

## **Women's Use of Healthcare Services and Their Perspective on Healthcare Utilization during Pregnancy and Childbirth in a Small Village in Northern India**

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### **Abstract**

**Purpose:** *This research study examines women's perspectives and utilization of health care services during pregnancy and childbirth in a rural community in northern India.*

**Design:** *This research project is a descriptive, qualitative study. Purposeful sampling was utilized to seek information-rich cases. A snowball technique was used for the sample population. An open-ended questionnaire was utilized to elicit information.*

**Sample:** *Ten women who had given birth within the last year, and who were 18 years old or older living in a rural community in northern India.*

**Results:** *Five participants did not seek out or receive any health care services. Five participants sought out healthcare during pregnancy and childbirth. All the women shared their perspectives on how utilization of healthcare could be improved within their community.*

**Conclusion:** *Women in rural India have little access to health care resources. This study showed that lack of educational resources, distance, cost and transportation, cultural, religious, and family influences all had an impact on women utilizing healthcare services.*

**Implications:** *Understanding women's perspectives can help reduce barriers to health care during pregnancy and childbirth.*

**Key words:** India, health care, pregnancy

### **Introduction**

Maternal mortality rates in India are alarmingly high. This study examines women's perspectives and utilization of healthcare services during pregnancy and childbirth in a rural village in northern India. Women within the community were asked to share their experiences and healthcare services they used during their own childbirth experience, as well as identifying obstacles in obtaining maternal care. In addition, the women stated their perspectives on how to improve utilization of care within their own communities. The need to address women's access and barriers to health care resources, adequacy of resources, and utilization of services is vital to the health and well being of rural Indian mothers.

Worldwide, over half a million young women die every year as a result of complications associated with pregnancy and childbirth (World Health Organization [WHO], 2004). India's maternal mortality rate is 540 per 100,000 live births, as compared to the United States, whose maternal mortality rate is 8 per 100,000 (Central Intelligence Agency (CIA), 2004). Inefficiencies of healthcare services and accessibility difficulties lead to health concerns for pregnant women in India (Nagdeve & Bharati, 2003; Navaneetham & Dharmalingam, 2002; WHO, 2004; Wiley, 2002).

The large geographical area and extreme vastness of the rural population, along with transportation and infrastructure deficiencies, contribute to the inability of women to access adequate healthcare services (Agarwal & Sarasua, 2002). The Human Development Report (2003) highlights that only 40% of rural communities have access to any Primary Healthcare Centers (PHC) in India. Approximately 80% of India's population lives in rural areas. Contradictorily, only 20% of the limited healthcare budget by the government is allocated to rural areas (WHO, 2004). Consequently, women in rural areas of India have few options for seeking maternal healthcare.

Furthermore, the healthcare system in India is among the most privatized in the world and less than one quarter of all healthcare related expenses is met by the government (India Together, 2005). Currently, India spends only 0.9% of its GDP on healthcare in the public sector. Government facilities are free for the initial visit, but if tests or additional services need to be rendered, fees are assigned, which may cost individuals and families too much money to utilize the services (Thaddeus & Maine, 1994).

Nationwide, healthcare utilization rates show that private health services are primarily directed at providing primary healthcare and financed by private resources, which places a disproportionate burden on those living in poverty. Health related expenses are among the most important causes of rural indebtedness and impoverishment (India Together, 2004). For some, the choice is often between healthcare in private systems that are financially beyond their reach, or death.

The World Health Organization (2004) states the majority of the maternal deaths could be prevented if women had access to and utilized skilled care during pregnancy, childbirth and family planning. The WHO (2004) also points out that maternal mortality is a human rights and equity issue. Women everywhere should have the right to safe, affordable and accessible health care.

