ISSN: 2395-7639

International Journal of Multidisciplinary Research in Science, Engineering, Technology & Management (IJMRSETM)

(A Monthly, Peer Reviewed Online Journal)

Visit: www.ijmrsetm.com

Volume 5, Issue 6, June 2018

Health of Rural Women in India And Initiatives by the Government

Dr. Abha Ojha

Associate Professor, Home Science Extension Education, Maharani Sudarshan Govt. Girls College, Bikaner, Rajasthan, India

ABSTRACT: Rural women experience poorer health outcomes and have less access to health care than urban women. Many rural areas have limited numbers of health care providers, especially women's health providers. Rural India is heterogeneous where problems vary depending on the region and state. Health care professionals should be aware of this issue and advocate for reducing health disparities in rural women.

KEYWORDS: rural women, health, India, government, initiatives, poor, schemes, professionals, care

INTRODUCTION

In India, discussing about women's sexual and reproductive health is still a taboo in many areas, especially in rural areas. According to Global Nutrition Report 2017, 51% of Indian women between 15 to 49 years are anaemic while according to the Ministry of Health and Family Welfare, India's Maternal Maternity Ratio (MMR) is at 113, which means there were 113 deaths per 1,00,000 live births between 2016-2017. However, India still has a long way to reduce its MMR to 70 per 1,00,000 live births by 2030 to match with the Sustainable Development Goal target. [1]Women are taught and expected to suffer in silence. If she is able to do that, she is considered a high value woman in the society. Hence, issues related to their health are always neglected, never spoken about. In rural India, it is worse than the cities. Here in Anantapur, many women have high risk pregnancies, which is a result of ignoring nutrition intake and subtle signs of complications. Anemia and urinary tract infections[2] (UTIs) are pretty much rampant among women here. However, they often avoid getting it treated and end up increasing their complications. Women are reluctant to go to faraway places for check-up even for severe problems. The absence of healthcare awareness in India has always been concerning, especially regarding women. Social stigma, superstition and lack of education among more than 50% population in the country lead to terrible scenarios in women's health. Maternal healthcare in rural communities[3] is gradually changing with the help of government initiatives and public-private partnership led campaigns. Considering the population rise, these initiatives are not enough and we still face episodes of complicated mortality and morbidity among women and children. The dearth of resources and skilled healthcare staff has been a major problem in remote locations. Super-speciality maternity hospitals are mainly located in urban areas and it is not always feasible to travel to these locations in complicated conditions. Even if it is feasible, the time has its limitations.[4] Over the years doctors have witnessed many cases where mothers have either lost their lives or faced severe complications because of not reaching the hospital in time.[5,6] The shortage of skilled birth attendants who are educated, qualified, and regulated at regional levels somehow contributes to many women dying during, before, and after childbirth. Mothers need complete prenatal to postpartum care which rural women find challenging. Family physicians, nurses, and community health workers provide maternal healthcare in these areas. The lack of staff makes it difficult for these people to give all patients adequate time. In spite of all the technological advances and hype about women's empowerment, rural women among all have been considering themselves as a weaker sex even in the 21st century. [7]They don't seem to break the boundaries for educating & caring for the sake of their health. The mindset of accepting a situation has created a huge gap in receiving access to healthcare. Educating a mother about her health or at least breaking the barriers will solve a higher percentage of the taboo leading to severe health cases in women. Women are an essential part of any society as they begin, shape and manage it. Enhancing their health status in every nook and corner of the country will automatically push the socioeconomic situation of the country to a more fantastic side.[8] Issues like malnutrition have also been due to a lack of nutrition for the baby when in the womb. All poor women have difficulty obtaining needed health services due to their poorer health status and lesser ability to pay for services. Rural poor women have additional

ISSN: 2395-7639

International Journal of Multidisciplinary Research in Science, Engineering, Technology & Management (IJMRSETM)

(A Monthly, Peer Reviewed Online Journal)

