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RECENT ADVANCEMENTS IN THE MATERNAL HEALTH AWARENESS PROGRAMMES AMONG THE RURAL AREAS OF NORTH INDIA

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ABSTRACT

It is estimated that over 80% of all maternal deaths each year are the result of preventable causes; nevertheless, these needless deaths can be prevented via the implementation of important health measures such as the provision of prenatal care and the use of medically assisted delivery. The primary purpose of this study is to investigate and analyse, in a methodical manner, the patterns of socioeconomic disparity that exist in the utilisation of maternal health care services. The study also attempts to examine the effect that socioeconomic and demographic factors play in the difference that exists between rural and urban areas in terms of the utilisation of maternal health care services in India. The data from the first four iterations of the National Family Health Survey (NFHS-1 to NFHS-4) have been incorporated into the current investigation.

Keywords: *Maternal health care utilization, Health*

INTRODUCTION

Social determinants of health

Access to and utilisation of maternity and reproductive health care services are influenced by contextual factors. Maternal and reproductive health is a social phenomena as much as it is a medical occurrence. The failure to attain the targets of MDG 5 is increasingly being evaluated and discussed in terms of equality, and in recent times, there have been calls for a fuller understanding of the patterns of disparity in health within a variety of contexts. Culyer has proposed that, in order to begin the process of addressing health disparities, the first step should be to identify vulnerable populations, such as those belonging to disadvantaged groups. In addition, there is a pressing need to go beyond the practise of isolating individual factors that contribute to health disparities and instead shed light on the interplay that exists between social and structural factors.

Inequities in health refer not only to the unequal distribution of health but also to the unjust distribution of health that can be attributed to social structures that are either inadequate or unfair. Inequalities in health are characterised by the fact that they are socially produced, that they are distributed in a systematic manner across the population, and that they are unfair. Determining what health inequities are and where they exist therefore requires conducting research into social justice and the factors that influence people's social environments. When taken into consideration together, the socioeconomic environment, political climate, and structural factors are conceptualised through the lens of the idea of social determinants of health disparities. The structural determinants, also known as the social determinants of health disparity, are those factors that work through a chain of other social factors as intermediaries. These intermediary factors include

material circumstances such as the quality of housing and the physical environment, psychosocial circumstances such as stressful living conditions and relationships, (a lack of) social support and coping styles, as well as behavioural and biological factors such as lifestyle and genetic factors. Material circumstances include things like the quality of housing and the physical environment. Additionally, the health care system is referred to as a social determinant of health, in particular due to the fact that it helps to moderate the various outcomes that are associated with poor health (Fig. 1).

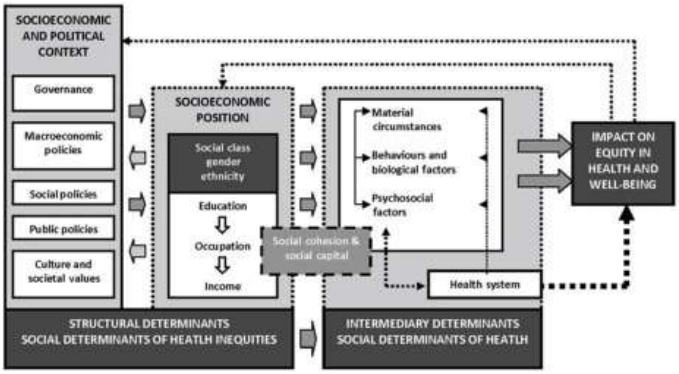

Fig. 1 Framework for social factors that influence health (WHO, 2010)

There have been a significant number of articles written and published on the subject of maternal and reproductive health in India. Several of these concentrate on various aspects of equity-related topics. To our knowledge, there has not been any attempt made to systematically map the established sources of inequality and their interrelatedness in maternal and reproductive health in India. This is something that we believe should be done. In order to contribute to a more nuanced conversation regarding the achievement of MDG in India and how to do so in an equitable manner, the purpose of this review was to provide a summary of the data on structural and social determinants that generate and sustain health disparities in India. In order to classify and provide an explanation for the factors that determine the degree of inequality in maternal and reproductive health in India, the CSDH framework is utilised.

