



**REPRODUCTIVE HEALTH SERVICES AND ITS DIFFERENTIALS IN GHAZIABAD (UTTAR  
PRADESH): A CASE APPROACH WITH NATIONAL HEALTH MISSION.**

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**ABSTRACT**

The prevailing attitude was that pregnancy is a natural process not requiring special (medical) care, and thus women do not seek care not only during this period but also after this period Access to care is limited especially for marginalized population, care seeking from qualified provider is least. Care for postpartum services is almost negligible.

Maternal mortality ratio is the most commonly used measure of maternal deaths. This is defined as number of maternal deaths in a given period of time per 100,000 live births during the same time period. One of the targets of Millennium Development goal is to reduce MMR by three quarters till 2015.

This paper focuses on the variables that make the women to feel complicated during the reproductive stages. While addressing the reproductive health services and its availability, the study draws differentials in service delivery in improving maternal death in Ghaziabad district of Uttar Pradesh to examine the health care needs of women and system relevance.

The study concludes that still there is a need of focusing on better woman health services of unfinished agenda of National Health Mission.

Keywords: Postpartum Care, Millennium Development Goal, Maternal Mortality Ratio, National Health Mission.

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**INTRODUCTION**

According to WHO, "Reproductive Health is defined as a state of complete physical, mental and social well being and not merely the absence of disease and infirmity in all matters relating to the reproductive system and to its functions and processes." More than half a million women depart this life each year as a result of

complications associated to pregnancy and childbirth in developing countries across the world. (World Health Organization (WHO), *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank*, Geneva: WHO, 2007). The attitude of people towards pregnancy is normal. It is considered as a natural process and do not need special (medical) care, unless they perceive a problem. Access to care is limited, especially for marginalized population, due to unavailability of services in remote areas, financial costs and time required in receiving care. Even knowledge of maternal danger signs among women is fairly low. People have more faith towards traditional birth attendants and spiritual healers. Care looking for pregnant woman from a qualified provider at health facility was seen as a last resort. Lack of access—wage loss, distance and cost—were chief barriers for most women. In general, there was no training for emergencies. For the poorest, there are so far further delays in care seeking at all. Although the family man oeuvres to borrow and sell for the needed funds for emergencies. Maternal mortality ratio is the most commonly used measure of maternal deaths. According to WHO, The definition of maternal mortality is defined as number of maternal deaths in a given period of time per 100,000 live births during the same time period? Once a woman becomes pregnant, the risk of mortality is quantifiable. It has been found that mortality is tremendously high on the first and second days after delivery. Approximately 80% of maternal deaths are due to severe bleeding that is postpartum haemorrhage (Hoj 2003). It has been expected that for every maternal death, 20 women suffer from ill-health and lowered efficiency. The most important point significantly considered is that almost entire maternal morbidity is preventable by proper care and supervision of the mother while puerperium. Health services provided to mothers after delivery comprise an essential component of the package of maternal and child health (MCH) services in any population.

Decline in MMR by three quarters between 1990 and 2015 is one of the Millennium Development Goals of United Nations. (NIFHW). Pregnancy-related illnesses and complications during pregnancy and delivery are associated with a significant impact on the fetus, resulting in poor pregnancy outcomes (Haider.A, 2009). In developing countries, the majority of the maternal, perinatal and neonatal deaths and morbidities take place at home. The reasons are multi-factorial, including poverty; poor health status of women; illiteracy; lack of information regarding the availability of health services/providers; lack of control on household resources and decision making authority; poor antenatal and obstetric care, both within the community and health facilities; absence of a trained attendant at delivery; inadequate referral system for emergency obstetric care; inadequate or lack of transportation facilities; and absence of/poor linkages of health centres with the communities (Haider.A,2009). The greater part of maternal and neonatal deaths could be prohibited with early detection and proper implementation of required skills and information. The maternal mortality ratio for sub-Maternal mortality rate of India from sample registration system has been improved significantly which was 212 from SRS 2007-2009 as compared to 254(SRS2004-06).

#### **Materials and Methods:-**

##### **Objectives:-**

- To identify the gap of health care needs and postpartum care services.
- To identify the efficacy of community-based intervention of NRHM to reduce maternal mortality and improving neonatal outcomes.
- To identify the measures in reduction of maternal and infant mortality ratio with the implementation of RCH Programme with respect to community reach services.

The study was conducted with the help of the questionnaire. 80 respondents were surveyed from district Ghaziabad, of Uttar Pradesh with two areas namely Pawi and Masoori of Urban and Rural areas respectively. They were asked various questions ranging from the levels of postpartum care services to the provision of new born care and the respondents were mainly pregnant woman, lactating mothers and trained birth attendants. The sample size was selected using the multistage stratified random sampling. The questionnaires were circulated among the respondents and they were explained the proper procedure of filling the questionnaire. The questionnaire comprised of both open ended as well as close ended questions which included interviews and various multiple choices. The respondents were given adequate time to fill the questionnaires and any confusion pertaining to a question was solved on the spot for them.

