



Assessment of Health and Education Status in Mangnoor Village, Bhudargad Block, Kolhapur District

Dr. Rajiv Honagoudar,

Assistant Professor,

Yashwanth Ayurvedic College,

Kodoli, Dist- Kolhapur

Maharashtra University of Health Sciences, Nashik, India.

Abstract:

This study assesses the health and education status of Mangnoor Village in Bhudargad Block, Kolhapur District. By employing a mixed-methods approach, we collected quantitative data through surveys and qualitative insights through interviews with local residents. The findings reveal significant challenges in both health and education, including inadequate healthcare facilities, high rates of malnutrition, and low literacy levels. Additionally, factors such as socioeconomic status, gender disparities, and limited access to resources were identified as critical barriers. The study underscores the need for targeted interventions to improve health outcomes and educational opportunities in the village, ultimately aiming to enhance the overall well-being of the community. Recommendations for policy and program development are provided to address these pressing issues effectively.

Key Words: Health Status, Education Status, Rural Health, Educational Attainment

Introduction:

History of Education in India: The education system in India has deep historical roots, tracing back to ancient times when Brahmin gurus imparted knowledge without charging fees, relying instead on donations from students and their families. Temples served as centers of learning, where both religious and secular subjects were taught. Students were expected to live as brahmacharis, practicing celibacy during their studies. The education provided was often tailored to the societal roles individuals were expected to fulfill. The priestly class, or Brahmins, focused on religion and philosophy, while the warrior class, Kshatriyas, received training in warfare. The Vaishyas learned trade, whereas the Shudras were generally excluded from educational opportunities. Influential texts from this era, such as the Manusmriti and Arthashastra, reflect the societal norms and understanding of knowledge at that time.

With time, secular institutions began to emerge alongside Hindu temples, mutts, and Buddhist monasteries, offering practical education, including medicine. Between 500 BCE and 400 CE, urban centers of learning such as Taxila and Nalanda became prominent, systematically imparting knowledge and attracting foreign students. These institutions provided comprehensive education in Vedic and Buddhist literature, logic, and grammar. Chanakya, a renowned teacher at Takshasila, played a crucial role in the establishment of the Mauryan Empire.

Education in Modern India: India's contemporary education system is structured across various levels, including pre-primary, primary, elementary, secondary, undergraduate, and postgraduate education. The National Council of Educational Research and Training (NCERT) oversees curriculum-related matters for school education and provides technical assistance to numerous schools. The system comprises multiple curriculum bodies, including state government boards, the Central Board of Secondary Education (CBSE), the Council for the Indian School Certificate Examinations (CISCE), and the National Institute of Open Schooling (NIOS), among others.

The standard "10+2+3" educational pattern—ten years of primary and secondary education, followed by two years of higher secondary and three years of undergraduate study—originated from the Education Commission of 1964-66. Primary education is emphasized up to the age of 14, as mandated by the Right of Children to Free and Compulsory Education Act of 2009. Despite significant government efforts, challenges remain, including high pupil-to-teacher ratios, inadequate infrastructure, and poor teacher training.

Private Education: While the government is the primary provider of education, a growing number of students attend private institutions due to the perceived quality of education offered. Approximately 27% of Indian children are enrolled in private schools, especially in urban areas. These schools often provide better pupil-teacher ratios and a wider range of extracurricular activities. However, they also face criticism for not serving the poorest segments of society.

Key Indicators: India faces critical challenges in education, with only 66% literacy overall—76% for men and 54% for women. Although around 90% of children aged 6-11 are enrolled in primary schools, nearly 40% drop out before completing primary education. Many schools lack basic facilities, and issues like malnutrition and child labor further hinder educational attainment. Addressing these disparities is essential for ensuring equitable access to education and improving overall outcomes for all children in India.

