Understanding Maternal Health Status among the Urban Poor of the Scheduled Caste Community of West Bengal: A Sociological Study based on a Municipality under Kolkata Metropolitan Area

Sucharita Halder
Research Scholar(UGC-JRF)
Department of Sociology, Kalyani University, Nadia
Email: sucharitahalder.31@gmail.com

Partha Sarathi De
Professor
Department of Sociology
Kalyani University, Nadia
Email: Parthade417@gmail.com

Abstract: The Janani Suraksha Yojana (JSY) is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among the poor pregnant women. The National Urban Health Mission (NUHM) as a sub-mission of an overarching National Health Mission (NHM). The present paper tries to assess the maternal health status among the reproductive mothers belonging to backward communities (viz. Scheduled Caste) and suffering from multiple socio-economic deprivations in slums of Kolkata Metropolitan area. Our findings suggest that more efforts are needed to ensure universal access to equitable and quality maternal healthcare services. Poor socio-cultural factors are associated with poor maternal health outcomes.

Key Words: Maternal Health, Universal Access to Healthcare, Janani Suraksha Yojana, Ante Natal Care, Institutional Delivery

I
Introduction

Maternal health refers to the health of women during pregnancy, childbirth and postnatal period. Each stage should be a positive experience ensuring women and their babies reach their full potential for health and well-being [1]. History of Maternal Healthcare dates back to Vedic age in Indian context. Evidence of maternal and child care can be seen in Rigveda and Yajurveda. In Atharvaveda description of concepts such as conception, fetal development, mechanism of labour, management of parturition are given. Ayurveda has laid importance of gestational rites, nourishment of pregnant women, intra-partum and neo-natal care. Throughout colonial period, attempts were made to modernise reproductive health by reforming birth practices. Missionaries and British doctors believed that the practices promoted by mid-wives or dais that was lower caste Hindus and Muslims were the reasons behind high rates of Maternal Mortality. In an attempt to rectify situation, books were published to educate women in reproductive health practices and midwifery training courses were introduced but these failed to improve the situation. Late Colonial India saw emergence of preventive healthcare. Greater focus was placed on disseminating and popularising health education among women through different agencies. There was also growth of voluntary associations devoted to maternal and child healthcare [8].

However, the global consensus on the concerns of maternal and reproductive health was emphasized in 2000 as the Millennium Development Goals (MDGs) and in 2015 as Sustainable Development Goals (SDGs). The Sustainable Development Goal (SDG) Target 3.1 calls for a reduction in the global maternal mortality ratio (MMR) to less than 70 by 2030. A recent report suggests that among the top 10 countries that have been constantly experiencing higher number of maternal deaths, India shares about 60 percent of the total burden; thus India is on the top spot of maternal health burden across the countries in the world

[2]. It was observed that India at the national level could not achieve the MDG target on maternal health which was ended in 2015; now we are approaching towards SDG target. The nature, severity and intensity of health problems vary across regions, religion, caste and economic status in India according to Oxfam India's report on India's unequal healthcare story.

Maternal health issues are important for various reasons; the most significant reason is that India at the aggregate level will enjoy the benefits of demographic dividend roughly after 2025 [4, 5]. Is India capable to reap the benefits of demographic gift? The answer of this question depends on the quality of our future human resources. Future human capital depends on the current health of the mothers and children. If the mother remains unhealthy and suffers from various reproductive and maternal health problems, the probability of malnourished children will go up and that will jeopardise economic returns from demographic dividend [4, 5]. This is because of poor quality human capital. Health and education complements to each other; a healthy child can easily accumulate human capital or knowledge compared to unhealthy and malnourished child. There exists an important linkage between improvement in maternal health and development process as poor reproductive and maternal health negatively affect child health, reduce women's productive capacity, lowers participation in economic activities and sabotages the poverty alleviation programme [4, 6]. Moreover, we shall not be able to reach the SDG target in respect of health and well-being if we do not give emphasis on maternal health. Therefore, in order to ensure gender equality, we must give focus on reproductive and maternal health. Keeping in mind the importance of maternal and reproductive health in India, the present study is structured as follows. Section-II deals with the recent literature on maternal and reproductive health in India especially in West Bengal. The scope and objective of the present study is highlighted in this section. Data, sample frame and methodology are mentioned in section-III. Analysis is carried out in section-IV. Concluding observations and policy implications are highlighted in section-V.

II
Review of Literature

National level studies indicate that religion, region, social hierarchy based of ethnicity and caste, literacy, healthcare accessibility and wealth status can influence maternal healthcare utilization [6, 7, 8, 9]. Maternal and reproductive health is a social-phenomena where access to and use of maternal and reproductive healthcare services are influenced by contextual factors; inequalities in health are not only the unequal distribution of health but also unfair distribution of health due to unfair social arrangements [7, 11, 12]. Due to wide disparities between and within states, which are often caused by varying policies and programmes, health infrastructural shortcomings and governance challenges, analysis of inequalities in maternal healthcare need to be undertaken at the state, district as well as block level.

