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The Structural and Social Determinants of Reproductive Behavioural Health: A Brief Appraisal of Indian Scenario

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ABSTRACT

Reproductive health plays a crucial role in maintaining the health status of an individual. The terms "Reproductive Rights" and "Reproductive History" were coined at the "International Conference on Population and Development (ICPD)" held in 1994, and the term "Reproductive Health" was connoted as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes". Collected details on the reproductive behavior of an individual, now known as "reproductive history," are defined as "an important aggregate factor in epidemiological studies of women's health." The concept usually includes the number and timing of pregnancies and their outcomes; the incidence of breastfeeding, and may include the age of menarche and menopause, regularity of menstruation; fertility, gynecological or obstetric problems, or contraceptive usage. Researchers, epidemiologists, and medical personnel have chronicled their findings and voiced their concerns about maternal and reproductive health on various platforms at national and international levels. Some of these papers are focused on this topic. In the present discussion, an attempt has been made to evaluate the role of structural and social determinants on reproductive health. The systematic analysis might help to pinpoint the populations that seem to be lacking in awareness of the importance of this vital but often ignored part of health, and thus there is a lag in reproductive health services.

Keywords: Reproductive Health, Women, Structural And Social Determinants, COVID-19 Pandemic.

INTRODUCTION

"Reproductive health" is one of the pivotal factors in the overall health status of an individual. The "International Conference on Population and Development (ICPD)", held under the auspices of the United Nations in Cairo, Egypt in 1994, rendered a formal status to health behaviour associated with reproduction by formalizing it as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes". According to Beall and Leslie (2014), "Reproduction is the coin of the evolutionary realm. Women's reproductive histories are central to addressing major scientific questions, including detecting natural selection and other forces of evolution and teasing apart the often complex relationships among fertility, mortality, and environmental (physical, biotic, and socio-cultural/economic) characteristics.

The amalgamation of facts related to the reproductive behaviour of an individual, summarised as reproductive history, is defined by Beall and Leslie (2019) as "an important aggregate factor in epidemiological studies of women's health."The concept usually includes the number and timing of pregnancies and their outcomes, the incidence of breast feeding; and may include age of menarche and menopause, regularity of menstruation, fertility, gynaecological or obstetric problems, or contraceptive usage." Reports have revealed that researchers have voiced their concern regarding the close questioning required to bring forth detailed reproductive

histories, which is very time-consuming as it takes social skill and time to make the respondent comfortable enough with the researcher to confide about embarrassing or traumatic events related to the reproductive history of the respondent concerned, thus incriminating cooperation in other aspects of the research and that they "decided to obtain demographic data in other ways". The researchers interested in evaluating the fertility determination factors consider socio-cultural background, economic status, institutional norms and traditions, and the legal framework of the area where the community under scrutiny resides; and these variables influence a milieu of intermediate eventual factors (affecting copulation, conception, gestation, and successful parturition), leading to a conclusion about a particular set of demographic variables like fertility rates and patterns, which are pooled from aggregated reproductive histories.

REVIEW LITERATURE

The majority of the population in India is residents in non-rural areas and India boasts the world's largest urban population, where the majority resides in the urban slums. The study conducted by Hazarika in 2010 on contraceptive use for birth spacing, utilization of skilled midwifery assistance during childbirth, and postpartum check-ups among women residing in urban slum and urban non-slum areas revealed that a significantly lesser proportion of slum resident women, in contrast to non-slum residents, had ever used contraceptives, accessed skilled attendants at delivery and received postpartum check-ups.

The study in New Delhi on contraceptive use among the women assessing the hospital's outdoor reproductive health unit facilities conducted by Kumar in 2011 pointed out that though the use of contraceptives among urban and rural poor is less similar at 50%, it is considerably less than the user frequency among educated and enlightened urban populations. Mental health is an important factor that hampers proper perinatal care of the infant and mother herself. In 2009, Kapetanovic, in his study on mothers affected by AIDS and normal healthy mothers, threw light on the fact that perinatal depression can occur during pregnancy and even after the child has attained one year of age and is termed "postpartum depression". According to NFHS-5 data, depression among mothers irrespective of age group varied from 3.1% to 4.9% during the perinatal period, and during the postpartum period, it varied from 1.0% to 5.9%.

