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A General Estimation Of Maternal Health Condition In India

KEYWORDS

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ABSTRACT *"Maternal deaths are both caused by poverty and are a cause of it. The costs of childbirth can quickly exhaust a family's income, bringing with it even more financial hardship."*

- *Tamar Manuelyan Atinc,*
- *Vice President for Human Development, World Bank*

Maternal health plays an essential role in women's health in India. Lot of researches have been undertaken in this area due to maternal mortality ratio. Even though Government agencies have been promoting various programmes on the basis of need, still maternal health conditions are not improved remarkably due to various reasons. The governmental programmes and data on maternal conditions are discussed in this paper.

INTRODUCTION

"Maternal deaths are both caused by poverty and are a cause of it. The costs of childbirth can quickly exhaust a family's income, bringing with it even more financial hardship."

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Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. It includes the health care dimensions of family planning, preconception, prenatal and postnatal care in order to reduce maternal morbidity and mortality.

Maternal mortality and morbidity continue to be high despite the existence of national programs for improving maternal and child health in India. Because of several factors such as non-utilization or under-utilization of maternal health-care services, especially amongst the rural poor and urban slum population due to either lack of awareness or access to health-care services. Understanding of the knowledge and practices of the community regarding maternity care during pregnancy, delivery and postnatal period is very much required

THE CONCEPT OF MATERNAL HEALTH

Maternal Health is not merely a health disadvantage, it is a subject of social injustice, low socio-economic status of girls and women confines their access to education, good nutrition as well as financial position for health care and family welfare services. The extent of maternal mortality is an indicator of disparity and inequality in accessing suitable health care and nutrition services throughout lifetime and especially during pregnancy and child bearing stage.

Studies have shown that exposure to mass media or modern forms of mass communication has a strong effect on reproductive outcomes, especially on contraceptive use (Westoff and Bankole 1997). Mass Media Expenditure is an important means of communication especially when the target group may be illiterate out of school of unemployed (Webb 1998). Exposure to Media also influences the utilization of antenatal care services (Mondal 1997).

MANAGEMENT OF MATERNAL HEALTH SERVICES

There are two main divisions within the Ministry of Health and Family Welfare: the Department of Family Welfare (DFW) and the Department of Health (DH). MCH, reproductive health, rural health, primary healthcare, and family planning come under the DFW while medical colleges, national institutes, and disease-control programmes come under the DH.

The Maternal Health Division within the DFW looks after all technical and administrative aspects of maternal health activities throughout India.

Functions of Maternal Health Division, Department of Family Welfare, India

- Provision of technical advice to the Minister and the Secretary of Health and Family Welfare who are non-technical officials
- Designing new evidence-based maternal health programmes
- Setting technical standards and developing guidelines
- Reviewing research and developing new evidence-based strategies
- Reviewing training content and tailoring it to emerging needs
- Monitoring programme, implementation, and performance, including quality and evaluation of outcomes
- Providing information to address questions in the parliament
- Providing technical information on policy, legal and other issues
- Commissioning special studies and reviewing data
- Dealing with professional organizations, non-governmental organizations, consumer groups, etc.
- Interacting with donors, international agencies, and development partners
- Planning and implementing national information, education, and communication
- Preparing budgets and funding programmes

The Maternal and Prenatal Death Inquiry and Response (MAPEDIR) innovation extends across select districts in Rajasthan, Madhya Pradesh (MP), West Bengal, Jharkhand, Orissa and Bihar providing an ongoing, systematic collection of data to reconstruct and analyze the cases of 1,600 women -- the highest number of audited maternal deaths in the world. It informs health officials about the challenges local women face in accessing reproductive health care.

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MAPEDIR follows a six step process:

1. Sensitizing communities on maternal and prenatal health issues, including birth preparedness and complication readiness;
2. Reporting and investigating maternal deaths;
3. Interviewing all families with a maternal death to determine the biological and social causes;
4. Analyzing and interpreting the data (embed data sheet);
5. Sharing the finding with communities to develop appropriate, high-impact, local interventions;
6. Monitoring the interventions with ongoing maternal death inquires and developing new evidence-based interventions as needed.

