

Does mother's socio-economic status affect the child's health in the fishing community of district south 24 parganas, West Bengal.

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Abstract: *The study reveals that the socio-economic status of women of the fishermen community in district south 24 parganas, West Bengal. The results indicated that the socio-economic status of women in this community are very dependant. it was found that this community most of the people are belongs to Muslim. A majority of women were poor 52.0 Percent. It can be said that 31.1 Percent of women were engaged in making net for fishing. It also has been found that most of the women revealed that they do not have the freedom to express their desire, spend money, and make decisions. 55.3 Percent of women revealed that they do not have any freedom to express their desires or wishes. It also a customary and also they believed that using kajal were protect their baby from "Kala Nazar , local term they used. It means using kajal were protect their baby from evil things. They were preferring to received treatment from traditional facilities in respect of govt. and private facilities. This women's in this community also did not complete the doses of medicine if they received the treatment from Govt. or private facilities. No education, poor socio-economic background and living in a poorest situation makes their way of thinking like that.*

Key words: Mother's education, Mother's occupation, knowledge, child morbidity.

Introduction:

"Child health is a state of physical, mental, intellectual, social and emotional well-being and not merely the absence of disease or infirmity. Healthy children live in families, environments, and communities that provide them with the opportunity to reach their fullest developmental potential (WHO, 1970)."

Child health is a key indicator of the quality of life in developing countries and also it is a global concern under several agenda e.g the recent one is sustainable development goals "No one left behind". For this we need policies and programme that focus on reaching vulnerable population. For example, populations in fragile states and areas affected by conflict and disaster need special attention to make sure their needs, from health care to food to education, are met.

Mothers play a central role in the care and nurturing the children. Numerous empirical studies disclose that maternal employment may also affect the incidence of infectious disease, which is directly related to child health. Maternal employment and child care may alter the number of contacts (exposure) and may chance the probability of infection given exposure because of changes in personal and household hygiene. Time-use studies show that working mothers spend less time on household work and food preparation (Bianchi 2006; Bianchi *et al.* 2000; Nock and Kingston 1988). So, working mothers may spend less time on children's hygiene (e.g., less attention to consistent hand washing) and household hygiene (e.g., less frequently changing sheets where infectious agents reside), which can increase the rates of infection.

Mothers' knowledge about child morbidity and child cares are highly significantly associated with child health. Absence of health care seeking and delay in seeking are associated with numerous infant deaths and infirmity in developing countries. In these countries, easily treatable diseases like pneumonia and diarrhoea are still the principal causes of illness and death among children under one year of age (Jones, Black, Morris *et.al.* 2003).

Literature Review:

With the enhancement in the number of women workers in India, it is required to understand their occupational pattern and its effect on child healthcare. The priorities of women have found to be changing all throughout the lifetime as affirmed by Srivastava (2005). During the unmarried period, women greatly prioritize occupation but after marriage and especially after children women seek for part-time or work from home jobs. It has also been found that earlier women workers greatly engage in agricultural and other activities which have been greatly shifted and transited. The paradigm shifts according to Rustagi (2010) has been observed from the various stereotyped teaching jobs, sales, service and related to production operations, managerial, professional and other technical activities. The Indian labor markets play a significant role in gender segregation and segmentation. Women generally engage in activities and jobs greatly affected by the traditional gender division. So, women are generally found in jobs that closely fits them to domestic responsibilities like maids, tailors, cook, nurses and others (Srivastava, 2005). Moreover, primary school teachers, crafts teacher are mostly performed by women as both help to incorporate cultural values and social acceptance in children and is related to parents. Nursing jobs in women have extended to the medical profession as technicians, cooks and maids to chefs and caretakers or housekeepers, and tailoring and sewing to fashion designers. In the scientific field as the women empowerment is increasing women also engage in the profession of social scientists and researchers. As per Levy & Murnane (2012) urban women are also adopting new professions like media include visual or print, information technology jobs, call centre jobs and others. This helps both the rural and urban women to move out from the household domain to grab paid employment opportunities that greatly empower them and contribute to the household income.

The Primary non-manual sector incorporates teaching which includes both men and women. The women primary sector includes the women particularly related jobs. Women secondary sector includes a semi-skilled profile of selling, childcare, and another low level clerical work.

Recently, Chandra (2016) in a report mentioned that with the accomplishment of independence a positive change exists in the political, economic and social status of middle-class working and non-working women. Emslie & Hunt (2009) in their study said that paid work and household responsibilities impact and also conflict each other. If more time is spent on one the other gets neglected or less time. If women actively full time engages in paid and household labor both then it is achieved by the expense of leisure activities and some unfulfilled demands in each.

The health of children is greatly determined by the level of education of parents. Various studies and researches like Shapiro & Browne (2016) consider that education level of parents especially mother determines the health and welfare of its children. As women greatly engage themselves in the daily activities of their children, so when the education of the women is greater, she would be able to gather more information about her children. For less educated parents, children behavior is observed in a positive and less flexible way and they neglect their children for other inappropriate activities. Moreover, with reduced education greater stress and negative psychology of women leads to the lower health of their children. In studies by WHO (2009) it has been stated that many health problems that children face today are due to the behavioral risks associated with their parents. It was also stated that in preschoolers the problems among the children was due to limitations in maternal education. Illiterate mothers or mothers with reduced literacy levels cannot effectively guide its children during sudden unintentional child injuries, or other harsh punishments. Schultz(2001) asserted that women with insufficient literacy also lack good career opportunity, has low self-esteem and do not gain family support in their children upbringing. So, it also greatly affects the health and welfare of their children as they lack the capability to conduct the behavior of their kids. Mirowski & Ross (2003) even stated that low education levels also leads to a teenage pregnancy that refers early parenthood, barriers in attaining education, women greatly engage into single parenthood, unemployment issues and poverty.

