Mother Andchild Health-Care Programme in Kadambattur Block of Tiruvallur District

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Abstract:

The main purpose of this paper was to examine the mother-child healthcare programme in the study area. The researcher aimed to find thesocio-economicconditionsofmaternalmotherandchildhealthcare, andtheutilization ofhealthcareprogrammes in thestudy area and also to find thehealth expenditureof the sample respondents and suggest-measuretoimprovetheefficiencyoftheprogrammeandhealthconditionsofmother-childin the studyarea. For that the researcher has computed the following hypothesis, there is significant association between the annual household income and mother and child health expenditure of the sample respondents, and there is significant association between the annual household expenditure and non-medical expenditure of the sample respondents. The researcher conducting a pilot study in Kadabature Block of Tiruvallur District, and theresearcher hasselected140samples from theselected two villages, each village carries 70 respondents.The researchercollectedtheprimary data byusinginterviewschedule. The researcher revealed that the computed Chi-square estimation of 16.163 is significant at 10 per cent level and along these lines the null hypothesis is rejected. The positive sign for liner-by-liner affiliation additionally infers that as the mother and child health expenditure, the acquiring limit of the respondents likewise increases. Also, the computed Chi-square estimation of 29.548 is significant at 5 per cent level and along these lines the null hypothesis is rejected. The positive sign for liner-by-liner affiliation additionally infers that as the non-medical expenditure, the acquiring limit of the respondents likewise increases. Hence, the researcher suggest and concluding that onecansay thatitisnow urgentthatthe nationadditionallytogenerate somecomprehensive legislative measuresinorder toimprovewomen's healthstatus.

Keywords: health status, human capital, development policies, medical expenditure, maternal-child healthcare

Introduction

Health Economics is primarily concerned with the formal analysis of expenditure, benefits, management and consequent of health status and health care. Over the years, as India's health system developed, there has been an increased focus on quality in the health sector. Health has been viewed as a dimension of human capital and treated as an indicator of social welfare of the people in all countries. Consumers do not purchase health from market. Instead, they produce it by spending time upon health improving activities and also purchasing medical inputs (Grossman M., 1972).

The low health status contributes less to human capital formation than others (Behrman et al., 1988). Hence, economists focused attention on the determinants and impact of health status. Health is broadly defined as longevity and 'illness free days' and is something all desire; but it cannot be bought directly. The demand for health is indirect, and therefore, very difficult to measure. Health status indicators suggest its useful applications of health economics in empirical studies. Human resource development is fostered by a mosaic of factors such as education, health, water supply and housing that constitute the basic needs.

The economic characteristics of developing countries are reflected in their health characteristics. Good health is fundamental to every man, women and child, not only for their well-being but also for their very survival. An estimated 56,000 maternal deaths take place in India every year, which is 19 percent of annual maternal deaths taking place globally (World Health Organization, 2010). Infant mortality rate (IMR) has declined from an estimate of 148 per thousand live births in 1951 to 44 in 2012 (Registrar General India, 2011).

Efforts towards this end require action on multiple fronts including improved access and quality of services, human resources, effective organization of delivery care and the effectiveness of social interventions to improve birthing practices (Parkhurst et al, 2005). Quality is by far the most critical determinant of maternal outcomes, influencing the decision to seek care, the time taken to reach appropriate care and the ultimate outcome of care (Hulton et al, 2000).

Quality of care encompasses both technical competence of service providers and patient satisfaction with treatment received (Hulton et al, 2007). Six key dimensions of health systems functioning – safety, effectiveness, responsiveness or patient-centred care, timeliness, efficiency and equity – have been identified as critical priorities for quality improvement (Institute of Medicine, 1990).India's health system development was guided by considerations of equity and expanding coverage; yet efforts were severely restricted owing to constrained resources (Amrith, 2009).

Maternal-child healthcare programme services were planned to be expanded with training of doctors, nurses and midwives. However, little progress was made in real terms and quality of infrastructure and human resources emerged as a concern (Ministry of Health and Family Welfare, 1961). Where primary level facilities are not geared up, deliveries are reaching the secondary and higher levels, which face severe over-crowding and shortage of beds and are therefore often compelled to compromise quality of care (Ministry of Health and Family Welfare, 2012). Mechanisms for quality monitoring are yet to be fully operational in all states, while institutions like Hospital Development Societies, set up for participatory management of facilities, need further orientation on their role in safeguarding equity, along with quality of services, besides other functions (Ministry of Health and Family Welfare, 2011).

