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Community and Public Health Nursing

Volume 3 Number 1
January - April 2018

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Citation:	N/A
MNISW 2016:	N/D
ICV 2016:	58.13
ICV 2015:	N/I

Community and Public Health Nursing
Vol. 3 No. 1, January - April 2018
DOI: http://dx.doi.org/10.21088/cphn.2455.8621.3118.1

A Study to Assess the Effectiveness of Structured Teaching Programme (STP) Regarding Prevention and Control of Rabies among High Schools Children at Selected High School Bidar

Nagaraj Killelli

Abstract

Background: Rabies is endemic in most countries of the world including India.Rabies remains a problem in many parts of the world. In developing countries rabies is a major threat to public health and is responsible for numerous human deaths. Rabies occurs in all parts of India with the exception of Andaman and Nicobar Islands and Lakshadweep. Approximately 33,000-40,000 human deaths occur every year. *Objectives:* To assess the pretest knowledge among high school children at selected high schools regarding prevention & control of rabies. To administer structured teaching programme to the high school children of selected high school regarding prevention & control of rabies. To assess the posttest knowledge among the high school children at selected high schools regarding prevention and control of Rabies. To determine the effectiveness of structured teaching programme in terms of gain in knowledge course. To know the association with pretest & posttest knowledge scores with selected demographic variables. *Methodology:* The research design selected for the study was a Pre-experimental one group pre- test and post-test design. A formal written permission was obtained from the higher authorities of the high school. The convenient sampling technique was used to select 60 high school children. In view of nature of the problem and to accomplish the objectives of the study a self administered questionnaire was prepared to assess the knowledge of high school children regarding prevention and control of rabies. The Reliability and validity of the tool was ensured in consultation with guide and experts in the related field. The data was collected and analyzed by using descriptive and inferential statistics. *Results:* The findings of the study revealed that there was a marked increase in knowledge of high school children after exposing them to structured teaching programme on advanced prevention & control of rabies. The mean Pre-test knowledge score of subjects was 13.52 with mean percentage of 33.8 where as the mean Post-test knowledge score of subjects was 28.3 with mean percentage of 74.The mean Post-test knowledge score was found to be significantly higher than mean Pre-test knowledge score at 0.05 level of significance (t_{59}=27.44 P<0.05). Findings of the study revealed that the calculated chi-square value for all variables was less than table value. Hence it was concluded that Post-test knowledge score of High school children on Prevention and control of rabies had no association with the demographic variables. But there was no association found between pre-test knowledge score with other demographic variables. *Conclusion:* The findings of the study suggested that the structured teaching programs are beneficial in improving the knowledge of high school children regarding prevention & control of rabies.

Keywords: Stuctured Teaching Programme, Rabies, Knowledge, High school students

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Recived on 16.05.2018, **Accepted on** 11.06.2018

Introduction

India is a developing country, where communicable diseases are one of the major health problems. Rabies is one of the communicable diseases and zoonotic diseases also known as Hydrophobia. Zoonotic diseases have been known since antiquity. Rabies

is known since biblical times. The discovery of causative agents during the "golden era" of microbiology called attention principally to diseases exclusively pathogenic to man. Zoonotic diseases were overshadowed by diseases peculiar to man alone. Only as human infections came under better control was attention drawn to zoonotic diseases [1].

Rabies is one of the oldest recognized diseases affecting humans and one of the most important zoonotic diseases in India. It has been recognized in India since the Vedic period (1500–500 BC) and is described in the ancient Indian scripture *Atharvaveda*, wherein Yama, the mythical God of Death, has been depicted as attended by 2 dogs as his constant companions, the emissaries of death. Rabies is endemic in most countries of the world including India [2].

Rabies remains a problem in many parts of the world. In developing countries rabies is a major threat to public health and is responsible for numerous human deaths. Rabies occurs in all parts of India with the exception of Andaman and Nicobar Islands and Lakshadweep. Approximately 33,000-40,000 human deaths occur every year [3].

Rabies is a zoonotic disease (a disease that is transmitted to humans from animals) that is caused by a virus. The disease infects domestic and wild animals, and is spread to people through close contact with infected saliva via bites or scratches. **Rabies** is present on all continents with the exception of Antarctica, but more than 95% of human deaths occur in Asia and Africa. Once symptoms of the disease develop, rabies is nearly always fatal [4].

Poor people are at a higher risk, as the average cost of rabies post-exposure prophylaxis after contact with a suspected rabid animal is US$ 40 in Africa and US$ 49 in Asia, where the average daily income is about US$ 1–2 per person. In India, 20 000 **rabies** deaths (that is, about 2/100 000 population at risk) are estimated to occur annually; in Africa, the corresponding figure is 24 000 (about 4/100 000 population at risk).