Visit: www.ijmrsetm.com

Volume 5, Issue 6, June 2018

conditions imposed on them by the isolation of the rural environment from resources commonly available in urban areas, such as public transportation to services and the availability of a wide range of health resources.[9,10] Strategies to address the health plight of rural women must first and foremost address their poverty. Strategies must also include a coherent national and state rural health policy that recognizes rural health as a distinct part of the larger health system. The health plight of rural women is rooted in poverty, which contributes to their poorer health status and creates financial barriers to obtaining health care. The special needs of rural women can be addressed through policies that diminish poverty and provide protection through a national health program for uninsured populations.[11] To improve health insurance coverage, the following are suggested: 1) eliminating Medicaid eligibility criteria tied to state welfare eligibility, 2) developing incentives for small businesses to provide adequate health insurance coverage for employees, and 3) restructuring or supplementing Medicaid and Medicare to cover self-employed farmers, seasonal workers, and others who fall between the cracks of eligibility requirements. To increase availability of services, there are 2 recommendations: reimbursing physicians and hospitals such that the costs associated with recruiting personnel to remote areas and serving a low volume of patients are recognized, and establishing or reinstituting federal and state programs that encourage health personnel through educational loans or tax incentives to practice in rural areas. To improve transportation, setting up special loan programs for rural providers or communities to upgrade facilities and to provide transportation services.[12]

II.DISCUSSION

The National Health Mission (NHM) is a Centrally Sponsored Scheme which envisages achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs, including women, across the country. The main programmatic components include Health System Strengthening in rural and urban areas, Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases.[13]

The primary responsibility for ensuring healthcare services lies with respective State/UT Governments. Under National Health Mission, Ministry of Health & Family Welfare provides financial and technical support to States/UTs, including Andaman and Nicobar Islands, to strengthen their healthcare systems, based on the requirements posed by them in their Programme Implementation Plans (PIPs) within their overall resource envelope. Various works/initiatives carried out under NHM in the country are as below:

Ayushman Bharat – Health & Wellness Centres (AB-HWCs): 1,50,000 Sub- Health Centres (SHC), Primary Health Centres (PHC) and Urban Primary Health Centres (UPHC) are transformed into Ayushman Bharat- Health and Wellness Centres (AB-HWCs) to deliver twelve packages of Comprehensive Primary Health Care (CPHC) that includes preventive, promotive, curative, palliative and rehabilitative services which is universal, free and close to the community. These AB-HWCs will provide Comprehensive Primary Health Care (CPHC), by expanding and strengthening the existing Reproductive & Child Health (RCH) services and Communicable Diseases services and by including services related to Non- Communicable Diseases (NCD), to begin with the common NCDs such as, Hypertension, Diabetes and 3 common cancers of Oral, Breast and Cervix. It is also envisaged to incrementally add primary healthcare services for Mental health, ENT, Ophthalmology, Oral health, Geriatric and Palliative health care and Trauma care as well as Health promotion and wellness activities like Yoga. Against the target of 1,50,000, a total of 1,54,070 AB-HWCs have been operationalized in the country .[14]

National Free Drugs Initiative: States/UTs are supported to provide essential drugs based on the level of public health facilities free of cost to all who access these facilities.

Free Diagnostics Initiatives. (FDI): Under the initiative, support provided to States/UTs to provide a set of essential diagnostics in 33 States/UTs at various levels of care, free of cost.

National Ambulance Services (NAS): Under the NHM, technical and financial support is provided for emergency medical services in States/UTs through a functional National Ambulance Service (NAS) network linked with a centralized toll-free number 108/102.[15]

ISSN: 2395-7639

International Journal of Multidisciplinary Research in Science, Engineering, Technology & Management (IJMRSETM)

(A Monthly, Peer Reviewed Online Journal)

Visit: www.ijmrsetm.com

Volume 5, Issue 6, June 2018

Mobile Medical Units (MMU) are supported to facilitate access to public health care at the doorstep particularly to people living in remote, difficult, under-served and unreached areas to provide primary care services.