Moreover, on the other hand, as the education level enhances among women it leads to greater engagement to professional or paid labor as denoted by Chandra (2016). This also leads to neglecting of children health and well-being. The caretaker left behind the mothers for their children have a low-level education of the enhancing and changing health factors which greatly affect the children healthcare. The women play a crucial and most significant role in maintaining the health of its children. The household food security is managed and improvised by the active involvement of women. Studies and researchers also reveal that women effectively use the resources and skills available compared to men to improvise the nutrition and health aspects of their family.

It has also been found that a positive correlation exists between women's status and her personal well-being. In South Asia, it has been found by Smith & Byron (2005) that as the women decision-making power is very low so it greatly affects the nutritional status of women leading to the highest chronic deficiency among women. Improvements in relative decision-making power also enhance their pre-natal and birthing care. Empirical results are also formulated to illustrate the relation between women status and the nutritional status of their children. The women status is directly related to the child care giving practices along with high-quality complementary feeding that greatly helps in the growth of children while the mother is working. Women status negatively links to the breastfeeding activities as with greater independence of women and working factors they comparatively reduce their breastfeeding. This also leads to a reduction in immunity level of their children and inversely relates their health factors. In terms of health-seeking practices, it has been found that women's relative decision-making power is positively related to diarrhea in South Asia and Child vaccinations in South Asia, SSA and LAC (Smith & Byron, 2005). It greatly helps to enhance the quality of the substitute child caretakers also. Thus, the negative influence of reduction in breastfeeding is managed by other care practices for children. The gap between the nutritional status of children in South Asia and SSA leads to the reduction in the lower level of women status. Other factors that widen the nutritional status gap include the sanitation and urbanization. Thus, incorporating activities like prenatal and birthing care for women, complementary feeding of children, including timely introduction, food quality, and feeding frequency; timely initiation of breastfeeding; treatment of illness of children; immunization of children; and quality of substitute caretakers for children directly relates to women decision making power. The child health and well-being are improvised by women empowerment, health care service barrier removal, enhanced education level and promotion of awareness in communities as concluded by Mahapatro (2012).

The importance of inculcating sanitation practices in household greatly helps to enhance child health in the community. Sanitation facilities include greater access to latrines by households. Sanitation as per Black & Fawcett (2010) is also referred as the process of collection and disposal of excreta and liquid waste from the community so that a germ-free environment is formulated that do not risk the health of people or community. The social and economic development indicators reveal that India still derails among the developing country. This is mainly as around 65% of the rural areas of India lack proper sanitation facilities due to the scarcity of

water (Kelkar-Khambete, 2012). Moreover, some of these areas also lack educational facility, high infant and mother morbidity rates and following superstitious traditional customs.

Need for the study:

Child health is an important policy issue in most countries due to its short-term and long term effects on both individuals and society. Child health is a sign of a society's or communities development level. Fisheries depends on the fisherman and fisherwomen. Most of them are very poor and illiterate. Due to lesser income of the fishing community, their family mainly children face high incidence of morbidity. The living condition, sanitation facilities are very poor in these communities. Children of that community mainly suffer from diarrhea and malnutrition along with several other diseases.

Majority of this population is classified as scheduled castes and schedule tribes, meaning that the Government of India considers them to be disadvantaged groups that needs special attention because of their levels of poverty, isolation, discrimination and neglect. Fishermen from interior villages with limited access to education, employment, lack of knowledge and their livelihood patterns make them poor. The health of families and communities are tied to the health of women – the illness or death of a woman has serious and far-reaching consequences for the health of her children, family and community as well. Women play a critical role in maintaining the health and well-being of their communities. But fishing community does not access the health care services due to their scatter settlement, illiteracy and lack of knowledge.

This study is necessary to develop and to assess the knowledge; attitude of child care practices, treatment seeking behavior and knowledge of child morbidity and nutrition of children in the fishing community of district South 24 parganas, West Bengal.

There are too many socioeconomic and demographical studies in the tribal communities. But very little research has been found related to the fishing community. Reviewing the ample research we can say that most of the study done regarding socioeconomic and market based study among the fishing community and also the women in the community. But there is no such adequate attention given in the area of socio-demographic aspects too. And how the water and sanitation, low demographic profile is directly related to child health status. So it is necessary to portray the association between socioeconomic and demographic condition in the fishing community and its relation to child health in South 24 parganas district. This is an imperative attempt to know the demographic appraisal in the perspective of policy implications regarding fishing communities in the state of West Bengal.

Existing literature regarding people in fishing community and their socioeconomic condition provide ample scope to further confirmation revisiting the theories especially their poor health status, poverty, illiteracy, not receiving health care services, improper child care are quite high. The study will deal those issues, which have not been explored at length in the rural areas of fishing community in the Indian context.

Objectives:

- 1) To study the women's knowledge about child care and child morbidity and treatment seeking behavior in the fishing community.
- 2) To understand the woman's occupational pattern, women's autonomy over economic resources and child care in the study area.

Data and Methodology:

The present study discusses the childcare practices and child health status in fishing community of South 24 parganas district, West Bengal. Women with children 0-5 years of age are considered as respondent for this study. Currently married women of fishing community in the age group 15-45 years old and those who have 5 years or less than 5 years children (at least one) is selected for this study.

