

Research Article

## Investigating Health Justice Indicators and Advocating Institutional Interventions: Ground Zero Reproductive and Child Health Assessment in District Bahraich-Uttar Pradesh in India

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### AN OVERVIEW

India is a society of patriarchal order<sup>1</sup> and hegemonic masculinity that rules the contours of human relationships within and outside the family. The reproductive deliberations and child health priorities are considered the forte of womenfolk contrary to the global norms of equality<sup>2</sup> justice<sup>3</sup> and constitutional mandate<sup>4</sup> of gender parity. Gender is not a property; it is a performance but an accomplishment performed by a person. Social situations provide occasions to deliver gender identity. But, unfortunately, the world of reproductive rights and child health is not a comfort zone for women in India. Women bear all reproductive procedure risk, particularly at the stage of advanced maternal age<sup>5</sup> and do not have any stakes in the reproductive decisions, and spousal intervention in such a decision must be regarded as an aberration, particularly in rural India. The male-controlled sociocultural space<sup>6</sup> considers reproductive rights and reproductive hygiene as a dirty dark secret.

<sup>1</sup>Suparnaa Chadda, 'Is India a patriarchal society? Youth Survey' April 2, 2016, <http://www.womanendangered.org/india-primarily-patriarchal-society/> <accessed on 14 January 2020>

<sup>2</sup>Article 14, the Constitution of India, 1950

<sup>3</sup>Preamble to the Constitution of India, 1950

<sup>4</sup>Article 21, the Constitution of India, 1950

<sup>5</sup>Brittany, J., Harrison, Tara N. Hilton, Raphaël N. Rivière, Zachary M. Ferraro, Raywat Deonandan and Mark C. Walker, (2017) 'Advanced maternal age: ethical and medical considerations for assisted reproductive technology' *International Journal of Women's Health*, Vol. 9, pp. 561–570.

<sup>6</sup>Cătălina-Ionela Rezeanu, The relationship between domestic space and gender identity: Some signs of emergence of alternative domestic femininity and masculinity' (2015). *Journal of Comparative Research in Anthropology and Sociology*, Vol. 6, No. 2, ISSN 2068 – 0317 9-12

The reproductive rights of women are under more threat now than ever before. The international organizations such as UNFPA<sup>7</sup> and the WHO<sup>8</sup> have been at the forefront in defending the reproductive rights of women since 1995. It was at the Beijing Conference<sup>9</sup> in 1995 on a theme called ‘women’s rights as human rights.’ In this context, the UN and WHO focused on a wide range of women matters such as access to family planning services, sex education, menopause, and the reduction of obstetric fistula, the relationship between reproductive rights and health, and economic status. Therefore, the reproductive rights of women are advanced in the context of the right to freedom from discrimination and the socioeconomic status of women. Reproductive control is a fundamental requirement, and it is a human right for every woman. Such a right has a direct connection with the health of a woman but societal structures created by the religious norms dictate such a right contrary to the legitimate aspirations of womenfolk’s motherhood. Further, state intervention and administrative apathy<sup>10</sup> are driven by private profit and have abated the lawful reproductive and child health claims of the women. But, unfortunately, global population trends are likely to mount significant pressure on resources and institutions.

Moreover, in the cycle of reproductive rights, women are pitted against women in vertically and horizontally fragmented traditional social milieu. Women’s rights of access to abortion and contraception remain a distant dream in India. However, India has started to extend— although gradually—women’s access to abortion, whereas the US continues to crack down on abortion. The amendment carried out in the Medical Termination of Pregnancy Act, 1971 (MTP) in 2018, has made the MTP Act, 2018<sup>11</sup> liberal, and it promotes gender-sensitive health policies and allows women to go for an abortion at up to 24 weeks. MTP also replaces the term “married women” with “all women” in the contraceptive failure clause. But, the policy appears to be useful in theory, but the reality is quite different for women, especially rural women, as most abortions are carried out by unauthorized, and medically novice professionals as unsafe abortions

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<sup>7</sup>The United Nations Population Fund (UNFPA) is the United Nations sexual and reproductive health agency that delivers a world where every pregnancy is wanted and respected and ensures the safety of every childbirth and fulfills every young person’s potentialities.

