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THE HEALTH STATUS OF WOMEN, IN PURBA BARDHAMAN DISTRICT, WEST BENGAL: A STUDY OF SPATIAL VARIATION

Ranjan Kumar Das[1] and Dr. Prolay Mondal[2]
[1] Research Scholar, Raiganj University
[2]Assistant Professor, Department of Geography, Raiganj University, India.

ABSTRACT

Economic status of a country depends upon the availability of resource, mainly the human resource which, makes the property with the help of his knowledge, experience and Excellency and consume it. All these are depended upon the mental and physical health of the population. So good health provides more efficiency of a man, which increases the individual income level and ultimately social status of the country becomes high. But there is some differences in earning capacity due to some physical and mental, educational health status of man and women.

As in modern age the man is main earning member of a family, so automatically male child is more valuable than the female child. Not only income level but also social, religious, political status of man is high. In this way, women deprived from ancient period in our nation as well as in the study area. So the all-human resources are not used properly for the progress of our nation as well as the study area.

The present paper is the expanded form of Thesis paper and focused on women health status and health care services mainly maternal health care services- in Purba Bardhaman District, West Bengal.

KEY WORD: *Health, women, maternal, education, Health Care Service, Purba Bardhaman.*

1.INTRODUCTION:-

A woman becomes a Mother, when she conceives, gives birth a child, and nourishes with affectionately for grown up child properly. She is a female parent and ancestor of all the human being who came to the Earth. There is no scope for compare with mother to any other. Mother means beautiful life. Mother means gift of better race. Ultimately, we can get delightful or graceful society. So education of Mother is the basement of future generation, Mother is a best temple of child. Therefore, mother is the best resource in the world. Napoleon Bonepart told that, -"You give me educated mother; I will give you educated nation."

The status of Indian women in ancient period was equal distribution with the men. They enjoyed all the events with them. Women are engaged in all the work like spinning, weaving of cloth and agriculture with their husband. So they were called "Ardhagini." . Women were freedom in life to learn Vedas. . As a result, Gargi and Maitreyi, Apala and Atreyi were the brightest crown in that time.

Late Vedic Period, rights (property, economic field) of women was started decline. In this time early marriage was started. Women education was prohibited. There was a great hateful work threshold on women such as Sati system. All the social work like prayers and sacrifices, chant Vedas mantra were stopped for women. They were only for love and the lust for sex.

The Medieval period when Muslims knocked to the door of our country, Shankaracharya led the Hindu society and raised his voice for the status of the Hindu women. But after that nearly during 700 years again women were neglected. As soon as ,women were denied from education and the same time of the Sati, child marriage, Devdasi custom, and dowry system were the common sceniores in the society. These made Indian society static and immobile situation.

After muslim period about 200 years British ruled in India. During this period, the some renounce social reformer changed some of Hindu laws. Such as,- Sati pratha and child marriage by Raja Rammohan Roy; widow marriage and Female education by Vidyasagar. And also Keshab Chandra sen, Annie Besant, Sister Nivedita, Dayananda Saraswati, Swami Vivekananda, Mahatma Gandhi all together they worked girls and women status.

Rural women are considered as back bone of the Indian economy (Nand and Kumar , 1980), because till now they are the main source of labor in agricultural field, brick fields, tea garden . Though they have a huge responsibility in their family for earning money and on the other side they have no power to take a decision for their own and family (patki and Nikhade 1999).

In a family, all members were benefited in different ways by the women. So her activeness is not a main power only of a family but also of a society and Nation and so on. In this situation all kind of problems, plans of a family easily done by the women. Therefore, we need emphasis the women health in our society. (Bhalerao ET all, 2008).

In the year 2005, a slogan has been given on world health day i.e. 7th April, 2005 “Make every mother and child count. “ This reveal the anxiety or solicitude about the health of mother and child in all and rural poor mother and child. So finally, we can say that the women are not only the main mechanic in the family but also in the society also.

