

Research Article

## UTILISATION AND AWARENESS OF 'BALSANJEEVINI' HEALTH SCHEME AMONGST MOTHERS IN FOUR PRIMARY HEALTH CENTRES OF BELAGAVI TALUKA

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### ARTICLE INFO

#### Article History:

Received 25<sup>th</sup> May, 2017

Received in revised form 13<sup>th</sup>

June, 2017 Accepted 20<sup>th</sup> July, 2017

Published online 28<sup>th</sup> August, 2017

#### Key words:

Balsanjeevini, Below Poverty Line, Integrated Child Development Services, Malnourishment.

### ABSTRACT

**Background:** "Balsanjeevini Scheme" (BS), is implemented by Women & Child Welfare Department, Government of Karnataka. The main objective of the 'BS' is to reduce mortality and morbidity among Children of 0 to 6 years of age belonging to Below Poverty Line (BPL) families under Integrated Child Development Scheme (ICDS). The 'BS' provides upto 50,000/- to the sick neonates and Rs. 35,000/- to the children from 1 month to 6 years who are admitted to the recognised Net Work Hospitals (NWHs).

**Methods:**The study was conducted in four select Primary Health Centres (PHCs) of Belagavi Taluka, Karnataka to explore utilisation of 'BS'. Health Check camps were conducted for needy ICDS children by Department of Paediatrics of Jawaharlal Nehru Medical College (JNMC), Belagavi. Pre designed, pre-tested questionnaire were administered to collect information on the house hold socio-economic and demographic data, literacy, disease the child is suffering from, occupation of mother & father, habits, supply of drinking water were recorded. Also information on utilization and awareness of 'BS' was recorded.

**Results:** Out of 319 children examined in health camps, 110 eligible children were referred for higher investigations/admission to recognised NWH i.e., KLE Dr.Prabhakar Kore Charitable Hospital, Belagavi. 46 (42%) parents admitted their children to NWH and utilized the treatment under the 'BS'. However, 64 (58%) parents did not utilise the facilities of the 'BS'.

**Conclusion:** Uptake of the 'BS' among eligible children was low (58%). Community level awareness programs are needed to improve utilization among its beneficiaries.

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### INTRODUCTION

The first six years are the most important years in the life of children; during this period the foundations are laid for intellectual, social and emotional language, physical/motor development and cumulative lifelong learning.<sup>[1]</sup>

The ICDS programme is one of the flagship programmes of the Government of India, aiming to comprehensively address the nutrition, health and pre-school needs of children under 0 to 6 years of age. Balsanjeevini Scheme is the ambitious program of Women and Child Welfare Department of Government of Karnataka. The scheme funds for free treatment/surgery in the designated Hospitals. The beneficiaries of the scheme are children of BPL families in the age group of 0-6 years. The sole purpose of the scheme is to offer best of the healthcare services in the designated

NWHs to reduce mortality and morbidity among the children. The prevalence of malnourishment in children in India is among the highest in the world, and is nearly double that of sub-Saharan Africa with adverse effects on productivity and economic growth because of increased morbidity and mortality, states World Bank.<sup>[2]</sup>

The poverty, illiteracy and ignorance are the risk factors for under-nutrition.<sup>[3]</sup> Children in low-income families are more malnourished than those in high-income families. Children of minority households and those belonging to scheduled castes or tribes also have higher rates of malnourishment. This phenomenon of malnutrition is more rampant in the rural India. Whether children have appropriate height and weight is highly dependent on the socio-economic status of the population.<sup>[4]</sup> Children of families with lower socio-economic status are faced with sub-optimal growth. While children in similar communities share similar levels of nutrition; but within the same community child nutrition is found to vary

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from family to family, depending on the parents' characteristics, household traditions, customs and places of residence. It is expected that with improvements in socio-economic welfare, child nutrition will also improve [5] In fact, according to WHO, about fifty percent of infant and child mortality may be associated with malnutrition [6]

The ICDS has been functioning for over four and half decades in the country; it has failed to address its objectives, due to which children health management continues to be dismal. A systematic capacity building approach is proposed to improve the health of mothers and development children in India. This approach entails rejuvenation of India's public health, rather than the ICDS, as a major facilitator of maternal and child health improvements [7].

**What is 'Balsanjeevini' Scheme?**

'Balsanjeevini' scheme not only addresses the problems of malnourishment but also takes care of viral fever, neonatal care, neurological disorders, diarrhea, congenital anomalies, infections, all surgical procedures, etc. BS funding for in-patient treatment of child is to the tune of Rs.50,000 to the new born and Rs. 35,000/- to the children above 1 month of age. The scheme also provides an incentive in the form of loss of work/wage at the rate of Rs.100/ per day to the parents of the children on admission to the Hospital [8].

