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ANALYSIS OF NUTRITION AND HEALTH STATUS WITH SPECIAL REFERANCE TO RURAL POPULATION OF CHAMRAJNAGAR DISTRICT, KARNATAKA, INDIA

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ABSTRACT

The study is designated to assess the Nutrition and Health status of rural population in Chamrajnagar District. Endemic poverty and rapid growth of population, inadequate nutrition and insanitary living conditions is the root of all types of health & health related problems. When a large number of people live in poor households located in crowed and in insanitary surrounding, communicable diseases spread easily and high mortality and morbidity result, particularly in the case of children. In this context the present attempt focus on this aspect, with reference to rural sector making a study of a typical Chamrajnagar district. A new quantitative measure of development has been used to asses, the level of health index and household consumption expenditures. The setting for such an analysis has been provided as assessing the economic status of the people through demographic characteristics, socio- economic characteristics, housing, and types of diseases household consumption expenditures.

KEYWORDS :*Nutrition, Health, Rural.*

INTRODUCTION

Nutrition has been a major health issue in India for centuries. It is a key to developing and maintaining a state of health that is optimal. Good nutrition requires a satisfactory diet, which is capable of supporting the individual consuming it. Nutritional status can be evaluated using internationally accepted BMI guidelines. World Health Organization (1995) has recommended that anthropometry could be used to assess the nutritional and health status of adults. The Malnutrition and gender discrimination, both of which Malnutrition remain widespread in south Asia, are inextricably linked. Across the region, there is a consistent pattern - where rates of malnutrition are high, gender discrimination is prevalent. However, the interaction is not simply one whereby girls are more likely than boys to be malnourished. In fact, in most instances, particularly among young children, a consistent

gender disparity in nutritional status is hard to find. Indeed, the relationship between malnutrition and gender is more complex and is linked to women's empowerment and social status and their implications for nutrition outcomes in women, children and adolescents [Osmani and Sen 2003]. The status of the population measures the quality of life of the people. It is well known that good health contributes to increasing productivity of the economically and well being of children and the aged population. Health confers benefits to the individual in whom it is embodied and to the society at large.

2. OBJECTIVES

- To assess the nutritional status among the rural household.
- To examine the determinant factors of health status in the study area.
- To suggest policy measure to improve nutrition and health status of respondents in the study area.

3. REVIEW OF LITERATURE

Ashokan (2006), in his study deal with issues related to health care system and its utilization specifically focusing on the implications for maternal and child health in rural areas. He points out to the wide gaps and inefficiency in health care services in rural areas and suggests for inter-sect oral co-ordination within the rural health network by integrating activities and the primary health centres, non-government organizations and the integrated child development services to meet the health needs of women and children.

Onis, et, al (2000), says that the nutritional status can be assessed by using clinical signs of malnutrition, bio medical indicators and anthropometry measures. Malnutrition refers to a number of diseases each with a specific cause related to one or more nutrients, protein, iodine, vitamin A or iron. The former leading to malnutrition in the form of wasting, stunting and under weight, and the later resulting in overweight and obesity. Nutrition is closely to several aspects of human life. Integration of educational, medical, nutritional and public health, including family planning services is there fore imperative for better health and ultimately human development.

Mira Seth (2001) shows that women are seen to be suffering from iron deficiencies. Many state level surveys on anaemia have indicted its prevalence among men and women. The National Nutritional Board conducted a survey in four cities of India, which showed higher anaemia rates in women than in men in al age groups in both rural and urban areas.

Gokhale M.K. et.al (2002), Showed in their study that Illiteracy of females had a more detrimental impact on rural than on urban areas. In the event of high female illiteracy, male literacy was beneficial for improving the use of services for reducing infant mortality rate. The micro-level study supported all major findings obtained for the national-level aggregate data, Programmes, like providing free education to girls, will yield long-term health benefits.

