Standard Scientific Research and Essays Vol 2(12): 652-656, December 2014 (ISSN: 2310-7502)
http://www.standresjournals.org/journals/SSRE

Research Article

Socio – Economic and demographic factors affecting child health in Rural Areas of Tehsil Jehanian District Khanewal

Atta UR Rehman

Margalla College of Pharmacy, Argalla Institute of Health sciences, Rawalpindi, Pakistan

Author E-mail: attaurrehman1987@yahoo.com

Accepted 07 January 2015

Abstract

The study was conducted with the objective to ascertain relationship of socio- economic and demographic factors and child health in rural areas of Tehsil Jahanian of District Khanewal One hundred and fifty women of child bearing age 19-50 years with two children of less than five years were taken at random for investigations. The study design was cross sectional design and study was based on comprehensive questionnaire. The study led to the conclusion that substantial number of women in study wasilliterate and poor. More than half the deliveries were administered by untrained village lady at home. Forty percent women had more than four children and common disease among children was diarrhea. The health facilities were not adequate and those available were not utilized, as women were hesitant to medical checkup and disease children were taken to the local medical practitioner. This is suggested that mother and child health may be assigned top priority for betterment of country and society.

Keywords: Socio- economic, demographic factors, child health, rural areas, health facilities

INTRODUCTION

Children are a future of a nation; healthy children of today would turn up into healthy nation of tomorrow. Child mortality is an index of socio-economic development and as such indication of health facilities available in a country. Children mortality is a global problem, but more so in developing countries including Pakistan. In southAsia two of three children were under weight and poverty was main cause of this problem, as mother waseither undernourished or malnourished. In Pakistan one out of (120) children had access to medical facilities and substantial Number of children dies before attaining the age of five years. The number of under nourished children in developing countries may be as high as five (5) percent.

The maternal mortality rate in Pakistan is 260 deaths/100,000 live. This is higher than observed in developed countries of Europe. Female mortality in child bearing years is higher than male mortality. The higher mortality in female is manifestation of socio- economic and demographic factors such as education of mother, age of mother at birth, birth interval, and number of children, household income, and occupation of father, standard of living and health facilities available.

Two third of Pakistan population live in rural areas, the women in rural areas are either not aware of balanced diet because of lack of education or subjected to take unbalanced diet because of poverty. Majority of women are anemic because of iron deficiency and iodine deficiency is also common in Southern areas of Punjab, Pakistan. According to medical specialist and nutritionist women require extra energy in form of extra food during pregnancy to make available food to child as well. The food may be balanced and it should include iron, protein, vitamins and iodine. Healthy women have healthy children.

The poor maternal nutrition results in low birth weight babies. Such children are susceptible to diarrhea, pneumonia,

whopping cough, respiratory infection and number of other diseases. The infection is main cause of death during first month. The substantial number of children dies during first six month. The children mortality rate is quite high as 14 % children die within first five years. The death rate is high in poor rural areas compared to rich urban areas. The facilities of child health are also scarce in rural areas compared to urban areas. Moreover, the rural women are also hesitant to medical checkup during pregnancy. The health worker posted at rural health centre is not adequately trained. As per custom the rural women prefer delivery at home by untrained village lady locally called dai.

The complication pertaining to children health indicates at time of birth and persists later on. The breast feeding is beneficial for child health, but is decreasing at alarming rate both in urban and rural areas. Reduced breast feeding, result in diarrhea, stunted growth and poor health conditions of children. The child health is a challenge to public / private health specialist, parents, community, and NGO s with save the children" slogan and all other concerned and it may be addressed in true prespective for good health of children.

Literature review

Irfan (1986) visualized the factors pertaining to child health and reported that illiteracy, malnutrition, unhygienic sanitary condition, environments, socio- economic conditions, unawareness of people about cause of disease among children were major causes of death among children. The inverse relationship between socio economic status and infant mortality indicate that various families differ in parental education as well as family resources.

