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A Study on Infant Mortality in Karnataka (With Special Reference to Shimoga district)

RASHMI R.K.*[1], RAMESH, B.[2] AND S. KUMAR[3]
[2]Registrar and [3]Assistant Professor
[1]Department of Social Work, Kuvempu University, Shankargatta (Karnataka) India
[2]KSOU Mysore University, Mysore (Karnataka) India
[3]Vijayanagarasri Krishnadevaraya University, Bellary (Karnataka) India

ABSTRACT

Introduction: Infant mortality is an indicator of the health status not only of infants, but also of the whole population and of their poverty ridden social and economic status in the country. They face excessive vulnerability, as under privileged, to a hostile environment and suffer malnutrition and serious health problems; all this leads to high rates of infant mortality and morbidity. Infant mortality *i.e.* deaths under one year of age in a year per 1000 live births, is an important indicator of child health and development. Many research studies conducted so far have explored the causes and determinants of infant mortality in India. The key findings, besides pointing at the medico-clinical causes, indicate that the socio-economic factors like household income, female education, access to health services and immunization programmes are important determinants to assess status of infant mortality.

Objective of the study is **t**o examine the relative importance of major socio-economic demographic factors associated with infant mortality and to assess the scope of health authority and health care delivery system in preventing infant mortality.

Results: Maternal factors, *i.e.* age at marriage, age at first birth, parity and birth intervals, household and community level factors are the reasons for infant mortality. The general standard of living and life style of people, the persisting poverty in every household, the feeble capacity of the head of the household to provide food for all the members and women and girl children of the family, and allied environmental and social factors influenced adversely on the infant mortality.

Key Words : Infant mortality, Health status, Population, Socio-economic factors

INTRODUCTION

A decade and a half ago, it was recorded that there was rapid decline in infant mortality, but it has apparently stagnated for the past five to six years. The current period of slow decline has made it difficult to achieve the National millennium goals by 2000. The reduction in infant mortality was declared as the major goal of our official strategy to achieve Health for All BY 2000. One of the main objectives of the Government of India's Population Policy 2000 was to reduce the present level of high infant mortality to bring it down to less than 30 per 1000 live births by the year 2010. As per the figures available in 2002, Infant Mortality rate has been 63 per 1000, which is reported to have come down to 59 in 2005-6. However, Neonatal Mortality declines rapidly from about 70 in 1981 to 40 in 2001. This was attributed to the focus given by the planners and policy makers to a reduction stance of Neonatal Mortality. More women die in India during child birth in India

Infant mortality is an indicator of the health status not only of infants, but also of the whole population and of their poverty ridden social and economic status in the country. They face excessive vulnerability, as

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underprivileged, to a hostile environment and suffer malnutrition and serious health problems; all this leads to high rates of infant mortality. Infant mortality *i.e.* deaths under one year of age in a year per 1000 live births, is an important indicator of child health and development.

Factors causes for IMR:

A pertinent question however, we need to ask is: why is the decline in Infant mortality rates slowing"? Many research studies conducted so far have explored the causes and determinants of infant mortality in India. The key findings, besides pointing at the medico-clinical causes, indicate that the Socio-Economic factors like household income, female education, access to health services and immunization programmes are important determinants to assess status of infant mortality. Some studies also identify a strong inter-relationship between mortality, fertility and gender bias. Others, emphasizes, how demographic factors impact on infant mortality, and vaguely touch on many other socio-economic factors that have contributed to high infant mortality: These include proximate factors, such as medical care of the mother during antenatal period, care at birth, preventive and curative care in the post natal period. Maternal factors, *i.e.*: age at marriage, age at first birth, parity and birth intervals, household and community level factors: They felt that better water, drainage, sanitation, housing could increase access to a minimum package of essential services and could significantly reduce infant mortality rates. Besides, reproductive health services, prenatal care, improved breast-feeding practices, immunization, home based treatment of diarrhea were also suggested. An elaboration of the social profile of the villages is necessary to explain how socio-economic factors are the main causes and determinants behind IMR. Community norms, values and practices are assiduously followed by the rural folk.

