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# Socio-economic determinants of maternal health care service utilization under National Health Mission in Indi taluk of Vijaypur District, Karnataka State.

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**Abstract:** Improving the well-being of mothers, infants, and children is an important public health goal for any country. The well-being mother and child determine the health of the next generation and can help predict future public health challenges for families, communities, and the health care system. In this background NRHM(National Health Mission since 2013) was implemented in 2005 to provide affordable, accessible and qualitative health care services to the rural population of the country by strengthening the rural health care system by providing the basic health care infrastructure in the rural India. One of the important components of the mission is to provide free maternal health care by reducing the financial burden of accessing maternal healthcare services to the rural people through ASHA and by giving cash incentives and by increasing institutional deliveries. Thus this paper intends to study the socio-economic determinants influencing the utilization of maternal health care services among the beneficiaries NRHM in a rural areas of Vijaypur district. The study has selected 4 Primary Health Centers in Indi taluk of Vijaypur district. Study area represents total of 218 samples distributed in the study area. The study found that the access to maternal health care services

is influenced by individual, household and community level factors. Socio economic factors like age, education, occupation of the women, occupation of the husband, household economic status are important determinant of access and under utilization of maternal health care services.

**Introduction**:

Since independence many national and state health policies have stressed to improve the maternal health care in both urban and rural areas. Investing in maternal health is not only a political and social imperative for Finance and Health Ministers, Heads of State and other policymakers, but it is also cost-effective. Investing in maternal health is urgent: not only because giving life should not result in death, but also because women are important economic drivers and their health is critical to long-term, sustainable economic development of any country. Furthermore, investing in maternal health is a way to improve health systems overall, which benefits the entire population of a country. Women in rural India experience more episodes of illness than males. These women have less access to health care facilities before the illness is well advanced. This situation is directly linked to poverty; a vast majority of poor women caught in this vicious circle are young mothers in the reproductive age, who are deprived of their basic right to be healthy [Kulkarni et al 2010.]. To a large extent, the National Rural Health Mission (NRHM) launched in April 2005 is beginning to contribute toward addressing rural health needs. Unlike Urban areas that have a dedicated government healthcare structure, rural areas do not have such a structure. (Yadav et al 2011). In this vision this paper is an attempt to study the socio-economic determinants of maternal health care utilization by the pregnant women in rural areas.

**Literature Review:**

**Kesterton et al (2010)** have observed that economic status emerges as a more crucial determinant to access the health care services. Economic status is also the strongest influence on the choice between a private-for-profit or public facility amongst institutional births.

**Pathak(2010)** found that enormous inequalities in utilization of PNC and SBA were observed largely to the disadvantage of the poor. Multi variation analysis suggests growing inequalities in utilization of the two outcomes across different economic groups.

**Prakash et al (2011)** observed the effects of early marriage on the reproductive health status of women and on the well-being of their children. Women married at an early age were exposed to frequent childbearing, unplanned motherhood and abortions, which negatively affected their nutritional status. Children born to mothers with poor reproductive health had lower chances of survival.

**Shah et al(2011)** observes the changes in utilization patterns that occurred along with the development of the socioeconomic and health sectors among tribal women. There is a significant variation in the utilization pattern of maternal health care services due to geographical variations across the country along with the differences in the availability and accessibility of health facilities.

**Singh et al (2012)** observed that there is a significant difference between the use of maternal health care services by the levels of education attainment, economic conditions and regional difference. Women belonging to backward classes like scheduled caste, scheduled tribe are less likely to use safe delivery facilities.

**Saxena et al(2013)** observed the significant association of poor economic status to less utilization of maternal health service. Socio structural determinants like case group, wealth status and level of educational attainment are other factors associated with minimum antenatal care visits and institutional deliveries.

**Vidler et al (2016)** The study recognized that exists significant barriers to timely maternity and postpartum care, particularly related to transport, perceived quality of facilities, the cost of care, and the lack of recognition that a large proportion of maternal morbidity and mortality occurs in the postpartum period.

**Objectives:**

- To study the socio-economic determinants influencing the utilization of maternal health care services among the beneficiaries NRHM in Indi taluk of Vijaypur district.

**Hypothesis:** There is a positive association between the socio-economic determinants and the utilization of maternal health care services.

**Selections of the Respondents**

Married women who have delivered a baby between the age group of 15 to 49 are the sampling units for the study. The random sampling was used to select the respondents for the primary study.

**Study area**: The study was conducted in Indi taluk of Vijaypur district of Karnataka State.

**Data Collection Procedure**

Using semi-structured questionnaire, interviews were conducted with married women regarding the information on place of residence, head of the family, religion, age, caste, family type, education, occupation, marital status, monthly income of the family and age at the first pregnancy have been collected from the respondents, who had delivered their babies in the health centre. Systematic random sampling method was used to select the sample. Results were obtained by frequency distribution and cross-tabulation of the variables.

