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A Descriptive Study to Assess the Knowledge and Attitudes Regarding the Benefits of Selected Government Schemes and Programmes for Mother and Child Health Among Women in a Selected Rural Community of Lucknow

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Abstract

Background: Government initiatives such as the Janani Shishu Suraksha Karyakram, Integrated Child Development Scheme (ICDS), and the Universal Immunization Program have significantly improved access to maternal and child health services by providing free institutional care, nutritional support, and immunization. Despite these efforts, gaps in awareness and utilization remain, particularly in rural areas. This study aimed to assess the knowledge and attitudes regarding the benefits of selected government schemes and programmes for mother and child health among women in a rural community of Lucknow, and to explore their association with socio-demographic factors.

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Objectives: To assess knowledge and attitudes regarding the benefits of selected government health schemes and programmes for mother and child health; to determine the association of knowledge and attitudes with selected socio-demographic variables; and to examine the correlation between knowledge and attitudes among women in a rural community.

Methods: A descriptive study was conducted among 120 women of reproductive age (20–45 years) in a selected rural community of Lucknow. Data were collected using a structured questionnaire assessing knowledge and attitudes towards selected schemes. A non-probability convenient sampling technique was used. Descriptive statistics were applied to analyse knowledge and attitudes, while inferential statistics tested associations and correlations with socio-demographic variables.

Results: Although participants demonstrated positive attitudes towards government health schemes, there were significant gaps in knowledge, especially among older and less-educated women. Younger and better-educated women showed higher knowledge levels and more favourable attitudes. Findings highlight the potential for targeted educational interventions to enhance awareness and utilization of these health schemes.

Conclusion: The study underscores the importance of strengthening behaviour change communication and community-based information, education, and communication (IEC) activities to bridge knowledge gaps. Enhancing awareness in rural areas can leverage existing positive attitudes and improve maternal and child health outcomes through better utilization of government health schemes.

Keywords: Government health schemes, rural health, maternal and child health, nursing practice, health education, socio-demographic factors

Introduction

Health care has gained increasing importance over the years, with the Government of India launching several schemes to provide essential services to women of reproductive age and children. Universal Health Coverage (UHC), outlined as Target 3.8 of the Sustainable Development Goals (SDGs), emphasizes equitable access to quality care. Despite progress, major coverage gaps persist, particularly in low- and middle-income countries, including rural India, where access to healthcare remains limited. Awareness and utilization of government schemes are critical for improving maternal and child health outcomes, yet knowledge among beneficiaries often remains inconsistent.

The Janani Shishu Suraksha Karyakram (JSSK) was introduced to ensure free institutional deliveries, caesarean sections, and care for sick infants up to one year. Reports indicate that the proportion of institutional deliveries in rural India rose from 41% in 2014 to 68% in 2017–18, highlighting its positive impact. However, maternal mortality remains a concern, with low-income countries recording an MMR of 430 per 100,000 live births in 2020 compared to just 12 in high-income countries. India reported an MMR of 97 per 100,000 live births, still above the SDG target of 70. Since inception, JSSK has benefitted more than 2.91 crore pregnant women in Uttar Pradesh alone.

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The Integrated Child Development Scheme (ICDS), launched to address nutritional needs, reached over 89 million mothers and children in 2021. Despite significant investment, ICDS continues to face implementation challenges. The Universal Immunization Program (UIP*)* targets 3 crore pregnant women and 2.6 crore newborns annually, conducting over 1.2 crore immunization sessions free of cost against 12 vaccine-preventable diseases. This initiative has contributed to reducing India's under-five mortality rate from 45 per 1,000 live births in 2014 to 35 in 2019. Similarly, the *Janani Suraksha Yojana (JSY)* has promoted institutional deliveries among poor women, leading to declines in both maternal and infant mortality since its introduction.

Despite these achievements, gaps remain in awareness and attitudes towards such programmes, particularly in rural settings. Assessing knowledge and attitudes is crucial for ensuring effective utilization and for designing targeted interventions.

Statement of the Problem:
A descriptive study to assess the knowledge and attitudes regarding the benefits of selected government schemes and programmes for mother and child health among women in a selected rural community of Lucknow.

Objectives:

1. To assess knowledge regarding benefits of selected government health schemes and programmes for mother and child health among women in a selected rural community.
2. To assess attitudes regarding these schemes and programmes.
3. To determine the association between knowledge and attitudes with selected socio-demographic variables.
4. To explore the correlation between knowledge and attitudes.

MATERIALS AND METHODS

Study Design and Setting:
A descriptive, community-based study was conducted in a rural area of Lucknow, India, to assess the knowledge and attitudes of women regarding government health schemes and programmes for mothers and children.