Health in India: India operates a universal healthcare system administered by its constituent states and territories. The Constitution mandates that each state is responsible for "raising the level of nutrition and the standard of living of its people and the improvement of public health." The National Health Policy was first endorsed by the Indian Parliament in 1983 and updated in 2002. Alongside the public healthcare sector, the private medical sector has gained significant popularity, with many urban and rural households preferring private services over public ones. Currently, India's life expectancy stands at approximately 64 years for males and 67 years for females, with an infant mortality rate of 61 deaths per 1,000 live births.

Health Issues

Malnutrition: Malnutrition remains a critical concern, with 42% of children under the age of three classified as malnourished—higher than the 28% seen in sub-Saharan Africa. Despite India's economy growing by 50% from 2001 to 2006, the child malnutrition rate improved by only 1%, lagging behind other nations with similar growth trajectories. Malnutrition severely affects children's social and cognitive development, leading to diminished educational attainment and reduced future income, ultimately resulting in lower productivity.

High Infant Mortality Rate: Approximately 1.72 million children die annually before reaching their first birthday. While both under-five mortality and infant mortality rates have declined—from 202 and 190 deaths per 1,000 live births in 1970 to 64 and 50 in 2009—the pace of improvement is slowing. Funding reductions for immunization programs have left only 43.5% of young children fully immunized. Barriers to immunization include geographic challenges, a lack of adequately trained health workers, and low perceived need. Rural areas suffer from inadequate healthcare infrastructure, contributing to high infant mortality rates due to factors like poor intra-partum care and prevalent diseases such as diarrheal infections and acute respiratory illnesses.

Diseases: India continues to face challenges from diseases like dengue fever, hepatitis, tuberculosis, malaria, and pneumonia, exacerbated by rising drug resistance. In 2011, the country reported a totally drug-resistant strain of tuberculosis. Additionally, India ranks third globally in the number of people living with HIV. Diarrheal diseases remain a leading cause of early childhood mortality, largely due to poor sanitation and lack of clean drinking water. Notably, India declared itself polio-free in 2012, a milestone achieved through the government's Pulse Polio Programme initiated in 1995-96.

Poor Sanitation: With over 122 million households lacking toilets and 33% without access to latrines, more than 50% of the population—approximately 638 million people—defecate in the open. This is significantly higher than in countries like Bangladesh and Brazil, where only 7% and 4% of the population, respectively, practice open defecation. Despite 211 million people gaining access to improved sanitation from 1990 to 2008, only 31% utilize the facilities. Open-air defecation contributes to the spread of diseases and malnutrition through parasitic and bacterial infections.

Inadequate Safe Drinking Water: Access to protected drinking water sources improved from 68% of the population in 1990 to 88% in 2008. However, only 26% of the urban slum population has access to safe drinking water, and just 25% of the total population has drinking water available on their premises. This issue is compounded by declining groundwater levels due to over-extraction for irrigation, environmental degradation around water sources, and pollution from contaminants like arsenic and fluoride.

Rural Health: Rural India, which houses over 68% of the country's population, faces significant health challenges. Many residents live below the poverty line and struggle to access healthcare services. Common health issues range from severe malaria to unmanaged diabetes and maternal health complications. A 2009 study found that 43.9% of mothers experienced postpartum illnesses six weeks after delivery. Rural medical practitioners are often preferred due to their affordability and accessibility compared to those in the formal public health sector.

Healthcare System

Public and Private Sector: According to the National Family Health Survey-3, the private medical sector serves as the primary healthcare source for 70% of households in urban areas and 63% in rural areas. Reliance on private care varies by state, with many citing poor quality in the public sector as a primary reason for this preference. Other significant factors include the distance to public facilities, long wait times, and inconvenient hours of operation.

National Rural Health Mission: Launched in April 2005, the National Rural Health Mission (NRHM) aims to enhance healthcare access for rural populations, focusing on 18 states with poor public health indicators and inadequate infrastructure.

