



## **COMPARISON OF REPRODUCTIVE AND MATERNAL HEALTH CORRELATES IN RURAL AND URBAN AREAS IN INDIA**

**Mercy Anjna Tirkey**

Assistant Professor,  
Dept. of Economics,  
K.B. Women's College, Hazaribag  
Email id-anjna15may@gmail.com

*Women health has always been a matter of concern. Reproductive and Maternal health is an important goal of Sustainable development goal. Our Government has also been focused in the improvement of reproductive and maternal health of India. This paper analyses the difference in utilisation of reproductive and maternal health in rural and urban India. This paper is based on the secondary data of NFHS-4 (2015-16). Three dependent variables of reproductive and maternal health are analysed for measuring rural-urban differences.*

**Keywords:** Health Care, Infant and Child Mortality, Reproductive and Maternal Health.

Health is an important indicator of development of any country. Reproductive and Maternal health was an important goal in Millennium Development Goal and presently following in Sustainable development Goal. India's sociodemographic goals for 2010 were to have 80% of all deliveries attended by trained personnel (MHFW India 2000). Proper care of pregnant women should begin at the early stages of pregnancy. Health care services during pregnancy and childbirth and after delivery are important for the survival and well-being of both the mother and the infant. Family welfare programs also includes maternal healthcare and infant and child mortality are the indicators of development of a country. Previous studies have established the fact that proper and timely prenatal and postnatal care reduces the risk of both maternal and child morbidity and mortality significantly (Heldi et al. 2006; Kamal 2009).

The first national health policy in 1983, based on the "health for All". It laid emphasis on the three -tier system of rural health centres in India ( Sub-centre, Primary Health Centre and Community Health Centre). The Reproductive and Child Health (RCH-1) was launched in 1997, aiming at integrated implementation of reproductive, maternal, child, adolescent health and family planning services through a participatory and decentralised "bottom-up" approach. Quality improvement strategies finally emerged with National Rural Health Mission (NRHM) launched in 2005 as India's flagship health programme. The aim of NRHM is to carry out fundamental reforms in the country's basic healthcare delivery system, integrating all existing programmes including RCH Programme phase II. In India, there is uneven socio-economic development. In recent years, Indian government has made effort towards rural development by opening new schools and colleges, construction of hospitals and roads. The National Population Policy of India 2000 has features such as free and compulsory school education up to age 14, reduction of infant and maternal mortality, universal immunisation of children and delivery assistance by trained health personnel for all births. Despite these efforts to reduce maternal mortality and to increase access of reproductive health, some regions have been

benefited. However, the benefit of maternal health care and reproductive health has been uneven and inequitable and many women still lack access to these services in rural India.

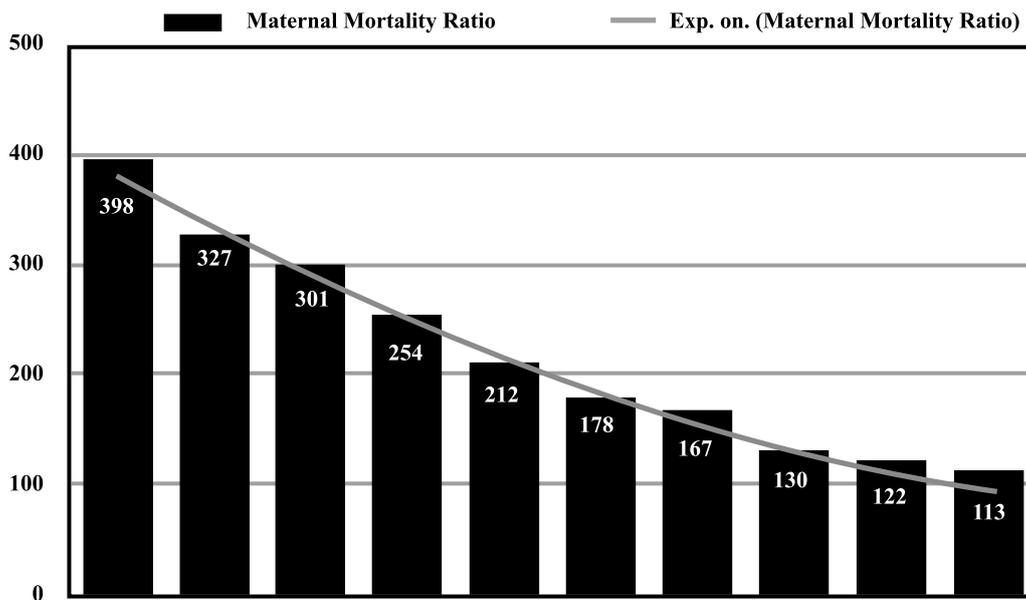
This paper analyse difference in utilisation of reproductive and maternal health in urban and rural India.

