Review Article

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MATERNAL HEALTH SITUATION IN UTTAR PRADESH, INDIA

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ABSTRACT

Health of children and their mothers is a vital aspect of a society's long-term development. Unfortunately, around half of all mothers and over 10 million children die due to preventable causes. Data from a current National Family Health survey (NFHS) was utilized and compared with the previous data of the surveys conducted at national level. The maternal mortality ratio in India has decreased to 113 per 100,000 live births, according to a report released by the WHO. Only 51.6% women reported three or more ANC visits where anaemia is still found among 35.4% women. Although 88% of women delivered in a health facility whereas only 5 7.5 % mothers received postnatal care within two months. The Maternal Mortality Ratio (MMR) in Uttar Pradesh is remains high due to a lack of utilisation of available maternal and child health services, putting the health of mother and children at risk. Hence, to improve the health status, evidence-based policies with grass root level programme planning are required**.**

KEYWORDS: Maternal Health, Antenatal care, Post - natal care, Utilisation.

INTRODUCTION

India is the third most dangerous country for women. According to the WHO, it contributes about 136,000 maternal deaths globally each year. Fertility and maternal mortality rates are high in Uttar Pradesh and Rajasthan while in Kerala and Tamil Nadu, rates are equivalent to middle-income nations. It has been seen that India's geography and culture diversity are some of the contributing factors to its diversity. Except in the southern and eastern states, women's position in India is generally low. Only 54% of women are literate, and they lack the authority to make decisions, including whether or not to use reproductive health care. This study aims to highlight various aspects of maternal and child health in India. It also aims to highlight the impact of various national safe motherhood programs. Also, it analyzes the pattern of Health care system at various level comprising the recent national health and family welfare program.

MATERIALS AND METHODS

A review of the literature, secondary analysis of data, and a study of key institutional factors were used to gather relevant information. National Family Health Surveys (NFHSs) and District Level Household Survey data were also used (DLHS). National government documents/website were used to gather data related to the infrastructure and available manpower in the health sector. The methods and implementation of safe motherhood programmes, including previous strategies and programme, were examined in order to focus on the emerging issues associated with low utilisation of the services.

MATERNAL MORTALITY RATE

As per the report of the Health Surveys and Development Committee, 2,000 maternal deaths were observed per 100,000 live births in India . Afterwards, In 1959, the Mudaliar Committee calculated that the MMR had dropped to 1,000 per 100,000 live birth.The decline in MMR was attributed by a fall in the incidence of malaria, which was assumed to be a contributing factor in MMR as pregnant women with co-morbidity like malaria had a higher mortality rate. The study, which was conducted in 1984-1985, estimated that there were around 798 maternal deaths in Ananthapur district during that period.

According to the report of Sample Registration System (SRS), Maternal Mortality Ratio (MMR) in India has decreased from 130 in SRS 2014-16 to 122 in SRS 2015-17 and to 113 per 100,000 live births in SRS 2016-18, while it is 197 per 100.00 live births in Uttar Pradesh. MMR in Assam is 237, which is the highest among all states, whereas MMR in Kerela is the lowest.

Country /State	(2014-15)	(2015-17)	2018
India	130	122	113
Uttar Pradesh	201	216	197
Assam	237	229	215
Kerela	46	42	43

Table 1: State Wise Variation in MMR Per 100,000 Live Births As Per Sample Registration System

Causes of maternal mortality

According to a recent study (Fig. 1), India is home to the world's largest number of maternal deaths caused by haemorrhage. The study found that this devastating illness is responsible for 38% of all deaths related to maternal cause in India. Anaemia was regarded as the most common cause of death among the women in our country. It is estimated that 60% of pregnant women experience this illness. (Table 2). The large proportion of home deliveries are the main cause of deaths from sepsis and obstructed labour. Despite India's liberal abortion laws, abortion-related complications are estimated to account for 8% of all maternal deaths.

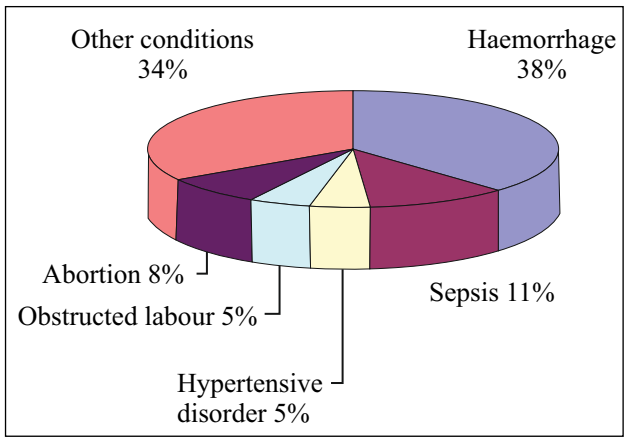

Fig. 1: Causes of Maternal Deaths in India, 2003 (14)

Utilisation of maternal health services

The maternal healthcare indices have gradually improved from the time of the first NFHS in 1992 to the fourth NFHS (2016). Table 2 shows that institutional deliveries have increased from 15.2 percent to 88 percent, with 88.6 percent of women having their babies in hospitals. These figures show that, despite the various national safe motherhood programs, most women still receive only a few hours of care after their babies are born. These numbers are still under the general development stage.