Although all age groups are susceptible, rabies is most common in children aged under 15; on average 40% of post-exposure prophylaxis regimens are given to children aged 5–14 years, and the majority are male [5].

Rabies is a vaccine preventable disease, where the co-ordinated efforts of the public and the health care workers can surely prevent rabies. The Alliance for Rabies Control's mission is to prevent human rabies deaths and to alleviate the burden of rabies in animal species. Its vision is a world where all countries have eliminated rabies. It began in 2005 as an independent, non-profit organization and has built an international community of individuals and organizations with an interest in and concern for rabies control. The Alliance is achieving its mission by raising awareness, supporting rabies control programs and promoting educational initiatives in order to stop the unnecessary loss of human life [6].

Objectives

1. To assess the pretest knowledge among high school children at selected high schools regarding prevention & control of rabies.
2. To administer structured teaching programme to the high school children of selected high school regarding prevention & control of rabies.
3. To assess the posttest knowledge among the high school children at selected high schools regarding prevention and control of Rabies.
4. To determine the effectiveness of structured teaching programme in terms of gain in knowledge course.
5. To know the association with pretest & posttest knowledge scores with selected demographic variables.

Methodology

Research Approach

Evaluative Research Approach

Research Design

Pre-Experimental; one group pretest post test design

Sampling Technique

Non-Probability; Convenient Sampling Technique.

Sample Size: 60

Setting of Study

Selected High school of Bidar

Tool used

Structured Knowledge Questionnaire to assess knowledge regarding nicotine consumption and its prevention among high school students.

Section I:

Socio-demographic variables of subjects.

Section II:

Knowledge items on nicotine consumption and its prevention.

Procedure of Data Collection

The formal permission was obtained from the Head Master of selected high school of Bidar. The written consent was obtained by the subjects. The pre-test includes structured knowledge questionnaire to assess knowledge of subjects regarding rabies control and its prevention. Stuctured Teaching Programme (STP) was administered at the end of the pre-test. The post-test of the study was carried out 7 days later, using the same tool as the pre-test. Data collected was then tabulated and analyzed.

Results

The findings related to socio-demographic variables of subjects:

- Majority 30 (50%) of the respondents were in the age group of 15 years.
- 35 (58.30%) of the respondents were males.
- Majority 38 (63.30%) of respondents were from Hindu religion.
- Majority 40 (66.70%) of the respondents were belongs to nuclear family.
- Majority 38 (63.30%) of the respondents had existing source of knowledge from Newspaper/ magazine/books.

Table 1: Mean, SD and Mean percentage of Pre-test knowledge N=60

Sl. No	Knowledge	Max Score	Range	Mean	SD	Mean Percentage
1	Knowledge regarding prevention & control of rabies	40	5-21	13.52	3.143	33.8

Table 2: Mean, SD And Mean Percentage of Post-Test Knowledge

Sl. No	knowledge regarding prevention & control of rabies	Max Score	Range	Mean	SD	Mean Percentage
1	knowledge regarding prevention & control of rabies	40	22 - 34	28.13	2.966	74

Table 3: Comparison of pre-test and post-test knowledge N =60

	knowledge regarding prevention & control of rabies	Pre-test Percentage	Post-test percentage
01	Poor (≤13)	51.7	00
02	Average (14-26)	48.3	30
03	Adequate (27-40)	00	70

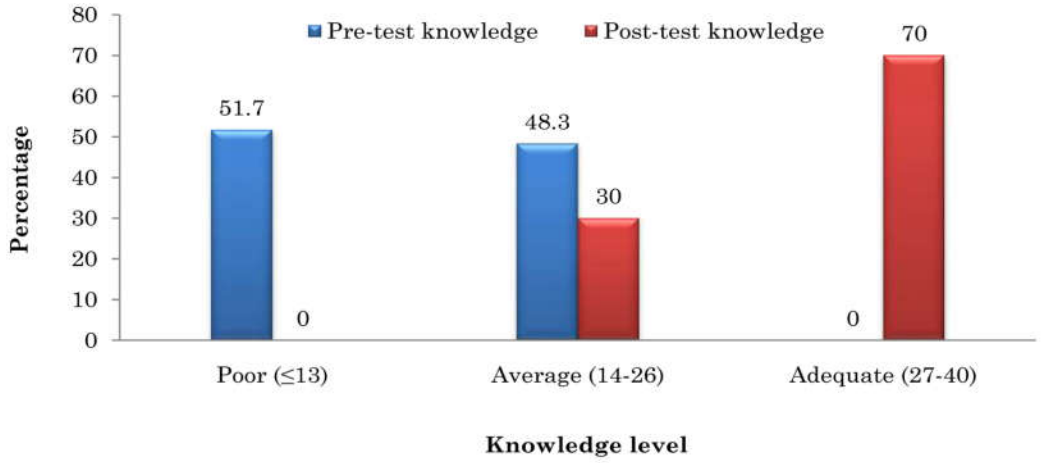

Fig. 1: Bar diagram shows the comparison of Pre-test and Post-test Level of knowledge