OBJECTIVES

1. To study advancements in the maternal health awareness programmes.
2. To study maternal health care services

METHODOLOGY

Using the online databases PubMed and Popline, a review of previously published research that had been subjected to peer review was carried out. The first author was the one responsible for conducting the search by using a carefully developed list of search terms that maternal and reproductive health and equity, including possible categories of disadvantaged populations such as place of residence, race/ethnicity, occupation, gender, religion, education, socioeconomic status, and age, amongst others. The search phrases for the two different subjects were merged into one, and the results were limited down to contain just articles on India. The titles of the 7,071 articles were manually read, and any articles that were obviously irrelevant to the purpose of the study were disregarded and removed from consideration. All of the articles that had titles that made it impossible to judge whether or not they were relevant were saved. This reduced the number of articles to be considered to 771.

RESULTS

The search led to the discovery of five primary structural characteristics that are significant in comprehending equity in the context of India: one's socioeconomic position, one's gender, one's educational attainment, one's social status (registered caste or tribe), and one's age (adolescents). The research shows that these five factors are intricately connected to one another, which is supported by the literature. The economic condition of the subject is the primary topic of the vast majority of the articles; in those articles in which it is not the primary focus, it is frequently brought up in the course of the discussion. It is common practise to discuss people's social status in terms of their economic standing. In the context of India, social status can be measured using the surrogate term "caste." The ways in which gender and adolescence contribute to the creation and maintenance of inequality overlap, as do the ways in which socioeconomic status and educational attainment. The determinants of equity that are reported in some of the publications that were retrieved are income, occupation, ethnicity, and religion; however, there were no articles discovered in which these factors were the primary emphasis or were examined in depth.

Because context is so important for comprehending the factors that lead to health disparities, we will begin our discussion of each of these factors by providing a concise summary of the current state of affairs in India, including at the subnational level whenever that is applicable.

Economic status and health financing

According to the report of the Tendulkar Committee, which was adopted by the Indian Government in 2011, the proportion of people who were considered to be living in poverty was 37% of the total population. However, the percentage of people living in poverty varies greatly across India; for example, the poverty rate is around 10% in Delhi, Goa, and Punjab, while it is over 40% in some states like Bihar and Orissa. Spending on healthcare by the Indian government accounts for about one percent of the country's gross domestic product, while the country as a whole devotes about five percent of its GDP to healthcare. Individuals and families are forced to shoulder a significant amount of additional financial responsibility as a result of India having one of the highest levels of out-of-pocket payments for health care in the world. It has been suggested that this is one of the factors contributing to the disparities in health that may be seen across the country. Since 2005, a nationwide initiative known as the National Rural Health Mission (NRHM) has been in operation as an umbrella project with the goal of addressing health disparities, with a particular emphasis on rural areas.

Over the course of the past 15 years, there has been a general rise in both the prevalence of prenatal care (ANC) and skilled attendance at delivery among India's general population. The rate of advancement, on the other hand, has been glacially slow for women who come from economically challenged parts of the community. In India as a whole, the use of ANC services increased by 12 percentage points between 1992 and 2006, but the increase among the poor was only 0.1 percentage points, according to the findings of a study that looked at progress based on data from the three rounds of the National Family Health Survey (NFHS), which were conducted in 1992–1993, 1998–1999, and 2005–2006. The same research revealed that there was a 13 percentage point increase in the use of trained birth attendants, although the women who belonged to the lowest income quintile were only responsible for a 2 percentage point increase in this trend.

Regional and rural/urban differences in health based on economic status

Only 32% of the women living in urban-slum areas had an institutional delivery, compared to 93% of the women living in non-slum urban areas and 79% of the women living in rural areas, according to the results of a household survey conducted in Chandigarh Union Territory that compared coverage of maternal health care. The survey was conducted among women who had given birth at least once. The typical costs associated with giving birth change from one region to another and from one provider to another. On the other hand, a study that used data from the National Sample Survey conducted in 2004 found that the vast majority of low-income households in the country spent more than forty percent of what they were capable of paying for maternal health services. According to the findings of a community survey conducted in South Delhi, the costs associated with direct maternity care are rather high, sometimes even exceeding 10% of the yearly family income for the most impoverished families.