Study area:

The area is chosen purposively for the present study to understand the child care practices and the status of child health. The sample for this study will be drawn from the purely rural area, Basanti under Canning Sub-division under the district South 24 parganas of the state West Bengal. Basanti block has a larger concentration of fishing community and it is one of the southernmost parts of south 24 parganas. Basanti Block is bounded by Gosaba Block towards East, Canning-I Block towards North, Canning-II Block towards North, Sandeshkhali-II Block towards East. Basanti is one of the main deltaic islands in the Sundarban region, bounded by the Matala and Vidyadhari rivers/creeks. Basanti is located at latitudinal extend of 22°33'45"N to 22°29'0"N and longitudinal extend of 89°4'50"E to 88°3'45"E. According to District Statistical Handbook of South 24 Parganas, 2009 Basanti has a population of 278592 out of these 34,164 is a 0-6 population. The entire population is classified as rural. The occupation of the people is mainly fishing, collecting honey etc. According to District Statistical Handbook of South 24 Parganas, 2009 the persons engaged in fishing is 16,610. It is quite apparent from the people's livelihood options and the social composition of the population that people living in this area remain socially and economically neglected. In Basanti most of the residents are stagger under an acute drinking water crisis. It becomes very difficult for the people to drink safe water. Therefore, many community members are suffer from diarrhea mainly children, which has direct bearing on child health.



In Basanti block there are number of villages. The villages were selected according to the concentration of fishing community. For this study five villages were selected that is Ramchandrakhali, Purandar, Napithkhali, Kathalberia, Kumirmari.

Sample size determination and implementation:

Total sample size for this study will be determined based on prevalence of diarrhea among children in South 24 parganas district. The third round of District Level Household Survey (2007-08) shows that 5 percent children of aged under five years were suffering from Diarrhea in South 24 parganas district. However, the estimates of diarrhea may be relatively high in the study population. To reach the minimum sample size for this study following assumptions which is consider here are: the anticipated proportion of children suffering from diarrhea is nine percent ($P = 0.09$) and assuming that the relative precision is 30 percent ($\epsilon = .3$), child proportion is 0.15% and confidence interval at 95 percent. For one sample situation the minimum sample size can be calculated using the formula given bellow:

$$N = Z^2 \frac{1-\alpha/2 * (1-P)}{P\epsilon^2}$$

Under the above assumption this study needs 508 households to be surveyed.

Tools for data collection:

In this study primary data is collected. To fulfil the purpose of the study both qualitative and quantitative methods of data collection will be used. **Household questionnaire** and **Individual questionnaire** is prepared to develop the work. For this present study qualitative information about the community is collected from questionnaires

and key informant interviews. Household questionnaire contains two sections and Individual questionnaire contains five sections.

Results and Discussion:

The following section has been developed to discuss the results gathered depending on the occupational pattern of the women belonging to the fishing community. After analysing the primary data in this section, it has been compared with the information gathered from the secondary information of the literature review section of the study.

Also, this chapter has been developed to find out the freedom of the women to take decisions while residing in the fishing community of West Bengal. The study here has expressed the decision-making of the women belonging to the fishing community. This section has depicted the results or expressions of women related to their freedom of making wish or choice or taking decisions for household matters and economic resources.

1.1 Women Characteristics:

1.2 To know about the child care practices and treatment seeking behavior of this community first of all I focused on women's background characteristics. From Table 5.2.a it was found that this community most of the people are belongs to Muslim. The respondents belonged to different religion apart. Hindu women are 36.7 Percent, 41.7 Percent of the women were Muslim, and 21.6 Percent were others category. Considering the caste of the population, a majority of them, 38.6 Percent, belonged to schedule caste, 33.0 Percent belonged to other backward classes, and 28.3 Percent women were from other castes/tribes. A majority of women were poor 52.0 Percent, 35.5 Percent belonged to the middle class, and 12.5 Percent of women were relatively rich.

Most of the women, 59.7 Percent, got married when they were between 16-20 years of age; a minority of 21.5 Percent of women married when they were more than 21 years of age, and it is to be noticed that about one in five (18.8 Percent) of women got married when they were more than 15 years. Considering the age when the women gave birth for the first time, a majority of 65.0 Percent women gave birth when they were greater than 20 years of age; 23.0 Percent of women gave birth when they were 20-29 years of age, and 12.0 Percent gave birth when being 30-39 years old.

Around 59.1Percent of the women were living with their husbands, and 40.9 Percent of women were staying elsewhere. Further, the husbands of 70.1 Percent of women stay outside, and a majority of 46.8 Percent stay outside for two weeks. Husbands of 39.1 Percent of women stay outside for one week and those of 14.1 Percent

for above two weeks. When the children are in a morbid condition, the family members of 39.0 Percent women look after them, 27.8 Percent of the women themselves take care of their children only, and remaining 22.4 Percent said their children looked after by their neighbours.

Table 1.1.a percent distribution of selected women characteristics of the study population.

