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UTILISATION OF MATERNAL HEALTH CARE: A CASE STUDY OF RAJASTHAN (NFHS-5, 2021)

Kalpana Choudhary
Asst. Prof. of Geography,
Govt. College Chhattargarh, MGSU Bikaner, Rajasthan.

"Health is like money. We never have a true idea of its value until we lose it".
-Josh Billings

INTRODUCTION:

"Health is more than just the absence of illness or weakness; it is a condition of total bodily, mental, and social well-being" **(WHO, 1948)**. Since the WHO Constitution's preamble states that health is one of every human being's fundamental rights, the importance of health for each and every individual is critical. As part of its culture, every community has its own notion of health. As health is the foundation of every society's and nation's growth, health issues have received a lot of attention recently, particularly with respect to maternal health across the country.

Inequity in health exists due to a lack of focus on social determinants of health, such as education, employment, sanitation, cleanliness, nutrition, community, and family support as well. The primary factors of proper use of the maternal health care system include women's or husband's education, awareness and understanding of health services provided by the government hospitals or schemes, and subsidies provided to rural families. In India, however, the culture of seeking professional counsel is lacking.

Another MDG Four target was to attain universal measles vaccination in children under the age of one year by 2015, up from 42 percent in 1992-1993. India's most important MDG goal is to decrease the 'maternal mortality rate' by 75 percent between 1990-2015, or from '437 maternal deaths per 100,000 live births to 109 maternal deaths per 100,000 live births' **(Hanimi Reddya, Manas R Pradhana, RohiniGhosh, and A G Khan, 2012)**.

- **Maternal Health Care: Concept and Definition**

Maternal mortality ratio is demarcated as any basis related to or provoked by pregnancy or its controlling (excluding accidental or incidental causes) those consequences in the bereavement of a woman during pregnancy, childbirth, or within '42 days' of closure of pregnancy, nevertheless of the period and place of the pregnancy. The position of women in a society is a key indicator of that cultural level and social fairness. Women's status is frequently defined in terms of their earnings, job, education, health, and fertility, as well as their responsibilities in the family, community, and society **(D.Usha 2014)**.

A community's health behaviour is influenced and dictated by its cultural ideas and traditions. The problem of health, sickness, and treatment is regulated by conventions, beliefs, and cultural traditions among numerous primitive and non-primitive cultures **(Deepani, V. et.al. 2017)**. Economic well-being, educational level of both husband and wife, working circumstances, quality of life and housing conditions, 'decision-making power' of women in the family unit, social and gender interactions, as well as the role of the community, all have a significant impact on 'maternal health'.

As a result, the understanding of reproductive health is not limited to healthcare interventions alone. On the other hand, maximum reproductive health issues cannot be avoided if there is a lack of information and skills regarding any health-related services. Women's reputation in any community, as well as how they are treated with equality, is an important factor in their maternity and reproductive health **(Ramana, D. 2014)**.

With a maternal mortality ratio (MMR) of approximately 445 per 100,000 live births, the state of Rajasthan contributes significantly to India's burden of maternal deaths. The context of Rajasthan sets the stage for this high MMR, both in terms of its terrain and the socio-cultural environment of women's lives. This paper reviews the context of maternal health in Rajasthan and the development and present status of maternal health services in the state.

Rajasthan is the largest state in the nation, with a land area that roughly equates to 10 percent of all of India. The state's desert region, which covers more than 60 percent of its entire geographical area, is characterised by scorching temperatures, scant rainfall, and sparse human population. With a total population of 68 million (Census 2011), three-quarters of whom reside in rural regions, it is also India's tenth most populated state. In comparison to other states, the decadal growth rate is quite high. The Hindu faith is practised by more over 90 percent of the populace, whereas 9 percent of people are Muslims. In the southern and south-eastern regions, the percentage of Hindus is higher (95 percent). The majority of Rajasthan's labourers are involved in agricultural and animal husbandry, though this is gradually changing in some areas. Agricultural labour is more prevalent in better-irrigated areas, but it is scarce in the tribally predominate southern region of the state. There is a lot of underemployment, and there is little industrial employment (7.5 percent). High rates of migration for employment are seen in the semi-arid north-central and tribal south; in the former, two-thirds of households reported moving, and over half of family income came from migration-related sources. Since 1998-1999, Rajasthan has experienced ongoing droughts, particularly in the desert western area (with the exception of 2005-2006). The livelihood support basis has severely broken down with rainfall at less than 30 percent of the yearly normal. Droughts are known to effect women differently because they are in charge of gathering natural resources including water, fuel-wood, feed, and forest food.