<sup>8</sup>The World Health Organization (WHO) is a specialized agency of the UNO that is entrusted with international public health. WHO was established on 7 April 1948, and it is headquartered in Geneva, Switzerland.

<sup>9</sup>The Fourth World Conference on Women at Beijing, 4-15 September 1995, adopted the Beijing Declaration and Platform for Action, and Recommended to the UN General Assembly at its 50<sup>th</sup> Session that it endorsed the Beijing Declaration and Platform for Action.

<sup>10</sup>Freedman, Lynn P., Isaacs, Stephen L. (1993) ‘Human Rights and Reproductive Choice’, *Studies in Family Planning*, Vol. 24, No. 1, pp. 18–30.

<sup>11</sup>Medical Termination of Pregnancy (Amendment) Act, 2018, [http://www.hims-hassan.org/STATUTORY\\_REGULATORY\\_ACTS/medical%20termination%20act.pdf](http://www.hims-hassan.org/STATUTORY_REGULATORY_ACTS/medical%20termination%20act.pdf) <accessed on 15 January 2020>

worldwide cause every year 4.7% to 13.2% of all maternal deaths<sup>12</sup>, and it is a big problem in India.

Therefore, women's sexual and reproductive rights are under constant threat<sup>13</sup>, driven by religion and the right-wing interpretation of sexual choices.<sup>14</sup> Hence, reproductive and child health has always been the most neglected area of health and medical consciousness in India. The sociocultural barriers have been guiding and dictating the extent of enjoyment of the reproductive and child health rights in India since time immemorial. Reproductive rights of women are not luxuries but responsibilities that have been envisioned as a subcategory of human rights. Thus, womenfolk have a fundamental human right to decide freely and conscientiously the number and the gap among their children. Further, the problems regarding the reproductive rights of women are strongly challenged, notwithstanding the socioeconomic level of the population, culture, or religion. Therefore, In India, women and child health are destined to suffer in silence and embarrassment.

## INTRODUCTION

It is aptly evident that India represents an exceptionally diverse collection of populations and peoples. Not only is each state different in its geographical and socio-cultural characteristics, but India's federal system means that provinces (called states in India) also differ in their politico-economic administrative structures. Given each state's unique attributes, health and development indicators vary widely among them. The states (provinces) such as Uttar Pradesh (UP) present some of the most significant health and development challenges in India. UP is the largest state in India in terms of population, with roughly 16.5% of India's 1.2 billion people living there. UP's considerable population size has complicated its path to achieving both national health goals and international targets enshrined in the UN 2030 Agenda known as the Sustainable Development Goals (SDGs).

Over the past 20 years, India has registered significant advances in improving its economic and health indicators, significantly lowering mortality and bolstering health facilities. Since the development of the National Rural Health Mission (NRHM) in 2005 to provide "accessible, affordable, and quality healthcare to the rural population," Indian health

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<sup>12</sup>WHO, 'Preventing unsafe abortion' 26 June 2019, <https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion> <accessed on 14 January 2020>

<sup>13</sup>Amnesty International, 'Sexual and reproductive rights under threat worldwide' 6 March 2014. <https://www.amnesty.org/en/latest/news/2014/03/sexual-and-reproductive-rights-under-threat-worldwide/> <accessed on 10 January 2019>

<sup>14</sup>Geeta Gangoli. (1997) 'Silence, Hurt and Chice: Attitudes to the Prostitution in India and the West', *Journal of Women in Culture and Society*, Vol. 22, No. 2, pp. 227-308.

policy on paper has demonstrated a clear commitment to local, community-based public health initiatives.<sup>15</sup> However, India failed to achieve many of the Millennium Development Goals (MDGs), and India is now tasked with delivering the SDGs to meet the needs of its massive population.<sup>16</sup> Principal among the current list of challenges facing India is its infant and maternal mortality rates; there are 25.4 neonatal deaths per 1,000 live births and 174 maternal deaths per 100,000 live births.<sup>17,18</sup> In India, the state of Uttar Pradesh has some of the worst health indicators. With a neonatal mortality rate of 48 per 1,000 live births<sup>7</sup> and a stark maternal mortality rate of 258 deaths per 100,000 births, there is significant room for improvement in Uttar Pradesh.<sup>19</sup> However, given Uttar Pradesh's size and diversity, broad generalizations are not appropriately descriptive or helpful. Locally adapted interventions predicated upon specific and targeted data should be prioritized to create interventions that are culturally appropriate and sustainable<sup>20</sup> in institutionalizing them.

