

# THE INTERNATIONAL JOURNAL OF HUMANITIES & SOCIAL STUDIES

## Reproductive and Child Health in India: Diversity, Control over Reproduction and Performance

**Dr. Niyati Joshi**

Deputy Director, Ministry of Commerce and Industry, Government of India, New Delhi, India

**Manoj Verma**

Deputy Director, Department of Animal Husbandry  
Dairying and Fisheries, Ministry of Agriculture, Government of India, New Delhi, India

**Dr. Mahesh Nath Singh**

Senior Research Officer  
Public Health Foundation of India at National Institute of Medical Statistics (ICMR)  
Ansari Nagar, New Delhi, India

### **Abstract:**

*Reproductive and child health (RCH) in India is characterised by differential diversity and women lack largely control over their reproduction which among many factors, is highly affected by the standard of living of women. This paper analyses the standard of living of women for their Reproductive and Child Health in India to study diversity and extent of control of their reproduction by developing two models-socio-economic model and demographic models. Two sets of variables viz. reproductive and child health care have been selected for analysis, based upon National Family Health Survey (2005-06), bi-variate and multi-variate regression tables have been generated for support of the findings. The study suggests that the policy makers should strategically focus specifically on achieving the goals of RCH especially upon bettering the standard of living of women.*

### **1. Introduction**

India is a signatory to the International Conference on Population and Development (1994), Cairo (Mertens, 1994) to implement the agenda and resolution of the conference. As a follow-up action, the Reproductive and Child Health (RCH) Programme was launched throughout the country on 15<sup>th</sup> October, 1997 (Govt. of India, 1997). The RCH concept provides need-based, client-centred, demand driven and high quality integrated services which include: Maternal and Child Health Services, Prevention and Management of Unwanted Pregnancies, Prevention and Management of RTI/STI and HIV/AIDS, Adolescent Health Services and Quality of Health Care

Mothers and children not only constitute a large group, but they are also a “vulnerable” as special-risk group. The risk is connected with child-bearing in the case of women; and growth, development and survival in the case of infants and children, whereas 50percent of all deaths in the developed world are occurring among people over 70, the same proportion of deaths are occurring among children during the first five years of life in the developing world (WHO, 2013). Global observations show that in developed regions maternal mortality ratio averages at 30 per 100000 live births; in India the figure is 301 for the same number of live births. From commonly accepted indices, it is evident that infant, child and maternal mortality rates are high in India (RGI, 2011). Further, much of the sickness and deaths among mothers and children is largely preventable. By improving the health of mothers and children, we contribute to the health of the general population. These considerations have led to the formulation of special health services for mothers and children all over the world.

The Maternal and Child Health (MCH) services encompass the curative, preventive and social aspects of obstetrics, paediatrics, family welfare, nutrition, and child development and health education which alongwith many important parameters depends upon standard of living of the population (Yunus et. al., 1983).

### **2. Evolution and Status of Reproductive and Child Health Programme in India**

Promotion of maternal and child health has been one of the most important objectives of the Family Welfare Programme in India. The Government of India took steps to strengthen maternal and child health services as early as the First and Second Five-Year Plan (1951-56 and 1956-61). As per part of the Minimum Needs Programme initiated during the Fifth Five Year Plan (1974-79), maternal, child health and nutrition services were integrated with family planning services. The primary aim at that time was to provide at least a minimum level of public health services to pregnant women, lactating mothers, and preschool children (Srinivasan, Saxena and Kanitkar, 1979).

Following the enunciation of the National Policy for Children in 1974, the Govt. of India introduced a number of programmes, viz. the ICDS Scheme, programme of supplementary feeding, nutrition education and production of nutritious food, constitution of the "National Children's Fund" under the charitable Endowments Act, 1980, institution of National Awards for Child Welfare, Welfare of the Handicapped, CSSM programme etc. The Expanded Programme on Immunization (EPI) was initiated by the Govt. of India in 1978 with the objective of reducing morbidity, mortality, and disabilities from six diseases by making free vaccination services easily available to all eligible children. Immunization against poliomyelitis was introduced in 1979-80 and tetanus toxoid for school children was added in 1980-81. Immunization against BCG was brought under the EPI in 1981-82. Programme on vaccination against measles was initiated in 1985-86 (Ministry of health and Family Welfare, 1991). As part of the National Health Policy (2002), the National Immunization Programme is being implemented on a priority basis (Khera, Gupta, Gogia and Rao, 2012)

