International Journal For Advanced Research In Science & Technology
A peer reviewed international journal
www.ijarst.in
ISSN: 2457-0362

A STUDY OF WOMEN REPRODUCTIVE HEALTH PRACTICES AND HEALTH CHECKS FOR NEW-BORNS

CANDIDATE NAME = SAHIN KHAN
DESIGNATION = RESEARCH SCHOLAR SUNRISE UNIVERSITY ALWAR
GUIDE NAME= DR. AMIT KUMAR
DESIGNATION= ASSOCIATE PROFESSOR
SUNRISE UNIVERSITY ALWAR

ABSTRACT

Women's health is of paramount importance since they are the backbone of society and the home. One of the primary goals of these initiatives is to promote reproductive health by raising public awareness about reproductive issues and helping individuals access the resources they need to create a more fertile and stable society. The preceding talk paints a vivid picture of why women's reproductive health is so crucial. Indicators used to assess women's health in India vary by region, socioeconomic status, and cultural norms. Improving women's health in India will need looking at their situation from several angles, including how they compare to males in India and how they do internationally. Human prosperity and economic expansion both benefit from improvements in health. The current state of women's health in India has a direct impact on the country's GDP. The state of a population's reproductive health is foundational to its social, economic, and individual development. Because people's vitality and imagination are what ultimately propel progress forward, ensuring that they enjoy the best possible health is not just a moral obligation but also a social and economic imperative. Since a result, a healthy and active population becomes a precondition for social and economic progress, since ill and tired individuals are unable to create such energy and inventiveness.

KEYWORDS: Women Reproductive, Prenatal care, Health Practices, Health Checks, New-Borns.

INTRODUCTION

Prenatal care, labor and delivery, and postpartum care are all crucial to the health of the mother and the newborn. Antenatal care (ANC) aims to prevent health risks for both women and their newborns by keeping tabs on pregnancies and screening for potential issues. Medical expertise and clean surroundings in the hospital may lessen the likelihood of difficulties during labor and prevent infections at the moment of birth.

To improve the availability and quality of excellent health for persons living in rural regions, particularly the poor, women, and children, the Government of India has launched the National Rural Health Mission. Improved health care for women in the home is a major focus of the National Rural Health Mission (NRHM), and ASHAs, who serve as a link between the public and the community, play a key role in this effort. On May 1, 2013, the National Urban Health Mission (NUHM) was officially recognized as a sub-mission of the NHM. RMNCH+A (reproductive, maternal, newborn, child, and adolescent health) is an initiative designed to reduce maternal and child mortality by improving women's and children's access to and use

of health care and related services. A 'continuum of care' is maintained via the implementation of this strategic strategy by giving equal weight to different phases of life.

Indian researchers recently conducted a National Family Health Survey in 2015 and 2016; the results provided a ranking of the country's current reproductive health practices across categories including antenatal care (ANC) utilization, delivery setting, labor and delivery support, cesarean rate, and prenatal and postnatal care cost.

TIMING AND NUMBER OF ANC VISITS

About half of pregnant women (51%) have had at least four ANC visits during their most recent pregnancy, with 17% of women having had to miss ANC appointments due to scheduling conflicts. Women in urban areas are more likely to take an interest in their children than women in rural areas, with 66% of urban women and 45% of rural women having visited an ANC more than four times.

The majority of women (59%), however, make their initial ANC visit before the end of the first trimester. Eighteen percent of pregnant women go to the ANC for the first time during months four and five. In the sixth month of pregnancy, just 7% of expecting mothers used ANC services. All pregnant women who have had at least one ANC visit had a median gestational age of 3.5 months at their initial appointment. In the United States, 51.2% of pregnant women had attended at least four ANC visits in the past. Bihar has the lowest percentage (14%), while Kerala and the Andaman and Nicobar Islands have the highest (90%), and Tamil Nadu has the third-highest (81.2%).

From 37% in 2005-06 to 51% in 2015-16, more women are meeting the ANC recommendation of four or more visits. The percentage of women who got ANC during the first trimester has grown from 44% to 59% throughout the same time period.