Participants:
The study included 120 women aged 20–45 years, selected through convenient sampling. Eligible participants were permanent residents who could understand Hindi or English and provided consent. Women with severe illness, psychiatric disorders, prior training in health services, or those employed in the public health sector were excluded.

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Sample Size:
Based on the formula $n = p(1–p)/e^2$, with p=0.5 and e=0.051, the estimated sample size was 96. Allowing for a 10% non-response rate, a final sample size of 120 was considered adequate.

Data Collection Tool:
Data were collected using a structured questionnaire developed by the researcher. It consisted of three sections:

- **Section A:** Socio-demographic profile (20 closed-ended items) including age, education, family income, type of family, source of healthcare services, availability of BPL card, and socio-economic status.
- **Section B:** Knowledge regarding government health schemes and programmes (20 items). Scoring categories:
  - Poor Knowledge: <10 marks
  - Average Knowledge: 10–15 marks
  - Good Knowledge: ≥16 marks
- **Section C:** Attitudes towards health schemes (14 items) measured on a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree). Scores were categorized as:
  - Poor Attitude: <33
  - Average Attitude: 34–52
  - Good Attitude: >52

Data Collection Procedure:
Face-to-face interviews were conducted using the structured questionnaire. Socio-demographic details, knowledge, and attitudes were recorded.

Ethical Considerations:
Participation was voluntary, and informed consent was obtained. Confidentiality and anonymity of responses were maintained.

Data Analysis:
Descriptive statistics (frequency, percentage, mean, standard deviation) were used to summarize socio-demographic data, knowledge, and attitude levels. Inferential statistics were applied to examine associations between knowledge, attitudes, and selected demographic variables, as well as to assess correlations between knowledge and attitudes.

Results

Based on the study objectives, data were analyzed and presented in five sections:

- Section I: Socio-demographic characteristics of respondents
- Section II: Knowledge regarding selected government health schemes and programmes

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- Section III: Attitudes towards selected government health schemes and programmes
- Section IV: Association of socio-demographic variables with knowledge and attitude
- Section V: Correlation between knowledge and attitude

Section I: Socio-demographic Characteristics

The study included 120 women from a rural community in Lucknow. Most participants (38.3%) were in the age group of 26–28 years, followed by 29–30 years (30%), 23–25 years (26.7%), and 20–22 years (5%).

Regarding educational status, 21.7% had completed high school, 17.5% each had intermediate or primary education, 16.7% had middle school education, 12.5% were illiterate, 9.2% were graduates, and 5% were professionals.

In terms of occupation, skilled workers formed the largest group (29.2%), followed by unskilled workers (22.5%). Other categories included clerks (11.7%), elementary occupations (8.3%), machine workers (7.5%), technicians (5.8%), legislators (5%), craft workers (3.3%), professionals (2.5%), while 5.4% were unemployed.

Monthly income distribution showed that 32.5% earned <₹25,000, 29.2% earned ₹25,000–50,000, and 38.3% reported >₹50,000. Half of the households (50%) depended on government employment, 44.2% on private jobs, and 5.8% reported no employment.

A large majority (74.2%) lived in joint families, while 25.8% belonged to nuclear families, reflecting the traditional family system in the community.

Table 1: Distribution of participants by source of healthcare (n=120)

Sources of Health Care	Frequency (f)	Percent (%)
Public Sector	56	46.7
Private Sector	56	46.7
Alternate medicine	34	28.3

Utilization of public and private healthcare services was nearly equal, while 28.3% reported relying on alternate systems of medicine. Only 10.8% possessed Below Poverty Line (BPL) cards, indicating that most households were above the official poverty line. Socioeconomic classification revealed that 36.7% of participants were in the upper-lower class, 31.7% in the lower-middle, 15% in the lower class, and only 16.7% in the upper-middle or upper categories.

Section II: Knowledge regarding benefits of selected government health schemes.

.Knowledge Levels The study found that 71.7% of participants had poor knowledge of government

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health schemes. This finding is consistent with other studies conducted in different regions of India.For instance, Thakur et al. (2017) reported low awareness of Janani Suraksha Yojana (JSY) in Himachal Pradesh, aligning with the present study's results[8].

