EquiNaM
building evidence to support equitable improvement in newborn and maternal health

Research jointly supported by the ESRC and DFID

SNEHA®

Institute for Global Health

Policy Brief

July 2015

Determinants and reasons for choice of maternity care provider in Mumbai's informal urban settlements

A. Background

India has more maternal deaths than any other country in the world (56,000 per year) [1]. Many of the deaths, most of which are preventable, occur in informal urban settlements. A safe and healthy pregnancy requires access to services such as regular antenatal care, skilled birth attendance and emergency obstetric care. Utilising these health services in a timely manner is equally important. Inadequate coverage and low uptake of skilled maternity care are major contributors to global maternal morbidity and mortality. Public health services in Mumbai are unable to meet the growing demand [2], including maternity care, due to inadequate investment aggravated by budgetary underutilization. On the other hand, private health care, while omnipresent, is prohibitively expensive and poorly regulated.

As education increases and awareness spreads, women in Mumbai are realising the importance of institutional care during pregnancy and childbirth. However, the decision to avail health services during pregnancy and the selection of a health care provider are complex processes influenced by interrelated individual, household, community, and health system factors. Most research to date has emphasised whether or not women have accessed public health services, the reasons why, and the quality of care they have received.

There has been limited examination of provider choice, the selection process, or the factors that govern this choice. This policy brief makes recommendations based on the findings of a study conducted by researchers from the Society for Nutrition, Education, and Health Action (SNEHA) and University College London (UCL) to quantify the pattern, determinants, and choice of maternity care provider in Mumbai's urban slums, and to explore the reasons underlying these choices.

B. About the study

The study used a mixed-methods design and was carried out in informal settlements in two eastern municipal wards in Mumbai (M and L wards) that rank lowest on the UN Human Development Index for the city [3]. We used data from a baseline census from our randomised controlled trial of community resources centres [4] to describe the determinants of maternity care and then, using a grounded theory methodology, we examined women's utilisation and choice of provider.

In the baseline census we interviewed 3848 women who had given birth in the preceding two years, about their age, education status, duration of stay in Mumbai, livelihood, religion, family details, assets and amenities, along with maternity history and family planning methods used. We then conducted seven focus group discussions and

sixteen qualitative semi-structured interviews to understand in detail, the respondents' background, experiences of pregnancy and childbirth, maternity care and choice of provider. The groups were purposively stratified to include women from diverse backgrounds; the discussions collated their experiences of prenatal care, home birth or institutional delivery.

C. Key findings

Uptake of prenatal and delivery care

- Overall, institutional care was high: 94% of respondents received 3 or more antenatal visits and 85% delivered in a health facility.
- Uptake of prenatal and institutional delivery care was higher among women who were more educated, less poor and who had lived in Mumbai longer i.e. for ten years or more. Women from higher economic positions were almost twice as likely to have more than three prenatal care visits.
- Uptake of institutional care was lower among recent migrants: of women who had arrived in Mumbai in the last year, 24% made fewer than 3 prenatal visits and 39% delivered at home, compared with women who had been living in the city for longer.

Choice of provider

- Among those who utilised public sector health services, most went to tertiary level hospitals (78% for prenatal care, 82% for delivery care) rather than smaller facilities such as maternity homes or general hospitals.
- Muslim women preferred the private sector: they were half as likely to deliver in a public facility as in a private one.
- More educated, less poor women, and those who had recently arrived in Mumbai preferred the private sector for both prenatal and delivery care.

The complexity of selecting a maternity care provider

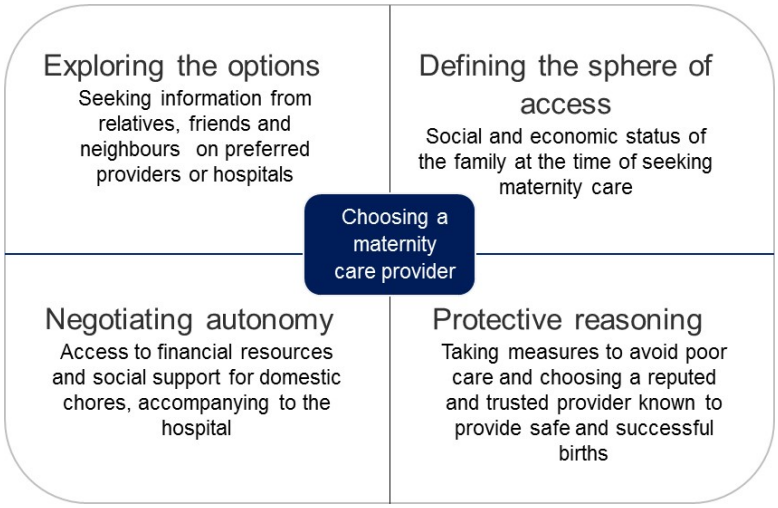
Women and their families underwent a complex process to select a suitable health care provider, operating from an apprehension to have an overall satisfactory experience of care and a desire for a safe and positive pregnancy outcome. Their choice was constrained by availability of finance, lack of precise information and a fear of institutional delivery with some providers. Women often sought maternity care from specific, local private providers who were recommended by family who reportedly offered good quality care. Staff attentiveness, competence of the doctor, convenience of location, extent of hospital infrastructure and services, and ease of navigation within the hospital were all factors that defined their experience of care.

