



# A Study On The Child Health With Special Reference To India

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## Abstract

India is a lower-middle-income country with one of the fastest growing economies in the world. Despite improvements in its economy, it has a high child mortality rate, with significant differences in child mortality both between and within different states. Poverty, malnutrition and poor sanitation are major problems for many Indians and are a major contributor to child mortality. More than 40% children are malnourished or stunted. Healthcare provision is poor, and many families, especially in rural areas, have major difficulties in accessing healthcare. Kerala has the lowest child mortality rates in India. This has been achieved by reducing poverty, malnutrition and inequalities. The provision of universal education alongside universal access to healthcare has demonstrated that child mortality rates could be reduced. India could significantly reduce its child mortality by following the example of Kerala. India comprises almost 13.1 per cent of child population aged 0-6 years. Children of today are tomorrow's citizens; hence it is very necessary to provide better health care facilities to them. India accounted almost 43 per cent underweight children against 32 percent in Pakistan, 9 percent in South Africa. Nutritional level among the children is the basic element of their overall mental and physical development.

**Keywords:** Growing Economies, Child Mortality, Malnutrition, Physical Development

## Introduction

India is a lower-middle-income country with the second largest population in the world. It is one of the G20 major economies worldwide, and over the last two decades has had an average growth rate of approximately 7%. In 2014, it became the world's fastest growing major economy. Despite this economic success, it has a high child mortality rate, and one in five deaths in children under the age of 5 years worldwide occurs in India. Child mortality rates in India are higher than in neighbouring Bangladesh and Nepal, both of which are poorer and have fewer doctors. India failed to achieve its millennium

development goal targets for child mortality. India consists of 35 separate states, each of which has its own government. There are major differences between the states economically and politically. Healthy children are more likely to become healthy adult. Health is a basic component of human development, and hence determines society's well-being. It is a means to empower the deprived sections of society and thus an important element in the strategy for poverty alleviation. Thus, in recent years there has been an increased focus on issues that affect children and on improving their health. The vital statistics like crude birth rate, crude death rate, infant mortality rate, and life expectancy at birth provide the base for information on the health status and human development of any state. Access to preventive and protective health care enhances entitlements of the poor by enabling steady employment, improving productivity and facilitating demographic transition. A country or states performance depends a lot on the health of its populace. Not only does it improve efficiency but it is also an indicator of an all-round performance of the nation. For a country like India where the achievement of better child health is a daunting task, the consequence of ignoring the problem of child health seems very disastrous. The present state of child health situation in India does not presents a rosy picture in front of our policy makers. Health is the state of physical, mental and social well-being and does not only mean an absence of illness or disease. The right to health is closely linked to other fundamental human rights, most notably access to potable water and adequate hygiene. All children have the right to timely access to appropriate health services. Measuring the status of health of a country or a state is a complex process. It is a multifaceted phenomenon which has been difficult to model and estimate. It becomes further complicated due to disparities among various states of India. India is home to the largest number of children in the world, significantly larger than the number in China. The country has 20% of the 0-4-year child population of the world. The analysis of the situation of children in India would be incomplete without paying attention to the disparities that exist between and within states, and the inequalities that persist among different subgroups of the population.

## Objectives

- To study improving children's health in rural areas.
- To study the awareness and create knowledge to their parents about children's health.

## Review of Literature

- ❖ **UNICEF (2020)** Improved complementary feeding practices including TIBF and age-appropriate feeding will help reduce stunting and related burden of diseases. Complementary feeding practices are demonstrated to increase through strategies like nutrition counselling, counselling in food insecure settings to improve nutrient rich food consumption and IYCN education. Promotion of age-appropriate complementary feeding practices is rooted in guidelines issued by WHO in

2003 and 2005. Though no guidelines from WHO exist for complementary feeding counselling but updated UNICEF programming has been released recently in 2020

- ❖ **Bishweshwar Bhattacharjee (2021)** Child health has a crucial role in the progress of a country like India where more than a tenth of the population are children. As children of today are tomorrow's citizen, thus it is extremely important to ensure good health for children. This study tried to build an comprehensive state wise child health index compressing various child health indicators namely NNR, IMR and U5MR into ma single indicator through the tool of machine learning. The analysis on CHI indicates that Kerala ranked first while Bihar becomes the worst performing state. On the categorisation of states across regions by various levels of Child Health it emerged that southern region has performed well followed by western region. On the other hand, Northern, eastern and north eastern regions performed poorly. Coming to evaluating a difference between the performances of the states with regard to child health during the span of two NFHS Surveys, there seems to be no significant enhancement in child health index (CHI) during the period as far as conclusion of the t-test is concerned.



