

Social Determinants of Reproductive and Child Health

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Abstract—Improvement in the health status of the population has been one of the major thrust areas for the social development programmes of the country. This was to be achieved through improving the access to and utilization of health services with special focus on under-served and underprivileged segments of the population. Over the last decades, India has built up a vast health infrastructure and manpower at primary, secondary and tertiary care in Government, voluntary and private sectors. The extent of access to and utilization of health care varied substantially between states, districts and different segments of society; this to a large extent, is responsible for substantially differences between states in health indices of the population. Traditionally, health service (both government and private) was perceived as a social responsibility albeit a paid one. Growing commercialization of health care and medical education over the last two decades has eroded this commitment, adversely affecting the quality of care, trust and the rapport between health care seekers and providers. Social factors and determinants have great influence on accessibility and utilization of health care services. Against this backdrop, present paper attempts to examine social determinants and performance of RCH programme in India. The paper is based mainly on secondary data and pertinent literature.

Keywords: Reproductive and Child Health (RCH), Social Determinants, Maternal Healthcare, Healthcare Accessibility, Socioeconomic Factors.

I. INTRODUCTION

It is now well acknowledged that excellent health has a significant role in productivity and economic expansion. Health is given more importance in India, yet the country's healthcare system has several serious issues. Since there is a low starting point for health indicators and pre-transition diseases account for a disproportionately large amount of available morbidity and mortality, rapid gains in health status are achievable. This necessitates greater public investment in health together with comprehensive changes at every level. Only with tremendous political commitment and will can this be accomplished. Decentralizing power, combining preventative, promotive, and curative care, and offering health services to the underprivileged are all necessary components of the states' public health systems' restructuring. A public-private cooperation is seen vital to lessen the burden of health expenditures and to advance community-based measures, such as providing RCH services, comprehensive health education, and counseling.

As combating resistant infections and non-communicable illnesses will surely lead to rising health care expenses, it is expected that bigger investments in health would be required even to maintain the current health status as the country goes through demographic and epidemiological transition. The last two decades have seen a rapid increase in high-priced health care-related technologies as well as expanded diagnostic and therapeutic options. The gap between what is feasible and what is affordable for a person or a nation has grown as a result of growing understanding and rising expectations to attain things. Policymakers

and programme administrators are aware that it is crucial to establish an integrated health system with adequate screening, access controls at various levels, and referral links in order to solve the increasingly complex issue of access to high-quality care at affordable prices. However, the one-to-one strategy continues to be more comfortable for both healthcare providers and patients than the health system approach. Maternal mortality and the level of maternal healthcare obtained are highly positively correlated. The need for screening pregnant women to identify the high risk cases and operationalizing a functional essential and emergency obstetric care was emphasized the .maternal health care, ensuring better antenatal care for women. Only a small minority of women can currently take advantage of hospital delivery services and prenatal care facilities.

