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A Systematic Review ofthe Maternal and Child Health System in India

Ms. CharulChhokra

Abstract:*The study investigates "the prevalence and causes related to the use of maternal and child health services by married young women in India". Results "indicate that the use of maternal and newborn health facilities by teenage women in India is far from adequate. A little over 10% of young women used antenatal treatment, about 50% used healthy contraceptive services, and about 41% children received complete immunization". Major disparities have arisen in urban-rural residency due to some factors such as "educational qualifications, gender roles, economic conditions etc., whicharealso the main determinants of the use of maternal and child health services". Health care services should focus primarily on teaching young women, offering financial assistance, increasing awareness and giving guidance to married adolescent couples. In addition, sufficient financial support for the birth and care of married women under the age of 19 should be given to strengthen the maternal and newborn health system in India.*

Keywords: *Maternal health, child health, adolescent women, antenatal care, women's education*

1. Introduction

The determinants of utilization of antenatal care treatment in India have also given rise to significant interest in social, economic, and public health literature, but comparatively little attention has been paid to the education of early teenage mothers and infants. Despite major improvements in the Indian public health system, the rate of early adolescent deaths (due to pregnancy or birth) in the overall maternal mortality remains at 10% (Government of India, 2009). "Several studies have shown that, on average, the child mortality rate of teenage mothers is around 50 % higher than that of mothers in their twenties.""Out of approximately 16 million young girls aged 15-19 giving birth,almost 95% of these births take place in the developing world (WHO,2008)". The increased occurrence of such cases of low age mothers has many adverse effects, in particular low birth weight, prematureness, and increased rate of neonatal, post-neonatal and children's mortality and morbidity, which are continuously related to these births. This link between early birth and health outcomes can contribute to the deathof women in the 15-19 years age-group. Interventionsareneeded for urgent recognition of the possible risk factors for teenage mothers and their babies, in particular in India, where more than one-third of all the child and perinatal fatality occurs,among the South Asian countries. Mortality rates are influenced by a number of social and political influences, such as the role of women in the family and social environments, the economic and educational position, the environment of health criteria (availability of health facilities and equipment). Several studies have found that the key factors of adverse health consequences for teenage pregnancy are mostly underestimated and are psychologically deficient, contributing to the poor maternal and infant outcomes. Girls are also more likely to become teenage mothers in situations of economic problems or in case of having single parents.

Freelance Researcher, Email: Charul.chhokra@gmail.com

2. Objectives of the study

This study aims:

To explore various literature to understand the maternal and child health system in India.

To find out various factors which influence the maternal and child health system in India.

3. Research Methodology

Keyword searches were used to classify recently written articles based on the context of the study from specified repositories such as researchgate.net and ProQuest. The author used keywords such as maternal health, child health, adolescent women, antenatal care, women's education etc. The search culminated large number of related articles based on the context of the study. Then the author had chosen the most relevant articles for an intensive review analysis.

4. Review of Literature

Maternity care and child education and welfare in India need to be addressedproactively.With a population of more than 1 billion, India faces many obstacles in improving the health and well-being of its people. Birth, maternal, infant and child mortality and the incidence of significant dietary shortages have gradually declined, but the rateshave stayed poor and below the national and the Millennium Development Targets. Potential causes include socio-economic inequalities, differences in health services between nations and populations, and the effects of urbanization and demographic change. In 2005, India embarked on an ambitious plan to strengthen the health quality with the introduction of the 'National Rural Health Programme'. However, the breadth of the goal interventions remains incomplete and the design and feasibility of the existing efforts are sub-optimal. There is also a major unaddressed need for contraception, underage pregnancy is common and access to legal abortion is inadequate. A significant increase in the number of births in hospitals has not been balanced by a rise in the level of obstetric and neonatal services. Young children may not be provided with the preventive services they need; there is no change of access to effective medications for neonatal cancer, diarrhoea and pneumonia; and there is a lack of funding for various school programmes. Absence ofawell-functioning health care system includes gaps in planning, funding, human capital, infrastructure, procurement networks, administration, information and surveillance. These advocate for a transformation of the health services by political stewardship, community participation and a systemic approach to funding that impacts the needsofthehealth care.An effective strategy should be adopted to increase mass-awareness and improve the wellbeing of the target population. Study of evidence-based child feeding programmes should be focused upon. This programme calls for the highest degree of political participation and expansion of the people's movement.

Singh et al.(2012)found in their study alittle over 10 per cent of pregnant women used antenataltreatment, about 50 per cent used secure delivery facilities and about 41 per cent of children received complete immunisation. Women's income, capital quintiles and regions are the major factors influencing the use of "maternal and child health services". Health care services should concentrate more on training teenagers, offering financial assistance, increasing awareness and advising households of married teen women, the authors add. The research was centred on the third round of the National Family Health Survey (2005-06).

Goli et al.(2013)stated "women and children are sensitive groups in terms of wellbeing and are significantly impacted by the effects of economic inequality across multidimensional networks. Urban areas are expected to have stronger socio-

economic and maternal and child welfare indicators than the rural areas". Findings suggest that "illiteracy among women and their husbands, low economic status and lower access to mass media are the main mechanisms by which external effects on maternal and child health disparities in urban India work. The study concludes that the various factors found have explained high gaps in maternal and child urban health in India".

