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A Study on Health Status of Infants in Tamil Nadu

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ABSTRACT

Principle I of the Rio Declaration on Environment and Development states that "Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature". The goals of sustainable development cannot be achieved when there is a high prevalence of debilitating illnesses, and population health cannot be maintained without ecologically sustainable development. Two billion people or more in developing countries, mostly women and girls, are exposed to indoor air pollution due to lack of access to modern energy carriers, resulting in over 1.5 million excess deaths each year. Today, more than 1 billion people are without access to improved water supply, and 2.4 billion lack access to improved sanitation. Diarrheal diseases, largely preventable through access to safe drinking water, sanitation and food hygiene, claim 1.5 million lives a year among children less than five years and account for several billion diarrheal episodes each year. . The term 'inclusive' growth is often used interchangeably with a suite of other terms, including 'broad-based growth', 'shared growth', and 'pro-poor growth'. Hence the researcher made an attempt to examine the health status of infants in Tamil Nadu. The secondary data was used to find out the health status of infants in Tamil Nadu. The indicators are infant mortality rate, neo natal mortality rate, postnatal mortality rate and peri natal mortality rate were taken and analyzed to find the exact stage of infants are at risk. The result reveals that the infants under perinatal mortality needs to addressed for mitigation of infant mortality rate in Tamil Nadu.

KEY WORDS: Health Status, Infant Mortality Rate, Inclusive Growth

1. INTRODUCTION

Investment in human capital is universally recognized as a key pillar of achieving inclusive growth. Investments in health and education have been statistically linked to better economic development outcomes and to how inclusive growth is in practice. (Ravallion (2004) "Pro-poor growth- a primer, World Bank". Washington DC).The term 'inclusive' growth is often used interchangeably with a suite of other terms, including 'broad-based growth', 'shared growth', and 'pro-poor growth'. Inclusive growth means economic growth that creates employment opportunities and helps in reducing poverty. It means having access to essential services in health and education by

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the poor. It includes providing equality of opportunity, empowering people through education and skill development. It also encompasses a growth process that is environment friendly growth, aims for good governance and a helps in creation of a gender sensitive society The agenda for inclusive growth was envisaged in the Eleventh Plan document which intended to achieve not only faster

growth but a growth process which ensures broad-based improvement in the quality of life of the people, especially the poor, SCs/STs, other backward castes (OBCs), minorities and women and which seeks to provide equality of opportunity to all. Bringing these excluded sections of the society into the mainstream of the society so that they are able to reap the benefits of faster economic growth is the kind of 'inclusion' which is being envisioned in the concept of inclusive growth (Arthapedia).

Some of the key ingredients for inclusive growth that are generally agreed upon include: a) Investment in human capital, b) Job creation, c) Structural transformation and broad-based growth, d)Progressive tax policies, e)Social protection, f) Non-discrimination, social inclusion and participation, and g) Strong institutions.Hence, the researcher interested to find the exact stage of infants to be protected for mitigating the infant mortality rate who are future human capital and the mother and father and all their social capital put their time and money for issue the baby. The cost of issuing a baby is not only emotional and interpersonal but financially and time also invested by each and every individual. So every stage of infant is crucial for enhance the survival rate of an infant.

STATEMENT OF THE PROBLEM

Today saplings will be tomorrow trees; like that today's infants will be tomorrow human capital. In addition, Infant mortality rate was an indicator used to monitor progress towards the Fourth Goal of the Millennium Development Goals of the United Nations forthe year 2015. It is now a target in the Sustainable Development Goals for Goal Number three. ("Ensure healthy lives and promote well-being for all at all ages").[1]Health is a component of Human Capital Formation. The healthy human capital is formed from its root level; it means that from their childhood. Hence the childhood and infant stage is an important in human capital formation. The infant mortality rate mitigation is one of the goals for all kinds of economy. Millennium Development Goals (MDG) was created to improve the health and well-being of people worldwide. Its fourth goal is to decrease the number of mortalities within the infant and childhood population by two thirds, a decrease from 95 to 31 deaths per 1000.Hence, the researcher made an attempt to reveal the trends of infant mortality rate, its components, predicting the future rate of the same and estimated which components of IMR influencing the risk of infants in Tamil Nadu.

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Infant mortality rate (IMR) is the number of deaths of children less than one year of age per 1000 live births. The rate for a given region is the number of children dying under one year of age, divided by the number of live births during the year, multiplied by 1,000.

- **PERINATAL MORTALITY** is late fatal death (22 weeks gestation to birth), or death of a newborn up to one week postpartum.(ENMR)
- **NEONATAL MORTALITY** is newborn death occurring within 28 days postpartum. Neonatal death is often attributed to inadequate access to basic medical care, during pregnancy and after delivery. This accounts for 40–60% of infant mortality in developing countries.(LNMR)

- **POST NEONATAL MORTALITY** is the death of children aged 29 days to one year. The major contributors to post neonatal death are malnutrition, infectious disease, and problems with the home environment.(PNMR)