## Various Health Problems among Children

### Poverty and malnutrition

Socioeconomic determinants play a major role in the health of young children. Improving sanitation has been shown to have a significant effect on reducing child mortality. Only 36% of the population in India have access to improved sanitation facilities. Poverty and malnutrition are major problems in India. Over 40% of children are underweight, and more than one in four babies have low birth weight. In rural areas, over 45% of children under the age of 5 are underweight. One in three of the population lives below the international poverty line of US\$1.25 per day. Poverty and malnutrition are closely linked, and approximately 45% of all deaths of children under the age of 5 years are linked to malnutrition. Inequalities are a major problem throughout most of India. Even in the richest state in India (Maharashtra), more than one in three children are underweight. The reduction of poverty and malnutrition would have a major impact on child mortality throughout India. This is illustrated by the example of Kerala, which has successfully reduced poverty and malnutrition, and has the lowest child mortality rates in India. The actions of the government in Kerala to reduce inequalities have been a deliberate political decision.

### Healthcare provision

The government provides public healthcare, but only 1.1% of gross domestic product (GDP) is allocated to health. In contrast, 2.7% of GDP is allocated to military spending. The private medical sector is the primary source of healthcare for the majority of the population in both urban and rural areas. Approximately, two-thirds of the population seek healthcare from the private medical sector. Even in rural areas, 63% of the population go to a private provider. There are numerous private healthcare providers, and this results in a lack of coordination in healthcare facilities. The private medical sector in

India is extensive and politically influential, with little desire to see implementation of universal healthcare. The need for universal healthcare in India is well recognised by health professionals. The majority of Indians cannot afford private healthcare. Only 5% of households have any health insurance.

The National Family Health Survey (NFHS-3) interviewed family members to identify why individuals did not use government health facilities. The two main reasons were the poor quality of care and the lack of a government health facility in the area. Other reasons were that the waiting time was too long in government health facilities and health personnel were often absent from the government health facilities. A major problem for rural women was the distance to a health facility. Concerns were also expressed that there may not be any drugs available at the health facility.

Recent welcome developments in healthcare provision include the programme for Accredited Social Health Activists (ASHA). These individuals can visit newborns and families at home and give advice regarding nutrition, infections and feeding. The benefit of ASHAs has been shown by a cluster randomised control trial that showed a significant decrease in the neonatal mortality rate in areas where ASHAs supported women's groups.

Another welcome initiative was the establishment in 2005 of the National Rural Health Mission. This is a public scheme that recognised that many poor households in remote rural areas did not have adequate access to healthcare. Other positive developments have been the provision of cash transfers to pregnant women and the expansion of inpatient coverage for the poor. Several other initiatives have been introduced by different states — all with the aim of expanding access to healthcare. Despite these initiatives, India fails to provide universal healthcare for many of its children.

## **Maternal health**

The health of the mother is clearly related to the health of the child. A malnourished mother is likely to result in malnutrition in the young infant. Antenatal care is crucial for the birth of a healthy baby. One in five women in India receives no antenatal care. There are huge variations in the provision of antenatal care across India. Antenatal care is almost universal in Kerala, Tamil Nadu and Goa. The NFHS-3 looked at nine summary indicators of the utilisation of antenatal care services. Kerala, Tamil Nadu and Goa ranked in the top five states in the country in almost all of the indicators. Bihar, Rajasthan, Uttar Pradesh and Jharkhand are large states that all perform poorly in the provision of antenatal care. The problems in accessing healthcare are illustrated by a study from southern Odisha, which highlighted the practical problems by pregnant women accessing healthcare. The main problem was physically getting to the hospital. Almost half the women had to hire an auto rickshaw in order to get to the hospital. The difficulties experienced by women in accessing healthcare has been raised as a human rights issue.