II. DETERMINANTS OF RCH

The literature review is crucial to examining the prior research in the topic, highlighting the new areas of investigation, and identifying any gaps in knowledge. Numerous studies have been done on the ideas of illness and recovery, medical procedures, societal changes, dietary state, health seeking behavior, etc. prominent anthropologists, namely. Hasan (1967) makes a distinction between two categories of social and cultural factors that have an impact on a community's health: (a) factors that directly affect the community's health because specific customs, practises, beliefs, values, and religious taboos, among other things, help to create an environment that aids in the spread or control of certain diseases; and (b) factors that indirectly affect the community's health because they are related to the issue of providing medical care to the ill and the influx of In her research, Das (2010) discovered that education had an impact on Santal Tribal Women's reproductive lives in Bangladesh. The results of the current study clearly show that education is positively correlated with the reproductive health of Santal females in the study region of Bangladesh. According to Singh et al. (1986), any treatment involves two people—the healer and the patient—and necessitates the participation of both. Unfortunately, when a medical system has roots in a foreign culture, there is a clash of cultural values that leads to the recipient rejecting the foreign system. In 1982, Bannerji noted how social classes, the rich and impoverished, and rural and urban sections of the nation all had different access to healthcare. The definition of health is relative and is determined by cultural, biological, and ecological considerations. According to Renu Dubos (1968), a population's resistance to disease is crucial for survival, and man's capacity to become well acclimated to an environment is equally necessary for the creation of a healthy state. Appearance of health does not, however, indicate the absence of sickness. The concepts of health and sickness have been significantly advanced by Rives (1924) and Clement (1932). Five fundamental notions of disease—sorcery, breach of taboo object incursion, spirit intrusion, soul loss—had been attempted to be traced by Clement. Other noteworthy research that was published in the 1930s should also be highlighted. Field research on the Ga people was conducted in 1973, when Spencer studied sickness, religion, and social issues on the Fijian island (1941). Numerous investigations on the causation, diagnosis, and treatment of disease have been conducted in the Indian cultural context by numerous scientists, including Gould (1957), Khare (1963), Hasan (1967), Madan (1969), Rizvi (1991), Bhat (1986), and Das, in various communities (1986). Among the Karbis of Assam, beliefs and behaviours around illness and treatment were examined by Moromi Talukdar in 2002. The Karbi are a significant Assamese tribe. This tribe can be found in the Meghalayan hills of Anglong, Nagaon, Kamroop, Sibsagar, and Jayantia. He made an effort to examine several magico-religious practices and beliefs among the Karbis of Assam's Kamroop area, including beliefs and rituals related to disease and its cure, divination, block magic, evil spirits, and evil eyes. He claimed that the cognitive domain of culture is where diseases are identified and treated. He came to the conclusion that most life occurrences, including illnesses, are attributed to a variety of supernatural powers and beings held sacred by the Karbis. This leads them to adore and treat several gods and deities in this manner. Their magico-religious beliefs are evolving as a result of acculturation with the nearby Assamese people in many areas of their lives, but these changes are happening much more slowly than in other areas. The majority of supernatural entities that cause various illnesses and fatalities have anthropomorphic personalities rather than taking the shape of animals or heavenly creatures. Plantain leaf, grammes, earthen lamps, incense sticks, and other items are necessary for their rites. Each rite places a high value on sacrifice. The traditional beliefs of the Karbis have a strong correlation between illness and magico-religious ideas. This can occasionally result in patient carelessness since they prefer to first appease paranormal forces and only turn to the treatment prescribed by doctors as a last resort when a patient's life is in danger. The health situation of the tribal

community in India is extremely bad, according to Salil Basu and Kumari Mitra's article on the subject, "Health Development of Tribal Communities of India." Numerous studies have identified a number of possible contributing factors for the poor health conditions present in this vulnerable population, including widespread poverty, illiteracy, malnutrition, the lack of safe drinking water and sanitary living conditions, inadequate maternal and child health services, and ineffective coverage of national health and nutritional services. In his study on notions of illness and healing among the folk cultures of Uttarakhand, Singh (2002) also looked at concepts of illness and healing among the folk cultures of Uttaranchal State's North-West Himalaya region. He claimed that the idea of disease, its various forms, and how it is treated are all influenced by the local ecosystem. Singh (2003) has conducted extensive research on the U.P. Bhoksa people's population structure and micro differences. He also looked at the changing Mortality trends among them.

III. PERFORMANCE OF RCH PROGRAMME

Under the auspices of the Government of India's (GoI) National Health Mission (NHM), the Reproductive and Child Health (RCH) programme is a comprehensive sector-wide flagship initiative that aims to achieve the RCH targets for lowering maternal and infant mortality as well as total fertility rates. The RCH programme seeks to lessen social and geographic inequalities in the utilization of high-quality services for reproductive, maternal, newborn, child, and adolescent health. RCH, which was launched in April 2005 in collaboration with State governments, is in line with the National Population Policy of India from 2000, the National Health Policy from 2001, and the Millennium Development Goals. Maternal health, child health, nutrition, family planning, adolescent health (AH), and PCPNDT are the six main pillars of the RCH programme. To increase justice, reduce poverty, and enhance social capital, maternal health is essential to the growth of any nation.

In the past two decades, India has achieved incredible strides toward lowering maternal fatalities. Building on the remarkable success of the Janani Shishu Suraksha Karyakram (JSSK), introduced in 2011, gives pregnant women, unwell babies, and infants the right to free birth, including caesarean sections, and free treatment in public health facilities. The National Health Mission's (NHM) child health programme targets variables that contribute to baby and under-five mortality as well as therapies that increase child survival. Improving infant health is essential for increasing child survival since neonatal deaths account for about 57 percent of all fatalities in children under five. In light of the complex relationship between maternal health and the survival of the kid, which is further influenced by the mother's health and adolescent development, it is now widely acknowledged that this issue cannot be handled in a vacuum. The Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) strategic approach, adopted in 2013, places a high priority on newborn and child health. In response to the Global Newborn Action Plan, India Newborn Action Plan (INAP) was introduced on September 18, 2014. The INAP outlines a vision and a strategy for India to stop unnecessary infant deaths, advance the cause, and scale up highly effective yet affordable initiatives. Newborn Care Corners (NBCCs) are being set up at delivery points to give crucial newborn care at birth, while Special Newborn Care Units (SNCUs) and Newborn Stabilization Units (NBSUs) care for un-well babies in these high priority districts' health indicators' worst priority districts.

