Issues in Utilisation of MCH Services: Qualitative Insights from Tribal Women of Himachal Pradesh, India

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Abstract

Mothers and children in any country comprise a large vulnerable population subgroup. In order to address the myriad health needs of women and children, maternal and child health (MCH) services have been bolstered in India. Tribal women are facing many hurdles in the utilisation of MCH services which is ultimately affecting their health outcomes. This study aimed to explore the issues and challenges faced by tribal women during the utilisation of MCH services. An exploratory qualitative research approach was adopted to conduct a study among women of the reproductive age group who were selected through stratified sampling techniques from selected tribal areas of district Sirmour, Himachal Pradesh. Focused Group Discussion (FGDs) was done to collect the data from participants. Content and thematic (Colaizzi method) analyses were used to identify common responses and ideas. Beneficiaries were facing issues like hospital environment and sub-centre issues, travelling/ transportation problems, lack of family support, awareness issues, and personal, social, and political issues while utilising maternal and child health services of tribal areas. It was concluded that there is a need to reduce the problems faced by tribal women regarding the utilisation of MCH services to enhance their level of satisfaction in order to promote maternal and child health which will ultimately help in achievement of SDGs.

Key words: MCH services, Tribal women, Utilisation

Maternal and Child Health services (MCH) are essential for promotion of mother and child health status in community. There have been many advancements in Maternal and Child Health services (Reddy, 2019). In 1977, the Government of India launched a rural health scheme based on the principle of 'placing people's health in people's hands'. MCH services are integral part of Primary Health Care. Community participation was greatly emphasised as a means to achieve the objective of health for all (Suryakantha, 2013).

In the wake of WHO goal of 'Health for All' by 2000 AD, Indian government evolved a National Health Policy based on the primary health care approach approved by Parliament in 1983. Universal Health Coverage (UHC) encompasses all individuals and communities to receive the health services they need without suffering financial hardship. Achieving UHC is one of the world's nations' targets when adopting the Sustainable Development Goals in 2015 (Kumar, 2019). All UN member states have agreed to achieve Universal Health Coverage by 2030 with the Sustainable Development Goals (SDGs) in view (Universal Health Coverage, 2019).

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Empowering women, families, and communities by supporting their involvement and proactive care-seeking for pregnancy care, nutrition, birth preparedness, use of a skilled attendant at birth, recognition of maternal and new-born danger signs, early initiation and exclusive breastfeeding, post-natal care, and support for optimal birth spacing is important (WHO, 2018). World Health Organisation is working with partners in supporting countries towards addressing inequalities, quality, and ensuring universal health coverage for comprehensive MCH services (WHO, 2019).

Mothers and children are major consumers of health services. They comprise approximately 2/3rd of the population in the developing countries. In India, women of childbearing age (18-49 years) constitute 21.7 percent, and children under 15 years of age constitute 37.3 percent of the total population. They are exposed to unusual risks of a widespread infection, poor nutrition, etc. which may cause deviation from normal health (Mahajan & Gupta, 2013).

Need of the study: Women's status has been considered an important measure of social development in a community. Women die as a result of complications during and following pregnan-

cy and childbirth. The main factors that prevent women from receiving or seeking care during pregnancy and childbirth are poverty, distance to facilities, lack of information, inadequate and poor-quality services, and cultural beliefs and practices (Neelam Kumari, 2006). As per the Sustainable Development Goals (2015), India is committed to reducing its maternal mortality rate (MMR) to less than 70 lakh live births. Every day 830 women die from preventable causes related to pregnancy over the world. Globally, there were a total of 303,000 maternal deaths in 2015. By 2030, no country should have an MMR greater than 140 maternal deaths per 100,000 live births (UN Report, 2017).

UNICEF supports the development of home-based maternal and new-born care programmes that incorporate CHWs and community women's groups along with strengthening of health facilities and the referral linkages between communities and hospitals (UNICEF, 2018). Tribal people are diverse populations and live in varied local environments and nations, with important implications for their health (Kirmayer & Brass, 2016). The tribal or Adivasi population in India stands at 104 million, i.e., 8.6 percent of the Indian population, which makes the world's largest population of indigenous people (Registrar General, 2011).

