A STUDY ON MOTHER AND CHILD HEALTHCARE UTILIZATION STATUS IN INDIA

Abstract

The National Family Health Survey 4 & 5 served as the sole source of information for this article. Describe the availability of maternal and child healthcare in India's rural and urban locations. India has already fallen short of millennium development targets pertaining to the health of disadvantaged populations. These objectives are currently being continued with sustainable targets. Through various schemes and programmes, India offers healthcare services. such as the universal immunisation programme, the janani suraksha yojana, the janani shishu suraksha karyakaram, the Pradhan Mantri Surakshit Matritva Abhiyan, and the integrated child development service programme The availability of maternal and child healthcare has generally increased, and both rural and urban child death rates have declined. In India, the majority of mothers and children seek out public health facilities. Additionally, the level of child immunization was raised, and further vaccines were obtained from a public health centre. Women and children can get nutritional support from the Anganwadi centres. This kind of data is not included in the national family health survey. Therefore, in the future, data on nutritional supplements from Anganwadi should be added in the national family health survey.

Keywords: Mother health, child health, antenatal care, postnatal care, Delivery care, child vaccination, Child mortality, Infant mortality and India

Authors

K. Prabhu
PhD Research Scholar
Department of Economics
Thiruvalluvar University
Vellore, India

Dr. C. Dhandapani
Professor,
Department of Economics
Thiruvalluvar University
Vellore, India

I. INTRODUCTION

In terms of maternal and child health, India has already fallen short of millennium development targets. While the enhanced maternal health aim was not met, the target for the child mortality rate was marginally met. The Millennium Development Goals are currently being replaced by Sustainable Development Goals.

Healthcare services have always been excellent in India. Health is significant, particularly for those who are vulnerable, such as mothers and children. Through health programmes and plans, India has continued to improve maternal and child health. such as the National Health Mission, the Integrated Child Development Program, the Pradhan Mantri Surakshit Matritva Abhiyan, the Janani Shishu Suraksha Karyakaram, the Janani Suraksha Yojana, the Universal Immunization Programme, and the Pradhan Mantri Matru Vandhana Yojana. The health services offered by each programme have specific goals.

The Janani Suraksha Yojana (JSY) is a demand-promotion programme that offers pregnant women who deliver in a hospital a conditional cash transfer of incentive. It makes sure that institutional deliveries, postpartum care, and antenatal care (ANC) are done on time (PNC). However, the beneficiaries had to pay for things like transportation, diagnostic tests, and medications, which made it difficult for them to receive high-quality medical care.

In order to increase access to care during ANC, PNC, and institutional delivery, Janani Sshishu Suraksha Karyakaram—which guarantees all pregnant women free treatment, medication, diagnostics, nutrition, and transportation—was then introduced as part of the NRHM platform.

As part of the Reproductive Maternal Neonatal Child and Adolescent Health (RMNCH+A) Strategy, the Pradhan Mantri Surakshit Matritva Abhiyan aims to increase the quality and accessibility of prenatal care, diagnostics, and counselling services. It has been proposed that PMSMA be held on the ninth of every month, when all necessary maternal health services will be provided at designated public health facilities as well as accredited private clinics and institutions donating their services to the Pradhan Mantri Surakshit Matritva Abhiyan. This is the result of extensive discussion with national experts.

India has made a number of vaccines available without charge to protect against diseases like diphtheria. Measles, severe types of child TB, pertussis, tetanus, polio, hepatitis B, etc. According to the National Immunization Schedule, the recommended vaccines have been shown to be safe for newborns, children, and expectant mothers under the Universal Immunization Programme.

The Integrated Child Development Services (ICDS) Scheme is one of the flagship programmes and represents one of the world’s largest and most unique programmes for young children and nursing mothers, as a response to the challenge of providing pre-school non-formal education on one hand and breaking the vicious cycle of malnutrition, morbidity, reduced learning capacity, and mortality on the other. The beneficiaries under the scheme are children in the age group of 6 months - 6 years, pregnant women and lactating mothers.

II. OBJECTIVE OF THE STUDY

The study analysed the mother and child health accessibility of antenatal, postnatal, and delivery care, immunisation services, and child mortality status in rural and urban India. All mother and child health related information was compared between the NFHS-4 and NFHS-5 surveys. What kind of health accessibility was increasing in rural and urban areas analysed. The rural and urban areas' mother and child health accessibility determines the national mother and child health accessibility status.

III. METHODS AND MATERIALS

In 1991, India made efforts to implement the national family health survey. From 1992–93, 1 survey was conducted in India. This survey has been conducted five times in India. The United States Agency for International Development (USAID) provided financial support for conducting the survey. The National Family Health Survey is mostly related to demographic characteristics and maternal and child health-related indicators. This study is based on the National Family Health Survey - 4 & 5 and other related sources. At the same time, this research article adopts a comparative method to describe rural and urban regions' mother and child health indicators in India.