**Figure 1: Map of India with Uttar Pradesh highlighted in red**



<sup>15</sup>Government of India Ministry of Health and Family Welfare, 2005. "National Rural Health Mission, Meeting people's health needs in rural areas: Framework for Implementation 2005-2012."

<sup>16</sup>Government of India, Ministry of Statistics and Programme Implementation (2015) Millennium Development Goals India Country Report 2015.

<sup>17</sup>World Health Organization (2017) "SDG Target 3.2 I Newborn and Child Mortality."

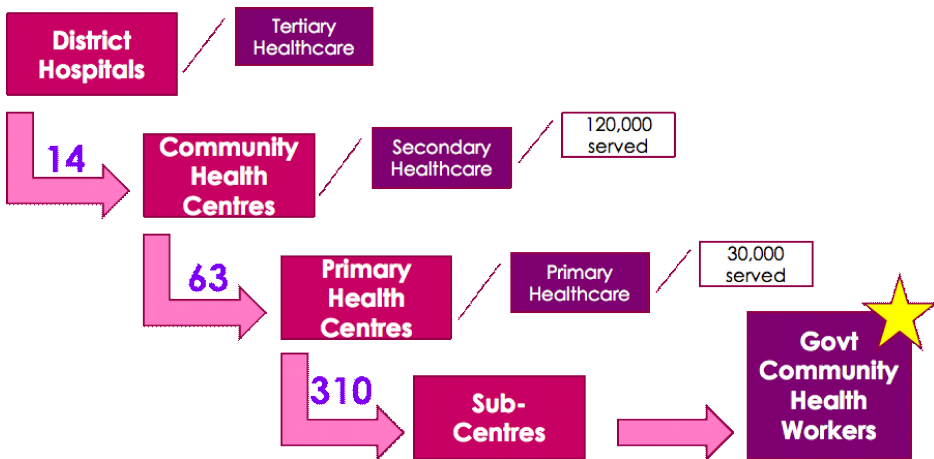
<sup>18</sup>World Health Organization (2015) "Maternal Deaths Data by Country"

<sup>19</sup>Office of the Registrar General and Census Commissioner (2014) "Uttar Pradesh Annual Health Survey 2012-13 Fact Sheet"

<sup>20</sup>Jones, Eleri, Samantha R. Lattof and Ernestina Coast (2017) "Interventions to Provide Culturally-Appropriate Maternity Care Services: Factors Affecting Implementation."

## Bahraich and FPHEd

Health systems and polices have a crucial role in establishing the mechanism with which health services have to be delivered, utilized, and accomplished. In India, ‘health’ is a provincial (state) subject, even though the central government has issued the guidelines but it is the final prerogative of the state governments concerning the implementation of the programmes and policies relating to the newborn children. Thus, according to District-Level data and NRHM’s infrastructure reports, Bahraich District has some of the poorest development indicators in UP. With significantly depressed literacy rates and poor maternal health outcomes, Bahraich was named by NITI Aayog as the sixth most backward district in India. While the District qualifies for all government health programs, Bahraich has not had significant NGO involvement in facilitating the dispersion and functioning of these resources.



The NRHM established a tiered program, as shown in the diagram above, for delivery of care from the Village to the Block Level.<sup>21</sup> Ranging from specialized, tertiary care for entire districts in District Hospitals to preventative care and education at the village level from Sub-Centres, the NRHM had a goal of making health care available to everyone in rural areas at every level of specialty. The role of Auxiliary Nurse Midwife (ANM) was established as the ultimate community-level health provider, covering a population between 3,000 to 5,000.<sup>22</sup> Accredited Social Health Activists (ASHAs) and Aanganwadi Workers

<sup>21</sup>Government of India Ministry of Health and Family Welfare (2005) “National Rural Health Mission, Meeting people’s health needs in rural areas: Framework for Implementation 2005-2012.”