An elaboration of the social profile of the villages is necessary to explain how socio-economic factors are the main causes and determinants behind IMR. Community norms, values and practices are assiduously followed by the rural folk. Their perception of various developmental indicators and their views on women, pregnancy, child birth etc.: Modern education is thought to be redundant and hence not pursued, there is total absence of scientific temper and non acceptance of new ideas, Pregnancy and child birth are considered a natural phenomena that require no medical intervention or attention, Girls are to be consigned to home based chores and they need to adhere to the Patriarchical imposed, norms and customs, women are not supposed to make decisions on any issue in the family, people have a boy preference as against girls; because they believe that boys will alone can atone their earthly faults and become an "old age" aid. Girls do not deserve attention since they have to go away to her husband's family. (They are called, a 'ParayaDhan' (other property and wealth). Deliveries are considered as pollution and hence low-caste dais alone is thought fit to handle the deliveries. There is no concept of safe-motherhood practices, total belief in Tantric, faith healers Ojha's and priests, tardy or no co-operation offered by villagers to governmental health and educational programmes, this credibility gap still fails to disappear, Majority of people suffer from poverty and lack of employment as there are no sustainable vocations, available for villagers locally, There is no concept of nutrition among the villagers nor do they understand the dangers of malnutrition, Crude ways of handling the new born and no understanding by Dais on dangers of infection persists, Absence of toilet facilities, sanitation and hygiene, particularly menstrual hygiene is totally absent. Belief in witchcraft, sorcery and magic abounds in the nooks of corner of India; no concept of clean drinking water exists. Non-availability of potable drinking water universally in the country - is the worst failure of the state.

Economic factors influence infant mortality in a big way. Child survival and maternal care depends on the ability of the parents to offer good care. If they are in the BPL category, their capacity for child care is minimal. Also, illiteracy and ignorance of the needs of child care are glaring. Many studies have highlighted that the degree and quality of survival of the infant lie with the quality of care providers. The numerous economic factors have both direct and indirect impact on the survival of the infant. The general standard of living and life style of people, the persisting poverty in every household, the feeble capacity of the head of the household to provide food for all the members and women and girl children of the family, and allied environmental and social factors do influence adversely the infant mortality in a community. Factors which are remote to the existing life styles, e.g. the availability and utilization of medical health facilities, also fall under socio-economic imperatives. (National Rural Health Mission (2005-2012).

The Rural profile and cultural practices have been found to be thriving even today, the deep rooted causes

and determinants lie deep in the village belief systems and cultural practices and taboos. If the cures to ailments by modern medi-care is necessary and welcome, to tackle the attitudes and behavior of the people steeped in superstition and fear of modern medicine however is also crucial. The root cause of non acceptance of modern Medicare is unfamiliarity, the lack of awareness and the fear of the unknown. Cultural Practices are mostly based on 'superstition'. Attributing infant mortality to supernatural forces and also to evil spirits has been a part of the village belief system. It assumes numerous dimensions and negatively impact on infant survival. The practice of giving away children and adolescents girls in marriage before the legal age of marriage at 18 has lead to early conception, which is common knowledge. The low birth weight babies are the outcome. Both congenital deformities and underdevelopment of the child are some of the handicaps that the young and immature mother has to handle. There is no data available on the number of adolescent marriages solemnized since there is no compulsory registration of marriages. However, infant mortality, both neonatal and post neonatal is common occurrences because of early marriages followed by early motherhood. How can it possible ensure safe motherhood and child care in such a situation? (Child Mortality in Rural India Bas Van der Klaavw - Limin Wang – April 2004.

