

Quantification of Satisfaction Level of Female Clients about maternal health services rendered at MCH Centers of City District Govt. Lahore

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ABSTRACT

Background: Pregnant mothers are vulnerable special risk groups. Women's health has long been a priority area of concern and activity for the United Nations development program (UNDP). Institutional capacity is a vital ingredient in translating Maternal Health Services and Family Planning policies into effective services.

Aim: To quantification of satisfaction level of female clients about maternal health services rendered at MCH Centers of City District Govt Lahore

Methods: It was cross section descriptive study done in City district Government Lahore, 90 clients and 18 LHVs from 18 MCH centers. Public MCH Centers located in territorial jurisdiction of City District Govt. Lahore having LHV as incharge and females visiting as clients for services at these centers were included in this study.

Results: In this present study about 77.7% female clients were belongs to <5000 monthly income. 11.12% were satisfied with prescription advised by facility providers. 38.88% were believed that service and facilities solved their problems. (61.12%) clients complained that LHV did not allow them to ask any question.

Conclusion: The gaps of service delivery of these MCHCs regarding utilization rate and clients satisfaction needs revisit of health planners.

Keywords: Maternal health service, MCH centres, family planning

INTRODUCTION

Women's health has long been a priority area of concern and activity for the United Nations development programme (UNDP). Maternal component of MCH Services caters a large group, which is a special or risk group. The problem affecting the health of mother is multi factorial and is serious health concern of community and states in developing countries. The present strategies like Safe motherhood clean delivery and Essential Obstetric Care an integrated package of essential health care for mothers. These considerations have led to the formulation of special health services for mothers all over the world^{1,2,3}.

But inaccessibility, lack of medicine and uncooperative staff produce dissatisfaction and reduce utilization of these services. The effect is two pronged, at one end state expenditures becomes a futile exercise and at other end clients are tamed to bypass these services provided by the state. The resultant impact is expensive provision of maternal health services to visiting clients^{4,5,6,7}.

Global observations show that in developed regions maternal mortality ratio averages at 30 per one lac live births, in developing region the figure is 480 for the same number of live births. Mortality Ratio of Pakistan is 320 per one lac live births and life time risk of maternal death is 1 in 74, whereas similar indicators for developing countries show that MMR is 450 and life time risk is 1 in 76. Similar indicators for Industrialized countries show MMR is 8 and life time risk is 1 in 8000^{1,8}. An estimated 16,500 maternal deaths occur annually in Pakistan. Reproductive health (RH) problems, which are largely preventable account for over 50% of the disease burden. The analysis of Pakistan's maternal health services planning reflect that major shift is towards curative aspects and preventive aspects of these services in neglected. Maternal Health services programmes needs to be addressed while setting overall national goals. Institutional capacity is a vital ingredient in translating Maternal Health Services and Family Planning policies into effective services. The need for a comprehensive Maternal Health and Family Planning framework, there is a need of strengthened stewardship in different sectors. The ability to ensure delivery of quality health services remains the biggest challenge in the Pakistani health sectors. Unless

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sound policies are backed by well-functioning programs, they are likely to become a victim of poor implementation^{9,10,11,12,13,14}.