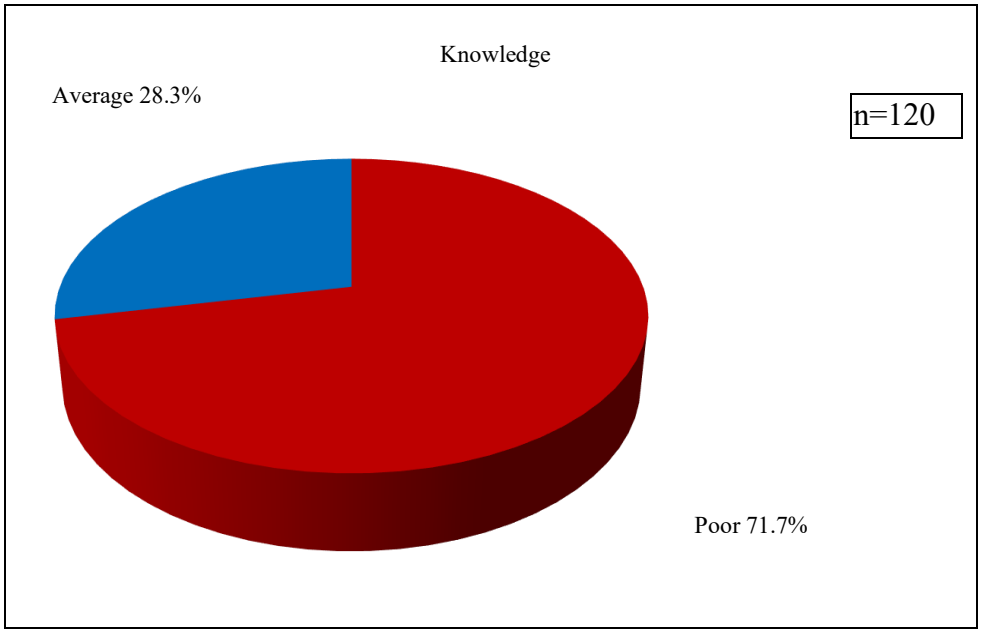

Fig 01: Knowledge levels

Section III: Attitude regarding benefits of selected government health schemes and programmes. Despite the low knowledge levels, 50.8% of participants exhibited positive attitudes towards government health schemes. This aligns with Patel et al. (2018), who found positive attitudes towards institutional delivery in Gujarat despite low awareness9.

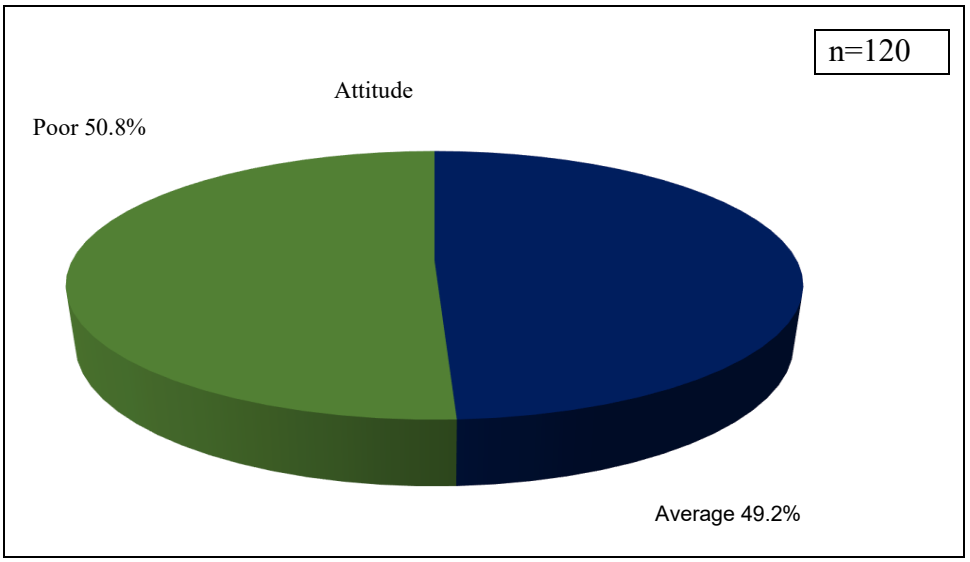

Fig 02: Attitude towards health schemes

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Section IV: Association of socio demographic variables with knowledge and attitude regarding government health schemes and programmes.

Knowledge and attitudes were significantly associated with education, occupation, and socioeconomic status. These findings are consistent with a systematic review by Sanneving et al. (2013), which highlighted similar associations in maternal health service utilization across India10.Urban-Rural Disparities.

Section V: Correlation between knowledge and attitude regarding government health schemes and programmes

A strong positive correlation was observed between knowledge and attitude scores ($r = 0.790$, $p < 0.01$). This is notable compared to other studies, such as Gupta et al. (2018), which found a moderate correlation between knowledge and utilization of maternal health services[11].

