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Characterization of Health Status of Women And Children Based On Basic Health Services (What Services Exist And Utilization Level And Why If Not Used) In West Bengali Case Of South Twenty Four Parganas Descriptive Study

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Abstract
Background:
Public health results from proper health of the children and mothers, it's not a single factor that determines this health, it's a combination of many determinants, family planning is still low in India and every fifth birth in the world is an Indian, and 50% percent of the Indian populations are of reproductive age Lack of knowledge about contraceptive methods and concerns about health side effects and effectiveness are also major barriers to adoption of family planning services, child health, incidences of malnutrition and children who are not vaccinated are still existing in India more so in rural parts, Children of today are citizens of tomorrow, which is why it is extremely important to ensure proper health care services as well as adequate nutritional intake for the children. The prevalence of low birth weight babies (less than 2.5 kg at birth) is 22.5% as estimated by NFHS 3, but In NFHS 3 birth weight was reported only in 34.1% of cases of live births (60% of urban and 25% of rural). Since in 75% cases in rural areas, birth weight was not recorded, and health conditions are poorer in rural areas, actual percentage of low birth babies could be more than the reported figure, still up to now, water for utilization and home consumption is still shared by domestic animals. Water table in west Bengali is shallow, there's likelihood of water contamination by human wastes. Around 8,00,000 people in India still live by manual scavenging by carrying feces in baskets on their heads. In the absence of vital data for the district level is likely to affect effective planning and action, particularly among districts requiring special attention.
Methodology: This cross sectional study involved 260 females aged 16 to 49 years in 24 south parganas in west Bengali state India . Data were collected using a pretested semi-structured questionnaire, entered in spss version 16 and analyzed. Descriptive statistics were generated and variables were tested for linear correction model to determine the signifance
Results: as the main objective states, Majority of (%) of respondents stated that they intended to go for health services in the subsequent six months. Majority of them have no health insurance(80.3%) the main reason being no one suggested about health insurance36.23%, 87% are willing. family planning is practices by majority of respondents(32.6%) commonly use pills, however majority had got married at the age of 16-20years(76.5%) and 39.2 claims that contraceptive methods has secondary effects on their health. the majority of children are vaccinated 69.3% and they appreciate breast feeding exclusively for six month 82.3%.majority of respondents reported that they have latrines 92% and 51% wash hands after defecation, water treatment for drinking water is not done at 80.77% And cleaning for houses is done once a week41.2%.common diseases reported for children are significant associated with common practices for health of children at p-value <0.05 and social demographics are also statistically significant with possession of health insurance
Conclusion: Public health is astudy of promoting,prolonging lives of people through different means,good health is human right,public health is determined by different factors either directly or indirectly,the achievement of public health is guided by world health organization standrds for intervention.
There is a very high intention to purchase for health insurance in health care services, the child health judged on the respondents ideas is not bad, but still need for effort in vaccination.The sanitation and hygiene status of community was inadequate and community lacked adequate knowledge regarding hand washing and proper cleaning for their environment. Further more communities are lacking the knowledge of treating drink water. The local authority should put in place stringent measures to ensure proper hygiene and sanitation and certify that communities meet the standard recommended by world health organization for health. This will ensure that health of the public is maintained properly which is the prime objective of this study.

Key words: Characterization, health services, mothers, children, existence of basic health services, utilization level

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I. BACKGROUND TO THE STUDY

1.1 Introduction: this chapter covers the description of the study area, literature on the variables of interest that includes, health care services, child health, family planning, water, sanitation and hygiene. it covers the significance of the study, objectives and research questions.

Westbengali state has several districts , South Twenty Four Parganas is among them, where the study was done. The district has 5 Sub-divisions namely (i) Alipore Sadar (ii) Baruipur (iii) Canning (iv) Diamond Harbour, and (v) Kakdwip District Highlights - 2011 Census, South 24 Parganas District comprises of 29 C.D. Blocks and 7 Statutory Towns.There are total 2,042 villages and 111 Census Towns in the District.South 24 Parganas District 2nd most populated District and has the highest Child (0-6 year's) Population in the State.South 24 Parganas District has highest Scheduled Caste Population in the State. South 24 Parganas District occupies 14th position in terms of Scheduled Tribe Population in the State. South 24 Parganas District ranks 4th in decadal Population growth rate among the Districts with 18.2%.The density of Population (Population per square km) of the District is 819 per square km which makes its rank 12th in the State. In case of proportion of Child Population (0-6 years), South 24 Parganas District ranks 6th in the State (12.6%).Literacy Rate of the District is 77.5% (higher than the State average of 76.3%) thereby making its rank 8th in the State.total population 9,12,76,115 (Handbook, 2011)

Health of the population significantly affects both social development and economic progress. Given the relevance of health for human well being and social welfare, women's health and children are fundamentals, it is important to ensure equitable access to health care services, health promotion and education by identifying priority areas and ensuring improvements in quality of healthcare services. However, the implementation of such measures requires a regular availability of district specific information on the varied dimensions of health, healthcare access and service delivery. In the absence of vital data for the district level is likely to affect effective planning and action, particularly among districts requiring special attention.(Dandona & Dandona, 2016) While the District Level Household Survey conducted every five years in india primarily focuses on indicators pertaining to maternal health and child welfare programmes none of the present Surveys provide estimates of core vital indicators on fertility ,child health practices, family planning services, water, sanitation and hygiene at house hold level at the district level.(Health, 2005) Recent years have therefore witnessed a Surge in demand from various quarters for generating timely and reliable statistics at the district level to enable informed decision making in the health sector. Timely and systematic estimates of the magnitude and changes in health indicators can play a crucial role in creating and assessing policies which aim to eliminate the disproportionate burden of health deprivations among disadvantaged populations Maternal and child health Access and utilization of health care services during pregnancy and childbirth is critical in determining the health of both the expectant mother and the unborn child. In this regard, an overview of maternal health status could be presented through an assessment of key indicators such as antenatal care (ANC), delivery care and postnatal care (PNC). Realizing the need for preparing a comprehensive district health profile on the basis of key parameters that indirectly or directly affects the health of mothers and children, this study identified areas that play big role in the health of the mothers and children and definitely the entire population, these areas of interest included the demographic information, access to health care and quality, knowledge on child health care practices, family planning, water, sanitation and hygiene at house hold level. (Health, 2005)

1.2 Family planning section

Every fifth birth in the world is an Indian, and 50% percent of the Indian population is of reproductive age. There is still a large unmet need for contraception in India, and efforts to tackle the situation need to be strengthened. The prevalence of male sterilization still stands at a scanty 2%.The relevance and importance of family planning in India has to be understood in the context of the burgeoning population, and the persistence of relatively poor social indicators in spite of a booming economy. India, the second most populous country in the world, is projected to exceed 2billion people by the turn of the twenty-first century.

According to the Census of India 2011, the population was nearly 1.210 million, of which 31% are below the age of 15 years and 53% of According to NFHS-3 in 2005–2006, the CPR among currently married women was 56.3% for any method and 48.5% for modern methods of contraception. CPR for modern methods has been increasing steadily from 36.5% in 1992 1993 (the time of NFHS-1), to 42.8% in 1998–1999,and reaching 48.5% in 2005–2006. CPR varies considerably with socioeconomic parameters. For example, in 2005–2006 use of any modern methods of family planning was significantly less among Muslims (36%) as compared to Hindu women (50%),while it was highest among Sikh women (63%). Similarly, CPR for modern methods

was only 35% among women in the lowest wealth quintile, compared to 58% among women in the highest wealth quintile(Analysis, 2011)

In another study done in India, the most preferred method of contraception in both urban and rural areas was found to be permanent method of contraception namely Female Sterilization. In an attempt to find awareness about non-scalpel vasectomy among our study subjects, we found that only about 65% of the subjects were aware. However, the awareness was more among the urban population. A higher awareness level was also noted among the higher income groups and a higher education status. Most of the males agreed frankly that they were not interested in considering a vasectomy in future, the few who agreed also belonged mostly to the urban study area. The main reason for acceptance was limitation of family size. Few of those who were aware of non-scalpel vasectomy believed in some myths about the procedure, the same are responsible to some extent for the non – acceptance of the procedure. The rural and urban population can be seen to derive their knowledge on non-scalpel vasectomy from the general practitioners. When compared to nonscalpel vasectomy, however, a much higher awareness was seen to be prevalent on tubectomy. Last but not the least, most of the study subjects were not curious to know more about non-scalpel vasectomy, as they strongly believed that family planning is a responsibility of the females.(Vaidyanathan, 2014)

Lack of knowledge about contraceptive methods and concerns about health side effects and effectiveness are also major barriers to adoption of family planning services. These factors may also argue against increased continuity of contraceptive use. For example, Bangladeshi women wishing to delay or prevent pregnancy chose not to practice contraception because of some of the above factors (Bongaarts & Bruce, 1995; Casterline et al., 2001; Feyistan & Casterline, 1999). However, Luck et al.,2000, in a study of family planning services in Bangladesh,found that culturally appropriate counseling can mobilize the most probably dormant demand for contraception by reassuring potential clients of the social acceptability and by allaying their fears about side effects of contraceptive methods (cf.Amin et al., 2000; Phillips et al., 1997). Various cross-national studies have also found that health and social concerns are the principal causes of the unmet need for contraception in many countries (Bongaarts & Bruce, 1995; Casterline & Sinding,2000).

