

Reproductive health care seeking behavior among urban slum women of Delhi

Adhapillil Mathai Elizabeth, Abdul Mazed Khan, Wahid Rashid

Department of Social Sciences, National Institute of Health and Family Welfare, New Delhi, India

ABSTRACT

Background: The study tries to understand what are the dimensions of Reproductive Health care seeking behavior among the urban slum women in Delhi, their level of awareness and treatment seeking patterns? **Materials and Methods:** The study was carried out in one of the slum in south district of Delhi. 253 women of reproductive age group were selected by systematic random sampling. Interpersonal interview was conducted to seek information on the selected parameter. **Results:** Around three-fourth women had undergone for blood pressure check up, weight recording and stomach/abdomen check up during pregnancy. Only 39.9% received advice on avoiding intake of medicine during pregnancy. About 14.6% mentioned that at least 40 days rest were required for resuming daily routine activities after delivery. Thus majority of these slum women are ignorant about the importance of post natal care which was necessary for post delivery care of the women and her infant. **Conclusion:** The correct knowledge on the importance of ANC and PNC and various checkups need to be carried out during pregnancy and postnatal period needs to be imparted to these women. Thus, health education and health promotion campaigns are needed for bring changes in the existing health-seeking behaviors among urban slum women.

Key words: Reproductive health, awareness level, antenatal care, postnatal care, slum women

INTRODUCTION

In India, pregnancy and childbirth are generally accepted as normal events of life, and it is not surprising that problems associated with pregnancy are also accepted without much havoc. The reproductive health care seeking behavior (RHSB) is culturally determined; and various sociocultural, economic, education, physiological and environmental factors do play a significant role and influence either directly or indirectly in shaping the RHSBs in men and women in the community.^[1] Promotion of maternal and child health concern is reflected through antenatal care (ANC) and postnatal care (PNC). ANC refers to pregnancy-related health care during

pregnancy. The safe motherhood initiative proclaims that all pregnant women must receive a basic, professional ANC.^[2] Ideally, ANC should monitor a pregnancy for signs of complications, detect and treat preexisting and concurrent problems of pregnancy, and provide advice and counseling on preventive care, diet during pregnancy, delivery care, PNC and related issues. Reproductive and child health (RCH) services introduced by government of India in 1997 include all these including two doses of tetanus toxoid (TT) vaccine to mothers, adequate amounts of iron and folic acid (IFA) tablets or syrup (to prevent and treat anemia), three antenatal check-ups that include blood pressure (BP) checks, weight monitoring and other procedures to detect pregnancy complications.^[3] Most of the available literatures focus on maternal mortality due to obstetric causes, complications due to contraceptive usage and sexually transmitted infections, etc. Most of the studies are based on hospital-based data

Address for correspondence: Dr. A. M. Elizabeth,
Department of Social Sciences, National Institute of Health and Family Welfare, New Delhi - 110 067, India.
E-mail: amelizabeth@nihfw.org

Access this article online

Quick Response Code:



Website:
www.jehp.net

DOI:
10.4103/2277-9531.171800

This is an open access article distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as the author is credited and the new creations are licensed under the identical terms.

For reprints contact: reprints@medknow.com

This article may be cited as: Elizabeth AM, Khan AM, Rashid W. Reproductive health care seeking behavior among urban slum women of Delhi. *J Edu Health Promot* 2015;4:87.

and hence do not reflect the true scenario of the problems prevailing in the community. There is a lack of authentic information about the extent of RHSB among the slum dwellers. Studies by Srinivasan, Mumiyandi, Gandotra and Das and Basu have however not focused on antenatal and postnatal health awareness among women in slums of greater Mumbai.^[4-7]

Study on the health-seeking behavior (HSB) and utilization of health services by pregnant mothers in Vadodara slums reported that majority of women preferred private hospital for delivery in spite of being from lower socioeconomic group and most of the mothers ignored PNC.^[8] A study by Manna *et al.*^[9] on the Mothers of Tea Garden in Jalpaiguri and Darjeeling Districts, West Bengal reported that nonutilization or under-utilization of maternal health care services, especially among urban slum population are high due to lack of awareness or access to health care and this calls for understanding the HSB and utilization of services by those in need of them. Identifying the areas that are critical will help on improving it. Dandappanavar and Khan^[10] conducted a study in an urban slum of Dharwad town in Karnataka and reported that antenatal period is determined by religious beliefs and practices, which were learnt through the process of socialization. Apart from this literacy, education and exposure to mass media are less significant when it comes to the HSB because the people opine that pregnancy and childbirth are intertwined with the functions of religion, family, kinship and marriage.