### Declining Maternal Mortality Ratio (MMR)

India, with a population of 121 Crore, has the highest maternal mortality in the world.. MMR of India has shown a decline from 398 per 1,00,000 live births in the period 2007-09 to 113 per 1,00,000 live births in the period 2016-2018.(Figure) India has committed itself to the latest UN target for the Sustainable Development Goals (SDGs) for MMR at 70 per 1,00,000 live births by 2030. As per NHP (National Health Policy) 2017 the target for MMR is 100 per 1,00,000 live births by 2020

(Figure 1).

### Sample Registration System



The national MMR in India is an aggregate that conceals wide regional variations. Regional variations shown through Maternal Mortality Ratio of India from the year 2004-2016 (Table 1).

Statewise maternal mortality analysed that there is higher maternal mortality in EAG states than in Southern States. There are differences with respect to women's employment status, women's autonomy, level of poverty, and contraceptive use among the southern states (IIPS, 1995; Srinivasan et al., 1997).

**Table1: Statewise Maternal Mortality Ratio (MMR)  
(Per 1,00,000 live Births) during 2004-2016**

<b>Maternal Mortality Ratio: India, EAG &amp; Assam, Southern States and other States</b>	<b>2004-06</b>	<b>2007-09</b>	<b>2010-12</b>	<b>2011-13</b>	<b>2014-16</b>
India Total	254	212	178	167	130
Assam	480	390	328	300	237
Bihar/Jharkhand	312	261	219	208	165
Madhya Pradesh/Chhattisgarh	335	269	230	221	173
Odisha	303	258	235	222	180
Rajasthan	388	318	255	244	199
Uttar Pradesh/ Uttarakhand	440	359	292	285	201
EAG & Assam Subtotal	375	308	257	246	188
Telangana	-	-	-	-	81
Karnataka	213	178	144	133	108
Kerala	95	81	66	61	46
Tamil Nadu	111	97	90	79	66
South Subtotal	149	127	105	93	77
Gujrat	160	148	122	112	91
Haryana	186	153	146	127	101
Maharashtra	130	104	87	68	61
Punjab	192	172	155	141	122
West Bengal	141	145	117	113	101
Other States	201	160	136	126	97
Other Subtotal	174	149	127	115	93

*Source: NITI AAYOG*

## **REVIEW OF LITERATURE**

Pathak Kumar Praween, Singh Abhishek and Subramanian S. V. (2010) examined prenatal care and skilled Birth attendant in three rounds of NFHS conducted during 1992-2006. The present study measures prenatal care in the first trimester with four or more antenatal care visits and birth attended by skill birth assistance. Utilisation of PNC is more among non-poor women as compare to poor women. PNC is varied across the states for example Tamilnadu is more benefited in this respect. On average the use of SBA is varied highest in Tamilnadu and lowest in U.P. Importantly the SBA use is more among non-poor and less among poor mothers.

Chandraleka S and Rajeswari M (2013) studied on the determinants of maternal mortality in Tamil Nadu districts of India. The study is based on data of Directorate of Family Welfare, Tamil Nadu from the year 2010. The following variables of maternal health services were analysed such as Neo-Natal Mortality Rate, Post-neonatal mortality Rate, Infant Mortality Rate, Under five Mortality Rate, Maternal Mortality Rate and Still Birth rate in Tamil Nadu. The maternal deaths are varied in all districts of Tamil Nadu and some districts have high mortality due to level of awareness in ANC check -up.

Shah Reena and Belanger Daniele (2011) explained factors responsible for maternal health services by tribal women in India. The study also aims to analyse and compare utility patterns of maternal health care services by scheduled tribes women from different parts of India. This study used data of National Family Health Survey 1998-99 (NFHS-2) and 2005-06 (NFHS-3). Both dependent and independent variable of maternal services were analysed.

Basu and Basu (1991) studied cross country comparison using large data sets, such as the World Fertility Survey and the Demographic Health Survey, have shown that various maternal characteristics ,such as education and work status, exert a strong influence on reducing child morbidity and mortality.