This study concluded that individual face-to-face counseling by family planning service providers is an effective means of providing potential users with necessary information, particularly regarding their health concerns(Nangendo, 2012)

Luck et al. (2000) found that the principal barriers to increased contraceptive use in rural Gambia are psychological. Village-based interventions designed to provide socially appropriate counseling to potential contraceptive users can help to overcome these barriers. The demand for contraception in Africa is driven by a wish to postpone and space births rather than a desire to control family size,Knowledge and Use of Family Planning Methods and Services,235(Nangendo, 2012) and traditionally postpartum abstinence was used to achieve these goals (Caldwell & Caldwell, 2002). Now, women in some regions of sub-Saharan Africa want a

contraceptive they can control themselves and that can be reversed, thus avoiding spousal quarrels or marital dissolutions (Caldwell & Caldwell, 2002; Kenya

1.2.1 Fertility trends in West Africa

Astudy on fertility trend in west Africa,Data from the Demographic and Health Surveys (DHS) have shown that fertility preferences and the total fertility rate (TFR) in many West African countries remains high. The lowest TFRs among these countries are in Ghana (4.1) and Liberia (4.2); the highest in Mali (6.6) and Niger (7.0).Those in the middle include Burkina Faso, Benin, Guinea Conakry, and Nigeria. Among West African countries, Mali ranks as third in relation to high fertility preferences (6.0) and second in TFR (6.6). According to the most recent DHS survey in Mali (EDSM 2006), there have been few changes in fertility preferences, birth rates, or contraceptive prevalence since the 2001DHS. This survey showed a national contraceptive prevalence of 6.9% among married women. Thechanges that drove fertility preferences down to 3.5 children in Ghana did not occur in Mali.(Yoder, Guèye, & Konaté, 2011)

1.3 Children Health section

Children of today are citizens of tomorrow, which is why it is extremely important to ensure proper health care services as well as adequate nutritional intake for the children. It is now globally acknowledged that investment in human resource development is a pre requisite for any nation. Early childhood, that is the first six years constitutes the most crucial period in life, when the foundations are laid for cognitive, social and emotional language, physical/motor development and cumulative lifelong learning. The young child under 3 years is most vulnerable to the vicious cycles of malnutrition, disease/ infection and resultant disability, all of which influence the present condition of a child at micro level and the future human resource development of the nation at the macro level. Thus the utmost importance of the findings on the nutritional and mortality status

of the children can never be over emphasized. India is among the countries where child mortality rate is alarmingly high. (Division, Office, & Implementation, 2012)

The problem has caught attention of policy makers and researchers for several decades. The data collected and published by the Office of the Registrar General and Census Commissioner, India, show that although mortality rate among infant and under 5 children is declining over the years, there are some states where mortality rates are very high. This shows that despite progress in health sector in the recent decades in India, precious young lives continue to be lost due to childbirth-related causes, inadequate newborn care and early childhood diseases. The mortality status of children in India reflects the threats in child health. The child mortality scenario varies widely across the states, ranging from moderate level of child mortality in some states to alarmingly high rates in some other states. (Division, Office, & Implementation, 2012)

The Sample Registration System, in 2010, estimated that, out of the total deaths reported, 14. 5% are infant deaths (< 1 years), 3.9% are deaths of 1 - 4 years children,18.4% are deaths of children of 0 - 4 years and 2.7% deaths pertained to children of 5 -14years. The percentage of infant deaths to total deaths varies substantially across the states. From moderate level of 2.8% in Kerala, 5.0% in Tamil Nadu to as high as 21.8% in Rajasthan , 21.2% in Uttar Pradesh, 20.4% in Madhya Pradesh with other states figuring in between these states. The percentage of under five deaths to total deaths ranges from 3.2% in Kerala, 5.9% in Tamil Nadu to 27.6% in Uttar Pradesh, 26.6% in Rajasthan, 26.4%in Madhya Pradesh, 26.7% in Bihar while other states figure in between these states. At the national level, the percentage share of infant deaths to total deaths in rural areas is 15.8%, whereas in urban areas, the same is 9.7%. Kerala registered the lowest share of infant deaths 3% in rural and 2.3% in urban areas, followed by Tamil Nadu 5% in rural and 5% in urban areas. The percentage share of infant deaths to total deaths is 24.5 % in rural Rajasthan and 11.9% in urban part, 21.9% in rural Uttar Pradesh, and 17.1% in urban areas, 21.6% in rural Madhya Pradesh and 14.1% in urban part. The percentage share of infant deaths to total deaths is not only much less in other states but the rural urban gap in the percentage is also lower in those states as compared to the States of Rajasthan, Uttar Pradesh, Madhya Pradesh. (Division, Office, & Implementation, 2012)

1.3.1 Infant Mortality

Infant mortality rate is defined as the infant deaths (less than one year) per thousand live births. The Report on Medical certification of cause of death Report (2006) of India (Office of the Registrar general of India), sites a number of causes for Infant Mortality.Among infants, the main causes of death are: Certain Conditions originating in the Perinatal Period (66.0%), Certain infectious and Parasitic diseases (8.6%), Diseases of the Respiratory System (8.3%), Congenial Malformations , Deformations& chromosomal Abnormalities (3.3%) , Diseases of Circulatory system (2.9%), Other major causes (11%).In 2010, IMR is reported to be 47 at the national level, and varies from 51 in rural areas to 31 in urban areas. (Division, Office, & Implementation, 2012)

1.3.2 Death rates for Children age 5-14 years

Ages 5-14 is generally a period of lower mortality than ages 0-4 years. According to the 'Report on Medical Certification of Causes of Death 2006, the leading causes of death at ages 5-14 are: Certain infectious and Parasitic Diseases (22.9%) , Injury Poisoning and Certain Other consequences of External causes (12.5%), , Diseases of the Nervous System (11.5%), Diseases of the Circulatory System (10.5%), Diseases of the Respiratory System (8.5%,) ,Other Major groups (34.2%).(Division, Office, & Implementation, 2012)

1.3.3 Nutritional Status of Children

It is well acknowledged that investment in human resource development is a pre requisite for any nation to progress. Children of today are citizens of tomorrow, and hence improving nutritional status of children becomes extremely important. Early childhood, that is the first six years constitutes the most crucial period in life, when the foundations are laid for cognitive, social and emotional language, physical/motor development and cumulative lifelong learning. The young child under 3 years is most vulnerable to the vicious cycles of malnutrition, disease/ infection and resultant disability all of which influence the present condition of a child at micro level and the future human resource development of the nation at the macro level. The assessment of the ground reality as reflected by the statistics on nutritional status of children becomes very significant in this context. (Division, Office, & Implementation, 2012)

India is one among the many countries where child malnutrition is severe and also malnutrition is a major underlying cause of child mortality in India. The problem has caught the attention of policy makers and researchers for several decades. Various studies and surveys have been conducted to find out the root causes of child malnutrition. All these studies including the three National Family Health Surveys (NFHS) reveal that malnutrition is not the result of a single cause; the problem is multifaceted, the causes acting singly or in

combination with other complex factors like poverty, purchasing power, and health care, ignorance on nutrition and health education, female illiteracy, social convention. The prevalence of low birth weight babies (less than 2.5 kg at birth) is 22.5% as estimated by NFHS 3, but In NFHS 3 birth weight was reported only in 34.1% of cases of live births (60% of urban and 25% of rural). Since in 75% cases in rural areas, birth weight was not recorded, and health conditions are poorer in rural areas, actual percentage of low birth babies could be more than the reported figure.(Division, Office, & Implementation, 2012)

1.4 Health care service section

1.4.1 Health care seeking behavior and quality of care

In the study done on Health Care- Seeking Behaviour of Women with Symptoms of Reproductive Tract Infections in Urban field practice area, Hubli,Karnataka shows the duration of symptoms before seeking health care by women. It was found that majority of women 88(60.3%) sought treatment for the duration of symptoms of 6-12 months, while 42(28.8%) women sought treatment for the duration of symptoms of 1-6 months,10(6.8%) women for less than one month duration of symptom and 6(4.1%) women for greater than 12 months symptom.(n=146)It was found that among symptomatic women who had sought treatment with duration of symptoms<1 month,In a study conducted at Hooghly, West Bengal by Samanta A et al,50% of female STI patients sought treatment from any of the health care providers,46.3% of women went to Govt facility.In a study done at Karachi, women consulted a variety of healthcare providers in their pursuit for treatment, mainly allopathic doctors and hakims. The different treatments prescribed to women ranged from oral and intra-vaginal medications to various home remedies including refraining from specific foods("Health Care- Seeking Behaviour of Women with Symptoms of Reproductive Tract Infections in Urban field practice area , Hubli , Karnataka 2012)

