

TRIBAL CHILDREN'S HEALTH AND HYGIENE PRACTICES DURING EARLY CHILDHOOD

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Paper Received On: 25 MAR 2022

Peer Reviewed On: 31 MAR 2022

Published On: 1 APR 2022

Abstract

Early Childhood Care and Education (ECCE) is an indispensable foundation for lifelong learning and development, and have critical impact on success at the primary stage of education. It therefore becomes imperative to accord priority attention to ECCE and invest adequately by providing commensurate resources. The present study was conducted in anganwadies centres of Nizamabad and Kamareddy districts of Telangana state. The result reveals that there were significant differences in the health and hygiene practices followed in anganwadies among tribal children during early childhood.

Key Words: Tribal Children, Early child hood care, Anganwadies.



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Introduction

Early childhood refers to the first six years of life. This is acknowledged as the most crucial period, when the rate of development is very high and foundations are laid for cumulative lifelong learning and human development. There is growing scientific evidence that the development of the brain in the early years is a pathway that affects physical and mental health, learning and behavior throughout the life cycle. Early Childhood Care and Education (ECCE) supports children's survival, growth, development and learning - including health, nutrition and hygiene, and cognitive, social, physical and emotional development- from birth to entry into primary school in formal, informal and non- formal settings. Developmentally appropriate early stimulation programmes (for 0-3 year olds) and ECCE programmes (for 3-6

year olds), with integrated nutrition and health components are a critical investment for enhancing elementary education outcomes; laying a strong foundation for cumulative lifelong learning and human development and also for intergenerational benefit towards ensuring social inclusion and equity. In India, ICDS is identified as a major programme to achieve the first goal of Education for All (EFA) i.e. universal provision of ECCE. It is the largest public provider of Early Childhood Care and Education. The Early Childhood Care and Education (ECCE) Scheme provides a free year of early childhood care and education for children of pre-school age. In general, children are eligible for the ECCE scheme if they are aged over 3 years 2 months and less than 4 years 7 months on 1 September of the year that they will be starting. Furthermore, early childhood education programmes result in easier transition to primary school, better completion rates, reduced poverty and social equality. Children from poor families, immigrant children and children from other vulnerable groups may particularly benefit from ECE's equalizing factor before compulsory schooling. ECCE policies and provision vary according to the age and development of the child, and can be organized in formal, non-formal and informal arrangements. The broad, holistic scope of ECCE is captured in the policy objectives associated with it around the world, they are:

- i) providing health care, immunization, feeding and nutrition;
- ii) supporting new parents through information sharing and parenting education;
- iii) creating a safe environment for young children to play and socialize with their peers;
- iv) compensating for disadvantage and fostering the resilience of vulnerable children;
- v) promoting 'school readiness' and preparation for primary school;
- vi) providing custodial care for children of working parents and family members;
- vii) Strengthening communities and social cohesion.

Objective

To know the Health and Hygiene Practices of tribal children during early childhood.

Research Questions

Question 1: How often do the anganwadi children are exposed to the common illness?

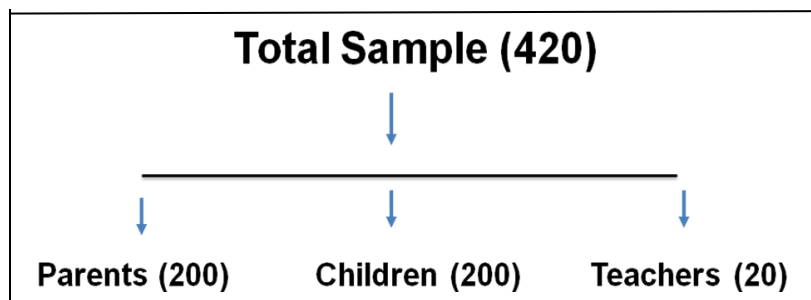
Question 2: How often do the anganwadi children are maintaining personal hygiene?

Question 3: How often do the anganwadi children are maintain cleanliness?

Sample Description / Sample Design

The sample for the present study consists of Anganwadi teachers, children and Parents from Nizamabad and Kamareddy districts of Telangana state. The Sample selection will be stratified random sampling method. From each mandal 5 anganwadies are selected, i.e one Anganwadi from each village comprising it to a total of 20 anganwadies.

From each Anganwadi 01 teacher, 10 parents and 10 children are selected. Thus making the total sample as 420.



