AN ECONOMIC ANALYSIS OF AWARENESS ON RURAL HEALTH PROGRAMMES IN MUDI KANDANALLUR VILLAGE, SRIMUSHNAM TALUK, CUDDALORE DISTRICT, TAMILNADU

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ABSTRACT

World Health Organization (WHO) defines adolescence as the period of life between 10 and 19 year of age. The adolescent experiences not only physical growth and change but also emotional, psychological, social, and mental change and growth. Physiological changes lead to sexual maturity and usually occur during the first several years of this period. Adolescence represents a window of opportunity to prepare for a healthy adult life. The world's adolescent population-1200 million persons, 10-19 year of age or about 19% of the total population-faces series of serious challenges not affecting their growth and development but also their livelihood as adults. Yet adolescents remain a largely neglected, difficult-to-measure, and hard-to-reach population, in which the needs of adolescent girls in particular are often ignored. Adolescence is period of increased risk taking and therefore susceptibility to behavioural problems at the time of puberty and new concerns about reproductive health. Majority of adolescents still do not have access to information and education on sexuality, reproduction, and sexual and reproductive health and rights, nor do they have access to preventive and curative service. Commercial innovation to address health needs at the bottom of the pyramid for more than 800 million men, women and children across India living on USD 1-3 A DAY, the idea of accessible and affordable medicine is often as remote as their rural homes. Arogya Parivar ("health family" in Hindi) is a for-profit social initiative developed by Novartis to reach the underserved million living at the bottom of the pyramid in rural India. After just years, Arogya Parivar is proving to be both a force for improving rural health programme in rural community and a sustainable business.

Keywords: *Rural Health, adolescence, psychological, social, mental change, growth*

1. INTRODUCTION

Rural Health Care is connected to issues of Transportation, Workforce Development, Economic Development, and Poverty. Recognizing that the health of community members is important to all aspects of community development, listening session participants placed a strong emphasis on the need for long-term planning in rural health care. Comments suggest that rural health network have positive community-level impact, stemming largely from their local nature and commitment to the community. Because of this community emphasis, health care professionals and volunteers who work in rural areas form a strong and dedicated

network. From a practical standpoint, health care service presents a sound linkage with economic development because they require stable, year-round employment. In the United States, the Health Resources and Services Administration Funds the Rural Hospital Performance Improvement Project to improve the quality of care for hospitals with fewer than 200 beds. Research centres (such as the Centre for Rural Northern Health Research at Laurentian University, the Centre for Rural Health at the University of North Dakota, and the RUPRI Centre) and rural health advocacy groups (such as the National Rural Health Association, National Organisation of State Offices of Rural Health, National Rural Health Alliance) are relatively new in comparison to other research centres. In Canada, many provinces have started to decentralise primary care and move towards a more regional approach. Recently in Ontario, Canada, “Local Health Integration Network” have been established in order to address the needs of the many Ontarians living in rural, northern, and remote areas. State rural health mission was launched in Tamil Nadu on 12.4.05 with the view to bring architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery as prescribed under the NRHM of India.

To achieve the objectives NRHM, the Tamil Nadu state health mission was constituted and Tamil Nadu state health society was registered under Tamil Nadu Societies registration act 1975 with registration no.47/2006. State health society is constituted merging the health societies for leprosy, tuberculosis, blindness control and integrated disease control programme except Tamil Nadu state aids control society. The National Rural Health Mission (NRHM) is an undertaken by the government of India to address the health needs of underserved rural areas. Founded in April 2005 by India Prime Minister Man Mohan Singh, the been identified as having weak public health indicators. Under the NRHM, the Empowered Action Group (EAG) State as well as North Eastern States, Jammu and Kashmir and Himachal Pradesh have been given special focus. The thrust of the mission is on established a fully functional, community owned, decentralised health delivery system with Inter-Sector convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all Health Facilities.

