HEALTH DISPARITIES IN MEWAT: STRATEGIES FOR REMOVAL

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Institute For Development And Communication
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HEALTH DISPARITIES IN MEWAT: STRATEGIES FOR REMOVAL

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Acronyms Used in the Study

ANC- Antenatal Care

ANM- Auxillary Nurse and Midwife

ARI- Acute Respiratory Infection

ASHA-Accredited Social Health Activist

AWW - Anganwadi Worker

CHC- Community Health Centre

DLHS- District Level Health Survey

IIPS- International Institute of Population Science

JSY- Janani Suraksha Yojana

LHV- Lady Health Visitor

NFHS- National Health and Family Survey

NRHM- National Rural Health Mission

OBC-Other Backward Class

ORS-Oral Rehydration Salts

PHC- Primary Health Centre

PNC- Post Natal Care

RCH- Reproductive and Child Health

RSBY- Rashtriya Swasthya Bima Yojna

SC- Sub Centre

SCs- Scheduled Castes

VHSC- Village Health and Sanitation Committee

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DISTRICT MEWAT: A PROFILE

Introduction

In the state of Haryana, Mewat is a recently created district made by carving out parts of Gurgaon and Faridabad consisted of 61.82 percent Hindu, 23.21 percent Muslim population i.e. *Meos* and remaining population consists of other minority religious groups i.e. Sikhs, Jains and Christians (Census, 2001).The *Meos* are reported to have embraced Islam during the reign of Sultan Mohammed Bin Tughlaq in the 14th Century A.D. and subsequently, during the Mughal emperor Aurangzeb's time in 17thcentury. Earlier they were *Kshatrias*/*Rajput* who traced their origins to Hinduism. They are among the oldest Indian community who embraced Islam under the influence of Sufism. Their adherence to the Islamic faith over time blended with their social and cultural life.

Years after India's independence the development indicators of Mewat show that it continues to live in perpetual backwardness. The district is at the lowest position on all development indicators. The district falls under the Sub-Tropical, Semi-arid climatic zone and agriculture is mostly rain fed. The Mewat Development Agency, which is a nodal agency of the government, reports that agriculture and livestock are the main occupations of the local people. The climatic conditions make the district's region resource poor leading to subsistence farming, limited alternative livelihood options hence poverty. Many studies have shown that Mewat continues to be ignored by policy makers and major development agencies due to its location in Haryana (Gandhi *et al*, 2009a; Gandhi *et al*, 2009b; Saxena *et al*, 2009 and Godyal *et al*, 2009). These studies have established that the district is largely agrarian with limited scope of diversifying livelihood and its people are therefore dependent on traditional varieties and primitive technologies for agriculture due to lack of awareness. Education and health continues to be an issue as well. The overall health outcome is very low in comparison to the state's average and other districts of the state (Jatrana, 2005). As reported in 2004, out of 503 villages of Mewat only 61 villages have fresh groundwater the rest have saline groundwater (Sharma, 2014). Mewat suffers not only from water scarcity but lack in good quality of water (Sharma, 2014). The district of Mewat experience's acute vulnerability along all the axis of development

District's Profile

The district came into existence on April 4, 2005 as the 20th district of the state. The newly constituted Mewat district consists of four tehsils— Punhana, Nuh, Taoru and Ferozepur Jhirka; and five blocks, namely, Nuh, Taoru, Nagina, FerozpurJhirka, and Punahana. The district is located in the extreme South of Haryana and has not been endowed with the basic infrastructure for its socio economic development.

Table 1.1 Administrative Structure of Mewat District

District	Sub-Division	Tehsil	Sub-Tehsil	Block
Mewat	FerozepurJhirka	FerozepurJhirka	Nagina	FerozepurJhirka
	Nuh	Punhana		Punhana
		Nuh		Nagina
		Taoru		Nuh
				Taoru

Source: Statistical Abstract Haryana, 2012-13.

Area and Population Distribution

The district has 531 villages out of which 490 are inhabited and 41 uninhabited and its total population is 1089263. Across the four tehsils of Mewat, Ferozepur Jhirka is the most populated one with population of 343406 followed by Punhana with population of 291978 (Table 1.2). Population density of Mewat is 729 persons per sq km. which is higher than the state's population density of 573 persons per sq km (table 1.3).

Table 1.2 Area and Population of Mewat District: 2011

District/Tehsil	Area (sq. km.)	Population		
District		**Total**	**Rural**	**Urban**
Mewat	1507.00	1089263	965157	124106
Tehsils				
Punhana	290.15	291978	254632	37346
Nuh	463.7	287101	265114	21987
Taoru	225.19	166778	138172	28606
FerozepurJhirka	521.05	343406	307239	36167

Source: Statistical Abstract Haryana 2012-13.

Table 1.3 Population Density in Mewat and Haryana 2011

	Area (sq. Km.)	Population	Pop. Density
Mewat	1,507	10,89,263	729
Haryana	44,212	2,53,514, 62	573

Source: Statistical Abstract Haryana, 2012-13.

The district's urbanisation is lowest as compared to the rest across the state. Merely 11 percent of the district's total population lives in the urban areas whereas the state average for the same is 34.9 percent (Table 1.4), clearly indicating a lack of development in the districts as majority of the population relies on the rural economy with limited growth of the urban centres.

In case of sex ratios the story reflects differently, since, Mewat has the highest number of females per 1000 males in Haryana. According to the census of 2011, sex ratio in the district is 907 while the state sex ratio is 879. Sex ratio for the age group 0-6 years shows similar trends, as, in Mewat this is 906 as compared to the state sex ratio of 834.

In terms of literacy rates the district is positioned last across all with literacy rate of 54.1 percent, which is much lower than Haryana's state literacy rate of 75.6 percent. Even literacy rate for males is 69.9 percent places the district as last in the state 84.1 percent. In case of female literacy rate a similar trend was observed i.e. 36.6 percent and it ranks the district last and much lower than the state average of 65.9 percent.

Table 1.4 Basic Demographic and Educational Statistics for Haryana and its districts

Districts	Urbanisation Rate	Sex Ratio Total	Sex Ratio 0-6 age group	Total Literacy rate	Male Literacy rate	Female literacy rate
Panchkula	55.8	873	863	81.9	87.0	76.0
Ambala	44.4	885	810	81.7	87.3	75.5
Yamunanagar	38.9	877	826	78.0	83.8	71.4
Kurukshetra	28.9	888	818	76.3	83.0	68.8
Kaithal	22.0	881	828	69.2	78.0	59.2
Karnal	30.2	887	824	74.7	81.8	66.8
Panipat	46.0	864	837	75.9	83.7	67.0
Sonipat	31.3	856	798	79.1	87.2	69.8
Jind	22.9	871	838	71.4	80.8	60.8
Fatehabad	19.1	902	854	67.9	76.1	58.9
Sirsa	24.6	897	862	68.8	76.4	60.4
Hisar	31.7	872	851	72.9	82.2	62.3
Bhiwani	19.7	886	832	75.2	85.6	63.5
Rohtak	42.0	867	820	80.2	87.7	71.7
Jhajjar	25.4	862	782	80.6	89.3	70.7
Mahendragarh	14.4	895	775	77.7	89.7	64.6
Rewari	25.9	898	787	81.0	91.4	69.6
Gurgaon	68.8	854	830	84.7	90.5	78.0
Mewat	11.4	907	906	54.1	69.9	36.6
Faridabad	79.5	873	843	81.7	88.6	73.8
Palwal	22.7	880	866	69.3	82.7	54.2
Haryana	34.9	879	834	75.6	84.1	65.9

Source: Statistical Abstract Haryana 2012-13.

Between 2001 and 2011 the district's decadal growth in population is very high and it is second to Gurgaon in growth of population. The percentage change in the district's population growth during these years was 38.65 percent, while the average annual growth rate was 3.27 percent per year. Whereas the overall increase in population in Haryana in terms of percentage change was 19.9 per cent with an average annual growth of 1.83 percent per year (Table 1.5).

Table 1.5 Increase in Population since 2001 by Districts in Haryana

District/State	2011	2001	Variation in Population between 2001 and 2011	Percentage Change between 2001 and 2011	Average Annual growth between 2001 & 2011
Panchkula	561293	468411	92882	19.83	1.83
Ambala	1128350	1014411	113939	11.23	1.07
Yamunanagar	1214205	1041630	172575	16.57	1.54
Kurukshetra	964655	825454	139201	16.86	1.57
Kaithal	1074304	946131	128173	13.55	1.28
Karnal	1505324	1274183	231141	18.14	1.68
Panipat	1205437	967449	237988	24.60	2.22
Sonipat	1450001	1279175	170826	13.35	1.26
Jind	1334152	1189827	144325	12.13	1.15
Fatehabad	942011	806158	135853	16.85	1.57
Sirsa	1295189	1116649	178540	15.99	1.49
Hisar	1743931	1537117	206814	13.45	1.27
Bhiwani	1634445	1425022	209423	14.70	1.38
Rohtak	1061204	940128	121076	12.88	1.22
Jhajjar	958405	880072	78333	8.90	0.86
Mahendragarh	922088	812521	109567	13.48	1.27
Rewari	900332	765351	134981	17.64	1.64
Gurgaon	1514432	***870539****	643893	73.14	5.69
Mewat	1089263	***789750****	299513	38.65	3.27
Faridabad	1809733	***1365465****	444268	32.54	2.86
Palwal	1042708	***829121****	213587	25.76	2.32
Haryana	25351462	21144564	4206898	19.90	1.83

Source: Statistical Abstract Haryana 2012-13.

Note:*Palwal and Mewat are new districts, formed in 2008 and 2005. Mewat was carved out from Faridabad and Gurgaon and Palwal was carved out from Gurgaon and Mewat. The population for Gurgaon, Mewat, Faridabad and Palwal are adjusted for 2001 as per the present area of the district. The adjustment is based upon the figures given in Haryana Statistical Abstract 2011-12.

Worker Population

According to the 2011 census the overall work participation rate (WPR) in the district is very low, 26.62 percent indicating limited work opportunities available to the people. Haryana's average work participation rate is 35.17 percent, which means that Mewat lags behind the state average by 9 percentage points. Gender differentials in work participation are also quite alarming in Mewat. The district's female work participation is very low at 12.61 per cent whereas for the males it is more than double at 39.33 percent (see table 1.6).

Tab1e 1.6 Work Participation Rate in Mewat in 2011

	WPR All	WPR Male	WPR Female
Panchkula	37.68	55.01	17.82
Ambala	32.98	53.47	9.82
Yamunanagar	32.06	52.94	8.26
Kurukshetra	34.91	52.56	15.04
Kaithal	34.80	51.26	16.13
Karnal	34.28	51.60	14.76
Panipat	34.20	50.81	14.98
Sonipat	36.08	50.06	19.75
Jind	39.23	51.65	24.98
Fatehabad	39.18	53.19	23.64
Sirsa	38.76	54.13	21.64
Hisar	39.66	52.42	25.03
Bhiwani	38.12	49.69	25.05
Rohtak	32.60	47.96	14.88
Jhajjar	34.07	48.58	17.24
Mahendragarh	36.72	47.86	24.26
Rewari	37.51	49.61	24.04
Gurgaon	35.97	52.95	16.09
Mewat	26.62	39.33	12.61
Faridabad	32.01	49.37	12.13
Palwal	29.69	43.55	13.95
HARYANA	35.17	50.44	17.79

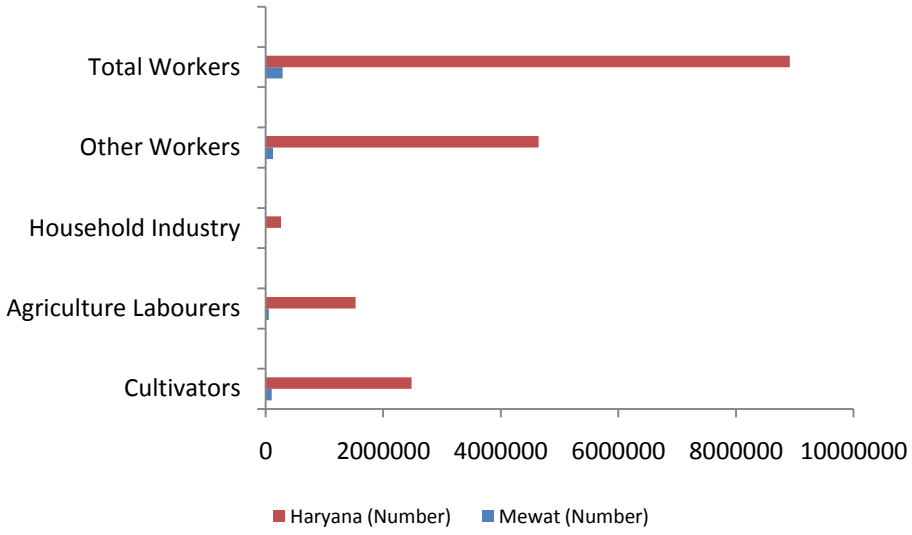
Source: Primary Census Abstract of Haryana 2011, Registrar General of India Year.

Table 1.7
Distribution of Workers in Different Economic Activities in Mewat and Haryana (2011)

Type of Economic Activity	Mewat (Number)	Haryana (Number)
Cultivators	104237 (35.95)	2480801 (27.82)
Agriculture Labourers	55278 (19.06)	1528133 (17.14)
Household Industry	6023 (2.08)	262280 (2.94)
Other Workers	124426 (42.91)	4645294 (52.10)
Total Workers	289964 (100)	8916508 (100)

Source: Statistical Abstract of Haryana, 2012-13.
Note: Workers are main and marginal.

Figure 1.1 Distribution of Workers in Different Economic Activities in Mewat & Haryana (2011)



Most of the workers in the district of Mewat are dependent on agriculture. Out of these total workforce 35.95 percent are cultivators and 19.06 percent are agricultural labourers. It means 55.01 percent are involved in agriculture while the 2.08 percent are in household industry and 42.91 in other works.

Health Care: Evidence from DLHS Survey

The recent third round of 'District Level Household and Facility Survey' DLHS-3, conducted during 2007-08 in 601 districts of India in 28 States and 6 UTs. It was designed to collect data at district level on various aspects of health care utilisation for RCH, accessibility of health facilities, assess the effectiveness of ASHA and JSY in promoting RCH care, to assess health facility capacity and preparedness in terms of infrastructure. DLHS Haryana is based on data collected from 21,406 households during 2007-08; that had 21,484 married women in the age group of 15-49 years and 5,031 unmarried women in the age group of 15-24 years. *Since "the survey was undertaken in the year 2007-08, there is no information about the newly formed Palwal district and this analysis is based on 20 districts".*

Antenatal Care and Institutional Delivery

For antenatal care (ANC) women in Haryana relied on government facility as well as private facility almost in same proportion, i.e. about, 46 percent all of women went to each of these facilities. For ANC, in case of Mewat, there is relatively lower reliance on both government facility 33.9 percent and private 21.1 percent. Interestingly, in Mewat dependency on community based services for antenatal care is quite high at 13 percent - the highest across all the districts. Ideally, it is advisable for women to have at least three visits of antenatal care for same mother and child health. For any antenatal care done by women, the district of Mewat ranks last among the state's other districts. Merely 54.2 percent of pregnant women reported of going for any ANC services, on the other hand, the state's average stands at 87.2 percent. In the district, only 17 per cent of women had three or more antenatal care, whereas, the state average is way above 51.8 per cent (Table 1.8).

