

The concept of reproductive health health and social care essay



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Development of a country is now marked by the 'human development' which constitutes the formation of human capabilities such as improved health, knowledge and skills and the use of their acquired capabilities for productive purposes (Rout and Murthy, 2010). In this regard, health of every individual plays a pivotal role as it not only determines the "quality of life" but also creates human capabilities that lead to productivity enhancement and acceleration in economic growth. World Health Organization (1946) describes health to be as "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity." The Cartesian dualism creates a split between the concrete (physical body) and the abstract (emotional being). The biomedical discipline overlooks the psychological, social, cultural, environmental interpersonal reactions to disease by just focusing on the human body. This complete disregard to other factors reflects as a failure of biomedical model to cope with lay persons' health issues (Kriel, 2003). Health care problems like 'patient dissatisfaction, inequity of access to care, and increasing costs to avail facilities' are some factors which bind an individual in seeking care (Kleinman, Eisenberg and Good, 1978). In the context of this new understanding, now human body is looked beyond scientifically observable entity rather it is a complex web of interconnections and linkages between social, cultural, economic and structural factors that arise from human interaction and different community context. To enhance the understanding 'health', can be looked from different perspectives

Perceptions of Health

Human rights based approachAs stated in Article 1 of the Universal Declaration of Human Rights (UDHR): " All human beings are born free and equal in dignity and rights." UDHR further states that these rights are the foundation of peace, justice and democracy in the world. They are entitlements that belong to all human beings regardless of race, ethnicity, or socio-economic class (Nussbaum, 1998). Further, Human Right Based Approach addresses two types of stakeholders- The ones who are unable to experience full rights entitled to them (right holder) and the second being those who are said to be responsible for fulfilling the rights of the former stakeholder (duty bearer). In HRBA, duty bearer position is fulfilled by people's government which at most times doesn't have sufficient resources to fulfil this role. As noted by Pogge (2005), the under fulfilment of human rights can directly be linked with poverty. Poverty includes the assessment of standard of living, health, and well being. The HRBA views health as an entitlement instead of a market based sector. As the latter differentiates uses based on their purchasing power it is considered by the HRBA as less suitable form of right as they tend to exclude the poor (Standing, 2004). Knowledge and realization about ones " right to health" doesn't necessarily entitle them to freely exercise them (London, 2012). Therefore " right to health" in spite of being an entitled human right diminishes its value for the marginalized people in society leaving a sense of powerlessness and subjugation. Therefore a HRBA aims to support better and more sustainable development outcomes by analyzing and addressing the inequalities, discriminatory practices and unjust power relations which are often at the heart of utilisation and accessibility of health services. Under Committee on <https://assignbuster.com/the-concept-of-reproductive-health-health-and-social-care-essay/>

Economic, Social and Cultural Rights (ICESCR), General Comment No. 14 highlights elements of availability, accessibility, acceptability and quality (AAAQ) as essential to enjoy the right to health for all. In order to access on a population's needs with regard to health services, five dimensions that encompass most of the barriers that patients come across namely; Availability, Accessibility, Affordability, Adequacy and Acceptability (Penchansky & Thomas, 1981; Obrist et. al 2007). In this approach access can be seen as the degree of " fit" between the patients and the system.

Behavioural Model of Health Andersen (1968) developed a model of health care utilization (Figure 1) which looks at three categories of determinants described as below: Predisposing Factors: Proclivity to use services is more in some individuals than others which may vary according to the individual characteristics prior to their illness. Such characteristics include demographic (Age, sex are closely related to health and illness), social structure and attitudinal belief variables. Social structure comprise of characteristics such as education and occupation of the family head which reflect on the location (status) of individual in the society. Such social variables reflect the social environment in which individual resides and associated behaviour pattern that emerges of it. The third subcomponent of the predisposing factor is - attitude or beliefs about medical care, physicians and disease. Health belief is an essential component to acknowledge the attitude, values and knowledge that people have about health and health services that might influence their subsequent perceptions of need and use of health services. Health beliefs provides a mean of explaining how social structure might influence enabling resources, perceived need, and subsequent use. Enabling Component. Even though individuals may be