The study conducted in three districts in different divisions of Bangladesh reported that less than half of the women received any ANC, and 1/10th received a minimum of four check-ups. Only 1/5th took iron tablets for at least 4 months during pregnancy. Over 90% took place at home, and only 1/10th were attended either by a doctor or by a nurse. About 54% of mothers reported three key hygienic practices in deliveries that is, attendants washing their hands with soap and boiling cord-tie and blade for cutting the cord. About 44% of the infants were bathed immediately after delivery, and 42% were given colostrum as their first food. The study suggested that maternal and newborn-care remains a cause of concern in rural Bangladesh. Short-term policies to promote healthy behavior in the home are needed, in addition to the long-term goal of skilled birth attendance.^[11]

A number of factors have been found to be associated with the utilization of obstetric health care which are directly related to social, cultural and economic factors.^[12] While Celik^[13] reports that besides socioeconomic factors, women's education, birth order and standard of living index have pronounced the influence in choosing the health care facility.

Warren *et al.*^[14] report that in order to be effective in reaching those mostly in need, PNC services must be located close to or at home so that identification, referral, and treatment of complications can occur as early as possible. PNC services can be delivered at a health facility, through home visits by health

workers, or through a combination of care in facilities and at home. At the level of community also, there are a number of institutions that have bearings to fertility and reproductive health decision-making and reproductive health status.^[15]

Literature review shows, there is a wide gap in awareness, attitude and practices with respect to RHSBs. In most developing countries, however, PNC may only occur if provided through home visits because geographic, financial, and cultural barriers typically limit care outside the home during the early postnatal period. Countries must adopt strategies that take into account unique cultural and social contexts, available financial and human resources, and existing health systems. In addition, strategies to provide PNC within a country should vary or be modified to target the hard-to-reach, marginalized, and poorest groups of women and newborns.^[16] Therefore, comprehensive reliable data on the nature, magnitude, and determinants of reproductive health problems in the slum area are needed to policy makers and program planners especially for multidimensional program like RCH. Hence, the HSB and its consequences need explorations. Present study on HSB among the urban slum women of South Delhi has been conducted to understand their knowledge, attitudes and prevailing practices during pregnancy, childbirth and observation of PNC.

MATERIALS AND METHODS

The urban slum population forms nearly a quarter of the total population of New Delhi. The study was conducted in one urban slum of South Delhi. The approximate population of the selected was about 6400 people consist of around 1400 households. A community-based cross-sectional survey was carried out to select sample. Systematic random sampling technique was used for the selection of households where every second household was selected to collect data. Selected household was left in case representative sample (i.e., women of reproductive age 15–45 years) was missing and next second household was selected. Each interviewed women was explained about the objectives of the study and informed verbal consent was taken before the interview. The sample selected for this study was 300 women of reproductive age group of 15–45 years of age, but during interview 47 women whom the investigator approached did not to fully participated and left without giving information in the middle of interview. Therefore, complete information for the study could only be obtained from 253 women. Hence, these 253 women of 15–45 years of age years were considered as valid sample size for the present study.