Some major initiatives under NHM focusing on women and children, including ST category women and children, throughout the country, are as follows:

Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), provides health coverage of up to Rs 5 lakh per family per year to around 10.74 crore poor and vulnerable families in the country as per Socio Economic Caste Census (SECC).

Surakshit Matritva Aashwasan (SUMAN) provides assured, dignified, respectful and quality healthcare at no cost and zero tolerance for denial of services for every woman and newborn visiting public health facilities to end all preventable maternal and newborn deaths.

Janani Suraksha Yojana (JSY), a demand promotion and conditional cash transfer scheme for promoting institutional delivery.[16]

Under Janani Shishu Suraksha Karyakram (JSSK), every pregnant woman is entitled to free delivery, including caesarean section, in public health institutions along with the provision of free transport, diagnostics, medicines, other consumables & diet.

Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) provides pregnant women a fixed day, free of cost assured and quality antenatal check up by a Specialist/Medical Officer on the 9th day of every month.

LaQshya improves the quality of care in labour room and maternity operation theatres to ensure that pregnant women receive respectful and quality care during delivery and immediate post-partum.[17,18]

Monthly Village Health, Sanitation and Nutrition Day (VHSND) is an outreach activity at Anganwadi centers for provision of maternal and child care including nutrition in convergence with the ICDS.

Reproductive and child health (RCH) portal is a name-based web-enabled tracking system for pregnant women and new born so as to ensure seamless provision of regular and complete services to them including antenatal care, institutional delivery and post-natal care.

MCP Card and Safe Motherhood Booklet are distributed to the pregnant women for educating them on diet, rest, danger signs of pregnancy, benefit schemes and institutional deliveries.

Delivery Points- Over 25,000 ‘Delivery Points’ across the country have been strengthened in terms of infrastructure, equipment, and trained manpower for provision of comprehensive RMNCAH+N services.[19,20]

Setting up of Maternal and Child Health (MCH) Wings at high caseload facilities to improve the quality of care provided to mothers and children.

Functionalization of First Referral Units (FRUs) by ensuring manpower, blood storage units, referral linkages to improve the access to quality of care for pregnant women.

Further, initiatives such as Mission Parivar Vikas, Adolescent Friendly Health Clinics (AFHCs), Weekly Iron Folic Acid Supplementation (WIFS), Menstrual Hygiene Scheme, Facility Based Newborn Care (FBNC), Home Based Newborn Care Program, Social Awareness and Actions to Neutralize Pneumonia Successfully (SAANS), Home Based Care for Young Child (HBYC), Rashtriya Bal Swasthya Karyakram (RBSK), Early Childhood Development (ECD),

ISSN: 2395-7639

International Journal of Multidisciplinary Research in Science, Engineering, Technology & Management (IJMRSETM)

(A Monthly, Peer Reviewed Online Journal)

Visit: www.ijmrsetm.com

Volume 5, Issue 6, June 2018

Comprehensive Abortion Care (CAC), Anemia Mukt Bharat (AMB) strategy, Nutrition Rehabilitation Centre (NRC) program are supported to increase access to quality healthcare services. Support is also provided to strengthen Universal Immunization programme, introduction of new vaccines.[21]

In tribal, hilly and desert areas, the norm can be relaxed to one ASHA per habitation, depending on the workload, geographic dispersion, and difficult terrain. To attract quality Human Resources special provisions like "You quote, we pay" / Hard area allowances.

III.RESULTS

Women are the nurturer of the world's future. They have been bestowed a boon to give birth and ensure quality care for their family and children. It's said, "if you educate a woman, you educate a family", in the same way, if a woman is ensured a healthy body and a sound mind, then the family's health is secured. The health of families and communities is connected to women's health. In today's time, women's health has become a priority in society and the sense of concern for it has improved the situation.

