Synergy between Women's Empowerment and Maternal and Peri-natal Care Utilization

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Introduction

Every year nearly 500,000 women die of complications related to pregnancy and childbirth, and 99 percent of these deaths occur in developing countries (World Health Organization, 1999). According to National Family Health Survey the maternal mortality ratio at the national level for the two years preceding the survey was 540 for 1998-99; and the government of India's (GOI) official figure from the SRS was 407 for 1998 (Office of the Registrar General, 2000).These imply that every year nearly 100,000 Indian women die due to causes related to pregnancy and childbirth, which is one-fifth of the maternal deaths in the world. According to the Government, the major causes of death under pregnancy and childbirth include bleeding during pregnancy and puerperum, abortion and anemia (Ministry of Health and Family Welfare, (MOHFW), 1999). Many of these deaths could have been avoided if the pregnant women had sought full antenatal and timely delivery care.

Utilization of maternal health care services depends not only on the availability of healthcare services but also on various other factors such as distance to health care facility; perception of women and their families regarding the need for care; social restrictions on freedom to movement; the opportunity cost of accessing health care; and the interaction between the client and the provider of formal health care system (World Population Monitoring, 1998; IIPS, 2000; IIPS, 2007). In addition, as a woman's social status and her health are intrinsically related, her low status often is the cause for poor access to essential healthcare (Report on Safe Motherhood Conference, 1987; Royston et al, 1989).

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The Government of India has established a wide network of maternal health care facilities all over the country. In rural areas, where a large majority of the population (72 percent) reside (Government of India, 2001), government sponsored health care facilities function as a three tier system - Sub-centre, Primary Health Centre (PHC) and Community Health Centre (CHC) - and cover almost all the rural population. As of 1998, there were 137 006 sub-centres, 23 179 PHCs, and 2913 CHCs in India (MOHFW, 1999). In the urban areas, state government or municipalities, and private and non-government organizations (NGOs) provide maternal health care. The Maternal and Child Health (MCH) programme is a national health programme funded by the central government and has recently been broadened into a Reproductive and Child Health (RCH) programme.

In spite of the government efforts to reach pregnant women in all parts of the country to provide all components of maternal health care free or with nominal charges, its utilization remains low in the country. Government statistics show that the maternal mortality ratio for India is as high as 301 maternal deaths per 100,000 live births in 2003; and the perinatal mortality rate is 37 in 2005 (MoHFW, 2007). According to the latest Indian DHS survey, three out of every five births in India take place at home; only two in five births take place in a health facility. This signifies a big gap between the availability and the utilization of maternal health care facilities. With this focus, the paper tries to analyse the synergy between women's empowerment, autonomy and attitude and maternal healthcare utilization in India.

Aim and methodology

The main aim of this paper is to explore the synergy between woman's empowerment and utilization of maternal healthcare facilities. The different components of empowerment, the sources of empowerment, reflection of empowerment - autonomy and attitude are analysed separately to study the linkages. The data from the third Indian DHS survey, National Family Health Survey (NFHS-3), conducted during 2005-06 is used.

NFHS-3 has collected information from a representative sample of 124 385 ever-married women in the age group of 15-49 years, from all the 29 states of India. The

sample represented more than 99 percent of India's population. The survey used uniform questionnaires, sample designs, and field procedures to facilitate comparability of the data within the country, so as to achieve a high level of data quality. Only the 11 649 women who have had a live birth one year prior to the survey were selected for this study. Their healthcare utilization pattern for their last birth and their empowerment indicators were also examined.

Chosen indicators

The three components of maternal health care, that is, antenatal care, natal care, post natal and peritnatal care are taken separately as dependent variables for this study.

a) Antenatal care (ANC) - No antenatal care at all; Minimum three antenatal checkups; First antenatal checkup during the first trimester; Two or more tetanus toxoid injections during pregnancy; and Full ANC [1](Utilization of all the recommended antenatal care).
b) Natal care (NC) - Institutional delivery; Delivery with the assistance of health professionals [2];
c) Postnatal care (PNC) – Postnatal care within 2 days of delivery (Home and hospital) and Perinatal care index[3].

Some proxy variables are used to quantify the different dimensions of empowerment, autonomy and attitude. They are given below.

a) Sources of Empowerment – Education, work participation; earning and media exposure.
b) Autonomy - Women's role in 'household decision making'; Final say on taking health care; and freedom to move outside home.

