Summer Training at

State Institute of Health & Family Welfare, Mohali
(9th April, 2012 – 1st June, 2012)

Existing Practices and Barriers to Access of MCH Services (A Case Study of Residential Residentialurban Slums in District Mohali)

By
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Under the guidance of
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Post Graduate Diploma in Hospital and Health Management
2011-2013

IIHMR JAIPUR

Institute of Health Management Research,
Jaipur
2012

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CERTIFICATE

This is to certify that **Parika Pahwa**, student of Institute of Health Management Research, Jaipur, has undergone summer training at State Institute of Health & Family Welfare, Mohali from 9 April, 2012 to 2 June, 2012.

The candidate has successfully carried out the study assigned to her during summer training and her approach to study has been sincere, scientific and analytical.

This summer training is done for partial fulfilment of the course.

I wish her success for all her future endeavours.

Dr. Seema Mehta
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Summer Internship completion Certificate

To Whomsoever Concerned

This is to certify that Dr. Parika Pahwa, student of IHMR Jaipur, PGDHM-16 Batch, has successfully completed her internship of 2 months from 9th April 2012 to 1st June 2012 here with State Institute of Health and Family Welfare, Mohali, (Punjab). She has worked on following Projects: "Utilization of MCH services and Janani Suraksha Yojna in Urban Slums of Mohali District" and "Knowledge, Beliefs and Practices of Family Planning with special focus on Vasectomy amongst males of Punjab".

Her work and contribution to the organization is appreciated and we are completely satisfied with her performance during her internship.

We wish her success in all her future endeavours.

Regards,
Dr. M.L. Sharma
MO / MLCD
SIHFW, Mohali
Punjab

Dated 1st June, 2012

PREFACE

Summer internship is an integral part of the PGDHM curriculum. As a part of the course; the students of first year are required to undergo summer placement at any reputed organization to get in depth exposure of various departments in the organization and better understanding of the health care delivery system and its functions.

The major objectives of the summer training programme are as follows:

1) To better understand the existing healthcare delivery system including public and private sectors.
2) To observe the implementation of various National Health Programmes at State/District/Block levels.
3) To acquire more knowledge on roles and responsibilities of key players and stakeholders in health sector.
4) To understand various functions of health system by interactions with key stakeholders, policy makers, programme managers, academicians and researchers.
5) To work on the project/task assigned by summer training organization.

During the training period we had an **Overview of various Programmes** under National Rural Health Mission, Punjab including the current status of the programmes. Besides, functioning of Department of Health and Family Welfare, Punjab Health System Corporation was also viewed with special reference to how they work in collaboration with NRHM. I also carried out a small study on the "**Existing Practices and Barriers to access of MCH services in Residential urban slums of District Mohali".**

The aim of the study was to analyze the how Antenatal, Intranatal and Postnatal services are being delivered and what is the status of immunization in the urban slums of the district. It deals with assessment of various indicators related to Maternal and child health services, as well as to identify and analyze the problems faced by both service providers and beneficiaries. I hope, this will not only help us in assessing the performance but identify the bottlenecks which will need corrective measures. The study design would really be beneficial to planners and administrators for better planning and implementation of Maternal Child Health services in urban slums.

ACKNOWLEDGEMENT

I extend my sincere gratitude **to Dr Jatinder Kaur**, Principal SIHFW, Mohali- cum -Director CTI, for giving me the opportunity to do this study and undergoing the process of learning at SIHFW. I thank her for all the trust and faith she posed in me and I only hope that I have been able to live up to her expectations. Her guidance and support was helpful in enhancing my work.

I extend sincere gratitude towards **Dr. M.L.Sharma**, who has been my mentor for the summer internship program & has been instrumental in helping me shape this study in a desirable way.

I would also like to thank Dr. Maninder Bajwa and Dr Rashmi Sharma, Medical officers at SIHFW and Dr Nirpal Kaur, Dr Karanpreet Johal and Dr Surinder Kaur, Consultants NRHM , for supporting my work all along.

Last but not the least; I would like to thank the entire staff of SIHFW, Mohali for their support and guidance.

We would like to express our sincere thanks to **Dr. S.D. Gupta**, Director, IHMR, **Dr. P.R. Sodani**, Health Stream In-charge, my mentor **Dr Seema Mehta** and **Dr Suresh Joshi** as well as all my faculty members for the proper guidance and cooperation extended by them. I am also grateful to my parents, my family and my friends for giving me moral support.

However, I accept the sole responsibility for any possible error of omission and would be extremely grateful to the readers of this project report if they bring such mistakes to my notice

Date- 1st June, 2012 **Parika Pahwa**

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ACRONYMS/ ABBREVATIONS

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga, Unani, Siddha and Homeopathy
AWW	Anganwadi Worker
BCG	Bacillus Calmette Guerrin
BCC	Behaviour Change Communication
BPL	Below Poverty Line
CSSM	Child Survival and Safe Motherhood Programme
CS	Civil Surgeon
CMO	Chief Medical Officer
CHC	Community Health centre
DLHS	District Level Health Survey
DPT	Diptheria Pertussis Tetanus
EAG	Empowered Action Group
ESI	Employees State Insurance
FRU	First Referral Unit
FP	Family Planning
FHW	Female Health Worker
GoI	Government of India
HPS	High Performing States
ICDS	Integrated Child Development Services
IUCD	Intra Uterine Contraceptive device
IPHS	Indian Public Health Standards
IEC	Information Education Communication

IFA	Iron and Folic acid
IMR	Infant Mortality Rate
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
MO	Medical Officer
MMR	Maternal Mortality Ratio
MCH	Maternal Child Health
MOHFW	Ministry of Health and Family Welfare
MTP	Medical Termination of Pregnancy
NFHS	National Family Health Survey
NIP	National Immunization Programme
NRHM	National Rural Health Mission
OPV	Oral Polio VACCINE
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PNC	Post Natal Care
PRI	Panchayati Raj Institution
PHSC	Punjab Health System Corporation
PSACS	Punjab State AIDS Control Society
RCH	Reproductive and Child Health
SMO	Senior Medical Officer
STD	Sexually Transmitted Disease
SI	Social Insurance
TFR	Total Fertility Rate
TT	Tetanus Toxoid
UIP	Universal Immunization Programme

List of Activities Performed During the Training Period

Work Assigned By the Organization

1.	Assisted Dr. M.L. Sharma in preparing schedule of 9th PDC for senior medical officer.
2.	Assisted consultants of SIHFW, Mohali for monitoring & evaluation of PHC,CHC, SC and District Hospital
3.	Existing Barriers and Practices to access of MCH services in residential slums of District Mohali
4.	KAP study of literate males towards family planning methods with special focus on Vasectomy in three districts of Punjab.
5.	Assisted the consultants in monitoring and evaluation of ongoing trainings.
6.	Attended state level workshops organized by Punjab Health System Corporation

Field Visits

Date	Visits
3/04/2012	Civil Surgeon Office
5/04/2012	Punjab Health System Corporation
16/04/2012	Department of Health and Family Welfare
17/04/2012	Directorate of Health Services
19/04/2012	District Hospital – Civil Hospital, Mohali
24/04/2012	ESI Hospital - Mohali
25/04/2012	ESI Dispensary 1 & 2, Mohali
6/05/2012	PHC, Ghruan
8/05/2012	SC, Santemajra
11/05/2012	CHC, Karauli
16/05/2012	NRHM, Chandigarh
18/05/2012	Punjab State AIDS Control Society

List of persons interacted during the training period

Sr No.	NAME	DESIGNATION	PLACE
1.	Dr. Jatinder Kaur	Principal	SIHFW, Mohali
2.	Dr. M.L. Sharma	Medical Officer	SIHFW, Mohali
3.	Dr. Maninder Bajwa	Medical Officer	SIHFW, Mohali
4.	Dr. Rashmi Sharma	Medical Officer	SIHFW, Mohali
5.	Dr. Surinder Kaur	CTI Consultant	SIHFW, Mohali
6.	Dr. Nirpal Kaur	CTI Consultant	SIHFW, Mohali
7.	Dr. Karanpreet Johar	Research Officer	SIHFW, Mohali
8.	Virender Singh	Computer Assistant	SIHFW, Mohali
9.	Dr. Deepinder Singh	State Programme Manager (Iodine, Blindness)	Department of Health & Family Welfare
10.	Dr. Rakesh Goyal	State Programme Manager (Cancer, Tobacco)	Department of Health & Family Welfare
11.	Dr. Veena Bansal	State Programme Manager (MCH)	Department of Health & Family Welfare
12.	Jaswinder Kaur	Mass media Communication Manager	Department of Health & Family Welfare
13.	Dr. SPS Dhillon	Assistant Civil Surgeon	Punjab Health System Corporation
14.	Dr Tejinder Singh Behal	District Immunization Officer	Civil Hospital
15.	Dr. Sarita	District Family Welfare Officer	Civil Surgeon's Office
16.	Dr. Ksithij Seema	District Programme Manager	Civil Hospital
17.	Navdeep Gautam	BCC Manager	NRHM Chandigarh
18.	Dr. Meenu Lakhanpal	NGO Coordinator	NRHM Chandigarh
19.	Dr. Balbir Singh	Medical Officer	PHC, Gharuan
20.	Natinder Kaur	ANM	Civil Hospital
21.	Gurmeet Kaur	ANM	ESI Dispensary 1
22.	Balwinder Kaur	ANM	ESI Dispensary 1
23.	Shashi	ANM	ESI Dispensary 2
24.	Gurleen Kaur	ANM	ESI Dispensary 3
25.	Jasvir Kaur	ANM	ESI Dispensary 4
26.	Paramjeet	ANM	Subcentre, Santemajre

DEFINITIONS

Antenatal Care -The care of a pregnant woman and her unborn baby throughout a pregnancy. Such care involves regular visits to a doctor or midwife, who performs abdominal examinations, blood and urine tests, and monitoring of blood pressure and foetal growth to detect disease or potential problems.

Intranatal Care – The care provided to pregnant woman throughout the labour

Postnatal Care – The care provided to a woman following the birth of child for at least 6 week period.

Immunization – It is the process that protects the body from communicable diseases by administration of a living modified agent (*e.g.,* yellow fever vaccine), a suspension of killed organisms (*e.g.,* Pertussis vaccine), a protein expressed in a heterologous organism (*e.g.,* hepatitis B vaccine), or an inactivated toxin (*e.g.,* tetanus).

Infant – A new born is an infant which comes under age of 1 month to 1 year.

Neonatal Mortality Rate – Neonatal Deaths are those occurring during the neonatal period, i.e. commencing at birth and ending 28 completed days after birth.

Post- neonatal Mortality Rate – Deaths occurring after 28 days of life to under 1 year are called Post –Neonatal deaths.

Infant Mortality Rate – It is defined as number of infant deaths registered in a given year per 1000 of live births in the same year.

Child Mortality Rate – It is defines as number of deaths at ages of 1-4 years in a given year, per 1000 children in that age group at the midpoint of year concerned.

Maternal Mortality Ratio – It is defined as death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not related from accident or incidental causes. It is calculated in terms of per 100000 population.

MATERNAL HEALTH INDICATORS

Indicator MH 1: **Antenatal care first visit coverage rate**

A: ANC – First Visit

B: ANC First Visit in first trimester

C: ANC registered under JSY

Definition - Percentage of pregnant women who used Antenatal Care (ANC) provided by skilled health personnel, for reasons related to pregnancy, registered in first trimester of pregnancy. This indicator is also known as "Any Antenatal care Visit".

Indicator MH 2: ANC third visit coverage rate

Definition - Percentage of women who utilized antenatal care provided by skilled health personnel for reasons related to pregnancy at least 3 times during pregnancy.