COMPONENTS OF ANC VISITS

Women who have gotten ANC in India for their most recent live delivery during the last five years have had their weight assessed, blood and urine samples obtained, abdomen inspected, and blood pressure checked in 87-91% of cases. The duration of labor (50%) and the prevalence of severe abdominal pain and high blood pressure during pregnancy (both 52%) are the most common pregnancy problems for which data has been obtained from women. Sixty-seven percent have been given information on where to go if they have issues during pregnancy. Over the previous five years, 78% of pregnant women have received or bought iron and folic acid (IFA) pills, but only 30% of those women took the tablets for at least 100 days throughout their pregnancy. During pregnancy, just 18% of women used a medication to prevent intestinal parasites.

SKILLED ASSISTANCE DURING DELIVERY

Help during labor and delivery may have an effect on the health of both the mother and the newborn. In the event of issues during pregnancy or delivery, a skilled assistant may take care of the situation or refer the mother and/or child to the next level of care. Eight in ten newborns (81%) in the five years before to the study were reported to have been attended by a medical professional. Doctors have attended 56% of births, followed by ANMs

(25%), nurses (25%), midwives (25%), LHVs (25%), and dais (TBAs) (11%).

Trends: Deliveries in India are now far more likely to be attended by a trained provider, with the percentage of births attended by such a person rising from 47% in 2005-06 to 81% in 2015-16.

Patterns by background characteristics

A trained attendant was present for 93% of deliveries to moms who had four or more ANC visits, but only 60% of births to mothers who had no ANC visits.

A professional provider was present for just 19% of deliveries that took place in the woman's own home.

Women in urban regions are more likely to have their babies delivered by a medical professional (90%) than those in rural ones (78%).

Skilled birth is far more likely when mothers have completed at least some college. The percentage of deliveries when a competent attendant was present was 95% for moms with 12 or more years of education and 66% for mothers with no training.

Sixty-four percent of women in the lowest income quintile had a skilled birth attendant, whereas ninety-six percent of women in the highest wealth quintile did.

DELIVERY BY CAESAREAN SECTION

Maternal and infant mortality, as well as complications like obstetric fistula, may be reduced by increasing access to caesarean section (C-section). However, a woman's health might be negatively impacted in the short and long term if a caesarean section is performed for no good reason. The World Health Organization recommends only performing caesarean sections when absolutely required and does not recommend a population-level goal rate for nations to achieve.

In the last five years, 17% of live births were recorded by the NFHS as being delivered through caesarean section. 45 percent of C-sections are planned after the first signs of labor begin, while 55 percent are scheduled beforehand.

The trend of C-sections having doubled from 9% in 2005-06 to 17% in 2015-16 is clear.

Patterns by background characteristics

Caesarean sections are more prevalent among first births (24%) than among higher-order births (2%-16%).

The percentage of births that are delivered through cesarean section has increased from 28% in 2005-06 to 41% in private sector health institutions.

In metropolitan regions, the rate of caesarean sections is 28 percent, compared to 13 percent in rural areas.

Women with higher levels of education are more likely to want cesarean sections. Women who have completed 12 or more years of education had a 34% lower caesarean delivery rate than those who have completed 10-11 years of schooling (26%), 5-7 years of schooling (15%), or no schooling at all (6%).

C-section birth rates tend to increase steadily with rising levels of income. C-section birth rates are 36% among moms from the top wealth quintile, but just 4% among those from the bottom quintile.

DELIVERY COSTS

Women between the ages of 15 and 49 who have given birth in the five years prior to the study and who have delivered in a health facility reported paying an average of Rs. 7,938 out of pocket for their most recent live birth. The average cost in private hospitals has been Rs. 16,522,

which is five times as much as the average cost in public hospitals, Rs. 3,198.

POSTNATAL CARE

The Postnatal Health Check for moms is crucial since many maternal and newborn fatalities occur in the first 24 hours following birth. Complications during childbirth need prompt attention and the mother should be provided with essential information on how to care for herself and her child. The Ministry of Health and Family Welfare (MoHFW) suggests that women who give birth in a health facility receive a postnatal health check within the first 24 hours after delivery, and that women who give birth elsewhere be referred for a postnatal check as soon as possible (ideally within 12 hours). Sixty-five percent of women aged 15 to 49 who gave birth in the five years prior to the 2015-16 NFHS survey reported receiving a postnatal check within the first two days after giving birth. Only 30% of women have had their postnatal checkups.

