

UTILIZATION OF MATERNAL AND CHILD CARE AND ITS ASSOCIATED FACTORS: A COMPARATIVE STUDY WITH NON-SCHEDULE CASTE IN SOUTH INDIA

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Abstract : This paper examines utilization of maternal health care services within and across social groups among married women in south India using data from National Family Health Survey-4 carried out during 2015–16. The inequality in Utilization of maternal health care services in social groups, bi-variate and multivariate were performed. Bi-variate analyses are used to examine the nature of association between utilization of maternal healthcare services among social groups by selected socioeconomic and background characteristics. Multinomial Logistic Regression model was used to predict the odds ratio and to understand the prime determinates of those maternal and child health care services utilization. Principal Component Analysis has been applied to construct a maternal and child health care index. Our findings show non-SC women from rural areas are at better risk to use high level of MCH services. In the rural areas the government has been trying hard to reach the women for the last few decades. The findings of the study indicate that the government efforts are giving fruit as rural women are at more risk of using the MCH care in comparison to urban women in south India. The study concludes that there is exist a difference between SC and non-SC women in seeking MCH care. The difference is in magnitude as well as in direction. There is a need on the part of the government to mitigate the difference between SC and non-SC women in use of MCH care.

IndexTerms - Maternal health care services, caste differences, NFHS-4 Survey, South India.

I. INTRODUCTION

Over half a million women from developing world die each year of the causes related to pregnancy and child birth. There are about 500 maternal deaths for every 100,000 live births, and around 10% of the pregnancy is high risk (UNFPA 1995). An important proximate determinant of maternal mortality is accessibility and utilization of quality health care services.(McCarthy J, Maine D, 1992).

People who belong to deprived social group they do not feel comfortable to avail health facility because they feel that they may be treated badly. Health is a primary concern which includes many dimensions to satisfy the condition of human beings. In India instead of institutional deliveries most common are the home deliveries. This happens because lack of awareness in vulnerable groups, as they do not have proper education and thus are in poverty. This becomes a very important reason for not having an institutional delivery. Again, Most of the women prefer home delivery because they have several of traditions which prevent them to use modern and skilled deliveries. It is also seen in this group distance become the most important problem in accessing services of institutional deliveries as most of the population of scheduled tribe lives in a remote area. In these groups because of their culture most of the people trust among their community people as they share their commonalities which shorter the social distance and increase comfort to have home deliveries form their community members mostly trained DAI.

India is a diverse country and, social exclusion is obvious fact which exists in India. In social exclusion health is one of the factors, if we see health then the various literatures about health highlights the fact of exclusion of health, which includes various branches where health is not same for all. Maternal and child health is one among these branches of health. Globally, 287,000 mothers die from complications of pregnancy and childbirth. Developing countries continue to account for 99% of the total maternal deaths. Of these estimated deaths, sub-Saharan Africa and South Asia accounted for 87% of the global maternal deaths. (WHO 2012, Kamal S 2013.).

There are various Strategies which focus on increasing antenatal Care uptake and increasing maternal health and their partner's education level, help to increase health facility and delivery care service utilization. (Daniel and Desalegan 2014) The likelihood of giving birth in health institution depends on many factors. Some of these factors are: residential area, availability and equality of health services, social factors such as being illiterate, lack of access to information, having poor knowledge about obstetric complications and delay in starting first ANC visit. (Abebe et. al. 2012).

A comprehensive study on tribes (Basu 1990) pointed out that maternal and child care, which is an important aspect of health care-seeking behaviour, is largely neglected among the tribal groups in Madhya Pradesh, Uttar Pradesh and Orissa. In Tamil Nadu, according to (Sivakami and Kulkarni 2003), only 33 percent of deliveries were performed in medical institutions among rural SC/ST women, among non-institutional deliveries, SC/ST Hindus received lower professional assistants than others. (Paul and Chellan 2009). Ethnicity may be an important factor in the respondent's health –seeking behaviour but other socio-economic and demographic conditions may influence their decision-making process. The proportion of women who had received safe

delivery care were the highest in urban areas, who belong to non- SC/ST category, and with high standard of living. It is also the highest among who had more than eleven years of schooling. (Paul and Chellan 2009).