The Universal Immunization Programme (UIP) was introduced in 1985-86 with the following objectives: to cover at least 85 percent of all infants against the six vaccine preventable diseases by 1990 and to achieve self-sufficiency in vaccine production and the manufacture of cold-chain equipment (Ministry of health and Family Welfare, 1991). This scheme has been introduced in every district of the country and the target now is to achieve 100 percent immunization coverage. Pulse Polio Immunization Campaigns began in December 1995 as part of a major national effort to eliminate polio. The Child Survival and Safe Motherhood Programme jointly funded by World Bank & UNICEF was started in 1992-93 for implementation onto 1997-98. The Child Survival and Safe Motherhood Programme were implemented in a phased manner covering all the districts of the country by the year 1996-97. The objectives of the programme are to improve the health status of infants, child and maternal morbidity and mortality. The programme seeks to sustain high coverage levels achieved under the Universal Immunization Programme (UIP) in good performance areas and strengthen the Immunization services of poor performing areas (Khera, Gupta, Gogia and Rao, 2012). In order to effectively improve the health status of women and children and fulfil the unmet need for Family Welfare services in the country specially the poor and under served by reducing infants, child and maternal morbidity and mortality, Govt of India has launched the Reproductive and Child Health (RCH) programme in October 1997 for implementation during the 9<sup>th</sup> plan period by integrating Child Survival and Safe Motherhood (CSSM) Programme with other Reproductive Tract Infection (RTI), Sexually Transmitted Infection (STI), HIV/AIDS, adolescent health has also been incorporated. RCH programme is in the 11<sup>th</sup> years of its operation and is currently operational in entire country. The entire programme was reviewed extensively not only in context of achievements during mid-term stage, but also in context of National Population Policy, 2000 (MoHFW, 2000). Thus, Government of India have implemented several programmes related to MCH from time to time and updated the strategy in order to improve the health status of women and children and fulfil the unmet need of the MCH care in all the states of India. We are using several indicators for components of MCH while either analyzing or evaluating the performance of MCH status and inferring the status of MCH care according to the individual indicator which is not helpful to get an idea about the total picture about the MCH care at different level of geographical area. With these views, the study on "RCH performance in India" has been undertaken.

### 3. Need of the study

Basic variables affecting Maternal and Child Health (MCH) status of women has been found to be showing different levels and patterns of relationship and association with different factors and components of MCH. NFHS-1 and NFHS-2 have revealed the variation in the status of MCH of women according to Standard Of Living. Therefore it would be interesting and pertinent examine the Standard of Living of women with reference to their MCH. This may throw out sharp differential in the status and would be able to foretell the prevailing diversity and to decipher the current prevailing status of diversity, the National family Health Survey (2005-06) (NFHS-3) has been analysed.

### 4. Objectives

- To find out the factors affecting the Maternal and Child Health (MCH) status of women according to Standard Of Living.
- To assess the extent of diversity in the Maternal and Child Health (MCH) status among currently married women according to Standard of Living.

### 5. Data Source, Methodology, Model Formulation and Selection of Study Variables

This study used the data collected through National Family Health Survey-3 (2005-06). NHFS-3 collected information from a nationally representative sample of 109,041 household, 124,385 ever-married women age 15-49. The NHFS-3 sample covers 99 percent of India's population living in 29 states. The target sample size was 4,000 completed interviews with ever-married women in states with population of more than 30 million, 3000 completed interviews with ever-married women in states with population lies between 5 & 30 million and 1500 completed interviews with ever-married women in states with population of less than 5 million according to 2001 census. The urban & rural samples within each state were drawn separately. In each state, the rural sample was selected in two stages, with the selection of Primary Sampling Unit (PSUs), which are villages, with probability proportional to population size (PPS) at the first stage, followed by the random selection of households within each PSU in the second stage. In urban areas, wards were selected with probability proportional to population size (PPS) at the first stage. In the second stage, one census enumeration block (CEB) was randomly selected from each sample ward. In the third stage, households were randomly selected within each selected CEB.