The study was carried out using semi-structured interview schedule. The interviews were conducted by research assistants trained for collecting data. To provide training to the research assistants' initial dummy interviews were conducted between the investigators. Pilot survey and pretesting of the questionnaire was done. Necessary changes were made in the questionnaire to encompass gap so that complete information could be obtained without any difficulty. Content validity of

the questionnaire was determined by taking opinion of the experts in the field of reproductive health. The questionnaires reliability was also checked out. Questionnaire was found to be reliable as shown by test-retest method ($r = 0.95$). All the instruments were translated in the vernacular (Hindi) for ease application when required. The final round of data collection was initiated after 1-month of the pretesting of the interview schedule. The questionnaire/schedule finalized after pretesting was canvassed in person to collect data on RHSB like health check-up during pregnancy, awareness of health care measures to be followed during pregnancy, nutritional intake and other planning such as birth planning behavior during pregnancy. Information on PNC, pregnancy-associated sociocultural practices and complications suffered by the women during pregnancy for which the health care services were utilized were also collected from the selected samples.

The data collected were entered into the computer using group codes and numbers so that when required it would lend itself to regrouping to understand the distribution pattern and trend for the selected variable. The computer entry of the data was made using Statistical Package for Social Sciences (SPSS) (version 10.0 manufactured by IBM) computer software for window. The data were analyzed for cross tabulation, frequency distribution and expressed in percentage for each variable chosen under the study.

RESULTS

Health check-up during pregnancy carries utmost priority in the strategies to ensure safe delivery. Analysis [Table 1] shows that during pregnancy around 75.5% of women had been examined for at least 1 parameter meant for health check-up during pregnancy. This shows that 3/4th of these women have received some form of anti natal care during pregnancy either self-visiting the nearby hospital or it has been provided at their door step by local health care providers. Of these women, 72.7% were examined for BP. In 73.5% of women, weight was recorded during pregnancy. Stomach/abdomen check-up was done in 75.5% of women, and urine test was done in 70.8% of women during pregnancy. They also reported to have received advice on the intake of enough nutritious food and to take 3–4 h rest in a day during pregnancy. Only 39.9% of women were advised to avoid intake of any medicine during pregnancy. Further, the data show that in all the pregnancy cases health check-up was not uniformly carried out covering all parameters necessary for ensuring quality of ANC check-up received at the time of pregnancy. Thus, the study shows the flaws of the health system particularly in the dimension related to quality of health care services delivered by health care providers.

Awareness of health care measures among women is important as it guides them to take timely action during pregnancy and childbirth that will safeguard both mother and child from rising serious complications and problems. In this study, effort was made to ascertain what a woman knows about excess bleeding after 7–8 h of delivery and what needs to be done

Table 1: Health checks-up during pregnancy

Indicators health checks-up during pregnancy	Responses Frequency (%)	
	Yes	No
Health check-up		
Eye	156 (61.7)	97 (38.3)
Tune	157 (62.1)	96 (37.9)
Nail	148 (58.5)	105 (41.5)
Pulse	130 (67.2)	83 (32.8)
Urine test	179 (70.8)	74 (29.2)
BP check-up	184 (72.7)	69 (27.3)
Weight recording	186 (73.5)	67 (26.5)
Palms	154 (60.9)	99 (39.1)
Stomach/abdomen	191 (75.5)	62 (24.5)
Whether following advises was given to you		
Eat enough nutrition food	193 (76.3)	60 (23.7)
Eat at least 3/4 times a day	192 (75.9)	61 (24.1)
Taken enough rest	192 (75.9)	61 (24.1)
Avoid taking medicine	101 (39.9)	152 (60.1)

in such cases? In response to this 70.8% women reported that hospitalization is necessary in case bleeding is continued for 7–8 h after the delivery, whereas 29.2% believes that there is no need for hospitalization. Refusing for hospitalization is risky for them self and for others to manage it. On enquiring what happens when there is excess bleeding? These Women reported palpitation (60.0%), sweating (61.7%), lower BP (60.5%), faintness (69.6%) and changes in the body color (generally yellowish/whitish) (79.8%) will occur in case of excess bleeding [Table 2].

The data on the awareness level related to health care measures to be followed during pregnancy revealed that among these selected women 91.7% reported the need for getting registered in hospital when pregnant. Three prenatal check-up should be done by the doctor was reported by 85.8% of women. The need for BP check-up was reported by 86.25% of women. The abdominal check-up should be done told by 88.5% of women. The need for weight measurement and recording it was reported by 88.1% of women. Further, two doses of tetanus toxin should be given to the pregnant women was told by 91.7% women and 89.3% of women reported that IFA should be given to the pregnant women [Table 2]. Thus, the study shows that these slum women seem to be well aware of the health care measures to be followed during pregnancy.