### **India's Healthcare Infrastructure**

India is made up of 27 states and is divided into approximately 397 districts, with a population of over 1 billion people (Government of India, 2001). Since the 1950's, the Indian government has been working on developing health services in rural areas to assist in reaching more people by improving distribution of services (Mavalankar & Rosenfield, 2005). A hierarchy of medical care facilities serves each district of one to two million people. Government district hospitals (DH) serve each district with 100 to 300 beds. Second to the district hospital (DH), is the City Hospital, which has 30 to 50 beds and serves a population of 100,000 to 500,000 people.

Below the City Hospital, is the primary healthcare center (PHC), which is staffed by a medical officer or medical doctor, and generally serves a population of 30,000 to 50,000, with up to two beds. At the local level, sub-health centers are staffed by auxiliary nurse midwives (ANMs), and serve a population of approximately 5000 people. The ANM's work mostly with women, infants and children, and provide services to five or six villages in rural areas (Mavalankar & Rosenfield, 2005).

### **Traditions and Culture**

With over one billion people, India has residents who speak approximately 200 different languages. Eighty five percent of the population is Hindu, and the remaining 15% are Muslims, Christians, and Buddhists (WHO, 2004). Although no longer officially recognized, the caste system still has an influence on Hindu families, especially in rural areas. There are four caste classifications. The Brahmins are considered the highest members of the caste system. The Ksatriya are the ruling caste, the Vaisya are described as the farmers and merchants, and the Sudras are described as the untouchables, or servants.

The caste system has been found to impact customs during childbirth by denying healthcare providers access to homes due to caste status (Gatrad, Ray, & Sheikh, 2004). The joint family is similarly influential on healthcare customs in the Eastern Hindu household. Husbands are considered the primary spokesperson for the family; the advice of family members is highly valued and implemented. Studies have shown that it is generally when home and family resources have failed that outside medical attention is sought (Agarwal & Sarasua, 2002).

Women living in rural areas of India without even a sub-center for healthcare have the highest maternal mortality rates (Stephenson & Tsui, 2003). In rural parts of developing countries, including India, the closest facility to a woman's home may not be equipped to deal with an obstetric emergency. Furthermore, there are concerns that the facility may not be adequately staffed or have the essential medications, supplies or resources to deal with the emergency (Thaddeus & Maine, 1994).

With a system of healthcare that is the largest infrastructure in the world, India also has one of the most inadequate. Maternal mortality continues to be a major concern. While literature supports the need for access to healthcare and addresses the inefficiencies of services and lack of resources for women in rural India, there is little research on the perspective of the individual woman. Understanding the services women feel they need and what factors would assist them in utilizing those services is crucial to an effective healthcare delivery system and maternal health and well-being.

## **Method**

### **Design**

This research project is a descriptive, qualitative study on rural Indian women's perspectives on utilization of healthcare during pregnancy and childbirth in a small village in northern India. The qualitative approach seeks to develop a more detailed understanding than a quantitative approach would offer by seeking insight into healthcare service utilization and barriers to care. Through the use of open-ended questions, the women provided a better understanding of commonalities and discrepancies in women's utilization of healthcare services and perceptions.

### **Conceptual Framework**

The framework for this research is based on Madeleine Leiningers Culture Care Theory. This theory focuses on methods of approach to care that means something to the people to whom the care is given. Research findings are used to develop protocols for culturally congruent care. Culture is defined as a "particular group's values, beliefs, norms and practices that are learned and shared and that guide thinking, decisions, and actions in a patterned way" (Leininger, 1985, p. 209). This research project examined patterns and practices that the women shared through discussing their personal beliefs and experiences.

### **Sample**

The ages of the participants ranged from 18 to 35 years old. Each woman had a child under one year old. All the participants lived in a geographical area that was being served by the same District Hospital and the same City Hospital. Purposeful sampling was utilized to seek information-rich cases. A snowball technique was utilized for the sample population to allow the participants to contact the researcher. The participants were compensated Rs 240 (U.S. \$5.00) for their participation in the study. The study was approved by the Institutional Review Board of the University of Minnesota.