Government of Punjab, considering the dismal state of health status, upcoming challenges of Maternal Health and commitment of Millennium Development Goals is keen to address all issues related to health services under the auspices of the Health Sector Reform agenda to improve the health status of women in Punjab. The effectiveness of a system to prevent or predict obstetric complications, early detection of risk factors and prompt treatment is questioned more and more but scarcity of reliable data is missing. The same situation is prevailing about health facilities and their services. Maternal Health Services are provided at tertiary, secondary and primary level. At primary level Maternal and Child Health Centers are basic level of provision of maternal services in the community which consist of tetanus toxoid immunization, antenatal, natal, post natal, antenatal care, Prevention and Management of Sexually Transmitted Infections (STI), FP Services, detection of major micro nutrient deficiencies, screening the of vulnerable groups and outreach service components. Promotion of maternal health has been one of the most important objectives of the health programmes at the primary facilities of MCH Centers. Prenatal care, care at the time of delivery and postnatal care are the three important components of reproductive health. The quality of prenatal care can be assessed by the type of provider, the number of prenatal visits and the timing of the first visit. Available state reports reflect that 61% of mothers receive prenatal care from skilled health providers (doctor, nurse, midwife or Lady Health Visitor). Only 3% of women receive pre natal care from a traditional birth attendant (Dai). In addition, 1% of mothers receive prenatal care from a Lady Health Worker, a dispenser or compounder, or a hakim. 35% of women receive no prenatal care at all. There has been a significant improvement over the past ten years in the proportion of mothers who receive prenatal care from a skilled health provider, increasing from 33% in 2003 to 61% in 2006. The PDHS data show that (28%) of pregnant women completely avail antenatal, natal and post natal Care. Overall, there has been some improvement in the utilization and quality of prenatal care services in recent years. For example, the percentage of mothers who received at least two tetanus toxoid injections during pregnancy has nearly doubled from 29% in 2001 to 53% in 2006. Only 34% of births in Pakistan take place in a health facility, 11% are delivered in a public sector health facility and 23% in a private facility. 65% births take place at home. The percentage of births that take place in a health facility

has doubled in the past ten years, increasing from 17% in 1996 to 23% in 2001 and to 34% in 2006. 39% of births take place with the assistance of a skilled medical provider. Prompt checkups following delivery are critical for monitoring complications for both the mother and the baby. In the five years preceding the survey, 43% of women received postnatal care for their last birth, making it far less common than prenatal care i.e. 65%. More than one-fourth of women received postnatal care within four hours of delivery, while 6% received care within the first 24 hours, 7% of women received postnatal care two days after delivery and 3% of women were seen 4 days following delivery. 16% Mothers received care from traditional birth attendants^{15,17,18}.

The commentary in preceding lines reflects that although Pakistan has made interventions at different times to improve maternal health services at national, provincial and district level but these services are below the international level and maternal health is not in safe hands regarding policy at health delivery system. There are serious gaps in delivery of preventive obstetrics services which are dispensed at the level of MCH Centers. To study these gaps MCH Centers of CDGL were chosen to evaluate maternal health services provided by City District Government Lahore and to determine the level of client satisfaction utilizing services.

MATERIALS AND METHODS

This cross-sectional descriptive study was carried out at All MCH centers of City Distt. Govt. Lahore during a period of 6 months. Sampling Units were 18 out of 52 MCH centers working under the control of City Distt. Govt. Lahore, which constitute 33% of total facilities as calculated with help of statistician. 18 MCH centers were selected by randomization technique at each town. Sample size was 90 clients and 18 LHVs from 18 MCH centers. (5 from each MCH Center which are 12 in the study)

Inclusion Criteria: Public MCH Centers located in territorial jurisdiction of City District Govt. Lahore having LHV as in charge and females visiting as clients for services at these centers.

Exclusion Criteria: Private MCH Centers located outside territorial jurisdiction of City District Govt. Lahore or where there is no LHV posted as in charge.

RESULTS

The study was done on 90 female clients who visited MCH center in district Lahore. In this present study about 77.7% female clients were belongs to <5000 monthly income and were illiterate. 50% female clients believed that waiting time before visit was 15

minutes and 38.8% believed that it was 30 minutes. 22.2% were satisfied with cleanliness and felt comfort at waiting area. 41.11% clients were satisfied with examination provided by LHV and examination time provided by LHV respectively and 38.8% were satisfied with competency of LHV. 11.12% were satisfied with prescription advised by facility providers. 38.88% were believed that service and facilities solved their problems. Most of 61.12% patients reached facility by walking, 33.33% reached their by using motorcycle and only 5.55% reached their by using public transport. About 77.78% answered that they would not recommend others to visit the facility. It was found that 88.8% clients were not assured about their privacy in examination. (61.12%) clients complained that LHV did not allow them to ask any question.

