Gaps in Service Provision - *Primary Level Facilities*

- Under utilization of primary and secondary facilities and major load of MNH handled by Capital Hospital; shortage of medicines, viz. calcium tablets, IFA
- Absence of MOs and frequent change of postings; Pharmacist was managing the role of clerical, managerial, data etc responsibilities
- **Unclear reporting mechanism:** Staff were unclear whom they should report to when there is a shortage in PHC
- Poor linkage between UPHC and secondary / tertiary level facilities
- Lack of defined population coverage by UPHCs

Gaps in Service Provision - *Secondary Level Facilities*

- Secondary facilities under process of upgradation
- Shortage of medicines, viz. IFA tablets, IFA syrup with dispenser, Zinc tablets, Inj Magnesium Sulphate, Misoprostol tablets
- Absence of MO, Specialists; Pharmacist were managing the roles of clerical, managerial, data related responsibilities etc.; shortage of staff nurses
- Lack of in house diagnostic services

Gaps in Service Provision - *Tertiary Level Facilities*

- The case load in OPD (both shifts) per day is around 2000 means per month is 60,000; altogether 600 functional beds available, still it was not adequate, patients get admitted with mattresses on floor; ***women delivering on the floor***
- Huge shortfall of Doctors, Specialists and staff ~ 30 more Gynec. and 15 more Paed.; 30 more Staff Nurse, 14 Pharmacists, 5 Radiographers

Patient Feedback:

- Many women across slums expressed dissatisfaction regarding quality of care - absence of empathy in the behavior of nurses at the hospital
- Demand for improvement of conveyance facility to the hospital. 108 not working properly. Even with the help of ASHA's - thus impacting out of pocket expenses as cost of transportation was a major cost ~ Pathological tests during pregnancy were the other direct Out of Pocket Expenses (OPE)
- Long waiting hours
- Treatment at capital hospital was dependent on the "personal reference and contacts" and presence of ASHA with the patient.

Conclusions

- Nearly 90% attained below secondary level of education ~ better to have visual heavy SBCC messages
- There was a gap of around 1 month between women becoming pregnant and registering for pregnancy
- With 40% of private sector deliveries through C-Section, unduly high out-of-pocket expenses for beneficiaries; need for regulation
- ASHAs seem to be playing crucial role in providing MNH care. Program investment to enhance their capacity seems need of the hour
- It is essential to upgrade and sustain systems at primary and secondary level so that the patient load in the tertiary hospital is manageable
- Secondary facilities require functional linkages with the primary facilities on one hand and tertiary facilities on the other hand
- Rationalization of specialist HR services; training on the basic maternal and newborn care

Acknowledgements

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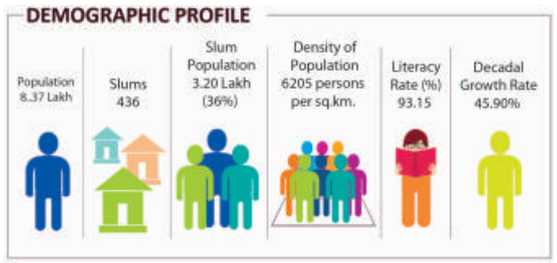
Objectives of the Study

- To understand the community needs, behaviors and perception for MNH in urban poor settings.
- To explore various factors (both demand and supply side) affecting care seeking for MNH.
- To assess the preparedness of the urban health system for providing MNH services at various levels of care in terms of infrastructures at various levels of care, HR availability and capacity, logistics, drugs & equipment, referral, recording & reporting, supervision, governance and financial modalities.