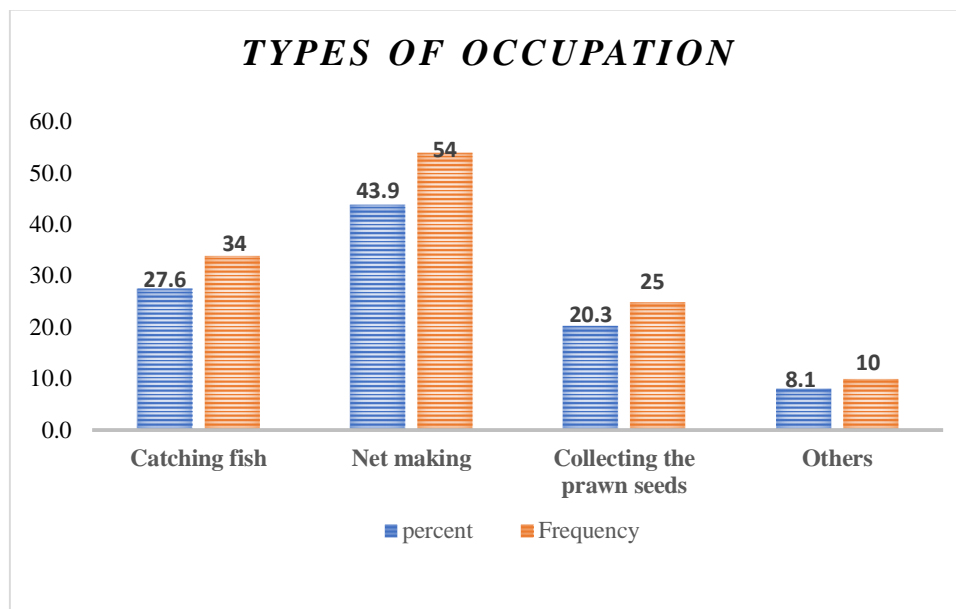
Background Characteristics	Percentage	Frequency
Religion		
Hindu	36.7	211
Muslim	41.7	240
Others	21.6	57
Caste/Tribe		
Schedule Caste	38.6	222
Other Backward Classes	33.0	190
Others	28.3	163
Wealth Index		
Poor	54.4	276
Middle	35.8	182
Rich	9.8	50
Mother's age at Marriage		
>15years	18.8	108
16-20 years	59.7	343
Above 21 years	21.5	124
Mother's age at First Birth		
<20 Years	65.0	374
20-29	23.0	132
30 -39	12.0	69
Marital Status		
Currently married	35.1	202
Separated/Divorce	55.1	317
Widowed	9.8	56
Living with Husband/elsewhere		
Living with husband	59.1	340
Staying elsewhere	40.9	235
Husband stay Outside/Not		
Yes	29.9	172
No	70.1	403
No. of Days Stay Outside		
1week	39.1	225
2 weeks	46.8	269
Above 2 weeks	14.1	81
Child Looked after in Morbid Condition		
Family members	39.0	224
Neighbours	22.4	129
Only own	27.8	160
Others	10.8	62

1.2.1 Occupation of Women:

On enquiring about the occupational pattern of the women from the fishing community, it has been interpreted that most of them are engaged in making nets, while others are engaged in catching fishes and selling them in the market. From Table 1.2.1a it showed that rest of them are engaged in selling fishes door to door, drying the fishes, collecting honey and other works. It can be said that 31.1 Percent of women were engaged in making net for fishing, 15.8 Percent of women are involved into catching fish, 12.7 Percent women are engaged into other activities and the rest 11.8 Percent women are selling fishes door to door. However, among the others around, 9.6 Percent were selling fishes in different markets and earning their money. 9.7 Percent of women are collecting honey and fuel and rest 9.2 Percent women are engaged into occupations like drying the fishes or smoking it. But, in the fishing community, the women are mainly engaged in fishing-related activities like net making or catching or selling fish.

Table 1.2.1a Percent distribution of women according to occupational pattern.

Occupational pattern	percent	Frequency
Catching fish	27.6	34
Net making/mending	43.9	54
Collecting the prawn seeds	20.3	25
Others	8.1	10

Fig 1.2.1b. Showing the occupational pattern of women.

This fig 1.2.1b also shows that occupational pattern of women in the fishing community. Most of the women that is 31.1 percent were engaged in net making/mending. The 15.8 percent women were engaged in catching fishes. The catching fishes includes here only those who were engaged in catching small fishes, crabs and prawn seeds collection.

1.2.2 Women Autonomy and Decision-making Power:

This section comprises women's autonomy and decision about child care, child immunization, child nutrition and to brought any household amenities. This section focused on the economic resources and the autonomy of women in Table 1.2.2c. As per the enquiry is concerned, it has been found that most of the women revealed that they do not have the freedom to express their desire, spend money, and make decisions. 55.3 Percent of women revealed that they do not have any freedom to express their desires or wish in the house while, 41.4 Percent said that they can take decisions and make wish or desire as per them. But, as per most of the women, in their houses, their husbands mainly take the decision, and they only decide whether the women can visit their relatives or families. Seventy Percent of women agreed to this and stated that their husbands take decisions in all the household purchases and other things related to them. Addition to this, 68.1 Percent of the women also said that their husbands play significant roles in taking decisions to send the women to their relatives and families. This shows that, the husbands of such families are the primary and major decision-makers and the women obey them. They

