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Reproductive health status of scheduled and non-scheduled castes women of Ludhiana district in Punjab

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Abstract

In India, access to healthcare facilities in rural areas remains significantly underdeveloped regarding health infrastructure. The present investigation endeavors to analyse the caste variation in the reproductive health status of Scheduled castes and Non-Scheduled castes. The study was conducted in rural areas of Ludhiana district of Punjab of India. It was conducted on 120 women in their reproductive age (15-45) that had given birth during four years preceding the study. It was conducted in villages which were randomly selected. Evidence suggests that demand-side barriers may be as important as supply factors in deterring patients from obtaining treatment. Relatively little attention is given, either by policy makers or researchers, to ways of minimizing their effect.

Keywords: caste, Indian women, primary health centres, reproductive health

Introduction

Reproductive health is an indispensable ingredient of women's health and a major determinant of the human population. The concept of reproductive health recognises the diversity of the special health needs of women before during and beyond child bearing age. Reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so. The term "reproductive health" was introduced in the late 1980s as an alternative to the population control approach to reproduction and women's health that developed in the 1960s and 1970s. In 1994, delegates from 179 Member States of the United Nations gathered in Cairo, Egypt for the International Conference on Population and Development (UNFPA 2004). The relationship between populations was addressed, and the needs of people as opposed to setting demographic targets were focused upon. Member state produced a consensus document called the Programme of Action, which sets forth goals to be achieved by 2014. Reproductive health covers diseases and conditions that affect the female reproductive system, including symptoms, diagnosis, treatment, and prevention of women's reproductive health issues (Bhardwaj & Tungdim 2010).

Data is collected from villages and Primary Health Centers were visited. The health of women had been researched well, but very few have studied the caste variation in the reproductive health status of women. The difference between the scheduled castes and non-scheduled women reproductive health and their assess ability towards the benefits are not discussed in detail.

In 1951, India became the world's first nation to launch a family planning programme. But, it was after 1994 ICPD that quality reproductive health services became key concern while framing reproductive health programmes in India (UNFPA, n.d.). For instance, Reproductive and Child Health Programme II (RCH II) 2005, National Rural Heath Mission (NRHM)[*] 2005, and Janani Suraksha Yojna (for promoting institutional deliveries (UNFPA.n.d.) were launched after ICPD. Despite these attempts, reproductive health services have not been utilized by everyone fully. Disparities exist in regards to regions, rural-urban divide, caste), age, gender, economic class and educational levels.

Baru *et al* (2010) analysed that despite India's impressive economic performance after the introduction of neoliberal economic reforms in the 1990s, progress in advancing the health status of Indians had been slow and uneven. Large inequities in health and access to health services continued to persist and had even widened across states, between rural and urban areas, and within communities. Three forms of inequities had dominated India's health sector: historical socio-economic and access to resources. Socio-economic inequities manifested in caste, class and gender differentials whereas access to resources and inequities are evident in the availability, utilisation, and affordability of health services by people. Of these, critical to ensuring health for all in the immediate future will be the effectiveness with which India addresses inequities in the provisioning of health services and assurance of quality care.

Rejoice, and Ravishankar (2011) assessed the utilization of antenatal care services among currently married scheduled caste women in Mysore district, Karnataka. They extracted the data from National Family Health Survey -3 (NFHS-3) conducted during 2005-06, all over India. A total of 6212 currently married scheduled caste women in the age group of 15-49 were taken as

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[*] **NRHM** - National Rural Health Mission was launched in 2005 to provide accessible, affordable and quality health care to the rural population especially vulnerable groups.
RCH ii -Objective of the program is to bring about a change in mainly three indicators reducing total fertility rate infant mortality and control of reproductive tract infection and sexually transmitted infection.

the sample for the study. Cross tabulation and binary logistic regression method were applied for determining the influencing factors. Out of 6212 respondents, 19.8 per cent of the scheduled caste women did not receive even a single antenatal care during their pregnancy period. 15.8 percent of the women did not receive Tetanus Toxoid injection and one-third (33.3) of the women did not receive Iron Folic Acid tablets during their pregnancy period. Only one-fifth of scheduled caste women (21.4) fulfilled the minimum recommendation with regard antenatal care services. Age, education, and wealth index were significantly associated with getting full antenatal care service among scheduled caste women. However, there was an urgent need for improving the implementation of reproductive health programs and strengthening health education for scheduled caste married women especially pregnant women.