Rural women in India are the most susceptible category in terms of health risks faced by women during childbirth, ultimately leading to mortality or other complications. The study carried out by the International Institute for Population Sciences and Macro International in 2019 pointed out that approximately 30% of births take place in "health centers" with assisted trained personnel, but the rest of the births (71%) take place in the homes without any trained medical assistance.

Noronha et.al (2010) in their study on women accessing the health services provided by the government of Karnataka, revealed that socio-economic status plays an important role in the high incidence of anemia among gravid women without any allied health complications.

Women bear the brunt of domestic violence, which in India is basically gender-oriented violence (Koski 2011). Domestic violence influences the proper utilisation of the privileges of state-aided and private reproductive health care facilities and services in the social and cultural context of India, which has a long-lasting effect on the biological and mental health of newborns as well as mothers. The study conducted by NFHS 5, in rural pockets of the Indian states of Bihar, Jharkhand, Maharashtra, and Tamil Nadu, revealed that gestating mothers with a history of stressful physical violence received antenatal care with less frequency.

Family planning methods and antenatal care of a gestating mother exhibit a strong association. The analysis of the National Family and Health Survey (NFHS 5) published by the International Institute for Population Sciences and Macro International in 2022 revealed that the fertility rate among illiterate women was around thrice more compared to women with a minimum of 12 years of a complete education. Consequently, 29% of illiterate women were provided with antenatal care facilities in the government-run health care centers, in contrast to 88% of women with a minimum of higher secondary education.

Reports on rural adolescent pregnant girls married before attaining 18 years of age have thrown light on the fact that child marriage is strongly associated with less access and utilization of mandatory antenatal care services (Singh et al, 2012) and postpartum delivery care (Santhya et.al., 2010). Gupta (2010), in his study on the Indian state of Rajasthan, observed that teenage pregnant mothers also have a 2.5 times higher mortality rate due to pregnancy-related complications than adult pregnant women.

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According to Khan and Khan (2016) "women with temporary marriages mostly suffered from psychological issues—causing two types of concerns, including intrapersonal communication disorders and interpersonal communication disorders." Khani and Moghadam (2018) pointed out the need to redress the sexual and reproductive health requirements and necessities of women who are out of marriage bonding or who have been in marriage for a brief period of time. The vision of human rights concerning women's reproductive sexual rights is at a crossroads with the concept of temporary and other forms of non-traditional marriage currently in vogue as understood from factual data.

The percentage of women adopting contraceptive methods of limited time span durability is around 40, out of which the majority resort to consumption of oral contraceptive pills and rarely rely on the insertion devices, amenorrhea of lactating mothers, and adoption of female contraceptive measures (Reproductive Health Supplies Coalition 2019).

It has been opined that transitory and often unannounced legal marriages are the common source of severe gender-based domestic oppression without freedom of sexual and reproductive rights choices along with socio-economic independence. They pointed out, "However, according to several experts, although temporary marriage is a legitimate response to young individuals' needs due to economic and social barriers to conventional marriage, it may threaten women's health by increasing the risk of STIs (sexually transmitted infections)/HIV, early child marriage, unwanted pregnancies, illegal abortions, coercion and loss of family and social support".

