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A STUDY ON POVERTY AND HEALTH ISSUES OF CHILDREN IN INDIA

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ABSTRACT

India with a population of 1.21 billion population stand at the second position as the most populous country in the world after China. 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. Malnutrition among the children reduced significantly over the time, but still the number of malnourished children is very high in the country. Malnutrition and mortality among children are the two faces of a single coin. Mortality among infants and under-5 children is also a major concern. In India the number of under-5 mortality rate and infant mortality rates are 49 and 42, respectively. Thus there is a need, to be more focused on the child health issues. The main objective of this paper is to study the child health condition in terms of nutrition and survival rate. The study is based on the secondary data from various published reports of the government of India.

***Keywords*:** Child health; poverty Malnutrition; Vaccination; Immunization; Infant mortality rate;

1. INTRODUCTION

India, with 1.21 billion of population is the world's second most populous country after China. An estimated 26 millions of children are born every year. It is alarming that with an absolute increase in population of about 181 million in the population during the census 2001 and 2011, there is a reduction of 5.05 million in the child population aged 0-6 years during the same period. According to 2011 census, the total number of children aged 0-6 years is 158.79 million which is reduced by 3.1 percent compared to the child population in 2001 census. According to the data available the share of children of the age group 0-6 years to the total population is13.1 per cent in 2011.

Children of today are tomorrow's citizen, thus it is extremely important to ensure good health for children. Child health plays a vital role in the development of a country. The first six years of life constitutes the most crucial span in life. At this stage if life, the foundation are laid for mental, physical and social development. Children are the assets for tomorrow's productivity. The growth of any country is depending onthe availability of healthy human resource. As children represent the future generation, thus makes them healthy is of crucial importance. Healthy children ensure for healthy adult who in turn ensure a sound growth and development of the economy. New-born particularly infant and under-five children are more vulnerable to malnutrition, mortality and other diseases, which can be easily, prevented or treated.

India is listed in the countries where malnutrition and child mortality is alarmingly high. According to the data released by the Office of the Registrar General of India, indicate that although the mortality rate especially infant and under-five mortality rate is declining over the years, yet there are some states where these rates are very high. This shows that instead the progress in health care sector in India, young population especially in the age group 0-6 years continuously lost their lives due to inadequate nutrition and proper care. The mortality rates and nutritional status of the children reflects the threats in child health. Despite various measures and programmes to control the malnutrition and mortality among children the condition remains a cause of serious concern that need to be addressed urgently. The latest survey on children brought out by the ministry of Women and Child Development titled "Rapid Survey on Children-2013-2014" [1] shows the deprived condition of children in thecountry.

The present paper made an attempt to study the child health issues related to the nutrition and

survival. Nutrition is the basic element of healthy life. Adequate nutrition is very essential in the early stages of life. Nutrition helps in the growth and development of body. Indian has the largest food supplementation programme in the world. Although country experiences rapid economic growth and easy access to affordable food and food supplementation programmes for children, yet there are nearly half the under-five children are underweight. Another important concern of the paper is child mortality. Despite progress in health sector, India has very high child mortality rates.The child mortality rates reflect the threats in child health. Malnutrition is the major cause of mortality among children.

2. USES OF CHILD HEALTH STATUS MEASURES

Improving the health and well-being of children is a primary goal of healthcare systems. To assess the achievement of this goal, the development and application of conceptually sound and reliable measures of child health status are important for health services researchers and clinicians. In addition, child health indicators have been shown to be excellent proxies for measuring the health of communities, states, and nations, further underscoring the importance of improving measures of child health status. The purpose of this article is to summarize the concept of child health and the measurement of child health status, in order to help guide the evaluation of the effectiveness of medical, social, and policy programs. We first summarize the potential uses of child health status measures. We then present a conceptual framework for assessing the health of children, including determinants of health and different perspectives on child health. The third section summarizes a large body of literature about key threats to child health that result in mortality and morbidity, and risk factors that lead to poor health. While child health status measures are increasingly needed, the measurement of child health is challenging from both a conceptual and a methodological standpoint. These challenges are discussed in the fourth section. The fifth section summarizes different means to assess child health and discusses both generic and disease-specific methods. Finally, we present recommendations for future research.