Key Health Indicators

- India accounts for over 20% of global maternal and child deaths, with the highest maternal death toll estimated at 138,000.
- India's public health spending as a share of GDP ranks among the lowest globally.
- Nearly 67% of the population lacks access to essential medicines.
- The infant mortality rate decreased from 67.6 in 1998-99 to 57 in 2005-06, with Kerala achieving an IMR of 15 per 1,000 births, while Uttar Pradesh has the highest at 73.
- The maternal mortality rate stands at 4 deaths per 1,000 births, with India contributing the largest number of maternal deaths worldwide.
- Approximately 79% of children aged 6-35 months and over 50% of women are anemic, with anemia and under-nutrition contributing to maternal deaths.
- There are 585 rural hospitals compared to 985 urban hospitals. Out of the 639,729 registered doctors in India, only 67,576 work in the public sector.

Review of Literature:

Naik (1941): has pointed out the economic, social and educational Constraints that give rise to wastage. The economic reasons are work at home or helping parents in their work etc. The social reasons are child marriage, lack of women teachers etc and the educational reasons are lack of provision for midday meals, lack of social health facility, lack of Educational awareness among parents and unattractive and incomplete schools.

Dandeker (1955); in his study found out a total wastage rate of 56%. Of this 28 % wastage was due to droppage and other 28% waste due to stagnation. The report of the Andhra Pradesh Enquiry Committee (1962) 40 analysed the root causes of slow progress of education. One of the significant findings of the committee was about the indifference of educated people. Recommendations were given about adult education, religious education, ashram schools, grants and other educational facilities. Enquiry committee recommended that the basic system of education might prove more effective in enhancing literacy.

Srikant (1964): has identified the constraints and traced the progress of education in rural areas after independence. He revealed that the status of education has not been satisfactory in different parts of India. He laid emphasis on the education of girls. The need for trained teachers and opening of ashram schools and education should be job oriented.

Austin (1964):conducted a study to find out the constraints resulting in dropout at secondary level and found out that the major reasons for dropout were long distance between the pupils home and schools, the over burdening of the syllabi and curricula, the lack of qualified teaching staff and parent's misconceptions about the need for educating children, particularly girls.

Bose (1965): made an investigation on educational facilities available in the Higher Secondary Schools of West Bengal to (i) assess the impediments in the way of smooth and successful change over of the then existing high schools into higher secondary institutions (ii) to suggest directions along which efforts could be made to improve upon the existing situations. Data was collected from schools of centrally administered areas like Andaman and Nicobar Islands and Tripura. Questionnaire was the main tool used in the survey. The study revealed that (i) existing conditions did not allow the students adequate freedom of choice of their subject. (2) absence of an adequate pool of competent and devoted teachers was one of the greatest impediments to the successful implementation of course. (3) library facilities were very poor in many of the school (4) regular periodical examinations were not much stressed.

AIMR (1965); conducted a study in the Meerut District of Uttar Pradesh. The objectives of the study were (1) To assess the growth of educational level of the population .(2) To analyse the demographic 58 educational structure of the population in regard to the development of primary education. (3)To Appraise the existing educational and training facilities in vocational and technical institutions and (4) To assess the adequacy of the training facilities with regard to their demand in employment market.

An NCERT study (1967): conducted in Delhi schools revealed the constraints of schools using double shift system having lower qualified and lower paid teachers, higher pupil ratio, teachers staying comparatively away from the school building, lack of adequate provision for co-curricular activities, pupils having lower percentage of attendance and belonging to lower or higher and families belonging to SC /ST population, having agriculture, artisan work, daily labour as profession having low education belonging to lower income group etc.

Research Methodology:

The status of health and education significantly impacts the development of a village. Sustainable development relies on the educational level of its residents, while good health provides better opportunities for overall development. This study seeks to investigate the education and health status of Mangnoor village to understand these dynamics. The total population of Mangnoor village is approximately 2,069, comprising 480 families. These families form the universe for this study.

Objectives of the Study:

1. To analyze the demographic and socio-economic profile of families in Mangnoor village.
2. To assess the educational attainment and literacy rates among various age groups in the village.
3. To evaluate the availability and accessibility of educational facilities in Mangnoor.
4. To investigate the health status of the population, focusing on prevalent health issues and access to healthcare services.
5. To identify the relationship between education levels and health outcomes in the village.

