REVIEW OF RESEARCH
IMPACT FACTOR : 5.2331(UIF) UGC APPROVED JOURNAL NO. 48514 ISSN: 2249-894X
VOLUME - 7 | ISSUE - 10 | JULY - 2018

POVERTY AND IT'S IMPACT ON HEALTH: STUDY OF BPL FAMILIES

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ABSTRACT

India is drawing the world's attention, not only because of its population explosion but also because of its prevailing as well as emerging health profile and profound political, economic and social transformations. Health is a state of complete physical, mental and social wellbeing. Health is an important aspect of human life. Non- availability of health facilities and poor economic condition leaves poor in pathetic condition. Poverty not only pulls back families economically but it effects on their social condition. Families those are below poverty line face many problems. Poverty also has a bad impact on the education, health and basic services. Government is spending lot of money in providing health facilities to rural poor but still that efforts are not sufficient. Primary health centre are unable to reach poor families due to many reasons. Unawareness about the health and non-availability of facilities, many of rural families spend lot of money on the health. Addiction is also reason for the poor health of rural people. Researcher studied the health status of BPL families from the Shirgaon village. Present study is descriptive in nature. There are 60 BPL families in the Shirgaon village and researcher taken the same as sample. The primary data has been collected by using the structured interview schedule. Study argues that families from the poverty line are not aware about the health and hygiene and it is the main reason for the poor condition of the health. It has also been found that they are expending money in local private hospital instead of the government primary health centre. Low education and limited access to resources keep them away from the government scheme and programme regards to health. It is an urgent need to aware rural poor about sanitation, personal hygiene, and proper drainage system, safety of drinking water and about the government facilities available to them.

KEY WORDS : *Poverty, Health, Below Poverty Line .*

INTRODUCTION:

Health is a state of complete physical, mental and social wellbeing. Health is an important aspect of human life. Non- availability of health facilities and poor economic condition leaves poor in pathetic condition. Poverty not only pulls back families economically but it effects on their social condition. Families those are below poverty line face many problems. Poverty also has a bad impact on the education, health and basic services. Government is spending lot of money in providing health facilities to rural poor but still that efforts are not sufficient. Primary health centre are unable to reach poor families due to many reasons. Unawareness about the health and non-availability of facilities, many of rural families spend lot of money on the health. Addiction is also reason for the poor health of rural people.

HEALTH AND POVERTY:

"Health is a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity so that each citizen can live a socially and economically predictive life". [World Health Organisation (WHO) 1948]

Dimensions of Health

1. Physical health
2. Mental health
3. Social health

Rural health:

Healthcare is the right of every individual but lack of quality infrastructure, dearth of qualified medical functionaries, and non- access to basic medicines and medical facilities thwarts its reach to 60% of population in India. A majority of 700 million people lives in rural areas where the condition of medical facilities is deplorable. Considering the picture of grim facts there is a dire need of new practices and procedures to ensure that quality and timely healthcare reaches the deprived corners of the Indian villages. Though a lot of policies and programs are being run by the Government but the success and effectiveness of these programs is questionable due to gaps in the implementation. In rural India, where the number of Primary health care centers (PHCs) is limited, 8% of the centers do not have doctors or medical staff, 39% do not have lab technicians and 18% PHCs do not even have a pharmacist.

India also accounts for the largest number of maternity deaths. A majority of these are in rural areas where maternal health care is poor. Even in private sector, health care is often confined to family planning and antenatal care and do not extend to more critical services like labor and delivery, where proper medical care can save life in the case of complications.

Below Poverty Line in India (BPL)

Going into a survey due for a decade, India's central government is undecided on criteria to identify families below poverty line. Internationally, an **income** of less than $1.90 per day per head of **purchasing power parity** is defined as **extreme** poverty. By this estimate, about 21.2% of Indians are extremely poor.