-Women make up 48.56% of eligible beneficiaries under AB PM-JAY as per SECC 2011 database. Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) is a flagship health assurance scheme of the Government which aims at providing a health cover of Rs. 5 Lakhs per family per year for secondary and tertiary care hospitalizations for 10.75 Crore beneficiary families.[22]

Janani Shishu Suraksha Karyakaram (JSSK)

– The JSSK was created with the goal of eliminating out-of-pocket payments for pregnant women and sick newborns visiting public health facilities, and it entitles them to free delivery, including caesarean section, free transportation, diagnostics, drugs, other consumables, diet, and blood.

Janani Suraksha Yojana (JSY)

It is a safe motherhood intervention with the goal of reducing maternal and neonatal mortality by promoting institutional delivery among pregnant women, particularly those with low socio-economic status, i.e. women from SC/ST/BPL households, with a special emphasis on low-performing states, and it provides cash incentives to women.

Ayushman Bharat- Health and Wellness Centres (AB-HWCs)

More than 77000 Health and Wellness Centres (AB-HWCs) are functioning across the country as part of Ayushman Bharat to provide comprehensive health care, including community-based preventive healthcare and screening of women for common non-communicable diseases.

–Rs 2,233.48 crore has been earmarked under National Health Mission for different Maternal Health Initiatives.[23]

– Mother and Child Health (MCH) wings are developed in District Hospitals/ District Women's Hospitals/ Sub-District Hospitals/CHC- First Referral Units (FRUs) under NHM to address the challenges of growing caseloads and institutional deliveries at these institutions.

– The NHM also contributes to the provision of a variety of free services in public healthcare institutions in rural and underserved areas, including the treatment of women's diseases.

Initiatives to tackle Anaemia in Pregnant women

ISSN: 2395-7639

International Journal of Multidisciplinary Research in Science, Engineering, Technology & Management (IJMRSETM)

(A Monthly, Peer Reviewed Online Journal)

Visit: www.ijmrsetm.com

Volume 5, Issue 6, June 2018

Women and children in India are largely anaemic, according to the National Family Health Survey with the condition being most prevalent in the Himalayan cold desert. The government, on the other hand, has taken initiatives to improve anaemia across all identifiable populations in all States/UTs. The government offers financial and technical support to States/UTs under the National Health Mission (NHM) for the implementation of the Anaemia Mukt Bharat Strategy as outlined by the States/UTs in their yearly Programme Implementation Plans. The Government of India has assessed the situation of pregnant women in the country, and the following are some of the efforts done by the Government of India to improve the health of pregnant women, including anaemia, in all States/UTs:

– Surakshit Matritva Aashwasan (SUMAN) ensures that every woman and newborn accessing public health facilities receive assured, dignified, respectful, and excellent treatment at no cost, with zero tolerance for denial of services, in order to eliminate all preventable maternal and newborn deaths.[24]

– Janani Suraksha Yojana (JSY) is a demand-driven, conditional cash transfer scheme that aims to improve institutional delivery.

– On the 9th day of each month, the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) provides pregnant women with a scheduled, cost-free, and high-quality antenatal checkup by a Specialist/Medical Officer.

– Village Health, Sanitation, and Nutrition Day (VHSND) is a monthly outreach programme at Anganwadi facilities that provides maternal and child care, as well as nutrition, in accordance with the ICDS.[25]

– The reproductive and child health (RCH) portal is a name-based web-enabled tracking system for pregnant women and newborns to guarantee that they receive frequent and comprehensive services, such as antenatal care, institutional delivery, and post-natal care.[26]

IV.CONCLUSIONS

We're all justifiably proud of the strides we have made as a country over the last few years particularly with regards to gender disparity. However, there are still several issues that need to be addressed. One of the most pressing concerns is the need to enhance women's healthcare in India, particularly when it comes to access to health insurance.[27]

According to data from the World Health Organization, India has a maternal mortality rate of 174 deaths per 100,000 live births, which is significantly higher than many other countries in the region. Around 50 million women in India suffer from reproductive health problems. Anaemia affects around 50% of women of reproductive age in India, leading to complications during pregnancy and childbirth.

