

To Assess The Impact of Government Nutritional Programme on Health Status of People of Kanpur



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Abstract

In rural and backward areas the majority of women are illiterate and women work force were involved in agricultural and other unskilled activities. Economic development depends generally on nutrition and it improves health, health and education improves attitude promote development by increasing production. Women contribute economically to the well-being of the family or the household members. The earning of working mother has positive influence on the nutritional and health status of their children. The dietary and nutrition transition, characterized by improved agriculture practices, food supplies and advances in food processing techniques.

Keywords: Particularly, Contribution, Unrecognized, Compensated, Illiterate.

Introduction

In Indian society, women's place has primarily been confined to the home and her role is limited to procreation, rearing of children and catering for the needs of men folk by way of creating comforts. Usually woman perform multiple duties by combing all types of households work including child care with such other jobs as farming, animal husbandry etc. women emancipation and empowerment cannot be complete if due importance is not given to her education. Depending upon the opportunities affected by the complex socio economic and organizational structure of the life.

Indian women from time immemorial, has been the nucleus of home. The first and important institution is home. Girls learn everything from home by imitating his or her family members, particularly, mother in rural areas where mothers are mostly uneducated, there is hardly any stress given to children's education whereas in urban areas the trend is just the reverse. Woman in a family, play their role as mothers, sisters, wives and grand mothers at various stages of their lives. Her tremendous contribution in household work, child rearing, preparing food for all family members, carrying drinking water and firewood from miles away, looking after the needs of husband and children etc. till date, is over looked and goes unrecognized. The time she spends for the above household activities and the labour she puts in, is not compensated in terms of money. Whatever it may be, a home without women is incomplete.

In rural and backward areas the majority of woman are illiterate and women work force were involved in agricultural and other unskilled activities. This is also true that is case of urban and developed areas, where the majority of women are engaged in unskilled labour, mostly involved in menial labour services, and hence remain unskilled throughout their work lives. Increased work participation of women is considered as one of the remedies to elevate their position in the society. In the poor communities, they do much strenuous physical work for a proper living. They spend 3-4 hours in agriculture production, 2-5 hours in food processing and preparation and 0.5-3 hours in collecting fuel and a further 1-5 hours in other work as production craft and marketing. The amount of time spent on working is, generally between 7 and 12 hours daily. They work long hours than men folk and have less time for leisure and social activities.

Objective:

1. To determine the impact of selected programmes on farm women health status.
2. To study the opinion of rural women towards management aspects of training programmes.

3. To visualize the impact of government nutritional programmes conducted in different areas.

Review of Literature

Marinda, P.B. *et al.* (2006) reviewed on their exists gender bias in resource ownership in many parts of Kenya with women being more disadvantaged. Resource ownership and control within the household has differential impacts on the health and overall well-being of male and female members. This paper examined intra-household resource ownership and how it affected nutrition and health status of household members. Data from a household survey containing detailed gender disaggregated information on resource ownership as well as food and anthropometry were collected from a rural Kenyan district and used in the analysis. Results showed that male members of the household had more access to education, income and land than the females. Mother's education, household income, frequency of illness and nutrient intake were the most important factors that contributed to the nutritional status of children.

The education and household's economic status were important determinants of child morbidity. Malnutrition and poor health of children and women is linked to the existing poverty in the study region, therefore emphasis needs to be put on eradication of discrimination against women in accessing education and accessing land, which will contribute to an increase in household incomes. Government policies need to focus on promotion of nutrition education through adult education programmes and incorporating it in the school curriculum. Improvement of healthcare facilities in rural areas is also paramount to improving health and nutrition in these areas.

Nwachuku, I.N. *et al.* (2007) showed that the rural development programmes which had poverty alleviation objectives impacted significantly on productivity and farm income at 5 percent level of probability. Awareness was perceptibly high. While participation was more in Agricultural Development Programme (ADP), with an overwhelmingly percentage representation of about 79, than in others programme planners and implementers are therefore urged to intensity awareness creation among rural dwellers and adopt the use of community driven development approach (CCD) in the execution of rural development projects with poverty alleviation thrust. Government, at all levels, was advised to adopt price support policy that raises income of producers.

