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BREAKING BARRIER TO ACHIEVE GLOBAL HEALTH PERSPECTIVE WITH REFERENCE TO CHILD HEALTH CARE

Social Science

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ABSTRACT

A number of financial and non-financial barriers may delay or prevent poor households from seeking health care for their sick infants and children. Such obstacles are common in low- and middle-income countries and include distance, financial barriers, socio-cultural norms, language barriers, and lack of knowledge and awareness. These difficulties affect all age groups and can lead to low demand for and use of services, particularly by the poor. Inequalities in child survival are not the result of a lack of technological solutions. Rather, poor children continue to suffer because cost-effective child health interventions fail to reach them. It has been estimated that taking existing child health interventions to scale can result in a two-thirds reduction in child mortality.

Infants, children, and adolescents face unique barriers to accessing care for several reasons. First, in many societies, the young fulfil a submissive social role relative to their elders. This power imbalance results in the subjugation of young people to their parents, relatives, and elder siblings. When at the bottom of the social structure in a family with limited resources, this can mean that priority will be given to others when medical care is needed. Similarly, children lack full adult rights which can lead to further reliance on others for appropriate care In addition, many health problems that occur in children require specialized health care procedures by specially trained health care personnel. For example, in the United States, paediatricians must specialize and train differently from general practitioners, and paediatric sub-specialists exist within all other specialties (surgery, ENT, ophthalmology, etc.). Access to these highly-trained physicians and healthcare workers may be limited or nonexistent in low- and middle-income countries, creating unique barriers for children in need.

KEYWORDS

socio-cultural norms, child health interventions, cost-effective, paediatric, healthcare workers, unique barrier, Health Care for Children

Global health scenario of children (Surviving the first five years of life) Although approximately 10.5 million children under 5 years of age still die every year in the world, progress has been made since 1970, when the figure was more than 17 million. Across the world, children are at higher risk of dying if they are poor. The most impressive declines in child mortality have occurred in developed countries, and in low-mortality developing countries whose economic situation has improved. In contrast, the declines observed in countries with higher mortality have occurred at a slower rate, stagnated or even reversed. Owing to the overall gains in developing regions, the mortality gap between the developing and developed world has narrowed since 1970. However, because the better-off countries in developing regions are improving at a fast rate, and many of the poorer populations are losing ground, the disparity between the different developing regions is widening.

In China, India, Nepal and Pakistan, mortality in girls exceeds that of boys. This disparity is particularly noticeable in China, where girls have a 33% higher risk of dying than their male counterparts. These inequities are thought to arise from the preferential treatment of boys in family health care-seeking behaviour and in nutrition. There is considerable variability in child mortality across different income groups within countries.

HEALTH SCENARIO OF CHILDREN IN INDIA:

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 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 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.

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.

HEALTH SCENARIO OF CHILDREN OF GUJARAT:

The state has earned the dubious distinction of being the only rich state to figure in the top 10 states that have the highest percentage of stunting in children. The figure was revealed in the National Family Health Survey (NFHS) India report that was published recently. Gujarat ranks eighth in the country as far as percentage of stunting in children is concerned. The state has 39% of the children in the age group of 0-59 months who are stunted

In fact, Gujarat has a higher percentage of stunted children than the Indian average of 39%. The prevalence of underweight children decreased from 45 percent to 39 percent. Although the prevalence of wasting increased from 19 percent to 26 percent. The survey concluded that despite the gains in stunting and underweight, child malnutrition remained a major problem in Gujarat. Smita Bajpai, Project Director with CHETNA, a non-profit that has worked in the field of nutrition and health for more than three decades said Gujarat's focus on child nutrition in the mission mode has been a recent one. Food and nutrition is one aspect of the problem. Access to clean and safe drinking water, timely access to quality health services including vaccination, sanitation are other important but often less emphasised factors when one talks about malnutrition and children's health.

Determinants of stunting The survey found that children's nutritional status does not vary by sex of the child, although differences are more pronounced by several other characteristics. Under nutrition is higher in rural than urban areas. It also found that under nutrition in children is inversely proportional to mother's schooling. The more educated the mother, the less likely her child is to be undernourished. Under nutrition is also directly related to mother's better nutritional status.

BARRIER IN CHILD HEALTH ACHIEVEMENTS:

Children from poor families or neighbourhoods are more likely than other children to have serious health problems.

1) LOW BIRTH WEIGHT

Poor nutrition and smoking during pregnancy are common causes of low birth weight. These babies have higher rates of rehospitalisation, growth problems, child sickness, learning problems, and developmental delays. Babies born with a low birth weight are at increased risk of dying in the first year of life.

2) CHRONIC DISEASES SUCH AS ASTHMA

Poor housing quality and exposure to second-hand smoke are contributing factors.

3) OBESITY AND HIGH BLOOD PRESSURE

Poor neighbourhoods may not have safe playgrounds, parks, or

organized sports for children. All of these things are barriers to a healthy body weight.

4) INCREASED ACCIDENTAL INJURIES
Living in a home which is not safe and a dangerous neighbourhood puts children at a greater risk of violence.