Indian society is patriarchal in nature; as women's autonomy in terms of decision making, mobility, work participation, and access to and control over resources is highly restricted. Research shows that female educational attainment is closely interlinked with reproductive health; women's position in the household and in the community influences women's access to contraceptives, use of abortion services, healthcare seeking behaviour during pregnancy and delivery [7, 10,11, 14, 15, 16]. An important area of research on inequities coming out of the feminist research literature which is dominated by the concept of intersectionality. Intersectionality is defined as 'a theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, socioeconomic status and disability intersect at the micro level of individual experiences to reflect interlocking systems of privilege and oppression [17]. An interesting multi-level study is carried out in the villages of Uttar Pradesh by Sridharan et al [18]; the study identifies several individual level predictors of healthcare utilization including literacy of the women, the husband's schooling, age at marriage and socio-economic factors. It is argued that interventions having equity considerations need to disrupt existing patterns of the health gradient; knowledge of key predictors of utilization can aid in the implementation of such complex interventions [17]. Sanneving [10] has rightly pointed out that how social determinants interplay in a specific context

influencing access to and use of maternal and reproductive health needs to be carefully considered when designing and implementing health policies and interventions.

A community-based observational study of 300 mothers was conducted by Bandyopadhyay in 2018 et al [20] in slums of Kolkata; they have found unsatisfactory utilisation of maternal health care services and suggest that awareness generation and behaviour change communication among mothers is necessary for proper utilisation of the services. My present study is to some extent motivated by their findings. However, our study is distinct from earlier studies in various grounds. Review of literature on maternal healthcare has identified several key population sub-groups that are disadvantaged in terms of access to and use of maternal and reproductive healthcare services that need to be addressed by health planners and development practitioners. The present paper tries to assess the status of married women of informal sector belonging to poor (viz. economically weaker section (EWS)) as well as Scheduled Caste (SC) of Sonarpur under Kolkata Metropolitan Development Authority (KMDA). Thus, our respondents are assumed to be vulnerable both socially as well as economically. The JSY Programme is basically meant for this vulnerable group. It is to be mentioned here that Sonarpur is a municipality town of South 24 Parganas. The government of India has launched JSY Programme to rectify maternal health inequities by offering conditional cash transfer with a view to encourage women to give birth in institutions with skilled birth attendants. Is it a sufficient measure to reach the most disadvantaged population? The present paper seeks to answer this question.

III
Data, Sample Frame and Methodology

A descriptive and cross-sectional study was undertaken among 50 married women of SC category in Harinavi neighborhood under ward 17 of Rajpur-Sonarpur which is a municipality town of South 24 Parganas district in the Indian state of West Bengal. All are poor under EWS category as defined by the Government. The area is part of the Kolkata Urban agglomeration and covered by the KMDA based on 2011 Census. Sampling method was purposive as married women of reproductive age group (15-49) and belonging to EWS category (viz. gross annual family income less than 8 lakh) and all are socially backward (viz. SC) category.

The subjects were interviewed with pre-designed structured interview schedule after taking informed consent. In case of non-response from any woman, information was taken from the next willing woman. The following information were collected from the respondents; most of the responses are ordinal viz. binary in nature (i.e. yes or no):
Socio-demographic, cultural and economic factors like child marriage, under-age pregnancy, still birth, living children exceeding two, completed school years, emotional support, maternity leave, expenditure incurred for hospitalization, nutritional status during pregnancy etc. The perception as well as experiences of the respondents pertaining to maternal and reproductive health is assumed to be important. The following psycho-social and ecological and environmental factors are incorporated: hospital experience, behavior of health workers, knowledge about JSY, sanitation at residence, water, menstrual hygiene. Data pertaining to family planning and utilization of maternal health care were also recorded.

The schedule was first prepared in English and then translated into Bengali keeping semantic equivalence. Data entry and analysis are done using excel and stata-12 software. Descriptive analysis is done and frequency and percentage for categorical variables are calculated. We study the association between maternal healthcare and socio-demographic and cultural variables using binary (viz. 1 or 0) correlation coefficient (viz. Tetrachoric Correlation). It needs to be mentioned here that the results of Chi-Square is consistent with the results of correlation of binary variables. Maternal health deprivation is considered as negative development variable; thus we define the maternal and reproductive health parameters as follows:

If the mother gets married before attaining age 18=1, 0 otherwise;
If the completed school years of the mother is less than 10=1, 0 otherwise;
If the mother does experience emotional negligence during pregnancy=1, 0 otherwise;
If the mother could not receive adequate maternity leave from her employer or husband or family=1, 0 otherwise;
If the mother does incur unexpenditure (exceeding her family daily income) in public hospital at the time of delivery=1, 0 otherwise;
If the mother does report lack of nutritious food during pregnancy=1, 0 otherwise;
If the mother does experience under-age pregnancy (viz. less than 18 years of age)=1, 0 otherwise;
If the mother experienced still birth=1, 0 otherwise;
If the mother does possess more than 2 children=1, 0 otherwise;
If the mother reported poor condition of public hospital=1, 0 otherwise;
If the mother does feel discontentment with health-workers in public hospital=1, 0 otherwise;
If the mother reports no previous knowledge about JSY and Ayushmati Scheme=1, 0 otherwise;
If the mother lives in a poor sanitary condition=1, 0 otherwise;
If the mother reports lack of potable water=1, 0 otherwise;
If the mother reports poor menstrual hygiene=1, 0 otherwise;
If the mother reports no antenatal care (ANC) visits=1, 0 otherwise.
If the mother reports less than 4 ANC visits=1, 0 otherwise;
If the mother reports no consumption of Iron & Folic Acid during pregnancy=1, 0 otherwise;
If the mother reports non-institutional delivery=1, 0 otherwise;
If the mother reports no post-natal care (PNC) at home=1, 0 otherwise;
If the mother reports no PNC visit at hospital=1, 0 otherwise;
If the mother reports no consumption of oral contraceptive pills=1, 0 otherwise;
If the mother reports unsafe sexual practices=1, 0 otherwise;
If the mother reports no female sterilization=1, 0 otherwise.