Those spending over Rs. 32 a day in rural areas and Rs. 47 in towns and cities should not be considered poor, an expert panel headed by former RBI governor C Rangarajan.This means 29.5% of the India population lives below the poverty line as defined by the Rangarajan committee, as against 21.9% according to Tendulkar. For 2009-10, Rangarajan has estimated that the share of BPL group in total population was 38.2%, translating into a decline in poverty ratio by 8.7 percentage points over a two-year period.The real change is in urban areas where the BPL number is projected to have nearly doubled to 102.5 million based on Rangarajan's estimates, compared to 53 million based on the previous committee's recommendations. So, based on the new measure, in 2011-12, 26.4% of the people living in urban areas were BPL, compared to 35.1% in 2009-10.

In 2012, the Indian government stated 22% of its population is below its official poverty limit. The World Bank, in 2011 based on 2005's PPPs International Comparison Program, estimated **23.6**% of Indian population, or about **276 million**people, and lived below $1.25 per day on purchasing power parity.

GOVERNMENT HEALTH SERVICES

A. Janani Shishu Suraksha Karyakram-

About 56,000 women in India die every year due to pregnancy related complications. Similarly, every year more than 13 Lac infants die within 1year of the birth and out of these approximately 9 Lac i.e. 2/3rd of the infant deaths take place within the first four weeks of life. Out of these, approximately 7 Lac i.e. 75% of the deaths take place within a week of the birth and a majority of these occur in the first two days after birth.

B. Primary Health Centres (PHCs)

PHC is the first contact point between village community and the Medical Officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and primitive aspects of health care. The PHCs are established and maintained by

the State Governments under the Minimum Needs Programme (MNP) Basic Minimum Services Programme (BMS). At present, a PHC is manned by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 Sub Centres. It has 4 - 6 beds for patients. The activities of PHC involve curative, preventive, primitive and Family Welfare Services. There are 22,370 PHCs functioning as on March 2007 in the country. (Rural Health Care System in India 2006)

C. National Rural Health mission

The National Rural Health Mission (NRHM) is a National effort at ensuring effective healthcare through a range of intervention at individual, household, community, and most critically at the health system levels. Despite considerable gains in health status over the past few decades in terms of increased life expectancy, reduction in mortality and morbidity serious challenges still remain. These challenges vary significantly from state to state and even within states.

D. Rajiv Gandhi JivandayiYojana (RGJY)

Rajiv Gandhi JivandayiYojana (RGJY) in order to improve medical access facility for both Below Poverty Line (BPL) families. The Rajiv Gandhi JivandayiYojana, enabling families with annual income of less than Rs. 1 Lac to avail free medical facilities worth Rs. 1.5 Lac. (Govt of India)

LITERATURE REVIEW:

Dr. K. S. Mali Patil (2009) studied Mother and Child Health of BPL families in Bellary district. All the respondents were nursing mothers having one year child. And research analysed about their health and nutritional status and measured BMI Gradation of mothers as per WHO Chart and also measured Growth Standard of their child as per new WHO growth standard. The study area was Bellary city Karnataka majority of respondents belongs to Hindu religion. Then their major occupation was agriculture. labour But they all had the average annual income Rs.10, 000 to 15,000 and majority of respondents that is 50 % were belongs to age group of 15-25 and only few of the respondents age group was 25-35.It was Shocking to Know that many of the respondents that is 36 percent of them got married below 18 years. Since 40 % were illiterate. Nearly 58 per cent of the respondents were living in joint family. But, over-majority of the respondents 80 percent was cared by their mother during Pregnancy and nursing the baby.40 per cent of respondents living in Katcha house. Majority of respondents that is 80 per cent put their vaccination and taken the iron tablets. In this area 68 per cent of the respondents suffer from anaemic during the pregnancy period.