5) LACK OF SCHOOL READINESS
Poor children are less likely to participate in organized activities and often do not have enough supplies or books in the home. Low parental education and single parent families are complex factors that may interfere with school readiness.

6) TOXIC STRESS
Being poor is stressful. It causes damage to the brain and to a child's overall physical and mental health into adulthood.

7) ADVERSE CHILDHOOD EXPERIENCES (ACES)
Violence in the home, having a parent in jail, and emotional neglect increase the amount of toxic stress children face.

Children in poverty are more likely to have these experiences than those living above the poverty line.

Social factors such as patriarchy and its influence on girl child health due to son preference and lack of nutritional food for girls and ignorance of proper treatment . Also due to poor economical condition women are tend to spend more time in working, whether in house or out-house, affects the health of young children.

ROLE OF VARIOUS STAKEHOLDERS:

PHC:
The Primary Health Care has a definitive role in the delivery of child health strategies and interventions in India, since it is the only system capable of reaching to the millions of children in rural parts of the country. India with a wide network of PHC system, can utilize it for ensuring child survival, as outlined in this article. India's diverse child health problems, coupled with differential needs of population and health system capabilities requires a multi-pronged approach, based on the principles of PHC. The sustained political will, better community participation, specially the role of PRIs in health planning, inter-sectoral coordination including those of private practitioners in the rural area and the non government organization, besides various ministries and departments working in the field of child health, strengthened district level health planning, and the use of data for action, are some of the areas for strengthening the PHC system.

CHC:
Community health centres are a major health care provider for children. They care for one of every six children of low-income families and serve 1.3 million children under age 6. Community health centres provide many valuable programs and services that promote the healthy growth and development of a large number of young children. Maintaining and expanding the ability of health centres to seek out and identify at-risk children, screen and assess their needs, and provide appropriate child development services are important to improving the health and welfare of young children and their families. t the majority of community health centres provide at least one type of health promotion and parent education program, fewer than half provide at least one program with home visits or parent groups. The combination of increased federal funding for health centres and efforts by NACHC to double the number of patients health centres serve could improve the quality of preventive services that enhance the development of young children.

Improving the quality of care in community health centres is already a priority of HRSA's Bureau of Primary Health Care (BPHC), the agency that oversees Federally Qualified Health Centres. In fact, initiatives to develop curricula and training modules to assist centres in their delivery of developmental services for young children are currently under way. The work of BPHC, in collaboration with the National Initiative for Children's Health Care Quality (NICHQ) and The Commonwealth Fund, could provide health centres with formal guidance and technical assistance to help centres improve their delivery of these services. Programs to improve the training of providers and other health centre staff in offering such services are also desirable. Health centres should take advantage of the increased attention to improving health care quality and seek out any available technical assistance tools or expertise to focus on early childhood development.

ROLE OF ASHA WORKER:
The ASHAs will receive performance-based incentives for promoting universal immunization, referral and escort services for Reproductive & Child Health (RCH) and other healthcare programmes, and construction of household toilets. ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services. ASHA will provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health & family welfare services.

She will counsel women on birth preparedness, importance of safe delivery, breast-feeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infections (RTIs/STIs) and care of the young child. The ASHA workers have been entrusted with the task of administering TT injections to all the pregnant women who are present in the villages

Postnatal care (PNC) is utmost importance duty of the ASHA worker, where ASHA worker ensure the care of mother and child after the delivery, which includes postpartum examination, which is means early diagnosis and treatment of complication usually done by the doctors and to some extent by the ASHA worker, medical care, follow-up, health education, family planning services, child spacing, nutrition, and psychological and social support to the mother. Providing PNC care is one of the critical interventions of ASHA workers. Through such interventions, ASHA workers are trying to prevent the death of new-born babies. Before the ASHA scheme was introduced, PNC had not received adequate attention in India. The earlier NFHS-III reports had brought out a very dismal position regarding the visits by the community health workers during the first month of the child. It is the duty of the ASHA worker to take care of the child after the birth for the post-natal check-ups to know the health status of the mother and the child. If the ASHA worker finds any health problems in the child, she has to intimate the same to the ANM worker, or the doctor

The ASHA workers is required to play an important and proactive role in the polio eradication campaign in the village; she has to inform the community members about the importance of immunisation and the consequences of not taking it within the prescribed time period. The ASHA worker visits the households and campaigns about the pulse polio immunisation vaccine and the day of the immunization, usually, the immunization camps are held weekly twice on the Wednesday and Saturday in the SC and PHC. On this day the ASHA workers visits the house to household and inform the community members about the immunization. Nowadays, the community members are also recognising the contribution or efforts made by the ASHA worker in this direction. The village community members are following the advice given by the ASHA worker and taking the immunization vaccine like DPT, BCG, OPV and TT injections for children.

ROLE OF PUBLIC HEALTH SYSTEM:
A Public health system comprises of all public, voluntary and private organizations that contribute to the delivery of necessary public health services within an authority. The objective of the public health system is to maintain and strengthen the health and well-being of people.

