



SOCIO-ECONOMIC CORRELATES OF REPRODUCTIVE AND MATERNAL HEALTH WITH SPECIAL REFERENCE TO JHARKHAND

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Reproductive health does not mean population control, it is a matter of right, informed choice, good health and well being. A country with its largest young people should ensure good food, health care, education, employment and amenities to its citizen. Basically for the reproductive health care focus should be on how to address the unmet needs for contraception and ensure access to adolescent, maternal and child care. Childbearing is associated with a woman, that is why female are affected more as compared to male counterpart. Maternal health is related to the health of women during pregnancy, childbirth and the postpartum period. After the birth of a child, it is a new life for women since sometimes motherhood is associated with suffering, ill-health, gender discrimination and even death also. The major causes of maternal morbidity and mortality include haemorrhage, infection, and obstructed labour. This paper aims on highlighting socioeconomic correlates of maternal and reproductive health utilization and to analyse the factors affecting reproductive and maternal health, in process the paper also analyses role of RCH programme on maternal and reproductive health.

Keywords: Maternal and Reproductive Health, Socio-Economic Correlates

INTRODUCTION

Reproductive and Maternal health are important aspect of women health. Improving maternal health is an important global health priority. The Sustainable Development Goals (SDGs) took the place of the Millennium Development Goal which emphasize on maternal and child health. Moreover, the SDGs targeted no one should be left behind in the achievement of these goals. There have been several efforts to improve maternal health through the removal of barriers that limit access and utilization of health services. Prominent among these are the call for Universal Health Coverage (UHC) which is defined by the World Health Organisation (WHO) as a state where people and communities can use health care services they need without any financial hardship .

The main aim of this paper is to provide an in -depth analysis of socio-economic correlates of maternal health care services in Jharkhand.

The Literature on socio-economic inequality in maternal health care utilization in low-middle income countries suggest that wealth -related inequality in maternal care has increased in some developing countries.

India is attracting world's consideration not because of its population explosion but also because of its current as well as emerging health profile. Some progress has been made since

independence in the health status of the population. So this chapter shows the health scenario of India and Jharkhand state by discussing on health services of the country which will help to understand the basic health structure/facilities of the country and different health programmes executed since independence particularly with reference to Jharkhand.

Reproductive Health-

At the ICPD, the nations of the world agreed that government should give special attention to the education of girls, the health of women, the survival of infants and young children, and in general, the empowerment of women. At the same time, comprehensive reproductive health services should be provided to enable couples to achieve their reproductive goals and determine freely and responsibly the number and spacing of their children (United Nations, 1994). The ICPD (1994) at Cairo defined 'Reproductive Health' as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. The document further elucidated that reproductive health also referred to the condition where human beings acquired physical, mental and social satisfaction along with a safe sex life, which was aimed at the enhancement of life and personal relations, ensuring the capability to reproduce and the freedom to decide 'when' and 'how often' to do so (ICPD 1994). There are various components of reproductive and sexual health that would ensure the physical and mental wellbeing of women.

- ◆ Ensuring safe motherhood along with promotion of family planning.
- ◆ Ensuring safe abortion facilities.
- ◆ Ensuring male participation while generating awareness about reproductive and sexual health.
- ◆ Providing adequate health care facilities for menstrual disorders, RTIs, STDs, problems related to breasts, cervical cancer and the like.
- ◆ Protection from sexual violence.
- ◆ Protection from gender based violence.
- ◆ Prevention of violence within sexual relationships.

Soon after the Cairo conference, the Government of India set in motion a process to translate the ICPD Programme of action within national context. In November 1994, a joint mission of the Government of India and the World Bank was set up to undertake a sectoral review. In 1995, the World Bank submitted a report entitled 'India's Family Welfare Program: Toward Reproductive and child Health Approach' to the Government of India (World Bank, 1995). On October 15, 1997, the reproductive and child health Programme was launched (Ministry of Health and Family Welfare).