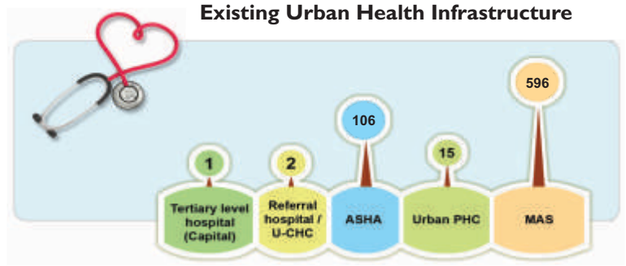
Conceptual Framework

Bhubaneswar City Profile



Source: Census 2011

Existing Urban Health Infrastructure

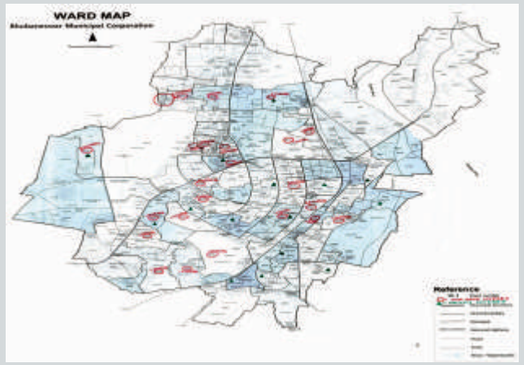


Source: Bhubaneswar Municipal Corporation / NHM, Odisha

Study Coverage

Respondent	Methods	No.
Census of 30 slum clusters	HH enumeration and mapping	28,590 HH
Recently Delivered Women (RDW) with 0-6 months child	Household survey	592 HH
	Event narratives	8 Case studies
Husbands & MIL	FGD	4 Groups each
Front Line Workers - ANM/ASHA/AWW	FGD	10 Groups
Members of MAS/ SHG	FGD	4 Groups
City and ward committee members, teachers, religious leaders	FGD	4 Groups
Facility Level MO/Ob. & Gyn., AYUSH; SN	Observations/audit In-depth Interviews (IDI)	13 Facilities 10 IDIs
Informal & Formal Pvt. Providers	IDI	8 IDIs (each)
Key NHM / Municipal Corporation officials	IDI	10 IDIs

