"NOBODY'S HERE WITH ME": A QUALITATIVE INVESTIGATION OF WOMEN'S DELIVERY LOCATION IN URBAN SLUM-DWELLING INDIA

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Introduction

Worldwide, roughly 350,000 women die each year from complications during pregnancy or childbirth . Reducing maternal mortality is a core focus of the international health community and features prominently in the Millennium Development Goals (MDGs).

Many countries have worked hard to meet the MDG5 targets, including India. During the period 1990 to 2008, India's maternal mortality ratio (MMR) declined by 59%, from 570 deaths per 100,000 live births to 230 deaths per 100,000 live births. Although these downward trends in MMR signal progress in India, they also mask significant disparities – particularly between urban and rural areas.

While, on average, urban areas have lower MMR than rural regions, disparities abound – notably between urban slum and urban non-slum populations. Despite the proximity of slum dwellers to urban hospitals, researchers find that many women in this group give birth in the home (i.e. in the slum) and in their natal villages (in the home or a rural hospital). These studies suggest that, for many women residing in urban slums, proximity to urban maternal health services is not sufficient to ensure utilization of these services.

Aims and Methods

Aims: To understand what factors influence the birth locations of urban slum-dwelling women (i.e. rural versus urban, institutional versus non-institutional); To distill our findings into a conceptual model to provide policymakers with data and insights needed to craft more informed interventions and programs to improve maternal health outcomes and further decrease MMR in India.

Study population: The study site was *Kaula Bandar,* a slum community located along the eastern waterfront of Mumbai home to roughly 18,000 people, including Hindus, Muslims, and Christians (Roman Catholics) from both North and South India. Due to an ongoing land dispute, the community retains an unregistered (i.e. illegal) status and thus receives limited municipal facilities such as water, electricity, and sanitation services. Study participants were women who had given birth to at least one child in the last five years; participants were randomly selected from the sub-population of eligible women.

Research instrument: Researchers at the Harvard School of Public Health and Partner's for Urban Knowledge, Action and Research designed a qualitative instrument to record women's delivery locations and possible determinants of that location. The first iteration of the qualitative instrument was used for focus group discussions (FGDs). In total, 32 women participated in the FGDs. A second iteration, which was refined based on feedback from the focus groups, and was administered as an individual interview. In total, 11 women participated in these interviews. In addition to questions regarding delivery location, information was also collected on age, religion, number of children born, and natal village. All research was conducted in *Kaula Bandar* during the period June to August, 2010, and all interviews were videotaped with the participant's consent.

Analysis plan: Results from the focus groups and interviews, which were conducted in Hindi or Tamil, were transcribed from the videotapes in the same week the data were collected and then coded using ATLAS.ti software.

References:
1. Hogan MC, Foreman KJ, Naghavi M, Ahn SY, Wang M, Makela SM, Lopez AD, Lozano R, Murray CJL. Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5. *Lancet.* 375:1609-1623
2. Chatterjee P. India addresses maternal deaths in rural areas. *Lancet* 2007;370(9592):1023-1024
3. WHO. Global Health Observatory Data Repository. 2010.

Selected Results

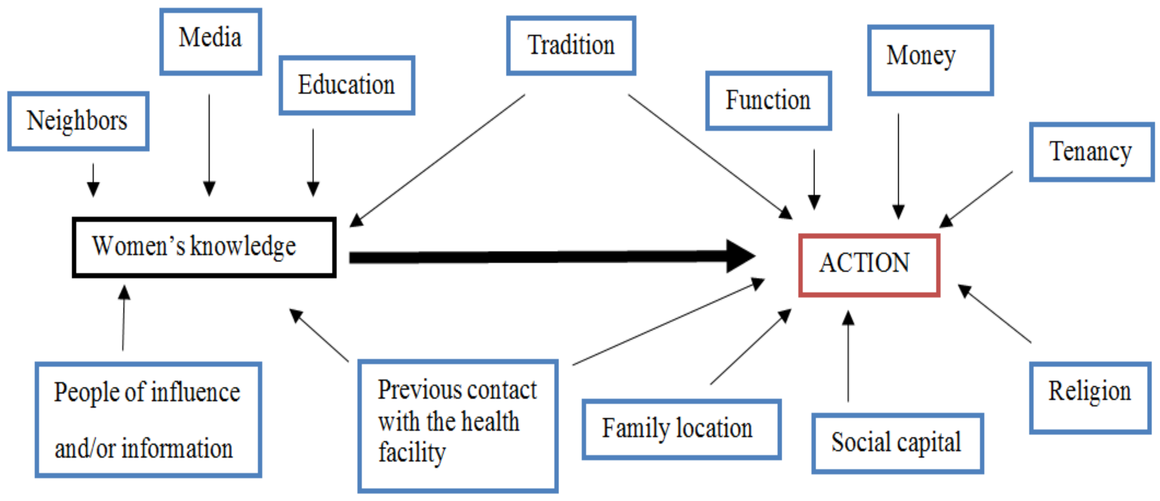
Women residing in *Kaula Bandar* appeared knowledgeable of the importance of institutional delivery and the use of health services:
'We get injections there and our children get immunization there [in the hospital]. Polio. We get rest there. If we stay at home [for delivery], then we never get any rest, no injection, no immunization.' Haleemah, a 25-year old Muslim with three children

Women's decisions depended largely on the needs and desires of her husband and his family:
'If your husband didn't give you permission for any kind of thing then you should not do that. It's all depending upon the husband. Even if you think to do something with your own mind it never works'. Zeenat, a 22-year old Muslim with one child

Distance from extended family and lack of social cohesion left many women feeling they did not have the help they needed before, during and after delivery; the help they would have received surrounded by extended family in their native village:
'Nobody's here with me so only my husband is here. So what can he do? So I went to the village.' Aarti, a Hindu woman of unknown age with three children

Women went back to their rural villages for weddings, funerals, and many expressly for their deliveries. Others went back for financial reasons:
'In the village…my husband does not have enough income. So how can I stay here for delivery?' Nusrat, a 25-year old Muslim woman with two children

Conceptual model of the factors affecting urban poor women's delivery location



Conclusions

We suggest the following policy changes and interventions on the behalf of poor urban women in India with proximity to health services but who are not yet using them optimally:

1) Involving men and other family- and community-level decision-makers in behavior change education and other interventions is essential, especially in settings like India where traditional family structures and social norms persist.
2) Quality improvements to government facilities must be invested in to improve women's institutional experiences
3) A most concerning finding in these data was that of women's feelings of isolation and helplessness in the face of family, financial and logistical pressures; more work must be done to better understand and improve both the formal and informal social networks in places like *Kaula Bandar*
4) Community health workers (CHWs) – generally trained and deployed in rural settings – could be equally valuable in urban areas as cultivators of social support and improved planning.