

# A Qualitative Assessment: Determinants of Utilisation of Maternal Health Services among Scheduled Castes and Muslims in Patna District

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## BACKGROUND

Reduction of mortality of women has emerged as an area of critical concern for governments across the globe. While the International Conference on Population and Development (ICPD) in 1994 had recommended improvement in maternal health by promoting universal access to all sections of society, the issue has gained even more importance since maternal health was made one of the eight Millennium Development Goals (MDG). A large number of women in the reproductive age die from the complications arising from pregnancy, and a vast majority of these deaths occur in developing countries, India being the one with the largest number of such deaths. According to Maternal Mortality Bulletin 2007-09, maternal mortality ratio (MMR) for India was 212 per 1,00,000 live births, however, many states had a higher figure and the MMR in Bihar was 262.

Bihar is a state with some of the poorest socio-demographic indicators and this high MMR is not surprising, given the fact that only 26% of the pregnant women had 3 antenatal care visits according to the latest round of the District Level Health Survey (DLHS 3). The survey also reveals that only 32% deliveries can be categorised as safe deliveries. Teenage pregnancy rates among the Muslim community and Scheduled Castes (SCs)/ Scheduled Tribes (STs) are 10% and 30% respectively. The National Family Health Survey (NFHS) 3, 2008 also indicates that 68% of Muslim and 75% of SC women population in Bihar are anaemic.

Among the anaemic women, consumption of 90 Iron Folic Acid (IFA) tablets in the Muslim and SC communities are 7% and 4% respectively. Only 10% Muslim and 11% SC women have delivered in a health facility. Only 5% pregnancies among SC women are registered with auxiliary nurse midwives (ANMs). Meager 8% of SC and 12% Muslim women had 3 or above numbers of antenatal care (ANC) visits (NFHS 3). NFHS 3 also reported that 40% of the Muslims, 50% of SCs and 40% of STs had not utilised ANC either at home or outside in Bihar.

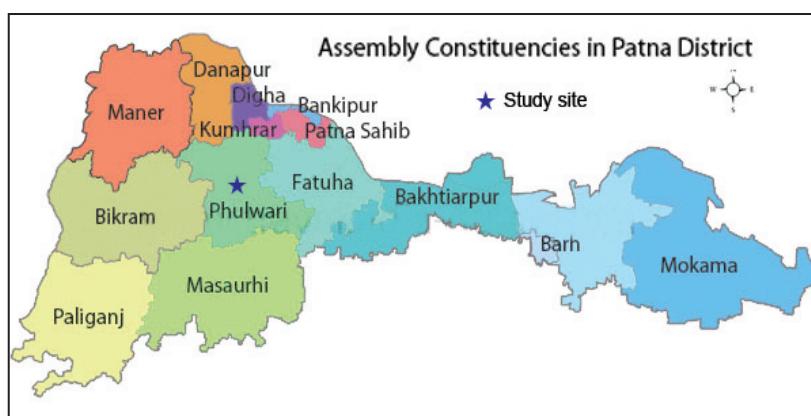
As evident from the above data, though there is information indicating low utilisation of maternal health services among SC/STs and Muslims in Bihar, the literature does not go into exploring the specific reasons for the low utilisation of services among them. The purpose of this study is to understand the determinants of low utilisation of maternal health services by elucidating the various factors influencing the use of these services among Muslims and SCs.

## STUDY OBJECTIVES

1. To understand the awareness about maternal health services among Muslims and SCs.
2. To find the major determinants affecting utilisation of services among Muslims and SCs.

## STUDY SETTING

The study was conducted in Patna district of Bihar. According to Census 2011, Patna district contributes 6% of the state's population and has a total literacy of 80.28% and female literacy of 63.72%. The proportion of Muslim population in the district is about 8% and SCs constitute 15% of the total population. The proportion of STs is very meager with 0.2%. One of the blocks of Patna, Phulwarisharif, with a total population 1.91 lakhs spread over in about 100 villages, was selected for the study (Census 2001). The selection of the block was purposive. According to Census 2001, the total population of SCs and



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Muslims in the Phulwarisharif block are 25% and 21% respectively. As far as availability of health facilities are concerned, there is one primary health centre (PHC), one additional primary health centre (APHC) and 17 sub centres in the study block.

## METHODOLOGY

The study was qualitative in nature.

