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KNOWLEDGE AND UTILIZATION OF MATERNAL AND CHILD HEALTH SERVICES AMONG THE WOMEN DOMESTIC WORKERS: A STUDY IN GUWAHATI CITY

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ABSTRACT

Rapid urbanization in India is fuelling the growth in urban poverty, particularly in the urban slums where the quality of life is extremely poor. Pregnant women living in urban slums are a vulnerable group having limited access to urban healthcare facilities. Hazardous maternal health practices are also common in the slums that affecting severely the women of childbearing age and children. Most of the maternal and child health (MCH) issues are largely preventable by increasing access to and utilization of available maternal health services. Maternal mortality is a global issue and WHO recommends the use of maternal health services to improve the health of women and children during pregnancy and childbirth. Availability, accessibility, acceptability and affordability of these services are important to reduce maternal mortality as well as morbidity. Though the maternal health indicators of urban population are better than those of rural population; however conditions of urban poor are worse than rural poor. Guwahati is one of the fastest growing cities of the country and most important economic hub for the northeast India. Guwahati is the home for migrants of different parts of the region. The people living below the poverty line in the city are mostly the migrants involved in different unorganized sectors. Women domestic workers are the most vulnerable section of unorganized workers due to their poverty, illiteracy, job insecurity, low wages, lack of legal protection, etc. In this present study, an attempt has been made to examine the awareness as well as the utilization of maternal health services among the women domestic workers of Guwahati city. The researchers have also tried to know the socio-economic background of the respondents and their basic health practices.

Keywords: Awareness, Maternal Health Service, Urban Poor

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INTRODUCTION

Pregnancy and childbirth are special events in a woman's life. But during this period they are also more vulnerable to disease and death. Maternal health care refers to pregnancy-related health care, which is usually provided by a doctor and other health staff. Maternal health refers to the health of women during pregnancy, child birth and post-partum period (WHO). It encompasses the care dimensions of family planning, preconception, prenatal, and postnatal care in order to ensure a positive and fulfilling experience in most cases and reduce maternal morbidity and mortality in other cases. Antenatal, perinatal and postnatal services are meant to monitor and ensure the safety of pregnant women and their babies in order to prevent and reduce the incidence of maternal morbidity and mortality. Complications in pregnancy can result from conditions that are specifically linked to the pregnant state as well as conditions that commonly arise or occur incidentally in women who are pregnant. Sometime, it creates life threatening condition for mothers as well as for baby, which resulted in increasing maternal and child mortality rate. India contributes around 20 percent of global birth each year. The finding of the studies shows that in India during 2001 to 2010, the mean maternal mortality rate in the study period was 302.23/1,00,000 live births and the maximum maternal deaths (49.16%) were reported in the age group of 20 to 24 years.

The importance of maternal health services in reducing maternal and infant morbidity and mortality has received increasing recognition since the Cairo Conference on Population and Development, 1994. Government of India has been providing Maternal and Child Health Services before, during and after pregnancy under ICDS. The use of maternal healthcare services is important for the early detection of mothers who are at a high risk of morbidity and mortality during pregnancy. Despite the benefits of MCH, many women in India do not receive pre-natal care at all, and the care that is received is often characterized by an insufficient number of visits during the pregnancy (NFHS 1992/93). Furthermore, the delivery care utilized in India is dominated by home births rather than institutional delivery. Hence, high risk pregnancies are often not identified, opportunities for transmitting family planning messages are missed and important information on child nutrition and health care is not disseminated to a large section of pregnant women and mothers.

In terms of employment, domestic work is the largest sector in India after agriculture and construction industries. Domestic workers, particularly women domestic workers are a constantly glowing section of workers in informal sector of urban India. The 61stround National Sample Survey Organization (NSSO) data (2004-05) reveals an approximate figure of 4.2 million domestic workers in the country. Domestic work can be defined as work performed in or for household or households; and domestic worker is a person engaged in domestic work within

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any employment relationship. In common parlance, domestic worker is defined as a person who is engaged in part time or full time domestic worker in return of remuneration payable in cash or kind (Article-1 of ILO domestic worker conversion, No. 189, 2011). The Draft National Policy on Domestic Workers, 2011 as recommended by the Taskforce on Domestic Workers appointed by Government of India, provides a definition of a domestic worker which says "domestic worker" means a person who is employed for remuneration whether in cash or kind, in any household through any agency or directly, either on a temporary or permanent, part time or full time basis to do the household work, but does not include any member of the family of an employer".