Bechuram Mondal [2005], study was to examine how different sources of income and occupational groups of tribal households operate in maintaining their nutritional status measured in terms of dietary intake (mainly calorie and protein intake) and BMI of the households. The results showed that owner cultivators were relatively better off in terms of their income and nutritional status as compared to those of tenant cultivators as well as landless labourers. Further, income and nutritional status of landless labourers was relatively better than that of the tenant cultivators. The present study however, revealed that the availability of work among the landless labourer households was the main criterion of ensuring stable income and in maintaining the better nutritional status of the households. Landless agricultural labourers in this region were able to do so particularly for the development of land-augmenting technology, which created employment throughout the year in the countryside of

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West Bengal.

4. METHODOLOGY

The present study attempts to examine nutrition and health status with special reference to rural households of Chamrajnagar District. This study based on primary data. The identified variables are correlated with respect to respondent socio economic status and thereby it gives analytical orientation to the study. The sampling method has been adopted to collect the primary data from the respondents. It is a known fact that in this study nutrition and health status. In total 120 respondents are selected as sample. This study covers only. The primary data are collected from the respondents by adopting a well structured from the district records. Then the researcher has contacted the respondents in their village. The relevant data are obtained from by establishing a good report with them. The respondents extended full cooperation towards the successful data collection. The collected data are classified and tabulated with the help of computer programming. Several combinations the interrelation among the determinants and suitable models were arrived at using percentage, Multi linear regression model test analysis.

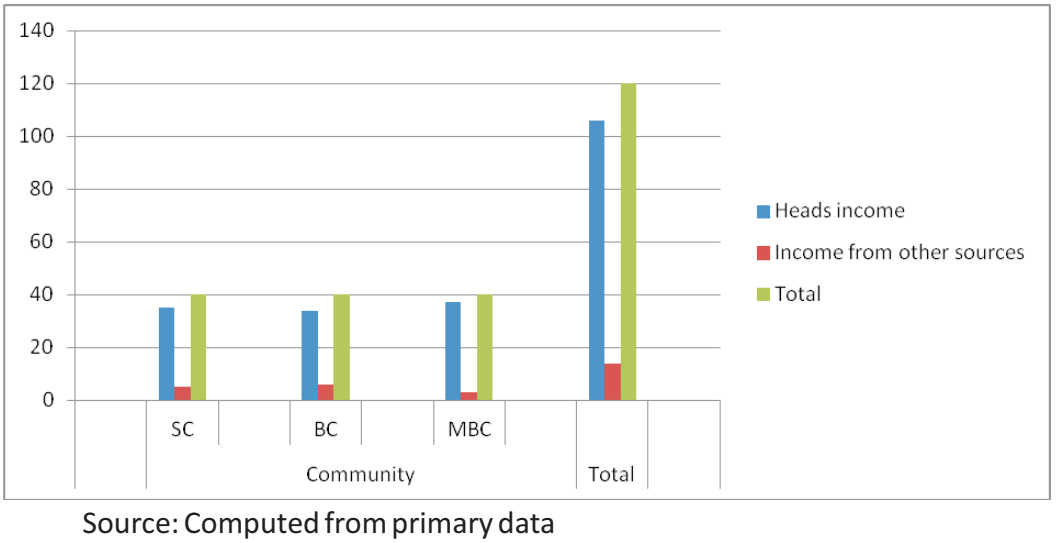
5. DELIMITATION

This study was to covered only Nutrition and Health status of rural households in Chamrajnagar District has been selected purposively due to time and money constrains, the researcher could not able to covered other villages in the district and other district of Tamil Nadu. Thus, this attempt limits its scope to find out the development of the village in respect of health achievement through demographic and socio economic status. It is hoped that all those planks of information put to gather would explain the Nutrition and Health status of village under study.

6. RESULT AND DISCUSSION

This chapter deals with the analysis of nutrition and health status of rural households in Chamrajnagar district. This chapter is divided in to two sections. The second one nutrition states of rural households and then last division health states of rural households.

