Maternal and Child Health Services: Issues in Utilisation

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Abstract
Maternal and child health constitute an important part of all the health programmes in the country as they together constitute more than half of the population in the country. Maternal and child health care constitute comprehensive care to improve all round health of the mother and child. Government of India has taken various steps to ensure access of maternal and child health services in the country and has ratified almost all the international commitments to accomplish the goal of mother and child health care. But there are various lacunae in utilisation of these services and issues such as lack of education, age, geographical locations, economic factors and the mind-set of the people that are hurdles in proper utilisation of maternal and child health services. The present paper is theoretical in nature and attempts to highlight the gaps in access and utilisation of maternal and child health services.

Index Terms: Health Programmes, Maternal & Child Health Care, Rural And Urban Areas Women, Government Initiative, Awareness Programmes.

1. Introduction
Utilisation of maternal and child health services is very important as mothers and children constitute the priority group. In India, women of the child bearing age (15-44 years) constitute 22.2% and children less than 15 years of age about 35.3% of the total population. Together, they constitute nearly 57.5% of the total population. Mothers and children not only constitute a large group, but they are also a ‘vulnerable’ or special-risk group (Gupta, S. 2013). Maternal and child Health services (MCHs) are the promotive, preventive, curative, rehabilitative health care directed to mother and children in the form of service programmes (Park, K). Maternal and Child Health care is defined as comprehensive care to improve all round health of the mother and child. MCH services are offered at Primary health centers and their sub centers and by general hospitals in the rural areas. MCH services run by the state health department and municipal and voluntary organization in urban
areas and also in rural areas. MCH services can be utilized by the mothers from the visit of health staff such as Auxiliary Nurse Midwife (ANM), Lady Health visitor (LHV), Female health worker of their domiciliary visits (Sinha, 1997).

Maternal and child health includes the broad meaning of health promotion and preventive, curative and rehabilitative health care for mothers and children. It thus, includes such areas as maternal health from planning, child health, school health, handicapped children, adolescence and health aspects of care of children in special settings such as day care” (WHO 1976). Maternal health in particular refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death. Women die as a result of complications during and following pregnancy and childbirth. Most of these complications develop during pregnancy. Other complications may exist before pregnancy but are worsened during pregnancy. The major complications that account for nearly 75 percent of all maternal deaths are severe bleeding (mostly bleeding after childbirth), infections (usually after childbirth), high blood pressure during pregnancy (pre-eclampsia and eclampsia), complications from delivery and unsafe abortion (WHO, 2014). In India, about 56,000 women each year are lost in childbirth, that's one in every eight minutes. This accounts for 19 percent of maternal deaths around the world. Seventy percent of these can be prevented. A large number of global maternal and neonatal deaths are from India. Despite the fact that government of India has taken lots of initiative in improving maternal health care services, yet the utilization of these services is a big question mark as utilisation of basic health services has remained poor. The reasons may be low levels of household income, high illiteracy and ignorance, and a host of traditional factors (Singh and Sharrif, 2002). Till today, maternal health care issues have been area of concern for policy makers and planner at national and international level as simple and careful measures can prevent most of the pregnancy related morbidity and mortality. However, child health includes neonatal care, care of infant and U5 children. The health of the mother and child is one of the most serious health problems affecting the community, particularly in the developing countries. To lessen this problem maternal and child health (MCH) services have gone through a gamut of changes till today (Banerjee, 2003).

2. MCH services in the Country

Since MCH services constitute an important part of health programmes in the country, it is interesting to know the history of MCH services in the Country. In India maternal health care started very early with the training of dais in Amritsar in 1880. These efforts were not only confined to India. Rather it was happening worldwide and passing of first Midwifery Act in London in 1902 to promote safe delivery is testimony to the commitment of governments to maternal and child health across the world. In the same vein, first midwifery Act was passed on maternal mortality in 1931-32 in India also. Bhore committee, set up in 1946, recommended health programmes to be built on foundations of preventive health and referral services. Primary health centres came up since 1952 & MCH centres become its integral part by 1956. Till 1977 the major health activity was family planning which was changed into Family welfare programme with Maternal and Child Health becoming an integral part of family planning programme but at the field level only. In practical terms, it simply shifted the focus of Maternal and Child Care to centrally driven, target oriented family planning programme with major emphasis on sterilisation. Efforts were on from government side as a result Universal Immunisation Programme was launched in 1985 and in 1992, this programme was integrated with National Child Survival and Safe Motherhood (CSSM) programme. In 1994, following the International Conference on Population and Development (ICPD) held at Cairo,
paradigm shift took place in maternal and child health care programme. And in 1997, the reproductive and child health programme was launched in India. The Reproductive and Child Health Programme consists of needs based client oriented, demand driven and high quality integrated services which include Maternal health services, Child health services, Prevention of unwanted pregnancy, Prevention and management of reproductive tract infections or sexually transmitted diseases, and Adolescent health services. The Reproductive and Child Health Programme was launched in two phases. The focus of the programme in phase-1 is to reduce the Maternal and Child Mortality and Morbidity with emphasis on rural health care. RCH-I had a number of successful and unsuccessful outcomes. Keeping in mind the outcomes of RCH-I, phase- II of the reproductive and child health programme was launched in the year 2005. Under RCH-II, Basic Emergency Obstetric Care and Essential Newborn Care & Basic Newborn Resuscitation services would be provided round the clock. Besides this, all the FRUs will also be made operational for providing Emergency Obstetric Care by the end of RCH-II. The component of essential obstetric care aims to promote institutional delivery. For this 3-4 staff nurses or ANMs should be provided in PHCs. Skilled attendance at delivery is also an important part of essential obstetric care to reduce the maternal mortality in the country. Maternal and child health is one of the eight components of RCH programme and constitutes most important component.

