Chapter - 6

Summary and Conclusions
CHAPTER-VI

SUMMARY AND CONCLUSIONS

Promotion of maternal and child health has been one of the most important objectives of the Family Welfare Programme in India. The Reproductive and Child Health Programme (RCH) Phase - I was launched in October 1997. The RCH programme incorporates the components covered under the Child Survival and Safe Motherhood (CSSM) Programme and includes an additional component relating to reproductive tract infection and sexually transmitted infections. The need for bringing down maternal mortality rate significantly and improving maternal health in general has been strongly stressed in the National Population Policy 2000. This goal is achieved unless otherwise the health care facilities and practices are extended to the grass root level of the community especially among the disadvantaged and country side people.

According to the World Health Report 2008, Primary health care, now more than ever, health systems in developing countries have not responded adequately to people’s needs. The report argues that health systems are failing because they have not kept abreast of the challenges of a changing world. It suggests that health authorities have tended to view primary health care, not as a key set of reforms, but as one health model among others.

Long before the declaration of Alma Ata, India adopted a primary health care model based on the principle that inability to pay should not prevent people from accessing health services. Derived from the recommendations of the health survey and Development Community Report (the “Sir Joseph Bhole Committee Report”) of 1946, the Indian Government resolved to concentrate services on rural people (Goel, 2008). In 2005, the United Progressive Alliance Government launched the National Rural Health Mission (NRHM) to improve access to quality health care, especially for poor rural women and children.
A characteristic feature of access to healthcare in the Indian context is the unevenness in the physical and functional provisioning of facilities across the country. The uneven access to antenatal care can, for example, be gauged from the fact that India is classified in the Class B category of nations in the world where between 11% to 50% of the districts are at ‘high risk’ of neonatal and maternal tetanus (UNICEF, WHO, UNFPA, 2000). Neonatal and maternal tetanus can be prevented by universal coverage of antenatal services and safe delivery practices. Further, a major public health problem like maternal mortality can be tackled by the provisioning of emergency obstetric care. Reduction in maternal mortality ratio can be effected by an equitable access to emergency obstetric care (as also safe abortion services).

Women’s health needs are numerous- nutrition, general morbidity, reproductive health, disability, mental health, occupational health, and are interrelated. Moreover, as women progress through the life stages, unresolved health needs can have cumulative burdens on their health. For instance, poor nourishment during childhood and adolescence can lead to unfavorable reproductive health outcomes starting from early adulthood. Otherwise unresolved mental health needs early in life can have lasting consequences on the physical well-being of women during old age. Thus, throughout the life cycle, childhood, adolescence and old age, women in India are vulnerable in terms of their health and healthcare seeking behavior.

Health care information and health care facilities for women are meager especially in rural areas. It is our hypothesis that documenting the information about women’s health and facilities would certainly help for community development. The possible causation for the prudence of our hypothesis is higher morbidity among women folk from rural segments. Unless otherwise documenting the root cause for the women’s health problems, the welfare measures may not be fruitful for their upliftment.

**STATEMENT OF THE PROBLEM**

NEED OF THE STUDY

Women are major consumers of health care services, negotiating not only their own complex health care but often managing care for their family members as well. Their reproductive health needs as well as their greater rates of health problems and longer life spans compared with men make women’s relationships with the health care system complex. Women are also more likely to be low-income and often face the added challenge of balancing work with family health and care giving responsibilities. Women have a vested interest in the scope and type of services offered by the health care system, as well as in the mechanisms that fund their health care services. Hence conducting periodic surveys on women's interactions with the health care system, monitoring reforms under consideration across the country especially at country side, conducting research to document the impact of policies and to identify emerging priority areas for women, as well as briefing policymakers and their staff on key trends and issues to inform current policy debates will greatly benefit to improve the health of the women. The aim of the study is to understand the maternal and child health care facilities and practices in relation to socioeconomic level among rural women in Chittoor district, Andhra Pradesh.

OBJECTIVES OF THE STUDY

1. To assess the demographic variables of the rural women.
2. To examine the status of women’s health and the prevalence of morbidity.
3. To study the health care facilities available to the rural women.
4. To understand the awareness of rural women on health care aspects.
5. To know the practices of women on health care aspects.
6. To study the influence of independent variables on awareness and practices of rural women on health care aspects.
HYPOTHESIS

Based on the above objectives, the following hypotheses were framed for testing

1. No single variable or a set of variables included in the study do not significantly exert their contribution to the awareness of the rural women about health care aspects.

2. No single variable or a set of variables included in the study do not significantly exert their contribution to the practices of rural women towards health care aspects.