When asked about the practices related to health care measures that they sought during last/present pregnancy, it was found that 76.3% of these pregnant women registered in hospital, and 75.5% had undergone health check-up. In 73.9% of these studied women, BP check-up was done and 74.3% women had undergone weight recording. Further, 81.4% of these pregnant women received two doses of TT and 75.9% of the pregnant women consumed prescribed IFA tablets [Table 2]. Thus, the study finding shows that there is well awareness among the women about the health care

Table 2: Awareness of health care measures, nutrition and other birth planning behavior during pregnancy

Indicators	Frequency (%)	
	Yes	No
Do you know if there is excess bleeding after 8 h of delivery the women has to change her pad after every hour, she need to be hospitalized	179 (70.8)	74 (29.2)
What happen in case of excess bleeding		
Palpitation	164 (64.0)	91 (36.0)
Sweating	156 (61.7)	97 (38.3)
Low BP	153 (60.5)	100 (39.5)
Faintness	176 (69.6)	77 (30.4)
Change in the body color (yellowish/whiteness)	202 (79.8)	51 (20.2)
Awareness and about health care measures during pregnancy		
Registration in hospital	232 (91.7)	21 (8.3)
Three prenatal visit to doctor	217 (85.8)	36 (14.2)
BP check-up	218 (86.2)	35 (13.8)
Abdominal check-up	224 (88.5)	29 (11.5)
Weight recording	223 (88.1)	30 (11.9)
Two doses of tetanus toxin	232 (91.7)	21 (8.3)
IFA	226 (89.3)	27 (10.7)
Had undergone health care measures during the last/present pregnancy		
Registration	193 (76.3)	60 (23.7)
Immunization	192 (75.9)	61 (24.1)
Health check-up	191 (75.5)	62 (24.5)
BP check-up	187 (73.9)	66 (26.1)
Weight recording	188 (74.3)	65 (25.7)
Two doses of TT	206 (81.4)	47 (18.6)
Consumed prescribed IFA	192 (75.9)	61 (24.1)
Supplementary nutrition during pregnancy		
Eat same amount of food that they used to eat before pregnancy	97 (38.3)	156 (61.6)
Less than usual food	88 (34.8)	165 (65.2)
More food than usual days	97 (38.3)	156 (61.7)
Birth planning behaviors		
Saving extra money to meet the expenses against delivery	184 (72.7)	69 (27.3)
Planning where delivery is to be conducted	20 (79.4)	52 (20.6)
Preference for trained/expert DAI for delivery	220 (87.0)	33 (13.0)
Going for delivery regardless of who will do	11 (4.3)	242 (95.7)
Arrangement of delivery kit in case of delivery be at home	240 (94.9)	13 (5.1)

IFA=Iron/folic acid, TT=Tetanus toxoid, BP=Blood pressure

measures to be followed at the time of ANC. But these were reluctant to adopt these health care measures into practice so that 100% of ANC is ensured, and reasons for these flippant attitudes needs to be identified.

The intake of supplementary nutrition is important to meet the additional nutritional requirements among the pregnant women due to pregnancy and child's growth in the womb. The information on the intake of supplementary nutrition during pregnancy was gathered from the studied women. When data were analyzed, 38.3% women mentioned that they ate same quantity of food as they use to eat before pregnancy. But surprisingly 34.8% of pregnant women reported to have reduced the food consumption during pregnancy. Only little >1/3rd women increased their consumption of food during pregnancy [Table 2]. The practice of reducing the consumption of food during pregnancy is often linked with the belief that eating more food makes baby healthier and bigger in size that causes the problem to the mother during delivery of the baby.