The results highlight the fact that STs and SCs are deprived in terms of access to safe delivery care even after controlling for other socio-economic demographic factors. As regarded the STs, there are variations in their situation across space. Besides, their position vis-à-vis the other population in the respective regions varies spatially. The result reveals that the practice of safe delivery is lower among ST women in the central and eastern regions. Safe delivery practice increases with education level, higher standard of living, higher age at marriage, higher pregnancy wastage, and number ANC visits. (Paul and Chellan 2009.). To deliver in a health facility than other women who were not contacted by the ASHA were generally located in distant hamlets and small remote villages where the ASHA does not reside; women from these villages are predominantly from scheduled castes or other backward castes. (Deepthi S. et. al 2010) The utilization of maternal services in rural areas is mainly driven by socioeconomic factors such as media exposure, standard of living and education, and much less by physical access and availability of health care and family welfare services. (Das N. et al 2001)

In the light of above discussion, it becomes clear that in India, there is wide variation in service delivery, service accessibility and mortality. The difference is caused by many factors of which some are from supply side and some are from demand side. In Indian society, there are occasions that there is no demand for services. For instance, certain cultural practices prohibit use of medicine during fasting, certain cultural practices inhibit child to take polio drops, certain cultural practices inhibit women to go for institutional delivery and so on. Under such circumstances, cultural values become very important and because of which health outcome varies with respect to cultural variation and regional variation. The women in the typical south Indian society are excluded which affects the pregnancy outcome and other health outcome. The health of a girl child is dependent on various social and cultural practices and values. Therefore, the present study endeavours to examine variations in social groups with respect to maternal and child health in south Indian states.

II. MATERIALS AND METHODS

Source of data: The present study uses data from the fourth round of the Indian counterpart of Demographic and Health Survey (DHS), popularly known as National Family Health Survey carried out during 2015–16. The National Family Health Survey (NFHS) is a large-scale, multi-round survey conducted in a representative sample of households throughout India. The survey covers a representative sample of 699,686 women in the age group 15–49 years from all 35 states. The present study examines the utilization of maternal healthcare services among married women in south Indian regions. The present study focused on SC-Schedule (4,420), and non-Schedule caste (13,028) married women who have had the experience of childbirth, during the five years preceding the survey date.

Selection and measurement of variables: Socio-economic and demographic predictors such as age of the woman at birth, women's education, husband's education, religion, wealth quintile, birth order and region of residence were included as predictor variables in the study. The dependent variable of Maternal and Child Health (MCH) care, a composite index was constructed using 31 variables such as antenatal care at the first trimester of the pregnancy, three ANV visits, TT injections, consumption of iron and folic acid tablets, full ANC, treatment for pregnancy problems, delivery care in terms of safe delivery, post-partum care, and child care etc.,

Analytical method: To identify the inequality in Utilization of maternal health care services in social groups, bi-variate and multivariate were performed. Bi-variate analyses are used to examine the nature of association between utilization of maternal healthcare services among social groups by selected socioeconomic and background characteristics. Multinomial Logistic Regression model was used to predict the odds ratio and to understand the prime determinates of those maternal and child health care services utilization. Principal Component Analysis has been applied to construct a maternal and child health care index. Component score coefficient matrix of maternal and child indicators was used eventually summated to compute a composite index of maternal and child health (MCH). MCH index are categorized from the Low, Medium and High groups. The analysis was carried out using Stata10 TM release 13.0 (Stata Corporation, College Station, TX, USA).

III. RESULTS

Table 1 shows the percent distribution of SC women receiving various levels of care like. Low level of care, medium level of care and high level of care with respect to selected background characteristics. Amongst the SC women who had received low level of care, 96% women were Hindus and around four percent were Muslims. Besides, 26% of women who had low level of MCH care were illiterate followed by 50% women were secondary educated. Only 11% higher educated women had low level of MCH care. As per wealth index, as high as 13% of women were in the poorest category received low level of MCH care. As the wealth level of the SC women increased, the percentage of levels of MCH care increased among SC women. The maximum percent of women receiving low level of MCH care were in the age group 25-29 years. The women in the age group 20-24 years had received 38% of MCH care followed by women in 45-49 age groups. There was very considerable difference found between the women whose age at first marriage was less than 18 years and more than 18 years. The prevalence of women having low level of MCH care was around 66% who were married above 18 years. As high as 73% of the rural SC women reported low level of MCH care, the same for urban area was only 27%.