**Justification of Study**

The Government of Karnataka has taken immediate measure to address the health problems of children up to the age of 6 years through BS. NWHs have taken lead to examine the children at their PHCs/Anganwadis in the designated blocks. Children who require further interventions are referred to NWHs. But unfortunately, even after repeated follow-ups by Child Development Project Officers (CDPOs), Anganwadi Supervisors, PHC staff and NWHs, parents do not bring their wards for further admission/investigations to NWHs resulting in mortality and morbidity among ICDS children.

**Objective**

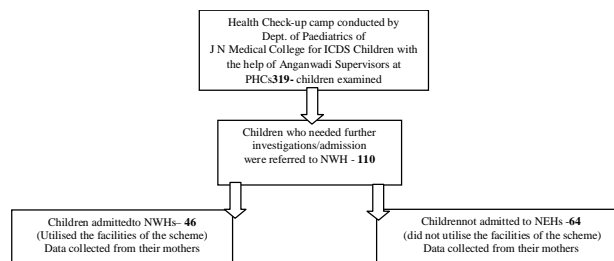
1. To study the utilization of 'Balsanjeevini' scheme amongst mothers.
2. To investigate the awareness and knowledge about of 'Balsanjeevini' scheme amongst care-takers.

**METHODOLOGY**

**Study sites and population**

A study was conducted to know the socio-economic background of parents and assess the utilization, awareness and knowledge about of 'Balsanjeevini' scheme among mothers of Primary Health Centres (PHC) of Handignur, Kadoli, Kinaye & Bendigeri of Belagavi Taluka, Karnataka. Department of Paediatrics of Jawaharlal Nehru Medical

College (JNMC), Belagavi conducted Health Check-up camps with the support of Anganwadi Supervisors/workers. In the health camps 319 eligible children were examined. Table (1) depicts the utilization and not utilization statistics.



**Study design**

A cluster sample survey was conducted on mothers of children up to 6 years of age who attended health camps in PHCs of Handignur, Kinaye, Kadoli & Bendigeri encompassing 21 villages of Belagavi taluka. The study was aimed to investigate the degree to which knowledge influences utilization, acceptability and smooth implementation of BS [9-11]. The pre designed, pre tested questionnaires were administered. Written informed consent was obtained from the participants prior to the interview.

**Data Collection**

The utilization of the scheme was determined by inverse sampling method. The data was gathered from the participants who utilized the services (46) and from those who did not (64). A total of 110 respondents who were advised further treatment after the health check-up were selected for the study. Data was collected from the mothers who utilized the services of 'Balsanjeevini' scheme during their hospital stay. Another group who refused admission (did not utilize the scheme) data was collected by visiting to their homes. The purpose of the study was explained to the parents and informed consent was obtained from the mothers. The household socio-economic and demographic data, literacy, disease the child is suffering from, occupation of mother & father, habits, supply of drinking water, etc were recorded.

**DISCUSSION**

The disease-wise break-up of the children who have utilized the facilities of the scheme is mentioned in table (2) and who did not utilize the facilities of the Scheme is shown in table (3)

**Group I (Utilised BS):** The study reveals that, 46 children have utilised the services of the BS. 19.6% (9) children had fever/infection, 30.4% (14) children were suffering from cough cold (Respiratory infection), in 13% (6) children weight was not matching to their age, 8.7% (4) children were suffering from Gastroenteritis and 28.3% (13) were victim of other ailments Viz; mental retardation, epilepsy, congenital heart diseases, delayed milestones, etc.

**Group II (Not utilized BS):** The study also established the fact that, the parents of 64 children did not avail the benefit of the scheme. Parents may underestimate the seriousness of the disease. However, the progression of the disease could be fatal. Children diseases cannot be neglected as they can aggravate rapidly leading to mortality or morbidity. 15.6% (10) children had fever/infection, 12.5% (8) had respiratory problems, 10.9 % (7) children reported loss of appetite and 53.1 % (34) children had poor weight compared to their age.

**Table 1** Health Check-up camps conducted at PHCs

PHC	No. of children examined	Children utilised scheme facilities	Children not utilised scheme facilities.
Handignur	95	12 (11.4%)	12 (11.4%)
Kadoli	120	12 (10.4%)	18 (21.6%)
Kinaye	87	12 (13.8%)	14 (16.1%)
Bendigeri	127	10 (7.9%)	20 (15.7%)
Total	319	46 (14.4%)	64 (20.1%)

1.6% (1) child had Gastroenteritis's and 6.2 % (4) children had other medical problems.

sickness in children. Diarrhoea leads to malnutrition while malnutrition aggravates the course of diarrhoea.