2. LOCATION OF THE STUDY AREA:

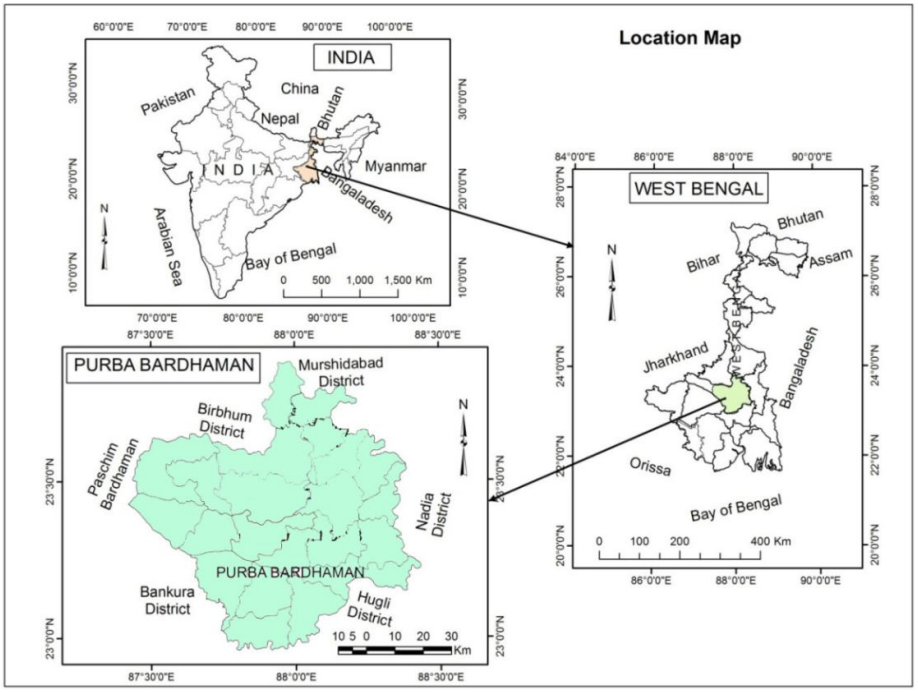

Figure 1: Location Map of the Study Area

Purba Bardhaman District is a part of Burdwan Division. It is located in between 22° 38'00'' N to 23° '53'' N latitude and between 87° 32'00'' E to and 88°25'00'' E longitude (Fig-1). It has an area of

5,432.69 square kilometers. The eastern side of the district is bounded by Nadia district. On the south-east it is bounded by Hooghly, on the south by Bankura district and on the west by Paschim Bardhaman district. On the northern side of the district it is bounded by Birbhum and Murshidabad districts.

Purba Bardhaman District consists of four sub-divisions namely Bardhaman Sadar North, Bardhaman Sadar South, and Katwa and Kalna sub-divisions. There are twenty-three CD blocks, six municipalities; those are Bardhaman, Guskara, Memari, Katwa, and Dainhat, Kalna. There are 215 Grampanchayats in the district and total numbers of populations are 530208 in the district Purba Bardhaman.

3. OBJECTIVES OF THE STUDY:-

The main objectives of the study include:

i) To give an over view of women health status mainly maternal health
ii) To give an idea about status of rural health care service.

4. DATA SOURCES:

The study will be based on both primary as well as secondary data. The secondary data will be collected from various issues of Statistical Abstract of India, Statistical Abstract of West Bengal, Health Information of India / National Health Profiles; Report on Currency and Finance, Economic Survey and Plan Documents etc. Also some data has been taken from WHO's reports.

5. METHODOLOGY:

Various mathematical and statistical tools like percentages, growth rates and semi-logarithmic trend etc. have been used for the purpose of quantitative analysis. ***Cartographic Techniques*** like Graphs, pie charts and bar diagrams will be used for presentation of data.

6. HEALTH STATUS OF WOMEN:-

6.1 Sex Ratio:-

There are many controlling factors of sex ratio such as, age of mother at birth, sex selective abortion and infanticide, war casualties, pesticide and other environmental contamination, which all together determined the human sex ratio. Sex ratio is (number of Female per 1000 males) reveal that, in study area sex ratio is higher than the state level from the year 1911 to 1951 and lower position from the year 1961 to 2011. The sex ratio of the study area and state level is all-time lower than the National level. Table- 1 shows the district, state and national level sex ratio and the Table -2 shows block wise sex ratio of the study area.

