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Research Article

MATERNAL HEALTH CARE INEQUITIES IN LAHORE: A POPULATION BASED USE CROSS-SECTIONAL RESEARCH

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Abstract:

Aim: Ensuring unbiased admission to maternal health care, including antenatal, transport, and postpartum administration, while fertility control strategies, is one of the most fundamental challenges for the general welfare sector. There are critical inconsistencies in the indications for maternal medical services in many topographical areas, maternal, financial, and socio-demographic factors in many countries in sub-Saharan Africa. In this review, we have almost investigated the level of utilization of maternal health care, and analyzed aberrations in the determinants of key maternal welfare outcomes.

Methods: This article used information from two sets of demographic and health surveys in Pakistan to examine the use and variation of components of maternal health service pointers using strategic models of relapse. There were 17,794 members and 16,599 women reached the age of maturity between 16 and 47 years of age in 2006 and 2012. The qualities of the women were reflected in the rate, mean and standard deviation. Our current research was conducted at Mayo Hospital, Lahore from March 2019 to February 2020.

Results: The mean age (\pm SD) of the limbs was 27.1 (\pm 8.1) in both examinations. The level of 5 prenatal care visits was approximately 63% with no change between the two sets of studies; office transport was 94.6% in 2012, with a 5.7% rise from 2006; postnatal care was currently 19.5% and prophylactic use was estimated at less than one-fifth. Hence the multivariate strategic relapse models showed differences in the use of maternal medical care administration, including prenatal care, office transport, postnatal care and preventive use compared to selected maternal components. The current BHDS indicated that age, region, and religion were fundamentally related to the administration of maternal medical care. Educated women, those from very large families, and those who are currently working are required to use maternal medical care services, as opposed to women with no formal education, those from less affluent families, or those who are not currently using them. Women who watched television were 1.33 (OR = 1.34; 96% CI = 1.14-1.53), 1.67 (OR = 1.68; 96% CI = 1.21-2.38) and 1.39 (OR = 1.39; 96% CI = 1.17-1.66) times more likely to use maternal health care benefits after changing covariates.

Conclusion: These findings would help manage partners to address imbalances in maternal health care delivery. In this way, the projects and strategies of the medical services should be strengthened to improve the openness as well as the use of maternal health care administrations, especially for the overburdened, poorly informed and those living in difficult to access territories in Pakistan. The government of Pakistan needs to put in place methodologies that cover both the elements of grace and demand in order to achieve inclusion of general welfare.

Keywords: Maternal health care, inequities, Lahore.

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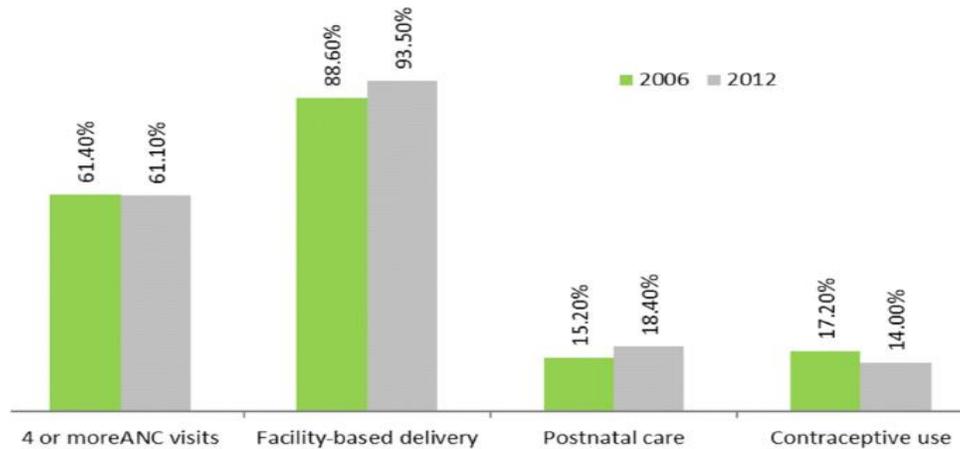
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INTRODUCTION:

The means to achieve the UN's third sustainable development goals, to reduce maternal morbidity and mortality, and to ensure the inclusion of widespread well-being by integrating the admission of basic medical care into government administrations by 2030, have been an extraordinary challenge in nation building, even in the presence of medical service intercessions [1]. Despite the fact that a variety of tasks exist in the delivery of medical services to advance safe parenting around the world, maternal morbidity and mortality remain a striking issue in medical care programs and strategies, particularly in low-income countries. Leaving aside the considerable efforts made by the global network to reduce the burden of mortality due to pregnancy and transport, the rate of mortality due to pregnancy-related difficulties is troubling [2]. Agricultural countries account for about 97 percent of global maternal mortality, while sub-Saharan African countries account for about 64 percent and have a maternal mortality ratio of 510 deaths per 100,000 live births [3]. The test of the unreasonable circulation of welfare administrations is increasingly being taken into account worldwide in the area of general welfare, with evidence that segments of the general public who are hindered have extremely serious medical problems. Like other sub-Saharan countries, Pakistan has an unreasonable supply of maternal medical care. With a total fertility rate of 6.5, Pakistan is the 34th country in the world to experience maternal deaths [4]. Lack of access to prenatal, intrapartum, and postnatal medical care is one of the obvious explanations for the high maternal and infant morbidity and mortality rates in sub-Saharan Africa and worldwide. Maternal health care administrations continue to be important benchmarks for observing improvements in maternal welfare outcomes, while maternal mortality continues to be a major concern [5].