Das, M. *et al.* (2010) study was carried out in 3 blocks of Jorhat district (Assam, India) namely, Baghchung block, Dhakorgora block and Sipahikhula block covering around 900 rural women (300 from each block) belonging to different self-help groups. It can be observed that out of 300 respondents from each block, the percentage involvement of rural women was different in respect to different activities under different blocks. Out of all the activities, it was found that highest percentage of involvement was in agriculture (30%), followed by weaving (26.7%) pickling (13.5%), confectionery and animal rearing (11.6%). Before training, it was found that only 28% of the rural women had basic knowledge and information

regarding different aspects of health, 26% on nutrition and only 12% on post harvest handling techniques. With the exposure to training programme definite improvement took place in terms of their knowledge, skill and adoption. Before the training, most of the women (70%) were poor and 25% in fair category but after the training programme, 84% were in good category, 2% in very good category and 14% in fair category. This showed that the programmes were effective in improving knowledge level of farm women.

Kavanagh, K.F. *et al.* (2010) focused group participants to inform the future development of region-specific educational strategies to modify infant feeding practices that may predispose children to obesity. Infant feeding perceptions and practices were collected from participants of the special supplemental nutrition programme for women. Infants, and children, through recorded focus groups, in two East Tennessee countries. Focus groups replaced the participant's required, prescheduled nutrition-education classes for participants with infants younger than 6 months of age. Twenty-nine focus groups were convened and recorded, reaching a total of 109 participants.

Results of this series of focus group indicate that the special supplemental nutrition program for women, infants, and children population in rural East Tennessee was similar to populations else wherein terms of early solid-food introduction, frequent switching of formula, and sources of and valuation of infant-feeding advice. However, this population seemed to be different in the magnitude at which they introduce infant cereal early (primarily as an addition to the bottle). For this reason, interventions designed to reduce inappropriate infant-feeding behaviours in this population should focus on early introduction of solid food.

Manjaliwala, J.G. *et al.* (2010) reported that major findings of how synergizing agricultural science and technology (research), development and training using the Agricultural Research and Development Programme (ARDEP) in Malawi as a case study can benefit the rural masses in Africa. Within the 3-5 years of implementation, ARDEP has registered 16 technologies whose uptake has increased by more than 75% contributing to increased income by over 20%, live stock units by more than 400% and under irrigation by more than 200% reaching 32-56% women farmer's, 15% of which are affected by HIV/AIDS.

Chandavari, V. *et al.* (2013) study was conducted during the year 2010-2011 in Dharwad block of Karnataka State purposive random sampling technique was used for selection of four blocks in Dharwad taluk i.e. garag, Mugad, Alnavar and Hebballi where the primary health centres are located. Random sampling procedure was used for selection of 210 respondents, which includes 150 mothers of below poverty line, 30 community leaders and 30 block level health official.

Community leaders had most favorable opinion about polio vaccine, polio disease, benefits of hospital delivery, immunization for children and pregnant women (100%). Majority of the mothers were facing problem in prasooti Arai programme

(96.66%) and were not getting incentives in time. Majority of the community leaders faced problems of untimely implementation of the programmes lack of improvement in the infrastructure of PHC neglecting the patients by the staff (90.00%). Cent per cent of the officials faced the problem of lack of knowledge and awareness. Amongst all independent variables caste was significant with knowledge at 5% level. Education was significant with awareness at 5% and knowledge at 1% level, while size of land holding was negatively significant with opinion at 5% and adoption at 1% level.

As per my knowledge the latest reviews has been found till 2013. We have tried out best but unable to find the data after 2014-2018.

Methodology

The research methodology has been discussed under the following heads:-

1. Selection of the Research design
2. Sampling procedure
 - (a) Location of district
 - (b) Selection of district
 - (c) Selection of block
 - (d) Selection of villages
 - (e) Selection of respondents
3. Selection of variables and their measurements
4. Selection of statistical tool
 - (a) Preparation of interview schedule
 - (b) Pre-testing the schedule
 - (c) Collection of data
 - (d) Analysis of data
 - (e) Statistical measurements

Research design refers to systematic plan to study a scientific problem "A plan that describes how, when and where data are to be collected and analyzed". The study was carried out by descriptive type of survey method. Accordingly, after a through meaningful formation of the problems specific

objective were decided. In the light of these objectives, techniques of investigation to be followed, extension tools to be used and major statistical plan of analysis to be followed were decided.

Further the presentation of the study was developed and given a definite shape in the form of an outline of the study. In order to understand the findings of the study in the wider context and to evaluate their relevance in the set objectives, an effort was made to make a through review of the relevant literature relating the previous research in this field.