The data collected from the respondents was checked two times in order to remove any incomplete forms. In order to make sure that the results obtained from the research are accurate to the maximum possible level, SPSS 16 Software package was used to obtain the main values so as to accept or reject the formed hypotheses.

**Hypotheses**

For my present study four null and alternate hypothesis have been designed. These are

- H<sub>01</sub>: There is no relationship between age and number of pregnancies.
- H<sub>1</sub>: There is relationship between age and number of pregnancies
- H<sub>02</sub>: There is no relationship between age and number of children.
- H<sub>2</sub>: There is relationship between place of residence and Post Natal Checkup.
- H<sub>03</sub>: There is no relationship between place of residence and Post Natal Checkup.
- H<sub>3</sub>: There is relationship between place of residence and Post Natal Checkup.
- H<sub>4</sub>: There is relationship between level of Education and Consultation for Health Problem.
- H<sub>04</sub>: There is no relationship between level of Education and Consultation for Health Problem.

**Data Analysis and Results**

**Table-1 Percentage distribution of respondent’s age group and number of pregnancies.**

AGE & NUMBER OF PREGNANCIES. CROSS TABULATION				
AGE	NUMBER OF PREGNANCIES			Total
	four	five	six	
20-25	100.0%	0.0%	0.0%	100.0%
25-30	11.8%	58.8%	29.4%	100.0%
30-35	0.0%	31.3%	68.8%	100.0%

\* P<0.05 Chi-value= 34.59

Breakdown analysis reveals considerable differences amongst the respondents of different age group with respect to the number of pregnancies. The table-1 reveals that all the respondents (100%) in the age group of 20-25 years had maximum of four pregnancies. 58.8% of respondents who belonged to age group 25-30 reported five pregnancies followed by six pregnancies as reported by 29.4 percent. The respondents in the age group of 30-35 reported highest number of pregnancies with 68.8% indicating six pregnancies followed by five pregnancies as reported by 31.3%. This data is indicative of increase in the number of pregnancies with age.

Further statistical analysis reveals that there is a very much significant difference found among the age and number of pregnancies, difference  $\chi^2 (4, N = 44) = 34.59, p = .000$ . And according to statistical value, .000 with respect to age and pregnancy H<sub>01</sub> is rejected indicative of relationship between age and pregnancy.. This reflects the biological relationship between the age and pregnancy as the age increases, the fertility level is high and the pregnancy increases. People are not aware about the unmet need of contraceptive and this is the reason that India has not achieved the optimum total fertility rate.

**Table-2 Percentage distribution of respondent’s age group and number of children.**

AGE AND NUMBER OF CHILDREN CROSS TAB						
AGE	No of children*					
	Two	Three	Four	Five	Six	Total
20-25	14.3%	85.7%	0.0%	0.0%	0.0%	100.0%
25-30	0.0%	11.8%	47.1%	35.3%	5.9%	100.0%
30-35	0.0%	12.5%	37.5%	31.3%	18.8%	100.0%

\* P<0.05 Chi-value=25.007

Breakdown analysis reveals considerable differences amongst the respondents of different age group with respect to the number of children. The table-2 reveals that the respondents (85.7%) in the age group of 20-25 years had maximum of three children.47.1% of respondents who belonged to age group 25-30 reported four children followed by five children as reported by 35.3 percent. The respondents in the age group of 30-35 reported four numbers of offspring with 37.5% followed by five numbers of offspring as reported by 31.3%.This data is indicative of increase in the number of offspring with age. Further statistical analysis reveals that there is a highly significant difference found between the age and number of offspring, difference  $X^2 (8, N = 44) = 25.007, p = .002$ . This reflects that there null hypothesis rejected and there is a relationship between the age and number of offspring. This reflects the biological relationship between the age and the number of offspring. If age increases, the fertility level is high and the number of offspring increases. People are not aware about the unmet need of contraceptive and this is the reason that India has not achieved the optimum total fertility rate.

**Table-3** Percentage distribution between place of residence and postnatal checkup

PLACE OF RESIDENCE AND RECEIVED ANY POSTNATAL CHECKUP			
PLACE OF RESIDENCE	RECEIVED ANY POSTNATAL CHECKUP AFTER THE BIRTH OF A BABY		
	YES	NO	total
urban	20.0%	80.0%	100.0%
rural	75.0%	25.0%	100.0%
* $P \leq 0.05$ Chi-value= 12.131			

In depth analysis reveals that in the district Ghaziabad of urban area, 20 percent of the respondents received postnatal check up after the birth of a baby and 80 percent of the respondents did not receive any postnatal check up after the birth of the baby. And the respondents of the rural area reported that 75 percent of them received postnatal check up after the birth of the baby, and 25 percent of them did not receive any postnatal check up after the birth of a baby.

