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MATERNAL HEALTH CARE FACILITIES TO RURAL WOMEN – A VIEW

M.Kalaiyarasu
Department of Commerce , Ph.D. Research Scholar , Annamalai University , Annamalai Nagar , Tamil Nadu, India.

Short Profile

M.Kalaiyarasu is a Department of Commerce, Ph.D. Research Scholar at Annamalai University , Annamalai Nagar , Tamil Nadu, India. He has completed M.Com., M.Phil., B.Ed. and Ph.D.

ABSTRACT:
Promotion of maternal and child heath has been one of the most important objectives of the Family Welfare Programmes in India. Various programmed interventions in the form of maternal of maternal and child health services through the years have come to stay, to protect the health of mother and child. In India women in reproductive age (15-45) years and children below 5 years of age, compromise 62% of the total population. The main focus of the study is to study the Socio-Economic, demographic which successfully the respondent's knowledge of reproductive health care facilities. Government and non-governmental agencies must expand services, improve their quality, and tailor them to meet the needs of women and communities.

KEYWORDS
Health care, rural women .

INTRODUCTION :

Reproductive and child Health care is an essential component of the primary health care services, and India is committed to the provision of "Health for All" through primary health care approach. The public health care delivery system in India at present has a three tier structure. The primary tier has been developed to provide health and family welfare related services to the vast majority of rural people. It comprises three types of health care institutions: Sub-Centre, Primary Health Centre and Community Health Centre. It is estimated that, only 30 – 45% of even the low income group seek medical help from Government Health Care Units, including the Primary Health Centers (PHCs).

Promotion of maternal and child health has been one of the most important objectives of the Family Welfare Programmed in India. The current Reproductive and Child Heath Programmed (RCH) was launched in October 1997. The RCH Programmed incorporates the components covered under the Child Survival and Safe Motherhood Programmed and includes an additional component relating to reproductive tract infection and sexually transmitted infections. In order to improve maternal health at the community level, a cadre of community level skilled birth attendant who will attend to the pregnant women in community, is being considered.

The present health scenario in India depicts the enormous efforts made by its Government with the assistance of international agencies, in promoting the health of its population and in particular women and children. Various programmed interventions in the form of maternal and child health services through the years have come to stay, to protect the health of mother and child.

In the post independent period, the policy makers have taken care of the health of its population by incorporating the recommendations of Bore committee (1946) and Mudaliyar Committee (1959) into the five year plans.

The primary health care approach was adopted long back as a measure, for rural health care and its delivery system. Later on, India being a signatory to the Alma-Ata Declaration (1978) has restructured and structured the primary health care delivery system. In fact the goals "Health for all by the year 2000 A.D." Through the National Health Policy which was unanimously endorsed by the nation in 1983. The National Health Policy accords high priority to maternal and child health programmers. The health of the mother and children, but also the Socio-Economic Cultural factors service under health interventions. India is the first country to officially launch the family planning programmers in 1952. However the programmes could make some strides during sixties after the clinic approach was replaced by extension by extension approach.

HEALTHCARE FACILITIES AMONG RURAL WOMAN

Pregnancy related conditions, including dysfunctional labor, hemorrhage, infection, toxemia, and unsafe abortion, are leading cause of death among women of reproductive age in many developing countries, the World Health Organization estimates that 585,000 women die from pregnancy – related conditions each year.

Since 1987, when the Safe Motherhood Initiative was created, efforts have been made to raise international awareness about safe motherhood programs, stimulate research, mobilize resources, and provide technical assistance and share information to make childbirth and pregnancy safer. These

efforts have rallies interest and commitment from donors, program planners, researchers and practitioners to reduce the maternal mortality rate, the indicator with the greatest disparity between developed and developing counties. However, in the desire to save women`s lives quickly, rigorous research to determine the most affordable, public health interventions was thought to be a wasteful detour.

Population Council researcher has argued that safe motherhood is best served through an evidence-based approach. In a recent article, "Where is the 'E' in MCH? (MCH is the acronym for maternal and child health), Council researchers recommended rigorous evaluation of theoretically promising and large-scale program implementation as the most efficient and ethical approach reducing maternal mortality.

