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Health Status Of Children In Rural Area Of Jhansi Bundelkhand

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Abstract

Poor health status in term of high mortality and morbidity among children in India had been major concern for public health professional even before attainment of independence, efforts to provide services to this vulnerable section of the population were initiated under maternal and child health services. Major hospitals in urban areas as well as primary health centers in the rural areas were responsible to render the services since independence. Recent work since 1980s has been a major concern regarding the sociology of childhood. It has been found that there is a strong association between socio economic status such as education, income, occupational, greater access to resources and political power. These factors are visible in the health of the child. Social factors have been found to be more responsible for the child health. It is accepted that social factors and disparities play a greater role in preventive and curative services.

WHO Report

Recently the release of the WHO commission on social determinates of health final report calls for closing the gap in generation. The report outlines three principles of action to reduce health inequality improved daily living condition, tackle the inequitable power, money and resources, understand the problem and access the impact of action (CSDH 2008 :2). The report emphasises investment in early child development and education as powerful equalizers and calls for as more comprehensive approach to understanding early child development and childhood intervention (CSDH 2008: 50-59)

Present study

AIMS at to study the status of children in rural area of Jhansi Bundelkhand few Indian researchers have Conducted various studies on the health status of children, particularly in Bundelkhand. The verma S.K (2009) 'children deaths' this study was conducted in all the districts of Bundelkhand Jhansi Lalitpur, Jalaun ,Mahoba, Hamirpur, Banda .They found this area is more prone for the children deaths because of anemia, early marriages, early pregnancy, poverty and malnutrition.

Singh S.S (2009) 'child welfare' on this study he discussed that various programmes of children welfare were initiated by the government like free iron tablets distribution and supplementary food to remove the malnutrition of children in Bundelkhand but lack of monitoring and apathy of health workers have not created desired results children between ages 5 to 15 years were suffering from various kind of diseases.

Dr.Awasthi N.N. (2009) 'home delivery vs. hospital delivery' in this paper he found that deliveries Conducted in hospitals were found to be safe and mortality was lesser in Comparison to home.

The recommendation of (CS DH 2008) Suggests that health agenda of children must be extended to integrate various methodologies quantitative approach and qualitative methods in the Study of children (Kickett tucker 2009 , williams et al 2009 , Pike and Colquhon 2009) there is a need to hear people voices as a bases for acting on Local Knowledge for improving health.

Objective of Study

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1 To Study the health status of children in rural area of Jhansi Bundelkhand.
2 To study the Socio economic and cultural factors responsible for child health.
3 To study the impact of government initiated Programme for children health.
4 To study the Knowledge attitude practices regarding child health.

Methodology:-

The study was undertaken in village Bhojla Situated at the distance of about 6 km. from the Jhansi City. The village had a primary health centre however the village was typical in rural character majority population engaged in agriculture. Total population of village was 1506 Consisting of 300 families study Sample Consisted only 135 families selected randomly from all families of the village and the head of the household of such selected families were interviewed for the purpose of the study. Study was Conducted July 2017 and information was collected by the researchers himself on a pre tested Schedule.

Result and discussion

Characteristics of Respondents

An Analysis of the demographic, educational and socio economic status of the respondent revealed majority (57.77%) were engaged as agriculture, Labour, and in other types of Activities. As for as educational status was concerned majority (29.62%) were studied up to High School followed by 22.23% who were illiterate. Religion wise analysis revealed as Majority (94.8%) were Hindus other religious groups were found to be insignificant. Majority of respondents (55.55%) were from the other backward classes other dominant group (28.89%) belonged to schedule caste family. Distribution of respondents according to their ages showed that 51.85% were between the age group of (15-30) years followed by another dominant group 40.74% were between (30-45) years of age it showed that majority of respondents were in younger age groups.

Study was concerned asses the status of child health and associated social problems it was found that majority (56.93%) were having male child on the other hand 43.07% were female child which indicated that female child ratio was lesser in comparison to male child.

As regard socio economic status of the families of respondents was concerned the majority (31.85%) were having income between (1500-2000) per month majority (73.47%) children were going to school while 26.53% were not going to school, reasons attributed for not going to school was poverty. It was heartening to note majority of deliveries were conducted in hospital this may be due to that medical service were available nearby places and majority of the deliveries were conducted by trained medical personnel.

From table 10 it is evident about the child health it was found to be positive and majority (38.52%) of the respondents consulted medical personnel while another dominant group of (25.93%) considered no need to consult medical personnel this shows that still awareness was lacking in many families regarding child care.

Primary health centre was located at the distance of 1 km child care services were available in the centre while(18.51%) did not know about the child care services.

Table 12 shows that majority of respondents (70.37%) were consulting Local doctor available in the village despite the fact that the trained medical doctor was available 1 km away in primary health centre.

Health of child is dependent by the spacing of the children because repeated pregnancies with fewer interval may detoriate the health of a child. In this study majority (42.96%) were having one year spacing of their children which shows they were having repeated pregnancies.

From table 14 it is evident that belief and customs were deep rooted in the families because majority (46.67 %) consulted medical personnel's after two to four months of pregnancy.