Table 1.8 ANC among Women at the age group (15-49)

Districts	Place of antenatal check up[a]			Utilisation of ANC	
	Government health facility[1]	Private health facility[2]	Community Based Services[3]	Any ANC	Three or more Antenatal Check UP
Panchkula	67.6	40.4	0.4	91.9	72.3
Ambala	37.1	56.3	4.5	84.3	57.7
Yamunanagar	28.2	60.2	3.9	90.8	60.8
Kurukshetra	34.3	60.8	4.9	92	61.5
Kaithal	50.9	45.8	5.3	95.1	64
Karnal	39.8	57.5	2.9	90.3	58.9
Panipat	34.7	63.9	1.5	87.2	51.1
Sonipat	37.4	51.7	2.4	95.5	57.7
Jind	50.7	42.2	0.9	93.2	55.4
Fatehabad	64.8	28.9	4	91	41.7
Sirsa	48.8	43.2	3.6	92.8	56
Hisar	55.3	42.9	5.3	92.9	44.3
Bhiwani	49	30.5	1.4	91	48.3
Rohtak	57.4	33.6	2.2	96.6	60.1
Jhajjar	63.2	43.6	2.9	92.1	59.7
Mahendragarh	51.9	37.1	1.8	95.2	53.1
Rewari	47.1	58.4	1.4	96.2	70
Gurgaon	41.5	53.8	2.3	94.1	60.1
Faridabad	40.3	49.7	6.9	81.5	43.8
Mewat	33.9	21.1	12.7	54.2	17
Haryana	45.7	45.8	3.8	87.2	51.8

Source: Haryana District Health and Facility Survey, 2007-08.

Note: 1. Includes sub-centre, primary health centre, community health centre or rural hospital,urban health centre/urban health post/ urban family welfare centre, government hospital or dispensary

2. Includes Private hospital/clinic,

3. Includes non-governmental hospital/ trust hospital or clinic, own home , parents home, other home and other.

Mewat also lags behind when it comes to institutional deliveries as about 85 percent of the total births still take place in homes, whereas, the state's average for home delivery is 52.7 percent. Only 14.8 percent of Mewat's women went for institutional delivery, the corresponding figure for the state is 46.8 percent. Unfortunately, practices of safe delivery suffers from the same fate; only 16.3 percent of mothers had safe delivery in the district, whereas, overall average for the state is 53.2 percent. Among all the districts Mewat is the last on account of institutional and safe deliveries (Table 1.9).

Table 1.9 Percentage distribution of women (15-49 years) according to place of delivery, assistance during home deliveries and Safe Delivery

	Institutional deliveries	Deliveries at home	Deliveries at Home assisted by skilled persons[1]	Safe Delivery[2]
Panchkula	64.3	35.4	3.5	67.8
Ambala	55.4	43.7	7.5	62.9
Yamunanagar	52.3	47.5	6.1	58.4
Kurukshetra	64.2	35.5	3.6	67.8
Kaithal	48	52	9.4	57.4
Karnal	51.3	47.8	5.8	57.1
Panipat	39	60.4	9.4	48.4
Sonipat	53.7	45.4	7.3	61
Jind	42.1	56.9	6.2	48.3
Fatehabad	48.6	51.1	9.5	58.1
Sirsa	53.5	46.4	16	69.5
Hisar	48.6	50.7	5.9	54.5
Bhiwani	35.7	64.6	9.1	44.8
Rohtak	52.8	46.4	6.1	58.9
Jhajjar	48	51.6	9.9	57.9
Mahendragarh	56.8	43.1	8.3	65.1
Rewari	65	35.1	8.5	73.5
Gurgaon	52.3	47.5	4.5	56.8
Faridabad	39.1	60.6	3.6	42.7
Mewat	14.8	84.5	1.5	16.3
Haryana	46.8	52.7	6.4	53.2

Source: Haryana District Health and Facility Survey (DLHS), 2007-08.

Note: Percentage of women who had institutional and home delivery may not add to 100.0, as some deliveries took place on the way to the institute, working place, other place etc.

1 Includes Doctor/ANM/Nurse.

2 Either institutional delivery or home delivery assisted by skilled person

Immunisation and Child Care

Overall, for Haryana full vaccination coverage has been 59.6 percent. Across all the districts, it has been highest in the district of Ambala at 79.1 percent. Mewat ranks lowest with a mere 11 percent of children being fully vaccinated. A similar trend was found with children receiving at least one dose of Vitamin A. In Mewat mere 7.9 percent of the children have received it, whereas, the state's average stood at 49.4 per cent (Table 1.10).

Table 1.10 Percentage of children aged 12-23 months received specific vaccination and Vitamin-A supplementation by districts, Haryana

Districts	Full Vaccination[1]	Atleast one dose of Vitamin A
Panchkula	78.1	73.9
Ambala	79.1	65.9
Yamunanagar	70	61.5
Kurukshetra	67.8	67.2
Kaithal	72.5	56.3
Karnal	75.2	78.4
Panipat	57	54.9
Sonipat	73	70.2
Jind	55.4	57.1
Fatehabad	62.8	45
Sirsa	61.3	59.6
Hisar	55.8	44.6
Bhiwani	58.4	44.5
Rohtak	75.7	46.8
Jhajjar	64.8	42.8
Mahendragarh	67.7	52.4
Rewari	67.3	54.1
Gurgaon	70.5	49.5
Faridabad	46.4	28.7
Mewat	11	7.9
Haryana	59.6	49.4

Source: Haryana District Health and Facility Survey, 2007-08.
Note: 1 BCG, three injections of DPT, three doses of Polio (excluding Polio "0") and measles.

Awareness and timely treatment of childhood diseases such as diarrhoea and acute respiratory infection (ARI) goes a long way in preventing infant and child mortality. For diarrhoea, the most commonly used treatment is the use of ORS to reduce dehydration of child. In Mewat, only 16.6 per cent of mothers reported that they were aware about the ORS. The incidence of diarrhoea in the district was reported to be 23 percent higher than the state's average of 16.5 percent. Among those who have reported about the disease, 74.8 percent have gone for the treatment, which is, again lower than the state's average of 83.3 per cent. 9.1 per cent of the children in the district were reported to be suffering from acute respiratory infections (ARI), out of them 75.9 per cent were taken for medical treatment, again much lower than the state's average of 88.1 per cent (Table 1.11).

Table 1.11 Percentage of women by awareness of ORS and percentage of children who suffered from diarrhoea and ARI and sought treatment

	Women aware of ORS	Children who suffered from diarrhea[1]	Children who sought Advice/ treatment	Children who suffered from ARI[1]	Children who sought advice/ treatment
Panchkula	56.0	15.7	97.5	9.8	98.4
Ambala	50.8	15.1	74.0	13.8	91.2
Yamunanagar	42.5	26.8	88.1	13.1	94.8
Kurukshetra	43.2	22.8	79.5	14.9	82.7
Kaithal	52.8	12.1	98.3	7.6	96.0
Karnal	39.4	33.4	88.3	14.6	91.5
Panipat	37.8	22.1	85.6	9.2	87.0
Sonipat	44.0	13.5	83.7	7.3	94.2
Jind	40.5	14.7	88.3	7.0	88.1
Fatehabad	29.2	9.3	81.4	10.1	89.7
Sirsa	55.7	7.5	87.8	5.6	88.5
Hisar	38.7	11.7	79.7	5.6	82.4
Bhiwani	37.8	12.1	81.3	4.1	95.2
Rohtak	59.1	11.5	74.5	8.2	88.4
Jhajjar	42.7	17.1	95.0	5.0	79.3
Mahendragarh	42.3	13.9	76.7	2.8	82.4
Rewari	63.5	9.5	86.5	4.9	97.1
Gurgaon	61.1	8.9	77.1	8.5	94.7
Faridabad	33.5	19.8	80.6	4.1	84.6
Mewat	16.6	23.0	74.8	9.1	75.9
Haryana	43.3	16.5	83.3	8.3	88.1

Source: Haryana District Health and Facility Survey, 2007-08.
Note: 1 Recall period for both diarrhea and ARI was two months prior to survey.

Health Services

The availability and quality of health services determines, to a great extent, the utilisation of health facilities. Mewat faces very poorly on this account. According to DLHS data for 2007-08, only 26.1 percent villages had any government health facility as compared to the state's average of 49.1 per cent. It is only slightly better than Gurgaon and Faridabad (25 percent each), which are both urban centres. Compared to rural areas, it is just above Yamunanagar district that stands at the lowest position with only 12.9 percent villages having some government health facilities. Furthermore, only **6.5 percent** villages in Mewat have PHCs and **19.6 per cent** have Sub Centres as compared to the state's average of **12.6 per cent** and **46.6 per cent,** respectively (Table 1.12).

Table 1.12 District wise percentage of villages having various facilities

Districts	Primary or middle school	Sub-centre	PHCs	Any Govt Health Facilites[1]	Doctor	ASHA	Anganwadi workers	JSY beneficiary	VHSC	Aware of Untied funds
Panchkula	100	21.4	7.1	28.6	42.9	78.6	96.4	78.6	14.3	32.1
Ambala	96.9	31.3	6.3	37.5	34.4	78.1	100	50	15.6	65.6
Yamunanagar	96.8	9.7	6.5	12.9	29	51.6	96.8	48.4	9.7	45.2
Kurukshetra	100	43.2	8.1	43.2	54.1	75.7	97.3	54.1	21.6	21.6
Kaithal	100	60	20	60	35	92.5	100	72.5	22.5	30
Karnal	100	32.4	18.9	40.5	54.1	83.8	100	70.3	13.5	40.5
Panipat	100	50	16.7	53.3	46.7	90	100	50	50	40
Sonipat	100	62.2	10.8	64.9	45.9	86.5	100	73	13.5	18.9
Jind	97.5	57.5	17.5	60	27.5	87.5	97.5	82.5	20	60
Fatehabad	100	68.3	9.8	68.3	12.2	92.7	100	85.4	29.3	61
Sirsa	100	48.6	13.5	56.8	21.6	91.9	97.3	86.5	45.9	81.1
Hisar	100	81.1	21.6	81.1	16.2	86.5	97.3	91.9	37.8	37.8
Bhiwani	97.6	56.1	22	56.1	12.2	61	100	63.4	2.4	22
Rohtak	100	78.1	21.9	78.1	18.8	81.3	100	65.6	6.3	34.4
Jhajjar	100	71.8	20.5	71.8	5.1	97.4	100	97.4	28.2	33.3
Mahendragarh	100	30.2	7	30.2	11.6	79.1	97.7	62.8	20.9	16.3
Rewari	100	41.5	4.9	43.9	19.5	90.2	97.6	65.9	19.5	36.6
Gurgaon	100	25	0	25	21.9	90.6	93.8	46.9	6.3	43.8
Faridabad	100	25	10	25	0	90	100	65	0	25
Mewat	95.7	19.6	6.5	26.1	13	47.8	93.5	45.7	15.2	19.6
Haryana	99.2	46.6	12.6	49.1	25.8	81.3	98.2	68.2	20.1	38

Source: Haryana District Health and Facility Survey, 2007-08.
Note: 1 includes PHC, Sub Centre, CHC, Government Hospital any government dispensaries

In the context of health facilities, the same picture comes forth in Mewat. It indicates that only **13 percent** of the villages showed presence of doctors as compared to **25.8 per cent** overall in Haryana, and ranking as the sixth lowest performing districts of Haryana. With reference to ASHA's presence, Mewat is the worst district with a mere **47.8 percent** villages having ASHAs, whereas, the state average is that of 81.3 per cent. Jhajjar tops the list with **97.4 per cent.** However, for Anganwadi Workers (AWW) the district presents a favourable picture with **93.5 percent** villages having Anganwadi Worker (AWWs). Mewat also has the lowest number of villages with JSY beneficiaries in the state with **45.7** percent compared to **68.2 percent** in the state. Only **15.2 percent** villages in Mewat have Village Health Sanitation Committees (VHSCs) set up, as compared to the state's average of **20.1 per cent.** 19.6 percent villages in the district are found to be aware of untied funds, as compared to the state average of 38 per cent (Table 1.12).

Table 1.13 Average Population served by Rural Health facility across districts in Haryana

District	Sub-Centre	PHC	CHC
Panchkula	6,570	34,595	1,62,673
Ambala	7,208	47,742	--
Yamunanagar	7,312	40,046	1,29,136
Kurukshetra	6,478	43,451	1,43,719
Kaithal	6,410	38,369	--
Karnal	7,689	47,933	2,20,523
Panipat	9,100	47,442	2,52,167
Sonipat	6,239	40,993	1,74,923
Jind	9,794	37,549	1,35,312
Fatehabad	7,687	38,626	1,74,891
Sirsa	6,699	36,504	1,48,852
Hisar	7,865	36,283	1,38,755
Bhiwani	6,692	35,128	--
Rohtak	5,925	29,177	1,37,271
Jhajjar	6,976	35,205	1,63,043
Mahendragarh	7,480	39,255	1,19,331
Rewari	7,924	39,320	1,49,688
Gurgaon	9,310	61,791	2,51,050
Faridabad	7,658	46,166	2,24,391
Mewat	10,395	64,096	2,63,275
Haryana	7,585	41,500	1,67,422

Source: Haryana District Health and Facility Survey, 2007-08.

Three tier rural health systems were systematically designed by the government to promote both preventive and curative care, with special emphasis on mother and child health. Sub-centre, the first unit of health care in rural areas, is meant to serve a population of 5,000, but, in case of Mewat the average population served by a Sub Centre is more than 10,000, much higher than the state average of 7585 persons. Similarly, in case of P.H.C. the population served is above the norm of 30,000, as each Primary Health Centres (P.H.C.) serves about 64,000 population, which is again higher than the state average of 41,500. Even regarding the Community Health Centre (CHC), Mewat on an average serves 263275 people, as compared to the national norm of 120000 and state's average of 167422 persons (Table 1.13).

PHC being the nucleus of rural health centre, it is worthwhile to view the existing facilities therein. In Mewat the facility, both in terms of manpower and physical condition, shows acute shortage and also it is way behind the state averages (Table 1.14). Out of 12 PHC surveyed in the district, none reported on conducting a minimum of 10 births. There is only one lady medical officer out of the sample PHC. Even in the case of medical officer, they are present only partially at the PHC and the average of the district is much lower than the state's average. Even in case of equipment such as cold chain or the availability of medicines Mewat lags behind the state average.

Table 1.14 Availability of Resources at PHC in Mewat and Haryana

Resources	Haryana	Percentage Surveyed	Mewat	Percentage
Medical officer	202	76.8	6	50.0
Lady Medical Officer	81	30.8	1	8.3
AYUSH Doctor	4	1.5	0	0.0
Pharmacist	246	93.5	8	66.7
Residential Quarter for MO	113	42.9	5	41.7
Functioning 24 hours basis	103	39.2	0	0.0
At least 4 beds	169	64.3	6	50.0
Regular power supply	110	41.8	2	16.7
Having functional vehicle	37	14.1	1	8.3
Cold chain equipments	174	66.2	5	41.7
Essential drugs	223	84.8	7	58.3
Conducted at least 10 deliveries	40	15.2	0	0.0
Total PHC Surveyed	263	-	12	-

Source: Haryana District Health and Facility Survey, 2007-08.

A study done by the Indian Institute of Human Development have also reported a shortage of health services in Mewat districts, not only that, they also reported growing reliance on quacks to meet the health needs of the people (IIHD, 2008). Given the shortages in rural health

services it is also important to see the availability of health services in terms of the district's tertiary care. Not much information is available to ascertain the status of hospitals at the district level, due to this limitation of data, researchers generally look at the availability of beds for the population. Lastly in Figure 1.2 and Table 1.15 shows the bed per 100000 population in different health institutions across the districts. The least number of beds are in Mewat and higher in Rohtak.

Table 1.15
Beds Per Lakh Population in Health Institutions in Haryana

Districts	Beds Per Lakh Population Health Institutions
Ambala	44
Panchkula	54
Yamuna Nagar	36
Kurukshetra	31
Kaithal	27
Karnal	31
Panipat	25
Sonipat	26
Rohtak	150
Jhajjar	32
Faridabad	37
Palwal	23
Gurgaon	40
Mewat	19
Rewari	37
Mahendragarh	33
Bhiwani	55
Jind	35
Hisar	42
Fatehabad	28
Sirsa	28

Source: Statistical Abstract of Haryana (2012-13).

Methodology for the Study

The present study has looked at existing sources of data and used available literature on the district of Mewat. The literature and data highlights the fact that despite being located in one of the developed states of the country, it is one of the least developed districts. Different indicators of health status and services have been studied from available data sources like the DLHS and the census. Analysis of the secondary data indicates:

1. Low utilisation rate of basic health services in Mewat.
2. Low utilisation of some govt. programmes/schemes like the immunization programme and the JSY.
3. Low development of health infrastructure.