<sup>22</sup>Government of India Ministry of Health and Family Welfare (2012) “Indian Public Health Standards (IPHS) Guidelines for Sub-Centres.”

(AWs) are women serving as community health workers who receive training to work under the ANM in their villages to provide sexual and reproductive health information and nutrition and children’s health information, respectively.

However, despite the existence of comprehensive government programs on paper, Bahraich’s reality looks quite different: many positions both at government health facilities and the community level are unstaffed, and many facilities do not meet the standard requirements laid out in the Indian Public Health Standards.<sup>23,24</sup> While emblematic of India’s commitment to community-level public health, it seems to be the case that Bahraich’s public health infrastructure (health centers, ANMs, ASHAs, and AWs) is not meeting the full need of the rural population.

**Table 1: Type of Provider for Antenatal Care**

Type of Provider	Frequency (N)	Bahraich (%)
ANM	125	54.1
AW	4	1.7
ASHA	18	7.8
Other	15	6.5
No Information	69	29.0

Civil society organization and an NGO such as the Foundation for Public Health, Education, and Development (FPHEd) has been working in Bahraich District since its inception, Uttar Pradesh, to develop appropriate interventions based upon the needs identified by the local community. As a grassroots organization that has been involved with community development in UP for six years, FPHEd aims to serve the marginalized, vulnerable, and oppressed groups of people who live there through public health, education, and sustainable development work. Acknowledging Bahraich’s unique local situation, FPHEd conducted a village-level survey in the Spring of 2017 to assure that its efforts are well-adapted to Bahraich’s specific situation and needs.

The following report has compiled the results of the baseline survey designed to assess the state of maternal and child health in Bahraich. Furthermore, this report discusses FPHEd’s prospective focus areas for interventions. This report starts with a breakdown of the methods FPHEd used for the survey, followed by a wide-lens compilation of the data that had been collected, interpreted, and concludes with a discussion of the results as well as the action steps for FPHEd to take going forward for sustainable, locally-sourced, and culturally-appropriate interventions and development.

<sup>23</sup>Department of Health and Family Welfare (2017) “District Profile: Bahraich.”

<sup>24</sup>Sharma, S. *et al.* (2014) “A Report on Monitoring of Important Components of Bahraich, Uttar Pradesh Programme Implementation Plan, (2013-14).”

**METHODS**

**Population and Sampling**

This survey is based upon data gathered in Chitaura Block, Bahraich District, Uttar Pradesh. Twelve villages were selected using a basic random sampling technique. These twelve villages compose roughly 10% of the population of Chitaura, which consists of 120 villages. A quota sampling technique was used to select 20 respondents from each village for a total of 240 respondents. The selected participants were married women in the reproductive age group of 15-49 years old. Participants were interviewed in their homes by pairs of teachers from the Global School of Learning, a local school run by FPHED. Information was gathered from this group of women using a structured interview schedule that targeted information on maternal health, child health, and the social factors that can contribute to health or illness.

**Data Analysis and Interpretation**

After reviewing the completed questionnaires, it was found that 10 of the surveys were more than 50% incomplete and were therefore not included in the analysis. After rigorous manual checking, data from a total of 230 respondents were analyzed using data analysis software. However, given the sensitive nature of these questions, the requirement for recall, and the fact that surveys were often administered in front of other family members, many women opted not to answer all questions due to sociocultural anathemas. While a total of 230 questionnaires were included, rarely is the total number of respondents for any given question N=230.

**RESULTS**

The data collected and interpreted has been divided into three categories: Socio-Demographic Factors, Socio-Economic Factors, and Maternal and Child Health Indicators as adumbrated below:

**Socio-Demographic Factors**

The demographics of our respondents aligned with those of Bahraich District overall in some categories, such as age given in Table 2.

**Table 2: Age Profile**

Age	Frequency	Bahraich
Less than 25 years	44	19.0
25-30 years	112	48.5
31+ years	75	32.5

The majority of respondents are in the age group of 25-30 years, followed by the 31+ years of age group. With women between the age of 25-30 making up 50% of our respondent sample as well as 48.5% of Bahraich District's overall female population, the age demographics of women of reproductive age for our study mirror those of the district level (GOI-Census, 2001).