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predisposed to use health services, some means must be available for them to do so. A condition which permits a family to act on a value or satisfy a need regarding health service use is defined as enabling. Enabling conditions make health service resources available to the individual. Enabling conditions can be measured by family resources such as income, level of health insurance coverage, or other source of third-party payment, whether or not the individual has a regular source of care, the nature of that regular source of care, and the accessibility of the source. Illness Level: The third category includes the perception of need for health services, whether individual, social, or clinically evaluated perceptions of need (Wolinsky, 1988) Illness level represents the most immediate cause of health service use. Need factor includes two aspects one is Evaluated need and other is perceived needs. Evaluated need represents professional judgment about people's health status and their need for medical care. Perceived need will better help to understand care-seeking and adherence to a medical regimen, while evaluated need will be more closely related to the kind and amount of treatment that will be provided after a patient has presented to a medical care provider. Gender based approach According to, United Nation Population Fund (UNFPA), gender equality implies a " society in which women and men enjoy the same opportunities, outcomes, rights and obligations in all spheres of life. Equality between women and men exists when both sexes are able to share equally in the distribution of power and influence; have equal opportunities for financial independence through work or through setting up businesses; and enjoy equal access to education and the opportunity to develop personal ambitions. A critical aspect of promoting gender equality is the empowerment of women, with a focus on identifying and redressing

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power imbalances and giving women more autonomy to manage their own lives. Women's empowerment is vital to sustainable development and the realization of human rights for all." The concept of reproductive health, which gained its momentum in 1980's is premised around feminist perspective that every woman has right to control her own sexuality and reproduction without discrimination as to age, marital status or income. To ensure that decisions regarding reproductive health are availed, every women has rights and freedom to exercise of the broad array of other human rights to which women are entitled (Dixon- Mueller , 1993). The female disadvantage in less developed countries with regard to health and well being has been well documented (Santow 1995). The health status of both women and children, suffers in relation that of males in areas where patriarchal kinship and economic systems limit autonomy (Caldwell, 1986). Women's reproductive health seeking behavior is correlated positively with freedom of movement and decision making power (Bloom et al., 2001) There may be various reasons which act as a hurdle during the process when maternal health services are utilized. It is reasonable to assume that utilization of maternal health services depends on individual and household factors, as well as factors operating at the community or policy levels (Babalola & Fatus, 2009). At individual level any decision to be made in regard with health choices are often collectively made by either husband or by older women within households in India(Dyson and Moore 1983; Griffiths 1998). Aspects like women's autonomy such as freedom of movement, decision making power in matters of households; control over finances and support of natal kin can be some of the few constrains among the marginalised women of society (Rutherford et al., 2010). Nutritional status is

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another determinant in (Jordan et al cited in Vlassoff et al 1996)The experiences that a client has had with previously utilized services can also act as a barrier for future use. When a client has had negative experiences in a health care facility it can result in the client not returning for further care. In addition, it can also influencing other client's health seeking behavior and lead them to make the decision to not use the services as well (Cooper & Ensor, 2004)Looking at health using different approaches/perspectiveDimension to explain " utilization" of health servicesSupporting literatureHuman Right based ApproachAccessibilityAvailabilityAffordabilityAcceptabilityAccountabilityAdequacyLondon, L. (2008); Obrist, B., et al(2007); HRBA(2012); Pogge, Thomas(2005); Penchansky R, Thomas JW (1981); Nussbaum(1998)Gender based ApproachAutonomy of women; Perception about health provider and facility(will determine the health seeking behavior –reluctance or acceptance); Education status; Awareness of the importance of Health Care; Past ExperiencesBabalola and Fatus(2009); Bloom et al (2001); Dixon-Mueller (1993); Dyson, T and Moore, T(1983); Griffiths, P(1998)Behavior based ApproachPredisposing factors (demographics, social structure and health beliefs); Enabling Component (family andcommunity characteristics); Illness Level (perceived and evaluated need)Andersen, R (1995); (Wolinsky, 1988)