Amongst the SC women who had medium level of MNC care, the maximum percentage was found with the Hindu women which were around 92%. Conversely, the Muslims SC women and others SC women had received 2% and less than 1 percent MCH cares respectively. A larger percentage, (61%) secondary educated women were found to be receiving medium level of care followed by illiterates, 20%. Around 9% of the poorest category women were receiving medium level of MNC care. The percentage was minimum for the women from highest quintile, 8%. The maximum percentage of women (42%) having medium level of care was in age group 25-29 followed by women in the age group 20-24 years, (32%). As high as 67% of women whose

age at first marriage was in the age group 18 years and above had medium level of MCH care. The percent distribution of those whose age at first marriage was less than 18 years was around 33% percent. About one-fourth of women who had 3 or more children ever born received medium level of MCH care. Besides, 69% and 31% of the rural and urban women received medium level of care respectively.

Table 1: Percent distribution of level of MCH care (low, medium and high) by scheduled caste women with respect to selected background characteristics in South Indian, 2015-16.

Social Characteristics	MCH Care				Chi-square	p-value	
	Low	Medium	High	Total			
	SC						
	Low	Medium	High	Total	N		
Religion						28.30	0.000
Hindu	95.59	91.73	92.70	92.69	4,097		
Muslim	3.05	2.29	1.03	1.43	63		
Christian	1.36	5.55	6.11	5.68	251		
Others	0.00	0.44	0.16	0.20	9		
Education of women						44.40	0.000
Illiterate	26.10	20.02	14.91	16.72	739		
1 – 5 standard	13.56	9.90	9.23	9.66	427		
6 – 12 standard	49.49	57.45	61.35	59.75	2,641		
12+ standard	10.85	12.62	14.50	13.87	613		
Education of Husband						18.86	0.004
Illiterate	28.33	15.48	13.28	14.82	122		
1 – 5 standard	20.00	14.29	10.25	11.79	97		
6 – 12 standard	43.33	57.74	62.35	60.02	494		
12+ standard	8.33	12.50	14.12	13.37	110		
Wealth Index						30.40	0.000
Poorest	13.22	9.03	6.80	7.69	340		
Poorer	27.80	27.31	26.26	26.58	1,175		
Middle	35.93	32.32	37.96	36.65	1,620		
Richer	16.61	23.07	22.08	21.92	969		
Richest	6.44	8.27	6.89	7.15	316		
Demographic variables							
Age (in years)						82.55	
15 – 19	2.03	3.48	3.81	3.62	160		
20 – 24	27.46	31.88	34.97	33.82	1,495		
25 – 29	38.31	41.57	40.64	40.68	1,798		
30 – 34	18.31	16.54	16.53	16.65	736		
35 – 39	10.51	5.11	3.52	4.32	191		
40 – 44	2.03	0.98	0.53	0.72	32		
45 – 49	1.36	0.44	0.00	0.18	8		

Amongst the SC women who had high level of MNC care, maximum percentage of women who received high level of MNC care were Hindus (93%) followed by Christians (6%). The maximum percent of women receiving high level of MNC care were secondary educated (61%), followed by illiterates (15%). When education level of husband was considered, it was found that, the highest level (58%) of MCH care was found amongst the women who had secondary educated husbands. Richer and richest women had equal prevalence of women receiving high level of MNC care services.

Table 1: Percent distribution of level of MCH care (low, medium and high) by scheduled caste women with respect to selected background characteristics in South Indian, 2015-16.

Social Characteristics	MCH Care					Chi-square	p-value
	SC						
	Low	Medium	High	Total	N		
Demographic variables							
Age at Marriage							
< 18 years	33.56	32.75	30.29	31.02	1,371		
18 - 20 years	66.44	67.25	69.71	68.98	3049	2.98	0.225
Children Ever Born							
1	27.12	37.00	37.84	36.95	1,633	42.66	0.000
2	40.68	38.52	43.33	42.15	1,863		
3+	32.20	24.48	18.84	20.90	924		
Residence / State							
Rural	73.22	68.55	72.18	71.49	3,160	5.07	0.079
Urban	26.78	31.45	27.82	28.51	1,260		

The women who were aged less than 18 years at their first marriage, around 30 percent of them received high level of MCH care. This percent was found around 38% and 43% amongst the women who has 1 and 2 children ever born, respectively. Among the women who received high level of MCH care, 72% were rural women and around 28% urban.