Indicator MH 3: Iron & Folic acid and Tetanus toxoid Coverage rate

a. % ANC TT-1 coverage rate

b. % ANC TT2 and TT booster coverage rate

c.ANC 100 IFA coverage rate

Definition - Percentage of pregnant women who used antenatal care and were given TT1, TT2 or TT booster vaccine.

Indicator MH 4: ANC Anaemia & Hypertension testing and management rates

A. % ANC moderately anaemic

B. % ANC severely anaemic

C. % ANC severely anaemic treated rate

D. % ANC hypertension new case detection rate

E. Eclampsia cases management rate

Definition –

- Percentage of pregnant women tested to be moderately anaemic (Hb <11g)
- Percentage of severely anaemic pregnant women treated (Hb <7g)
- Percentage of pregnant women tested with hypertension/ high blood pressure (BP>140/90)

Indicator MH 5: Skilled Birth Attendant (SBA) delivery rate

Definition - Proportion of total deliveries assisted by a Skilled Birth Attendant (at home and at institutions)

Indicator MH 6: Institutional delivery rate

A Institutional delivery rate

B Reported Institutional Delivery Rate

C Institutional delivery complication attendance rate

D Postnatal maternal complications attendance rate

E % Institutional delivery receiving JSY benefit

Definition- A) Proportion of total deliveries that took place in any health facility

B) Institutional deliveries that took place in health facilities

C) Proportion of Institutional deliveries with delivery complications

D) Proportion of Institutional deliveries with maternal postnatal complications

E) Proportion of institutional deliveries where the woman got JSY benefits

Indicator MH 7: Home delivery rate
A Home delivery rate
B Reported home delivery rate
C Home delivery by Skilled birth attendant (SBA) rate
D Home delivery by Non Skilled birth attendant rate
E % Home delivery receiving JSY benefit
Definition - A) Percentage of total deliveries that took place at home
B) Reported home delivery rate
C) Home deliveries attended by SBA
D) Home deliveries attended by Non-SBA
E) Home deliveries receiving JSY benefit

Indicator MH 8: Basic Emergency Obstetric Care (BEmOC) availability
Definition - Number of facilities with functioning BEmOC per 500,000 population

Indicator MH 9: Comprehensive Emergency Obstetric Care (CEmOC) availability
Definition **-** Number of facilities with functioning CEmOC functions per 500,000 population. This implies that the facility has provided BEmOC signal functions in addition to CEmOC functions.

Indicator MH 10: Admission duration after delivery
Definition **-** Percentage of women who were discharged in less than 48 hrs of delivery.

Indicator MH 11: Maternal Mortality Ratio
Definition **-** The death of a woman while pregnant or within 42 days of delivery or termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental causes.

Indicator MH 12: Birth reporting rate
Definition - Proportion of births reported over a given period of time.

Indicator MH 13: Postnatal care
Definition - Percentage of women who used postnatal care provided by skilled health personnel.

IMMUNIZATION INDICATORS

Indicator CH IMM 1: Vaccine Specific Immunisation coverage under one year
A BCG
B OPV (1,2,3)
C DPT (1,2,3)
D Measles
E Hep B (1,2,3) where used
Definition - Vaccine specific immunisation coverage is the percentage of children under a year who have received particular doses of a specific vaccine.

Indicator CH IMM2: Full Immunisation coverage
Definition **-** Full Immunisation coverage is the percentage of one-year-old children who have received all required vaccines.

Indicator CH IMM 3: Immunisation adverse reactions
Definition **-** An adverse immunisation reaction is an unwanted or harmful reaction experienced following administration of a vaccine. It can be described as a medical event that takes place after an immunisation that causes concern and is believed to be caused by immunisation (Immunisation handbook for health workers GoI 2007)

Indicator CH IMM 4: % of planned immunisation sessions held
Definition - Percentage of total planned immunisation sessions held.

Indicator CH IMM 5: Vitamin A coverage rate
Definition **-** Percentage of children who have received all required vitamin A doses.(One dose for a child under one and five doses for a child under three years).

Indicator CH IMM 6: Immunisation drop out rate
Definition **-** Comparison of the number of children who start receiving immunisation and the number who do not receive later doses for full immunisation.

Executive Summary

Maternal mortality and morbidity continue to be high despite the existence of national programs for improving maternal and child health in India. This could be related to several factors, an important one being non-utilization or under-utilization of maternal health-care services, especially amongst the rural poor and urban slum population due to either lack of awareness or access to health-care services. Therefore, the present study was carried out to evaluate the socio-demographic correlates and barriers of maternal child health-care utilization amongst married women aged 15-45 years living in slums of Mohali District. The findings of the study are as follows:

- 64% of the population residing in the slums are migrants from UP and 29% from Bihar.
- 66% of the population is illiterate.
- 86% of the women in slums are housewives.
- 73% of family's per month income lies between Rs 1000- 5000.
- Only 51% of the women that is 83 out of 164 got registered by the ANM's during their pregnancy.
- Out of those 83 women only 38 got registered in 1st trimester of pregnancy.
- About 77% of the women received Antenatal check up out of which only 34% of women completed 3 visits of ANC.
- 77% of women had TT vaccination and about 71% had received iron and folic acid tablets.
- About 49% of mothers delivered their child at home.
- About 81% delivered with SBA but still 19% deliveries conducted without SBA.
- 53% of the women said that they don't feel necessary and 20% said that because of non cooperative hospital staff and 23% revealed due to absence of husbands at home prevent them going for hospital for conducting delivery.
- Only 11% of the women received cash incentive under JSY scheme.
- 40% women told that due to non filling of JSY card by ANM's while 20% said they themselves don't know and 24% revealed again due to non cooperative hospital staff didn't get money under JSY scheme.
- Only 23% of the women received PNC check up while remaining 77% didn't have at least one PNC check up.
- Presently in those slums only 26% of the women are using any family planning method.
- About 13% of the child death reported in age group of less than a month and all of them being delivered at home.
- Only 57% of the child received all vaccinations till date.
- The dropout rate of Measles and DPT+POLIO vaccination is very high in slums i.e. 67% and 76% respectively.
- About 78% of the mothers revealed that due to lack of information, they failed to vaccine their child while still 36% of the women said that they don't feel necessary to give vaccine to their child.

INTRODUCTION TO PUNJAB HEALTH SYSTEM

Fig 1

Punjab is a state endowed with rich culture, tradition, religion and acknowledged for its self dependence, self-reliance and glory. It is located in the North-Western region of India and is bounded on the West by Pakistan, on the North by Jammu and Kashmir, on the North East by Himachal Pradesh and on the South by Haryana and Rajasthan.

The state is subdivided into three parts namely Malwa, Majha and Doaba. Malwa regions constitutes majority of the region in the state and comprises of cities like Ludhiana, Patiala, Bhatinda and Mohali , whereas Majha embrace modern districts of Amritsar, Gurdaspur and Tarn Taran and lastly, Doaba, is one of the most fertile regions of the world and was the centre of the Green Revolution in India, includes biggest cities such as Jalandhar, Hoshiarpur, Adampur, Nawansher and Phagwara. Punjab is predominantly an agrarian state and more than 60% of the population lives in rural area.

Health – The State Government has given top priority to augment health infrastructure in terms of construction of new buildings, purchase of equipment and recruitment of the required manpower. A sum of Rs. 720 crore has been allocated for development of health infrastructure in the annual budget FY2011-12. Government of India in its 4th Common Review Mission Report has rated health infrastructure of the state as excellent and placed the state at number one position. The Health infrastructure in the state comprises of 63 hospitals, 129 community health centres, 1309 dispensaries and 446 Primary Health Centres (PHC). Punjab has 529Ayurvedic and Unani institutions and 107 Homeopathic institutions. There are 20375 beds in the government hospitals of the state. The Various departments functioning under Punjab Health System are:

- Department Of Health and family Welfare
- National Rural Health Mission, Punjab
- Punjab Health System Corporation
- Directorate of AYUSH
- Directorate of Homeopathy
- Punjab State AIDS control Society

The Health and Family Welfare Department is committed to provide preventive, promotive and curative Health Services to the people of the State through a good net-work of medical institutions such as sub-centres, subsidiary health centres (dispensaries/Clinics etc.), primary health centres, community health centres, Sub-Divisional and District Hospitals, Government Medical & Dental Colleges (attached hospitals).

Primary Health Care

Primary Health Care Services in the rural areas of the State are provided through a net work of Medical Institutions comprising of Sub- Centres (2950) i.e. each for approximately 5000 population, SHCs/Rural Dispensaries/Clinics (1336) i.e. each f or approximately 10000 population, PHCs (395) i.e. each for approximately 30000 population and CHCs (129) i.e. each for approximately 100000 population. Under Alternative Health Care Delivery System, 1187 subsidiary health centres (rural dispensaries have been transferred to department of Rural Development and Panchayats. Where rural medical officers i.e. service providers (doctors) have been appointed by the Zila Parishad. For the promotion of Indian Systems of Medicine & Homoeopathy (AYUSH), 507 Ayurvedic /Unani dispensaries, 17Ayurvedic Swasth Kendra's, 5 Ayurvedic Hospitals, one Govt. Ayurvedic college at Patiala and 107 Homoeopathic dispensaries are functioning in the State. The various National and State Health Programmes which have been launched to provide Primary Health Care include a crusade against Malaria, Tuberculosis, Blindness, Leprosy and AIDS. All the programs have been successfully implemented in the State.

Secondary Level Health Care System

While the CHCs established in rural areas serve as the first level of referral services, the Hospitals at Sub-Divisional level and District Hospitals serve as secondary level of health care system and give support to the services being provided in the Primary Health Care System. Since CHCs in a way also provide specialist services, these can be considered as a part of the secondary level health care system. Hospital Services at the secondary level play a vital and complementary role to the Primary Health Care System and together form a comprehensive district based health care system. A health care system based on PHC cannot exist without a network of hospitals with responsibilities for supporting primary care and hospital care. Both are essential part of a well-integrated health care system.

Tertiary Level Health Care System

Tertiary level health care services are provided in the State by the specialized hospitals and hospitals attached to State Medical Colleges. These institutions besides providing support to the secondary level health care system, are expected to carry out research and manpower development for the health services of the State.

