

## Children, Change Makers Rural Communities

S Chhabra<sup>1\*</sup> and Saraf S<sup>2</sup>

<sup>1</sup>Director Professor, Obstetrics and Gynaecology, Mahatma Gandhi Institute of Medical Sciences, Sevagram, Wardha, Maharashtra, India

<sup>2</sup>Ex Social Worker, Obstetrics and Gynaecology, Mahatma Gandhi Institute of Medical Sciences, Sevagram, Wardha, Maharashtra, India

\*Corresponding Author: S Chhabra, Director Professor, Obstetrics and Gynaecology, Mahatma Gandhi Institute of Medical Sciences, Sevagram, Wardha, Maharashtra, India.

Received: March 31, 2018; Published: May 29, 2018

### Abstract

**Background:** For development, it is essential that people are prepared to change, which is not easy in grown-ups. Children are usually receptive to new ideas. They adapt to change easily.

**Objectives:** Objectives of study were to know about knowledge of children about basics for healthy communities, create awareness and encourage them to do doable for their own self, their communities.

**Material and Methods:** Social worker who was briefed about study objectives, accompanied health teams visiting villages for Health camps in first phase. Information was collected from children with a predesigned questionnaire. later some children were asked to visit institute for advocacy for doing doable, phase II.

**Phase - 1:** On day of health camp, children between 9 - 14 years, minimum 10 from each village were called near make shift Diagnostic cum Therapeutic camp for women. From 28 villages, 300 children were interviewed with predesigned questionnaire in local language by social worker assigned responsibility. Information was collected about background, attitude towards education, responsiveness to needs from every child who reported. Their height weight were also recorded. In first phase 242 (80.66%) were boys 58 (19.34%) girls (one fifth), 122 (37.33) were of 9 to 11 years studying in 4<sup>th</sup> - 6<sup>th</sup> standard, 188 (62.66) of 12 - 14 years studying in 7<sup>th</sup> - 9<sup>th</sup>. Half of children (150) were from nuclear families, half joint families.

**Phase II:** Of 56 children who had agreed to report to institute (2 from each village), 54 reported (2 from 27 villages). Two could not report because of transport problem. During discussions in villages, girls' parents had refused to send girls, but finally 14 girls did report with 40 boys.

**Results:** All 300 children were either under-weight or with less height or both, for their age. Between 9 - 11 years, studying in 4<sup>th</sup> - 6<sup>th</sup> standard, 20.58% and of 12 - 14 years, studying in 7<sup>th</sup> - 9<sup>th</sup> standard, 19.14% had height at lower limit of standard for their age. Over all 17.91% children said, they had to face problems in going to school because of road or vehicle or other problems, 2.9% had to work at tea stall after school hours. Some children (38.23%) did watch television at Gram panchayat (village meeting area), 61.76% children had toilets with drainage, 14.7% used toilets of their neighbors, 23.52% had to use fields on outskirts of village (open defecation). Only 38.23% children said that their villages had fixed waste disposal area. Only fifty (13.3%) children's families had water supply with hand pumps. Most used public hand pumps at periferi of villages or uncovered wells. Two hundred and seventy eight (79.33%) children used to participate in extracurricular activities of schools. Children were enthusiastic to help their communities.

**Conclusion:** Many rural children were underweight and had height less for their age. There are challenges of safe water, waste disposal, toilets and opportunities for development. However children were willing to do something for themselves and their communities.

**Keywords:** Children; Rural Communities; Development

## Background

For development, it is essential that people are prepared to change, but change is not easy, specially in grown-ups. Children are usually receptive to new ideas and have the capacity to adapt to change. Also the change that comes at this age, lasts long, which helps the children as well as the communities in which they live. So the children could be the best change makers. They have the potential to enhance the development of their communities and improve quality of life. Children with their ideals, attitudes, zeal, given the right knowledge and guidance, can carve a better future for themselves and their communities [1]. So children could become natural agents of change. However they need to have normal development and be in good health for helping their communities. Any investment in them is worthwhile. With this thought in mind, an initiative was taken. Mission was to sensitize children, encourage them to do something for their own selves and wellbeing and encourage them to do something for their own communities.