INDEPENDENT VARIABLES

1. caste
2. education
3. income

DEPENDENT VARIABLES

1. Awareness of Health care aspects.

TOOLS USED

The following tools were used by the investigator for the purpose of the study

1. A Schedule on health care facilities.
2. A Schedule on awareness of health care aspects and practices of health care aspects.

SELECTION OF THE SAMPLE

The sample selected for the present study is married women (rural) in the age group of 20 years and above. The sample size is 750. A multistage simple random sampling technique is employed in selecting the sample. Chittoor District is having three revenue divisions mainly i.e. Tirupati, Chittoor and Madanapalle. All the revenue divisions are taken into consideration. In each revenue division, two mandals are picked through simple random
technique. Further in each mandal 4 villages are randomly selected. Each person is interviewed individually. Apart from this, 6 primary health centres located in the study area are enquired about the availability of various health facilities for the women.

COLLECTION OF DATA

For the purpose of collection of data from the rural women, the investigator administrated the tools namely A Schedule on health care aspects A Schedule on awareness of health care aspects and practices of health care aspects Data regarding the personal variables of the sample viz. 1) Age 2) caste 3) religion 4) education 5) occupation 6) income 7) type of house 8) type of family 9) self reported health was collected by using personal data sheet.

ANALYSIS OF DATA

Data coded and fed to the computer for analysis. Statistical analysis is carried out via SPSS 16.0. Percentage frequencies are provided to all qualitative variables. Chi-square test is used to see the strength of association of independent variable on dependent variable

Findings

- The aim of the current study is to understand the maternal health and healthcare facilities and practices in a free leaving sample of women. A total of 750 rural women interviewed on demographics and knowledge on healthcare facilities and practices.
- Around 86 percent of the women are in the range of 21 to 35 years. Around 30 percent of the women belongs to backward and scheduled caste, 22 percent of the women are from other caste and only 15 percent of the women represented by scheduled tribe. In the study sample, 84 percent of the samples are from Hindu religion, followed by 10 percent of Christians and 6 percent of Muslims.
- In the current study, 16 percent of the women are illiterates, 39 percent attained primary education followed by 26 percent secondary education and 19 percent higher education. More than 15 percent of the sample’s incomes fall in 25000 to 45000,
followed by 35 percent in 45000 to 64000, 11 percent in below 24000 and only 3 percent in above 65000.

- 65 percent of the women own pucca house. 22 percent of the women are living in tiled house followed by 10 percent in terraced house and only 2 percent of the women are staying in thatched house.

- For the question “how would you rate your health at present?” 60 percent of the women expressed that their self reported health is good. 37 percent of the women’s self reported health is fair and only 3 percent of the women expressed that their self reported health is poor.

- Educational level and income of the sample is having good association ($\chi^2=78.470$: p<0.001). The frequency of low income (>24000) is 22% among the illiterates and the same is only 4 percent among the samples with higher education. Sample income above 65000 is only 5 percent among illiterates, where as 8 percent of the sample income is above 65,000 with higher education. Feeling good self reported health is 53 percent among the illiterates and the same is 66 percent among the sample with higher education.

- Forty one percent of the women expressed that they do have health problems.

- Thirty two percent of the sample with illiteracy expressed that they do have certain health problems. The same is recorded as 27 percent in both primary and secondary level of education. Among the sample with higher level of education, only 15 percent expressed that they do have certain health problems. When compared to higher education the risk of being subjected to ill health is 1.8 times greater among the sample with primary education (95%CI: 1.177-2.730).

- A maximum of 54 percent of the sample from ST community reported with health problems and this percentage gradually came down to 33 percent in OC community. When compared to OC the risk of being subjected to ill health is 2.4 times higher in ST community (95%CI: 1.453-3.922).

- Only 3 percent of the sample with income range of >65000 INR reported with health problems and the same is noticed to an extent of 27.9 percent in 45000-64000 INR, 53.4 percent in 25000-44000 INR and then 15.7 percent in <24000 INR. Sample with an income range of <24000 INR are 1.618 (95%CI: 0.593-4.416) times likely
subjected to health problems when compared to sample with an income of >65000 INR.