Accessibility and Utilization

Several explanations have been given by different studies which result is no definite standard to describe the meaning of accessibility. On one hand it is described to be as ' fit' between those seeking health services and health

services themselves (Penchansky & Thomas 1981) whereas on the other hand, Andersen (1995) describes access as being influenced by population characteristics and health services provided for that population. As suggested further, that access could be assessed by both health service use and health service outcomes, pinpointing utilization as an important part of the access concept (Gulliford et al 2002). Hence access to health services implies 'the timely use of service according to need' (Peters et al, 2008). There are several models that surround in explaining the concept of access and utilization in relation to health care services. Several frameworks have been designed to evaluate access. The Penchansky and Thomas framework employs five dimensions of access: Availability, Accessibility, Accommodation, Affordability and Acceptability (Penchansky & Thomas 1981). These are assessed by patient perception, detailing a patient's ability to get to a health facility; knowledge of facilities; difficulty of obtaining care because of health service factors; financial costs; ability to pay for treatment; satisfaction with the health centre, including location and clientele (Penchansky & Thomas 1981). On the other hand, to see the factors influencing utilization of health services, Andersen (1968) developed a model of health care utilization (Figure 1) which looks at three categories of determinants described as: Predisposition; enabling and illness needs. Overall Andersen model demonstrates the complex nature of various determinants that influence each other as well as in accessing the health services. Although the above two mentioned frameworks describe the accessibility and utilisation of health services but doesn't take account of important factors which hamper access to health care, such as, female

autonomy; role of social networks; cultural influence etc (Rutherford et al 2010; Portes et al. 1992; Guendelman 1991)

Two dimensions of Accessibility and Utilization- Demand-side and Supply-side

Victoria et al (2000) in her study points to the concept of 'inverse equity hypothesis' which states that new health policies and programmes, first benefits socio-economically well off population rather than poor who eventually access and utilize the health services later in time. The financial burden in regard with health, which the developing country's poor population ends up paying, results in a cause of impoverishment (Noponen et al. 2004; Van Doorslaer et al. 2006). This inadequate distribution of health care services led to universal coverage as endorsed by World Health Organisation (WHO) in 2005. The reason behind inadequate distribution of health services were beyond the financial interventions rather there were other factors which highlighted the barriers in accessing health services. Two dimensions for enabling better access to health services for poor and vulnerable population, namely are, supply-side and demand side strategy (Ensor & Cooper, 2004) . The former helps to strengthen the capacity of health care providers for better outcome in target service intervention, whereas the latter ensures to reduce hurdles or barriers in accessing and utilizing of health care services (Bornemisza et al. 2010). Barriers to accessing & utilizing health services can emerge either from the demand side and/or from supply side (Ensor and Cooper 2004; O'Donnell 2007). Demand-side determinants are factors influencing the ability to use health services at individual, household or community level, while supply-side determinants are

aspects inherent to the health system that obstruct service uptake by individuals, households or the community (Jacob, 2012). As the research aims to provide an insight to the barriers facing an urban poor woman in accessing and utilizing maternal health services, the researcher will be looking exclusively the women's perspective and their share of experiences. In this regard, the research would be reflecting on some barriers that come across from the demand as well as supply side only from the consumer's perspective, that is, woman who went through utilizing of maternal health services. The availability of maternal health services does not guarantee their proper utilisation by women. Neither does the use of maternal health services guarantee favourable outcomes for women. There are various reasons as to why a woman do not access the service at all, access them late or suffer an avoidable adverse outcome despite timely utilising them.

Understanding Maternal Health- Global Overview

Emergence of the issue During the initial years, a little attention was paid to Maternal and child health. Before 1970s, developing countries used approaches concentrating on urban medical centers and use of highly trained personnel and modern technology (Rosenfield & Main, 1985). Later it became more clear that adopting approaches based on Northern systems of medical care , without taking account of contextual circumstances resulted in difficulties to access the health services and other primary health programmes focussing on maternal health. As a consequence to this, a shift can be noticed since 1970's where the needs and resources were taken into account by the developing nations before formulating policies and programmes. In 1985, two prominent academicians (Rosenfield and Maine ,

1985) wrote highly influenced papers which galvanised interest and put forth the issue of maternal mortality on an international health policy agenda. The argument focus was to highlight 'M' in MCH as most of the programmes were child oriented and assumptions were made that "whatever is good for the child is good for the mother" (Rosenfield & Maine 1985). Safe Motherhood Conference in Kenya was the first international conference directed towards maternal mortality which eventually led to the launch of the Safe Motherhood Initiative. With maternal mortality becoming the focus of health service research (Brouwere et al 1988) a shift was observed in the theme of Reproductive Health. Role of women was not merely confined to child-bearing and child-rearing but had gone beyond that. This phenomenon was further catalysed by the 1994 International Conference on Population and Development (ICPD), in Cairo. International conferences, such as the Cairo Programme of Action, were held, and the goal to decline the maternal mortality rates was set (AbouZahr & Wardlaw 2001). The approach to improving maternal health changed as well as during the International Conference on Population and Development in 1994 the focus on maternal health transferred from a demographically driven approach to a human rights approach (Potter et. al. 2008). Later, with Millennium Development goals the focus of maternal mortality became a high priority. Millennium development goals give a holistic approach in improving women's overall well being. Here is a small brief about how the goals are oriented and directed towards the improvement of women's health.