It has also been established that economic status and domicile status play a role in determining the quality of treatment provided by maternal health services. Poor and non-poor groups were shown to have significantly different levels of access to ANC in the results of a cross-sectional study carried out in the Indian states of Andhra Pradesh, Karnataka, Kerala, and Tamil Nadu. A study that was carried out in New Delhi revealed that health care providers in the more economically disadvantaged parts of the city were unable to meet the national standards on minimal care during pregnancy and delivery. On the other hand, this did not appear to be a problem in the more prosperous parts of the city. When it comes to understanding the user's viewpoint on barriers to maternal health care, a qualitative study that encompassed both rural and urban parts of Maharashtra found that financial constraints are essential, but that these are also closely tied to perceptions about health care. The study came to a number of conclusions, one of which was that ANC and institutional delivery are both regarded as preventative rather than therapeutic approaches, and as a result, they are not prioritised owing to cost constraints.

India has one of the largest urban populations in the world, and a significant portion of that population lives in urban slums. According to the findings of a study on the reproductive health of women, a significantly lower percentage of women living in slum areas than women living in non-slum areas had ever used contraceptives. Additionally, women living in slum areas were significantly less likely to use skilled attendants at delivery and significantly less likely to receive postpartum check-ups. The usage of contraceptives was found to be 52% among urban poor, according to a study that was carried out in a hospital in New Delhi. This percentage is comparable to the use of contraceptives in rural areas, but it is lower than the use among well-educated urban people. The findings of the first and third rounds of the NFHS indicated, among other things, that progress toward higher use of ANC and institutional delivery is occurring primarily among the urban non-poor, whereas progress among inhabitants of urban slums is occurring more slowly. The population that lives in slums typically has a large financial burden in regard to the costs of maternal health care. An investigation into the costs of maternal healthcare revealed that low-income residents of slums in the city of Mumbai spent a catastrophic amount on treatment. Catastrophic spending on healthcare is assumed to occur when the cost of treatment exceeds a certain percentage (typically forty percent) of a household's total income. The findings of the study also revealed that the informal charges accounted for a significant share of the total expenditures. According to the findings of the same research project, low-income families living in slums are more likely to rely on wage income to pay for maternal health care, in contrast to higher-income groups, which are more likely to rely on savings and money obtained through loans. This is thought to increase the likelihood of experiencing both temporary and long-term poverty.

Gender

In its role as a structural determinant of health, gender works through a variety of intermediary determinants to impact the maternal and reproductive health of women as well as their access to care. On the worldwide gender gap index, India ranked 112 out of 134 nations in 2010. This ranking was achieved in 2010. Since the country's independence, the government of India has enacted a great deal of legislation to safeguard the rights of its female citizens. However, in general, the implementation of a significant number of these regulations is lacking. Literacy rates for Indian men are 78%, whereas just 55% of Indian women can read and write. Even in the younger age groups of 15–19 years, gender differences continue to be disproportionate, with one in four women being illiterate compared to one in ten men. Women continue to occupy a subordinate role within their families and in their communities. According to the findings of the NFHS 3 survey that was carried out in 2005–2006, the vast majority of men believe that although husbands and wives should make decisions together, the husband should have the final say in all matters. This has ramifications for the health-seeking behaviour of women, who may be dependent on the approval of their husbands to obtain health services. This has repercussions for the health-seeking behaviour of women.

There is a correlation, in the country of India, between the utilisation of appropriate prenatal, birth, and postnatal care and the autonomy of women. Access to maternal and reproductive health care is also connected with the quality of family interactions as well as the type of household that a person lives in. A study that used data from the NFHS 2 found that women who lived in joint households (households in which the couple lived together with the parents of the husband) were less likely to report using contraceptives and were also less likely to use ANC than women who lived in nuclear households (households in which the husband, wife, and children all lived together). Women who lived in joint households with their in-laws had a lower likelihood of giving birth in a medical facility or with the assistance of a trained birth attendant. This was shown to be the case regardless of whether or not the in-laws were present. Women who had better marital relationships and those who lived in nuclear households were more likely to use ANC services and to have an institutional delivery than other women. On the other hand, women who lived in joint families and who had a better relationship with their in-laws were more likely to use ANC services. These findings come from the Women's Reproductive History Survey from 2002. In a qualitative study that was carried out in rural areas of Madhya Pradesh, it was found that the majority of mothers-in-law were of the opinion that they should be the ones to make decisions regarding the use of sterilisation among the wife(s) of their son(s), and that this decision was frequently based on the number of grandsons that were born into the family.

