



**TO STUDY ABOUT THE UTILIZATION OF MATERNAL HEALTH SERVICES AND
MAJOR GOVERNMENT PROGRAMMES IN SELECTED RURAL AREAS OF
JAMMU AND KASHMIR**

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ABSTRACT

The goal of the current study was to better understand how the rural mothers in Udhampur District, State of Jammu and Kashmir, used government health care initiatives. The study's goals were to assess the knowledge of mothers regarding maternal health services provided by the Govt of India during (a) pregnancy, (b) Intranatalperiod (c) postnatal period (d) immunization services, (e) family planning services; and to determine how often mothers used maternal and child health care services while they were pregnant and raising their children. The findings showed that most mothers had average knowledge about the various health services, but not all of them had access to antenatal, immunization,post-natal, and family planning counseling. Most mothers opted to give birth in medical facilities. Most of the babies were breastfed exclusively, and infant vaccination was 100 percent in almost all the villages. Despite receiving advantages from numerous government programs for maternal and child health owing to the actions of healthcare professionals like ASHA workers and ANMs, many rural women were unaware of these programs and their services.

KEYWORDS:Maternal Health Services, Utilization, Pregnancy Women

INTRODUCTION

MATERNAL HEALTH SITUATION: INDIA

Pregnancy is a crucial period in a woman's life. This is a moment of eager waiting, and every woman hopes to be in this position at least once in her life. Every mother's greatest wish is to have a safe and healthy pregnancy. Most pregnancies and births go smoothly, however, all pregnancies are at risk. According to a report published by the World Health Organization in 2000, over 15% of all pregnant women have a potentially life-threatening condition that necessitates professional treatment, and some require substantial obstetrical intervention to survive. High maternal mortality and morbidity are always caused for worry. As a result, it is critical to look after pregnant women, as this is the time when they require extra care, support,



attention, and correct nutrition for themselves and their fetuses. Poor maternal care typically results in the death of the child; even if the mother survives, a newborn's prospects of survival are jeopardized. Women who receive excellent maternal health care throughout pregnancy and childbirth are more likely to trust additional medical services for themselves and their families. According to the World Health Organization (WHO), UNICEF, UNFPA, and the World Bank, 536,000 maternal fatalities occur globally each year, with 136,000 deaths occurring in India. According to estimates of the global burden of disease in 1990, India was responsible for 25% of disability-adjusted life-years lost owing to maternal diseases alone. Unfortunately, despite national safe motherhood regulations and programmatic attempts, there is no indication that maternity in India has been considerably safer over the last two decades. In 2010, there were an estimated 287,000 maternal deaths worldwide, with a global maternal mortality rate of 210 deaths per 100,000 live births. In 2010, maternal fatalities in Sub-Saharan Africa (56%) and Southern Asia (29%) accounted for 85 percent (or 245,000 in absolute numbers) of the worldwide burden.

Every year, India accounts for 19 percent of all global maternal deaths, or one every eight minutes, accounting for over a quarter of all maternal deaths worldwide. Heavy bleeding (hemorrhage) and high blood pressure (eclampsia) were the leading causes of death, and 70% of these deaths could have been avoided. More women die in India than anyplace else in the world as a result of pregnancy-related problems. On the one hand, India is advancing economically, but the country continues to struggle with inequity and the fundamental right to good maternity health. India is anticipated to account for a high proportion of global maternal and newborn fatalities. India was placed 142 out of 176 countries in Save the Children's World's Mothers survey. This rating is based on five parameters, including maternal health, children's well-being, education, and women's economic and political status in the country.

Despite being among the top five countries in terms of absolute maternal fatalities, India has achieved significant progress in lowering maternal and child mortality rates. The Maternal Mortality Rate (MMR) was 519 per lakh live births in 1987-91, and 440 per lakh live births in 1991-96, according to the Sample Registration System (SRS). In India, the Maternal Mortality Rate (MMR) has been slowly declining, remaining at 407 per 100,000 live births from 1997-1998. According to the Annual Health Survey, maternal mortality rates have decreased from