Since India has a massive shortage of medical and nursing staff, it becomes increasingly difficult for citizens to access healthcare facilities. Disrespect, violence, mistreatment, and neglect during childbirth are violations of women's fundamental human rights. Thus it is the state's responsibility to ensure that women using these facilities feel safe and secure (Golechha, 2015). Beneficiaries' perception help understand the ground realities to throw light on the quality, need, and sustainability of the MCH services. People have a right to be involved in decision making. Client perception and satisfaction will help to understand the gaps and adopt a bottom-up approach for MCH-related programmes (Bhargavi & Sharma, 2014). In considering explanations for poor MCH outcomes, many investigations have focused on receivers' decision-making patterns instead of exploring the barriers faced by beneficiaries.

Objective

The purpose of the study was to explore the issues faced by tribal women during utilisation of MCH services.

Methodology

An exploratory qualitative research design was used to explore issues in MCH care among women of reproductive age group (18-49 years) residing in tribal areas of district Sirmour, Himachal Pradesh. Participants belonged to Gujjar tribe having Hindi as local language. They were selected through a probability stratified sampling technique till data saturation. Total sample size for study was 98.

Criteria for Sample Selection

Inclusion criteria: (1) Women of reproductive age group between 18-49 years who were residing in the selected tribal areas (2) Women who were willing to participate in the study (3) Women who were able to understand Hindi language.

Exclusion criteria: (1) Women who were mentally retarded or mentally ill (2) Women who were not available at the time of data collection.

Ethical consideration was maintained during data collection i.e., formal permission was obtained from concerned authority and written informed consent was taken from the participants.

Secondary data was taken from previous literature, books, policies, records & reports, online databases & websites, journals, etc. Primary data was collected from the beneficiaries, i.e., women of reproductive age group (18-49 years). Ten focused group discussions (FGDs) were conducted with 8-10 participants from each village for 30-40 minutes. ASHAs and Anganwadi Workers were present during the discussions in order to make the beneficiaries more comfortable.

Primary data were analysed with Colaizzi procedural steps and N-Vivo software. The different issues affecting MCH services' utilisation have emerged as significant themes from the data (FGD transcripts, notes, field observations). These were thoroughly read and re-read to identify index topics and categories. Finally, both the predetermined and emerged themes were pooled together to address the research question.

Socio-demographic Variables

Table 1 covers various socio-economic variables of the study participants. Colaizzi's method is used to analyse the data (Fig 1). It consists of the following steps:

Cluster of Themes

After analysis of the transcript of the Focus group discussion, themes, and subthemes have been formulated. A total of 27 responses evolved from the data of focused group discussion. Out of these, 29 meanings were derived because some of the study's responses were not exclusive but are interconnected and overlapping. The responses were grouped under various subthemes under the main six themes.

Themes & Sub-Themes: Issues Faced By Beneficiaries

1. Hospital Environment issues

   Manpower issues; Scarcity of resources

2. Sub-centre services issues

   Lack of infrastructure & manpower; Insufficient resources & Inaccessibility of MCH Services; Irregular UIP guidelines implementation

3. Travelling/transportation issues

   Long distance issues; Lack of transport facilities; Unaffordable fare rates

4. Lack of family support

5. Awareness issues

Table 1: Frequency & percentage distribution of demographic variables of beneficiaries of MCH services (N=98)

S. No.	Demographic variables	Frequency (percentage) (n) (%)
1	**Age (in years)**	
	a. 18-24	30 (30.6)
	b. 25-31	39 (39.8)
	c. 32-38	24 (24.5)
	d. 39-45	05 (5.1)
2	**Religion**	
	a. Hindu	64 (65.30)
	b. Muslim	34 (34.70)
3	**Educational status**	
	a. Preliterate	32 (32.65)
	b. Primary	18 (18.36)
	c. Middle	22 (22.45)
	d. Secondary	12 (12.24)
	e. Senior secondary	06 (6.2)
	f. Graduate & above	08 (8.1)
4	**No. of living children**	
	a. None	07 (7.2)
	b. 1	12 (12.3)
	c. 2	30 (30.6)
	d. 3	27 (27.5)
	e. >3	22 (22.4)
5	**Occupation**	
	a. Home maker	87 (88.6)
	b. Own Business	02 (2.1)
	c. Govt. Employee	03 (3.1)
	d. Private Employee	02 (2.1)
	e. Labourer	04 (4.1)
6	**Type of family**	
	a. Nuclear	44 (44.9)
	b. Joint	54 (55.10)
7	**Monthly Income (in Rs)**	
	a. 5571 and above	06 (6.1)
	b. 2586-5570	12 (12.2)
	c. 1671-2785	41 (41.9)
	d. 836-1670	28 (28.6)
	e. <836	11 (11.2)
8	**Source of information**	
	a. Mass media	03 (3.1)
	b. Health care personnel	87 (88.7)
	c. Elders & relatives/friends	04 (4.1)
	d. Others	04 (4.1)

