Factors Governing Maternal Health Care Utilization in India: A Cross Cultural Comparison

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Introduction:

Every minute of every day, somewhere in the world and most often in a developing country, a woman dies from complications related to pregnancy or childbirth. Around 515,000 women are dying every year and nearly all-maternal deaths (99 percent) occur in the developing world, making maternal mortality health statistic with the largest disparity between developed and developing countries. Pregnancy-related complications are among the leading causes of death and disability for women age 15-49 in the developing countries. More than a decade of research has shown that small and affordable measures can significantly reduce the health risks that women face when they become pregnant. Most maternal deaths could be prevented if women had access to appropriate health care during pregnancy, childbirth, and immediately afterwards. Safe motherhood means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy, childbirth and soon after childbirth. The Safe Motherhood Initiative is a worldwide effort that aims to reduce the number of deaths and illnesses associated with pregnancy and childbirth. The global initiative was launched at a conference held in Nairobi, Kenya in 1987. Its aim was to draw the world's attention to the thousands of deaths and millions of serious illnesses that afflict women every year. (www.safemotherhoodinitiative.org).

Child Survival and Safe Motherhood Programme Initiatives in India:

In India the Child Survival and Safe Motherhood Programme was launched on 20th August 1992 with the objective to improve health status of women and children and reduction of maternal, infant and child morbidity and mortality rates. As per the National Family Health Survey-I (NFHS-I), India, 1992-93 the Maternal Mortality Ratio was 4.37 per thousand live births, whereas according to the NFHS II, 1998-99, the corresponding ratio has increased to 5.40 per 1000 live births although the increase is not significant statistically (NFHS II, 1998-99 p.196). In

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a Developing country like India where the problem of maternal morbidity and mortality exists since a long the government has taken various steps to get enlightened regarding this deep-rooted problem and the Reproductive and Child Health (RCH) Survey is commandable endeavour in this direction.

The Maternal and Child Health services have occupied the priority list of the Government. Although various measures have been taken by the Government all-over the country simultaneously but the outcome or the performance of different States differ among themselves. As such there is a need to examine the underlying factors governing the utilization of maternal health services prevailing in the states under consideration. The present study therefore is an attempt in this direction.

Objectives:

The main objective of the present paper is to study the factors governing safe motherhood among the women of the four states under study. However specific objectives are as follows:

1. To study the important factors leading to antenatal care (ANC) in the states under study.
2. To explore some of the socio-economic and demographic factors influencing safe delivery.
3. To find out some of the socio-economic and demographic factors governing post-purtum care in the selected states under consideration.

Source of Data:

For the present study the data has been extracted from the Reproductive Child Health Survey (RCH) Round I, Phase II. It is a national level study covered 255 districts of India. All the married women in the age group 15-44 in a household were interviewed, constituting a sample of 210000 women. The sample size for the state of Gujarat was 2758 women, for Tamil Nadu 2844 women, 2426 women for Punjab and 5674 women for Orissa. In District level Household Survey (DLHS) every women who delivered at least one child in the preceding three years of survey was asked specific questions about the type of antenatal care and place of delivery. The full antenatal care was defined as having at least one Tetanus injection, Iron and Folic Acid tablets and receiving at least three Antenatal visits. Safe delivery was defined as either institutional delivery or home delivery attended by either a Doctor or Nurse or Auxiliary Nurse Midwives. The post-delivery problem was defined as any gynecological problem to mothers up to 42 days after delivery.

Methodology:

For the present study a bi-variate tabulation plan has been done to depict the level of full antenatal care and safe delivery practice with different socio-economic, demographic and health variables of the respondents.

To study the effects of socio-economic, demographic and health characteristics of the women regarding full antenatal care a logistic regression analysis has been used. In this analysis *full antenatal care* is used as the *dependent variable*. It has made dichotomous in nature, where *full antenatal care* = 1 and *not full antenatal care* = 0. The *predictor variables* used for the analysis include; *type of residence, caste, religion, women's education, husband's education, standard of living index, age, age at marriage, children ever born, child loss, problem related to pregnancy and delivery related complications*.

To study the effect of socio-economic, demographic and health characteristics of the women on safe delivery a logistic regression analysis has been used. In this analysis *safe delivery* is used as the *dependent variable*. It is dichotomous in nature, where *safe delivery* = 1 and *not safe delivery* = 0.The variables; *type of residence, caste, religion, women's education, husband's education, standard of living index, age, age at marriage, children ever born, child loss, problem related to pregnancy, delivery complications and full ANC* have been used as *predictor variables*.

Salient Findings:

Some of the salient findings of the study are given below:

The analysis revealed that in India, 32 percent women received full ANC, whereas the corresponding figures for Tamil Nadu 75 percent, Gujarat 43 percent, Orissa 32 percent and for Punjab 25 percent. The wide variation in the utilization of the ANC services among the states under consideration could be attributed to relatively better socio-economic, demographic scenario as well as the better infrastructural facilities available in Tamil Nadu. In addition the poorest performance of the utilization of the ANC services in case of Punjab may be explained by relatively poor status of women and sex-selective abortion. While considering safe delivery situation, the corresponding values for Tamil Nadu 82 percent, Gujarat 56 percent, Orissa 33 percent and for Punjab 55 percent respectively.

Further the study shows that, the cross tabulation between socio economic variables and safe motherhood, except Tamil Nadu, people belonging to higher caste have relatively more

utilization of antenatal care. Hindus have relatively better utilization of ANC services compare to their Muslim counterparts.

Higher levels of education and standard of living have been found governing women's utilization of antenatal care. As the level of education increases from illiterate to 9+ years of schooling the utilization of full ANC increased from 26 percent to 62 percent in Gujarat, 22 percent to 31 percent in Punjab and from 20 percent to 62 percent in Orissa. Also these results are found to be statistically significant.

The study has shown positive relationship between consummation of first marriage and utilization of ANC services, i.e., higher the age of consummation higher would be utilization of ANC services among the women. However the state of Tamil Nadu was found as an exception in this regard.

As far intrastate comparisons are concerned, rural women have shown relatively poor utilization of full ANC with the exception of Tamil Nadu and Punjab. But among the state under consideration, the performance of Tamil Nadu was found much better than the remaining three states. Besides, the performance of urban women in case of safe delivery is relatively better than the rural women in all the four states under study. As far children ever born and utilization of ANC services is considered it was observed that with the exception of Tamil Nadu women in other three states with lesser number of children ever born are going for full antenatal care.

As per maternal health and utilization of the ANC services is considered, the study reveals that women having pregnancy related problems and delivery related complications had utilized full antenatal care.

Based on the above findings the significant phenomenon emerging out is that the incidence of safe delivery is much higher in the southern and western states (Tamil Nadu and Gujarat) as compared with the northern and eastern states (Punjab and Orissa).

To sum up, it may be stated that there is a wide variation in the maternal health seeking behaviour among the different states of the country. The study reveals that some of the factors governed maternal health utilization were education of women, education of husband, standard of living, and pregnancy related problems and delivery related complications. Thus, it may be conclude that, there is a need for formulation of revised strategies for better and effective reach of maternal health care services in India as a whole and the states under consideration in particular.