Infant Mortality Rate in India:

Reacting to the report Union Women and Child Development Minister Krishna Teerath told CNN-IBN that she would take up the issue with the Health Department. Save the Children, a voluntary group reports one infant dies every 15 seconds in the country. Over 4 lakh newborns die in the first 24 hours of their life and 90 per cent of deaths are due to preventable diseases like pneumonia and diarrhea. The high mortality rate is also due to fact that India ranks 171 out of 175 countries in the world in public health spending.

Objectives:

The study is **t**o examine the relative importance of major socio-economic demographic factors associated with infant mortality

To assess the scope of health authority and health care delivery system in preventing infant mortality.

METHODOLOGY

The study was conducted in Shimoga District in (Karnataka) both secondarily and primarily sources of information were resorted to collect necessary information for writing this paper. To have the information from the respondents, they were identified from the D.H.O Office, P.H.C and even from the community. A preliminary study was conducted to frame and finalize the structure interview schedule. The interview schedule is a devised to collect the information relating to their family profile, reasons for poverty, source of income, cultural impact, utilization of microfinance system, health status etc. in the present study descriptive research design has been adopted. Stratified random sampling had been adopted in the present study 104 respondent were selected for the study in that 91 respondent were deceased Infant mothers, 08 were deceased infant father and 05 were nearby relatives of the deceased infant.

RESULTS AND DISCUSSION

Based on the primary data collected for the study it has been discussed about various aspects of the socio-economic determinants of infant mortality

Profile of the respondents:

A majority of the deceased infant families were interviewed and revealed in the village social profile because an elaboration of the social-economic profile of the respondents is necessary to explain how socio-economic factors were the main causes and determinants of IMR.

Socio economic determinants infant mortality:

The Table 1 shows the causes of Infant Mortality, from the table it can be seen that 75.96% of the deceased infant respondents opined that age of deceased Infant Mother is one of the determinants of Infant Mortality, when the deceased Infant Mother get conceived her age was between 22-26 at this age deceased Infant Mother was more likely to utilize modern health care facilities than older women, as they are likely to have greater exposure and knowledge to modern health care, also more access to health education but they were consigned to home based chores and they need to adhere to the Patriarchic imposed, norms and customs, because they were completely dependent on their in-laws and father ,even in the name of cultural practices women were restricted from their rights even today.

69.23% of the deceased infant respondents opined that early marriage of the deceased Infant Mother is one

Table 1 : Causes of Infant Mortality

Sr. No.	Causes	Yes		No		Total	
		Fre	%	Fre	%	Fre	%
1.	Mother age	71	75.96	33	31.73	104	100.00
2.	Early marriage	72	69.23	32	30.76	104	100.00
3.	Early conception	63	60.57	41	39.42	104	100.00
4.	Lower status of education	83	79.80	21	20.19	104	100.00
5.	Employment status of the mother	87	83.65	17	16.34	104	100.00
6.	Lack of women empowerment	91	87.5	13	12.50	104	100.00
7.	Cultural beliefs	76	73.07	28	26.92	104	100.00
8.	In laws greediness	28	26.92	76	73.07	104	100.00
9.	Caste	26	25.00	78	75.00	104	100.00
10.	Environmental factors	93	89.42	11	10.57	104	100.00
11.	Poverty	89	85.57	15	14.42	104	100.00

Source-collected through primary data

of the determinants of Infant Mortality, deceased Infant Mothers early marriage caused because their parents consider girls has others property or wealth so they wants to reduce their responsibility as soon as possible, fear of dowry is one of the reason if the girl is aged then there is a possibilities of demanding dowry etc. so deceased Infant Mothers parents decided for early marriage of the deceased Infant Mothers. Early marriage of the deceased Infant Mothers directly caused for early conception, no birth spacing, low birth babies etc. leads to Infant Mortality, and 60.57% of the deceased infant respondents had agreed that early conception of the deceased Infant Mother is one of the determinants of Infant Mortality,