254 per lakh live births in 2004 to 212 per 100,000 live births in 2010 and 190 per 100,000 live births in 2013. (AHS). In India, Assam, Uttar Pradesh, Uttarakhand, Rajasthan, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, and Odisha account for nearly two-thirds of maternal mortality. Only one-third (34%) of deliveries in India take place in healthcare institutions, and two-fifths (42%) of deliveries are not carried out by skilled birth attendants, according to the National Family Health Survey (NFHS)-2. The use of public health facilities for institutional deliveries is low, and more intense interventions are needed. Home deliveries are still common in the community, and most are attended by unskilled birth attendants. According to the 17 District Level Household Survey (DLHS)-2, 73.6 percent of mothers received some prenatal care services, while 40.4 percent of mothers received antenatal care services in the first trimester. In the 2007-08 DLHS-3, 75 percent of mothers received antenatal care services, and 45.0 percent of mothers received antenatal care services in the first trimester, indicating no significant change in antenatal care utilization. In India, one out of every three women, or 34%, did not have an ante-natal check-up throughout their pregnancy. In 1990, the global child mortality rate (CMR) (under five years old) was 88 per 1000 live births; however, India had a substantially greater burden of child mortality, with 115 per 1,000 live births. In 2010, India's child death rate (59 per 1,000 live births) nearly equaled the global average of 57 due to different child survival interventions. The country's current CMR is 53.

Since the First and Second Five-Year Plans (1951-56 and 1956-61), maternal and child health has been an important aspect of India's Family Welfare Programme. The Minimum Needs Programme (MNP), which began during the Fifth Five-Year Plan, merged maternal and child health and nutrition services with family planning services (1974-79). In 1992-93, the Child Survival and Safe Motherhood (CSSM) Program continued the integration process by combining numerous critical child survival interventions with safe motherhood and family planning activities. The Reproductive and Child Health Programme included safe motherhood and child health services in 1996. (RCH). The government created the National Population Policy (NPP) in 2000 to promote safe motherhood programs in the context of reproductive health. Safe motherhood is mentioned in several of the policy's national socio-demographic goals for 2010. The goals for 2010 were to have 80% of all deliveries take place in hospitals, 100% of deliveries be attended by professional and trained care providers, and the maternal



death rate to be below 100 per 100,000 live births. The National Rural Health Mission (NRHM) was established by the government in 2005 to ensure the timely availability and accessibility of high-quality health services for individuals living in rural regions, the poor, women, and children. One of the major objectives of the National Rural Health Mission is to improve access to improved health care at the household level through female workers, known as Accredited Social Health Activists (ASHAs), who serve as a link between the community and the public health system, promoting immunization referrals, household toilet construction, RCH escort services, and other health-care delivery services.

Despite extensive efforts through various programs and activities, the rate of utilization of maternal health services such as antenatal and postnatal care, deliveries by skilled birth attendants, and family planning by the urban poor, rural women, and socially disadvantaged groups remains low across the country, and maternal mortality due to pregnancy and childbirth-related causes continues to rise. As a result, it is critical to identify factors that prevent deprived sections of the community, particularly the urban poor, from using maternal health services.

MATERNAL AND CHILD HEALTH INITIATIVES IN INDIA

Since India's independence, maternal and child health care has been an important part of the country's health care system. Various constitutional provisions and Acts have expressed this dedication. Similarly, policies and programs for providing health care in general, as well as mother and child health care, have been developed and implemented.

India was the first country in the world to implement a family planning program in 1951. Since then, a number of initiatives aimed at limiting population increase have been implemented. Family planning was the primary health activity until 1977 when it was replaced by the Family Welfare Program, which included Maternal and Child Health. The main premise was that lowering the birth rate would result in lower infant and child death rates. Then, in 1978, India implemented a diarrheal disease control program with the primary goal of preventing mortality among children under the age of five owing to dehydration caused by diarrheal infections. By the year 2000, the National Health Policy of 1983 envisioned a major reduction in infant mortality, neonatal mortality, and child mortality rates. The Universal Immunization Program (UIP) was initiated in 1985 to combat six preventable diseases: diphtheria, pertussis, pediatric TB, poliomyelitis, measles, and neonatal tetanus. By 1990, the program had covered the entire



country. This program made great progress, with nearly 90% coverage for each of the six antigens. The UIP was renamed the National Technology Mission in 1986, and it went live in all of the country's districts in 1989-90. The Child Survival and Safe Motherhood program (CSSM) was established in 1991 with the primary goal of reducing infant and child mortality owing to dehydration-induced by diarrhea. In 1992, UIP was included in the Child Survival and Safe Motherhood (CSSM) Program, and in 1997, it was incorporated into the Reproductive and Child Health (RCH) Program. By 1996-97, the Child Survival and Safe Motherhood Program had been phased in and had reached all of the country's districts. The initiatives' goals were to enhance infant health, as well as child and mother morbidity and death. Below are the specifics of the Reproductive and Child Health (RCH) program.