[1] Full ANC: Utilization of, three or more antenatal check-ups (with the first checkup within the first trimester of pregnancy), two or more tetanus toxoid injections, and Iron and folic acid tablets or syrup for three or more months.

[2] Health professionals - births assisted by doctors, nurse/midwives and other health professionals.

[3] Women who had received more than 3 antenatal check ups; ANC check up during the third trimester; institutional delivery; and postnatal check up with in 2 days of home delivery.

c) Attitude - Perceived 'self-worth' (Attitude towards wife beating) and gender preference attitude on children.

Empowerment, Autonomy and Attitude of Women

Empowerment is a process, by which women gain greater control over material and intellectual resources which will, assist them to increase their self reliance, enhance them to assert their independent rights, challenge the ideology of patriarchy, and the gender-based discrimination against women. This will also enable them to organize themselves to assert their autonomy to make decisions and choices, and ultimately eliminate their own subordination in all the institutions and structures of society (Batliwala, 1995; Malhotra, 2002).

Many studies have identified education, work participation, exposure to mass media and household standard of living, as determinants or factors or sources for empowerment. Education enhances a woman's position through decision-making autonomy, control over resources, knowledge, exposure to the modern world and husband-wife closeness (Jejeebhoy, 1996 and Kishor et.al, 2004). Female work participation in non-agricultural sector and level of wage are also considered as determinants of empowerment (Srinivasan, 1990 and Kulkarni, et al, 1990). A woman's gainful employment outside the home exposes her to the outside world, delays age at marriage, provides a sense of financial independence and increases her bargaining power and autonomy within the household and society (Chen, 1995; Pruthi, et al, 1999; and Dixon-Mueller, 1993). Also, women's paid employment could alter the perception of women's value and motivate parents to invest in the girl child's education and health (United Nations, 1999).

The investment of power on a woman becomes evident through her participation in household decision making, financial autonomy and freedom of movement (Kishor, 2004). Lack of decision making power by a woman could result into lesser timely health seeking behaviour and leads to greater adverse health consequences (Sundari, 2004).

Further, a fundamental shift in perceptions, or "inner transformation," is essential to the formulation of developmental choices. It is crucial that the input of empowerment enhances her intrinsically by changing her attitude or ideology into egalitarian ideas,

otherwise the power or autonomy she has gained, may not channel her to make welfare and developmental decisions (Malhotra A, 2002). Non-egalitarian gender relations deny women an egalitarian decision making role during health care need, and other family matters (Jeejebhoy, 1998). Positive change in the attitude could alter the current submissive image of an Indian woman as merely a reproductive tool, homemaker, caregiver and subordinate.

Findings

I. Utilization Pattern of Maternal Care

The patterns of utilization of healthcare during pregnancy, delivery and postnatal period among the mothers who had given birth one year preceding the survey were not uniform (Table 1). Nearly one-fifth of the mothers did not utilize antenatal care at all (No ANC check-up, no TT injections and no intake of IFA syrup or tablets). Further, only 43 percent of the mothers had their first ANC checkup during their first trimester of pregnancy. More than three fourth of the mothers (76.2%) reported that they had received more than two tetanus toxoid injections. The proportion of women who received all the recommended ANC care was found to be very low, only 14.4 percent.

Only 41.1 percent of the mothers had delivered in a health facility; 8.9 percent delivered at home (whether own or parents) with the help of healthcare professionals; and the remaining 57 percent of these mothers had delivered at home without the assistance of any healthcare professional.

A wide variation was observed in the maternal health care utilization pattern among urban and rural mothers. Urban mothers have used maternal care much more as compared to rural mothers. Utilization by urban mothers of full ANC is more than three times; institutional delivery more than two times and perinatal care nearly two times more, as compared to utilization rates among rural mothers.

Table 1: Utilization Pattern of Maternal Care by women who have had a live birth during last one year preceding the survey

	Urban	Rural	Total	
			percent	no. of women
No ANC at all [1]	4.4	13.6	11.4	1325
Components of Antenatal care				
Atleast one ANC checkup	90.6	73.0	77.3	9001
ANC at first trimester	62.9	36.5	43.0	5007
Two or more Tetanus toxoid injections	87.0	72.7	76.2	8878
Iron and folic acid tablets or syrup for three more months	76.4	63.0	66.0	7724
Full Antenatal care [2]	27.1	10.3	14.1	1678
Natal care				
Institutional delivery	70.9	31.9	41.4	4826
Delivery with assistance from health professionals [3]	75.9	41.3	49.7	5791
Assisted by health professionals for home deliveries	18.5	14.3	14.8	1010
Postnatal care				
Postnatal check up within two months	64.9	34.0	41.5	4839
First PNC check up with in two days for both home and hospital births	61.6	29.3	37.2	4331
Perinatal care [4]	77.7	43.3	51.7	6020
Total	24.4	75.6	100	11649

Source: National Family Health Survey, 2005-06

Note: [1] No antenatal checkup, no intake of iron folic acid/syrup and no tetanus injection.