Geographical Coverage

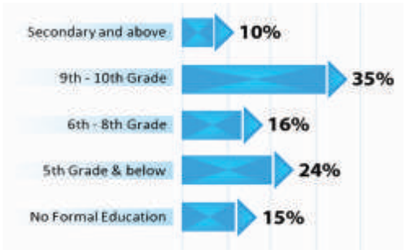


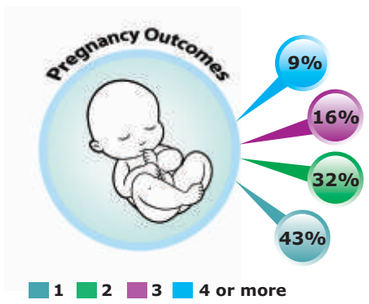
Results

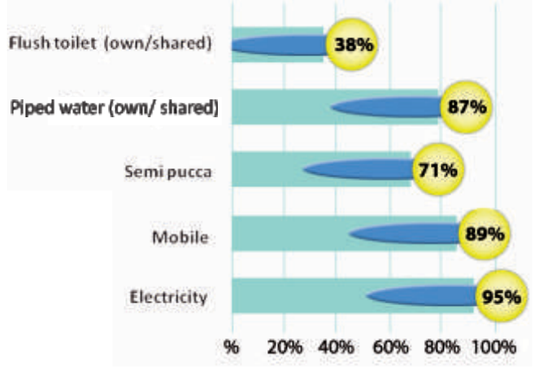
Social Profile

N=592

Education Level

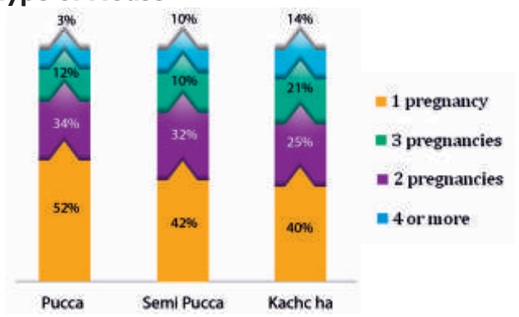




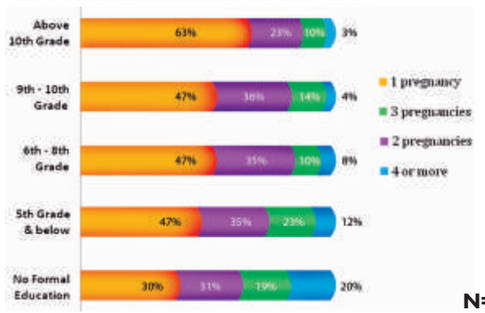


Distribution of Number of Pregnancies of RDWs by…

Type of House

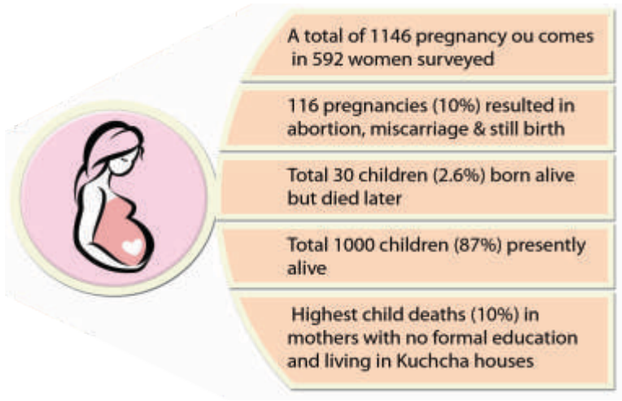


Educational Status of Mothers

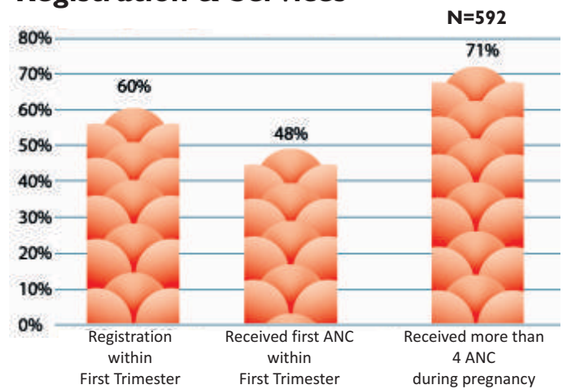


N=592

- By the age 24 years, over 39% RDWs have already had more than one pregnancy
- About 15% of the RDWs had first pregnancy beyond 29 year age