## Objectives

Objectives of the study were to know awareness of children about basic essentials for healthy communities with mission of encouraging children to do doable for their own communities.

## Material and Methods

For service oriented research in the rural communities, ethics committee approval was there. Keeping in mind the objectives, attempts were made to collect desired information. Under Community Based Reproductive Health Care Project of the institute, where the study has been done, Diagnostic cum Therapeutics camps for women of 28 villages (population around 26,500) were being conducted. Because there were no resources this opportunity was utilized for getting the desired information, the first step in the direction of the objectives. A social worker who was briefed about the study objectives accompanied the health teams during each camp for collecting the information about children's growth and their awareness (Phase I). Some children were invited to the institute for advocacy for doing the doable (Phase II).

After reaching the villages, before calling and talking to the children for participation in the program, school teachers were briefed about the mission. Information was collected about children who could be the participants of the study. Opinion of the local multipurpose workers and some elder nonpolitical senior members of the villages, (other than the parents of children) were also sought about selection of children. So there was a bias in the selection of the study subjects. Permission was sought from school teachers and parents. Parents approval and help were taken to collect the children near the camp area in each village. Consent was also taken from children. For the second phase some children were requested to come to the institute with assurance for meals, refund of travel expenditure and some other incentive (not money). The mission was to encourage children to develop an attitude of self-reliance, social responsiveness, healthy living with cleanliness for their own selves and their communities, working on their ambitions, inspirations with the resources they had.

## Phase I

CBRHC Project camps were held on every alternate day, so the study duration of phase I was spread over nearly 3 months. A total of 300 children were interviewed by the social worker, Information was collected with the help of a predesigned questionnaire in local language from every child about their economic background, attitude towards education and social responsiveness,. Their height and weight were also recorded. On the day of camp children between 9 - 14 years, minimum 10 from each village were called near the make shift Camp area. Of the 300 children, 242 (80.66%) were boys and 58 (19.34%) girls (only one fifth girls), 122 (37.33) students of 9 to 11 years were studying in 4<sup>th</sup>- 6<sup>th</sup> standard and 188 (62.66) of 12 - 14 years were studying in 7<sup>th</sup> - 9<sup>th</sup>. Half of the children (150) had nuclear families and other half joint families.

**Phase II**

After the first phase of recording children’s height, weight and interviews carried out in the villages, two children from each village, who seemed to have some leadership qualities, who could travel on their own to the base institute and whose parents were also willing to send their children were invited to the institute for few hours on a fixed day and time for sensitization and encouraging them to do something to try keep their communities healthy. Out of 56 children who had accepted to report, 54 reported and two could not because of transport problems. During the discussions in the villages, girls’ parents had refused to send their daughters, but finally 14 girls did report with 40 boys. There was face to face discussion, advocacy to children for helping their communities to try to live healthy life in the given circumstances. They were served lunch and shown Gandhi Aashram, located near the institute.

**Results**

All 300 children were either under-weight or of less height or both for their age. Between 9 - 11, years 20.58% had height at lower limit of standard for their age. Between 12 - 14 years, 14.28% girls and 53.84% boys had height at lower limit of the standard for their age. Of children between 9 - 11 years studying between 4th - 6th standard, 19.14% said they had problems in going to school, and of age 12 - 14 years studying in 7th - 9th standard also, 17.91% children said they had problems in going to school due to road, transport or other problems (Table 1). When asked about missing school, 29.4% said they did miss school frequently for various reasons. About leisure time utility, 38.2% said that they helped in the field work during leisure time, 28.47% helped in household chores, 28.47% utilized this time for studying more, and 2.9% worked at tea stall after school hours to increase their families income (Table 2). Only two children honestly said that they did nothing after coming back from school. Some children (58.82%) did read newspapers, books to increase their knowledge, however 17.6% believed that going to school was enough for increasing their knowledge, and 23.52% said they did know that there was more, but had no idea about how to increase their knowledge. Over all 280 (79.33%) children used to participate in extracurricular activities of the schools (Table 3). All three hundred (100%) children said they enjoyed television and movies, however only some (38.23%) could watch television at Gram panchayat (Village Meet Area) 11.76% said they wanted but could not. Of all children, 61.76% said that they had toilet with drainage, but 38.23% children’s families did not have. So 14.7% children used the toilets of their neighbors’ and 23.52% had to use fields on the outskirts of the village (open defecation). Only fifty (13.3%) children’s families had their own water supply, 50 (13.3%), used water from public hand pumps, 50 (13.3%) children’s families used river water as they did not have any other source of water and they liked river water Others used well water. Almost everywhere wells were uncovered. Over all 150 children said that they did have cleanliness around their house and campus and believed that their villages were clean. Half 150 (50%) children had no idea about cleanliness in or around house. Most of children did not have any knowledge about immediate measures which could be taken for commonly encountered problems in villages like snake bite, scorpion bite but some did have some vague idea but they were enthusiastic to learn. Only 38.23% children said that their villages had waste disposal in the form of garbage pit at a fixed place in the village and the rest did not know. All the children were enthusiastic about studies and each one seemed to be desirous to do something (Table 4).

