

Who Decides ?

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Many studies have documented unacceptably high perinatal and infant mortality in Uttar Pradesh(1,2). Underutilization of preventive, promotive and curative maternal and child health services, are stated to be a major factor for the very high infant mortality in rural India(1,3). The utilization of available health care facility for the purpose of optimal maternal and child health outcome is considered to be determined and decided at the household level by the senior female member. The latter's decisions are likely to depend on her educational status, religious, cultural, social background and knowledge, attitude and perception regarding the need for the maternal and child health care. We undertook the present pilot study in a rural community of Varanasi District in Uttar Pradesh in order to identify the individuals who took the decision in the household ('decision makers') regarding issues of maternal and child health. We also

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recorded the perception of such 'decision makers' regarding common problems during pregnancy and early childhood.

Material and Methods

The study was conducted over a period of one year (1989*90) in the Cholapur Primary Health Centre area of rural Varanasi in Uttar Pradesh. Three villages were selected at random from three different geographical areas of the Cholapur block. A set of proformae were prepared in consultation with social scientists, statisticians and demographers. The information was collected in the course of nonformal talking with pregnant women by the Auxilliary Nurse and Midwives (ANMs) who stayed in the village and were cross-checked by doctors from time to time. One-hundred consecutive pregnant women irrespective of their parity were selected at random out of three villages. Once the pregnant woman was taken into confidence, further enquiry was made as regards 'decision makers' regarding the health care of the pregnant woman and her children. The so called 'decision makers' were interviewed separately if they were other than the pregnant women themselves.

Results

The socioeconomic classification of the households surveyed, depending upon the total monthly income of the household, was as follows: upto Rs. 300/- in 51%; Rs. 301-600 in 25%; Rs. 601-1000 in 16%; Rs. 1001-1500 in 4% and more than Rs. 1500/- in 4% households. Most of the pregnant women were housewives (80%); 20% of them were manual or agricultural laborers. Majority (86%) of the men were agricultural laborers, 8% were semiskilled laborers and 6% skilled laborers.

Majority (79%) of the mothers were illiterate, 12% had studied upto primary

school, 5% high school and 4% were intermediate or above. Majority of the men (54%) were illiterate, 15% had studied upto primary school, 10% middle school, 15% high school and 6% were intermediate or above. All the mothers-in-law or the fathers-in-law were either illiterate or had received only nonformal education. Sixty-four per cent of the households surveyed were joint families and 36% nuclear.

It was the mother-in-law whose words were honored so far as maternal and child health matters were concerned (56%), followed by the husband who decided in (15%) households. Only in 12% households did the pregnant woman make decisions regarding her health and that of the children (*Table I*). The age distribution of the decision makers revealed that 55% of them belonged to the age group of 30 to 70 years, 5% were less than 30 years and 7% above 70 years.

All the decision makers were of opinion that a doctor or other health professional need be consulted only if there were problems during pregnancy or labor. However, 38% had no perception regarding, complications likely to occur during pregnancy or labor. The perception of the 'decision makers' regarding intrapartum care showed

that 70% of them preferred home delivery and 80% of them thought that the delivery should be conducted by the ANMs at home.

Majority (76%) of the 'decision makers' felt that in case the child has complications they would consult doctors, 19% of them opined that they would resort to indigenous method of treatment like *jhadphook* (witchcraft) and showing to *ojha* and 5% of them had "no idea". When asked about their perception regarding what should be done when the baby is very weak or small sized, 53% opined that they should be given tonics, but none of them felt that the health personnel should be consulted as regard the further management. Only 16% of the 'decision makers' were aware of oral rehydration therapy during episodes of diarrhea.

Discussion

Our study shows that the mother-in-law plays an important role in taking decision as regards issues concerning maternal and child health. Similar observations have been made by Dali from Nepal(4). The 'decision makers' did not recognize any need for routine antenatal care in the community. The earlier reported studies have also made similar observations(1,5). Home deliveries by the ANMs/TBAs is the preferred modality of intrapartum care in most of the families interviewed. An ICMR study(1) has also observed that almost 90% deliveries in rural areas were conducted at home by trained birth attendants(1).

About one fifth of 'decision makers' felt that they would resort to methods like *jhadphook* (witchcraft) by *ojha* for the treatment of sick neonates. Bhandari *et al.*(3) also made similar observation from rural Rajasthan. Low birth weight babies contribute significantly to the unacceptably high perinatal and neonatal mortalities in developing

TABLE I—*Decision Makers on Issues Concerning Maternal and Child Health*

Decision vaaker	Number (n=100)
Mother-in-law	56
Husband	15
Self	12
Father-in-law	04
Sister-in-law	03
No idea	10

countries(1,6). The perception of the 'decision makers' regarding management of the low birth weight babies needs correction if improvement in the child survival rate is to be expected in the rural communities. Similarly, in diarrheal disorders in children the ORS therapy, in spite of its wide publicity, appears to have hardly any effect in the rural community. Agrawal *et al.*(7) also have made similar observations in the rural community of Varanasi.

Literacy influences all aspects of life and maternal and child health care practices appear to be no exception to it. An inverse relationship has been documented between maternal literacy status and infant mortality(1). The education of an individual is stated to make one aware of various happenings in the surroundings and also more perceptive. The capability of the mother in collecting information, reasoning and applying the same for their welfare and health improves with education.

The knowledge and attitude of the 'decision makers' towards maternal and child health care practices appear to have significant role in deciding utilization of available health care facilities and hence, in determining the outcome of pregnancy in the community. This indicates the need for action in training, health education and community participation in order to achieve improvement in the perinatal, neonatal and infant mortality and morbidity trends. These observations are reflections of social behavior and must be addressed at the level of mass health education policy to improve the maternal and child health.

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