From 2005-06 to 2015-16, the percentage of women who had a postnatal check during the first two days after giving birth rose from 37% to 65%.

Patterns by background characteristics

Unlike women who gave birth elsewhere, those who gave birth at a health center are eligible for several postnatal health checks during the first two days.

Seventy-three percent of women in urban areas get a postnatal check within two days, whereas just 62 percent of women in rural areas do.

Women who have completed 12 or more years of education are more likely to have a postnatal check within two days (78%) than those who have not completed any schooling (51%).

Women from the top wealth quintile (80%) are more eager to have a postnatal checkup within two days than those from the bottom wealth quintile (48%).

When compared to women of other castes and tribes, scheduled tribe women are less likely to accept a postnatal check within two days (59% vs. 64-93%).

While 93% of women in Goa and Lakshadweep, 91% in Chandigarh, 91% in Kerala, and 89% in Punjab are open to a postnatal check within the first two days after giving birth, 23% of moms in Nagaland agree. Bihar (46%) and Arunachal Pradesh (30%) The provider's competence is a major element in influencing the accuracy of their diagnoses and the quality of their treatment or referral suggestions.

Less than half of women in India (43%) planned to see a doctor for their first postnatal check; 22% expected to see an ANM, nurse, midwife, or LHV; and 2% expected to see an ASHA.

Only 2% of women got more than a day's pay (to be determined) in their checks.

POSTNATAL HEALTH CHECKS FOR NEWBORNS

The first 48 hours of a newborn's life are crucial since that's when most neonatal fatalities occur. Newborn problems may go undetected and untreated for longer than necessary if there are no postnatal health checkups during this time. Only 27% of babies in India have had their main postnatal checkup during the first two days after birth. About two-thirds of infants do not have a postnatal checkup.

Patterns by background characteristics

It has been shown that babies born in hospitals are substantially more likely to have a postnatal health check during the

first two days of life compared to babies born at home or with their parents.

Mothers with higher levels of education are more likely to have a postnatal check during the first two days after giving birth. Babies delivered to moms with a high school diploma or above are more likely to have a postnatal check within two days after birth (31% vs. 22%). Only 18% of babies have seen a doctor for their first postnatal check, while 12% have seen an ANM, nurse, midwife, or LHV.

Many health programs have been implemented at the federal and state levels for the benefit of expectant mothers and their newborns as part of a larger effort to restore reproductive health practices. The most important aspects of these types of shows have been covered so far:

NATIONAL FAMILY WELFARE PROGRAMMES

A total of roughly 121,080,000 people called India home as of the 2011 census, making it the world's second-most populated nation after China. There are 17% more people in the world than there is land to sustain them. There is currently a population boom in India. If India's population growth pace continues unchecked, it might become the world's first to surpass a million people before the turn of the century.

THE MENSTRUAL HYGIENE PROGRAMMER

Once every two months, an Anganwadi worker will provide three packs of sanitary napkins (six in each pack, Puduyugam) and eight IFA pills to adolescent females. Adolescent girls in SABLA and Non-SABLA areas have access to lessons taught by Anganwadi workers on menstrual hygiene and health.

MENSTRUAL HYGIENE SCHEME (MHS)

Menstrual hygiene promotion among females aged 10-19 has been launched by the Ministry of Health and Family Welfare. Sanitary napkins were provided via central procurement in 107 districts and by local Self Help Groups in 45 districts, with the program's overall reach spanning 152 districts in 20 states. There are 6 sanitary napkins in the package, and they're all officially part of the 'Freedays' program.

NATIONAL IMMUNIZATIONS PROGRAMME

Children's morbidity and death rates are disproportionately high due to infectious illnesses. On the other hand, many children are left permanently crippled as a result of the problems that arise as a result of being sick with or dying from these disorders. In many sections of the nation, especially in rural regions, neonatal tetanus is the leading cause of infant death. In children less than five years old, poliomyelitis has caused widespread lameness. About 1.3 million Indian youngsters perish annually from vaccine-preventable illnesses. Each year, cases of infectious diseases including diphtheria, pertussis, tetanus, TB, and typhoid are documented. Measles, diphtheria, whooping cough, tetanus, TB, and polio may all be avoided with timely inoculation, and the cost of doing so is negligible. These vaccine-preventable illnesses of childhood kill three million children and cripple five million more each year in the underdeveloped countries.