Reproductive health does not mean population control, it is a matter of right, informed choice, good health and wellbeing. A country with its largest young people should ensure good food, health care, education, employment and amenities to its citizen. Basically for the

reproductive health care focus should be on how to address the unmet needs for contraception and ensure access to adolescent, maternal and child care. Childbearing is associated with women, that is why female are affected more as compared to male counterpart.

Maternal Health

Maternal health is related to the health of women during pregnancy, childbirth and the postpartum period. After the birth of a child, it is a new life for women since sometimes motherhood is associated with suffering, ill-health, gender discrimination and even death also. The major causes of maternal morbidity and mortality include haemorrhage, infection, and obstructed labour.

The use of maternal health is not equal in all states of India. Basically the socio-economic correlates contribute a lot in the utilisation of maternal health care services. Jharkhand studies several factors affecting maternal and child health economic inequality (Pathak et.al., 2010), mother's education (Jat et. al. 2011), caste (Mohindra et.al 2006; Mukherjee et al., 2011), immunization, mother's age, gender (Kusuma, et.al, 2010, Fatiregun and Okoro 2010) and social structure (Sannerving et. al., 2012).

Half a million women die annually and, in addition, three hundred million in the world suffer from long-term or short-term illness brought about by lack of health care during pregnancy and child birth (UNICEF 2009). India alone accounts for a fifth of the global maternal mortality.

Improving maternal health has been a great challenge in developing countries like India. Since the inception of family planning programme India has made through lower fertility level with varying paces in different states but reproductive health remains unacceptably poor (Visaria et al, 1999).

With large regional disparities in health, Jharkhand needs a special attention as it has maternal mortality of 261 compared to maternal average of 212 per 1 lakh child birth (Ogala et. al., 2012)

Factors affecting Reproductive and Maternal Health

Various factors are responsible for utilization of reproductive and maternal health variables in India, dependent and independent variables which affect the reproductive and maternal health are:

Dependent Variable

Utilization of reproductive and maternal health includes three dependent variables including complete antenatal check-up, institutional delivery and assistance by a trained health professional. There are five main indicators of maternal and child care utilization i.e antenatal care visits, tetanus-toxoid vaccine, receiving of iron/folic acid tablets, place of delivery, assistance during delivery and post-natal care.

Independent Variable

Maternal mortality is highly affected by factors including socioeconomic, cultural and

demographic such as education, employment, religion, residential, household standard of living, availability and quality of care and child birth order etc.

This paper aims on highlighting socioeconomic correlates of maternal and reproductive health utilization and to analyse the factors affecting reproductive and maternal health, in process the paper also analyses role of RCH programme on maternal and reproductive health.

METHODOLOGY

The present study is based on data from 4th National Family Health Survey, 2015-16 (NFHS-IV) and Economic survey of Jharkhand 2020-21 to study socioeconomic correlates of utilization reproductive and maternal health in Jharkhand.

Socio-economic Correlates in Jharkhand

Jharkhand has around 2 percent of the country's population and amounting 33.0 million. There exists a large tribal population, comprising nearly 25 percent of state's population. The population density is 414 (person per sq km).

Health

Status of health is the most important determinant of reproductive and maternal health. Jharkhand is one of the Empowered Action Group State, continues to share a number of characteristics with other backward states of India such as high infant mortality, low immunization of children and expectant mothers, high mortality due to infectious and contagious diseases, high maternal mortality and low institutional delivery. These coupled with poor accessibility to health care facilities and high cost of treatment by households have made all the achievements in health sector insignificant. Despite the National Rural Health Mission (NRHM) and Government's commitment to improve the availability of and access to quality health care by people, especially for those residing in the rural area, the improvement in public health care services in the states has not shown marked improvement in public health indicators.

The crude birth rate in the state is 26.2 per 1000 (SRS, 2007) while the infant mortality rate is 49 (SRS, 2007) and 69 per 1000 live births (NFHS-III, 2005-06). 60 percent of infant deaths are neo-natal deaths. Only 52 percent children are fully immunised (as per CES, 2007) and 35 percent according to NFHS-III. About 78 percent of children were anaemic (NFHS-III, 2005-06) and 59 percent of children below three years of age were underweight.