The needed conceptual classification about the terms and items used within the frame work of the study was considered necessary for which the help of both literal and operational definitions was taken.

The findings of this study have been properly discussed in the light of the available research material on the subject and subsequently summarized throwing light on all major aspects covered within the scope of study. The conclusion and the action implication are made to satisfy the fruit bearing aspect of the research.

Uttar Pradesh is comprised of 75 districts. Out of this one district viz., district Kanpur Dehat was purposively selected for this study. This helped in collecting the necessary information accurately and timely.

There are 10 blocks in district Kanpur Nagar. Out of these blocks, two blocks viz., Kalyanpur and Chaubepur was randomly selected for the study.

Selection of villages was based on availability of respondents. Six villages were randomly selected from the selected block.

A list of women, girls belonging to different villages was prepared separately from each selected village, 25 women and girls were selected randomly from each village. Thus, in all 150 respondents were selected for study purpose.

Result and Discussion

Annual Income

Table 1 : Distribution of respondents according to annual family income

N=150

Annual Income	Frequency	Percent	Mean	S.D.
Up to Rs. 50000	56	37.3	36129	7497
Rs. 50000 to Rs. 100000	63	42.0	70254	14478
Rs. 100000 to Rs. 150000	17	11.4	122647	14756
Rs. 150000 and above	14	9.3	305643	154903
Total	150	100.0	85421	89164

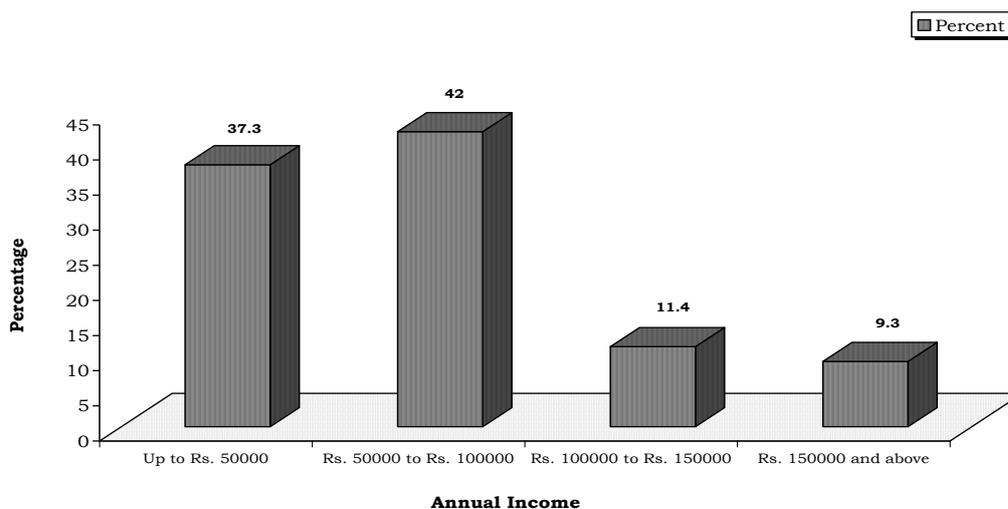


Figure-1 : Distribution of respondents according to annual family income.

Table-1 distribution of respondents according to family income annual with maximum 42.0 percent respondents with mean 70254 and SD is 14478 belonged to those families whose annual income were between 50,000 to 1,00,000, 37.3 percent respondents with mean 36129 and SD is 7497 belonged to those families whose annual income were upto 50,000, while 11.4 percent respondents with mean 122647 and SD is 14756 belonged to those families whose annual income were between 1,00,000 to 1,50,000 and minimum 9.3 percent respondents with mean 305643 and SD is 154903 belonged to those families whose annual income were between 1,50,000 and above.

The economic status is major common to procure the facilities and amenities in every part of life and economy is important resource for the recipient medical care and health services to women and children. It holds more constraints in nuclear family where family size is more and source of income was less.

Table 2 : Distribution of respondent according to participation in local area training programmes.

N=150

Local area participation	Frequency	Percent
Yes	63	42.0
No	87	58.0
Total	150	100.0

Table-2 reveals that distribution of respondents among participation in local area with

maximum 58.0 per cent were not participated in local area in training programme and minimum 42.0 percent respondents were participated in local area training. Because maximum women were found unaware about training programmes because long distance travelled from home to center and some women showed lack of interest in trainings and she felt no proper way how to implement this training programme in daily life. Hence it shows that majority of respondents were not participated in local area training.