Statement of the Problem/ Rationale of the Study

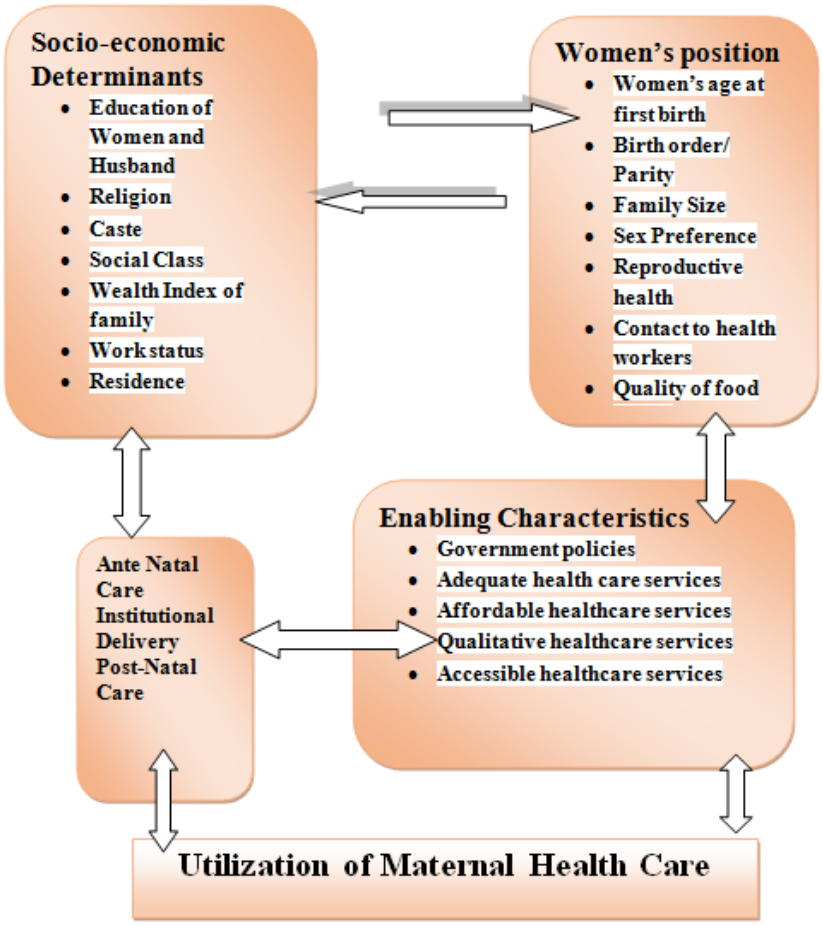
Child health and proper care of the child are intricately linked with maternal health and the level and quality of care that is provided to the mother during her pregnancy. All these, in turn, depend upon the socio-economic factors surrounding the mother and the kind of autonomy, authority and attitude that she possesses. All this determines her position in society and her power to look after her baby the way she wants. But the irony of India is that it is more rural in character especially when the focus is on EAG states like Rajasthan of India. This state needs the most attention in terms of infrastructure development, raising awareness, reducing discrimination between girl children and boy children and proving equal accessibility in many fields. These states constitute more than half of India's population and are the most backward than other states. Analysing the figures relating to maternal health and child care, therefore, becomes crucial in this regard.

- ## Limitations of the study

Rajasthan state in India is categorised on the basis of their need to focus more on them as they need to be uplifted urgently than the rest of the states of India. Rajasthan state constitutes a major portion of the worst performing state in India where females have a more suppressed position than their counterparts. This state shares almost similar characteristics in terms of its socio-economic,

demographics, cultural and economic platform. Besides varying widely from well-performing states, these are strong variations among the EAG states themselves in many maternal health care indicators.

Conceptual framework of the Utilization of Maternal Health Care



- **OBJECTIVES**

- To analyse the socio-economic factors of the study area.
- To analyse the Spatio-temporal (trends and pattern) changes in utilization of maternal health in Rajasthan
- To attempt a district-level analysis with respect to maternal health care in Rajasthan.
- To critically appraise the various Governments' policies and programmes for maternal health and child care with a special focus on NRHM.

- **RESEARCH QUESTIONS**

- Have any far-reaching changes in utilization of MHC services taken place with passage of time in Rajasthan state?
- In what manner do socio-economic, demographic and health care characteristics impact maternal health status in Rajasthan state?
- How are the various policies and programme targeted toward utilisation of maternal health?

- **DATA SOURCES**

DLHS-1, DLHS-2, DLHS-3, NFHS-4, NFHS-5 and Census of India.

- **METHODOLOGY**

The methodologies that have been used for the research are

- Bar diagrams, graphs and maps have been used to show spatial distribution and trends in the utilization of maternal health care in Rajasthan and India.
- Using Arc GIS 10 software is used to show district wise map of study area for showing patterns of 'ante-natal care", "institutional delivery" and "post-natal care".
- Cross-tabulation is used to analyze the relation between two variables such also see relation between background characteristics and utilization of maternal health care.