Table 1: Time taken to reach facility

Time taken	n
Less than 15 minutes	55(61.12%)
More than 30 minutes	30(33.33%)
More than one hour	5(5.55%)

Table 2: Measures to reach facility

Mode of transport	n
Walking	55(61.12%)
Motorcycle	30(33.33%)
Public Transport	5(5.55%)

Table 3: Satisfied with comfort and cleanliness of waiting area

Satisfaction	n
Yes	20(22.22%)
No	70(77.78%)

Table 4: Satisfied with examination time provided by LHV

Satisfaction	n
Yes	37(41.11%)
No	53(58.89%)

Table 5: Assurance of privacy in examination

Satisfaction	n
Yes	10(11.12%)
No	80(88.88%)

Table 7: Would your comment this facility to someone else

	n
Yes	20(22.22%)
No	70(77.78%)

DISCUSSION

The present study was done city district Government Lahore to determine the Quantification of Satisfaction level of female clients about Maternal Health Services rendered at MCH Centers. Total 90 clients were enrolled in this study.

The issue of integrating MCH services has gained an increasingly high priority on public health agendas in recent years. In the prevailing climate of health sector reform, policy-makers are likely to be increasingly pressed to address the broader concept of 'reproductive health' in the terms consolidated at the Cairo International Conference on Population and Development, and the UN Conference on Women in Beijing. Integrated MCH services could be regarded as a significant step towards providing integrated reproductive health services, but clarity of issues and concerns is essential¹⁹.

The present study showed that 61.12% clients reach facility within 15 minutes. 77.7% female clients were belongs to <5000 monthly income, 41.11% clients were satisfied with examination provided by LHV and examination time provided by LHV respectively as supported by other authors discussed here. Maternal health indicators are poor, especially for the lowest socioeconomic groups and in rural areas. The health services provided to these segments of society are also poor, as shown by numerous health and demographic surveys. The management of health care at provincial and district levels is poor²⁰.

Providers should be aware of the contraceptive needs of women with all levels of education and parity. Additionally, family planning facilities may be able to increase clients' contraceptive use by providing diversity in method choice, keeping offered methods in stock, displaying informational materials, and raising staff levels.²¹ only 35%—40%. Lack of transportation, particularly in hilly and desert regions of the country, is a significant drawback to the use of health services in rural areas²².

Some other authors also support our study results. Following this the Government of Pakistan launched a comprehensive national maternal and child health program to improve the accessibility of high quality and effective maternal-child health (MCH) services for all, particularly the poor and disadvantaged, through development and implementation of a sustainable MCH program at all levels of the health care delivery system^{23,24,25,26, 27, 28}.

CONCLUSION

These primary health service facilities regarding maternal health were neglected in monitoring and supervision. These MCH Centers were deficient in basic amenities, equipment and services. The mind set of spending 80% on curative services and 20% of preventive services should be reversed. The gaps of service delivery of these MCHCs regarding utilization rate and clients satisfaction needs revisit of health planners.

