Rural Reproductive Health– A Study

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Abstract: Maternal health is a key indicator of women's health and status. It is widely recognized fact that the status of women in India with regard to men is particularly low. Women's poor health in India are bound up with social, cultural and economic factors, which exert a negative impact on the health status of women and children. It has been estimated that nearly 45,000 mothers die due to causes related to childbirth every year in India that can be preventable. Majority of the deaths take place in rural areas where there is no adequate health facility. Therefore, this study was conducted to assess the maternal health care of rural women.

Keywords: Antenatal Care, Maternal Health, Maternal Mortality, Maternal Death, WHO.

Introduction

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period (WHO, 2009). Improving maternal health is one of the United Nations Millennium Development Goals (MDGs), with the primary target of reducing the maternal mortality ratio (MMR) by three quarters and achieving universal access to reproductive health by 2015 (United Nation, 2015). It is estimated that globally, approximately 830 women die from complication in pregnancy or childbirth, 99% of the deaths take place in developing countries. The maternal mortality ratio (MMR) in developing countries is 239 per 100,000 live births while the maternal mortality ratio in developed countries is 12 per 100,000 live births. Most of the maternal deaths, which occur in developing countries, are preventable, as many healthcare solutions to prevent, manage and treat the complications are well known (WHO, 2015).

Reducing maternal mortality rates have been the primary focus in developing countries since the late 1980's. The maternal mortality ratio estimates for India decline from 178 in 2012 to 174 per every 100,000 live births in 2015 (WHO, 2015a). Although there has been great progress in India still about five women die every hour in India from complications developed during childbirth (Kaul, 2017). Despite initiating several programmes by the government regarding maternal health care (MCH) in India to reduce maternal mortality still India is lagging behind to fulfill Millenium Development Goal (Gogoi, Unisha & Prusty, 2014). Antenatal care (ANC) is potentially one of the most effective health interventions for preventing maternal mortality and morbidity (Kumar, K.C., S & Jha, 2015). However, the utilization of maternal healthcare services is a complex phenomenon and has been influenced by many factors (Kunal, Shantibala & Manihar Singh, 2016). Various studies show that several underlying factors such as autonomy, access to transport, quality of facilities, incentive-based programs and poverty play important roles in maternal healthcare-seeking (Srivastava et al, 2014).

Review of Literature

Materia et al., (1993) conducted a study on utilization of Maternal and Child Health Services (MCH). In this study researcher conducted household health interview survey in Ethopia. The result revealed that women who lived in 10 km of the health centre in the district capital Robe were more likely to use prenatal services than those who lived in a greater distance. Only 5 percent of women 15-49 years used family planning. The researchers concludes that integration of MCH services including out-reach activities may increase access and coverage of MCH services.

Babalola and Fatusi (2009) conducted a study to assess the use of maternal health services in Nigeria. The study included 2148 women who had a baby. The data was collected by survey method. The result revealed that 60.3% of the mothers used antenatal services, 43.5% had gone for hospital delivery and 41.2%

received postnatal care. The three indicators of maternal child health services are utilizing inadequately. The study concluded that use MCH services knowledge is suboptimal among the women of Nigeria.

Kakati et al., (2016) examined a study on factors associated with the utilization of antenatal care services in rural areas of Johrat district, Assam, India. They have found that out of 300 women 53% were registered during first trimester. Among them 68.7% women had more than three antenatal visits, 90% were immunized with TT and 71.6% had consumed 100 or more IFA tablets. The utilization of antenatal care services were found to be significantly associated with the age of the women , religion, caste, socioeconomic class, place of delivery, mode of delivery and parity.

Arora (2005) while explaining maternal mortality in Indian scenario and its associated problems, stressed the need for a strong and sustained government commitment, favorable policy of environment and well targeted resources as a strategy for improving maternal health. She concluded that the existing health system does not adequately meet the needs of pregnant women, particularly for complications of pregnancy and obstetrical emergencies.