Studies conducted by a multitude of authors aptly point out the fact that the adolescent and young adult populations are more likely to resort to perilous health behaviours, mainly due to insufficient erroneous information about the gamut of sexual and reproductive health issues. Tripathi, (2021) revealed the disturbing realities from the previous research (Santhya and Jejeebhoy, 2015) conducted on sexual and reproductive health (SRH) issues concerning adolescents and young adults in India

Studies conducted by Stanger and Hall, 2011; Kraft et al., 2012; Lindberg and Maddow, 2012; have revealed that positive behavioural changes can be brought about among adolescents and young adults by imparting life skill knowledge which influences the better understanding of Sexual Reproductive Health issues, increase in contraceptive habits, delayed initiation in sexual activities, better wisdom in partner selection, avoiding termination of pregnancy through nonmedical means, improved menstrual hygiene and low risk of Sexually Transmitted Infections and diseases like HIV/AIDS.

As per the survey conducted by the National Family Health Survey, though 75% of Indian households are eligible for various constitutional safeguards, including reproductive health services in government-run health facilities, India is often clubbed with less access to reproductive health services, resulting in adverse maternal and child health status. NFHS 5 revealed that women belonging to scheduled tribes and scheduled castes had a decreased possibility of being provided with any type of antenatal care. Only 14% of SC/ST pregnant women had an assisted childbirth in a health facility, compared to 61% of non-OBC, non-SC/ST women. Several studies have revealed that SC/ST women exhibit a less tendency to use safe reproductive health care practices, mainly in the use of family planning measures. A study conducted in Rajasthan pointed out that

sterilization is the most popular and frequently used contraceptive method among Scheduled tribe women (Gupta et al 2010). The finding was further substantiated by the study conducted by Deb in 2010, which threw light on the fact that, though rural areas of the north-eastern state of Meghalaya exhibit increased levels of awareness of contraceptives it does not ensure the optimum level of dependence in the community members of scheduled tribal caste groups (Deb, 2010).

DISCUSSION

According to the studies and observations done by World Health Organization (2009, 2010), the health pertaining to reproductive behaviour is a pan-world cause of concern, where adolescent girls, young adult women, and adult women are an essential part. The age ranging from 15 to 49 years is considered to be crucial in women's health but women face maximum health challenges during the crucial fecund period.

It is apparent that women's health is a culmination of their emotional and social needs combined with physical well-being. The chief constraints for women to attain the level of wellness are inequality, in terms of gender, social-cultural norms across diverse ecological niches, and social groups in terms of indigenousness and ethnicity, which in turn acts as the pivotal determinant of quality of life (Aiman and Ahmed 2022; Sarli 2019; Soelar and Mustaffa 2022 and Nachimuthu et al 2022). Saccone et al 2019, Junagari 2020, Wahyuni 2020 and Phelan et al 2021 threw considerable light on the effect of pandemic due to Corona virus outbreak on the maternal health and accessing health care facilities.

The power that an individual woman command is determined by her economic freedom, and social strata which influence the woman's freedom in decision-making abilities regarding access to and use of reproductive health care facilities. According to Nayar (2007) "a review of social exclusion, caste and health concluded that the health status and health care seeking behavior of SC and ST provides an indication of both their social exclusion as well as the linkage between poverty and health for a population". (Sanneving, 2013 and Ajith 2014) reported that "Gender norms are closely linked to adolescent's sexual and reproductive health. In the Indian context, pre-marital sexual relations are widely discouraged and this review found studies showing that adolescents face barriers in accessing contraceptives and reproductive health services".

CONCLUSION

The review will help the personnel working in the domain of reproductive health by categorizing the deprived, underprivileged populations who either due to one or a multitude of factors discussed above, remain disadvantaged and lack the awareness to access and properly utilize reproductive health services essential for maintaining the status of healthy well being. The position in society determines the awareness and susceptibility of individuals as a precursor of determinants inducing ill-health. Reproductive behaviour and the consequent effect on health are determined and influenced by rural/urban dichotomy in health, gendered domestic violence, educational attainment, and social ranking of the social group. Social cultural norms influencing sexual and reproductive health, use of family planning measures, and juvenile age at marriage are the dormant yet powerful motivators in understanding the determinants for necessity and importance of access to and use of reproductive health care facilities.

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