Table 4: Association between Pre-test and Post-test knowledge scores N=60

Aspects	Max. Score	Respondents Knowledge Scores Mean difference	SE of mean	't' value	DF	P value	Inference
Difference in pre-test and post-test knowledge	40	14.617	0.533	27.444	59	<0.001	HS

Findings related to Pre-test knowledge score of High school children regarding Prevention and control of rabies:

The data in the table 1 shows the Pre-test knowledge score of the subjects. The mean Pre-test knowledge score of subjects was 13.52 with mean percentage of 33.8.

Findings related to Post-test knowledge score of High school children regarding Prevention and control of rabies.

The data in the Table 2 shows the Post-test knowledge score of the subjects. The mean Post-test knowledge score of subjects was 28.13 with mean percentage of 74.

The Bar diagram shows the comparison of Pre-test and Post-test level of knowledge. It is clear from the diagram that Most of the subjects had (70%) adequate Post-test knowledge whereas (51.7%) subjects had poor Pre-test knowledge regarding Prevention and control of rabies.

Findings related to effectiveness Self instruction module on knowledge regarding Prevention and control of rabies

It is evident from the data presented in the table 4 that the calculated 't' value (27.44) was greater than the table value. Hence the research hypothesis was rejected at 0.05 level of significance. The mean difference between pre-test and post-test knowledge score was a true difference and not a chance difference. This indicates that the Self instruction module was significantly effective in increasing the knowledge of High school children regarding Prevention and control of rabies.

Association between knowledge score and selected variable

Association between pre-test knowledge score and selected demographic variable:

The calculated chi-square value for all variables was less than table value. Hence it was concluded that Pre-test knowledge score of High school children on Prevention and control of rabies had no association with the demographic variables.

Association between post-test knowledge score and selected demographic variable:

The calculated chi-square value for all variables was less than table value. Hence it was concluded that post-test knowledge score of High school children on Prevention and control of rabies had no association with the demographic variable

Overall experience of conducting this study was satisfying and enriching. For the investigator the study was a new learning experience.

Conclusion

Knowledge of high school students regarding the rabies control and prevention was inadequate before the administration of STP. The STP was effective in increasing the knowledge of high school students about rabies control and prevention i.e, overall and in all aspects in the post-test.

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Community and Public Health Nursing
Vol. 3 No. 1, January - April 2018
DOI: http://dx.doi.org/10.21088/cphn.2455.8621.3118.2

Prevalence of Disability among Adult Population at Maraimalai Nagar, Kancheepuralm District

M. Hemamalini*, Kanmani**

Abstract

The prevalence of disability is growing due to population ageing and the global increase in chronic health conditions. Patterns of disability in a particular country are influenced by trends in health conditions and trends in environmental and other factors such as road traffic crashes, natural disasters, conflict, diet and substance abuse. The objective of the present study was to assess the prevalence of disability among adult population. Quantitaive approach and descriptive cross sectional design was adopted for this study. The study was conducted among the adults who were residing in Maraimalai nagar. The sample size was 250. Non- probability purposive sampling technique was adopted. Census Questionnaire was to assess the prevalence of disability tool was used . The results of the present study revealed that, Among the adult population, with respect to difficult in seeing, only 4 (1.6%) have always difficult in seeing. Considering the difficult in hearing, 4 (1.6%) persons always have difficult in hearing. Considering difficult in walking and climbing 32 (12.8%) have always difficult in walking. Regarding remembering and concentration 9 (3.6%) persons have most of the times difficult in remembrance and none of them have always difficult in concentration and remembrance. Considering the difficult in self-care 24 (9.6%) have always difficult in self-care. Considering the difficult in communication none of them reported difficult in communication.

Keywords: Disability; Prevalence; Population; Adults.

Introduction

In recent decades the move has been away from a medical understanding towards a social understanding. Disability arises from the interaction between people with a health condition and their environment. The prevalence of disability is growing due to population ageing and the global increase in chronic health conditions. Patterns of disability in a particular country are influenced by trends in health conditions and trends in environmental and other factors –such as road traffic crashes, natural disasters, conflict, diet and substance abuse.