They also had less blood at the delivery. Many of the respondents (90 percent) had taken normal food during the pregnancy. And they prefer green leaves, vegetables, fruits, milk etc. And majority of respondents (68 per cent) had some physical problems in pregnancy period, delivery time and after delivery. In the most of them had pressure, sugar, in the pregnancy time; High temperature, bleeding and no labour pain in the delivery time; and back pain, stomach pain during their post natal period. It also noted that psychological fear was high among the respondents during the end period of pregnancy. Many of the respondents (50 per cent) BMI Status was normal, (26 percent) were found underweight and (16 per cent) respondents BMI status is overweight and few respondents (8 per cent) found obese. In child growth standard many (50 Percent) respondent's child growth standard normal, 22 per cent moderate and 28 per cent fond under weight. Many of the respondents (94 per cent) had delivery at the right month and rest of them had (6 per cent) had pre-mature birth. Regarding the birth weight of the baby, 40 per cent had low birth weight and others 60 per cent had the baby weight 2.500 to 3.500 Kg. Majority (90 per cent) feed their babies at least 6 months.

While some of them still now breast feeding and few respondents (10 per cent) not possible to breast feed for their babies due to lack of breast milk and their health condition. Many of the respondents (76 per cent) put the vaccination completely, 20 percent put vaccination partially and few (4 per cent) of respondents were not vaccinated. Most of the respondents started giving weaning food at the month of 4 to 6. Their babies also suffer from cold; diarrhoea and itches due to environmental condition. It also noted the

living environment also plays some significant role in determining the health of the mother as well as their child.

P. Manikanta (2012) conducted study on Socio-Economic and Health status of Elderly belongs to Rural BPL Families in Chittoor District of Andhra Pradesh. Health is everyone's right. The Health systems across the globe are gearing up for meeting the rights of people. In the era of rights, inequity in health that too among men and women need to be explored and understood to bring equity in health. However defining woman's health in itself is a challenge.The ageing process is of course a biological reality which has its own dynamic, largely beyond human control. However, it is also subject to the constructions by which each society makes sense of old age. In the developed world, chronological time plays a paramount role. The age of 60 or 65, roughly equivalent to retirement ages in most developed countries is said to be the beginning of old age. The reduction in fertility level, reinforced by steady increase in the life expectancy has produced fundamental changes in the age structure of the population, which in turn leads to the aging population. The analysis of historical patterns of mortality and fertility decline in India indicates that the process of population aging intensified only in the 1990's. The older population of India, which was 56.7 million in 1991, is 72 million in 2001 and is expected to grow to 137 million by 2021. Today India is home to one out of every ten senior citizens of the world. Among the total elderly population, those who live in rural areas con- statute 78 percent.India is an agriculture dominated economy where about 70 percent population lives in rural areas and is dependent on agriculture and allied occupations. The aged (60+) represent about seven to eight percent of this population, most of them are living below poverty line. The aged in the unorganized sector like agriculture workers, casual workers, and landless labourers are in economically desperate position. Economic hardships, health problems, family responsibilities and disturbed relations are the major problems faced by the elderly people. Due to the pressing needs of family and their personal requirements they have to work as long as they live. Moreover, the problems become more complicated when their children start neglecting them and the elderly people face psycho-social problem coupled with economic and health problems. The health care facilities for the aged have been a big question. So far as the availability and availing of these facilities is concerned, Desai (1987), while analyzing the health situation of the rural aged pointed out that "to reach a hospital or to get a doctor means money and the rural poor are too poor to afford it. So to suffer and die without even the prospect of a healing hand is the lot of the rural aged."Health problem, physical or mental, brings down the level of coping and tolerance in any individual of any age group. Due to biological aging the level of resistance to illness is less and recovery takes longer time and the gradual decline in physical strength is common. This, of course, varies from individual to individual. Some age related diseases like arthritis, low vision, poor hearing, fluctuations in blood pressure, respiratory problems diabetes, etc. become a part of day-to-day life.

OBJECTIVES:

1. To understand socio-economic status of BPL families.
2. To understand awareness about Health and availability of Health service for BPL families.
3. Possible suggestions to improve the health condition of BPL families.