REFERENCES

1. Bhutta ZA, Gupta, De'Silva H, Manandhar D, Awasthi S, Hossain SM, Salam MA. Maternal & Child Health: Is south Asia ready for change. *BMJ* 2004; 328:816-819.
2. Kabusingye OC, Hyder AA, Bishai D, Hicks ER, Mock C, Joshipura M. Emergency Medical Systems in low Income Countries. *Bull World Health Organ* 2005; 83:626-631.
3. Razzak JA, KelLerman AL. Emergency Medical Care in Developing Countries. *Bull World Health Organ* 2002; 80:900-905.
4. Kavitha N, Audinarayana N. utilization and determinants of selected MCH care services in Rural Areas of Tamil Nadu. *Health and Population perspective and issues* 2007; 20: 112-125.
5. Underwood C. perceptions of Jordanian Religious leaders about family planning. *International family planning perspectives* 2000; 26: 110-117.
6. Gage AJ Calixite MC. Effects of Physical Accessibility of Maternal Health Services in Rural Haiti. *Population studies* 2006; 60:271-288.
7. Bazant ES, koeing MA, Fosto JC, Mills S. Use of Private and Government Health Facilities for Child Birth in Nairobi's Informal Settlements. *Studies in Family Planning* 2009. 40:39-50.
8. Basu AM. Cultural Influences on Health Care Use: Two Regional Groups in India. *Studies in Family Planning* 2002; 21:275-286.
9. Bhatia J, Cleland J. Determinants of Maternal Care in South India. *Health Transition Review* 2003;5:127-142.
10. Sanders D, Kravitz J, Lewrin S, MckeeM. Zimbabwe's Hospital Referral System: Does it work *Health Policy and Planning* 2005; 13:359-370.
11. HarnoK, Paavola T, Carlson C, Viikinkoski P. Effectiveness and Cost analysis of Health System. *Journal of Telemedicine and Telecare* 2006; 6:320-329.
12. Abou Zakr C, Wardlaw T. Maternal Mortality at end of decade: signs and progress. *Bulletin of health organization* 2001; 79:561-598.
13. Rasoulynejad SA. Study of Referral Factors in the Three Level Health Care Delivery System, Kashan, Iran. *Rural and Remote Health* 2004; 4:237.
14. Pakistan Institute on Maternal and Newborn Health (PIAMAN) Report 2005. Health Care facility assessment survey.
15. Government of Punjab Notification 2007. Punjab Developed Social Sector Program (PDSSP).
16. Government of Punjab Notification 2004. PDSSP, Minimum Service Delivery Standards, Government of the Punjab.
17. Government of Punjab Report 2008. Punjab Millennium Development Goal Program (PMDGP) 2007-2008.
18. Government of Punjab Database 2008. Health Sector Reform Program (HSRP) database, Punjab 2008
19. Susannah Mayhew, Integrating MCH/FP and STD/HIV services: current debates and future directions 2014, *Oxford Journals*, Volume 11, Issue 4 Pp. 339-353.
20. Jafarey, S., I. Kamal, et al. (2008). "Safe motherhood in Pakistan." *International Journal of Gynecology & Obstetrics* 102(2): 179-185.
21. Hamid, S. and R. Stephenson (2006). "Provider and health facility influences on contraceptive adoption in urban Pakistan." *International family planning perspectives* 32(2).
22. Jafarey, S., I. Kamal, et al. (2008). "Safe motherhood in Pakistan." *International Journal of Gynecology & Obstetrics* 102(2): 179-185.
23. Z. Bhutta, I. Gupta, H. de'Silva, D. Manandhar, S. Awasthi, S.M. Hossain et al. Maternal and child health: is South Asia ready for change? *BMJ*, 328 (7443) (2004), pp. 816-819
24. F.F. Fikree Safe motherhood in Pakistan: past failures and present challenges *J Pak Med Assoc*, 52 (12) (2002), p. 538
25. Z.A. Bhutta (Ed.), *Maternal and child health in Pakistan*, Oxford University Press, Karachi (2004)
26. A.G. Tinker *Improving women's health in Pakistan Health, nutrition, and population working paper series*. Human development network, World Bank, Washington DC (1998)
27. S. Bhutta, S.N. Jafarey, F. Midhet *Safe motherhood. A situation analysis and recommendations for evidence based approaches* Z.A. Bhutta (Ed.), *Maternal and child health in Pakistan*, Oxford University Press, Karachi (2004)
28. F.F. Fikree, F. Midhet, S. Sadruddin, H.W. Berendes *Maternal mortality in different Pakistani sites: ratios, clinical causes and determinants* *Acta Obstet Gynecol Scand*, 76 (7) (1997), pp. 637-645