Fig 2

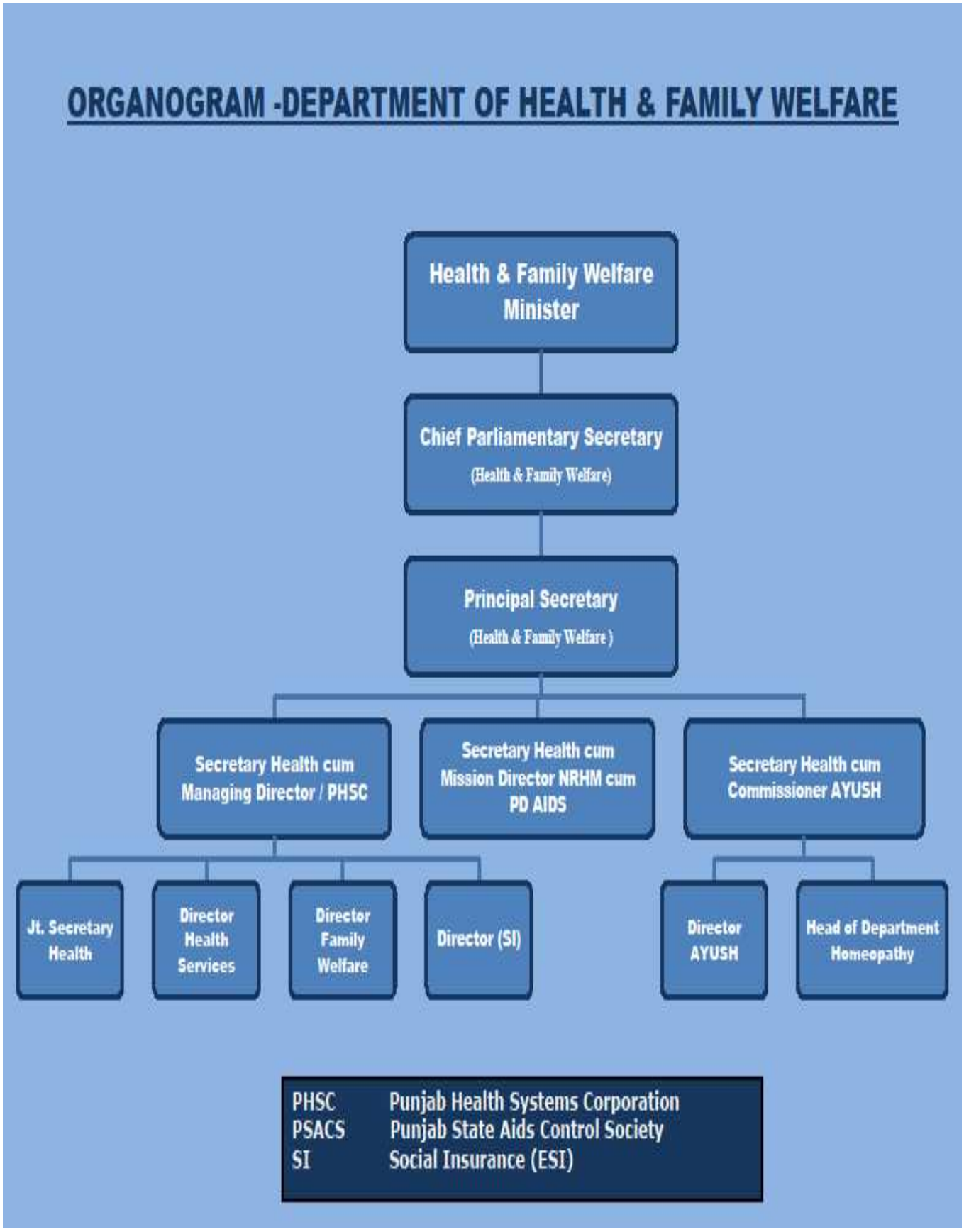

ORGANOGRAM -DEPARTMENT OF HEALTH & FAMILY WELFARE
Health & Family Welfare Minister
Chief Parliamentary Secretary (Health & Family Welfare)
Principal Secretary (Health & Family Welfare)
Secretary Health cum Managing Director / PHSC
Secretary Health cum Mission Director NRHM cum PD AIDS
Secretary Health cum Commissioner AYUSH
Jt. Secretary Health
Director Health Services
Director Family Welfare
Director (SI)
Director AYUSH
Head of Department Homeopathy
PHSC Punjab Health Systems Corporation
PSACS Punjab State Aids Control Society
SI Social Insurance (ESI)

Table 1 Health Indicators of Punjab

Sr No	Item	Punjab	India
1	Total Population (Census 2011)	2 crores	1.2billion
2	Decadal Growth (Census 2011)	13.73	17.64
3	Crude Birth Rate per 1000 midyear population (SRS Dec 2011)	16.6	22.1
4	Crude Death Rate per 1000midyear population (SRS Dec 2011)	7	7.2
5	Total Fertility Rate (SRS, Dec 2011)	2	2.6
6	Infant Mortality Rate (SRS, Dec 2011)	34	47
7	Maternal Mortality Ratio per 100000 population (SRS Dec 2011)	172	212
8	Sex Ratio (Census 2011)	893	940
9	Population Below Poverty Line (%)	6.16	26.10
10	Schedule Caste Population (in million)	7.03	166.64
11	Schedule Tribe Population (in million)	0	84.33
12	Total Literacy Rate (Census 2011) (%)	76.68	74.04
13	Female Literacy Rate (Census 2011) (%)	81.48	82.14
14	Male Literacy Rate (Census 2011) (%)	71.34	65.46

Table 2 Health Infrastructure of Punjab

Particulars	Required	In Position	Shortfall
Sub-centre	3219	2858	361
Primary Health Centres	536	484	52
Community Health Centres	134	126	8
Multipurpose workers (Female)/ANM at Subcentre	3342	2706	636
Health Worker (Male) MPW(M) at Sub Centres	2858	1983	875
Health Assistants (Female)/LHV at PHCs	484	179	305
Health Assistants (Male) at PHCs	484	139	345
Doctors at PHCs	484	201	283
Obstetricians & Gynaecologists at CHCs	126	46	80
Physicians at CHCs	126	56	70
Paediatricians at CHCs	126	39	87
Total specialists at CHCs	504	210	294
Radiographers	126	61	65
Pharmacists	610	666	-
Laboratory Technicians	610	270	340
Nurses/ Midwives	1366	1024	342

(Source: RHS Bulletin, March 2008, M/O Health & F.W., GOI)

State Institute of Health and Family Welfare, Mohali, Punjab is a well known SIHFW of the country because of the fact that it is having the privilege of scoring top position amongst the total 18 Collaborating Training Institutes (CTI's) of the country for conducting the professional Development Courses. In 1992, the health and Family Welfare Training Centre was upgraded to State Institute of Health and Family Welfare (SIHFW), Kharar, District Ropar under the World Bank aided project and functioned under the Directorate of Health & Family Welfare, Punjab.

State Institute of Health and Family Welfare, Mohali was established under the IPP – 7 Project as an apex institute to cater to the training needs of northern states of the country i.e. Punjab, Chandigarh, Haryana, Himachal, J&K. The Institute shifted to its new complex at Mohali on 1/04/04. It has been declared as Collaborating Training Institute (CTI) to work in unison with NIHFW, New Delhi for the conduct of trainings under RCH and NRHM. It has been declared as Collaborating Training Institute (CTI) to work in unison with NIHFW, New Delhi for the conduct of Trainings under RCH and NRHM. It is working under the overall administrative control of Directorate of Health Services (Family Welfare), Punjab, Chandigarh. SIHFW is working under the overall administrative control of Directorate of Health Services (FW) Punjab, Chandigarh.

Various Trainings imparted by SIHFW, Mohali are:

- EmOC, BEmOC, MTP
- Strengthening of training institutes
- Life Saving Anesthesia Skills
- Induction Trainings
- SBA, RTI/STI
- PDC
- IMNCI, F-IMNCI
- NSSK
- Laproscopic Sterilisation, Minilap, NSV, IUCD Insertion, Contraceptive Update
- BCC Skill Building FOR Mo's AND Paramedics
- HA Promotional
- NIHFW and other outside trainings
- ICD -10 training for SMO's & Paramedics
- Computer Training; ARSH; Programme management Units
- Integrated NRHM Training for RMOs; ANMs; IMEP training for MO's & Paramedics

Duties and Responsibilities : The State Institutes of Health and Family Welfare (SIHFWs) have been envisaged as state level institution for improving the total effectiveness of health care delivery system by imparting knowledge and technical skills at different levels. Specifically, SIHFWs are responsible for imparting training of trainers of identified selected institutions in accordance with the approved training plans. Also, identify training institutions for skill-based training, assist the state authorities and nodal agencies in selection of appropriate training institutions for implementing skill-based training, provide guidance to the districts in preparation of district training plans and procuring training materials from nodal agencies and translate, adapt and print copies as per requirements of the state governments.

Existing Practices and Barriers to access of Maternal and Child Health services (A case study of Residential Urban Slums Of District Mohali, Punjab)

Introduction

Promotion of maternal and child health has been one of the most important objectives of the Family Welfare Programme in India. The Government of India took steps to strengthen maternal and child health services as early as the First and Second Five-Year Plans (1951–56 and 1956– 61). As part of the Minimum Needs Programme initiated during the Fifth Five-Year Plan (1974–79), maternal health, child health, and nutrition services were integrated with family planning services. The primary aim at that time was to provide at least a minimum level of public health services to pregnant women, lactating mothers, and preschool children.

A country like India with wide variations in socio-economic, cultural and geographical attributes, understanding the influence of various independent variables on Maternal and Child Health (MCH) is the need of hour. One of the important thrusts of the Reproductive and Child Health Programme (RCH) is to encourage deliveries under proper hygienic conditions under the supervision of trained health professionals. The provision of delivery care in the public health institutions is one of the components of the RCH programme. Supervision and care from skilled professionals during delivery is important to achieve Millennium Development Goal-5 which aims to reduce the maternal mortality ratio by three-quarters between 1990 and 2015. Improvement of health status plays a vital role in the enhancement of human capabilities. The challenge before the developed countries is to maintain a higher level of health status than what they have already achieved. For the developing countries, the challenge is to attain a better health status.

India is the first country in the world to have officially declared 11th April as National Safe Motherhood Day, which is the birth anniversary of Kasturba Gandhi. On April 11, 2003, Ministry of Health & Family Welfare, Government of India in collaboration with White Ribbon Alliance of India (WRAI), organized a function to launch with the purpose of declaring the first Janani Suraksha Diwas (National Safe Motherhood Day) and for launching the Maternity Benefit Scheme.

Overall development of a country is incomplete without women who constitute nearly half of the human resource potential available. A woman requires special attention during 15-44 years of her life since she gets matured sexually and socially, gets married, conceives and gives birth to children during this phase. If proper care is not taken during this childbearing process, It affects the overall health especially the reproductive health of the woman as well as the health and well being of the newborn children. In real sense, the place of delivery is an important aspect of reproductive health care provided to the mother and the quality of care received by the mother and the newborn baby depends upon the place of delivery.

Institutional delivery means giving birth to a child in a medical institution under the overall supervision of trained and competent health personnel where there are more amenities available to handle the situation and save the life of the mother and child. If the child is born at home, then chances of getting infected from unhygienic environment are more and it is very tough and sometimes impossible to handle childbirth complications. In India, it is a prevalent practice to deliver the child at home instead of taking the pregnant women to some health facility. This is more common in rural areas as compared to urban areas. Institutional births result in reduced infant and maternal mortality and increased overall health status of the mother and the child.

Many programmes in India like the Child Survival and Safe Motherhood (CSSM) and the Reproductive and Child Health (RCH) etc are focused on this aspect. Under these programmes, encouraging deliveries in proper hygienic conditions only by trained health staff and to provide better health care to the mothers and children are emphasised. Our government's commitment in this direction is reflected in the goals of the National Population Policy (NPP), National Health Policy (NHP), and the National Rural Health Mission (NRHM) launched by the Honourable Prime Minister of India on 12 April 2005. The NRHM has a safe motherhood intervention programme (Janani Suraksha Yojana-JSY). The objective of JSY is to reduce Maternal Mortality Rate (MMR) and Neo-natal Mortality Ratio (MMR) through the promotion of institutional deliveries.

According to DLHS- 3 conducted in year 2007-2008, the institutional delivery rate is 63% while 36% deliveries are conducted at home only, out of which only 13% deliveries are conducted by skilled birth attendant. Only 14% mothers had received full antenatal check up. The most astonishing thing is mothers who received financial assistance for delivery under JSY scheme is only 2.7%.

