Accessibility And Utilisation of Maternal and Child Health Services Among Bpl Households: A Case Study of Guntur District

Ms. Himabindu Edara

Ph.d Scholar, Department of Sociology, Dr. B.R. Ambedkar Open University, Hyderabad-Telangana-033

Abstract:

Mothers and children make up over 2/3 of the whole population. Women in reproductive age (15-49) constitute 21%, pregnant women, 4.5%, children under15, 47%, children under 5, 18%, under 3: 12% and infants: 4%. Maternal mortality is an adverse outcome of many pregnancies. About 80 percent of maternal deaths in are directed obstetric deaths. They result from obstetric complications of the pregnant state (pregnancy, labour, and puerperium), from intervention, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

Introduction:

Maternal and child health (MCH) care is the health service provided to mothers (women in their child bearing age) and children. The targets for MCH are all women in their reproductive age groups, i.e., 15-49 years of age, children, school age population and adolescents. Throughout the world, especially in the developing countries, there is an increasing concern and interest in maternal and child health care. This commitment towards MCH care gains further strength after the World Summit for Children 1991 and which gave serious consideration and outlined major areas to be addressed in the provision of Maternal and Child Health Care services.

Objectives of the Study:

1. To make a comparative study of the status of maternal and child health in Guntur district particularly among the tribal and non-tribal BPL households.
2. To make an in-depth analysis of knowledge, attitude and practices of the units of study relating to maternal and child health services by using household data collected from the field.
3. To examine whether the MCH services in the sample districts are adequately available, easily accessible and properly and timely utilised by the households.
4. To investigate into the role of civil society organisations particularly the women self-help groups as the facilitators in the provision and utilisation of MCH care services in the study area.

Research Methodology:

Guntur district of Andhra Pradesh is taken to constitute the sample district representing the BPL householders. Though the choice is purposive it is not biased. It is based on certain criteria befitting the theme of the study. After collecting the BPL lists for the sample Blocks, it is to be ascertained those

households having an expectant mother and/or a lactating mother. While the expectant mother can better focus on the maternal health care services, the lactating mothers can respond queries to both maternal and child health care services. Thereafter the questionnaire will be canvassed to the sample units for recording their responses. Where the questionnaires will not be possible to be filled in by the respondent, interview schedule will be used. Focused Group Discussion (FGD) will also be conducted with the respondents to probe deep into the matter.

Sample of the Study:

The study includes 200 households to which these mothers belong (64 from Pregnant Women and 136 from Lactating Women) as the final sample units.

Data Collection:

Data from published sources and field survey will be used to reach the objectives of the research. Secondary data will be collected from the sources like Annual Health Survey (AHS), District Level Household Survey (DLHS), Sample Registration System (SRS), National Family Level Household Survey (NFHS), World Bank, National Sample Survey Office (NSSO), Coverage Evaluation Survey (CES), Health Management and Information Systems (HMIS), ICDS reports and other relevant reports and publications. Secondary data will not only be used to put the things in their historical perspective but also to be used for validation purposes wherever appropriate.

Data Analysis:

Simple analytics and empirics have been used in the study. Use of only analytics will not be enough to derive the conclusion in a world where empirics conduct the way of research almost in all branches of knowledge. In the present study, depending upon the situation, necessary empirical facts have been used to reach the inference. Most frequently used variables in the study are institutional delivery, breast feeding within half an hour of delivery, exclusive breast feeding, number of PNC visits, 48 hours stay after delivery, SBA attended delivery, LBW, children under severe and mild malnutrition, number of SAM child, the level of maternal education and household income. In a social science research, all variables may not be listed for inclusion at a single spell. This may increase as the research proceeds to its final conclusion. Accordingly, the list is not exhaustive. This may include some few more variables depending upon the requirement.

Distribution of respondents in sample district

S. No	Category	Frequency	Percentage
1	Pregnant Women	64	32
2	Lactating Women	136	68
	Total	**200**	**100**

It is observed from above table that sample in Guntur district comprises 32% pregnant women and 68% lactating mothers.

Occupational distribution of the husbands of the respondents

S. No	Indicator	Frequency	Percentage
1	Agricultural Wage Labourer	92	46

2	Non-agricultural Wage Labourer	32	16
3	Self Employed (excluding Cultivators)	20	10
4	Employer	1	0.5
5	Regular Salaried/Wage Employee	11	5.5
6	Did not work but was seeking and/or available for work	38	19
7	Attending routine domestic chores, etc.	6	3
	Total	**200**	**100**

The occupational distribution of the husbands of the respondents is presented in this table. It is observed that majority of the respondents husbands in the study district 46% were agricultural wage labourer, 19% were did not work but was seeking and/or available for work, 16% were non-agricultural wage labourer, 10% were self employed (excluding cultivators), 5.5% were regular salaried/wage employee, 3% were attending routine domestic chores, etc. and only 0.5% was employer.

Distribution of respondents on the basis of average monthly income (in Rs.)