Methodology

This article is based on the primary data collected in the year 2014 from Ludhiana district of rural Punjab of India. It is a quantitative study and is based on random sampling technique. A total cluster of 120 married women from four villages was personally interviewed. Four blocks from Ludhiana district were randomly selected. From each block 15 respondents from

Scheduled Castes and 15 from Non-Scheduled Castes were selected respectively. The interview was conducted in Punjabi and Hindi language as convenient with respondents. Firstly, in selected villages required number of respondents gathered from village panchayat (governing body in village level) and Primary Health Centers.

Profile of the participants

The reproductive health status reproductive health status three successive chronological phases of pregnancy antenatal, natal and postnatal care. The data is collected through random sampling technique. Data is collected with personal visits. This facilitates insight knowledge on account of respondents and their exact situations.

The health conditions of a woman are influenced by the socio-economic set-up in which she is placed, her level of awareness about health facilities, propensity to avail the health services. Caste influences socio-economic variables that include educational status, work status, and land ownership.

 A perusal of Table 1 reveals a variety of attributes of respondents who form the basis of the present study. The information is listed separately for the Non-SCs and SCs, so as to provide a framework for comparison.

Table 1 Distribution of respondents according to background characteristics of sampled households

Background Characteristics	SCs n_1=60	Non-SCs n_2=60	TOTAL n=120
Age at marriage(years)			
Up to 20	26 (43.34)	5 (8.33)	31 (25.50)
21-25	19 (31.66)	32 (53.33)	51 (43.50)
26-30	7 (11.67)	21 (35.00)	28 (23.00)
Above 30	8 (13.33)	2 (3.33)	10 (8.00)
Household Income (INR)/Annual			
Up to 50,000	25 (41.67)	5 (8.33)	30 (25.00)

50,000-1 lacs	21 (35.00)	13 (21.67)	34 (28.30)
1-2lacs	12 (20.00)	20 (33.33)	32 (26.70)
2-3 lacs	2 (3.33)	12 (20.00)	14 (11.70)
Above 3 lacs	-	10 (16.67)	10 (8.30)
Type of Family			
Nuclear	36 (60.00)	13 (21.67)	49 (40.83)
Joint	24 (40.00)	47 (78.33)	71 (59.17)
Landownership Status			
Landowner	4 (6.67)	54 (90.00)	58 (48.33)
Landless	56 (93.33)	6 (10.00)	62 (51.67)

Occupation of Husbands			
Farming	2 (3.33)	52 (86.67)	54 (45.00)
Labourer	28 (46.67)	0	28 (23.33)
Service	19 (31.66)	5 (8.33)	24 (20.00)
Business	10 (16.67)	3 (5.00)	13 (10.83)
No occupation	1 (1.67)	0 -	1 (0.83)
Occupation of respondents			
Regular labour	5 (8.33)	0 -	5 (4.17)
Casual labour	2 (3.33)	0 -	2 (1.67)
Service(Public/Private)	3 (5.00)	8 (13.33)	11 (5.00)
Housewives	50 (83.34)	52 (86.67)	102 (85.00)

Education of husbands			
Illiterate	5 (8.33)	2 (3.33)	7 (5.83)
Up to middle	30 (50.00)	23 (38.33)	53 (44.17)
Up to higher secondary	25 (41.66)	34 (56.66)	59 (49.17)
Graduation and above	0 -	1 (1.67)	1 (0.83)
Education of respondents			
Illiterate	7 (11.66)	4 (6.66)	11 (5.00)
Up to Middle	27 (45.00)	21 (35.00)	48 (40.00)
Up to Higher Secondary	20 (33.00)	23 (38.33)	43 (35.83)
Graduation and above	6 (10.00)	12 (20.00)	18 (15.00)