Every minute, at least one woman dies from complications related to pregnancy or childbirth –that means 529000 women a year. In addition, for every woman who dies in childbirth process, around 20 more suffer injury, infection or disease – which means approximately 10 million women each year. Five direct complications account for more than 70% of maternal deaths: haemorrhage (38%), infection (11%), unsafe abortion (8%), eclampsia (very high blood pressure leading to seizures – 5%), and obstructed labour (5%) [report of ministry of health and family welfare-2011]. While these are the main causes of maternal death, unavailable, inaccessible, unaffordable, or poor quality care is fundamentally responsible. They are detrimental to social development and wellbeing, as nearly one million children are left motherless each year. These children are 10 times more likely to die within two years of their mothers' death. The basic problem is because of three delay model. The "three delays" model focuses on the factors that contribute to the time interval between the onset of a complication and its care. The first delay is the delay in deciding to seek care, the second is the delay in identifying and reaching an appropriate health facility, and the third is the delay in receiving adequate and appropriate care.

Table 3 According to DLHS -3 PUNJAB

Antenatal care (based on women whose last pregnancy outcome was live/still birth during the reference period)

Particulars	Total	Rural	Urban
Mothers who received any antenatal check-up (%)	83.3	81.7	87.4
Mothers who had antenatal check-up in first trimester (%)	62.9	60.4	69.3
Mothers who had three or more ANC (%)	64.6	61.8	71.7
Mothers who had at least one tetanus toxoid Injection(%)	82.5	80.9	86.6
Mothers whose Blood Pressure taken (%)	69.4	67.4	74.4
Mothers who consumed 100 IFA Tablets (%)	33.5	34.4	31.3
Mothers who had full antenatal check –up (%)	14.3	13.3	17.0

Table 4 Delivery care (based on women whose last pregnancy outcome was live/still birth during reference period

Particulars	Total	Rural	Urban
Institutional delivery (%)	63.3	59.7	72.3
Delivery at home (%)	36.4	40.0	27.4
Delivery at home conducted by SBA (%)	13.8	14.8	11.2
Safe Delivery (%)	77.1	74.5	83.5
Mothers who received post-natal care within two weeks of delivery (%)	78.9	76.7	84.4
Mothers who received financial assistance for delivery under JSY (%)	2.7	3.0	1.9

The present policy climate in India is clearly in favour of institutionalization of births. Maternity benefit schemes like the Janani Suraksha Yojana are clearly linked to this policy framework and the government health workers at the grassroots, including the accredited social health activist and the auxiliary nurse midwife, are being used to push this strategy. It is assumed that giving birth in a healthcare facility will lead to better obstetric care and reduce mortality. But this assumption is not backed by hard evidence. Experiences from several states in India and even from DLHS-3 PUNJAB clearly shows that in total only 2.7 % of mothers received financial assistance for delivery which clearly indicates that several things can go wrong in the pathway leading from institutionalization to mortality reduction - as for example lack of adequate personnel and infrastructure at various levels of healthcare institutions and compromises on the quality of services.

Urban Slums

As the world moves into the year 2012, there will be more number of people living in urban areas than rural areas. In fact 20th century witnessed a rapid growth in urban population. The next few decades will see unprecedented scale of urban growth in the developing world including those in Asia and Africa continents. The urban population in these two continents will double in a period of 30 years. Asia has been witnessing the triple dynamics of growth, rapid urbanization and growing poverty. While many Asian countries witnessed higher economic growth, the growth pattern brought about enormous disparities across and within nations. India has shared the growth pattern and rapid urbanisation with some of the fastest growing regions in Asia. The Country has witnessed around 8% growth in GDP in the last couple of years and has planned to achieve a target of over 9% growth by the end of 11th plan period. India's urban population is also increasing at a faster rate than its total population. With over 575 million people, India will have 41% percent of its population living in cities and towns by 2030AD. Currently urban population of India is about 377 million out of which 97 million people belongs to urban poor population (Census 2011). There has been a growth of 17.8 million in urban slum population of India in the last decade, according to a government committee formed to create a 'reliable statistical model' of enumerating people living in such areas. There are about 49000 slums in India. 70% of the slums are situated in main 5 states namely Maharashtra (35%), Andhra Pradesh (11%), West Bengal (10%), Tamil Nadu and Gujarat (7%). With India becoming increasingly globalized and urban, there is also an increase in the number of poor people living here. As per the latest NSSO survey reports there are over 80 million poor people living in the cities and towns of India. It is interesting to note that the ratio of

urban poverty in some of the larger states is higher than that of rural poverty leading to the phenomenon of 'Urbanisation of Poverty'

The level of urban poverty in India is increasing, while rural poverty is decreasing. Given the difficulty of accurately estimating the size of the poor and slum populations residing in urban areas, it is also difficult to assess the health and nutritional status of such populations. The subject of slum welfare is immensely important, yet until recently it was largely ignored. Most people are simply unaware of the gravity of the slum problems. The details of the problem are frequently unknown, because so often the poorest communities within an urban population are unmapped and hence are unknown to officialdom. Moreover, when morbidity statistics are collected, those for the poorest, tend to be grossly under recorded and seems to be a conspiracy of silence about health and welfare of the inhabitants of those lucky slums that succeed in getting official recognition.

Maternal mortality and morbidity continue to be high despite the existence of national programs for improving maternal and child health in India. This could be related to several factors, an important one being non-utilization or under-utilization of maternal health-care services, especially amongst the rural poor and urban slum population due to either lack of awareness or access to health-care services. The vast majority of maternal deaths and disabilities can be prevented through appropriate maternal health services before, during, and after pregnancy. The Millennium Development Goals 5 - focuses to improve maternal health (MDG 5 WHO), with targets to reduce maternal mortality by three quarters between 1990 and 2015, and to achieve universal access to reproductive health by 2015. To achieve this goal, urban population needs to be given scope. Urban poor population constitutes nearly a third of India's urban population. Health status among urban slum dwellers is poor and far from adequate, due to factors like inadequate reach of services (Agarwal S 2005). Though on average health indicators, the situation in cities is better than in rural areas, the enormous social and economic stratification with in urban areas results in significant health inequalities (World Health Report 2008). Definition of Complete utilization of maternal services is, mothers with early registration (within 1st trimester), minimum 3 ANC (antenatal checkups), inj TT 2 doses/ booster, consumption of minimum 100 IFA (Fe & folic acid) tablets, delivery by skilled birth attendant/institutional delivery and two postnatal check-ups. Health indicators in urban slums are below urban average. Urban average of complete utilization of antenatal care is 23.7%, where as in urban slums the complete utilization is just 11%.(NFHS-3). So this shows that though a variety of health services are available in our country, not all sections of the community are benefited by these facilities.

Introduction to schemes

Reproductive and child health approach has been defined as "people have the ability to reproduce and regulate their fertility, women are able to go through pregnancy and child birth safely, the outcome of pregnancy is successful in terms of maternal and infant survival and well being, and couples are able to have sexual relation free of fear of pregnancy and of contracting disease". In 1997, the govt of India followed up the International recommendation on Reproductive and Child Health (RCH) as a National programme which integrates all the programmes of the eight plan and it aims to bring all RCH services easily available for the community. The various components of RCH programme are:

RCH PHASE I - Various components under this are

1. Child survival and safe motherhood.
2. Family planning.
3. Client approach to healthcare.
4. Prevention and management of RTI's and STD's

RCH I technically ended on 31st march 2004. The government of India has however extended one year Interim period for preparation of project implementation for RCH II. Since there have been improvement in the areas of services provided to some extent during RCH I, govt of India decided to continue RCH II during 2005-2010, so that the targeted group may get better health at maximum level.

Objective of the Programme: The main objective of RCH is to provide quality Integrated and sustainable Primary Health Care services to the women in the reproductive age group and young children and special focus on family planning and Immunization.

RCH PHASE II - The second phase of RCH program i.e. RCH – II has been commenced from 1st April, 2005. The main focus of the program is to bring about a change in three critical health indicators i.e. reducing total fertility rate, infant mortality rate and maternal mortality ratio with a view to realizing the outcomes envisioned in the Millennium Development Goals, the National Population Policy 2000, and the Tenth Plan Document, the National Health Policy 2002 and Vision 2020 India. The various components under this are:

1. Essential obstetric care
2. Emergency obstetric care.
3. 24 hours delivery services at PHC and CHC
4. Medical termination of pregnancies.
5. Immunization

The RCH-II concept is in keeping with the evolution of an integrated approach to the programme, aimed at improving the health status of women and children. The RCH programme envisaged a totally different approach with emphasis on `Target Free Approach', which was a total shift from the implementation of family planning targets. The concept of RCH was to provide need based, client centred, demand driven, high quality and an integrated package of RCH services.

JANANI SURAKSHA YOJNA - JSY is a safe motherhood intervention under the NRHM, launched on 12TH April 2005 and is being implemented in all the states and UTs of the country. It integrates the financial assistance with antenatal care during the pregnancy, perinatal care during the delivery and immediate post partum period in a health centre by establishing a system of coordinated care by field level health worker. It is a 100% centrally sponsored scheme and focuses on the specific aims and objectives.

1. **Objectives :**
   1) To reduce over all maternal mortality ratio and infant mortality rate
   2) To ensure 100% Institutional Deliveries in BPL/SC/ST families
   3) Home delivery, if any, by SBA

2. **Eligibility Criteria :**

Target Groups	Delivery Point	Conditions
All Pregnant women from – SC/ST Families BPL Families	• Govt. Health Institutions • Private Hospitals accredited under JSY • Homes of the beneficiaries	• Age-19 years and above • Up to 2 live births • JSY Card

3. **Benefits:** Financial assistance through Bearer Cheque only.

I. To the Mother :

a) From Rural Area, Rs. 700/- at the time of discharge from hospital (preferably 48 hours after delivery) at the Govt. institution / Accredited Private institution.

b) From Urban Area, Rs. 600/- at the time of discharge from hospital (preferably 48 hours after delivery) at the Govt. institution / Accredited Private institution.

c) For Home Delivery, Rs. 500/- positively within 7 days of delivery by the ANM of the area

d) All the payments under a), b) and c) are to be made through bearer cheque only, no payment is to be made by cash**.**

e) Arrangements must be made that the cheques are available with the staff on duty so that the payments are made during the odd hours and on holidays even.
   - At Govt. Medical Colleges, timely payments are to be ensured through PP Units.
   - At the Accredited Private Hospitals, payments are to be made through the owner of the hospital before discharging the beneficiary from the Hospital.

   Sufficient funds are required to be transferred to the JSY accounts at different institutions and must be replenished from time to time.

f) An additional assistance of Rs. 200/- under referral transport to the beneficiary at Govt. as well as Pvt. Accredited at the time of delivery, by the institution.

g) All the JSY payments are to be entered in the JSY Card immediately by the person making them. The ANM will also enter these payments in the register at her center.

II. To ASHA or Equivalent Link Worker :

a) Rs. 200/- per delivery after she pays immediate one post natal visit for follow up of the mother & well being of the new born, preferably at the time of BCG vaccination of the baby. ASHA will be getting all the incentives for her contribution under different heads during the previous month, on the day of monthly meeting at PHC/CHC.