In rural India, the prevalence of disability was much higher (2.21%) as compared to that in its urban counterpart (1.93%). Again, among males, the prevalence of disability (2.37%) was significantly higher than that among females (1.87%).

Disability is more common among women, older people and households that are poor. Lower income countries have a higher prevalence of disability than higher income countries. No population-based study has been conducted at the national level to provide authentic data on the prevalence and incidence of disability in India. Therefore we must rely on the projections made by sample surveys.

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Recived on 18.05.2018, **Accepted on** 11.06.2018

The National Sample Survey Organization (NSSO) 2001, estimated that approximately 100 million Indians are affected with one or more disabilities. This projected nearly 10% of Indians with some disabling condition. However, according to the Census 2001, approximately 5% of people in India are affected with impairment or disability. The three most common causes of disability continued to be arthritis or rheumatism (affecting an estimated 8.6 million persons), back or spine problems (7.6 million), and heart trouble (3.0 million). Women (24.4%) had a significantly higher prevalence of disability compared with men (19.1%) at all ages. For both sexes, the prevalence of disability doubled in successive age groups (18-44 years, 11.0%; 45-64 years, 23.9%; and ≥ 65 years, 51.8%). The number of adults reporting a disability likely will increase, along with the need for appropriate medical and public health services, as more persons enter the highest risk age group (≥ 65 years). To accommodate the expected increase in demand for disability-related medical and public health services, expanding the reach of effective strategies and interventions aimed at preventing progression to disability and improving disability management in the population is necessary

Research Methodology

The research approach in this study was Quantitative approach, which focused on the assessment of prevalence of disability . The research design selected for the present study was a descriptive cross sectional study design. The variables of the study includes demographic variables and study variable. Demographic variable comprises of age, sex, marital status, type of family, education, occupation and income. Prevalence of disability among adults was the study variable. The study was conducted among the adults who were residing in Maraimalainagar. Target population comprises of adults whose age was between 20 to 50 years. Accessible population comprises of adults whose age is between 20 to 50 years who were available at the time of data collection. The sample size was 250. Non- probability purposive sampling technique was used as sampling technique.

The following instruments were used by the researcher for the study. The tool consists of two parts:

Section A : Demographic variables: Age, gender, marital status, educational status, type of family, occupation, income.

Section B: Census Questionnaire to assess the prevalence of disability tool was used in this study.

Table 1: Frequecny and percentage distribution of adult population with respect to type of disability

Type OG Disability		Distribution	
		N	%
Difficult in seeing	No	191	76.4
	some times	43	17.2
	most of the time	12	4.8
	Always	4	1.6
	No	217	86.8
Difficult in Hearing	some times		11.2
	most of the time	1	0.4
	Always	4	1.6
Difficult in walking and climbing	No	189	75.6
	some times	21	8.4
	most of the time	8	3.2
	Always	32	12.8
Difficult in remembering and concentrating	No	205	82.0
	some times	36	14.4
	most of the time	9	3.6
	Always	0	0
Difficult in self care	No	204	81.6
	some times	16	6.4
	most of the time	6	2.4
	Always	24	9.6
Difficult in communicating	No	244	97.6
	some times	5	2.0
	most of the time	1	0.4
	Always	0	0

The research proposal was approved by the dissertation committee and Dean of S.R.M College of nursing, S.R.M University, Kattankulathur, Kancheepuram District. Permission was obtained from the ward counselor, maraimalainagar where the study was conducted. Informed consent was obtained from the study participants.The investigators had collected data for one week. Before conducting data collection, formal approval was taken from the Authority. Informed consent was taken. Data collected from the adults who were residing at Maraimalai nagar.

Discussion

The results of the present study revealed that, Among the adult population, with respect to difficult in seeing, 191 (76.4%) have no difficult in seeing, and only 4 (1.6%) have always difficult in seeing. Considering the difficult in hearing, 217 (86%) have no difficult in hearing 28 and 4 (1.6%) persons always have difficult in hearing. Considering difficult in walking and climbing, 189 (75.6%) have no difficult in walking and climbing and 32 (12.8%) have always difficult in walking. Regarding remembering and concentration 205 (82%) adult have no difficult in remembrance and concentration, 9 (3.6%) persons have most of the times difficult in remembrance and none of them have always difficult in concentration and remembrance. Considering the difficult in self-care 204 (97.6%) persons have no difficult in self-care and 24 (9.6%) have always difficult in self-care. Considering the difficult in communication 244 (97.5%) disabled persons have no difficult in communication. and none of them reported difficult in communication.