Birth planning is necessary for ensuring the safe delivery by choosing the place of delivery, who should conduct the delivery and also saving money for meeting the additional requirement and monetary expenses involved at the time of delivery. The study reveals that the majority of the women do make some planning for pregnancy. About 72.7% of women mentioned that they do saving of some money to meet the expenses at the time of delivery. Most of them (79.4%) also planned where the delivery is to be conducted. About 87.0% reported to have planned for trained Dai for the purpose of safe delivery. About 95% of respondents refused the idea of conducting delivery by anybody. Almost all of them (94.9%) made arrangements for delivery in case the delivery is to be carried out at home [Table 2].

Postnatal care is important for the health and well-being of the mother and her newborn baby. In this study, information on the awareness of PNC was also collected from these slum women and is presented in Table 3. Analysis of the table

Table 3: Postdelivery care (n=253)

Days required resuming daily routine activities after delivery	Frequency (%)
Within home	
< 10	23 (9.7)
10-20	25 (9.9)
20-30	3 (1.2)
30-40	30 (11.9)
>40	37 (14.6)
Don't know	135 (55.4)
Outside home	
< 10	8 (3.2)
10-20	12 (4.7)
20-30	2 (0.8)
30-40	11 (4.3)
>40	16 (6.3)
Don't know	204 (80.6)
Health check-up during pregnancy	
Yes	199 (78.7)
No	54 (21.3)
Months in which health check-up was taken	
1-3	46 (18.2)
3-6	126 (49.8)
6-9	35 (13.8)
Not required	46 (18.2)

showed that 55.4% of the women don't know anything about the number of days required for resuming to daily routine activities after delivery. Only 14.6% of these women reported rest of >40 days followed by 11.9% of women reported rest of 30–40 days after delivery. Those women who mentioned 10 days of rest were 9.7% and 10–20 days of rest were 9.9%. Thus, these women were definitely at greater risk in case if they were outside their home immediately after delivery. The study reveals that 80.6% of these women don't know the importance of PNC. Lack of knowledge about PNC and number of days required for resuming to daily routine activities after delivery (within home) would be definitely a harmful factor leading to the development of health risk among the mother and newborn baby.

DISCUSSION

To make the health care system more accessible and responsive to women particularly in developing countries, it is imperative to study the HSBs and factors determining utilization of health care services. There is a need to understand the drivers of HSBs of the population. This relates to both public as well as private sectors. The study finding reveals that only around three-fourth of the slum women undergo for health check-ups during pregnancy. The study also shows that these women were well aware of the health care measures of ANC like registration in hospital, three prenatal visits to doctor, the need for BP check-up, abdominal check-up, weight recording, two doses of tetanus toxin, IFA intake etc. However, they were reluctant to practice these health care measures during pregnancy. Bhandari and Kannan reported that the majority

of women had at least one of the reproductive morbidity; but only 1/3rd sought health care, and it depends on the distance from health center and duration of illness.^[17] One study conducted by Mohindra *et al.* reports that there is a strongest association between caste and socioeconomic inequalities in women's health care seeking behavior,^[18] while another by Matthews *et al.* reports that perceived quality of care was found to be an important factor in HSB, as well as wealth, caste, education and experiences of previous problems of pregnancy.^[19] According to Ahmed *et al.* low income results unaffordable healthcare, lack of awareness of the kind of healthcare services available, deficiencies and inconsistencies in the quality of services, and lack of close proximity to the healthcare facility are the reason for the scanty health care seeking behavior among the poor.^[20] Study done by Hazarika reports that the barriers to of ANC visits and delivery care depended significantly on the level of education and economic status, caste, lack of awareness on the kind of health care services available, deficiency and inconsistencies in the quality of services, lack of close proximity to health care facility besides parity and prior antenatal visit and experiences of previous problem of pregnancy.^[21] According to Ay *et al.* 2009, women experience pregnancy as a burden and are not motivated to seek ANC. During pregnancy, only "serious" conditions are considered as legitimate reasons for accessing care. However, the decision regarding whether a pregnant woman is seriously sick or not belongs to the responsibilities of elder women, which delays service utilization. These are sociocultural practices.^[22] Singh *et al.* 2010 report that among the women of resettlement colony in Delhi 79% conceived within 9 months of marriage. Only 25% pregnancies got registered in first trimester. Reproductive and nutritional status of the newly married women were unsatisfactory.^[23] Another study carried out in Dhaka slum by Rashid reveals adolescent women take decisions surrounding marriage, fertility, childbearing etc., within the socioeconomic constraints that surround them and the larger structural conditions which govern their lives.^[24] Khan *et al.* 2009 report that though majority of slum women receive ANC and it cannot be translated to safe delivery practices as majority of these women had home delivery conducted by traditional untrained or trained birth attendants with unhygienic practices, poor initiation of neonatal feeding practices and several mothers having breastfeeding problems.^[25] Study done by Mistry *et al.* 2009 reports that the pregnancy care has the effect of women's autonomy in seeking health care that shows regional variation in India. Thus, there is a need to generate confidence among these slum women about the importance of ANC for ensuring safe motherhood and child delivery. They have to be provided with good information about the disadvantage of their sociocultural practices that would be harmful to both child and mother.^[26]