[2] Utilization of, three or more antenatal check-ups (with the first checkup within the first trimester of pregnancy) & two or more tetanus toxoid injections, an & Iron and folic acid tablets or syrup for three or more months.

[3] Women's delivery assisted by doctors, nurse/midwives and other health professionals.

[4] Women who had received more than three antenatal check ups; & ANC check up during the third Trimester; & institutional delivery; or postnatal checkup within two days of home deliveries

II. Synergy between Sources of Empowerment and Maternal Health Care Utilization

II.a. Educational Status of the Mothers:

Though the utilization pattern of ANC components was high among literate mothers, it was much higher among the mothers who had completed high school and above level of education (Table-2). The educational level of the study mothers are divided into four groups – illiterates (46.6%); primary (6.9%); up to middle schooling (36.1%); and secondary and higher level of education (10.4%). Nearly one in every two mothers (46.5%) who were with high school and above level of education had received full ANC, where as among illiterates, less than one in every twenty mothers (3.7%) had taken full ANC.

Table 2: Percentage distribution of women with different components of empowerment by their utilization of maternal health care during their latest birth in the last one year preceding the survey

	More than 3 ANC	More than 2 TT	ANC recommended	Institutional delivery	Assistance	PNC within 2 days	Perinatal care index	**Total**
Education								
Illiterate	29.1	63.3	3.7	19.5	28.2	18.2	31.4	5432
< Primary	49.3	80.1	10.3	39.1	48.8	32.4	51.9	808
Primary	67.0	86.6	19.7	57.3	65.8	51.2	66.9	4200
Sec & above	87.3	95.8	46.5	86.6	91.3	77.1	90.1	1208
Work participation								
Not working	54.7	79.5	16.7	47.1	55.1	41.8	56.5	8131
Working/worked in the past 12 months preceding the survey	39.7	68.5	9.2	28.3	37.2	26.5	40.6	3518
Earnings*								
Not paid	33.2	65.6	5.6	22.5	32.3	20.4	35.5	1643
Earnings in cash	45.4	71.0	12.3	33.4	41.5	31.8	45.0	1874
Media exposure								
No media exposure	27.7	62.5	3.7	18.5	28.2	17.8	31.2	3663
Exposure to atleast one	60.5	82.5	19.3	52.0	59.6	46.1	61.1	7986
Total Percent	50.2	76.2	14.4	41.4	49.7	37.2	51.7	11649

Source: National Family Health Survey, 2005-06
Note: * Applicable to only working/worked in the past 12 months women

The first antenatal check-up in the first trimester was very low among illiterate mothers, and only one fourth of them had undergone the recommended three antenatal check-ups. More than three-fourth of the mothers (86.6%) with higher education had delivered in a health facility, whereas less than one fifth of the illiterate mothers (19.5%) had delivered in a health facility. Additionally, mothers with high school and above education used postnatal care much better than mothers with some education and illiterate mothers. Perinatal care was also used by majority of the women with secondary and above educated women (90.1%) than the illiterate women (31.4%).

II.b. Employment Status of the Mothers:

To assess the employment status of the mothers the survey had asked the respondents whether they had worked in the last 12 months preceding the survey, nature of their occupation, the form of payment, and their economic contribution to the family. In order to study the impact of employment on maternal care, the mothers were divided into three categories: mothers who were not working (69.8%) and the working mothers were further classified into, mothers who were not earning cash (16.1%) and mothers who were earning cash (14.1%).

The pattern of maternal healthcare utilization was found to be better among the non-working mothers than the working mothers. A larger proportion of non-working mothers (47.1%) opted for institutional deliveries than working mothers (28.3%). This is observed for each and every chosen indicator. However among the working women, mothers who worked for cash had relatively better utilization of the entire maternal healthcare services provided as compared to mothers who worked but not for cash. On the whole, utilization of maternal health care was worse for mothers who worked but did not earn cash. The utilization of full ANC is much higher (12.3%) among mothers working/ed for cash than mothers who were not working for cash (5.6%), where as this utilization is higher for mothers who were not working (16 .7%). The national average for full ANC is 14.4 percent.