Similar study was conducted by *Marianne Holmgren, Anna Lindgre, Jeroen de MunterFinn Rasmusse and Gerd Ahlstrom 2014* on association of mobility disability with overweight status and obesity in a large population-based Swedish. It included 13,549 randomly selected individuals aged 18–64 years who answered questions about mobility disability, weight, height, health-related quality of life and participation in society in the Stockholm Public Health Survey 2002 and 2010. The respondents both with and without mobility disability increased in BMI, but with no significant difference in the longitudinal changes Presence of mobility disability increased the risk of low health-related quality of life and lack of participation in 2010.The risk of pain and low general health (parts of health-related quality of life) increased for every 5 units of higher BMI reported in 2010.

Conclusion

The present study assessed the prevalence of disability among adults The results of the present study revealed that, Among the adult population, with respect to difficult in seeing, only 4 (1.6%) have always difficult in seeing. Considering the difficult in hearing, 4 (1.6%) persons always have difficult in hearing. Considering difficult in walking and climbing 32 (12.8%) have always difficult in walking. Regarding remembering and concentration 9 (3.6%) persons have most of the times difficult in remembrance and none of them have always difficult in concentration and remembrance. Considering the difficult in self-care 24 (9.6%) have always difficult in self-care. Considering the difficult in communication none of them reported difficult in communication. Hence awareness should be created among the adult population on type of disabilities and the resources available to manage the disabilities.

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Community and Public Health Nursing
Vol. 3 No. 1, January - April 2018
DOI: http://dx.doi.org/10.21088/cphn.2455.8621.3118.3

Current Updates on Child Morbidity and Mortality Rates: 2011-2017

K. Mohanasundari*, A. Padmaja**

Abstract

The leading causes for death among under-five children changes over a period of time but the cause diarrhea and ARI remains unchanged. India is the leading country in death due to pneumonia. Comparing to the last decade the under five mortality is reduced but it is still not the reduction which is expected. The still birth rate is 22/1000 total birth, perinatal mortality rate is 26/1000 live birth, neonatal mortality rate is 18/1000 live birth, post neonatal mortality rate is 19/1000 live birth, infant mortality rate is 40/1000 live birth, Underfive mortality rate is 48/1000 live birth. More than half of the causes for death can be preventable or treatable through safe childhood and effective neonatal care. The purpose of this review is to understand the present mortality rate and causes for this as well as tog et clues for epidemiological research in future.

Keywords: Morbidity; Mortality; Diarrhea, ARI.

Introduction

- Morbidity and mortality from childhood illnesses has remained a major point of interest globally. Around 5.9 million children under the age of 5 years died in 2015.
- The leading causes of death among children under five in 2015 were preterm birth complications, pneumonia, intrapartum-related complications, diarrhoea, and congenital abnormalities. About 45% of all child deaths are linked to malnutrition. India has the largest number of deaths due to pneumonia. In 2015 under five mortality rate is 48 per 1000 live birth,
- But the rate of this reduction in under-5 mortality was insufficient to reach the Millennium Development Goal (MDG) target of a two-thirds reduction of 1990 mortality levels by the year 2015.
- A child's risk of dying is highest in the neonatal period, the first 28 days of life. Prematurity was the largest single cause of death in children under five in 2015. 45% of child deaths under the age of 5 years take place during the neonatal period (2015).
- More than half of these early child deaths are due to conditions that could be prevented or treated with access to simple, affordable interventions. Safe childbirth and effective neonatal care are essential to prevent these deaths.
- Morbidity and mortality indicators are best indicators of health out of all other health indicators.
- Mortality is the condition of being mortal, or susceptible to death; the opposite of immortality
- The morbidity is the condition of being diseased or rate of disease in a population.

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Recived on 01.02.2018, **Accepted on** 26.02.2018