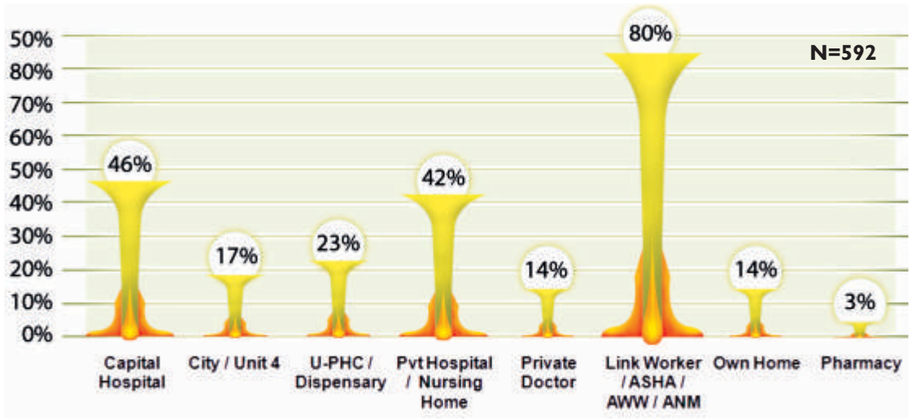


Antenatal Care (ANC) Registration & Services



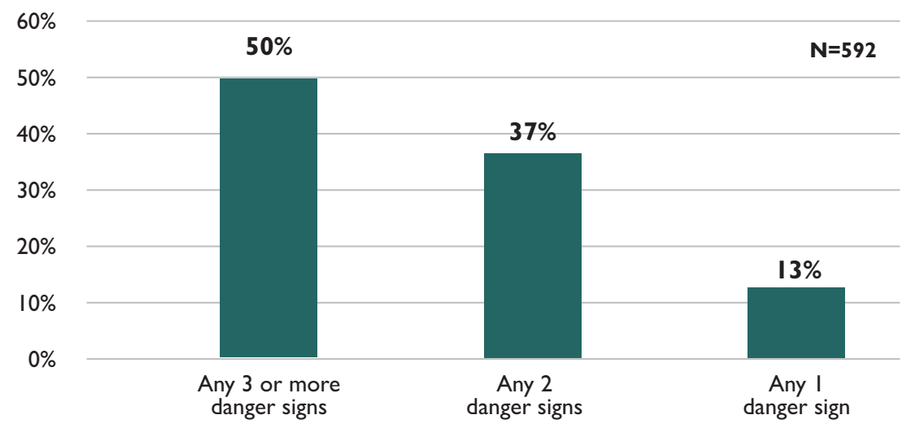
- 60% women registered within first trimester, however, 48% have received their first ANC in the first timester
- 70% have received more than 4 ANCs during last pregnancy

Type of Facilities visited for ANC Services



- More than one facilities accessed during ANC
- 84% of the women have received ANC from front line workers
- Visited Capital hospital (46%) or private hospital (42%) in case of any complications
- Contribution of primary facilities in providing ANC have been minimum or negligible (23%)

Awareness of Danger Signs during Pregnancy

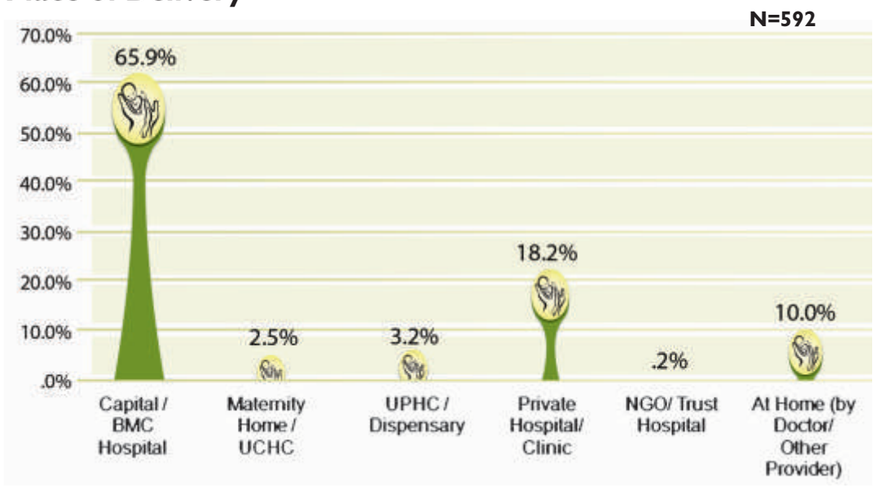


- Severe abdominal pain, headache and oedema of face/hands/ legs, most cited symptoms of danger signs
- In case of any danger signs during pregnancy, around two-third would visit Capital hospital and rest, one-third would consult a private sector facility
- ANC counselling was mostly on place of delivery and early initiation of breast feeding less than 40% counselled on maternal dryer signs