3. POTENTIAL USES OF CHILD HEALTH AND FUNCTIONAL STATUS MEASURES

It is essential that anyone developing or interpreting child health status measures consider their specific objectives and uses. Different uses may require different population subgroups (e.g., age groups, children with chronic conditions); specific characteristics of the assessment tool (e.g., length, mode of application, frequency of application); and particular methods of presenting results (Deyo and Carter 1992). A measurement tool designed for screening for clinical problems in a busy practitioner's office may not be appropriate for evaluating the effect of medical financing on vulnerable children. There are four broad categories of uses of child health status measures.

Assessing the Impact of Disease or Injury on Health

Studies have assessed the general health of child populations, the impact of chronic diseases or injuries on children, the clustering of conditions in childhood and the relationship between childhood conditions and adult diseases. Public health leaders and child health researchers are particularly interested in using child health status measures for these purposes.

Identifying Vulnerable Patients and Populations

Children's health could be substantially improved if vulnerable children were readily identified (Greenfield and Nelson 1992). Child health status measures could be used in physicians' offices to identify children with unrecognized conditions, social or emotional problems, or poor functioning. At a population level, these measures can identify vulnerable (and costly) groups of children within health plans or geographic regions allowing for risk adjustment for case mix. It is especially important to monitor the health of these vulnerable populations (such as children who have chronic conditions or are poor) in light of the pressures to limit healthcare costs.

4. DETERMINANTS OF CHILD HEALTH

The conceptualization of health that guides most measurement is ordinarily derived from beliefs about what the factors are that affect or determine health. One approach to dealing with this inherent bias, that is, selecting an outcome based on what is thought to have caused it, is to employ a multidimensional, multilevel measure of health as a matter of routine, thus covering all the bases. Ware suggests (Bungay and Ware 1993) that biological normalcy or functioning is at the core of other concepts of health. Therefore, biologic measures are the purest measures of health, and other measures, such as physical functioning, are more or less proximal to that biologic core. Since the source of conventional biomedical information (e.g., symptoms, signs, and laboratory data) often is not available from the parent or the patient while information is available from them on functioning and well-being, measures of child health status that rely on one source of information will be incomplete. Thus, generic measures of health status are often supplemented with disease specific, clinical

information. A reductionist, biomedical view of health leaves out the less specific dimensions of health that many parents judge to be important (Evans and Stoddart 1994). In addition, current therapies are not uniformly able to modify the body's physiology directly. Children's behaviors and circumstances are intermediary between interventions to improve health and the desired biologic responses. Therefore, if one chooses to measure physical functioning as one aspect of health, that choice rests on the assumption that factors that affect physical functioning are important determinants of health. The circularity of this formulation highlights the duality of selected concepts and definitions of health, the determinants of those definitions, and the importance of distinguishing between them.

5. THE INFLUENCE OF THE FAMILY ON CHILD HEALTH

Children are uniquely dependent on their families to control their social and physical environments and therefore the characteristics and timing of their experiences. This dependence is so pronounced at young ages that much intervention-medical, educational and social-is directed not at the child but rather toward influencing the parents' attitudes and behaviors (Schor 1997b). Society expects parents to carry out a number of functions on behalf of their children. These include the material and instrumental functions of providing food, clothing, shelter, supervision, and access to healthcare and education, and adherence to treatment. They also include cognitive and affective functions such as providing social support, teaching coping skills, and socializing the child for a secure life in the world (Schor 1995b).

6. SOCIAL DETERMINANTS OF HEALTH

Healthcare is important to individuals; it can relieve suffering and in some cases extend life. But it does not explain differences in health status among populations. These differences fail to conform to the expected segregation of populations into haves and have-nots based on their access to healthcare. They demonstrate a social gradient instead, in which rates of morbidity and mortality decrease with each step up the social hierarchy. To account for this gradient, social scientists point out that social class is powerful, complex, and pervasive, and that it affects nearly every facet of life from lifestyle choices and nutrition to self-esteem, empowerment, entitlement, and feelings of control. As class influences the quality of the social environment, so too does the ability to control or cope with the stresses of the social environment affect health outcomes. In general, a poor ability to manage stresses, both physical and social-including the inability to muster social support for oneself-can adversely affect body physiology and immune responses, and can diminish health. Children, who are physically and emotionally resilient, and thus healthier, have the innate capacity or the learned ability to adapt to challenging or threatening circumstances (Garmezy 1991). Both macro-social (e.g., inequality in the distribution of wealth), and micro-social (e.g., family, circumstance) factors modify children's development and health status by altering biologic pathways and responses.