NeedoftheStudy

Healthstatusisoneoftheimportantindicatorsofthewelfareofthepeople.Theissueofhealthis greatimportancebothfromthepointofviewoftheindividualsandthenationaswell.Inanycountryitisthe health status of the peoplethat determines their well-being and thepaceofeconomic andsocial development. Healthexpenditure hasanimpactonaverageexpectationoflife,productive age,and production,productivity, earning capacity,employmentandwell-beingofthepeople.Ontheotherhandseveraleconomicsvariables likeemployment,income,purchasingpowerandpoverty determinethe healthstatusofthe people.Thereare many studieshavebeencarriedouttoassesstherelationshipbetweenhealthandeconomicdevelopmentat macro level.Assessing thisrelationship,that is,betweenhealthandeconomics,atmicroleveli

sneed ofthe hour; in this perspectivethis studyisgettingimportance.

Asstatedearlier,the healthofwomenisanimportantone.Simultaneo usly mother-childhealthcare shouldalsobetakencare.Malnutritionto motherandchildleadstonumberofhealthproble ms;sometimeit causesdeathbothtomotherandchild.Oncetheq uantumofhealthhascomedown,onecannotexp ectthe real economicgrowth and development.Toavoidsuchthings,thegovern menthasimplemented the mother-childhealthcare programme.The firstandforemostproblemi.e.,thetargetgroupo rbeneficiaryshouldawareaboutthisprogramm e.Hence, the researcher has takenKadambatturBlock ofTiruvallurdistrict randomly.

Objectives oftheStudy

On the beginning of overdiscussed premises, this studysets thefollowingobjectives:

1. Tostudythesocio-economicconditionsofmaternalmothe randchildhealthcare, andtheutilization ofhealthcareprogrammes in thestudy area;

2. To explorethehealth expenditureof the sample respondents and suggest-measuretoimprovetheefficiencyofthe programmeandhealthconditionsofmo ther-childin the studyarea.

Hypothesis

1. There is significant association between the annual household income and mother and child health expenditure of the sample respondents.

2. There is significant association between the annual household expenditure and non-medical expenditure of the sample respondents.

Methodology

Themethodology consistsoftheresearchdesignused,thetechniqu esusedintheselectionand constructionof tool,the manner inwhichthe requireddata were collected, tabulation,analysisand interpretationandpresentationoftheresearchre port.Theresearcherhastaken descriptivedesignfortheresearch.Itmeansdesc ribing the variouscomponentsofproblemsfacedby thehealthstatusofmotherandchild.Thisdesign

helpedthe researcher todescribe theireducationalstatus,economic condition,mother childhealthstatus,maternaland childhealthcareprogrammeinKadambatturBl ock.Afterconducting apilotstudy in the following twovillagesnamely: (i) Perambakkamand (ii) Mapped wherethe mother-child health careprogrammeis goingon.

Aftergoing throughtherecordsoftheconcernedPHCs,ther esearcher hasselectedeach70samples from theselected two villages.The researcher collected the primary data by using interview schedule because most of the respondentswerenotinapositiontofillupthequ estionnairecorrectly.Theresearchertranslatedt he questions into Tamil. Sothat theycould understand the questions wellandanswercorrectly.

