Original Articles

Perspectives of women on availing antenatal services in urban poor areas of Rishikesh, Uttarakhand

ANUSHA SHARMA, MEENAKSHI KHAPRE, SANTOSH KUMAR, SUREKHA KISHORE

ABSTRACT

Background. Antenatal care (ANC) is the essential regular care of women that prevents potential health problems during pregnancy. In India, the proportion of women who received four or more antenatal visits was only 51% (National Family Health Survey, 2015–2016). An even worse situation prevails in urban areas where women from poor communities face greater health risks. We assessed various barriers women residing in these areas come across in availing ANC services.

Methods. This study is a part of a mixed-methods, community-based study, and we report its qualitative component. We conducted the study at the residence of the study participants in September–October 2019. The study participants were women who had less than four antenatal visits throughout the pregnancy. Twelve in-depth interviews were conducted based on data saturation. Data were transcribed and themes were drawn concerning the gender analysis framework.

Results. Through this study, we found how gender relations affect the utilization of antenatal services concerning access to resources, division of labour, social norms including the belief of husband and other family members towards pregnancy and decision-making power of women.

Conclusion. Our findings underline the importance of making the urban health system gender-sensitive and responsive to the needs of women during pregnancy. There is a need to educate men regarding maternal health so as to allay such social norms that label pregnancy as a woman's responsibility and encouraging them to accompany their wives during pregnancy visits, thus making men a part of antenatal services.

Natl Med J India 2022;35:325–9

All India Institute of Medical Sciences, Rishikesh, Uttarakhand, India
ANUSHA SHARMA, MEENAKSHI KHAPRE, SANTOSH KUMAR, SUREKHA KISHORE Department of Community and Family Medicine

Correspondence to ANUSHA SHARMA; *sharmanusha04@gmail.com*

[**To cite:** Sharma A, Khapre M, Kumar S, Kishore S. Perspectives of women on availing antenatal services in urban poor areas of Rishikesh. *Natl Med J India* 2022;**35:**325–9.]

INTRODUCTION

Motherhood is the most crucial and fulfilling phase in a woman's life. Pregnancy and childbirth are considered a normal physiological process. However, some women may experience health issues and even mortality during this phase.[1]

In 2017, globally about 295 000 women died during pregnancy and childbirth. In India, the maternal mortality ratio (2014–2016) is 130, while according to Sustainable Developmental Goals 2030, the target to reach is 70, which is almost half the current ratio.[2] To achieve this target, a well-defined evidence-based strategy is needed.

Antenatal care (ANC), also called prenatal care, is the essential and regular care of women that prevents potential health problems during pregnancy. It aims to assure the well-being of the mother and the child by promoting a healthy lifestyle during pregnancy. ANC among pregnant women is a key factor in reducing maternal mortality and morbidity.[3] During pregnancy, every woman should make at least four antenatal visits, as per Government of India norms.[4]

In India (2015–2016), the proportion of women who received four or more 4 ANC visits was only 51%.[5] The situation was even worse in urban areas as women from poor communities face greater health risks. Their social and economic roles expose them to environmental hazards.[6] In India, the urban poor constitute nearly one-third of the urban population.[7] The actual case scenario of these deprived sections of society is diluted by country-level estimates.[8] Women face difficulties in accessing healthcare services because of deep-seated discriminations and inequities related to gender norms, which are just not exclusive to the urban poor areas but pervasive throughout the country.[9]

The gender analysis framework examines an issue by aggregating information and promoting gender integration into the programme or system. It helps to understand the interaction of biological and sociocultural factors to highlight how these factors affect health behaviours, access and control over health resources.[10]

We aimed to understand the gender dynamics that affects adequate utilization of accessing ANC services. We also aimed to determine the barriers in accessing ANC services during pregnancy from the perspectives of women who had delivered.

METHODS

Rishikesh is a town in the Dehradun district of Uttarakhand

state in India. The study was done in the four urban poor settlements we identified in Rishikesh.[11] This was part of a mixed-methods study to determine as well as explore the factors affecting the utilization of ANC services in these areas. We report here the qualitative component of the study.

Study population

Women who delivered during the past 1 year and were residing for >6 months in the area were eligible for inclusion in the study. Of these, women who had less than four ANC visits (considered one of the components of full ANC)[12] throughout the pregnancy were selected by purposive sampling. Women who did not consent to participate were not included in the study.