Table-1 Sex Ratio India, West Bengal and Bardhaman

Year	Sex Ratio		
	India	West Bengal	Bardhaman*
1901	972	945	-
1911	964	925	997
1921	955	905	965
1931	950	890	934
1941	945	852	893
1951	946	865	888
1961	641	878	858
1971	930	891	886
1981	934	911	897
1991	927	917	899
2001	933	934	922

2011	940	950	945

**In 2017, Bardhaman district divided into two district: Purba Bardhaman and Paschim Bardhaman*
Source: Census Reports, Various Years

Table -2:- Sex Ratio Block Wise

Block	Population	Sex ratio	Rank	Block	Population	Sex ratio	Rank
Ausgram-1	154751	972	5	Memari-1	218425	973	4
Ausgram-2	150896	955	12	Memari-2	150252	964	7
Bardhaman-1	530208	935	21	Khandoghos	189336	950	15
Bardhaman-2	152939	979	2	Jamalpur	266338	980	1
Bhatar	263064	962	9	Raina-1	180952	959	10
Galsi-1	187588	939	19	Raina-2	150401	953	14
Galsi-2	147177	969	6	Kalna-1	263667	958	11
Mongalkot	263240	954	13	Kalna-2	167335	976	3
Ketugram-1	165408	947	16	Manteswar	237398	963	8
Ketugram-2	118567	931	23	Purbasthali-1	206977	934	22
Katwa-1	254702	943	17	Purbasthai-2	212355	940	18
Katwa-2	161105	937	20				

Source: Census Reports, Various Years

From the bellow figure it is cleared that Jamalpur, bardhaman-2 and Kalna-2 are respectively stand first, second and third position on sex ratio. Here the female population is high than the male because migration of male person from these rural blocks to the urban blocks. So the male population is basically high in the town area, as a result the sex ratio is low.

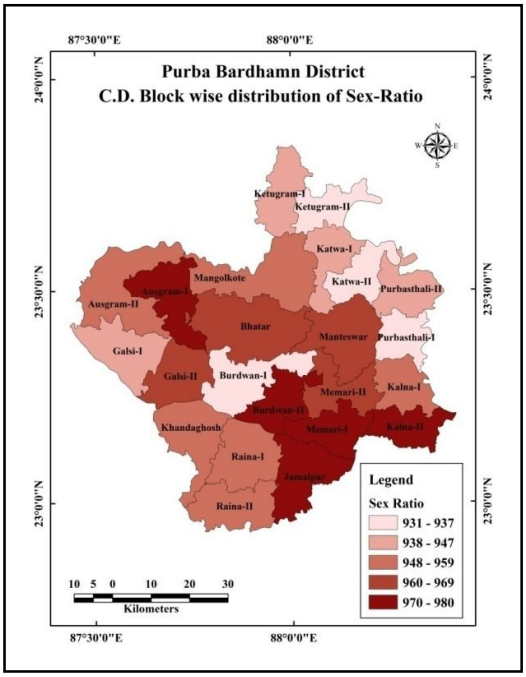

Figure.2: C.D. Blockwise distribution of sex ratio, 2011

6.2 Morbidity:

According to the World Health Organization (WHO), "Morbidity could be measured in terms of …(i)Number of person who were ill, (ii) illness these persons experienced, and (iii) the duration of these illness." It means physical and mental illness of individuals or general. There are so many disease found in the study area due to some special geographical location. As the study, area is under the Rarha Bengal, and three side of it bounded by the three rivers. The Ganga is In the Eastern side, Damodar is in the southern part and Ajoy River is in the northern side of the study area. Naturally, this area is the flood prone area. In every year mainly in rainy season flood occurred due to southwest monsoon wind. Ausgram 1, Ausgram 2, Mangolkot, Ketugram, Raina, Arambag, and Kalna all of these CD Blocks are flood prone. During this time, Diraha and other water born is common diaesea in that locality. Malaria, Dengue, Kala- azar , also seen. In the western part of the area covered with lateritic soil which prone to Leprosy.