Table 2 shows the results of multinomial logistic regression of the level of MCH care in southern states of the country for SC women. The dependent variable for the analysis was level of MCH cares, which has three categories namely, low level of MCH care, medium level of MCH care and high level of MCH care. For the present analysis, low level of MCH care has been considered as a reference category and all explanations have been done with respect to the reference category.

Table 2: Multinomial logistic regression showing results of level of MCH care by scheduled caste women with respect to selected background characteristics in South India, 2015-16.

Background characteristics	Medium				Higher			
	RRR	p-value	Lower CI	Upper CI	RRR	p-value	Lower CI	Upper CI
Place of residence								
Urban ®								
Rural	0.89	0.486	0.65	1.23	1.05	0.763	0.78	1.40
Education level								
Illiterate ®								
Primary	0.87	0.546	0.54	1.38	1.01	0.974	0.66	1.53
Secondary	1.19	0.337	0.83	1.71	1.56	0.008	1.12	2.16
Higher	1.05	0.865	0.60	1.82	1.61	0.064	0.97	2.67
Wealth index								
Poorest ®								
Poorer	1.32	0.247	0.83	2.10	1.57	0.038	1.02	2.39
Middle	1.15	0.563	0.72	1.82	1.63	0.022	1.07	2.48
Richer	1.60	0.083	0.94	2.74	1.72	0.030	1.05	2.81
Richest								

Table 2: Multinomial logistic regression showing results of level of MCH care by scheduled caste women with respect to selected background characteristics in South India, 2015-16.

Background characteristics	Medium				Higher			
	RRR	p-value	Lower CI	Upper CI	RRR	p-value	Lower CI	Upper CI
Total children ever born								
One ®								
Two	0.72	0.054	0.51	1.01	0.87	0.370	0.64	1.18
Three and above	0.67	0.056	0.45	1.01	0.63	0.015	0.43	0.92
Age at marriage								
< 18 years ®								
≥ 18 years	0.93	0.652	0.68	1.28	1.08	0.610	0.81	1.45
Age of the respondent								
15-20 ®								
21-25	0.94	0.854	0.48	1.84	0.58	0.086	0.31	1.08
26-30	0.96	0.899	0.47	1.94	0.60	0.126	0.31	1.15
31-35	0.83	0.642	0.38	1.80	0.47	0.037	0.23	0.95
36-49	0.41	0.043	0.18	0.97	0.16	0.000	0.08	0.36
Religion								
Hindu ®								
Muslim	0.69	0.362	0.31	1.54	0.31	0.003	0.14	0.66
Others	4.45	0.002	1.59	12.44	4.82	0.002	1.77	13.12

Note ® = Reference category, RRR = Relative Risk Ratio, CI = Confidence Interval

The SC women belonging to other than Hindu and Muslim religion were about four and a half times more risk for receiving medium level of MCH care as compared to Hindu women. In case of high level of MCH care, the same category of women was 4.82 times more risk to receive the MCH care. The SC women more than 35 years of age were at 84 percent low risk for receiving the MCH care as compared to those women who had received and low level of care in the age group less than 20 years. The SC women who had three or more children were at relatively low risk for receiving the MCH care as compared to women had one child and had received low level of MCH care. The rich women belonging to SC group were at 1.72 times more risk for receiving the MCH care as compared to poorer women in the same group and who had received low level of MCH care. The SC women who were secondary educated were 1.56 times at more risk of receiving the MCH care in comparison to women who had received low level of MCH care and were illiterate.

Table 3 shows the percent distribution of level of care of Non-SC women for the southern states of the India. Amongst the non-SC women who had low level of care, 78 percent of women were Hindu and around 17 percent were Muslim. Likewise, around 15 percent of illiterate women had low level of MCH care followed by 57 percent secondary educated and 9 percent primary educated women. About 18 percent of higher educated women received low level of MCH care. When wealth category was looked up on, it was found as only 4 percent of women were in the poorest category had low level of MCH care. Poor and middle income category women had 17 and 27 percent prevalence of women having low level of care. The women whose husbands were secondary educated, around 60 percent of them received low level of MCH care. The maximum percent of women receiving low level of MCH care were in the age group 25-29 years were 39 percent followed by the women of age group 20-24 years, the lowest percentage of women receiving low level of care was amongst the 45-49 age group, i.e., less than one percent only.