Maternal mortality was high at 371 per 100,000 live births (SRS, 2003). Around 45 percent women have reproductive health problems and 30 percent women complain of reproductive tract infection. About 70 percent of women in Jharkhand were anaemic and about 30 percent of them were moderately to severely anaemic. According to state government figure among all pregnant women, antenatal care was received by only 38 percent (whereas NFHS-III shows 36%), IFA consumption was 15 percent (NFHS-III) and 50 percent received tetanus toxoid injection. Nearly 80 percent deliveries take place at home. Only 31% of all couple use any modern methods of family planning (NFHS-III). Permanent sterilization particularly female sterilization dominates (23%) and total unmet need for family planning was as high as 24%. Above statistics shows that in almost every health indicators Jharkhand fares poorly.

Table 1: State wise Maternal Mortality Rate in Last Few Years

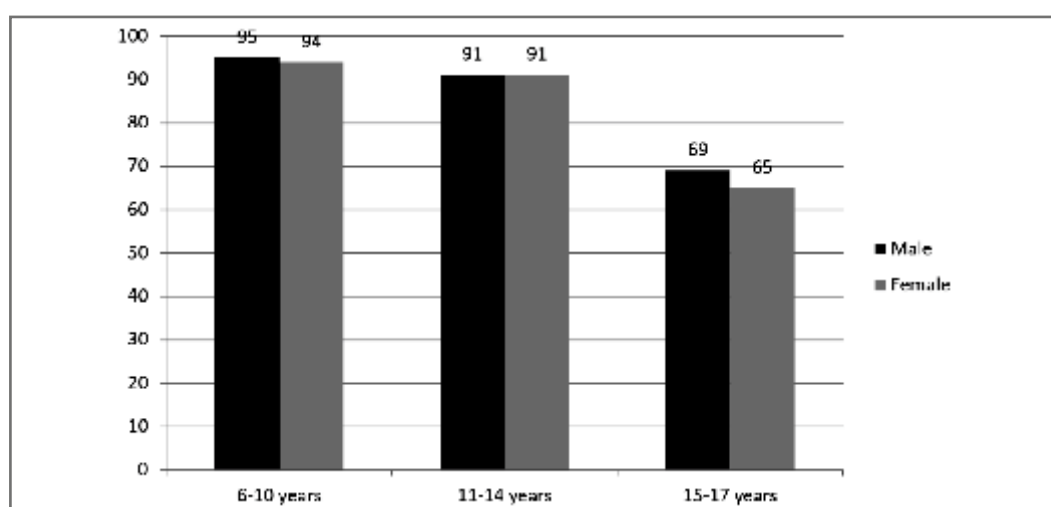
State	Maternal Mortality Ratio		
	2014-16	2015-17	2016-18
Assam	237	229	215
Bihar	165	165	149
Jharkhand		76	71
Madhya Pradesh	173	188	173
Chhatisgarh		141	159
Odisha	180	168	150
Rajasthan	199	186	164
Uttar Pradesh	201	216	197
Uttrakhand		89	99
EAG AND ASSAM TOTAL	188	175	161
Andhra Pradesh	74	74	65
Telangana	81	76	63
Karnataka	108	97	92
Kerala	46	42	43
Tamil Nadu	66	63	60
South Subtotal	77	72	67
Gujrat	91	87	75
Haryana	101	98	91
Maharashtra	61	55	46
Punjab	122	122	129
West Bengal	101	94	98
Other States	96	96	85
Other Subtotal	93	90	83
India	130	122	113

Source: Sample Registration System (SRS) report of Registrar General of India

Education

Education is very important socio-economic determinant in utilization of reproductive and maternal health. The status of women of any civilized society can be judged by the position of women. As per NFHS -4, 84 percent children attend school in the age-group 6-17 years, out of which 87 percent in urban areas and 83 percent in rural areas. Percentage of school attendance drops from 91percent (age group 6-14) to 67 (age group 15-17). There is no gender disparity in school attendance in 6-14 year age group. However in the age group 15-17 years, 65 percent of girls are compared with 69 percent of boys attending school.

