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# Womens Maternal Health in India

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***Abstract - India is responsible for at least 25 percent of all maternal fatalities recorded abroad since the Safe Motherhood Initiative commenced. India's objective is to decrease maternal mortality to less than 100 per 100,000 live births, yet despite its programmatic efforts and swift economic development over the previous 20 years, that target is still far away. Maternal mortality varies among the states due to geography and sociocultural variety, making it unable to execute health sector reforms uniformly. The case study examines national trends in maternal mortality, the delivery of healthcare to mothers at various levels, and the execution of national maternal health initiatives, including more recent cutting-edge tactics.It suggests improving the reporting of maternal fatalities and putting evidence-based, targeted measures into practise, combined with efficient monitoring for quick progress. Additionally, it emphasises the necessity of private sector regulation and calls for more public-private collaborations and policies, as well as a strong political commitment and enhanced managerial skills for enhancing maternal health.***

***Keywords - Delivery, Health indicators, Healthcare, Maternal health, Maternal health services, Maternal mortality, India***

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## INTRODUCTION

A state of physical, mental, and social wellbeing in all aspects pertaining to the reproductive system, at all phases of life, is referred to as reproductive health. A pleasurable and safe sexual life, the ability to reproduce, and the flexibility to choose if, when, and how often to do so are all indications of good reproductive health. The right to proper healthcare services that allow women to safely experience pregnancy and childbirth should be guaranteed to both men and women, who should also be informed about and have access to the safe, acceptable, inexpensive, and effective family planning techniques of their choice. Reproductive Health encourages submissions from academics based in low- and middle-income countries since it is particularly interested in the effects that improvements in reproductive health have globally.

Many feminists have taken up the cause of women's health, particularly as it relates to reproductive health. The World Health Organization, among others, situates women's health within a larger body of knowledge that emphasises gender as a social determinant of health.

Indian women's social standing and health are inextricably intertwined. In India, sons are strongly preferred since they are expected to take care of their ageing parents. Due to this predilection for sons and the large dowry expenses for daughters, it occasionally happens that females are mistreated. Indian women also have low levels of formal labour force involvement and education. They often have minimal independence, being ruled over by their sons, husbands, and fathers in that orderLow birth weight babies are more likely to be delivered by women who are ill. Additionally, they are less likely to be able to give their kids healthy food and proper care. Finally, a woman's health has an impact on the household's financial stability because a sick woman will be less effective in the workforce.

## WHO DEFINATION FOR HEALTH

Reproductive health considers the reproductive system, processes, and activities over the lifespan from the viewpoint of the World Health Organization's definition of health as a state of full physical, mental, and social well-being and not only the absence of sickness or infirmity. Therefore, the capacity to reproduce and the autonomy to decide for oneself whether, when, and how frequently to do so constitute reproductive health. There is hope for a safe, joyful, and responsible sexual life.

Included in this are the rights of both sexes to information about and access to methods of fertility control that are safe, effective, affordable, and socially acceptable, as well as the rights of women and couples to receive the prenatal and postnatal care that will ensure a healthy baby is born to them.

## MATERNAL HEALTH

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Women's health before, during, and after childbirth is referred to as maternal health. In order to lower maternal morbidity and mortality, it includes the health care facets of family planning, preconception, prenatal, and postnatal care. To lower risk factors that can effect future pregnancies, preconception care might include education, health promotion, screening, and other interventions among women of reproductive age.

Prenatal care aims to identify any potential pregnancy issues early, avoid them where possible, and refer the pregnant lady to the proper professional medical services when needed. Recovery from childbirth, worries about newborn care, nutrition, nursing, and family planning are all postnatal care difficulties.