This highlights that government of India has also given due attention to maternal and child health services and all these services to improve maternal and child health have been implemented in almost all the states in the country through various programmes as detailed above from time to time. Punjab has not been an exception. Government of Punjab has also implemented all the programmes relating to MCH care. Various maternal and child health services provided by the government of Punjab are ANC which includes registration of pregnancy, immunisation given to pregnant women, administration of iron and folic acid tablets, Deliveries which include institutional and non institutional deliveries, by Skilled Birth attendants and Non skilled birth attendants, Pregnancy outcome and weight of the new born, Complicated pregnancies, Post natal care within 48hours to 14days, Medical termination of pregnancy, Child immunization, Administration of vitamin A doses and Number of childhood disease reported from 0 month to 5 years. Maternal and Child Health Action Plan (2014-17) of Government of Punjab states that the State of Punjab has performed better in all the relevant health indicators. Punjab’s MMR stands at 172 (SRS 2007-09) having declined from 192 a few years earlier (SRS 2004-06), while the IMR at 28 (SRS 2012) has decreased from 38 in 2008 (SRS 2008). TFR at 1.8 (SRS 2011) is already at the replacement level. During 2012-13, out of a total 413,845 deliveries, 163,490 (39.5%) took place in government institutions. Though this report claims the improvement in utilisation of maternal and child health services, yet there are various issues in utilisation of MCH services which are discussed in various studies cited below.

3. Informational Records Related To study

Garg et al. (2010) conducted a study titled “Study on Delivery practices among women in Rural Punjab” in Verka Block of Amritsar. The primary objective of the study was to assess the delivery practices and factors associated with it. Door to door survey was conducted and 945 respondents were covered from 20 villages. It was found that only 47. 4 percent of the respondents had safe deliveries and when correlated with age group, it was observed that 33.7 percent of the respondent in the age group of 26-35 years had got their deliveries done by a doctor as compared to 20.3 percent respondents in the age group of 36-45 years. Education was positively associated with
the person who conducted the delivery. It was found that majority of the respondents who opted for doctor for conducting deliveries i.e. 53.1 percent were educated up to twelfth or above the delivery and only 1.4 percent of the deliveries were conducted by untrained dais among the respondents who were educated up to twelfth or above. It was observed in the present study, that the institutional delivery was reported in 43.1 percent of the women in the age group of 18-25 years. According to NFHS-II, institutional deliveries opted by women aged less than 20 years was 48.9 per cent and in the age group of 20-34 years it was 36.1 per cent in Punjab. In the present study, it was found that 20.0 percent illiterate women in Punjab preferred institutional deliveries while the corresponding figure in NFHS-III is 30.8 per cent. More institutional deliveries were found among educated females in the present study which is similar to the findings of NFHS-III. It was observed that about half (47%) of the deliveries were safe which was similar to the findings of NFHS-III for India (total 48.3%, rural 39.1%)21, and NRHM (42.3%). However, the NFHS-III reported 67.4 per cent safe deliveries in rural Punjab. The study concluded that home and unsafe delivery is still widely prevalent in rural areas of Punjab and is significantly more among the elderly and less educated females.

Gupta et al (2010) carried out a study “Determinants of Utilization pattern of Ante Natal and Delivery services in an Urbanized village of East Delhi”. The primary objective of the study was to identify some of the demographic and economic factors that affect the utilisation of antenatal care and delivery care in women from an urbanised village of East Delhi. The study was carried out on 102 women with child birth in past one year. The results of the study showed that 92.2 percent of respondents had received tetanus toxoid vaccine in their last pregnancy. 51 percent of study subjects had institutional deliveries and 49 percent were home deliveries. The study concluded that majority of women received antenatal care during pregnancy and had three or more ANC visits. Women having lower education and those belonging to lower education groups were more likely to have less than three Iron and Folic Acid tablets. Intake was more likely in women married at later age. Women married early were more likely to have home deliveries than women after 18 years.