Apart from these women are also sufferings from various diseases like Anemia, Jaundice, Malnutrition, Thyroid Misbalance and Iron deficiency. This is because of insufficient food value of mother and child. Usually mother takes food like carbohydrate and vegetables. But other nutrition food is very precious for their low income. In india, maximum mother belong lower and middle income family. So they have no enough money to buy normal fruits. It is also true that in a family some time they could not bear doctor's fees and after check up doctor they failure to buy the medicine. But some human merciful or pitiful doctors normally give their specimen medicine to the patient. In figure-3 has shown the various diseases in the study area.

Table-3:- Diseases in Study Area in percentage (2015-16)

Indicators	Bardhaman*		
	Rural	Urban	Total
Prevalence Diarrhea (Under age 5)	1.8	3.4	2.4
Acute Respiratory Infection (ARI) (Under age 5)	1.7	00	1.0
Anemia(<11.0g/dl) Age 6-59 month	40.1	49.4	44.2
Anemia(<12.0g/dl) Women age 15-49	66.7	60.1	63.1
Anemia Women age 15-49	24.7	23.0	24.0
Women Blood sugar (>140mg/dl)	7.3	7.8	7.6
Blood women sugar (>160mg/dl)	3.0	4.6	3.7

**In 2017, Bardhaman district divided into two district: Purba Bardhaman and Paschim Bardhaman*
Source: NFHS-4 (2015-16)

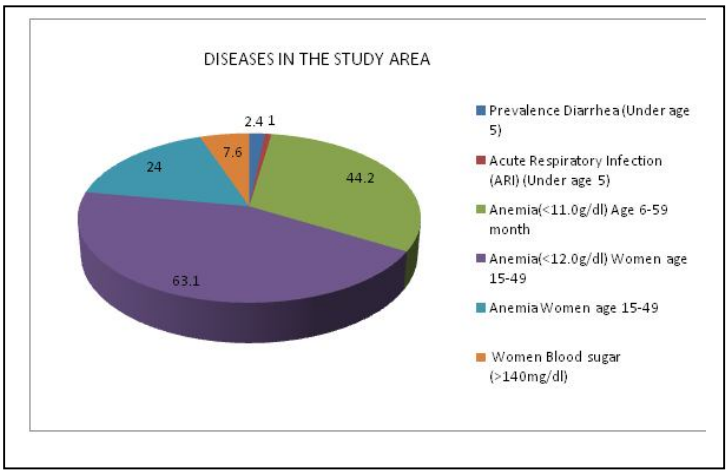

Figure-3:- Pie Diagram showing various Diseases in Study Area

6.3 Infant mortality:-

Breast-feeding is the main source of food for infants, which is collect from the mother. Therefore, the health of both depends upon the food intake by mother. Thus all the infants are not same healthy because of all mother's status are not same. Economically sound women can give birth healthy infant where as lower income family group, all is suffering from malnutrition, (1977, UNICEF). So the all infant are naturally weak in nature. Some time infant mortality is common at the time of delivery. So we need to

protect this condition by the long term policy. Such as five year planning which should emphasis the women development. Figure-4 showing the gradual decreasing trend of infant mortality rate in West Bengal.

Table -4 Infant Mortality Rate in West Bengal (per 1000 live Births)

Year	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003	2002	2001	2000
West Bengal	25	26	28	31	32	32	31	33	35	37	38	38	40	46	49	51	51

Source: National Institution for Transforming India(Govt. of India)

6.4 Reproductive Health Care

There have relatively higher fertility between the scheduled caste and scheduled tribe and in Muslim family. It is proven that education is more powerful than religious to control the fertility (Rele and Kanitkar, 1976; cited in Bhagat and Praharaj, 2005; cited in biswaranjan & anuradha, 2016). (except muslim).

