Vol 4 Issue 8 Feb 2015

ISSN No :2231-5063

International Multidisciplinary Research Journal

Golden Research Thoughts

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RNI MAHMUL/2011/38595 **ISSN No.2231-5063**

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Golden Research Thoughts
ISSN 2231-5063
Impact Factor : 3.4052(UIF)
Volume-4 | Issue-8 | Feb-2015
Available online at www.aygrt.isrj.org

PREFARANCE TO CLINICAL DELIVERY IN INDIA: A CASE STUDY OF KARNATAKA

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Abstract:-The present study makes an attempt to cover the aspects, i.e., knowledge and utilization of reproductive health services in terms of place of delivery The overall target sample size' for Karnataka was 4,000 eligible women. The data has been analyzed using appropriate statistical techniques, such as uni-variate biuariate and MultiMate analysis which lay the ground work for developing a model based on cultivate relationships which helps to come to some conclusion. The study found that there exists a considerable difference among the respondents in their knowledge and utilization of place of delivery services, with reference to their background (societal) characteristics. Like socio, economic demographic and developmental. The important variables which have significant influence on the utilization of modern health services are caste, education of husband as well as education of wife. The effect of these variables was positive.

Keywords: Women delivery, knowledge and utilization.

INTRODUCTION

The Department of Health and Family Welfare understands reproductive health and child health as an appropriate programme wherein focus on mother and child health, family planning, reproductive health can be integrated in an incremental manner thus drawing upon the strengths of different areas for purposes of implementation.

The Ministry of Health & Family Welfare, GOI, in cooperation with the World Bank, had organized a series of workshops on Rural RCH and Urban RCH in September, 1995 and November, 1995. The workshops were held with a view to enriching and facilitating the preparation of the proposal for a World Bank funded project on implementing recent policy decisions for improving the impact of the family planning programme in the country. These workshops, which included participants from different strate of administrative and technical services having working experience at different levels of the health care system, reviewed the draft essential package of cost effective interventions known as the Essential Reproductive and Child Health Services as contained in the RCH sector study (brought out in grey cover by the World Bank), and later modified by the Task Force of MOHFW with a view to providing guidelines for operationalizing the essential package. The RCH matrix as adopted by these workshops are appended with this note (MOHFW, 1991).

One way to conceptualizing state-specific strategy is to classify various states in the country according to the proportion of home/hospital based deliveries, since neo-natal, maternal and moralities are known to be closely linked to the level of hospital based deliveries. For instance, BIMARU states which have high shares of home-based deliveries are also the ones which currently exhibit high maternal and infrant mortality. A main reason is that home-based deliveries are also ones which currently exhibit high maternal and infant mortality. A main reason is that home-based deliveries lack right infrastructure to carry out these deliveries, including inadequately trained dais. On the other hand, states with a high proportion of hospital based deliveries indicate lower levels of neo-natal, maternal and infant mortalities, largely because of their having access to proper infrastructure, including facilities to deal with emergencies and complications.

In order to reduce the high rate of morbidity and mortality and to raise the health status of mother and child it is important to be aware of modern health facilities in terms of availability, accessibility, and knowledge because it is

a prerequisite for utilization. Hence to strengthen the existing programme, there is a need to understand the extant to which people possess knowledge about the various components of the programme, to what extent they are utilizing the different services and most importantly to identify the factors including the knowledge which the to given utilization.

Hence, there is a greater important attached with this concept study the people who possess knowledge who have utilized the reproductive health services and those who do not. What are the causes responsible? How for the para medical staff succeeded in making the programme successful? These are the matters which definitely need further investigation and the current study try to provide the relevant information on these issues.

Bhargava (1983) reported that an integrated approach to material and child health and family planning will have an effect on mothers health by lowering material morbidity and mortality, an improved nutritional status, and low incidence of preventive complication of pregnancy, total health, low fetal mortality and still birth rate, proper care of the new born, preventive and early detection of abnormalities of her and child health. This will further lead to greater acceptance of family planning as it will give creditability and improve cost effectiveness.

Services for maternity care should be designed to ensure timely detection, management and referral of complications during pregnancy, delivery and the post-partum period. Maternity services have received inadequate attention in the National Family Welfare Programme. In recent years, however, there has been an effort to remedy this neglect with the implementation of the safe motherhood initiative. This safe motherhood programme must now receive priority within the family welfare strategy (Sholapurkar, 1982).