Utilization of Maternal Health Care Services in Rajasthan

- **General Profile of Rajasthan**

A brief overview of India's high fertility and mortality rates can be attributed to a group of states known as 'Empowered Action Group' (EAG) States, which were previously known as BIMARU States. These eight states are divided into two groups: Uttar Pradesh, Chhattisgarh, Bihar, Odisha Jharkhand, Rajasthan Uttarakhand, and Madhya Pradesh. This group of states account for 46 percent of India's overall residents as well as 59 percent of the country's total impoverished population. This group of states accounts for more than half (55 percent) of all estimated live births, 66 percent (two third) of all infant deaths, and 80 percent (eight out of ten) of all maternal fatalities in the country. Rajasthan is one of the states that belong to this category. The state has been designated as a 'High Focus State' under the 'National Rural Health Mission', owing to the fact that the majority of the people and health indicators are at or below the national average in the state **(NRHM: 2005-2012)**. The present study presents an overview of Rajasthan with particular reference to the status of Maternal Health.

➢ Population and Geographical Area:

Rajasthan is a state in India's northern region, having a common border with Pakistan. According to Census 2011 population totals, it is one of the most populous states in India and the state with the biggest geographical area, accounting for 10 percent of India's total physical area and 5.67 percent of the country's total population. Deserts cover a major portion of the state's geographical mass, with towns spread throughout and a population density that is relatively low as evaluated to other states. The desert covers almost 60 percent (233,100 square kilometres) of the state's entire land area (342,239 sq. km). As of the 2011 Census, it was administratively split into seven divisions, thirty-three districts, and 44,672 villages. In the past, the last three decades, 1981-2011, Dhaulpur was formed during the epoch 1981-1991, five districts of Dausa, Karauli, Baran, Rajasamand, and Hanumangarh, were imprinted out throughout the period 1991-2001, and the district of Pratapgarh was carved out during the period 2001-2011 from the three districts (Banswara, Udaipur and Chittaurgarh).

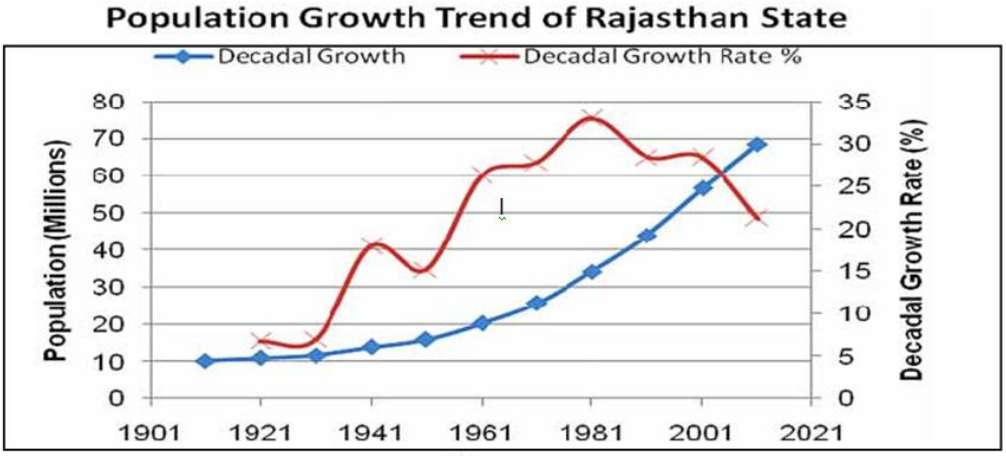
According to the census 2011, India has a population of 121.02 million people, with 6.86 million people living in Rajasthan. According to the United Nations Development Programme, Rajasthan's percentage difference between its projected population for 2011 and its actual population for 2011 stands at just 1.17 percent, whereas India's percentage variance stands at 1.48 percent. Divisionally, the population is concentrated in the Jaipur division, which has a populace of 13,762,203 people (which accounts for approximately 20 percent of the state's population), and the Kota division has lowest population in number, which has a population of 4,733,121 inhabitants (which accounts for approximately 7 percent of the Rajasthan's population).

➢ Decadal Growth of Population:

According to the Census 2011, approximately 21.44 percent of Rajasthan's population has increased over the last decade, as opposed to a pace of 28.41 percent over the previous decennial era of 1991-2001. Nonetheless, it is greater than India's average 'decadal growth rate' of 17.64 percent between 2001 and 2011, a pace that has dropped from a peak of 21.54 percent between 1991 and 2001. Despite the fact that the rate of growth of the population in Rajasthan has been decreased, it is still

greater than the overall rate of growth in India. The 'decadal growth rate' varies in Rajasthan by district, series from 32.55 percent (in Barmer district) to 10.06 percent (in Ganganagar district).