Methodology

The present study has been carried out to analyze the maternal health care of rural women with reference to Marudur village, in Cuddalore District, Tamilnadu. The total population of the village is 1,165. Among them 595 are males, 570 females. The village has one primary health centre. The data pertain only to married women in the reproductive age group of 15-45 years. Out of 332 rural women in their reproductive age group, 120 were selected by using systematic random sampling method. The primary data had been collected through a well structured interview schedule. The collected data had been classified, tabulated and interpreted in terms of simple percentage calculations. The data collection had been carried out during the period of April to June 2016.

Research Findings

The research findings of the study have been summarized as follows.

Table 1 reveals the socio-economic profile of the study area.

Table 1: Socio-economic Profile

Characteristics	Frequency	Percentage
Age (years)		
Less than 18	12	10.0
18-30	87	72.5
31-45	21	17.5
Educational Qualification		
Non-literate	21	17.5
Primary	78	65
Secondary	16	13.3
Post-secondary	5	4.2
Occupation		
Homemakers	92	76.7
Government Employee	7	5.8
Private Sector Employee	2	1.7
Others	19	15.8
Monthly Income (Rs)		
Below 5000	96	80
5000- 10,000	15	12.5
Above 10,000	9	7.5
Religion		
Hindu	112	93.3
Christian	2	1.7
Others	6	5
Family Type		

Joint Family	103	85.8
Nuclear Family	17	14.2

Table 1 indicates the socio-economic profile of the women of the sample village. Among the total 120 respondents, nearly three-fourths (72.5%) of the respondents belong to the age group 18-30 years. While 17.5% and 10% belong to the age group of 31-45 and below 18 years respectively. Nearly two-thirds (65%) of the women completed only primary level of education. In addition, 17.5% of them are non-literate, 13.3% completed secondary education and only 4.2% of them are educated up to the post-secondary level of education. More than three-fourths of the women i.e. 76.7% are homemakers. Other workers constitute 15.8% which comprises of agricultural laborer, weavers, and small-scale business women. The remaining 5.8% and 1.7% of the women are government and private sector employee. Majority of the women i.e. 80% in the study village earn below Rs 5000 while 12.5% and 7.5% earn between Rs 5000-10,000 and a meager percentage of women i.e. 7.5% earn above Rs 10,000. In the study village majority of the women (93.3%) belong to Hindu religion and only a few of them i.e. 1.7% and 5% belong to other religion and Christianity. An overwhelming majority of the respondents i.e. 85.8% belong to a joint family and 14.2% of them belong to a nuclear family.

The following are the various facts revealed when the respondents were asked about their reproductive health care.

The two major female sex hormones in the body are estrogen and progesterone. They are produced in a pair of organs in the abdomen, known as the ovaries. The ovaries start producing large quantities of estrogen when a girl reaches about 12 years of age. This enables her to grow rapidly and develop into a normal young woman. The commencement of menstruation at this time heralds the reproductive phase of her life, when she can have children. The main problems relating to menstrual flow are pre-menstrual tension, painful menstruation, stoppage of menstruation, and excessive menstruation. 43% of the respondents in this study area told they attained puberty at the age of 12-14 years, 32% of them at the age of 14-16 years. 10% and 5% respondents attained puberty below the age of 12 and above the age of 16 respectively. As far as menstrual disorder is concerned 87% of them reply negatively only 13% of them admit that they undergo some irregular periods, excessive bleeding, body ache, etc.

While the respondents were asked the age at which they got married, 58% of them replied that they got married at the age of 15-20 years. It reveals the fact that marriage at early age is quite predominant in rural areas. While 72% respondents gave birth to their first child within a year after their marriage, 28% of them gave birth after 1 year. Obviously most of the respondents are not in favor of postponing the childbirth as they believe that those who have early parenthood are the fortunate ones and that children are the gifts of God. More than half of the respondents i.e. 58% of them have two children, 30% of the respondents have three children. Only 12% of the respondents have only one child and they have the hope of being blessed with another child in the near future. Thus the respondents having two or three children totally constitute 88% of the total respondents.

The following table gives a clear picture of various reproductive health care practices of rural women in this study area.