- Among the sample, 24 percent attained menarche in their below 11 years of age. 18 percent of the women attained menarche in between 14-15 years. A maximum of 58 percent of the women attained menarche in between 12-13 years.
- Sixty six percent of the women got married in their below twenties. 31 percent of the women attained first conception in their below twenties.
- Age at menarche is showing good association with educational level of the sample ($\chi^2=16.335$: p<0.01). Age at menarche below 11 years is 15 percent among illiterates and 21 percent in the higher education. Getting marriage in below 20 years of the age is 72 percent among illiterates and this percentage is about 50 percent among the sample with higher education ($\chi^2=43.548$: p<0.001). First conception in below 20 years of age is 28 percent among the illiterates and 26 percent among the literates.
- Among the study sample, 81 percent of the women are having awareness on legal policy on age at marriage.
- Normal delivery is recorded to an extent of 67 percent only. Delivery in the hospital is recorded to an extant of 86 percent and only 5 percent in the domestic houses.
- Getting delivered at hospital is 92 percent among the sample with higher education and it came down to 77 percent among the illiterates. Getting delivered at domestic house is 7 percent among the illiterates and it is only 4 percent among the sample with higher education ($\chi^2=23.874$: p<0.005).
- Relationship with husband as good is noticed among 58 percent of the illiterate women, while it is only 51 percent among the women with higher education.
- In the present study, 95 percent of the people expressed that they do have access to preliminary health check up. Only 5 percent of the women mentioned that lack of access to preliminary health check up. Among the illiterates, 5 percent of the people are not having immediate access to the preliminary health check up; whereas only 3 percent of the people with higher education expressed that they do not have access to the preliminary health check up. When compared to illiterates the access to health care is 1.535 times greater in sample with higher education.
Among the OC, 5 percent of the people are not having immediate access to the preliminary health checkup, while 5.7 percent of the BC, 6.1 percent of SC and 3.7 percent of the ST people expressed that they do not have access to health care. When compared to OC, the access to health care is 1.535 times lesser in ST samples. Among the low income group 6.2 percent of the sample do not have access to health care and the same is 5.3 percent among the sample with an income of >65000 INR. When compared to sample with an income of <24000 INR, the odds of health care is 1.173 times (95%CI: 0.129-10.675) in sample with an income of >65000 INR.

In the present study 94 percent of the sample are having awareness about HIV/AIDS. Only 6 of percent the people are unaware of HIV/AIDS. Knowledge on PAP test is seen among 72 percent of the people. A high of 28 percent of the women does not have knowledge on PAP test. Around 12 percent of the illiterates are not having knowledge on HIV/AIDS. Among the sample with primary education, 11 percent of the people are not having knowledge an HIV/AIDS. Cent percent of the people with secondary and higher education are having knowledge on HIV/AIDS (χ²=40.334: p<0.001). Among the illiterates cent percent of the people are unaware of PAP test. Awareness about PAP test is seen to an extant 90 percent among the sample with higher education (χ²=3.697: p<0.001). When compared to illiterates the knowledge about HIV/AIDs is 2.523 times (95%CI: 1.290-4.932) greater in sample with literacy. A maximum of 42.2 percent of the SCs do not have knowledge on HIV/AIDS. When compared to OC the odds of HIV/AIDs and PAP is 0.640 (95%CI: 0.181-2.266) and 0.497 (95%CI: 0.288-0.860) respectively. In the high income sample, cent percent of the women are aware of HIV/AIDS. Lack of awareness about HIV/AIDS is 18 percent in <24000 INR. When compared to low income sample, the odds of HIV/AIDS is 2.696 (95%CI: 1.025-7.092).

Eighty seven percent of the sample expressed that women should consult the physician every month. Around 80 percent of the sample is having knowledge on tetanus oxide injection. 96 percent of the women mentioned that their pregnancy confirmed by urine test on 45 days. 95 percent of the women mentioned that medical staff (ANM) is conducting required medical checkup and providing medicines from first trimester onwards.
• 91 percent of the samples with higher education expressed that pregnant women have to consult doctor every month while only 84% of the women with illiteracy mentioned that pregnant women have to consult doctor every month. Knowledge on tetanus injection is similar across the educational level of the samples. 87 percent of the women accepted that pregnant women have to take Iron rich tonic and folic acid tablets against while it is 85 percent among the sample with illiteracy.

• Confirmation of the pregnancy through urine test on 45 days is 95 percent among the higher education sample and 98 percent among the illiterates. Around 96 percent of the women with higher education mentioned that ANM is conducting required medical checkup from first trimester onwards and providing medicines from first trimester onwards, on the otherhand only 92 percent of the women with illiteracy accepted that ANM is conducting required medical checkup from first trimester onwards and providing medicines from first trimester onwards.

• 18 percent of the women mentioned that their children subjected to health problems after birth. Jaundice is the predominant to an extent of 8.4 percent followed by 8 percent of anemia, 2 percent of fever, and 0.3 percent of fits. Breast feeding is seen to an extent of 84 percent.

• A high of 21 percent of the women with illiteracy mentioned that their baby had health problems right after birth. Among the women with higher education only 12 percent expressed that their baby had health problems right after birth. Breast feeding is more in practice (89%) among the women with higher education when compared to women with illiteracy (86%). No significant variation is seen in the odds of children health status according to the mothers’ educational level.

• Fifty percent of the SC children are reported with various health problems right after birth. The corresponding figure for OC is 25 percent and 13 percent in BC and ST respectively. When compared to OC, the risk of being child subjected to different health problems in ST community is 1.415 (95%CI: 0.066-8.249) respectively.