However, in other categories such as child marriage, literacy, and religion, our respondents had significantly different demographics than those of UP and India in general. Concerning marriage, 59.3% of respondents in Table 3 were married before attaining the age of 18, which is the legal age of marriage for a woman in India. However, the median age of first marriage was 16. It was found that some respondents were married at ages as young as ten. This is significantly higher than the rates of child marriage in UP and in India as a whole, which were 21.2% and 26.8%, respectively (GOI-Census, 2001).

**Table 3: Age at First Marriage**

Age at Marriage	Frequency (N)	Bahraich (%)	Uttar Pradesh Average (%)	National Average (%)
10-17 years old	137	59.3	21.2 (FHSUP)	26.8 NFHS
18+ years old	94	40.7	78.8	73.2

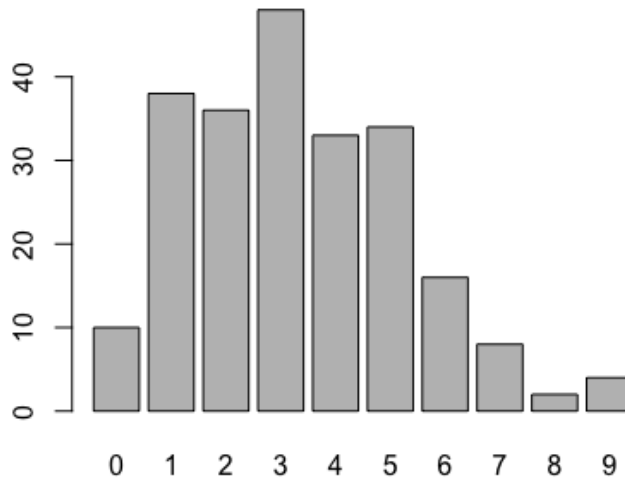
Furthermore, a stark difference in literacy rates, as indicated in Table 4, emerged between our respondents and the average for UP in general. The vast majority of respondents were found to be illiterate, as only about a fifth of women interviewed were able to read and write their names. This is considerably lower than what is found in national-level data, which reports more than three-fifths of India's women are literate.

**Table 4: Literacy**

Education	Frequency (N)	Bahraich (%)	Uttar Pradesh Average (%)	National Average (%)
Literate	41	18.5	61.0 (FHSUP)	68.4 NFHS
Illiterate	181	81.5	39.0	31.6

Concerning religion, our respondents' demographics had an inverse composition to India as a whole, as indicated in Table 5. The vast majority of respondents were Muslim (80.5%), and only 19% identified as Hindu. In comparison, national-level data indicates that almost 80% of the country's population identifies as Hindu, while only about 14% identifies as Muslim.

The villages surveyed presented in Table 6 had much smaller percentages of Scheduled Caste (1.7%) and Scheduled Tribe (2.6%) as compared to the nation as a whole (16.2%



**Table 5: Religion Distribution**

Religion	Frequency (N)	Bahraich (%)	Uttar Pradesh Average (%)	National Average (%)
Hindu	44	19.0	79.73	79.8 census
Muslim	186	80.5	19.26	14.2

**Table 6: Caste Distribution**

Caste	Bahraich	Uttar Pradesh Average
Scheduled Caste	1.7	20.7
Scheduled Tribe	2.6	0.6
Other Backward Caste	48.5	NA

and 8.2% respectively), but the villages in our survey had a higher percentage of people identifying as Other Backward Caste (48.5%) than did the nation (41%).

Family size varied among our respondents, but contraceptive use was low, as indicated in Table 7. The median number of children per family was found to be three, with a first to third quartile range from 2 to 5. Those who currently did not have any children were all pregnant at the time of the survey. Only 7.9% of women reported that they use any type of contraceptive. The type of contraceptive use and whether or not it was used correctly was not reported.

**Table 7: Contraceptive Use**

Contraception	Frequency (N)	Percentage
Yes	17	7.9%
No	198	92.1%

## Socio-Economic Factors

Our survey used type of house, possession of agricultural land, source of water, and drainage systems as indicators of both socioeconomic status and access to appropriate hygiene and sanitation presented in the Table 8.