Sarin & Lunsford (2017) described ASHAs as professional health workers who are responsible for the preservation of wellbeing in their communities and for connecting them to the health care system. Their research explores the socio-economic, cultural and structural factors that either promote or obstruct the capacity of ASHAs to provide quality services.

They discuss possible strategies for strengthening ASHA 's capability, such as increased understanding of social, cultural and gender standards, strengthened leadership skills, and awareness-raising, and advocacy of the work with health authorities and state officials.They find that while the work of ASHAs has contributed to some positive improvements in the wellbeing of the population, giving them a sense of self-esteem and inspiration, behaviours and policies in the health care system have restricted their ability.

Sharma et al. (2016)found that the "Health Information Management System (HMIS) records for the Maternal and Child Health (MCH) services at the sub-center level in the state of Haryana are satisfactory in terms of comprehensiveness. However, there have been substantial differences in the recorded and calculated provision of MCH facilities. The HMIS quality has to be improved to make it applicable to the planning and review of public health programmes".

Balakrishnan et al.(2016)stated mobile phone technology is being used to enhance the quality of healthcare facilities worldwide. Mobile phones are now widely available in low and middle-income countries. It is also increasingly common in these countries to exploit applications for mHealth in the healthcare field. A measure of the efficacy of the mHealth System network of care facilities in improving the delivery of child and perinatal health services in the district of Bihar was studied and the result of the study has a positive impact on the child and perinatal health services.

Prakash & Kumar (2013)compared the use of voting in the maternal and child health facilitiesamong urban poor and non-poor in Bharat and through elected Indian states. The economic status of families has been a significant obstacle to the utilization of health facilities within the Indian population. Results indicate that maternal and child health measures among the urban poor are much worse than their non-poor counterparts, especially the socio-economic ones.

Thomsen et al.(2011) stated that in many nations, maternal and infantmortality rates stay intolerably high. Few nations have created substantial strides in reducing maternity and childbearing mortality rates at thenational level. However, at the sub-national level, most countries have broad inequalities in health indices that don't seem to be typically expressed in the national statistics. This is often an emblem of unequal access to and provision of health care. However, no focus has been given to health justice with reference to the Millennium Development Goals. Instead, countries have focused on striking individual goals. This has contributed to the stress on utilitarian, instead of practical, public policy methods that they're addressing here. They propose a policy of "proportional religious doctrine." Universal health care and comprehensive policy are the main objectives of this strategy; however, intermediate measures are administrated in proportion to the disadvantage of the severity. They also briefly discuss an attempt geared towards encouraging evidence-based methods and initiatives that may minimise inequity of access to maternal and child health care of China, India, Dutch East Indies and Vietnam.

5. Conclusion

There are some important results from this report. “The first is that the health status of the urban poor mothers and their children in India or in the sample countries selected remains dismal. The condition is more volatile in those countries where the rate of urbanization is very high. Previous studies have found that urban poor people have less access to resources than rich people, making them more vulnerable than their peers in the wealthier areas”.These findings bring “attention to the need to increase the standard of healthcare in the country. Like earlier research, this paper highlights the importance of controlling private health facilities in India, especially in the urban areas, to meet the fundamental needs of maternal health, especially for the poor women”. Looking at India's restlessness, unwillingness to schedule, insufficient public health services, uncontrolled private health facilities, it is evident that these add to the worsening of the pregnancy outcomes and increase the financial distress of the households at large, particularly the poor ones.

Reference

[1] Balakrishnan, R., Gopichandran, V., Chaturvedi, S., Chatterjee, R., Mahapatra, T., & Chaudhuri, I. (2016). Continuum of Care Services for Maternal and Child Health using mobile technology–a health system strengthening strategy in low and middle-income countries. BMC Medical Informatics and Decision Making, 16(1), 84.

[2] Goli, S., Doshi, R., & Perianayagam, A. (2013). Pathways of economic inequalities in maternal and child health in urban India: a decomposition analysis. PloS One, 8(3), e58573.

[3] Prakash, R., & Kumar, A. (2013). Urban poverty and utilization of maternal and child health care services in India. J Biosoc Sci, 45(4), 433–449.

[4] Sarin, E., & Lunsford, S. S. (2017). How female community health workers navigate work challenges and why there are still gaps in their performance: a look at female community health workers in maternal and child health in two Indian districts through a reciprocal determinism framework. Human Resources for Health, 15(1), 1–10.

[5] Sharma, A., Rana, S. K., Prinja, S., & Kumar, R. (2016). Quality of health management information system for maternal & child health care in Haryana state, India. PLoS One, 11(2), e0148449.

[6] Singh, L., Rai, R. K., & Singh, P. K. (2012). Assessing the utilization of maternal and child health care among married adolescent women: evidence from India. Journal of Biosocial Science, 44(1), 1.

[7] Thomsen, S., Hoa, D. T. P., Målqvist, M., Sanneving, L., Saxena, D., Tana, S., Yuan, B., & Byass, P. (2011). Promoting equity to achieve maternal and child health. Reproductive Health Matters, 19(38), 176–182.