Gaps with respect to antenatal care

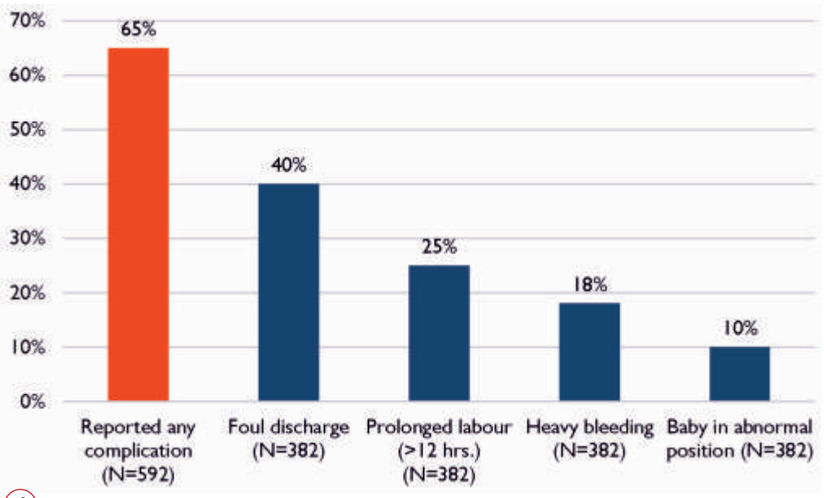
- Inadequate eating: regular receipt of nutritional benefits from Gov. health workers in form of sattu - yet mothers skip meals
  - Skipping of meal, improper nutrition lead to weakness and anemia
  - Absence of consistent information regarding mother's diet during pregnancy
- Around half of the women complained about prenatal complications, viz. anamia, fever, pain during urination etc.
- Recording of right age of the mother at times difficult for ANM, ASHAs
- Registration process gets delayed as
  'Multiple steps before getting the actual registration: ASHA identifies the pregnant women and write her name. On Urban Health and Nutrition Day (UHND) she takes pregnant women to ANM where she again enters her name in another register. The name of the pregnant woman gets entered in the formal register only at the monthly meeting where both ASHA and ANM are present hence the name gets verified and the card is issued to the pregnant woman'.
- Non-compliance on part of mothers in taking the recommended dosages of IFA tablets

Place of Delivery



- Overall, 90% of the deliveries took place in institutions ~ 72% in govt. and 18% in private
- Home deliveries were due to delay in identification of labour and miscalculation of expected date of delivery
- More than one-fifth of the deliveries are C-section ~ Govt.: 18% and Pvt.: 40%
- Only 9% utilized any govt. vehicle for delivery
- Those who have not delivered in the govt facilities, cited 'poor quality of service', and 'husband/ family didn't allow' as the main reasons.