Figure: Population Growth Trend of Rajasthan (In Percent), 2011

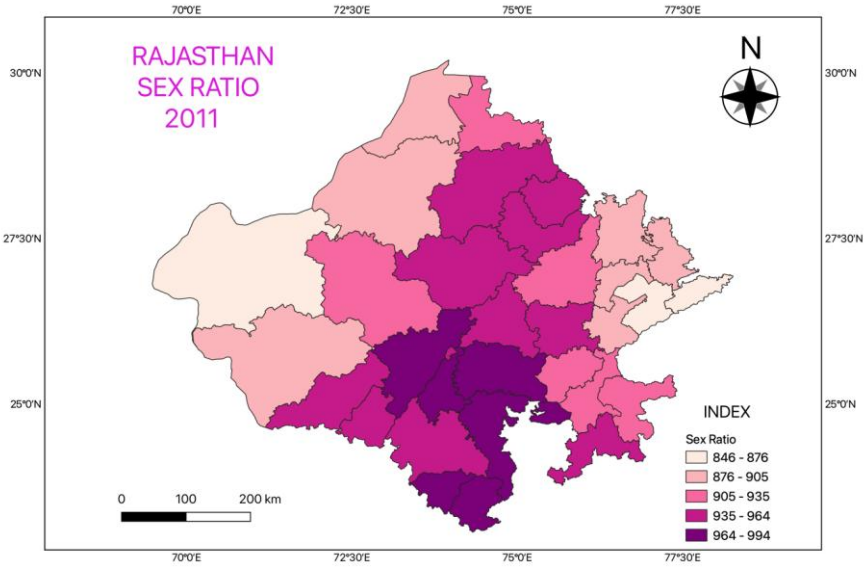


Source: Census of India (1901-2011)

➢ Sex-Ratio: -

A generalized sex ratio of 926 is seen in Rajasthan when measured in conditions of females for every thousand males, as evaluated to 940 for the entire population of India. From 2001 to 2011, there has been a small rise in the number of females for every thousand males, with five more females for every thousand males. In the previous centaury of years, from 1901 to 2011, the entirety sex ratio in Rajasthan state has full-grown from 905 to 926 points, but the general sex ratio in India has decreased from 972 to 940 over this period.

Map: Sex Ratio of Rajasthan, 2011



Source- Census of India, 2011

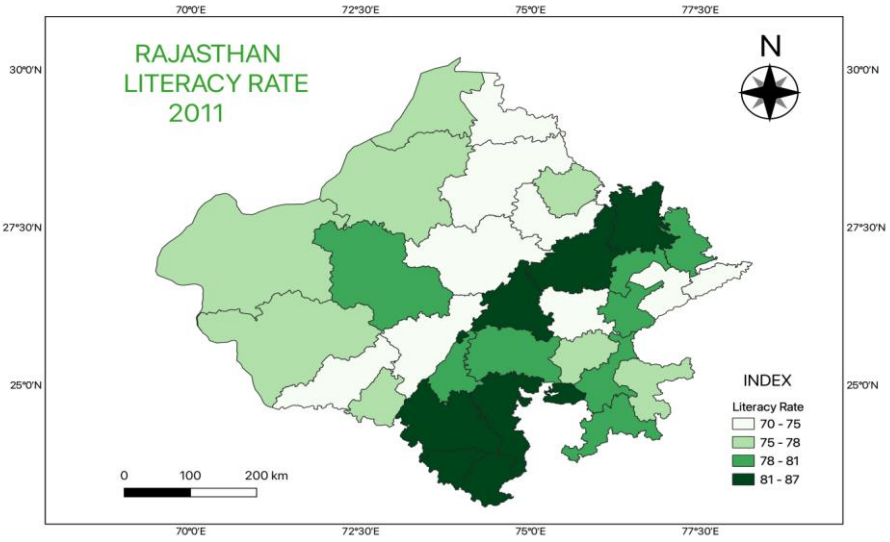
In the Rajasthan state, it ranges of sex ratio from 990 (in Dungarpur district) to 845 (in Dhaulpur), with the highest number being in Dungarpur. It is a matter of concern that the 'child sex

ratio' (0–6 age group) has experienced a significant drop, falling from 909 in 2001 census to 883 in the 2011 census of India. The child sex ratio in the districts vary from 926 in Pratapgarh district that is highest to 831 in Jhunjhunu (lowest in all over the state). With the exception of Sri Ganganagar district, all of the districts have seen a decrease in the child sex ratio.

➢ Literacy:

The Rajasthan state's whole literacy rate is 67.06 percent, with Rajasthan's male literacy rate of 80.51 percent and female literacy rate is around 52.66 percent respectively, as compared to 74.04 (India as whole) percent, 82.14 percent (male literacy), and 65.46 percent (female literacy) for India respectively. The overall literacy rate in Rajasthan's districts ranges from 77.48 percent in Kota district (which has the highest rate) to 55.58 percent in the Jalore district (which has the lowest rate). The male literacy rate is highest in Jhunjhunu district (87.88 percent) to lowest in the Pratapgarh district (87.88 percent). When it comes to tendency in literacy rates, the picture is bleak, as the literacy rate in some districts (Churu and Barmer) has fallen over the previous period of time with male literacy rates declining more than female literacy rates.