This benefit can be given to any other link worker who attends on / facilitates the beneficiary in case ASHA has not done so

Specific MCH Programme Running Under Punjab

SURAKHIT JANEPA YOJNA -

- The Surakhit Janepa Yojna intends to cover the BPL and SC families in all the districts. The beneficiary has the facility of being referred to any empanelled Private Service Provider, hereafter referred as Accredited Private Institution (API), to get the delivery done (normal, caesarean or complicated) without paying any charges.
- Under this scheme, families having BPL card or having income certificate to that effect by village Sarpanch or Municipal Councillor and families belonging to Schedule Castes can avail this facility. The benefit package also includes free medicines for delivery. The APIs under the scheme will be reimbursed at a fixed rate for each delivery carried out by them.
- ***In underserved District (i.e. Barnala, Ferozepur, Gurdaspur, Mansa, Moga, Muktsar, Nawanshahar, Ropar, Sangrur & Tarn Taran*****. -** BPL mothers will receive cash-less maternity services. In view of underserved districts, a sum of Rs. 3500 has been estimated for normal delivery, Rs. 8000 for caesarean delivery and Rs. 5000 for any other complicated case in these districts. API will be paid an average of fixed service charge for each delivery, whether it is normal, caesarean or complicated. This approach will discourage the API's in manipulation of normal deliveries into caesarean or complicated deliveries.
- ***In remaining District (i.e. Amritsar, Bathinda, Fatehgarh Sahib, Faridkot, Hoshiarpur, Jalandhar, Kapurthala, Ludhiana, Mohali and Patiala*****. -** BPL mothers will receive cash-less maternity services. In remaining districts, a sum of Rs. 2000 has been estimated for normal delivery, Rs. 6400 for caesarean delivery and Rs. 3200 for any other complicated case. API will be paid an average of fixed service charge for each delivery, whether it is normal, caesarean or complicated. This approach will discourage the API's in manipulation of normal deliveries into caesarean or complicated deliveries.
- The total charges per delivery include: provision of 24-Hour delivery services free of cost to the pregnant woman (normal, complicated and caesarean deliveries), cost of laboratory procedures, New Born Care, medicines, immunization requirement of the child at birth.

Literature review

Various Studies Conducted on Maternal and Child Health service Utilization in Urban slums of India

Slums are pockets of poor houses, poor people and poor environment either in the middle or in the periphery of a big city. Dirt, filth and stink fill the whole terrain. In one room the human beings of three generation are huddled together like sardines. The same room is used for cooking, co-habitation and breeding. The area of health and welfare is conspicuous by its absence. Slum has been variously described as a cancer on the body of a city, a veritable hell and utmost form of human degradation. Crimes, vices, diseases and illiteracy consistently show higher degree of occurrence in such surroundings. There are abundant cases of starvation, malnutrition of children, women and the old, unemployment and under employment, exploitation, torture, delinquency, desertion, and heinous crimes. They are devoid of food, sanitation, water, electricity, privacy, quietude, and protection against diseases, health, medical care and above all any help.

The review of literature on the health care utilization shows that urban health is still a less researched area in the context of its complexities. In the process of urbanization, the cities are swelling due to population growth and migration. This has resulted in further deterioration of physical environment in these cities not backed by adequate expansion of civic amenities as well as health and other services. Though all the varieties of health services are available in our societies, not all sections of the society are benefited by these facilities. The worst sufferers in the urban areas are the people belonging to the economically weaker sections of the society. As part of review of literature important studies reviewed here is mainly related to morbidity, socio-economic status, factors affecting health services utilization including utilization of maternal and child health services, factors affecting the perception of diseases and certain specific studies related to health services utilization in urban and slum areas.

- ***In a study conducted at Rohtak, Haryana in 1994*** to study the pattern of utilization of various treatment services by rural women for common maternal and child health problems, it was observed that nearly 61.8% of women have contacted private practitioners, 50% Anganawadi centers , 21% faith healers 18.4%, sub centres, 19.1% PHC's and 6.5 % government hospital in last 6 months.

- ***Jatinder Bajaj (1999)*** in his paper attempts to study the knowledge and utilization of maternal and child health services available to women residing in the slums of Delhi. It reveals that sanitation facilities were very worst with chocked drains and foul smell. Nearly 46% of the slum dwellers depend on private sector for their health problems. The services of NGO's are also utilized by the slum dwellers to an extent of 22% and another 22% approached Government health centres and hospitals. The remaining households approach private practitioners. The study reveals low utilization of maternal and child health services provided by the public health care system. The reasons for non utilization of these services are the lack of awareness about these services, offered by the Government due to their illiteracy and lower accessibility of these institutions providing the services. The proportion of immunization was also very low and fell short of the achievement of the goal of universal immunization against major vaccine preventable diseases. The study points out the need for augmenting awareness among slum women for better utilization of maternal care services provided by the Government.

- ***Sundar (2000) in her field study conducted in Dakshinpur, Delhi*** a low income re-settlement colony of Delhi reveals the under utilization of Government health services by the slum dwellers. Poor environment and living conditions have given rise to high incidence of diseases like tuberculosis, respiratory tract infection, worm infestation, and diarrhoea1 diseases. The study revealed that poor health status of population is mainly due to ignorance and a greater reliance on traditional practices than due to lack of purchasing power or non- availability of health services. The study pin points that the health project undertaken for the area with the objective of improving awareness of family planning, antenatal care, post partum care and checking malnutrition succeeded in spreading General awareness among the target population about the need for practicing family planning and importance of maternal and child health care. The study proved that the reason for under utilization of health services mainly rests with an array of functionaries involved in the health care system and their dedication is a must for the success of any health services utilization programme.

- ***Shalini Samnla and her co workers (2011***) conducted A Comparative Study of Delivery Practices Among Home Deliveries In Two Urban Resettlement Colonies Of Delhi With And Without Augmented RCH Services . The study findings shows that Majority of the mothers belonged to age group of 20-24 years in both the areas which is higher than the Delhi average of 21.7%., but lower than that reported by Bang et al (60.6 %). Prior to the delivery, contact with dai was made by majority of the mothers (92.7% and 85.8% in Nandnagri and Sundarnagri respectively. Use of delivery kit was also common although significantly higher in Sundarnagri than Nandnagri. Cord care was heavily influenced by cultural practice of application of ghee and neem although no other form application was reported. About 79%% and 44 % applied ghee to the cord stump in Nandnagri and Sundarnagri respectively. This is in contrast to the most of the studies that have reported that the dai had resorted to multiple types of application on the cord stump, like ghee, neem paste , haldi etc . Various methods were used in both the area to augment labour including fundal pressure, use of drugs and injections, enema etc. The findings by Sharma et al in a study in1990 conducted in an urban slum area of Delhi have revealed that the dais had given enema either with soap suppository (12%) or soap and water (8%)

- ***R.C. Bajpai and his co workers (2011)*** conducted a study on Assessment of Utilization of Antenatal Care Services and Their Associated Factors in Slums Of Varanasi. The study findings shows that Only 11.5% female had utilized the ANC services completely, 18.1% visited more than, only 42.3% received TT vaccine and majority of population were illiterate whereas only 10.3% had more than 10 years of education. It was found that education (p=0.001), place of delivery (p=0.001), number of visits (p=0.000), caste (p=0.040), and parity (p=0.048) were significantly associated with complete ANC.

The review of literature on the health care utilization depicts that urban health is still a less researched area in the context of its complexities. In the process of urbanization, the cities are swelling due to population growth and migration. This has resulted in further deterioration of physical environment in these cities not backed by adequate expansion of civic amenities as well as health and other services. Though all the varieties of health services are available in our societies, not all sections of the society are benefited by these facilities.

Rationale

The urban population is increasing at a very rapid rate in India. Currently it is estimated that the urban poor population is about 377 million and projected to increase up to 432 million by 2021. Rapid urban growth has led to an increase in the number of urban poor, especially those living in slums. India's urban poor have even outnumbered the rural poor, since 1998. Different studies done across the country revealed that, among the urban population, slum dwellers have higher rate of morbidity prevalence and their living condition is extremely poor. Although uniformly disadvantaged, the urban poor cannot be treated as homogenous entities; there exist important socio demographic variations within the urban poor population in relation to their use of services and the barriers faced in service utilization. The vulnerable sections in the urban areas are suffering from morbidity problems especially diseases of poverty and are not having enough access to health care services. Though urban India has a relatively strong health and nutrition infrastructure - with public sector investments coming from central, state, and local bodies as well as a vast private sector - there is marked inequitable distribution of service availability and utilization between the rich and poor, between the settled urban population and the marginalized slum dwellers.

The main reasons behind poor utilization of maternal health services among urban slum dwellers are lack of awareness (or) assess to the health care services, socioeconomic conditions, religious barrier, cultural beliefs, illiteracy, ignorance and poverty. Therefore all pregnant women must be encouraged to opt for institutional deliveries. As any complication can occur, which are not always predictable, they can cause the life of the mother and/or the baby

So Attention to vulnerable communities in the slums is needed from a public health perspective, and pregnant females and children constitute the major “high risk” group.

The present study intends to assess the utilization of maternal health services by women residing in urban slum areas of district Mohali, Punjab.

Objectives

General Objective – To study the status of Utilization of Maternal Child Health Services in Urban Slums of District Mohali.

Specific Objectives –

- To assess the utilization of ante-natal, Intra-natal and Post-natal services by the females during pregnancy and child birth.
- To study the health seeking pattern of women for utilization of Maternal Child Health services.
- To identify the barriers in maternal child health care utilization.
- To determine the pattern of child birth in the slums and the factors responsible for the practice.
- To study the utilization of JSY incentives by the beneficiaries.
- To study the utilization of family planning services available.
- To assess the immunization coverage among children of age group 1-5 yr

Methodology

The present study was carried out in the Mohali district in the state of Punjab. The district has a population of about 986147 people. The relevance of choosing this district was that it is situated in the periphery of State Capital i.e. Chandigarh which has access to all the health facilities. In district Mohali, there are about 20 slums out of which 6 slums are residential type of slums, other 6 are situated near industrial area and remaining 8 are located at construction sites. For the purpose of study 6 residential type of slums were selected randomly. These slums are located at Udham Singh Colony, Amar Colony, Ambedkar Colony, Balmiki Colony, Madanpura slums and Verka chowk. The estimated number of households/ jhuggies in these slums are 3296. These slums have been in existence for the last 10 years with an approximate population of 18000.

- ***Study Type*** – Cross- sectional Descriptive study which is quantitative in nature.
- ***Study Area*** - Urban Slums of District Mohali
- ***Sampling method*** – 6 residential type of urban slums were selected.
- ***Study Participants*** – Women 15-45 years of age having less than 3 years old children
  - Children of age group below 5 years
- ***Sample size*** – 164 females were randomly selected. Every fourth household was visited for gathering the information; some of households were visited twice or thrice also until the desired information was obtained.
- ***Study Technique*** - Face to face interview with females
- ***Study Tool*** – Semi- structured questionnaire

- ***Data Collection Plan*** – All married women in the age group of 15-45 years who were either pregnant at the time of interview or had delivered within the last 3 years were included in the study. A total of 515 such women were identified in these slums and 164 women i.e one third of the 515 women were interviewed during door to door survey as per the randomization method explained above. The information was collected on a semi-structured questionnaire. The females were interviewed in detail about socio-demographic profile, their reproductive behavior and intentions, details of antenatal care, delivery, postnatal care, attitude and level of satisfaction towards various maternity and child health schemes like Janani Suraksha Yojana, family planning methods, child immunization and perceived barriers for non-utilization of maternal health-care services. At least three visits were made to include all the women who could not be contacted in the first visit. A list of ANM's who look after these slums was obtained from the Civil Surgeon Office and their help was sought to identify the women. For these slums, there is no separate ANM appointed by the State Government and these ANM's are catering about 25000 – 30000 population each.
- ***Data Analysis*** - Data entry and analysis was done using SPSS 16.0 software. MS 2007 was used for the graphical representations and further analysis.
- ***Exclusion Criteria*** –Women who didn't belong to age group 15-45 yrs or who were not willing to participate or who had the children more than 3yrs ago.
- ***Ethical consideration*****:** -The respondents were orally explained the purpose of the study
  -Verbal consent was taken from them
  -The respondents were assured of the data confidentiality

RESULTS & FINDINGS

The results are being presented in sections as per the objectives of the study.