IMMUNIZATION, HEALTH SERVICES & HEALTH CHECK-UPS

All of the actions, both direct and indirect, have contributed to the completion of the ICDS program via the convergence mechanism. Health intervention efforts,

including as vaccination of children and expectant women, IFA supplementation, referral services, and supplying Vitamin-A, have been meticulously planned and conducted by ICDS and Health personnel. Pregnancy and postpartum care have received mostly excellent reviews from women. Pregnant women with children less than 6 years old get antenatal care, while women who are breastfeeding and adolescent girls (10-19) receive postnatal care. The State mandated the use of the pentavalent vaccinations (DPT, Hepatitis B, and Hib) on December 21, 2011. The Hib (Haemophilus influenzae type B) vaccine recently replaced the Hepatitis-B and DPT combinations. The ICDS has brought essential medical care to the countryside.

ANEMIA CONTROL PROGRAMME

According to GOI Guidelines by the Health department, children aged 1-3 years are given 1 ml (20 mg) of IFA syrup for a period of 100 days to treat anemia. This IFA syrup (100 ml) was also part of the medical kit distributed by the Anganwadi center. The Anganwadi staff will provide instructions on how to use and distribute the medication. Children between the ages of 36 and 60 months get IFA (small) tablets from the Village Health Nurse at the Subcenter, or sometimes from the Anganwadi worker.

WEEKLY IRON AND FOLIC ACID SUPPLEMENTATION (WIFS)

Adolescent anemia in India has been an ongoing public health issue for the nation for a long time, with an estimated 5 Cores (15–19) affected. Rapid increases in height and weight, diets low in iron, and widespread illness and infestation all contribute to the widespread prevalence of anemia and other health issues today. Iron deficiency anemia is a real risk for women who menstruate. Weekly supplementation with 100mg elemental Iron and 500 g Folic Acid (IFA) has been shown to reduce the incidence of anemia in teenagers. In this light, the Ministry of Health and Family Welfare (MoHFW) is about to roll out the Weekly Iron and Folic Acid supplementation (WIFS) Programme for both in-school and out-of-school teenage females.

Public health initiatives like weekly IFA supplementation and biannual deworming will be supervised by Anganwadi Kendras for out-of-school adolescent girls in Government/Government-aided and Municipal Schools for school-going children.

JANANI SURAKSHA YOJANA (JSY)

The Janani Suraksha Yojana, a government program designed to reduce maternal and infant mortality rates, has significantly increased the number of births that occur in hospitals. Institutional delivery is encouraged by monetary incentives. The number of people who received aid grew by 1.09 crore between 2005–06 and 2011–12.

From Rs 38.29 crores in 2005-06 to Rs 1552.85 crores in 2011-12, spending more than quadrupled. On 12 April 2005, the National Rural Health Mission (NRHM) launched the Janani Suraksha Yojana to encourage low-income pregnant women to give birth in hospitals. All of the States and Union Territories are now carrying out the Yojana. The federal government is footing the whole bill for this initiative.

Centrally funded JSY primarily targets low-income pregnant women in states with low rates of institutional births, including as Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh,

Assam, Rajasthan, Odisha, and Jammu and Kashmir. Low Performing States (LPS) have been assigned to these countries, whereas High Performing States (HPS) have been designated for those that have managed to stay the course.

All qualified moms have had access to financial stability and medical treatment thanks to this program. The Accredited Social Health Activist (ASHA) credential is a valuable tool for strengthening relationships between medical centers and their surrounding communities.

JANANI SHISHU SURAKSHA KARYAKRAM (JSSK)

On June 1, 2011, the government of India unveiled the Janani Shishu Suraksha Karyakram (JSSK). All pregnant women who give birth in publicly funded health care facilities are entitled to this program's free and fully covered labor and caesarean section. Key benefits of this program include no out-of-pocket costs for necessary medications and supplies, a three-day food allowance for women who give birth naturally and up to seven days for those who have a cesarean section, and no out-of-pocket costs for necessary diagnostics and blood transfusions. The project also offers free rides from home to the facility and return in the event of a recommendation. Public health institutes also provide comparable benefits to the infant for up to 30 days after delivery if the baby is unwell. More than 12 million expecting mothers should have access to maternity care at public hospitals. Additionally, this plan will encourage women who traditionally have given birth at home to switch to a hospital setting. Free benefits for pregnant women and newborns with serious illnesses up to one month of age are now being provided by all States and Union Territories as part of JSSK.