could not take their own decisions. Other than these, the husbands also play important roles in taking other decisions even though they were fully involved in fishing activities. For instance, the husbands take the decisions for health concerns, food and nutrition and expenditure. More than half 56.5 Percent of women said that their husbands take decisions regarding the health of them and their children. On the other hand, 59.0 Percent of women also agreed that their husbands take important decisions in terms of bringing food or nutrition of their children. About four in every five 79.6 Percent of women also stated that their husbands spend money in their family and they do not have any freedom in terms of expenditure. Even, the money owned by the women are spending by taking the husband's decision. However, the women can only take decisions during delivery of the baby. A similar proportion of (79.4 Percent) women agreed to this and said that among other decisions that are taken by their husbands, this is the only decision which is taken by the women. But, other than that, the decisions to purchase food, clothes or shoes for the children are taken by the husband (Annadurai *et al.* 2015). Fifty eight Percent (58.2 Percent) of women said that they cannot buy or take decisions to buy something for their children. They are not allowed to buy clothes, food and shoes for themselves and their children. The women are thus discriminated in those houses. The women do not have any freedom to take the children to the market, job place, fishing landing centre, water fetching centre, and at the time of fish vending. Similar conditions have been identified as per the secondary information of the study. Thus, as per the data gathered from both primary and secondary information, the husband is the ultimate decision-maker of the family (Bharti, 2016).

Table 1.2.2a Percent distribution of women's Autonomy and decision-making power by background characteristics.

Women's Autonomy and decision-making power	Percent	Frequency
Freedom to express/make own wish/desire		
yes	41.4	217
no	55.3	290
Freedom to spend the money of own choice		
yes	3.8	20
no	92.9	487
Decision about major household purchases		
Respondent	0.2	1
Husband	70	367
Respondent and husband	22.1	116
Respondent, husband and others	4.4	23
Decisions about visits to your family or relatives		
Husband	68.1	357
Respondent and husband	15.8	83
Respondent, husband and others	12.8	67
Decisions about health for yourself and your children		
Husband	56.5	296
Respondent and husband	22.5	118
Respondent, husband and others	17.7	93
Decisions about food and nutrition of children		
Respondent	0.2	1
Husband	59	309
Respondent and husband	21.6	113
Respondent, husband and others	16	84
Decisions on spending money by your family		
Husband	79.6	417
Respond and husband	16	84
Respondent, husband and others	1.1	6
Decisions on own earned money if working		
Husband	14.3	75
Respondent and husband	6.5	34
Decision on delivery of baby (last two survival child)		
Respondent	79.4	416
Respondent and husband	16.4	86
Respondent, husband and others	1	5
Decision on Immunization (last two survival child)		
Respondent	0.2	1
Husband	58.2	305
Respondent and husband	35.1	184
Respondent, husband and others	3.2	17
Decision on buy something for their children		
Respondent	0.3	2
Husband	58.2	305
Respondent and husband	35.1	184
respondent, husband and others	3.2	17
Finally, the decision maker of family		
Respondent	0.4	2
Husband	70.4	369
Husband and respondent	11.1	58
In-laws	13.9	73

1.2.3 Women's knowledge and Child Care:

From Table 1.2.3a as per the current analysis, a majority of 67.3 Percent of the women knew about breastfeeding. When the respondents were asked about their level of knowledge regarding child nutrition, only 11.8 Percent replied that they knew about nutrition and rest of the mother did not know about the child nutrition. Further, only 5.3 Percent of the women were aware of childhood morbidity. On the question regarding intestinal worm, 11.8 Percent mothers replied that they knew about them and rest of the mothers did not know about this particular disease. On other hand, 25.9 Percent of mothers replied that they were aware about child spacing, which is associated with child health too. Regarding question on cleanliness of defecation places only 13.6 Percent of mothers replied that they were knew about them but maximum percentage of mothers did not have knowledge regarding it.

Table 1.2.3.a Percent distribution of women's knowledge and awareness by selected background characteristics.

Background Variables	Percentage (%)	
Knowledge of breastfeeding	67.3	Chi-square test was performed for evaluating the relation between the knowledge of mothers and child care indicators.
Knowledge of vaccination	46.4	
Knowledge of child nutrition	11.8	
Knowledge of nutritious food	15.0	
Awareness about child morbidity	5.3	
Awareness about intestinal worm	11.8	
Awareness about child spacing	25.9	
Knowledge about cleanliness of defecation place	13.6	

From the table 1.2.3b the indicators taken here are 'Regular bath', 'besides breastfeed given any solid/semi solid food' given ORS during Diarrhea', and 'received any vaccination'. The analysis was performed for two categories. As per the results of the study, there is a significant relationship between the knowledge of mothers about breastfeeding, vaccination, knowledge of ORS, and the child care indicators for both the categories. A significant positive relationship was also found between the knowledge of breastfeeding, child nutrition, childhood morbidity, awareness regarding Intestinal worm, seek treatment for worm disease with child care indicators.

Table 1.2.3b Association of Mother's knowledge and selected child care indicators.

Mothers knowledge and Awareness	Regular Bath	Chi-Square	Besides breast milk given any solid/semi solid food	Chi-Square	Given ORS during diarrhoea	Chi-Square	Received any Vaccination	Chi-Square
Knowledge of breastfeeding	20.8	18.189** *	89.9	2.172	41.4	27.97** *	66.3	1.09***
Knowledge of vaccination	25.4	29.027** *	85.9	8.27** *	50.9	31.13** *	88.1	25.66** *
Knowledge of child nutrition	46.7	48.03***	98.3	5.13*	65.0	43.59** *	86.7	36.03** *
Awareness about childhood morbidity	11.5	0.396	96.2	1.20*	66.7	10.05** *	70.4	4.63*
Knowledge of ORS during diarrhoea	21.7	10.67***	93.7	8.72** *	65.8	1.63***	64.5	36.1***
Awareness about intestinal worm	50.8	60.82***	98.3	5.26*	75.5	50.61** *	100	67.2***
Seek treatment of intestinal worm diseases	15.7	0.75	90.4	6.46**	38.7	5.85**	50.2	0.11