With a population of nearly a billion and a decade-on-decade increase of 21%, India's MMR in 2003 was projected to be 301 (maternal deaths per 100,000 livebirths). (2) Different states have different MMRs, with the big states in North India accounting for a disproportionately high number of fatalities. Comparatively, Kerala and Tamil Nadu have fertility and maternal mortality rates similar to those of middle-income nations, whereas Uttar Pradesh and Rajasthan's rates are far higher. There is a wide range of lifestyles and customs because of India's huge geography and rich cultural variety. With the exception of the southern and eastern regions, women in India have a relatively low social position. Literacy among women is barely 54%, and they are not given the freedom to choose whether or not to utilize reproductive health care. Since states are responsible for overseeing these services, the quality of their leadership and administration is crucial.

Demographic and health indicators of India and her states

| Indicator | India | Tamil Nadu | Gujarat | Rajasthan | Andhra Pradesh |
|---|---|---|---|---|---|
| Population (million) (Census 2001) | 1,028 | 62 | 51 | 57 | 76 |
| Decadal growth rate (1991-2001) | 21 | 12 | 23 | 28 | 15 |
| Population density per sq km (2001) | 324 | 478 | 258 | 165 | 275 |
| Birth rate (2005) | 24 | 16 | 24 | 29 | 19 |
| Death rate (2005) | 7.5 | 7.4 | 6.9 | 7.0 | 7.3 |
| Total fertility rate | 3.2 | 1.7 | 2.9 | 3.7 | 2.0 |
| Mean age (years) of effective marriage (2005) | 20 | 22 | 20 | 20 | 19 |
| Literacy rate: total (2001) | 65.3 | 73.4 | 69.1 | 60.4 | 60.4 |
| Male | 75.3 | 82.4 | 79.9 | 75.7 | 70.3 |
| Female | 54.1 | 64.4 | 57.8 | 43.8 | 53.7 |
| Sex ratio (no. of females per 1,000 males) | 933 | 987 | 920 | 921 | 978 |
| Life expectancy at birth—females (2005) | 66 | 69 | 69 | 67 | 68 |
| Infant mortality rate (2006) | 58 | 37 | 54 | 68 | 57 |
| Child mortality rate (2005) | 17 | 9 | 16 | 20 | 15 |
| Maternal mortality ratio as per SRS (2003) | 301 | 134 | 172 | 445 | 195 |

SRS=Sample Registration System

This case study aimed to summarise the current state of maternal health in India, as well as the country's national safe motherhood programmes, and to assess their effects. The country's maternal health can be improved, according to suggestions.

## MATERIALS AND METHODS

For the purpose of gathering pertinent data, a variety of techniques were used, such as a review of the literature (i.e., published and unpublished reports of government and non-government agencies), secondary analysis of data from the management information system of national programmes and from states, stakeholder interviews, and an examination of important institutional processes, key actors' roles and powers, organisational structures and functions, and administrative support. Additionally, information was gathered from the District Level Household Survey and National Family Health Surveys (NFHSs) (DLHS). Information about healthcare facilities and personnel was compiled using data from DLHSs, facility surveys, and official government publications and websites.

Strategies and execution of the safe motherhood programme, including earlier efforts and new initiatives, were analyzed to determine their impact on maternal health performance metrics. However, there were no reliable statistics on maternal mortality and morbidity in India, therefore the current figures range greatly. Indicators of the process and input, such as the quantity of operational First Referral Units (FRUs) for emergency obstetric care (EmOC) and the availability of specialists, also lacked sufficient information.

## RESULTS

For the purpose of making educated health decisions, women require a variety of maternal health information. While they acknowledged the need for professional healthcare providers to deliver that information, the majority of it was obtained from unofficial and non-professional sources, such as community health workers, traditional birth attendants, and family members. The lack of healthcare facilities and restricted access to qualified medical care are among the reasons for the usage of these sources.

## CONCLUSION

In order to raise knowledge and provide women the power to decide for themselves what is best for their reproductive health, access to pertinent and trustworthy maternal health information is crucial. When women rely on unreliable sources for their various information requirements, they increase their risk of receiving misleading data and making poor decisions.

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