### **Setting**

The research reported in this article is based on interviews of ten rural women living in a village in northern India, Laxman Jhula. This village consists of a population of approximately 50,000 people. It is part of a group of villages that make up the city of Rishikesh, which has a population of 500,000 people. Uttaranchal, the state Rishikesh resides in, is one of the most economically disadvantaged states of India. The literacy rate, similar to statistics from the rest of India, is higher for males (74%) than females (49%) (Government of India, 2001).

### **Data collection**

The ten women were interviewed in their homes, or a place of their choosing. A semi-structured interview (Appendix I) was utilized to explore and probe within the predetermined inquiry areas. The areas addressed by the interview guide focused on background, pregnancy, delivery, healthcare services utilized and ideas on what could be done to improve utilization of services by women during pregnancy and childbirth. An interview guide ensured a focus for the interaction and assured each inquiry area was covered with each interviewee. One interview took place with each participant. Each interview lasted approximately 60-90 minutes in length. All interviews were taped with interviewee's knowledge and permission. Notes were also taken during the interview. An interpreter assisted with the interviews and data analysis. An informal interview of local healthcare providers was also conducted to gain insight into the resources and services that were available within the community.

### **Human Subjects Approval**

The research conducted for this project was approved by the University of Minnesota's Institutional Review Board for Human Subjects. All data collected was kept in a safe and secure place during the research.

### **Method of Analysis**

This study used inductive analysis to look at the themes that emerged out of the data collection (Silverman, 2000). Narrative inquiry was utilized to examine the ways the women experienced their pregnancies and childbirth in regards to utilization of healthcare. Words, phrases and events that appeared to be similar were grouped into the same category. The categories were then compared and combined to assist in seeing a bigger picture. A use of "voice" was utilized to assist in illustrating the themes. Assessing trustworthiness was done through a coding consistency check.

## Results

### Interviews

Three of the ten interviews took place in the village of Laxman Jhula. The other seven interviews took place 6 km. or further out of the village of Laxman Jhula in the foothills of the Himalayan Mountains. Nine of the interviews took place in the homes of the participants; one interview took place in a public setting per the request of the participant.

### Utilization of healthcare services

For all participants, the distance to the District Hospital was 20 km. or more. For eight of the participants, the distances to the Primary Healthcare Centers (PHC's) were more than 6 km. with the average distance of 16.7 km. Eight participants had access to an Auxiliary Nurse Midwife (ANM) who visited their village. The other two participants moved into the village to live with other family members so they would have access to the Primary Healthcare Center and a physician during their pregnancy and childbirth. Five of the participants sought out healthcare and five did not.

### Women who did not utilize healthcare services

Participant's reasons for personally not seeking healthcare were categorized into three main categories from the themes that emerged. The three main categories were related to family influences, religious and cultural reasons, and the natural process of childbirth.

#### Theme 1

Family influences made up a category with the mother-in-law having the most influence. Participants shared:

*"My mother-in-law was there to take care of me. She was afraid something would happen to me if I went to see a doctor."*

*"I could hardly stand, I was so weak, I thought I was going to die, I was afraid. I wanted to go to a doctor and couldn't, my mother-in-law didn't want me to."*

*"I did not need her (the ANM's) help. My husband and mother-in-law were not happy if I went to see the doctor."*

#### Theme 2

Religious reasons made up another category. Participants shared:

*"It is our fate, God will determine if my child will live or die".*

*"God is the best doctor; nothing can happen without his will, we don't need a doctor".*

*"If my child were to die, it would be as if he were never meant to be born, if I were to die, so be it."*

#### Theme 3

All five of the participants stated that childbirth was a natural process and as such they did not feel the need to seek out healthcare.

*"My mother gave birth for generations before me, am I so different?"*

*"It is the way with the Indian women."*

*"Having a baby does not mean you are sick."*

The five participants who did not seek healthcare services during their pregnancy or childbirth shared many similar characteristics. They all lived in very poor settings with large family units and limited resources. They also did not have the opportunity to attend school or have any educational background. These five participants were also of the Muslim religion and living in the outskirts of the city of Rishikesh, a mostly Hindu city. Two of the Muslim participants indicated that Muslims were not very welcome in Rishikesh.