IV. RESULTS AND DISCUSSION

This section discussed the accessibility of antenatal, postnatal, and delivery care, immunization, child feeding practices, and child mortality details. Table-1 shows the antenatal and postnatal usage status among women in both regions. Every pregnant woman they will get a mother-child proction card. Almost all pregnant women receive the MCP card in rural and urban areas, as per NFHS–4 & 5 surveys. The first trimester ANC visit is it inticate women's health seeking behaviour and awareness. In both survey periods, above 10 percent creased in rural women's ANC accessibility, as well as urban and urban areas' accessibility also increased.

Table 1: Antenatal and Postnatal care Usage

S. No	Indicators	**NFHS – 4** (2015 – 16)		**NFHS – 5** (2019 – 21)	
		Rural	**Urban**	**Rural**	**Urban**
1	Received MCP card	90.0	87.8	96.3	94.9
2	1st trimester ANC	54.2	69.1	67.9	75.5
3	At least 4 ANC visits	44.8	66.4	54.2	68.1
4	TT injection	88.6	89.9	91.7	92.7
5	IFA tablets	25.9	40.8	40.2	54.0
6	Mother received PNC	58.5	71.7	75.4	84.6
7	Child received PNC	23.0	27.2	76.5	85.7

Source: National Family Health Survey – 4 & 5

The government maternatal benefit schemes required minimum four ANC vists among the pregnant women, at least four ANC visits increased in rural areas and small percent increased urban areas. Tetanus Toxcite injection administration level increased in both areas during both survey periods. The consumption of iron folic acid tavlets has increased, but rural women's IFA consumption has not reached 50% in NFHS-5. After delivery or child birth, there is a need for PNC care services among the mothers and newborn babies. Its PNC care services reduce neonatal/infant and maternal mortality. The postnatal care service utilisation of mothers and child status increased in both areas at NFHS – 5 only. Currently, India is providing healthcare services free of cost through the Janani Shishu Suraksha Karyakaram programme.

Table 2 shows delivery care related information. The Janani Suraksha Yojana scheme provides financial assistance for instutitionatal delivery. It aims to promote institutional delivery, reducing delivery complications and preventing mortalities. As a result, institutional delivery has significantly increased in both areas and surveys.The public health facility or hospital birth level also improved, but not the miximum level. At the same time, the caesarean delivery system is higher at the urban level than at the rural level. Most of the private hospitals conducting delivery were adopting the caesarean method. The private hospitals mostly promoted caesarean methods, but public health facility caesarean methods are low but slightly increasing in urban regions. At the time of delivery, there is a need for money for delivery expenses. The rural level average out of pocket expenditure is 2946 and the urban level is 3913 rupees at NFHS–4. This expenditure level is declining in the NFHS–5 period. It means government maternity schemes to reduce the out-of-pocket expenditure level.

Table 2: Delivery care

Sl .No	**Indicators**	**NFHS – 4** (2015 – 16)		**NFHS – 5** (2019 – 21)	
		Rural	**Urban**	**Rural**	**Urban**
1	Institutional Births	75.1	88.7	86.7	93.8
2	Institutional Birth in Public Health Facility	54.4	46.2	65.3	52.6
3	Births attended by SBA or HP	78.0	90.0	87.8	94.0
4	Births delivered by Caesarean Section	12.8	28.2	17.6	32.3
5	Caesarean delivery in Private Hospital	37.7	44.9	46.0	49.3
6	Caesarean delivery in Public Health Facility	9.3	19.9	11.9	22.7
7	Average OPE per delivery in Public health Facility (in Rs.)	2946	3913	2770	3385

Source: National Family Health Survey – 4 & 5

- *OPE – Out-of-Pocket Expenditure
- *SBA – Skilled Birth Attendant
- *HP – Health Personnel

Table 3 shows child immunization status (age 12 – 23 months). After child birth there is need adequate vaccines for infants. The immunization level is increased in bothe region and both surveys period. The rotavirus vaccine adminiration level was 37 in rural and 34.9 in urban region. Both region resinding child mostly received vaccines from public health facility in free of cost, the private hospital contribution is very low in both regions.

The feeding practice is necessary for every child, this practice is inducing child well being and reducing morbotity and mortality. After child birth there is need the first nurtrituitional food of colostrum breastmilk for newborn babies. The breastmilk practices is inducing the child health improvement and increasing women's pregnancy gap. The below 50 percent of mothers gave the colostrum breast milk after childbirth in both regions and surveys.