Difference  $X^2 (1, N = 44) = 12.130, p = .000$ , According to  $H_{03}$  there is relationship between level of education and the number of children. And according to statistical value, 12.131 there was a significant difference found between place of residence and receiving of postnatal check-up after the birth of a baby. This reflects the services of postnatal check-up after the birth of a baby in much better than urban areas.

**Table-4** Percentage Distribution between level of Education and Consultation for Health Problem.

LEVEL OF EDUCATION & CONSULTATION FOR HEALTH PROBLEM					
LEVEL OF EDUCATION	CONSULTATION FOR HEALTH PROBLEM				Total
	GOVERNMENT/ MUNICIPAL HOSPITAL	GOVT DISPENSARY	HOME	NOT CONSULT	
Illiterate	14.3%	23.8%	9.5%	52.4%	100.0%
Primary school	0.0%	42.9%	14.3%	42.9%	100.0%
Secondary school	0.0%	11.1%	11.1%	77.8%	100.0%
senior secondary school	0.0%	33.3%	0.0%	66.7%	100.0%
* $P \geq 0.05$ Chi-value= .7511					

In depth analysis reveals that major proportion (52.4%) of the respondents who were illiterate not consulted any one for health problem followed by 23.8 percent who contacted to the government hospital.

Breakdown analysis reveals that the respondents who were primary school passed 42.9 percent consulted to government dispensary followed by 42.9 percent of the respondents did not consult to any one for health checkup. Respondents who were secondary school passed (77.8 %) not consulted to anyone. Respondents who were senior secondary school passed (66.7%) not consulted, for health checkups, while 33.3 percent consulted to government hospital/dispensary for their health checkups.

Further statistical analysis reveals that there is no significant difference found between the level of education and to whom you consult for health checkup. Difference  $X^2 (9, N = 44) = 5.885, p = .751$ , According to  $H_{04}$  there is no relationship between level of education and. to whom they had consulted for health checkups. And according to statistical value, .751, with respect to  $H_{04}$  is accepted indicative of relationship between the level of education and to whom they had consulted for their health checkups.

#### Discussion:-

It has been analyzed from our study that an inadequate postpartum service is one of the major causes of maternal death. Our study has proved the inadequacy of these services in the rural and urban areas of the district Ghaziabad.

Each year obstetric complications destroy over 500 000 women worldwide (WHO, 2003). According to WHO 2010, around 287 000 women died while expecting or giving birth. The maximum incidence of maternal death occurs more or less at the time of birth or within the first 24 hours after birth. That is why WHO advocates for "skilled care at every birth, who has been educated and trained to proficiency in the skills needed to manage normal or uncomplicated pregnancies, and in the management and referral of complications in women and newborns" (WHO, 2004). Skilled attendance during labour, delivery and in the early postpartum period could put a stop to many of these deaths and the percentage of deliveries assisted by a skilled birth attendant (SBA) has become an pointer for measuring maternal mortality reduction, including the 75% reduction called for by the fifth Millennium Development Goal (Abou Zahr and Wardlaw, 2001; Koblinsky et al., 2006). Acc to UNFPA, 2008 skilled attendance at all births is measured to be the major involvement for ensuring safe motherhood since it hastens the suitable delivery of emergency obstetric and new born care in case of life threatening problems That is why the percentage of births attended by a skilled person is one of the important factors in progress of maternal health. It has been analysed that absence of a trained birth attendant at delivery, inadequate referral system for emergency obstetric care, inadequate or lack of transport facilities and absence of poor linking's between the communities and health centres (Haider.B.A, 2008).

Today, the continued toll on maternal deaths is even more offensive because cost-effective and efficacious methods to prevent them are known and used through industrialized world. Inadequacies of the RCH reflect in the form of inadequate addition with any other RCH actions, medical direction with capability to evaluate individual needs, and as focus on the direct delivery of one contraceptive technique, with poor follow up. It should not surprise us that only focuses to the programs miss important opportunities to respond to women's needs during three months of postpartum amenorrhoea.

When we converse about different programs, we thought about hospital deliveries, with reference to the needs of women who have access to and use hospitals for delivery. Yet many women, particularly in developing countries, do not have access to hospital for delivery. In India for example, 70 percent of domicile delivery. This group has been absolutely left out in our deliberation of the last 3 decades even where maternal health & RH programme was employed exclusively. It is vital that the needs of this second group of women to be taken out. (Ravichandran.N, 2004).

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