THEORIES ON UTILIZATION OF MATERNAL HEALTHCARE SERVICES

Many factors determine how often people use healthcare services. In this sense, a variety of models attempt to describe how individuals manage their health. The health belief model (Hochbaum 1958) and the psychological model (Suchman 1965) both consider motivating factors and examine the concept of decision-making through perception and analyzing the cost-benefit action in relation to sickness (Mackian et al 2004). The health belief model is a behavioral health paradigm that encompasses an individual's or group's knowledge, opinion, and actions in relation to their health. The health belief model assumes that decision-making takes place when the elements (a person's notion) of perceived vulnerability, perceived threat, and perceived benefit vs perceived barriers come together. When a person recognizes reasons to be concerned about a specific disease as something undesirable that could potentially affect them, this is known as perceived susceptibility. When a person realizes that they may be individually vulnerable to this disease, it is referred to be a perceived threat. When a person assesses the expense of a required behavior change against the potential rewards, this is referred to as perceived benefit vs perceived barriers. Barriers may include a lack of transportation to the nearest health center, a lack of health insurance, a conflicting work schedule, and the cost of treatment, among others. Predisposing factors such as age, sex, occupation, education, ethnicity, social network, health belief, attitude, values, and knowledge that people have about the healthcare system; enabling factors such as income, household durables, health insurance, a regular source of care, travel, available health personnel; and need



factors, such as perception illness and service indicators are all included in behavioral models (Anderson, 1968, Pokharel&Sauerborn, 2004). (Pokharel& Sauerborn,2004). The most immediate source of healthcareutilization is functional and health-related issues that necessitate the use of healthcare services. "Perceived need will better assist in understanding care seeking and adherence to medical regimens, whereas evaluated need will be more closely tied to the type and amount of therapy offered after a patient has presented to a medical care provider." (Andersen,1995). Another model is the Three Delays model, which identifies the various obstacles that women encounter in obtaining the timely and effective medical care required to avoid deaths during pregnancy and childbirth. This model analyses the various obstacles that women encounter in obtaining the timely and effective medical care that is required to reduce maternal and childbirth-related mortality. These are the three groups of factors: Phase I: Delay in seeking care due to a) low women's status, b) a lack of understanding of pregnancy complications and risk factors, c) previous poor health-care experience, d) acceptance of maternal death, and d) financial implications. Phase II - Delays in receiving care - a) distance to health centers and hospitals, b) transportation availability and cost, c) insufficient and poor roads Phase III- Delays in accessing proper health treatment due to substandard facilities and a lack of medical supplies, as well as inadequately qualified and motivated medical personnel and referral systems. These models are based on the elements that influence health decision-making, such as economic circumstances, travel distances, degree of education, perceived quality of services, and so on. As a result, these ideas highlight the importance of conducting research to learn more about the factors that influence healthcare usage. Health care is a multi-faceted notion that is influenced by the interactions of numerous other elements. These factors will be examined in the current study in Assam in order to improve maternal health care services for this group.

RESEARCH METHODOLOGY

Selection of the study area

The current research was carried out in the state of Jammu and Kashmir. It is one of the Indian Union's oldest states. Previously, Hindu rulers and Muslim sultans ruled over the state of Jammu and Kashmir. It became a part of the Mughal Empire under Akbar in 1586. After a period of Afghan domination beginning in 1756, the state was ceded to the Sikh Kingdom of Punjab in 1819. Gulab Singh was given the province of Jammu by Maharaja Ranjit Singh in



1820. The Treaty of Amritsar between the British Government and Maharajah Gulab Singh, which was signed on March 16, 1846, also gave Kashmir to Gulab Singh. The Treaty of Jammu and Kashmir gave the Dogra kings of Jammu sovereignty of the Kashmir state, which they already had over the Ladakh region. Maharaja Gulab Singh annexed Ladakh in 1830. (Hunter, 2016). Gulab Singh controlled the state from 1846 to 1856, Ranbir Singh reigned from 1857 to 1885, Pratap Singh ruled from 1885 to 1925, Hari Singh ruled from 1925 to 1961, and the final President of the state, Karan Singh, served from 1961 to 1971. (Rai, 2004). Thus, Maharaja Gulab Singh formed this northernmost state in 1846, and it was India's largest princely state before the country's partition in August 1947. The Instrument of Accession governs and regulates its relationship with the Union of India. On October 26, 1947, Maharaja Hari Singh, the princely state's then ruler, signed the Instrument of Accession in Jammu and Kashmir. This contract was signed under the terms of the India Independence Act of 1947, in which Maharaja Hari Singh decided to join India's dominion (Instrument of Accession of Jammu and Kashmir, 1947 p: 2).