The Muslim women shared that they were not allowed to leave their homes alone and did not have many opportunities to go to the city. Three of the participants had never been to the city. All five of these participants had their deliveries in the home setting. Of those five, one had the assistance of an untrained traditional birth attendant; the other four deliveries were assisted by the mother or mother-in-law. Three of the participants stated they had bleeding complications after delivery and were afraid they were going to die.

### Women who utilized healthcare

The five participants who sought out healthcare services also shared characteristics. First, they had all received some level of education. In addition to educational background, the homes were better built and participants appeared to have more financial resources available. The family units living in the same household were smaller than those of the five participants who did not access healthcare. All five participants lived closer to healthcare facilities than the participants who did not seek out healthcare services, with the exception of one. Furthermore, all five of these participants were of the Hindu religion, and while family influence is important and respected; all five stated that even if their mothers did not seek out healthcare services, they knew prenatal care was important.

### Perspectives on Utilization of Healthcare for other women

The participants shared their perspectives on deterrents for women seeking healthcare services during pregnancy and childbirth. Themes that emerged included education about importance of healthcare, distance and costs, family influences, feelings of embarrassment and privacy, and childbirth being a natural process.

#### Theme 1

The first category was education. This category focused on women's knowledge of the necessity for and importance of healthcare during pregnancy. Nine participants stated they believed women would utilize healthcare services if they had some education about the importance of healthcare during pregnancy. Some of the statements the women shared are as follows:

*"Many women are very poor and careless of their health, they just don't know."*

*"Women who live in more rural areas do not have the chance to go to school and are just not educated about the importance of healthcare for themselves and their babies."*

#### Theme 2

Distance and cost were also a concern and combined into one category. Nine participants agreed that distance to a healthcare facility was a reason women in general did not seek out healthcare. Only two participants stated that the cost was a deterrent for them, while seven participants stated that they felt it was a deterrent for other women. All ten of the participants felt that more women would utilize healthcare services during pregnancy and childbirth if the hospital or clinics were closer and the services were free. Six participants felt that transportation to the clinic visits would improve utilization of healthcare. *"The ordinary woman doesn't get to use the government facilities that are free and sometimes they have to suffer. It is too far for them to travel to the government clinics and hospitals, and the private ones are too expensive."* *"For many women the clinics are too far away and they have no money to pay for services."*

#### Theme 3

Seven of the women stated that family influence was a significant reason women did not seek healthcare. It is customary for both Hindu and Muslim women to have their mother-in-law or mothers taking care of them during this time. *"It is normal that the mother-in-law takes care of the woman during her pregnancy."* *"Sometimes women are not allowed to go to the clinic or see a doctor."* *"The mother-in-law has much say in how a woman takes care of herself during pregnancy."*

#### Theme 4

Five of the participants stated that for most women being pregnant is a very private thing. Most women do not want to talk about it and are shy and embarrassed, thus they do not seek out healthcare. *"Women are embarrassed of their bodies, so they don't go to a doctor."* *"Having a baby is a private thing, you don't talk about it."* *"Women are also shy; they do not like to talk about private things, so they may not go to the doctor because they are embarrassed."*

#### Theme 5

All participants stated that childbirth is seen as a natural process and many women feel there is no need to seek out healthcare. *"Many women think that their ancestors had babies and delivered without any help, and on their faith, they will be okay too."* *"Most women feel childbirth is a natural process and rely on their mothers or mother-in-laws to instruct them."*

In summation, the determinants identified by the participants in regards to using healthcare services for them were related to family influences, religious and cultural reasons, and the natural process of childbirth. Their perceptions of determinants for other women within their communities utilizing healthcare included (a) a lack of education regarding the importance of healthcare, (b) distance, cost and transportation, (c) the natural process of childbirth, (d) religious and cultural beliefs, and (e) family influences.