Amongst the non-SC women who had medium level of MNC care, the maximum percentage of medium level of MNC care received was amongst the Hindu women which were around 76 percent. For similar level of MCH care, the Muslims women and others women it was 17 percent and less than one percent respectively. A larger percentage of secondary educated women (56%) were found to be receiving medium level of care followed by illiterate women (11%). The percentage was lowest in case of women belonging to poorest category (3%). There was highest percentage of women (41%) having medium level of care was in age group 25-29 followed by women in the age group 20-24 years (27%). As high as 75 percent of women whose age at first marriage was in the age group 18-20 had medium level of MCH care, the percentage for those whose age at first marriage was less than 18 years was around 25. About 18 percent of the women who had 3 or more children ever born received medium level of MCH care. Those who had 2 children ever born, the percentage was around 43 percent. Around 51 percent and 49 percent of the rural and urban women received medium level of care respectively.

Table 3: Percent distribution of level of MCH care (low, medium and high) by non-scheduled caste women with respect to selected background characteristics in South Indian, 2015-16.

Social Characteristics	MCH Care				Chi-square	p-value
	Low	Medium	High	Total		
	Non – SC					
					N	
Religion						7.86
Hindu	77.53	76.60	78.75	78.23	10,333	
Muslim	17.17	17.41	15.91	16.29	2151	
Christian	5.30	5.85	5.27	5.40	713	
Others	0.00	0.14	0.07	0.08	11	
Education of women						75.50
Illiterate	15.41	10.56	8.37	9.17	1,211	
1 – 5 standard	8.67	8.15	7.54	7.72	1020	
6 – 12 standard	57.46	55.94	62.46	60.83	8,035	
12+ standard	18.46	25.35	21.63	22.27	2942	
Education of Husband						19.38
Illiterate	13.53	11.05	7.19	8.33	220	
1 – 5 standard	10.53	7.84	9.35	9.09	240	
6 – 12 standard	57.89	56.86	62.59	61.14	1,614	
12+ standard	18.05	24.24	20.86	21.44	566	
Wealth Index						89.07
Poorest	4.49	2.98	2.72	2.86	378	
Poorer	17.50	12.37	11.34	11.85	1,565	
Middle	27.13	22.62	26.24	25.51	3,369	
Richer	31.46	32.26	35.98	34.97	4,619	
Richest	19.42	29.78	23.72	24.81	3,277	
Demographic variables						
Age (in years)						84.22
15 – 19	0.80	2.23	2.87	2.63	348	
20 – 24	25.52	27.33	31.23	30.13	3,979	
25 – 29	39.49	41.23	41.27	41.18	5,439	
30 – 34	24.72	21.34	18.19	19.17	2,532	
35 – 39	6.26	6.45	5.51	5.75	759	
40 – 44	2.57	1.21	0.82	0.98	130	
45 – 49	0.64	0.21	0.11	0.16	21	
Age at Marriage						0.56
< 18 years	23.43	24.81	24.42	24.45	3,230	
18 - 20 years	76.57	75.19	75.58	75.55	9,978	
21+ years						
CEB						53.42
1	32.58	39.24	39.39	39.04	5,156	
2	42.86	42.93	45.72	44.99	5,942	
3+	24.56	17.83	14.89	15.98	2,110	
Residence / State						64.26
Rural	53.77	50.66	58.96	56.94	7,521	
Urban	46.23	49.34	41.04	43.06	5687	

Amongst the non-SC women who had high level of MCH care, the percent distribution for Hindus, Muslims and others were 79%, 16% and 0.07% respectively. The highest percent of women receiving high level of MNC care were secondary educated (62%), followed by higher educated (22%). When education level of husband was considered, it was found that, the highest level (63%) of MCH care was found amongst the women who had secondary educated husbands. The same was lowest and almost equal for the women who had illiterate and primary educated husbands. Richest category women had highest percentage of

women (24%) receiving high level of MNC care services. The women aged between 25-29 years had maximum prevalence of those receiving high level of MCH care (41%). The women who were aged less than 18 years at their first marriage, around 24 percent of them received high level of MNC care. The women who has 1 and 2 children ever born, for them the percentage of high level of care was 39 percent and 46 percent respectively. Among the women who received high level of MNC care, 59 percent were rural women and around 41 percent urban.

Table 4 shows the results of multinomial logistic regression analysis for different levels of MCH care in southern Indian states for non-SC women. The dependent variable for the analysis was level of MCH cares, which has three categories namely, low level of MCH care, medium level of MCH care and high level of MCH care. For the present analysis, low level of MCH care has been considered as a reference category and all explanations have been done with respect to the reference category.