79.80% of the deceased infant respondents had agreed that Low status of education of the deceased Infant Mother is one of the determinants of Infant Mortality, the deceased Infant Mothers were unaware of family planning and spontaneous birth is the reason for Infant Mortality, even deceased infant father was also not aware of family planning. Educated women or mother are considered to have a greater awareness of the existence of child health care services and benefited in using such services. Educated mothers are likely to have better knowledge and information on modern treatment and have greater capacity to recognize specific illnesses. As education empowers women, they have greater confidence and capability to make decision to use modern health care services for themselves and for the children. Education also enables women to take personal responsibility for their own health and the health of their children. Finally, schooling reflects a higher standard of living and access to financial and other resources, because better educated women are likely to marry wealthier men or they have increased earnings themselves.

83.65% of the deceased infant respondent agreed that deceased Infant Mother failed in balancing work and life this caused mental pressure and some disturbance in relationship between the deceased infant father, in-laws and deceased Infant Mother due to this problem deceased Infant Mother was completely stressed during pregnancy.

87.5% of the deceased infant respondents had opined that lack of empowerment of the deceased Infant Mother is one of the determinants of Infant Mortality, deceased Infant Mothers were not having any idea regarding sterilization and completely bounded in the name of culture and traditional practices and Socialized with belief in Evil Spirits sorcery, witches and these Custom, cultural practice govern the deceased Infant Mothers life this shows the low empowerment and also discriminated at every step reduces to low status and loaded with work and no right to take decision, No right to decide the size of the family, lack of nutrition's, lacks right to seek health care even in emergency, deprived of sanitation, No right of mobility, no right in family resources, No right to demand, no idea and right to childcare, lack of equal pay for equal work etc. all these factors cause threat to mother life.

73.07% of the deceased infant respondents had opined that cultural beliefs of the deceased Infant Mother family is one of the determinants of Infant Mortality, faulty feeding and raring practice of the deceased infant family members is one of the reason for Infant Mortality, when the pregnant women are expected to make dietary changes that increases their intake of food high in protein,

in calcium, milk and in green vegetables, these are forbidden in many rural societies for reasons that the fetus is located in the stomach and that it makes fetus to grow enamors, during pregnancy deceased infant mothers were not fed adequately due to the fear of growth of the fetus, lending the delivery difficult. Even women are fed with methi, ajwain and hing to keep the stomach clear of flatulence, during the Pregnancy they said that drinks will help the fetus to move freely in the stomach, and which is necessary for its proper growth. There is no concept of Immunization of the deceased infant even it is avoided and also the vaccination of the child. Pregnant women though they receive folic acid and iron tablets from the anganwadis, they throw them away, considering them to be heat and dangerous to the body, during pregnancy and after delivery deceased Infant Mother need to consume alcoholic drink they believe it is a must for the lactating mother to recoup her strength. "India is an anthropological wonder" with too many beliefs and numerous practices and which one is right or bad is hard to say, so it is concluded that from the above mentioned practices directly and indirectly caused danger to the mother life and infant life

26.92% of the deceased infant respondents had agreed that deceased Infant Mothers In-laws greediness is one of the determinants of Infant Mortality, deceased Infant Mother was completely stressed because of loneliness during the pregnancy and after delivery, this is because due to the greediness of the deceased infant in-laws, because some demands of the in-laws was not able to fulfill by the parents due to this reason in-laws stop caring and started to neglect the deceased infant and mother during the maternal stage, this caused stress and loneliness during the maternal stage of the deceased Infant Mother.

25% of the deceased infant respondents had agreed that deceased infant families caste is one of the determinants of Infant Mortality, the different customs and traditions, different way of thinking between deceased infant in-laws and parents and failed to balance these rituals caused threat to infant life and mother's in-laws different food system and different type of cooking method was one of the reason.