• About 37.5 percent of the children in 25000-44000 INR are prone to different health problems and the same is 62.5 percent in 45000-64000 INR.

• Knowledge on 108 services is little bit higher among the higher education. Almost all the people accepted that 108 services will come to their village regularly and they
are satisfied with 108 services. 97 percent of the women with higher education are having knowledge about 104 services while it is only 92 percent among the samples with illiteracy. 96 percent of the women with higher education felt that 104 services are Excellent/Good and the same is observed to an extent of 89 percent among the sample with illiteracy.

- Knowledge on Rajeev Aroghya sree programme is uniform across the education level of the sample. 35 percent of the women with the higher education against 25 percent of the illiteracy women expressed that Rajeev Aroghya Sree Programme is good.

- Access to primary health care centre is 20 percent among higher education sample and the same is 14 percent among the illiterates. When compared to higher education the odds of access to primary health care centre among illiterates is 1.567 (95%CI: 0.953-2.576). Around 10 percent of the sample in the income of <24000 INR are not having access to primary health care centre and the same is only 1.8 percent in >65000 INR. When compared to low income sample, the odds of having access to primary health care among high income sample is 1.632 (95%CI: 0.594-4.483). Access to health care centre among OC sample is 21 percent and the corresponding figures for BC is 30 percent, ST is 37 percent and 12 percent in ST sample. When compared to OC the odds of having access to health care centre in BC is 1.032 (95%CI: 0.685-1.555), SC is 1.287 (95%CI: 0.862-1.923) and in ST sample is 0.787 (95%CI: 0.474-1.307) respectively.

- Almost all the samples accepted that ANM comes to their village regularly. 98 percent of the sample opined that ANM comes monthly once.

- Almost all the women mentioned about nutrition food centres organised by government for child and pregnant women. 58 percent know about balabadi and 42 percent about ICDS. 97 percent of the women mentioned that they had been to ICDS centres during their pregnancy. Children aged above 5 years are also visiting ICDS centres. Majority of the samples are going to the ICDS centre with the help of others. Butter is the predominant nutritional supplement provided in the ICDS centres.

- 91 percent of the women expressed that ICDS personnel are not conducting medical checkups. Among the sample, around 30 percent of the women expressed that their
children are falling sick due to insufficient nutritional supplementation. A majority of 40 percent expressed that it cannot be due to insufficient nutritional food supplementation. 54 percent of the rural women accepted that rural women are still being delivered at home due to insufficient transport. Around 44 percent of the samples agreed that village women folk should be informed of modern healthcare facilities provided by the government. Similarly 44 percent of the womenfolk are falling sick due to lack of personal hygiene.

- The results of the present study clearly demonstrate that illiterate women especially from economically deprived communities are more vulnerable towards the precipitation of health problems. Further access to health care facilities and utilization of various health services is poor among this segment of women.

SUGGESTIONS

Undoubtedly, India has experienced considerable improvement in accelerating coverage in MNCH care since the Millennium Declaration, 2000. However, the persistent inequity in access to maternal and child health care across different economic groups is masked by the average improvement in the majority of states.

- An important hurdle in addressing this issue has been the identification of the deprived people who deserve special attention.

- The existing health inequity in India is due to the lack of attention to social determinants of health (including education, employment, improved water, hygiene and sanitation, nutrition, community and household environment, etc.) and the failure of the health system to provide essential health services to those in need.

- The low literacy levels among poor households coupled with a lack of proper health knowledge and health services/schemes are the key determinants of health care services utilization.

- It has been well acknowledged in Indian literature that poor households are socially marginalised, and indeed in many cases detached from the social network, which is
one of the powerful tools for disseminating knowledge about the betterment of health among the marginalised sections of society.

- Self motivation and knowledge about health care services lead to increased utilization; our study reiterate this hypothesis.

- Only self motivation may not be enough for women using health care. External motivations like motivation from husband, relatives or health professionals are also in need for pregnant women using maternal health care. Importance of husband’s involvement for enhancing maternal health care services is not a new phenomenon; there have been ample numbers of studies that support how husband’s participation enhance women’s maternal health care utilization.

- Strengthening health care infrastructure, i.e. increasing supply of health care services, is essential for enhancing health care utilization.

- Increasing supply does not mean only provision of health infrastructure; it must ensure how to reach people. Parallel efforts of strengthening health care infrastructure and maintaining affordable cost must be placed for ensuring universal maternal health care utilization.

- The main priority should be given to increase the demand for health care through providing women’s higher education and improved economic status than only setting up health centre since enhanced demand is found to be more effective than the enhanced supply as far as adaptation of maternal health care services is concerned.