The NRHM would seek to involve the PRIs at each level i.e. Gram Panchayat , janpad Panchayat and Zila Panchayat and enhance their capacities for ensuring community mobilisation efforts for appropriate health seeking behaviour. The Village Health and Sanitation Committee (VHSC) will be formed in each village under each Gram sabha ensuring adequate representation to the disadvantaged categories like women SC /ST/OBC/ minority communities. The Sub Health Centres shall function in close coordination with village health and sanitation committees as well as the village development committee at the Gram panchayat level. Some of the major initiatives under National Health Mission (NHM) are as follows: Accredited Social Health Activists, Health care , JananiSurakshaYojana (JSY), National Mobile Medical Units (NMMUs), Janani Shishu Suraksha Karyakarm

(JSSK), Rashtriya Bal SwasthyaKaryakram (RBSK) , Mother and Child Health Wings (MCH Wings), District Hospital and Knowledge Center (DHKC) and TAMIL NADU Integrated Nutrition Programme

2. REVIEW OF LITERATURE

Goddard and Smith (2014). The literature on health care access offers useful frameworks for considering question of rural health and health care access. The analytical approach for this review follows the framework which Godard and Smith have proposed for considering questions of equitable access to health care. Drawing from Aday and Andersen, Vladeck, Culyer, and Donabedian, Goddard and Smith set out that equitable (or inequitable) access to health care lies at the intersection of three components; population need, health care supply, and “Realised Access”

Coward Davis et al. (2016). Rural people are said to marry earlier, to bear more children and hold more conservative values. Subtle interactions of social environment and biology are seen to affect social roles and longer term social outcomes. For example, social conservatism is argued to accelerate girls’ progression from childhood to social maturity, through mutually reinforcing mechanisms of accelerated developmental timetables, and adoption of adult behaviours. The result for these women is younger pregnancy than their urban counterparts, accompanied by “attendant, usually negative, consequences” in the form of reduced educational achievement, lower status within society and poorer lifetime health.

Eyre and Gauld (2013). Eyre and Gauld gathered interview data from seven participants to assess the Lawrence health trust’s performance in each dimension, and then compared these ratings with performance in each dimension and then compared these ratings with performance ratings provided by the interviewees themselves. The broad finding was that the Lawrence trust had functioned very well in most pentagram dimensions, although there was some for improvement. Nothing that the framework used did not focus on those who did not participate in the trust, some distrust of “marginalised voices with their own agenda” by one trustee, and noting also academic criticism of the co-option of community involvement by government agencies, the authors suggested that assessment of privatisation must first answer questions such as “ ‘Why is community being involved?’ ” and “ ‘Who stands to gain by the community being involved?’ ”

Kohli, (2015). Ageing as associated with the decline in physiological effectiveness. which affect us all sooner or later and is an intrinsic part of growing old. Unlike the universal changes disease is sporadic. a particular disease affecting only certain members’ of the population. The analysis of national sample survey data reveals that about 45 per cent of the rural elderly are chronically ill among whom 45.01 per cent are men and 45.85 per cent are women. Cough and problem of joints are the most common health problems among rural older people. As for as physical disability are concerned, in the rural areas, 5.4 per cent of all the elderly (6.8 per cent females 4.4 per cent males) are physically disabled.

Rosenblatt (2013) However “rural” is define (and there are variations both among those who assume a definition and those who attempt to provide one), it should be uncontroversial to state that rural areas are typified by lower population densities and less infrastructure than “non-rural” areas. That is, there are fewer people with greater distances between them. Rurality thus creates diseconomies of scale and extra distribution costs for the production of any good or service, and as authours such as note, health services are not immune fro this effect. It might be said that health services are intrinsically more difficulty to deliver in rural areas.

Mathews-Cowey and Weinand (2012), geographical proximity is not the only, or even the most important, factor affecting the accessibility f heat care. Participants in this study rated having a doctor, and being able to call a doctor any time as more important than spatial proximity. However, responses did vary between demographic groups.

Shirley (2012) The universal difficulty for rural health care providers to attract and retain health professionals is exacerbated, in the case of the CHC, by flat federal funds and diminishing reimbursement from the Medicaid and Medicare programmes, at the same time as health costs increase and the number of uninsured people grow. Shirley (1995) also comments on a general stigma perceived especially by younger physicians in being associated with a “program”, and isolated from the mainstream medical establishment.

Almedom et al (2015). As mentioned, hygiene awareness and education inform community members about the correct use, strong and disposal of water the importance of sanitation and general hygiene. However, supplying clean drinking water and better methods of excreta disposal do not automatically reduce disease or improve health. Therefore, hygiene awareness and education are essential parts of water range of activities aimed at changing attitudes and behaviour in order to break the chain of disease transmission associated with inadequate water supply and sanitation.