Data collection

The information was collected by conducting in-depth face-to-face interviews in September–October 2019 with the eligible participants at their residence. Before starting the interview, the participants were explained about the purpose, why they were chosen, expected duration of the interview and what was expected, how the information would be kept confidential and the use of a note-taker and/or tape recorder. Initially, we planned to audiotape the interviews, but as the majority of participants declined giving consent for audio taping the interview, field notes were taken after taking informed consent of the participants. Each interview was of 45–50 minutes during which privacy was maintained. A trained person (AS) interviewed the participants with the help of a pilot-tested guide prepared by the researchers for the interviews (Box 1). The final summarized key data were shared with the participants to assess for any discrepancies in paraphrasing and understanding of the interviewer. The recorded data were reviewed and transcribed into written text on the same day the interview was conducted. Interviews were continued till data saturation, which arrived after 12 in-depth interviews. Four participants refused to participate in the study because of reasons such as (i) 'mother-in-law not permitting to leave household chores'; (ii) 'leaving home for going out to the local market'; (iii) 'no spare time from doing household chores'; and (iv) 'taking care of children'.

Box 1: Questionnaire

1. What factors are associated with antenatal check-ups in your area?
2. What kind of problems did you face for antenatal check-ups during pregnancy?
3. Can you tell me the major barrier stopping you from going for antenatal check-ups?
4. Did any of your friends/relatives/ASHA (accredited social health activist)/ANM (auxiliary nurse and midwife) tell you to go for antenatal check-ups? If yes, why didn't you go?
5. Did you tell your family members that you want to go for antenatal check-ups? If yes, what was their response? If no, why?
6. Was your family financially supporting you during your pregnancy? If no, why?
7. Was your family emotionally supporting you during your pregnancy? If no, why?

Data analysis

This was done by a gender framework approach using thematic analysis.[13] The information collected was transcribed into written text. This text was read and re-read line by line to generate codes using the inductive approach (AS and MK). These codes were then grouped into categories, then themes were established following the gender analysis framework.[14] Investigator triangulation was achieved by analysing data separately by two independent trained investigators (AS and MK).

Rigor of the study

Lincoln and Guba's criteria including credibility, dependability, transferability and confirmability were used to ensure the rigor of the study.[15] To ensure credibility, diligent observations of the participants were made, emphasis was on capturing their emotions, investigator triangulation was done and member checking by sharing summary with participants. For transferability, a detailed description of the findings and characteristics of participants is provided in the report. To ensure dependability and confirmability, the Consolidated Criteria for Reporting Qualitative research Guidelines was followed.[16] Ethical clearance was granted by the Institutional Ethical Committee AIIMS, Rishikesh.

RESULTS

Of 176 women, the number of women with less than four ANC visits was 71 (40.3%). Twelve in-depth interviews with women were considered for the qualitative component based on data saturation.

The age group of the study participants ranged from 19 to 35 years. Of 12 study participants, 4 studied till primary school, 2 till middle school and the rest were illiterate. All the study participants were unemployed, and the majority of them belonged to the upper-lower socioeconomic class. Nine participants belonged to a nuclear family, 10 were Hindus and 2 were Muslim.

The four themes generated from the verbatim in-depth interviews of the study participants about the various reasons for inadequate antenatal visits, i.e. access to resources, division of labour, social norms and decision-making are given in Table I.

Access to resources

Lack of access to resources emerged as an important factor affecting the utilization of ANC services. According to one participant:

> *Mere saare kharchon ke liye mujhe apne pati se hi paise lene padte hain, unki ijaazat ke bina main apni sehat pe koi kharcha nahi kar sakti. Vaise toh sarvajanik parivahan se hospital jaane ke liye itne paise nahi lagte, lekin mere pati mujhe itne paise dene se bhi manaa kar dete the.* (I have to take money from my husband for all my expenses and I cannot spend money on my health without his permission. Although the public transport facility is not expensive, but my husband refused to give me that much money too—participant 10, 29 years old).
>
> *Panchave mahine mein dard ke karan doctor ne mujhe ultrasound karwaane ko kaha. Us time government hospital mein ye suvidha nahi thi aur mere pati ne mujhe private se ultrasound karwaane*