Pahwa et al. (2013) in their study “Existing Practices and Barriers to Access of MCH Services: A Case Study of Residential Urban Slums of Mohali District of Punjab” have evaluated 164 respondents regarding their socio-demographic profile, their reproductive behaviour and intention, details of Antenatal care, delivery, postnatal care, attitude and level of satisfaction towards various maternity and child health schemes like Janani Suraksha Yojana, family planning methods, child immunization and perceived barriers for non-utilization of maternal health care services. The objective of the study was to assess the utilization of maternal health care services by women residing in urban slums of district Mohali, Punjab. Women in the age group of 15-49 years who were either pregnant or had delivered within the last three years were selected. A sample of 164 women was selected. The study concluded that 77.4 per cent of women availed the antenatal care services but only 52 percent mothers received complete three antenatal checkups. Numbers of institutional and home deliveries were almost same. Only 4 percent of home deliveries were done without a government trained skilled birth attendant while 77 percent were done from attendants whose whereabouts were not known to any government health staff. 42 percent of women cited non-cooperative attitude of the staff as the reason for home delivery. Immunization of children below 5 years of age was found in 56.7 per cent children. The study suggested health education component of care needs to be strengthened to bring about change in attitude and practice of health services.

Sanjay Gupta (2014) carried out a study namely, “ A Study of Efficiency of MCH Services in Rural Area of Ludhiana District, Punjab” and the objective to study the efficiency of maternal and
child health (MCH) services in terms of quantitative indicators of MCH services. The study was conducted in the field practice area of rural health training centre of Dept. of Community Medicine, Christian Medical College, Ludhiana, Punjab. A population of 10,000 under four villages was covered under the study and it was found that the birth rate of the community was 14.5 i.e., much less than of national average indicating an effective family planning coverage. The infant mortality rate was found to be 41.4 i.e., higher than the national average and much far away of the national target of < 30. As far as institutional deliveries are concerned, it was 59.8 percent. The 59.8% of institutional deliveries indicates a great need of mobilization of community towards institutional deliveries. The immunization coverage for Bacillus Calmette-Guerin (BCG) was found good but there was need to stress to immunize in the first year of life as early as possible. The oral polio vaccine type 3 (OPV-3) and diphtheria, pertussis, tetanus type 3 (DPT-3) coverage was again found to be less in the first year with 56.7 percent. Measles coverage was again found to be poor in the first year of life but a good coverage in the second year. It was concluded in the present study that except a few, most of the other indicators were lagging behind the desired. There is a great need of mobilization of both the health personnel and the community towards the utilization of the services of MCH.

Mahajan and Sharma (2014) in their study “Utilization of Maternal and Child Health Care services by Primigravida Females in Urban and Rural Areas of India” evaluated the literacy level, antenatal care registration, Iron and Folic acid tablet consumption etc. from Rural and Urban health centre of Cheetah Camp. The objective of the study was to compare the utilization of Maternal and Child Health Care services in Urban and Rural primi gravida females of India. The study was conducted on 240 participants in parole primary health centre covering seven sub centres and maternity home of Cheetah Camp Urban Centre. Findings of the study showed that maternal complications and poor perinatal outcome are highly associated with non-utilisation of antenatal and delivery care services and poor socioeconomic conditions of the patient. It is essential that all pregnant women have access to high quality obstetric care throughout their pregnancies. More illiteracy and less mean age at the time of marriage were observed in rural population. Participants of the study in both rural and urban areas had poor knowledge and awareness about Iron and Folic Acid tablets consumptions and the importance about tetanus toxoid injections. Very few respondents from both areas were counselled for HIV testing before pregnancy. More numbers of abortions (19.2%) were noted in urban study participants compared to rural area. Thus utilization of maternal and child health care (MCH) services was poor in both urban and rural areas. It is suggested in that a sustained and focussed IEC campaign will improve the awareness amongst community on MCH and will help in improving community participation. This may improve the quality, accessibility, and utilization of maternal health care services provided by the government agencies in both rural and urban areas.

4. Conclusion

After reviewing the governmental initiatives for maternal and child health services and various studies on utilisation, it can be concluded that although governments are making efforts to provide MCH services to the people, yet their utilisation is not up to the mark. A lot needs to be done for improving the utilisation of maternal and child health services as there are various issues involved in the utilisation of MCH services such as lack of education, age, social taboos, unawareness, poverty and geographical locations. It is found that people with less education and from rural areas go for unsafe deliveries, do not go for three ANC checkups and do not utilise other MCH services. It is also important to mention that some studies have highlighted the discrepancies in
data provided by the national reports. Therefore it is suggested that apart from generating awareness through IEC among the populations about the programmes and services, focus should be on removing the barriers in utilising these services and for that governments should take initiatives on area specific research studies on utilisation of MCH services in order to get the grass roots level picture.

References