In 2000 the Millennium Development Goals (MDG's) were adopted by the international community. These goals aim to encourage development by giving strength, to back the social and economic conditions in the world's poorest countries. United Nations International Development Goal 5 emphasizes to " Improve Maternal Health" and the reduction of maternal mortality was adopted by the International Monetary Fund (IMF), the World Bank (WB), Organisation for Economic Cooperation and Development (OECD). It was supported by 149 heads of state at the Millennium Summit in 2000 (AbouZahr & Wardlaw 2001). This Millennium Development Goal (MDG) for 2015 includes target 5. A: " Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio" and Target 5. B: Achieve, by 2015, universal access to reproductive health (UN, 2012). This development goal is strongly interlinked with other development goals namely, MDG1 " Eradicate extreme poverty and hunger", MDG3 " Promote gender equality and empower women", MDG4 " Reduce child mortality rates" and MDG6 " Combat HIV/Aids, malaria and other diseases".

Maternal Health in Developing countries (previous lit review) Globally, an estimated 287 000 maternal deaths occurred in 2010, a 47% decline from levels of 1990, (WHO 2010) and that 88-98% of these deaths are avoidable (WHO, 1986). Despite this decline, developing countries continued to account for 99% of the deaths. Sub-Saharan Africa (56%) and Southern Asia (29%) accounted for 85% of the global burden (245 000 maternal deaths) in 2010. The global MMR in 2010 was 210 maternal deaths per 100 000 live births, down from 400 maternal deaths per 100 000 live births in 1990. In sub-Saharan Africa, a number of countries have halved their levels

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of maternal mortality since 1990. In other regions, including Asia and North Africa, even greater headway has been made. However, between 1990 and 2010, the global maternal mortality ratio (i. e. the number of maternal deaths per 100 000 live births) declined by only 3. 1% per year. This is far from the annual decline of 5. 5% required to achieve MDG5. The MMR in developing regions (240) was 15 times higher than in developed regions (16). Sub-Saharan Africa had the highest MMR at 500 maternal deaths per 100 000 live births, while Eastern Asia had the lowest among MDG developing regions, at 37 maternal deaths per 100 000 live births. The MMRs of the remaining MDG developing regions, in descending order of maternal deaths per 100 000 live births are Southern Asia (220), Oceania (200), South-eastern Asia (150), Latin America and the Caribbean (80), Northern Africa (78), Western Asia (71) and the Caucasus and Central Asia (46). At the country level, two countries account for a third of global maternal deaths: India at 19% (56 000) and Nigeria at 14% (40 000). Apart from the above two countries other eight comprise of 60 per cent of the global maternal deaths: India (56, 000), Nigeria (40, 000), Democratic Republic of the Congo (15, 000), Pakistan (12, 000), Sudan (10, 000), Indonesia (9, 600), Ethiopia (9, 000), United Republic of Tanzania (8, 500), Bangladesh (7, 200) and Afghanistan (6, 400) (WHO, 2010). Full scale of the burden is not acquired and confined by the numbers of deaths alone. Much less is known about the scale of ill health resulting from pregnancy complications. Maternal deaths in developing nations are mainly from obstetric causes (OC) -bleeding, hypertensive disease, infection, obstructed labour and unsafe abortion (Khan et al., 2006). Life threatening complications are experienced in 15% of pregnant women, although some

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form of obstetric problem occurs in over 40% of pregnancies (WHO, 1994). It is estimated that over 300 million women suffer ill health as a consequence of pregnancy or childbirth, with 20 million new cases occurring annually (WHO, 2005). For instance, 12% of women who survive severe bleeding will suffer severe anaemia (AbouZahr, 2003). Two million women are thought to live with debilitating complication like obstetric fistula as a result of obstructed labour (Lewis and de Bernis, 2006). Depression is thought to appear during pregnancy in between 6% and 25% of women in developing countries (WHO and UNFPA, 2009).

