MAK HILL Publications Research Journal of Medical Sciences

Research Article
doi: 10.59218/makrjms.2023.8.190.194

Satisfaction and Dissatisfaction about Delivery Care Services in Urban Slums

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ABSTRACT

Global reviews and studies reveal that maternal deaths are clustered around labor, delivery, and the immediate postpartum period with obstetric hemorrhage being the main medical cause of death. To identify the reasons for satisfaction and dissatisfaction about delivery care services. The present community based cross sectional descriptive study was carried among women who had delivered in the period from January 2008-December 2009. A total of 89.57%respondents who had delivered in public health facility were satisfied about delivery care services as compared to 94.76% respondents who had delivered in private health facility. The difference between proportions of respondents who were satisfied with delivery care services with respect to place of delivery i.e. either public or private health facility was not statistically significant. (p>0.05). Respondents who were satisfied with public health facility delivery care services stated the following reasons for satisfaction: 'good institutional care provided there(48.94%),'low cost of services' (40.43%), 'conducted normal delivery' (9.22%) where as for private facility delivery services the reasons stated were: there was 'good institutional care' (78.19%), 'conducted normal delivery' (11.17%). The difference between proportions of respondents who were satisfied with delivery care services with respect to place of delivery i.e. either public or private health facility was not statistically significant. (p>0.05).

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Key Words
Satisfaction, delivery care services, place of delivery

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Received: 2 June 2023
Accepted: 10 July 2023
Published: 16 August 2023

Citation: Sunita Parshuram Pawar, Geeta Pardeshi and Sagar S. Bhalerao, 2023. Satisfaction and Dissatisfaction about Delivery Care Services in Urban Slums. Res. J. Med. Sci., 17: 190-194, doi: 10.59218/makrjms.2023.8.190.194

INTRODUCTION

In India both child mortality(especially neonatal)and maternal mortality are high. Seven out of every 100 children born in India die before reaching age one and approximately five out of 100 mothers who are pregnant die of causes related to pregnancy and childbirth. India accounts for more than 1/5th of all maternal deaths from causes related to pregnancy and childbirth[1]. One of the socio-demographic goals mentioned in the National Population Policy 2000 of India is to achieve 80% institutional deliveries and 100% deliveries to be assisted by skilled health personnel by 2015[2].

Maternal mortality and morbidity continue to be high despite existence of national programmes for improving maternal and child health in India. This could be related to non-utilization or underutilization of maternal health care services amongst rural poor and urban slum population due to either lack of awareness or access to health care services[3]. MCH services have been recognized as an important thrust area not only to rural population but also to urban slump welters by government under National Population Policy 2000, National Health Policy 2002, Reproductive Child Health II and Tenth Five Year Plan[4].Ministry of Health and Family Welfare (MOHFW) has constituted a "Strategies for Urban Health Care" which in dicates the Government's commitment to improve health services for urban poor.

Urban slums lack basic health infrastructure and outreach services. In such conditions, ill health and premature deaths are rule rather than exception and the most severely affected are the women of childbearing age and children[5]. The reach of essential preventive health services to urban poor and utilization of health services by these segments is a by small low where about 60% of children are not completely immunized by age of 1 year and almost 6 out of 10 babies are delivered athomeinab sence of trained health worker[6]. Health status and access of reproductive and child health services of slum dwellers ispoor.Theinformationonexistingpatternofintranatalc areserviceutilization in urban slums is essential for planning need based health care delivery services to urban slums.

MATERIALS AND METHODS

The present community based cross sectional descriptive study was carried among women who had delivered in the period from January 2008-December 2009. The present study was conducted in the urban slums of a city. Studyareais situated in the perimeter of 8-10kma way from Government Medical College of a city. Information about various delivery care services in a city was obtained from the Assistant Medical Officer of Health of City Municipal Corporation. This city has Public and Private Health Facilities providing delivery care services which include one Government Medical College and Teaching Hospital, one Government Ayurvedic College and Teaching Hospital and one Urban Health Center run by Municipal Corporation, 197 Private Health facilities like nursing homes/maternity clinics or private clinics. Among these 12PrivateHospitalsareaccreditedfordeliverycareunde rJananiSuraksha Yojana.