Lack of knowledge regarding JSY; unsupervised home deliveries

6. Personal, social & political influence

Description of Themes

Manpower issues: Shortage of human resources is an emerging issue that has a greater impact on quality patient care. The beneficiaries reported a shortage of doctors in Civil Hospital. Moreover, they have to wait for a long time. Hospital staff (doctors & nurses) have rude behaviour while dealing with clients.

"Most times, we have to wait for more than an hour or till evening before attending. We actually find this to be a terrible practice on their part. In the same manner, another participant stated that some of our hospitals lack basic equipment, but still health care staff can be very polite."

Muslim beneficiaries do not prefer delivery in government hospital because of male gynaecologists. Their families are not allowing them to visit a male doctor for delivery purposes. So, they usually prefer home deliveries.

Scarcity of resources: There is no adequate provision of emergency services at Civil Hospital. There is non-availability of ambulance services near border areas. Inadequate availability of ultrasound facilities in Civil Hospital is also responsible for their preference to visit private hospital for diagnostic and delivery services.

"There is no ambulance services facility in our village because an ambulance cannot cross border areas; therefore, they are dropping us sometimes outside the village."

Sub-centre Services Issues: Sub-centre is acting as first link between community and First Referral Unit (FRU). The issues include lack of infrastructure and manpower, insufficient resources and irregular universal immunisation program, etc.

Lack of infrastructure and manpower: In sub-centre, there is an incomplete infrastructure of building. There is not sufficient place for the set up of cold chain system. They did not have adequate water and electricity facilities. Beneficiaries do not prefer Copper-T insertion as there is no privacy set up. Skilled health care personnel available for insertion in nearby healthcare centres cause various complications such as bleeding, automated expulsion of Copper-T, or displacement to the upper part of the uterus, responsible for less usage of family planning methods. In some village areas, there is non-availability of trained birth attendants (TBA) responsible for unsupervised home deliveries.

Insufficient resources and inaccessibility of MCH services: The beneficiaries reported inadequate

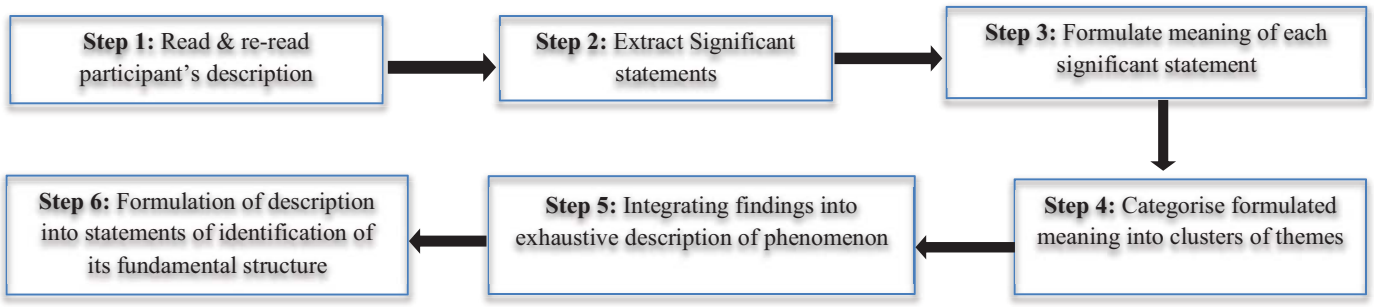

Fig 1: Data analysis by using Colaizzi's procedural steps.

availability of medicine and supplements (IFA & Calcium tablets) at Health Care Centres. They do not have a dispensary or clinic in nearby areas of the village for health care services. Sub-centre is located at a long distance from some villages. Hence, there is inaccessibility of MCH Services.