Religion			
Sikh	39 (65.00)	53 (88.33)	92 (76.67)
Hindu	21 (35.00)	7 (11.67)	28 (23.33)

Figures in parenthesis indicate percentages

INR = Indian National Rupees

1.1 Age

According to NFHS-3 adolescents (15-19 years) contribute about 16 per cent of total fertility in the country, and 15-25 years age group contributes 45 per cent of total maternal mortality. Nearly 21 percent of all pregnancies are either unwanted or mistimed. This not only exposes women to reproductive health complications, but it also affects their overall development and well-being. Therefore, age plays an important variable in the reproductive health status of women. It is evident from the data that one-fourth of the respondents got married up to 20 years of age. Comparatively greater percentage of scheduled castes (43.3%) respondents got married up to 20 years than Non-scheduled castes (8.3%). Little less than half (43.5%) of respondents got married up to 25 years of age and amongst them, Non-scheduled castes respondents more (53.3%) than their SCs (31.7%) counterparts. Eight percent got married after 30 years of age, and amongst them, SCs were more (13.3%) than Non-SCs (3.3%) counterparts. Data clearly revealed that SCs got married either too young (up to 20 years) or were married late (>30 years) whereas a significant majority of Non-scheduled castes (88.33%) got married between 21 to 30 years of age.

1.2 Income

Income is the sum of all the wages, salaries, profits, interests, payments, rents and other forms of earnings received. The table further depicts the annual family income of respondent's family. It was revealed from the data that Non-SCs had better economic status than their SCs counterparts.

One-fourth of respondents earned income up to 50, 000, included with a maximum number of SCs (41.67 %) where it was just 8.33 per cent amongst Non-SCs. The table further highlighted that one-third of Non-SCs (33.33 %) earned income up to 2 lacs, where it was 20 per cent amongst SCs. It was also found from the study that Non-SCs earned an income more than 3 lacs annually, which was not found in the case of SCs respondents.

1.3 Type of family

The family is an intimate domestic group made up of people related to one another by bonds of blood, sexual mating, or legal ties. Review of the literature suggested a significant association between the type of family (nuclear or joint) and the reproductive health status affecting the health seeking behavior during pregnancy and childbirth (Jha 2012; Kopparty 1991; Madhavi & Singh et al., 2011). Availability of workforce is an asset in the case of joint families. In the event of sickness, a woman has a substitute for fulfilling her responsibilities in joint family, an advantage which is missing in nuclear families. Data revealed the dominance of nuclear families amongst the SCs (60%) as against their Non-SCs (8.33%) counterparts. The joint family system was prevalent more among Non-SCs (78.3%). The majority of them were agriculturist and joint family structure substantiated the farming occupation.

1.4 Land

Another determinant of economic and social status is the land owned by the respondent's family. The SCs were not fortunate on this count. In all 93.33 percent, SCs were landless whereas 90 per cent of Non-SCs owned land.

1.5 Occupation

It is one of the pertinent features of economic life. It means an instrument of livelihood. Among SCs half of men (46.67%) worked as laborers among Non-SCs major occupation among men was farming (86.67%). The female work participation is low in both the communities. A relatively higher proportion of SCs female worked as labourers, which included the regular and casual laborers who were 11.66 percent collectively. Comparatively higher percentage of Non-SCs women (13.33%) were in service than their SCs counterparts (5.00%).

1.6 Education

Education is another factor considered for development. Data reveals that illiteracy was higher among SCs men (8.33%) as well as women (11.66%). Amongst scheduled castes, 10 percent women were graduate and above, whereas none of their men folk was educated above higher secondary level. Amongst Non-SCs 20 percent had education level up to graduation and above compared to just 1.7 percent of men folk graduate and above. Amongst SCs men, 41.66 percent were up to higher secondary which was 56.67 percent in the case of Non-SCs.