Maternal health in Indian context

Status of women-India is ranked at 129 in the 2011 HDI with a value of 0.617, placing it at number 134 in the world rank out of a total of 187 countries with data (HDR, 2011). The gender bias towards men is also reflected in the Indian sex ratio. The sex ratio in India, which presents the proportion of women compared to the proportion of men in the country, was 940 females per 1000 males (Census, 2001). The 2011 Census indicated that the sex ratio for children was 914 females for 1000 males, indicating that the gap is increasing. The cultural view that male children are preferred over female children is an important reason that this ratio is unbalanced in favor of men (Patel, 2002).

Emergence of maternal health issues- Indian context (A paradigm shift from family welfare programme to Reproductive Health)

In India, to fulfill the basic health facilities and services, State has been taking the primary responsibility by laying down provisions, priorities and

directions in its 5 year plan since 1951. There is no denying the fact that health status and standards in India have significantly improved over the years since independence. With its health policies and programmes it acted as a strong pillar in reaching out to the marginalized and weaker section of the society. India, through its health policy shifted the focus from comprehensive universal care system to selective and targeted programmes. This is very well evident in respect to maternal health in India, with various implementations of programmes at different intervals. Reproductive health concerns to a large extent surrounds with restricted parameters, which tend to look women's health with a myopic lense of patriarchal dominant society. These parameters put a boundary around our understanding of women's reproductive health and reduce the same to issues in regard with maternal and child health. Understanding women's health is not merely constrained to the concept of reproductive health nor is the concept of reproductive health is to be associated with women. Both men and women are inextricable to the important concept of Reproductive Health. In India, the role of the husband has been noted in decisions mainly confined to the use of contraception and expenditure for health care (Barnett 1998; Sharma and Sharma 1993). In 1960's and early 1970s , India's programmes for maternal and child health and family planning were mostly vertical which did not take an account of needs of community, outreach programmes and facilities. In 1992, India launched the Child Survival and Safe Motherhood (CSSM) Programme by bringing together interventions for child survival and maternal health. In 1997, Reproductive and Child Health Program was launched as the national policy of the government of India. This program was based on the existing Safe Motherhood Program and connected maternal and child health with the <https://assignbuster.com/the-concept-of-reproductive-health-health-and-social-care-essay/>

strengthening of referral systems for obstetric care. RCH -II followed RCH -I in the year 2005 with the objectives of reducing maternal mortality. The focus on reproductive and child health shifted to births in institutions and emergency obstetric care as the key strategy for reduction of the maternal mortality rate. According to National Institute of Health and Family Welfare, the official RCH programmes include the conventional maternal and child health services including immunisation of children and contraceptive services to couples, treatment of RTIs and STDs, provision of reproductive health education and services for adolescent boys and girls, safe abortion and pregnancy related issues . In the same year the National Rural Health Mission was launched by the government to strengthen the existing health services. Essential components of NRHM were inclusion of training local residents as Accredited Social Health Activists (ASHA) and the Janani Surakshay Yojana (motherhood protection program).

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This picture of " health for all" and " reaching out to all with strong policies and programmes", contrasts rather sharply with the failure of schemes and the under investments made in health sector. Though on papers India reflects concrete and genuine policies that reach out to the poorest of poor but the fact somehow is deplorable. Within this large segment of our population specially the Women and children have been left outside the growth process and are the easy victims of the (denied) health care system in India. ASHA considered to be the backbone of the programme has so much of work pressure or it seems the whole programme is relied on ASHA. This program aims at improving the availability and accessibility of effective

health care for especially people residing in rural areas (Govt. of India, 2012).

Urban Poor

Emergence of Urbanisation

One of the most remarkable features of the second half of the twentieth century has been the spectacular growth of urban population in the world. Developing countries, in particular, have experienced rapid urbanization and the mushrooming of huge metropolises. However, the level of urbanisation in India is one of the lowest in the world. With about 31% of the total population living in the urban areas (Census 2011), India is less urbanized compared to many countries of Asia, viz., China (49%), Indonesia (50%), Japan (91%), South Korea (83%), and Pakistan (36%). Urbanisation can result from (1) natural increasing population (2) net migration from rural areas to urban areas and (3) reclassification of villages as towns largely because of changes in the nature of economic activities. Rural urban migration has often been considered the major factor for growth of slums in urban areas (Kundu, 2009). There is an increasing trend in rate of migration from rural to urban areas and with migration rate attaining its peak, there is a need to view urban poverty as distinct from rural poverty and not as mere transfer of rural poverty into urban areas. According to Planning Commission Report (2012), "the urban poverty manifests in the form of inadequate provision of housing and shelter, water, sanitation, health, education, social security and livelihoods along with special needs of vulnerable groups like women, children, differently abled and aged people. Most of the poor are involved in informal sector activities where there is constant threat of eviction, removal,