Fig.1: Comparison of School Attendance in Jharkhand State



Source: NFHS-4, Jharkhand

Employment

In India, women's unemployment has a multidimensional problem. There are large female job -seekers, unwillingness of the employers to employ women, women's preference of job, discrimination and especially in Jharkhand a highly prejudiced social norms.

According to PLES 2017-18, the Female Labour Force Participation Rate was 10.9 percent in Jharkhand against 50.4 percent of Male Labour Force Participation. In 2018-19 the Labour Force Participation rate increased to 14.3 percent as compared to 51.9 percent Male Labour Force Participation. Increased enrolment in secondary schooling, rising household income and lack of employment opportunities are some reason behind low rate Female Labour Force Participation.

Demographic Indicators

Jharkhand is one of the Empowered Action Group (EAG) states, striving to reduce poverty and demographic indicators to achieve Sustainable Development Goals (SDGs). India

continued to expand and improve its public infrastructure for the health service delivery. The NHP-2002 highlighted the achievements through the years (1951-2002) in the form of demographic characters, health infrastructures, and epidemiological shifts.

Table - 02: Demographic Changes in India through the Years

Indicators	1951	1981	2000	2011-15
Life Expectancy	36.7	54	64.6 (RGI)	68.3
Crude Birth Rate	40.8	33.9 (SRS)	26.9 (99 SRS)	20.4
Crude Death Rate	25	12.5 (SRS)	8.7 (99 SRS)	6.4
Infant Mortality Rate	146	110	70 (99 SRS)	34

Source: Compiled from reports of National Health Policy, of different years.

The expansion in the infrastructure was undertaken to keep the public health service in rural areas keeping in pace with population growth following the norms that the country had adopted for facilities at the various levels. Though concept of primary health care is appropriate in rural areas but it remained sound on paper only. For example in many places health centers were in poor condition. The necessary staffs were not allocated; equipments are may not be in that state to be used, and supplies of inadequate medicines. Specialist has been appointed in few CHCs only and in many places they are working on ad-hoc basis during their due course of training. These things reflected a clear vision of health arrangements in the rural health centers.

Demographic Indicators of Jharkhand

Jharkhand is one of the empowered action group state, continues to share a number of characteristics with other backward states of India such as high infant mortality, low immunization of children and expectant mothers, high mortality due to infectious and contagious diseases, high maternal mortality and low institutional delivery. These coupled with poor accessibility to health care facilities and high cost of treatment by households have made all the achievements in health sector insignificant. Despite the National Rural Health Mission (NRHM) and Government's commitment to improve the availability of and access to quality health care by people, especially for those residing in the rural area, the improvement in public health care services in the states has not shown marked improvement in public health indicators.

Many factors contribute to the poor health status including poverty, poor infrastructure and high morbidity. Poverty associated communicable diseases like tuberculosis and malaria along with maternal mortality and morbidity comprise a major portion of the disease burden.

Table 3: Comparative Chart of Demographic Indicators of Jharkhand and India

Indicators	Jharkhand					India				
	2011-15	2016-20	2021-25	2026-30	2031-35	2011-15	2016-20	2021-25	2026-30	2031-35
Population growthrate	16.4	14.4	12.5	10.7	8.8	12.7	10.7	8.9	7.2	5.7
Crude Birth Rate(CBR)	22.1	20.5	18.8	17.3	15.6	19.6	17.9	16.1	14.4	13
Crude Death Rate(CDR)	5.8	6.1	6.3	6.5	6.8	6.9	7.2	7.2	7.2	7.3
Infant Mortality Rate(IMR)	34	31	28	26	24	42.9	38.5	35.3	32.3	29.7
Under-5 mortality Rate (q5)	49	45	42	38	35	56.7	50.9	46.7	42.8	39.4
Total Fertility Rate (TFR)	2.78	2.46	2.17	1.98	1.87	2.34	2.13	1.93	1.8	1.72
Life expectancy of males	68.4	69.4	70.4	71.2	72	66.87	68.37	69.37	70.37	71.17
Life expectancy of females	69.06	70.56	71.76	72.96	73.96	69.96	71.46	72.66	73.66	74.66

Source: Report of the technical Group on Population Projection

The demographic indicators of the Jharkhand and India have been presented in table 3. The table shows that both India and Jharkhand has improved over the years. However the under-5 mortality rate is still 43 which is higher than SDG of 25 to achieve it by 2030.