1.7 Religion

Reflecting the religious composition data reveals that among the Non-scheduled castes 88.33 percent respondents followed Sikh religion and 11.67 percent followed Hindu religion, whereas in SCs 65 per cent followed Sikh religion and 35 percent followed Hindu religion.[*]

Result and Discussion

Table 2 Status of Primary Health Centre in Sample Area

Variables	IPHS Standards	(NFHS-3; DLHS-3)	Sample Area (mean)
In patients beds	6	6	3.25
Medical Officer	5	2 (one from Ayush* or lady medical officer)	1.22
Pharmaceutical	1	1	0.50
Nurse-midwife for 24 hour PHC'S	5	3	2.00

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[*]In Indian society, Government of India Act, 1935, for the first time, provided for notification of socially disadvantaged castes as 'Scheduled Castes', and a list of such castes was accordingly notified in the Government of India (Scheduled Castes) Order, 1936. 'Scheduled Castes' are defined in Article 366(24) of the Constitution of India

Health worker (female)	1	1	0.50
Lab technician	1	1	0
Class IV	4	4	2.00

*The department of Ayurveda, Yoga, and Naturopathy, Unani, Siddha, and Homoeopathy abbreviated as AYUSH. It is a governmental body.

Table 2 presents a comparative picture of different variables pertaining to infrastructural and medical staff, as prescribed by IPHS standards, norms of NFHS-3 and as was observed in the sample area. The study found significant gaps in all the variables. According to the norms of Indian Public Health Standards and NFHS the inpatients beds should be six which were found 3.25 on an average in our sample areas. Against the five medical officers prescribed under IPHS norms, study area had only 1.22 medical officers on an average. The number of health workers (0.50) and nurses/midwife (2.00) were also found not relatively matched to prescribed standards. It was also revealed that availability of class IV and pharmacists was also below the given standard.

3. Antenatal care (ANC)

The antenatal stage is the period from conception to the onset of the labour. Antenatal care (ANC) is imperative for maternal and foetus health. In the present study, ANC is assessed by the immunization status of women during pregnancy, (two doses of Tetanus Toxoid to fight infections) intake of additional supplements (iron and folic acid tablets to control anaemia) and incidence of loss of pregnancy

Table 3 reveals that percentage of respondents who took supplements i.e. iron and folic acid tablets was higher among the Non-SCs (83.33%) compared to their SCs (70%) counterparts. Status of immunization also reflected same differentials where again Non-SCs (93.3%) had the edge over their SCs (86.7%) counterparts.

Table 3 Distribution of the respondents according to antenatal care received

ANC	SCs (n₁=60)	Non-SCs (n₂=60)	Total (n=120)
Intake of supplements			
Yes	42 (70.00)	50 (83.33)	92 (76.67)
No	18 (30.00)	10 (16.67)	28 (23.33)
Immunization			
Yes	52 (86.67)	56 (93.33)	108 (90.00)
No	8 (13.33)	4 (6.67)	12 (10.00)

Figures in parenthesis indicate percentages

4. Contraceptive use

Use of contraceptives is another important indicator of reproductive health. Empirical evidence shows that contraceptives use contribute to fertility decline and improvement in women's health independent of other variables. Female contraceptives use reflects their control over decisions concerning childbearing and their knowledge about family planning.

Table 4 Distribution of respondents according to the use of contraceptives

Contraceptives usage (Any method)	SCs (n₁=60)	Non-SCs (n₂=60)	Total (n=120)
Yes	21 (35.00)	44 (73.33)	65 (54.16)
No	39 (65.00)	16 (26.67)	55 (45.84)

Figures in parenthesis indicate percentages

Table 4 depicts that majority of Non-SCs (73.3%) were using at least one method of contraception (condoms whereas just one-third (35%) of SCs were using contraceptives. The study revealed that in all 54.16 per cent respondents were using family planning measures and 45.84 per cent respondents were not using any contraceptives.