Note: Chi-Square values significant at $p < 0.10 = *$, $p < 0.05 = **$, $p < 0.01 = ***$

The time spend on child care include the times spend on dressing, feeding and other activities related to child except at night when they were asleep. Here 0-1 years and 2-5 years two category was done to obtained the answer of those mothers who had given time to their children. In the survey total 508 household were surveyed. Among 508 household 173 women of household had 0-1 years child and 335 women had 2-5 years children. Here researcher categorised the hours into three categories, that is 1-4 hrs, 5-6 hrs and 7-9 hrs. From Table 1.3.c it was found that 67.6 percent child (0-1 yrs.) received 5-6 hrs time to child care. Only 1.7 percent child (0-1 yrs) received 1-4 hrs time to child care. In case of 2-5 yrs. children (33.4 percent) they also received 1-4 hrs per day

for child care. Around fifty eight percent of 2-5 years child receive 5-6hrs per day from their mothers. From this table it was found that younger children received more time than older children.

Table 1.3.c Percentage of mothers given time to child care in a day.

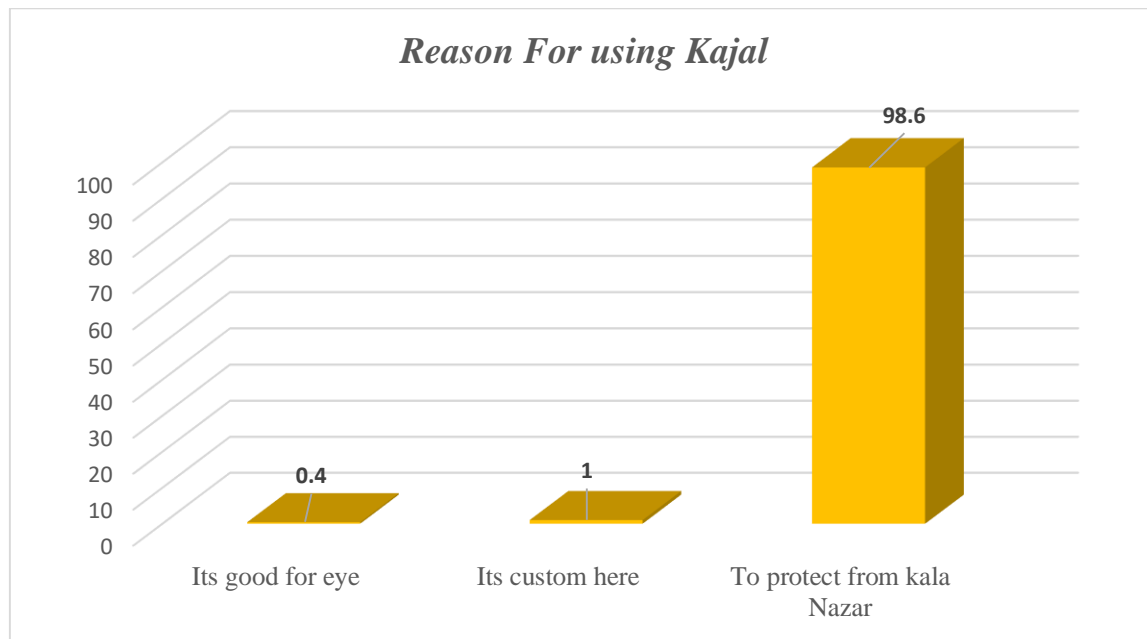
Mothers given time to child Hours per day	Children 0-5 years	
	0-1 yrs. Child	2-5 yrs. Child
1-4 hrs	1.7	33.4
5-6 hrs	67.6	57.7
7-9 hrs	30.6	8.9
Mean	2.28	1.75
Total (N)	173	335

Mothers education have also a positive influence on child care. In the study area the education of mothers was less. Majority of women were not literate and some women were completed their schooling up to 4th standard and 5-8th standard completed were very less. And above 8th standard completed only 1. That's why the child care percentage of above 8th standard has been shown very less. From Table 5.3.d it has shown that more mothers with no education were using kajal to their babies' eye in respect of women with higher education. Similarly, women with education up to 4th standard were using common powder 68.4 percent and local market powder 59 percent. Half of the women changing the dresses after bath of their baby in up to 4th grade standard when 16.7 percent women changing the dresses after bath of their baby with no education. It has been seen like that because maximum percentage of women was up to 4th standard. So, the percentage was shown higher in this category.