Maternal Healthcare Services

Maternal health services are provided as a package of health care measures adopted during pregnancy, childbirth and after childbirth. The study indicates that maximum population residing in urban slums of Mohali District are migrants from Uttar Pradesh and Bihar. Due to lack of their permanent residency proof, they are deprived of various beneficiary schemes available in the State and none of them has a BPL card. Even it was revealed that many women while pregnant went to their own state for having delivery conducted. Such women were not included in the study, but the women who had utilized ANC services for more than 6 months were included.

Figure 3 Distribution of pregnant women according to Educational Status (n= 164)

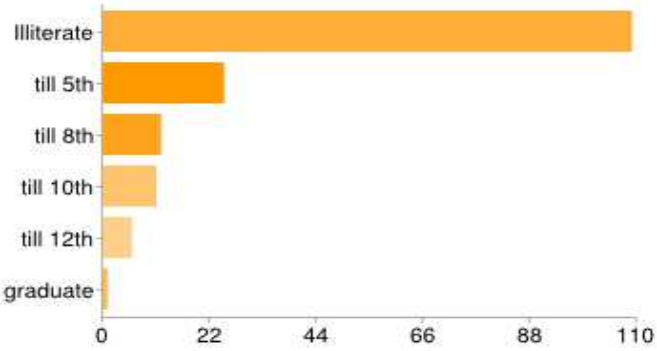
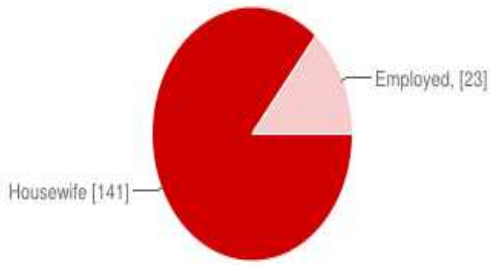


Table 5

Education	No	Percentage
Illiterate	109	66 %
Till 5th	25	15 %
Till 8th	12	7 %
Till 10th	11	7 %
Till 12th	6	4 %
Graduate	1	0.60 %

As the above figure indicates that 66% of the slum women who utilized maternal and child health care services were illiterate while only 7% of them were literate up to 10th standard. Only 7 women were educated up to 12th standard or more.

Figure 4 Distribution of women according to Occupation (n=164)



The study revealed that 141(86%) of the women were housewives and only 23 (14%) of them were working .About 73% of the population have their family monthly income between Rs 1000- 5000. Following table reveals that socio- economic status of women rises with better education and thus contributing to better utilisation of maternal child health care services.

Table 6 Educational Qualification * Family Income (Crosstab)

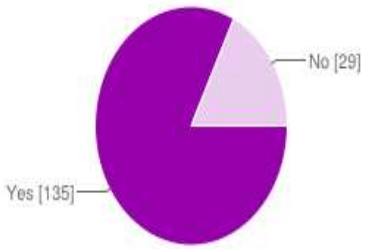
Educational Qualification	Family Income				
	1000-5000	5000-10000	>10000	Below 1000	Total
Illiterate	81	24	3	1	**109**
Graduate	0	1	0	0	**1**
Till 12th	0	4	7	0	**11**
Till 10th	0	2	4	0	**6**
Till 8th	5	7	0	0	**12**
Till 5th	4	21	0	0	**25**
Total	**90**	**59**	**14**	**1**	**164**

Knowledge regarding services provided by ANM from the health centre at their door steps

ANM's from the health centres are supposed to visit homes during pregnancy for giving advice and guidance regarding maternal and child health care. They are registering all the pregnant women so as to make them beneficiary for the schemes run by government of India & the state govt as well. In order to assess this, the respondents were asked about their knowledge of providing services at their door steps of the by the ANM's from health centres and the responses obtained are being reflected in following figures and tables.

It was found that near about 82% (135) of the urban slum women were aware regarding ANM's of their area. On further probing, it was found that only 59% (97) of the women said that ANM's visited when they were pregnant while 41% (67) said that ANM's did not visit them even once while they were pregnant.

Fig 5 Do you know ANM's of your area? (n=164)



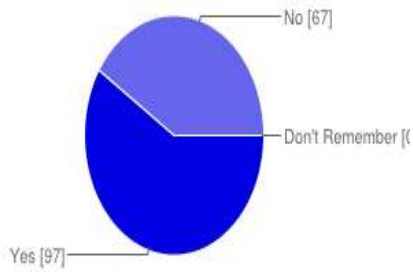
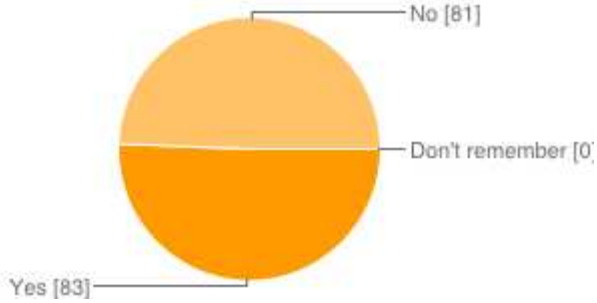


Figure 6 Did ANM visit you during pregnancy?

Figure 7 Did ANM register your name? (n=164)

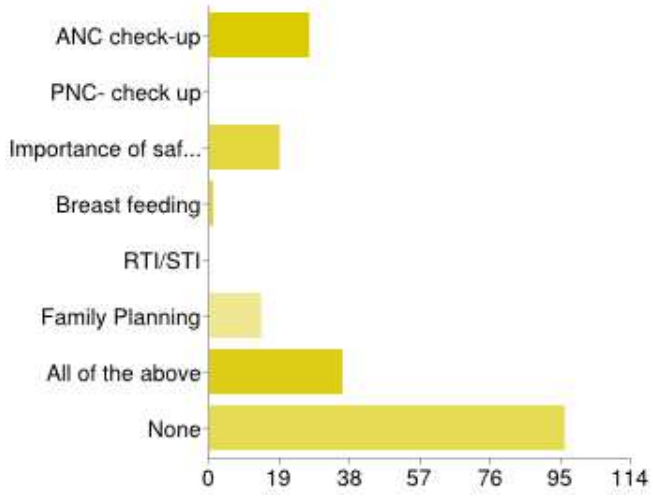


83 women, i.e. 51 % were registered while remaining 49% were not. And on cross tabbing the registrations with the month in which they got registered, it was found that out of the 83 women who got registered, only 38 women were registered in first trimester while remaining were registered in second and third trimester of pregnancy.

Table 7 Did ANM register your name? * In which month you got registered? (Cross-tabulation)

Did ANM register your name?		In which month you got registered?				
			1st trimester	2nd trimester	3rd trimester	Total
	No	81	0	0	0	81
	Yes	4	38	39	3	83
	Total	84	38	39	3	164

Figure 8 what did ANM advise you?



(Table 8, n=83 i.e. those registered by ANM's)

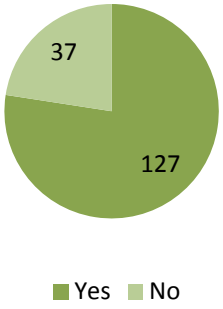
Particulars	Number	Percentage
ANC check up	27	32 %
PNC check up	0	0 %
Imp of safe delivery	19	22 %
Breast feeding	1	1 %
RTI/STI	0	0 %
Family Planning	14	16 %
All of the above	36	43 %
None	96	59 %

Research showed that out of 83 who were registered, 36 (43%) were told about all the above mentioned parameters. 22% were told only about the importance of safe deliveries and rest of the important aspects were not discussed at all. 16 % of them had been imparted knowledge only about family planning methods. 96 women i.e. 59 % of the total respondents were not rendered any knowledge about any of the aspects as they were not registered by the ANM's

Utilization of Antenatal care services

Ante-natal care means the care provided to the pregnant women with an objective of having a healthy foetal development and a good maternal outcome of each pregnancy. Antenatal care comprises of a variety of preventive measures during pregnancy including a minimum of 3 regular checkups, 2 shots of Tetanus Toxoid injections, provision of Iron and folic acid tablets and educating woman about nutrition, delivery care, and postpartum care. Antenatal care enables women to have safe delivery even in cases of' high-risk pregnancies. The figure below represents the proportion of women under study who received Antenatal care services.

Fig 9 Do you receive ANC check up? (n=164)



Study revealed that although the registration rate of women during pregnancy was low but the rate of utilization of Antenatal care services was much better. Out of 164 women, 127 had utilized Antenatal services that means ANC coverage rate is about 77%.

Type of Health Centre Utilized for ANC

Figure 10

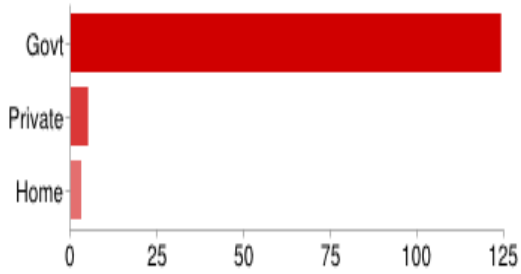


Fig 8shows that Government health centres are the most preferred choice, around 95% chose government facilities over private and home care. .

Number of times gone for Antenatal care

The number of ANC visit indicates the intensity of utilization of maternal health care services by the pregnant woman. Fig 8 indicates that 34% mothers had received all three ANC checkups. Analysis showed that out of total 127 women who had utilized ANC services, 18 women had gone for 1 visit , 31 women for 2 visits, 43 women for 3 visits and 32 women for more than 3 visits while 2 did not go to any facility for checkups, they got their check up done at home .Therefore, it was inferred that 41% of women did not receive the required 3 Antenatal check up

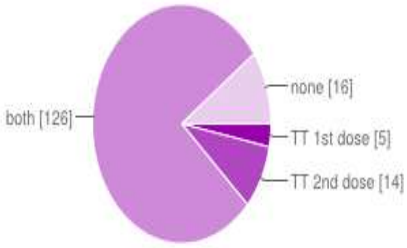
Table 9 No. of ANC visits?
(n=127 i.e. those who had received ANC)

Antenatal visits	Number	Percentage
1 visit	18	14 %
2 visits	31	25 %
3 visits	43	34 %
More than 3	32	25 %
None	2	2 %
Don't remember	0	0 %

Services utilized during Antenatal check up

To know the full extent of utilization of **ANC,** in addition to the number of visits, one must know the type of **ANC** received during the pregnancy period. Important elements of ANC services used were; measurement of weight, blood pressure, consumption of iron and folic acid tablets, tetanus toxoid injections, abdominal check up and rest are blood and urine test and dietary advice.

Figure 11 Did you receive Tetanus Toxoid injection?



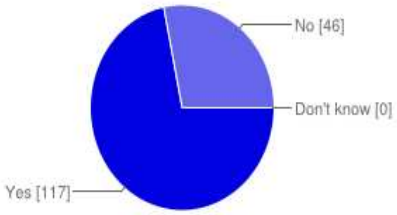
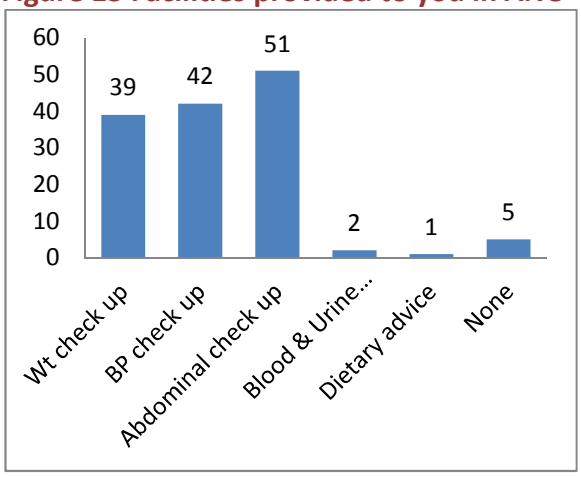


Figure 12 Did you receive Iron & Folic acid tablets?