**Table 8: Water Source**

Source of Water	Frequency (N)	Bahraich (%)
River	11	4.8
Well	9	3.9
Hand Pump	193	83.5
Others	18	7.8

A type of house was recorded as either pukka (a house-made with cement and/or sturdier building supplies), *Kachcha* (a house-made with mud, straw, and/or stones), or semi-pukka (a combination of building styles for different parts of the house) presented in the Table 9. Of the respondents in this study, approximately 30% lived in pukka houses with the majority residing in *kachcha* or semi-pukka houses (44.2% and 25%, respectively).

**Table 9: Housing Quality**

Housing Quality	Frequency (N)	Bahraich (%)
Kachcha	99	44.2
Pukka	69	30.8
Kuchcha & Pukka	56	25

Throughout the world, human development and expansion are based on agriculture that has been regarded as a dominant and leading form of land management, and India is not an exception to the global arrangement (Table 10). The social impact on the land has been accelerating due to the rapid growth of population and growing food requirements. The mounting agricultural intensity creates pressure not only on land resources but also across the whole agrarian income. Thus, in a community where the vast majority of people make a living in the agricultural sector, the distribution of land is indicative of

**Table 10: Agricultural Land Owned**

Agricultural Land	Frequency (N)	Bahraich (%)
Landless	63	30.6
Marginal	8	3.9
Medium	115	55.8
Large	20	9.7

resource distribution. Out of our respondents, 39% indicated that they owned no land, while roughly 57% indicated that they owned a medium amount of land.

The majority of respondents take their water from hand pumps (83.5%). However, the quality of the water available from the pumps used has not been evaluated. An additional water quality study would be necessary to determine if the water taken from these pumps is suitable for consumption and use.

There is a want of awareness regarding the benefits of outlet for wastewater drainage and disposal mechanism and management among the impacted class of people. Therefore, very few respondents reported having an appropriate drainage system or outlet for wastewater. Of the 231 respondents, only 4% indicated in Table 11 that they made use of a drainage system, which they had constructed themselves. The other 96% of respondents disposed of wastewater in surrounding open areas.

**Table 11: Outlet for Waste Water**

Outlet for Waste Water	Frequency (N)	Bahraich (%)
In the Open	221	95.7
Drainage	10	4.3

### Maternal and Child Health Indicators

India is responsible for no less than a quarter of maternal deaths reported globally. However, India has been striving to reduce maternal mortality to less than 100 per 100,000 live births, but, unfortunately, it is still far away from its planned targets despite the fact of rapid economic progress in the last two decades. The geographical vastness of India and its socio-cultural diversity signify that maternal mortality varies across the Indian states, and, therefore, homogeneous and consistent implementation of health-sector reforms is not a viable possibility. Thus, to evaluate maternal and child health, our survey focused on the following indicators: breastfeeding practices, as signified in Table 12, utilization of public health resources and outreach programs, and quality of care and information.

Breast milk is recognized to be the best source of nutrition for newborns and infants, with colostrum as shown in the Tables 13 and 14 (the milk produced or secreted by a

**Table 12: Feeding Practices**

	After 6	Four to Six	Two to Four	One and Two	One Hour
Animal Milk	19	3	4	12	60
Honey	2	0	1	3	5
Mother's Milk	4	0	3	18	80
Other	2	0	0	0	1

**Table 13: Any Colostrum Given**

Colostrum	Frequency	Percentage
Yes	102	47.4%
No	113	52.5%

**Table 14: Colostrum Fed (N=221)**

Colostrum	Frequency (N)	Bahraich (%)
Yes	103	46.6

**Table 15: Iron Tablets**

Type of Provider	Received Any Iron	Took Any Iron
No	108	NA
Yes	115	94

mother for few days or immediately after childbirth that is characterized with high antibody content and protein) and Table 15 (distribution of iron tablets) to be densely packed with critical nutrients and immunity-boosting agents for the child.<sup>25</sup>

Only 48.6% of women surveyed as per Tables 16 and 17 stated that breast milk were the first food given after delivery. The majority of women gave foods such as animal milk or honey. Regardless of whether or not milk was the first food feed, 77.1% of women reported feeding breast milk within the early two hours after birth.