II.c. Exposure to Mass media:

Media is a medium through which a woman could obtain knowledge/ awareness/ information outside school curriculum. It was felt that in the present female literacy level and economic condition, exposure to at least one of the media was sufficient. So a composite index, exposure to mass media [4] was formed using three questions asked regarding their exposure to the mass media (print, audio and visual). The index divided the study mothers into two categories, mothers who were not exposed to any of these media (31.4%); and mothers who were exposed to at least one of these media (68.6%).

Media exposure had high impact on all the aspects of maternal healthcare. The gap between these two groups is very wide for each and every component of utilization of maternal care. Just 3.7 percent of non-media exposed mothers achieved full utilization of antenatal care, where as 19.3 percent of media exposed mothers had full utilization of antenatal care. The utilization pattern was quite notable during natal care too. One in every two media exposed mothers (52.0%) had delivered in a health facility, where as this proportion among non-media exposed mothers are 18.5 percent. Perinatal care utilization is also very high among media exposed mothers, that is, 61.1 percent among media exposed mothers to 31.2 percent among non-media exposed mothers.

III. Synergy between Women's Autonomy on Maternal Health Care

The NFHS-3 survey had asked the respondents some specific questions to assess their decision-making autonomy within their household. These are, a) Final say on own healthcare; b) Final say on making day to day purchases; c) Final say on visits to family and friends; d) Final say on what to do with husband's earnings; e) Final say on the cash earning-working mother's salary; and f) whether the mother is allowed to keep money. All the a-d questions are with options, 1) respondent herself takes the decision, 2) Jointly with husband, 3) husband and 4) someone else in the family.

[4] Exposure to mass media: This index was formed by using four responses the mothers had given; a) Read news paper every day, b) Watch Television every day c) Listens to radio every day and d) Go for movies atleast once a month. If the response was 'yes' to atleast one of the above four questions, they were considered as having 'exposure to mass media'; otherwise 'not exposed to any media'.

Table 3: Percentage distribution of women with different level of decision making autonomy by their utilization of maternal health care.

Autonomy Indicators/Maternal Healthcare	Maternal healthcare utilization							Total
	More than 3 ANC	More than 2 TT	ANC recommended	Institutional delivery	Assistance	PNC within 2 days	Perinatal care index	
Has money for her own use								
Full autonomy	49.6	78.6	16.6	42.4	50.0	37.4	52.0	4793
No autonomy	50.7	74.5	12.9	40.7	49.5	37.0	51.5	6849
Household decisions (3 variables combined)								
Full autonomy	49.0	74.3	14.9	40.9	48.6	35.3	50.8	1144
Partial autonomy	53.4	76.5	16.7	43.7	51.9	40.5	54.1	6032
No autonomy	46.3	76.7	11.3	38.7	47.3	33.3	48.8	4371
Own healthcare decision								
Full autonomy	50.2	78.1	15.6	40.7	48.5	36.1	50.6	2455
Partial autonomy	54.7	77.2	17.4	46.0	54.0	42.3	55.5	3849
No autonomy	47.0	74.9	11.8	38.6	47.3	34.2	49.5	5247
Spend husband's salary								
Full autonomy	41.8	75.6	14.3	34.0	44.9	29.0	40.1	524
Partial autonomy	52.1	75.9	15.3	42.4	50.4	38.3	52.4	6259
No autonomy	49.3	76.9	13.4	41.1	49.5	37.3	43.8	4487
Spend own salary*								
Full autonomy	49.7	72.5	13.0	34.0	59.6	26.9	45.1	386
Partial autonomy	44.8	70.7	14.0	34.0	56.4	33.9	45.6	1001
No autonomy	44.4	61.4	8.6	32.5	61.3	33.6	45.7	431
Mobility index (3 variables combined)								
Full mobility autonomy	58.0	78.8	19.9	50.8	58.1	46.1	59.6	2850
Partial mobility autonomy	47.8	75.3	12.5	38.2	46.9	34.3	49.0	8278
No mobility autonomy	46.1	76.4	14.6	42.0	49.3	34.0	50.3	521
Total Percent	50.2	76.2	14.4	41.4	49.7	37.2	51.7	11649

Source: National Family Health Survey, 2005-06
Note: *Applicable to working women who earn cash or cash and kind

For the purpose of analysis, the respondents were divided into three categories, mothers who took the decisions independently were considered as women with full autonomy, mothers who made decisions jointly with the husband were considered as women with partial autonomy, and mothers whose decisions were taken by their husband or someone else in the family were considered as women with no autonomy. A composite index was formed using the three variables, final say on purchasing daily, final say on purchasing

large household items and final say on visiting friends and family. The synergy between women's autonomy and maternal healthcare is presented in the Table-3.