Sampling Technique

For the purpose of studying rural populations, the researcher intends to use the Multistage Cluster Sampling method. Cluster sampling is a method of probability sampling that is often used to study large populations, particularly those that are widely geographically dispersed. In cluster sampling, the researcher divides a population into smaller groups known as clusters. Then the desired sample is randomly selected from among these clusters to form a sample.

Population

Target Population: In this study target population include all women in the reproductive age group residing in Jammu and Kashmir

Accessible Population: In the present study accessible population is randomly selected women in the reproductive age group (18yrs -45yrs) residing in selected rural areas of Jammu and Kashmir.

RESULTS AND DISCUSSION

GOVERNMENT PROGRAMS AND SCHEMES

Local and State Government has made a few projects and strategies to support safe parenthood in rural areas of J&K. These incorporate Janani Shishu Suraksha Karyakram (JSSK), Janani Suraksha Yojna (JSY), Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) and MKKS (Mata



KaushalyaKalyan Scheme. The significant point of these projects is to give motivating forces or administrations at exceptionally affordable expenses for pregnant ladies and to advance Institutional deliveries.

JSSK (Janani Shishu Suraksha Karyakram) was started in January 2011 by the Ministry of Health and family welfare. Under this plan, free medications and consumables, diagnostics, and reference transport are given to pregnant ladies and youngsters. One more plan which was begun to draw in pregnant ladies to health care facilities, particularly the Government Hospitals, was JSY (Janani Suraksha Yojna) which was started by the Government of India on 12.04.2005 in rural regions, and from 01.04.2006, this plan became practical for Below Poverty Line (BPL) ladies, pregnant ladies independent of the BPL card. Under this program, an incentive of Rs. 500 is given to all Below Poverty Line/Scheduled Caste/Scheduled Tribe ladies above 19years old enough, up to two residing youngsters independent of the sex of the kid during home delivery, and extra Rs. 200 and Rs. 100 for institutional delivery to Rural (Total Rs.700) and Urban (Total Rs. 600) pregnant ladies individually for delivery in a Government or Private Institution (JSY, 2014). Pradhan MantriSurakshitMatritvaAbhiyan (PMSMA) acquainted in July 2016 points with giving exhaustive and great nature of Antenatal consideration to every single pregnant lady. Under this program, Antenatal services are given to pregnant ladies which incorporates examinations, prescriptions, diet supplements (calcium and Iron and Folic Acid tablets).

Prior a plan named MKKS (Mata KaushalyaKalyan Scheme) was begun under National Rural Health Mission to advance safe deliveries and hence, limit youngster and mother death rates. In this plan, each mother was given Rs 1,000 alongside Rs 200 as transportation charges. However, these days just JSY is practical potentially because of monetary deficiencies looked at by the State Government.

In the current review, it was applicable to gather information in regards to the awareness level and the use of the significant Government projects and Schemes by the respondents.