In India, women in reproductive age (15-45) years and children below 5 years of age, compromise 62% of the total population. They are the most vulnerable group in the society. Naturally they need better health care and attention. In spite of the wide spread infrastructural facilities and services interventions in the rural areas, the morbidity and mortality among the women and children continue to be a major cause of concern to the planning commissions. The adoption of reproductive and child health approach by the Government in 1996 is a right step and right direction to ensure greater health care of mothers and children. So, the researcher's intention is to point out imminent need to analyse the factors that, the hinders the reproductive health care importance of women (with special reference to rural women).

So, the researcher made an attempt to identity the needs and areas of challenges in 'Health Care Facilities' to promote the health of the rural women, with special reference to their personal health activities and the activities associated with the other members of the family.

The main focus of structure the study is to trace the Socio-Economic demographic which prevail the respondents knowledge of reproductive health care facilities. It also tries to identify the level of the utilization of maternal, child health and family planning health services by the rural women in Thiruvannamalai district. Hence, the present study is under taken to assess the influencing factors that hinder the women reproductive health and to enumerate appropriate strategies to come over to the benefit all health care facilities.

MATERNAL HEALTH

Foetal, infant, and maternal mortality are disproportionately high in rural areas. Rural women are more likely to smoke during pregnancy, are less likely to engage in healthy lifestyle activities such as regular physical exercise and activity and are more likely to be obese than urban women.

GAY RURAL WOMEN

Lesbians are frequently shunned in rural society because of the traditional values and strong conservative ideas within these communities. There are fewer social support connections and a lack of a helping community. Reduces resources can lead to low self-esteem and depression.

ELDERLY RURAL WOMEN

Elderly rural women often outlive their husbands by as much as 20 years. Incomes of rural elderly women are considerably less than their urban counterparts and non-metropolitan elders account for 20.3% of those living in poverty. Elderly rural women elderly are more likely to be disabled, to have chronic health and physical impairments, and to consider themselves to be in poor health, than their urban counterparts. The most common disorders afflicting rural elderly women are arthritis, hypertension, and cardiovascular problems. Elderly rural minority women appear to experience the highest rates of chronic illnesses. Rural residents and health care providers are more dependent on receiving Medicare for services that urban residents (nearly double the reliance on Medicare

OBJECTIVES OF THE STUDY

1.To study the socio-economic, demographic status of the respondents.
2.To study the socio-cultural practices of respondents, associated with the different stages of maternal care.
3.To study the infrastructural facilities related to reproductive and child health care.

On the basis of the objectives, the researcher tries to incorporate the activities related to antenatal, Natal, Postnatal periods and the need for child health care, knowledge of family planning to stress the importance of reproductive health care facilities and precautions.

Sample Frame and Size

A sample of 100 respondents selected from 50 families two respondents from each family. The respondents for the study from each family were selected in married women in reproductive age group (18-45 year) and are having least one to three children for family.

Thiruvannamalai district Arni Taluk village primary health care centers. Among the 40 villages, randomly selected then ten villages were selected for the researcher's study. Five families from each village were selected with specific preference to the families with education illiterates and at least to the primary level. Interview schedule method was used for data collection from the respondents. Main focus was on rural background, pregnancy, delivery, and health care services.

The data were analyses and interpreted, having in the mind. The objective of the study, to trace the existing health care facilities related to reproductive maternal and child health services to rural women. Results were tabulated in accordance with the sections. 1. Socio-Economic status, 2. Socio-Economic Cultural Practices of health care, 3. Health Care Facilities reproductive.

1.Socio-Economic Variables: Education, Occupation, Income and working hours.
2.Socio-Economic Variables: Religion, Caste, Inter Spousal Communication.
3.Health Care Facilities reproductive Variables: (During Natal period, Post Natal period): Knowledge of Health Agencies, Choice of Medical Care, Health Care Providers, Infra structure facilities.

Determinants of Reproductive Health Care Facilities

Various intervening factors influence in the availability and accessibility of the health care facilities are examined separately and the utilization of maternal, child health and family planning services have been studied by the multiple factors together. Multivariate analysis is carried out to study the extent of influence of the individual factors on dependent variable (Antenatal, Natal Services, Child health services and planning adoption).

Education, Caste and Family Structure

Majority of respondents (34%) were illiterates. Rural women are educationally and economically disadvantaged. The findings show that the education status of the respondents does not show the non-acceptance of health care facilities. It shows their concern to the family affairs and health care importance rests on their responsibilities made them to avail the free medical care from the government agencies, irrespective of the lower income groups, majority of women go for work much importance of health care facilities is insisted and accepted by the higher percentage of the respondents.