Given these deductions, it will be interesting to find reasons for the district's dismal utilisation and *viz-a-viz* utilisation across population. To analyse the above, three socio-religious groups have been identified. It includes Hindu, Others – which includes upper caste and OBCs, Hindu Scheduled Caste (SC) - the most backward category in the Indian caste system and Muslims - who comprise a significant religious group in Mewat. Hindus are divided into two parts, keeping in mind that as caste and class is strongly correlated. SCs, who have been discriminated for ages, are relatively more backward as compared to others in the range of the development parameters (De haan and Dubey, 2005). The inclusive growth approach of twelfth five year plan also acknowledges the backwardness of SCs.

The study would like to examine the following spectrums:

a. What is the effect of the socio-economic condition of the household, including income, literacy, occupation etc. on health seeking behaviour?
b. Whether there exists any socio-economic inequality in the utilisation rate, in other words, is it the norm that only few have access to health services, and therefore are able to utilize services, with special emphasis on institutional delivery and ANC among the mothers?
c. How health services, both government and private, one of have been perceived by the population (since this would also relate to utilization)?
d. What is the overall access to health services in terms of cost of services? The main motivation is to see whether people are able to pay for the health services, given the economic backwardness of the district and also what is the economic implication of out of pocket expenses for these services at the household level?
e. What is the economic consequence of poor health at the household level? Ill health brings in different kind of losses and one of them is the loss of employment days which leads to loss in income.

Sampling method for selection of Household

Households were selected from two villages from each block of the district. At present, Mewat has five blocks namely, Nuh, Taoru, Nagina, FerozpurJhirka, and Punahana. *This study, in addition to the above mentioned five blocks also includs one more block called Hathin. It was part of Mewat till 2008. With the creation of Palwal district, it was transferred to the new*

district. Hathin shares a very similar socio-cultural profile with Mewat, hence, its inclusion. The study includes both urban as well as rural areas. In order to select households from urban areas, urban wards were taken into consideration.

Two Villages from each block and one ward from urban area were selected on the basis of distance from block PHC. One village which is very near to the Block PHC and another one that lies farthest from the PHC were selected. The list of selected villages and wards under each block is given in table 1.16.

Table 1.16 Sample of Villages and Wards

Sr. No.	Name of the Village/Ward Number	Name of the Panchayat	Name of the Block	Approximate Population of Villages/Town	Approximate Total Number of Household
Villages					
1	Sakras	Sakras	Firojpurjhirka	17000	3300
2	Kameda	Kameda	Firojpurjhirka	5500	450
3	Jamal pur	Jamal pur	Punahna	20000	4500
4	Chandanki	Chandanki	Punahna	2000	250
5	Kansali	Kansali	Nagina	3500	450
6	Gumat Bihari	Gumat Bihari	Nagina	2000	300
7	Didhara	Didhara	Taoru	5500	450
8	Dhoulawat	Dhoulawat	Taoru	4200	1200
9	Mindkola	Mindkola	***Hathin****	12000	5000
10	Buraka	Buraka	***Hathin****	4000	305
11	Kherla	Kherla	Nuh	4800	712
12	Salehdi	Nuh	Nuh	7000	800
Ward	**Ward No.**				
1	7	Zakirhussaincolny	Nuh	2000	100
2	9	Balmiki	Nuh	400	600
3	3	Firojpur	Firojpurjhirka	8000	3000
4	13	Taoru	Taoru	2500	1400

Source: I.D.C Field Survey 2014.

Note: *Block Hathin was selected for the sample because earlier it was a part of Mewat District and is part of Mewat region for comparative purposes.

A total of 391 households were selected using the proportionate random sampling method. The main basis was the social groups, divided into three broad categories

1. Hindu SCs
2. Hindu Others which includes OBC and upper caste
3. Muslims.

Sample Household and Population

The number of selected households under each of the villages and ward is given (Table 1.17). A total of 391 households were surveyed for the study areas with 305 households in the rural areas and 86 in urban areas. Total population covered in this study was 2637 out of which 2033 persons were in rural areas and 604 persons in urban areas.

Table 1.17 Sample of Households in the Study Area

Villages	Number of Households	Population Source
Kherla	27	183
Salehdi	25	177
Dildhara	26	161
Dhoulawat	26	181
Sakras	24	153
Kameda	25	171
Gumat Bihari	25	172
Kansali	25	197
Jamal pur	25	162
Chandanki	26	169
Mindkola	25	169
Buraka	26	138
Total	305	2033
Wards		
Nuh_Ward no.7	21	154
Nuh_ Ward No.9	21	168
FerozepurJhirka_Ward No.3	22	142
Taoru_Ward No.13	22	140
Total	86	604
Grand Total	391	2637

Source: I.D.C Field Survey 2014.

Facilities at the Village Level

Table 1.18 reveals that most of the villages and wards have a primary and middle school and are not far, as average distance travelled to reach them is less than 1 km. Table 1.18 shows that the education facility at the village level and that at the higher level were lacking in the study area, as only four villages had senior secondary school and the average distance travelled to reach senior secondary school was about 2-10 Km. Similarly, colleges are not present in the study area and the average distance travelled to reach college is more than 12.5 kms.

Table 1.18 Education Facility in the Study Area

	Village/Ward No.	Primary School	Middle School	High School	Senior Secondary School	College	Madarsa
Sr. No.	**Name of the Village**	**P=1**	**P=1**	**P=1**	**P=1**	**P=1**	**P=1**
		A=0	**A=0**	**A=0**	**A=0**	**A=0**	**A=0**
1	Mindkola	1	1	0	1	0	0
2	Sakras	1	0	0	1	0	1
3	Kameda	1	1	0	0	0	1
4	Jamal pur	1	1	1	1	0	1
5	Chandanki	1	1	0	0	0	0
6	Buraka	1	1	0	1	0	1
7	Gumat Bihari	1	1	0	0	0	1
8	Didhara	1	1	0	0	0	1
9	Dhoulawat	1	1	0	0	0	1
10	Kansali	1	1	0	0	0	1
11	Kherla	1	1	0	0	0	
12	Nuh	1	1	0	0	0	0
Ward	**Ward No.**						
1	7	0	0	1	0	0	1
2	9	1	0	0	0	0	0
3	3	1	1	0	0	0	0
4	13	0	0	0	0	0	0

Source: IDC Field Survey, 2014.
Note: P= Present
A = Absent

Health Facilities in Villages

Table 1.19 shows the health facilities which are available and the distances required to be covered on an average, in order to access the same in the villages covered for the study. It is seen that government hospital and dispensary are at an average distance of 16.6 kms. and 13 kms. respectively.

Table 1.19 Government health facilities and average distance

Health Facility	Average Distance (Km).
SC	3.2
PHC	5.2
CHC/Rural Hospital	9.0
Government Dispensary	13.0
Government Hospital	16.6

Source: I.D.C Field Survey 2014.

Socio-Economic Profile of the Sample Households

Household Condition and Basic Amenities

Ownership and Housing condition

Ownership of the house was significantly high with residents being predominantly in their own house (96.6 percent). This is true for the three socio-religious groups, all having (over 96.4 percent) and residing in their own house. Rural areas also present the same picture. However, urban areas present a slightly different picture. Although residence in own house is still predominant, the three socio--religious groups don't fare equally. While in Hindus, both others and Hindu SCs, over 95 percent resided in their own houses in urban areas, in the case of Muslims around 74.3 percent resided in their own houses in urban areas (see Table 1.20).

Table 1.20 Ownership of house across Socio-Religious Groups

		Own	Rented	Total
Rural	Hindu SC	25	1	26
	%	*96.2*	*3.8*	*100.0*
	Hindu Others	33	1	34
	%	*97.1*	*2.9*	*100.0*
	Muslim	244	1	245
	%	*99.6*	*0.4*	*100.0*
	Total	**302**	**3**	**305**
	%	*99.0*	*1.0*	*100.0*
Urban	Hindu SC	26	1	27
	%	*96.3*	*3.7*	*100*
	Hindu Others	23	1	24
	%	95.8	4.2	100
	Muslim	26	9	35
	%	74.3	25.7	100
	Total	**75**	**11**	**86**
		87.2	12.8	100
All	Hindu SC	51	2	53
	%	*96.2*	*3.8*	*100.0*
	Hindu Others	56	2	58
	%	*96.6*	*3.4*	*100.0*
	Muslim	270	10	280
	%	*96.4*	*3.6*	*100.0*
	Total	**377**	**14**	**391**
	%	*96.4*	*3.6*	*100.0*

Source: IDC Field Survey, 2014.

Table 1.21 Type of House by Socio-Religious Group

		Thatched	Katcha	Semi pucca	Pucca	Others	Total
Rural	Hindu SC	4	1	11	10		26
	%	15.4	3.8	42.3	38.5		100.0
	Hindu Others	1	2	10	21		34
	%	2.9	5.9	29.4	61.8		100.0
	Muslim	32	7	119	84	3	245
	%	13.1	2.9	48.6	34.2	1.2	100.0
	TOTAL	37	10	140	115	3	305
	%	12.1	3.3	45.9	37.7	1.0	100.0
Urban	Hindu SC	0	1	5	21		27
	%	0.0	3.7	18.5	77.8		100.0
	Hindu Others	0	1	3	20		24
		0.0	4.2	12.5	83.3		100.0
	Muslim	1	1	15	18		35
	%	2.9	2.9	42.8	51.4		100.0
	TOTAL	1	3	23	59		86
	%	1.2	3.5	26.7	68.6		100.0
All	Hindu SC	4	2	16	31		53
	%	7.5	3.8	30.2	58.5		100.0
	Hindu Others	1	3	13	41		58
	%	1.7	5.2	22.4	70.7		100.0
	Muslim	33	8	134	102	3	280
	%	11.8	2.9	47.8	36.4	1.1	100.0
	TOTAL	38	13	163	174	3	391
	%	9.7	3.3	41.7	44.5	0.8	100.0

Source: IDC Field Survey, 2014.

With regards to the type of housing, table 1.21 shows that more than 50 percent of the population don't have pucca house. While 44.5 percent reported living in a pucca houses, 41.7 percent reported in Semi Pucca followed by 9.7 percent in thatched dwellings and very few in Katcha houses (3.3 percent). Hindu others constituted a higher proportion (70.7 percent) living in pucca houses, followed by Hindu SCs (58.5 percent) and over 36.4 percent while Muslims had Pucca houses. In rural areas, most respondents have Semi pucca houses (45.9 percent) or Pucca houses (37.7 percent). Hindu Others lead at 61.8 percent in owning pucca houses in rural area; while Muslims and Hindu SCs are still in majority living in semi pucca houses.

In urban areas, the picture is more or less the same, with 68.6 percent living in pucca houses and close to 26.7 percent in semi pucca houses. Here, for Hindus Others and Hindu SCs, the

figure is substantially high at 83.3 percent as well as 77.8 percent respectively, while for Muslims it is just 51.4 percent. In urban areas, 42.8 percent Muslims reported living in semi pucca houses, while for Hindus other it was 12.5 and 18.5 percent for Hindu SCs.

Electrification

Most of the households covered in the study area had electricity. The picture is encouraging with an overall figure of 94.4 percent of respondents reporting having electricity/connection. The Hindu Others have shown 100 percent, while Hindu SCs are over 96 percent while Muslims at 93 percent. In rural areas 93.4 percent of respondents have electricity and 6.6 percent did not have. It is interesting to note that the 6.6 percent who do not have electricity are Muslim families, as all Hindus Others and Hindu SCs have electricity. In urban areas, 2.3 percent of the population reported not having electricity, while an overwhelming majority reported having electricity (97.7 percent). Some families amongst the Hindu SCs were the ones who did not have (Table 1.22).

Table 1.22 Distribution of Houses having Electricity by socio-religious groups

	No	Yes	Total
Rural			
Hindu SC	-	26	26
%	-	100.0	100.0
Hindu Others	-	34	34
%	-	100.0	100.0
Muslim	20	225	245
%	8.2	91.8	100.0
Total	**20**	**285**	**305**
%	6.6	93.4	100.0
Urban			
Hindu SC	2	25	27
%	7.4	92.6	100.0
Hindu Others	-	24	24
%	-	100.0	100.0
Muslim	-	35	35
%	-	100.0	100.0
Total	**2**	**84**	**86**
%	2.3	97.7	100.0
All			
Hindu SC	2	51	53
%	3.8	96.2	100.0
Hindu Others	-	58	58
%	-	100.0	100.0
Muslim	20	260	280
%	7.1	92.9	100.0
Total	22	369	391
%	5.6	94.4	100.0

Source: IDC Field Survey, 2014.

Toilet and Drainage

Inquiring about the type of toilets used in households under the study area, showed that, overall in Mewat, use of fields for defecation is predominant, with more than half of the respondents claiming to defecate in the open. A breakup by social-religious groups (Table 1.23), further shows that a much higher proportion of Muslim (56.8 percent) and Hindu SCs (43.4 percent) use the fields as compared to the Hindu Others (24.1 percent).

As expected, in the rural areas also defecation in the open/fields is the highest with 58 percent doing so. This is followed by the use of septic tank latrines (37.4 percent). As in the overall picture of Mewat, in the rural areas also, it is the Muslims (61.2 percent) and the Hindu SCs (69.2 percent) who don't have access to toilets and use the fields. In case of the other significant types of toilet used-the septic tank latrines, a greater proportion of Hindu Others (73.5 percent) use it, followed by the Hindu SCs (30.80 percent). It is used by only 33.1 percent Muslims.

The situation in the urban areas, is, however different. Here, the use of septic tank latrines is the highest with 76.7 percent respondents using it. A greater proportion of Hindu SCs (81.5 percent) reported using it, followed by the Hindu Others at 79.2 percent and the Muslims at 71.4 percent. Defecation in the open, in the urban areas, was at 22.1 percent, and all three groups presented which is more or else the same picture. Community toilets were also used (1.2 percent), although interestingly, data shows only the Muslims using it.

Table 1.23 Types of Toilet Facilities in the Households

	Septic Tank Latrine	Pit Latrine	Covered Dry Latrine	Community latrine: Covered Dry Latrine	In the Field	Others	Total
Rural							
Hindu SC	8	-	-	-	18	-	26
%	30.8	-	-	-	69.2		100.0
Hindu Others	25	-	-	-	9	-	34
%	73.5	-	-	-	26.5	-	100.0
Muslim	81	8	2	2	150	2	245
%	33.1	3.3	0.8	0.8	61.2	0.8	100.0
Total	**114**	**8**	**2**	**2**	**177**	**2**	**305**
%	37.3	2.6	0.7	0.7	58.0	0.7	100.0
Urban							
Hindu SC	22	-	-	-	5	-	27
%	81.5	-	-	-	18.5	-	100.0
Hindu Others	19	-	-	-	5	-	24
%	79.2	-	-	-	20.8	-	100.0
Muslims	25	-	-	1	9	-	35
%	71.4	-	-	2.9	25.7	-	100.0
Total	**66**	-	-	**1**	**19**	-	**86**
%	76.7	-	-	1.2	22.1	-	100.0
All							
Hindu SC	30	-	-	-	23	-	53
%	56.6	-	-	-	43.4	-	100.0
Hindu Others	44	-	-	-	14	-	58
%	75.9	-	-	-	24.1	-	100.0
Muslims	106	8	2	3	159	2	280
%	37.8	2.9	0.7	1.1	56.8	0.7	100.0
Total	180	8	2	3	196	2	391
%	46.0	2.04	0.5	0.8	50.12	0.5	100.0

Source: IDC Field Survey, 2014.

With regards to the drainage facilities, it is seen that close to half the population didn't have any drainage facility in Mewat. Muslims fared the worst with close to 60 percent followed by the Hindu SCs at 26.4 percent and only 19.0 percent Hindu others not having any drainage facilities. In rural areas, about 60 percent of the households did not have drainage facilities and across the socio-religious groups the worst off were the Muslims and the Hindu SCs where 64.9 percent and 50.0 percent of the households respectively said there was absence of any kind of

drainage facilities. In urban areas, although very few did not have drainage facility (14 percent), even then share of Muslims among the socio-religious groups was highest, as 25.7 percent of them reported an absence of drainage facilities (Table 1.24).