The survival and wellbeing of both the mother and the child depend on the availability of health care services during pregnancy, labour, and the postpartum period. Antenatal care (ANC) monitors pregnancies and checks for issues to lower the health risks for women and their infants. Labor and delivery problems and infections are less likely to occur when the delivery takes place in a medical setting with expert medical care and sanitary settings. The National Rural Health Mission was established by the government for the years 2005 to 2012 with the goal of enhancing access to high-quality healthcare, particularly for individuals living in rural regions, the poor, women, and children. Providing access to better health care at the household level through female Accredited Social Health Activists (ASHAs), who serve as a bridge between the community and the public health system, was one of the key objectives of the National Rural Health Mission (NRHM). The National Urban Health Mission (NUHM) and the National Rural Health Mission (NRHM) are both sub-missions of the National Health Mission, which was created in 2013.

The RMNCH+A (reproductive, maternal, newborn, child, and adolescent health) approach was introduced at the same time to address the primary causes of mortality in women and children as well as the delays in accessing and making use of healthcare and services. In order to ensure equal attention is paid to all life stages, the RMNCH+A strategic approach was created to provide a knowledge of the "continuum of care." Ninety-four percent of women aged 15 to 49 who gave birth to a live child in the five years prior to the poll reported being pregnant at the time of delivery. With the exception of women aged 35 to 49, women without a high school diploma, and deliveries of order four or more, pregnancy registration rates for all groups are 90% or above. The National Rural Health Mission (NRHM) of the Ministry of Health and Family Welfare and the Integrated Child Development Services (ICDS) programme of the Ministry of Women and Child Development both use the Mother and Child Protection Card (MCP Card) as a tool for informing and educating mothers and families on various aspects of maternal and child care and linking them into a continuum of care. In order to guarantee that the recipient receives the required package of services, the card also documents some of the important services provided to mothers and babies throughout prenatal, delivery, and postoperative care. The card can also be used as a tool for early and exclusive breastfeeding, complementary feeding, growth tracking, and full immunization of infants and children. In the five years prior to the study, 96 percent of women aged 15 to 49 who had a live birth and registered their most recent pregnancy received an MCP Card for that birth. 85 percent of women aged 15 to 49 who gave birth to a live child in the five years prior to the survey had prenatal care from a qualified provider at least once. Doctors provided the bulk of antenatal care for women, followed by nurses, midwives, auxiliary nurse midwives (ANMs), and lady health visitors (LHVs). Between 2015–16 and 2019–2021, 59 percent more women than the recommended four or more ANC visits were made, up from 51 percent in the previous two years. Neonatal tetanus, a leading cause of newborn mortality in many underdeveloped nations, is frequently brought on by a failure to follow hygienic protocols after delivery. An important step toward lowering maternal and neonatal mortality is to increase institutional deliveries. In the five years prior to the survey, 89 percent of live births took place in a medical facility. The most frequent justification for not giving birth in a medical institution was that the mother did not believe that societal influences predominated. The outcome of childbirth and the health of the mother and the baby might be affected by assistance. A qualified staff member can handle pregnancy and delivery difficulties or refer the mother and/or the infant to higher-level treatment. Nearly 90% of live births in the five years prior to the poll were delivered by a trained professional. Most maternal and neonatal deaths take place in the first 24 hours following delivery. Prompt postnatal care is necessary for both the mother and the child to manage issues that emerge after delivery and to give the mother crucial knowledge on how to care for herself and her child. The Ministry of Health and Family Welfare (MoHFW) advises that all women who give birth in a medical facility receive a postnatal health check within the first 24 hours of delivery and that women who give birth outside of a medical facility be referred to one within 12 hours of delivery for a postnatal check. In the five years before to the study, 61 percent of women aged 15 to 49 who gave birth had a postnatal check during the first two days after delivery, according to the 2019–21 NFHS. About 16 percent mothers had no postnatal care. Between 2015–16 and 2019–21, fewer mothers—61 percent—had a postnatal check within the first two days following giving birth, down from 65 percent. When evaluating a child's health for early exposure to childhood morbidity and mortality, birth weight is a crucial indication. A child's risk of dying in their first five years is higher than average if they are under 2.5 kilos at birth. Immunization against diseases that can be prevented by vaccines can significantly lower childhood morbidity and mortality. The child's health card and direct reporting from the mother were used to gather information regarding vaccine coverage. In India, 77 percent of children aged between one and 23 months had gotten all recommended vaccines at some point prior to the study, and 67 percent had done so by the time they were 12 months old. The proportion of kids aged 12-23 months who have had all of their recommended vaccines rose from 62% in 2015–16 to 77% in 2019–21. Infant and child mortality data is pertinent to a demographic analysis of the population and serves as a key barometer of the socioeconomic progress and standard of living of the nation. These estimations can also be used to identify kids who could be more likely to die young and assist develop ways to lower that risk, such encouraging birth spacing. The neonatal mortality rate for the five years preceding the 2019–21 NFHS was 25 fatalities per 1,000 live births. 35 newborn deaths per 1,000 live births represented the infant mortality rate. In the five years prior to the 1992–1993 NFHS survey, the neonatal mortality rate was 49 deaths per 1,000 live births; in the five years prior to the 2019–21 NFHS survey, it was 25 deaths per