Table 3 : Distribution of Respondent According Known Training Center

Training center	Frequency	Percent
Aganwari Center	29	26.4
KVK	74	67.3
Mahila Mandal	7	6.3
Total	110	100.0

Table-3 Shows that distribution of respondents according to known training center that provided training for rural women in rural areas, maximum 67.3 respondents were known KVK training center, 26.4 percent respondents were known aganwari center and minimum 6.3 percent respondents were known Mahila Mandal as training center. This was mainly due more training camp organized by KVK so, women were more aware about this training center than rest of other center. Hence it shows that majority of respondents were known KVK training center.

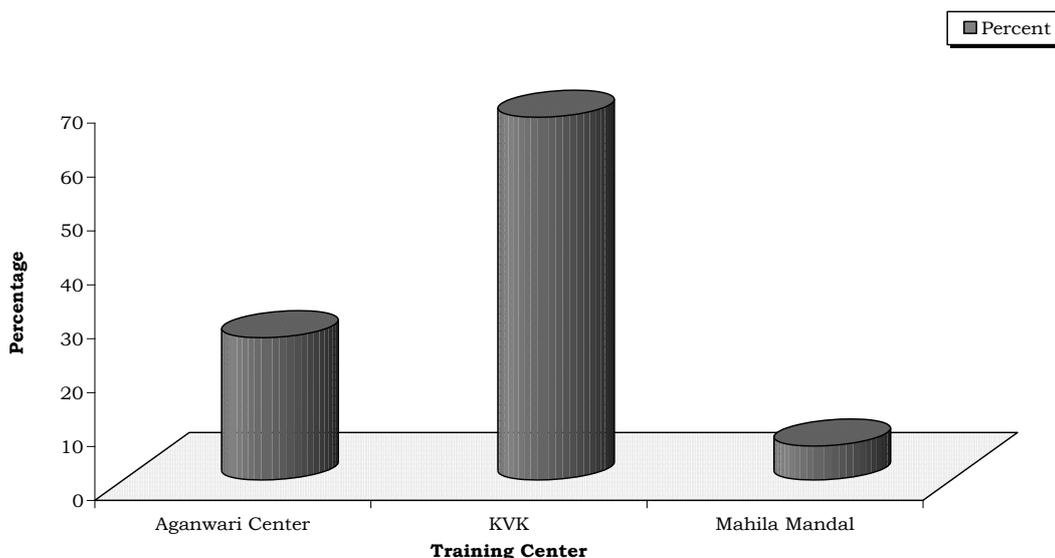


Figure - 3 : Distribution of respondent according known training center.

Table- 4 : Distribution of Respondent according to Membership and Participation in Different Organization

N=150

Membership	Frequency	Per cent
1. Members		
Member	70	46.7
Non-member	80	53.3
2. Organization		
Gram panchayat	3	4.3
Mahila mandal	6	8.6
Self help group	28	40.0
Women group	27	38.5
Any other	6	8.6

Table - 4 shows that distribution of 46.7 percent respondents because of membership, 53.3 percent respondents were non members of any organization mainly due to lack of encouragement, unawareness and other personal problem while, 46.7

percent respondents was member of different society like SHG, Mahila Mandal, gram panchayat, women group and other group, reveals that distribution of respondents according to participation in different type of organization with maximum 40.0 percent respondents were participated in SHG organization, followed by 38.5 percent respondents were participated in women group, 8.6 respondents were participated in mahila mandal and any other organization and minimum 4.3 percent respondents were participated in gram panchayat.

This table shows that majority of respondents were member of SHG (40.0) percent and evenly participated in this group and minimum 4.3 percent respondents were member and participated in gram panchayat mainly due to lack of sources of government nutritional programmes and training, so people less aware and participate in gram panchayat.