Results and Discussion

Table 1.1 Annual Income of the Household and Medical Expenditure of the Sample Respondents

Medical Expenditure	Household Income				Total
	Up to `25000	`25001-50000	`50001-75000	Above `75000	
Up to `2000	15	27	20	11	73
	(20.5)	(37.0)	(27.4)	(15.1)	(100.0)
	[88.2]	[55.1]	[48.8]	[33.3]	[52.1]
`2001-2500	2	13	11	11	37
	(5.4)	(35.1)	(29.7)	(29.7)	(100.0)
	[11.8]	[26.5]	[26.8]	[33.3]	[26.4]
`2501-3000	Nil	7	6	6	19
	Nil	(36.8)	(31.6)	(31.6)	(100.0)
	Nil	[14.3]	[14.6]	[18.2]	[13.6]
Above `3000	Nil	2	4	5	11
	Nil	(18.2)	(36.4)	(45.5)	(100.0)
	Nil	[4.1]	[9.8]	[15.2]	[7.9]
Total	17	49	41	33	140

	12.1)	(35.0)	(29.3)	(23.6)	(100.0)
	[100.0]	[100.0]	[100.0]	[100.0]	[100.0]

Note: Figures in round brackets () are row-wise percentage and those in square brackets [] are column-wise percentage.

Source: Field survey.

The table 1.1 is noted that out of the 73 respondents who spend for their medical expenditure up to `2000, 15 (20.5 per cent) has their family income up to `25000 per annum, 27 respondents (37 per cent) each come under the annual income range of `25000-50000 and 20 (27.4 per cent) respondents come under their family income of `50001-75000, while 11 respondents (15.1 per cent) fall in the income slab of above `75000 per annum; in the case of the 37 respondents who belong to the spending range of their Medical Expenditure `2001-2500, 2 (5.4 per cent) come under the annual family income slab of upto `25000, 13 (35.4 per cent) belong to the annual family income class of `25001-50000, 11 (29.7 per cent) fall in the annual family income slab of `50001-75000l per annum and there are another11 respondents (29.7 per cent) who earn above `75000 per annum; among the 19 respondents who spend for their Medical Expenditure `2501-3000, none of them come under the annual family income range of upto `25000, 7 (36.8 per cent) belong to the

annual family income class of `25001-50000, 6 (31.6 per cent) fall in the income slab of `50001-75000 per year and another 6 (31.6 per cent) come under family income slab of above `75000 per annum; and out of the 11 respondents who belong to the Medical Expenditure range of above `3000, none of them belong to the annual family incomeslab of upto `25000 per annum, 2 (18.2 per cent) come under in the range of `25001-50000 per year, 4 (36.8 per cent) fall in the annual family income slab of `50001-75000s per annum and there are 5 respondents (54.5 per cent) who come under annual family income range of above ` 75000per annum.

Thus, among the Medical Expenditure respondents of up to `2000, 57.5 per cent upto `50000 per year, which is 40.5per cent among the Medical Expenditure range of `2001-2500, 36.8 per cent among the Medical Expenditure range of `2501-300 and 18.2 per cent among the Medical Expenditure range of above `3000 respondents, while 42.5 per cent of the

Medical Expenditure respondents of up to `2000come under above `75000 per annum, which is 59.4 per cent, 63.4 per cent and 81.9 per cent among the `2001-2500, `2501-3000 and above `3000 Medical Expenditure respondents respectively.

Hypothesis One: There is significant association between the annual household income and mother and child health expenditure of the sample respondents.

Null Hypothesis: there is no significant association between the annual household income levels of the sample respondents and the mother and child health expenditure in the study area.

To test the hypothesis, the sample respondents' yearly income and the mother and child health expenditure of them are taken and it is tested with the application Chi-square test. The test outcome exhibited in Table-1.2.

Table-1.2 Testing the association between Annual Income of the Households and Medical Expenditure among the Sample Respondents

Statistic	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	16.163*	9	0.064
Likelihood Ratio	19.363**	9	0.022
Liner-by-Liner Association	12.800***	1	0.000
N of Valid Cases	140		

Note: * indicates significance at 1 per cent level**

Source: Computed from field survey data.

It is observed that the computed Chi-square estimation of 16.163 is significant at 10 per cent level and along these lines the null hypothesis is rejected. Thus, it is reasoned that the income levels of the sample respondents and the mother and child health expenditure pay out by them are essentially related. The positive sign for liner-by-liner affiliation additionally infers that as the mother and child health expenditure, the acquiring limit of the respondents likewise increases.