Pandey Vaibhav Vipul, Singh S. K. And Kumar Anil (2018) studied reproductive and maternal services among tribes. There are various direct and indirect causes for improper use of maternal health services. Social determinants of maternal mortality are poor in Jharkhand. Three indicators of maternal health services are analysed namely TT Vaccine, Place of Delivery and Skilled Birth Attendant. Binary logistic analysis and cross tabulation.

## **METHODOLOGY**

The objective of this paper is to analyse the rural urban differences in utilisation of reproductive and maternal health services in India. This paper is based on the secondary data of National Family Health Survey 2015-16 (NFHS-4).

### **Dependent Variables of Reproductive and Maternal Health Care**

Reproductive and Maternal Health care covers medical check-ups, care during pregnancies for ensuring survival and healthiness of both the mother and their babies. Present study analyses three dependent variables i.e (i) Complete Antenatal Check-up (ii) Institutional Delivery (iii) Skilled Birth Attendant , have been considered for analysis of utilisation of reproductive maternal health care services.

**(i) Complete Antenatal Check-up**

The focused ANC (FANC) model / basic model of WHO suggests 4+ ANC visits. From table 2, it can be seen that utilisation of maternal health care services have been more by urban women than rural women. 19.6% rural women had no ANC visit and 44.8% rural women had 4+ ANC visit whereas 9.3% urban women had no ANC visit and 66.4% urban women had 4+ ANC visits.

Negligence of ANC visits has been more in rural women as compared to rural women. 54% rural women had 1st ANC visit during <4month pregnancy, whereas 4+ANC visit (as per WHO guidelines) completed by only 44.8% rural women. 69.1%urban women had 1st ANC visit during <4 months pregnancy, whereas 4+ANC visit completed by 66.4% urban women.

**Table 2 : Rural Urban Comparison of ANC visits during 2015-16**

<b>Number and timing of ANC Visit</b>	<b>Urban</b>	<b>Rural</b>	<b>Total</b>
Number of ANC visits	-	-	-
None	9.3	19.6	16.5
1	4.2	6.3	5.7
2	8.5	14.0	12.4
3	10.7	14.6	13.4
4+	66.4	44.8	51.2
Don't Know/missing	1.1	0.7	0.8
Total Number of months pregnant at time of first ANC visit	100.00	100.00	100.00
No antenatal Care	9.3	19.6	16.5
<4	69.1	54.2	58.6
4-5	14.7	19.4	18.0
6-7	2.9	3.9	3.6
8+	3.9	2.8	3.1
Don't Know/missing	0.1	0.2	0.2
Total	100.00	100.00	100.00
Number of Women	54,847	1,29,794	1,84,641
Median Months pregnant at First visit	3.3	3.6	3.5
Number of Women with ANC	49,771	1,04,404	1,54,175

Source: NFHS-4 (2015-16)

**(ii) Institutional Delivery**

To mitigate the risk of maternal and neonatal mortality during child birth, it is very essential to have institutional deliveries under proper assistance of doctors and medical staff. India's major population lives in rural areas. The same is evident from NFHS 4 survey data (Table 3). Total 1,79,849 birth cases were surveyed in rural area as compared to 70,118 birth cases in urban areas. Table 3 also explains that percentage of institutional deliveries in urban areas is more as compared to rural areas. But percentage of institutional deliveries in rural areas i.e 75.1 is notable, out of which more deliveries have been in public sector facilities (54.4%) than in private sector facilities (20.3%). The reason for this is poor availability/option for deliveries in private sector facilities in rural areas.

In urban areas 88.7% institutional deliveries were recorded out of which almost equal percentage of deliveries were in both public sector facilities (46.2%) and private sector facilities (41.6%). This is possible due to option/ availability of private sector facilities for deliveries in urban areas.