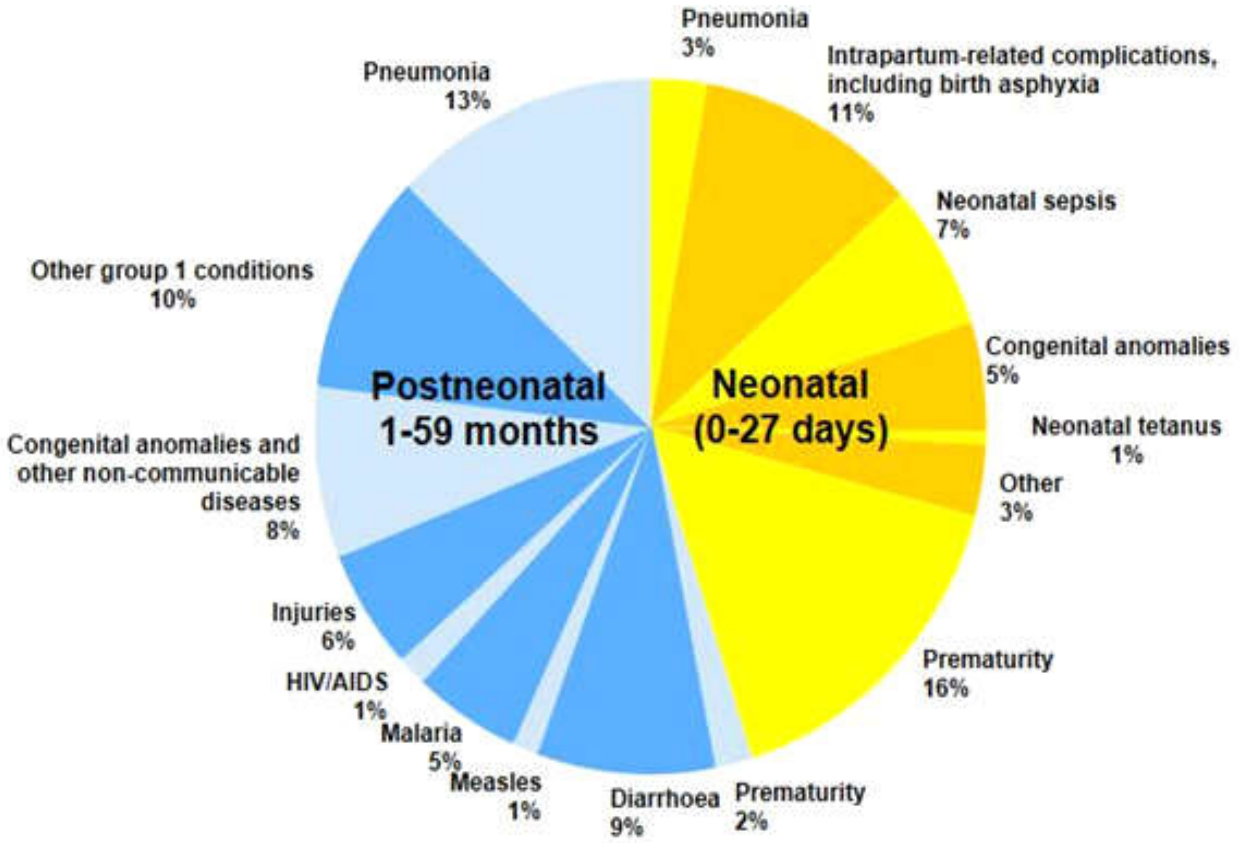


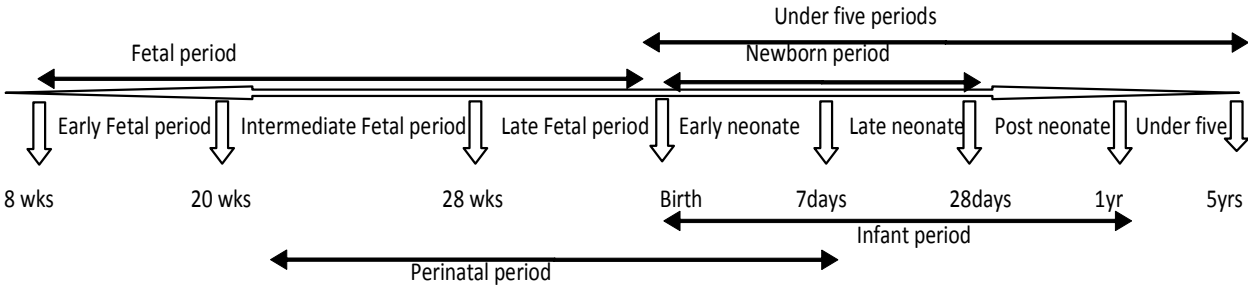
Fig. 1: WHO causes of mortality among under 5 years -2015

Needs/ Importance/Indication for mortality and morbidity indicators

- In explaining trends and differentials in overall mortality
- Indicating priorities for health action and allocation of resources
- In designing intervention programme
- Assessment and monitoring of public health problems and programmes
- Gives clues for epidemiological research

