenatal and other gynecological examination because RTIs/ STIs during pregnancy may cause foetal deformity or abortion.

The researcher observed that health facilities were lacking in basic maternity equipment, in equipment for delivery, as well as in basic medicines and other medical supplies such as syringes, needles and gloves. Providers also mentioned shortages of essential medicines such as antibiotics, reagents for STIs testing, and ring for laparoscopic sterilization... etc. One fact the peripheral level provider did not communicate and was revealed by higher level authority, the degree to which shortages derive not necessarily from the lack of supplies, but from the lack of systems to ensure that existing stocks are distributed in response to routine reporting of health facility needs. This reveals the lack of effective communication between health care facilities and higher level authority on logistics-related matters. Above mentioned incidences reveal poor communication, inadequate management and procedures for re-supply were major constraints faced by health care providers. If communities are to receive adequate reproductive health care coverage, then services must either be brought to them or they must be brought to the appropriate health care facilities. Shortages of adequate transport have had a major impact on both the quality and accessibility of existing services. To those in slums areas, providers as well as users, it is a sign that management is either unaware of, or unconcerned with problems at the grass root level. It is a challenge to determine how best to narrow the gap between existing service delivery facilities and the population whose access to them is so limited.

Women in an urban slum remain one of the most underserved segments of the Indian population and there is a need to look broadly at these women's reproductive rights, their needs as well as their limited access to reproductive health care services. There is a need to make programme more sensitive, within easy reach of women and more affordable for the women who belong to the underprivileged section of society, to be able to achieve its intended benefits. In addition, a well- organized referral system, a good supervisory system to monitor the work of health care providers at each level of the health system, a mechanism to ensure that relationship between traditional and organized reproductive health care services is maintained. It is thus important that while aiming at improving the reproductive health standards of the women living in the slums, policy makers should address factors which are responsible for the spread of diseases as well as its socio-cultural dimensions. Use of mass- media in the community to promote institutional deliveries, adopting a family planning method can have great impact on slum women. Talks, discussions, exhibitions and counselling sessions must

be arranged in communities on general and reproductive health, and nutrition by social workers, gynaecologists, and nutrition experts. More innovative and systematic intervention strategies involving slum communities are needed to meet this challenge.

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