



Birth preparedness and determinants of birth place among migrants living in slums and slum-like pockets in Delhi, India



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ABSTRACT

Objective: The objective of this paper is to report birth preparedness and place of birth and its determinants among recent- and settled- migrant households living in slums of Delhi.

Methods: In a cross-sectional survey, 458 migrant mothers with a child aged below one year of age were identified. Socio-demographic details, data on the place of childbirth, antenatal care (ANC) and birth preparedness in terms of planning for home birth or hospital birth, transport, saving money, knowledge of danger signs were collected through interviewer-administered pretested questionnaire. Logistic regression was carried out for the determinants of hospital birth.

Results: The present study migrants are characterised by younger ages, low educational attainment, low incomes and represented by socioeconomically disadvantaged communities. They mainly relied on government health-care services for maternal care. ANC seeking was not satisfactory with 16% of women with no ANC; 46% receiving 1–3 visits; and only 23% of women reported health worker visited them at home. 59% of the births took place at hospitals. Having ANC visits (Adjusted Odds Ratio (AOR) for having 4 or more ANC visits = 5.252), planning for hospital birth (AOR = 6.114), plan for transport (AOR = 1.989), mass media exposure (listening to radio; AOR = 2.871) and knowledge of danger signs (AOR = 3.872) resulted in significant chances of hospital birth.

Conclusion: Migrant women are at the risk of utilizing the services to a less extent. The health systems need to take measures to mitigate the disadvantage due to migration through specific strategies to make them inclusive and outreach to the poor migrants.

Introduction

Maternal mortality rates are still high in developing countries. In India, every year an estimated 47,000 women continue to die from pregnancy, childbirth and post-partum related causes [1]. India was able to reduce maternal mortality to 167 maternal deaths per 100,000 live births by 2013. The National Health Mission (NHM) of India aimed to reduce maternal mortality to 100 per 100,000 livebirths by 2017 [2]. In order to achieve improved maternal health, the countries, where still half of the births were not assisted by skilled birth attendants, need to strengthen their healthcare strategies to reach out to the poor and vulnerable. Birth preparedness and complication readiness is a planning process for giving birth and anticipating the actions to follow in case of emergency and includes knowledge of danger signs, planning for birth attendant and birth location, planning for transport, saving money for birth related emergencies and identifying a blood donor [3]. Some of the key maternal health strategies of the government of India include

provision of free services for delivery including caesarean section at public health institutions, free transport between home and healthcare facilities including referral facilities. Since it is not possible to predict which women will experience life-threatening complications during childbirth, receiving care from a skilled healthcare provider during childbirth was identified as the single most important intervention in safe motherhood [4]. However, the use of skilled healthcare providers remain low in developing countries and home deliveries are often synonymous to giving birth without the help of a skilled provider. Home deliveries are mainly assisted by *dai* (traditional birth attendants), mother/mother-in-law or elderly lady, who may not be able to deal with the complications that can occur during childbirth. Hospital is the place where skilled providers are available, and hence, childbirth at hospital is considered safer in India as is evident from the Government of India's Janani Suraksha Yojana (JSY, meaning safe motherhood scheme), a conditional cash transfer scheme, to incentivise women of low socio-economic status to give birth at a government health facility

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[5]. The objective of JSY is reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women [5].

Migration is a livelihood strategy and even inevitable for the poor. Migration is identified to have an impact on poverty reduction and economic growth [6–8]. The 2030 agenda for sustainable development reiterated migrants' contribution for inclusive growth and sustainable development [9]. However, the migrants at the lower socio-economic strata who mainly work in the informal sector remain vulnerable in the new urban environment. Often, benefits of internal migration of poor people are not recognized despite that migrants are a bare necessity for developmental activities in cities [10]. The poor migrants often utilize the healthcare services to a lesser extent owing to various factors and are vulnerable to forego maternal healthcare services. The migrants who have come recently to the cities are either not familiar with the health facilities or live in those areas that are not usually catered by the formal healthcare services. Lack of social support, non-familiarity of existing services including healthcare services, negligence and alienation in the new socio-cultural environment leads to less control over the available resources that are meant for all members including migrants. The poor migrants are often occupied with livelihood concerns and preventive health and healthcare takes a backseat in their lives. Earlier studies from India [11–17], and other countries [18–20] reported lower utilization of general and maternal health care services.

In this paper, we report birth preparedness, hospital births and its determinants among recent- and settled- migrant households living in slums and slum-like pockets in Delhi, the capital of India.