161 respondents out of 165 responded to this question, 126 (76%) received both the doses of tetanus toxoid injections. 16 of them did not get themselves vaccinated while 5 received only first dose. 14 got only the second dose as they were already vaccinated during their previous delivery

Figure 13 Facilities provided to you in ANC



(Table 10,n=127 i.e. those who had received ANC)

Particulars	Number	Percentage
Weight check up	39	30 %
B.P. check up	42	33 %
Abdominal check up	51	40 %
Blood& Urine Check up	2	6 %
Dietary advice	1	2 %
None	5	4 %

(Multiple options were selected by respondents)

Research analysis depicts that only 2 women underwent blood and Urine examination and only 1 woman was given advice regarding diet to be taken during pregnancy. Despite of the fact that ANM's are provided with all the required equipments yet the BP check up coverage is 33%, weight check up is 30% and Abdominal Check up is only 40%. Women were also asked about the pregnancy complications and health problems they experienced during pregnancy, during delivery and after delivery , it was found that 16% of women suffered from complications during pregnancy or delivery.

Intra-natal care

Intra-natal care is important for the survival of mother and the child. Utilisation of untrained persons at delivery and prevailing unhygienic and non-sterile conditions at home, are responsible for a large number of babies and mothers getting severe infections resulting into high infant mortality rate and maternal mortality ratio. Non-availability of trained health personnel and poverty to some extent are responsible for the high incidence of home deliveries apart from social and ritual

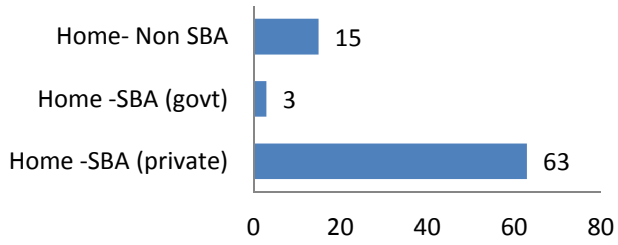
taboos. Therefore, an attempt is made here to understand the prevailing intra-natal care by examining: (1) type of place where the babies are delivered; (2) type of attendants who helped in delivering the child; and (3) reason behind home deliveries.

Place of Child birth

Place of delivery is divided into three categories including govt hospital, private hospital and home. From the figure, it is clear that out of the 164 study participants, 81(49%) women delivered their child at home , 78 (47%) delivered at govt hospitals. And the rest at some private hospital

Type of attendant who helped in delivering the child at home

Fig 15 Type of attendant assisted during delivery (n= 81, those who delivered their child at home)



Particular	Number	Percentage
Home- SBA (private)	63	77 %
Home- SBA (Govt)	3	4 %
Home- Non SBA	15	19 %

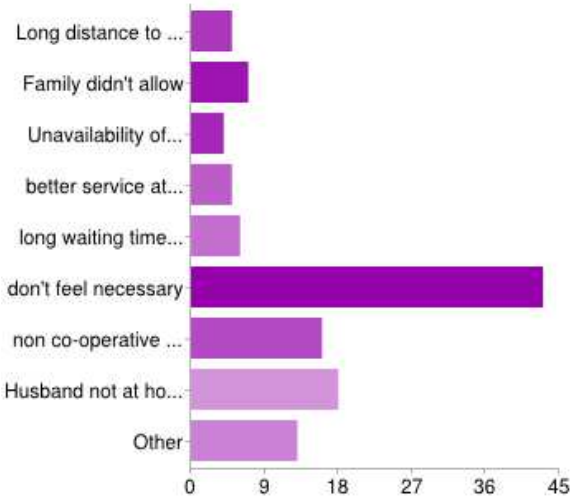
Table - 11

Above data clearly indicates that out of 81 mothers who delivered at home, 63 (77%) were assisted by private Skilled birth attendant.15 mothers delivered their child at home without the presence of any skilled birth attendant i.e. 19% .

Reason behind Home deliveries

The most common reason found for delivering their child at home was that they don't feel necessary (about 53%). 23% of women said that their husbands were not at home so nobody was there to take them to the hospital. In 20 % cases, non cooperative hospital staff was the reason that discouraged women to get admitted to hospital for delivery. 8 % of the women said that it takes lesser time to deliver at home so they don't go to hospitals. Then there were other reasons like unavailability of transport (5 %), long distance to facility (6%) and family members approval (9%).

Figure 16- Reasons for Home delivery (Table 12, n=81, those who delivered their child at home)



Particulars	No	Percentage
Long distance to facility	5	6 %
Family didn't allow	7	9 %
Unavailability of Transport	4	5 %
Better service at home	5	6 %
Long waiting time at hospital	6	8 %
Don't feel necessary	43	53 %
Non co-operative hospital staff	16	20 %
Husband not at home	18	23 %
Others	13	17 %

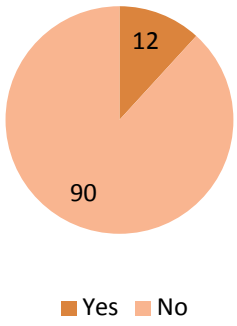
(Multiple options were selected by respondents)

Utilization of JSY Benefits

Janani Suraksha Yojna is a safe motherhood intervention under NRHM and is implemented in all the states and UT's of India. It is basically a cash incentive scheme with main aim of increasing the institutional deliveries among BPL,SC/ST families and to promote home deliveries with SBA so as to reduce Maternal Mortality Rate and Infant Mortality Rate. The mother will receive Rs 700 is she belongs to rural area, Rs 600 if belongs to urban area and Rs 500 if delivered at home. Therefore an attempt was made to know whether the mothers are getting the benefits under Janani Suraksha Yojna and how much they are getting and at what time and if not then what are the reasons behind this.

Cash Benefit Under JSY :

(n= 102, those who were eligible for JSY)



On questioning the respondents, research team found that 164 women, 102 were eligible according to JSY scheme and only 12 women (11%) got the money while remaining 90 (89%) did not receive any money at all.

52 mothers were not eligible as they were having more than two kids. The remaining 10 mothers received money under Mata Kaushlaya Scheme.

Figure 17 Did you get payment under JSY?

Reasons for not getting the money under JSY scheme

40 % of the mothers said that they were not registered and were not issued the card either. 20 % said that they dont know the reason and were not entertained by the staff on inquiring. 24% of the mothers said that the hospital staff was non co-operative and not serious regarding making

payments.In 16% cases, paper work did not complete on time. So whatever be the reason , 89% of the mothers didnt receive cash incentives under JSY scheme.

Table -13

Particulars	No.	Percentage
JSY cards not issued by ANM's	36	40 %
Hospital staff non cooperative	22	24 %
Paper work not completed upto time	14	16%
Don't know	18	20 %

Post Natal Care

Postnatal care covers health check-up of the mother and child and treatment of all post delivery complications. According to standard norms the mother should go for at least 3 PNC check up same as ANC check up.

Figure 18 Did you receive PNC check up?

(n=164)

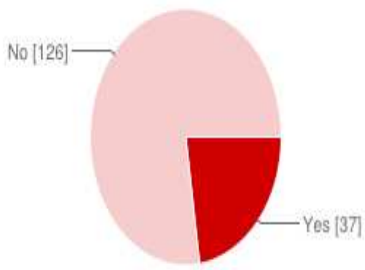


Table 14 No. of PNC visits

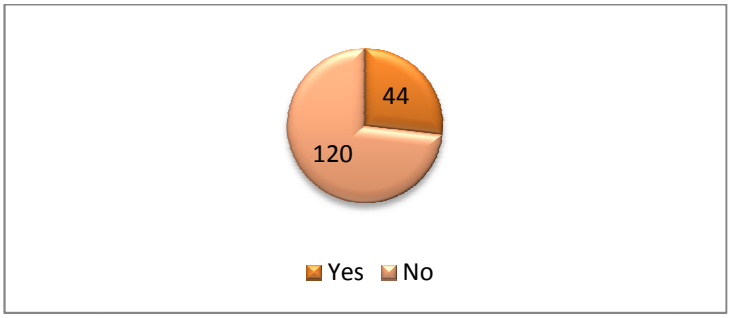
(n= 37, those who received PNC)

No of visits	No	Percentage
1 visit	13	35 %
2 visits	9	24 %
3 visits	13	35 %
More than 3 visits	2	6 %

In these urban slums rate of utilization of ANC is much better than PNC which is clear from the fact that only 23% of the women that is only 37 mothers out of total 164 received PNC check up remaining 77% of the mothers did not even receive 1 PNC check up. Out of the 37 mothers who had received PNC check up from government institutions, just 13 women received all 3 PNC check ups (Table 10).

Utilization of Family Planning Methods

Figure 19- Utilization of Family Planning Methods (n=164)



The above figure indicates that out of 164, only 44 i.e. 27% are using any family planning method while 73% are not . The mothers were also asked about any child death incidence in their families, the age of the child and the causative factor responsible for their death. It was found that 13% of the women reported child death in their families and that too before completing one month of age. On probing the reasons for the same ,it was known that those children were delivered at home and most of them had not received any vaccination.

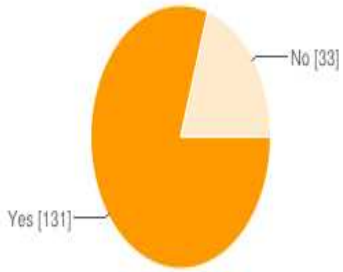
Childcare services

In this section the important immunization card with coverage of children is studied along with the type of immunization covered, the health centre utilized for coverage, if not immunized the reasons for non immunization. For analysing the immunization coverage of children, data was collected from all those mothers selected for sample and who had children in the age group 1-5 yrs.

Immunization Card and Utilization of Immunization services

Figure 20

Do you have your child's immunization card?



80% women had the immunization card with them while the remaining 20% either lost it or left the card at their home state.

Figure 21 Did your child receive all vaccinations? (n=164)

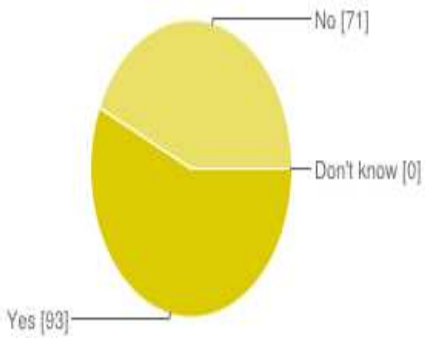


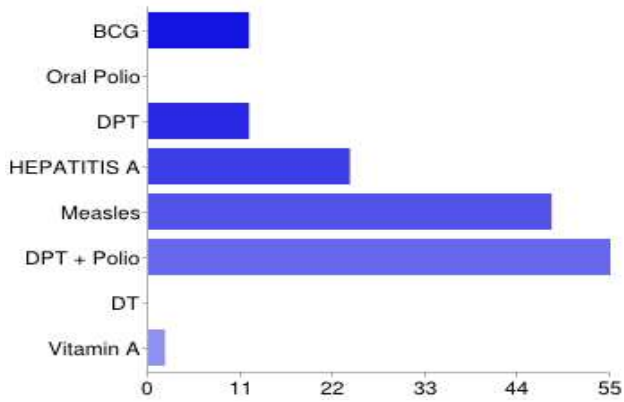
Table -15

	No.	Percentage
Yes	93	57%
No	71	43 %

57% told that their child had received all the vaccinations up to their completed present age while remaining 43% had received either one or two vaccination but not all.

