REVIEW OF RESEARCH

"IMPACT OF SOCIO-ECONOMIC PREDICTORS ON MATERNAL AND CHILD HEALTH; A COMPARATIVE STUDY OF RURAL HARYANA AND KERALA"

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ABSTRACT:

The maternal and child health of a population depends upon many factors such as income class, education status, sanitary and medical facilities, culture, social control, climate, and different phases of the environment. That wealthy people live longer and lower risk prevalence of morbidity, on average, than do poor people has been well documented across countries. The level of earnings inequality in a country, state, society, or community is linked with the health of the population. Children's health canbe affected by the health conditions of their parents, possibly through an inherited susceptibility to different diseases.In the present study, District Level Household and Facility Survey (DLHS-4) have been used For the study, a total number of ever-married women from Kerala and Haryana used as a primary unit of analysis. Logistic Regression has been used for this analysis. This study also concludes that determinant sof maternal healthcare services are not the same across two states and for different maternal and child healthcare indicators. Only women education and exposure to mass media have emerged as the most solid significant positive factors in Kerala for all indicators of maternal and child health services as compared to Haryana.

KEYWORDS: *Maternal, Child, Health, Haryana, Kerala,Socio-Economic.*

INTRODUCTION:

The maternal and child health of a population depends upon many factors such as income, education status, sanitary and medical facilities, culture, social control, climate, and particular phases of the environment. The relationship between socio-economic status and health is one of the most strong and well-documented findings in social sciences. That wealthy people live longer, and risk is lower prevalence morbidity, on an average, than to do deprived people has been well documented across country and inside the country at a point in time, and over time with economic development (Case et al. 2002; Currie and Stabile, 2003).

The statusof income inequality in a country, state, society or community is directly linked with the health of the population. More specifically, as income inequality increases, health status declines. This claim is consistent with medical sociologists and psychologists ' long-standing contention that physiognomies of the societies in which we live impactof health and happiness independent of personal resources, skills, and behaviours (Durkheim, [1897] 1951;Susser, Watson, and Hopper; and 1985 Faris and Dunham, 1939).

Even thoughamassed interests in exploratory population the effect of disparity on population health, empirical evidence regarding the aggregate link between variance and health remains questionable. This area has been disapproved on several grounds, most notably for its reliance on bivariate analyses that exclude appropriate controls such as the racial composition of the

population. Reviews of the association with income inequality with population health become insignificant (McLeod et al. 2004 Mellor and; and Milyo, 2001) .raising fundamental questions about the evidence on which claims of inequality's effects on health. What should we conclude about the impact of income inequity on health in light of these contradictory results? We re-evaluate this problem in the analysis of the associations between income inequality, and the aggregate well-being of children in the fifty states of the U.S.

Children's health can also be affected by the health status of their paternities, possibly through an inherited weakness to different diseases, a less healthy uterine environment, or lower quality care by sick parents. Also, the health of parents and children might be affected by common but unmeasured climatic factors, resulting in a correlation between their health status (Case et al. 2002).It is likely that maternal health status is a `third factor' that accounts for the economic effect in children's health: an income effect in children's health influence be observed if parents in poor health have lower earnings, and poor health is passed on from parents to children--producing a spurious correlation between earnings and children's health. We should comprise controls for parental health in the determination of children's health. However, doing so has several potential pitfalls. If the effect of the health of parents is affected by their earnings levels, and earningsare measured with error, then the `effects' of paternal health may reflect the effects of income. Also, if the health of both parents and children are affected by income, maternal health may serve as a proxy for the earnings levels experienced by children at earlier ages. For these reasons, we cannot separate the effects of parent's health and family earnings on children's health. Aware of these problems, we estimate models with additional switch for maternal health status Maternal health is percent of children whose mother's mental and physical health is excellent or very good, to see whether this eliminates the economic effect in children's health.

NEED FOR THE STUDY

This study is dealing with the utilisation of maternal child health care services in rural areas of Kerala and Haryana. Maternal and child health is a complicated issue in health development. Females especially those who are in the reproductive age group are regarded as one of the weakest parts of the population in a situation of diseases and physical condition. Maternal mortality and morbidity add up 6,00,000 women each year. Every minute, at least one woman dies from complications of pregnancy and childbirth. Maternal mortality and morbidity represent one of the broadest health gaps between developed and developing nations. In India utilization of maternal and child care services is very low because of some custom, tradition, and believes are behind that, and the second thing is that women's right to use access is less because women's health problem is given a low priority by the family members, women's access to resources a decision-making power. The reason for not using health facility in India was unavailability of transport, indifferent attitudes of health staff, and non-availability of doctor's especially female doctors at the referral centres, earlier negative experiences, and expense and only superior caste women only use antenatal and postnatal care more than those belonging to lower caste women.

Education is playing an essential role in the utilization of health services. Educated women are using more maternal and child health care services than those who are not attending school. The utilization of health facility is low among scheduled castes and scheduled tribes as compared to higher class women. Kerala is one of the literate and Haryana is a high-income state in India, but now Haryana also struggles with many maternal and child problems especially in the rural part of Haryana. Majority of women's in rural part they don't utilise any health facility like antenatal care, antenatal care visits, tetanus toxoid injections and immunisation because they are not aware about that .

OBJECTIVES:

To study the impact of socio-economic predictors on maternal and child health indicators.

DATA SOURCE & METHODOLOGY

In the present study, District Level Household and Facility Survey (DLHS-4) have been used. It provides the district-level estimate of the demographic and socio-economic characteristic of the population. For the study, the total number of ever-married women from Kerala and Haryana used as a primary unit of analysis. The sample size of the primary unit- 13780 and 28776 for Kerala and Haryana respectively. Logistic Regression has been used for this study.