In the study, 1/3rd of the women reported to reduce their food intake and other 1/3rd women were found to take the same quantity of food as before pregnancy. These were linked to general faith and belief about pregnancy, pregnancy care, and delivery. Such cultural faith would be dangerous for the care

of both mother as well as the newborn baby. A little >1/3rd of these women only increased their consumption of food during pregnancy. According to Nisar and White, women receiving ANC were more knowledgeable about the importance of dietary protein, intake of green leafy vegetables for the prevention of anemia and reporting of danger signs. It is related to some social cultural background and value system.^[27] Why within one slum area three patterns of food consumption during pregnancy has emerged? We need to explore in order to develop community friendly feasible health care delivery strategies. Further to find out whether a similar situation exists or a different kind of scenario subsists needs detail good studies on this dimension. With respect to PNC, lot of misconception exists among these slum women. Around 55.4% said that they don't know anything about the number of days required for resuming to daily routine activities after delivery. Lack of knowledge among the slum women about PNC would definitely be a dangerous factor for the health risk of these pregnant women and their newborn babies. Thus, there was a dire need to create awareness among these women on the importance of adopting and scientifically following PNC for improving maternal and infant health in the slum areas.

The study reveals that though these slum women seek ANC the quality of antenatal care received or provided to them needs to be ensured. Majority of these women were ignorant about the importance of ANC and PNC, which is necessary for health and wellbeing of mother and her infant. Thus, the health education and health promotion campaigns are needed to bring changes in the existing HSBs among urban slum women for improving their reproductive health status.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