Mara,(2017) there are ways in which communities can change their practice as far as health and hygiene related to water and sanitation are concerned. Hygiene awareness and education inform community members about hwt collect, store, use, and dispose of waste and general food preparation, bathing practices and domestic cleanliness. Supplying clean drinking water and methods of excreta disposal do not automatically reduce diseases or improve in waterborne diseases or improved health.

3. RESEARCH METHODOLOGY

Objectives of the study

- ❖ To study Demographic characteristics of the Respondents.
- ❖ To study economic- status of the Sample Respondents in study Areas
- ❖ To analyses the Awareness of Rural Health Programmes study Area.

Hypotheses

There may be relationship between health and age category

Research Design

Sampling Technique

The Samples are selected by simple random sampling technique was embraced in the present investigation to choose the example respondents. It is a technique in which a total rundown of the populace is accessible from five villages where tests are to be drawn

Sample size

The Present study is based on the Primary Data. Primary Data were collected from the Mudikandanallur village respondents in Srimushnam taluk of Cuddalor district. Simple random technique was adopted to identity the 40 married sample respondents. Cross classification tables with average and percentage were calculated in order to analyse the Project socio-economic conditions and health awareness programs of the sample population.

Data Analysis

The collected data are classified and tabulated with the help of computer programming. Cross tabulation is made for data pertaining to socio-economic background of the respondents. The percentage and average are extensively applied in the study to discuss field data.

4. RESULTS AND DISCUSSION

Table-4.1 Religion-wise distribution of the sample Households by their Age category

Sl.No	Religion	<=30years	31-40years	41+years	Total
1	Hindu	9	8	10	27
2	Muslim	2	2	3	7
3	Christian	3	1	2	6
Total		14	11	15	40

Source: Computed from the Primary Date

It is important to study the personal characteristics of the respondents before discussing other aspects of the respondents. Table 4.1 demonstrates the religious characteristics of the sample households. It was found that Hindu religion was the dominant group in all the age category compare to Muslim and Christian religion. Among the age group wise concern, the entire sample were scattered in the each religious group.

Table-4.2 Community wise distribution of the Sample Households by the Age category

Sl.No	Community	<=30years	31-40years	41+years	Total
1	BC	2	3	4	9
2	MBC	6	5	8	19
3	SC/ST	6	3	3	12
Total		14	11	15	40

Source: Computed form the Primary Data

Table 4.2 demonstrates the community status of the sample households by their age group category. The result found that there has been more number of the most backward community available in all the age-group followed by scheduled caste and backward caste. In Cuddalore and Nagapattinam district belt mostly Most Backward Community people only available. It reflects the our sample size also.

Table-4.3 Education wise distribution of the Sample Households by the Age category

Sl.No	Education	<=30years	<=31-40years	41+years	Total
1	Illiterate	1	3	6	10
2	Up to primary	8	5	7	20
3	High School	5	3	2	10
Total		14	11	15	40

Source: Computed form the Primary Date

Table 4.3 demonstrates in educational in status of the sample respondents by their age category. Out of the total respondents, half of the respondents completed up to primary school only followed by illiterate and high school. In age group wise concern, majority of the illiterate respondents comes under the 41 years and above age group were engaged I self-employee only. In the study area sample respondents opines that seasonal time only they engaged in wage work remaining period they were simply sitting at home. This opinion was not that much vary in gender wise also.

Table-4.5 Occupational Status wise distribution of the sample households by the age Category

Sl.No	Occupational status	<=30years	31-40years	41+years	Total
1	Wage Employee	5	3	4	12
2	Self-Employee	9	8	11	28
	Total	14	11	15	40

Source: Computed from the Primary Data

Table-4.4 depict the details of Occupation of the sample households. It was found that in the study area, Majority, of sample households were self-employee followed by wage employee. In age group wise concern, nearly one third of the 41 years and above age group were engaged I self-employee only. In the study area sample respondents opines that seasonal time only they engaged in wage work remaining period they were simply sitting at home. This opinion was not that much very in gender wise also.