TABLE I. Gender framework analysis of inadequate antenatal care (ANC) visits

Theme	Categories	Codes
Access to resources	Financial support	• Not getting money for transport • Not getting money for ANC services
	Lack of quality services in health facility	• Long waiting hours • Occasional provision of services • Out-of-pocket expenditure
	Absence of effective communication/ access to information	• Messages not understandable • Short interaction time with doctor
Division of labour	Heavy workload and lack of help from husband	• Husband not taking responsibility for household work • Husband not accompanying woman to healthcare facility • Women need to manage household chores, childcare responsibilities and sometimes continue earning
Social norms (belief, perception, and behaviour of pregnant women and family members towards pregnancy)	Home remedies are more trustworthy than medicines	• Health issues during pregnancy can be easily cured by home remedies • Antenatal visits to be made when home remedies are not effective
	Seeking healthcare during pregnancy	• Antenatal visits important only when a problem arises • Only one ultrasound at 6–7 months is needed • Visiting hospital is a waste of money
	Considering events during each pregnancy is same	• Antenatal visits needed only during the first pregnancy
	Behaviour of healthcare workers	• Staff always in a hurry due to high patient load • Staff not listening to the problems of women • Rude and unfriendly behaviour of the staff
Decision-making	Patriarchal nature	• Need permission to leave home • Need to ask the husband for money
	Feudal nature	• Involvement of elder members (like mother-in-law) for decisions related to pregnancy care

> *ke liye paise dene se manaa kar diya.* (During the 5th month of pregnancy, I had pain in my abdomen and the doctor advised me to get an ultrasound done. At that time, the facility of ultrasound was not available at the government hospital and my husband refused to give me money for getting an ultrasound done from a private hospital—participant 6, 23 years old).

Uncertain availability of facilities at the government hospital was reported because of which the participants had to go to private facilities for getting an ultrasound done and the services provided in private facilities were highly priced.

> *Private hospital se ultrasound karwaane ke liye kaafi paise lagte hain aur hum gareeb log itne paise kahan se laaye?* (Getting an ultrasound done from a private facility is expensive and we are poor people, from where will we get that much of money?—participant 9, 22 years old).

As women are already loaded with household work, waiting in long queues for their check-up also affected their visits to the hospital.

> *Hospital jao toh doctor se jaanch karwaane ke liye lambi line mein ghanto intezaar karna padta hai… ghar pe itna kaam chhod ke hospital jaana kaafi mushkil ka kaam hai.* (There is a long queue in the hospital when we go there for a check-up and it takes hours before the doctor examines us. To leave so much household work behind is a difficult situation—participant 1, 28 years old).

According to participants, because of being less educated, they are sometimes not able to understand the instructions given by the doctor:

> *Jab main apne teesre maheene mein doctor ke paas gayi toh doctor ne mujhe meri sehat ke baare mein jankaari di, mujhe unki baat thodi samjh nahi aayi kyunki main itni padhi likhi nahi hoon…isliye maine doctor ko dobaara puchha aur mujhe doctor se ye sunne ko mila ki itna time nahi hai humaare paas ki tumhe baar baar baat samjhayen. kya mujhe apni sehat ke baare mein puchhne ka bhi haq nahi hai?* (I had gone to the hospital for an antenatal check-up during the 3rd month of my pregnancy. The doctor gave me information about my health and I able to understand certain things because I am not that literate. When I requested him to please explain again, he replied by saying that he does not have the time to explain things to me again and again. Do I not have the right to ask about my health?—participant 8, 19 years).

Division of labour

Heavy workload of women during pregnancy and lack of help form husbands was also reported by a participant:

> *Pregnancy ke dauraan mere pati ne kabhi meri kaam mein madad nahi ki, humaare ghar mein paanch log rehte hai aur maine pregnancy ke dauraan saara ghar ka kaam akele hi kiya hai. Mere pati ka kehna hai ki bacche paida karna aur ghar ka kaam karna bas aurat ki hi zimmedari hai.*

(My husband never helped me in my household work during those 9 months. I did all the household work alone for five people without any help. According to her husband, giving birth to children and doing household work is only a woman's responsibility—participant 11, 27 years old).