Method

Study design and population

Delhi has become the largest urban agglomeration in the country with 21.75 million population in 2011, which has increased from 13.8 million in 2001 [21]. Estimated figures reveal that yearly 200,000–300,000 people from other states in India come and settle in Delhi [22]. The data were collected as a part of a major interventional study to improve healthcare access to labour migrants in Delhi. The methodological details of this study are available elsewhere [23]. This is a cross-sectional study and cluster-random sampling technique was used. A total of 189 clusters (slums, slum like pockets, dwellings at construction work sites, open spaces), where a considerable proportion of newly migrated live were identified. Further, migrant households were identified and considered for inclusion. Though the study mainly intended to include only those who have migrated to the city within the last 10 years; some of the households who have been staying in Delhi for more than 10 years were also included from some clusters, in order to avoid misrepresentation/misreporting of the migration duration and also respecting the community leaders' request to include the older migrant households also. Thus, a total of 4773 recent-migrant (those who have migrated to the city of Delhi within the last 10 years from other states of India) and 1389 settled-migrant (those who have migrated from other states of India and living in Delhi at least since 10 years) households participated in the study. Among these households, 242 recent-migrant and 222 settled-migrant households had a mother with a child up to the age of 1 year. One mother refused to participate and five questionnaires were incomplete, hence excluded from the present analysis, leaving a final sample of 458 (236 recent-migrants and 222 settled-migrants). Information pertaining to the most recent childbirth were sought from the mothers. Socio-demographic details, migration history, details on various components of ANC, birth preparedness (in terms of knowledge of danger signs, plan for where to give birth, plan for transport, plan for saving money) were collected through interviewer-administered questionnaire.

Ethical considerations

Ethical approval was given by the institutional ethics committee of the first author's institute. Informed consent was taken prior to the interview. The purpose of the study was explained to each participant that we are trying understand the households' situation and their access to various services including healthcare. The information they provided is totally confidential and will not be disclosed to anyone and the information will only be used for research purposes. Their participation is completely voluntary, and they may stop the interview any time they wish or may skip any question if do not want to respond. However, their participation for sharing information and their experiences could be helpful in improving the healthcare access.

Measures

The outcome variable is the place of childbirth, with two categorical variables, namely: 1 = mother gave birth at home and 2 = gave birth in health facility. Various socio-economic and demographic characteristics were considered as independent variables. Individual level independent variables were mother's age, educational status, and number of pregnancies. The household-level characteristics were size of household, household income per month, migration status and social class. Other variables were exposure to mass media in terms of watches TV and listens to radio; number of ANC visits, time of 1st visit, plan for birth place, plan for transport, plan for money, knowledge of danger signs and danger signs experienced during pregnancy.

Statistical analyses

To examine the association of place of childbirth (home birth/hospital birth), multiple logistic regression was carried out. To identify the independent variables for the regression analyses, initially, each independent variable was regressed against dependent variable (home birth/hospital birth). Those variables with a minimum P-value of 0.25 were included for multiple logistic regression analyses [24,25]. Hosmer and Lemeshow test was employed as goodness-of-fit test. All analyses were carried out using SPSS 20.0 (IBM Corp., Armonk, NY, USA).

Results

Characteristics of the study participants

A majority of women were in the age group of 21–30 years, and around 13% were young mothers aged 20 years or below (Table 1). Around 44% of the mothers didn't attend school, while rest of the mothers had school education. A majority of the households had a monthly income up to INR 5000; and only 8% reported to earn more than INR 10,000 per month. A majority belong to underprivileged groups (70%) such as scheduled castes, other backward classes; however, scheduled tribes are less represented. Regarding access to information and mass media, 50% of the recent-migrants and 69% of the settled-migrants had access to TV, however, radio listening habit was low (14%) and only 5% reported reading newspaper daily.

Table 2 presents the details of pregnancy and ANC utilization for the recent pregnancy. Nearly half of the mothers experienced more than 3 pregnancies and one fifth (27.5% of recent- and 23.9% settled-migrants) were primiparous. A higher proportion (21%) of recent- migrant women didn't seek ANC compared to settled- migrant women (11%). Only 32% of recent- and 45% settled-migrant women had a minimum of four ANC visits. Only one-third (31% of recent- and 38% of settled-migrants) made their visit in the first trimester. Only 23% of women reported that a health worker (Anganwadi Worker-AWW or Accredited Social Health Activist-ASHA, Auxiliary Nurse Midwife -ANM) visited them at home. For ANC, a majority (62.7% recent and 71.6% settled-migrant women) relied on government healthcare sources while 17%

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