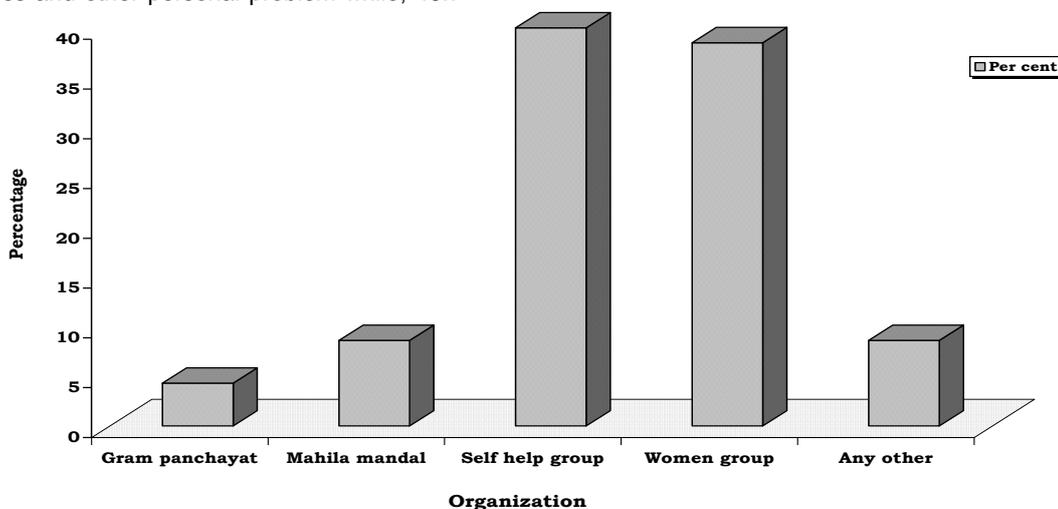


Figure - 4 : Distribution of respondent according to membership and participation in different organization.

Table - 5: Distribution of respondents according to problem experienced in utilizing training inputs.
N=150

Problem experienced in training	Frequency	Percent
Yes	28	18.7
No	122	81.3
Total	150	100.0

Table - 5 shows that distribution of respondents according to problem experienced in utilization of training inputs in which 81.3 percent respondents were faced no problem and 18.7 percent respondents were faced problem in utilization of

training. This was mainly majority of women were not practice again at home so, they felt no problem in utilization of training input.

Balance Diet
Table - 6: Distribution of respondents according to awareness about balance diet.
N=150

Awareness about balance diet	Frequency	Percent
Yes	34	22.7
No	116	77.3
Total	150	100.0

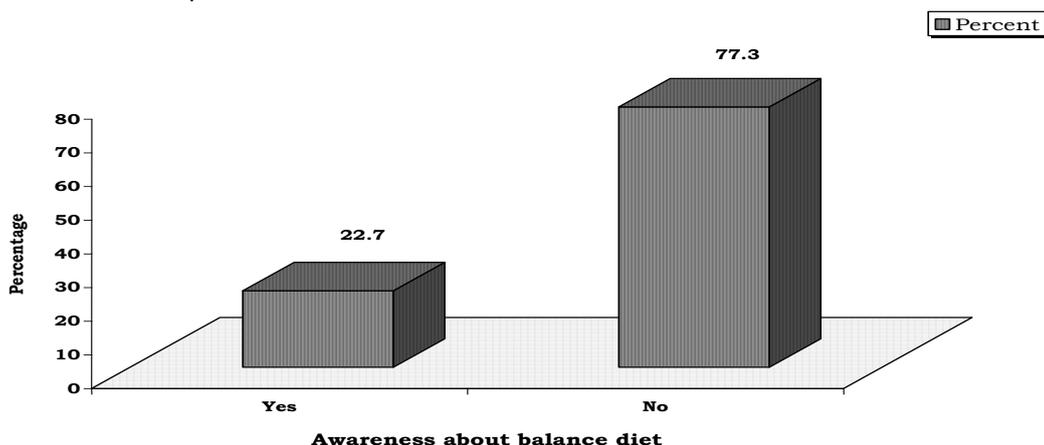


Figure - 6 : Distribution of respondents according to awareness about balance diet.

Table - 6 depicts that respondents were have knowledge about balance diet and maximum 77.3 percent respondents were not aware about balance diet and 22.7 percent respondents were aware about balance diet.

provided in Aganwari Center were found that maximum 52.7 percent respondents were not aware about the facility provided in Aganwari Center and minimum 47.3 percent respondents were aware about the facility provided in Aganwadi Center.

Balance diet is consisting of five basic food groups i.e. cereals, pulses, and legumes, milk and meat products, fruits and vegetables, fat and oils in such quantities and proportion so that need for calorie, proteins, minerals, vitamins, and other nutrients is adequately met.