Also, breast cancer and cervical cancer remain the most common cancer among women in India. According to the National Health Profile 2017, there were approximately 96,922 deaths due to cervical cancer in India. Additionally, according to the Indian Council of Medical Research, an estimated 87,000 women died from breast cancer in India latest. This highlights the urgent need to improve access to quality healthcare services for women in the country.[28]

The best way to approach this enhancement would be to examine the tools that India already has but currently remain under utilised. The first of these tools is technology.

Technology in women's healthcare

Technology has the potential to transform the landscape of women's healthcare in the country. For example, early detection of cancers, including cervical cancer, can be improved through the use of technology. The reported cancer incidences in India are lower than expected, with the majority of cases being detected in late-stage cancer types. This highlights the need

ISSN: 2395-7639

International Journal of Multidisciplinary Research in Science, Engineering, Technology & Management (IJMRSETM)

(A Monthly, Peer Reviewed Online Journal)

Visit: www.ijmrsetm.com

Volume 5, Issue 6, June 2018

to focus on early detection and prevention. Cervical cancer is particularly concerning as it is the second most common cancer despite being largely preventable. Technology can be leveraged to improve early detection rates.

Also, more investment and resources should be allocated to sex-aware care, where research and clinical trials diagnose and treat women specifically. Mental health practitioners should also receive training in gender-sensitive care to better serve diverse communities. Collaboration is essential for the future of women's healthcare, with public-private partnerships needed to enable healthcare innovators to scale and reach more women. Moreover, the inclusion of women leaders within the healthcare workforce is critical to introducing more women-centric interventions and driving better patient outcomes.[29]

Insurance for assurance

When it comes to preventive care it is important to go back to fundamentals. Health insurance is the most established societal tool to provide preventive care. Therefore, the most effective way to enhance women's healthcare in India is to improve access to health insurance. Many women in India, particularly those in rural areas, are not covered by any kind of health insurance. This means that they are often forced to pay out of pocket for medical expenses, which can be prohibitively expensive. This can lead to women delaying or forgoing necessary medical treatment, which can have serious consequences for their health and well-being.

There are several steps that can be taken to improve access to health insurance for women in India. One of the most important is to make health insurance more affordable. This can be done by offering subsidies or other financial incentives to women who purchase health insurance policies. Governments and private insurers can also work together to develop policies that are specifically tailored to the needs of women, including those that cover reproductive health and maternity care.

Another important step is to increase the number of health insurance providers in India. Currently, there are only a handful of insurance providers that offer policies specifically designed for women. By encouraging more insurers to enter the market and develop policies that are tailored to the needs of women, it will be easier for women to find policies that meet their specific healthcare needs.

Need for better awareness

However, making health insurance more affordable will not automatically result in making women healthier. It is equally important to improve awareness of the benefits of health insurance among women in India. Many women are unaware of the benefits of health insurance and may not realize that it can help them access quality healthcare services when they need them most. Governments and insurers can work together to develop public awareness campaigns that educate women about the importance of health insurance and the specific benefits that it can provide.[30]

It is also important to ensure that women in India have access to quality healthcare services. This includes not only access to medical facilities and healthcare providers, but also access to necessary medications and treatments. By ensuring that women have access to the healthcare services they need, it will be easier for them to stay healthy and avoid serious health problems.

Enhancing women's healthcare in India is a crucial need of the hour, and requires a multifaceted approach. Technology, sex-aware care, gender-sensitive mental health services, collaboration, public-private partnerships, women leaders in the healthcare workforce, better awareness and access to insurance and related healthcare facilities are all critical to driving change. Many are already working towards these goals, it is now time to bring them in synergy. We all know the women in our country don't just need it, they deserve it.[30]

REFERENCES

1. Chatterjee, A, and VP Paily (2011). "Achieving Millennium Development Goals 4 and 5 in India". BJOG. 118: 47–59. doi:10.1111/j.1471-0528.2011.03112.x. PMID 21951502. S2CID 31000506.