**Table 16: First Food After Birth**

First Food	Frequency	Percentage
Honey	11	5%
Animal Milk	98	44.9%
Mother's Milk	106	48.6%
Other	3	1.4%

**Table 17: Time to First Feed**

First Food	Frequency	Percentage
Within an Hour	146	67.3%
One to Two	33	15.2%
Two to Four	8	3.7%
Four to Six	3	1.4%
More than Six	27	12.4%

<sup>25</sup>WHO India (2018), "Breastfeeding-A Healthy Start to Life."

There is a very high percentage of home births, as shown in Table 18, in the study on population (56.3%) as compared to the people of Uttar Pradesh and the country as a whole (32.3% and 21.1%, respectively) (GOI, NFHS 3). There is a correspondingly low rate of birth registration. While some children were registered after a home delivery, 36.4% of women reported not registering their children at all.

**Table 18: Birth Statistics**

<b>Birth Statistics</b>	<b>Frequency</b>	<b>Bahraich</b>	<b>Uttar Pradesh Average</b>	<b>National Average</b>
Birth at Home	130	56.3	32.2 FHSUP	21.1 (NFHS)
Child Registered	84	36.4	60.2 FHSUP	79.7 (NFHS)

It was found that nearly 30% of respondents received no sort of prenatal care or information. Furthermore, the quality of the care and counseling that women did receive is unclear. Even though many women were able to access a doctor and receive care, such as TT vaccinations, only 24% received any nutritional counseling about increased caloric intake. Subsequently, only 25.3% of women indicated that they increased their caloric consumption during pregnancy. Additionally, 35.7% of women stated that they had complications during pregnancy. Further analysis and studies will be necessary to understand the relationship between poor nutrition, prenatal care access, and complications during pregnancy in this area.

## **DISCUSSION**

This survey was developed to establish a baseline understanding of the current state of maternal and child health in Bahraich District, UP. The results found are evidence of the fact that the current health care system in Bahraich is not meeting the needs of women and children there. From the survey, FPHED has identified the most critical issues in Bahraich’s profile to be indicators of maternal care and a shortage of resources for adolescent girls. This section will break down those issues, as well as address current barriers to health programs and socioeconomic considerations important for future initiatives in this area, concluding with FPHED’s plan of action going forward.

### **Maternal Care Indicators**

In this community, there is both a high level of home deliveries and a low level of birth registration. While home deliveries are not inherently unsafe, it is necessary to ensure that there is a skilled birth attendant available to oversee the delivery. While some women are bringing their children to be registered after home deliveries, approximately 36% of mothers are still not registering the births of their children. This is problematic because, without appropriate birth registration, it will be challenging to access government

resources in the future. Furthermore, lower rates of breastfeeding immediately after birth are indicative of children missing a critical source of nutrition and immunity boost. To better understand why such a low percentage of mother's immediately feed breast milk, it will be necessary to do further studies about knowledge, attitude, and practices surrounding breastfeeding. The solutions to health problems such as these lay in basic educational and awareness programs from women who understand both the context and attitudes of families in these village and the evidence-based recommendations.

Furthermore, nearly 30% of women in Bahraich still receive no health information during the antenatal period. While ANMs, ASHAs, and Anganwadi workers are present in the area, it is clear that they are not able to meet the expectation and demand for services. For those women who are able to access these resources, it is not known whether or not they are receiving quality information. One of the most distressing trends to emerge includes the information gathered about nutritional counseling and caloric consumption. The data from this survey indicate sporadic and incomplete prenatal counseling and care that could have adverse outcomes for both mother and child. In order to fully understand the landscape of prenatal care in Bahraich, it will be necessary to do further studies on the quantity and quality of prenatal care visits.

### **Adolescent Girls**

One of the most troubling indicators of women's health and status in this population was the unusually high rate of child marriage. The percentage of women married before attaining the legal age of 18 years was found to be nearly 40 percent higher than UP generally. This indicates that one of the primary concerns to be addressed in this community will be the status of adolescent girls. With the demographic profile of likely mothers in mind, it is possible to develop programs that address the specific needs of this community and to make certain information pertaining to maternal and child health reaches the appropriate audiences.