Table-4.7 Average Household Physical Wealth Composition of the Sample Households

Sl.No	Physical Wealth	<=30years	31-40 years	41+years
1	Cycles	2,230 (n=7)	2,400 (n=5)	1,750 (n=6)
2	TV	2,910 (n=11)	3,230 (n=11)	7,250 (n=12)
3	Fan	1,100 (n=14)	1,670 (n=11)	1,470 (n=15)
4	Fridge	9,000 (n=7)	9,400 (n=8)	8,750 (n=8)
5	Furniture	4,610 (n=12)	2,070 (n=8)	3,000 (n=11)

Source: computed from the Primary Data

The Table 4.7 presents the Average Household Physical Wealth composition of the sample household by their Age category. It was found that majority of the respondents have TV and fan followed by cycles, furniture and fridge. The overall physical assets wise concern, half of the respondents have fridge, more than one third of the respondents have bi-cycles, more than three fourth of the sample respondents having television and all the respondents having fan even in shortage of electricity. The amount wise concern, the mean value of the fridge was higher in the entire age group category. Out of the total respondents, 41 years and above age group category have more physical assts followed by <=30 years age group category and 31-40 years age group category.

Table-4.9 Annual Income status of sample households

Sl.No	Annual income	<=30years	31-40years	41+years
1	Income of the Respondent	31,150 (n=14)	44,230 (n=11)	22,800 (n=15)
2	Income of other Sources	3,375 (n=8)	24,200 (n=5)	5,780 (n=9)
3	Income of other Family members	2,840 (n=6)	9,000 (n=7)	10,000 (n=7)

Source: Computed from the Primary Data

Annual Income status of the sample households is explained in the **Table 4.9**. out of the total sample respondents, all the respondents have earning members and their family members wise concern, nearly half of the sample household family members were earned. The result found that, more than half of the sample household getting income from other source also. Their age group wise concern, 31-40 years age group had more annual household income than other age group household income. But the number of earning members wise concern, 41 years and above age group have more earning persons compare to other age group have more earning persons compare to other age group category. It clearly indicates that 31 -40 years age group category income status is for better.

Table-4.10 Average Household Expenditure of the Sample Households

Sl.No	Household Expenditure	<=30 years	31-40years	41+years	Total
1	Food	4,790 (n=14)	6,690 (n=11)	2,540 (n=15)	5180 N=40
2	Clothing	4,790 (n=15)	3,600 (n=11)	2,570 (n=15)	3660 N=40
3	Education	3,780 (n=15)	2,375 (n=8)	1,480 (n=5)	2545 N=40
4	Medical	4,600 (n=8)	2,590 (n=6)	2,000 (n=5)	3070 N=21
5	Recreation Festivals	2,100 (n=6)	2,660 (n=5)	2,220 (n=7)	2330 N=19
6	Cooking/ lighting fuel	3,290 (n=15)	2,925 (n=10)	2,540 (n=15)	2920 N=36

Source: Computer from the Primary Data

Table-4.10 explains the average annual household expenditure pattern of the sample respondents in terms of food, clothing, education, medical, recreation/festivals, house rent/repairs and miscellaneous. It was found that the all the respondents spending their amount for food, clothe, cooking and education purpose. Only half of the respondents spent their amount for medical and recreation purposes. The amount wise concern, core amount spending for food purposes followed by clothing, medical, cooking and education etc., but in the age group wise concern, <=30 years age group have spent the more expenditure on cloth, education, medical and cooking purpose compare to other age group category. 31 -40 years age group have spend the more expenditure on food and recreation purpose compare to other age group category. It clearly indicates that the young age group households spent large amount for education and medical purpose and middle age group spent large amount for food and recreation purposes.

Table-4.11 Health Awareness Programs in Sample Household by the Age Category

Sl.No	Health Awareness Programs	<=30 years	31-40 years	41+years
1	Supply for Preventive Medicine	13	10	13
2	Health Awareness Camp	12	7	10
3	Beneficiaries of Government Awareness Programs	9	9	11

Source: Computer from the Primary Data

Table-4.11 explains health awareness programs in sample households by the age category. The result found that supply of preventive medicine wise concern, <=30 years and

41 and above years respondents were more aware, health awareness camp wise concern, the same age group years also more aware and beneficiaries of government awareness programs wise concern, category. The third age group category had more beneficiaries of government awareness programs compared to other age category.