**Table: 1.1 Age, Caste and Religion of the beneficiaries (n=218)**

| variable | Category | Frequency | Percentage |
|---|---|---|---|
| Age | Less than 25 years | 162 | 74.31 |
| | 25 to 30 years | 51 | 23.39 |
| | Above | 5 | 2.29 |
| | | | |
| Caste | General | 69 | 31.65 |
| | Other Backward caste | 85 | 38.9 |
| | Schedule tribe | 8 | 3.66 |
| | Schedule caste | 56 | 25.68 |
| | | | |
| Religion | Hindu | 189 | 86.69 |
| | Muslim, | 29 | 13.30 |

Source: Primary Data

Table.1 shows that the highest distribution of 74.31%(162) respondents were less than25-years age group, followed by 23.39% (51) were between 25-30 and remaining 2.29% (5) were above 30 years of age in the NHRM Scheme. The majority of beneficiaries were from less than 25 years age group that decides safe motherhood influencing on her life-threatening event as well during pregnancy any complications that require medical care. Further the table reflects that out of total 218 respondents majority of them about 86.69% (189) were Hindus whereas Muslims constituted 13.30%(29) of the study sample. Among Hindus Three forth of them belonged to OBC scheduled caste and scheduled tribe. Nearly one-third belonged to General Category. It was seen that backward communities are accessing the maternal health care services than the general category. caste system has been deeply rooted in the human minds, which leads to income inequality in the society. Caste system has serious consequences towards women and children's health (Jungari& Chauhan, 2017).

**Table 1.2 Education and Occupational status of the benefeciries(n=218)**

| Variable | Category | Frequency | Percentage |
|---|---|---|---|
| Literacy status of Respondents | Illiterate | 38 | 17.43 |
| | Primary | 101 | 46.33 |
| | Secondary | 62 | 28.44 |
| | PUC | 15 | 6.88 |
| | Graduation | 2 | 0.917 |
| | | | |
| Literacy status of spouse | Illiterate | 15 | 6.88 |
| | Primary | 95 | 43.57 |
| | Secondary | 82 | 37.61 |
| | PUC | 22 | 10.09 |
| | Graduation | 4 | 1.89 |
| | | | |
| Occupation of Respondents | Agriculture | 32 | 14.67 |
| | House maker | 56 | 25.68 |
| | Service | 40 | 18.34 |
| | Labor | 90 | 41.28 |
| | | | |
| Occupation of spouse | Agriculture | 60 | 27.5 |
| | Industry | 62 | 28.44 |
| | Service | 96 | 44.03 |

Source: Primary Data

Table 1.2 depicts the educational status of the respondents indicating nearly 46.33% (101) of them have completed primary education; followed by 28.44% (62) said that they had attained secondary school. About 6.88%(15) respondents indicated PUC and 0.917% (02) went to graduation level. 17.43 %( 38) were Illiterate means had not attained primary school. When it comes to their spouse education level, 43.97 % (95) were completed primary school, followed by 37.61% (82) of spouses had attained secondary school. About 10.09 % (22) have attained PUC and the remaining 1.89% (4) of the spouses belongs to graduate and 6.88% (15) never went to school or that they hadn't completed their schooling. As far as respondents occupation is concerned majority of the respondents 41.28% (90) said that they were labour, followed by 25.68% (56) who belongs to Homemaker, 14.67%(32) of respondents belongs to Agriculture while 18.44 % (40) engaged in Business/Service. Majority of the respondent 41.28% (90) were working in different sectors as labourers which may have adverse affects on pregnancy.

Almost one third the respondents indicated 44.03 % (96) of spouse belongs to Service, followed by 27.5 % (60) who belongs to agriculture, and 28.44 % 68) whose spouse were working in Industry. Study observed that occupational pressure exists between house and the job which result in conflict among married couples.

**Table 1.3 Basic amenities of the respondents(n=218)**

| Amenities | Category | Frequency | Percentage |
|---|---|---|---|
| Housing Structure | Katcha | 95 | 43.57 |
| | Semi-pucca | 105 | 48.16 |
| | Pucca | 18 | 8.25 |
| Toilet Facility | OwnToilet Facility | 69 | 31.65 |
| | Open defacation | 149 | 68.34 |
| Drinking Facility | Public tap | 135 | 61.92 |
| | Own tap | 83 | 38.07 |

Source: Primary data

The above table revealed that a larger proportion of the respondents 48.16% (105) were reside in Semi-Pucca, followed by 43.57% (95) of respondents reside in Katcha. About 8.25 % (18) respondents had Pucca housing structure facility. As far as drinking water facility is concerned study shows that a larger proportion of the respondents 61.92% (135) said that Public Tap was the source of their drinking water. Remaining 38.07% (83) of respondents indicated that they Own tap facility for drinking water., Along with the findings reveal that most of the respondent's 68.34 % (149) said that they were depend on open defecation in their location, remaining followed by 31.65 % (69) who said they have Own Toilet facility. Result shows that there are huge potential differences in accessing toilet facility, Sanitation and hygiene facilities are essential for human dignity, to maintain good health and well-being of the society.