Only one-third of babies born in the 5 years preceding the NFHS-3 survey had their birth weight recorded. The percentage of babies with a recorded birth weight ranged from 97% in Kerala to 8% in Uttar Pradesh. The lack of antenatal care for many women during the pregnancy is probably one of the major reasons for the high maternal mortality ratio in India. Kerala and Tamil Nadu, which both have excellent antenatal care, have achieved the millennium development goal target of a maternal mortality

ratio of 109 deaths per 100 000 live births. The states with the poorest antenatal care also had the highest maternal mortality rate ratios.

### **Empowerment of Women**

Women play a crucial role in the health of children. Empowerment of women is crucial for the health of children. One in three women is illiterate. In many rural areas, women need to seek permission from a man in the family before being allowed to travel or use money to pay for either healthcare consultations or drug treatment. Even within urban areas, the financial autonomy of women is a key determinant of child health. The NFHS-3 asked numerous questions about the empowerment of women in India. They found a direct relationship between the empowerment of women and lower child mortality rates (neonatal, infant and under 5 mortality rates). It is no coincidence that Kerala, which has the best education of women, also has the best health outcomes for children. Education alongside financial autonomy are key determinants of child health in India.

### **Breast Feeding**

Breast feeding is almost universal in India. However, very few children are put to the breast immediately after the birth. Only a quarter of infants started breast feeding within an hour of birth and only 55% started breast feeding within the first 24 hours. The majority of mothers (57%) in the first 3 days after delivery gave their infants other liquids (other milks, honey, water or glucose water). The value of education for the mothers is illustrated again by Kerala, where 95.7% of mothers started breast feeding within 1 day of birth; in contrast only 23% of mothers in Uttar Pradesh started breast feeding within the first 24 hours. Infant mortality is greatest in the neonatal period, and the 48 hours immediately following birth is the most crucial period. The reluctance to initiate breast feeding in the first 24 hours will increase neonatal mortality rates. Again, Kerala with its high breast feeding in the first 24 hours and universal provision of antenatal care has the lowest perinatal mortality rate.

### **Immunisation**

Immunisation plays a crucial role in reducing infant and child mortality. The WHO considers infants fully vaccinated if they have received Bacillus Calmette-Guérin (BCG) against tuberculosis, three doses of the diphtheria pertussis and tetanus vaccine, three doses of the polio vaccine and one dose of the measles vaccine by the age of 12 months. Unfortunately, only 36% of children were fully vaccinated by the age of 12 months. The highest percentage rate of all immunisations was in Tamil Nadu (80.9%). Kerala and Goa both had immunisation rates above 75%. In contrast, Uttar Pradesh only achieved immunisation rates of 23% and Nagaland achieved immunisation rates of 21%.

### **Access to healthcare: antibiotics for respiratory tract infection (RTI), oral replacement solution for diarrhoea**

Acute respiratory tract infections are one of the leading causes of the death of children throughout the world. Early diagnosis with treatment with antibiotics can save many lives. In the NFHS-3, 6% of children showed symptoms of an acute respiratory tract infection in the 2 weeks preceding the survey. In 69% of the cases, treatment was sought from a health facility or provider. This percentage ranged from

60% in the lowest quintile in relation to wealth, to 80% in the highest quintile. When comparing different states, there were marked differences in the percentage of children for whom treatment was sought from a health facility. The lowest percentage was in Nagaland, where only 27% sought treatment. In contrast, in both Delhi and Kerala, 89% sought treatment. Not every child with an acute respiratory tract infection requires antibiotics. Overall, 12% of all children received antibiotics. This ranged from 6% in the lowest quintile for wealth to 20% in the second highest quintile for wealth. Only 1% of the children in the state of Chhattisgarh with symptoms of an acute respiratory tract infection received antibiotics. This contrasted with 46% in Uttaranchal.

Diarrhoea is the second most common cause of death in children under the age of 5. In the vast majority of cases, simple rehydration can prevent death. In the NFHS-3 survey, 9% of children had diarrhoea in the 2 weeks preceding survey. Overall, 60% of children with diarrhoea were taken to a health provider. Again, there were significant differences in the percentage of children taken to a health provider in relation to income, ranging from 50% in the lowest quintile and 73% in the highest quintile. Overall, 43% of children received oral rehydration therapy or increased fluids. Only 37% of children in the two lowest quintiles in relation to wealth received either oral rehydration therapy or increased fluids. This contrasted with 59% of children in the highest quintile for wealth. There were marked regional variations in the provision of treatment with oral rehydration therapy or increased fluids. Eighty-five per cent of children in Kerala received oral replacement therapy (ORT) or increased fluids. In contrast, only 25% of children in Assam and Rajasthan received ORT or increased fluids.