## 6. Standard of Living (SLI)

The scores related to response categories for each question is given in the table:

To assess the extent of diversity in the Maternal and Child Health (MCH) status among currently married women. The components of maternal and child health is given below:

Sr. No.	Variable	Categories	Scores
1.	Source of Drinking Water	<ul style="list-style-type: none"> <li>• Tap (own)</li> <li>• Tap shared</li> <li>• Hand pump + Well</li> <li>• Others</li> </ul>	3 2 1 0
2	Type of House	<ul style="list-style-type: none"> <li>• Pucca</li> <li>• Semi Pucca</li> <li>• Kachcha</li> </ul>	4 2 0
3	Source of Lighting	<ul style="list-style-type: none"> <li>• Electricity</li> <li>• Kerosene</li> <li>• Others</li> </ul>	2 1 0
4	Fuel for Cooking	<ul style="list-style-type: none"> <li>• LPG</li> <li>• Kerosene</li> <li>• Others</li> </ul>	2 1 0
5	Toilet Facility	<ul style="list-style-type: none"> <li>• Own Flush Toilet</li> <li>• Own Pit Toilet</li> <li>• Shared Toilet</li> <li>• No Toilet</li> </ul>	4 2 2 0
6	Ownership Of Items	<ul style="list-style-type: none"> <li>• Fan</li> <li>• Radio/Transistor</li> <li>• Sewing machine</li> <li>• Television</li> <li>• Telephone</li> <li>• Bicycle</li> <li>• Motor cycle/Scooter</li> <li>• Car</li> <li>• Tractor</li> </ul>	2 2 2 3 3 2 3 4 4

The total of the scores may vary from the lowest of 0 to a maximum of 40. On the basis of the total score, the households are divided into three categories as:

- Low- if total score is  $\leq 9$
- Medium- if total score is lies between 9 & 19
- High- if total score is  $\geq 19$

## 7. Selection of Study Variable

### Maternal care

ANC visit: Visit of Doctor/ANM/Dai/Anganwadi for /ANC Check-up, Month of pregnancy at first visit of Doctor/ANM/Dai/Anganwadi for ANC, Check-up, Place of visit for ANC Check-up

Nature of ANC services: Abdomen examined, Weight measured, Blood pressure measured, Urine sample taken, Blood sample taken, Advice during pregnancy, TT injection received, No. of IFA tablets received Pregnancy complication

Natal care: Place of delivery

Post-natal care: Visit of Doctor/ANM/Dai/Anganwadi for Post-partum check-up, ime after delivery first visit of Doctor/ANM/Dai/Anganwadi for /ANC for Post partum check-up

**Child Care:** ARI, Immunization, Availability of vaccination card, Fully vaccination and Anaemia

## 8. Model Formulation

Current contraceptive use have been taken as a dependent variable, as an indicator of MCH status because current contraceptive use contains itself the decision making power of women, interpersonal communication, control over reproductive right and the quality of care. She is receiving this current use of contraceptive has been analysed for each categories of women according to standard of living.

To explore some of the factors that might be associated with current use of contraceptives. Among currently married women logistic regression is used.

Two logistic regression models are used in this study:

- Socio- Economic characteristics Model
- Demographic & Behaviour Model

The variables used in the analysis are as follows:

- Dependent Variable  
Current contraceptive use (Assuming two values, 1 for using & 0 for not using)
- Independent variables for model-1  
Residence, Education, Caste, Religion, Current Working and Media Exposure
- Independent variables for model-2  
Age group, Number of Living Children, Heard of STD/HIV/AIDS

## 9. Analysis and Findings

This study provides information on Maternal Health & child Health e.g. current contraceptives use & Unmet need for family planning, Ante-natal care & Ante-natal services, Place of delivery, Post-natal care, Immunization, Diarrhoea, Acute Respiratory Infection (ARI) and Anaemia among the currently married women by Standard of living at National level

### 9.1. Women's Residence

Characteristics	Standard of Living			Total+	Number of Women**
	Low	Medium	High		
<b>Age Group</b>					
15-29	52.9	54.1	52.1	54.7	68008.0
30-39	29.9	27.7	26.7	26.9	33522.0
40+	17.2	18.2	21.1	18.4	22856.0
<b>Residence</b>					
Urban	11.4	22.9	53.3	32.7	40817.0
Rural	88.6	77.1	46.7	67.3	83567.0
<b>Education</b>					
No Education	71.4	49.5	17.4	40.7	50636.0
Primary	14.6	17.9	12.0	14.6	18138.0
Middle	8.3	16.2	16.8	14.7	18275.0
High School	4.7	11.8	24.2	15.5	19267.0
Above HS	1.0	4.6	29.5	14.5	18066.0
<b>Currently Working</b>					
Yes	47.6	43.2	27.1	36.4	45140.0
<b>Media Exposure</b>					
Yes	20.1	28.7	39.3	31.4	39090.0
<b>Religion</b>					
Hindu	80.5	81.7	79.5	80.6	100152.0
Muslim	15.2	13.8	12.4	13.5	16936.0
Christian	1.9	2.6	2.8	2.5	3052.0
Others	2.4	1.9	5.3	3.4	4246.0
<b>Caste</b>					

SC	29.8	20.9	12.2	19.3	23331.0
ST	16.3	9.1	3.5	8.3	10052.0
7OBC	37.1	46.6	38.2	40.9	49277.0
General	16.9	23.4	46.1	31.5	37918.0
<b>Total</b>	<b>22.9</b>	<b>31.1</b>	<b>40.4</b>	<b>100.0</b>	<b>124385</b>

Table 1: Socio-Economic Characteristics of Ever Married Women in India, 2005-06, NFHS-3  
+Missing cases has not been analyzed, \*\*Women with not de jure residence has not been considered for analysis.