### ***Discussion and Findings***

All the women had access to some form of healthcare, even if it was in their village with a visiting ANM. Access to the first level of healthcare within the village was not an issue; utilization of that healthcare appeared to be. Understanding why women choose not to utilize the available services is key in determining how to help address the concern of maternal mortality and problems associated with pregnancy and childbirth in rural areas of India.

#### **Educational impact on utilization of healthcare services**

The five women who sought out healthcare had some form of education. The literature suggests that women who have some form of education have a tendency to be more likely to seek out healthcare. They have a greater awareness of the existence of maternal healthcare services and understand the benefits in utilizing them (Nagdeve, & Bharati, 2003; Navaneetham & Dharmalingam, 2002; Ramarao, Caleb, Khan, & Townsend, 2001). Furthermore, educated women may have greater decision making power on health related matters and also attach a higher value to personal welfare and health. Socioeconomic characteristics such as education, wealth and status contribute to the likelihood of women accessing health care services (Navaneetham & Dharmalingam, 2002).

#### **Distance, cost and transportation impact on utilization of healthcare**

While subjective, socioeconomic conditions may have played a role in why the five women did not seek healthcare. The literature indicates contributing factors to prevention of seeking healthcare services are related to distance, cost, and quality of services (Wiley, 2002). Other studies show key determinants of women's health and survival to be related to socioeconomic conditions, education, nutrition and utilization of healthcare (Nagdeve & Bharati, 2003; Wiley, 2002).

#### **Cultural, family influences and religious impact on utilization of healthcare services**

Culture plays a very significant role that influences a woman's perception of the childbirth experience (Callister, Vehvilainen-Julkunen, & Sirkka, 1996). For the Muslim woman, pregnancy is considered a state of wellness, and a natural process, so traditional families may not seek prenatal care or childbirth education (Callister, 2005). In India, especially in rural areas, it is customary for the woman to travel with another person, especially in the Muslim faith, which limits her exposure to the outside world, including seeking out healthcare (Nagdeve, & Bharati, 2003; Navaneetham & Dharmalingam, 2002; Ramarao et. al, 2001). A correlation may exist between their confidence in the ability to seek out healthcare and their willingness to travel outside their home.

The caste system has also been found to impact customs during childbirth by denying healthcare providers access to homes due to caste status (Gatrad, et al., 2004). The joint family is similarly influential on healthcare customs in the Eastern Hindu household. Husbands are considered the primary spokesperson for the family, and the advice of family members is highly valued and implemented. All ten participants shared they believed that birth was a natural process. Studies have shown that outside medical attention is sought only after home and family resources have failed. Increased usage of health care services can also be attributed to social support and networks that encourage prenatal care (Wiley, 2002).

#### **Limitations of study**

The limitations of this study include cultural differences that may have impacted the collection and analysis of the data by the researcher. There are various cultural assumptions that might have been made based on perceptions and lack of understanding by the researcher within the Indian culture. Variables in interpretation of the data due to the use of an interpreter could also have occurred. The interpreters bias, age, and lack of experience as an interpreter, were also factors that may have contributed to limitations of this study. Judgments about usefulness and credibility of this study are left to the researcher and the reader. Five of the women were Hindu and five were Muslim. Cultural and religious backgrounds made it impossible to fairly categorize the two groups by comparisons. The study would have been strengthened if all 10 women were of one faith with similar backgrounds.

## **Strengths**

A major strength of this study included the narration of each woman's personal experiences with the pregnancy and childbirth process. The use of their 'voices' to give their perspective on utilization of healthcare gave the research project substance and credibility. The interviews took place in the participant's surroundings, which put the participant more at ease. All women contacted the researcher for participation in the study and wanted to be interviewed. An interpreter was available and assisted with both the interviews and analysis of this research project.