Table 1.24 Drainage Facilities in the Households

Sector	Absent	Present	Total
Rural			
Hindu SC	13	13	26
%	50.0	50.0	100.0
Hindu Others	9	25	34
%	26.5	73.5	100.0
Muslim	159	86	245
%	64.9	35.1	100.0
Total	181	124	305
%	59.3	40.7	100.0
Urban			
Hindu SC	1	26	27
%	3.7	96.3	100.0
Hindu Others	2	22	24
%	8.3	91.7	100.0
Muslim	9	26	35
%	25.7	74.3	100.0
Total	12	74	86
%	14.0	86.0	100.0
All			
Hindu SC	14	39	53
%	26.4	73.6	100.0
Hindu Others	11	47	58
%	19.0	81.0	100.0
Muslim	168	112	280
%	60.0	40.0	100.0
Total	193	198	391
%	49.4	50.6	100.0

Source: IDC Field Survey, 2014.

Economic Condition

Economic conditions of the households were analysed basically on two accounts, main occupation and total net income of the households for the last one year. Most of the households reported practicing multiple occupations, for instance, a household engaged in agriculture might have some members engaged in other jobs as well. Similarly, those engaged in agriculture labour may also work as non-agriculture worker during off-season or they might lease the land for agriculture purposes. In order to identify the main occupation of the households, the methodology adopted of National Sample Survey (NSSO) was used. Households were asked about the primary source of income, that is, the source that contributes a major share in a household's income. Households in rural areas were divided into four groups, i.e. self-employed in agriculture and non agriculture; labour-both agriculture and casual and others - which can be a combination of the above mentioned occupations or some other dominant occupations. In urban area households, there are three main categories, *viz* regular wage/salary earnings, casual labour and self-employed. Apart from these categories, there is the others that encompasses all the above mentioned categories or some new category. Although it is difficult to ascertain the occupation pattern in rural areas due to multiplicity of work, this method helps us to categorise households into broad categories that reflect their economic conditions.

A majority of the households in the rural areas fall under the labour category, followed by self-employment in non-agriculture, and least in the category of agriculture labour (table 1.25). Across the socio-religious groups, there is a similar pattern for both Hindu SCs and Muslims as in both cases the highest proportion is of other labour, where 38.5 percent of Hindu SCs and 35.1 percent of Muslims were dependent on other labour. The other important category for both these groups were self employed in non agriculture that is 23.1 percent of Hindu SCs and 29.8 percent of Muslims were dependent on self employment in non-agriculture. Hindu Others had highest dependency on agriculture (32.4 percent). So overall, a higher reliance on labour especially among Hindu SC and Muslims in the rural areas is on other labour and self employed in non-agriculture.

In urban areas, the most important category was regular wage/salary earnings which contributed employment to 45.3 percent in total. Across the socio- religious groups, 59.3 percent of Hindu SCs, 50 percent of Hindu others and 31.4 percent of Muslims were dependent on regular wage/salary earnings. Contrary to this, 40 percent of Muslims were dependent on self-employment. Muslims also had the highest dependence on casual labour (20 percent) in respect to other categories.

Table 1.25 Main Occupations of Households

	Hindu SC	Hindu Others	Muslim	Total
Rural				
self-employed in non-agriculture	6	2	73	81
%	23.1	5.9	29.7	26.6
agricultural labour	2	3	19	24
%	7.7	8.8	7.8	7.9
other labour	10	9	86	105
%	38.5	26.5	35.1	34.4
self-employed in agriculture	3	11	45	59
%	11.5	32.4	18.4	19.3
Others	5	9	22	36
%	19.2	26.4	9.0	11.8
Total	26	34	245	305
%	100.0	100.0	100.0	100.0
Urban				
self-employed	3	6	14	23
%	11.1	25.0	40.0	26.7
Regular wage/salary earnings	16	12	11	39
%	59.3	50.0	31.4	45.4
Casual labour	4	4	7	15
%	14.8	16.7	20.0	17.4
Others	4	2	3	9
%	14.8	8.3	8.6	10.5
Total	27	24	35	86
%	100.0	100.0	100.0	100.0

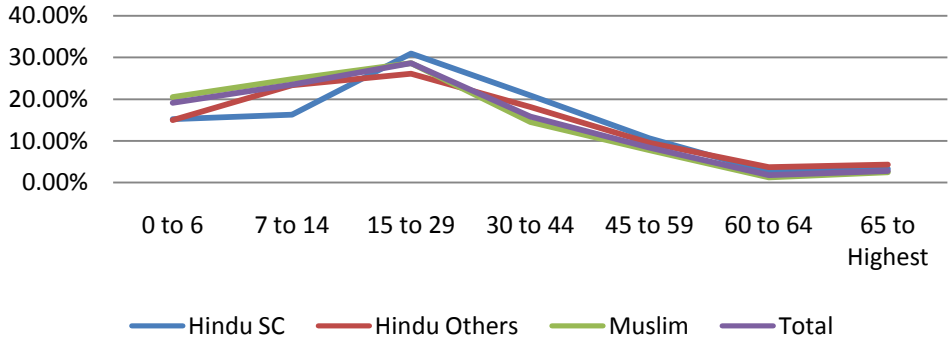
Source: IDC Field Survey, 2014.

Demographic characteristics of the Sample

A total of 2637 persons in 391 households are covered under the survey, out of which, 604 resided in urban areas and 2033 in rural areas.

The population structure suggests that there is an inverted U-shape with respect to age in the study area (Figure 1.2). Most of the population is concentrated in the middle age groups, i.e. between 15 and 29. As the age increases level of population falls down.

Figure 1.2 Socio-Religous Groups and Different Age groups



Source: IDC Field Survey, 2014.
Note: Information is based on 2637 sample

Out of 2637 persons, 1376 are males and 1261 are females with overall sex ratio of 916 females per 1000 males in the study area. Sex ratio for the age group 0 to 6 years is 877 female children per 1000 male child. Across the social groups, the child sex ratio was more favourable towards the girl child in case of Hindu others and Hindu SCs as compared to Muslims. Sex ratio for population age group 0 to 6 for Muslims is 831, whereas for Hindu Others it is 1130 and for Hindu SCs it is 1038. Similarly in case of overall sex ratio, for Muslims it is 899 females per 1000 male whereas for Hindu Others it is 988 and 939 for Hindu SCs (Table 1.24).

Table 1.26 Sex Ratio across the Socio-religious groups

	Sex Ratio (0-6)	Overall Sex Ratio
Rural		
Hindu SC	800	882
Hindu Others	1273	968
Muslim	868	899
Total	884	904
Urban		
Hindu SC	1364	981
Hindu Others	1000	1043
Muslim	600	903
Total	849	961
All		
Hindu SC	1038	939
Hindu Others	1130	988
Muslim	831	899
Total	877	916

Source: IDC Field Survey, 2014.
Note: Analysis is based on 268 males and 235 females for 0-6 age group and 1376 males and 1261 females for the whole population

Comparing sex ratio in the rural and urban areas for age group 0 to 6 population shows that in the rural areas the ratio is better, but in case of overall sex ratio, urban areas have performed better than rural areas. In rural areas, sex ratio of both 0 to 6 and overall have been most favourable to females for Hindu others. In urban areas, both Hindu SCs and Others have shown relatively better sex ratio as compared to Muslims.

Education

Illiteracy is more prominent in case of Muslims wherein 39.10 percent are illiterate followed by Hindu SCs where 26.90 percent are illiterate and least in the case of Hindu Others (20.40 percent) as per illiteracy rate shown in table 1.25. The female illiteracy is also highest in case of Muslims wherein 52.90 percent are illiterate followed by the Hindu SCs where 39.00 percent are illiterate. In case of Hindu SCs, majority of respondents have finished primary level of education (24.80 percent) followed by middle school (20.10 percent). For Hindu Others, majority have done middle school (21.10 percent) followed by secondary school (16.70 percent) and for Muslims majority have done primary (20 percent) followed by middle (15.10 percent). At the higher secondary level of education, we see more of Hindu SCs and Others as compared to Muslims, for instance, 9.50 percent of Hindu SCs and others have finished high secondary whereas for Muslims it is only 3.30 percent. With regards to graduates, 5.10 percent Hindu SCs and 4 percent of Hindu others were graduate and above, whereas the corresponding share of Muslims is a mere 1.70 percent. At the higher level of education, a lesser participation of females as compared to males was observed. It is true for all the socio-religious male groups with female participation in higher education share of Muslim females lower as compared to both Hindu SC and others.

Table 1.27 Educational level across the Socio-religious groups for the age 7 and above (Overall)

	Hindu SC			Hindu Others			Muslim		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Not literate	24	55	79	16	40	56	217	389	606
%	15.70	39.00	26.90	11.40	29.60	20.40	26.70	52.90	39.10
Literate: without formal schooling	1	0	1	2	3	5	29	31	60
%	0.70	0.00	0.30	1.40	2.20	1.80	3.60	4.20	3.90
Below primary	4	4	8	18	10	28	68	61	129
%	2.60	2.80	2.70	12.90	7.40	10.20	8.40	8.30	8.30
Primary	42	31	73	18	25	43	176	134	310
%	27.50	22.00	24.80	12.90	18.50	15.60	21.70	18.20	20.00
Middle	33	26	59	31	27	58	162	72	234
%	21.60	18.40	20.10	22.10	20.00	21.10	20.00	9.80	15.10
Secondary	17	5	22	27	19	46	70	25	95
%	11.10	3.50	7.50	19.30	14.10	16.70	8.60	3.40	6.10
Higher secondary	13	15	28	19	6	25	41	10	51
%	8.50	10.60	9.50	13.60	4.40	9.10	5.00	1.40	3.30
Diploma/certificate course	4	2	6	1	1	2	7	2	9
%	2.60	1.40	2.00	0.70	0.70	0.70	0.90	0.30	0.60
Graduate	13	2	15	7	4	11	19	7	26
%	8.50	1.40	5.10	5.00	3.00	4.00	2.30	1.00	1.70
Post-graduate & above	2	1	3	1	0	1	23	5	28
%	1.30	0.70	1.00	0.70	0.00	0.40	2.80	0.70	1.80
Total	153	141	294	140	135	275	812	736	1548
%	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Source: IDC Field Survey, 2014.

Note: Non response in 14 cases. Responses are based for the population of 2117 whereas the total population of age 7 and above is 2131 as per Census of India (2011) literacy rate has calculated for age 7 years and above.

CHAPTER II
HEALTH SEEKING BEHAVIOUR AND PERCEPTION OF HEALTH SERVICES

Introduction

Health seeking behaviour is determined by a gamut of factors that influences a person interaction with divisions of the health system. These influences range from the individual level to the community level furthering into policy level. Thus, going to a certain health facility or not going at all is indicative of many factors involved in the health care system. Moreover, quality of health services provided influences immensely the use of health amenities. One of the ways to ascertain quality is to know the experience of seeking health services. This experience forms the basis of perception of people towards the service provider.

This chapter not only examines the utilisation pattern but also tries to analyse how people perceive the services that they have received and whether they are satisfied with the same. It looks at both the outpatient care (OPC) and hospitalisation cases. For OPC, the recall period is three months and for hospitalisation, it is one year. So, the chapter is based on respondents at the household level who reported about a member taken ill in last three months as well as those who reported at least one person of the household was hospitalised in the last one year.

Utilisation of Health Services

Out of the sample's total population, 611 persons reported mortality. Out of which, 461 cases were reported in the rural areas and 150 cases in urban areas. 104 cases of hospitalisation were reported in the study area, of which 66 were in rural areas and 38 in urban areas (Table 2.1).

Table 2.1 Outpatient and Hospitalised cases

	Outpatient	Hospitalised Persons
Rural	461	66
%	75.5	63.5
Urban	150	38
%	24.5	36.5
Total	611	104
%	100	100

Source: IDC Field Survey, 2014.

Health seeking behaviour in the study area shows that around 86 percent of the respondents went for formal medical treatment i.e. with qualified medical professional when they were ill.

There is a marginal difference between rural and urban areas as 87 percent in the urban areas and 85 percent in the rural areas reported going for formal medical care (table 2.2). Across the socio-religious groups, a relatively higher number of Hindu others have reported not going for formal medical treatment but they went to quacks etc. (24.2 percent) followed by Hindu SC (12.7 percent) and Muslims (12.3 percent). Further, incidence of non-formal treatment among Hindu SCs and others is relatively higher in the rural areas as compared to the urban areas (Table 2.2).

Table 2.2 Outpatient and their source of Socio-Religious Group

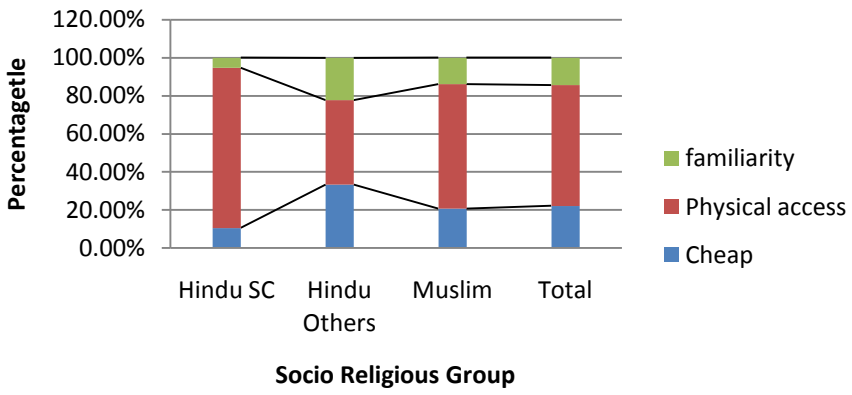
	Socio-Religious Groups	Informal Source	Formal Source	Total
Rural	Hindu SC	12	32	44
%		27.3	72.7	100.0
	Hindu Others	9	37	46
%		19.6	80.4	100.0
	Muslim	46	325	371
%		12.4	87.6	100.0
	Total	67	394	461
%		14.5	85.5	100.0
Urban	Hindu SC	1	57	58
%		1.7	98.3	100.0
	Hindu Others	14	35	49
%		28.6	71.4	100.0
	Muslim	5	38	43
%		11.6	88.4	100.0
	Total	20	130	150
%		13.3	86.7	100.0
All	Hindu SC	13	89	102
%		12.7	87.3	100.0
	Hindu Others	23	72	95
%		24.2	75.8	100.0
	Muslim	51	363	414
%		12.3	87.7	100.0
	Total	87	524	611
%		14.2	85.8	100.0

Source: IDC Field Survey, 2014.
Note: Out of 611 cases 87 went for informal medical treatment from formal sources like Quacks.

Incidence of medical treatment does not reflect adequately on the concentration of non-treatment in certain socio-religious groups. Health care in rural areas or in less developed areas that lack formal health infrastructure is characterised by high dependency on informal sources such as RMPs, Quacks, etc. Almost 14.2 percent of the respondents reported choosing informal health services and from them Hindu Others (24.2 percent) had the highest share. For other social religious groups, dependency is relatively lower in urban areas (Table 2.2).

One of the prominent reasons for using informal services is the physical accessibility (figure 2.1), as more than 60 percent respondents cited the reason of physical accessibility for using informal health care. Another vital reason is the relatively low cost of the treatment prescribed. Around 22 percent respondents felt that informal health services are cheaper. Familiarity with the service provider was also a reason reported by 14 percent respondents. Both, low costs and familiarity have been reported in high numbers by Hindu Others as compared to Hindu SCs and Muslims, and that, partly explains the higher utilisation of the informal services by the Hindu others.

Figure 2.1 Reason for going to Informal Services



Source: IDC Field Survey, 2014.

The formal health services include both public and private services reported in the study area. Majority of the respondents said that they went to private clinics for outpatient treatment. Overall, more than 50 percent reported using private clinics (Table 2.3). The other significant service used was private hospitals, especially, in the urban area where utilisation rate is 21.54 percent. In rural areas, availability of government hospitals was another important service as reported by 9.14 percent respondents.