## **Anaemia**

Anaemia is a major problem in children throughout India. Almost 70% of children under the age of 5 years in India are anaemic. There are only four states in India in which less than half of the children are anaemic (Goa, Kerala, Manipur and Mizoram). In five states, more than 70% of children are anaemic.

Anaemia is also a significant problem for adults throughout India. Approximately, one in four men is anaemic and 55% of women are anaemic. Again, there are major regional variations in the prevalence of anaemia in women in India. The four states (Goa, Kerala, Manipur and Mizoram) with the lowest prevalence of anaemia in children also had the lowest prevalence of anaemia in women (33%–38%).

## **Child Health Programmes**

### **Facility Based New born and Child Care**

Neonatal mortality is one of the major contributors (2/3) to the Infant Mortality. To address the issues of higher neonatal and early neonatal mortality, facility based newborn care services at health facilities have been emphasized. Setting up of facilities for care of Sick Newborn such as Special New Born Care Units (SNCUs), New Born Stabilization Units (NBSUs) and New Born Baby Corners (NBCCs) at different levels is a thrust area under NHM.

## Special New born Care Units (SNCU)

- States have been asked to set up at least one SNCU in each district. SNCU is 12-20 bedded unit and requires 4 trained doctors and 10-12 nurses for round the clock services.

## Newborn Stabilization units (NBSUs)

- NBSUs are established at community health centres /FRUs. These are 4 bedded units with trained doctors and nurses for stabilization of sick newborns.

## New Born Care Corners (NBCCs)

- These are 1 bedded facility attached to the labour room and Operation Theatre (OT) for provision of essential newborn care. NBCC at each facility where deliveries are taking place should be established.

## Mother New born Care Units

### SNCU complex are enumerated as under:

- **Waiting Area** in front of SNCU with simple amenities like comfortable sitting space, safe drinking water, AV system, Tea/Coffee vending machine and a wash room for the parent or attendants.
- **Entry area** – space for Gowning, hand washing, Shoe rack
- **Follow UP area** with AV facilities and adequate space for daily counselling, during discharge and imparting FPC training
- **Reception area** for receiving the cases and assess under triage area
- **Newborn care area** (SNCU area for cases admitted as per Admission criteria for SNCU) -to accommodate at least 20 Radiant warmers with additional clear, designated area as isolation ward for the infectious cases like Varicella, diarrhea etc. and area for procedures (desirable). Separate out-born and inborn units may not be required if strict asepsis protocols like that of an OT are followed. Additional hand washing facility within the SNCU, Mother's area, feeding room (Human Milk Storage Room) will help in ensuring hand-washing before handling of newborn.
- Doctor's and sister's duty room with wash rooms, storage rooms and Janitors/slucice room
- A separate Step down/ KMC unit which is existing in many units as per the existing guidelines can now be upgraded and named as mother newborn care unit (MNCU) which will be an ideal available space to keep the mother- baby dyad together to fulfill the following objectives:
- Decongesting SNCU of newborns who do not require intensive care but need observational care for their medical conditions.
- Making provisions (Bed, diet and treatment) for the mothers of SNCU admissions.
- The admission criteria of SNCU as per FBNC Operational Guide lines will continue to be followed.
- NO new born deserving admission in SNCU will be shifted to the MNCU
- Step down/ KMC unit may be amalgamated as **MNCU** to have provisions for both mother and baby.

As described above the existing step down/KMC area as per the existing guidelines can now be upgraded as MNCU. Each state will have to customize it facility-wise, based on local needs and make it contextual requiring renovation, extension or create additional space. The states in the forthcoming PIPs can include the budget proposals for gap filling of SNCUs having high case load/overcrowding/ units in the process of developing KMC or step down area. Once successful they can extend it later to all units in phased manner. The state should make an effort to have a room close to SNCU and big enough to have adult beds, a separate eating and washing area for the mothers. MNCU will be jointly owned by both Department/Unit of Pediatrics and Obstetrics and Gynecology for management of common conditions of both the mother and baby and the designated doctors and nurses will monitor them daily.