## ***Implications for Clinical Practice and Future Research***

Understanding deterrents to seeking healthcare is crucial to the implementation of services. The importance of utilizing healthcare during pregnancy and childbirth needs to be communicated and understood by rural Indian women. Community outreach educational programs need to be implemented. Education in identification of impending danger, promotion of clean and hygienic delivery practices, information on sources of care, timeliness of seeking care and improved nutritional status through education of food choices and vitamin supplements are all important for the well being of the mother and child.

The findings of this study provide insight for planning and implementing appropriate maternal health service delivery programs in order to improve the health and well-being of both mother and child. Nursing can be in the forefront of policy changes and implementation, encouraging improved healthcare services and resources for the rural population.

## **Implications for research**

Utilization of healthcare services by rural Indian women is influenced by many factors. Socio-economic status, educational background, distance, cost, culture, religion, family influences, and parity may all play a part in influencing women in seeking healthcare during an important time of their lives and that of their child. While literature reports that all of these factors may play a role, there is not much research on what Indian women feel they need in order to utilize services. Further research on women's perspectives in regards to improving utilization of the available services is needed.

The utilization of healthcare by Indian women is much more complex than just having available resources. Research needs to continue to understand what services women would utilize if they were available and what would be the best way to educate the rural population on the importance of those services. All five Muslim participants indicated reluctance by family members to seek healthcare. In one case it was the husband and in all cases the mother-in-law objected. It would be beneficial for future research to examine this point in more detail to understand its roots and implications.

## ***Summary***

Understanding the reasons for lack of utilization of healthcare for women is important for the delivery of services and access to care. This study showed that lack of educational resources, distance, cost and transportation, cultural, religious, and family influences all had an impact on women utilizing healthcare services. Because this is a public health issue, further research and programming may be warranted to examine this complex issue. The infrastructure and healthcare facilities should be widespread in the rural areas in order to reduce disparities in the use of maternal healthcare services.

Mothers in rural areas who are not provided with pregnancy and childbirth care by trained persons may be more likely to develop postnatal complications that endanger their lives (Nagdeve & Bharati, 2003). Benefits of utilization of healthcare services during pregnancy and childbirth need to be communicated to all women, regardless of location, caste membership, economic status, or religious beliefs. Women not only need to have access to healthcare, they need to be educated to understand the importance of healthcare and outcomes for themselves and their children.

The ANM's may be the only healthcare provider the rural women ever see. For effective management of pregnancy and childbirth, it is imperative that the ANMs are educated to provide skilled attendance to detect and manage obstetric complications and be provided with the necessary supplies to accomplish that task. Timely recognition of a complication and effective referral can be life-saving for the mother.

The government must take the necessary steps to improve maternal child health, including the provision of information and education campaigns, and sending dedicated health personnel to remote and inaccessible rural areas in order to reduce both maternal and child mortality.

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## ***Appendix I***

### **Interview Guide**

1. Tell me about your background (general prompts in areas of education, job, number of children, family structure, utilization of healthcare for family, previous complications with pregnancies, and utilization of healthcare services during other pregnancies).
2. Tell me about your pregnancy (general prompts in areas of concerns or problems during pregnancy, length of pregnancy, nutrition, diet restrictions, weight gain, visits to healthcare providers, home visits, by health provider, use of dias, family support system).
3. Tell me about your delivery (general prompts in areas of complications during delivery, size of baby, sex of baby, who assisted with delivery, where was delivery, support system during delivery, follow up care after delivery).
4. If you did not use healthcare services during your pregnancy, can you tell me why, and what would have helped for you to use healthcare services?
5. Can you share some ideas on what could be done so women would utilize healthcare services during pregnancy and childbirth?

An Interpreter will accompany the researcher on the interviews and will assist in interpretation as needed.

Note: The interview guide was reviewed by two professors at the University of Minnesota, two peer nursing students in the Master's program, and two mothers who had recently delivered.