According to the study done on factors affecting the healthcare-seeking

behavior of mothers regarding their children in a rural community of Darjeeling district,West Bengal.Among the 256 mothers under study (256), the age range varied from 17 to 44 years, with the mean (±S.D) being 24.2, One hundred and eighty-two were Hindus (71.09%), 30 were Muslims (11.72%), and 44 belonged to other religions (17.19%). Mothers belonging to the general caste were159 (62.11%) and SC/ST/OBC were 97 (37.89%). Among the studied children of 256 mothers, 142 were males (55.4%) and 114 were females (44.5%). During the study period, the total number of children below the age of one year (infants) was 44 (17.2%), of whom 29 were males and 15 females(Chakraborty & Biswas, 2013)

Two hundred and twelve (82.8%) children were aged between one and five years, with 113 males and 99 females. The results revealed that 100% of the males and females had completed their primary immunization coverage. Thus preventive healthcare-seeking behavior was practiced by all the mothers, which was a welcome finding. Regarding the curative aspect of healthcare-seeking behavior, among a total of 142 male children, no treatment was received in 16.2% of the cases (23 males). Treatment at the public sector was received by 97 males (in 68.3% cases) and treatment at private sector was received by 22 males (in 15.5% cases) The reasons stated by their mothers for not seeking health care behavior were noted. Multiple responses were given; 71.2% of the mothers opined that ignorance, lack of awareness, fixed firm cultural beliefs, male-dominated society, more concern for the well-being of the male child, as he was the future bread winner of the family, and the final word of the head of the family, were contributory factors; 62.3% of the mothers stated the cause to be dissatisfaction with the health care services, along with lack of accountability and humaneness of the healthcare providers. Lack of accessibility, availability, and affordability of the health care services provided was also a cause, according to 57.11% of the mothers.(Chakraborty & Biswas, 2013)

1.4.2 Quality concepts in health care

The words used to describe quality in health care, and the thinking behind them, vary between countries, between stakeholders and over time. This variation reflects a shift in health care policy – such as that from hospitals to networks and primary care – and in perceptions of what constitutes quality in health care. These perceptions can be summarized as beginning with "hospital quality assurance", moving to "health care quality improvement" and heading for "population health improvement". The specific tools used for quality improvement in health care depend on local and national priorities, but some global concepts are generally applicable. In general, improvement may target processes (such as infection control), systems (such as clinical indicators) or strategies (such as health reform). These concepts are not in themselves tools for developing, measuring or improving standards, but they provide overall frameworks for quality improvement. Many of them derive from manufacturing and service industries whose values and methods have been adapted to health care. There is no definitive international classification of these concepts, and, even where there are clear differences, the words are often used interchangeably. This section does not aim to resolve the debate about quality models,

but to outline the concepts and to highlight more detailed descriptions. There no studies found concerning the concept of quality of health care in India

A Study on Performance of Health Insurance Schemes in India. During the last 50 years India has developed a large government health infrastructure with more than 150 medical colleges, 450 district hospitals, 3000 Community Health Centers, 20,000 Primary Health Care centers and 130,000 Sub-Health Centers (Mavalankar, D. and Bhat, R.2000) . On top of this there are large number of private and NGO health facilities and practitioners scatters throughout the country. (Chakraborty & Biswas, 2013)

1.4.3 The Need of Health Insurance

According to a survey by NSSO (National Sample Survey Organization), 40% of the people hospitalized have either had to borrow money or sell assets to cover their medical expenses. A significant proportion of population may have had to forego treatment all together. Thus, more than the disease it is the cost of treatment that takes its toll. To get rid of health worries health insurance is the answer.(Chakraborty & Biswas, 2013)

The study on awareness of health insurance in a south Indian population – a community-based study

The whole study was based on the awareness of the respondents. 64 percent of the respondents were aware of health insurance of the total 242 respondents, whereas 36 per cent of them had no idea about it . In a similar study done by Patro8 *et al* only 22.7 per cent of the study population was aware of health insurance. The high awareness in the present study may be attributed to the high literacy percentage among the respondents. depicts the source of information and awareness of health insurance.34.8 per cent of the respondents said that family/friends was the source of information followed by from newspaper (32.35%), television (10.3%) and radio (1.9%). A good number of respondents also got to know about it from insurance agents (9%), doctors (9%) and from the internet (2.6%).(Chakraborty & Biswas, 2013)

1.5 Water, sanitation and hygiene section

Lack of safe water, sanitation and hygiene remains one of the world's most urgent health issues. Almost one tenth of the global disease burden could be prevented by improving water supply, sanitation, hygiene and management of water resources. Ensuring poor people's access to safe drinking-water and adequate sanitation and encouraging personal, domestic and community hygiene will improve the quality of life of millions of individuals. Better managing water resources to reduce the transmission of vector-borne diseases (such as viral diseases carried by mosquitoes) and to make water bodies safe for recreational and other uses can save many lives and has extensive direct and indirect economic benefits, from the micro-level of households to the macro-perspective of national economies (WHO, 2008).

In 2015, 5 billion people used an improved sanitation facility that was not shared with o their households, and thus are classified as having at least basic sanitation services. In addition, 600 million people (8 percent of the population) used improved but shared facilities that are classified as limited sanitation services. Globally; use of basic sanitation services has increased more rapidly than use of basic drinking water services, at an average of 0.63 percentage points per year between 2000 and 2015. However, coverage is generally lower for basic sanitation than for basic water, and no SDG region is on track to achieve universal basic sanitation by 2030, with the exception of Australia and New Zealand, where coverage is already nearly universal. Figure 20 shows that 9 out of 10 countries where more than 5 per cent of the population lacked basic sanitation in 2015 are progressing too slowly to achieve universal basic sanitation by 2030, and suggests that in one out of seven countries, use of basic sanitation is actually decreasing. Progress needs to accelerate in these countries to achieve SDG target 1.4, universal access to basic services by 2030. (Water, 2017)

1.5.1 Types of improved sanitation

Improved sanitation facilities are those designed to hygienically separate excreta from human contact. These include wet sanitation technologies (flush and pour flush toilets connecting to sewers, septic tanks or pit latrines) and dry sanitation technologies (ventilated improved pit latrines; pit latrines with slabs; or composting toilets). Improved facilities shared with other households have previously been reported separately and did not count towards the MDG target. The JMP now divides improved sanitation facilities into three categories: limited, basic and safely managed services. The population using improved facilities that are shared with other households will now be called limited rather than shared. Improved facilities that are not shared count as either basic or safely managed services, depending on how excreta are managed. Improved sanitation facilities can be connected to either sewer networks or to on-site storage and treatment facilities such as septic tanks or latrine pits. With the SDG focus on safe management of excreta, it is useful to distinguish between sewered and non-sewered sanitation facilities, as they require different forms of excreta management. Globally, improved sanitation facilities (including shared facilities) are evenly split between sewer connections and on-site systems,

with 2.8 billion people (38 per cent) using sewer connections and another 2.8 billion using septic tanks, latrines or other improved on-site system(Water, 2017)

1.5.2 Basic hygiene facilities

Hygiene has long-established links with public health, but was not included in any MDG targets or indicators. The explicit reference to hygiene in the text of SDG target 6.2 represents increasing recognition of the importance of hygiene and its close links with sanitation. Hygiene is multi-faceted and can comprise many behaviors, including hand washing, menstrual hygiene and food hygiene. International consultations among WASH sector professionals identified hand washing with soap and water as a top priority in all settings, and also as a suitable indicator for national and global monitoring. The new global SDG indicator for hand washing is the proportion of population with hand washing facilities with soap and water at home. Hand washing facilities can consist of a sink with tap water, but can also include other devices that contain, transport or regulate the flow of water. Buckets with taps, tippy-taps and portable basins are all examples of hand washing facilities. Bar soap, liquid soap, powder detergent and soapy water all count as soap for monitoring purposes.(Water, 2017)

People living in households that have a hand washing facility with soap and water available on premises are classified as having basic facilities. Households that have a hand washing facility but lack water and/or soap are classified as having limited facilities. (Water, 2017)

In some cultures, ash, soil, sand or other materials are used as hand washing agents, but these are less effective than soap and are therefore counted as limited hand washing facilities. Household surveys increasingly include a section on hygiene practices where the surveyor visits the hand washing facility and observes if water and soap are present. Observation of hand washing materials by surveyors represents a more reliable proxy for hand washing behavior than asking individuals whether they wash their hands. The small numbers of cases where households refuse to give enumerators permission to observe their facilities are not used in calculating JMP estimates. Following the standardization of hygiene questions in international surveys, data on hand washing facilities are available for a growing number of low- and middle-income countries. (Water, 2017)