	Problems in School Going	Standard	Age				Total		
			9-11 Years		12-14 Years		No	%	
			No	%	No	%	No	%	
Nuclear family 150	Yes	4-6	22	36.66	7-9	35	38.88	57	38.00
	No		38	63.34		55	61.12	93	62.00
	Total		60	100.00		90	100.00	150	100.00
Joint family 150	Yes		20	38.46		35	35.72	55	36.66
	No		32	53.34		63	64.28	95	63.34
Total			52	100.00		98	100.00	150	100.00
Total			112	37.33		188	62.66	300	100

**Table 1:** Age and Standard and Problems in Going To School.

Family	Hobbies	Age				Total	
		9 - 11		12 - 14			
		NO	%	NO	%	NO	%
Nuclear family	Yes	25	41.66	42	46.66	67	44.66
	No	35	58.34	48	53.34	73	52.14
Total		60	100.00	90	100.00	150	100.00
Joint family	Yes	38	73.08	65	66.32	103	68.66
	No	14	26.92	33	33.68	47	31.34
Total		52	100.00	98	100.00	150	100.00
Grand total		112	37.34	188	62.66	300	100.00

Table 2: Age, type of family and hobbies.

Family	Entertainment from TV/ Movies	Age				Total
		9 - 11 yrs age		12 - 14 yrs age		
		No	%	No	%	
Nuclear family	Yes	54	90.00	44	48.88	98
	No	06	10.00	46	51.12	52
Total		60	100.00	90	100.00	150
Joint family	Yes	37	71.15	52	53.07	89
	No	15	28.84	46	46.93	61
Total		52	100.00	98	100.00	150
Grand total		112	37.33	188	67.66	300

Table 3: Age and type of family and entertainment.

Age	Std.	Cleanliness in house and campus	Total		Grand total	
			No	%	No	%
9 - 11	4 - 6	Yes	90	80.36	112	37.34
		No	22	19.64		
				100.00		
12 - 14	7 - 9	Yes	90	47.88	188	62.66
		No	98	52.12		
				100.00		100.00
			300	100	300	100

Table 4: Cleanliness in House and Campus.

Over all 138 (92%) children of nuclear families said that they were satisfied with their economic status, 52 (34.66%) middle economic status, 52 (34.34%) lower middle economic and 32 (21.33%) lower economic status [2] and only 12 (8%) said they were not satisfied with their economic status, Of joint families also 146 (97.33%) said that they were satisfied with their economic status. 56 (37.33%) middle economic status,43 (28.66%) lower middle economic status and 47 (31.33%) lower economic and only 4 (2.66%) were not satisfied with their economic condition (Table 5). All the children who attended the advocacy session in phase II said that they will try to maintain cleanliness around their houses and campus and keep their villages clean and try about safe drinking water. Also they will work on proper waste disposal possibilities.