S. No	Monthly Income (Rs)	Frequency	Percentage
1	Less than 5,000	23	11
2	5,001 to 7,000	18	9
3	7,001 to 9,000	45	23
4	9,001 to 12,000	82	41
5	12,001 to 17,000	32	16
	Total	**200**	**100**

The data presented in this table shows that the majority of the respondents monthly income is 9,001 to 12,000 and they were 41%, followed by 7,001 to 9,000 and they were 23%, 12,001 to 17,000 and they were 16%, Less than 5,000 and they were 11% and last monthly income group is 5,001 to 7,000 and they were only 9%.

Distribution of respondents by their social category

S. No	Caste	Frequency	Percentage
1	OC	17	8.5
2	BC	44	22
3	SC	60	30
4	ST	79	39.5
	Total	**200**	**100**

The details mentioned in the above table reveals that the majority of the respondents belong to ST category 39.5%, followed by SC category 30%, BC category 22% and only 8.5% of them taken as a sample from OC category.

Distribution of respondents on the basis of family types

S. No	Family Type	Frequency	Percentage
1	Joint	172	86
2	Nuclear	28	14
	Total	**200**	**100**

The data mentioned in this table indicating that an overwhelming majority of the respondents 86% were belonging into joint family whereas only 14% of them belong to nuclear family taken as a sample for this study.

Distribution of respondents by religion

S. No	Religion	Frequency	Percentage
1	Hindus	80	40
2	Muslims	31	15.5
3	Christians	62	31
4	Others	27	13.5
	Total	**200**	**100**

The information projected in this table shows that the majority of the respondents 40% taken from Hindus by religion followed by Christians 31%, 15.5% of them taken from Muslims category and 13.5% of the respondents belongs to other religions.

Distribution of respondents on the basis of education

S. No	Level of Education	Frequency	Percentage
1	Illiterate	35	17.5
2	Literate without Formal education	33	16.5
3	Primary (Class I-V)	19	9.5
4	Upper Primary (Class VI- VIII)	23	11.5
5	Secondary (Class- VIII – X)	31	15.5
6	Intermediate	27	13.5
7	Graduation	18	9
8	Post-Graduation	14	7
	Total	**200**	**100**

Mother's education is one of the important determining factors in utilisation of MCH services. This table presents the distribution of respondents by their level of education in the study area. The majority of the respondents 17.5% were illiterates, 16.5% of them literate without formal education, 15.5% of them secondary (Class- VIII – X), 13.5% of them were Intermediate, 11.5% of them were Upper Primary (Class VI- VIII), 9.5% of them were Primary (Class I-V), 9% of them were Graduation and only 7% of the respondents were post graduation.

Distribution of respondents according to the sources of ANC

S. No.	Sources of ANC	Frequency	Percentage
1	Anganwadi	132	66
2	Sub - Centre	24	12
3	PHC	10	5
4	CHC	3	1.5
5	Hospital	31	15.5
	Total	**200**	**100**

Details in this table present the distribution of respondents availing antenatal care services. The table reveals that 66% of total respondents are availing Anganwadi as a source of ANC, 15.5% of them opted the hospitals, 12% of them went to Sub centres, 5% of them approach to PHCs and only 1.5% of the respondents availing CHC services.

Distribution of respondents availing antenatal services

S. No.	Type of Tests	Frequency	Percentage
1	Abdominal Examination	152	76
2	Blood Pressure	174	87
3	Breast Examination	128	64
4	Weight Measurement	189	94.5
5	Urine Test	164	82
6	Blood (For Hb estimation)	171	85.5
7	All above Tests	123	61.5

The table reveals that 76% getting Abdominal Examination, 87% Blood Pressure, 64% Breast Examination, 94.5% Weight Measurement, 82% Urine Test, 85.5% Blood (For Hb estimation) and only 61.5% of the respondents getting all above tests.

Pattern of delivery care services in percentage

S. No.	Parameters	In Guntur District
1	Institutional delivery against reported delivery	87
2	Home delivery against reported delivery	13
3	Home delivery by SBA	34
4	Home delivery by Non-SBA	66
5	Minimum 48 hrs stay in case of institutional delivery	76
6	Availed maternity financial assistance	91

The data in the above table depicts the utilisation pattern of MCH services particularly delivery care services in the sample district. The information reveals that 87% of the respondents choose the Institutional delivery against reported delivery, 66% of them choose the Home delivery by Non-SBA, 76% of them go to Minimum 48 hrs stay in case of institutional delivery, 91% of them availed maternity financial assistance and only 13% of the respondents choose the Home delivery against reported delivery. Choice of institutional delivery has been on increase. Stated differently, consequent upon the percentage increase in institutional delivery, this has acted as a motivating force to the service providers.