Self Reported Complications during Delivery

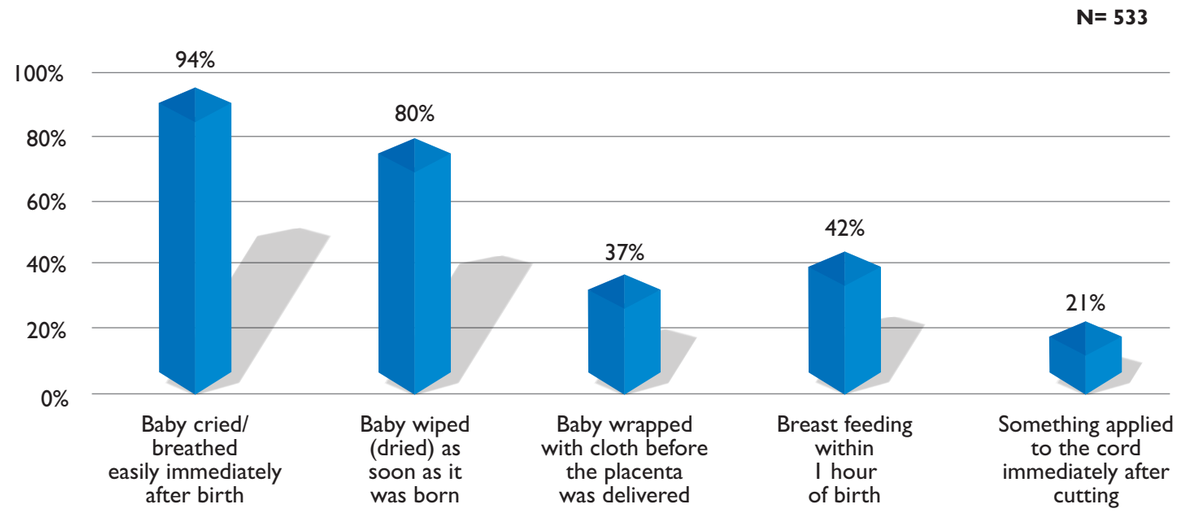


- 10% of the women who had delivery complications, were referred to a higher up facility
- 6% of the RDWs never landed up in the referral facility they were referred to, cited it was unnecessary to visit the referred facility

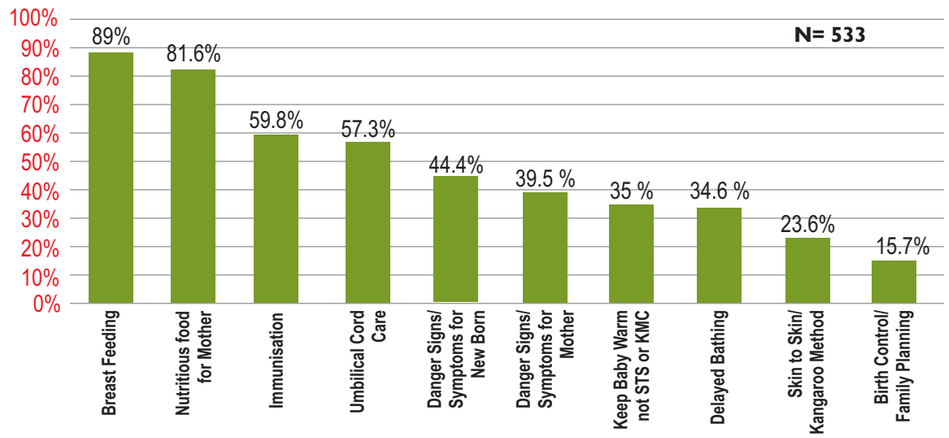
Gaps with respect to Delivery Services

- Unavailability of 102, 108 at the time of delivery.
- Transportation turns out to be major out of pocket expense: failure of implementation of JSY scheme.
- Utilization of services at the Capital hospital dependent on presence of ASHA at that time; Only 26% of the RDWs reported that ASHAs accompanied them during delivery.
- Cash crunch at the time of delivery: non receipt of entitlements like JSSK, Mamta by the time of delivery.
- Lack of empathy in care provided at the Capital Hospital during labor.

Immediate Newborn Care

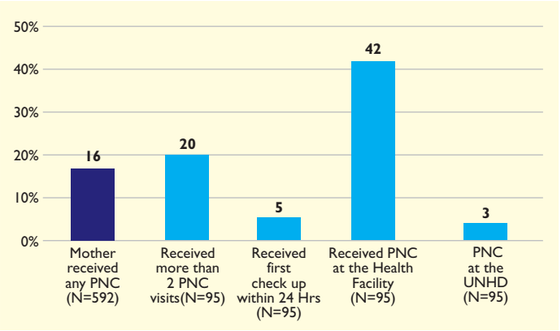


Pre-discharge Counseling



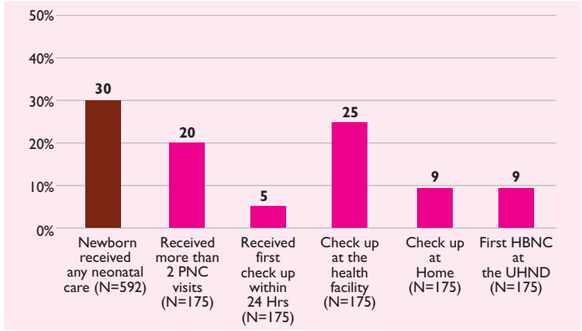
- Little discussion on danger signs or critical aspects of newborn care
- Limited discussion of family planning (need or methods)
- The three most popular topics were breast feeding, nutrition and routine immunization