**Table 3 : Rural Urban Comparison of Institutional Delivery**

Backgr- ound Charac- teristics	Health Facility			Home			Other	Total	Percentage delivered in a health facility	Number of Births
	Public Sector	NGO/ Trust	Private Sector	Own Home	Parent Home	Other Home				
Mother's age at Birth										
<20	57.9	0.6	23.0	14.3	3.8	0.2	0.3	100.0	81.4	33,928
20-34	51.7	0.5	27.0	17.7	2.6	0.2	0.3	100.0	79.3	2,06,369
35-49	39.9	0.4	21.5	35.5	1.4	0.3	1.0	100.0	61.8	9,670
Birth Order										
1	53.7	0.7	33.8	9.3	2.2	0.1	0.2	100.0	88.2	97,213
2-3	52.8	0.5	24.4	18.7	3.1	0.2	0.3	100.0	77.7	1,17,595
4-5	47.4	0.2	12.7	35.7	3.1	0.3	0.5	100.0	60.3	26,273
6+	38.9	0.3	8.8	49.0	2.0	0.3	0.7	100.0	48.0	8,885
<b>Residence</b>										

*Mercy Anjna Tirkey*

Urban	46.2	0.9	41.6	9.4	1.5	0.2	0.2	100.0	88.7	70,118
Rural	54.4	0.4	20.3	21.2	3.2	0.2	0.2	100.0	75.1	1,79,849
<b>Antenata care visit</b>										
None	43.4	0.2	13.1	37.6	4.8	0.4	0.6	100.0	56.7	30,466
1-3	56.5	0.3	20.5	19.6	2.5	0.2	0.3	100.0	77.4	58,096
4+	53.2	0.8	37.2	6.9	1.6	0.1	0.2	100.0	91.2	95,541
Don't know/missing	55.4	0.8	30.2	10.4	2.4	0.0	0.8	100.0	86.4	1,537
<b>Mother's Schooling</b>										
No Schooling	49.5	0.3	11.8	33.4	4.3	0.3	0.4	100.0	61.6	75,535
<5 years complete	54.4	0.4	15.2	24.6	4.8	0.3	0.4	100.0	69.9	15,079
5-7 years complete	58.4	0.5	21.2	16.4	2.8	0.3	0.4	100.0	80.2	40,773
8-9 years complete	60.9	0.7	23.7	12.2	2.1	0.1	0.2	100.0	85.3	41,205
10-11 years complete	53.8	0.7	37.0	6.8	1.5	0.1	0.2	100.0	91.5	29,868
12 or more years complete	41.2	0.7	52.8	4.3	0.7	0.1	0.2	100.0	94.7	47,506
<b>Religion</b>										
Hindu	54.0	0.5	26.2	16.3	2.4	0.2	0.3	100.0	80.8	1,96,629
Muslim	43.9	0.4	24.9	25.8	4.4	0.3	0.3	100.0	69.2	41,379
Christian	43.2	0.6	34.8	18.9	2.0	0.1	0.4	100.0	78.5	5,111
Sikh	53.1	0.3	39.1	6.2	1.0	0.2	0.1	100.0	92.5	3,060
Buddhist	63.5	1.1	27.6	5.4	2.2	0.1	0.1	100.0	92.2	1,930
Jain	31.7	1.1	65.3	1.7	0.2	0.0	0.0	100.0	98.1	265
Other	41.6	0.1	9.3	43.1	5.6	0.1	0.1	100.0	51.0	1,592

<b>Caste/Tribe</b>										
Scheduled Caste	59.9	0.4	18.1	18.5	2.6	0.2	0.3	100.0	78.3	53,851
Scheduled tribe	55.9	0.4	11.6	27.9	3.6	0.2	0.4	100.0	68.0	26,350
Other Backward class	50.4	0.5	28.9	17.1	2.6	0.2	0.3	100.0	79.8	1,10,399
Other	46.1	0.7	36.1	14.1	2.6	0.2	0.3	100.0	82.9	57,172
Don't know	54.7	0.4	18.5	21.2	3.8	0.5	0.9	100.0	73.6	2,194
<b>Wealth Index</b>										
Lowest	51.7	0.1	7.8	35.1	4.6	0.3	0.4	100.0	59.6	63,394
Second	60.4	0.3	14.4	20.7	3.6	0.2	0.4	100.0	75.1	54,939
Middle	58.8	0.6	25.5	12.2	2.3	0.2	0.3	100.0	85.0	49,577
Fourth	49.8	0.7	40.0	8.0	1.2	0.1	0.2	100.0	90.5	45,305
Highest	34.1	1.0	60.1	4.0	0.5	0.1	0.2	100.0	90.3	36,752
<b>Total</b>	52.1	0.5	26.3	17.9	2.7	0.2	0.3	100.0	78.9	2,49,967

*Source: NFHS-4 (2015-16)*

From table 4 it can be seen that major reasons for non-institutional deliveries in urban and rural is that women don't think it necessary to have institutional delivery. Other notable reasons of non-institutional deliveries in both urban and rural areas are family don't allow, no transportation facility, cost too much etc.