Table 2.1 Household Expenditure and Non-Medical Expenditure of the Sample Respondents

Household Expenditure	Non Medical Expenditure				Total
	Up to `1000	`1001-1500	`1501-2000	Above `2000	
Up to `15000	10	6	4	5	25
	(40.0)	(24.0)	(16.0)	(20.0)	(100.0)
	[34.5]	[12.2]	[14.8]	[14.3]	[17.9]
`15001-20000	11	16	6	11	44
	(25.0)	(36.4)	(13.6)	(25.0)	(100.0)
	[37.9]	[32.7]	[22.2]	[31.4]	[31.4]
`20001-25000	6	19	3	5	33
	(18.2)	(57.6)	(9.1)	(15.2)	(100.0)
	[20.7]	[38.8]	[11.1]	[14.3]	[23.6]
Above `25000	2	8	14	14	38
	(5.3)	(21.1)	(36.8)	(36.8)	(100.0)
	[6.9]	[16.3]	[51.9]	[40.0]	[27.1]
Total	29	49	27	35	140
	(20.7)	(35.0)	(19.3)	(25.0)	(100.0)
	[100.0]	[100.0]	[100.0]	[100.0]	[100.0]

Note: Figures in round brackets () are row-wise percentage and those in square brackets [] are column-wise percentage.

Source: Field survey.

The table 2.1 revealed that there is a positive relationship between household expenditure among the respondents and their non-medical expenditure capacity. For instance, among those who spending range of up to `15000 as their Household Expenditure, only 36 per cent of the respondents who can spend for non-medical expenditure above `2000 per annum, which is 38.6 per cent among those who spending range of up to `15001-20000 their Household Expenditure, 24.3 per cent in the case of those who spend as their Household Expenditure of `20001-25000 and 73.8 per cent among those who are having the spending capacity of above `25000 for their Household Expenditure.

Hypothesis Two: There is significant association between the annual household expenditure and non-medical expenditure of the sample respondents.

Null Hypothesis: there is no significant association between the annual household expenditure levels of the sample respondents

and the non-medical expenditure in the study area.

To test the hypothesis, the sample respondents' yearly household expenditure and the non-medical expenditure of them are taken and it is tested with the application Chi-square test. The test outcome exhibited in Table-2.2.

Table 2.2 Testing the association between Annual Household Expenditure and Non-Medical Expenditure among the Sample Respondents

Statistic	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	29.548**	9	0.001
Likelihood Ratio	29.306**	9	0.001
Linear-by-Linear Association	9.517**	1	0.002
N of Valid Cases	140		

Note: * indicates significance at 1 per cent level**

Source: Computed from field survey data.

It is watched that the computed Chi-square estimation of 29.548 is significant at 5 per cent level and along these lines the null hypothesis is rejected. Thus, it is reasoned that the annual household expenditure levels of the sample respondents and the non-medical expenditure pay out by them are essentially related. The positive sign for liner-by-liner affiliation additionally infers that as the non-medical expenditure,

the acquiring limit of the respondents likewise increases.

Conclusion

This paper has attempted to assess the mother and child health care program in Kadambattur block of Tiruvallur district and it revealed that the medical expenditure of the respondents up to `2000, and 57.5 per cent up to `50000 per year, which is 59.4 per cent, 63.4 per cent and 81.9 per cent among the `2001-2500, `2501-3000 and above

`3000 medical expenditure respondents respectively. And in the case of annual household expenditure and non-medical expenditure of the sample respondents those who spending range of up to `15000 as their Household Expenditure, only 36 per cent of the respondents who can spend for non-medical expenditure above `2000 per annum, 73.8 per cent among those who are having the spending capacity of above `25000 for their Household Expenditure.

Toconclude,itisessentialtogivewomen'shealthinaholisticwaywithinthesocio-economicandpoliticalcontextoftheirlives.Improving women'shealthrequiresastrong andsustainedgovernment commitment,aconstructivepolicy environment,andwell-targetedresource.Therefore,onecansay thatitisnow urgentthatthe nationadditionallytogenerate somecomprehensive legislative measuresinorder toimprovewomen's healthstatus.Education on health, nutrition awareness for mothers, and balwadi-anganwadi workers are necessary to promote good nutrition practice for children. The government needs to provide nutrition foods such as diet powder for the health endorsement of children. Those children are need to get good health and prosperous in their future, and also to generate a good homeland in the world.

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