89.42% of the deceased infant respondent had opined that environmental factors of the deceased infant family is one of the determinants of the Infant Mortality, there was no matter of cleanliness and hygienic, no proper ventilation and no portable drinking water in deceased infant family caused threat to infant life.

From the Table 1, it is concluded that majority *i.e.* 85.57% of the deceased infant respondents had agreed that deceased infant families' poverty is one of the determinants of Infant Mortality. Economic factors influences infant mortality in a big way, child survival depends on the ability of the parents to offer good care .many studies have highlighted that the degree and quality of survival of the infant lie with the quality of care providers, the numerous economic factors have both direct and indirect impact on the survival of child and on infant mortality.

Suggestions:

Since the PHCs play a pivotal role in the Government sponsored Rural Health Service System and as the empirical surveys reveal that they are in disarray and do deserve heightened training and orientation. There is adequate political will to develop rural health services. Government should respond to several public health workers who have pointed out that in spite of their concern for the women and children's health needs, there is still a lack of co-ordination and commitment of the official apparatus at the village level. The Panchayats, the PHCs, ICDS, Health workers all work in isolation. There is considerable degree of Unmet needs for maternal and child health services. There is no collaborative and co-ordinate functioning of these agencies and other institutions. Therefore the efforts have not helped in reduction of IMR. Besides this, it is recommended that the recruitment of staff to the Anganwadis, Primary health centers and ASHAS to the PHCs, Sub-Centers need a thorough review. ANMs regular home visits to counsel women on maternal and child health care has to be regular and has to be constantly monitored.

Some Legal Points Concerning IMR:

1. The practice of feticide, the killing of the unborn child and later committing infanticide are cognizable offences. They are non-boilable to, and the punishment under the act need to strengthen, imprisonment years need to raise and fine need to increase, compulsory registration of medical practitioner need to strengthen.

2. Solemnizing of child marriages is against the law prohibiting child marriage. Marriage of girls below the age of 18 years is also prohibited and need to strengthen the Act and need punishment with rigorous imprisonment etc.

3. Strictly Dowry giving and taking are offences under the dowry prohibition act, in the study majority of the infant mortality caused due to early marriage so the act need to strengthen according to the cases and imprisonment term need to increase, more advertisement regarding the Act and create awareness.

4. The prenatal diagnostic techniques tests with a view to reveal the sex of the fetus is banned by law but still it need to strengthen and need to create more awareness.

5. Only the Medical termination of pregnancy act enables women to terminate pregnancies for certain valid reasons. The MTP act empowers accredited hospitals and doctors to undertake such operations.

6. Domestic violence perpetrated on women is prohibited by law so also is the torturing and abuse of children and women.

7. Registration of births, marriages and deaths have been initiated by states not merely for purposes of census records but to ensure a variety of safety measures to the infant/child, and the mother. The lack of awareness of our laws is a negative feature. The National health and other policies on empowerment of women, alas, receive a scant or no attention from the rural community. Abetments to such offences are also cognizable and severely punishable yet it continues, in our large country. This was also confirmed by our field investigators. In the villages visited by them, none of these laws or policies, have been followed or obeyed by the local village community. One can attribute ignorance for such inaction, yet one cannot ignore the fact that the social disregard against the laws appears more powerful than the laws themselves. This dishonoring of the law is again the outcome of strong socio-economic causes and the cultural way of life and lack of awareness. Such a situation is not at all conducive to reducing infant rates. One can deduce from such a rural scenario which is bereft of the respect of law besides being indifferent to the modern medical care. What hope then can have in preventing the rising/stagnating IMR.

This state of affair does seem very bleak. It calls for innovative programmes and strategies towards multi-pronged attempt to change the behavior of the people

Women's Empowerment: A Sure Recipe to Reduce IMR:

A. Healthcare empowerment: needs massive awareness and contact strategy.

1. Available health infrastructure especially in rural areas is too inadequate to cater to Women who are half of the Existing Population.