Findings

Logistic regression analysis of full antenatal care among women aged 15-49 for rural areas of Kerala and Haryana, DLHS 4

The result shows the logistic regression analysis, carried out for the rural areas of Kerala and Haryana. The dependent variable chosen for the study is the 'Full antenatal care', which is one of the most important indicators of the maternal health condition. From the table, it is clear that very few variables are found to be significant in the case of Kerala, whereas almost all the variables are significant in the case of Haryana. In both the states, women with 10 or more years of education are more than two times more likely to go for the full antenatal check-ups. Muslim women in rural areas of Haryana are less likely than Hindu women to go for the full antenatal care. Caste is one factor which is observed to be a highly significant predictor for full antenatal care in the rural areas of both states. Women in the other backward castes (OBC) and other caste groups are around 1.3 times more likely to go for the full antenatal care than women in SC/ST caste groups. A different result is observed for both the states in case of a number of living children and full antenatal care. With the increase in the number of living children for women in Kerala, the likelihood for full ANC is observed to be increasing, whereas in the case of Haryana it is seen to be decreasing. In Haryana, women living in semi pukka or kachha houses are less likely to go for the full ANC. In Kerala, the women living in the homes with the improved source of drinking water are 50% more likely to go for the full ANC.

Table of Logistic regression analysis of full antenatal care among women aged 15-49 for rural areas of Kerala and Haryana, DLHS 4

	Kerala		Haryana	
	exp(β)	P-value	exp(β)	P-value
Background characteristics				
Age of the women				
15-24®				
25-29	0.95	0.71	1.23	0.01
30+	0.96	0.78	1.14	0.14
Education level				
less than 10 years®				
10 or more years	2.26	0.00	2.04	0.00
Religion				
Hindu®				
Muslim	1.01	0.91	0.43	0.00
Others	0.80	0.11	0.87	0.42
Caste				
SC/ST®				
OBC	1.38	0.04	1.33	0.00
Others	1.25	0.03	1.30	0.00
Number of living children				
0-1®				
2-3	1.34	0.00	0.77	0.00

3+	1.24	0.01	0.51	0.00
Type of house				
Pukka®				
Semi pukka	0.94	0.54	0.52	0.00
Kachha	0.72	0.18	0.55	0.00
Water facility				
Non-improved ®				
Improved	1.47	0.03	1.18	0.53

® shows the reference category

Logistic regression analysis of acute respiratory infection in rural areas of Kerala and Haryana, DLHS 4

The result represents the logistic regression analysis, taking severe respiratory infection as the dependent variable, which is an important indicator to show the situation of health among children aged 0-5. It is evident from the table that most of the predictors are found to be insignificant in rural areas of Kerala except the sex of the child and the educational status of the mother. On the other hand, in Haryana, most of the predictors are observed to be significant. A different result is seen in case of the educational level of a mother for both the states. In Kerala, higher education of mother is found to be positively associated with an acute respiratory infection. Children of women with 10 or more years of education are at higher risk of having ARI, whereas, in Haryana, it is observed to lower among children whose mothers fall in the category of 10 or more years of education. In both states, the female children are seen to be at lower risk of having ARI than their male counterparts. Children living in the houses with an improved source of water are found to be at lower risk of ARI in Haryana.

Table of Logistic regression analysis of acute respiratory infection in rural areas of Kerala and Haryana, DLHS 4

	Kerala		Haryana	
Background characteristics	**exp(β)**	**P-value**	**exp(β)**	**P-value**
Age of the mother				
15-24®				
25-29	1.26	0.43	1.07	0.00
30+	1.10	0.75	1.01	0.00
Education level of mother				
less than 10 years®				
10 or more years	1.32	0.04	0.98	0.00
Religion				
Hindu®				
Muslim	1.14	0.66	1.28	0.01
Others	0.72	0.42	0.44	0.00
Caste				
SC/ST®				
OBC	0.80	0.51	1.20	0.06
Others	0.70	0.37	1.08	0.69
Sex of the child				
Male®				
Female	0.84	0.04	0.71	0.02
Type of house				
Pukka®				
Semi pukka	0.89	0.65	1.13	0.46

Kachha	0.96	0.95	1.29	0.00
Water facility				
Non-improved ®				
Improved	0.63	0.21	1.45	0.00

® shows the reference category

CONCLUSIONS

This study also concludes that determinant sof maternal healthcare services are not the same across two states and for different maternal and child healthcare indicators. Only women education and exposure to mass media have emergedas the strongest significant positive factor sin Kerala for all indicators of maternal and child health services as compared to Haryana. Although, child health care services is also better in Kerala as compared to Haryana. Full vaccination is around 82 % in Kerala than in Haryana 51%. Nutritional status among children below five years is better in Kerala than Haryana because all demographic and socio-economic indicators are good in Kerala as a comparison to Haryana. Also, treatment of childhood disease and anaemia status is good in Kerala than Haryana. Even, in the case of vaccination among children and acute respiratory infection (ARI), all demographic and socio-economic indicators are good in Kerala as compare to Haryana.

In Kerala, disease severity and economic conditions predict whether children with acute respiratory infection or diarrhoea are taken to medicinal providers. In contrast, most studies of this issue carried out in other populations recognised economic status as the primary predictorof medical system utilisation. Also, in Kerala, the gender of the childs did not influence whether or not the child was taken for treatment but did influence whether care was sought inthe substitute or the allopathic system.

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