Duch (1990) studied the mother and child health in Poland and described that the factors affecting health were; economic, housing, nutrition, occupation, smoking, health awareness and utilization of health services. He concluded that education was best indicator of social position and health status in Poland. Persons with poor socioeconomic conditions had poor health and vice versa. Pakistan demographic health survey (1990-91) earmarked the significance of social factors in respect of child health. The inferences were that child survival chances in Pakistan were closely associated to mother level of education. Behrman (1994) established relationship between socioeconomic conditions, environmental pollution, domestic hygienic conditions and child health. He observed that all these factors affected the child health to considerable extent. Hoa et al. (1997) observed a relationship between socioeconomic factors and child morbidity and mortality in Vietnams. The rural mothers, 1132 in number, with children under five years of age were taken for study. They visualized that death during infancy was more common than the children of five years or more age. Most of deaths occurred due to tetanus, acute respiratory problem and other diseases. Acute respiratory disease affects 56 % children and disease was more common in poor families compared to rich families.

Narayan and Sastry (1997) computed the differential of child survival in rural versus urban areas of Brazil. Child mortality rates were substantially lower in urban compared to rural areas of Brazil. The differences in mortality rate were attributed to variation in socio economic and demographic variables. In addition to differences in individual house hold level, the differences at community level were also responsible for variation in child mortality. The effect of community characteristics was moderated by house hold socio economic factors especially maternal education. Hadi (2001) studied the role of micro credit program in increasing the health knowledge among poor rural women in Bangladesh. The data comprised of 500 mothers aged 15-49 years with at least one child of less than five years. They observed that health knowledge among women. The multivariate analysis of data revealed that duration of credit program participation and time of exposure to media had significantly increased health knowledge among women provided the socioeconomic and demographic factors were constant. He concluded that micro credit was effective tool in promoting health knowledge among poor women in Bangladesh. Ashraf (2002) conducted a study pertaining to socio medical factors of child health. He observed that disease children were common in families of low income that lack mother education and were subjected to poor environmental conditions.

The rural areas of Pakistan had posed a challenge to public health workers, medical specialist, sociologist, planners, administrators, parents, civil society, NGOs and all other concerned in child care to formulate a program to overcome serious health problems of children as these health problems induce high child morbidity and mortality that is detrimental for nation development. Hence a study was undertaken to investigate the socio economic and demographic factors affecting child health in rural areas of Tehsil Jehanian of Khanewal district with the objectives.

OBJECTIVES

- To study the relationship of socio economic and demographic factors and child health in rural areas of Tehsil Jehanian.
- To assess the present status of child health and suggest measures to improve child health in rural areas of Tehsil Jehanian.

Hypothesis:

The hypothesis tested in the study were
H0: socio economic and demographic factors had no effect on child health.
H1: socio economic and demographic factors had effect on child health.

MATERIALS AND METHODS

The study conducted pertains to rural areas of Tehsil Jehanian of Khanewal district. The population of Tehsil is 270,000. Most of people live in rural areas. The study design was cross sectional design. The study duration was six months conducted from January to June 2014. One hundred and fifty 150 women of child bearing age 19-50 years with two children of less than five years were taken for study at random. The women may belong to any socio economic group. A comprehensive questionnaire comprised of name, husband name, age, number of children, interval of children, medical checkup, mode of delivery, income, education of women, relation with husband, diseases of children and health facilities available. The mother was coded to keep the confidentiality of data. The verbal consent of the respondents was taken before interview. The respondents were informed that aim of study was to formulate and suggest measures to improve health status of children. The respondents were told about confidentiality of data that will be utilized for academic purposes. The questionnaire though was in English language, yet for the sake of convenience of respondents, the interview was conducted in local Urdu language. The interview schedule was prepared and followed earnestly. The interview was conducted in friendly atmosphere so as to obtain requisite information in amicable way. The local lady health worker assisted in collection of data.

The data was collected in face to face interview and response was recorded instantaneously on the Performa. The data was tabulated, summarized and subjected to descriptive statistics special package for social scientists (SPSS) Version 16 was applied to analyze the data and inferences were drawn accordingly.