2. The Indian planning being predominantly an economic process, offers a miss-match to respond to our tradition-bound superstitious rural ethos. This public policy is not able to break this superstitious life cycle handed over from one generation to another;

3. Behavior modification is a big communication challenge to grapple with and there is need to retune the Planning process for the social sector.

4. Identification and removing of a plethora of handicaps suffered by women including lack of autonomy in decision making even about her own health and that of her infant are imperative and important.

5. Therefore, need to step-up ten times massive awareness programmes for the rural folk to make them grasp positive information about health to their own advantage. A triple insurance scheme for women's empowerment: We need to introduce a triple insurance scheme ensuring Health, Education and Employment for all women especially for those living below poverty line. Offer nutritious and cooked meals to children of anganwadis and pregnant and lactating mothers. Women's empowerment in the household and community, needs integrated Planning with multispectral policy assuring economic cover and opportunities for free health, education, right to life and survival and freedom of choice and right to regular employment and income. Unless the woman is liberated and enabled to seek health care, any amount of superstructure with adequate infrastructural facilities will be futile. Empowering women to take their own decisions and to free them from the patriarchic hold is a top priority for Planners and Policy makers.

Education: Awareness and People's Empowerment:

The social, cultural and health conditions related to low status of women in India have a negative impact on child survival; improvements in female education, nutrition and the use of maternal health care services would help in reducing infant mortality.

Needed strategies:

– Identification of high risk blocks showing high infant deaths especially female infanticide.

– Establish Health Co-ordination Committees involving Panchayath at leaders, ward members, medical officers and health staff, revenue department officials,

voluntary agencies, community leaders and other influential persons at village /block and district levels. Functions of this committee would be to. Identify families with more than one female child. Encourage these to avail all health services for safe pregnancy, delivery and child survival and curbing infanticide practices.

– Highlighting government of benefit schemes for women and girl child. To involving adolescent girls groups and PRI groups for health issues related to body mapping, reproductive health, family welfare, girl child protection, institutional delivery, to eliminate sex determination tests and work for gender equality .

– To introduce the cradle baby scheme of Tamilnadu to prevent babies from infanticide. To establish operation theatres in PHCs to facilitate family planning services and medical termination of pregnancies.

– To ensure early registration of pregnancies, and for early detection of high risk cases, improving institutional deliveries, providing skill development training to health staff on new born resuscitation techniques are important.

– To provide RCH training to medical staff, providing health management information system and also training for record management etc.

– To educate the mother of the merits of antenatal care, institutional delivery, importance of exclusive breast feeding, immunization, home care for diarrhea; all these are meant to create awareness among family members to provide support to women during pregnancies and deliveries.

Direct and indirect plan schemes deserve fresh look and new emphasis:

Now turn to some ideas of the direct and indirect schemes which can help mission of getting rid of this social malaise and scourge of Infant Mortality. One small point would like to repeatedly emphasize is that the Policy makers should continue to remember is that the Indian populace lives, simultaneously, in several centuries time frame and concomitant practices. As hinted earlier, therefore, some Plan Schemes, all, propounded by the First Five Year Plan and by succession thinkers may still be valid in some parts of India. However, that does not prevent from fresh creative thinking for and towards future.

Role of Anganwadi Workers and ANM'S:

Need to look at two additional points here. As they also deserve Scrutiny and remedial measures to augment the role of Anganwadis and ANMs. The Anganwadi workers along with ANMs are expected to attend to women for antenatal care and post natal care; care of infants and provide for women and children for immunization and vaccination needs. The Anganwadi worker also counsels them on the advantages of these Procedures and about the nutrient requirements. During pregnancy however, all the children were coming for the 'nashta' only. They were seldom engaged by the Anganwadi workers in teaching them good sanitary practices, even through, "Role Play". It is apparent that for this government need to have highly trained Anganwadi workers. The ANM's have hardly any time for such activities. Women of the villages strongly fell that the ANMs are only occasional visitors. Hence they cannot entirely depend on them as ANMs are not available daily and certainly not during emergencies.