GOVERNMENT PROGRAMMES

The following programmes were launched by the Government of India, to benefit the health of the community, particularly mother and children include:

- Community Development Programme (1952)
- Family Planning Programme (1952)
- Sharada Act (1952)
- Applied Nutrition Programme (1961)
- Midday Meal Programmes (1962) later revised as, School Health Programme
- Iron and Folic Acid Supplementation Programme (1970)
- Vitamin 'A' Prophylaxis Programme (1970)
- Special Nutrition Programme (1970)
- Balwadi Nutrition Programme (1970)

Later on Special Nutrition Programme and Balwadi Nutrition Programme were merged into Integrated Child Development Services Scheme (1975)

- Medical Termination of Pregnancy Act (1971)
- Water Supply and Sanitation Programme (1972)
- Minimum Needs Programme (1974 - 78)
- Family Welfare Programme (1977)
- Rural Health Programme (1977)
- Rural Health scheme (1977)
- Diarrhoeal Disease Control Programme (1974 - 78)
- Dai's Training Programme (1971)
- Expected Programme of Immunisation (1978) later revised as Universal Immunisation Programme (1985)
- Integrated Rural Development Programme (1978)
- Child Marriage Restraint Act (1978)
- National Health Policy (1983)
- Revised National Population Policy (1986)
- Child Survival and Safe Motherhood Programme (1992)
- Acute Respiratory Tract Infections Control Programme (1992)
- Pulse Polio Programme (1995)
- Prevention of Deaths from Hunger and Malnutrition Programme (1996) and
- Reproductive and Child Health Programme (1996)

The Cairo International Conference on "Population and Development (1994)" formalized a growing international consensus for improving reproductive health, including family planning for human welfare and development. It gives crucial distinction between the overall goals of population policy and the reproductive and child health programme. The goal is to reduce unwanted fertility safety and to provide high quality health services which intern respond to the needs of individual and to stabilize the population growth.

Janani Suraksha Yojana

The National Maternity Benefit Scheme has been modified into a new Scheme called Janani Suraksha Yojana since April 2005 with the objective of reducing maternal mortality/infant mortality through increased delivery at health institutions. Even though the state/UTs do lot of intervention, it is felt that effective care is possible by making essential and emergency obstetric services, by way of focusing at increased institutional care, among women in Below Poverty Line families. It is for the welfare of rural and urban women who come under Below Poverty Line. The Accredited Social Health Activist (ASHA) work as a bond health worker between the poor pregnant women and public sector health institution.

DATA ON MATERNAL HEALTH CONDITIONS

- It is estimated 80,000 pregnant women or new mothers die every year in India frequently from preventable causes including hemorrhage, eclampsia, sepsis and anemia.
- India's goal is to lower maternal mortality to less than 100 per 100,000 live births but that is still far away despite its programmatic efforts and rapid economic progress.
- India occupy the third lowest rank in combating pneumonia and diarrhoea:
- The current maternal mortality ratio (MMR) in India is 301/100,000 live births
- The total fertility rate stands at 2.9 which contributes to increase lifetime risk of maternal deaths. The unmet contraceptive need results in unwanted pregnancies. It is no wonder to record that 13% of maternal deaths in India are still attributed to unsafe abortions.
- Even though the Medical Termination of Pregnancy (MTP) Act was passed in the country way back in 1971, all PHCs and FRUs are not equipped to carry out MTP. Even in states like Tamil Nadu, unsafe abortions account for 4 – 6 % of all maternal deaths.
- More than half of pregnant women in India (52%) receive three or more antenatal care visits and about three-fourths of them (72%) receive on antenatal visit by any health worker.
- About two-thirds of pregnant women (65%) receive iron and folic acid (IFA) tablets under the anemia prophylaxis program but only one-fourth consume them for the recommended duration of 90 days.
- According to NFHS – 2 (1994 - 1996) and NFHS – 3 (2005 - 2006) institutional delivery rose from 34% to 41% and deliveries assisted by skilled health professionals from 42% to 49%.
- With regard to postnatal care only 37% of mothers received postnatal care within 40 hours of childbirth.
- The Government of India estimates that 301 women die annually for every 100,000 live births. The maternal mortality ratio is even higher - 358 in Orissa, 371 in Bihar and 379 in MP.
- Women who die in India during pregnancy, delivery or from post-partum complications have largely untold – until now.