Among the ever married women living in household having low standard of living, 87 percent of women have reside in rural area. This is very high as compared to the percentage of women in medium (77 percent) and high (47percent) standard of living.

#### 9.2. Women's Age, Education, Employment and Media Exposure

Among the ever married women living in household with high standard of living, 52 percent of women belong to age group 15-29 as compared to the percentage of women in medium (54 percent) and high (52 percent) standard of living. Educational attainment varies more across standard of living index. Among the ever married women living in household with high standard of living, 17 percent of women have never attained school as compared to the percentage of women in medium (50percent) and high (17 percent) standard of living.

#### 9.3. Women's Religion & Caste

The percentage of ever married women is much higher in Hindu as compared to Muslims, Christian and Others across standard of living index. Among the ever married women, almost 80 percent of women belong to Hindu religion across standard of living index. 14 percent of Muslims women belong to low standard of living as compared to the percentage of women in medium (15percent) and high (14percent) standard of living. Among the ever married women living in households having high standard of living, 46 percent of women belong to General caste as compared to the percentage of women in medium (23 percent) and low (17 percent) standard of living.

#### 9.4. Women's Marriage

Among the currently married women living in household having low standard of living, 91 percent of women have got first marriage before reaching age 19 years. This is very high as compared to the percentage of women in high (20 percent) standard of living.

#### 9.5. Family Planning Knowledge & Use

The knowledge of modern method among the currently married women is nearly universal across standard of living index.

Characteristics	Standard of Living			Total
	Low	Medium	High	
<b>Age at First Marriage</b>				
<19 years	90.6	86.4	67.9	79.8
≥19 years	9.4	13.6	32.1	20.2
<b>Number of Marital Unions</b>				
Once	96.9	97.8	98.8	98
More than Once	3.1	2.2	1.2	
<b>Husband Lives in House</b>				
Living with Her	89.2	91.4	93.1	90.4
Staying Elsewhere	10.8	8.6	6.9	9.6
<b>Knowledge of Contraceptives</b>				
No Method	3.1	2.1	1.2	2
Folkloric Method	0.1	0	0	0
Traditional Method	0.2	0	0	0.1

Modern Method	96.6	97.8	98.8	98
<b>Use of Contraceptives</b>				
Never Method	52.8	48.4	43.6	48.2
Folkloric Method	0.6	0.3	0.1	0.3
Traditional Method	7.5	6.6	5.3	6.3
Modern Method	3.1	44.8	51.0	45.2
<b>Intention to Use Contraceptives in the Next 12 Months</b>				
Yes	12.7	10.7	8.1	10.8
<b>Unmet Need</b>				
No Unmet Need	15.2	22.3	28.7	24.1
Unmet Need to Space	5.3	4.3	2.8	4.1
Unmet need to Limit	7.8	5.3	3.1	4.6
<b>Number of Living Children</b>				
No Child	23.3	27.9	32.8	29.3
≤ Two Children	30.6	31.1	38.7	35.0
> Two Children	46.0	41.0	28.5	35.7
<b>Total</b>	23.9	31.4	38.4	100

Table 2: Marriage, Family Planning and Fertility among Currently Married Women by Standard of Living, 2005-06, NFHS-3

5 percent of women belong to low standard of living in the case of unmet need for spacing. This percentage decline to 4 for women belongs to medium standard of living and this declines to 3 percent for women with high standard of living. In the case of unmet need for limiting, 8 percent of the women among the currently married women belong to low standard of living which is slightly declines to 5 percent for the women belonging to medium standard of living this percentage, further decline to 3 percent in case of high standard of living.

#### 9.6. Health Problem during Pregnancy and Maternal Health Care

Among the currently married women living in household with low standard of living, 13 percent of women had night blindness during the pregnancy which declines to 10 percent for women in medium standard of living and this percentage further decline to 2.5 percent in high standard of living. During pregnancy period, 27 percent of women living in household with low standard of living had swelling of leg, body or face. Among the currently married women living in household having low and medium standard of living, 47 percent and 46 percent of women had excessive fatigue problem.