Stepping up of Training and Mass Awareness Programmes:

The Government's plan to train PHC staff as multi-purpose health workers in curative skills is a welcome step. But what is ailing PHCs is lack of supplies and medicine, even for the qualified doctors, to dispense. There is an urgent need to equip near empty PHCs with medicines and other needed resources by way of staff, equipment to make them effective medi-care service provider. Equally important is the intensive training of the PHC staff to develop a more adequate health care delivery system. Even modern doctors need to be trained to make them more sensitive to the villager's needs. These doctors need to think of their as 'authority' this will enable them to pass on valuable health ideas to people in a manner they can understand. Hopefully it may add to the quality of life. Besides such sensitivity may have indirect and direct impact towards the reduction IMR. Responsive Health planning and medical orientation will require the benefit of anthropological research into regional health profile. This will help planners to assess their right manpower, and supplies. If training gets supplemented by the region specific modules, then we can impart a new knowledge. And above all to equip all Rural Medical Practioners (RMPs) to be given better knowledge of allopathic medicines. They can become helpful change agents in the rural area, since people need to have faith in them.

NGO'S can be additional trainers:

To some extent the health culture of a community gets reflected in the health behavior of the people. The introduction of the health delivery system by the government, can be effective only if the cultural perception accept, and sees the public health care interventions, as purposive and useful, could encourage NGOs, assisted by the State; to help orient husbands and mothers-in-law to become more caring a person towards the expectant mothers and the girl child. Some Ngo used the tool of 'Role Play' approach through social worker it was made a tool to train a group of husbands to sensitize them towards expectant mothers. These husbands were asked to dress like a woman; pillows were tied to their tummy to make them feel that they were heavy like the pregnant women. They were asked to cook with 3-4 children wailing around them. Simultaneously, they were to take care of the children while they were cooking. Besides their heads were totally covered, face not visible and they faced smoking too. Finally, they were asked," will you agree to like this for nine months? In just one hour it was reported that this short experience did make some impact on the participating husbands and their perception of woman did alter a wee - bit. Similar programmes can be designed for mothers-in-law, to not consider a girl, "others property" and an expensive commodity or only a machine to produce 'boy' child. A doctor in the group explained later, how a pregnant woman should be treated;" why there is an urge to kill a girl child when the woman has gone through the same pain and suffering as they gone through by delivering a male child." The truth of the matter is, and it is very significant that, invariably, the killer of the girl child, in majority of the cases, is the mother-in-law who demands of the dais to kill the newborn baby girl.

Conclusion:

It would be insane and Churlish to suggest that the Planning Commission and the Policy making personnel are not trying to invigorate to the best of their effort for the neediest sector of Rural India. What is it then that the Government of India's plethora of schemes is missing? For the indirect steps, they are regulating ground water use; they are stepping up development by industrializing locally and also integrating agricultural markets. They have introduced the Kisan Credit cards and yashasvini yojane allied reforms to strengthen the economic base for the poor people.

The decline in IMR was on account of the decline in post neo-natal mortality. The future decline is anticipated due to decline in neonatal mortality. The neonatal mortality is primarily consequences of endogenous factors, which are largely governed by the maternal causes and thereby call for the monitoring of infant mortality ratio in the population. The results of large-scale survey have however shown that there was a decline in IMR over time indicating an urgent public health concern. The complications of pregnancies and the births are found to be the leading causes of deaths and disability among women of reproductive age. The health problems of mothers and newborns arise as a result of synergistic effects of malnutrition, poverty, illiteracy, unhygienic living conditions, infections and unregulated fertility. At the same time, poor infrastructure and ineffective public health services is also responsible for low inadequate obstetric care. The exact ascertainment of the situation could be monitored with the availability of IMR estimate and causes of infant deaths.

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