Social norms

Some participants believed that ANC is needed only when the problem arises. Most participants felt that ANC check-up was needed only during the first pregnancy when women received all the information related to pregnancy care. Also, going to the hospital in between household chores was perceived as a waste of money and time.

According to another participant, home remedies were better than hospital visits:

Pregnancy ke dauraan sehat kharaab hona mamooli baat hai aur iska ilaaj ghar pe hi kiya jaa sakta hai. Hospital se jyaada bharosa mujhe apne poorvajon ki batayi hui baton pe hai, agar kabhi ghar ke nuskhe kaam nahi kar rahe toh fir hospital jaana chahiye. (Having issues related to health is common during pregnancy and some can be cured at home. I believe more on the recipes suggested by my elders. Hospital visits should be made only when home remedies are not effective—participant 5, 30 years old).

Some women reported that their husbands were not supportive emotionally, nor did they provide them any care during this vulnerable period. Their husbands denied accompanying them to hospitals because according to them having health problems during pregnancy is not a serious matter.

The behaviour of the doctor also affected the participant's visit. According to a participant, the behaviour of the doctor was rude and unfriendly during the antenatal visits:

Doctor hamesha jaldi jaldi hi jaanch karte hai, kyuki unko bohat saare mareez ko dekhna hota hai. Shayad isi wajah se unka bartaav humaare saath bohat hi bura hota hai. Woh ye nahi samajhte ki hum pehle se hi kitni takleef mein hain. (Doctors are always in a hurry during examining us, because of high patient load. Perhaps that is the reason for their rude behaviour but they should understand that we are already facing so many problems—participant 7, 29 years old).

Participants believed that doctors should listen to their problems more empathetically.

Decision-making

Some participants reported they have to take permission of the husband or elder member of the family to leave home. They are dependent on their husband concerning financial matters. Most of the decisions regarding pregnancy and care during birth are vested with the mother-in-law or elder women of the household.

DISCUSSION

Our study focuses on the population most deprived of the healthcare services, i.e. the urban poor and how the gendered power relation, which consists of access to resources, division of labour, social norms and decision-making, acts as a barrier to utilization of ANC services.

Having limited access to money for their health is a big hurdle in accessing ANC services. The role of men as the breadwinners of the family restricts access of women to resources and also affects their decision-making.[17] Pandey found that women during their pregnancy generally do what they are told to do by their husbands and other family members. Women not going for ANC were not aware of ANC services.[18] Poor services and out-of-pocket expenditure further restrict the utilization of services. Lama and Krishna reported that out-of-pocket expenditure for medicines, ultrasounds and other tests act as a barrier in accessing ANC services. When these services are not available at a government facility the patients are sent to private facilities.[19] Similarly, in our study, women reported that the facility of ultrasound was not always available and they had to visit a private facility, which is not easy on the pocket. In a study by Griffith and Stephenson in Maharashtra, some women reported that private hospitals offer quality service, but they could not afford private healthcare services.[20] Lack of access to satisfactory and comprehensive health service is a barrier to healthcare utilization and due to the reproductive and care-giving roles women play, they are affected more in comparison to their partners.[21,22]

Effective communication between the doctor and the pregnant woman is lacking during ANC visits. Women residing in urban poor areas are less literate and unable to understand the messages of healthcare providers. This was further enhanced by the negative attitude of the hospital staff when they blame the women for poor health. Conveying the right information is crucial because if the woman will understand the information it is more likely that she will act upon it.[23] A qualitative study by Nyathi *et al*. found that an indifferent attitude of the nurses was a reason for some women to not go to the health facility for an ANC visit and for not taking the prescribed medicines.[24] The gender implication of the rude behaviour of the staff is that a pregnant woman can react to such behaviour differently compared to men and such behaviour of the staff can affect women more because they are availing service during a vulnerable period.

The lack of respect from health workers, and their abusive and degrading behaviour towards women, emerged as an important factor that undermined their willingness to seek care across various studies.[21,25,26] This behaviour of healthcare staff reflects gender norms that devalue women during a sensitive phase of their lives.[27] This treatment of women and its impact on access provides evidence that health systems are gendered inequitably—not simply lacking financial resources.