III.a. Household decision making

i. Regular household decisions

Three questions were asked in this survey a) Final say on making day to day purchases b) Final say on large purchases and c) Final say on visits to family and friends, are used to make a composite index, on household decisions. Although full and partial autonomy on this decision making had almost equal impact on utilizing the components of antenatal care, the mothers with partial autonomy had slightly better utilized all the maternal care services provided.

ii.. Own Healthcare Decision:

Like the above household decision making here also women with partial autonomy utilized all the selected indicators of maternal care.

One area here which has to be taken in to consideration is that for these above decisions, the women with partial autonomy are those who make these decisions jointly with her husband. Here the power of women's communication with her husband as well as husband's involvement in women's maternal health is reflected.

III.b. Control over Economic Resources

i) Has money for her own use

There are two major questions asked in this survey which could reflect a women's empowerment through her autonomy over economic resources - a) Whether the women has money for her own use and b) whether the women has a saving account. As the response rate for the first question was found to be high, it was decided to use the first question. The mothers were divided into two groups, women who have the autonomy to keep the money for her own use (41.1%) and the other group of women who do not have this autonomy (58.8%).

Except utilization of more than three ANC care and Tetanus use, all the other aspects of maternal care are better used by mothers who had autonomy - the power to own money for her own use.

ii) Decision on spending Husband's salary

As in the case of household autonomy, here also the women with partial autonomy have better utilized all the selected maternal care services provided.

iii) Decision to spend own salary

This decision is applicable to only women who were working and earning cash. The antenatal care such as more than three ANC and tetanus consumption, are high among women who have full autonomy for this decision. However, natal as well as postnatal care is almost equal or relatively higher among mothers with partial autonomy on this decision.

It would be apt to state here that only one in five mothers (20.6 %) who earn cash for their work has full autonomy to spend their own salary. More than half of these women have partial autonomy (53.4 %) i.e. make the decision jointly with husband.

III. c. Mobility Autonomy[5]**:**

According to this mobility index, one fourth of these mothers have full mobility autonomy, 71.1 percent of them have partial mobility autonomy and 4.5 percent of the mothers are not allowed to out at all, alone or with anyone accompanying.

IV. Synergy between Women's Attitudes on Maternal Care

Violence has significant public health consequences, including effects on unwanted fertility and contraceptive use, rates of HIV and other STI's, infant and child mortality

[5] Mobility autonomy: The mobility index was drawn using three questions asked to the respondents. a. whether the woman was allowed to go to market?; Whether the woman is allowed to go to a health facility? and whether the woman is allowed to places outside village or community? The options given to the respondents are they can go 'alone' or 'with someone' or 'not allowed to go out'. Using these three variables the mobility index is formed. If the women is not allowed to go out for all these questions they are considered to have '**no mobility autonomy**'. If they are allowed to go alone, then considered as women with **'full mobility autonomy'** and others are considered to have '**partial mobility autonomy'**.

and children's access to immunization and other healthcare. Spousal violence is deeply embedded with the patriarchal norms and attitudes about gender relations in India. Socially conditioned women often tend to accept spousal violence as a 'natural' response to their not following certain normative behavior, which suggests that low self esteem among Indian girls, who are brought up in cultures where sons are clearly favored, contributes to women accepting beating at the hands of their husbands. The input of empowerment can transform one intrinsically, which can be captured by his/her attitude or ideology into egalitarian ideas. The following two indicators are chosen to study the attitude and ideology of the study women.

IVa. Justifying Wife-beating

According to NFHS-3, around one-third (34.0 %) of the surveyed women age 15-49 have experienced violence at any time since the age of 15 and among married women majority of the perpetrators (85.3 %) were their husbands (IIPS, 2007). Often women justified and accepted the ill treatment of their husbands, showing their subordinate attitude and low status. An attitude towards wife beating index[6] was formed using five questions asked during the survey to study their attitude towards domestic violence. Little more than half (58%) of the surveyed women had justified that a husband could beat his wife under any one of the given five reasons.

