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Factors Affecting Child Health: A Study of Rural Faisalabad

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ABSTRACT

In this paper an attempt is made to explore the effect of socio-cultural and democratic factors on the health of children. The study was conducted in rural tehsil Faisalabad, Pakistan. One hundred and twenty women of childbearing age 20 to 45 years with at least two living children under the age of 5 years were selected through systematic random sampling technique. A well structured questionnaire consisting of open-ended and close-ended questions was used for gathering information from the selected respondents. 84.2% of the respondents reported that their children are suffering from one or more of these diseases e.g. diarrhea, worm infestation, goiter, cholera and gastroenteritis and they also expressed about their poor health. Majority of the women were mal-nourished and anemic. The problems of antenatal and post-natal care were common in the selected area due to the unavailability and inaccessibility of the health care services along with traditional and dogmatic attitude towards the utilization of available limited health facilities. Delivery of baby under the supervision of untrained birth attendants at home was also responsible factor for high incidence of morbidity among children.

Key Words: Socio-cultural; Demographic; Health; Disease; Children

INTRODUCTION

Children are the future builders of every nation. Future of the nation depends upon the health of the children. Healthy children would turn up into healthy nation of tomorrow. Children's health can be best examined in the light of the level of infant and child mortality prevailing in the society and also it is the most important index of socio-economic development. The high level of infant mortality is an indication of discouraging socio-economic development and along with the poor government commitment for improving health status of its nation. Like many developing countries Pakistan too, is facing with problems of high infant mortality.

All the developing countries including Pakistan are making utmost effort to decline the mortality rate among the mothers and children right from the pre-natal stage to toddler stage. The main factors responsible for the increased death rate among the women are the high level of still-birth and physically or mentally handicapped births of the children, lack of health facilities, lacking in utilizing of these facilities, financial incapacities to afford health facilities, repeated pregnancies, and the poor level of nutrition and polluted environment. At the same time, the traditions of our country have hinder our people to be benefited from the modern health care system because in rural areas still the people don't want to use the facilities available at hospital or medical centers. Due to these reasons, the maternal-child health is severely affected and the result is in the form of many diseases and disabilities (United Nations, 1999).

According to Mahmood (1993) mortality and health status cannot be treated in isolation but it is related very intricately with some of the social economic conditions. Economic aspects of illness may often over shadow the other aspects of social component. Poor income may result in lower standard of living which stands for inadequate food, shelter and recreational that adversely affects health of family members. Above all, the cost of the medical care may put a family under a heavy burden of debt, which may further deteriorate their living conditions. Thus it may prove a vicious circle specifically for people with poor resources. The significance of phenomena of infant mortality is hardly irrevocable for its socio-economic and demographic implications. As infant mortality, in general is considered to explanative of overall socio-economic development. The factors that play an important role in the child health are education of mother, household income, occupation of father, standard of living etc., and other demographic factors such as age of mother at birth, birth interval and health care factors like medical facilities and immunization.

According to Rashida (2000) the 70% population of Pakistan lives in rural areas, so majority of the children are born and brought up there. The overall condition of our villages gives their life as start with multiple disadvantages. They suffer from illness caused by malnutrition and unsanitary conditions. Iodine deficiency is quite prevalent in the Northern areas of Pakistan. Poor maternal nutrition status result in the high incidence (about 25%) of low birth weight babies, iron-deficiency anemia and other complications of pregnancy in the women of child bearing age persist. Protein-energy-malnutrition is prevalent in the vulnerable population (Government of Pakistan, 1997).

Therefore, rural areas of Pakistan have become challenge to planners, sociologists, administrators and even to politicians to chalk out some programs to overcome the serious health problems particularly the high level of child

morbidity and mortality. The study is designed to explore the social-cultural and demographic dimensions of child health and child morbidity.

METHODOLOGY

The study was conducted in rural tehsil Faisalabad, Pakistan. Two union councils No. 176 and 195 were selected at random. From each union council two villages Chak Munianwala and Chak Gatwala from union council 176 and Chak Lathianwala and Chak Sharianwala from union council 195 were selected randomly. One hundred and twenty women of childbearing age (20 to 45 years) who had at least two living children under the age of 5 years, were selected through systematic random sampling technique. An equal representation was given to each village by selecting 30 respondents. A well designed interview schedule consisting of structured and unstructured questions was prepared to explore the research objective. Pre-testing was also carried out to examine the workability and sensitivity of measuring instrument. The collected data were analyzed by using descriptive statistics.