Majority of the respondents are dependent only on their husband is income since they are housewife. None of them had higher occupational status. Nearly one third of the respondent's (31%) were belonging to middle income group only. The respondents Economic Status is indicating the poor status of the respondents attributed by not having enough regular income.

Nearly (32%) respondents of women hardly engage themselves to generate additional income for more than 2 hours, from regular household activities and occupational activities to meet the economic needs of the family. It clearly exposes the fact more the women work, the more she needs proper health care environment. In the study area, backward castes constitute about (86%) and the rest of the caste percentage is about less then (10%). Majority of the sample were agricultural workers belong to backward castes.

More than two thirds of families (73%) were nuclear and the remaining (27%) were joint families. In the study sample, more than half of the respondents (26% maternal uncle: 34% cousins) married their relatives. Consanguinity is said to affect the progeny, hence, the respondents view clears the need for more care and health practices from the medical point of view, since most of the marriages are consanguineous only.

Inter personal communications access facilities the decision making process easy on women health care practices. It explains about, choices of freedom to women respondents "to have or not to have a child, depending on their health condition". All the respondents agreed that, they were given full choice to decide to have a child when they were newly married (100%). In the later stage, it was compelled to abort or it was accidental to have second child and more than two.

Age is demographic variable, which influences the utilization of health services indirectly. It explains that, women in the younger age group > 20 years (26%) and 21-24 years of age (52%) together constitute, the major percent of the total sample. It reveals that, most of the respondents' are prevented legally as per the child marriage act, it could not restrict the marriage of girls at an early age. That age at marriage is preferred by less than 18 years and the data clearly shows that, more than one third of the respondents' age at marriage was > 18 years only.

About (55%) of respondents were aware of the health agencies who are providing health services. Most of them were belongs to the health agencies and to avail the services by government agencies in the village. Rest of them are getting the relevant information's from (20%) Neighbors and (15%) Relations. The antenatal health care services include antenatal checkup, physical examination, lab investigation, health education to the preparation for child birth etc. All the respondents have admitted all antenatal services, but only for first pregnancy.

In the sample population, (53%) of women wished to have their delivery only at the nearby government hospitals. Stating about their period of staying at mother's home, majority of the respondents (83%). Stayed for 1-3 months. Majority of the respondents prefer to go for allopathic medicines.

Health Care Practices – Post Natal Period

More than half of the respondents (55-60%) were taking good care, hygienically and medically, though they were not able to take proper food, with rich calories, but with enough dietary practices. Major percentage of women (70%) resumed their normal work within 3 months. The information from respondents are aware of vaccination, immunization conditions and also about preventive measure about dehydration and Mal Nutrition (100%).

Higher level of getting supports from mother's (93%) and next, they revealed, that, it was easy to get any sort of help from their own brother's and sister's (55%) by the respondents.

Meet Women's Needs:

- Services should be provided in health facilities that are as close as possible to where women live and that can provide the services safely and effectively.
- Services should be sensitive to cultural and social norms, such as preferences for privacy, confidentiality and care by female health workers.
- Staff should be respectful, non-judgmental and responsive to clients.
- Women should be treated as active participants in their own health, and offered information and counseling so they can make informed decisions about their health and treatment.
- Women health in particular level of good health food and water.

What can be done?

Governments and non-governmental agencies must expand services, improve their quality, and tailor them to meet the needs of women and communities by:

- Ensuring that, health facilities are located close to where women live, have an adequate number of trained staff, a continuous supply of drugs and equipment, and are linked to hospitals by an emergency transport and referral system.
- Enforcing standards and protocols for service delivery, management and supervision, and using them to monitor and evaluate the quality of services, along with feedback from clients and health providers.
- Providing fee or affordable maternal and infant health services that manage any complication as well as offer routine care.

- Educating women and communities about the importance of maternal health and appropriate services.

CONCLUSION

Women in rural India have little access to health care resource. This study showed that, lack of educational resources, distance, cost and transportation, cultural, religious and family influences all had an impact on women utilizing health care services. Utilization of health care services by rural Indian women is influenced by many factors. Socio-Economic status, educational background, culture, religion, family influences, and parity may all play a part in influencing women in seeking health care during an important time of their lives and that of their child.

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258/34 Raviwar Peth Solapur-413005,Maharashtra
Contact-9595359435
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