The division of labour is often mediated by social norms. Some men do not support their wives in household work thinking it is a women's work. Men do not accompany pregnant women for check-ups because of the belief that men should not be a part of the issues related to pregnancy and giving birth is just a woman's responsibility.[28] This affects the pregnant woman's health as her body is already going through hormonal changes that further affect the utilization of ANC services.

A study in Maharashtra to understand the barriers of the utilization of maternal healthcare services found that women consider ANC as curative rather than preventive.[20] Similarly, in our study, women believed that hospital visits were important only when health issues arise, and for some ANC was important only during the first pregnancy. The belief of women regarding

ANC stems from social norms—for some women consumption of medicines during pregnancy can harm the baby and for others home remedies are more trustworthy than hospital care. Similar results were reported by Lama *et al*. where some women did not take iron tablets as they felt these could harm the foetus.[19] Nisar *et al*. reported that women were scared of the side-effects of medicines.[29]

The decision-making power of women is shaped by the patriarchal and feudal nature of society. Some women said they were dependent on their husbands/elder members to get money or permission to leave home. They were not independent to take decisions regarding their health. The relation of this unbalanced power in decision-making with the other three gender power relations is critical as these play an important role in the utilization of maternal health services.[28]

Addressing the barrier related to gender power relation in the urban health system

Health programmes should be made gender-sensitive by using a life cycle approach to reduce inequalities between men and women by elevating the position of women, redefining the distribution of resources and duties among men and women, and by addressing the relationships between women and service providers. Efforts are needed at the community level to challenge the norms that support that pregnancy is only a woman's responsibility. Challenging the ignorant attitude of men regarding pregnancy and encouraging them to help pregnant women with household work and assist in ANC visits is of paramount importance. It is necessary to empower women starting from educating girls and delaying their marriage so that in the future they can independently spend on their health resulting in betterment of women and their families. Efforts are needed to make hospital staff more responsive and empathetic towards the needs and problems of pregnant women.

Our study has some limitations. First, we aimed to identify barriers in the utilization of antenatal services, 'gender' was identified as an important factor during the analysis phase and then the gender framework analysis was considered. Therefore, in-depth issues related to gender have not been addressed. Second, men were not interviewed and this could have provided an in-depth understanding of their perspectives.

Conclusion

We came across various gender power relations such as access to resources, an unequal division of labour in the family, social norms, and limited involvement of women in decision-making. It is important to strengthen the health system to be supportive to women during this crucial phase of their life. Therefore, demand-side intervention in the urban health system needs to incorporate gender into the programme design.

Conflicts of interest. None declared

REFERENCES

1 Gudayu TW, Woldeyohannes SM, Abdo AA**.** Timing and factors associated with first antenatal care booking among pregnant mothers in Gondar Town, North West Ethiopia. *BMC Pregnancy Childbirth* 2014;**14:**287.

2 WHO. Maternal mortality. Available at *www.who.int/news-room/fact-sheets/detail/maternal-mortality* (accessed on 10 Apr 2020).

3 Rejoice PR, Ravishankar AK. Differentials in maternal health care service utilization: Comparative study between Tamilnadu and Karnataka. *World Appl Sci J* 2011;**14:**1661–9.

4 National Health Portal of India. Pregnancy. Available at *www.nhp.gov.in/healthlyliving/pregnancy* (accessed on 10 Apr 2020).

5 International Institute for Population Sciences and ICF. *National Family Health Survey (NFHS-4), 2015-16: India*. Mumbai:International Institute for Population Sciences; 2017.

6 Prakash R, Kumar A. Urban poverty and utilization of maternal and child health care services in India. *J Biosoc Sci* 2013;**45:**433–49.

7 Sharma N, Kiran Kumar HV, Devgan S. A study on utilization of antenatal care services in urban slums of Amritsar city, Punjab, India. *Int J Community Med Public Health* 2017;**4:**698.

8 Mony PK, Verghese L, Bhattacharji S, George A, Thoppuram P, Mathai M. Demography, environmental status and maternal health care in slums of Vellore town, southern India. *Indian J Community Med* 2006;**31:**5.

9 Namasivayam A, Osuorah DC, Syed R, Antai D. The role of gender inequities in women's access to reproductive health care: A population-level study of Namibia, Kenya, Nepal, and India. *Int J Womens Health* 2012;**4:**351–64.