Map: Literacy Rate of Rajasthan (In Percent), 2011



Source- Census of India, 2011

In Female literacy rates Kota district has highest percentage (66.32 percent), whereas Jalore district having the lowest rates of literacy with 38.75 percent. Rajasthan is ranked 33rd among all the states and union territories of nation (35) in conditions of overall literacy and it ranked 27th and 35th in terms of male and female literacy, respectively in the country. Rajasthan is the state with the lowest female literacy rate when compared to the rest of the country.

Since 1990, when the Millennium Development Goals were decided with the objective of reducing maternal mortality in India, maternal deaths in India have been falling. According to statistics, 600 women die every year while giving birth to one lakh live babies, implying that around 1.5 lakh women die each year **(AHS, 2014).** However, the good news is that as compared to this statistic, MMR in India fell to 178 per 100,000 live births in 2011. **(AHS, 2017)**. According to SRS data, India's 'Maternal Mortality Ratio' has decreased from 167 in 2011-2013 to 130 in 2014-2016. The drop was most pronounced in India's high-focus states, where the number fell from 246 to 188. The drop has been decreased from 93 to 77 in the southern states, and from 115 to 93 in the remaining states **(SRS, 2014-16)**.

Table: Status of Maternal Health during Survey Period of DLHS-2,(2004) and DLHS-3)

Status	DLHS-2 (in Percent)	DLHS-3(in Percent)
Mothers Who had Received any ANC	73.6	75.2
Mothers Who had 3 or more ANC	50.4	49.8
Mothers Who had Full ANC Check-ups	16.5	18.8
Intuitional Delivery	40.9	47
Safe Delivery	48	52.7
IFA Consumed for 100 days	20.5	46.6
Mothers who Received PNC within 2 Weeks of Delivery	N A	49.7

Source- DLHS-2 (2004) and DLHS-3 (2008)

➢ Ante- Natal Care

Goal four of the MDGs is to decrease child mortality rate by two-thirds among children under the age of five, while goal five intends to enhance maternal health-seeking. The quantity of antenatal care visits and the time of the first appointment are crucial for the mother's health and the pregnancy's outcome. All pregnant women should receive at least four antenatal examinations under the supervision of a professional attendant, according to the World Health Organization **(WHO, 2006)**. According to NFHS-5 (2019-21) in Rajasthan, 55 percent of mothers were in the category of 'mothers who had at least 4 ANC Visits' and in India, this present is 58 percent.

Undernourished girls are more likely to become undernourished mothers, as they are high probability to give birth to a malnourished child. Poverty and malnutrition are linked, indicating poor family situations, as these children suffer from deplorable living conditions, insufficient nutrition intake, increased susceptibility to illness, and limited access to infrastructure services, including inadequate health facilities **(Judson, 2004)**. As a result, proper maternal nutrition is critical for preventing malnutrition in children. When a study is conducted in a rural environment, caste and location of residence become highly crucial considerations. In a rural context, caste is more rigid than in an urban setting. On the other hand, lessons learned regarding the effectiveness of the initial antenatal check-up demonstrates that even if antenatal treatment is obtained late, such as in the third trimester, there is a considerable reduction in pre natal death, **(Ramachandran, 1992)**.

➢ Institutional Delivery

The execution of the Government's policies in programmes like "Janani Suraksha Yojana," with specific emphasis provided by NRHM programmes in these states, is the most likely explanation that may be viewed as the closest and most suitable factor for their awareness. In India, less than half of all births take place in health institutions, either private or public. Deliveries that take place in institutions are rare and mostly take place in houses of the women's in-laws, with just approximately 9 percent of births taking place in the homes of the parents. In terms of where infants are born, one out of every three newborns is born in a hospital in a city, while around 29 percent of babies are born in a hospital in a rural location **(NFHS, 2005-06)**. According to NFHS-5 institutional birth in Rajasthan is 94 percent and 88 percent in India according to same survey report.

Table: Utilization of Maternal Health Care in India and Rajasthan (2015-2021)

Indicators (in Percentage)	NFHS-4 (2015-16)		NFHS-5 (2019-21)	
	India	Rajasthan	India	Rajasthan
Mothers Who had an ANC in 1st Trimester	58.6	63.0	70.0	76.3
Mothers Who had at Least 4 ANC Visits	51.2	38.5	58.2	55.3
Mothers Who Consumed IFA Tablets for 100 Days	30.17	17.3	44.1	33.9
Institutional Birth	78.9	84.0	88.6	94.0
Mothers Who Received PNC	79.1	69.3	68.2	86.9