"We are not receiving enough medicines and supplements from the health care centre. Sub-centre is also very far away from our homes."

Irregular UIP guidelines implementation: Beneficiaries reported that there is a lack of regular vaccine administration as per universal immunisation programme (UIP) guidelines. In some areas, children did not receive vaccination at regular interval. Vaccination administration was after the gap of three months which should be administered on monthly basis. Sometimes beneficiaries had missed vaccination due to travelling issues.

"We have to walk for 2 km for the vaccination of children. That is why sometimes we missed vaccination, and it is more difficult to reach in the rainy season because of road blockage."

Travelling / transportation issues: Long distance issues: Health Care Centres are established far away from residential areas, so it is challenging to reach health care centres in hilly areas because they need to walk for long-distance. Even during pregnancy and labour pains they had to walk for long distance.

Traveling cause minor ailment such as nausea & vomiting (health issues) in hilly areas. Women who were on referral from one facility to another are facing difficulty during referral cases also (Fig 2).

Lack of transport facilities: It was reported that there is a non-availability of public transport services for travelling to the hospital. Most of them replied that they have to walk during labour pain; even some women delivered before hired vehicle reached home.

Unaffordable fare rates: Cost emerged as another challenge for utilising maternal health care services. All the participants anonymously reported that cost is a significant constraint in seeking maternal health care services during pregnancy and delivery. Hospital is 38 km far away from some villages so they could not pay travelling charges which are expensive than their financial revenues.

"It took us almost an hour to travel down from the hills, and the transport fare is costly. Also, because transportation was too expensive for us to afford, we had to walk down here on foot".

Lack of family support: They are not getting any family support for traveling to the health care centre because all members are busy in fieldwork or labourers and their own work.

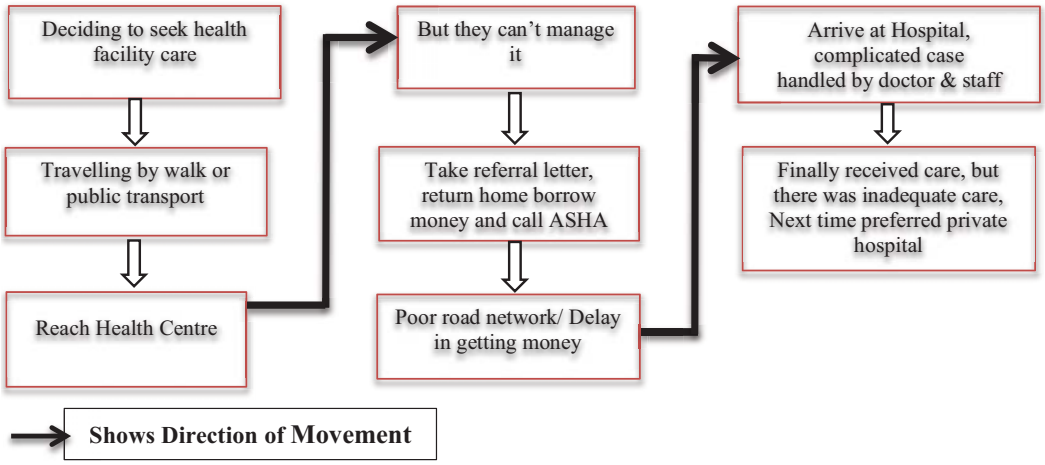

Fig 2: Referral of cases.

Awareness Issues

Lack of knowledge: They have inadequate knowledge regarding form filling and opening of bank accounts of Janani Suraksha Yojna necessary to benefit from scheme. There was also inadequate knowledge regarding the importance of facility-based delivery,

and most participants across all communities preferred home-based delivery. The beneficiaries reported no presence and supervision of trained birth attendants during delivery because there is no skilled birth attendant in some areas.

Personal, social and political influence: Some beneficiaries reported that civil hospitals have an 'influential' approach, i.e., if there is a need for an immediate consultation with a doctor and quick treatment, then there should be someone familiar in the hospital from social and political background for reference.