Major causes of child mortality (%)

Major reasons of death of children under 5-years of age	%
Neonatal (0-27 Days)	
Pneumonia	3
Birth Asphyxia	10
Neonatal Sepsis	7
Congenital Anomalies	5
Neonatal Tetanus	1
Premature	16
Other	3
Post-Neonatal (1-59 Months)	
Pneumonia	13
Congenital Anomalies and Non-Communicable Diseases	8
Injuries	6
HIV/AIDS	1
Malaria	5
Measles	1
Diarrhoea	9
Premature	2
Other	10

This table presents the causes of child deaths in the study area. It is observed that birth asphyxia and premature births are the main reason for neonatal death. Similarly, pneumonia, diarrhoea, congenital anomalies are the major causes for post neonatal (1 to 59 months) deaths. If we compare the neonatal and post-neonatal period, the major reason for death of the infants is premature. Causes responsible for neonatal deaths can easily avoided by ensuring professional attendant during pre and postnatal periods.

Prevailing of major superstitions and distribution of respondents

Sl. No.	Major Superstitions	Guntur
A	**Ante Natal Period**	
1	Not consuming IFA with a belief that the fetus will be larger and will create problem during delivery	154 (77)
2	Not taking full meal because of growth of fetus and delivery will be painful.	104 (52)
3	Food superstitions like not eating guava, papaya etc. with a fear of miscarriage.	112 (56)
B	Delivery Period	
1	Using tickets (Train/flight) for quick delivery	74 (37)
2	Using traditional methods like performing worship, eating sacred roots or leaf for quick delivery	120 (60)
3	Offering sacrifice	100 (50)
4	First trying at home for normal delivery, then to seek institutional delivery if any problem arises.	116 (58)

5	Non availability of hygienic equipment at Government hospital	50 (25)
C	Post Natal Period	
1	Throwing of colostrum to River with an anticipation that the flow of milk will be more	154 (77)
2	When the baby is looking in good condition, why should a mother will visit the AWC or ANM center without any medical requirement. It is just waste of money and loss of wages.	86 (43)
3	A newborn baby should not be weighed because this process will result in loss of weight of baby in future	90 (45)

Mentally some of the respondents do not feel urgency in visiting health facilities for post-natal checkups. Women also find it difficult to visit the health care institutions due to their social and household's cores. During this study, attempt has been made to find the prevailing cultural practices or superstitions among the respondents in the study area.

Distribution of respondents on the basis of their attitude and practices related to child health care

Parameters	Yes	No
Attitude		
Should colostrums be given to newborn?	185 (92.5)	15 (7.5)
Is exclusive breast feeding helpful to a baby up to six months?	165 (82.5)	35 (17.5)
Is vaccination helpful for a newborn at birth?	172 (86)	28 (14)
Should the birth weight of a baby be taken at birth?	184 (92)	16 (8)
Practices		
Have you fed colostrums to your newborn baby?	168 (84)	32 (16)
Have you breastfed to your baby up to six months?	162 (81)	38 (19)
Have you vaccinated to your newborn baby at birth?	166 (83)	34 (17)
Have you taken the birth weight of your baby?	178 (89)	22 (11)

However, in case of Guntur district, it is found that while 92.5% of the respondents know and believe that colostrums should be given to the newborns but only 84% have fed colostrums to their newborns. Similarly, 92% of the respondents in study area feel that birth weight of the baby should be recorded at birth but only 89% of the respondents have recorded the birth weight of their babies. The reasons behind such gaps have been revealed during FGDs with the respondents. The respondents agreed that they know the right things but more often they don't practice it. This may be attributed to the age-old misconceptions regarding child care, low level of education, lack of exposure to the mass media,

lack of strong determination of practicing the best practices (or a casual outlook towards such matters), etc.

Distribution of respondents by utilisation of child health care

S. No.	Parameters	In Guntur District
1	Newborn vaccinated at Birth	166 (83)
2	Newborn weighed at Birth	178 (89)
3	Children fully immunised	88 (44)
4	Infant breastfed exclusively	172 (86)
5	Newborn fed with colostrums just after birth	168 (84)

The information in this table shows the child health status of the respondents in the study area. It is revealed that 83.3 percent of them Newborn vaccinated at Birth, 89% Newborn weighed at Birth, 44% Children fully immunised, 86% Infant breastfed exclusively and 84% Newborn fed with colostrums just after birth.

Postnatal care services in percentage

S. No.	Parameters	In Guntur District
1	48hrs stay after delivery	46
2	PNC within 48 hrs after delivery	76
3	Women getting PNC within 48hrs and14days	88
4	Newborn breastfed within 1 hour	93
5	Home delivery newborn visit rate within 24hrs	77
6	Newborn weighed at birth	85
7	Immunisation session held	99

The data in the above table shows that 46% of the respondents were 48hrs stay after delivery, 76% of them were in PNC within 48hrs after delivery, 88% of Women getting PNC within 48hrs and 14 days, 93% of them give Newborn breastfed within 1 hour, 77% were Home delivery newborn visit rate within 24hrs, 85% were Newborn weighed at birth and 99% of the respondents were availed Immunisation session held.

Conclusion:

Accessibility of maternal and child health services and its utilisation by BPL women is greatly influenced by various socio-economic factors. Looking at the importance of the reproductive health of the mother and for better outcome of pregnancy, various interventions have been undertaken by both state and central government. Efforts have been made to find out the determinants of accessibility of MCH services in the study area. It is found that access to health care services increase with increase in the level of education.

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