Education

Literacy rates in India are quite high, with 74% of the population being able to read and write. The Indian government has identified increased literacy rates as a critical component in the process of decreasing inequalities in India. The rate of literacy among women increased more quickly than the rate of literacy among men, which increased from 75.3 to 82.1% during the same time period. The literacy rate among women rose from 53.7% in 2001 to 65% in 2011. The percentage of illiterate women in each state varies widely, ranging from 92% in Kerala to 52.7% in Rajasthan.

According to the available research, there is a significant correlation between educational attainment and the utilisation of reproductive health services including family planning and ANC. According to the findings of the NFHS 3, the fertility rate for women with no education was 3.55, while the fertility rate for women with 12 years of education or more was 1.8. In addition, the percentage of women who had gotten at least one ANC visit ranged from 29% for those with little education to 88% for those with at least 12 years of comprehensive education.

Similar connections have been identified by other researchers in their research. A study conducted in the Indian state of Madhya Pradesh found that the likelihood of a woman receiving antenatal care, trained delivery attendants, and postnatal care is dramatically increased for women with secondary education or above as opposed to women with no education at all. Less educated women (1–11 years) living in both slum and non-slum areas are more likely to be sterilised, less likely to use other modern contraceptives, and more likely to have an unmet demand for family planning than more educated women (+12 years of education). This finding was found in a large study that looked at family planning among the urban poor in Uttar Pradesh. According to the findings of a study that was carried out on the basis of data that was obtained from the NFHS 2, it was discovered that women who had completed middle school or above were more likely to be utilising contraceptives. According to the findings of a cross-sectional survey carried out in rural Punjab, 65.9% of the women who did not have any level of education, 78.1% of the women who had elementary education, and 80% of the women who had high school education were using some kind of birth control. The most prevalent technique of birth control used by women who are illiterate or who have only completed primary school is sterilisation. However, condoms are the most popular method of birth control used by women who have completed high school.

Adolescence

Inequalities in health can also be caused by factors such as age. The World Health Organization (WHO) considers a person to be between the ages of 10 and 19 years old. It appears that children and adolescents in India do not have access to reproductive health care on an equal basis. Within the context of Indian culture, premarital sexual encounters are strongly forbidden, and the topic of teenage reproductive health is still taboo. There have only been a few of studies conducted on the subject of reproductive health in adolescents, and national health surveys do not include single women when compiling information on women's maternal and reproductive health as well as their consumption of health care services. The subnational study titled "Youth in India: Situation and Needs," which was done between 2006 and 2020, provides some useful information. According to the findings of the poll, 19% of males and 9% of women between the ages of 15 and 24 had experience from a romantic relationship before to marriage, the vast majority of which involved some sort of physical contact. Additionally, two-fifths of the males and one-quarter of the women who reported having experience from pre-marital romantic relationships had also engaged in a sexual relationship with the romantic partner at some point throughout the relationship. There were not significant differences discovered between teenagers living in rural areas and adolescents living in urban areas, according to the research. Condom use was observed to be low among adolescents who were involved in premarital sexual interactions. Only 13% of the men and 3% of the women claimed that they always wore a condom in all of their sexual encounters. The results of a survey that was carried out in the states of Bihar and Jharkhand showed that young unmarried women had a difficult time gaining access to abortion care in a timely manner. This was due to the late recognition of their pregnancy as well as difficulties in gaining access to health care.

In spite of the fact that it is against the law, child marriage is nonetheless widely practised in India. 18% of women in the age group of 20–24 married before the age of 15, and 47% of women married before the age of legal consent in the United States, which is 18. These statistics are from the NFHS 3, which was done in 2006–2007. In addition, in the quintile with the least amount of money, as many as 78 percent of women got married before they became 18 years old. A woman's reproductive health might be affected by her age at marriage, particularly if she marries at a young age. It is linked to low rates of contraceptive use, an unmet demand for methods of spacing out pregnancies, high fertility, multiple unintended pregnancies, and