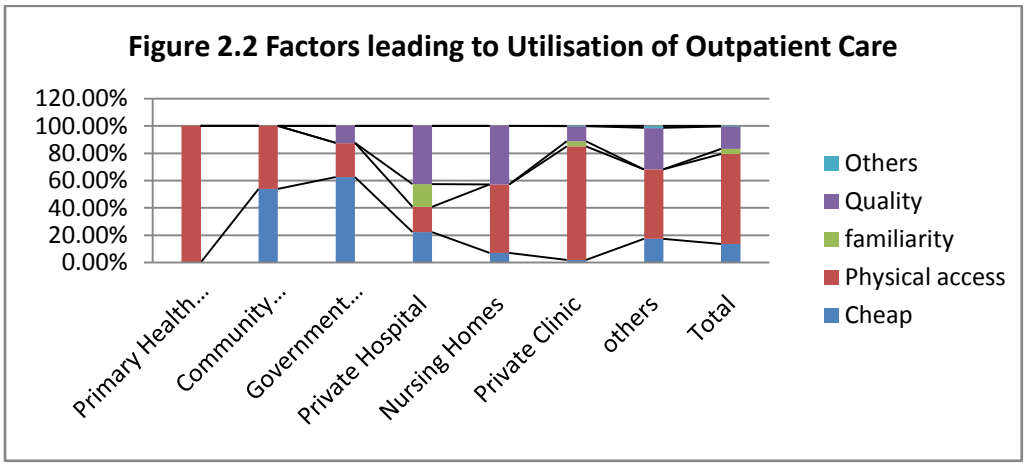
Table 2.3 Different Formal sources for Outpatient care in formal sectors

	Primary Health Centre	Community Health Centre	Government Hospital	Private Hospital	Nursing Homes	Private Clinic	Others	Total
Rural	30	25	36	27	10	212	54	394
%	*7.60*	*6.35*	*9.14*	*6.85*	*2.54*	*53.81*	*13.71*	*100.00*
Urban	11	2	5	28	5	62	17	130
%	*8.46*	*1.54*	*3.85*	*21.54*	*3.84*	*47.60*	*13.08*	*100.00*
All	41	27	41	55	15	274	71	524
%	*7.82*	*5.15*	*7.82*	*10.50*	*2.86*	*52.30*	*13.55*	*100.00*

Source: IDC Field Survey, 2014.

Respondents were also asked the reason for using a particular service (figure 2.2). Overall, the most prominent factor identified was the physical accessibility of the health services. 66 percent of the respondents favoured it, followed by quality (16 percent) and cheap services (13.5 percent) while choosing a particular service. In the case of government services such as primary health centre (PHC) or community health centre (CHC), the two key aspects were physical accessibility and cheap services. For private services, such as nursing homes or private clinics, apart from the physical accessibility, quality of services is also important. Analysis of both formal and informal services for outpatient care suggests that physical access to the services plays an important role in utilisation of health services. Given these deductions, it is pertinent to build more health services in the study area.

Figure 2.2 Factors leading to Utilisation of Outpatient Care



Source: IDC Field Survey, 2014.
Note: Information is based on 524 cases.

Utilisation pattern across the socio-religious groups suggested high reliance on private health care providers (Table 2.4). Hindu SCs showed highest reliance on private services followed by Hindu Others and Muslims. Overall, 83.10 percent of Hindu SCs and Others went for private services. In case of Muslims, 77.7 percent utilised private services. In rural areas, 81.10 percent of Hindu others have gone for private services followed by 77.80 percent among the Muslims. In urban areas, on the other hand, 94.70 percent of Hindu SCs reported going to private care followed by 82.90 percent among Hindu others.

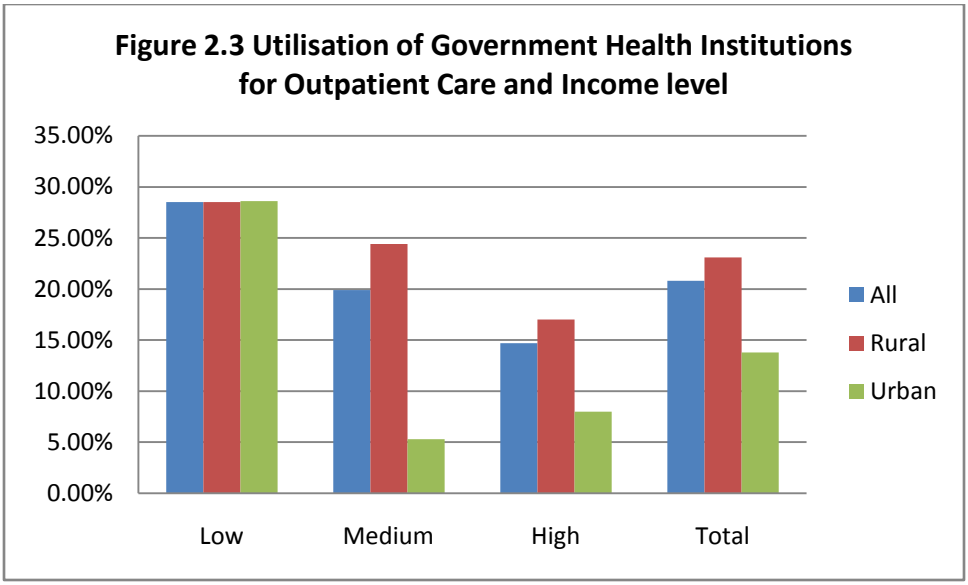
Table 2.4 Utilisation Pattern of medical services for Outpatient care across socio-religious groups

		Private	Government	Total
Rural	Hindu SC	20	12	32
	%	*62.50*	*37.50*	*100.00*
	Hindu Others	30	7	37
	%	*81.10*	*18.90*	*100.00*
	Muslim	253	72	325
	%	*77.80*	*22.20*	*100.00*
	Total	303	91	394
	%	*76.90*	*23.10*	*100.00*
Urban	Hindu SC	54	3	57
	%	*94.70*	*5.30*	*100.00*
	Hindu Others	29	6	35
	%	*82.90*	*17.10*	*100.00*
	Muslim	29	9	38
	%	*76.30*	*23.70*	*100.00*
	Total	112	18	130
	%	*86.20*	*13.80*	*100.00*
All	Hindu SC	74	15	89
	%	*83.10*	*16.90*	*100.00*
	Hindu Others	59	13	72
	%	*81.90*	*18.10*	*100.00*
	Muslim	282	81	363
	%	*77.70*	*22.30*	*100.00*
	Total	415	109	524
		79.20	20.80	100.00

Source: IDC Field Survey, 2014.
Note: Out of the total sample of 611, 524 went for formal medical care.

There is a difference in the utilisation pattern on the basis of socio-religious groups, as certain collective entities tend to use private services more. At the same time, it is relevant to examine factors that are responsible for the use of private services. Income is one such determining factor in choosing a particular facility, as public services are either subsidised or free, on the other hand, private providers are costly. The Figure 2.3 below clearly shows that with the increase in the level of income there is a decline in use of government health services.

Figure 2.3 Utilisation of Government Health Institutions for Outpatient Care and Income level



Source: IDC Field Survey, 2014.
Note: Information is based on 524 cases.

The chi square test (X^2) between level of income and utilisation/non utilisation of government services showed significant result overall and also establishes the fact that in the rural areas with the increase in level of income utilisation of government services declines and private services increases (Table 2.5).

Table 2.5 Chi square result for Utilisation/non Utilisation of Outpatient services for hospitalisation and Income

	All	Rural	Urban
Chi2(4)	10.626	5.152	11.414
Pr.	0.005	0.076	0.003

Utilisation pattern for hospitalisation indicated an overwhelmingly high reliance on the private hospitals (Table 2.6). 52.0 percent of the respondents reported going to private hospitals in the study area. Government hospitals and Nursing Homes were the second important categories that were reported by 22.1 percent and 21.2 percent of the respondents respectively. Use of

other government facilities such as CHC and PHC was minimal in the study area, clearly indicating noticeable overtly reliance on private services for hospitalisation.

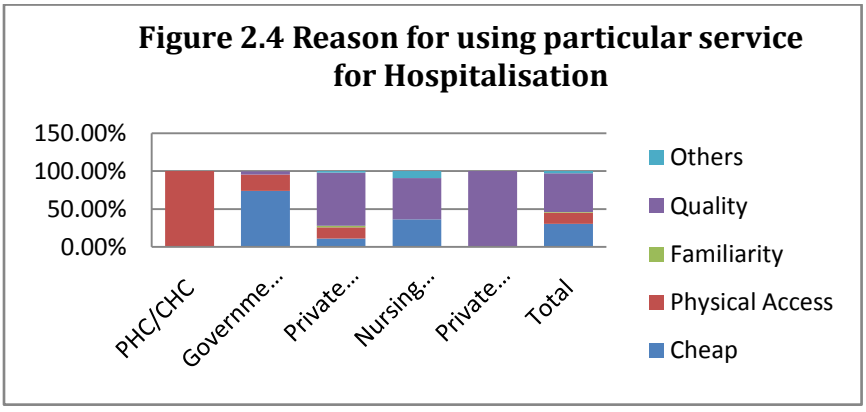
Table 2.6 Different sources for Hospitalisation

	Government			Private			
	Primary Health Centre	**Community Health Centre**	**Government Hospital**	**Private Hospital**	**Nursing Homes**	**Private Clinic**	**Total**
Rural	1	0	17	34	11	3	66
%	*1.5*	*0*	*25.8*	*51.5*	*16.7*	*4.5*	*100*
Urban	0	1	6	20	11	0	38
%	*0*	*2.6*	*15.8*	*52.6*	*29.0*	*0*	*100*
All	1	1	23	54	22	3	104
%	*0.9*	*0.9*	*22.1*	*52.0*	*21.2*	*2.9*	*100*

Source: IDC Field Survey, 2014.

Respondents were asked the reason for utilising a certain service for hospitalisation, whether it is public or private. In the overall deductions it was revealed that the most prominent reason reported was quality of services as perceived by people, around 50 percent of the respondent reported thus (Figure 2.4). The second factor was the cost of inpatient care, since around 30 percent respondents admitted going to a particular service due to low costs as 30 percent reported using a particular service because it is cheap. Two most significant reasons for using the government facilities are physical accessibility and low cost of services. For example, 74 percent of the respondents who went to government hospital did so because of lower costs. On the other hand, for private health services quality is the deciding factor, for example around 70 percent of the respondent have used private hospital for good quality.

Figure 2.4 Reason for using particular service for Hospitalisation



Source: IDC Field Survey, 2014.

Hospitalisation pattern across socio-religious groups clearly indicates higher reliance on private health institutions. Relatively higher use of government facility is seen among Muslims (30.3 percent) followed by Hindu SCs (19 percent) and is least in the case of Hindu Others (5.9 percent). A similar trend is seen in the rural and the urban area, highest dependency on government institutions for hospitalisation, was among the Muslims followed by the Hindu SC and lastly Hindu others (Table 2.7).

Table 2.7 Hospitalisation across Socio-Religious Groups

Sector	Socio-Religious Groups	Private	Government	Total
Rural	Hindu SC	2	2	4
	%	*50.0*	*50.0*	*100.0*
	Hindu Others	10	1	11
	%	*90.9*	*9.1*	*100.0*
	Muslim	36	15	51
	%	*70.6*	*29.4*	*100.0*
	Total	48	18	66
	%	*72.7*	*27.3*	*100.0*
Urban	Hindu SC	15	2	17
	%	*88.2*	*11.8*	*100.0*
	Hindu Others	6	0	6
	%	*100.0*	*0.0*	*100.0*
	Muslim	10	5	15
	%	*66.7*	*33.3*	*100.0*
	Total	31	7	38
	%	*81.6*	*18.4*	*100.0*
All	Hindu SC	17	4	21
	%	*81.0*	*19.0*	*100.0*
	Hindu Others	16	1	17
	%	*94.1*	*5.9*	*100.0*
	Muslim	46	20	66
	%	*69.7*	*30.3*	*100.0*
	Total	79	25	104
	%	*76.0*	*24.0*	*100.0*

Source: IDC Field Survey, 2014.
Note: Total hospitalisation cases were 104.

Given the fact that private health institutions actually charge higher amounts of money and government health facilities are usually free or subsidised, the study attempted to evaluate the relation between utilising government health facility and income levels. Figure 2.5 below clearly shows that there is no clear income gradient in use for government health facilities. In other words, it is not only the poor who are dependent on government health facilities as the economically empowered also use government health facilities. Insignificance of the chi square (X^2) test further reiterates the point of no relationship between economic status and lower use of government health facilities (Table 2.8). However, it is pertinent to note that the relatively low sample size, as a result of which chi square (X^2) results are not conclusive.

Figure 2.5 Hospitalisation in Government Institutions and Income Level

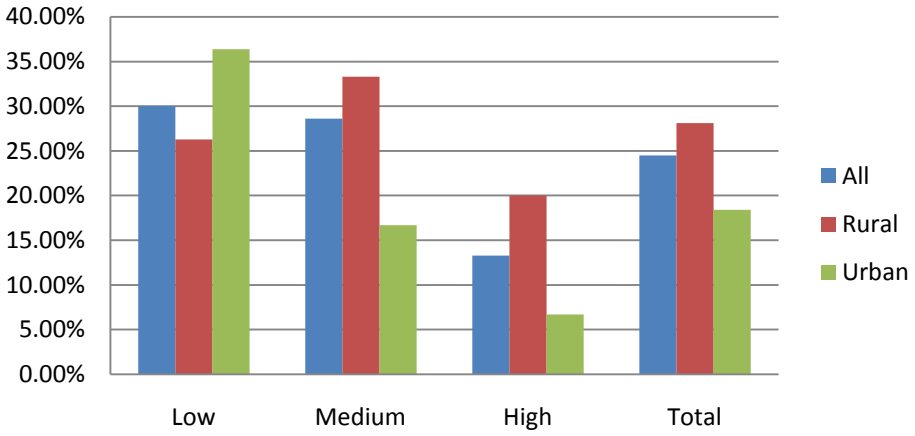


Table 2.8 Chi square result for utilisation/non Utilisation of Govt. services for hospitalisation and Income

	All	***Rural***	***Urban***
Chi2(2)	2.889a	.923a	3.760a
Pr.	0.236	0.63	0.153

a = More than one cell have expected count less than 5

Health Services: Perceptions

Perception regarding efficient functioning of health delivery system to a great extent determines use of particular service. One of the important determinants for choice of health care is the level of satisfaction with the service, which depends upon the experiences people

have had when they have undergone treatment at a particular service. It becomes particularly true in case of government facilities where the quality of service has been questioned to a great extent.

The issue of quality of medical care has received considerable attention since the last two decades within the context of increasing privatisation of the social sectors. Here, the issue of quality has been used to compare social services provided through the public and private system, with the latter being described as providing better quality care in terms of infrastructure, technology, being less bureaucratic and more responsive to patient needs. At the same time, for the study undertaken, the goal of public service as well as private services was kept in mind. For the private service, it is more about maximizing profit, whereas, the public health service is more directed towards universal access (Baru and Kurien, 2002). The authors, while deciding the parameters for assessing quality in public health service share given the following criteria:

- Tangible Dimensions (including availability of infrastructure, personnel and drugs/technology) and
- Intangible Dimensions (that would include accessibility viz. physical, social and economic, empathy, sympathy and responsiveness of personnel in terms of waiting time, time spent during consultation and effectiveness of care).

Quality of health services can be divided into two fronts- one looking at the available services and other looking at the perception of people about it, which is, to a great extent shaped by the experience in utilising the service. Numerous studies have been carried out on quality of health services in terms of reproductive health care mostly using the NFHS (National Health and Family Survey) data which provides some information on quality of services in terms of ANM (Auxiliary Nurse and Midwife) visits etc. Survey of IIPS on facilities in rural areas, also called as Health Facility Survey also gives information on type of services available in different rural health centres.

The present study looks at the perception of people based on their experience in use of particular health services. Respondents were asked about their last visit to a particular service. The main focus here is on intangible dimensions where the respondents were asked about the behaviour of the health personnel. In order to ascertain quality for outpatient care, questions on behaviour of doctor, waiting time, availability of medicines and satisfaction of services were asked. Among all the given factors, respondents identified behaviour of doctor to be the most important aspect in accessing the system. And the satisfaction of the system was directly linked to it. Behaviour, here basically meant how the health personnel interacts and talks with the patient and his overall attitude towards the patient.