ISSN: 2395-7639

International Journal of Multidisciplinary Research in Science, Engineering, Technology & Management (IJMRSETM)

(A Monthly, Peer Reviewed Online Journal)

Visit: www.ijmrsetm.com

Volume 5, Issue 6, June 2018

2. ^ Ariana, Proochista and Arif Naveed. An Introduction to the Human Development Capability Approach: Freedom and Agency. London: Earthscan, 2009. 228-245. Print.
3. ^ United Nations. "Sustainability and Equity: A Better Future for All." Human Development Report 2011. (2011): n. page. Web. 12 April 2013.
4. ^ Raj, Anita (2011). "Gender equity and universal health coverage in India". Lancet. 377 (9766): 618–619. doi:10.1016/s0140-6736(10)62112-5. PMID 21227498. S2CID 22151807.
5. ^ Balarajan, Y; Selvaraj, S; et al. (2011). "Health care and equity in India". Lancet. 377 (9764): 505–15. doi:10.1016/s0140-6736(10)61894-6. PMC 3093249. PMID 21227492.
6. ^ Pandey, Aparna; Sengupta, Priya Gopal; Mondal, Sujit Kumar; Gupta, Dhirendra Nath; Manna, Byomkesh; Ghosh, Subrata; Sur, Dipika; Bhattacharya, S.K. (2002). "Gender Differences in Healthcare-seeking during Common Illnesses in a Rural Community of West Bengal, India". Journal of Health, Population, and Nutrition. 20 (4): 306–311. JSTOR 23498918. PMID 12659410.
7. ^ Raj, Anita (2011). "Sex selected abortion in India". Lancet. 378 (9798): 1217–1218. doi:10.1016/s0140-6736(11)61535-3. PMID 21962555. S2CID 20124955.
8. ^ Patel, Vikram; Rodrigues, Merlyn; et al. (2002). "Gender, Poverty and Postnatal Depression: A Study of Mothers in Goa India". Am J Psychiatry. 159 (1): 43–47. doi:10.1176/appi.ajp.159.1.43. PMID 11772688. S2CID 6479675.
9. ^ Khera, R; Jain, S; Lodha, R; Ramakrishnan, S (April 2014). "Gender bias in child care and child health: global patterns". Archives of Disease in Childhood. 99 (4): 369–74. doi:10.1136/archdischild-2013-303889. PMID 24344176. S2CID 36547372.
10. ^ Sen, Gita; Iyer, Aditi (2012). "Who gains, who loses and how: Leveraging gender and class intersections to secure health entitlements". Social Science and Medicine. 74 (11): 1802–1811. doi:10.1016/j.socscimed.2011.05.035. PMID 21741737.
11. ^ Kimuna, Sitawa; Yanyi, Djamba (2012). "Domestic Violence in India: Insights From the 2005—2006 National Family Health Survey". Journal of Interpersonal Violence. 28 (4): 773–807. doi:10.1177/0886260512455867. PMID 22935947. S2CID 206562887.
12. ^ Singh, Ashish (2012). "Gender based within-household inequality in childhood immunisation in India: changes over time and across regions". PLOS ONE. 7 (4): e35045. Bibcode:2012PLoSO...735045S. doi:10.1371/journal.pone.0035045. PMC 3324412. PMID 22509379.
13. ^ Choi, Jin; Lee, Sang-Hyop (2006). "Does prenatal care increase access to child immunisations? Gender bias among children in India". Social Science and Medicine. 63 (1): 107–17. doi:10.1016/j.socscimed.2005.11.063. PMID 16443313.
14. ^ Mechakra-Tahiri, Samia; Freeman, Ellen; et al. (2012). "The gender gap in mobility: A global cross-sectional study". BMC Public Health. 12: 598. doi:10.1186/1471-2458-12-598. PMC 3506530. PMID 22856611.
15. ^ Sen, Amartya. "Gender and cooperative conflicts." Wider Working Papers. 18. (1987) Web. 28 April 2013.
16. ^ Rao, Mohan; Rao, Krishna (2011). "Human resources for health in India". Lancet. 377 (9765): 587–98. doi:10.1016/s0140-6736(10)61888-0. PMID 21227499. S2CID 33914370.
17. ^ Adamson, Paul; Krupp, Karl (2012). "Are marginalised women being left behind? A population-based study of institutional deliveries in Karnataka, India". BMC Public Health. 12: 30. doi:10.1186/1471-2458-12-30. PMC 3269389. PMID 22240002.
18. ^ Doshi, Sonal; Gandhi, Bindi (2008). "Women in India: The Context and Impact of HIV/AIDS". Journal of Human Behavior in the Social Environment. 17 (3–4): 413–442. doi:10.1080/10911350802068300. S2CID 216113851.
19. ^ Ministry of Health and Family Welfare, . "About NHRM." National Rural Health Mission. Government of India. Web. 28 April 2013.
20. ^ Nair, Harish; Panda, Rajmohan (2011). "Quality of maternal healthcare in India: Has the rural health mission made a difference". Journal of Global Health. 1 (1): 79–86. PMC 3484741. PMID 23198105.
21. ^ Singh, S. Harpal (13 April 2015). "Survey of tribal women shows up breast abnormalities". The Hindu – via thehindu.com.
22. ^ Tarozzi, Alessandro (2012). "Some Facts about Boy versus Girl Health Indicators in India: 1992—2005". CESifo Economic Studies. 58 (2): 296–321. doi:10.1093/cesifo/ifs013.