Table- 7: Distribution of respondent according to awareness Aganwari programmes.
N=150

Awareness of Aganwari Center	Frequency	Percent
Yes	71	47.3
No	79	52.7
Total	150	100.0

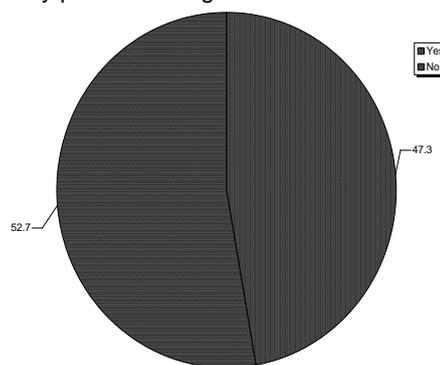


Figure - 7 : Distribution of respondent according to awareness Aganwari programmes.

Table - 7 shows that distribution of respondents according to awareness about the facility

Awareness about sources of information

Table - 8 : Distribution of According to Source of Information Provided by Government
N=150

Sources of information about government programmes	Frequency	Percent	Score
Panchayat Samiti	3	2.0	Below average
B.D.O.	2	1.3	Least
Aganwari Center	38	25.3	Average
Other source	107	71.4	Above average
Total	150	100.0	

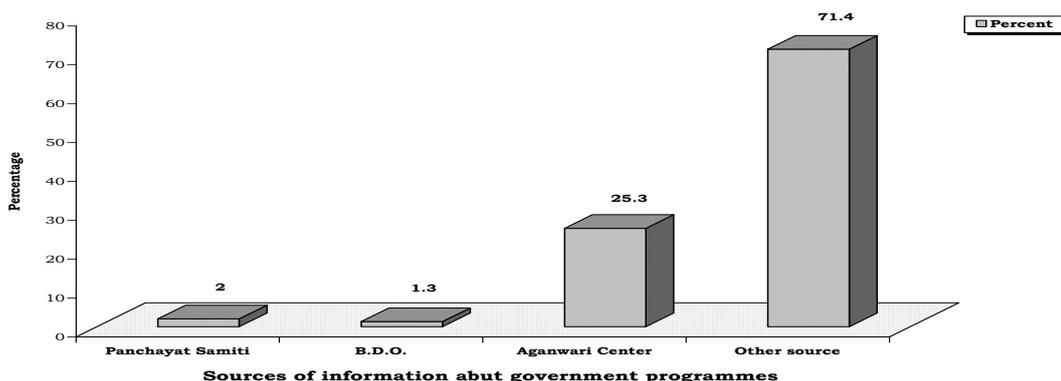


Figure - 8 : Distribution of according to source of information provided by government.

Table - 8 it was evident that the distributions of respondents according to source of information about government programmes for rural women were found to be maximum. 71.4 percent of respondents were received source of information about government programmes from other sources (neighbours, family members, relatives etc.) followed by 25.3 percent of respondents were received awareness about source of information from aganwari center and considered as average, only 2.0 percent of respondents were having source of information

received from panchayat samiti about government programmes and were consider as below average and minimum 1.3 percent of respondents were having source of information received from Block Development Office (B.D.O.) and were consider as least. So, it shows that maximum information were received from other source. It was analyzed that the source of information about different programmes for rural women were found that majority of respondents were received awareness from other sources.

Lactating Mothers

Table - 9 : Distribution of the respondents according to knowledge about different programmes for lactating mothers.

Nourishment of lactating mothers	Nil knowledge	Partial knowledge	Complete knowledge	Mean score	Rank
ICDS	30.0	62.0	8.0	1.78	I
SNP	80.0	19.3	0.7	1.21	II
NMBS	82.7	16.7	0.7	1.18	III

Table - 9 shows that distribution of respondents according to knowledge of ICDS programme for lactating mothers were found that maximum 62.0 percent respondents were partial knowledge about the programme followed by 30.0 percent were will knowledge and minimum 8.0 percent were complete knowledge of the programme with mean score 1.78 and rank I. Knowledge of SNP programme were found that maximum 80.0 percent were nil knowledge followed by 19.3 respondents were partial knowledge and minimum 0.7 percent

respondents were complete knowledge about the lactating programme with mean score 1.21 and rank I.T. knowledge of NMBS programme were found that maximum 82.7 percent respondents were nil knowledge of the programme followed by 16.7 percent were partial knowledge and minimum 0.7 percent were complete knowledge about the programme for lactating mothers with mean score 1.18 and rank III. It was analyzed that majority of respondents had nil knowledge about government programme for lactating women.