Nuclear Family	Age		Satisfaction with Economic Status	Economic Status			Total
				Middle	Lower middle	Lower	
	9 - 11	No %	Yes	30 53.57	26 45.61	20 54.05	76 50
		No %	No	12 21.42	14 24.56	03 8.10	29 19.33
	Total			42	40	23	105
	12 - 14	No %	yes	14 25	15 26.31	11 29.72	40 26.66
		No %	No	-	02 3.50	03 8.10	05 3.33
	Total			14	17	14	45
Total		No %		56 37.33	57 38.00	37 24.67	150 100.00
Joint family	9 - 11	No %	YES	17 29.82	11 25	12 24.48	40 13.33
		No %	NO	-	-	02 4.08	02 0.66
	Total			17	11	14	42
	12 - 14	No %	YES	31 54.38	31 70.45	30 61.22	92 11.66
		No %	NO	09 15.78	02 4.54	05 10.20	16 1.0
	Total			40	33	35	108
Total		No %		57 38.00	44 29.33	49 32.66	150 100.00
Grand Total		No %		113 37.66	101 33.66	86 28.66	300 100.0

Table 5: Type of family economic status and satisfaction.

## Discussion

Earlier in another near-by rural community, it was found that majority of children in the tribal villages were below average for their body mass, with some just average for their body mass. It was also found that as the age increased the number of children with malnutrition increased as requirements for the growth were not getting fulfilled. Almost 25% children had exophthalmia, 5% had Bitot's spot and another 5% had other eye problems [3]. Problem seems to be common even now after 2 decades in near-by villages. Children were either underweight or with less height or both. Children have to be healthy for themselves, their community if they have to study well and help their communities.

Investing in children in the present could be the best possible strategy for future of children and communities. Attempts must be made to create an environment conducive to the growth and well-being of children to ensure that every child enjoys a healthy childhood, free from hunger, neglect and insecurity within enabling environment for their holistic development [4]. In the present analysis it was revealed that knowledge of safe drinking water was low though feeling of social responsiveness was there. Importance of cleanliness and hygiene was also low in some and needed to be stressed upon. Only 50% children had some vague idea about cleanliness. Awareness of responsibility and importance of discipline in going to school needed to be stressed upon as many remained absent from the school because of various reasons and seemed to take it casually. It has been understood that Innovative methods for involving rural communities in-sanitation, safe drinking water, health and nutrition need to be created [5]. Many said that they lacked safe drinking water. They were using water of uncovered villages, even of rivers with no treatment to water. The program was conducted to be wiser for plans of community development with the hope of changed attitude, a more positive way of thinking, improving life of rural communities by encouraging children to live with cleanliness, making them aware of safe water more knowledgeable and socially responsiveness, Bringing about changes from within these children could become change makers and help to have a better future for their communities. One child gave a very good example. He said that as the sun dazzled light and warmth equally on everyone with no discrimination between poor and rich, irrespective of caste and creed so should be done by everyone in the community. Ghosh., *et al.* [6] also reported that, children of lower primary school in Assam India became the torch bearers in hand washing for clean, hygienic and disease free school environment in their respective communities. Over the years, civil society organizations have been struggling with the uncomfortable question of how to reach a large number of citizens [7]. So it could be children who are the future rural communities. To bridge the divide between shining and deprived communities, the community resource persons are the country's resource persons, children the best.

## Bibliography

1. Shinha A. "Child Survival and Development". Health for the Millions 26.3 (2000): 16-18.
2. Bairwa M., *et al.* "Modified Kuppaswamy's Socioeconomic Scale Social Researcher Should Include Updated Income Criteria, 2012". *Indian Journal of Community Medicine* 38.3 (2013): 185-186.
3. Chhabra S., *et al.* "Our experiences with school health in tribal Village of eastern Maharashtra India, Three aspects". *International Child Health. A digest of (current) information* 2 (1997): 39-43
4. Ali A. Safe Drinking water and Sanitation. Chapter -1 Nutrition State in India's Health.
5. Ministry of Work and Housing National Master Plan for water supply and sanitation.
6. Ghosh., *et al.* "School children as torch bearers of hand-washing" (2015).
7. Community resource persons are torchbearers of a resurgent countryside (2017).

**Volume 7 Issue 6 June 2018**

**©All rights reserved by S Chhabra and Saraf S.**