METHODOLOGY:

Information for this survey was obtained from two series of sector and health surveys in Pakistan that provided data on prenatal considerations, institutional transmission and prophylactic use. The data sets include a record for each woman qualified as having a family plan. The survey contains all the information collected from the woman for whom the data on prenatal care, institutional transmission and preventive use and some factors of the family unit were inspired. Our current research was conducted at Mayo Hospital, Lahore from March 2019 to February 2020. The information from the 2009 and 2017 Pakistan Demographic and Health Survey contains 18,798 and 17,598 cases (examination units), including the woman in this document. The BDHS conducted cross-sectional examinations, making extensive use of agents' information, to collect data on segment markers, well-being, and diet. The study is largely funded by the U.S. Agency for International Development. Both sets of HSDBs used a separate, multi-stage examination design, with families as the inspection unit. Within each sample family, all qualified ladies were interviewed. We conducted the examinations using freely available information from segment welfare examinations. Moral strategies were the obligation of the foundations that commissioned, supported or handled the examinations. All DHS studies are approved by the ICF worldwide, as is an institutional audit board in each country to ensure that the conventions are consistent with the U.S. Health and Human Services Division's guidelines for the insurance of human subjects. Summary overviews, including rates and averages (\pm standard deviation), were used to analyze the diffusion of distal and proximal maternal attributes from a social and financial perspective. To change the representation of information, a complex review module was used for all surveys to represent clustering, delineation, and test weights. In addition, the rates of outcome factors were plotted in a bar graph.

Figure 1:**RESULTS:**

As part of this review, respondent attributes were examined separately for 2006 and 2012. The average age of respondents was comparable ($29.0 \pm 9.1/9.0$) between the long overview periods. Respondents' core attributes in the social domain were introduced in Table 1. In this survey, four outcomes were estimated to be specific: prenatal consideration of 5 visits in any case, transportation to the office, postnatal consideration and use of prophylactic techniques. The level of at least 5 prenatal visits was 61.4% in 2006, and 61.1% in 2012, suggesting that there has been no expansion in the level of prenatal visits over the long term. Office transport was 89.7% in 2006, rising to

Table 1:

Variable	2006		2012	
	n (17,794)	%	n (16,599)	%
Wealth index				
Poorest	3357	18.9	3139	18.9
Poorer	3347	18.8	3274	19.7
Middle	3448	19.4	3433	20.7
Richer	3753	21.1	3511	21.2
Richest	3889	21.9	3242	19.5
Parity				
1-4	8379	60.7	8377	66.9
> 4	5435	39.3	4145	33.1
Women decision making power				
Low	4140	35.1	2534	35.4
Moderate	7664	64.9	2741	38.2
High			1892	26.4
Currently working				
Yes	14,114	79.6	10,643	64.1
No	3628	20.4	5956	35.9
Sex of household head				
Male	14,353	80.7	13,326	80.1
Female	3441	19.3	3273	19.7

5.7% in 2012. Postnatal care represented 16.3% in 2006, but rose to 19.5% in 2012. In addition, the level of use of prevention was 18.3% in 2006, but has declined to 15% in 2016 (see Figure 1 for subtleties). Results indicate that women aged 35-49 are more likely to be transported to an office, and women aged 15-19 are more likely to be transported to an office. In addition, women aged 44-48 experienced a critical 46% decrease in the likelihood of using prophylaxis, while women aged 14-18 changed covariates (OR = 0.56; 96% CI = 0.34-0.94). In addition, geographical location was entirely related to prenatal care visits, office, postpartum considerations and prophylactic use.

Borgou	1535	8.6	1323	8.0
Collines	1234	6.9	1256	7.6
Couffo	1530	8.6	1225	7.4
Donga	893	5.0	950	5.7
Littoral	1831	10.3	1949	11.7
Mono	1196	6.7	1043	6.3
Quémé	2142	12.0	1811	10.9
Plateau	862	4.8	1046	6.3
Zou	1880	10.6	1654	10.0
Type of place of residence				
Urban	7471	42.0	7070	42.6
Rural	10,323	58.0	9529	57.4
Educational attainment				
No formal education	11,577	65.1	10,383	62.6
Primary	3460	19.4	2766	16.7
Secondary	2595	14.6	3219	19.4
Higher	162	0.9	231	1.4

Table 2:

Table 1 Characteristics of respondents, Benin DHS 2006–12

Variable	2006		2012	
	<i>n</i> (17,794)	%	<i>n</i> (16,599)	%
Age (Mean ± SD)	29.0 ± 9.1		29.0 ± 9.0	
15–19	3036	17.1	2922	17.6
20–24	3117	17.5	2820	17.0
25–29	3640	20.5	3147	19.0
30–34	2801	15.7	2720	16.4
35–39	2151	12.1	2185	13.2
40–44	1626	9.1	1667	10.0
45–49	1423	8.0	1138	6.9
Region				
Alibori	1197	6.7	1000	6.0
Atacora	1506	8.5	1476	8.9
Atlantique	1988	11.2	1866	11.2
Borgou	1535	8.6	1323	8.0
Collines	1234	6.9	1256	7.6
Couffo	1530	8.6	1225	7.4
Donga	893	5.0	950	5.7
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Higher	162	0.9	231	1.4
Religion				
Christianity	9484	53.4	9226	55.6
Islam	3878	21.8	3919	23.6
Traditional	3178	17.9	2284	13.8
Others	1210	6.8	1170	7.0
Read newspaper/magazine				
Yes	1701	9.6	2140	12.9
No	15,957	90.4	14,459	87.1
Listen to radio				
Yes	14,499	81.7	10,525	63.4
No	3257	18.3	6074	36.6
Watch TV				
Yes	6398	36.1	7556	45.5
No	11,320	63.9	9043	54.5

DISCUSSION:

This review was the first to investigate and inspect clear evidence of the use of maternal health care administration in Pakistan, and therefore used two rounds of large-scale data collection on agents from 2008 and 2017 [6]. The main outcome measures examined were antenatal care visits, institutional transport, postpartum care, and prophylactic use among women of childbearing age [7]. The number of antenatal care visits, at least 4, office transport, postpartum management and prophylactic use in women of regenerating age were moderately equivalent in both examination cycles [8]. The assessments are predictable with the literature from other sub-Saharan African countries where maternal medical services need further improvement. In addition, social, financial, and immediate determinants were the core indicators of maternal health care administration [9]. Age, topographical area, place of residence, education level, strict beliefs, media use, abundance file, and equality were critical indicators for divergence in admission to skilled care and control of maturity [10].

CONCLUSION:

This review recognized the importance of the fundamental benefits of maternal care and the related social segment, the monetary aspect, and the inconsistencies between related elements and the landscape of indicators of maternal well-being in Pakistan. Findings demonstrated predictable differences in the use of key administrations of maternal well-being, for example, prenatal care visits, transportation to the office, postpartum care and prophylactic use, for educated, high financial status, and use of the media. Despite the fact that the survey revealed variations in the selected determinants of maternal consideration administrations in Pakistan, in any case, there are different factors, for example, ecological conditions, administration, culture, foundation and accessibility of clinical equipment and manpower that assume a fundamental function in diminishing these distinctions.

REFERENCES:

1. Irwin A, Valentine N, Brown C, Loewenson R, Solar O, Brown H, Koller T, Vega J. The commission on social determinants of health: tackling the social roots of health inequities. *PLoS Med.* 2006;3:e106.
2. Culyer AJ. Equity - some theory and its policy implications. *J Med Ethics.* 2001;27:275–83.
3. Gwatkin DR, Bhuiya A, Victora CG. Making health systems more equitable. *Lancet.* 2004;364:1273–80.
4. Gwatkin D, Rutstein S, Johnson K, Suliman E, Wagstaff A, Amozou A. Initial country-level information about socioeconomic differences in health, nutrition, and population. Washington: The World Bank; 2007.
5. Boerma JT, Bryce J, Kinfu Y, Axelson H, Victora CG. Mind the gap: equity and trends in coverage of maternal, newborn, and child health services in 54 countdown countries. *Lancet.* 2008;371:1259–67.
6. Victora CG, Wagstaff A, Schellenberg JA, Gwatkin D, Claeson M, Habicht JP. Applying an equity lens to child health and mortality: more of the same is not enough. *Lancet.* 2003;362(9379):233–41.
7. Qian Y, Gao J, Zhou Z, Yan J, Xu Y, Yang X, et al. An equity analysis of health examination service utilization by women from underdeveloped areas in western China. *PLOS ONE.* 2017;12(10):e0186837.
8. Benin Demographic and Health Survey, 2006 & 2012.
9. Wanjira C, Mwangi M, Mathenge E, Mbugua G, Ng'ang'a Z. Delivery practices and associated factors among mothers seeking child welfare services in selected health facilities in Nyandarua South District, Kenya. *BMC Public Health.* 2011;11:360.
10. Adebowale AS, Palamuleni ME. Modern contraceptive use, sex refusal and spousal difference in level of education among married women in Nigeria: are they interrelated? *Int'l J of humanities and. Soc Sci.* 2014;4(6):217–30.