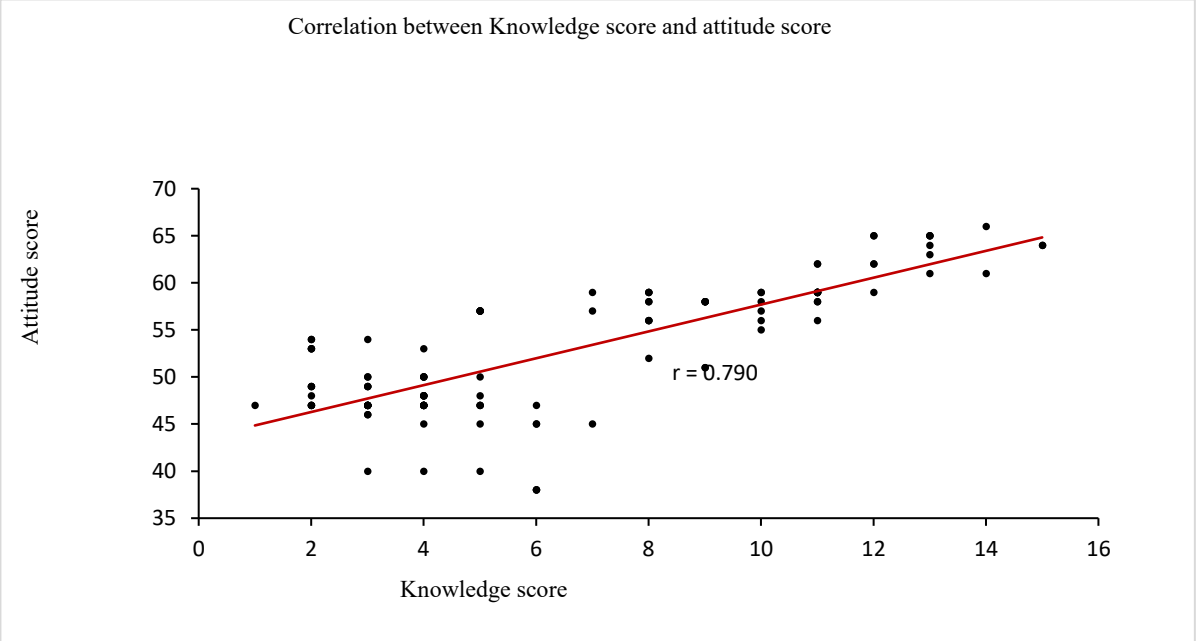

Fig 03: Correlation between knowledge score and Attitude score

Discussion

The study highlights significant gaps in awareness of government health schemes among rural women, despite generally positive attitudes towards their benefits. The mean knowledge score was 6.7 ± 3.8 out of 20, with 71.7% of participants classified as having poor knowledge. In contrast, the mean attitude score was 53 ± 6.8 out of 70, with over half (50.8%) demonstrating good attitudes. This disparity suggests that while women view these programmes favourably, they often lack detailed information about their availability and benefits.

These findings align with Gogoi et al. (2014)[12], who reported urban-rural disparities in maternal health service utilization, with rural women showing lower awareness and uptake. Similarly, Agarwal et al.

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(2019)[13] demonstrated the positive impact of community-based health education in improving knowledge and utilization of maternal health services. A descriptive study in Pune by Sakhardande et al. (2021)[14] also reported that 66.5% of participants had only average knowledge of government health schemes, underscoring the need for targeted interventions. Ray (2014)[15] further highlighted low awareness and insufficient utilization of National Rural Health Mission services in Maharashtra.

The association between knowledge and socio-demographic factors in this study reinforces the importance of tailored health education strategies. Younger and more educated women exhibited better awareness, indicating that targeted educational interventions could significantly enhance the effectiveness of maternal and child health programmes.

Limitations

1. The study was confined to a single rural community in Lucknow, limiting generalizability.
2. Being cross-sectional, it only reflects knowledge and attitudes at one point in time.
3. The focus was limited to knowledge and attitudes, without assessing actual utilization of services.

Recommendations

1. Conduct larger multi-site studies for broader generalization.
2. Strengthen information dissemination through mass media and community campaigns.
3. Engage peer educators and local health workers to improve household-level knowledge transfer.

Conclusion

Bridging the gap between positive attitudes and poor knowledge presents a critical opportunity to enhance the reach and impact of government health schemes. Targeted, community-based educational interventions can improve awareness, foster informed decision-making, and ultimately contribute to better maternal and child health outcomes in rural areas.

Conflict of Interest: None declared.
Source of Funding: Self-funded by the study group members.
Ethical Clearance: Obtained from the Institutional Ethics Committee of Command Hospital (Central Command), Lucknow.

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