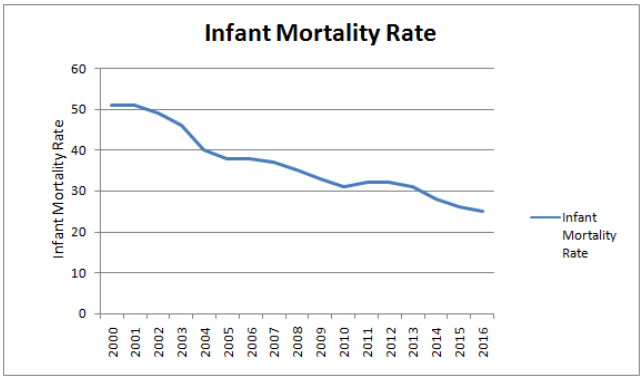

Figure. 4: Trend of infant mortality rate

6.5 Antenatal care (ANC)

Natuarally in urban area the number of educated women are more than in rural area but they are not in seeking wage earning than rural women. In rural area, maximum women work as a labour in various fields such agriculture, firm etc. Because poverty compel them to engaged more time in wage earning (Mondal 2013). Many studies have revealed that in Andhra Pradesh (Neeraja, 2014) and in Tamilnadu (kavita & Audinarayana,1997; Sivakami and Kulkarni, 1998; cited in Neeraja, 2014; cited in biswaranjan & anuradha,2016) poor working women have no enough time for their maternal health care services. Bellow the Table-5 shows the different antenatal Check up in the study area, District of Bardhaman.(*In 2017, Bardhaman district divided into two district: Purba Bardhaman and Paschim Bardhaman)*

Table-5:- Details of Antenatal care 2015-16 (in percentage)

Antenatal care 2015-16 (in percentage)	Urban	Rural	Total
Percentage of Antenatal Check up in the first trimester	80.7	59.4	68.0
Percentage of at least 4 Antenatal Care visit	85.0	820.	83.3
Mother who received Iron folic acid for100 days	44.7	30.0	35.9
Mother who received tetanus injection	89.5	91.9	90.9
Mother received all Antenatal care	38.2	23.1	29.2

Mother received Postnatal care within 2 days of delivery	63.6	61.5	62.4

Source: NFHS-4, 2015-2016

6.6 Delivery and Post delivery Care:

The lack of education is a major problem of institutional delivery. All though there many programmes are arranged but they have no enough time to attend the programme because of work and other restriction of religious .and also at the present time delivery expenditure is high. For Sometime PHC worker do not support properly. They avoid poor people. And some time they have deficiency of kindness in their dutifulness. So they prefer home delivery. Even the Village 'Dai' use traditional equipment for their delivery.

But the below figure-5 shows that in the study area the Institutional delivery is higher than the home delivery by the skill person. Because Government has announced the free cost of delivery, postnatal care and ambulance for bellow poverty level (BPL) mother in any hospital.

Table-6:- Details of Delivery care 2015-16 (in percentage)

Delivery Care (for births in the 5 years before the survey)	Urban	Rural	Total
Institutional birth	85.1	80.8	82.6
Institutional birth in public facility	45.2	63.2	55.6
Home delivery by skill personnel	8.4	2.4	4.9
Birth delivery by caesarean	34.7	24.6	28.9
Birth delivery by caesarean in private	72.3	**	75.2
Birth delivery by caesarean in public	13.0	16.6	15.4

**In 2017, Bardhaman district divided into two district: Purba Bardhaman and Paschim Bardhaman*
Source: NFHS-4, 2015-2016

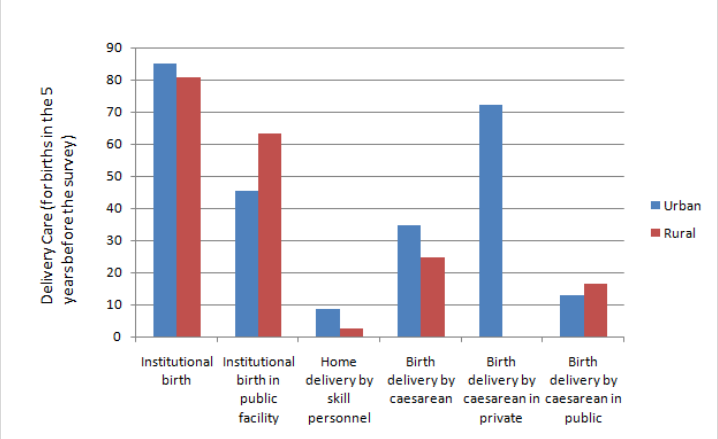

Fig.5: Delivery Care of Bardhaman District (for births in the 5 years before the survey)