RESULTS AND DISCUSSION

Table I indicates the percentage distribution of respondents according to their current age, age at marriage, years of schooling and the family income. 43.3% of the respondents belonged to the age group of 26-30 years while in the age groups of 18-25 and 31-35, the percentage of the respondent was almost the same. It reflects from the study findings that marriage pattern was very young in the study area. Almost all the women got married before reaching the age of 25 years. It is very surprising to note that still in the modern age, a substantial percentage of the respondents (41.7) had their marriages in teenage. The marriages at young ages have health implications for both mothers and children indicated in many studies. The education which is an important indicator of social development of any society has multidimensional positive effects on the development process in almost in all sectors. Unfortunately, Pakistan is far behind in achieving the desired level of education. The situations are more discouraging in the rural Pakistan. The poor level of education has been identified as the most important factor of the country's emerging problems in every sector including the health sector. The situation of literacy level in the selected area was not encouraging. Still 40% of the respondents were illiterate and who were literate had just few years of schoolings. Although they were categorized as literate but with this level of education they could not properly understand the health related complicated issues. Another aspect of socio-economic development is income. The income has been viewed as an important correlate of mother-child health status. Most (54.2%) of the families earn upto Rs. 4000 per month (Table I). Families with a reasonable level of income were only 15.8%. Poverty, the most important national social problem, is still rising despite of the government tremendous effort. The rising level of poverty in the rural areas which is more than one third of the rural population of Pakistan are also complicating the health problems resulting in increasing incidence of women and children mortality and morbidity.

In order to study the impact of blood and non-blood relation on the child health, the information regarding the wife marriage within the family or out of the family are collected. Most of the respondents (49.2%) had no relationship with their husbands before marriage (Table II). While, 41.7% of the respondents were married with first cousin. It reflects from the study findings that liberal environment regarding marriages is developing and traditional family ties are changing because in recent past marriages out the family were not respected and appreciated.

The family size is an important determinant of child health. Studies indicate that the incidence of child mortality and morbidity is high among the families which have large family size. Child health was poor in families having more than four children. Data given in Table III indicate that 4-5 children were most common in the selected area. There were 34.2% of the respondents who had 4-5 children. There were a substantial percentage of the respondents i.e. 15% who had 6 to10 children. The mean number of children was 3.91 with standard deviation 1.90 children. It reflects from the study findings that still majority of women were in their peak age childbearing and it is more likely they will bear more children and this will be very risky behavior from the view of their own health and children health as well.

A vast majority of the respondents (64.2%) reported that they are suffering from one or more one diseases (Table IV). It emerges from the findings that a high incidence of morbidity was prevalent in rural area. The diseases in which they were suffered were also asked. They told a number of diseases as indicated in Table V.

Diarrhea was most common, 47.2% respondents were suffering from this disease. Gastroenteritis was also very common and its percentage was 32.5. Respondents were suffered from cholera and its percentage was 20.8%. Goiter and worm infestation was very rare. It is important to mention here is that a vast majority of the women mentioned that they are anemic and the main reason they viewed of their anemic condition was poverty.

Only 39.2% of the respondents went to health clinic for regular medical check up before delivery while 25% never went to health unit for medical check up before delivery (Table VI). 23.3% of the respondents reported that they had gone to clinic sometimes for medical check. It is surprising to note that 12.5% of the selected women reported that they went for medical check up when it was need, however three or four times medical check up before delivery is minimum requirement because growth monitor of the baby is vitally important.

Table I. Socio-economic and demographic characteristics of the respondents

Current Age	Frequency	Percentage
18-25	31	25.8
26-30	52	43.3
31-35	29	24.2
36+	8	6.7
Total	120	100.0
Age at marriage		
15-19	50	41.7
20-23	48	40.0
24-25	19	15.8
26-30	3	2.5
Total	120	100.0
Years of schooling		
Illiterate	48	40.0
1-5	26	21.7
6-10	35	29.2
11+	11	9.2
Total	120	100.0
Family income (monthly)		
Upto 4000	65	54.2
4001-9000	36	30.0
More 9000	19	15.8
Total	120	100.0

Table II. Distribution of the respondents according to their relation with the husband before marriage

Relation	Frequency	Percentage
First Cousin	50	41.7
Second Cousin	11	9.2
Out of Family	59	49.2
Total	120	100.0

Table III. Distribution of the respondents according to their number of children

Children	Frequency	Percentage
2 children	29	24.2
3	32	26.7
4-5	41	34.2
6-10	18	15.0
Total		
Mean =3.91	Standard deviation= 1.90	

Table IV. Distribution of the respondents whether their children suffered from any disease

Family suffer from poor quality of water	Frequency	Percentage
Yes	77	64.2
No	43	35.8
Total	120	100.0

In developing societies like Pakistan, people still seek health care from the traditional health care practitioners. This is a significant factor of poor mother-child health status and high incidence of children mortality and morbidity. Majority of the selected women (47.5%) delivered their baby under the supervision of traditional birth attendants at home (Table VII). The majority of traditional birth attendants do not know the procedure required for safe delivery. They use un-sterilized instruments during the delivering process and resulting effect is high incidence of infectious diseases. This is why the high level of early

Table V. Distribution of the respondents according to the diseases in which their children suffered from

Diseases in which family suffer	Frequency	Percentage
Diarrhea	33	42.7
Vormintation	1	1.3
Goiter	2	2.6
Cholera	16	20.8
Gastroenteritis	25	32.5
Total	77	100.0

Table VI. How often the respondents had medical check-up before delivery?