IV
Results and Analysis

Following the above cited methodology, we have calculated the percentages of respondents (reporting yes or no) in each sub-dimension of maternal and reproductive health outcomes. The results are shown in Table-1.

Table-1 Utilization of Maternal Healthcare Services and Reproductive Health Outcomes

Socio-cultural factors	**Percentage**	**Socio-economic factors**	**Percentage**
Child Marriage	48	No maternity leave	56
Lack of Education	32	Expenditure in public hospital	48
Emotional Negligence	30	Lack of nutrition during pregnancy	48
Demographic factors		**Psycho-social factors**	
Underage pregnancy	32	Poor situation of Hospital	40
Still birth	52	Discontentment with health-workers	50
More than two children	40	No knowledge about JSY and Ayushmati scheme	44
Ecological Factors		**Maternal Health Care Services**	
No sanitation facilities at home	32	ANC not received	28
Lack of potable water	34	Less than 4 ANC Checkup	72
Poor menstrual hygiene	50	No having IFA tablets	26

Institutional Delivery and PNC Variables		**Family Planning Variables**	
Non-institutional Delivery	34	Not consuming oral contraceptive pills	34
PNC not received at home	44	No safe sexual practices	72
PNC not received at hospital	22	Not female sterilization	54

Authors' estimation.

Child marriage is found to be predominant among the poor and underprivileged section of the society. The recent data from the National Family Health Survey (NFHS-5) do not indicate any improvement when it comes to girl child marriage in West Bengal; the percentage of women aged 20-24 married off before the age of 18 remains high at 41.6% as in NFHS- 5 report. In order to combat such social evil, the Government of West Bengal has initiated Kanyashree Prokolpo (KP) in 2013. The KP is a conditional cash transfer scheme with the aim of improving the status and wellbeing of the girl child in West Bengal by incentivizing schooling of all teenage girls and delaying their marriages until the age of 18, the legal age of marriage. Our survey results show that 40 percent mothers have more than two children. Higher fertility is caused by many socio-cultural and economic factors; we do not study any causality of poor maternal health status of the respondents. This is because our sample is purposive and small. Majority of the respondents are homogenous in respect of social class, economic class and they live in a same place with identical social, environmental and ecological factors. Non institutional delivery is found to be 34 percent though they live in an urban settlement! Why do they choose non-institutional delivery given the physical availability of public hospitals? This is an important area of research. About 44 percent respondents report that they have no knowledge about JSY and Ayushmati scheme! The ANC is extremely poor among the respondents. The results of Table-1 clearly show that women from informal sector living in slums do face problems in accessing the JSY.

We study the degree of association between the selected maternal and reproductive health parameters with socio-cultural variables.

We find that child marriage is positively and significantly associated with low level of schooling. Similarly, lack of nutritional food intake is positively associated with lack of post natal care. Miscarriage is positively and significantly associated with low level of schooling. The relationship using correlation analysis between the other maternal health indicators are not found significant statistically.

V
Conclusion

The present study aims to explore the status of maternal and reproductive health of the mothers in a particular region under KMDA. It has been observed that those working mothers under EWS category in the informal sector are not always able to enjoy benefits of sick role as more than half of the women had to work during third trimester of pregnancy and near about fifty percent mothers reported not having nutritional diet throughout their pregnancy. Under destitute situation, mothers are forced to work. The eligibility criteria of JSY and Ayushmati Scheme is that the mother should be above eighteen years old, which needs to modified as many women suffered from underage pregnancy as they were married off earlier. Other factors like Safe Sexual Practices and Menstrual Hygiene is very poor in our findings, so government should take enough initiatives to curb this problem, apart from all of these, we need to empower women through education as it will help them to ascertain their sexual reproductive rights. It can help them with better communication with husbands and healthcare workers. The JSY under NUHM needs to be strengthened with a view to achieve the desired goal of SDG.

The present study has some limitations. Firstly, our sample size is small and it is chosen purposively; hence, there is a limitation of application of inferential statistics. Secondly, only one area from Sonarpur is chosen for data collection of the respondents and majority of the respondents are found to be more or less

homogenous. Thirdly, the underlying causality of poor maternal and reproductive health parameters are not explored here because of insufficient samples in one hand and lack of variability among the respondents on the other hand.

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