Table 2: Reproductive Health Care of Rural Women

First Childbirth after Marriage		**No. of Children**		**Health Problem during Pregnancy**		**Type of First Delivery**		**Breast Feeding Practices**		**Birth Space**		**Complications during Pregnancy**		**Contraceptive Method**		**Reproductive Health Problem**	
Period	%	No.	%	Health problem	%	Delivery	%	No.of years	%	Space	%	Complicatio-ns	%	Methods	%	Reproductive health problems	%
Below 1 year	52	1	12	Tooth ache	12	Normal delivery	78	Up to 1 year	54	1 year	56	Prolonged labor	17	Female sterilizati-	16	Menstrual disorder	6

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1-2 years	40	2	58	Swelling of legs	34	C-section	10	1 to 2 years	33	2 year	30	Complicated labor	12	Pill	12	Urinary tract infection	10
Above 2 years	8	3	30	Anemia	37	Forceps	12	Above 2 years	13	Above 2 years	14	Fits	4	Condom	27	Reproduc-tive tract infection	8
-	-	-	-	No major health problems	17	-	-	-	-	-	-	Excessive bleeding	15	Male sterilizati-on	3	No health problem	76
-	-	-	-	-	-	-	-	-	-	-	-	No complication	52	IUD	2	-	-
-	-	-	-	-	-	-	-	-	-	-	-	-	-	None	40	-	-

Due to complications during childbirth, Nearly 45,000 mothers die every year in India. This means that on an average 5 women in India die every hour during childbirth, according to the report from World Health Organization 2016. In this study area 52% women did not face any major complications during delivery. While 17% of the respondents suffered from prolonged labor, 15% of them from excessive bleeding which is followed by complicated labor 12% and fits 4% respectively. As far as delivery is concerned 78% of the respondents had normal delivery, forceps was used in the case of 12% of the respondents, and 10% of the respondents underwent C-section due to complications during delivery. Women experienced most of these problems and complications only during their first delivery.

Table 2 indicates that 24% of the respondents had suffered from severe reproductive health problems like urinary tract infection, reproductive tract infection and menstrual disorder. As far as the general health problems during pregnancy is concerned 37% of them suffered from anemia, 34% of them from swelling of legs and 12% of them from tooth ache. 17% of the respondents told that they had suffered from minor health problems like drowsiness and vomiting sensation.

Awareness of breastfeeding is one of the major requirements of child rearing practices today as it not only increases the immunization capacity of children but also safeguards the health of mothers in a number of ways such as increasing birth space between children, preventing breast cancer, etc. Irrespective of their awareness rural women tend to practice breastfeeding for a longer period of time. While 54% of the respondents in this study area breastfed their babies up to 1 year, 33% and 13% of the respondents' breastfed their babies up to 2 years and above 2 years respectively.

Immediate breastfeeding after childbirth is often insisted by doctors as it increases the immunization capacity of children. While 67% of the respondents practiced it, 33% of the respondents did not do so. May be they might not be well informed about the necessity of immediate breastfeeding.

The birth space is another important factor that affects the health of rural women. More than half of the respondents i.e. 56% of them have minimum of 1 year birth space, 30% and 14% of the respondents have 2 years and more than 2 years space between childbirths respectively.

The choice of contraceptive methods by couples for fertility control is one of the central issues concerning the reproductive rights and reproductive health of women. Out of 120 respondents in our study area, only 60% use contraceptive method for birth control. Out of 60% only 16% women had sterilization. However, condom, IUD and pill are the other contraceptive methods used by 12%, 27%, 2% of the respondents respectively 3% of them have reported that their husbands had undergone sterilization for birth control.

Abortion is the least considered option by the rural women to curtail the childbirth while 89 respondents never opted for abortion; only 11% of them cared for abortion. Abortion by folk medicine is preferred by rural women as they are cost effective and not time consuming.