METHODOLOGY:

Researcher studied the health status of BPL families from the Shirgaon village. Present study is descriptive in nature. There are 60 BPL families in the Shirgaon village and researcher taken the same as sample. The primary data has been collected by using the structured interview schedule.

Sampling:

Universe of the study is 60 BPL families from the Shirgaon village. All the families selected for the study i.e. census survey technique has been applied. So the sample of the study is 60 BPL families form the Shirgaon village.

RESULT AND DISCUSSION:

Table No. 1 Socio-Economic Background of BPL Families

Sr. No.	Variables	Findings
1.	Caste	43.3% belongs to Schedule Caste
2.	No. of Family Member	46.7% families 3-4 family members
3.	Type of Family	Around three fourth of the BPL families living in nuclear type of family
4.	Education	63.3% heads of the family taken secondary education
5.	Occupations	Half of the BPL families main occupation is daily wage and remaining are having agriculture
6.	Annual Income	Majority of them i.e. 70% reported that they have annual income □25000/-

Table no. 1 shows the socio-economic background of the BPL families of the Shirgaon village. From above table it has been seen that majority of the respondents those below poverty line are from scheduled caste because of no land and other livelihood resources. Land and other resources are distributed on the basis of caste so the families from scheduled caste belong to BPL category. Majority of the BPL families are having the 3-4 family members. It shows that medium size of the family and they are living in the nuclear type of family. It is clear from the finding that joint family system is decreasing and nuclear families are increasing in rural area. That social change has been observed with BPL families also.It is found that majority of the heads of the BPL families are educated up to secondary education.Most of the BPL families are depends upon the daily wage in agriculture and agriculture activities. Due to dependency on seasonal daily wage their annual income is very low which one of the causes for below poverty line is. Lack of land, lack of assets and seasonal employment push them to below poverty line. Due to this majority of them are having annual income up to □25000/- which affects on their social and economic development. It is found that majority of the heads of the BPL families are educated up to secondary education.

It is clear from the above findings that low income, low education, dependency on daily wage, lack of livelihood sources, lack of agriculture land these families are having low social and economic status which affects on the overall development of family members.

Table No. 2 Health Status of BPL Families

Sr. No.	Variables	Findings
1.	Availability and Use of Toilet	56.7% BPL families having the toilet at their home and all of them are using the same
2.	Availed Government Subsidy for Toilet Construction	46.7% received subsidy to construct toilet
3.	Source of Drinking Water	More than half of the BPL families are using tap water for drinking purpose While remaining are using water directly from the river
4.	Daily Cleaning of Drinking Water Pot	60% reported they are cleaning regular
5.	Waste Water Management	70% reported that there is a proper drainage system
6.	Disposal of Daily Garbage	46.7% BPL families dispose garbage on road side, Very few of them using the proper dustbin
7.	Addiction in BPL Families	50% had addiction of Tabaco and 43.3 having the addiction of alcohol, remaining having addiction of smoking

Table no. 2 depicts the health status of the BPL families. When we discussed the availability and use of toilet in the BPL families more than half of them are having the toilets and they are using the same. Around half of the family are received subsidy for the construction of the toilet. Health status is depends on

the use of toilets. Still around half of the families don't have toilets so they use open defecation. Open defecation is an open invitation for the various deceases. So this badly affects on the health of the family members. More than half of the families using tap water for drinking purpose and remaining are using the water directly from the river. Clean and safe drinking water is one of ways to reduce the health issues. Still half of the families facing the issue related to the clean and safe drinking water.It has also found that majority of the BPL families use to clean the water pot on regular basis. Still around 40 per cent are not cleaning the water pot on regular basis that may be the one reason for the illness of the family members. 70 percent BPL families reported that they are having proper drainage system for waste water. It is good to know that at least they are having proper drainage system. Less than half of the familiesare disposing garbage on road side and very few of them using the proper dustbin. The dirty environment due to disposal of garbage creates more health issues for the BPL families. Health and addiction is closely related to each other. All the heads of the BPL family reported that they have any kind of addiction. Half of them are reported that they are having addiction of chewing tobacco and around 40 per cent having addiction of alcohol some are having addictionof smoking. It is a very horrible situation in the BPL families, even though they are having low income they had various kinds of the addictions.