ISSN: 2395-7639

International Journal of Multidisciplinary Research in Science, Engineering, Technology & Management (IJMRSETM)

(A Monthly, Peer Reviewed Online Journal)

Visit: www.ijmrsetm.com

Volume 5, Issue 6, June 2018

23. ^ Jose, Sunny, and K Navaneetham. "A Factsheet on Women's Malnutrtion in India." Economic and Political Weekly. 43.33 (2008): 61-67. Web. 21 February 2013.
24. ^ Shetty, Anita (2012). "India faces growing breast cancer epidemic". Lancet. 378 (9820): 992–993. doi:10.1016/s0140-6736(12)60415-2. PMID 22432152. S2CID 5855196.
25. ^ Thorat, Mangesh (2012). "Tackling breast cancer in India". Lancet. 379 (9834): 2340–2341. doi:10.1016/s0140-6736(12)61017-4. PMID 22726513. S2CID 27807532.
26. ^ Pathak, Praveen (2010). "Economic Inequalities in Maternal Health Care: Prenatal Care and Skilled Birth Attendance in India, 1992-2006". PLOS ONE. 5 (10): 1–17. Bibcode:2010PLoSO...513593P. doi:10.1371/journal.pone.0013593. PMC 2965095. PMID 21048964.
27. ^ Thaddeus, S.; Maine, D. (July 1991). "Too far to walk: maternal mortality in context". Newsletter (Women's Global Network on Reproductive Rights) (36): 22–24. PMID 12284530.
28. ^ Matthews, Zoe. "Village in the City: Autonomy and Maternal Health-Seeking Among Slum Populations of Mumbai" (PDF). Collected Papers on Gender Using DHS Data: 69–92.
29. ^ Badge, Vijay Loknath; Pandey, Minal; Solanki, Mridula J.; Shinde, Ratnendra Ramesh (2016). "A cross-sectional study of migrant women with reference to their antenatal care services utilization and delivery practices in an urban slum of Mumbai". Journal of Family Medicine and Primary Care. 5 (4): 759–764. doi:10.4103/2249-4863.201157. ISSN 2249-4863. PMC 5353809. PMID 28348986.
30. ^ Das, Sushmita; Bapat, Ujwala; More, Neena Shah; Chordhekar, Latika; Joshi, Wasundhara; Osrin, David (30 July 2010). "Prospective study of determinants and costs of home births in Mumbai slums". BMC Pregnancy and Childbirth. 10 (1): 38. doi:10.1186/1471-2393-10-38. ISSN 1471-2393. PMC 2928174. PMID 20670456.