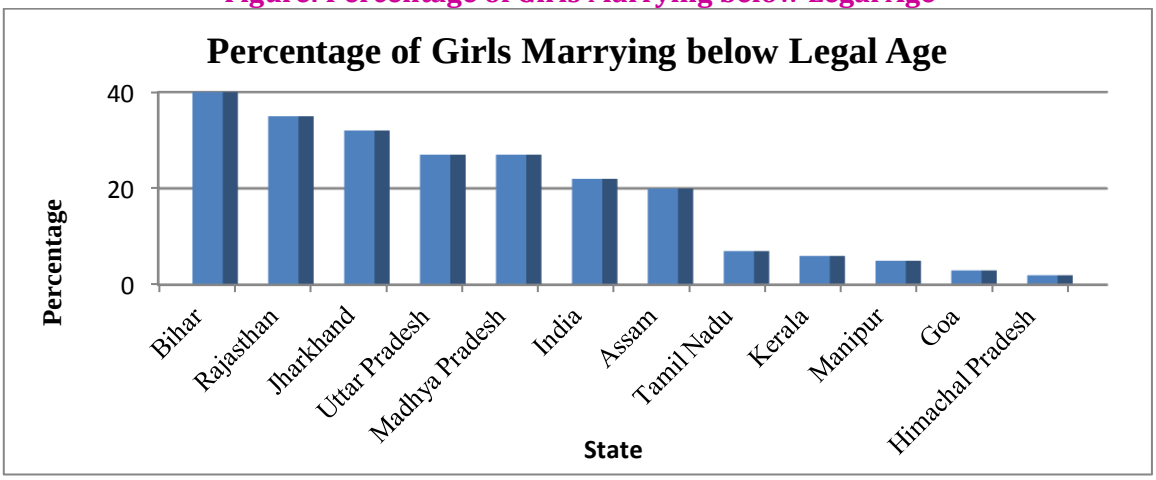
Source- NFHS-4 (2015-2016), NFHS-5 (2019-21)

However, there is a lack of exact evidence to corroborate this assertion. Maternal mortality has been claimed to be greater among the indigenous tribes. Unhygienic and fundamental parturition practices were discovered to be some of the primary causes of maternal death. Rajasthan's MMR is higher than the national average. Maternal fatalities accounted for 29 percent of all deaths amongst women of the 'reproductive age group', with lifetime risks ranging from 1.9 percent to 2.2 percent **(AHS, 2013)**. It is the surprising truth that in certain circumstances, the woman needs to deliver her baby in a half-squatting posture while gripping a rope strung down from the hut's ceiling so that she may apply pressure for the birth of the infant when no one arrives on time. It is apparent that in difficult labour, this method might result in maternal and infant death.

- **Maternal Health in India and Rajasthan**

The well-being of women throughout delivery, pregnancy, and the postpartum period is known as 'maternal health'. 'Maternal and child health' were included in India's Family Welfare Programme shortly after independence. From the beginning of the 1st and 2nd Five-Year Plans (1951-56 and 1956-61) until the present, this has been a critical component of the programme. Under the "Minimum Needs Programme," which was implemented during the Fifth Five-Year Plan (1974–79), the health of the mother, the health of her children, and the availability of nourishment for both mother and children were linked with family planning services. Several important child survival initiatives, as well as safe motherhood and family planning activities, were regularly incorporated in the programme during the years 1992-1993 under the name of "Child Survival and Safe Motherhood Programme" **(MoHFW, 1992)**. The Reproductive and Child Health Programme (RCH) was introduced to the list of welfare programmes in 1996, with the goal of ensuring a healthy childhood and safe motherhood. The "National Population Policy" established by the "Government of India" in 2000 was a key step in the Government's commitment to safe and effective maternity programmes in the broader context of reproductive health **(MoHFW, 2000)**. India's focus on decreasing maternal mortality and improving maternal health care facilities, on the other hand, was inspired by international conferences that focused on lowering maternal mortality in nations with high rates of mother and child fatalities. The worldwide label has been focusing on reducing maternal mortality since the Safe Motherhood Conference in Nairobi in 1987. The "International Conference on Population and Development (ICPD)" in 1994 and the 'Millennium Development Goals (MDGs)' Millennium Summit in 2000 were the next critical steps in maternal care, with the goal of reducing maternal mortality to fewer than 100 between 1990 and 2015. India was one of the first countries to embrace the 'Millennium Development Goal's'.

Figure: Percentage of Girls Marrying below Legal Age



Source-NFHS-4

The regional differences in the proportion of females marrying before reaching the legal age are given in the graph , and a comparison across states have been provided. The health of both the 'mother and the child' is exaggerated by early marriage. In India, over 20 percent of girls marry before they reach the legal age of marriage. Bihar has the greatest proportion of early marriages, with around 40 percent of girls married before the age of 18; Rajasthan follows closely behind with approximately 35 percent of females married before the age of 18. At least 20 percent of females in Jharkhand, Madhya Pradesh, Uttar Pradesh, and Assam marry before they reach the age of 18. On the other hand, only 2 to 3 percent of females under the age of 18 marry in Himachal Pradesh and Goa.