Table-4.12 Type of Disease in Sample Households by the Age category

Sl.No	Type of Diseases	<=30years	<=31-40 years	41+years
1	Polio	7	6	9
2	Malaria	3	2	3
3	Pylaria	4	3	3

Source: Computed from the Primary Data

Table-4.12 explains types of Diseases in sample households by their age group category. The result was found that majority of the sample respondents well aware about polio awareness camp followed by malaria and awareness camp. Among the age group wise concern, 41 years and above age group have more awareness camp compare to other age group category. It clearly indicates that in the present situation, youth people more awareness about such type of awareness camp.

Table-4.13 Satisfaction of Government Awareness Programs in sample Households

Sl.No	Satisfied Govt. Programs	<=30years	31-40years	41+years
1	Satisfied	10	8	9
2	Not Satisfied	4	3	8

Source: Computed from the Primary Data

Table-4.13 explains the satisfaction Government programs in sample households by their age category. Out of the total respondents, majority of the respondents satisfied their government awareness programs and only one third of the respondents opines that not satisfied by their government awareness programs. The result found that their age group wise concern, younger age group have more satisfied for government various awareness programs compare other elder age group sample respondents.

Table-4.14 Nutritional Food for sample Households by the Age category

Sl.No	Nutritional Food	<=30years	31-40years	41+years
1	Vegetables health foods	8	7	9
2	Foods and egg	6	4	6

Source: Computed form the Primary Data

Table-4.14 explains the Nutritional food for sample households by the age category. The results was found that, more than half of the respondents opines that vegetables are the nutritional food and less than half of the respondents opines that non-veg like egg food are nutritional food By their age group wise concern, more or less equal numbers of young age group respondents willing to eat both vegetarian and non-vegetarian foods compare to other elder age group category.

FINDING CONCLUSION AND SUGGESTION

Create awareness about the government Health Program like food and nutrition program, Rural Sanitation, JananiSuraskaYojana, National Mobile Medical Units, Mother and Child Health Wings. Crete more awareness about government eye camp, ambulance facilities polio camp through health worker, advertisement, media, advertisement, media, news paper, phamlets etc. Government give rural Health Awareness training village level youth, Woman, children. Government always ready to provide more awareness camp in all over Tamil Nadu. People are willing to come forward to utilize those type of camps. It was found that Hindu was the dominant group in age the category compare to Muslim and Christian religion. The result found that community wise concern, of the respondents comes under the category of most backward class, followed by backward caste and scheduled caste in entire age group. In education wise concern, most of the respondents were completed up to primary education only. Only few of the respondents were illiterate in the entire age category. Out of the total sample respondents, Majority of Sample households are engaged in self-business. It was found that majority of the sample respondents (26) are living in nuclear family type followed by joint family in both gender. Out of the total sample households, majority of the household's family size was less than three. It was found that the mean value of the house for the total respondents. Household asset wise concern, more number of respondents having fan and less number of respondents having fan and less number of respondents having fridge in all the age category. This result clearly indicates the economic conditions. More liquid assets are having 31-40 years age group followed by <=30 years and 41+years. The result found that, average annual income was more in 31-40 years category, less in 41 and above years category. It was found that the most of the respondents household expenditure was more in cloth purpose followed by medical, cooking, food, etc The result found that supply f preventive medicine wise concern, <=30 years and 41 and above years respondents were more aware, health awareness camp wise concern, the same age group also more aware and beneficiaries of government awareness programmes wise concern, 41 and above years age group people are more aware.

CONCLUSION

The national health programmes at the state and district level are brought under one umbrella and it will function through the individual sub committees. This will help to pool all resources available in implementation of the programme. NRHM – aims to improve the health status of the People Especially those who live in the Villages. Reduction of infant and mortality and maternal mortality. Universal access to public health services /women's health, child health, Drinking water, sanitation and hygiene, nutrition and universal immunisation. Prevention and control of communicable and non-communicable disease, Population stabilisation-gender and demographic factors. Access to integrated comprehensive primary health care. Revitalising local health and traditions and mainstreaming ISM. The vision is to provide universal access to equitable, affordable and quality health care services which is accountable at the same time responding to the needs of the people. The awareness of rural health care system most of the people aware about polio awareness camp only one third of the respondents opines that not satisfied their government awareness programs and only one third of the respondents opines that not satisfied by their government awareness programs. The result was found that, more than half of the respondent opines that vegetables are the nutritional food and less than half of the respondents opine that non-vegetarian like egg food are nutritional food.

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