#### 9.7. Maternal Health Care

Among the currently married women living in household having high standard of living, 68 percent of women had four and above ANC visit during the pregnancy. This is very high as compared to the percentage of women in medium (38 percent) and low (20 percent) standard of living.

Characteristics	Standard of Living			Total
	Low	Medium	High	
<b>Health Problems During Pregnancy</b>				
Difficulty in Daylight Vision	8.7	7.3	4.6	6.5
Night blindness	13.3	7.9	2.5	7.3
Convulsions	12.7	10.3	7.7	9.8
Swelling-Leg, Body and Face	26.7	25.5	28.9	27.3

Excessive Fatigue	47.8	46.0	44.7	46.1
Vaginal Bleeding	4.1	4.1	6.1	4.9
<b>ANC Visits</b>				
0	36.5	21.7	6.0	18.5
1	8.3	6.9	2.8	5.5
2	19.8	18.1	10.5	15.4
3	15.0	17.1	12.2	14.6
4+	20.3	36.1	68.4	46.1
<b>Number of months Pregnant at the Time of First Visits</b>				
1-3	41.7	49.8	70.9	56.7
4-5	38.8	33.7	19.5	29.1
6-7	13.6	12.4	7.4	10.5
8+	5.8	4.1	2.2	3.8
<b>Number of Living Children</b>				
No Child	23.3	27.9	32.8	29.3
≤ Two Children	30.6	31.1	38.7	35.0
≥ Three Children	46.0	41.0	28.5	35.7
<b>Total</b>	23.9	31.4	38.4	100

Table 3: Health Problems, ANC Visits and Type of Health Care Provider during Pregnancy for the Last Child, 2005-06, NFHS-3

In case of all the three ANC visit during the pregnancy the percent of women almost same in low (15 percent) and medium (17 percent) standard of living but this

Characteristics	Standard of Living			Total
	Low	Medium	High	
<b>TT Injection Before Birth</b>	72.5	82.5	94.7	83.7
<b>ANC Services</b>				
Abdomen	56.0	67.3	85.4	72.0
Weighed	50.0	56.5	76.6	63.3
Blood Pressure Measured	44.9	56.7	80.5	63.7
Urine Sample Taken	35.5	50.4	77.6	58.5
Blood Sample Taken	39.1	51.8	77.6	59.4
<b>Components of ANC</b>				
NO	6.2	6.0	3.1	4.8
IFA (100 Tablets Taken)	81.2	77.9	63.1	72.5

Type of ANC Care Provider During Pregnancy				
Doctor	29.5	44.8	73.7	50.1
ANM/LHV/Midwife	35.2	38.2	33.2	35.6
Anganwadi/ICDS	5.8	4.3	2.3	2
Dai/TBA	2.3	2.4	1.9	2.1
Other Health Professional	2.0	1.6	1.2	1.5
No One	38.0	24.7	7.5	22.8
<b>Total</b>	<b>23.9</b>	<b>31.4</b>	<b>38.4</b>	<b>100</b>

Table 4: Type of Antenatal Care Services and Components of ANC for the Last Child among Currently Married Women in India, 2005-06, NFHS-3

percentage decline to 12 for women belongs to high standard of living which is striking considering the developmental level of women.

Characteristics	Standard of Living			Total
	Low	Medium	High	
<b>Place of Delivery</b>				
Own Home	35.6	23.2	9.0	20.5
Parents Home	0.2	0.2	0.1	0.2
Other Home	5.2	3.9	1.7	3.7
Public Sector	6.3	8.6	6.0	7.9
Private Sector	3.7	5.9	16.5	9.3
NGO/Trust/Hospital	0.0	0.1	0.4	0.2
Others	49.0	58.1	66.3	58.2
Delivery by Caesarean Section	2.9	5.9	19.4	9.8
<b>Size of Child at Birth</b>				
Very large	4.3	4.5	4.3	4.4
Larger than Average	17.6	19.7	20.1	19.3
Average	52.0	53.1	57.1	53.3
Smaller Than Average	17.1	15.1	13.0	15.1
Small	7.1	6.5	4.8	6.1
<b>Type of Post-Partum Care Provider</b>				
Doctor	17.4	31.0	63.3	38.0
ANM/LHV/Midwife	16.2	26.0	43.5	29.0
Anganwadi/ICDS	54.4	45.3	24.5	40.9
Dai/TBA	53.2	43.1	22.2	39.0
Other Health Professional	1.6	1.6	1.7	1.6
No One	0.2	0.2	0	0.1