It is clear from the above findings that use of toilets, availability of safe drinking water, safe disposal of the garbage are the important aspects of the health. But the BPL families are facing the problems regarding above requirement that creates the nasty situation for health. Addiction is present in each family which increase the expenses on addiction and increase the expenditure on health so it is causing two ways to the BPL families.

Table No. 3 Health Facilities and BPL Families

Sr. No.	Variables	Findings
1.	Place of Treatment	66.7% BPL families takes treatment from the local clinics
2.	Use of Services of PHC	Only 20% visit PHC for treatment
3.	Reasons behind not approaching PHC	Unawareness, Doubt on quality of treatment and nasty behaviour of staff of PHC
4.	Annual Expenditure on Treatment	86.7% reported that they have expenditure up to □. 3000/- per annum
5.	Awareness of Government Health Scheme among BPL Families	70% BPL families told that they are not aware about the Government Health Scheme
6.	Awareness Rajiv Gandhi JivandayiYojana	83.3% know about the Rajiv Gandhi JivandayiYojana
7.	Got Card of Rajiv Gandhi JivandayiYojana	73.3 had Card of Rajiv Gandhi JivandayiYojana
8.	Beneficiary of Rajiv Gandhi JivandayiYojana	6.7 % i.e. only two families reported that they got benefit from the Rajiv Gandhi JivandayiYojana.

Table no. 3 speaks about the health facilities for the BPL families. Majority of the BPL family member takes the treatment at local clinics. It is also found that only 20 per cent of the family members are taking treatment from the primary health centre. It is clear from this the people do expense on health to private clinics. Though government is providing health treatment through the primary health centrenut people are not availing the health services. The reasons for not approaching PHC are unawareness about the service, doubt on quality of treatment and nasty behaviour of staff of PHC. Most of the respondent reported that they have expenditure up to □. 3000/- per annum. This is the huge amount as compare to the income of these families. It is necessary to aware the BPL families about the facilities provided by the PHC so that they can avail the health services from the same. It will reduce the expenditure on health. Majority of the BPL families told that they are not aware about the Government Health Scheme. Most of them reported that

they are know the Rajiv GandhiJivandayiYojana and majority of them are received the card of the scheme. But only 7 % i.e. only two families reported that they got benefit from the Rajiv Gandhi JivandayiYojana. It seems that there are schemes and programmes for the BPL families but there are hardly families which received benefits of the same.

It is clear from the above findings that though government taking efforts to provide the health services to BPL families but unawareness about the schemes and programmes, not positive approach towards PHC are the main reasons behind the keeping people away from the benefits.

SUGGESTIONS:

- Need to aware rural families especially BPL families about the health concern.
- CBO's at village level need to strengthen and trained to aware the people.
- NGO's can intervene in the awareness about the sanitation and health.
- Approach of people towards Primary Health Centre need to change for that PHC need to take initiative.
- Awareness is necessary about the government schemes and programmes.
- Urgent need of awareness about the addiction and need to deaddict them

CONCLUSION:

Good health is very essential things for the human being but poor economic condition, low education, unawareness about the health pushes them in bad condition of health. The government efforts in providing the health services are not sufficient. It is necessary to take the more efforts to reach the poor families. It is urgent need to aware the people about the government schemes and programmes so that they can take the benefits of the same. The families living under poverty line are not having the good economic condition so they can't afford the treatment form the private hospitals. Government also need to improve the condition of the PHC. Peoples approach towards primary health centre has to change. NGO's can also play an important role in the deaddiction in these families.

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