Antenatal services should be organized to detect and manage complications related to pregnancy such as anemia, infection, pre-eclampsia, malpresentation and obstructed labour. Women should be educated about the danger signs of pregnancy and provided information on where to seek help. Antenatal visits should provide an opportunity to offer advice and counseling on hygiene, breastfeeding, nutrition, family planning and immunization as well as to treat pre-existing conditions such as diabetes, and infections such as malaria and tuberculosis that are commonly prevalent, may be aggravated by pregnancy, and may complicate pregnancy (World Bank, 1994)

Outreach services should be strengthened to ensure that all women are registered as early in pregnancy as possible and antenatal care initiated. In addition, PhDs must also be upgraded to manage some complications and provide facilities for delivery. Some complications can and should be treated at the PHC, while others must be referred to the CHe (Rupert Samuel, 1992).

OBJECTIVES:

Moreover the concept of modern maternal health service internal of knowledge and its utilization can not be studied in isolation there fore to objective of the study are as follows:

1) Identity the factual associated with knowledge and utilization of place of delivery.
2) To study the background characteristics like social economic and demographic profile the study area and respondent.

HYPOTHESIS:

An attempt was made to formulate the few important hypothesis for its empirical testing and scientific dissection are as follows:

1. castes system
2. Education
3. Economic status
4. Children even born
5. Place of residence

Research Methodology:

There types of questionnaire were used in the NFHS the household questionnaire the womans questionnaire and the village questionnaire. The household questionnaire was used to list all usual residents of each sample household, plus all visitors who slept in that household the night before the interview. Some basic information was collected on the characteristics of each person listed, including age sex, marital status, education, occupation and relationship to the head of the household as well as health status.

RESULTS AND DISCUSSION

Table – 1 Background characteristics of respondents Percent distribution of ever-married women age 13-49,

by selected background characteristics, according to residence, Karnataka 1992-93.

Background characteristic	Residence			Total number of women
	Urban	Rural	Total	
Age				
13 – 14	0.3	0.7	0.6	25
15 – 19	7.7	12.3	10.8	477
20 – 24	17.3	20.4	19.4	856
25 – 29	21.9	19.3	20.1	888
30 – 34	17.8	15.3	16.2	713
35 – 39	13.5	12.9	13.1	577
40 – 44	11.2	10.5	10.8	475
45 – 49	10.3	8.5	9.1	402
Marital Status				
Currently married	93.6	91.8	92.4	4076
Widowed	4.3	5.4	5.0	222
Divorced	0.1	0.1	0.1	4
Separated	2.0	2.8	2.5	111
Education				
Illiterate	38.3	72.9	61.6	2719
Literate, <primary complete	5.7	7.0	6.5	289
Primary school complete	17.1	10.7	12.8	563
Middle school complete	8.0	4.2	5.5	241
High school complete	22.1	4.9	10.5	464
Above high school	8.8	0.3	3.1	137
Religion				
Hindu	79.6	88.9	85.9	3790
Muslim	15.8	8.7	11.0	487
Sikh	--	--	--	1
Christian	3.7	1.2	2.0	90
Jain	0.7	0.9	0.8	36
Other	0.1	0.2	0.2	9
Caste / tribe				
Scheduled caste	11.2	12.2	11.8	522
Scheduled tribe	3.7	6.1	5.3	236
Other	85.1	81.7	82.8	3655
Work status				
Not working	71.5	44.1	53.0	2340
Working in family farm / business	5.3	22.7	17.0	74
Employed by someone else	18.7	31.5	27.3	1206
Self-employed	4.6	1.8	2.7	118
Husband's education				
Illiterate	20.7	48.0	39.1	1726
Literature, <primary complete	9.2	13.4	12.0	531
Primary school complete	15.7	16.9	16.5	728
Middle school complete	9.3	5.8	7.0	307
High school complete	24.6	12.7	16.6	733
Above high school	20.1	3.0	8.6	379
Don't know / missing	0.3	0.2	0.2	9
Total percent	100.0	100.0	100.0	NA
Number of women	1442	2971	4413	4413

NA: Not applicable Less than 0.05 percent

Table – 2 Percent of clinical delivery by their education level

Education of women	Place of delivery		Total
	Home	Clinical	
Illiterate	455 72.7%	216 33.1%	671 52.5%
Primary school complete	83 13.3%	128 19.6%	211 16.5%
Middle school complete	35 5.6%	75 11.5%	110 8.6%
High school and above	53 8.5%	234 35.8%	287 22.4%
Total	626 100.0%	653 100.0%	1279 100.0%
Chi-Square Test:	222.950		
Significant at P = 0.05 level			

The concept of illiteracy is the major cause of concerned still in Indian society as a hole and Karnataka in particular. It was observed that 53 percent of the women were found with no education whereas only 23 percent of women just completed their education upto high school or above. These days modern education provides a platform for the individuals all-round personality development and brings the sea changes in their conceptual and attitudinal behavior among the young generation of today. And that is what got evidence from this data too. As the educational level got increased the women respondents preferred to have an clinical delivery (i.e., 12%, 20% and 36% respectively) living behind the practice of good old traditional system of home delivery. However, the chi-square value at five percent significant level indicates that there is a strong correlation between education levels of individual and use of modern health facilities.