Domestic work is an occupation characterized by low wage, no job security and lack of legal protection. The domestic workers mostly found living in the slum settings and leading a substandard life due to poverty. Health is a major economic issue for women domestic workers (WDWs). The unhealthy physical environment leads to sickness, demanding medical treatment, which results in the reduction of workdays, followed by economic loss. Economic loss leads to inability to invest in a clean environment. WDWs were found to seek treatment only when their health problems caused great physical discomfort or when it affected their work performance. Though pregnancy being a natural phenomenon in a women's life, it is a very complex situation for these domestic workers considering their nature of job and living condition. Pregnant workers living in urban slums constitute a vulnerable group having limited access to urban healthcare facilities. Hazardous maternal health practices are also common among them that affecting severely the women of childbearing age as well as children. The utilization of available maternal and child health care services will be beneficial for minimizing the vulnerability during this period among the women domestic workers. Hence it is important to determine the awareness about maternal and child health services among the women domestic workers of Guwahati city. This paper has attempted to examine the awareness as well as the utilization of maternal and child health services among the women domestic workers of the city. The researchers have also tried to know the socio-economic background of the respondents and their basic health practices.

OBJECTIVES

1. To know the socio-economic status of the respondents
2. To examine their knowledge of Maternal Health Care
3. To study the utilization of Maternal Health Care by the respondents

MATERIAL AND METHOD

a. **Design of study:** The present study is exploratory in design

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b. **Sample size and technique:** Non-probability purposive sampling is used in the study and total 50 women domestic workers are interviewed from two major slums of the city, Bhaskar Nagar and Sijubari
c. **Tools of data collection:** Semi-structured interview schedule has been used for data collection
d. **Inclusion criteria: W**omen domestic workers who delivered during last 6 months are interviewed for the purpose of study.

RESULTS AND DISCUSSION

A. Socio-economic Status of the respondents:

In socio economic status, the researchers mainly tried to know about the age, caste, religion, educational qualification, occupation, age at the time of marriage, no of children etc. The data collected about the socio economic condition of the respondents under the study is presented here in table-1.

Table 1: Socio-economic Status of the respondents

Total no. of respondents= 50

Characteristics	**No. of respondents**	**Percentage**
Age		
Below 18 years	7	14%
18 to 25 years	10	20%
26 to 30 years	13	26%
31 to 35 years	11	22%
Above 36 years	9	18%
Religion		
Hindu	17	34%
Muslim	33	66%
Caste		
General	31	62%
Schedule caste	11	22%
OBC	8	16%
Educational qualification of the respondents		
Illiterate	27	54%
Primary education	23	46%
Educational qualification of the husbands of respondents		
Illiterate	19	38%

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Primary education	22	44%
Secondary education	9	18%
Occupation of the husband of the respondents		
Unemployed	5	10%
Construction worker	19	38%
Wage labour	9	18%
Driver	6	12%
Industrial worker	11	22%
Age at marriage		
Below 18	43	86%
Above 18	7	14%
Age at first child birth		
Below 18	31	62%
Above 18	17	34%
No. of children		
1	7	14%
2	9	18%
3	11	22%
More than 3	23	46%
Living Status		
Living with husband	26	52%
Living with husband and in-laws	5	10%
Living alone with children	19	38%
Average Monthly Family Income		
Below 10,000	19	38%
10,000-20,000	31	62%
Above 20,000	0	0
General health issue of the family (n=50)*(multiple response)*		
Gastric	50	100%
Skin diseases	33	66%
RTI	21	42%
TB	7	14%
Jaundice	5	10%

