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A Study On Child Health And Nutritional Status In Tamil Nadu

Gowtham Aashirvad
Assistant Professor of Management Studies.
Bharath Institute of Science and Technology,
Selaiyur, Chennai, Tamil Nadu 600 073
Bharath Institute of Higher Education and Research

ABSTRACT

Poverty in Tamil Nadu multidimensional concept refers to lack of access to the basic needs of food, shelter, security, education, health services, safe drinking water, and sanitation for a decent, normal and effective existence. Conventional measures of poverty, however, are narrowly defined making reference to a poverty line based on income thresholds consistent with a certain level of consumption of food. Poverty is a major area of concern. Although the State has been successful in reducing poverty (measured by the head-count ratio) Rural poverty in Tamil Nadu as measured by Head Count Ratio (HCR) was about 15.8 percent in 2011-12. It fell from 37.5 percent in 2004-05- rural Tamil Nadu was lower than the corresponding ratio at all India, wherein the reduction in the poverty ratio was from 42.0 percent in 2004-05 to 25.7 percent in 2011-12 **. National Family Health Survey-III (2005-06)** throws light on the nutritional With regard to the nutritional status of the children, 29.8 percent of the children below five years in the State were having underweight. It was comparatively lower than all India as well as Andhra Pradesh and Karnataka. 30.9 percent of the children were having stunted growth in the State as compared to48 percent at all India. Among the southern States the ratio was the lowest in Kerala. 22.2 percent of children in Tamil Nadu were with wasted growth. The proportion was higher than all India as well as the three neighboring southern States. Among 6-59 months children 64.2 percent were anemic in Tamil Nadu and it stood second lowest among the southern States, the first being Kerala with 44.5 percent.. The study high lights Rural poverty and Child nutritional status in Tamil Nadu. Key words: Poverty , Tamil Nadu, Child, Nutritional Status

1. INTRODUCTION

Poverty and disease are tied closely together, with each factor aiding the other. Many diseases that primarily affect the poor serve to also deepen poverty and worsen conditions. Poverty also significantly reduces people's capabilities making it more difficult to avoid poverty related diseases. The majority of diseases and related mortality in poor countries is due to preventable, treatable diseases for which medicines and treatment regimes are readily available. Poverty is in many cases the single dominating factor in higher rates of prevalence of these diseases. Poor hygiene, ignorance in health-related education, non-availability of safe drinking water, inadequate nutrition and indoor pollution are factors exacerbated by poverty.

2. OBJECTIVES

- To Study about Rural Poverty status in Tamil Nadu
- To Study about the Socio-economic and health profile of Tami
- l Nadu
- To Study about the poverty head count ratio in Tamil Nadu

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- To Study about the child health and nutritional status of Tamil Nadu

3. METHODOLOGY

This Study is based only on secondary data

DEFINITION OF POVERTY

ACCORDING TO 'ADAM SMITH' POVERTY IS DEFINED AS

'Man is rich or poor according to the degree in which, he afford to enjoy the necessaries , the conveniences, and the amusements of life'. The world degree is not equal in all periods and in all places

ACCORDING TO 'WORLD BANK' POVERTY IS DEFINE AS

"Poverty is hunger. Poverty is lack of shelter. Poverty is being sick and not being able to see a doctor. Poverty is not having access to school and not knowing how to read. Poverty is not having a job, is fear for the future, living one day at a time. Poverty is losing a child to illness brought about by unclean water. To know what helps to reduce poverty, what works and what does not, what changes over time, poverty has to be defined, measured, and studied – and even experienced. As poverty has many dimensions, it has to be looked at through a variety of indicators – levels of income and consumption, social indicators, and indicators of vulnerability to risks and of socio/political access

TABLE 1
DEMO GRAPHIC SOCIO -ECONOMIC AND HEALTH PROFILE OF TAMIL NADU STATE AS COMPARE TO INDIAN FIGURE

Indicator	Tamil Nadu	India
Total population (in core) census 2011	7.21	121.01
Decadal growth (%)census 2011	15.60	17.64
Infant mortality rate (SRS 2010-12)	21	40
Maternal mortality rate (SRS 2010-12)	90	178
Total fertility rare (SRS 2012)	1.7	2.4
Crude birth rate(SRS 2013)	15.6	21.4
Crude death rate(SRS 2013)	7.3	7
Natural growth rate (SRS 2013)	8.3	14.4
Sex ratio(Census 2011)	995	940
CSR (2011)	946	914
Schedule caste population (census 2011) in core	1.18	16.6
Schedule tribe population census 2022 in core	0.065	8.4
Total literacy rate	80.33	74.04
Male literacy rate	86.81	82.14
Female literacy rate	73.86	65.46

Source: RHS Bulletin, March 2012 M/O Health & Family Welfare .GOI
The above table shows the socio-economic and health profile of Tamil Nadu as compared to India .