Inclusion criteria: Women who were residing in the study area and who had delivered in the period from January 2008 to December 2009.

Exclusion criteria:

- Women who had delivered in the period from January 2008 to December 2009 while residing in the study area and have since then migrated
- Women who were resident soft the study are a but who have delivered outside the study area during study period
- Women who were not residents but had come for delivery in the study area

Sample size: According to National Family Health Survey 3 (2005-2006), prevalence of home deliveries in a slum of Maharashtra was 23%17. The sample size was calculated with 20% allowable error, 95% of confidence level and observed prevalence of 23%.

Sample Size:

$$(N) = Z2pq/l^2_{1/a}$$

Where:

$$Z_{1/a} = 1.96,\ p = 23,\ q = 77,\ l = 4.6$$

$$1.96 \times 1.96 \times 23 \times 77/4.6 \times 4.6$$

$$N = 321$$

To reduce error due tonon compliance,25% additional sample was taken

$$321+(321\times25/100) = 400$$

Probability Proportional to Size Sampling Technique was used for selecting the sample[7]. Data for the present study was collected by conducting house to house survey. While selecting households the selected PSUs were surveyed to identify any temple, hospital, mosque or restaurant situated approximately at the centre of the slum and a bottle was rotated there. Survey was started from the lane towards which mouth of the bottle was directed. Each house along the lane was visited and at the end of the lane, survey was continued along the lane on left turn to the initial lane till sample size of selected slum was completed. Information as per pretested schedule was collected by interviewing women who had delivered in the period from January 2008 to December 2009.If there was no woman in the house satisfying the inclusion criteria then that house was skipped and next house was

Table1: Decision make rabout place of delivery

	Place of Delivery			
Decision by	Public health facility	Private health facility	Home	Total
Self	8 (4.93%)	10 (4.80%)	08 (29.62%)	26 (6.54%)
Husband	64 (39.50%)	43 (20.67%)	01 (3.70%)	108 (27.20%)
Motherin law	61 (37.65%)	85 (40.86%)	09 (33.34%)	155 (39.04%)
Fatherin law	01 (0.62%)	-	-	01 (0.25%)
Sisterin law	14 (8.64%)	22 (10.57%)	01 (3.70%)	37 (9.32%)
Mother	57 (35.18%)	60 (28.64%)	07 (25.92%)	124 (31.23%)
Sister	02 (1.23%)	11 (5.28%)	-	13 (3.27%)
Brother	07 (4.32%)	02 (0.96%)	-	09 (2.26%)
Father	06 (3.70%)	05 (2.40%)	-	11 (2.77%)
Neighbours	02 (1.23%)	02 (0.96%)	-	04 (1.01%)
Family	02 (1.23%)	04 (1.92%)	-	06 (1.52%)
Other	03 (1.85%)	05 (2.40%)	-	08 (2.02%)
Not specified	01 (0.62%)	02 (0.96%)	07 (25.92%)	10 (2.51%)

Table2:Reasonsforchoosingplaceofdelivery

Reasons	Frequency	Percentages
Home		
Economic constraint	3	11.11
Decision of family members	5	18.52
Feels comfort able at home	5	18.52
Fear of hospital	5	18.52
No time to reach to hospital	7	25.93
Experience of others	3	11.11
No specific reason	4	14.81
Private health facility		
Experience of others	77	36.67
Experience of previous delivery	17	8.10
Same antenatal care provider	15	7.14
Good quality services	31	14.76
More chances of normal delivery	11	5.24
Proximity to home	14	6.67
Antenatal complications	9	4.29
Afford ability of services	12	5.71
Fear of government hospital	12	5.71
Others	8	3.81
No specific reason	15	7.14
Reasons		
Public health facility		
Economic constraint	124	76.07
Referred from other hospital	13	7.97
Experience of others	11	6.75
Availability of necessary services	14	8.59
Proximity to home	4	2.45
Others	3	1.84
No specific reason	2	1.23

visited. If there were more than one woman in the house satisfying the inclusion criteria, then all were selected to participate in the study. This survey method was adopted in all selected PSUs. Thus total 400 women from the selected PSUs were included in the study. Before starting the study, methodology and procedure was reviewed and approved by teaching staff of Department of Preventive and Social Medicine and the Institutional Ethical Committee.