negative obstetric outcomes. There were low levels of full coverage of ANC (i.e. those having 3 ANC visits, IFA and TT2/booster) (14%), of skilled attendants at delivery (46%), and of postnatal care (35%), according to a major study that looked at married teenagers in rural India between the ages of 15 and 19. Women who entered into marriage before the age of 18 had a higher risk of experiencing both physical and sexual forms of domestic violence than women who entered into marriage after the age of 18. It has also been demonstrated that a young age at marriage is connected with decreased use of ANC and delivery care among married teenage pregnant women in India. [Citation needed] [Citation needed] A study that was carried out in a hospital in Kolkata found that teenage pregnancies were associated with more adverse complications, such as preterm births and stillbirths, when compared to adult mothers. Additionally, a study that was carried out in Rajasthan found that pregnant adolescent mothers had a risk that was as much as two and a half times higher of dying from complications related to pregnancy than adults. In conclusion, a study conducted in Maharashtra found a correlation between getting married at a young age and experiencing high levels of anaemia during pregnancy.

Scheduled castes and scheduled tribes

The caste system is still very much alive and well in Indian society, despite the fact that it has been abolished legally. One of the most powerful social factors that affects an individual's health is their caste, which is India's system of social stratification. In addition, research has revealed that caste is the most accurate household feature to utilise when attempting to identify low-income and disadvantaged households. In India, the phrase "socially backward classes" (SBC) is frequently used to characterise some of the most socially disadvantaged groups. This word encompasses not only the scheduled castes (SC) and scheduled tribes (ST), but also other backward castes (OBC). They are differentiated not only by their economic precariousness but also by their marginalisation and isolation from the rest of society, distinct cultural practises, and residence in the most economically impoverished places.

In India, being a member of an OBC is connected with lesser use of reproductive health care and poorer results for maternal health. According to the NFHS 3, the percentage of women who belong to SC or ST who receive any kind of ANC is at its lowest. Only 18% of births that occur among these women take place in a health facility, whereas 51% of births occur in health facilities among women who do not belong to any SC, ST, or OBC. Studies conducted at the state level corroborate these findings. Women who belong to a tribal caste, for instance, are less likely to have gotten ANC, more likely to have given birth at home, and less likely to have received a postnatal check-up, according to the findings of a study that was conducted in the Indian state of Jharkhand. Caste did not appear to have an effect on the consumption of iron and folic acid supplements, according to the findings of a study that was carried out in Uttar Pradesh. The study found that women who belonged to the SC or ST were less likely to obtain ANC and were also less likely to be assisted by a skilled birth attendant. Women who belonged to tribal castes had a significantly reduced likelihood of receiving expert medical assistance during childbirth, according to the findings of a comprehensive survey that covered most of India. This was in contrast to women who belonged to non-tribal groups. Home births were found to be relatively common in the Indian state of Jharkhand, but the percentage of ST women who gave birth at home was significantly higher than that of women from other groups, at 94% compared to 69% for non-tribal groups. These findings are similar to those that were found in Jharkhand. Even though just 37% of the women in the study sample belonged to the SC and ST, as much as 74% of the maternal deaths occurred among women who belonged to these groups. The research came from Rajasthan and used verbal autopsy to investigate pregnancy-related deaths.

Muslim community

It is believed that over 138 million people in India adhere to the faith of Islam, making it the largest minority religion in the country. The rural communities of West Bengal, Bihar, Maharashtra, and Uttar Pradesh are home to a disproportionately high number of the country's Muslims. Religion and the caste system are intertwined in India; as a result, 40.7% of India's Muslim population identifies with the category of "other backwards castes." It is estimated that 43 percent of Muslims are living below the country's official poverty level, and the literacy rates for this group are lower than the norm for the country as a whole. There is a disproportionately low number of Muslims serving in political and administrative capacities across all levels of society. In the course of this review, we came across only one item that was explicitly devoted to the Muslim population. Some of the research include data pertaining to religion, however they do not further investigate the link between not belonging to a Muslim community and disparity in terms of maternal and reproductive health. In what follows, we will offer findings that are pertinent for the Muslim population that were nested within research that primarily focused on another equity measure.