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confiscation of goods and almost non-existent social security cover. Even when segments of the urban population are not income-poor, they face deprivation in terms of lack of access to sanitary living conditions, and their well-being is hampered by discrimination, social exclusion, crime, and violence, insecurity of tenure, hazardous environmental conditions and lack of voice in governance."

Defining Urban Poor

According to a recent report of an expert group set up by the Planning Commission's perspective planning division submitted a detailed methodology to identify below poverty line (BPL) households in urban areas. It is using this recent report the definition of urban poor is considered in the research study. According to the group's report, income-based criteria will not be used to identify the poor. Rather, it has created a simple and transparent formula where households will be either automatically included or excluded from the list. Stage 1: Automatic Exclusion: If the number of dwelling rooms exclusively in possession of the household is 4 and above (dwelling rooms as specified in the Report) that household will be excluded. Secondly, the household possessing any one of the assets, i. e., ' 4 wheeler motorized vehicle', ' AC Set' and ' computer or laptop with internet' will also be excluded. Besides the households possessing any three of the following four assets, i. e., refrigerator, telephone (landline), washing machine, two wheeler motorized vehicle will also be excluded. Stage 2: Automatic Inclusion: households facing various kinds of deprivations and vulnerabilities viz. residential, social and occupational vulnerabilities would be automatically included in the BPL List. i. Under residential vulnerability, If the

household is 'houseless' as defined in the Report or the household has a house with roof and wall made of plastic/polythene or the household having only one room or less with the material of wall being grass, thatch, bamboo, mud, un-burnt brick or wood and the material of roof being grass, thatch, bamboo, wood or mud, then that will be automatically included. ii. Under occupational vulnerability, the household having no income from any source; any household member (including children) engaged in a vulnerable occupation like beggar/rag picker, domestic worker (who are actually paid wages) and sweeper/sanitation worker /mali); and all earning adult members in a household are daily wagers or irregular wagers, then that household should be automatically included. Automatic Exclusion Automatic Inclusion 1. Household having a house of four rooms 2. Households possessing any one of the following assets: four wheeler motorised vehicle, air conditioner, computer or laptop with Internet 3. Households possessing any three of these: refrigerator, telephone (land-line), washing machine, two-wheeler motorised vehicle. a) Residential Vulnerability (indecisive) b) Occupational vulnerability i. If the household has no income from any source, then that household will be automatically included. ii. Any household member (including children) who is engaged in a vulnerable occupation like beggar/rag picker, domestic worker (who are actually paid wages) and sweeper/sanitation worker /mali) should be automatically included. iii. If all earning adult members in a household are daily wagers or irregular wagers, then that household should be automatically included. The framework depicts the following things: Maternal Health Care Services Different aspects that the researcher would be looking at Method Antenatal Care Full or

Complete ANCT Three or more Antenatal checkups; Two or more Tetanus
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Toxoid Injection; 100 or more Iron and Folic Acid Supplementation; Other Services: General examination such as height, weight, B. P., anaemia, abdominal examination, breast examination, treatment of anaemia, awareness regarding family planning and symptoms of complications during pregnancy.-Semi structured interview would be used for acquiring on:-

Pattern of utilisation of ANC-Selection of provider-If there is non-utilisation or irregular utilisation then the causes associated-information on the satisfaction level derived

During Delivery Provider type Institutional Delivery: Private or Public Home deliveries: skilled or unskilled birth attendant Using the same semi-structured interview following things would be raised:-

Reasons behind selecting a particular type of provider (Health Seeking Behaviour)- Obstacles (if any) faced during delivery- Accessibility; availability; affordability; acceptability; Autonomy of women; perceptions and beliefs about the health care provider etc- Quality of care and the satisfaction level (respondents experience vs. her expectations)

Post Natal Care Duration in which Postnatal Care was delivered or utilised Number of the visits Awareness and providing Information on the following : Counselling on family planning, breast feeding practices, nutrition, management of neo-natal hypothermia, early detection of postpartum complications and referral for such problems.