Time after Delivery First Post Natal Care Took Place				
<4 Days	24.1	32.4	25.8	28.6
4-23 Days	6.5	10.7	22.2	11.4
1-2 Days	67.5	54.0	51.7	58.3
3-41 Days	1.9	2.7	0.2	1.7
<b>Total</b>	<b>23.9</b>	<b>31.4</b>	<b>38.4</b>	<b>100</b>

Table 5: Delivery and Post-Partum Care for the Last Child among Currently Married Women in India, 2005-06, NFHS-3

Among the currently married women who received antenatal care during pregnancy, and living in household having high standard of living, 85 percent of women had an abdominal examination. This is very high as compared to the percentage of women in medium (67 percent) and low (56 percent) standard of living. 81 percent of women had their weight measured belong to high standard of living which decline to 57 percent for women in medium standard of living and further decline to 50 in low standard of living. 38 percent of currently married women, who did not receive antenatal care during pregnancy, belongs to low standard of living which declines to 25 percent in medium standard of living and these percentage further declines to 8 percent in high standard of living.

Among the total deliveries, 17 percent of women belong to high standard of living, which had private sector delivery. This is very high as compared to the percentage of women in medium (6 percent) and low (3 percent) category standard of living.

In case of own home delivery, 28 percent of women belong to low standard of living. Which sharply declines to 23.2 percent in medium standard of living and these percentage further declines to 7 percent for women high standard of living? Among the currently married women living in household having high standard of living, 57 percent of women have average size of the child as compared to the percentage of women in medium (53 percent) and high (52 percent) standard of living. In case of first postnatal visit in the less than four hrs after delivery, 32 percent of women among the currently married women belong to medium standard of living. On analysing the reason, why the women did not deliver at a health facility, it was found that high cost of delivery at a health facility is the most important reason for women in low SLI alongwith the distance of the health facility from home.

Characteristics	Standard of Living			Total
	Low	Medium	High	
<b>Post-Partum</b>				
Vaginal bleeding	5.3	4.0	2.7	3.9
Fever	7.2	4.4	2.2	4.3
<b>Reason did not Deliver a Health Facility</b>				
Costs too Much	34.8	23.7	11.8	26.2
Facilities not Open	4.5	2.8	2.3	3.4
Too Far/Transportation Facility not Available	13.2	10.2	8.1	11.0
Do not Trust Facility	2.4	2.7	3.4	2.6
No Female Provider	1.1	0.9	1.3	1.2
Not Customary	6.4	6.5	5.4	6.4
Others	2.7	3.0	4.3	3.1
Not Necessary	67.9	73.0	78.5	71.8
Husband by Family did not Permitted	5.9	6.1	5.3	5.9
<b>Total</b>	<b>23.9</b>	<b>31.4</b>	<b>38.4</b>	<b>100</b>

Table 6: Post-Partum Health Problems to Women for the Last Child and Reason did not deliver at a Health Facility, 2005-06, NFHS-3

**10. Childhood Vaccination and Diseases**

Characteristics	Standard of Living			Total
	Low	Medium	High	
<b>Ever Had Vaccination</b>				
No	15.3	11.4	6.7	11.7
Yes	84.3	88.3	93.2	88.0
<b>Has Health Card</b>				
No Card	42.0	31.3	13.0	28.0
Yes, Seen	27.2	32.1	45.5	33.8
Yes, Not Seen	23.6	29.3	34.6	30.9
No Longer has Card	7.2	7.3	7.4	7.3
<b>BCG</b>				
No Card	35.9	26.1	11.2	24.2
Vaccination Date on a Card	23.9	28.8	40.9	30.3
Reported by Mother	38.9	43.3	45.3	43.6
Vaccination Marked on Card	0.9	1.4	2.5	1.5
<b>Measles</b>				
No Card	61.7	52.1	33.6	49.8
Vaccination Date on Card	12.5	17.6	27.9	18.3
Reported by Mother	23.1	27.5	36.1	29.4
Vaccination Marked on Card	0.4	0.6	1.0	0.6
<b>DPT</b>				
No	40.3	30.3	14.1	28.6
At Least Once	59.7	69.5	85.9	71.6
All	36.1	47.4	67.9	49.9
<b>Polio</b>				
No	13.6	9.2	4.7	9.5
At Least One (including 'Polio 0')	86.4	90.8	95.3	90.5
All (including 'Polio 0')	22.5	32.1	51.4	35.0
<b>Total</b>	23.9	31.4	38.4	100