Background characteristics	Medium				Higher			
	RRR	p-value	Lower CI	Upper CI	RRR	p-value	Lower CI	Upper CI
Place of residence								
Urban ®								
Rural	1.06	0.526	0.88	1.29	1.50	0.000	1.25	1.80
Education level								
Illiterate ®								
Primary	1.27	0.213	0.87	1.86	1.43	0.047	1.01	2.04
Secondary	1.13	0.415	0.85	1.50	1.50	0.002	1.15	1.96
Higher	1.47	0.039	1.02	2.11	1.58	0.008	1.13	2.23
Wealth index								
Poorest ®								
Poorer	1.03	0.893	0.64	1.67	0.99	0.958	0.64	1.54
Middle	1.17	0.524	0.73	1.87	1.36	0.163	0.88	2.10
Richer	1.68	0.034	1.04	2.71	1.88	0.005	1.21	2.92
Total children ever born								
One ®								
Two	0.92	0.462	0.75	1.14	1.01	0.951	0.82	1.23
Three and above	0.75	0.040	0.56	0.99	0.69	0.006	0.53	0.90
Age at marriage								
< 18 years ®								
≥ 18 years	0.800	0.0610	0.634	1.010	0.887	0.2810	0.714	1.103
Age of the respondent								
15-20 ®								
21-25	0.89	0.617	0.57	1.40	0.88	0.567	0.57	1.36
26-30	0.76	0.264	0.48	1.23	0.69	0.098	0.44	1.07
31-35	0.72	0.198	0.43	1.19	0.58	0.026	0.36	0.94
36-49	0.68	0.195	0.38	1.22	0.49	0.011	0.28	0.85
Religion								
Hindu ®								
Muslim	1.03	0.839	0.80	1.31	0.99	0.930	0.79	1.25
Others	1.07	0.736	0.72	1.58	0.98	0.902	0.68	1.41

Note : ® = Reference category, RRR = Relative Risk Ratio, CI = Confidence Interval

The non SC women living in rural areas and who had received high level of MCH care were at one and a half times more risk of receiving the MCH care as compared to women from urban area and who had received the low level of MCH care. Similarly, non-SC women who had received secondary and higher level of education and had received high level of MCH care were at about more than one and half times more risk of receiving the MCH care compared to those who are illiterate and had received low level of MCH care. The non-SC women belonging to rich wealth quintile were more than one and a half times at risk of receiving medium and high level of MCH care in comparison to women who were poorer and had received low level of MCH care. The non-SC women whose children ever born was three and more were 25% and 31% at lower risk of receiving the MCH care compared to non-SC women who had one child ever born and received low level of MCH care. Again, the non-SC women who had received the highest level of MCH care and belonging to more than 35 years of age in comparison to non-SC women who had received low level of MCH care and less than 20 years of age were at 50% less risk of receiving the MCH care.

IV. CONCLUSIONS AND DISCUSSIONS:

The SC and non-SC women are considered as dissimilar in terms of education. Literature suggests that non-SC women are more educated therefore, are better informed. This makes them a better user of MCH care and services than the SC women. However, the result of the multinomial regression analysis suggests that secondary educated women from both the group, that is, SC and non-SC, are at greater risk of receiving the medium and high level of MCH services with respect to illiterate women. However, this is not the case with highly educated women. Therefore, further enquiry is needed to ascertain the relationship. There is difference between rural and urban non-SC women when it comes to receiving services for MCH care. The non-SC women from rural areas are at better risk to use high level of MCH services. In the rural areas the government has been trying

hard to reach the women for the last few decades. The findings of the study indicate that the government efforts are giving fruit as rural women are at more risk of using the MCH care in comparison to urban women in south India. Women from rich wealth index are at greater risk of receiving the high level of MCH care in comparison to poorer women. The rich women have better access to services and they are well informed too. Therefore, there is greater probability of them to use the MCH services. The children ever born to a mother is a good proxy indicator to understand the use of MCH care. It is understood that if the mother having children ever born more and she is availing MCH then it is more likely for her to use MCH services in the future too. However, the analysis suggests that women with more children ever born are at less risk of receiving the MCH care. The study concludes that there is exist a difference between SC and non-SC women in seeking MCH care. The difference is in magnitude as well as in direction. There is a need on the part of the government to mitigate the difference between SC and non-SC women in use of MCH care.

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