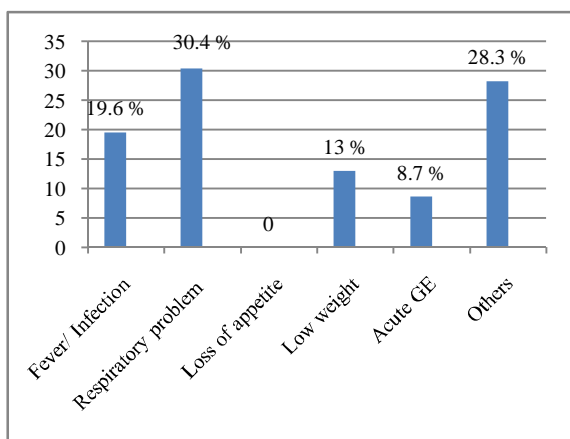


Table 2 Utilized Services (Disease patterns)

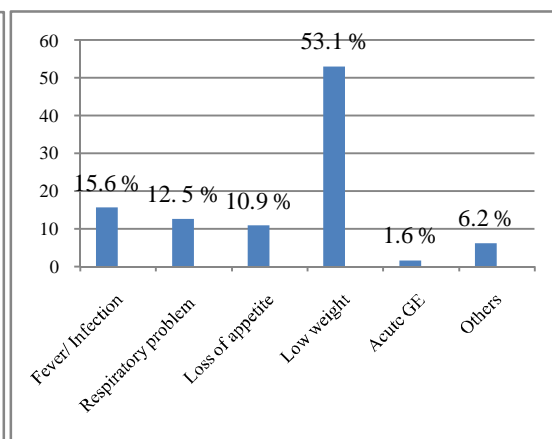


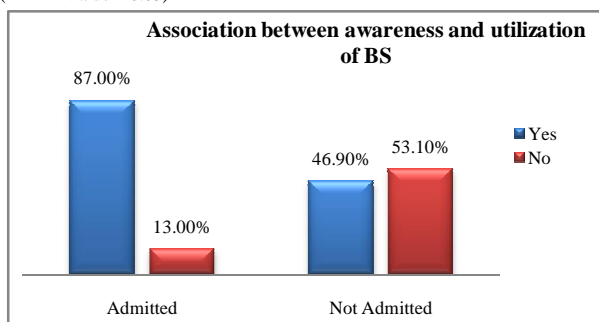
Table 3 Not utilized Services (Disease pattern)

Others - Mental retardation, epilepsy, congenital heart diseases, delayed milestones, etc

**Association between utilization of 'BS' and awareness regarding treatment for 0 to 6 years BPL family children**

Admission status	Awareness about BS			Chi square value	P-value
	Yes	No	Total		
Admitted	40 (87.0%)	6 (13.0%)	46 (100.0%)	18.581	0.001 (**)
Not admitted	30 (46.9%)	34 (53.1%)	64 (100.0%)		
Total	70 (63.6%)	40 (36.4%)	110 (100.0%)		

(\*\* = P- Value < 0.05)



Significant association was seen between utilization of service and awareness regarding 'BS' for 0 to 6 years BPL family children. We observe that among those who were aware, 87% of the participants had admitted their children, and 46.9% had not admitted (P- Value < 0.05). From this we can state that previous awareness increases rate of admission and utilization of service.

**Association between Malnourishment & Child sickness**

From the table (2 & 3) it can be interpreted that, low weight among children in the aforesaid PHCs is common and regrettably majority of the parents refused to utilize the services of scheme; 53% of malnourished children care-takers refused to get admitted to Hospital based Nutritional Rehabilitation Centre (NRC) and this is the major cause of concern. Parents do not recognise malnourishment as disease. Malnourished children fall prey to the disease quickly as their resistance to disease is poor. Various studies have clearly established strong association between malnourishment and

Lactose intolerance is a common cause of persistent diarrhoea<sup>[12]</sup>. Childhood malnutrition is an important risk factor for child mortality and contributes close to 50% of child deaths world wide Reducing the prevalence of malnutrition may contribute to the success of child survival strategies<sup>[13,14]</sup>. Pneumonia accounts for nearly one in five deaths world wide among children less than 5 years of age. Important risk factors associated with pneumonia in children include a lack of exclusive breastfeeding, malnutrition, poverty, cigarette smoke, air pollution and other common co-morbid conditions. It is important for clinicians and public health administrators to consider the barriers and work on reducing malnourishment to implement primary pneumonia prevention strategies<sup>[15,16]</sup>. Improving caretaker skills to recognize danger signs in child illnesses may improve health-seeking behaviour. Integrated Management of Child Illnesses (IMCI) programmes must be accessible to the poor in order to increase health care seeking and bring about improvements in child survival<sup>[17]</sup>.

**Need for further study**

1. Those who did not utilize the benefit of the 'BS' need to be probed, on questions like what were the barriers for underutilization.
2. Parents refused to accept higher treatment in NWH. Then where did they seek treatment and what is the condition of the children who did not utilize the facilities of the scheme need to be probed.