REVIEW OF EARLIER STUDIES

National Family Health Survey in India (1992-93) found that antenatal care was provided at home by a health worker for only 21 per cent of births during the last 4 years. However, in the case of 40 per cent of births, the mother went outside her home and received antenatal care from an allopathic doctor. Antenatal care was provided by nurse/midwives, ayurvedic or through home visits is much more common in rural areas (Covering 25% of births) than in urban areas (covering 10% of births). Urban women receive antenatal care more (70%) from allopathic doctor than rural women (31%). Utilization of antenatal service is nearly universal in Kerala (97%). Goa (95%), Tamil Nadu (94%). On the contrary only 31 per cent of births in Rajasthan received antenatal care from an allopathic doctor.

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61 per cent of mothers received atleast one dose of Tetanus Toxoid vaccine. Over half of births (51%), mothers received Iron and Folic acid tablets. Institutional deliveries were conducted for 26 per cent of mothers. Women in southern states of India had utilized maternal and child health services comparatively at higher side than those women residing in central and northern parts of India.

Only 26 per cent of births during the last four years were delivered in health institutions and 74 per cent delivered at home. However, 34 per cent of deliveries were attended by trained personnel. In Tamil Nadu (71%), Andhra Pradesh (50%) and Uttar Pradesh (17%) deliveries were conducted at health facility centres, 74 per cent of deliveries are carried at natal home. Home deliveries are performed in other states as under in Karnataka (28%), Maharastra (20%), Tamil Nadu (11%), Haryana (9%), Uttar Pradesh (7%) and in Goa (3%).

Shah and Shah, (1992) in Calcutta found that mothers who failed to avail the antenatal care, delivered low weight babies as compared to those who had more antenatal care.

In Morocco study, Obermeyer (1993) revealed that, urban women of lower age groups, higher age at life events, higher educational attainment and small household size utilized the antenatal services and natal services more than women living in rural areas lower age at life events, lower educational levels and large family size.

Becker et al (1993) in Metro Cebu study found that the differentials in prenatal care vary considerable by child's age, maternal age, education of couple, economic status, place of residence and possession of radio or T.V. when all the other variables were held constant, the receiving of prenatal care was observed to be large and statistically significant with maternal education and place of residence

Sharma, et al (1995) in a semi-urban community of Pondicherry observed the trend of mothers in utilization of maternal care services. His findings revealed that 26 per cent of women sought antenatal care in the first trimester and 40 per cent did so during their subsequent pregnancies. Primipara had the highest average clinic visits.

Audinarayana and Sheela, (1998) in their analysis of NFHS data observed that, women educated upto high school or more had utilized the maternal care services significantly at a higher level than the illiterate women.

Masuma Mamdani (1999) limited decision making power in their sexual relationships is an obstacle to obtaining appropriate and timely care among adolescent women.

It is observed from the above studies that higher level of education enhances the women's knowledge of modern health care facilities, modifies their beliefs about pregnancy and child care practices. It also enhances their status within the family and role in decision-making, improves their ability to communicate with modern health care providers and utilizes the health care services to obtain optimum health and prevent/reduce morbidity and mortality level.

SUGGESTIONS

- Social and economic factors such as low status of women in communities, the poor understanding of families in utilizing health care services, lack of transport, poor roads, medical expenditure, multiple referrals to different health facilities and a delay in life-saving measures in need to be addressed.
- Medical records only capture biological causes of death. Other crucial factors that contribute to mothers dying can be identified by communities and health systems.
- Periodical health camps and check-ups should be organized in coordination with the Government and NGOs.
- Poor coverage of postnatal care is a serious concern as a large proportion of maternal deaths are concentrated during the early postpartum period (NFHS-3)
- The coverage of family welfare programme should be further improved as evidenced by a poor contraceptive prevalence rate of 56% and unmet contraceptive need of 13% in eligible population groups (NFHS-3).
- Even though we have National Health Policy, we much have National Health Act to curb injustice in the private medical field.

CONCLUSION

The progress in maternal health has been uneven, inequitable and unsatisfactory. MDG-5 stands for improving maternal health and aims at reducing the MMR by 75% between 1990 and 2015. For India, the target is to achieve an MMR of 108 by 2015. Global reviews and studies reveal that maternal deaths are clustered around labour, delivery and the immediate postpartum period with obstetric hemorrhage being the main medical cause of death. We have still long way to reach good maternal health conditions.

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