Classification of age till 5 years

- Fetal period: 8 weeks of gestational age to till birth (early + Intermediate +late fetal period)
- Perinatal period: 28 weeks of gestational age to till 7 days after birth (late Fetal +early neonatal + late neonatal period)
- Newborn period: birth to 28 days (Early + Late+ Post neonatal period)
- Infant period: birth to 1 year (Newborn+ Post neonatal period)
- Under five: birth to 5 years (Newborn + Infant+ 1 to 5 years of period)



Child Mortality Indicators

1. *Perinatal morality rate (PMR) (22weeks of gestation to 7 days after birth):* Perinatal mortality as the "number of stillbirths (death of fetus during 22 weeks to till delivery) and deaths in the early neonatal period (first week of life) per 1,000 total births, the perinatal period commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth", Current PMR is 26/1000 total births in 2013.

$$\text{PIMR} = \frac{\text{No: of stillbirth and deaths in the 1st week of life X 1000 total births}}{\text{No of live birth}}$$

Table 1: Causes for PMR:

Still birth (22 weeks to till delivery)	Early neonatal period (birth to 7 days)
• Abruption, • Unknown • Severe preeclampsia, congenital anomalies, • Birth asphyxia • Preterm labour • Severe IUGR • Uterine rupture, • Eclampsia • Gestational diabetes • Cord prolapse • Immune hydrops	• Hyaline membrane disease • Meconium aspiration • Extreme prematurity • Sepsis • Congenital malformation • Pulmonary hemorrhage

Neonatal Mortality Rate (NMR) (0-28days)

A neonatal death is defined as a death during the first 28 days of life (0-27 days) for 1000 live birth divided by total no of live birth. Current NMR is 18/1000 live birth in 2015.

It is classified as early neonatal mortality rate (ENMR) and late neonatal mortality rate (NLMR).

$$\text{ENMR} = \frac{\text{No: of death under 7 days after birth X 1000 live births}}{\text{No: of live birth during that year}}$$

$$\text{LNMR} = \frac{\text{No: of death from 7 to 28 days after birth X 1000 live births}}{\text{No: of live birth during that year}}$$

Causes

- Intrapartum-related complications (birth asphyxia or lack of breathing at birth) is leading cause for ENMR. (prolonged labor, Birth injury, Hypothermia, HIE, Asphyxia, Neonatal seizure, Neonatal sepsis, Congenital disorder, Bleeding disorder)
- Preterm birth, Infections cause most neonatal deaths in late neonatal period.

Post Neonatal Mortality Rate: (28 days to 1 year): It is defined as the ratio of the postneonatal death in a given years to the total number of live births in the same year, expressed as a rate of 1000 live birth. The current PNMR is 19/1000 live birth in 2011.

$$\text{IMR} = \frac{\text{No of death from 28 days to 1yr of age X 1000 live births}}{\text{No of live birth during that year}}$$

Causes

- Diarrhea
- ARI
- Malnutrition

Infant Mortality Rate (IMR) (birth to 1 year): Infant mortality rate is defined as " the ratio of infant deaths registered in a given year to the total number of live birth registered in the same year; usually expressed as a rate per 1000 live births" The current IMR is 40/1000 live births in 2015.

In India (2013) IMR is 40/1000 live births, Kerala have lowest IMR rate (14 per 1000 live births) and Uttar Pradesh (83 per 1000 live births) and Orissa (96 per 1000 live births) have highest IMR rate.

$$\text{IMR} = \frac{\text{No: of death under 1yr age X 1000 live births}}{\text{No: of live birth during that year}}$$

- In past times, infant mortality claimed a considerable percentage of children born, but the rates have significantly declined in the West in modern times, mainly due to improvements in basic health care, though high technology.
- Infant mortality rate is commonly included as a part of standard of living evaluations in economics.
- The infant mortality rate correlates very strongly with and is among the best predictors of state failure.
- IMR is also a useful indicator of a country's level of health or development, and is a component of the physical quality of life index. But the method of calculating IMR often varies widely between countries based on the way they define a live birth and how many premature infants are born in the country.
- The World Health Organization (WHO) defines a live birth as any born human being who demonstrates independent signs of life, including breathing, voluntary muscle movement, or heartbeat. Many countries, however, including certain European states and Japan, only count as live births cases where an infant breathes at birth, which makes their reported IMR numbers somewhat lower and raises their rates of perinatal mortality.