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TABLE 2
POVERTY HEADCOUNT RATIO IN RURAL (%) TENDULKAR METHODOLOGY

Category	2004-05	2011-12
Tamil Nadu		
Rural	37.5	15.8
Urban	29.5	11.3
All India		
Rural	42.0	25.7
Overall	37.2	21.9

Source : press note on poverty estimates 2009,10, union planning commission July 2012 Press note on poverty estimate 2011-12 planning commission July 2013

Rural Poverty: Rural poverty in Tamil Nadu as measured by Head Count Ratio (HCR) was about 15.8 percent in 2011-12. It fell from 37.5 percent in 2004-05. The ratio in rural was higher than the urban in the State 19.7 percent in 2004-05 as well as at 6.5 percent in 2011-12. High dependence on agriculture and wage employment was the major factors behind it. The State Government aims to bring down the poverty ratio below 10 percent by the end of the 12th Plan. The ratio in rural Tamil Nadu was lower than the corresponding ratio at all India, wherein the reduction in the poverty ratio was from 42.0 percent in 2004-05 to 25.7 percent in 2011-12. Between these two years, the decline in poverty ratio at rural in the State was 21.7 percentage points. It was higher than the reduction in urban poverty in the State (13.2%)

TABLE: 3 RURAL POVERTY RATIO IN MAJOR STATES HEAD COUNTS RATIO (TENDULKAR METHODOLY)%

STATE	2004-05	2011-12
Andra Pradesh	32.3	11.0
Bihar	55.7	34.1
Gujarat	39.1	21.5
Haryana	24.8	11.6
Karnataka	37.5	24.5
Kerala	20.5	9.1
Madhya Pradesh	53.6	35.7
Maharastra	47.9	24.2
Odisha	60.8	35.7
Punjab	22.1	7.7
Rajastan	35.8	16.1
Tamil Nadu	**37.5**	**15.8**
Uttar Pradesh	42.7	30.4
West Bengal	38.2	22.5
All India	42.0	25.7

Source : press note on poverty estimates 2010, union planning commission july 2012 Press note on poverty estimate 2011-12 planning commission july 2013

Among the major States, the rural poverty ratio was the lowest in Punjab (7.7%) and it was the highest in Madhya Pradesh and Odisha (35.7 % each) during 2011-12. Compared with the ratio at the all India (25.7%), among the States the rural poverty ratio was only higher in Bihar, Madhya Pradesh, Odisha and Uttar Pradesh. Tamil Nadu with the rural poverty ratio 15.8

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percent occupied the fifth place among the major States. Between these two years 2004-05 and 2011-12, the reduction in the ratio at the all India was 16.3 percentage points. Among the major States, the reduction was the highest in Odisha 25.1 percentage points. **Tamil Nadu with the reduction of 21.7 percentage points occupied the third position**, the top two being Odisha (25.1%) and Maharashtra (23.7%)

POVERTY RELATED CHILD HEALTH DISEASES

- **Contaminated water**

Each year many children and adults die as a result of a lack of access to clean drinking water and poor sanitation. Many combinable diseases and many of the poverty related diseases spread as a result of inadequate access to clean drinking water. According to UNICEF 3,000 children die every day, worldwide due to contaminated drinking water and poor sanitation. Though access to water has improved for some, it continues to be especially difficult for women and children. . There have been further efforts to improve water quality using new technology which allows water to be disinfected immediately upon collection and during the storage process. Clean water is necessary for cooking, cleaning, and laundry because many people come into contact with disease causing pathogens through their food, or while bathing or washing.

- **Inadequate sanitation**

Contaminated water and inadequate sanitation are related to diseases of poverty such as malaria, parasitic diseases, and Schistosomias is. These infections act as cofactors that increase the risk of HIV transmission. Standpipes and sanitation are provided in most developing areas, but the death rates are not significantly reduced. One of the reasons that water-related diseases are still occurring because water supplies can be contacted by contaminated surface water. To effectively decrease the morbidity and mortality of diseases, the population should get access to water from home instead from outside. Therefore, in addition to the installation of standpipes, water supplies and sanitation should be provided within houses.