Summary and Conclusion

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The analyses of data brought out the level of literacy was (22.23%) while majority was studied up to high school, but there was little awareness among the people for the recognition of health need of the children. socio economic status was lower and majority consisted of agriculture labour village was dominated by Hindus and majority consisted of other backward classes majority families were having male children in comparison to female children poverty was the main reason of the children who were not going to school . It was significant to note that most of the delivery conducted in hospitals but nearly 18 % were having deliveries in their home despite the reason that medical facilities were available at the distance of 1 Km .There was significant percentage of people who did not want to consult doctor regarding the sickness of their children, people were still in favor of going indigenous remedies because there were deep rooted customs associated with the causation and treatment of various disease.

Thus it reveals that there was initial resistant to accept the modern medicine. This situation needs improvements so as to bring them more in tune with the modern development in medical care services of the children.

Recommendation

i) Children health care services needs to be started after providing health education, taking in to account broad socio economic and cultural setting of the village community.

ii) There was a need to strengthen child health care services so that people adopt rational attitude towards the health of their children.

iii) From time to time simple training programmes need to be organised for the formal and non-formal leaders of the community at village level for the utilization of existing health services of the children.

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Table-1
(Table Showing Distribution of respondents according to occupation)

S.No.	No. Of Respondents	Occupation	Percentage
1		Service	
2	54	Agriculture	40%
3	3	Business	2.23%
4	78	Ag. Labour	57.77%
Total	135		100%

Table-2
(Distribution of respondents as Educational Status.)

S.No.	No. Of Respondents	Education	Percentage
1	30	Illiterate	22.23
2		Literate	
3	27	Primary	20
4	40	Junior High School	29.62
5	22	High School	16.29
6:-	16	Inter + Above	11.86
Total	135		100%

Table-3
(Religion of respondents)

S.No.	No. Of Respondents	Religion	Percentage
1	127	Hindu	94.08
2	8	Muslim	5.92%
3		Sikkh	
4		Christian	
Total	135		100%

Table-4
(caste Status of respondents)

S.No.	No. Of Respondents	Caste	Percentage
1	21	General	15.56
2	75	OBC	55.55
3	39	SC	28.89
Total	135		100%

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Table-5
(Distribution of respondents according to their ages)

S.No.	No. Of Respondents	Age	Percentage
1	70	(15-30)	51.85
2	55	(30-45)	40.74
3	10	(45-60)	7.41
4		(60-1)	
Total	135		100%

Table-6
(Table Showing total No of Female and Male child)

S.No.	No. Of Respondents	Child	Precentage
1	177	Female	43.07
2	234	Male Child	56.93
Total	411		100%

Table-7
(Monthly Income of the respondents)

S.No.	No. Of Respondents	Income	Percentage
1	9	(1000-1500)	6.67%
2	43	(1500-2000)	31.85
3	31	(2000-2500)	22.96
4	29	(2500-3000)	21.48
5	23	(3000-5000)	17.04
Total	135		100%

Table-8 (A)
(Table Showing status of School going children of the respondents)

S.No.	No. Of Respondents	Response	Percentage
A	177	School going	73.47
B	234	Non school going	26.53
	411		100%

Table-8 (B)
(Reasons of non going children)

S.No.	No. Of Respondents	Response	Percentage
1	19	Not Interested In Studies	17.44
2	57	Poverty	52.29
3	13	Not Interested	11.92
4	20	Any Other	18.35
Total	109		100%

Table-9(A)
(Distribution of respondents according to Place of delivery)

S.No.	No. Of Respondents	Place Of Delivery	Precentage
1	336	Hospital	81.76
2	75	Home	18.24
Total	411		100%

Table-9 (B)
(Opinion of respondents regarding Existing Health service Provider in the area)

S.No.	No. Of Respondents	Responses	Percentage
1	231	Doctor	56.21
2	67	Nurse	16.31
3	38	A.N.M	9.24
4	75	Local Dai	18.24
Total	411		100%

Table-10
(Table Showing awareness regarding child health)

S.No.	No. Of Respondents	Responses	Percentage
1:-	23	Child Care At Home	17.04
2:-	52	Consultation With Doctor	38.52
3:-	35	No Need To Consult	25.93
4:-	25	No Response	18.51
Total	135		100%

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Table-11
(Table Showing Person Who Conducted delivery)

S.No.	No. Of Respondents	Conduct	Precentage
1	135	Existence Of P.H.C. Primary Health Care	
2	1km.	Distance Of P.H.C.	
3	110	Child Care Services Provided	81.49
4	25	Not Provided	18.51
Total	135		100%

Table-12
(Consultation Provided by Health Person)

S.No.	No. Of Respondents	Consultant	Precentage
1	95	Local Doctor	70.37
2	23	Allopathic Doctor	17.04
3	10	Local sorcerer	7.41
4	7	Health worker	5.18
Total	135		100%

Table-13
(Distribution of respondents according to birth Interval)

S.No.	No. Of Respondents	Birth	Precentage
1	58	1 Year	42.96
2	33	2 Year	24.45
3	25	3 Year	18.52
4	19	4 Year	14.07
Total	135		100%

Table-14
(Table showing Doctor consulted after Pregnancy)

S.No.	No. Of Respondents	Duration	Percentage
1	17	Immediately after Pregnancy	12.59
2	63	After 2 months	46.67
3	32	After 4 months	23.70
4		After 6 months	-
5	23	Not Consulted	17.04
Total	135		100%