Table – 6.1
Annual income – Wise Distribution of the Respondents



Source: Computed from primary data

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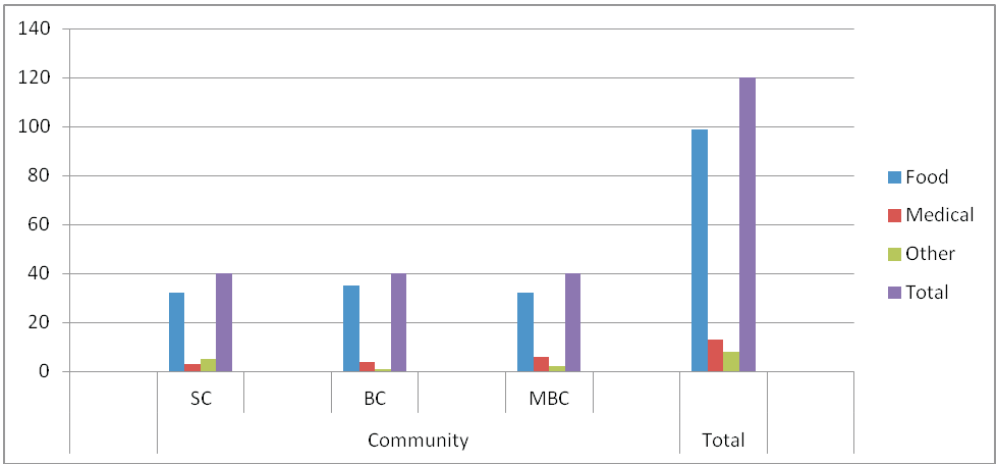
Table 6.1 give the annual income wise distribution of the respondents. The scheduled caste and 35 respondents higher in head income and 5 respondents lower in other income 34 respondents higher in head income and 6 respondents lower in other income. The backward classes 37 respondents higher in head income and 3 respondents lower in other income. The most backward classes 37 respondents higher in head income and 3 respondents lower in other income.

Table 6.2
Monthly expenditure – Wise Distribution of the Respondents



Source: Computed from primary data

Table – 6.2 illustrates that monthly expenditure wise distribution of the respondent. In food expenditure of maximum for 99 respondent out of 120 respondent and medical expenditure of 13 respondent out of 120 respondent. Other expenditure is 8 respondents out of 120 respondents. Each community maximum expenditure in food next preference medical and minimum level of the other expenditure.

Table 6.4
Household consumption expenditure on Nutritional items

Particulars	Amount in World (Rs)
Pulses	100-150
Cereals	500-1000
Vegetables	300-500
Oil	100-150
Milk/Milk Products	300-450
Fish	200-300

Source: Computed from primary data

Table 6.4 shows the monthly expenditure of rural households of study area on nutritional items in term of food, this data reflects that the households spend nearly just at the average limit of nutritional values. From this behaviour the chances becoming of becoming victim of malnutrition can be expected at high level.

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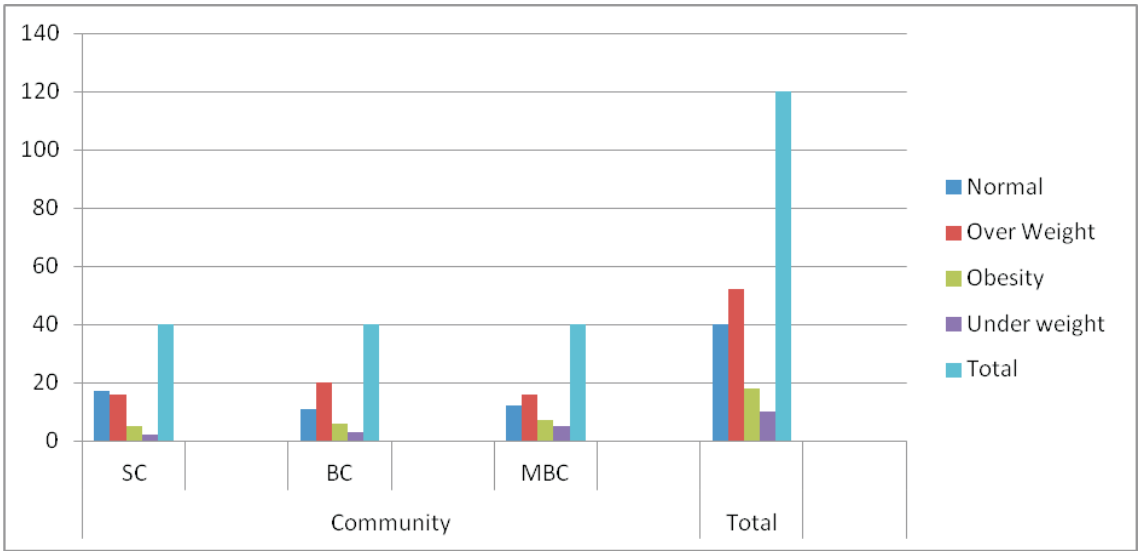
Table – 6.5
Nutrition status of rural households (calculated in BMI)