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Table-1 shows that majority (68%) of the respondents under the present study belongs to the age group of 18 to 35 years. Only 18% are above 36 years. Even though it's less in number considering the other categories, the mothers below the age of 18 years (14%) can be seen as a threat to the safe motherhood mission and vision of government. Further, it is found that both Hindu and Muslim respondents are found during the study but majority of the respondents are Muslim (66%) and general in caste (62%). other than general caste, the researchers also found SC (22%) and OBC (16%) respondents. The researchers found that most of the respondents are illiterate (54%) and others are educated upto the primary level (46%). Again, while finding out about the educational qualification of the husbands of the respondents, it was seen that they are mostly (62%) literate and most of them are primary educated (44%) and others are secondary educated (18%). It was found that 90% of the respondents' husbands are employed. The occupation of the husband was mostly construction labourer (38%), industrial worker (22%), daily wage labourer (18%) and driver (12%). The table also indicates the age of marriage of the respondents and it was found that majority (86%) of the respondents got married before they attain their legal age of marriage, i.e. 18 years. It was also found that 86% of the respondents have more than one child. Regarding the living status of the WDWs, the table depicts that 62% of the respondents live with their husband and in-laws and remaining 38% respondents live alone with their children. Again about average monthly income of the family, it is found that 62% of the respondents' family income range between Rs. 10,000 to Rs. 20,000 per month and remaining 38% respondents' family income is below 10,000 rupees per month. The table also shows the general health issues of the respondents' family. Gastric being the most common health issue of the people found in all the respondents' house. Among the other health issues skin diseases (66%), RTI (42%), TB (14%) and Jaundice (10%) are the most common diseases. Therefore, from the table-1, the pitiable socio-economic condition of the WDWs can be understood. It also reflects the compulsion under which these women joined domestic work as occupation.

B. Knowledge/Awareness of Maternal Health Care Service By The Respondents:

Here the researchers mainly tried to discuss the different parameters that determine the level of awareness among the women domestic workers about maternal and child health care and available MCH services.

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Table 2: Knowledge about Maternal & Child Health Care Services

Total no. of respondents= 50

Characteristics	No. of respondents	Percentage
Knowledge of age of getting pregnant (n=50)		
Any age after puberty	39	78%
After 18 years	11	22%
Knowledge of family planning (n=50)		
Aware	13	26%
Not aware	37	74%
Mostly known family planning methods (n=13)		
Condom	13	100%
Oral tablets	13	100%
Knowledge about minimum age gap between the children (n=50)		
1 to 1 ½ year	50	100%
Knowledge of registration of pregnant mother (n=50)		
Aware	14	28%
Not aware	36	72%
Knowledge of minimum antenatal check-up (n=50)		
As per the choice	27	54%
At least 1 check-up	10	20%
2 to 3 check-up	8	16%
Minimum 4 check up	5	10%
Knowledge about need of IFA Consumption (n=50)		
Aware	13	26%
Not aware	37	74%
Knowledge about need of TT boost (n=50)		
Aware	11	22%
Not aware	39	78%
Knowledge about the need of institutional delivery (n=50)		
Needed	16	32%
Not needed	34	68%
Knowledge about postnatal check-up (n=50)		
As per the choice	22	44%
At least 1 visit	10	20%
2 to 3 visit	11	22%
Minimum 4 check up	7	14%

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Knowledge about government scheme for safe motherhood (n=50)		
Aware	33	66%
Not aware	17	34%
Mostly known scheme (n=33)		
JSY	33	100%

Table-2 of the present study shows the awareness level of the respondents about maternal and child health care services. The table shows that majority (78%) of the respondents consider that a women can get pregnant at any age after they are biologically fit to conceive a child, i.e. after their puberty. It was also found that most (74%) of the respondents are not aware about the methods of family planning and spacing between the children. The remaining 26%, who are aware about it, have the information of only condom and oral contraceptive pills. For all the respondents, the ideal spacing between the children is 1 to 1 ½ years. The table further shows that majority of the respondents (72%) are not aware of the provision of registration of pregnant women and mothers in the government hospital. The table-1 of the study showed that 52% of the respondents got registered, but with the in-depth inquiry it was found that they were taken to the health center by their neighbors or family members in case of sickness. Some of them were also got registered with the help of the ASHA workers. Again regarding antenatal check-up, majority are not fully aware, only a few (10%) have the information of minimum 4 check-up. It was also found that majority of the respondents (78%) were not aware of the benefit of IFA (74%) and TT booster dose during the pregnancy. It was found that majority of the respondents have not gone for institutional delivery and 68% of the total respondents felt that it is not needed. Again regarding postnatal check-up, only 14% of the respondents were aware of minimum 4 visits, whereas majority (44%) said that it should be done as per the choice and need. When the researchers asked them about the scheme related to MCH, 66% of them have taken the name of Janani Suraksha Yojana (JSY).