Profile of Post-natal care for Mother



- About 16%, i.e. only 95 women have received any post natal check up within first one month after delivery

Profile of Post-natal care for Newborn



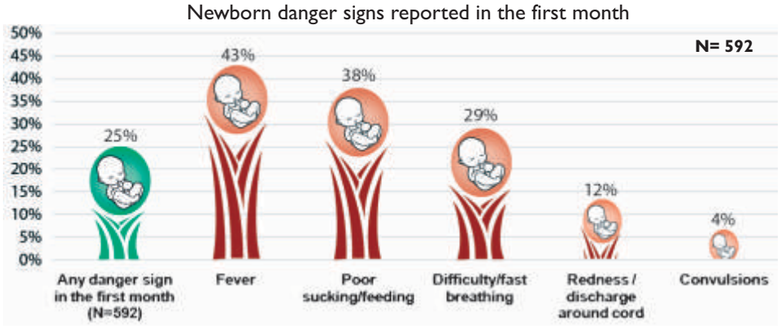
- About 30%, i.e. Only 175 newborns have received any check up after birth within one month after birth

Gaps with respect to Post-natal Care

- Broader determinants of health, i.e. sanitation – vaginal infection of woman post delivery due to sanitation and hygiene problem was quite common.
- Lack of participation of men in household chores forces women to go back to work earlier than expected.
- Decrease in home visits by ASHA post delivery. Most PNCs were carried out at the facility; FLWs role negligible in complete continuum.
- Even among those who received any post natal check-up, half of them reported to have received just one post natal check-up in the crucial first month after delivery.
- Reluctance in post natal checks for baby if the baby was fit

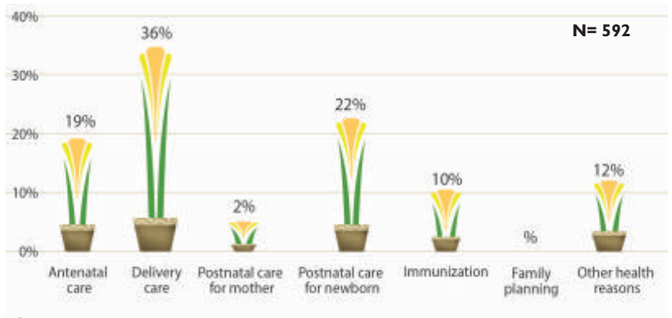
Sick Newborn Care

Newborn danger signs reported in the first month

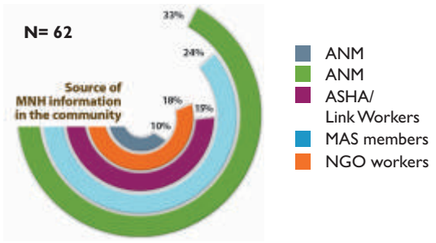


- 25% of the RDWs reported that the newborn had at least one danger signs in the first month of life
- 69% of the RDWs reported that their baby had at least 2 sickness episode in the first month itself
- 44% sought treatment from Capital hospital and another 42% of the mothers took their sick newborns to private health care facility
- At least 36% of those who took their newborns to Pvt. at the first time, took their newborns to Govt./ Capital as a referred case in the second time