Table 5 Distribution of respondents by the loss of pregnancy

Incidence of Miscarriage	SCs (n₁=60)	Non-SCs (n₂=60)	Total (n=120)
Due to illness/ill-treatment	6 (10.00)	0	6 (.05)
Induced on doctor's advice	2 (3.33)	-	2 (.01)
After sex detection	4 (6.67)	5 (8.33)	9 (.75)

Figures in parenthesis indicate percentages

Another important component of antenatal care stage focused upon by ICDS[1] (Integrated Child Development Services) is that the outcome of pregnancy should be successful regarding maternal and foetus/infant survival and well-being. The study further found a variation on this account too, where a greater percentage of SCs experienced loss of pregnancy. SCs respondents divulged that they underwent miscarriage on account of maltreatment (by their husbands). Some got foetus aborted (3.3 %) on the advice of doctor due to foetus abnormality. On deeper investigation into the matter front forth that sex detection leads to abortion. When it was observed after detection male foetus was given more priority.[*]

Table 6 Distribution of respondents according to birth order

Birth order	SCs (n=60)	Non-SCs (n=60)	Total (n=120)
Up to 3	48 (80.00)	55 (91.67)	103 (85.83)
More than 3	12 (20.00)	5 (8.33)	17 (14.17)
Birth interval(Years)			
Up to 2	37 (61.67)	51 (85.00)	88 (73.33)
More than 2	23 (38.33)	9 (15.00)	32 (26.67)

Figures in parenthesis indicate percentages

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[1] ICDS is a Government of India sponsored programme and is a primary social welfare scheme to tackle malnutrition and health problems in children below 6 years of age and their mothers)

[*]A type of contraceptives mainly used in India includes condoms, Tubectomy, Vasectomy, oral pills, copper-T.

Table 6 shows that majority of respondents had up to three children. It was also revealed that 80 percent SCs had up to three children which was 91.67 per cent in Non-SCs. It was also found that amongst the SCs 20.00 percent respondents had more than three children as compared to 8.3 per cent in case of their Non-SCs counterparts.

Birth interval refers to the time interval from one child's birth until the next childbirth. Table 6 reveals that majority of Non-SCs 85 per cent respondents had up to 2 years of the interval between their last delivery and preceding delivery which was 61.67 per cent amongst the SCs. It was revealed that 38.36 per cent SCs and 15 percent from Non-SCs had birth interval more than two years between their last birth and preceding birth.

7. Anaemia

Anaemia is a condition that develops when blood lacks enough healthy red blood cells or haemoglobin. Haemoglobin is the main part of red blood cells and binds oxygen.

Table 7 Distribution of respondents on the basis of anaemia

Anaemia	SCs (n=60)	Non-SCs (n=60)	Total (N=120)
Yes	40 (66.67)	34 (56.67)	74 (61.67)
No	5 (8.33)	23 (38.33)	28 (23.33)
Not aware	15 (25.00)	3 (5.00)	30 (25.00)

Figures in parenthesis indicate percentages

The prevalence of anaemia, defined by low hemoglobin is commonly used to assess the severity of iron deficiency. Caste difference was observed in the prevalence of anaemia. Table 7 reveals

that the 66.7 percent of SCs respondents were anaemic whereas 56.7 per cent women from Non-SCs reported that they were anaemic. It was also revealed from the study that one-fourth (25 %) of SCs women and 5.00 percent of Non-SCs women were not aware of it.

Clinically, the natal period extends from the onset of labour till delivery is complete. It was viewed as a natural process, not requiring any medical assistance, and the presence of the family members made the women feel more comfortable. Deliveries conducted in a hospital are definitely safer yet, in case, it not being possible, the next best option is to get the assistance of a trained person at the time of delivery. It is also imperative to provide hygienic conditions during home deliveries to protect both the mother and child against infections.