This type of information is not available from most high-income countries, where access to basic hand washing facilities is assumed to be nearly universal. In this 2017report, hand washing data are available for 70 countries, nearly half of which are in sub-Saharan Africa. No data on hand washing facilities are available for Oceania. Since the availability of hand washing facilities is considered a basic level of service, regional and global estimates can only be made when data are available for at least half of the population. Estimates could be made for two SDG regions, as well as for Small Island Developing States (SIDS), Least-Developed Countries (LDCs) and Landlocked Developing Countries (LLDCs). Availability of hand washing facilities is higher in urban than in rural areas in each of these regions. (Water, 2017)

In October 2014, the Prime Minister of India launched an ambitious national sanitation programme that aims to eliminate open defecation by 2019. The Swachh Bharat Mission (SBM) has unprecedented political support and has mobilized nearly $25 billion from Government, the private sector and civil society. The rural programme promotes pour flush twin-pit toilets, which are designed to contain wastes in situ until they are safe to handle. The programme targets behaviour change and community approaches to sanitation are being adopted throughout the country. The SBM has developed a national database with detailed information on latrine coverage down to the household level and a multi-stage verification process.33 As of June 2017, according to the SBM, over 205,000 villages, 149 districts and five States had reported themselves to be open-defecation free (ODF). The Government estimated that since the start of the Mission, in October 2014, coverage of latrines in rural India has increased from 42% to 65%, and the number of rural Indians defecating in the open had come down from 550 to 330 million people by June 2017. The SBM programme recognizes the need to go beyond reporting infrastructure coverage, and is conducting population-based surveys to determine household **use** of sanitation facilities, which is the internationally agreed-upon indicator, used by JMP to compare progress across countries. The National Annual Rural Sanitation Survey (NARSS) will generate up-to-date data on progress towards elimination of open defecation and trigger rewards for areas that have achieved targets(Water, 2017).

The SDG targets aim to achieve 'universal access' by 2030 (Section 1). 'Universal' implies all settings, not only households, but also schools, health care facilities, workplaces and other public spaces. The JMP is therefore expanding its global databases to include information on WASH in institutional settings. The first priority is to establish baseline estimates to inform global monitoring of SDG targets relating to WASH in schools (SDG 4a) and health care facilities, with plans to expand global monitoring to include other institutional settings in the future. Initial landscaping reviews of WASH in schools and health care facilities from 2015 have identified datasets for at least 149 and 54 countries, respectively, and highlighted serious shortcomings in water and sanitation coverage, and availability of hand washing facilities with soap and water.35,36 However the lack of harmonized definitions has made it difficult to compare progress across countries. Some of these datasets are

not representative of the entire country, and cover only certain regions or types of schools or health care facilities. In 2016, the JMP convened expert group meetings to define harmonized criteria and indicators for monitoring WASH in each setting based on global norms and standards and existing national and international surveys.37,38 The JMP is currently compiling national sources of data, with a view to publishing comprehensive harmonized global baseline estimates for WASH in schools and WASH in health care facilities in 2018**.** (Water, 2017).

The study done on Household sanitation and personal hygiene practices are associated with child stunting in rural India: a cross-sectional analysis of surveys, The prevalence of stunting ranged from 25% to 50% across the three studies. Compared with open defecation, household access to toilet facility was associated with a 16–39% reduced odds of stunting among children aged 0–23 months, after adjusting for all potential confounders (NHFS-3 (OR=0.84, 95% CI 0.71 to 0.99); HUNGaMA (OR=0.84, 95% CI 0.78 to 0.91); CNSM (OR=0.61, 95% CI 0.44 to 0.85). Household access to improved water supply or piped water was not in itself associated with stunting. The caregiver's self-reported practices of washing hands with soap before meals (OR=0.85, 95% CI 0.76 to 0.94) or after defecation (OR=0.86, 95% CI 0.80 to 0.93) were inversely associated with child stunting. However, the inverse association between reported personal hygiene practices and stunting was stronger among households with access to toilet facility or piped water (all interaction terms, $p<0.05$).(Rah et al., 2015)

Water and sanitation are key elements in the field of development. Shortage of water is now recognised as one of the world's biggest problems. As brought out at a recent Global WASH (Water, Sanitation and Hygiene for All) Forum in Dakar, Senegal,people are far more concerned about what emanates from their mouths than from other orifices in their bodies. The technology employed in ridding ourselves of our bodily wastes has remained unchanged, more or less, for three centuries. The Water Supply & Sanitation Collaborative Council (WSSCC), a multistakeholder organization under the umbrella of the World Health Organization in Geneva, has been almost single-handedly trying to put sanitation and hygiene on the international agenda. It succeeded in including sanitation as one of the UN's Millennium Development Goals (MDGs), at the 2002 World Summit on Sustainable Development in Johannesburg (the precursor to which was the spectacular Earth Summit at Rio 20 years earlier).Countries have now pledged to halve the number of people without access to sanitation in the world, a staggering 2.5 billion, by 2015 (Rah et al., 2015)

1.5.3 Nature and Scope of Rural Sanitation in India

Providing better sanitation facilities is one of the biggest challenges till date. After the millennium era, tackling sanitation and hygiene issues is becoming a key issue in terms of providing sanitation facilities and in creating awareness among the masses for behavioral change. Social ailments like poverty are more than a lack of income or a shortage of material goods. Human poverty, lack of basic capabilities for participating in the standard activities of the communities is aggravated by lack of sanitation. For urban slum dwellers and rural population, living in areas surrounded by human waste and garbage is creating. Embarrassment and depriving people of participation, choices and opportunities. Around 8,00,000 people in India still live by manual scavenging by carrying feces in baskets on their heads, a livelihood that bars their inclusion in mainstream society. In these pathetic conditions, people are suffering due to lack of basic sanitation amenities. Poor awareness is the main cause for this problem. The sanitation problems in rural and urban areas are different and challenges also vary(Grottola, 2014)

The world will miss the sanitation target by more than half a billion people. A staggering, 1 billion people (15% of the world population) remain with no access to toilets, latrines or any form of sanitation facility, and have no other choice than to defecate in the open, resulting in high levels of environmental contamination and exposure to the risks of microbial infections, diarrhoeal diseases (including cholera), trachoma, schistosomiasis and hepatitis. Encouraging progress has been made, 1.9 billion people gained access to improved sanitation facilities between 1990 and 2011. The continued trend of population growth and rapid urbanization further strains a deteriorating water and sanitation infrastructure (GLAAS, 2012).

These global aggregates mask large disparities between nations and regions, rich and poor, between rural and urban populations, as well as between disadvantaged groups and the general population.(Programme & Unw-dpac, 2014)

1.6 SIGNIFICANCE OF THE STUDY/ JUSTIFICATION

This study was done to provide statistical data of health parameters to the district and entire country for intervention purposes

-The results of this study is expected to serve as evidence on the ground for decision making by both charity organization and government of west Bengali on the parameters of

-The results of the study will serve as source of knowledge by other researchers, since it provide the framework and methodology for success
-The results of this study will be published and therefore informs the world about the existing situation and hence interventions
-The results of this study will be the source of funding for several interventions identified as gap in this specific area of interest
-This study will provide the recommendations that will guide in decision making by local, central government and individual

1.7 PRIMARY OBJECTIVE OF THE STUDY

To generate the statistical data on utilization level of health services available and why not used for the purposes of education

1.7.1 Specific objectives

- ✓ To assess the health services available and health seeking behaviors' by mothers
- ✓ To measure the level of knowledge and practices by the mothers towards child health
- ✓ To understand the level of utilization of family planning as key to mother health and fertility level
- ✓ To determine the water quality, hygiene and sanitation levels with in the community as primary indicator for general health.
- ✓ To determine social demographic characteristics of women

1.7.2 Research questions

1.What is the health care seeking behavior by the mothers?
2.What are the level of knowledge of mothers in providing health care of their children?
3.What is level of utilization of family planning and why if not used?
4.What are sanitary services available at the community level?
5.what is social demographic characteristics of women in south 24 parganas?