7. RISK FACTORS FOR ILL HEALTH AMONG CHILDREN AND ADOLESCENTS

A large body of literature is available on the social and demographic risk factors for poor health in childhood. Starfield and Budetti (1985) have pointed out that poor health in children is often associated with multiple risk factors, and that there is a vicious cycle of child health problems increasing the risk of either similar or other health problems (Starfield 199 lb). There are several key risk categories.

Age

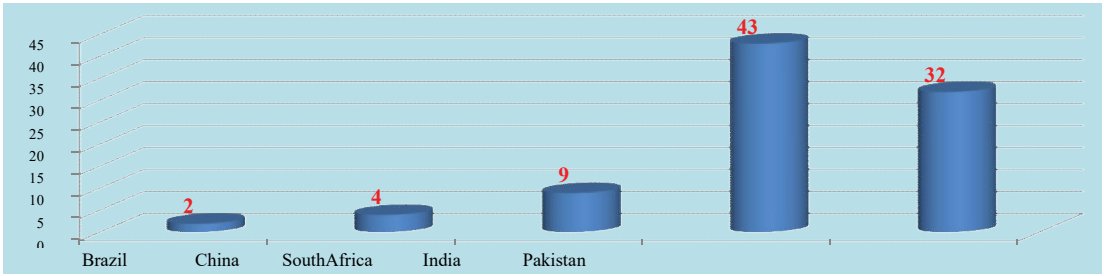
Since illnesses and their manifestations are age-specific, it will often be useful to perform separate assessments for infants and very young children, for school-age children, and for adolescents.

Culture and Race

Children from ethnic and racial minority populations have been noted to have poorer access to healthcare and poorer health outcomes in some areas

8. INTERNATIONAL COMPARISON OF CHILD HEALTH

Internationally child health has approved as the most important indicator for the development of the world. In every country the respective governments have made every possible effort to tackle down the prevalence of underweight children. Underweight percentage reflects the percentage of malnutrition. According to the World Health Organization (WHO) [2], 43 per centof Indian children are under weight. Figure 1 shows the underweight children in the developing countries. From the figure it is cleared that India is far behind in the health status of children comparatively to other neighboring countries. Among these countries India (43%) has the highest percentage of underweight children. The percentage of underweight children in China is 4 per cent, Brazil (2%), South Africa (9%).The percentage of underweight



Source: World Health Organization [2]**Figure 1:** Underweight children in the developing countries (%).

Children in Pakistan are also very low comparatively to India. Pakistan has only 32 percent of underweight children. The health condition of children is worst in India comparatively to other developing countries. Though Country experience higher economic growth but stands far behind in terms of underweight children in the world comparatively to other developing countries.

According to former Vice President of India, Hamid Ansari: "it seems the state you are born in determines how long you live". Table 2 presents the extent of malnutrition in India and major states. Child malnutrition measures are based on weight-for-age, height-for- age and weight-for-height. Each of these measures gives somewhat different percentage of nutritional level of children. The weight-for- height index measures body weight in relation to body height, case of acute malnutrition. Height-for-age index measures growth retardation (stunting) among children, case of chronic malnutrition. Weight-for-age index reflects both the case of chronic and acute malnutrition. Nutrition plays a central role in human well-being. Nutrition acts both as an essential element of and a vital input to other aspects of well-being and development. On the other side, under-nutrition represents a deprivation of basic aspects of well-being.

The implications that child malnutrition have for growth and development are multiple and cumulative. About 38.7 percent of children were stunted, 15.1 percent were wasted and 29.4 percent of children were underweight in India in 2013-14 (RSoC 2013-14). Among the states, Uttar Pradesh (50.4) has the highest percentage of stunted children followed by Bihar (49.4), Gujarat (41.6), Madhya Pradesh (41.5) and Assam (40.6). The states of Kerala and Tamil Nadu have the lowest percentage of stunted children. Kerala has only 19.4 percent and Tamil Nadu has 23.3 percent of stunted children. The percentage of wasted and underweight children for India is 15.1percent and 29.4 percent, respectively. The numbers of malnourished children are quite high in the country. In terms of wasted and underweight children, the highest percentage of wasted children is in the states of Tamil Nadu (19) followed by Gujarat (18.7), Bihar (13.1), Karnataka (17), Kerala (15.5), Madhya Pradesh (17.5), Maharashtra (18.6) and Odisha (18.3). The lowest number of under-weight children is in the states of Punjab (8.7) followed by Haryana (8.8) and Uttar Pradesh (10). On the contrary, underweight children are quite high in the country and in states. The states of Bihar and Madhya Pradesh have the highest number of underweight children among the major states in the country. Bihar (37.1) has the highest number of underweight children followed by Madhya Pradesh (36.1), Uttar Pradesh (34.3) and Gujarat (33.6). The lowest number of underweight children is in the states of Punjab (16) and Kerala (18.5)