Table 3: Child Immunization (age 12-23 months)

Sl. No	Indicators	**NFHS – 4** (2015 – 16)		**NFHS – 5** (2019 – 21)	
		Rural	**Urban**	**Rural**	**Urban**
1	Child age 12 -23 months full immunized	61.3	63.9	76.8	75.5
2	BCG	91.4	93.2	95.4	94.7
3	3 doses of Polio	72.6	73.4	80.9	79.2
4	3 doses of penta or DPT vaccine	77.7	80.2	87.0	86.0
5	Measles vaccine	80.3	83.2	88.1.	87.1
6	3 doses of Rotavirus vaccine	NA	NA	37.0	34.9
7	3 doses of hepatitis B vaccine	62.5	63.3	84.2	83.0
8	Most of the vaccines received from Public health facility	94.2	82.1	97.0	87.7
9	Most of the vaccines received from Private health facility	3.4	16.7	1.6	11.1

Source: National Family Health Survey – 4 & 5. NA – not available

Most of the mothers gave exclusive breasmilk upto 6 months after birth and after 6 months there is a need for adequate breastmilk plus solid food, this feeding practice level is small percent increased in both regions and surveys (Table – 4). The ICDS centre providing nutritional supplementation for child, pregnancy women and lactating mothers and these service-related details has not available in NFHS surveys.

Table – 4: Child Feeding Practice

S. No	Indicators	**NFHS – 4** (2015 –16)		**NFHS – 5** (2019 – 21)	
		Rural	**Urban**	**Rural**	**Urban**
1	Breastfed within one hour of birth	41.1	42.8	40.7	44.7
2	Child under age of 6 months exclusive Breastfed	55.9	52.1	65.1	59.6
3	Child age 6 - 8 months received solid food + breasted	39.9	50.1	43.9	52.0

Source: National Family Health Survey – 4 & 5

Table -5 describes child mortality rates. India's child mortality rate was falling down from last few decades. Always the rural child mortality rate is higher than the urban moratality. The rural neonatal mortality rate was declined from 33.1 to 27.5 and urban mortality was declined from 20.1 to 18.0 per 1000 live births in both surveys. This neonatal is dying befor the reaching their 28 days of life. The rural infant mortality rate was declined from 45.5 to 38.4 and urbanely declined from 28.5 to 26.6 per thousand live births in surveys, this infant dying below one year age of life. The rural under five mortality rate was declined from 55.8 to 45.7, urbanely declined from 34.4 to 31.5 per thousand live births in surveys, this children dying under the five year age of life. Overall child mortality is slightly step by step declining in India.

Table – 5: Child Mortality (per 1000 live births)

S. No	Indicators	**NFHS – 4** (2015 – 16)		**NFHS – 5** (2019 – 21)	
		Rural	**Urban**	**Rural**	**Urban**
1	Neonatal mortality rate (NNMR)	33.1	20.1	27.5	18.0
2	Infant mortality rate (IMR)	45.5	28.5	38.4	26.6
3	Under – five mortality rate (U5MR)	55.8	34.4	45.7	31.5

Source: National Family Health Survey – 4 & 5

V. CONCLUSION

India is implementing various welfare programmes for mother and child health promotion. to provide free medical treatment through the Janani Shishu Suraksha Karyakaram, to administer free immunization/vaccination through the universal immumanization programme, and to provide financial assistance through the Janani Suraksha Yojana and Pradhan Mantri Surakshit Matrivat Abhiyan. This is due to increasing

accessibilty of mother and child healthcare services in both areas. But accessibility is different between rural and urban areas At the same time, the child mortality rate is decreasing in both areas.. The women seeking is increasing to access public health centres to get health services themselves.

The anganvadi centres (ICDS) provide nutritional supplementation for women and children during pregnancy and after childbirth. This kind of information is not available in the national family health survey. So, in the future, information about nutritional supplements from anganvadi should be added to the national family health survey.

REFERENCES

[1] Ministry of Health and Family Welfare. (2021). National Family Health Survey – 5 (2019 – 2021) in India. Retrieved from International Institute for Population Sciences Website: www.rchiips.org/nfhs.
[2] Ministry of Health and Family Welfare. (2016). National Family Health Survey – 4 (2015 – 2016) in India. Retrieved from International Institute for Population Sciences Website: www.rchiips.org/nfhs.
[3] Department of Health & Family Welfare. (2022). Janani Shishu Suraksha Karyakram. Retrieved from National Health Mission Tamil Nadu: www.nhm.tn.gov.in
[4] Ministry of Health and Family Welfare. (2015). Janani Shishu Suraksha Karyakram. Retrieved from National Health Portal: www.hnhp.gov.in
[5] Ministry of Health and Family Welfare, Govt. of India. (2005). Janani Suraksha Yojana. New Delhi: Maternal Health Division, Ministry of Health and Family Welfare.
[6] Maternal health Division. (2016). Pradhan Mantri Surakshit Matrtva Abhiyan. Ministry of Health and Fa,mily Welfare, Government of India.
[7] Ministry of Health and Family Welafre. (2018). Universal Immunisation Programme. Retrieved from National Health Portal: https://www.nhp.gov.in/universal-immunisation-programme_pg
[8] Minstry of women and Child Development. (n.d.). Integrated child development services (icds) scheme. Retrieved from Ministry of Women and Child Development: www.wcd.gov.in
[9] Ministry of Women and Child Development. (2019). Restructuring of ICDS. Retrieved from Press Information Bureau, Government of India.