Table 7: Childhood Vaccinations and Child Health for the Last Child for the Currently Married Women in India, 2005-06, NFHS-3

93 percent of children received vaccination with high standard of living as compared to the percentage of children in medium (88 percent) and low (84 percent) standard of living

Characteristics	Standard of Living			Total
	Low	Medium	High	
<b>Recently Had Diarrhoea</b>				
Yes	10.9	10.8	10.1	10.7
<b>Fever in the Last two Weeks</b>				
Yes	17.6	16.9	15.8	16.7
<b>Had Cough</b>				
Yes	20.2	21.1	19.1	20.1
<b>ARI</b>				
Yes	56.9	53.4	47.8	52.6
<b>Problem of Chest/ Blocked Nose</b>				
Chest	18.8	16.7	19.0	17.8
Nose	34.7	36.6	39.9	36.2
Both	45.5	45.0	38.8	44.3
<b>Anaemia</b>				
Severe	3.4	3.2	2.4	3.0
Moderate	48.7	43.8	35.7	42.8
Mild	26.7	26	25.4	25.9
No Anaemia	21.1	26.7	36.4	28.1
<b>Table</b>	<b>23.9</b>	<b>31.4</b>	<b>38.4</b>	<b>100</b>

Table 8: Childhood Diseases for the Currently Married Women for the Last Child, 205-06, NFHS-3

Among the currently married women living in household having high standard of living, 68 percent of children received all three DPT vaccination belong to high standard of living as compared to the percentage of children in medium (47 percent) and low (36 percent) standard of living. 86 percent of children received at least one DPT vaccination belong to high standard of living. Which decline to 68 percent in medium standard of living, and this percentage further decline to 60 in low standard of living. 16 percent of children had Fever in the last two weeks belong to high standard of living as compared to the percentage of children in medium (17 percent) and low (18 percent) standard of living. 19 percent of children had Cough belong to high standard of living as compared to the percentage of children in medium (21 percent) and low (20 percent) standard of living.

## 11. Findings of Regression Analysis

### 11.1. For Model-1

It is found that use of current contraceptive is more likely in urban area as compared to rural area. Education is significantly associated with use of contraceptives.

Socio-Economic Characteristics	Standard of Living					
	Low		Medium		High	
	OR	Sig.	OR	Sig.	OR	Sig.
<b>Residence</b>	0.805				0.80	
Urban (R)				0.0		
Rural		0	0.76			0.0
<b>Education</b>						
No Education(R)						
Primary	0.718	0	0.74	0.0	0.58	0.0
Middle	1.2	0	1.2	0.0	1.34	0.0
High School	1.7	0	1.8	0.0	1.78	0.0
Above High School	1.3	0	2.34	0.0	1.22	0.0
Not Working (R)						
Currently Working	1.61	0	1.45	0.0	1.29	0.0
Not Exposed (R)						
Media Exposure	1.2	0	1.006	0.4	1.89	0.0
<b>Caste</b>						
SC (R)						
ST	1.0	0	1.0	0.0	1.2	0.0
OBC	1.5	0	1.5	0.0	1.3	0.0
General	1.8	0	1.3	0.0	1.5	0.0
<b>Religion</b>						
Hindu (R)						
Muslim	0.8	0	0.842	0.0	0.89	0.0
Christian	1.2	0	1.22	0.0	1.23	0.0
Others	1.04	0	1.37	0.0	0.76	0.0
<b>Model R<sup>2</sup>(percent)</b>	42.0		59.0		58.0	
<b>Level of Significance</b>	5 percent for both the Models					
<b>Model Significance</b>	Significant					

Table 9: Logistic Regression of Socio-Economic Model (Model I) for Current Use of Contraceptives among Currently Married Women in India, 2005-06, NFHS-3

Note : R is reference category

Contraceptive use increases with education across the standard of living but currently married women who educated above the high school and living in medium standard of living had more likely to use of contraceptive as compared to low and high standard of living. Media has a positive impact on contraceptive use but it is not significant for medium standard of living. Religion also has a positive impact in affective contraceptive use among currently married women. Muslim women are less likely to use the contraceptive than women belong to other religion across the standard of living. Further caste also has positive impact in affective contraceptive use.

#### 11.2. For Model-2

With the increase in the no. of living children and age of the women, the current contraceptive use increase and affect significantly. Further knowledge of STD and

HIV/AIDS also increases but women belong to low standard of living have less likely to have knowledge of STD and HIV/AIDS as compared to medium & high standard of living which shows that use of contraception is highly affected by age of the women and number of living child.