6.7 Maternal Mortality Rate

Now women are in danger at the time of their delivery of baby. But in recent Government has been taken over the situation. Though the risk is not completely over gone with the help of family planning, we may reduce the maternal death. The following figure-6 shows the maternal mortality ratio in study area with state and national level in different years. From the table it is cleared that maternal mortality rate is decreasing year after year.

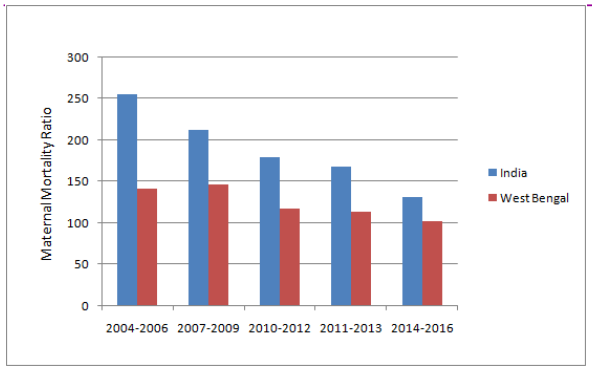

Table:- 7:- Maternal Mortality Ratio (per 100000 live birth)-From2004-2006 to 2014-2016

YEARS	India	West Bengal
2004-2006	254	141
2007-2009	212	145
2010-2012	178	117
2011-2013	167	113
2014-2016	130	101

Fig. 6: **Maternal Mortality Ratio** *Source: National Institution for Transforming India(Govt. of India)*

6.8 Age of Marriage and Fertility

Early marriage is common incident in our country due to some specific social backwardness. Such as low-income level, low education and religious status. In lower income group they compelled to early marriage for dowry system, lack of proper education, religious and most vital is wage earning capacity ,if the family member is high then the income level is also the high., so their tendency any how to grow population with the help of child marriage. The following table -8 shows the real picture of the age of marriage.

Table-8:- Age of Marriage and Fertility

State/District	Marriage Before age 18 years (%)			Already mother or pregnant at age 15-19		
	Rural	Urban	Total	Rural	Urban	Total
West Bengal	47.3	28.1	41.6	20.6	12.4	18.3
Bardhaman*	49.9	28.3	41.2	19.1	8.4	14.4

**In 2017, Bardhaman district divided into two district: Purba Bardhaman and Paschim Bardhaman*
Source NFHS-4 (2015-16)

6.9 Family Planning

Maternal death is common scenario in our country, like poor and developing country. About 1000 women per day lost their life during this period. (2013, k, Vandana.) And also 99% per year in developing country Perhaps this death may be measured with the help of family planning.

Thus, we need to take care of the mental and physical health of the Mother. But in present time the health of women is miserable in the World.

India is becoming lager-populated country followed by China. So it is very important for controlling the population with the help of various methods of family planning such as pill, intra Uterine Device and condom. Among them pill is easy to use for birth control. In western India, they are more conscious than Eastern and North-Eastern India. In rural, low- income, uneducated family and also minority group they think contraceptives is forbidden due to the child birth as , "Good's Willingness."(Neeraja,2014,p,p- 33; cited in biswaranjan & anuradha, 2016). The following figure-7 and the pie Diagram shows the uses of different methods for family planning.