- **Poor nutrition**

.Malnutrition, the immune system, and infectious diseases operate in a cyclical manner: infectious diseases have deleterious effects on nutritional status, and nutritional deficiencies can lower the strength of the immune system which affects the body's ability to resist infections Similarly,malnutritionofboth macronutrients (suchas protein andenergy)and micronutrients (su ch as iron, zinc, and vitamins) increase susceptibility to HIV infections by interfering with the immune system and through other biological mechanisms. ...

- **Improper health care**

Degrees of social status are closely linked to health inequalities Those with poor health tend to fall into poverty and the poor tend to have poor health. According to the World Health Organization, within countries those of lower socioeconomic strata have the worst health outcomes. Health also appears to have a strong social component linking it to education and access to information. n terms of health, poverty includes low income, low education, social exclusion and environmental decay. The poor within most countries are trapped in a cycle in which poverty breeds ill health and ill health breeds poverty.

- **Health disparities**

Socioeconomic status affects three areas of health; healthcare in general, environmental exposure, and health behavior. When examining child health within the United States, those

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with the worst health were found to be those from low incomes families and those with little education. As socioeconomic status increased so did overall health outcomes..

- **Child Health and Nutrition Status**

Child health is foundational to adult health and well-being. When children's health is nurtured and supported and there is an absence of physical and mental abuse, or other intentional childhood trauma; and there exists opportunities to gain habits that support good health during childhood, the stage is set for a healthy adulthood less likely to include chronic health problems such as overweight/obesity, poor oral health, diabetes and other chronic physical and mental health problem

Nutrition: Nutritional status is one of the indicators of the overall well being of population and human resources development. Malnutrition is the cumulative effect of factors like poverty, inadequate access to food, illiteracy, large size of families, poor environmental sanitation, lack of basic minimal health care, lack of personal hygiene, lack of easy access to adequate safe drinking water and lack of awareness. The manifestations of malnutrition could be seen in the prevalence of specific nutrient-deficiency disorders such as protein-energy malnutrition, anemia night blindness, goitre, susceptibility to a number of infectious diseases, low birth weight of children, high IMR and MMR, lack of resistance to illnesses among mothers and children, growth retardation (both physical and mental) and stunting among toddlers.

The above table states nutritional status of the children, 29.8 percent of the children below five years in the State were having underweight. It was comparatively lower than all India as well as Andhra Pradesh and Karnataka. 30.9 percent of the children were having stunted growth in the State as compared to 48 percent at all India. Among the southern States the ratio was the lowest in Kerala. 22.2 percent of children in Tamil Nadu were with wasted growth. The proportion was higher than all India as well as the three neighboring southern States. Among 6-59 months children 64.2 percent were anemic in Tamil Nadu and it stood second lowest among the southern States, the first being Kerala with 44.5 percent.

THE TWELFTH PLAN AIMS TO

- provide effective tertiary care and integrated comprehensive primary health care,
- prevent and control communicable and non communicable diseases,
- promote healthy lifestyles and
- Mainstream Indian System of Medicine.

TAMIL NADU'S TARGETS RELATING TO HEALTH AND NUTRITION IN THE TWELFTH PLAN ARE

- Reduce Infant Mortality Rate (IMR) to 13
- Reduce Maternal Mortality Ratio (MMR) to 44,
- Reduce Total Fertility Rate (TFR) to 1.6,
- Reduce child (0-3 years) malnutrition to 16 percent
- Reduce the proportion of women who are anemic to 33.2 percent,
- Increase the Life Expectancy at Birth to 70 years for male and 73 years for female, and clean drinking water for all.

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4. SUGGESTIONS

- Improving the nutritional status of poor children should be more focused
- Along with ration items like sugar , rice oil ,government should give fruits and vegetables for the lower income group
- Nutrition Education package should be developed for the parents and care takers of the children

5. CONCLUSION

Through the implementation of Integrated Child Development Services Schemes (ICDS) through 54.439 Child Centres (49,499 Anganwadi Centres+ 4940 mini Anganwadi Centres) in 434 child development blocks (385 rural, 47 urban and 2 tribal) and Puratchi Thalaivar MGR Nutritious Meal Programme the State has envisaged to improve the nutritional status of children, pregnant women, lactating mothers and adolescent girls and thereby to attain the goal of Malnutrition free Tamil Nadu. These two schemes together had benefited 88.65 lakh persons in the State in a year. Of them as high as 87.8 percent were children, 7.6 percent pregnant women, 4.5 percent adolescent girls and 0.1 percent old age pensioners.

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