➢ Anti-Natal Care in India and Rajasthan

When DLHS-4 is compared to DLHS-3, it has been seen that women are receiving more reproductive health-related care services. The following map depicts district-level variation in women's "Ante Natal Care" in the EAG states of India, as depicted by the colours on the map. Due to the fact that this area of India lags behind in many socio-economic indices as compared to the rest of India; so it is important to undertake research in this region. For many years, the status of women, particularly in rural regions, has been a source of great concern, contributing to overall low performance in other areas as well.

Dhaulpur (29 percent) and Baratpur (29 percent) have the greatest proportion of women seeking any kind of ANC in Rajasthan, whereas Ajmer (82 percent), Pali (78 percent), and Sikar (70 percent) have the lowest proportion of women seeking any form of ANC (27 percent). Institutional delivery is most common in Jaipur (62 percent), Dausa (60 percent), and Sikar (59 percent), while it is least common in Jaiselmer (26 percent) and Barmer (26 percent) (21 percent). The largest concentration of PNC is found in southern Rajasthan, specifically in the districts of Dungarpur (86 percent) and Udaipur (85 percent) (86 percent).

According to DLHS-3 survey, the northern districts, which include Hanumangarh (15 percent) and Jhunjhunu (15 percent), have the lowest percentage of women who take part in PNC (16 percent) whereas Kota, Bundi, Banswar, Jhalawar, Sirohi and chhitorgarh districts have more than 70 percent mothers had four and more ANC visits in Rajasthan. According to NFHS-5 (2019-2021), very less number of mothers in Bharatpur, Dholpur , Karouli and Churu districts r recieve ANC visits from healt centre (less than 45 percent) . In India, EAG states are in very backside for receiving ANC.

➢ Institutional Deliveries in India and Rajasthan

The major reason for not delivering in an institution is because of the expense and cost which they cannot afford. Since 2005, India has been one of the few countries in the world to implement a cash transfer scheme for transportation expenditures. Some people believe that going to a hospital for birth is unnecessary. One cause for not seeking medical advice is the lack of time.

One of the main causes of the decreasing number of deliveries at health centres are women's preference for home birth. Some women believe that birth in a hospital is only necessary when there are issues or concerns. Aside from all of the other characteristics that impact women's health-care-seeking behaviour, their husband's education and residency are equally important.

Closer access to traditional birth attendants makes it easier for the family to choose for a home birth. People seek appropriate infrastructure in hospitals, such as a clean bed, facilities for relatives to stay, toilets, water, and a decent area where the family may prepare food for one or more meals. Some of the needs that make the reason for travelling to a hospital for delivery are the availability and quality of qualified birth attendants, medical shops in surrounding regions, and enough equipment available in the hospitals. Giving information to the mother or her family, maintaining a constant attention on the mother, and giving information about the infant are all factors that contribute to the mother's happiness. Furthermore, candour and openness between trained employees and doctors are critical in convincing women to seek medical counsel and give birth in hospitals **(Sanghita Bhattacharya, 2016)**.

Graph depicts the institutional delivery in India's EAG states on the whole. In no EAG state, more than half of pregnant women seek birth in a health-care facility. Even after the implementation of the National Rural Health Mission (NRHM), Jharkhand has the lowest rate of delivery from health centres, at barely 17 percent. Since the prior survey, the percentage has been decreased (from 22 percent to 17.7 percent). According to official figures, since 2004, just around 3 percent of deliveries in Jharkhand have been aided by the JSY programme **(DLHS-3, 2008)**. According to the state's health department, the percentage of institutional delivery in non EAG states across Kerala and Goa is the norm, and it is close to 100 percent in Tamil Nadu. In Maharashtra, more than half of pregnant women choose to give birth in a health-care facility.

The proportion of institutionalized delivery has risen in Tamil Nadu throughout the years. Women who attend higher secondary levels of education, particularly first-time mothers, prefer to give birth in a health-care facility. The second order of birth, and then the succeeding order of birth, may not take place in an institution; however for the first infant delivery, institutions are preferred more than any other setting. Education, age at marriage, birth order, and a low level of living are the most significant factors to consider while selecting a site of delivery in an institution **(Puthuchira, Ravi et al., 2013)**.

➢ Post-Natal Care in Rajasthan and India

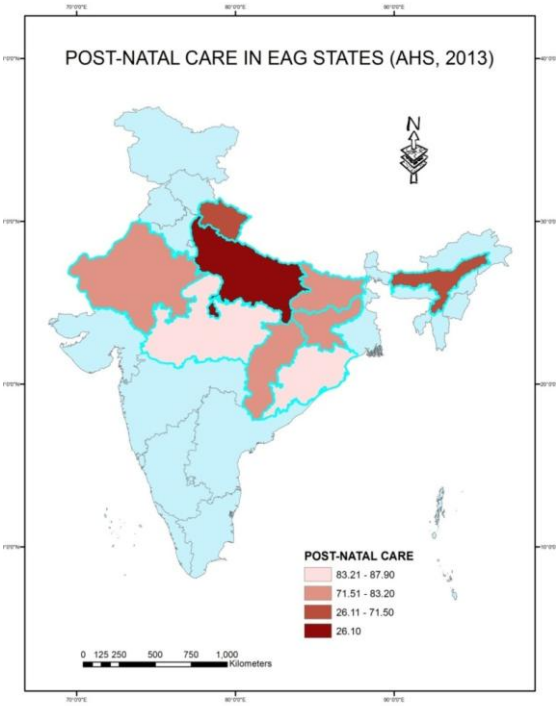
The MMR in Rajasthan ranged from 627 per 100,000 live births in 1982-1986 to 405 in 2011-12, according to the data obtained. Rajasthan's MMR has been more to the countrywide average for all time periods.