Out of 524 outpatient respondents who reported about quality of health services, almost 74.8 percent of the respondents who went to private health institution reported that behaviour of a Nurse was satisfactory. But in the case of government facilities, the same was reported by merely 14.2 percent of respondents (Table 2.9). Out of 524 respondents who reported about doctors, good behavioural of doctors was reported by 93.9 percent who went to private services and in case of government facilities, it was mere 45 percent. Perception of health personnel clearly proves the fact that the quality in terms of behaviour of doctors as well as of nurses were much better in the private health institutions.

Table 2.9 Perception of Outpatient regarding Behaviour of Doctors and Nurses in Health Institutions

Nurse	**Bad**	**Fine**	**Good**	**Total**
Private Health Institution	6	99	310	415
%	1.4	23.8	74.8	100
Government Health Institution	47	47	15	109
%	42.7	42.7	14.2	100
Total	53	146	325	524
%	10.11	27.86	62.02	100.00
Doctor				
Private Health Institution	-	25	390	415
%	-	6.1	93.9	100.0
Government Health Institution	4	56	49	109
%	4.0	51.0	45.0	100.0
Total	53	146	325	524
%	10.1	27.9	62.0	100.0

Source: IDC Field Survey, 2014.

CHAPTER III
PATTERN OF HEALTH EXPENDITURE & BURDEN OF ILLNESS

Introduction

An episode of severe ill-health imposes both direct and indirect costs. Direct financial costs in the form of increased household expenditure may be incurred if treatment is sought. These costs, including treatment and travel expenses, must generally be met in cash, imposing additional burdens on household cash budgets and other assets holdings. If the individual is economically active, sickness can result in loss of current income. Other household members may also be required to devote time to the care of ill health can have economic consequences at the household not only in terms of expenses incurred in treatment but also in terms of loss of working days or days spent in taking care of patient that is indirect financial cost.

Health expenditure in terms of cost of drugs, doctor's fees and other costs such as transportation and lodging are the part of direct expenditure due to illness.This chapter looks at the pattern of health expenditure at the household level and it analyses both direct and indirect expenditure due to ill health and how it is detrimental to the economy of the households.

Bad Health: Loss of Income

Estimating the indirect loss due to ill health has been a matter of challenge for researchers as it is very difficult to estimate loss not merely in terms of income but also in terms of time loss not just for the patient but also for the person who takes care of the patient. McIntyre and Thiede (2005) while studying the indirect loss due to ill health observe that apart from direct estimation of loss of income on the basis of lost of work days, there are still other issues, for instance, it may be a child that stops attending school – or to work in place of a sick parent, that may have implications for their level of educational achievement particularly if adult family members are ill frequently. A wife may work in the fields while her husband is ill, and as a result be unable to undertake household chores, some of which could have implications for the health of other household members (e.g. fetching clean water, cooking nutritious food). If there is no intra-household labour substitution and no employment of someone else to undertake these activities, the household may lose wage income or other income (e.g. from the sale of crafts) during the period of illness. Alternatively, crop production may not be as successful as usual in the case of subsistence agricultural activities. These issues highlight the difficulty of estimating accurately the actual burden of indirect costs of illness for households. In this study, we have evaluated loss of income in terms of employment. Loss that might have occurred if a person could not go for the job and that absence will have its bearing on the household income. Study done by Attanayake et al (2000) in Sri Lanka looked at the loss due to Malaria, the study measured loss in terms of output related approach wherein productive work was broadly defined as involvement in any economic activity with the potential to add to the disposable

income (in kind or cash) to the household. Therefore, whenever illness had adversely affected the productive work of any household member, it was measured either in terms of output units or person days. Their method excluded time loss of economically inactive patients such as schoolchildren, pre-school children, job seekers and people with learning difficulties.

In this study, we have focused on actual loss in income due to loss in employment days. Since loss may not affect just the individual and there is a high chance it might affect the other members of the family, so it is imperative to look at loss at the household level. In the study area, 35.27 percent of total cases for Muslims reported loss of income, followed by Hindu Others where 21.05 percent reported loss of income and least in case of Hindu SC where 17.65 percent reported loss of income. In rural and urban areas also incidence of loss of income for Muslim is much higher as compared to both Hindu and Hindu SCs. Average amount loss for Muslim households was Rs.1755 followed by Hindu SCs with loss of Rs.1444 and it was least in case of Hindu Others where the loss was Rs.730. In rural areas, loss in income is highest among Muslims Rs.2014, and then in Hindu Other it is Rs.908. On the other hand in urban areas among Hindu SC loss in income is Rs.2450 and among Muslims it is Rs.502 (Table 3.1).

Table 3.1 Loss of Income for Outpatient across Socio-religious groups

		No	Yes	Total	Total Amount loss (in Rs.)	Average amount loss (in Rs.)
Rural	Hindu SC	34	10	44	6400	640
	%	77.27	22.73	100		
	Hindu Others	34	12	46	10900	908
	%	73.91	26.09	100		
	Muslim	250	121	371	243700	2014
	%	67.39	32.61	100		
	Total	318	143	461	261000	1825
	%	68.98	31.02	100		
Urban	Hindu SC	50	8	58	19600	2450
	%	86.21	13.79	100		
	Hindu Others	41	8	49	3700	463
	%	83.67	16.33	100		
	Muslim	18	25	43	12550	502
	%	41.86	58.14	100		
	Total	109	41	150	35850	874
	%	72.67	27.33	100		
All	Hindu SC	84	18	102	26000	1444
	%	82.35	17.65	100		
	Hindu Others	75	20	95	14600	730
	%	78.95	21.05	100		
	Muslim	268	146	414	256250	1755
	%	64.73	35.27	100		
	Total	427	184	611	296850	1613
	%	69.89	30.11	100		

Source: IDC Field Survey, 2014.
Note: 611 cases that went for outpatient treatment.

Average loss of income is more prominent in the rural areas (Rs.1825) since the illness affects the day to day life of the people and missing a day's work or labour directly affects the economic condition of the households (table 3.1). Across the socio-religious groups, it is the Muslims who

have reported the highest incidence of loss of income as compared to other groups. As it was seen earlier, there was higher dependency of Muslim households on casual labour which had its direct bearing on economic condition at the household level.

In order to see the relationship between economic activity of household and loss of income we looked at the relationship between household type and loss of income. Table 3.2 shows that in rural areas of agriculture labourers it is highest proportion (47.06 percent) who have reported loss of household income in case of outpatient treatment. Next comes self-employed in non-agriculture 35.42 percent. Average loss is highest in case of other labour household where loss was Rs.2478 followed by self-employed in non-agriculture with loss of Rs.1122.

In urban areas loss was more prominent in case of casual labourers (42.86 percent) followed by self-employed (40 percent). Average loss for casual labour was Rs.1172 followed by loss of Rs.820 among the salaried/regular wage and Rs.742 among the self-employed households.

Table 3.2 Household Type and Loss of Income for outpatient in last three months

	Loss of Income			Total Amount loss (in Rs)	Average amount loss (in Rs)
Rural	**No**	**Yes**	**Total**		
Self-employed in non-agriculture	62	34	96	38150	1122
%	64.58	35.42	100		
Agricultural labour	18	16	34	12750	797
%	52.94	47.06	100		
Other labour	167	77	244	190800	2478
%	68.44	31.56	100		
Self Employed in Agriculture	61	12	73	17500	1458
%	83.56	16.44	100		
Other Household	10	4	14	1800	450
%	71.43	28.57	100		
Total	318	143	461	261000	1825
%	68.98	31.02	100		
Urban					
Self-employed	18	12	30	8900	742
%	60	40	100		
Regular wage/Salary earnings	76	20	96	16400	820
%	79.17	20.83	100		
casual labour	12	9	21	10550	1172
%	57.14	42.86	100		
Others	3	0	3		
%	100	0	100		
Total	109	41	150	35850	874
%	72.67	27.33	100		

Source: IDC Field Survey, 2014.
Note: 611 cases that went for outpatient treatment.

Rural areas of the district of Mewat have relatively higher loss of income as compared to its urban counterpart, as revealed in this study. In rural areas, average loss was Rs.1825, almost double the loss of Rs.874 as reported in the urban areas. Moreover, concentration of loss mostly in labour households indicate the economic cost of illness faced by these households and the limited option they have to avoid these loss.

Out of 104 hospitalised patients 68 (65.4 percent) reported loss of income. The Muslims and Hindu SCs reported loss in income in equal proportion i.e. 66.7 percent. Among Hindus Others, this proportion was 58.8 percent. In rural areas too, Muslims (68.6 percent) and Hindu SC (75 percent) have relatively higher proportion of hospitalisation cases, leading to loss of income as compared to Hindu Others (54.5 percent). On the other hand in urban areas 66.7 percent of Hindu Others reported loss of income, which was the highest followed by Hindu SC (64.7 percent) and Muslims (60%).

Table 3.3 Loss of Income Due to Hospitalisation in last one year

		Loss of Income			Total Amount Loss (In Rs.)	Average Amount Loss (In Rs.)
		No	Yes	Total		
Rural	Hindu SC	1	3	4	4900	1633
	%	25	75	100		
	Hindu Others	5	6	11	17000	2833
	%	45.5	54.5	100		
	Muslim	16	35	51	270000	7714
	%	31.4	68.6	100		
	Total	22	44	66	291900	6634
	%	33.3	66.7	100		
Urban	Hindu SC	6	11	17	79000	7182
	%	35.3	64.7	100		
	Hindu Others	2	4	6	75000	18750
	%	33.3	66.7	100		
	Muslim	6	9	15	213800	23756
	%	40	60	100		
	Total	14	24	38	367800	15325
	%	36.8	63.2	100		
All	Hindu SC	7	14	21	83900	5993
	%	33.3	66.7	100		
	Hindu Others	7	10	17	92000	9200
	%	41.2	58.8	100		
	Muslim	22	44	66	483800	10995
	%	33.3	66.7	100		
	Total	36	68	104	659700	9701
	%	34.6	65.4	100		

Source: IDC Field Survey, 2014.

Average loss of income due to hospitalisation has been Rs.9701 in the study area. Across the socio- religious groups, highest loss has been for the Muslims with the loss of Rs.10995, followed by Hindu others with the loss of Rs.9200 and Rs.5993 for the Hindu SCs. Similar trend exists both in rural and urban areas where Muslims have reported highest loss in the study area. Overall loss among Muslims in urban areas is Rs.23756, which is higher than what is reported in the rural areas, that is Rs.7714. Average loss in rural areas was Rs. 6634 and in urban areas it was Rs.15325.

Out-of-Pocket Expenditure on Different Health Facilities

Health expenditure in terms of cost of drugs, doctor's fees and other costs such as transportation and lodging are the part of direct expenditure due to illness. Cost of treatment do differ across different type of health services. The average health expenditure is for outpatient treatment in the study area was Rs.790. In rural areas, it was Rs.649 and in urban areas it was Rs.1219. Among all the service providers for outpatient care, average expenditure on private health services was Rs.935 followed by government Rs.239 (table 3.4). Similar pattern was seen even in rural and urban areas for outpatient, where, the private services were the costliest. In case of inpatient services, average expenditure in the study area was Rs.27051. In rural areas, the average expenditure was Rs.25116 and in urban areas it was Rs.30411. Across the different services, private health services was costlier as compared to government overall. Inpatient average health expenditure for the district on private health services was Rs.29332, whereas, in government health services it was Rs.19841.

Table 3.4 Average Health Expenditure across different Formal health facilities

		Average Health Expenditure for Outpatient (Rs.) in last three months			Average Health Expenditure for Inpatient (Rs.) in last one year		
Sector	**Type of Services**	**Total Expenditure**	**No. of cases**	**Average Health Expenditure**	**Total Expenditure**	**Hospitalisation Cases**	**Average Health Expenditure**
Rural	Government[1]	22620	91	249	425815	18	23656
	Private[2]	233020	303	769	1231850	48	25664
	Total	255640	394	649	1657665	66	25116
Urban	Government	3380	18	188	70210	7	10030
	Private	155031	112	1384	1085410	31	35013
	Total	158411	130	1219	1155620	38	30411
Total	Government	26000	109	239	496025	25	19841
	Private	388051	415	935	2317260	79	29332
	Total	414051	524	790	2813285	104	27051

Souce: IDC Field Survey, 2014.

Note: *1. Govt. Health Facilies include PHC, CHC and District Hospitals.

*2. Private Health Facilities includes Nursing homes, Private Hospitals, Private clinics and Others Sources.

It is important to understand the economic bearing of these expenditure of health at the household level and one way to do it is to see whether the expenditure is catastrophic or not. Health expenditure as a share of total expenditure and if it crosses certain threshold we call it catastrophe expenditure.

$C = \frac{H}{T} > Z$

Where H is the health expenditure and T stands for total income and Z represents a threshold crossing it will be catastrophic expenditure at the household level. The threshold level used in this analysis is 10 percent; Threshold level of catastrophic expenditure, even though, a bit arbitrary in nature also varies across countries. In case of India, two levels 10 percent and 25 percent were used in studies (Vaishnaviand Dash, 2009). Apart from looking at catastrophic expenditure, we also looked at the share of health expenditure in total food expenditure for a month. Since expenditure on food is a basic necessity and it is not possible to cut down this expenditure. And health care is also a kind of necessity good and people would not like to spend a higher sum on it. So, in an ideal situation health expenditure should not exceed total expenditure on food. So, higher the share of health expenditure on total food expenditure means higher will be the financial stress. Of course in this analogy there can be an exception when health care becomes a luxury good and people are ready to pay a high price. Given the backwardness of the Mewat district, we presume that health expenditure exceeding food expenditure will have its financial bearings.

The expenditure data for both hospitalisation and outpatient care are taken for analysis and they have been converted into month by dividing outpatient health expenditure by three and inpatient health expenditure by 12. The income figures are also converted into month. The table 3.5 shows the incidence of catastrophic expenditure and also share of household's health expenditure. Around 18 percent of the households in the study area had undergone catastrophic expenditure. Incidence of catastrophic expenditure in rural areas was 17 percent and 22 percent in urban areas. Health expenditure for most of the households falls under 25 percent of total food expenditure as reported by 80 percent in rural areas and 73 percent in urban areas. But at the same time, 6 percent also spent more than 50 percent of the total food expenditure and another 5 percent spent more than total food expenditure in a month (Table 3.5).

Table 3.5 Catastrophic Expenditure in the Study Area

	Rural	Urban	All
Catastrophic expenditure (More than 10%) at the household level	17.3	21.6	18.5
Health Expenditure as a Share of Food Expenditure			
0 to 25%	79.7	73.0	77.9
26% to 50%	8.6	16.2	10.7
51% to 100%	6.1	5.4	5.9
More than 100%	5.6	5.4	5.5

Source: IDC Field Survey, 2014.
Note: Information is based on 290 households that includes expenditure for both inpatient and outpatient services.

Source of Finance for Health Expenditure

Source of finance for health care has a very important bearing on financial access to health service. Although, measures such as catastrophic health expenditure do indicate the financial burden health expenditure can have at a household level, it does not say much about how people are paying for the health services. For instance, the economic consequences will be much worse off if a household had to borrow and pay for health services as compared to paying from own income or saving. Paying from their income/saving, although, would have its bearing but it is less as compared to borrowing or selling of assets.

Table 3.6 Source of finance for Treatment who availed Formal Medical Facilities in the Study Area

Sources	Outpatient cases			Hospitalisation cases		
	Rural	Urban	All	Rural	Urban	All
Employer Government	0	1	1	0	0	0
%	0.0	0.8	0.2	0.0	0.0	0.0
Income and Saving	366	112	478	17	25	42
%	92.8	86.2	91.2	25.8	65.8	40.4
Borrowing and Selling of assets	27	17	44	49	13	62
%	6.9	13.1	8.4	74.2	34.2	59.6
Other	1	0	1	0	0	0
%	0.3	0.0	0.2	0.0	0.0	0.0
Total	394	130	524	66	38	104
%	100.0	100.0	100.0	100.0	100.0	100.0

Source: IDC Field Survey, 2014.