**Sample selection and data collection:** The study covered 4 health sub centres and eight villages. The villages were purposively chosen keeping in view the following criteria. Two sub centres were close to the block headquarters and two far from the block headquarters. Under each sub centre, one village with a predominance of SC population and one village with a high proportion of Muslim population was identified. Two women who had delivered in the last 1 year were identified in each village, giving a total of 16 women with whom semi structured indepth interviews (IDIs) were conducted. In addition, one focus group discussion (FGD) was conducted in each of these eight villages giving 8 such in total and community interviews were conducted with four ANMs, the medical officer of the PHC and one paramedical staff from the additional PHC. The data was collected using semi-structured interview and FGD guides and the data collection was done by the researchers themselves. The data from the IDIs and FGDs was analysed by manually coding the text.

**Ethical review:** Ethical clearance for the study was obtained from the Institutional Ethics Review Committee of School of Public Health, SRM University. Data collection was done after seeking informed consent and explaining the purpose of the study to all respondents.

## FINDINGS

### Awareness about maternal health services

**Janani and Bal Suraksha Yojana (JBSY):** Out of 16, only one woman was aware of JSBY by its name but all were aware that there is a scheme in which a woman gets Rs.1400/- if delivery takes place at a government health facility.

#### Antenatal care:

- All 16 women were aware of a few components of ANC like registration, TT vaccination, consuming IFA tablets but their level of awareness on doses of TT vaccine and number of IFA tablets was not adequate.
- None of them were aware of other ANC components like weighing, haemoglobin estimation, urine analysis,

abdominal examination and minimum numbers of ANC visits.

- All knew about *jacha-bacha* (mother and child) card but 12 did not know about importance of the card.
- None of them were aware about home visits by ANMs and AWWs for ANC.

*"I was not aware of a health sub centre present in the village."*

- One of the respondents of IDI

**Postnatal care:** All women were completely ignorant about the need or importance of postnatal care.

**Ambulance service:** All the 16 women interviewed were unaware that ambulance services for visiting the health facilities can be availed free of cost

**Services:** No one was aware about the types of services to be provided by the sub centre.

### Utilisation of health services

During FGDs and interviews with the respondents, it emerged that the distance of a functioning government health facility is a big impediment in getting the services. They informed that most of the sub centres were non-functional and the nearest health facility was the Phulwarisharif PHC. Although, there was an Additional PHC (APHC), it functioned irregularly due to absence of doctors, unavailability of drugs and non-existing facilities to conduct delivery. Cost incurred on visits to health facility was another barrier in utilisation of the services by the communities. Even if an ambulance is arranged by ASHA, they need to pay about Rs.300- 400/- for one-way travel. The cost of alternative transport was around Rs 100-200/-. Due to these reasons, the commonly used

#### Utilisation of maternal health services

- Fifteen out of 16 women received a TT injection, 8 received it either from the anganwadi centre or ANM.
- Nine women received IFA tablets, 8 from the public sector. None of them had the prescribed 90 tablets.
- One woman said she had a urine test at the sub centre.
- None of the women had a home visit during her pregnancy.
- Six women delivered in institutions including two who had their delivery in a private institution.

modes of transportation were bullock carts, rickshaw carts or auto rickshaws. Some respondents also shared that it was easier for them to reach the district hospital in Patna by train than to reach Phulwarisharif PHC by road.

*“The cost of transport, medicine, investigations, payment for services and tips are the expenses to be borne by the mother for a delivery at the PHC. So almost all money received under JSBY is spent”,* informed a few respondents. The women do not find JSBY cash benefit an attractive proposition. Hence, they preferred domicile delivery.

With regard to frontline health workers, the women said that the ANMs do not visit the villages except, for the monthly visit to AWC for immunisation of children and very rarely in case of pregnant women.

The community was not satisfied with the services being provided at the PHC. They informed that proper examination of the patients is not done and they almost always have to buy most of the medicines prescribed from the chemists.

*“The behaviour of the service providers are very unfriendly, insulting and humiliating at times. If we are unable to pay bribe, they become more rude.”*

- FGD in Muslim village

The IFA tablets were not distributed to mothers regularly. Payments have to be made for different services. Some of the respondents informed that they have to pay Rs 10/- to ANM for getting TT vaccines. Some of them complained that they have to pay money to the hospital staff for cutting the umbilical cord of the child. Even health administration agreed that sometimes they have to ask patients to buy injections and intravenous fluid from the market, if the hospital does not have these items in stock.