Antenatal care is the systematic medical supervision of women during pregnancy. Its aim is to preserve the physiological aspect of pregnancy and labor and to prevent or detect, as early as possible, all that is pathological. Early diagnosis during pregnancy can prevent maternal ill health, injury, maternal mortality, fetal death, infant mortality and morbidity. Hence the earlier in pregnancy a woman comes under the supervision of an obstetrician, the better. When the respondents were asked whether they had proper antenatal care like administration of recommended vaccines (three doses of a vaccine containing tetanus and diphtheria toxoids) 78% of them replied positively, only 22% of them said that they did not have enough antenatal check-up during the last childbirth due to several reasons ranging from lack of awareness, family circumstances, lack of time and money etc., It clearly indicates that women still need to be better informed about the benefits of antenatal check-ups.

Just as pregnancy is a time of transition, so is the postnatal period. New mothers should know how to adjust to this transition and be fit for the upcoming demands of motherhood; and receive information pertinent to mothers. In this study area, two-thirds of the respondents went for post-natal care as prescribed by the doctors after the delivery and one-third of the respondents did not care for post-natal care as they had not come across any significant health problems after the childbirth.

Although the literacy levels in the country have risen substantially in the last few decades, the knowledge about certain issues is woefully lacking. According to a recent report by the National Family Health Survey (NFHS), more than 40% of women in India have not heard of AIDS. Awareness was found to be especially low in the rural areas and among less educated women. The study found out that awareness increased with an increase in the level of education of women. 83% of the respondents do not have knowledge about HIV/AIDS; only 17% of the respondents have some knowledge about HIV/AIDS disease. When the respondents are asked about their awareness of breast cancer, 13% of them replied positively and 87% of them negatively. Uterus cancer is the second most common cancer in women after breast cancer. It is most common between the ages of 40-50 years, and the risk increases with age. Among the respondents 8% know somehow or other about uterus cancer while 92% of them denied any awareness of this disease.

The study indicates the fact that empowerment of rural women has a long way to go as nearly three-fourth of the respondents (78%) replied negatively, when they were asked about their participation in household decisions. Only 22% of them gave positive reply. Moreover, almost all the respondents experience domestic violence either in the form of emotional and sexual violence.

Conclusion

The overall analysis reveals that the majority of rural women are aware of the importance of breastfeeding, usage of contraceptive methods, prenatal and postnatal care, etc. However their knowledge about HIV, breast cancer, uterus cancer, and the time of space between childbirth etc., is comparatively low which needs to be improved. The study also reveals the pathetic condition of respondents as far as their status in the families is concerned. They are still being subject to domestic violence, participate less in household decisions, etc., for which economic dependence is the major cause.

Recommendations

While an impressive array of programmes exist in India to improve maternal health, in practice the focus has been on sterilization, and the reproductive health care of women has been relatively neglected. Programmes suffer from poor outreach, quality of services and care, and an inability to adapt services and messages to the cultural milieu of their beneficiaries. In this regard the following recommendations have been proposed to improve the overall maternal health of rural women.

- Women need to be educated regarding the symptoms and consequences of reproductive health problems and there is the need to expand counseling and reproductive health services in rural areas particularly through the public sector. If left untreated, reproductive tract infections can cause pregnancy related complications congenital infections, infertility and chronic pain. They are also risk factors for pelvic inflammatory diseases and HIV.
- Pregnant women and their families should be trained to recognize life-threatening complications of labor and delivery so that treatment could be sought at health care centers at the earliest.

- As nearly 20 to 60 percent of births in rural areas are unintended, either unwanted or mistimed, rural women need access to a range of contraceptive choices as well as high quality information and services.
- Majority of rural women have never heard of AIDS. Even among those who have heard of the disease, there were many misconceptions about modes of transmission. They could benefit from a strengthened national HIV/AIDS educational programmes and intervention programme targeting rural women.
- As women's education is strongly related to reproductive health care, empowering them in the educational sector will go a long way in improving the overall maternal health care of rural women.
- Laws related to domestic violence should be strictly enforced as more and more research studies indicate that acceptance and experience of domestic violence has adverse consequences on women's health.
- Health promotion via mass media, health education in schools, community based intervention programme, legal sanctions against marriages at young ages are other strategies to achieve the objective of maternal health care.

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