Table 8 Distribution of respondents according to skilled help received at the time of delivery

Delivery	SCs (n=60)	Non-SCs (n=60)	Total (N=120)
Unassisted home delivery	1 (1.67)	-	1 (0.83)
Assisted home delivery	1 (1.67)	-	1 (0.83)
Institutional delivery*			
Public	52 (86.66)	2 (3.33)	54 (45.00)
Private	6 (10.00)	58 (96.67)	64 (53.34)

Figures in parenthesis indicate percentages

It is heartening to observe from data that except 3.33 per cent SCs respondents rest all the respondents underwent institutional deliveries. Study further revealed that majority of SCs (86.7%) underwent deliveries at government hospitals due to financial aid, whereasNon-SCs (96.7%) preferred private hospitals for deliveries. Overall 53.34 percent respondents of both castes had undergone institutional deliveries under private hospitals as compared to 45.00 per cent respondents who went to public hospitals.[*]

Technically, the postnatal period starts from delivery of the placenta and continues for 42 days after that. Once the baby is born, the prime concern is to provide postnatal care services to both the mother and her child, so as to ensure their survival and a healthy life. During this period, mothers are vulnerable to a set of health risks, in addition to the responsibility of childcare. It is very important that women should get a regular check up to avoid the complications.

Table 9 Distribution of respondents on the basis of having post-natal information care

Post-natal status	SCs n_1=60	Non-SCs n_2=60	Total n=120
Breastfeeding	47 (78.33)	52 (86.67)	99 (82.50)
Supplementary diet	15 (25.00)	43 (71.67)	58 (48.33)
Infant immunization	49 (81.67)	57 (95.00)	106 (88.33)

Figures in parenthesis indicate percentages

[*]Janani SurakshaYojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality. JSY is a 100 % centrally sponsored scheme and it integrates cash assistance with delivery and post-delivery care. It is also included referral transport.

*Multiple responses

The study (Table 9) further investigated whether or not women had information on three pertinent aspects of postnatal care i.e. breastfeeding, supplementary diet and infant immunization. Timely and adequate breastfeeding is the best guard against malnourishment and susceptibility to infections. In all, a higher proportion of Non- SCs (86.67%) revealed breastfeeding practice than their SCs (78.30%) counterparts. It was further revealed that intake of supplementary diet was found in the majority of Non-SCs (71.67%), which was just one-fourth in SCs. A greater percentage of Non-SCs (95%) had immunized their newborns, while still one-fifth (18.3 %) of SCs, disclosed that they had not immunized their infants.

Table 10 Distribution of respondents according to perception about ASHA workers

Perception	SCs	Non-SCs	Total
Visit			
Regular	49 (81.67)	10 (16.67)	59 (49.17)
Irregular	11 (18.33)	50 (83.33)	61 (50.83)
Iron & Folic acid			
Distributed	37 (61.67)	17 (28.33)	54 (45.00)
Not distributed	23 (38.33)	43 (71.67)	66 (55.00)

Registration of pregnancy			
Registered	40 (66.67)	20 (33.33)	60 (50.00)
Not registered	20 (33.33)	40 (66.67)	60 (50.00)
Health information			
Given	34 (56.67)	17 (28.33)	51 (42.50)
Not given	26 (43.33)	43 (71.67)	69 (57.50)

Figures in parenthesis indicate percentages

Study sheds light on the perception of SCs and Non-SCs respondents regarding the functioning of ASHA workers. Accredited Social Health Activists (ASHAs) is a community health workers instituted by the government of India's Ministry of Health and Family Welfare (MoHFW) as part of the National Rural Health Mission (NRHM). Table 10 shows that majority of Non-SCs (83.33 %) reported irregular visits by the ASHA workers. Investigation of the matter revealed that since ASHA workers were aware that Non-SCs would not visit PHCs (Primary Health Centres) for delivery, they rarely visit their homes. The majority of SCs (61.67%) reported the distribution of iron and folic acid tablets by ASHA workers which was 28.33 per cent among Non-SCs. The study also depicted that amongst SCs 56.67 per cent was provided information about the importance of nutritional and sanitation etc. during pregnancy by Asha workers. Two third of the SCs and one third of Non-SCs reported their pregnancy were registered by ASHA workers. It was explained that how many times Asha workers visited the respondent house during the antenatal, natal and postnatal period.