Discussion

Universal health coverage focused on delivery of primary health care among rural people. In order to address the myriad health needs of women and children, maternal and child health services have been bolstered in India. The study has revealed various issues related to utilisation of MCH services. Hospital issues include shortage of manpower and scarcity of resources. Boro & Saikia (2020) found similar results such as perceived negative behaviour of hospital staff, and lack of infrastructure as the main barriers to utilising healthcare facilities. Consistent with our results, Otani et al (2006) also revealed that lack of transport services, inadequate resources, and workforce were considered major contributing factors for patient satisfaction and quality care. There was lack of infrastructure and manpower, insufficient resources & inaccessibility of MCH services and irregular implementation of (UIP guidelines) at sub-centre level. Similar findings were found in study conducted by Lama & Krishna et al (2014). Difficulty in accessibility to hospital was also found in study by Jose et al (2014).

Travelling & transportation issues include commuting long distance, lack of transport facilities and unaffordable fares. Most of the participants replied that they have to walk during labour pain; even some women delivered before hired vehicle reached home. Say & Raine (2007) found similar outcomes. Oiyemhonlan et al (2013) conducted a study which highlighted that many women did not have readily available transportation to come to the hospital in an emergency.

Women had lack of family support, inadequate knowledge regarding JSY and unsupervised home deliveries. Sharma et al (2012) found similar results. Personal, social and political factors have also impacted the utilisation of MCH services among tribal women. This was endorsed by Jain et al (2014); the authors highlighted the influential approach to healthcare utilisation. This study has found significant barriers affecting the quality and appropriateness of maternal & child health services in tribal communities which should be addressed to achieve better health outcome of mother and child.

Implications

For provision of comprehensive services in community area, there is need to take important steps for strengthening health facilities for delivery of maternal & child health services, and interventions such as preparing and implementing facility-specific plans for ensuring quality and meeting service guarantees as specified under Indian Public Health Standards.

Training programme for medical specialists, nurse practitioners, advanced nursing, community health officers and public health professional should be redesigned, standardised and scaled up.

There should be adequate pre-service or orientation training for health care personnel (staff nurses, ANMs, ASHA & AWWs) regarding maternal & child health services, family planning services etc. Innovative approaches in training and education for maternal & child health in tribal areas for rapid and high quality content will be encouraged.

Apart from facility-based care, community outreach would also strengthen health promotion and disease prevention. It should be augmented by nurse practitioners in place of physician to provide essential drugs and basic diagnostic free of cost. MCH services must have convergence with other programmes for effective utilisation and implementation.

More efforts are needed to increase the beneficiary's participation at the community-level. The community leaders, existing Village Health Nutrition and Sanitation Committees and ASHAs should be leveraged to engage women in taking responsibility of their own health in a more systematic way.

Targeted awareness campaigns' should be organised on the basis of age, occupation, economics and education. These can be more fruitful in comparison with general campaigns. In order to make effective communication, different audio-visual aids can be used.

Conclusion

Maternal and Child Health services are beneficial for the promotion of mother and child's heath status. Women were facing various problems and challenges while utilising maternal and child health services of tribal areas. Government Health Care Centres should be equipped with adequate health care facilities and resources in order to deliver the quality health care services. Health care personnel should deliver MCH services effectively so that they can enhance the satisfaction level

of beneficiaries. Grass root level workers such as ASHA and AWW can play intensive role in delivery of MCH services at their doorstep level. They have to do evaluation with regular follow-up for delivered services. Supervisors can contribute with periodic monitoring of health care workers to enhance the delivery of quality care services which is essential to achieve international targets and bridge inequities in access to essential Maternal and Child Healthcare Services.

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हिंदी लेखकों से अनुरोध

हिंदी में लिखने वालों से आग्रह है, मासिक टीएनएआई बुलेटिन के लिए रचनाएं भेजें। मौलिक, सुरुचिपूर्ण, नर्सिंग पेशे, स्वास्थ्य सरोकार तथा संबद्ध विशयों पर आलेख, अनुभव, ज्ञानवर्धक सामग्री, हास्य, कविता आदि स्वीकार्य होंगी। हस्तलिखित या कंप्यूटर से टंकित रचनाएं साधारण डाक या मेल से मुख्य संपादक के नाम भेजी जाएं।