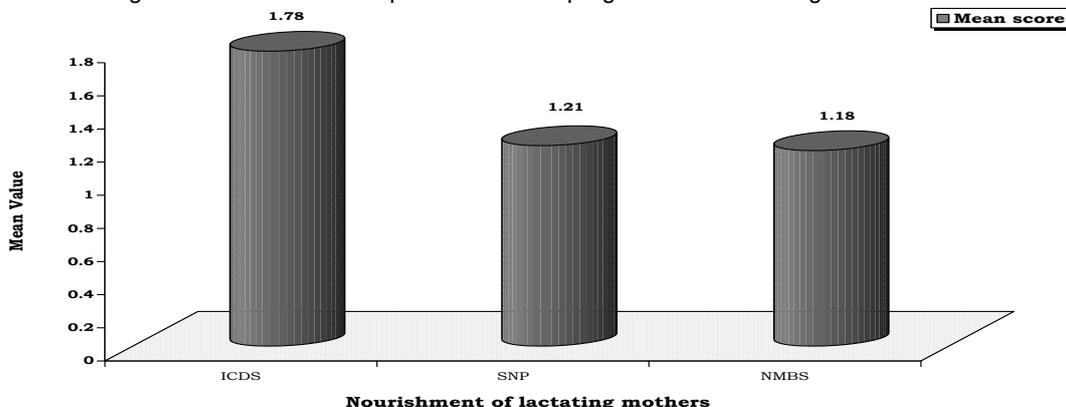


Figure - 9 : Distribution of the respondents according to knowledge about different programmes for lactating mothers.

Summary and Conclusion

1. Majority 42.0 percent respondents were fall under 50,000 to 1,00,000 income group, 37.3 percent respondents were fall under upto 50,000 income group, while 11.4 percent respondents were fall under 1,00,000 to 1,50,000 income group and remaining 9.3 percent respondents are from above 1,50,000 income group.
2. Majority 73.3 percent respondents were just aware about training center and minimum 26.7 percent respondents were not aware about training center. So, it focused that majority of respondents were just aware about training center that provided training to the women in rural areas.
3. 58.0 percent respondents were not participated in local area in training programme and remaining 42 percent respondents were participated in local area training. Hence it shows that majority of respondents were not participated in local area training. Hence it shows that majority of respondents were not aware and participated in training programmes.
4. Majority 67.3 respondents were known KVK training center, 26.4 percent respondents were known Aganwari center and minimum 6.3 percent respondents were known mahila mandal as training center. Hence it shows that majority of respondents were know KVK training center and no other training programme run in village.
5. 53.3 percent respondents were about social organization but not the members of any organization mainly due to lack of encouragement, unawareness and other personal problem and 46.7 percent respondents were participated in the organizaiton. Maximum 40.0 percent respondents were aware and participated in SHG organization, followed by 38.5 percent respondents were participated in women group, 8.6 respondents were participated in mahila manadal and any other organization and minimum 4.3 percent respondents were participated in gram panchayat.
6. Maximum 77.3 percent respondents were not aware about balanced diet and 22.7 percent respondents were aware about balance diet.
7. Maximum 52.7 percent respondents were not aware about the facility provided in aganwari center and minimum 47.3 percent respondents were aware about the facility provided in Aganwari center.

Women contribute economically to the well-being of the family or the house hold members. In rural and backward areas the majority of women are illiterate and women work force were involved in agricultural and other unskilled activities. This is also true that in case of urban and developed areas, where the majority of women are engaged in unskilled labour, mostly involved in mental labour services, and

hence remain unskilled throughout their work lives. In the poor communities, they do much strenuous physical work for a proper living. The dietary and nutrition transition, characterized by improved agriculture practices, food supplies and advances in food processing techniques. While making more food available to people has also resulted in imbalanced nutrient intakes changing health profiles. Peoples are consuming different types of diets resulting in changes in body composition and occurrence of chronic diseases at an unrepresented rate not seen before. Unhealthy diets and physical activity are two of main risk factor for increased blood pressure, increased blood glucose, abnormal blood lipids. Hence, it concluded that on the basis of above parameters it observed that maximum respondents have level of knowledge and skills related to programmes were fair, confidence in solving problem related to programmes and decision making were good, while on the basis of overall productivity and effectiveness in division of training programmes were good and expectation of respondents regarding post training programmes were fair. This was mainly due to lack of practice to improved skills related to training programmes in work environment.

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