II. METHODOLOGY

2.1 Study design: this was across-section-descriptive study that involving quantitative data
2.2 Target population: this study involved mothers in South Twenty Four Parganas in all grampachite
2.3 Sample size and selection: sample selection was done randomly in all grampachite, where four to six grams were selected depending on the size of the grampachite and this led to 260 women that were selected for this study. A systematic data collection was done in conjunction with community health workers where every fifth house hold were selected for survey until the required number was obtained
2.4 Instruments for data collection: a well designed questionnaire was prepared in English and then translated into Bengali language for the understanding of the respondents, the questionnaire was pre-tested on 30 families for consistency of questionnaire and avoidance of errors and time management purposes and these families were not involved in general data collection
2.5 Data collection method: Data was collected by trained community health workers by administering questionnaire to those who are able to read and write, whereas those who are not, the questionnaire was filled by health worker in consultation/interviewing the respondents
2.6 Data analysis: data was collected and entered into computer and descriptive statistics were done, showing the percentages of intended variables and this was presented by use of charts and tables and graphs, the regression analysis was performed to measure the associations of variables using linear model
2.7 Ethical considerations: data was collected in consultation of sabujsangha organization that funded this study, and before data collection the objective of the study was explained to the participants and assurance of confidentiality was done,the involvement of the respondents was not mandatory at any time respondents were told that they can stop their involvement if situation need be.
2.8 Limitation of the study: this study was limited to one district which might not be enough to generalize the health of India and again their no views of males on the issue of health

III. RESULTS OF THE STUDY

This chapter of results describes the variables of interest, which the researcher was objectively focusing to portray the general situation of health of the community, but in particular, mothers and children. All 260 respondents selected took part in the study. Majority of these were from rural areas 260 (100%) and married 246 (96.4%). 40% of respondents were aged 16-20 years , 104(46%) were illiterate,97(37%) had no occupation and majority earns less than 5000rupees83(31.9%) (Table1).

Table 1: Social demographic characteristics of respondents

Variables		Frequence N=260	Percent(%)
Age of respondent	16-20	104	40.0
	20-24	68	26.2
	24-28	7	2.7
	28-32	25	9.6
	32-36	31	11.9
	36-40	16	6.2
	40+	9	3.5
Marital status	Never married	4	1.5
	Married	246	94.6
	Separated	6	2.3
	Widowered	4	1.5
Education of respondents	Illitrate	120	46.2
	Primary	74	28.5
	Secondary	43	16.5
	High secondry	20	7.7
	Vocational	3	1.2
Occupation of respondent	No occupation	97	37.3
	Agriculturalist	19	7.3
	Daily laborer	21	8.1
	House wife	110	42.3
	Nutritional teacher	6	2.3
	self employed	7	2.7
Income of respondent per year	Less than 5000RS	83	31.9
	5000-10000	43	16.5
	10000-50000	9	3.5
	no income	125	48.1

3.1 Health care services section

This section asked questions about the frequency of health care services the respondents seek in the past six months, the rate of quality of health care, confidence of respondents about given care when their sick, and if not confident, the reasons, the researcher also asked respondents about if they have health insurance and if not why and their willingness to purchase, the researcher also asked about their suggestion about how to increase awareness and finally the barriers they face to access health care services.

The majority of respondents reported that they had physical health issues 45(17.3%)the quality of health care the majority of respondents were not able to determine 101(38.8%) and majority 136(52.3%) of them were some how confident regarding the confidence of given health care when they fall sick and they claimed that the distance between health facility and their home is the main reason as to why their not confident 86(33.1%) and finally inadequate means of transport is the main reason as to why their not accessing health care66(25.4%)

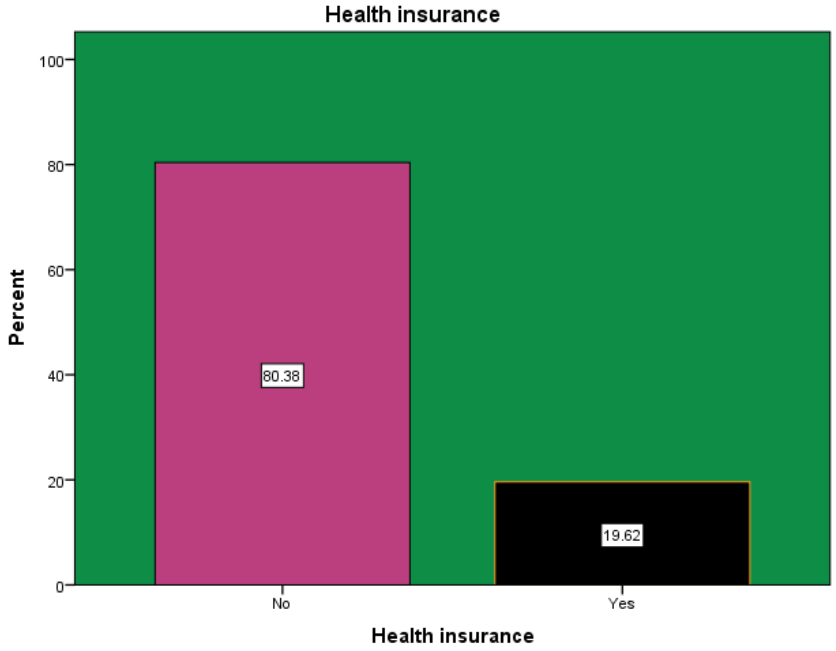
Table 2: Summary results of health care services

Variables	categories	Frequency(N=260)	percentage%
Health issues	No issues	36	13.8
	Physical	45	17.3
	Did not go to doctor	44	16.9
	Domestic violence	6	2.3
	Other rare diseases	35	13.5
	Respiratory	34	13.1
	Digestive	23	8.8
	Skin diseases	37	14.2
Quality of health care given to respondent	Total	260	100.0
	Good	33	12.7
	Very good	16	6.2
	Mixed	90	34.6
	I do not know	101	38.8
	Use quack doctors	20	7.7
	Total	260	100.0
Respondents Confidence to be treated			
	Not at all	20	7.7
	Some how confident	136	52.3
	Very confident	24	9.2
	I do not know	80	30.8
	Total	260	100.0
If not confident why			
	Cost of care is high	30	11.5
	Distance to health care	86	33.1
	No near good health facility	55	21.2
	Total	171	65.8
Total		260	100.0
Barriers to access health care			
	Inadequate transport means	66	25.4
	Difficulties of contacts	46	17.7
	Cost of health care	53	20.4
	Disclosure of health by health provider	57	21.9
	No better treatment	38	14.6
	Total	260	100.0

3.2 Health insurance

Health insurance is very fundamental in as far as health care is concerned, the respondents were asked with option of yes and No answers respectively, majority of respondents 80.38% have no health insurance and only 19.62% claim to have it.

Bar chart 1: utilization of health insurance



The willingness to purchase health insurance visa-vi type of insurance, majority 87.8% have no insurance but willing to purchase 17(9%) community health insurance and 3.2% agree to purchase private health insurance

Bar chart 2: Reasons to why respondents do not use health insurance

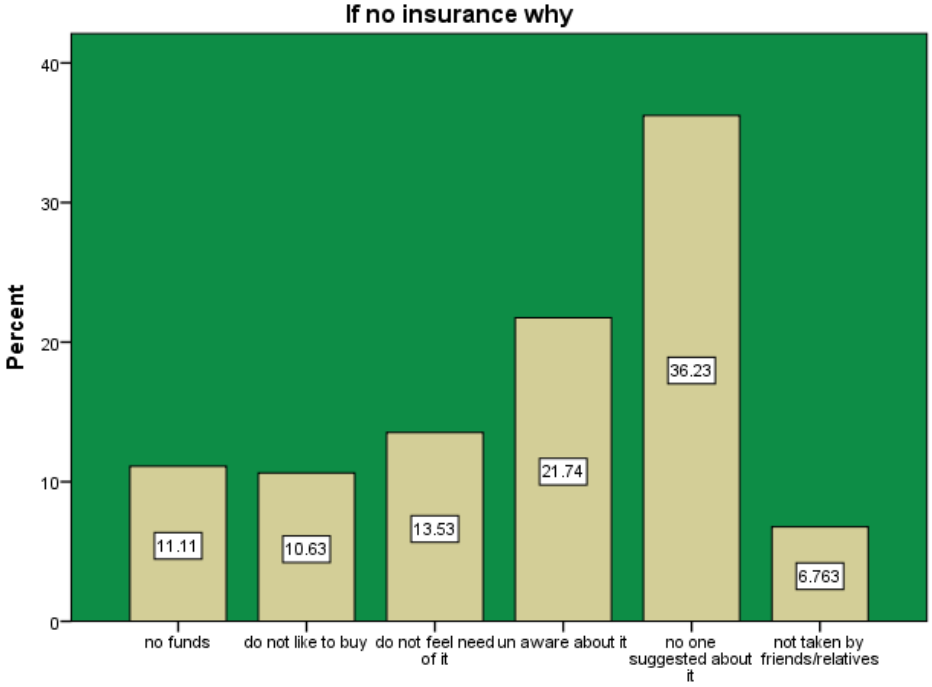


Table 3: Willingness to purchase health insurance visa-vie type

		No health insurance		**Community health insurance**		**Private insurance**		**columTotal**	
Willing to purchase health insurance	Yes I gree	166	87.8%	17	9.0%	6	3.2%	189	100.0%
	I will think about it	15	100.0%	0	0.0%	0	0.0%	15	100.0%
	Not interested	0	0.0%	0	0.0%	8	100.0%	8	100.0%
	Buy if certain condition occurs	27	87.1%	0	0.0%	4	12.9%	31	100.0%
	RowTotal	208	85.6%	17	7.0%	18	7.4%	243	100.0%

3.3 Family planning section

This section was considered to be important in as far as health of mothers is concerned, it asked questions regarding age at marriage, number of children by respondents, age spacing of children, views by respondents about contraceptive methods, utilization of family planning methods and if not some reasons are included in this section.