Demographic Characteristics	Standard of Living					
	Low		Medium		High	
	OR	Sig.	OR	Sig.	OR	Sig.
<b>Age Group</b> 15-29(R) 30-39 40+						
	1.36	0.0	1.47	0.0	1.6	0.0
	1.42	0.0	1.28	0.0	1.82	0.0
<b>Current Living Child</b> No Child (R)						
≤ Two Child	2.01	0.0	2.34	0.0	2.7	0.0
>Two Child	2.34	0.0	2.12	0.0	2.89	0.0
<b>Heard of STD</b>						
No (R)						
Yes	1.85	0.0	1.96	0.0	2.69	0.0
<b>Heard of HIV/AIDS</b>						
No (R)						
Yes	0.76	0.0	2.28	0.0	2.4	0.0
<b>Model R<sup>2</sup> (percent)</b>	24.0		34.0		38.0	
<b>Level of Significance</b>	5percent for both the Models					
<b>Model Significance</b>	Significant					

Table 10: Logistic Regression of Demographic Model (Model II) for Current Use of Contraceptives among Currently Married Women in India, 2005-06, NFHS-3

Note : R is reference category

## 12. Conclusion and Policy Implications

The present study set out to find out the diversity, control over reproduction and reproductive and child health status among current married women by standard of living. It appears that standard of living of ever married women is improving along with use of contraception, pregnancy outcome is better and family is more involving in the care of women. Among the currently married women, 80 percent have got married before reaching 19 years of age and teenage marriage is very in low for women with high standard of living. Mostly women are married once and living with their husband. Currently married women have knowledge of contraceptives across the standard of living. Unmet need to space and limit is very low among women in high standard of living. Women are having different health problem during their pregnancy but as expected, women in low standard of living have more health problem and over all women in high standard of living are getting better Antenatal care (ANC). It is found that 74 percent of women in high standard of living visited Doctor for ANC but only 30 percent of women in low standard of living visited the doctor. Therefore, standard of living is much affecting the women for receiving ante-natal care & services. It is found that deliveries taking are taking place at home are more as compared to deliveries taking place at public and private sector. It is interesting to learn that caesarean section delivery is highest among currently married women in high standard of living. This may be because of the life style factor among women in high standard of living. It is found that a large majority of women who did not deliver their last birth in a health facility (71 percent) said they do not feel it necessary to deliver in a health facility. Further, 90 percent of children have received at least polio vaccine including polio "0". As expected children in low standard of living have more diarrhoea, fever, cough, Acute Respiratory Infection (ARI) and anaemia problem. With the progress on standard of living, though unavoidable diversity exist, women are gaining greater control over their reproduction which is established by better utilization of ante-natal, natal and post-partum services. The selected variables for socio-economic model (model-I) has been able to highly explain the variation medium and high SLI category of women as compared to low SLI women.

The study has suggested for strategic action to be taken by the policy makers that ante-natal care (ANC), Delivery care, post-partum care and services should be focused on priority for the women in low standard of living, Childhood vaccination, anaemia and other diseases should be given priority in different RCH programme, Teenage marriage should be discouraged by suitable policies and scheme, reduced unmet need for family planning and reduce the high fertility among low standard of living.

**13. References**

- 1 Khera, A., Gupta, A., Gogia, H. and Rao, S. (2012): India's national immunization programme, accessed from [http://www.india-seminar.com/2012/631/631\\_ajay\\_khera\\_et\\_at.htm](http://www.india-seminar.com/2012/631/631_ajay_khera_et_at.htm) dated 29.04.2014
- 2 Mertens ,W (1994):The 1994 International Conference on Population and Development (ICPD); IUSSP; MOHFW (2000): National Population Policy (NPP), Government of India
- 3 RGI (2011): Maternal & Child Mortality and Total Fertility Rates: Sample Registration System (SRS), Office of the Registrar General and Census Commissioner, Ministry of Home Affairs
- 4 Srinivasan, K, Saxena, P.C. and Kanitkar, T.(1979): Demographic and the Socio-Economic Aspects of the Child in India, Himalaya publishing House, Delhi.
- 5 WHO (2013):High-risk groups, accessed from dated 27.04.2014
- 6 Yunus, M.;Koblinsky,M.;Simmons,R. and Phillips, J.F. (1983):Strategies for Implementing Change in Rural Health and Family Planning in Bangladesh, ICDDR-B, Bangladesh; pp:236-243