According to the findings of a study that used information from the NFHS 3 as its source of information, the relative odds that a Muslim couple would have concordant desired waiting time were only 42% of the odds that a Hindu couple would have concordant wants. According to the findings of a study that was carried out in rural Punjab, the rate of contraceptive utilisation was found to be 61.2% among Muslims, 72.8% among Hindus, and 82.1% among Sikhs. When compared to non-Muslim women, Muslim women in urban areas of Uttar Pradesh were found to have a lower rate of having been sterilised and a lower rate of utilising contraceptives, according to the findings of a study that investigated family planning practises among the women of these areas. According to the findings of a research project that compared Muslims and non-Muslims in urban areas of India regarding their utilisation of reproductive health care services, the gap between the two socioeconomic statuses was found to be significantly wider among Muslims than it was among non-Muslims. In a study based on data from the NFHS 3, it was discovered that Muslim women have much lower probabilities of having assistance during childbirth provided by a trained birth attendant when compared to women of other faith groups. A study that was also based on data drawn from the NFHS 3 found that married adolescent Muslim women (and women belonging to other religions) were less likely to be using safe deliveries compared with Hindu women. Additionally, a study that used the same data set and focused on married adolescent residents in rural areas came to the conclusion that married adolescent Muslim women were less likely than married adolescent Hindu women to have a safe delivery. According to the findings of a study that investigated the factors that influence the utilisation of maternal health care services in the state of Madhya Pradesh, it was discovered that Muslim women and women who belonged to groups that were not classified as ST were more likely to receive ANC than other groups of women. In a study carried out in rural West Bengal, it was discovered that Muslim women were more likely than Hindu women to seek care for postpartum morbidities from formal providers. The study compared these two groups of women.

Policy implications

In India, there is simply too much variety in terms of states, places of residence, age groups, social standing, and economic background to permit such generalisations. It will be necessary at the national, state, and district levels to have a very focused campaign of action delivery services to the most disadvantaged, in order to reduce inequities in health, particularly in maternal and reproductive health. This will be necessary in order to have a significant impact on the populations that are the most significantly disadvantaged. In

addition, an analysis of inequities in maternal health care needs to be carried out at both the state and district level in order to account for the wide disparities that exist both between and within states. These disparities are frequently the result of different policies and programmes, deficiencies in health infrastructure, and challenges associated with governance. This also asks for additional research to be conducted, this time concentrating on particular regions of the country or subsets of the overall population. To answer issues regarding the ways in which socioeconomic determinants influence access to and utilisation of maternal and reproductive health services in a particular location or among a particular group, research, particularly qualitative research, is required. The disparities that exist between regions and subpopulations further highlight the necessity for policies and programmes that are sensitive to context. It is obvious that one size will not fit all, and those who are less fortunate and more susceptible will be excluded as a result. When formulating policy and carrying out interventions, it is essential to give careful consideration to the ways in which socioeconomic factors interact within a given setting to have an effect on individuals' access to and utilisation of maternal and reproductive health services.

In the course of our study, we came across a number of critical populations that are disadvantaged with regard to their access to and use of maternal and reproductive health care. These populations are in need of policymakers and programmers all throughout India to assist them in resolving these issues. Some of these groups are well-known yet nevertheless receive inadequate services; examples include castes that are socially backward and the economically disadvantaged. Although the Indian government has attempted to address some of these inequalities through programmes such as the Janani Suraksha Yojana (JSY), which provides conditional cash transfers to women in an effort to encourage them to give birth in institutions that are equipped with trained birth attendants, these efforts have not been successful in reaching the most marginalised members of the population. Additionally, the quality of care provided under JSY is questionable, and as a result, the program's influence on outcomes such as MMR and IMR will be uncertain.

CONCLUSION

The rate of maternal death in India is decreasing, and the country is also making strides to enhance access to reproductive health care. Despite this, there is evidence to suggest that the development accomplished has been both unequal and uneven. The purpose of this review was to provide an explanation of the evidence pertaining to the structural determinants of maternal and reproductive health in India, as well as how the influence of these factors manifests itself in access to care. The overall impression that is given is that structural determinants are responsible for preventing a reduction in maternal mortality as well as an increase in access to reproductive health services for women who are members of disadvantaged communities. Interventions that aim to reduce maternal mortality and expand access to reproductive health care need to take into account the ways in which these structural variables function in Indian society and the ways in which this may affect access to health care for particular groups of women.

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