Fig 22 represents individual vaccine dropout rate .The results revealed that there is good coverage of BCG and DPT vaccination(drop out of 17 %) and all the children had received polio drops. Rate of utilization of DPT+ POLIO and Measles is very low, 76% and 67% children had not received DPT+POLIO and Measles vaccine respectively.33 % children did not receive Hepatitis A.

Figure 22 Vaccines not received (n=71, those who didn't received all vaccinations upto their age)



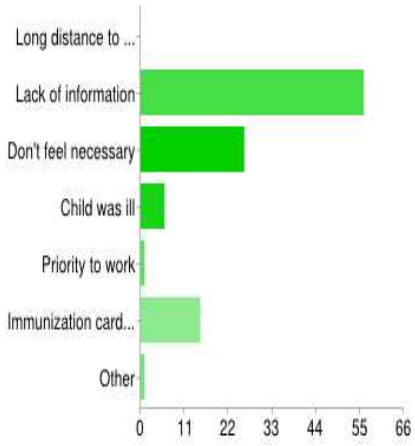
Vaccine	No.	Percentage
BCG	12	17%
Oral Polio	0	0%
DPT	12	17%
Hepatitis A	24	33%
Measles	48	67%
DPT + Polio	55	76%
DT	0	0%
Vitamin A	2	3%

Table -16

Reasons stated by mothers for not getting their children vaccinated

When the respondents were asked about the reasons for non-vaccination of their chidren, 78% of the respondents revealed that they were ignorant, not aware of number of doses and also did not know when to get their child vaccinated.36% of the mothers revealed that, 'they dont feel vaccination was necessary as their children were not facing any health issues'. 21% lost their child's immunization card or it was left at their maternal home state where child was born. In certain cases (6%), mothers informed that their child was ill during the vaccination dates, so they did not take them for the same. 1% gave importance to their work as these vaccinations were provided at day time and they could afford a single leave from their jobs

Figure 23 Reasons for not giving vaccination (n=71, those who didn't received all vaccinations upto their age)



Particulars	No.	Percentage
Long distance to facility	0	0%
Lack of information	56	78%
Don't feel necessary	26	36%
Child was ill	6	8%
Priority to work	1	1%
Immunization card lost/ Left at home state where child was born	15	21%
Other	1	1%

Table -17

CONCLUSION

Maternal mortality is the outcome of a complex web of causal factors that include social, economic, educational, political and cultural causes as well as issues such as gender inequity, state of physical infrastructure, geographic terrain and the health system. The introduction of Janani Suraksha Yojana (JSY) under the National Rural Health Mission (NRHM) was launched for increasing institutional deliveries by provision of cash assistance to mothers and Accredited Social Health Activists (ASHAs). The current study revealed that utilization of healthcare services is poor in urban slums even though Healthcare facilities are available and accessible .Literacy seems to be playing a very important role in utilization of MCH services, as the research indicates that literate women had a better household income and were more aware and active about getting MCH services. Most of the women knew about the ANM of their area and shared a good reputation with each other but the registrations of the pregnant women were not upto the mark. Only half of the respondents got registered and that too not in the first trimester, but in most cases. This makes us conclude that the ANM's had a very large population to cover so they were not able to do registrations effectively and efficiently on time. Even those women who were registered and given ANC facility, did not get all the required guidance and counselling. Government health centres were clearly the first choice for the ANC check up among slum women and the researchers found out that two third of them decided to deliver at these facilities ,the rest either went to their home states to deliver or called private skilled birth attendants at home. Thus it is very clear that despite the JSY scheme being in full swing, uninstitutional and unsafe deliveries are still taking place in slums of Mohali district. It was very important to understand their psychology behind choosing home deliveries and the study revealed, the major reason stated by them was, that "they did not feel it to be necessary" as they were not facing any complications before or during pregnancy. Another startling fact which was highlighted from the study was, that, "there was no one to take them to the hospital when the labour pain aroused". Some of them were afraid of the hospital staff, as according to them, staff was insulting and non cooperative. Only 1 out of 10 eligible women got JSY benefit, the reasons varied from person to person but the most substantial being, " Non-issuing of JSY cards by the ANM's". Followed by; again, non cooperative hospital staff and incomplete paper work. Thus it is concluded that hospital staff's indifferent attitude was one of the major obstacles in utilizing MCH services by women. Study revealed that the attitude towards providing as well as getting PNC services was irresponsible and indifferent in comparison to ANC services.

Talking about the Immunization status of the children below 5 years of age, it was known that majority of the mothers got the card made, but either lost it during resettlement/migration or left it at their maternal homes in Uttar Pradesh and Bihar, and that is why most of the children failed to receive proper and timely immunization. Also, coverage of the vaccines, like BCG, DPT, Polio drops and Hepatitis A which were administered during the initial months of a child's life, was better than the vaccines like Measles and (DPT+ Polio) booster dose, which were administered later on. The reason found for this, was, in more than half the cases, that the mothers were uneducated and ignorant about the information written on the cards as well as lacked information, due to indifferent attitude by the hospital staff and the concerned health workers. Although the migrant population in Mohali does not belong to Punjab but still it is the moral and official responsibility of the Government of Punjab to look after the health needs of this underserved and neglected community residing in the slums.

Recommendations

Based on the findings of the present study, the following recommendations are made for the improvement of health services in slums.

- Provision of separate healthcare staff for these slums.
- Like National Rural Health Mission, separate ANM's should be appointed to a population of 5000 with assistance of health workers and separate Angandwadi centre.
- Allotment of more financial resources and more control to ANM's and other grass root level health staff
- Provide infrastructure within periphery of the slums for better provision of healthcare delivery
- Effective training for the government health staff regarding their sympathetic and positive attitude towards slum dwellers.
- Strengthening IEC activities regarding the proper usage of health services by slum dwellers.
- Better maintenance of records and statistical data of slums
- Better coordination and coherence between grass root level and their superior health staff
- Conduct frequent health check-up camps in the slum areas.
- Involvement of youth group and mahila mandals and other NGO's for motivating pregnant women and children to utilize health services.
- Increase the frequency of health workers' visits to the slum areas.
- Motivate the people to accept family planning methods by conducting role-plays etc in the areas frequently.
- Improve the literacy status of the slum people by providing schools with free education in these areas.
- Imparting the health education regarding good personal hygiene, satisfactory disposal of refuse and consumption of safe drinking water.

Learnings

- Learnt monitoring and evaluation of PHC's CHC's, SC's and DH while accompanying CTI consultants.
- Various aspects of formulation, execution and the problems faced in implementing trainings to health care staff of all ranks.
- Importance of work specialization, team work, group and interpersonal communication.
- Importance and lack of Co-ordination between NRHM chd. ,SIHFW, PHSC & DHS & the problems associated.
- Person to person discussions with various SPM's DPM's & Civil Surgeon regarding implementation of different National Health programmes.

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ANNEXURE

Questionnaire – Study on Utilization of MCH Services

1. Serial No
2. Name of the Respondent
3. Age
4. Address
5. Educational Qualification:

   1) Illiterate 2) Literate, specify class.....
6. Occupation:

   1) Housewife 2) Employed, specify.....
7. Family Income (per month) :

   1) Below 1000 2) 1000-5000 3) 5000-10000 4) >10000
8. Do u have BPL card? 1) Yes 2) No
9. Do you know about ASHA/ANM? 1) Yes 2) No
10. Did ASHA/ANM visit when you were pregnant?
    1) Yes 2) No 3) Don't remember
11. Did ASHA/ANM register your name?
    1) Yes 2) No 3) Don't remember
12. In which month you got registered?
    1) 1st trimester 2) 2nd trimester 3) 3rd trimester

14. What did ASHA/ANM advise you?
    a) ANC Check-up b) PNC Check-up c) Importance of safe delivery
    d) Breast-feeding e) RTI/STI f) Family Planning f) All of the above g) None

15. Place of Delivery:
    1) Home- SBA 2) Home- Non SBA 3) Private Institution d) Govt Institution

16. Why home delivery?
    a) Long Distance to facility b) Family didn't allow c) unavailability of transport
    d) Better service at home e) Long waiting time f) don't feel necessary
    g) Non Co-operative hospital staff h) others.....

17. Why Private Institution:
    a) Better quality b) Family decision c) Referred by govt institution due to Complication d) Referred by govt institution due to lack of services available e) more accessible f) others.....

18. Did u receive ANC check-up: 1) Yes 2) No

19. If no, what are the reasons?

    .....

20. Source of ANC: 1) Govt 2) Private 3) home

21. If private, then why?

:.....

22. No of ANC visits:
1) 1 2) 2 3) 3 4) >3 5) None

23. Facilities provided to you in ANC:
a) Weight check up b) B.P. Check up c) Abdominal check up
d) Blood and urine exam. e) Dietary advice f) All of the above g) None

24. Did u receive Tetanus toxoid Vaccination?
1) TT 1st dose 2) TT 2nd dose 3) both 4) none

25. Did u receive Iron and Folic acid Tablets?
1) Yes 2) No 3) Don't Know

26. Did you suffer from any kind of complications?
1) Yes 2) no

27) If yes, then
a) During pregnancy b) During delivery c) After delivery

27.a) What were the complications?
.....

28. Did u get payment under JSY? 1) Yes 2) No

29. If no, then why:
a) Have more than two kids b) Private Non accredited Institutional delivery c) Belongs to non SC,ST /BPL category d)less than 19 years old e) Non availability of JSY card f) non co-operative staff
g) others.....

30. If Yes, how much: 1)Rs 500 2)Rs 600 3)Rs 700

31. When did u receive money?
1) After delivery 2) At the time of discharge 3) Within 7 days in case of Home delivery
4) others.....

32. Did u get transport money (Rs 200)? 1) Yes 2) No

33. Did u receive PNC check up? 1) Yes 2) No 3) Don't remember

34. a) Where did you get PNC check up done?

1) Government facility 2) Private facility 3) home

34. No of PNC visits: 1) 1 2) 2 3)3 4) > 3 5) None

35. Are you using any family planning method? 1) Yes 2) No

36. Which family planning method are you using?

a) Condom b) Copper-T c) Oral pills d) Tubectomy f) Vasectomy

37. Do you have history of abortion: 1) Yes 2) No

38. If yes: 1) Planned 2) Spontaneous

39. Place of abortion: 1) Govt Institutions 2) Private Institutions 3) Home

40. Reason for abortion:

.....

41. Number of children < 5 years old.....

42. Age of the Children < 5 years old:.....

43. Weight of the children .....

44. Was there any child death in your family?
1) Yes 2) No

44 a) if yes, and then at what age death took place?
a) < 1 month b) 1month-1year c) 1 year – 5 year

45. Reasons for death.....

46. Do u have immunization card: 1) Yes 2) No 3) Don't Know

47. Where did your child receive all vaccinations till now?
1) Govt Institutions 2) Private Institutions 3) both

48. Did the child receive all the vaccines till date 1) Yes 2) No

49. If no, then why?
a) Long distance to facility b) Lack of information c) Don't feel necessary
d) Child was ill e) priority to work f) others.....

50. Are u satisfied with the health care services provided by ANM?
1) Yes 2) No 3) Somewhat

51. Any suggestions you want to give

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Vaccine	Birth	6th week	10th week	14th week	9-10th month
BCG	*				
ORAL POLIO		*	*	*	
DPT		*	*	*	
HEPATITIS B	*	*	*		
MEASLES					*
BOOSTER DOSES					
DPT + POLIO	16-24 MONTHS				
DT	5 YEARS				
VITAMIN A	9,18,24,30&36 MONTHS				

A visit to Slums of Mohali District