RESPONSIBILITIES OF A PUBLIC HEALTH OFFICER:
To Coordinate or combine the resources of health care institutions, social service organizations, public safety personnel, or other agencies to enhance the community health. Design or use monitoring tools, like as screening, lab records, and vital information, to recognize health risks. To Develop tools to address behavioural causes of diseases. Direct or control prevention programs in specialized areas such as aerospace, work-related, infectious disease, and environmental medicine.

Assess the effectiveness of recommended risk reduction actions or other interventions. Recognize groups at threat for specific preventable diseases. Carry out epidemiological research of acute and chronic

diseases. Prepare precautionary health reports which include problem explanations, analyses, alternate solutions, and suggestions. Deliver details about potential health risks and possible treatments to the media, the public, other health care experts, or local, state, and national health regulators.

Manage or coordinate the work of doctors, nurses, statisticians, or other staff members. Educate or train medical team regarding precautionary medicine problems. Design, implement, or assess health service delivery systems to enhance the health of specific communities.

HEALTH PROBLEM OF CHILDREN IN RURAL INDIA:

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.

Children in rural areas face particular risks to their health and well-being. Some risks relate to their demographic characteristics; rural children are more likely to live in poverty than those in urban areas. Some relate to their physical environment; the risks of injury and of death from injury are greater among rural children. Still others are related to the family and community contexts in which children grow up; rural youth are more likely to smoke or use chewing tobacco than their urban counterparts. Differences in the health status of urban and rural children are not necessarily attributable to children's geographic location but rather are related to the demographic characteristics of the children and families who live in rural areas.

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. 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 have been raised as human rights issue. Unhygienic atmosphere, which produces disease causing agents and once they get proper conditions, they affect the host and produces diseases and these again pollute the atmosphere. So this becomes a Triad, one is the unhygienic atmosphere, the other is production of disease causing agents and third one is the host.

These people are malnourished, malnourishment means improper nutrition. Malnutrition is basic problem in rural India. The Causes being: - 1. Inability to afford due to less income. 2. Illiteracy: having no knowledge about balanced diet and their nutritional value. 3. Faulty food habits. 4. Eating stale& un-hygienically kept food. 5. Male members of family eating first. Woman eat leftover food resulting in malnourishment. 6. Children get unbalanced diet resulting into protein deficiency causing various diseases. 7. Sharing common utensils while eating. 8. Dining in an unhygienic place that too infested with flies, rodents and arthropods.

Some of the customs are really bad in India. Some are:

1. Child marriage and early marriage.
2. Will to have male children only.
3. Giving less opportunity to female child.
4. Having more number of children which gives them physical strength, social status and feeling of personal elevation. They believe that those having more number of children have good say and respect in rural society.
5. Sacrificing first born for more no. of children

98% of people in rural area use open field for defecation. This practice is because rural population is not aware of the idea of hygienic latrines. They feel that are meant for urban areas where there are no or lesser fields. They are ignorant that faeces is infectious and pollute water and soil thereby promoting fly breeding and spread of infections.

Mostly from wells, people go to bathe and wash their clothes and utensils. Animals are also washed here and given water to drink. These practices lead to pollution of well water which becomes source of infection. Tanks, ponds and rivers are also used by them in the same way. Some rivers are considered holy. People take dip in that, drink the same water and bottle this water as it is considered sacred. Epidemics of cholera and gastro-intestinal diseases have occurred due to these habits.

ROLE OF SOCIAL WORKER IN HEALTH MANAGEMENT:

COUNSELLING:

Social worker advise and counsel patients and their families. it explain the nature of an illness to them and advise them how to effectively deal with symptoms and treatment. Social worker serves as a grief counsellor to help them deal with the trauma of experiencing a chronic or an acute illness.

FINANCIAL ASSISTANCE:

As the expense for an acute and chronic illness is very high, families may not be able to financially provide for the care of an ill family member; financial support for the care of dependents must also be dealt with. Social worker refer and assist the patients in obtaining financial assistance, food assistance and health care coverage through city, state and federal programmes

LEGAL ASSISTANCE:

Social worker must take legal action to protect the patient. Aspect in which social worker may take action are following situations, parents are unable to take care for their sick child, accident cases, abuse cases and encounter cases. In these cases a conservator, a power of attorney or a public guardian may need to be appointed.

CARE PLANNING:

Families and patients often don't know where to turn to get medical care., social worker assists patients and families in finding and arranging services such as in home care , nursing home care and counselling . The social worker work with the medical team and discuss about care planning.

POLICY MAKING

From a social welfare policy standpoint, social workers do everything from helping craft federal, state, and local policies to overseeing the administration of social programs to working directly with the recipients of assistance, ensuring that they meet qualifications and that they receive the help they need and are entitled to. Without social workers' in-depth knowledge of the needs of individuals and communities, our social welfare system might cease functioning. It takes the efforts of social workers in policy-making and program administration, plus social workers in the field, to adequately provide the assistance our nation promises to those who are in need

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