1,000 live births. In the five years prior to the 1992–1993 NFHS survey, the infant mortality rate was 79 per 1,000 live births; in the five years prior to the study in 2019–21, it was 35 per 1,000 live births. For both the mother and the infant, nursing should be started as soon as possible. Colostrums, which is extremely nutritious and contains antibodies that shield the infant from illnesses, is found in the first breast milk. Regular breast milk production is made easier by early breastfeeding since it promotes the mother and child's attachment. Therefore, it is advised against prelacteal feeding (i.e., giving babies anything other than breast milk before breast milk is regularly supplied) and that children be put to the breast as soon as possible after birth, preferably within an hour. 96 percent of children born in the two years before to the poll were nursed at some point, the data reveals. Regarding background traits, there are no significant differences. In the two years prior to the poll, 87 percent of infants started breastfeeding within a day of birth, and almost two-fifths of last-born children who had ever breastfed did so within an hour of birth. Prelacteal feeds were given to sixteen percent of the children.

IV. CONCLUSION

India has never had a definite policy for women's and children's health, although a number of policy choices have had an impact on it either directly or indirectly. Family planning programmes were the main emphasis of health policies and programmes, but now that they have a Reproductive and Child Health slant, women's reproductive health is a recognized issue. Women's health, however, goes much beyond just their reproductive and working conditions. Thus, there is an urgent need for a comprehensive policy on women's health as a significant part of the broader National Health Policy. The evaluation of policies and programmes identifies the major planning obstacles that have greater detrimental effects on the health of women. The size and number of services offered by the Indian family welfare programme are among its many strengths, but the program's key weaknesses are its poor service quality and insufficiently large population coverage. Numerous evaluation studies have been done on people's opinions toward the government's strategy of employing contraceptive targets and incentives to reduce fertility. Because they distracted health professionals from providing health care, contraceptive targets were specifically criticized for poor service quality. While the Indian government transitioned to offering a package of reproductive services under the RCH programme, including safe delivery, pre and postnatal care, abortion, treatment for sexually transmitted diseases (STDs) and reproductive tract infections (RTIs), sexual health counseling, and contraceptive services. Some of these services are already offered; others need to be strengthened; and some will be added to the programme in a new way. The service package was intended to be provided through local health planning, which would enhance service quality and boost customer satisfaction. However, in terms of freedom of movement, inheritance rights, control over financial resources, and support from their natal home after marriage, women in the northern states enjoy comparatively little autonomy. Because they are more defenseless and defenseless, women in Uttar Pradesh suffer more from greater fertility and mortality rates. Their lack of information and awareness regarding reproductive health, in addition to their lack of autonomy, are additional variables that affect the standard of treatment they receive and the preventive steps they are able to take. Once more, it is critical to address the administrative limitations and procedural bottlenecks that impede the program's efficient operation. System changes will be needed for this. Therefore, it is anticipated that the current proposed study will deliver the needed database and insights for developing an action plan and policy measures to improve the effectiveness, efficiency, and wider impact of the programme while ensuring participation from the community and the private sector.

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