**Table 4 : Percentage Differences of Rural Rrban Women not Utilising Health Facility, During 2015-16**

<b>Reasons for not delivering in a health facility</b>	<b>Urban</b>	<b>Rural</b>	<b>Total</b>
Costs too much	14.5	16.2	15.9
Facility not open	7.9	9.9	9.6
Too far/ no transportation	11.0	19.3	18.1
Don't trust facility/ for quality service	6.9	5.7	5.9
No female provider at facility	3.0	3.7	3.6
Husband/family did not allow	16.8	18.2	18.0
Not Necessary	43.8	38.8	39.6
Not Customary	3.6	4.0	3.9
Other	9.3	8.1	8.3
Number of Women	<b>5230</b>	<b>29,095</b>	34,324

*Source NFHS 4 (2015-16)*

**(iii) Skilled Assistance during Delivery**

Assistance of Skilled Medical Professionals during deliveries is helpful in identifying health complications, remedies of health complications, thus reducing the risk of maternal and neonatal mortality. Percentage delivered by a skilled provider in urban areas is 90% whereas in rural areas, it is 78%(Table 5). Percentage of deliveries in urban areas under assistance of doctors 72.7% whereas in rural areas is 49.5%.

Percentage of deliveries in urban areas under assistance of ANM/Midwife/ LHV is 17% whereas in rural areas is 27.7%. Comparison of data of urban areas and rural areas as shown in table shows that percentage of deliveries under assistance of doctors in urban areas is more as compared to rural areas. Deliveries under assistance of other less skilled provider like ANM/ Midwife and non-skilled provider like Dai, friends /Relatives etc is more in rural areas as compared to urban areas.

**Table:5 Rural Urban Differences in Utilisation of Skilled Birth Attendant**

Background characteristic	Persons providing assistance during deliveries									Timing of decision to conduct a C-section				Number of births
	Doctor	ANM/nurse/ midwife/LHV	Other health personnel	Dai (TBA)	Friends/ relatives	Other	No one	Don't know/missing	Total	Percentage delivered by a skilled provider	Percentage delivered by caesarean section	Before onset of labour pains	After onset of labour pains	
Mother's age at birth<20	58.3	24.8	0.6	9.4	5.8	0.7	0.3	0.1	100.0	83.7	15.2	7.8	7.3	33,928
20-34	56.3	24.7	0.7	10.8	6.3	0.9	0.3	0.0	100.0	81.7	17.6	9.7	7.7	206,369
35-49	41.7	23.0	0.9	19.5	11.6	1.7	0.9	0.6	100.0	65.6	14.5	8.6	5.7	9,670
Birth order														
1	66.1	22.7	0.5	6.0	4.0	0.5	0.2	0.0	100.0	89.3	24.0	12.3	11.5	97,213
2-3	55.0	24.9	0.7	11.5	6.6	0.9	0.3	0.1	100.0	80.6	15.6	9.4	6.1	117,595
4-5	34.5	29.4	1.0	21.0	11.6	1.8	0.6	0.1	100.0	65.0	3.9	2.0	1.9	26,273
6+	22.9	28.5	1.1	28.1	15.5	2.6	1.0	0.3	100.0	52.5	2.1	0.8	1.3	8,885
Residence Urban	72.7	17.0	0.2	5.9	3.4	0.5	0.1	0.0	100.0	90.0	28.2	16.0	12.1	70,118
Rural	49.5	27.7	0.9	12.9	7.6	1.0	0.4	0.1	100.0	78.0	12.8	6.9	5.9	179,849
Mother's schooling														
No schooling	35.9	28.9	1.1	20.4	11.1	1.8	0.6	0.1	100.0	66.0	6.0	2.9	3.0	75,535
<5 years complete	48.8	24.3	1.0	15.6	8.8	0.9	0.4	0.2	100.0	74.1	10.6	5.7	4.7	15,079
5-7 years complete	56.1	26.0	0.6	10.3	5.9	0.6	0.3	0.0	100.0	82.8	14.7	8.1	6.4	40,773
8-9 years complete	59.7	27.0	0.6	7.5	4.5	0.4	0.2	0.0	100.0	87.3	17.4	9.6	7.7	41,205
10-11 years complete	72.2	19.7	0.4	3.8	3.2	0.4	0.2	0.0	100.0	92.3	25.7	14.4	11.1	29,868