**CONCLUSIONS**

Considering the findings in this study, it is important that community-based interventions need to be formulated and implemented in order to improve child health. Educational interventions which target both the literate and illiterate women in society are necessary for effective utilization of the scheme. Governments announce public health schemes for the benefit of the needy population, but lack of awareness amongst the beneficiaries is the main reason for underutilization. It is equally important that all the documents required to utilize the scheme must be made available at single window. The scheme envisages that the document processing and admitting the child is the responsibility of AWWs, but unfortunately it is not

happening as designed. Malnourishment control is the one of the oldest and toughest challenges to the Clinicians, Health care administrators and policy makers. All the stake holders like Child Development Project Officers (CDPOs), AWW Supervisors, ASHAs, PHC and NWH staff are required to create awareness among the beneficiaries for better utilization of the 'BS'

### Acknowledgments

This study is part of the research registered with KLE University, Belagavi. We are grateful to Department of Paediatrics of JNMC, CDPOs urban & rural Belagavi, PHC Medical officers and AWWs. No grant was received for this study from any funding agency in the public, commercial or not-for-profit sectors.

### References

1. Children in India 2012 - a statistical appraisal. Social Statistics Division Central Statistics Office. Ministry of statistics and Programme Implementation. Government of India available at [www.mospi.nic.in](http://www.mospi.nic.in)
2. "World Bank Report". Source: The World Bank (2009). Retrieved 2009-03-13. "World Bank Report on Malnutrition in India"
3. Kanjilal, B; *et al* (2010). "Nutritional Status of Children in India: Household Socio-Economic Condition as the Contextual Determinant". *International Journal for Equity in Health* 9: 19.
4. "HUNGaMA Survey Report". Naandi foundation. Retrieved 1 February 2012.
5. Kanjilal, Barun; Mazumdar, Mukherjee, Rahman (January 2010). "Nutritional status of children in India: household socio-economic condition as the contextual determinant". *International Journal for Equity in Health* 9: 19-31.
6. [www.who.org/india/countryhealthsystemprofile](http://www.who.org/india/countryhealthsystemprofile)
7. Parakh A, Dubey AP, Gahlot N, Rajeshwari K. Efficacy of modified WHO feeding protocol for management of severe malnutrition in children: a pilot study from a teaching hospital in New Delhi, India. *Asia Pacific Journal of Clinical Nutrition*. 2008; 17(4):608-11.
8. DNA 19 Mar 2011-10:11am , Bangalore & The Hindu Bijapur., September 27, 2012
9. Ensor T, Cooper S. Overcoming barriers to health service access: influencing the demand side. *Health Policy Plan*. 2004; 19(2), 69-79.
10. Griffith SP, Stephenson R. Understanding user's perspectives of barriers to maternal health care in Maharashtra, India. *Journal of Biosocial Science*. 2001 Jul; 33(3): 339-359.
11. Boateng D, Kwapong GD, Agyei-Baffour, P. Knowledge, perception about antiretroviral therapy (ART) and prevention of mother-to-child-transmission (PMTCT) and adherence to ART among HIV positive women in the Ashanti Region, Ghana: a cross-sectional study. *BMC Women's Health*. Jan 2013; 13(2):13-2.
12. Ketevan N *et al* Primary Lactase Deficiency among Malnourished Children with Persistent Diarrhea in Tbilisi, Georgia, *Journal of Child Science* Vol. 1 No. 1/2017
13. Müller O, Krawinkel M. Malnutrition and health in developing countries. *Can Med Assoc J*. 2005; 173(3):279-286.
14. Black RE, Victora CG, Walker SP, *et al*. Maternal and child undernutrition and overweight in low-income and middle-income countries. *Lancet*. 2013; 382(9890): 427-451.
15. Walker I *et al*. Global burden of childhood pneumonia and diarrhea. *Lancet*., 381 (9875) (2013), pp. 1405-1416
16. L. Liu, S. Oza, D. Hogan, J. Perin, I. Rudan, J.E. Lawn, *et al*. Global, regional, and national causes of child mortality in 2000-13, with projections to inform post-2015 priorities: an updated systematic analysis. *Lancet*., 385 (9966) (2015), pp. 430-440
17. NegussieTaffa and G. ChepngenoDeterminants of health care seeking for childhood illnesses in Nairobi slums *Tropical Medicine and International Health* volume 10 no 3 pp 240-245 march 2005

#### How to cite this article:

Pramod N Sulikeri and Godhi A S (2017) 'Utilisation And Awareness of 'Balsanjeevini' Health Scheme Amongst Mothers in Four Primary Health Centres of Belagavi Taluka ', *International Journal of Current Advanced Research*, 06(08), pp. 5646-5649. DOI: <http://dx.doi.org/10.24327/ijcar.2017.5649.0769>

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