**Economic Status of the respondents (n=218)**

**Table 1.4 Respondents Monthly family Income and landholdings:**

| Family Income | No.of Respondents | Percent | Family Land Holding | No. of Respondents | Percent |
|---|---|---|---|---|---|
| Less than 5000 | 171 | 78.44 | No Land | 44 | 20.1 |
| 5000 to 10000 | 30 | 13.76 | Less than 4 Acres | 142 | 65.13 |
| More than 10000 | 17 | 7.79 | More than 4 Acers | 32 | 14.67 |
| Total | 218 | 100 | Total | **218** | **100** |

Source: Primary data

The table shows that most respondents 78.44 % (171) said they earn Less than Rs. 5000 as Monthly family Income, followed by 13.76 % (30) who said they earn Rs. 5000 to Rs. 10000 as Monthly family Income, with 7.79 % (17) who said they earn Rs. More than 10000 as Monthly family Income. It is indicated that three forth of families earning less income to meet uncertain family expenditure. In terms of owing a land it was revealed that most respondents 65.13 % (142) indicated they own less than 4 Acres land, followed by 20.1 % (44) who said that they do not have any land, with 14.67% (32) who stated they own more than 4 Acers of land. Hence three forth of families owned less than 4 Acres land size as primary source of income to meet uncertain family expenditure.

**Results and discussion:**

Age of the marriage for girls is deciding factor which directly associates with maternal health of women. At the time of interview majority of the subjects were of age 25 to 30 (98%) in rural area which is reproductive capacity age, this indicates that many of the married girls had become pregnant around the age of 30 years. This early age of getting pregnant has significant impact over the mother's health and also her attitude towards self-care. Religion brings a gambit of cultures and practices pertaining to pregnancy, nutrition, and diet in pregnancy and child rearing. Hence the Study findings revealed that majority of the respondents about 91% were from Hindu religion participating in the NHM Scheme as a pregnant women and women in labor in the study area. Further three fourth of beneficiaries belonging to OBC, Scheduled caste and Scheduled tribe communities are gaining larger beneficiaries from the NHM Scheme. Education is the key factor for improving quality of maternal health care and access to and utilization of ANC services. Educational level was low in the study area. The status of women's education shows that nearly than 50% of women need compulsory education which positively effects on maternal health and reduces the risk of selected maternal complications. In the present study not only the study participants but also their husbands lacked education. It was found that larger proportion of the Spouses about 40% (103) of spouse attained less education. Thus both partners were in need of good educational attainment to know the importance of maternal complications and issues in maternity period. In spite of having low educational status in the study area more than 70% of respondents were working as labourers engaged in some kind of work like in farm or brick furnaces, Thus the reason could be that low education can only fetch a pity job in city with low earning associated with working status which may have adverse affects on their pregnancy and the new born infant. As far as partner's occupation is concerned majority of them have involved in service sector like driving, etc. Hence it is highlighted that three forth of families earning less income to meet their uncertain family expenditure. Nearly 80% of respondents were less and marginal farmers and living below standard level of living in the study area and are unable to meet uncertain family needs which indicates that these families were in need of health security schemes during maternal health. It was seen above 90% families are having income of less than 10,000 showing that these families come under below poverty line indicating the life cycle approach to

nutritional food security to all pregnant and lactating mothers through local governments and added government facilities to the eligible households as social security.

**Conclusion:**

The National Rural Helath Mission was implemented with a great thrust to promote maternal health care services in rural areas across the country by promoting institutional deliveries through cash incentives under the scheme. The study found that the access to maternal health care services is influenced by individual, household and community level factors. Socio economic factors like age, education, occupation of the women, occupation of the husband, household economic status are important determinant of access and under utilization of maternal health care services. Religion, caste and economic status play a major role in access to the services in the study area. Therefore social identity plays a crucial role in maintaining the inequality of access and utilization of the services. In the present study it was found Muslim women were less likely to utilize the services than women from other religious groups. Along with religion, educational and economic status are the retarding factors in the utilization of MCH services. Hence there is a need to promote education among rural people to understand the importance of health and hygiene. The NRHM was aimed to reduce the inequity in MCH services across socio-economic class, rural-urban, and state-regions but the barriers in the health system and the socio-economic determinants of health that still, constraints in reducing the gap which prevails in accessing the scheme. Thus strengthening the health system is required in order to improve the service utilization in the study area. Since ASHA workers play a vital role in dealing with the community level issues from tracking pregnancy to childbirth, they have to be trained well. Asha workers must be encouraged to identify the right beneficiaries of the scheme in order to increase the utilization of the service. They must be educated at the community level to reduce the influence of dominance of caste groups as well as they must be recruited from the same caste in order to reduce the inequity associated with the social discrimination. The NRHM scheme has a great influence on those women who are economically disadvantaged community in utilizing the services and therefore the scheme should be implemented at the the individual and the community level in the study area.

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