C. Utilization of Maternal and Child Health Care Service by Women Domestic Workers:

Utilization of the available MCH services can reduce the pregnancy related health problems among the women and ensure the safe delivery of a healthy child. In the following table the researchers tried to examine the utilization of maternal and child health care services by the women domestic workers.

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Table 3: Utilization of Maternal & Child Health Care Service

Total no. of respondents= 50

Characteristics	No. of respondents	Percentage
Spacing between the children (n=43)		
Less than a year	29	67.44%
1 to 2 years	14	32.55%
More than 2 years	0	
Use of family planning method (n=50)		
Condom	0	
Contraceptive pill	7	14%
Natural method	9	18%
Not used	34	68%
Place of child birth(n=50)		
Home	39	78%
Hospital	11	22%
Registered antenatal mother (n=50)		
Registered	26	52%
Not registered	23	46%
Early registration	**9**	**18**%
No of antenatal care visit (n=26)		
1	9	34.61%
2	6	23.07%
3	7	26.92%
4	3	11.53%
Consumption of IFA (n=50)		
100 days	7	14%
60 days	18	36%
30 days	14	28%
Not taken	11	22%
Received two TT injection	**11**	**22**%
No of post natal check-up		
1	13	26%
2	28	56%
3	9	18%

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Table-3 describes the knowledge/awareness of maternal and child health care service by the women domestic workers. Moving toward to their reproductive health, the researchers tried to know the spacing between the children of the respondents from 43 respondents having more than one child and it was found that majority (67.4%) of them have less than a year gap between their children, while remaining 32.5% respondents have 1 to 2 years gap between children. The table further depicts the use of family planning method among the respondents. It was found that only 14% of the respondents have used the oral contraceptive pill as a method for the purpose of spacing and 18% said that they have used natural method. It is learnt that they are using natural methods like withdrawal and not having sexual intercourse. Others (68%) have not use any family planning method till now and most of them do not have any knowledge of spacing methods. The table has depicted the use of MCH services by the respondents in their recent pregnancy and it was found that majority (52%) of the respondents are registered under health centers, but only 18% are found to get registered in 1st trimester and others got it lately. It also shows that even after having the majority of the respondents with hospital registration, 78% of them has given birth to their child at home. While finding out about the health check-up during antenatal period, it was found that out of 50, only 3 respondents have done 4 antenatal check-up and remaining gone for 1 to 3 check-up visits. In case of consumption of IFA tablets, only 14% are found taking it for all prescribed 100 days, and 22% of the respondents have not taken any doses of IFA tablet. On the other hand, only 22% of the total respondents have taken two TT injections. The table lastly shows that none of the respondents have taken their children for 4 postnatal check-up, but 56% of them have done only 2 postnatal check-up for their children.

Table 4: Major Reasons for Not Utilizing MCH Services

Total no. of respondents= 50

Characteristics	**No. of respondents**	**Percentage**
Reason for not being register for pregnancy (n=23)		
No knowledge	3	13.04%
No money	6	26.08%
No need	14	60.86%
Reason for not being early register for pregnancy (n=41)		
No knowledge	27	65.85%
No need	14	34.14%
Reason for incomplete consumption of IFA tablet (n=43)		
Did not get	7	16.27%
Side effects	11	25.58%
Not allowed by the family members	17	39.53%