REFERENCES

- Khan A.M. Population stabilization behavioral approach. *Indian J Soc Res* 1997;37:295-306.
- Harrison K.A. The political challenge of maternal mortality in the third world. *Maternal Mortality and Morbidity – A Call to Women for Action. Special Issue. Women's Status and Reproductive Health Rights*. New Delhi: Har-Anand. Publications; 1990.
- Government of India. Reproductive and child health programme. Ministry of Health and Family Welfare, Government of India; 1997. Available from: mohfw.nic.in/WriteReadData/1892s/Chapter_04final-85836829.pdf [Last accessed on 01 Feb 2015].
- Srinivasan. S. Primary health care services in rural India: Current status and future challenge. *Kurukshetra* 2002;50:22-27.
- Mumiyandi M. Utilization of Health Care Services in India. Mumbai: Seminar Paper for MPS, IIPS; 1996-97.
- Gandotra MM, Das N. Impact of health care intervention and nutrition on infant mortality in India. *Indian Association for the Study of Population (IASP)*, Jaipur: Rajasthan University, 1983.
- Basu AM. Cultural influences on health care use: Two regional groups in India. *Stud Fam Plann* 1990;21:275-86.
- Kotecha PV, Patel SV, Shah S, Katara P, Madan G. Health seeking behavior and utilization of health services by pregnant mothers in Vadodara slums. *Health Line* 2012;3:30.
- Manna PK, De D, Ghosh D. Knowledge attitude and practices for antenatal care and delivery of the mothers of tea garden in Jalpaiguri and Darjeeling Districts, West Bengal. *Natl J Community Med* 2011;2:4-8.
- Dandappanavar AA, Khan CG. Health-seeking behaviour and antenatal period among the women of Jannath Nagar: An Urban Slum of Dharwad Town (Karnataka). *Glob Res Anal* 2014;3:1-2.
- Barnett S, Azad K, Barua S, Mridha M, Abrar M, Rego A, *et al.* Maternal and newborn-care practices during pregnancy, childbirth, and the postnatal period: A comparison in three rural districts in Bangladesh. *J Health Popul Nutr* 2006;24:394-402.
- Ciceklioglu M, Soyer MT, Ocek ZA. Factors associated with the utilization and content of prenatal care in a western urban district of Turkey. *Int J Qual Health Care* 2005;17:533-9.
- Celik Y. The socio-economic determinants of alternative sources of antenatal care in Turkey. *Int J Health Plann Manage* 2000;15:221-35.
- Warren C. "Postnatal care, In: Opportunities for Africa's Newborns. Ed. Lawn J, Kerber K, (Cape Town, South Africa: Partnership for Maternal, Newborn, and Child Health, Save the Children, UNFPA, UNICEF, USAID, WHO, and Partners); 2006.
- Chaurasia AR. The Institutional Context of Fertility and Reproductive Health in Madhya Pradesh, India. Seattle: University of Washington Centre for Studies in Demography and Ecology; 2000.
- Winch PJ, Alam MA, Akther A, Afroz D, Ali NA, Ellis AA, *et al.* Local understandings of vulnerability and protection during the neonatal period in Sylhet District, Bangladesh: A qualitative study. *Lancet* 2005;366:478-85.
- Bhandari MN, Kannan S. Untreated reproductive morbidities among ever married women of slums of Rajkot City, Gujarat: The role of class, distance, provider attitudes, and perceived quality of care. *J Urban Health* 2010;87:254-63.
- Mohindra KS, Haddad S, Narayana D. Women's health in a rural community in Kerala, India: Do caste and socioeconomic position matter? *J Epidemiol Community Health* 2006;60:1020-6.
- Matthews Z, Ramakrishna J, Mahendra S, Kilaru A, Ganapathy S. Birth rights and rituals in rural south India: Care seeking in the intrapartum period. *J Biosoc Sci* 2005;37:385-411.
- Ahmed NU, Alam MM, Sultana F, Sayeed SN, Pressman AM, Powers MB. Reaching the unreachable: Barriers of the poorest to accessing NGO healthcare services in Bangladesh. *J Health Popul Nutr* 2006;24:456-66.
- Hazarika I. Women's reproductive health in slum populations in India: Evidence from NFHS-3. *J Urban Health* 2010;87:264-77.
- Ay P, Hayran O, Topuzoglu A, Hidiroglu S, Coskun A, Save D, *et al.* The influence of gender roles on health seeking behaviour during pregnancy in Turkey. *Eur J Contracept Reprod Health Care* 2009;14:290-300.
- Singh S, Chaturvedi S, Kumar A, Kannan AT. Reproductive health of newly married women residing in a resettlement colony of Delhi: A longitudinal study. *Indian J Public Health* 2010;54:30-2.
- Rashid SF. *Worried Lives: Poverty, Gender and Reproductive Health for Adolescent Women in a Slum in Dhaka, Bangladesh*. Boston, Maryland: In Population Association of America, Annual Meeting Program; 2004.
- Khan Z, Mehnaz S, Khaliq N, Ansari MA, Siddiqui AR. Poor perinatal care practices in urban slums: Possible role of social mobilization networks. *Indian J Community Med* 2009;34:102-7.
- Mistry R, Galal O, Lu M. Women's autonomy and pregnancy care in rural India: A contextual analysis. *Soc Sci Med* 2009;69:926-33.
- Nisar N, White F. Factors affecting utilization of antenatal care among reproductive age group women (15-49 years) in an urban squatter settlement of Karachi. *J Pak Med Assoc* 2003;53:47-53.