In the study the main source of finance (Table 3.6) for outpatient treatment in rural area was income and/or saving (92.9 percent) and the second important source was borrowing and/or selling of assets (6.9 percent). In case of hospitalisation in rural area the main source of finance was borrowing and selling of assets (74.2 percent) followed by income and savings (25.8 percent). In case of urban areas for outpatient treatment the main source of finance is income and savings 86.2 percent whereas for inpatient treatment it is again income and savings 65.8 percent.

Table 3.7 Source of finance for Outpatient care across socio-religious groups

Area		Hindu SC	Hindu Others	Muslim	Total
Rural	Income and /or Saving	30	36	300	366
	%	93.7	97.3	92.3	92.8
	Borrowing and /or Selling of Assets	2	1	24	27
	%	6.3	2.7	7.4	6.9
	Other	0	0	1	1
	%	0.0	0.0	0.3	0.3
	Total	32	37	325	394
		100.0	100.0	100.0	100.0
Urban	Employer & government	0	0	1	1
	%	0.0	0.0	2.6	0.8
	Income and /or Saving	51	29	32	112
	%	89.5	82.9	84.2	86.2
	Borrowing and /or Selling of Assets	6	6	5	17
	%	10.5	17.1	13.2	13.1
	Total	57	35	38	130
		100.0	100.0	100.0	100.0
All	Employer government	0	0	1	1
	%	0.0	0.0	0.3	0.2
	Income and /or Saving	81	65	332	478
	%	91.0	90.3	91.4	91.2
	Borrowing and /or Selling of Assets	8	7	29	44
	%	9.0	9.7	8.0	8.4
	Other	0	0	1	1
	%	0.0	0.0	0.3	0.2
	Total	89	72	363	524
	%	100.0	100.0	100.0	100.0

Source: IDC Field Survey, 2014.

Overall, in rural and urban areas, the main source of finance for outpatient treatment is income and savings (91.2 percent) and next is borrowing and selling (8.4 percent). In rural and urban areas separately, it is again income and savings (92.8 percent) and 86.1 percent respectively.

Table 3.8 Source of finance for hospitalisation care across socio-religious groups

	Hindu SC	Hindu Others	Muslim	Total
Rural				
Income and Saving	1	3	13	17
%	25.0	27.3	25.5	25.8
Borrowing and /or Selling of Assets	3	8	38	49
%	75.0	72.7	74.5	74.2
Total	4	11	51	66
%	100.0	100.0	100.0	100.0
Urban				
Income and Saving	10	3	12	25
%	58.8	50.0	80.0	64.6
Borrowing and /or Selling of Assets	7	3	3	13
%	41.2	50.0	20.0	35.4
Total	17	6	15	38
%	100.0	100.0	100.0	100.0
All				
Income and/or Saving	11	6	25	42
%	50.3	35.3	37.9	40.0
Borrowing and /or Selling of Assets	10	11	41	62
%	49.7	64.7	62.1	60.0
Total	21	17	66	104
%	100.0	100.0	100.0	100.0

Source: IDC Field Survey, 2014.

Majority of the households across the socio-religious groups reported of using borrowing and selling of assets to finance their expenses for hospitalisation (table 3.8). Hindu Others with 64.7 percent respondents, were the highest in terms of using borrowing and/or selling of assets. Muslims were next on the list with 62.1 percent respondents relying on borrowing and /or selling of assets. Muslims have reported relatively less in numbers in urban areas of using borrowing and/or selling of assets (20 percent) but in rural areas their share is 74.5 percent. In urban areas, share of Hindu SCs and Hindu Others in borrowing and/or selling assets were around 41.2 percent and 50 percent respectively.

Indebtedness due to Health Expenditure

Indebtedness signifies the fact that a household was not able to finance the given expenditure and they had to borrow money which has not been repaid. It also means household remain in financial obligation and as a result this leads to stress at the household level. Out of 106 cases (see tables 3.7 and 3.8) that reported borrowing for both outpatient services and hospitalisation, 76 (71.7 percent) of them had principle outstanding or they have not been able to repay the amount or the households were indebted.

Table 3.9 Average amount outstanding across socio-religious groups

Socio- religious Groups	Average amount outstanding (Rs.)
Hindu SC	2875
Hindu Others	3076
Muslim	2277
Total	2496

Source: IDC Field Survey, 2014.

The average outstanding debt upto survey was Rs.2496 and the maximum outstanding debt was of Hindu Others i.e. Rs.3076 and the minimum amount of Rs.2277 was of Muslims (Table 3.9).

CHAPTER IV
MATERNAL AND CHILD HEALTH CARE

Introduction

Maternal health care, whether it is antenatal care, postnatal care or institutional delivery, has a very important bearing on the mothers' health and also on the newborn. This chapter looks at the different maternal health facilities that are available to mothers and what is their utilisation pattern. It looks at the perception of mothers about the services and what are the factors that lead to utilization or non-utilisation of these services. This chapter looks at the place of birth and the kind of medical assistance that was received.

The data is based on mothers who have given at least one birth in the last five years. In case of antenatal and other services information has been collected regarding only the latest birth and in case of institutional deliveries all the births in the last five years have been taken into account. Due to the small sample size most of the analysis in this chapter is at the aggregate level and there is no rural urban break up.

Characteristics of Sampled Women

The characteristics of the 218 sampled women in Mewat district can be seen in Table 4.1. Nearly 39.9 percent sampled women belong to age-group 25 to 34 years, whereas 33 percent and 27.1 percent women belong to age-group of less than 25 and more than 35 respectively. With regards to educational qualifications of the sampled women, we see that majority of the sampled women (64.7 percent) are found to be non-literate in this region. Only 17.9 percent women are found to have middle and higher education. Remaining 17.4 percent have been educated upto primary.

A look at the socio-economic characteristics shows that more than one-third (37.6 percent) women are from low income family group in comparison to 22.5 percent women who are from high income households. Around 82.1 percent women are from rural areas whereas 17.9 percent are from urban areas. The population is predominantly Muslim as 78.4 percent women are found to be Muslims. On the other hand, nearly 9.6 percent and 11.9 percent belong to Hindu SC and Hindu others.

Table 4.1: Characteristics of sampled women in Mewat district

Background Variables	Percent	Sample
Age of the Mother*		
less than 25	33.0	72
25 to 34	39.9	87
35 and more	27.1	59
Mother's Education*		
Non-literate	64.7	141
Upto Primary	17.4	38
Middle and higher	17.9	39
Income Level		
Low	37.6	82
Medium	39.9	87
High	22.5	49
Place of Residence		
Rural	82.1	179
Urban	17.9	39
Socio-Religious Group		
Hindu SC	9.6	21
Hindu Others	11.9	26
Muslim	78.4	171

Source: IDC Field Survey, 2014.
Note: Information is based on the response of 218 respondents who had at least one birth in last five years.

Table 4.2 shows the further bifurcation of women by different socio-religious groups. Muslim women found to be more vulnerable in terms of literacy as almost 72.5 percent of them are found to be non-literate followed by Hindu SC women (42.9 percent). In terms of income, a greater number of Hindu SCs are found to be low income households (42.9 percent), followed by Muslim women (38.6 percent). The percentage share in high income households are found to be maximum among Hindu others (34.6 percent) whereas only 19.9 percent Muslim women belong to high income household groups. The age composition of women of different socio-religious groups shows that among Muslims and Hindu Others maximum women are in the age category of 25-34 years. On the other hand in Hindu SC, it is in less than 25 years (Table 4.2).

Table 4.2 Background Characteristics of Women in Different Socio-Religious Groups

Background Variables	Hindu SC	Hindu Others	Muslim	Total
Mother's Age				
Less than 25	8	9	55	72
%	38.1	34.6	32.16	33.0
25 to 34	7	13	67	87
%	33.3	50.0	39.2	39.9
35 and more	6	4	49	59
%	28.6	15.4	28.7	27.1
Mother's Education				
Non-literate	9	8	124	141
%	42.9	30.8	72.5	64.7
Upto Primary	2	6	30	38
%	9.5	23.0	17.5	17.4
Middle and higher	10	12	17	39
%	47.6	46.2	9.9	17.9
Income Level				
Low	9	7	66	82
%	42.9	26.9	38.6	37.6
Medium	6	10	71	87
%	28.6	38.5	41.5	39.9
High	6	9	34	49
%	28.6	34.6	19.9	22.5

Source: IDC Field Survey, 2014.
Note: Information is based on response of 218 respondents/women who had at least one birth in the last five years.

Next, we study the household characteristics of the women (Table 4.3). One good thing is that most of the women (nearly 95.4 percent) have been living in their own house and 44 percent and 45 percent of them have pucca and semi-pucca houses respectively. Though, the vulnerability could be understood from the fact that around 39.45 percent of these women are having only one room in the house. The drinking water facilities shows 51.4 percent women are using public tubewell/hand pump as the source of their drinking water and more than 54.1 percent women responded that they have no toilet facilities in their houses.

Table 4.3 Housing and Civic Amenities of Sampled Women

Household Variables	Percent	Sample
Ownership of the House		
Own	95.4	208
Rented	4.6	10
Type of House		
Thatched	7.8	17
KatchaKhaprail	3.2	7
Semi pucca	45.0	98
Pucca	44.0	96
Number of Rooms		
One	39.45	86
Two	36.24	79
Three	13.30	29
More than three	11.01	24
Has Electricity in the House		
No	5.5	12
Yes	94.5	206
Source of Drinking Water		
Hand Pump / tube well in dwelling/tap	35.8	78
Public hand pump / tube well	51.4	112
Others	12.8	28
Toilet Facility		
In house	45.9	100
Outside	54.1	118

Source: IDC Field Survey, 2014.
Note: Information is based on response of 218 respondents/women who had at least one birth in the last five years.

Antenatal Care among Sampled Women

Utilisation of antenatal care (ANC) services is seen as an important indicator in assessing reproductive health status of women. The next table (Table 4.4) reveals the utilisation of antenatal care by our sampled women in Mewat. It has been found that during pregnancy, only 45 percent women responded that they have any contact with Auxiliary Nurse Midwife (ANM) or Local Health Visitor (LHV). When ANC should be the most important concern for both mother and child, this information should raise an alarm about the situations of pregnancies in this region. Even the first visit by ANM or LHV taken place between 3 to 4 months of pregnancy for

most of the women (58.2 percent). Nearly 53.1 percent women responded that they have received upto 2 visits by any health worker.

Table 4.4 ANC Characteristics of Sampled Women

Variables	Percent	Sample
Any Contact with ANM or LHV		
Yes	45.0	98
No	55.0	120
Total	100.0	218
Months of Pregnancy when a Health Worker (from PHC/SC) First Visited You		
Upto 2 months	20.4	20
3 to 4 months	58.2	57
5 to 7 months	21.4	21
Total	100.0	98
Numbers of Visits by Health Worker		
Up to 2	53.1	52
3 to 4	32.7	32
More than 4	14.3	14
Total	100.0	98
Received Any Antenatal Care Service		
Yes	70.2	153
No	29.8	65
Total	100.0	218
ANC Times		
One	16.3	25
Two	55.6	85
Three	22.9	35
More than 3	5.2	8
Total ANC received	100.0	153
Place for ANC		
PHC	28.8	44
SC	11.8	18
Others	59.5	91
Total ANC received	100.0	153

Source: IDC Field Survey, 2014.
Note: Information is based on response given by 218 women.

Most importantly, 70.2 percent responded that they have received some antenatal care services. When three ANC visits are considered as the safest for the mother, only 5.2 percent of women responded that they have had three or more ANC visits. More than half of the women (55.6 percent) have ended with 2 ANC visits. In terms of place of ANC taken, it has been found that women do not believe in government services or found them dysfunctional, as nearly 59.5 percent of them visited health institutions other than PHCs or SCs.

Table 4.5 gives details regarding the ANC services utilised among 153 women in Mewat district of Haryana. It has been found that 86.3 percent women have been given iron and folic acid tablets and around 71.9 percent of them received IFA tablets twice during their visits (Table 4.5).

Table 4.5 Utilizations of Total ANC Services

Variables	Percent	Sample
Whether Given Any Iron Folic Acid Tables		
Yes	86.3	132
No	13.7	21
Numbers of Times IFA Tablets Given		
One	15.0	23
Two	71.9	110
More than Two	12.4	19
None	0.7	1
Received Tetanus Toxiod Injection		
Yes	90.2	138
No	9.8	15
Numbers of Times TT Injection Given		
One	7.84	12
Two	78.43	120
Three	13.73	21

Source: IDC Field Survey, 2014.
Note: Information is based on response given by 153 women who availed Total ANC (Antenatal Care).

In case of TT injections, 90.2 percent women confirmed that they have received tetanus toxiod injections (Table 4.5).

Visits for ANC by different socio-religious groups have been given in table 4.6. The maximum ANC was availed by Hindu Others (53.8 percent) and the minimum was availed by Hindu SC (42.9 percent) and Muslims (43.9 percent) (Table 4.6).

Table 4.6 Visits for ANC by Socio-Religious Groups

Socio-Religious Group	Any contacts with an ANM or Lady Health Visitor		
	Yes	No	Total
Hindu SC	9	12	21
%	42.9	57.1	100.0
Hindu Others	14	12	26
%	53.8	46.2	100.0
Muslim	75	96	171
%	43.9	56.1	100.0
Total	98	120	218
%	45.0	55.0	100.0

Source: IDC Field Survey, 2014.
Note: Responses are based on those responded out of 218 women.

Utilisation of different components of ANC services by different socio religious groups is shown in the table 4.7. It has been found that the utilisation of basic ANC services like height measured is same for all the socio-economic groups i.e. 100 percent. But differentiation exists with regard to utilisation of other ANC services (Among all other medical checkups which are carried out during pregnancy). Muslim women are found to be more vulnerable. In terms of important advices like checking of BP and testing of blood and urine, only 86.78% and 63.64% Muslims availed these ANC services. Advice on nutrition during pregnancy is also very low among Muslim women, less than 3 percent in comparison to Hindu SC 14.29% and Hindu Others 16.67 percent women.

Table 4.7 Utilization of Total ANC by Different Socio-Religious Groups

ANC Variables	Hindu SC	Hindu Others	Muslim	Total
Weight Measured	**2**	**0**	**3**	5
%	14.29	0.00	2.48	3.27
Height Measured	**14**	**18**	**121**	153
%	100.00	100.00	100.00	100.00
Blood Pressure Checked	**14**	**16**	**105**	135
%	100.00	88.89	86.78	88.24
Blood & Urine Tested	**12**	**13**	**77**	102
%	85.71	72.22	63.64	66.67
Abdomen Examined	**8**	**9**	**59**	76
%	57.14	50.00	48.76	49.67
X-Ray	**7**	**8**	**37**	52
%	50.00	44.44	30.58	33.99
Ultra-sound	**4**	**5**	**13**	22
%	28.57	27.78	10.74	14.38
Advice on Nutrition	**2**	**3**	**3**	8
%	14.29	16.67	2.48	5.23
Told Expected Delivery Date	**1**	**1**	**2**	4
%	7.14	5.56	1.65	2.61
Total Women who availed ANC	**14**	**18**	**121**	**153**

Source: IDC Field Survey, 2014.
Note: Responses are based on 153 cases.

Table 4.8 reveals among different socio-religious groups in the reason for not using PHC/SC for ANC. Overall, reasons for not using the PHC/SC for ANC is lack of knowledge 41.76% and poor quality of services 24.18% and lack of facilities 20.88% (Table 4.8).

Table 4.8 Reasons for Not Going to PHC/SC for ANC by Different Socio-Religious Groups

Reasons for Not Going to PHC / SC for ANC	Hindu SC	Hindu Others	Muslim	Total
Lack of Knowledge	3	3	32	38
	37.5	27.27	44.44	41.76
Inaccessibility	0	1	11	12
	0	9.09	15.28	13.19
Poor Quality Service	3	4	15	22
	37.5	36.36	20.83	24.18
Lack of Facilities	2	3	14	19
	25	27.27	19.44	20.88
Total Women who availed ANC other than Government Health Institutions	8	11	72	91

Source: IDC Field Survey, 2014.
Note: The table is based on 91 responses.

In total sample of 218 women, there were 65 women who did not avail any ANC. Out of 65 women, 58 were Muslim (see table 4.9).