Table 1 Distribution of respondents according to their access to primary health centers/hospitals

Access to PHC/Private	SCs (n₁=60)	Non-SCs (n₂=60)	Total (n=120)
Within village	35 (58.33)	17 (28.33)	52 (43.33)
Adjoining villages/cities	25 (41.67)	43 (71.67)	68 (56.67)

Figures in parenthesis indicate percentage

Physical access is an important barrier as longer distances entail higher transportation and opportunity costs. It is clear from Table 15 that during antenatal and natal period majority of Non-SCs (71.67%) respondents visited health services from adjoining village/ cities which were 41.67 percent of the SCs respondents. As most of the Non-SCs preferred private hospitals than public PHCs. It was also revealed from the data that 56.6 percent of total respondents visited adjoining villages/ cities and 43.3 percent had accessed to health centers within their village.

Table 12 Distribution of respondents according to their perception about Primary Health Centres

Reasons	SCs n₁=60	Non-SCs n₂=60
Inadequate facilities	10 (16.67)	22 (36.67)
Conduct of staff	15 (25.00)	20 (33.33)

Lack of trust in doctor	5 (8.33)	10 (16.67)
Unaware about Govt. schemes	4 (6.67)	2 (3.33)
Male gynecologist	12 (20.00)	2 (3.33)

Figures in parenthesis indicate percentages

*Multiple responses

The study tried to investigate the perception of respondents regarding the functioning of Primary Health Centres (PHC's). Perceptions were sought from all respondents irrespective of the fact that whether or not they availed the facilities of PHC's. The majority of respondents who were going to PHC's divulged that since they could not afford the expenses of the private hospital they were forced to avail due to their economic condition. Inadequate facilities were included lack of medical lab, lack of ambulance, lack of Pharmacy in Public Health Centers whereas conduct of staff varies from SCs to Non-SCs. Non-SCs were provided with more information and attention as to fetch money at the time of delivery. One- fourth of SCs and one-third Non-SCs perceived the conduct of staff was not up to the mark. It was also found that lack of trust in doctors was mainly perceived notion amongst Non-SCs (16.67 %) than their SCs counterparts. The study further revealed that due to a male gynecologist in PHCs, hesitation among SCs was more than their Non-SCs (3.33) counterparts as problems could not be expressed completely.

Conclusion and recommendations

The concept of reproductive health recognizes the diversity of the special health needs of women before, during and beyond childbearing age. It implies that people can have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so. Accessibility to health facilities is a critical factor in effective health treatment for people in rural areas in India. It also varies by caste, as education, awareness, and access to health facilities also

differ, for example, Non-SCs were given more preference. The problem of rural health is to be addressed both at the macro (national and state) and micro level (district and regional), in a holistic way, with genuine efforts to bring the poorest of the population to the center of the fiscal policies. The findings of the study provided an insight that efforts should be made to create awareness among socially and economically disadvantaged groups of the society about the benefits of utilisation of health care services.

Maternal care interventions in India need focused programs for rural, uneducated, poor scheduled caste women so that they can avail themselves of measures to delay childbearing, and for better antenatal consultation and delivery care in case of pregnancy. "The culture of Silence" need to be broken among poor, uneducated women in general and scheduled castes women in particular, so that they discuss their health issues with doctors/husband/other. This way various health hazards of pregnant ladies could be timely address. Infrastructural facilities need to be upgraded and revamped. Work conducted at a grass-root level should be timely checked. Health facilities should be properly distributed and timely checked by health officials. Better policies should be implemented for the timely upliftment of the society. There should not be any discrimination by access to any health facilities. Socio-Economic measures like age at marriage, reproductive age, the size of family, economic status should keep in a glance to maintain the equality at national and local level.

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