Majority of respondents 199(76.5) got married at the age between 16-20, big number129(49.6%) of respondents claim that between one child to another the time interval is more than two years , and of 260 respondents 102(39.2%) says the contraceptives have side effects on them.

Table 4: summarize data on age at marriage, child spacing and views on contraceptive methods

Variables		**Frequency N=260**	**Percent (%)**
Age of respondents at marriage			
Age at marriage	14-16	7	2.7
	16-20	199	76.5
	20-24	39	15.0
	24-28	15	5.8
	Total	260	100.0
Ideal age space between children			
Child spacing	0-one year	14	5.4
	1year-2years	111	42.7
	more than two years	129	49.6
	am pregnant	6	2.3
	Total	260	100.0
Views on contraceptives as family planning methods			
Views on contraceptives	Never used	19	7.3
	I have used contraceptives with out problem	13	5.0
	I have used contraceptives irrespective of effects	95	36.5
	It has side effects	102	39.2
	It is against nature	31	11.9
	Total	260	100.0

Family planning as important variable in this study, the researcher wanted to know the common method used by respondents, 32.69% use pills and small percentage 2.7% use IDU (bar graph) and the reasons as to why these participants did not go for health insurance, majority of 36.23% claims to have never been suggested, the association between utilization of family planning methods and social demographics of respondents were statistically significant ($p<0.05$)
(bar graph 3 and table 5)

Bar graph 3: Utilization of family planning methods

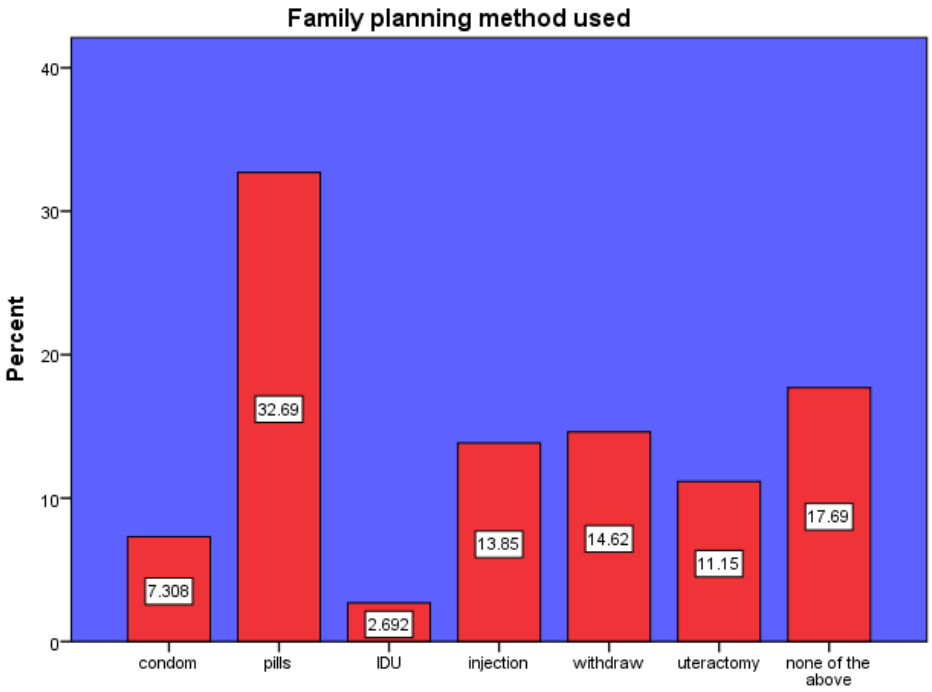


Table 5:association of family planning methods with social demographics

Variables		Frequency N=260	Percent (%)	*p-value*
Age at marriage	14-16	7	2.7	
	16-20	199	76.5	
	20-24	39	15	
	24-28	15	5.8	
	Total	260	100	0.232
Education of respondents	Illiterate	120	46.2	
	Primary	74	28.5	
	Secondary	43	16.5	
	High secondary	20	7.7	
	Vocational	3	1.2	0.045
Income of respondent per year	Less than 5000RS	83	31.9	
	5000-10000	43	16.5	
	10000-50000	9	3.5	
	no income	125	48.1	0.002

3.4 Child health section

This section entails questions concerning child health and captures fundamental variables these variables includes Number of children in a family which plays role in general health status, Frequency of breast feeding a baby rating the knowledge of mothers on how good is to breast feed a baby exclusively, How difficult to breast feed a baby ,age a baby starts eating foods, common diseases child suffers ,vaccination status, if not vaccinated why.

These variables were assumed to be fundamentals for child health the table 6 summarizes the results.

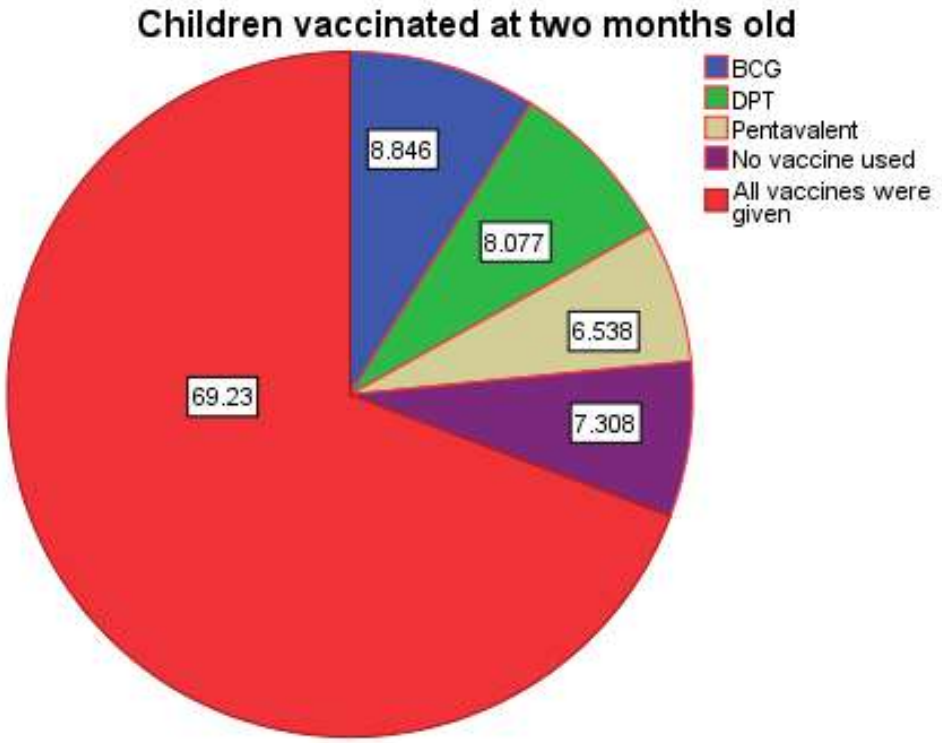
Of all respondents, 150(57%) have two children and 82% claims that breastfeeding exclusively is good on the scale not good, good, very good and I do not know, the respondents who said very good and good were categorized as knowledgeable and those who said I do not know or not good were considered as not knowledgeable.,90% said its not difficult to breast feed their children and frequency ranges from any time to no knowledge about it, the majority of 70.8% responded that they breast feed their babies when ever they want. whereas the time they start feeding their babies, majority of respondents 116(44.6%) feed boy at six months and girls at seven months. question concerning common diseases that affects their children coughs and fever account for 31.2%.The researcher was so much interested on if the respondents vaccinate their children and if not why, the big percentage 69.23% depicted that their children have completed all vaccine necessary and the main reasons as to why some children are not vaccinated is not feel like vaccinating a child which claimed to be high at 87.04% of respondents. the association between child diseases and age of a baby, food in take and immunization was statistically significant($p<0.05$) (table 6 and table 7 pie chart 1.)