In Bahraich, the high rates of child marriage pair dangerously with very low literacy levels. With only 21.6% of women reporting any level of literacy, it is clear that adolescent girls are not being appropriately educated in Bahraich. Efforts to improve maternal health will fall short if the social status of teenage girls is not adequately addressed. It will be insufficient to provide additional healthcare resources if these social aspects of health and wellbeing are not also addressed.

### **Current Barriers**

Community specific traditional practices and other sociocultural beliefs play a role in maternal and child morbidity and mortality. These types of concerns are not given

appropriate consideration in the existing health care system. This study is interested in understanding all of the factors that contribute to poor health for women and children, including cultural, socioeconomic, demographic, and healthcare-related issues.

While frontline health workers such as Anganwadi workers, ASHAs, and ANMs work to provide care in remote areas with a higher degree of local cultural competence, they face significant challenges to provide quality care to such large populations. Our data indicate that many women are not being reached by these service providers and will need additional resources to address this gap in services. A significant constraint in the current system arises from the district level, where administrative requirements end up drawing resources away from women and children. With only curative services available at most healthcare facilities, expansion of prevention and promotive health programs has been ignored. However, it is these basic, village-level programs that are necessary to change local attitudes-government resources are not accessible if the community does not understand and trust them.

### **Socioeconomic Considerations**

Taken together, the quality of housing and the source of water can be a reliable indicator of socioeconomic status and available resources. Pukka houses are composed of more sturdy materials and are indicative of higher socioeconomic status. Kachcha or semi-pukka houses are typically built of mud or some type of unsuitable material and are indicative of lower socioeconomic status. The majority of respondents stated that they used a hand pump for water, which is the safest of the options available in this community. However, the quality of this water was not studied, and therefore it cannot be confirmed that this is a safe water source.

It will be necessary to consider the socioeconomic resources of people in this area while designing any interventions or educational programs. One must be mindful of the limited financial resources available in this community and consider both out of pocket costs and opportunity costs that will arise for people to attend educational programs or avail themselves of any resources offered. Therefore, any program must make sure to integrate itself within existing, free government resources and schemes.

### **Going Forward**

Novel interventions that respond specifically to the landscape of disease and illness in Bahraich must be implemented to meet the current gaps in community health and healthcare delivery. The need to explore and develop a community-sensitive model of reproductive and child health is urgent.

The ideal scenario would be a healthcare system that is family-oriented as opposed to the current system, which is based upon curative services for individuals. A family-

centric healthcare model should pay careful attention to local norms and realities. An environment for establishing and enabling a healthy life for women and children, it is necessary to avail of the social capital that already exists in the area. Trusted community leaders and other local people who hold credibility in the eyes of community members must be involved in any decision making to help ensure local acceptability and that it is well suited to local needs.

To alleviate the current workload of existing frontline health workers (Anganwadi workers, ANMs, and ASHAs), Village Health Volunteers should be established to begin bridging the gap between services and local people. Within villages, there is a wealth of untapped potential and underutilized social resources. By turning to local communities and enabling them to take health into their owns, people will become less dependent upon a system that is too overburdened to meet their needs. Village Health Volunteers would be given extensive health education and begin to serve as a link between the healthcare system and those it is intended to serve, with a primary focus on women, children, and adolescent girls. The Comprehensive Rural Health Project (CRHP) in rural Maharashtra has developed such a role under their “Jamkhed Model.” Over the past 48 years in Jamkhed, CRHP has not only trained over 30,000 community health workers, lowered the area’s infant mortality rate from 176 to 18, and brought the percentage of women accessing prenatal care and delivering safely from less than 1% up to 99%, they have also fostered a sense of trust between the community and healthcare institutions.<sup>26</sup>

The goal of FPHEd would not be to provide new services but to begin to address knowledge, attitudes, and practices in the local context. Village Health Volunteers (VHVs) would serve as advocates for women and children, ensuring they make use of available resources. VHVs would also be able to educate community members about the essential health and social factors that contribute to disease and illness from a trusted perspective. With the data from this survey available as a baseline, FPHEd will continue to use top scientific and research methods to test the efficacy of our programs. FPHEd will continue to grow its resources, strengthen its evidence-based models, and adapt to the local context to facilitate inclusive growth with a human face in an age of global priorities, policies, and programs.

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