According to the DLHS-3, rural women were 26 percent less probable than their urban counterparts to get three ANC visits (68 percent). The percentage of women giving birth in a facility has gradually increased, reaching nearly one-third in 2005-2006 **(NFHS-3)**. Within two days of giving delivery, just about a third of indigenous mothers received postnatal care. “Post- natal care” is the care which a mother needs after the delivery of her baby. After the birth of baby, the mother becomes very fragile and weak; and she needs continuous and strong care for attainment of that energy which she has lost during her child birth. However, usually it happens that the family starts caring for the baby more than the mother. The new born baby captures the attention of the households and in the process many a times, mother’s health is neglected. This can be seen more when the new born is a boy. As the boy has always been preferred more in the male- dominated society and could be especially seen in North India, particularly in EAG states. In many families, only health of the baby boy is given importance and care

because it is believed culturally that the boy will bring fame to the family and will go out for earning, and serve his family in future.

Considering all these notions, the boy's health is given more importance over his mother. When the child is a girl and even if she needs care, the probability of her getting the required care from family is very low, especially when the other babies are girls in the family.

Map: Utilisation of Maternal Health Care in EAG States and Assam, 2013



Source: AHS-2013

The Government's programmatic interventions are focussing on reproductive and maternal health, new-born health, Child health, adolescent (RMNCH+A) health interferences, which contain numerous programmes such as the Janani Suraksha Yojna's promotion of institutional births, inclusive obstetric attention and following of 'each and every' pregnant woman through the involvement of ASHAs. The government's programme has focused on antenatal, institutional deliveries, and postnatal care. Despite these efforts, there has been a little progress in lowering the disparities in maternal morbidity and death among women from Scheduled

Despite the Government of India's efforts, the use of antenatal care (ANC) services amongst women belonging to rural areas, mainly those from Scheduled Tribes regions, remains low. Mutually socio-economic and healthcare organization variables contribute to Scheduled Tribe women's low usage and non-utilisation of antenatal care and subsequent care. ASHA personnel must appropriately address affordability in order to improve ANC utilisation across tribes, diverse socio-economic variables, and health accessibility, with specific importance on women's educational accomplishment of higher education. There is also a need to raise awareness about the need of early ANC treatment among pregnant indigenous women and their families **(Adhikari, T, 2016)**. During her last pregnancy, a woman is considered to have completed ANC if "mother had three ANC check-ups, had at least one dose of tetanus toxoid (TT) injections, and ingested 100 iron-folic acid (IFA) tablets/syrup".

• CONCLUSIONS

The biggest problem facing the nation is reducing maternal and newborn mortality, particularly in regions and their sub-regions where institutional delivery rates are relatively low. Rajasthan is one of the states where the institutional delivery rate is not only low but also significantly varies between districts. The quality of mother and child health care varies greatly throughout the state's 33 districts. In the western, southern, and southeast regions of the state, at least one-third of the districts have low to very low levels of maternal and child health. Districts in the central and northeastern regions of the states, on the other hand, have relatively high levels of mother and child health. The mother and child health is moderately good in the remaining districts. Physical and sociological limitations, such as the state's hilly terrain and western desert region, as well as the southern region's concentration of tribal people, have had a negative impact in this regard. In hill tribal and desert-prone districts of the state, poor accessibility caused by topographical restrictions, particularly in rural areas, along with social taboos among the tribals, have been acting against institutional delivery. This is all due to the low knowledge and literacy rates among females. Contrarily, areas with a mix of commercial agricultural and urban-industrial basis have fared better on this score. At the district level, there was a significant positive correlation between female education and awareness and maternal and child health. The National Health Mission's Janani Suraksha Yojana, a centrally funded programme, has recently been instrumental in improving the infrastructure for maternal and child health care in certain of the state's districts, particularly those that fall under the intermediate maternal and child health category. Overall, mother and child health is at its highest in the five districts of Jhunjhunun, Jaipur, Kota, Ganganagar, and Sikar, while it is at its lowest in the districts of Barmer, Jaisalmer, Jalor, Udaipur, and Sawai Madhopur.
In the future, areas that continue to have social and physical handicaps must receive more attention. Otherwise, even in 21st-century India, geography will continue to be their fate.

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