Table 6 : summarizes data on variables of interest for child health

Variables	Categories	Frequency	Percent
Number of children	No children	45	17.3
	One	34	13.1
	Two	150	57.7
	Three and above	31	11.9
	Total	**260**	**100**
How good is breastfeed a baby exclusively	Not good	5	1.9
	Good	214	82.3
	Very good	19	7.3
	I do not know	22	8.5
	Total	**260**	**100**
Difficult to breast feed	Not difficult	236	90.8
	Difficult	24	9.2
	Total	**260**	**100**
Breast feeding	When ever a baby needs	184	70.8
	I do not know	5	1.9
	Total	189	72.7
Missing	System	71	27.3
Total		**260**	**100**
Age a baby starts eat foods	At six months	12	4.6
	I do not know	11	4.2

	Boys at six months	95	36.5
	Girls at seven months	26	10
	Six for boys and seven months for girls	116	44.6
	Total	**260**	**100**
Common diseases	Coughs and fever	81	31.2
	Digestive	19	7.3
	Skin diseases	60	23.1
	Headache	19	7.3
	Cough, fever and skin itch	41	15.8
	Rare diseases	19	7.3
	no diseases	16	6.2
	Total	255	98.1
Missing	System	5	1.9
Total		**260**	**100**

Pie chart 1: vaccination status among children



Bar chart 4: Description of reasons why respondents do not vaccinate children

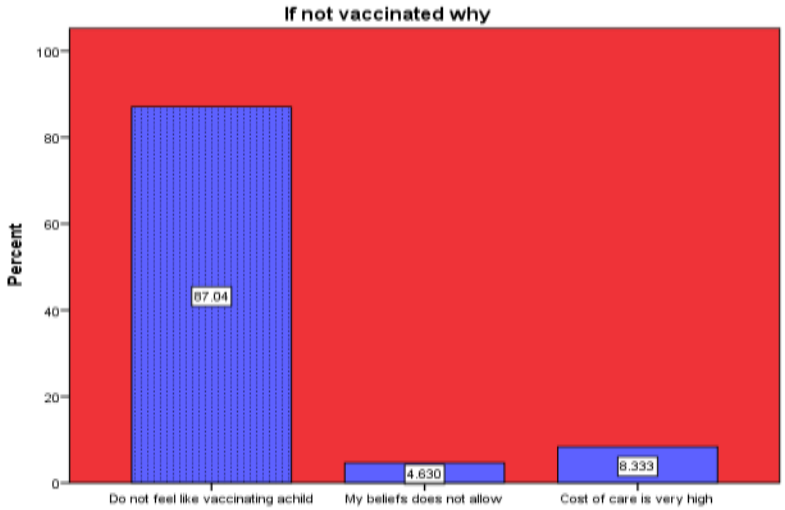


Table 7: Association between common diseases for the children and vaccine status, age of a baby, breast feeding and food in take

Variables	Categories	Frequency	Percent(%)	*p-value*
breastfeed a baby exclusively	Not good			0.000
	Good	214	82.3	
	Very good	19	7.3	
	I do not know	22	8.5	
Age a baby starts eat foods	At six months	12	4.6	0.001
	I do not know	11	4.2	
	Boys at six months	95	36.5	
	Girls at seven months	26	10	
Children vaccination	BCG	23	8.7	
	DPT	21	8.0	0.033
	Pentavalent	17	6.4	
	No vaccine used	19	7.2	
	All vaccines were given	180	68.2	

3.5 Water, sanitation and hygiene section

This section was involved in this research targeting women and children because it has cross-cutting effects, it covers questions on sources of drinking water, distance it takes to reach source of water, quality of water, on whether their good or bad, treatment of drinking water to free micro-organisms causing diseases, Frequency of Availability of drinking water, sources of water for washing utensils at homes, knowledge on hand washing, area of defecation by children disinfectants for washing hands after defecation, Type of toilet they use, Distance of latrine from kitchen for food contamination purposes, Number of heads in family dwelling in that house, Number of living rooms in the house to be able to know the transmission of diseases level and Frequency of cleaning house to be able to measure facilitating factors for growth of micro-organisms causing diseases. All

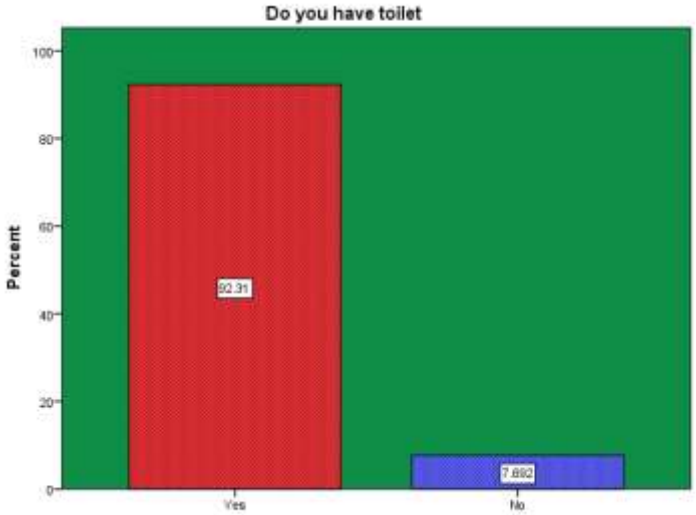
respondents 260(85.5%) the main source of water is public tubewell, and the time it take is between 25-20minutes,the availability is at some hours of the day and 55% says the quality of water is good, whereas source of water for washing utensils 87.3% use home ponds a round their homes. On the question regarding hand washing a total of 57(21.9) respondents wash their hands during bathing. kathalatrine is a traditional latrine commonly used by communities 44.2% use this type of latrine and 51% does not use any disinfect to wash their hands they use water only.73.3% claims that their toilet is in 0-3 meters from kitchen.107 of the participants have two living rooms and 87.7% claims that their homes have four and above people and majority 41.2% of participants clean their house once a week. the majority of respondents have latrines in their homes(92.3%) and unfortunately 80.7% do not treat drinking water , source of water, use of disinfectants and treatment of drinking water are statistically significant($p<0.05$) (Table 8 and bar chart)

Table 8 summarizes variable studied

Variables	Categories	Frequency	Percent
source of drinking water	Public tap	37	14.2
	Public tube well	223	85.8
	Total	260	100.0
Time it takes	Below15 minutes	39	15.0
	15-20 minutes	40	15.4
	20-40minutes	24	9.2
	40-60minutes	5	1.9
	Total	**108**	**41.5**
Missing	System	152	58.5
Total		**260**	**100.0**
Availability of water	Daily,24hrs	24	9.2
	Daily, some hours	74	28.5
	One to two days a week	6	2.3
	Total	**138**	**53.1**
Missing	System	122	46.9
Total		**260**	**100.0**
Quality of water	Good	145	55.8
	Bad	26	10.0
	I do not know	89	34.2
	Total	260	100.0
source of water for washing utensils	Pond	227	87.3
	Tap	15	5.8
	Tube well	18	6.9
	Total	**260**	**100.0**
Time to wash hands	Before eating	50	19.2
	After eating	26	10.0
	After defecating	70	26.9
	Before coming back from outside	3	1.2
	During bathing	57	21.9
	Before and after eating and after defecating	54	20.8
	Total	**260**	**100.0**
Area of defecation	Use sanitary facility	106	40.8

	Khata'latrine	115	44.2
	Out side	39	15.0
	Total	**260**	**100.0**
Disfectacts used	Soap	133	51.2
	Ash	13	5.0
	Soil	22	8.5
	Water only	92	35.4
	Total	**260**	**100.0**
Distance of latrine from kitchen	0-3m	192	73.8
	3-4m	54	20.8
	>4m	14	5.4
	Total	**260**	**100.0**
Number of living rooms	2 rooms	107	41.2
	3 rooms	65	25.0
	more than three	88	33.8
	Total	**260**	**100.0**
Number of people in living house	2 persons	25	9.6
	3 persons	7	2.7
	4 persons and above	228	87.7
	Total	**260**	**100.0**
Frequency of cleaning house	Once a week	107	41.2
	More than twice a week	64	24.6
	Daily	35	13.5
	Total	**258**	**99.2**
Missing	System	2	.8
Total		**260**	**100.0**