Purpose of visit to any govt. health facility in the last six months



Community structure and support



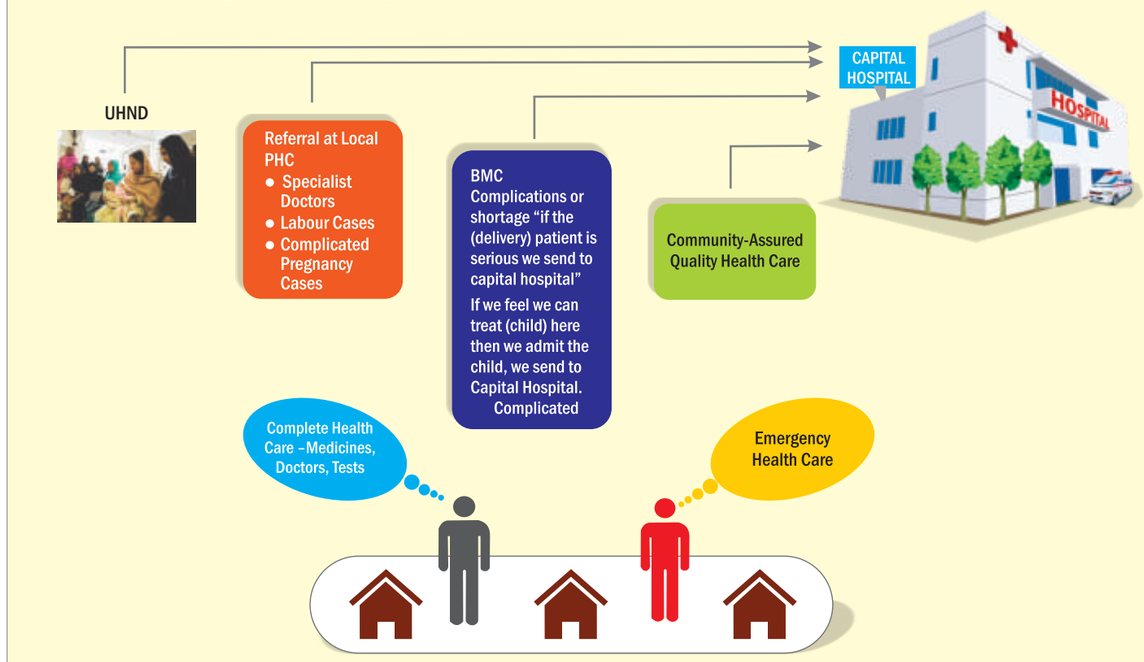
- Only 10%, i.e. 62 women have attended any community meeting in the last six months
- Counselling provided on: nutritional counseling, pregnancy care, management of newborn illness etc.

Access to Primary Health Services

Primary health centers were not even considered by the slum dwellers

Unavailability	**of local Primary/ Health** service provider on **regular basis at a fixed time was** a reason for not availing services there.
Timings	**Once in a month availability** of specialist doctors at Local PHC makes it "not worthy " for community to seek care at a different place.
Lack of Assured Treatment	at Primary public health care centers makes Capital hospital a preferred place to seek health care.
Lack of Infrastructure at local Health center	such as doctors, medicine, test etc. makes the local PHC **as an unreliable** option to be availed rarely.
Perception of PHCs for general, small ailments	Govt. hospitals were preferred for delivery while PHC for cough and common cold i.e. "not so serious diseases." Private hospitals for serious health problems, emergency cases.

Overcrowding at the Capital Hospital



Gaps in Service Provision - *Outreach*

- About 50% ASHA were not in position; ASHAs role decreases significantly post delivery
  - Increased involvement of ASHAs in administrative activities due to NUHM ~WKS, MAS, urban home visits etc.
  - ASHAs lack confidence in identifying newborn danger signs during Home Based New Born Care (HBNC) visits
  - ASHAs expressed overt demand for hike in incentives; they are at present managing 42 schemes
- UHND lack of uniform system; concerns over supply of consumables: pricking needles, reagents like $N_{10}HCL$, Dipstick. etc. short in supply.
- 60% MAS were functional as per the mandates of NUHM; helps in community mobilization; however, role in MNH services unclear