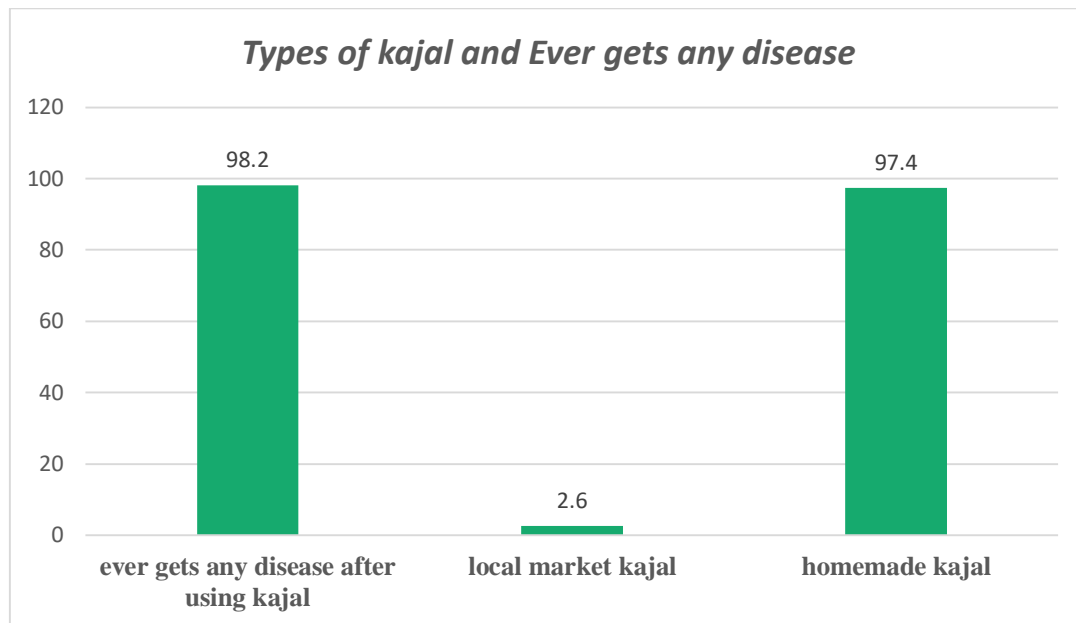
Table. 1.3.d Percentage of selected child care indicators by mother's education.

Child care Indicators	Mothers Education			
	No Education	Up to 4th std	5-8 std	above 8th std
Use kajal				
yes	71.1	26.2	2.4	0.2
Powder use				
branded	0.0	0.0	0.0	0.0
common powder	15.8	68.4	15.8	0.0
Local market powder	26.7	59.0	12.4	1.0
Changing dresses after bath				
yes	16.7	50.0	33.3	0.0

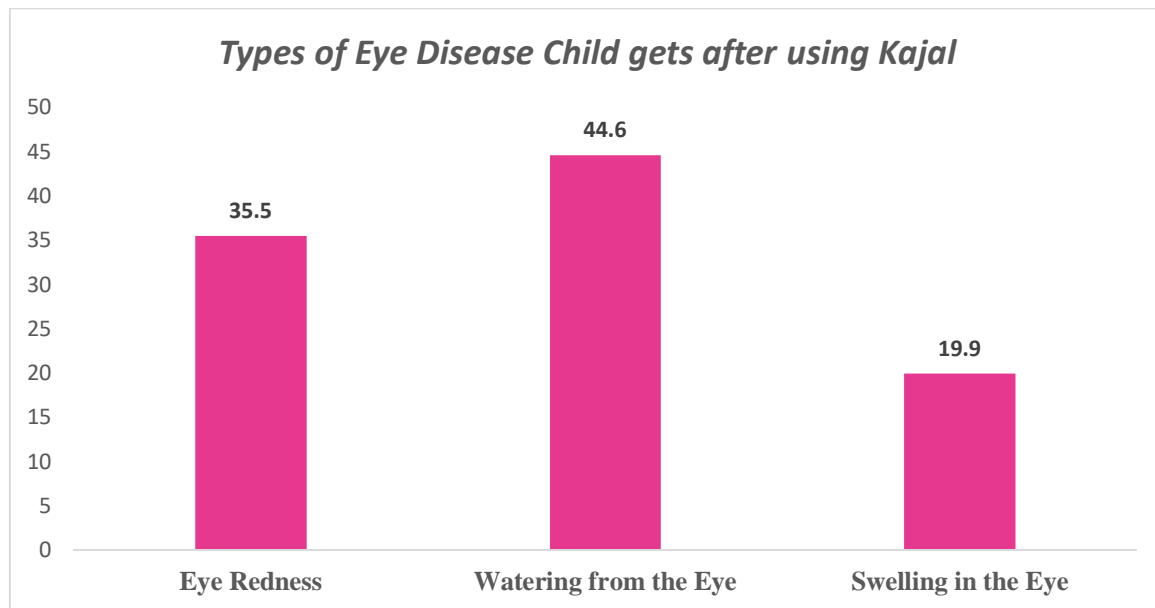
In this community using kajal to babies' eye were very much common. Its also a customary and also they believed that using kajal were protect their baby from "Kala Nazar", local term they used. It means using kajal were protect their baby from evil things. In Fig 5.3.1a It has been shown that 98.6 percent women were using kajal to their babies' eye to protect from "Kala Nazar" (Believe to be evil's eyes). No education, poor socio-economic background and living in a poorest situation makes their way of thinking like that.

Fig.1.3.1a Percentage showing reason for using Kajal.

In the study area the most of the children were using Kajal to their eyes and after using Kajal children also gets eye diseases 98.2 Still they were using kajal to their baby's eye. Question was asked to mothers of the baby that after using kajal had their child suffered any kind of diseases? Most of them agreed with it and said yes there had been some disease occurs even after using kajal. The fishing community people use home made Kajal. It is said when asked how it is prepared then they replied "*Aam pata te sorsher tel lagiye aguner shikhai dhore je kali ta hoi seta bacchar chokher pokkhe khub valo*". It means they used mango leaf and on it they used mustard oil and keep above the candle/lamp's fire, after that what black charcoal they found it was used for their baby's eye and its good for them. From Fig 5.3.1b it has been shown that only 2.6 percent women using local market kajal and 97.4 percent women using home made kajal.

Fig. 1.3.1b Percentage showing children ever got any eye diseases and types of kajal used.