The respondents were informed about the purpose of study and approximate time required for completion of the interview and if they had any queries, then were solved. In for medconsent was obtained from them. They were assured of confidentiality about information obtained from them. A pre designed and pre tested semi structured preform was used for the collection of required information from respondents.

Before commencement of the study, community leaders, Anganwadi workers, ANM, link workers in the study area were visited and rapport was developed with them. They were informed regarding the conduct of study. Data was collected by face to face interview of the respondents. It was observed from preliminary survey that most the of women were house wives and were relatively free in afternoon from 1-4 pm. If the study respondents were not available at the time of first visit, then 2^{nd} and 3^{rd} visits were paid on subsequent days with in 2 weeks. If even then study respondents were not available then that house was excluded from study. For subsequent visits, suitable time was considered for the interview as per convenience of the respondents.

Statistical Analysis: Chisquare test was used to assess the difference between various proportions. Mc Nemars chi square test was calculated to compare the place of delivery of recent birth and previous birth.

RESULTS

The decision about place of delivery was taken by family members i.e. mother in law (39.04%), mother (31.23%) and husband (27.20%) and decision by self was taken by only 6.54% respondents. Out of deliveries which were conducted at home, majority were decided by mother in law (33.34%), by self (29.62%) and by mother (25.92%). For Home delivery majority said that they had chosen this place because there was 'no time to reach hospital' (25.93%), 'fear of hospital' (18.52%), 'feels comfortable at home' (18.52%), 'decision of family member's (18.52%). Respondents who had delivered in public health facility majority said that they had chosen this place because of 'economic constraint' (76.07%),'availability of necessary services' (8.59%).There a sons for choosing place of delivery as private health facility were given as 'experience of others' (36.67%), 'good quality services provided there' (14.76%) and 'experience of previous delivery' (8.10%).

Out of 163 respondents who had delivered in public health facility, 146 (89.57%) were satisfied with delivery care services. Out of 210 respondents who had delivered in private health facility, 199 (94.76%) were satisfied with delivery care services. The difference between proportion of respondents who were satisfied with delivery care services in public and private health facilities was not statistically significant.

Table 3: Place of delivery and satisfaction

	Satisfied with service		
Place of delivery	Yes	Yes	Total
Public health facility	146(89.57%)	17(10.43%)	163(100%)
Private health facility	199(94.76%)	11(5.24%)	210(100%)
Total	345(92.49%)	28(7.51%)	373(100%)

Table 4 : Reasons for satisfaction with delivery care services.

Reasons	Frequency	Percentage
Private health facility		
Good institutional care	147	78.19
Availability of facilities	11	5.85
Conducted normal delivery	21	11.17
Good house keeping of hospital	9	4.79
Others	9	4.79
Public health facility		
Good institutional care	69	48.94
Conducted normal delivery	13	9.22
Low cost of services	57	40.43
Others	10	7.09

Table 5: Reasons for dissatisfaction with delivery care services.

Reasons	Frequency	Percentage
Private health facility		
Costly	17	80.95
Others	04	19.05
Public health facility		
No cleanliness	37	84.09
Rude behavior of staff members	12	27.28
No availability of beds	14	31.82
Others	0s1	2.27

private health facilities was not statistically significant. (p>0.05). Majority respondents who were satisfied with the private facility delivery services because of 'good institutional care' (78.19%), 'conducted normal delivery' (11.17%). The reasons stated for satisfaction with public health facility delivery care services were stated as that there was 'good institutional care' (48.94%), 'low cost of services' (40.43%), 'conducted normal delivery' (9.22%).

Majority of respondents who were dissatisfied with delivery care services at public health facility stated that there was 'no clean liness in hospital' (84.09%), 'no-availability of beds' (31.82%) and 'rude behavior of staff members' (27.28%). While reason for dissatisfaction of delivery service at private facility was 'costly' (85.71%).