ROLE OF RCH PROGRAMME IN REPRODUCTIVE AND MATERNAL HEALTH

Reproductive and Maternal health programme focuses on potential age group. In India, the implications of the reproductive health approach is to shift the focus from the use of family planning as a tool intended essentially for population stabilization, to use family planning as one among a constellation of interventions that would enable women and men to achieve their personal reproductive goals without being subjected to additional burdens of disease and death associated with their reproduction.

Reproductive and Child Health (RCH) is a comprehensive sector wide flagship programme, under the bigger umbrella of the Government of India's, National Rural Health Mission(NRHM)(Now part of National Health Mission), to deliver the RCH targets for reduction of maternal and infant mortality and total fertility rates. RCH program aims to

reduce social and geographical disparities in access to, and utilization of quality reproductive and child health services. Launched in April 2005 in partnership with the state governments, it is consistent with GOI's National Population Policy-2000, The National Health Policy-2001 and the Millennium Development Goals and presently Sustainable Development Goals (SDGs). Deogharia (2011) has examined the gender aspect of RCH programme in Jharkhand and explained its importance is maternal and reproductive health of the State.

World Health Organization (WHO) has defined reproductive health as "within the framework of WHO's definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity; reproductive health addresses the reproductive processes, functions and systems at all state of life. Reproductive health therefore implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decided, if when, and how often to do so. The definition focus on right of men and women to be informed of and to have access to safe, effective, affordable, and acceptable methods of fertility regulation of their choice, and the right to access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couple with the best chance of having a healthy infant."

Essential Components of RCH Programme is

- a) Prevention and management of unwanted pregnancy
- b) Maternal care that includes antenatal, delivery and postpartum services.
- c) Child survival services for newborns and infants
- d) Management of Reproductive Tract Infection(TRIs) and Sexually Transmitted Infections(STIs)

Reproductive and Child Health (RCH) programme was launched by the Government of India (Department of Family Welfare) in October ,1997 all over the country. RCH programme is to provide need-based, demand-driven, High quality health and family welfare services to the mothers and children and to ensure client's satisfaction which needs improving the existing facilities and creating new facilities. Implementation of RCH programme was preceded by historic policy reform undertaken by GOI in 1996-97 which focuses on two basic and most significant initiatives which are

- (a) Decentralized Participatory Planning and
- (b) Bottom-up approach for programme implementation dispensing with decades old target oriented approach for implementing family welfare programme. For better implementation of the programme, it is very important that the perception and attitude towards reproductive health should also change (Deogharia 2011a).

Both the initiative are to be taken care of under the innovative approach called Community Needs Assessment Approach (CNAA). Therefore, under RCH programme building up of an efficient machinery of management particularly for monitoring of progress and evaluation of effectiveness of the programme is treated as one of the most important thrust areas. It is an encouraging fact that there is a permanent system of evaluation of the health care services under the Family Welfare Programme and currently under RCH programme.

In the context of Reproductive and Child Health(RCH) Programme undertaken by the Government of India, the basic needs of health care of tribal women mainly relate to nutritional deficiency, child bearings, reproductive health and hygiene, unwanted pregnancies, abortions, RTIs and HIV. Pregnancy related risk and complications among tribal women in particular and various types of mortalities among the tribal population in general are high. So, this programme is important for tribal dominated areas of Jharkhand.

It is striking feature that though the tribal population in India suffers from high levels of female morbidity and mortality, they do not seek generally medical facilities from health centres. They simply neglect the serious health problems like, RTIs/STDs, menstrual disorders and unwanted pregnancies primarily due to lack of awareness and generally due to lack of accessibility to health facilities proper information and guidance.

NOTES

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