Bar chart 5: describing availability of latrines in the community



Bar chart 6 : Description of water treatment

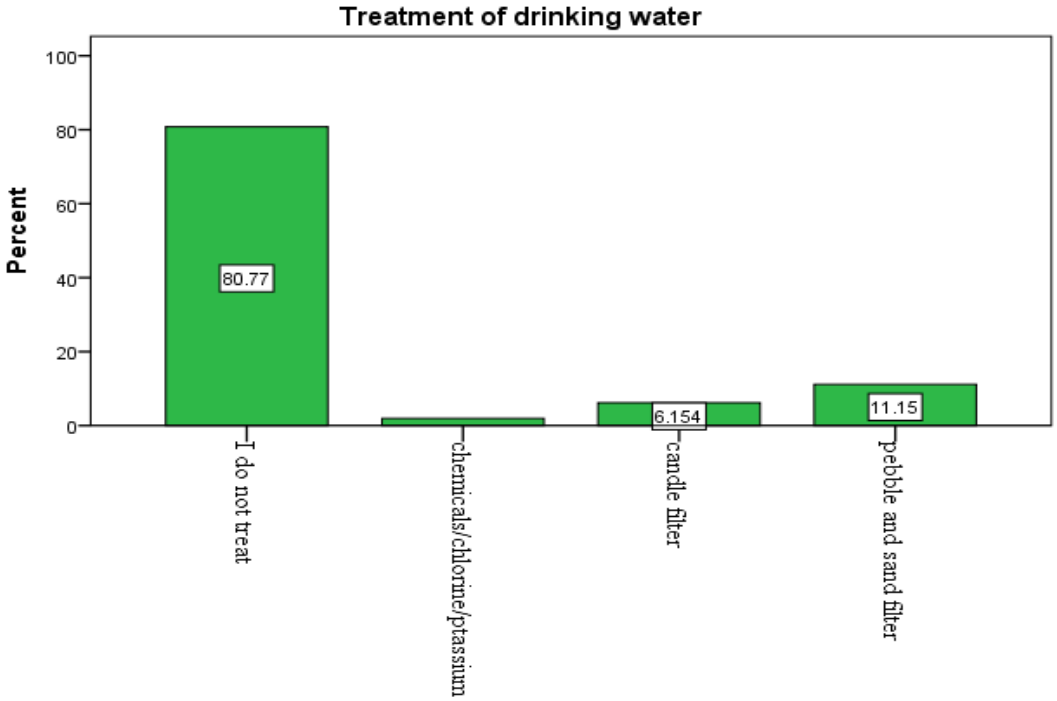


Table 9 : Association between frequencies of health issues and water sources, washing hand practices and water treatment

Model	Unstandardized Coefficients		Standardized Coefficients	t	p-value
	B	Std. Error	Beta		
(Constant)	4.868	.492		9.896	.000
Water sources for washing utensils	-1.435	.222	-.354	-6.454	.000
Disinfectants used for washing hands after defecation	.099	.148	.043	.666	.506
Treatment of drinking water	.948	.198	.306	4.786	.000

IV. DISCUSSION OF RESULTS

The main aim of this study was to generate the statistical data on utilization level of services available and why not used if available for the purposes of education specifically that have direct impact on women and child health, these services included health care services and seeking behavior, family planning, child health services and water, sanitation and hygiene for respondents and also social demographic characteristics. The education of respondents is still low 46.2% compared to the general level of literacy rate standing at 76.3% in south 24 parganas (census india,handbook 2011)This study looked at economical status of women and majority reported to earn less that 5000rupees.this study indicates that health seeking behavior and health services provided in the last 6sixmonths prior to the study,the skin diseases is the most affecting them 14.2%,similary another study on health care seeking behavior done in 2013,60.3% sought treatment in 6-12 moths after presenting the symptoms though this study was studying infectious diseases only. under health care seeking behavior quality of health care was looked upon and 34.6% acknowledged to be good though the quality varies from country to country and context in which quality is measured in((Mavalankar, D. and Bhat, R.2000).futher more barrier on access to health care this study indicated that 25.4% have inadequate means of transport and is considered to be a limiting factor to access health care and the same study was done in Darjeeling district indicated that access, affordability of health care stands on 57.1% (chakraborty and biswas, 2013)

The results of this study depicts that over 260 respondents 80.3% have no insurance may be due to inability to pay as indicated earlier the income per year is still low, however 87.8% are willing to purchase. Another study on utilization of health insurance also show similar results and 40% of hospitalized individuals had to pay out of pocket model, however this study focused on sick individuals. on the same study about health insurance, this study did not ask questions about whether respondents knows the insurance due to the fact that literature shows that up to 99% knows that health insurance exist and therefore the study focused on ways of promotion and revealed that 75% suggested to use village ceremonies whereas study on awareness about health insurance indicated that 36% had no idea on health insurance and 34.8% gets information from family friends.(biswas,2013).

The study was done on family planning; we asked questions on whether family planning is practices, the age of respondents at marriage, the common method used, views on modern contraceptive methods and why respondents do not used family planning and fertility rate.

All respondents reported to know family planning , and 76.5% got married at the age of 16-20 years, on the question regarding views on health effects majority of 39.2% claims to have been affected and may be a supporting idea of not adopting family planning services, use of pills is the common method 32.6% and the main reason as to why participants do not go for family planning is cost of care the average children that a mother have is 2.The same study was done in India 56.3% use any method and 48.5% use modern method and permanent sterilization was perceived to be common for both rural and urban (analysis,2011,vaidynathan,2014).

Child health this section involve questions on what Frequency of breast feeding a baby, At what age a baby starts eat foods, Did you vaccinate your children at two months old if not vaccinated, why, Common diseases child suffers

This study revealed that 82.3% appreciates breastfeeding exclusively with acceptance to breastfeed their children any time 70.8% this supports the idea of world health organization which says that its important breast fed exclusively up to six months for better health of a child, the study indicated that the common practice in this target area is to feed children based on sex and majority of respondents feeds girls at seven months and boys at six months .no study done to understand the implication of this practice .on the other hand study on nutrition the national family health revealed that their combination of factors that facilitate child malnutrition like health care, ignorance by mother about nutrition and illiteracy level.(National health survey 2012).This study was done focusing on nutrition only whereas this study aim to know the feeding practices with out deep analysis on cause relation effect. Vaccination is crucial in child health this study shows that 69.23% completed vaccine and small number do not vaccinate their children because of attitude (do not feel like vaccinating a child) ,common diseases was skin diseases. The similar study was done in Darjeeling showed that 100% of children completed primary immunization (charkrabortyand Biswas,2013) which is contrary to our study in 24 south parganas,may be the difference is due to location of Darjeeling in terms of accessibility and availability of health care services.

Water, sanitation and hygiene,these variables were considered significant for this because of its effect on both health and women and children. This study report that majority of respondents drinking water is from public tube well and majority do not treat water for drinking (80.7%),the big percentage reported that they use water from pond for washing utensils at home, as an observation, this water is shared by domestic animals like dogs and cows and at the same time human being use them for bathing especially children aged 5-12years.this is the same water used for washing clothes, plates and cups. the skin diseases mentioned earlier may be attributed to this water. This study also shows that majority of respondents wash their hands after defecating 26.9% and moreover only 51% wash their hands with water only soap. There is likelihood of food contamination and thus diseases outbreak like diarrhea and typhoid in other studies also indicated the high prevalence of typhoid though this study did not involve that study. This study also asked question on presence of latrine majority of respondents have latrines in their homes and distance of latrine from kitchen was reported to be 0-3meters 73% this distance is small compared to the standards given by world health organization of six meters and there is possibility of contamination of foods by flies from latrine. the questions regarding house cleaning, majority of respondents said that they clean their houses once a week, this may lead to growth of bacteria and fungi which may cause several diseases. a study on association between child stunting and house hold defecating area indicated that 25%-50 are associated with child stunting thus this study did not further analyze the associations between these variables(Rah et al,2015) .Another study done in India around 800,000 people still carry feces in baskets on their heads for disposal and still people are suffering because of lack of basic sanitation facilities (Grottala, 2014)

V. CONCLUSION AND RECOMMENDATIONS

Public health is astudy of promoting,prolonging lives of people through different means,good health is human right,public health is determined by different factors either directly or indirectly,the achievement of public health is guided by world health organization standrds for intervention. There is a very high intention to purchase for health insurance in health care services, the child health judged on the respondents' ideas is not bad, but still need for effort in vaccination. The sanitation and hygiene status of community was inadequate and community lacked adequate knowledge regarding hand washing and proper cleaning for their environment. Further more communities are lacking the knowledge of treating drink water. The local authority should put in place stringent measures to ensure proper hygiene and sanitation and certify that communities meet the standard recommended by world health organization for health. This will ensure that health of the public is maintained properly which is the prime objective of this study.

Based on the results of the survey it is recommended that

Behaviour change communication program should be put in place for the purposes of preventing diseases with in the community

It is recommended to do,further analystical studies done to rule out the cause-relation effects pertaining common diseases with in the community

It is recommended that health education and health promotion should be incouraged

it is recommended that,communities should be incouraged on use of health insurance by either charity organizations or government as whole.

It is recommended to innitiate an adult learning program to improve level of literacy

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APPENDICES

Map of south 24 parganas district

DEFINITION OF TERMS USED

Basic health services: for the purposes of this study, this means child health, family planning, water and sanitation

Child health: here means the accessibility to vaccines that prevent diseases, access to health care in general, access to foods and availability, access to hygiene and sanitation facilities

Women health means the ability to access health care, access to clean water and minimum standards to sanitation and hygiene

Utilization level: means initiative by women to use the health care services available for their own and children as well

Picture show Area of interest

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