In the group discussions and interviews, the researchers identified four broad processes involved in choice: exploring the options, defining a sphere of access, negotiating autonomy and protective reasoning (Figure 1).

- *Exploring the options*: Women garnered information from various sources – relatives, friends and neighbours – about the availability of health facilities as well as their experiences to compare options for practitioners for both antenatal care and delivery. Factors such as convenience, affordability, quality, and outcomes of care (a healthy live birth) were all considered in the selection process. In particular, primagravid women and recent migrants depended on information and advice.

- *Defining a sphere of access*: Choosing a health care provider depended largely on the economic and social status of the family. Through this, women defined their level of access to different public and private providers. However, decisions were not permanent; they were reconsidered throughout pregnancy, based on the ongoing financial capacity of the family and perceptions about the level of care required.

Figure 1: Conceptual process of choosing a maternity care provider



- *Negotiating autonomy*: Institutional prenatal care and delivery meant time away from home and disruption of routine domestic chores. Choosing a provider often involved a process of negotiating the financial and social resources available. For example, the location of a preferred provider was an important consideration with respect to the distance from home, costs involved, loss of wages on days of prenatal check-up or delivery, presence of other family members at home, or support from neighbours or friends for domestic work, care of older children or accompanying the mother to the hospital. Women from wealthier households with access to more social support were better able to go to their preferred health care provider. Others had limited choices and prioritised minimising disruption to the family over affordability and quality of care.

- *Protective reasoning*: The safety of the mother and her unborn child, and a desire for a positive pregnancy outcome were crucial to decisions about provider choice. When exploring the options, women drew on their own knowledge and experiences, and were influenced by the experiences of others. They used various strategies to protect themselves from poor quality care and from providers whose practices were thought to be risky. Protective strategies included avoiding certain health facilities, switching health sector or provider, or avoiding care altogether.

- Other women sought out specific providers with whom they had previously had a positive experience and those known for good care or a reputation for successfully conducting normal deliveries.

D. Recommendations

The study contributes to an understanding of how families in underserved urban communities with inequitable access to health services choose their health care. This important aspect of health service utilisation has received limited attention. Future health policies will benefit from a greater understanding of how vulnerable groups decide in a context of uncertain health care choices.

The following recommendations can help address inequalities in access to maternal health care and to improve the experiences of the urban poor.

- Provision of clear and up-to-date information about local health care providers and the range of health services they offer would help poor urban residents make more informed choices. Information could include number and availability of staff, equipment and supplies, facility timings, terms and conditions for accessing services – such as prenatal care – and charges for OPD, investigations, and medicines.

- As a critical provider of health care services to the poor, local government must work towards a more equitable provision of health services in terms of availability, functioning, adequacy, and appropriateness of facilities and services in the public health care system.

- Improvements in administrative and organizational processes in public sector health facilities could enhance the experience of the urban poor. These could include 1) improving admission and consultation procedures to reduce waiting times, 2) training staff on interpersonal skills and nonviolent communication, 3) establishing effective grievance mechanisms that give people the opportunity to report poor care and make service providers more accountable to clients, and 4) a move towards "patient friendly" health care and a more sensitive attitude to patient health care rights.

- We restate the need for systematic implementation of regulatory mechanisms, particularly in the private health care sector, to ensure the capacity of providers, adequacy of facilities and equipment, and the appropriateness and quality of health care practices.

- Given the barriers to delivering comprehensive maternity care in primary level facilities, the system of patient referrals across facilities needs to be clearer, with effective coordination, documentation and feedback. Mechanisms through which the private sector is incorporated should also be explored.

References

1. Save the Children. State of the world's mothers 2013: surviving the first day. 2013.

2. Dilip TR, Duggal R: **Unmet Need for Public Health-Care Services in Mumbai, India.** *Asia-Pacific Population Journal* 2004, **19:** 27-40.

3. Municipal Corporation of Greater Mumbai. Mumbai Human Development Report 2009. 2010. New Delhi, Oxford University Press.

4. Shah More N, Das S, Bapat U, Rajguru M, Alcock G, Joshi W *et al*.: **Community resource centres to improve the health of women and children in Mumbai slums: study protocol for a cluster randomized controlled trial.** *Trials* 2013, **14:** 132.