Table-9:- Use of Family Planning Methods in percentage (married women age 15–49 years)

State/District	Bardhaman*		
	Rural	Urban	Total
Any method	77.2	77.0	77.1
Any Modern Medhod	59.5	50.8	56.1
Female sterilization	37.0	29.5	34.1
IUD/PPIUD	0.5	00	0.3
Pill	18.8	13.8	16.8
Condom	3.1	7.6	4.9

**In 2017, Bardhaman district divided into two district: Purba Bardhaman and Paschim Bardhaman*
Source NFHS-4 (2015-16)

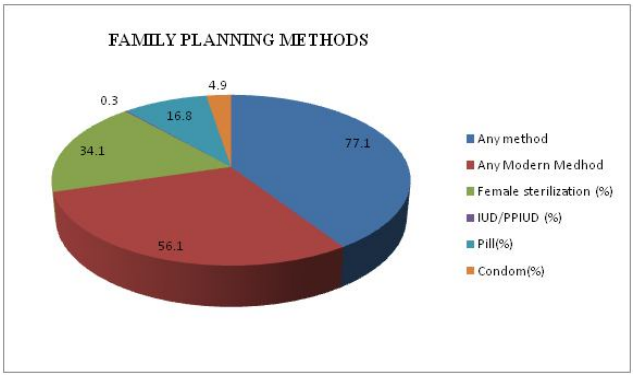

Figure-7:- Pie Diagram shows the Family Planning Methods in the study area.

Women are deprived from ancient period in india. In family planning 2020 (FP2020) is a Global approach which gives the women freedom to decide for themselves, "Whether, When and How many children they want to have."(Taneja, 2015;p.116; cited in biswaranjan & anuradha, 2016). Now in present time women are treated as same position to men. Though it is ruled by the Government but the real picture is not same. Because still now in our family decision taken by the senior adult men for the treatment of spouses. Though they are now very liberal for maternal health care due to various Govt. awareness programme.

6.10 Disability

It is a common disease in our society. Each man is little bit disability because every man has some limitation in another field. So it is a one kind of disability. In recent 1.79 %, women are disability in the district. Bellow the Table-10 shows The many kind of disability in the study area.

Table-10:- Disable person in Study Area*

Disable	Male	Female	Total
	85881	67049	152930
Percentage of Disable population to the Respective Total Population	2.16	1.79	1.96

**In 2017, Bardhaman district divided into two district: Purba Bardhaman and Paschim Bardhaman*
Source: Census of India, 2011

6.11 Literacy and Education

If the education level is high then the maternal health care services is high (Thaddeus & Maine, 1994; Elo, 1992; cited in biswaranjan & anuradha, 2016). But some time it has adverse relationship between

education and health care. In Tanzania, there is no change in maternal mortality with increasing literacy (Thaddeus & Maine, 1994; Elo, 1992; cited in biswaranjan & anuradha, 2016). And this also happen in higher caste (Brahmin / Chetri) because they have higher culture practice. But in lower caste there have positive relation between education and (health acre) utilization of maternal health care services. And inverse relationship between education and fertility. But there is noticeable change in fertility in Muslim community with increasing women education in Iran and Bangladesh (Bhagat & Praharaj, 2005; citd in biswaranjan & anuradha, 2016).

The following table -11&12 shows the literacy rate of women in various census, where it is seen that the number of educated women are increasing gradually in the study area.

Table -11:- Literacy Rate By Sex in the District Bardhaman *(in percentage)

District	2001			2011		
	Person	Male	Female	Person	Male	Female
Bardhaman*	70.18	78.63	60.95	76.21	82.42	69.63

**In 2017, Bardhaman district divided into two district: Purba Bardhaman and Paschim Bardhaman*
Source Census of India, 2001,2011.

Table-12:- Literature Sex Ratio in the District Purba Bardhaman

Parameter	1991	2001	2011
Literature Sex Ratio (Female Literature per 1000 male literatures)	623	719	820

Source Census of India, 1991 ,2001,2011.

7. CONCLUSION:-

From the above discussion it is stated that, status of women health in urban area is better than the rural area. Because in Rural area people are generally poor, illiterate, so they have no enough money and time to care their health. Moreover, the condition of rural women are very miserable than the urban women and rural men. In sex ratio, the women are vulnerable condition in study area than the State and the Nation. From the maternal care, antenatal care, literacy, age of marriage, morbidity and family planning women are backward in the rural area.

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