10 Warren H. Using gender-analysis frameworks: Theoretical and practical reflections. *Gend Dev* 2007;**15:**187–98.

11 Phnom P. Multiple indicator assessment of the urban poor. Available at *http://ticambodia.org/library/wp-content/files_mf/1448965357URBANPOORMULTIPLEINDICATORASSESSMENTOFTHE.PDF* (accessed on 10 Apr 2020).

12 International Institute for Population Sciences. National Family Health Survey (NFHS-4), 2015-2016. State Fact Sheet Uttarakhand. Available at *http://rchiips.org/NFHS/pdf/NFHS4/UT_FactSheet.pdf* (accessed on 10 Apr 2020).

13 Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess RG (eds). *Analysing qualitative data*. London:Routledge; 1994:173–94.

14 Morgan R, George A, Ssali S, Hawkins K, Molyneux S, Theobald S. How to do (or not to do) … gender analysis in health systems research. *Health Policy Plan* 2016;**31:**1069–78.

15 Lincoln YS, Guba EG. But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Dir Program Eval* 1986;**1986:**73–84.

16 Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007;**19:**349–57.

17 Scott K, McMahon S, Yumkella F, Diaz T, George A. Navigating multiple options and social relationships in plural health systems: A qualitative study exploring healthcare seeking for sick children in Sierra Leone. *Health Policy Plan* 2014;**29:**292–301.

18 Pandey N. Perceived barriers to utilization of maternal health and child health services: Qualitative insights from rural Uttar Pradesh, India: Available at *https://paa2011.populationassociation.org/papers/111751* (accessed on 10 Apr 2020).

19 Lama S, Krishna A. Barriers in utilization of maternal health care services: Perceptions of rural women in eastern Nepal. *Kathmandu Univ Med J* 2015;**12:**253–8.

20 Griffiths P, Stephenson R. Understanding users' perspective of barriers to maternal health care use in Maharashtra, India. *J Biosoc Sci* 2001;**33:**339–59.

21 Percival V, Dusabe-Richards E, Wurie H, Namakula J, Ssali S, Theobald S. Are health systems interventions gender blind? Examining health system reconstruction in conflict affected states. *Global Health* 2018;14:90.

22 Agadjanian V, Hayford SR, Luz L, Yao J. Bridging user and provider perspectives: Family planning access and utilization in rural Mozambique. *Int J Gynecol Obstet* 2015;**130:**E47–E51.

23 WHO. Communicating for health, Use plain language. Available at *www.who.int/about/communications/understandable/plain-language* (accessed on 19 May 2020).

24 Nyathi L, Tugli AK, Tshitangano TG, Mpofu M. Investigating the accessibility factors that influence antenatal care services utilisation in Mangwe district, Zimbabwe. *Afr J Prim Health Care Fam Med* 2017;**9:**e1–e5.

25 Anastasi E, Borchert M, Campbell OM, Sondorp E, Kaducu F, Hill O, *et al*. Losing women along the path to safe motherhood: Why is there such a gap between women's use of antenatal care and skilled birth attendance? A mixed methods study in northern Uganda. *BMC Pregnancy Childbirth* 2015;**15:**287.

26 Munguambe K, Boene H, Vidler M, Bique C, Sawchuck D, Firoz T, *et al*. Barriers and facilitators to health care seeking behaviours in pregnancy in rural communities of southern Mozambique. *Reprod Health* 2016;13 (Suppl 1):31.

27 Maung TM, Show KL, Mon NO, Tunçalp Ö, Aye NS, Soe YY, *et al*. A qualitative study on acceptability of the mistreatment of women during childbirth in Myanmar. *Reprod Health* 2020;**17:**56.

28 Morgan R, Tetui M, Muhumuza Kananura R, Ekirapa-Kiracho E, George AS. Gender dynamics affecting maternal health and health care access and use in Uganda. *Health Policy Plan* 2017;**32:**v13–21.

29 Nisar YB, Aurangzeb B, Dibley MJ, Alam A. Qualitative exploration of facilitating factors and barriers to use of antenatal care services by pregnant women in urban and rural settings in Pakistan. *BMC Pregnancy Childbirth* 2016;**16:**42.