DISCUSSION

In the present study decision about place of delivery was taken in a majority of cases by mother in law (39.04%),mother (31.23%) and husband (27.20%) and decision by self was only by6.54% respondents. In deliveries which were conducted at home, majority were decided by mother in law (33.34%), by self (29.62%) and by mother (25.92%). Timsi J[8] in their study in slum population of Meerut city observed that almost two thirds (64.3%) of the mothers commented that they had themselves taken the decision about the place of delivery, 33.8% by other family members, while in only 2% the decision was taken by their husbands.

However in this study only 27.2% of the total deliveries were conducted in an institutions as against 93.25% institutional deliveries in our study. In this study some of them ajor reasons for home delivery were reported as 'no time to reach hospital' (25.93%): `fear of hospital' (18.52%): 'feels comfortable at home' (18.52%), 'decision of family members (18.52%)', 'economic constraint' (11.11%), 'experience of others' (11.11%) (Table No. 43). Khan *et al*[9] conducted a study in peri-urban area of Nabi Nagar, Aligarh. Reasons for home delivery was stated as was a 'norm followed in their family and society' (42%), 'economic constrain' (30%), 'rude behavior of hospital personnel' (7%), 'nobody to take care of home during her absence' (13%), 'fear of hospital' (4.8%) and 'other reasons' (3.2%). Das *et al*[10] in their study in 48 slums communities in six wards of Mumbai observed that commonest reason for home birth was 'custom and tradition' (28%), 'lack of time to reach a facility due to rapid progress of labour' (13%), 'difficulty in finding someone to accompany the woman in labour to hospital' (8%) and 'fear of hospital staff' (7%). 56% of women had planned to deliver in an institution, but did not manage to get there because of 'rapid progress of labour' (23%) or 'lack of a companion' (12%). Sid dhart 39 conducted a study in 11 slums of Indore City. Reasons for most of home deliveries were given as due to 'economic constrains' and 'delivery practices influenced by ingrained beliefs and traditions'.

In the present study reason for public health facility delivery was stated that it was due to 'economic constrain' (76.07%), 'availability of necessary services' (8.59%). In a study conducted by Khan *et al*[9] in peri-urban area of Nabi Nagar reasons for choosing government hospital were stated as its 'proximity to home', 'history of complications in earlier pregnancy'. Varma [11] conducted a for mative study in rural Uttar Pradesh which showed that the main reason for opting institutional delivery was their 'concern regarding safety of mother and child'.For more husbands (22%) than women (16%) and mothers in law (14%) the 'JSY' incentive was main reason for delivery in an in stitution.

In the present study reasons for dissatisfaction of public health facility delivery services were stated as 'there was no cleanliness in hospital' (84.09%), 'no availability of beds' (31.82%) and 'rude behavior of staff member's (27.28%). Varma[11] conducted a for mative study in rural Uttar Pradesh which showed that

'Bad behavior of the staff' was mentioned more often by women who delivered at home than those who delivered at health facility. 'Poor quality of client-provider interaction and the lack of basic services like electri city in health facilitie's were identified as barriers to institutional delivery. During in-depth interviews, 'lack of privacy' was identified as a barrier to in stitutional delivery. Iyaniwura *et al* conducted a study in Sagamu town of Nigeria which revealed that of the 177 women who did not deliver their babies in government facilities, 31.6% gave 'no reason', 29.4% complained of the 'long waiting time', 'bad attitude of staff' (11.3%), 'non-availability of government facility in their community' (10.2%) and 'transportation problem' (8.0%).

CONCLUSION

A total of 89.57% respondents who had delivered in public health facility were satisfied about delivery care services as compared to 94.76% respondents who had delivered in private health facility. The difference between proportions of respondents who were satisfied with delivery care services with respect to place of delivery i.e. either public or private health facility was not statistically significant. ($p>0.05$). Reasons for dissatisfaction of delivery care services at public health facilities were stated as 'there was no cleanliness in hospital' (84.09%), 'no availability of beds' (31.82%) and 'rude behavior of staff members' (27.28%) while main reason for dissatisfaction of delivery care services in private health facility was that it was 'costly

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