Causes of IMR

Leading causes of infant death are

- Congenital anomalies
- Pre-Term Birth/Low Birth Weight
- Sudden Infant Death Syndrome
- Problems related to maternal complications of pregnancy
- Problems related to complications of placenta, cord, membranes
- Respiratory Distress Syndrome
- Accidents
- Diarrhoea
- Pneumonia
- Poison
- Infections

Under Five Mortality Rate(1 to 5 years) : It is defined as the number as the number of death <5 yrs in a given year, per 1000 children in that age group at the midpoint of the year concerned. It thus excludes infant mortality. The current Under 5 Mortality rate is 48/1000 live births in 2015. At 2015 Kerala have lowest Under 5 mortality rate (9 per 1000 live births) and Uttar Pradesh (40 per 1000 live births) and Orissa (39 per 1000 live births) have highest IMR rate.

$$\text{Under 5 mortality rate} = \frac{\text{No of death of children <5 years of age in a given year x 1000}}{\text{No of live birth in the same year}}$$

Child Survival Index

A child survival rate per 1000 birth can be simply calculated by subtracting the under 5 mortality rate from 1000 dividing this figure by ten shows the percentage of those who survive to the age of 5yrs

$$\text{Child survival rate} = \frac{\text{1000 – under 5 mortality rate}}{\text{10}}$$

Under 5 Propotionate Mortality Rate: It is the proportion of total death occurring in the under 5 age group . This rate can be used to reflect both infant and child mortality rate. In communities where sanitation is poor the proportion may exceed to 60%.

Causes of under five mortality

- Pneumonia
- Diarrhea
- Congenital anomaly accident
- Injury
- Accidents
- Poisons
- Infectious Diseases

Causes for Adolescent Mortality

- Suicide
- Accidents

Maternal Mortality Rate (MMR)

Maternal death is defined as the death of a woman while pregnant or within 6 weeks of termination of pregnancy irrespective of the duration,and the site of pregnancy from any cause related to or aggravated to by the pregnancy or its management but not from accidental or incidental causes. The current MMR is 167/ 100000 live births in 2013. High MMR is reported in Assam (300/1 lack live birth) and low in Kerala (61/ 1 lack live birth).

$$\text{MMR} = \frac{\text{No of female death from pregnancy, child birth, Puerperial causes in an year}}{\text{No of live birth in same area during that year}} \times 1000$$

- According to WHO report 2015 every day about 830 women died due to complications of pregnancy and child birth.
- Almost all of these deaths occurred in low-resource settings, and most could have been prevented
- Maternal mortality is a health indicator that shows very wide gaps between rich and poor, urban and rural areas, both between countries and within them.
- The risk of a woman in a developing country dying from a maternal-related cause during her lifetime is about 33 times higher compared to a woman living in a developed country

Causes

- The primary causes of death are hemorrhage, hypertension, infections, and indirect causes,
- Mostly due to interaction between pre-existing medical conditions and pregnancy.

Table 2: Current MCH mortality indicator in India:

Mortality Indicators	Rate	Years
Still birth rate	22/1000 total birth	2015
Perinatal mortality rate	26/1000 total birth	2013
Neonatal mortality rate	18/1000 live birth	2015
Postneonatal mortality rate	19/1000 live birth	2011
Infant mortality rate	40/1000 live birth	2013
Under five mortality rate	48/1000 live birth	2015
Maternal mortality indicators	167/ 100000 live birth	2013

The new national health policy 2017 aims to reduce mortality rate of children under 5 years of age to 23 (per 1000) by 2025 and maternal mortality rate (MMR) from current levels to 100 by 2020. Reduce infant mortality rate to 28 by 2019. Reduce neo-natal mortality to 16 and still birth rate to 'single digit' by 2025.

Measures to Prevent Mortality

Almost 2/3rd of child deaths are avoidable through following implications.

1. Skilled care: skilled care during pregnancy, childbirth and in the post-natal period
2. Infant feeding: exclusive breastfeeding, complementary feeding and micronutrients, Vital vaccines: measles and tetanus immunization and other conventional and new vaccines (Hib, pneumococcus, rotavirus) at ages 0-5 years.
3. Combating diarrhoea: low osmolarity ORS and zinc in case management of diarrhoea, antibiotics for dysentery, Exclusive breastfeeding, Adequate sanitation and hygiene, Safe water and food, adequate nutrition and vaccination.
4. Treating pneumonia and newborn sepsis: prompt treatment with appropriate antibiotics
5. Others measures: Combating malaria and preventing and caring for HIV (mother and child), Oxygen for severe illness, Reduction of household air pollution.

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[9] National Statistics Online—Trends in suicide by method in England and Wales, 1979-2001. www.statistics.gov.uk/downloads/theme_health/HSQ 20.pdf (accessed Jan 24, 2005): 7-18. Only verified references against the original documents should be cited. Authors are responsible for the accuracy and completeness of their references and for correct text citation. The number of reference should be kept limited to 20 in case of major communications and 10 for short communications.

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