Data shows that, the prevalence of anaemia rose to 51.6 percent between 1998-2006 and then dropped to 35.4 percent in 2015-16. Despite the fact that antenatal check-up coverage increased by up to 50%. Table 3 manifest the increase in the percentage of women who received Iron and folic acid (IFA) pills for preventing anaemia during antenatal appointments. In 2016, the majority of institutional deliveries were made to public institutions. More women are relying on doctors for their deliveries as a result of 'increased assistance by a health professional, In 2015-16, about 88.6 percent of women sought assistance from health care workers for birth, up from 27.2 percent in 1999 and nearly 51 percent of women are using family planning methods. (See Table 3) Despite the government's emphasis on antenatal care, over half of pregnant women are still not attended three antenatal visits, and a quarter do not obtain prophylaxis for the tetanus.

Indicator	NFHS (1998-1999)	NFHS (2005-2006)	NFHS (2015-16)
Pregnant women with anemia	45.8	51.6	35.4
Three antenatal check-ups	14.6	26.3	51.6
Institutional Deliveries	15.2	22	88
Deliveries assisted by health personal	21.8	29.2	88.6
Mothers who got postnatal care within the first two months following their child's birth	Data not available	14.3	57.5

Table 2: Maternal Health Indicators (%) in Uttar Pradesh as Per National Family Heath Survey (NFHS)

Indicator	NFHS (1999)	NFHS (2006)	NFHS (2016)
Coverage of maternal health services			
Tetanus toxoid injection	67	76	92
Completed antenatal care visits	14.6	26.3	51
Received IFA tablets	NA	8.7	18

Table 3: Improvement in the Utilisation Rate (%) of Maternal Health Services in Uttar Pradesh

Institutional deliveries in public sector	16	22	51.6
Assistance obtain during delivery by health workers	21.8	29.2	88.6
Use of family planning methods	27.2	43	51.6

Cont. Table 3: Improvement in the Utilisation Rate (%) of Maternal Health Services in Uttar Pradesh

Maternal health care-delivery system In India

Since independence, India has prioritized rural healthcare. Despite the fact that many people residing in rural areas still do not have proper access to healthcare services Hence the government has built a three-tier system from the grass root level through sub centres up to a tertiary level with proper referral system in order to achieve a goal of 'Health for all'.

Rural health services were gradually developed after independence in 1947, with primary health centres servicing a population of 30,000 people in plain and 20000 in hilly and tribal areas. To provide maternal health care, trained nurses-midwifes were placed under hospitals or PHCs to deliver basic medical services. Temporary workers were also recruited and trained to provide these services.

A committee headed by A Shetty suggested that auxiliary nurses be trained to do certain tasks that they were not trained to do. Various other committees have also advocated the establishment of auxiliary healthcare units. The ANM started as a midwife providing public health services in 1960. Eventually, they became full-time employees of the health system. In 1975, ANM became a multipurpose health worker. This was carried out following the advice of the Kartar Singh Committee. In 1977, a policy modification was made that incorporated maternal and child health into family planning which deprives the quality of ANMs' training and practice throughout the country. In 1977, the ANM programme was reduced to 18 months. This was because of government pressure. The public's perception of ANMs also shifted during this period. Concept of health is changing from the comprehensive health care to primary health care following the conference at Alma Ata which is accepted almost by all the countries as the key to achieve the goal of Health for all. Maternal and child health care services including the family planning services is one of the main element of primary health care.

Health care delivery system in India is operated at the national/central, state, and local level or peripheral level. There are three official organs at centre level viz the Ministry Of Health and Family Welfare which has two divisions known as the Department of Family Welfare which is responsible for the various aspects of healthcare, such as primary healthcare, family planning, and reproductive health and the Department of Health. Directorate general of health services(CGHS) and the central council of health and family welfare are the other two organs at central level responsible for implementation of national health and family welfare programmes.

Child survival and safe motherhood (CSSM), prevention and management of RTI and STD like AIDS and family planning are the various component of reproductive and child health (RCH) programme phase I while the essential obstetrical care, Emergency obstetrical care and Strengthening referral system along with various innovative schemes are the components of RCH phase II. Janani Surkasha Yojna (JSY) is a modified National maternity benefit scheme launched on 12 April 2005 which aims to promote institutional deliveries among women in below poverty line families thereby reducing the infant mortality rate. Cash assistance for post-delivery care is also being provided to the women.

CONCLUSION

On the socioeconomic front, India has made remarkable progress, but the progress made in improving maternal health has been gradual. Despite the various safe child and motherhood initiatives, the availability of adequate antenatal care services remains a challenge for women wanting to have a child. In India, the MMR is approximately 113, and it is still high in Uttar Pradesh and Assam. Now the challenge is how to make our safe motherhood programmes more successful in future.Hence the focus of policies and programmes should be on evidence-based strategies with more focus on grass root level programme planning.

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