How often	Frequency	Percentage
Never	30	25.0
Sometimes	28	23.3
Regularly	47	39.2
When need arise	15	12.5
Total	120	100.0

Table VII. Percentage distribution of the respondents according to the health personnel who helped in delivery?

Who helped in delivery	Frequency	Percentage
Doctor	42	35.0
Nurse	21	17.5
TBA/Dai	57	47.5
Total	120	100.0

Table VIII. Distribution of the respondents according to the diseases of respondents' last baby faced

Diseases	Yes		No		Total	
	Freq.	%age	Freq.	%age	Freq.	%age
Gastroentestivis	48	40.0	72	60.0	120	100.0
Junevile diabetes	2	1.7	118	98.3	120	100.0
Meuingtis	0	0	120	100.0	120	100.0
Rickets	1	.8	119	99.2	120	100.0
Typhoid	17	14.2	103	85.8	120	100.0
Malaria	13	10.8	107	89.2	120	100.0
Vominefestation	9	7.5	111	92.5	120	100.0
Glumerulonephritis	3	2.5	117	97.5	120	100.0
Ditry insufficiencles	21	17.5	99	82.5	120	100.0
Tonsillitis	29	24.2	91	75.8	120	100.0
Anemia	21	17.5	99	82.5	120	100.0

Table IX. Distribution of the respondents according to their satisfaction level about the health of last child

Satisfaction with the health of last child	Frequency	Percentage
To great extent	45	37.5
To some extent	30	25.0
Unsatisfied	45	37.5
Total	120	100.0

neonatal mortality has been reported for Pakistan (Pakistan Demographic Survey, 2002). Doctors only supervised 35% births. The dream of high health status for all Pakistani can only be achieved when people have access to modern health care system.

Table VIII gives the percentage distribution of different diseases in which the last baby suffered from. According to 40% of respondents' gastroenteritis is disease in which their last child was suffered. Tonsillitis in children was problem of 24.2% respondents. 17.5% told that their children had dirty insufficiencies. 17.5% of respondents reported anemia in which the children are suffering.14.2% of respondent's complaint was against typhoid. Malaria was a problem of 10.8% respondents. 7.5% told that their last baby generally faced worm infestation. Glumerulonephritis, Junevile diabetes, rickets and Meningitis were also the diseases reported by some respondents in which their last baby suffered.

The mothers' satisfaction level about the health of their last baby was explored in the study. The health status of their last baby was not encouraging as viewed by the mothers. 47.5% respondents were unsatisfied with the health of their last child while 25% of the respondents expressed that they are satisfied to some extent with the health of their last baby. This finding is very important for health care providers and the authorities who are involved in framing health care strategies. Health sector is very important and priorities should be given to this sector to improve the health status of people of Pakistan. Development in any sector can not be possible without a healthy nation. Carelessness and negligence in the health care sector should not be tolerated. High level of commitment at individual, family, community and national level is the only option for achieving enhanced health status in Pakistan.

SUGGESTIONS

1. There is a desperate need to make women aware about the importance of pre-delivery and post-delivery medical check up along with the delivery of baby under the supervision of trained medical health care practitioners.
2. Traditional birth attendants should be trained through short stipend courses, so that high level of infectious diseases can be reduced.
3. Awareness about the adverse effects of closely spaced many pregnancies must be given to all women of childbearing age. Information about the safe motherhood and on important aspects of reproductive health should be the part of curriculum at higher secondary level.
4. Awareness about the adverse implications of marriages at younger ages should be given to people.
5. Availability and accessibility of health care services should be ensured in rural and urban areas of Pakistan. This is only possible with the high level of government commitment.
6. All the communication channels should be used to make people aware about the issues related to mother-child health.
7. Education particularly female education in Pakistan is one of the neglected sectors as compared to many other countries while it needs immediate attention for quick development and better future of its people. To increase the education level in the country, particularly in rural areas, emphases will have to be placed on both the improvement in quality and expansion of the education system at the primary and secondary level.

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