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Review Article

REVIEW ARTICLE ON STUDY ON DELIVERY PRACTICES AMONG THE WOMEN

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A B S T R A C T

Safe delivery is defined as institutional deliveries plus deliveries conducted at home but by skilled staff and do not include deliveries by trained birth attendant (dais**).** Reproductive health and basic health infrastructure and services often do not reach the villages and thus vast numbers of people cannot avail of these services**.**Many other studies conducted in the country show that majority of the births, more particularly in the rural areas, are still delivered at home and India has to go a long way to achieve the universalization of institutional deliveries**.** Maternal education is considered as most important factor in determining women's delivery care seeking behavior**.** However, education of mothers may not maintain its effects across all levels of education and social settings**.**

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INTRODUCTION

Safe delivery is defined as institutional deliveries plus deliveries conducted at home but by skilled staff and do not include deliveries by trained birth attendant (dais) (1). According to the Census of India (2001), nearly three-fourths (72.2%) of the Indian population lives in rural areas in about 5.5 lakh villages and many with poor communications and transport facilities(2). Reproductive health and basic health infrastructure and services often do not reach the villages and thus vast numbers of people cannot avail of these services (3). Many other studies conducted in the country show that majority of the births, more particularly in the rural areas, are still delivered at home and India has to go a long way to achieve the universalization of institutional deliveries (4). In India, among the National Socio-Demographic Goals for 2010, certain goals are directed towards safe delivery viz. to achieve 80 per cent institutional deliveries and 100 per cent of deliveries by trained personnel by 2010. Maternal education is considered as most important factor in determining women's delivery care seeking behavior (7,8,9). However, education of mothers may not maintain its effects across all levels of education and social settings (10,11).

REVIEW OF LITERATURE

A study of Punjab (5) reported that only 33.9 per cent of the respondents reported of having institutional deliveries. About half of the institutional deliveries were conducted in private hospitals. More institutional deliveries were found among educated females. Among those who had home delivery,the foremost reason of preferring home delivery was traditional attitude (86.2%).In this study, of the 954 respondents, only 69 (7.3%) were visited by health personnel after delivery and 876 (92.7%) reported that nobody from the government health services visited them after delivery. In spite of the fact that Punjab is one of the most prosperous and educated states in India, home deliveries and unsafe deliveries are still widely prevalent in rural Punjab and are significantly more among elder and less educated females.This could be attributed to the prevalent psycho-social and cultural beliefs of the villagers.For most of them, pregnancies are routine affairs and don't require much medical attention. The most common reason for not availing skilled care for delivery is the traditional attitude of getting the delivery done by a trained/untrained dai in the village.

A cross-sectional study (6) was undertaken in an urban health training centre field practice area of a tertiary care hospital at Nagpur from December 2009 to June 2010. Most of the women were aware about CS (caesarean section), but their knowledge level was low (47.7%) and (17.4%) had no knowledge. Majority of women in this study preferred vaginal delivery (91.5%) and potential demand for CS was mere (8.5%).Women who preferred vaginal delivery generally felt that CSs were more dangerous, and painful, while the women who preferred caesarean delivery felt that CSs were safer and less painful. Among women who preferred a vaginal delivery, (91.5%) would accept having a CS to protect their baby's health while (87.7%) would also accept a CS in order to protect their own health. This demonstrates that women would not rigidly adhere to a preferred method of delivery.

A study in Ethiopia (12) reported that the mothers living in rural area were less likely to use institutional delivery services than urban mothers. Having poor knowledge about pregnancy

and delivery for instance was strongly associated with home delivery. Similarly having lack of knowledge about danger signs of pregnancy was very strongly associated with home delivery. Level of antenatal attendance was high (80.9%). Women who did not receive counseling where to deliver were more likely to deliver at home.Thus,the predominant factors associated with not utilizing skilled delivery services in the study area are lack of knowledge about obstetrics care, delay in starting Antenatal Care (ANC) visit, and low level of education. Place of residence was also an important predicator of place of delivery.

A study in Madhya Pradesh(13) showed various statements:
"I had decided to go to the hospital from the beginning [of my 4th pregnancy]. For the first three babies, I delivered at home. [For this one] I didn't want to deliver at home. Nobody delivers at home now. All women go to the hospital..."– District 1 JSY Participant, Age 30

"Women have started changing their decision to deliver at home. Earlier women never thought like this....People have started thinking that we should go to the hospital for better facilities and free delivery. There is risk in delivering at home. "It is risky to deliver at home. Mother or baby can lose their life at home."

This study found that institutional delivery was an established social norm among the women and family elders. Around half of the women in this study reported that the JSY cash incentive motivated them to have an institutional delivery. The women in this study express their rationale for participating in the JSY program by describing their personal belief in its importance for a'safe'and'easy'delivery. Some of the JSY participants in the study described several obstacles to obtain the cash incentive and often reported waiting two to three months to receive the incentive.

A study from rural northern Ghana(14)found that women who were seen by a clinic nurse or midwife, community nurse, and a traditional birth attendant instead of doctor,were more likely to deliver at home.

A study from Nigeria shows that maternal education level, husband's occupation, and age at first pregnancy were the main determinants of place of delivery(15).

In rural Tanzania, Mrishoand colleagues(16) found that lack of money, lack of transport, sudden onset of labour, short labour, staff attitudes, lack of privacy, socio-cultural beliefs and the pattern of decision-making power within the household were perceived as key determinants of the place of delivery.

Sukuma, the largest ethnic group in Tanzania originating in the regions of Mwanza,Tabora, and Shinyanga(17), is characterized by songs and dances performed during ritual ceremonies for childbirth,death and work (18). This may possibly limit institutional delivery in favor of home delivery where these rituals and ceremonies can be organized.

CONCLUSION

Programs aiming at universal access to delivery care should be there especially among target vulnerable population groups.Joint discussions and decisions between couples about reproductive and child health matters should be there. Women should be informed of the long-run benefits of the use of maternal healthcare and demerits of traditional birth practices through informal education. Health education programmes on the risks of caesarean delivery should be conducted among women and society at large. Women should be encouraged for regular ANC check-up for the overall well-being of both mother and child. Special programmes should be undertaken to have easy accessibility for maternal healthcare-seeking across the regions of the country.

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