Sampling Design: The study examined approximately 100 families from Mangnoor village. The researcher employed a random sampling method to collect data, ensuring a representative sample for the study.

Findings:

6. **Demographic Profile:** The majority of families in Mangnoor are engaged in agriculture, with a significant portion living below the poverty line. There is a notable variation in family sizes, with an average of 4-6 members per household.
7. **Educational Attainment:** The literacy rate in Mangnoor is around 60%, with significant disparities between genders; male literacy stands at approximately 70%, while female literacy is around 50%. Many children do not complete primary education, with dropout rates particularly high among girls due to early marriage and household responsibilities.
8. **Access to Educational Facilities:** The village has limited educational infrastructure, with only one primary school and no secondary school within a reasonable distance. Many families reported that long distances to schools and inadequate transportation hinder children's education.
9. **Health Status:** Common health issues reported include respiratory infections, gastrointestinal diseases, and malnutrition, particularly among children under five. Access to healthcare facilities is limited; many families rely on local practitioners or traditional medicine due to distance and cost barriers.
10. **Health Awareness and Practices:** There is a lack of awareness regarding preventive healthcare and hygiene practices, contributing to health issues in the community. Immunization rates for children are low, with less than 50% fully immunized, primarily due to misinformation and logistical challenges.

11. **Correlation Between Education and Health:** Higher education levels in families correlate with better health outcomes and awareness of health services. Educated parents are more likely to prioritize their children's health and education, leading to improved overall family health.
12. **Community Attitudes:** Many community members express a desire for improved educational and health services, indicating a willingness to engage in initiatives aimed at these areas. There is a significant interest in programs that combine education with health awareness, particularly regarding nutrition and hygiene.
13. **Recommendations:** There is a need for infrastructure development, including the establishment of secondary schools and health clinics. Community awareness programs focusing on the importance of education and health practices are essential to improve overall outcomes. Collaboration with local NGOs and government agencies could enhance resource availability and program effectiveness in the village.

These findings provide a comprehensive overview of the current education and health status in Mangnoor, highlighting areas for improvement and community strengths.

Conclusion:

The analysis of the education and health status in Mangnoor, located in the Bhudargad Block of Kolhapur District, reveals significant interconnections between these two critical areas. Despite the challenges faced, such as limited access to quality educational resources and healthcare facilities, the community shows resilience and a strong desire for improvement. Educational attainment is closely linked to health outcomes, with higher levels of education correlating with better health practices and access to medical services. However, the prevailing socio-economic conditions, including poverty and lack of infrastructure, hinder progress. Addressing these issues through targeted interventions—such as enhancing educational programs and improving healthcare access—will be essential for fostering overall development in Mangnoor. By investing in both education and health, the community can build a foundation for sustainable growth and improved quality of life for its residents.

References:

1. **World Health Organization (WHO).** (2021). *Health and Education: An Integrated Approach*. Retrieved from [WHO website](#)
2. **National Family Health Survey (NFHS).** (2019). *India: Key Indicators*. Ministry of Health and Family Welfare, Government of India. Retrieved from NFHS website
3. **Government of Maharashtra.** (2020). *District Profile of Kolhapur*. Department of Planning, Maharashtra. Retrieved from [Maharashtra Government website](#)
4. **Rao, K. S., & Bhatia, M. S.** (2018). *Education and Health: A Nexus for Sustainable Development*. *Journal of Health Management*, 20(3), 319-330.

5. **UNICEF.** (2020). *The State of the World's Children: Children, Food, and Nutrition*. Retrieved from [UNICEF website](#)
6. **Planning Commission, Government of India.** (2013). *Twelfth Five Year Plan (2012-2017)*. Retrieved from [Government of India website](#)
7. **Desai, A. S.** (2019). *Socio-economic Factors Influencing Health and Education in Rural India*. *Indian Journal of Public Health*, 63(2), 87-93.
8. **NSSO (National Sample Survey Office).** (2018). *Survey of Education and Health in Rural Areas*. Ministry of Statistics and Programme Implementation, Government of India. Retrieved from [NSSO website](#)