RESULTS AND DISCUSSION

The results of study captioned, socio- economic and demographic factors affecting child health in rural areas of Tehsil Jehanian district Khanewalare discussed in the following text. The data pertaining to age of women is presented in table 1-A. The data in the table revealed that mostly the child bearing women belong to age group of 27-34 years, followed by age group of 35-42 years and 19-26 years respectively. The lowest number of women only 6 percent was recorded in age group of 43-50 years. The substantial number of women is married at young age. The marriages at young age had implication for both mothers and children. The data in table 1-B indicate that more than 50 percent marriages are settled with relative, 40 % with first cousin and remaining with second cousin. Such marriages within relatives result in prevalence of inheritory diseases, such as tuberculosis is function of family history. The data of present study indicate that significant numbers of marriages were settled out of family. That revealed that traditional family ties of marriage, with in family were on the decrease and liberal environments for marriages out of family were on the increase. In recent past the marriages out of family were neither appreciated nor respected. The data in table 1-C depict that 1/3 of women participating in present study were illiterate. Almost 18 % women had primary, 5 years schooling, education, while 36 % had secondary school education, and only 12 % had college / higher education. An illiterate woman is not conversant to child health care system. Such women mostly adopt unscientific method for child health, that methods in many instances are fatal to child health. Education is viable component of social development of any society, as education had multidimensional positive effect on development process in almost all sectors including the child health sector.

These results are in conformity to Dutch (1990) who elucidated the factors affecting mother and child health in Poland and concluded that education was best indicator of social position and health status in Poland. He further inferred that persons with poor socio economic status had poor health.

The family income of women that participated in the study is presented in table 2-A. This is evident from the data that 44 % women had monthly income of less than ten thousands rupees. The income of almost 13% women was more than twenty thousand rupees. The monthly income of remaining 43.5% women was between ten to twenty thousand rupees. This demonstrate that majority of women were from low to medium income group. The women of poor families were undernourished and malnourished. Because of financial constraints these women fail to take balanced diet and were mostly anemic. The children of such women at birth were under weight and later on susceptible to diseases. The poverty and poor health of child are synonymous phenomenon and once this vicious cycle begins, it continues for considerable period of time. The data pertaining to medical checkup of women is presented in table 2-B. Almost 1/3 women never went to any health clinic for medical checkup, while 41% women opted for regular medical checkup. Some women, 15 %

availed health facilities sometimes while 12.5% women visited health clinic as per need. The result of study revealed that medical checkup of women is neglected aspect; the medical checkup of women ought to be regular feature to cultural complication, right at its inception. The data pertaining to health personnel involved in delivery are presented in table 2-C. the data indicate that 52% deliveries were administered by untrained village lady locally called Dai, at home. The remaining 48 % deliveries were conducted by Doctors and nurses at health clinic. The complication mostly occurs in children born at home, that causes high morbidity/ mortality among children. The results of present study are in conformity to those obtained by Behrman (1994).

The data pertaining to number of children in respect of women participating in study is present in table 3-A. the data revealed that almost 41% women had 2-3 children and remaining 59.5% women had four, five, six and more than six children. The family size is an important determinant of child health. This was observed that child health was poor on families that had more than four children and this was common in study area, as 40% women had more than four children. The population in Pakistan is a problem and may be addressed earnestly. The data of children suffered from various diseases is presented in table 2-B. in study area the most common disease among children was diarrhea, with 44% occurrence. The other common diseases sequentially were infection,gastro intestine, cholera and others. A number of babies were born under weight. In rural areas of Pakistan the patient babies are mostly taken to local practitioners for treatment and not to a child specialist. The situation needs to be reversed to ensure better health and reduce mortality in children. The data pertaining to satisfaction of respondents in respect of health facilities is presented in table 3-C. almost half of the respondents women were satisfied with health facilities available for their children , while remaining half of women were either not satisfied or partially satisfied. This observation needs consideration of health care providers, authorities and all others involved in formulation and implementation of health care strategies, specifically pertaining to mother and child health.