9. INFANTS MORTALITY RATE:

Infants are the most sensitive and vulnerable section of the population. Infants show a higher rate of mortality among all other indicators of child survival. Neo-natal Mortality (NNM) and post-natal Mortality (PNM) are the components of IMR. NNM and PNM have a lower rate because most of these deaths often biological in nature especially. All these constituents of IMR are expressed at per1000 live births. Infant mortality is defines as the number of deaths in the first year of child's life per thousand live births in the given year. Though at the all India level IMR has declined continuously since after their form, yet it was as high as 40 per thousand live birth in 2013 [6]. Infant mortality rate since 1990 in India from 80 in1991 IMR has come down 66 in 2001. It was recorded at 58 in 2005 from 66 in 2001. It was seen that the number of infant deaths declined almost at a constant rate but after the launch of NRHM (2005) the percentage growth of declining infant

mortality is somewhat constant but more than before the introduction of NRHM. From 80 per 1000 live births in 1990 IMR has reduced to 40 per thousand live births in 2013(SRS).Infant mortality by residence shows that rural infants are less cared for than their urban counterpart. This is an effective cause of higher infant mortality rate in rural areas of the country. India experiences a huge difference in rural-urban rates of Infant deaths. In rural areas where healthcare services are rarely available and if, available they are not sufficient to catering such a big population. Infant mortality rates are quite high in rural areas as comparatively to urban areas of the country. In rural areas of the Indian major states IMR ranges from 13 to 58 percent and 9 to 39 percent in urban areas. Figures show that there is a gap of almost 50 percent among rural and urban areas. Among the better performing states in terms of rural IMR Kerala leads and is much ahead of their states. Kerala has IMR of 13per 1000 live births in rural areas and 9 percent per thousand live births in urban areas. Other states of Tamil Nadu (24), Maharashtra (30) and Punjab (30) also performed better in rural areas.

10. NEONATAL MORTALITY RATE

Almost 0.76 million new-borns die every year in India, the highest among all the countries in the world. Neo-natal mortality (NNM) is the deaths of a new-born before completing 29 days of his life. At the all India level the NNM is 29. The NNM of the country falls from 51 per 1000 live births in1991to29 per thousand live births in 2012.Therate of decline has been slow, as compared to IMR and UMR. The major causes of neonatal mortality are preterm birth complication, infection during birthing. About 2/3 of infant deaths and half of under-5 deaths are during the neonatal period of the new-born. Neonatal mortality rate has declined over the years. Figure 3 presented the NNM has declined from 51 in 1991 per 1000 live births to 29 per thousand live births in 2012.Over the period from 1991-2012 neo-natal mortality has reduced by 0.57 percent [8].Same is in the case of rural and urban areas but data available from the government sources indicate that the rate of reduction is higher in rural areas comparatively to urban areas (Table 5). Rural areas accounted for 0.60 percent reduction in NNM while urban areas account only 0.50 percent in 1991-2012. The rural NNM falls from 55 per thousand in1991 to 33 per 1000 live births in 2012, likewise urban NNM has fallen only to 16 percent per thousand live births in 2012 from 32 percent per 1000 live births in 1990's. The Average Annual Growth Rate (AAGR) of reduction of NNM was only mode stat around -1.961 percent in the period from 1991-2012. The rate of reduction in neonatal mortality is somewhat less than that of infant mortality during the same period (-1.989 percent annual reduction.

CONCLUSION

It is proved from the above discussion that the child health status of India is very poor and there are wide inter-state disparities in the country. Though child health shows improvement over the years but still India is far behind in terms of child health standard because of the increasing population of the country. Child health status is in very pity condition and overall health status of the country is not improving without the improvement in the health condition of children.

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