### **Janani Shishu Suraksha Karyakram (JSSK)**

Janani Shishu Suraksha Karyakram (JSSK) was launched on 1st June 2011 and has provision for both pregnant women and sick new born till 1 year after birth are (1) Free and zero expense treatment, (2) Free drugs and consumables, (3) Free diagnostics & Diet, (4) Free provision of blood, (5) Free transport from home to health institutions, (6) Free transport between facilities in case of referral, (7) Drop back from institutions to home, (8) Exemption from all kinds of user charges.

The initiative would further promote institutional delivery, eliminate out of pocket expenses which act as a barrier to seeking institutional care for mothers and sick new borns and facilitate prompt referral through free transport.

### **Family Participatory Care**

Realizing that parents if trained during their stay in the hospital to provide essential care to their sick and small newborns and explained what to do at the time of crises will not only help in improving survival of the babies after discharge from newborn care units but also help in the overall growth and development of the baby. In this regard Child Health division MoHFW, released Operational Guidelines on Family Participatory Care (FPC) at a recently concluded 4th Summit on Best Practices held at Indore. Family-participatory care (FPC) for newborn essentially provides a setting in which family is empowered, encouraged and supported as the constant care-provider, in addition to available nursing staff, to complement care of their sick newborn in nursery, from admission until discharge and continue in home settings too. However, the primary responsibility of care continues to rest with the conventional health care provider namely the nurse and doctor. Under FPC capacities of parents-attendants is built in essential newborn care through a structured training programme (Audio -Visual module and a training guide). The staff at newborn care unit provides continuous supervision and support. Provisions for infrastructure and logistics strengthening required for implementing FPC are ensured in the annual state PIP. States like Madhya Pradesh, Odisha, Rajasthan and Bihar have already implemented in SNCU across the state (with technical support from NIPI-Newborn Project). Parents-attendants are involved in a limited way for maintaining hygiene, cleaning the soiled baby, positioning of babies, and alerting the staff if they notice anything unusual with the baby.



## **Navjat Shishu Suraksha Karyakram (NSSK)**

NSSK is a programme aimed to train health personnel in basic newborn care and resuscitation, has been launched to address care at birth issues i.e. Prevention of Hypothermia, Prevention of Infection, Early initiation of Breast feeding and Basic Newborn Resuscitation. Newborn care and resuscitation is an important starting-point for any neonatal program and is required to ensure the best possible start in life. The objective of this new initiative is to have a trained health personal in Basic newborn care and resuscitation at every delivery point. The training is for 2 days and is expected to reduce neonatal mortality significantly in the country.

## **Reduction in morbidity and mortality due to Acute Respiratory Infections (ARI) and Diarrhoeal Diseases**

### **Childhood Diarrhoea**

In order to control Diarrhoeal diseases Government of India has adopted the WHO guidelines on Diarrhoea management.

- India introduced the low osmolarity Oral Rehydration Solution (ORS), as recommended by WHO for the management of diarrhea.
- Zinc has been approved as an adjunct to ORS for the management of diarrhea. Addition of Zinc would result in reduction of the number and severity of episodes and the duration of diarrhoea.
- New guidelines on management of diarrhoea have been modified based on the latest available scientific evidence.

### **Acute Respiratory Infections**

- Acute Respiratory Infections forms 19 % of all under five mortalities in India (WHO 2007 report) and along with Diarrhoea are two major killers of under five children.
- India leads the world in the number of pneumonia cases with nearly 44, 00, 000 cases yearly. Early diagnosis and appropriate case management by rational use of antibiotics remains one of the most effective interventions to prevent deaths due to pneumonia. The ARI guidelines are being revised with the inclusion of the latest available global evidence.

### **Conclusion**

Much progress has been made over the past century in understanding the special attributes of children and the importance of their healthy development to the health of the population as a whole. Nevertheless, in the United States, the current failure to adequately consider, define, conceptualize, and measure the dynamic and multidimensional aspects of children's health has profound implications for the entire population, with potentially compromising effects on the nation's health. It is time—arguably overdue—to repurpose efforts at the federal, state, and local levels to focus on the nation's most valuable national resource—children. The reasons for and the steps involved in this establishment of children and their health as a national priority have been described in this report; in short, it is time to develop ways of looking at and assessing children that will demand that the nation nurture and develop their inherent

richness and potential across the multitude of geographic, racial, cultural, socioeconomic, and developmental spectrums. This effort requires a shared vision from local communities through the highest levels of national government and should be treated as an urgent national priority.

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