Using this index the study mothers were divided in to two groups, mothers with high self esteem (49.8%) and mothers with low self esteem (47.3 %). The mothers with high self esteem utilized all the components of maternal healthcare better than their counterparts who were with low self esteem.

[6] An attitude towards wife beating index: To measure the attitude towards wife beating the paper has used had asked, five questions probing their attitude on wife-beating on the given six circumstances. They are whether they think a husband is justified in beating his wife if, a) she goes out without telling him? b) she neglects the house or children? c) she argues with him? d) she refuses to have sexual intercourse with him? e) she does not cook food properly?. If the respondents agree to husband's beating atleast for one of these questions, she is assigned as with 'low self worth' ; and if she does not agree to husband's beating for any of these questions, then she is considered as women with 'high self esteem'.

IVb. Gender Preference

The survey also asked mothers, how many children they would like to have, including how many boys and how many girls. If a woman responded that she likes to have equal number of boys and girls, then she was considered as having an 'egalitarian gender attitude'. If a woman responded that she likes to have more boys than girls, she was classified as having a 'son preferring attitude'; and if one likes to have more number of girls, then she is considered as having 'daughter preference attitude'. By these criteria, the mothers with egalitarian attitude are 70.7 percent; son preference attitude are 27 percent and daughter preferring mothers are just 2.3 percent.

Table 4: Percentage distribution of mothers by their attitude and utilization of maternal healthcare

	More than 3 ANC	More than 2 TT	ANC recommended	Institutional delivery	Assistance	PNC within 2 days	Perinatal care index	**Total**
Justification for husband's beating								
High self esteem	53.2	79.6	16.8	45.3	53.9	39.6	55.1	5806
Low self esteem	47.2	72.8	11.9	37.5	45.5	34.4	48.1	5507
Gender preference for children								
Equal preference	56.5	79.3	17.2	48.0	56.1	42.8	57.8	8231
Son preference	33.4	67.8	6.7	23.5	32.6	22.3	35.3	3149
Daughter preference	55.2	80.7	(17.8)	48.5	55.2	37.4	56.7	270
Total Percent	50.2	76.2	14.4	41.4	49.7	37.2	51.7	11649

Note: Figure in parenthesis is un-weighted figure for less than 100 cell value
Justifying spousal violence with DK and missing value for 388 cases which is not shown separately

The utilization pattern of maternal health is much higher among mothers who have equal gender preference and daughter preference than mothers with son preference. The difference is very wide for full ANC, natal care and post natal care.

Conclusion and Discussion

The results reveal that only one in every five women has utilized all the recommended ANC services. There is vast difference in the maternal healthcare utilization pattern in rural and urban settings.

Empowerment factors such as education and exposure to mass media show positive relationship towards maternal care utilization. Women's involvement in labour force shows negative impact on maternal care utilization. Household autonomy, does not show any positive impact, whereas self health care autonomy reveals positive impact. Economic autonomy i.e. women who are allowed to keep money and have autonomy on buying important household assets; and, women with freedom of movement show better impact on maternal care than their counter parts. Attitude towards domestic violence has marginal impact than expected. Although empowerment sources and attitude have high impact on maternal care seeking behaviour, there is not much impact on women's decision making autonomy and maternal health care utilization.

The study clearly brings out the synergy between social determinants that impact the utilization of maternal and perinatal healthcare. Women's employment did not show much impact on maternal care utilization because in the Indian setting women often go to work out of economic compulsion and employment does not necessarily mean that women could use the money that they have earned. The government is making excellent efforts to make maternal health services accessible to women by giving them financial incentives for institutional deliveries and bringing antenatal care to their door step. Although births in medical facilities have increased over the years – 26 percent (1992-93); 34 percent (1999-2000); and 41 percent (2005-06) – there is still a long way to go, to reach the National Population Policy goal of achieving 80 percent of institutional deliveries by the year 2010 (National Population Policy 2000). There is a growing need to design and implement programmes that are tailored to the needs and realities of the national and sub-national settings and to scale up known or new cost-effective (social and economic) interventions. However, all these efforts will not yield results unless there is perceptible change in the social context, where decisions are taken to utilize healthcare. Therefore it is crucial that the government evolve policies to improve the social environment of women, which will in turn be conducive for them to utilize maternal healthcare.