CONCLUSION

Women's reproductive lifespans begin at the age of menarche and end at the age of menopause, with at least 35–40 years of potential life between these two milestones, making health a crucial aspect in women's empowerment. Findings from this study, which aims to better understand reproductive health practices among rural women, suggest that, as might be expected given the study's rural setting, roughly half of respondents tied the knot before the age of majority. Three-quarters of respondents don't know anything about menstruation until they reach adolescence, and talking about it is seen as taboo because of this. Two-thirds of respondents still felt uncomfortable talking to their husbands about reproductive health issues, despite being married. It's possible that around half of the respondents rarely use napkins as an absorbent because they didn't know about menstruation and got married before the legal age of marriage, putting them in a precarious position fraught with health risks. In addition, over two-thirds of respondents who had menstrual-related issues opted to purchase medication independently. When it comes to prenatal care, just around 20% of respondents went to all five of their recommended appointments. These inappropriate visits have affected many facets of prenatal and postnatal health care, including the value of the TT injection, the reasons for high blood pressure, the advantages of iron and folic acid tablets, the decreased consumption of food, green leafy vegetables, fruits, and milk, and the length of time spent breast-feeding and its benefits. Similarly, some respondents'

negative attitudes on public hospitals and their services discouraged them from making as many prenatal visits, and even when they did, they did not strictly adhere to the government doctors' orders.

REFERENCES

Mittal Kundan and Goel Manish Kumar (2010). "Knowledge regarding reproductive health among urban adolescent girls of Haryana", Pub Med, 35(4); 529-530.

Muhammed Qasim andAroj Bashir(2013). "Motivational factor and Adoption of family planning methods by married women", Middle East Journal of Scientific Research, 17 (12), 2013, pp. 1626-1631.

Ministry of immigration and population (1995). "Myanmar population change and fertility survey, 1991 yangon, unpulihed

Nilanjan Patra,(2008). Exploring the Determinants of Childhood Immunization, Economic and Political Weekly, March 22, 2008, pp.97.

Nivedita Ravindra and Ravindra Puranik (2016). "Assess the Reproductive Health Problems among Reproductive Age Group Women in the Selected Urban and Rural Area of Jalgaon" International Journal of Science and Research (IJSR) ISSN (Online): 2319-7064.

Nomita Chandhiok, Balwan S Dhillon, IndraKambo, Nirakar C Saxena (2006). Determinants of antenatal care utilization in rural areas of India : Across-sectional study from 28 districts (An ICMR task force study)" The Journal of Obstetrics and Gynecologyof IndiaObstetGynecol India Vol. 56, No. 1 : January/February 2006 Pg 47-52.

Pokarna, Kanwar Lal (1994). the Structural and Authorial Factors in Health and Diseases: A Sociological Study and Rural Communities of Rajasthan, a University of Rajasthan

Prasad, J.H., S. Abraham, K.M. Kurz, V. George, M.K. Lalitha, R. John, M.N.R. Jayapaul, N. Shetty and A. Joseph (2005). "Reproductive Tract Infections Among Married Young Women In Tamil Nadu, India." International Family Planning Perspectives 31(2): 73-82.

Park K. (2011). Preventive Medicine in Obstetrics, Paediatric sand Geriatrics. In: Park's text book of preventive and social medicine. 21st ed. Bhanot Publications; Jabalpur.

Ramachandrudu G. (1996). Reproductive Health in AndhraPradesh Published in Research Forum Monthly Bulletin,Andhra University 1996; 2(3): 69-73.

Rangaiyan,G. and S. Sureender. (2000). Women's Perceptions of Gynaecological Morbidity in South India: Causes and Remedies in a Cultural Context. The Journal of Family Welfare 46 (1): 31-38.

Ramasubban, Radhika and Rishyasringa Bhanwar (2000). Treatment Seeki11g by Women in Mumbai Slums. Paper presented at the Workshop on'Reproductive Health in India: New Evidence and Issues', Pune, 28 February to 1 March 2000.