MAJOR GOVERNMENT PROGRAMMES AND SCHEMES

Health Blocks→		Pancheri	Ramnagar	Dalsar	Chenani	Panjar	Tope	Total
Responses↓	Awareness level							
Janani Suraksha Yojana	Yes	30(43)	36(60)	32(46)	28(47)	35(50)	25(36)	186(46.5)
	No	40(57)	24(40)	38(54)	32(53)	35(50)	45(64)	214(53.5)
	Utilization pattern							
	Yes	23(33)	35(58)	26(37)	36(60)	37(53)	13(18)	170(42.5)
	No	47(67)	25(42)	44(63)	24(40)	33(47)	57(82)	230(57.5)
	Awareness level							
Janani Shishu Suraksha Karyakram	Yes	14(20)	12(20)	17(24)	12(20)	13 (18)	--	68(17)
	No	56(80)	48(80)	53(76)	48(80)	57(82)	70(100)	332(83)
	Utilization pattern							
	Yes	--	--	--	--	--	--	--
	No	70(100)	60(100)	60(100)	50(100)	70(100)	70(100)	400(100)
	Awareness level							
Pradhan Mantri Surakshit Matritva Abhiyan	Yes	33 (47)	31 (52)	31(44)	30(52)	33(47)	25(36)	183(45.7)
	No	37 (53)	29 (48)	39(56)	30(48)	37(53)	45(64)	217(54.2)
	Utilization pattern							
	Yes	25(36)	38(64)	36(51)	42(70)	36(51)	30(43)	207(51.7)
	No	45(64)	22(36)	34(49)	18(30)	34(49)	40(57)	193 (48.2)
	Awareness level							
Mata Kaushalya Scheme	Yes	33 (47)	34 (57)	31(44)	30(50)	33(47)	25(35)	186(46.5)
	No	37 (53)	26 (43)	39(56)	30(50)	37(53)	45(35)	214(53.5)
	Utilization pattern							
	Yes	--	--	--	--	--	--	--
	No	70(100)	60(100)	70(100)	60(100)	70(100)	70(100)	400(100)
	Total	70(100)	60(100)	70(100)	60(100)	70(100)	70(100)	400(100)

The table features that in general, 46.5% of the respondents knew about Janani Suraksha Yojana. Around 53.5% of the respondents didn't know about this plan. Among 46.5% of the respondents who knew about the Janani Suraksha Yojana, a larger part for example 60% of the respondents were from Ramnagar followed by 50% from Panjar, 46% of the respondents from Dalsar, 43% of the respondents from Pancheri and 36 percent of the respondents were



from Tope block. The table likewise shows that generally, 42.5 percent of the respondents used this plan though 57.5 percent of respondents profited no advantage from this plan. Block-wise conveyance shows that out of 42.5 percent of the respondents who used this plan, 60% of the respondents were from Chenani followed by 58% of the respondents from Ramnagar, 37% of the respondents from Dalsar and Panjar, 33 % of the respondents from Pancheri and six percent of the respondents from Tope.

CONCLUSION

The information uncovers that a greater part of the respondents for example 83% of the respondents didn't know about Janani Shishu Suraksha Karyakaram (JSSK). Just six percent of the respondents knew about this plan. Out of this six percent, 24 percent of the respondents were from Dalsar followed by eight percent from Pancheri, six percent from Panjar, and four percent from Ramnagar and Chenani. The information additionally uncovers that none of the respondents used benefits under this plan.

As to Mata Kaushalya Scheme, just 46.5% of the respondents knew about this Scheme. Out of this, 57 % of the respondents were from Ramnagar followed by 50% from Pancheri and Panjar, 44% from Dalsar, 50% from Chenani, and 35 percent of respondents from the Tope wellbeing block. Nonetheless, none of the respondents used this plan. The information features that a greater part of the respondents is ignorant about the different Government plans and the advantages given under these plans.

As to Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA), the information uncovers that a 41 percent of the respondents knew about this plan while 54.2% of the respondents were ignorant about this plan. Among the 45.7% of the respondents who knew about this plan, 47% were from Pancheri and Panjar, 52% were from Ramnagar and Dalsar, and Chenani, and 36 percent of the respondents were from Tope. The information on the use of this plan by the respondents uncover that 52% of the respondents used this plan. Out of this 52%, 84% of the respondents were from Chenani followed by 56% from Ramnagar, 52% from Dalsar and Panjar, 40% from Tope, and 30 percent of respondents from Pancheri. The analyst saw that respondents had profited from benefits like free Iron and Folic Acid tablets, and free research facility examinations however they didn't know about the name of a plan under which they had used the advantages.



The information further features that few respondent could express the name of JSY (Janani Suraksha Yojana) and Mata Kaushalya program under which they benefitted certain advantages. It becomes appropriate to specify here that albeit 42% of respondents knew however they had deficient information with respect to the plans. The researcher saw that absence of awareness was the main reason for the non-usage of Government Schemes by the respondents. A review completed in Mohali, Punjab presumed that only 12% of the review subjects got Janani Surakshayojanato benefit, the principal reasons being nonavailability of Janani Surakshayojana cards for example 40%, trailed by non-agreeable clinic staff. (Pahwa and Sood, 2013).

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