From Fig. 1.3.1c it has been shown that types of eye diseases child suffered from. The results showed that 44.6 percentage children were suffered from watering from the eye, 35.5 percent children suffered from eye redness and 19.9 percent child suffered from swelling in the eye. Though children in this community had suffered from different types of eye diseases they still using Kajal to their babies eye because they believed that using Kajal will protect their children from evil's eye.

Fig. 1.3.1c Percentage showing types of eye diseases child gets.

1.2.4 Treatment Seeking Behavior among Children:

On verifying regarding the child morbidity and treatment seeking behavior, it has been found that in morbid condition children were received treatment, but most of them traditionally (Diarrhoea 64.1 Percent) received the traditional treatment. Some of them even stopped taking medicines as soon as they got well. Others have received treatments from the government and private institutions. Similar situations were shown in all the morbidity conditions also. They were preferring to receive treatment from traditional facilities (ARI 70.0 Percent, Cold & Cough 93.2 Percent, Fever 58.5 Percent, Skin infection 91.6 Percent) in respect of govt. and private facilities. This women's in this community also did not complete the doses of medicine if they received the treatment from Govt. or private facilities. From the Table 1.2.4a it reflects all the above.

From the secondary information, health-seeking behavior has been identified as an important factor for the well-being of the children (Chandwani & Pandor, 2015). A woman plays the significant role in maintaining the health conditions of the family. As per the previous studies are concerned, the women of the fishing community due to lack of knowledge and education and work schedule cannot identify or take proper care of their children (Bharti, 2016). Hence, their children become the sufferers. Also due to gender discrimination and gender bias, women in rural areas cannot take any decisions or translate the health disparities or inadequate access to health care services (Jamison *et al.*, 2006). Women in this study area could not take own decisions and this make them more vulnerable by their inaccessibility to the health care services.

Table 1.2.4a Percent distribution of treatment seeking behaviour of child received in morbid condition.

Child Morbidity	Percentage (%)
Diarrhoea	
Treatment received (yes)	84.2
Traditional	64.1
Govt.	15.1
private	4.0
Complete the doses (yes)	7.6
ARI	
Treatment received (yes)	70.0
Traditional	30.0
Govt.	23.1
private	17.0
Complete the doses (yes)	6.7
Cold & Cough	
Treatment received (yes)	93.2
traditional	53.4
Govt.	23.0
private	10.1
Complete the doses (yes)	10.2
Malaria/Fever	
Treatment received (yes)	84.2
Traditional	58.5
Govt.	23.1
private	2.5
Complete the doses (yes)	7.4
Skin Infection	
Treatment received (yes)	91.6
Traditional	53.2
Govt.	17.0
private	8.7
Complete the doses (yes)	8.8
Chicken Pox	
Treatment received (yes)	66.6
Traditional	21.0
Govt.	35.6
private	10.11
Complete the doses (yes)	8.8
Abdominal Pain	
Treatment received (yes)	90.3
Traditional	38.7
Govt.	36.0
private	15.4
Complete the doses (Yes)	10.1



1.3 Conclusion:

As per the current analysis, of this work majority of 67.3 Percent of the women knew about breastfeeding. When the respondents were asked about their level of knowledge regarding child nutrition, only 11.8 Percent replied that they knew about nutrition and rest of the mother did not know about the child nutrition. Further, only 5.3 Percent of the women were aware of childhood morbidity. On the question regarding intestinal worm, 11.8 Percent mothers replied that they knew about them and rest of the mothers did not know about this particular disease. On other hand, 25.9 Percent of mothers replied that they were aware about child spacing, which is associated with child health too. Regarding question on cleanliness of defecation places only 13.6 Percent of mothers replied that they were knew about them but maximum percentage of mothers did not have knowledge regarding it.

As per the results of the study, there is a significant relationship between the knowledge of mothers about breastfeeding, vaccination, knowledge of ORS, and the child care indicators for both the categories. A significant positive relationship was also found between the knowledge of breastfeeding, child nutrition, childhood morbidity, awareness regarding Intestinal worm, seek treatment for worm disease with child care indicators.

In this community using kajal to babies' eye were very much common. It's also a customary and also they believed that using kajal were protect their baby from "*Kala Nazar* , local term they used. It means using kajal were protect their baby from evil things. In Fig 5.3.1a It has been shown that 98.6 percent women were using kajal to their babies' eye to protect from "*Kala Nazar*" (Believe to be evil's eyes). No education, poor socio-economic background and living in a poorest situation makes their way of thinking like that.

It has been shown that types of eye diseases child suffered from. The results showed that 44.6 percentage children were suffered from watering from the eye, 35.5 percent children suffered from eye redness and 19.9 percent child suffered from swelling in the eye. Though children in this community had suffered from different types of eye diseases they still using Kajal to their babies' eye because they believed that using Kajal will protect their children from evil's eye.

As per the discussion, it can be concluded that the women residing in the fishing community are mainly dependent on the net making as a source of their income. Though, there are other occupational options for them like selling fish or catching fish and others. Most of the women have tried to take care of their children beside their occupation. But, some of them cannot take care properly for which they need to give extra effort and look after both their household and children. However, in the fishing community of West Bengal, still, there have been many households where the women are unable to take proper care of their children due to lack of money and resources. They are not using separate towel, comb or bed for their children to keep them clean and safe. Transportation was the main barriers in seeking health care services. Thus, those children are suffering the most and need proper care in the fishing community. Hence, the government organizations have taken the initiatives to maintain the childcare practices in such rural areas as a fishing community.

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