Many respondents informed that they usually go to an unqualified medical practitioner who is easily available, accessible and also affordable in case of seeking medical advice.

*“One of the sub centres is used as mango godown during summer and as a marriage hall during other seasons.”*

- SC woman

## Response of health care providers

One ANM informed that the sub centre opens only on Mondays and Saturdays every week. She also added that most of the sub centres in the area lack vital equipment like haemoglobinometer, thermometer, stethoscope, lab facility, etc.

*“We do not provide postnatal care services and can visit few houses only. They said there is no privacy to examine the women in their houses.”*

- ANM

The MO in charge of the PHC denied that the APHC does not open daily. He said that there is a homeopath doctor posted there, but at this point of time due to state elections, she has been deputed for election duty. With regard to free ambulance facility, he said that this service is provided to the poor. When asked for the records of free ambulance service, he said that it is not documented well and thus he cannot share it.

He also denied that free medicines are not provided.

He said *“People were asked to purchase oxytocin and methergin only sometimes and rarely people are asked to buy saline. We provide saline and other drugs and for Mushars and other poorer people, we arrange all the things through Rogi Kalyan Samiti.”*

*“Free ambulance services are provided to few people. It is difficult to say whether they come under BPL or not. When a patient come in emergency they do not carry their card, so we use our sense to judge. Secondly, we are also aware that the BPL list itself is faulty. Thus, we use our good sense in providing free services of ambulance.”*

- Doctor at the PHC

## CONCLUSION AND RECOMMENDATIONS

Bihar is one of the states where the NRHM has been credited with improving health services considerably. The Bihar State Report on progress of NRHM in the state till June 2009 notes this with satisfaction. *“The capacity to manage the programme in the state has significantly strengthened. There is a significant increase in outpatients and institutional deliveries. The availability of human resources has increased substantially at different levels of health institutions.”* However, the same report also notes some areas of concern which relate to VHSC and Rogi Kalyan Samiti functioning, further strengthening provisions for institutional delivery, prioritizing child health interventions and so on. In the light of the existing reports and concerns for improving health services delivery in Bihar, this report provides some important insights from the district of Patna. While the district has locational advantage of being the capital, yet the study area shows



how some communities may continue to be disadvantaged. Some of the findings which may require specific attention are as follows:

- **Continuing social marginalisation** - The lack of awareness among SC and Muslim communities about provisions of NRHM and the fact that none of the women had reported a home visit is an area of concern that needs to be understood and managed separately. Communities also complained of disrespectful behaviour. Health providers are known to have a provider bias and this must be addressed through specific trainings and addressing communication skills. These trainings can go a long way in improving communication between communities and the providers and the quality of care of service delivery and thereby improve utilisation and outcomes in the long run.
- **Public facilities functioning below optimum levels** – The process of strengthening of public facilities has begun and will continue in a phased manner for some more time, especially in a state like Bihar where the shortfall was high to begin with. In such situations it is necessary to understand the vulnerability of specific population groups living in some areas and address these needs first.
- **Strengthen the participation of marginalised communities** - In order to mainstream the

participation of socially marginalised communities, it may be necessary to strengthen the different mechanisms available within NRHM for community participation. Unfortunately, the provisions for VHSC involvement have not been adequately realised in Bihar. The participation of such communities must be strengthened in all NRHM committees with provision for training of such members.

- **Develop disaggregated indicators** - In order to ensure that the service delivery is more robust for those who need it most, it may be useful to develop disaggregated indicators and these must be monitored regularly.

The NRHM has started making significant differences in the way health care services are perceived and used by millions living in the rural areas of India and we are certain that the recommendations made through this study will help it function more effectively.

## REFERENCES

- District Level Health Survey 3. <http://www.jsk.gov.in/dlhs3/Bihar.pdf>
- National Family Health Survey 3. <http://202.71.128.172/nihfw/nchrc/sites/default/files/Fact%20Sheet-Bihar-566.pdf>

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**About the Organization:** Centre for Health and Resource Management (CHARM) is a nongovernmental organization based in Patna, Bihar, focusing on health, poverty, development and allied themes. It is primarily involved with community health services, training, advocacy, research, situation analysis and developing IEC materials on health relevant topics and the well being of the disadvantaged citizens. The vision of the organisation is to improve health and development of all people, and strengthen advocacy, policy and action in the promotion and protection of health of all.

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