EARLIER STUDIES

According to Patil, et.al., (2002), India is the second most populous country of the world and has changing socio-political demographic and morbidity patterns that have been drawing global attention in recent years. Despite several growths orientated policies adopted by the government, the widening economic, regional and gender disparities are posing challenges for the health sector. About 75% of health infrastructure, medical man power and other health resources are concentrated in urban areas where 27% of the population lives. Contagious, infectious and waterborne diseases such as diarrhea, amoebiasis, typhoid, infectious hepatitis, worm infestations, measles, malaria, tuberculosis, whooping cough, respiratory infections, pneumonia and reproductive tract infections dominate the morbidity pattern, especially in rural areas. However, non-communicable diseases such as cancer, blindness, mental illness, hypertension, diabetes, HIV/AIDS, accidents and injuries are also on the rise. The health status of Indians, is still a cause for grave concern, especially that of the rural population. This is reflected in the life expectancy (63 years), infant mortality rate (80/1000 live births), maternal mortality rate (438/100 000 live births); however, over a period of time some progress has been made. To improve the prevailing situation, the problem of rural health is to be addressed both at macro (national and state) and micro (district and regional) levels. This is to be done in a holistic way, with a genuine effort to bring the poorest of the population to the center of the fiscal policies. A paradigm shift from the current 'biomedical model' to a 'socio-cultural model', which should bridge the gaps and improve quality of rural life, is the current need. A revised National Health Policy addressing the prevailing inequalities, and working towards promoting a long-term perspective plan, mainly for rural health, is imperative. Mohindra, et.al., (2006) commented that even in a relatively egalitarian state in India, there are caste and socio economic inequalities in women's health. Anjaneyulu, (2012) stated that India is one of the few countries that have recorded substantial decline in maternal mortality. India is still

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far from achieving the target set in the millennium development goals. Despite several growth-orientated policies adopted by the government, the widening economic, regional, and gender disparities are posing challenges for the health sector. About 75% of health infrastructure, medical manpower, and other health resources are concentrated in urban areas where 27% of the populations live. To reduce this double burden of diseases, public health has to focus on health promotion, and disease prevention and control, while taking into consideration the social determinant of health. The focus of public health is to bring about change at the policy level not only for preventing disease but also for the health promotion through organized action at societal level. ThokalaSivaiah and Sitarama, A., (2013) found in a micro level study that, dental problems (29.2%), skin disorders (22.9%), history of passing worms in stool (18%), ENT problems (17%), B-complex deficiency (4.5%), Vitamin A deficiency (2.2%), and the prevalence of Anemia 47.7% in the study area . Yerpude, et.al., (2013) identified that health and nutritional status among the adolescents was low in India. A periodical and regular health check-up with concerted efforts towards nutrition of adolescents along with focused health education will improve the health and nutritional status of these schools going adolescents in their future. Malay Das, (2015) investigated the inter-district disparity in RCH care utilization status in India; suggest that economically backward districts in India were lagged behind in health care utilization. The degree of inequality in this dimension was found to be large among economically well-off districts. Madhur Borah et.al (2015)studied on health status of infants in rural areas of Kamrup, Assam; Female infants were found to be more malnourished. A statistically significant association was found between gender and nutritional status of infants. Improving sanitation, access to clean drinking water, immunization against infectious diseases, and other public health measures can help reduce high rates of infant mortality and enhance the human capital for future. Hence, this kind of research study will help the policy makers to know the exact components of IMR and can make a policy and preventive programme for the same.

2. OBJECTIVES

The general objectives are to find the Health status of infant in Tamil Nadu, in particularly the following are the objectives as follows: a)To trace the trend in IMR and its Components in Tamil Nadu and b)To find the influencing components of IMR in Tamil Nadu and India

TOOLS OF DATA ANALYSIS

The researcher used the simple statistical tool for analysis. The tools are growth models, such as Linear, Logarithmic, Quadratic, Compound, and Exponential models were used through using, SPSS (Statistical Package of Social Science). This analysis focused to find the status of Infant

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Mortality in Tamil Nadu. The model used for studying the influencing components of Tamil Nadu is regression and tried to find the unknown parameter by OLS estimation procedure.

FINDINGS

The table-1 and table -2 helps to know the real situation of Tamil Nadu. From the data over the period it's visible that the Infant Mortality Rate is constantly reduced from 113 in 1971 to 21 in 2013. There are 92 children's saved over the period. On an average, Tamil Nadu is able to control 2% of children from the death. The R^2 value for all regression was manipulated for Early Neonatal Mortality Rate, Late Neonatal Mortality Rate, and Post Neonatal Mortality Rate of Tamil Nadu. The goodness fitness varies from 82 percent to nearly 99 percent for all growth models. Peri-Natal Morality Rate is constantly reduced from 55.2% in 1971 to 18.0% in 2013. There are 37 children's saved over the period. On an average Tamil Nadu able to control 3% of children's from the death. Post-Natal Morality Rate in Tamil Nadu visible that the Rate is constantly reduced from 60.2% in 1971 to 6.0% in 2013.From the table -3, the value of R^2 depicts the explanatory variables explained chosen variable percent (100%). The F value is also is significant and proves that the model specification is good. The coefficient of each component tells about the risk of a child. On an average, there is a positive relationship between the all components and IMR. A child death in every component in Tamil Nadu affects the total IMR in the same proposition as a child in Tamil Nadu. Post-natal mortality Rate is influencing the total Infant Mortality in Tamil Nadu.

3. CONCLUSION

A first priority for the further reduction in infant mortality in Tamil Nadu is to improve equality among regions, particularly rural areas. Further reductions in infant mortality will largely depend

on decreasing deaths due to perinatal causes. Improvements in the coverage and particularly in the quality of antenatal and delivery care are urgently needed. A child death in every component in Tamil Nadu affects the total IMR in the same proposition. Post-natal mortality Rate is influencing the total Infant Mortality in Tamil Nadu and India.

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