Table 1. Socio Economic and Demographic Characteristics of Respondents

A- Age

Years	Frequency	Percentage	Cumulative Percentage
19-26	33	22	22
27-34	65	43.33	65.33
35-42	43	28.67	94.00
43-50	9	6	100.00
Total	150	100	

B- Relationship with Husband

Relationship	Frequency	Percentage	Cumulative Percentage
First cousin	60	40	40
Second cousin	20	13.33	53.33
Out of family	70	46.67	100.00
Total	150	100	

C- Education

Year of schooling	Frequency	Percentage	Cumulative Percentage
0	50	33.33	33.33
1-5	28	18.67	52.0
6-10	54	36.0	18.0
7-11	18	12	100
Total	150	100	

Table 2. Family income, Medical checkup and health personnel involved in delivery of Respondents

A- Family Income

Monthly income rupees (000)	Frequency	Percentage	Cumulative Percentage
< 10	66	44	44
10-15	39	26	70
15-20	25	16.67	86.67
>20	20	13.33	100
Total	150	100	

B- Medical checkup

Type	Frequency	Percentage	Cumulative Percentage
Never	47	31.33	31.33
Sometime	23	15.33	46.66
Regular	62	41.34	88.0
When needed	18	12	100
Total	150	100	

C- Health personnel involved in Delivery

Personnel involved	Frequency	Percentage	Cumulative Percentage
Doctor	46	30.67	30.67
Nurse	26	17.33	48.0
Untrained village lady Dai	78	52	100
Total	150	100	

Table 3. Number of children, children suffered various diseases and satisfaction of respondents in respect of Health facility

A- Number of children

Number	Frequency	Percentage	Cumulative Percentage
2	29	19.33	19.33
3	33	22	41.33
4	28	18.67	60.0
5	26	17.33	77.33
6	22	14.67	92.0
>6	12	8	100
Total	150	100	

B- Children suffered various diseases

Disease	Frequency	Percentage	Cumulative Percentage
Diarrhea	66	44	44
Infection	27	18	62
Cholera	19	12.67	74.67
Gastro intestine	23	15.33	90.0
Other	15	10	100
Total	150	100	

C- Satisfaction of Respondents in respect of Health facility

Satisfaction	Frequency	Percentage	Cumulative Percentage
To great extent	77	51.33	51.33
To some extent	41	27.33	78.66
Unsatisfied	32	21.34	100
Total	150	100	

CONCLUSION

This may be concluded from the investigations conducted that substantial number of women in study area were illiterate and poor. More than half the deliveries were administered by untrained village lady at home. Forty percent women had more than four children and common disease among children was diarrhea. Almost one third women never went to health clinic for medical check. The health facilities were not adequate and almost half of women were not satisfied or partially satisfied, as far as health facilities in the area are concerned the integrated effect of all these socio economic and demographic factor induce high mortality among women and children.

This is suggested that health sector in Pakistan may be assigned top priority by individual community, policy makers, administrators and all concerned so that health of people specifically of women and children is improved to significant extent, that will be precursor for development of nation and country at large and fulfill the aim of healthy children and healthy Pakistan.

References

Ashraf F(2002).Socio medical study of child diseases. Ghareeb Abad near Chaklala Scheme III, study at university of arid agriculture Rawalpindi, Pakistan.

Behrman JR(1994). Children health and achievement schedule living standard measurement. Pp. 104.

Duch M(1990). Health inequalities in Poland, Philosophy and sociology.Polish Academy Science, United States. Pp. 56.

Government of Pakistan (1991). Pakistan demographic health survey, 1990-1991.

Hadi A(2001). Promotion of health knowledge through microcredit programmes; experience of BRAC in Bangladesh. Health Promotion Intl. 16(3): 219-227

Hoa DP, Hojer B, Persson LA(1997). Are there social inequalities in child morbidity and mortality in rural Vietnam? J. Trop. Paediatries. 43(4): 226-231.

Irfan M(1986). Mortality trends and pattern in Pakistan. Asian population studies serial no. 75 United Nations.

Narayan and Sastry(1997). Child survival in rural versus urban areas of Brazil. Study report SPSS-16 Computer special package for social scientist version 16