They cited various reasons for not going for ANC. Most prominent was, they did not consider it necessary (55.2 percent) (See Table 4.9).

Table 4.9 Reasons for Not Going for ANC by Muslim Women

Total Sample Women Who Did Not Utilized ANC	65
Hindu SC	6
Hindu Others	1
Muslim	58
Reasons for Not Utilizing ANC by Muslim Women	
Lack of Knowledge	10
%	17.2
Not Necessary	32
%	55.2
Not Customary	7
%	12.1
Others	9
%	15.5
Total	58
%	100

Source: IDC Field Survey, 2014.

Institution Delivery and Non-Institutional Services

Home deliveries are one of the major reasons for high maternal mortality. Institutional deliveries have been promoted in a big way under National Rural Health Mission (NRHM) to promote safe child and motherhood. In this study, 218 women gave birth to 225 children during the last five years. It was seen that majority of women have gone for home delivery and it accounts for 50.2 percent of the total birth that has taken place in the last five years in the study area (Table 4.10).

Table 4.10 Institutional and Non Institutional Deliveries in the Study Areas

	Hindu SC	Hindu Others	Muslim	Total
Home	9	5	99	113
%	40.9	19.2	55.9	50.2
Government Hospital	2	7	35	44
%	9.1	26.9	19.8	19.6
Primary Health Centre	4	6	15	25
%	18.2	23.1	8.5	11.1
Sub-centre	1	2	6	9
%	4.5	7.7	3.4	4.0
Private Hospital/ Clinic/Maternity Home	6	6	22	34
%	27.3	23.1	12.4	15.1
Total	22	26	177	225
%	100	100	100	100

Source: IDC Field Survey, 2014.
Note: 218 Women gave birth to 225 children in the sample during last five years.

Across the socio-religious groups there is a variation as both Muslims as well as Hindu SC have relatively higher share of home deliveries. Child deliveries conducted at home reported in the study was, in case of (55.9 percent) Muslim women and Hindu SCs (40.9 percent) women. Hindu others opt more for institutions deliveries (80.8 percent) (Table 4.11).

Table 4.11 Socio-Economic condition and Institutional Delivery in the Study Area

	Institutional		Home Delivery		Total	
Socio-Religious Groups	Number	%	Number	%	Number	%
Hindu SC	13	59.1	9	40.9	22	100
Hindu Others	21	80.8	5	19.2	26	100
Muslim	78	44.1	99	55.9	177	100
Total	112	49.8	113	50.2	225	100

Source: IDC Field Survey, 2014.

Still, a majority of the deliveries is conducted by untrained persons, as 32.2 percent deliveries were attended by untrained persons and 17.3 percent were conducted with the help of a family friend or a relative. Among trained health professional, majority of the deliveries were done by nurses/midwife (28.0 percent).

Table 4.12 Assistance for Delivery across the Socio-religious groups in the Study Area

	Hindu SC	Hindu Others	Muslim	Total
Doctor	7	10	26	43
%	31.8	38.5	14.7	19.1
Ayurvedic Doctor/ Vaidya	0	2	4	6
%	0.0	7.7	2.3	2.7
Nurse/ Midwife /ANM	6	9	48	63
%	27.3	34.6	27.1	28.0
Untrained Birth Attendant	6	3	65	74
%	27.3	11.5	36.7	32.9
Family / Relative / Friend	3	2	34	39
%	13.6	7.7	19.2	17.3
Total	22	26	177	225
%	100.0	100.0	100.0	100.0

Source: IDC Field Survey, 2014.

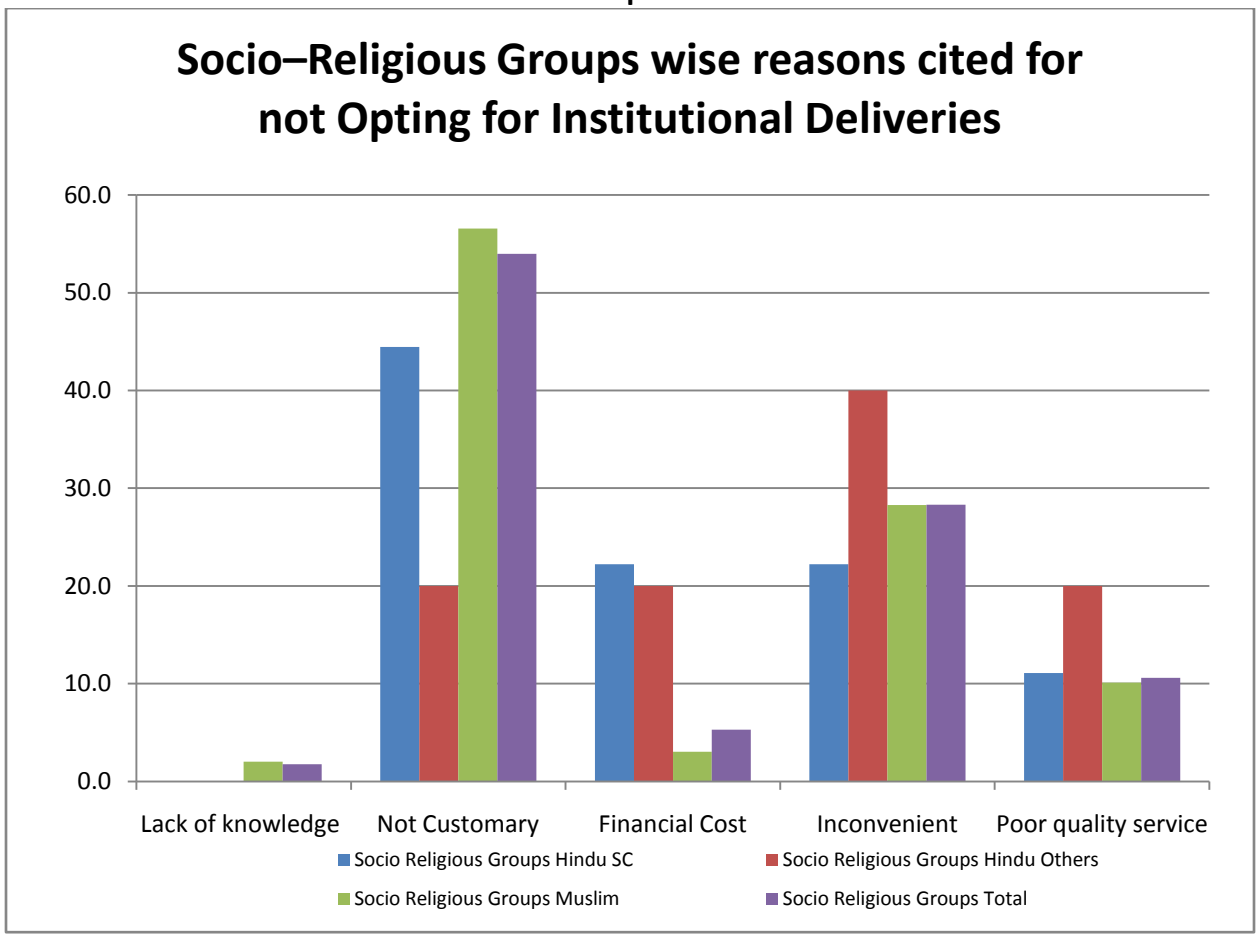
In this study, we probe further into the reasons why women from different socio-economic groups do not opt for institutional deliveries (Table 4.13). The main prominent reason cited was institutional deliveries are not customary (54.0 percent) and the least reason cited was lack of knowledge (1.8 percent). Across the social groups, Muslim and Hindu SCs not prominently mentioned that opting institutional deliveries is not in their custom (Graph 4.1).

Table 4.13 Socio–Religious Groups wise reasons cited for not Opting institutional Deliveries

	Socio-Religious Groups			
	Hindu SC	**Hindu Others**	**Muslim**	**Total**
Lack of knowledge	0	0	2	2
%	0.0	0.0	2.0	1.8
Not Customary	4	1	56	61
%	44.4	20.0	56.6	54.0
Financial Cost	2	1	3	6
%	22.2	20.0	3.0	5.3
Inconvenient	2	2	28	32
%	22.2	40.0	28.3	28.3
Poor Quality Service	1	1	10	12
%	11.11	20.0	10.1	10.6
Total	9	5	99	113
%	100	100	100	100

Source: IDC Field Survey, 2014.
Note: The table is based upon non-institutional deliveries which are 113.

Group 4.1



Source: IDC Field Survey, 2014.

CHAPTER V
SUMMARY AND POLICY SUGGESTIONS

Summary

Mewat district, although, located very close to the capital of the country, and a growing business hub like Gurgaon, is one of the least developed districts of Haryana. The development indicators of Mewat show that it continues to live in perpetual backwardness even years after India's independence. This underdevelopment is also reflected in the health status of the district. Analysis of existing secondary data shows that Mewat is an outlier in a developed state like Haryana. The outcome indicator of mother and child health clearly suffices the fact that Mewat is extremely poor in serving basic health services such as those pertaining to mother and child health. The picture regarding health services in the district is also the same, with these services lagging behind other districts. This is true in the case of both quantity and quality of health services in the district with both leaving much to desire. Primary Survey of the selected villages reveals that basic water supply and sanitation facilities are also poor in the study area. Even in case of other parameters of social development such as, employment and education, Mewat faces the same.

In the present study, three socio-religious groups namely Hindu Others, Hindu SC and Muslims were identified to measure the disparity in access to health services and their utilisation in the selected villages of the study area. With regards to housing and water supply and sanitation, the data suggests that Hindu Others are much better off than Hindu SCs and Muslims. In case of literacy and levels of education, Hindu Others have done far better, followed by Hindu SCs and the performance of the Muslims has been the most deplorable. Even in the case of employment and income, Hindu Others are ranked first followed by Hindu SCs and Muslims, clearly indicating the backwardness of Muslims in the study area.

As with health services, health seeking behaviour in the study area of Mewat, also to a great extent reflects the underdevelopment that plagues the health sector in Mewat district as a whole. Utilisation pattern for outpatient clearly highlights the fact that it is physical access and cheap health services forms the important contributory factor, especially, when it comes to choosing government health services. Private health services are utilised because of better quality that is attributed to them. It is also interesting to note that informal services forms a significant part of the outpatient care in the study area and that it roughly captures around 15 percent of the total outpatient care. Here again, physical accessibility becomes one of the important factors for using the informal health services. People go to quacks, RMPs etc. because they don't have to travel much for them and they are easily available to them.

In the case of hospitalisation, again an overwhelmingly high proportion of patients resorted to private health facilities primarily for better quality of care and preference for government health facilities was either due to low costs or because it was physically accessible. In terms of cost, Nursing homes were the costliest followed by Government hospitals which were costlier than Private hospitals. So, even though fees in Government hospitals were highly subsidized, purchase of medicines and other items from outside made treatment in government hospitals costly. This high utilisation of private facilities in turn means underutilisation of Government health facilities due to lack of quality.

A higher reliance on private health services is also a cause of concern as people seem to have by-passed the rural health infrastructure such as PHC, CHC or district hospitals. This is a cause of concern especially because of the high cost of private health services and its financial bearing at the household level. This high utilisation of private health services, however, cannot be blamed as people's experience of using private health services is much better than government institutes. In government institutes, there have been instances of discrimination against vulnerable groups such as Hindu SCs in outpatient care. A very low proportion of Hindu SCs were satisfied with the health personnel in government institutes. In the case of hospitalisation, there was no sharp distinction across socio-religious groups, however, what was common across the groups was the feeling that better quality of health personnel was at private health institutions as compared to government institutions.

Mewat not only faces challenges in terms of having inadequate health infrastructure but affordability of health in the region is also a serious issue. The analysis shows that there is considerable loss of income accruing to absence from work due to ill health and it is the labour households who are worst affected from it. There doesn't exist much of social security, as people rely on borrowing and selling of assets to a great extent to compensate for these losses.

A higher out of pocket expenditure in the study area has shown that considerable numbers of households in the study area are undergoing catastrophic health expenditure. To make matters worse, it is the poor who are most affected as their share in catastrophic health expenditure is much higher than their richer counterparts. When we examined the source of finances for health expenditure, it was seen that a very high reliance on borrowing and /or selling of assets, especially, in case of hospitalization still existed. The sources of borrowing are mostly informal in nature making people vulnerable to different kinds of financial obligations. Even in case of borrowing and/or selling of assets it was seen that low income groups had higher chances of going in for borrowing and/or selling of assets compared to the rich. Around 80 percent of those who borrowed for outpatient services and hospitalization reported that they were indebted. Again it was seen that it is the poor who are having to face disproportionately higher sums of money to be repaid as compared to the rich. With these financial obligations faced by

the poor it is safe to assume that it will be difficult for them to improve their living condition and chances are high that health expenditure will lead to further impoverishment.

Study on Maternal health in the study area reveal that in Mewat district of Haryana, Muslim women are found to be utilizing ANC services the least, followed by women from Hindu SC background. Lack of knowledge and low importance accorded to ANC services among these groups of women make them more vulnerable by not letting them use these services. Moreover, the usage of public health services like PHC and SC are surprisingly low in Mewat. This may be due to the trust in private health facilities or they may be going in for big public health centres/tertiary public health centres. Poverty and low education low awareness are the main reasons of poor utilization of ANC services among Muslim and SC women in Mewat. The conditions are relatively better among women who belong to Hindu other caste groups. In terms of specific ANC services, advices on nutrition and other care need to be improved as it is alarming low currently.

Major chunk of deliveries still take place at home and there is a clear difference between socio-religious groups with Hindu Others having the least chance of going for home delivery followed by Hindu SC and Muslims. Further disaggregated analysis shows that mother's education and level of income of the households have a positive effect on institutional delivery. Assistance of health personnel also showed significant difference between socio-religious groups with Hindu Other having the highest share of births taking place in the presence of qualified health personnel followed by Hindu SC. The Muslims are in the last position in this regard. There has been hardly any progress of safe motherhood programme such as JSY in the study area. There are very few beneficiaries and these were not many who received money under this programme.

Overall, it can be said that Mewat suffers from development due to lack of facility and very low level of awareness and low implementation of government programmes such as JSY. Government intervention, in terms of building infrastructure for mobilising people for health campaign have been very limited and quality of services in government institutions have left people with much to be desired. There also exists a significant socio-religious and economic have division as a result of which there are differential outcomes. Muslims in Mewat are the most deprived in most of the parameters analysed in this study, Hindu SCs especially in rural areas are the other vulnerable group.

Policy Suggestions

The overall development of Mewat based on study areas suggest for two prong strategy. First there is a need for overall development in the area and secondly special emphasis should be given to vulnerable groups such as Muslims and Hindu SCs. The specific policy interventions are follows.

1. Strengthening of the already existing NRHM programme with a special emphasis on Mewat district. Although Haryana does not fall under focus state under the NRHM, its indicator in health is as bad as any underdeveloped state. So, there is an urgent need to implement programmes such as JSY and health infrastructure development.
2. There is a need to actively implement RSBY in the study area as it was seen that it is the poor who are facing high catastrophic expenditure on health.
3. Steps are required to make hospitalisation in government institutions affordable by buying drugs and other essential equipment for the hospitals.
4. There is need for some initiative from government to ensure economic development in the region. Although Mewat is located so close to the industrial hub of Gurgaon and is not very far from Delhi the capital of the country, it still has areas that areas lacks in economic development. The growth centres have not been able to bring in change in the region.
5. Thrust should be given to improve the educational status in the areas, especially to the educational status of the females.
6. Concrete efforts are required to improve water supply and Sanitation situation in the region.
7. There is a need to improve quality in government run Health institutions.
8. There is a need to increase awareness, especially among the mothers at the reproductive age groups about maternal and child health which includes the importance of antenatal and postnatal care and institutional deliveries in the presence of qualified health personnel.
9. There is an urgent need to end discrimination both in economic opportunity and also in other spheres, such as, health care as faced by vulnerable groups such as Muslims and Hindu SCs.
10. There is an urgent need to create awareness about preventive health care and also about the safe motherhood programme.
11. Special emphasis must be given to bridge the gap between Hindu Others and Hindu SC and Muslims in health status as well as in the utilisation of health services.

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