*Mercy Anjna Tirkey*

12 or more years complete	76.6	18.0	0.3	2.4	2.3	0.3	0.1	0.0	100.0	94.9	33.6	18.8	14.6	47,506
Religion														
Hindu	56.3	25.9	0.6	9.8	6.1	0.9	0.3	0.1	100.0	82.8	17.3	9.5	7.6	196,629
Muslim	52.7	19.9	0.9	16.8	8.2	1.0	0.4	0.0	100.0	73.6	15.1	8.2	6.8	41,379
Christian	64.4	15.7	0.7	8.7	9.1	1.0	0.4	0.1	100.0	80.8	24.8	14.6	10.0	5,111
Sikh	63.1	32.1	0.2	3.7	0.8	0.0	0.1	0.0	100.0	95.4	25.7	13.5	12.1	3,060
Buddhist/ Neo-Buddhist	74.4	18.0	1.1	3.2	2.8	0.1	0.5	0.0	100.0	93.4	17.7	8.5	9.2	1,930
Jain	83.9	13.9	0.1	1.3	0.5	0.0	0.3	0.0	100.0	97.8	37.2	21.5	15.7	265
Other	40.5	18.7	1.8	29.3	8.3	1.1	0.3	0.0	100.0	61.0	11.0	4.3	6.7	1,592
Caste/tribe Scheduled caste	52.2	27.8	0.6	11.2	6.8	1.0	0.3	0.0	100.0	80.7	14.5	8.0	6.3	53,851
Scheduled tribe	44.8	25.8	1.0	17.4	9.3	1.1	0.6	0.1	100.0	71.5	8.3	4.3	3.9	26,350
Other backward class	54.9	26.4	0.7	10.6	6.1	0.9	0.3	0.1	100.0	82.0	17.2	9.3	7.8	110,399
Other	66.8	18.0	0.6	8.4	5.3	0.6	0.3	0.0	100.0	85.3	23.7	13.2	10.3	57,172
Don't know	57.3	19.8	1.1	11.9	8.1	0.7	0.7	0.4	100.0	78.2	15.9	11.1	4.1	2,194
Wealth index														
Lowest	32.4	30.5	1.2	21.0	12.3	1.8	0.7	0.1	100.0	64.1	4.4	1.9	2.5	63,394
Second	48.3	29.0	0.9	13.0	7.3	1.0	0.4	0.1	100.0	78.3	9.7	4.9	4.8	54,939
Middle	61.5	24.8	0.5	7.9	4.4	0.5	0.2	0.1	100.0	86.8	19.0	10.6	8.3	49,577
Fourth	72.2	19.2	0.3	4.9	2.9	0.3	0.1	0.0	100.0	91.8	26.8	15.1	11.5	45,305
Highest	80.7	14.6	0.1	2.4	2.0	0.2	0.1	0.0	100.0	95.5	35.9	20.7	15.0	36,752
Antenatal care visits <sup>2</sup>														
None	32.9	25.9	1.3	22.1	14.4	2.1	0.9	0.3	100.0	60.2	6.4	3.5	2.7	30,466
1-3	46.6	32.9	0.8	12.0	6.5	1.0	0.3	0.0	100.0	80.3	12.1	6.2	5.8	58,096
4+	74.1	18.2	0.4	4.3	2.7	0.3	0.1	0.0	100.0	92.7	27.7	15.6	12.0	94,541

Don't know /missing	69.0	15.5	0.8	6.6	6.7	0.5	0.9	0.0	100.0	85.3	22.2	13.7	7.8	1,537
Place of delivery														
Public sector health facility	60.2	36.9	0.4	0.7	1.6	0.2	0.1	0.0	100.0	97.4	11.9	6.5	5.3	130,200
NGO or trust hospital/clinic	79.4	16.8	0.1	0.5	3.2	0.0	0.0	0.0	100.0	96.3	35.8	20.5	15.0	1,295
Private sector health facility	83.6	13.8	0.1	0.2	2.0	0.1	0.1	0.0	100.0	97.6	41.0	22.6	18.1	65,693
Own home	9.5	7.7	2.2	51.3	24.6	3.4	1.2	0.0	100.0	19.4	0.0	0.0	0.0	44,728
Parent's home	16.8	9.9	2.0	46.5	20.2	3.8	0.8	0.0	100.0	28.7	0.0	0.0	0.0	6,769
Other home	12.6	18.9	5.4	37.8	21.2	1.6	2.5	0.0	100.0	36.9	0.0	0.0	0.0	514
Other3	28.1	12.8	0.8	8.6	18.9	5.5	4.7	20.5	100.0	41.7	0.0	0.0	0.0	769
Total	56.0	24.7	0.7	11.0	6.4	0.9	0.3	0.1	100.0	81.4	17.2	9.4	7.6	249,967