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Did not know the benefit	8	18.60%
Reason for not taking TT injection (n=39)		
Fear of infection	11	28.20%
Not allowed by the family members	21	53.84%
Not needed	7	17.94%
Reason for less antenatal check-up (n=47)		
Customary belief	21	44.68%
Financial problem	9	19.14%
Not needed	17	36.17%
Reason for non-institutional delivery (n=39)		
Customary belief	14	35.89%
Financial problem	6	15.38%
Not needed	8	20.51%
No faith on health center	11	28.20%
Reason for less post natal check-up (n=50)		
Not needed	11	22%
Customary belief	31	62%
Financial problem	8	16%

The table-4 of the study describes about the reasons of not using the MCH services. Since the present study is attempting at knowing their knowledge of the maternal and child health care services, the reason of not utilizing the existing services were expected to give a better insight into the proposed objective. Here, it was found that among the 23 non-registered respondents, majority (60. 8%) said that this registration is not needed. Some of them have also mentioned that they did not have money to get registered but shows their lack of knowledge only. The table further shows that the reason of not being early registration was due to the lack of knowledge (65.85%) about the need of getting registered in 1st trimester. It is also found that most (39.53%) of the respondents did not take the prescribed number of IFA tablets as they were not allowed by their family members. Not being able to tolerate the side effects of IFA was another reason of non-completion of the prescribed doses (25.5%). Some of them (16.2%) claimed that they did not receive the medicine and 18.60% said that they did not know the importance of IFA. The table further depicted the reasons of not taking TT booster doses; it is found that all 39 respondents are not aware of the importance of taking TT booster doses during pregnancy. Some of the other reasons of not taking TT booster doses are – Not Useful (17.94%), fear of infection (28.2%) and not allowed by their family members (53.84%). All these responses show their lack

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of awareness. The researchers found that most of the respondents under the study have not done required antenatal check-up (47 respondents). While inquiring upon it, the researchers found that customary beliefs (44.68%) of the respondents play a very crucial role here along with ignorance about the importance of such check-up (36.17%) and financial problem (19.14%). It was seen from the table-1 that even after being registered, the women did not go for institutional delivery. This table shows that customary belief (35.89%), lack of confidence on the staff of health centers (28.20%), ignorance about usefulness (20.51%) and financial constrain (15.38%) are the main reasons for less institutional delivery among the respondents. It is also found that none of the respondents have gone for required no. of postnatal health check-up. The table shows that superstitious belief of black magic, etc. (62%), ignorance about usefulness (22%) and financial problems (16%) are the major reasons of less postnatal health check-up.##

RECOMMENDATIONS & CONCLUSION

From the major findings of the present study, the researchers have come up with the following recommendations:

1. Literacy through Non-formal education to be popularized among the WDWs to improve their knowledge about MCH services.
2. The duty and services provided by ASHA workers need to be monitored regularly.
3. NGOs involvement to be encouraged by the concerned authority for realization of safe motherhood goal of government of India.
4. Special awareness camps for women domestic workers and slum dwellers are to be organized.

Knowledge about health is considered as one of the key factors that enable women to be aware of their health rights in order to seek appropriate health services. The women domestic workers in India are the most vulnerable section of the urban population in terms of the health indicators. Utilization of healthcare services is poor among the WDWs due to the nature of their work and long working hours. Social and cultural barriers are common among these illiterate poor domestic workers which prevent them to access existing MCH services. The present study depicts an unsatisfactory picture about the awareness and utilization of MCH services among the women domestic workers of Guwahati city. Even though the study was conducted with a small size of sample, yet the findings are significant. From the above discussion, it is found that utilization of maternal health services is dependent on socio-economic determinants and attitude belief system of the WDWs and their family. Cultural barriers are also common reason for which they are not able to take the benefit of healthcare services. Giving birth at home and unsafe deliveries are still widely prevalent among them. The researchers also found that the whole

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pregnancy – antenatal and postnatal period is full with superstitious beliefs that restrain these women from accessing the services and practicing healthy habits. It is needless to mention that poverty plays an important role in the health seeking behavior of the people. As the respondents of the study are employed as domestic workers, they are not getting paid leave for their health check-up and found to be drop out from the antenatal and postnatal check-up. For concluding the discussion, it can be said that for addressing the gap between provided services and accessed services, we need to focus on the social and economic determinants along with medical interventions for fulfilling the mission of a healthy nation.

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