Table – 3 Percent of clinical delivery by their standard of living

Household standard of living index	Place of delivery		Total
	Home	Clinical	
Household standard of living index Low	296 47.4%	135 20.7%	431 33.8%
Medium	281 45.0%	342 52.5%	623 48.9%
High	47 7.5%	174 26.7%	221 17.3%
Total	624 100.0%	651 100.0%	1275 100.0%
Chi-Square Test:	138.587		
Significant at P = 0.05 level			

The modern think thank interpreted in a way that the standard of living is the rout solution of all social problems which we see in these days in all society. Hence Indian society is not exceptional to get away from this sort phenomenon. As one can see from the above table 3 that the major chunk of the respondents belong to middle class status 50% followed by lower middle class i.e., 34 percent and hardly 18 percent of the respondents only enjoy the higher-standard of living. And the similar scenario is existing at national level too. Thus the above table also presents that the increase in individual or family's found that 53 percent of women respondents preferred to have clinical delivery compared to their counter parts that belongs to lower middle class status. The chi-square value at 5 percent significant level strongly support that there is a positive correlation ship between standard of life and the issue of clinical delivery system is concerned.

Table – 4 Results and logistic regression: Place of delivery

Independent variables	B	S.E.	Wald	df	Sig.	Exp (B)
age (1)	-0.288	-0.205	1.975	1	0.160	0.750
ooccu(1)	1.281	0.576	4.957	1	0.026	3.602
hoccu(1)	-0.741	0.915	0.655	1	0.418	0.477
ceb(1)	1.516	0.531	8.153	1	0.004	4.533
livch			2.345	2	0.310	
livch(1)	-0.931	0.884	1.110	1	0.292	0.394
livch(2)	-0.871	0.569	2.337	1	0.126	0.419
educa			28.824	2	0.000	
educa(1)	-1.418	0.276	26.314	1	0.000	0.242
educa(2)	-0.637	0.263	5.845	1	0.016	0.529
huseduc			0.504	2	0.777	
huseduc(1)	-0.152	0.226	0.298	1	0.585	0.867
huseduc(2)	-0.152	0.225	0.459	1	0.498	0.859
ssli			3.447	2	0.178	
ssli(1)	-0.579	0.312	3.442	1	0.064	0.561
ssli(2)	-0.353	0.255	1.915	1	0.166	0.703
v102(1)	1.153	0.195	34.930	1	0.000	3.166
religion			2.870	2	0.238	
religion(1)	0.092	0.546	0.028	1	0.867	1.096
religion(2)	-0.307	0.565	0.295	1	0.587	0.736
caste(1)	-0.282	0.236	1.428	1	0.232	0.754
constant	-0.160	0.802	0.040	1	0.842	0.852

a. variable(s) entered on step 1: age, occ, hocc, livch, educa, huseduc, ssli, v102, relgion, caste.

CONCLUSION

In the preliminary analysis is was found that there exists a considerable difference among the respondents in there knowledge and utilization of place of delivery services with reference to their background characteristics like socio-economic demographic and developmental unlike earlier studies the present study also caught under the influence of Indian traditional culture, And the major out come after carryngout the multivariate analysis was found to be that the women respondents who are slightly higher in age and education the oldrabo tenad to prefer inclincal delivery two times high then that of their counter parts. Nevertheless economic standard of living and the place, of dwelling still found to be played a very vital role in all accessibility and utility the modern health facilities compared to their counterparts who were economically weak and residing in rural areas of it was also observed when the effect of all the other variable were controlled. This is consistent with our findings in the preliminary analysis.

SUGGESTION

Services for maternity care should be designed to ensure timely detection, management and referral of complications during pregnancy, delivery and the post-partum period. Maternity services have received inadequate attention in the National Family Welfare Programme. In recent years, however, there has been an effort to remedy this neglected aspect with the implementation of the safe motherhood initiative. The safe motherhood programme must now receive priority within the family strategy.

First of all, one should be discouraged to have home deliveries because, may a times it has been handled by the untrained unskilled, and unqualified staff that no in a very unhygienic conditions. The reasons for prevailing this traditional system due to the lack of development in a field of health and information technology rather, the human society was in its evaluation face or in a transit period at that time.

The need of the day is clinical delivery services should be encouraged and given first priority because it has been managed by the trained, skill and specialized staff at the community, subcentre and PHC levels and danger signs should be recognized by staff at these levels so that cases requiring emergency obstetric care can be appropriately referred. There is an urgent need to develop systems to ensure that cases requiring emergency referral can be transported to the first referral unit (FRU) on time.

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