Note: If the respondent mentioned more than one person attending during delivery, only the most qualified person is considered in this tabulation. ANM = Auxiliary nurse midwife; LHV = Lady health visitor; TBA = Traditional birth attendant; NGO = Nongovernmental organization  
 1 Skilled provider includes doctor, auxiliary nurse midwife, nurse, midwife, lady health visitor, and other health personnel  
 2 For the most recent birth in the five years preceding the survey  
 3 Includes missing

Source: NFHS 4 (2015-16)

## CONCLUSION

Utilisation of maternal health care services in urban areas and rural areas in India has been analysed. Utilisation of maternal health care services in urban areas is more as compared to rural areas. They are as follows:

- 1) Timely 1st ANC visit and 4+ ANC visit percentage of women in urban areas is more as compared to rural areas.
- 2) Institutional deliveries in urban areas is more as compared to rural areas. Reasons of less utilisation of maternal health care in rural areas is less utilisation of private health care facilities due to poor option of private health care facility in their pocket range in rural India

- 3) Percentage of deliveries by skilled provider in urban areas is more as compared to rural areas. This is because in urban areas option for assistance of doctors is better than rural areas. In rural areas women are highly dependent on less skilled providers like ANMs/Midwives/Nurses and unskilled providers like friends, relatives etc.

Thus the present research paper has focused on rural-urban differences of utilisation of reproductive and maternal health care services. For better utilisation in rural areas improvement in public medical infrastructure and better availabilities of doctors is required.

#### **REFERENCES**

- Basu A. M. (1997), "Mother's education and childhood mortality : The status of women as a 'proximate' determinant, p.p.181-202 in Maternal education and child survival, edited by L. Visaria, J.Simons and P. Berman. Delhi : Vikas publishing House Pvt.Ltd.
- Basu A.M. and K. Basu (1991), "Women's economic roles and child survival :The case of India. Health Transition Review 1(1) : 83-104
- Chandraleka S and Rajeswari M. (2013): "A study on determinants of Maternal Morbidity Rate in Tamil Nadu" , Language in India, Vol. 13(4), pp: 40-47
- Ghosh Arabinda (2015), "Inequality in maternal health care services and safe delivery in eastern eastern India, WHO South-East Asia, Journal of Public Health, January-June 2015 4(1)
- Heldi, W.R.,L. W. Emelita, and H. Tucker (2006), " Adolescents use of maternal and child health services in developing countries . International Family Perspectives 32(1) : 6-6
- IIPS (International Institute for Population Sciences) 2017, NFHS-4 National Survey Report 2015-16, Mumbai : IIPS, 1995; Srinivasan et al.,1997
- Kamal, S. M. M. (2009), "Factors affecting utilisation of skilled maternity care services among married adolescents in Bangladesh, Asian Population Studies 5(2) : 153-70
- Pandey Vaibhav Vipul, Singh S. K. And Kumar Anil (2018): "Study on Reproductive and Maternal Health Care Services among Tribes: Research for Tribe Development in Jharkhand", International Journal of Pediatrics and Neonatal Health, Volume 2
- Pathak Kumar Praween, Singh Abhishek and Subramanian S. V. (2010): "Economic Inequalities in Maternal Health Care: Prenatal Care and Skilled Birth Attendance in India,1992-2006
- Registrar General India. Special Bulletin on Maternal Mortality in India, 2016-18
- Shah Reena, Belanger Daniele (2011), "Socio-economic correlates of utilisation of maternal health services by tribal in India, Canadian Studies in Population 38, No. 1-2 (Spring/Summer 2011):83-98
- World Health Organisation. Trends in Maternal Mortality: 1990 to 2010. WHO, UNICEF, UNEPA, and the World Bank Estimates. Geneva: WHO; 2012