Source: Computed from primary data

Table – 6.5, Nutrition statuses of rural households calculated in BMI of the respondents. The majority of the 52 respondent nutrition status in overweight and few the nutrition statuses are under weight. The scheduled caste maximum normal nutrition status in 17 respondents and minimum nutrition status is under weight 2 respondents. The backward classes maximum nutrition status in 20 respondents and minimum nutrition status is under weight in 3 respondents. The most backward classes maximum nutrition status is over weight in 16 respondents and minimum nutrition status is under weight in 5 respondents.

Table – 6.6
Health Statistics of the rural Households

Health and vital statistics	Community			Total
	SC	BC	MBC	
Birth statistics				
Male	5	3	3	11
Female	9	7	5	21
Total	14	10	8	32
Health care				
Hospital delivery	14	10	8	32
Number of alive	14	10	8	32
Number of vaccinated	14	10	8	32
Total	42	30	24	96

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Death statistics				
Male	1	-	-	1
Female	3	2	-	5
Total	4	2	-	6
Reason for death				
Fever	5	2	1	8
Heart attack	1	-	-	1
Tuberculosis	2	-	-	2
Total	8	2	1	11

Source: Computed from primary data

Table 6.6 illustrates that every category has on an average a birth per two years. Expecting the scheduled caste the number of children alive is larger. Then the backward classes the number of children alive than the most backward classes. The details regarding the reasons for death are given in table. The details regarding the reasons for death are given in table. The delivery of children accuse in hospital. In rural household vaccination is performed for all the children in the categories.

Table – 6.7
Health care particular of sample household

S NO	Practice of health care	Persons treated in hospital			
		PHC	Govt	private	Total
1.	Care of pregnancy	9	3	5	17
2.	Delivery	-	16	1	17
3.	Care of new born	-	5	1	6
4.	care of common disease	23	20	11	54
5.	General health care	15	17	3	35
Total		47	61	21	129

Source: computed from primary data

Table 6.7 shows that the health care particulars treated in hospital distribution of the respondents. The most of the 61 respondents visits to primary health centre 47 respondents visit to primary health care centre and 21 respondent visits private hospital .Care of pregnancy maximum is 9 respondents in primary health care. For delivery maximum 16 respondents in government hospital. Care of new born, care of common disease and general health care maximum in government hospital.

7. FINDING, SUGGESTION, AND CONCLUSION

In this chapter the findings of the study are summarized and presented for this present work "Nutrition and Health status with special reference to rural population of Chamrajnagar district". From study if is found that most of the respondents nearly 70 percent are literate. From total population nearly half of the population 54.4 percent are engaged in directly or indirectly in farming workers. From all sources the majority of the respondents earned income above Rs. 5000 was found in the study area. Majority of respondents 92 belong to backward caste. Among the farm worker the majority of 40 percent are average in their health status followed by 37 percent in poor health status and only 23 percents are normal health condition. Among the scheduled caste population the majority of them belong to fair in health status followed by 37 percent in poor and only 23 percents are in normal health status. The rural people were severally affected by various diseases. In our study take in to account major disease such as Fever, Cold, colic, head ache, diabetes, asthma, cough, malaria, heart disease, jaundice, dysentery, blood pressure. Scheduled caste people maximum use the facilities of PHC and backward caste population prefers to visit private.

On the basis of results are derived from the analysis of primary data the following conclusion and suggestions may be given.

• Awareness about health and health seeking behaviour is the key to the solution of the all health and nutritional related problem, followed by the easy approachable and economical health service in the locality.

• Improvement in economic status thus contributes in the increase in the nutritional level of the households.

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