Tools for data collection

1. Structural Interview Schedule for Parents
2. Questionnaire for Anganwadi Teachers
3. Checklist of facilities of Anganwadi centres
4. Checklist of observation of inmates (children) at Anganwadi centres.

The researcher prepared the tools with the help of experts from psychology, education and sociology departments. As per the suggestions of the experts, the final tools were prepared and reliability and validity was established.

Analysis

Question 1: How often do the anganwadi children are exposed to the common illness?

Table No. 1: Distribution of health status of anganwadi children with respect to common illness

S. No	Common illness	Very often	Often	Sometimes	Rarely	Never
1	Cold	18 (09%)	55 (28%)	87 (43%)	33 (17%)	07 (04%)
2	Cough	22 (11%)	54 (27%)	74 (36%)	38 (19%)	12 (06%)
3	Fever	20 (23%)	46 (23%)	93 (46%)	27 (14%)	14 (07%)
4	Skin infection	14 (07%)	33 (17%)	71 (35%)	52 (26%)	30 (15%)

The above table displays the health status of the anganwadi children with respect to common illness in the tribal area. Among the total of 200 anganwadi children, with respect to the exposure to cold, 18 (09%) responded very often, 55 (28%) responded often, 87 (43%) responded sometimes, 33 (17%) responded rarely and 07 (04%) responded as never. with respect to the exposure to cough, 22 (11%) responded very often, 54 (27%) responded often, 74 (36%) responded sometimes, 38 (19%) responded rarely and 12(06%) responded as never. With respect to the exposure to fever, 20 (23%) responded very often, 46 (23%) responded often, 93 (46%) responded sometimes, 27(14%) responded rarely and 14 (07%) responded as never. With respect to the exposure to skin infection, 14 (07%) responded very often, 33 (17%) responded often, 71 (35%) responded sometimes, 52 (26%) responded rarely and 30 (15%) responded as never. It can be inferred from the above that, most of the anganwadi children (i.e. nearly less than half of the sample) were frequently exposed to cold and fever when compared to other common illness like cough and skin infections.

Question 2: How often do the anganwadi children are maintaining personal hygiene?

Table No. 2: Showing distribution of health status of children with respect to personal hygiene

S. No	Personal hygiene	Very clean	Clean	Sometime clean	Rarely clean	Never clean
1	Teeth	18 (09%)	51 (26%)	94 (46%)	28 (14%)	09 (5%)
2	Ears	22 (11%)	46 (23%)	99 (49%)	25 (13%)	08 (4%)
3	Nose	27 (14%)	45 (23%)	89 (44%)	27 (14%)	12 (6%)
4	Eyes	29 (15%)	54 (27%)	85 (42%)	25 (13%)	07 (4%)
5	Skin	24 (12%)	49 (25%)	92 (45%)	27 (14%)	08 (4%)

The above table displays the health status of the anganwadi children with respect to personal hygiene in the tribal area. Among the total of 200 anganwadi children, with respect to the cleanliness of teeth, 18 (09%) responded very clean, 51 (26%) responded clean, 94 (46%) responded sometimes clean, 28 (14%) responded rarely clean and 09(05%) responded as never clean. With respect to the cleanliness of ears, 22 (11%) responded very clean, 46 (23%) responded clean, 99 (49%) responded sometimes clean, 25 (13%) responded rarely clean and

08 (04%) responded as never clean. With respect to the cleanliness of nose, 27 (14%) responded very clean, 45 (23%) responded clean, 89 (44%) responded sometimes clean, 27 (14%) responded rarely clean and 12 (06%) responded as never clean. With respect to the cleanliness of eyes, 29 (15%) responded very clean, 54 (27%) responded clean, 85 (42%) responded sometimes clean, 25 (13%) responded rarely clean and 07 (04%) responded as never clean. With respect to the cleanliness of skin, 24 (12%) responded very clean, 49 (25%) responded clean, 92 (45%) responded sometimes clean, 27 (14%) responded rarely clean and 08 (04%) responded as never clean. It can be inferred from the above that, most of the anganwadi children (i.e. nearly half of the sample) were maintaining personal hygiene like cleanliness of teeth, ears, nose, eyes and skin for a short period of time.

Question 3: How often do the anganwadi children are maintain cleanliness?

Table No. 3: Showing Distribution of health status of anganwadi children with respect to cleanliness

S. No	Cleanliness	Very clean	Clean	Sometime clean	Rarely clean	Never clean
1	Dress	30 (15%)	44 (22%)	81 (40%)	34 (17%)	11 (06%)
2	Hands	37 (19%)	48 (24%)	72 (35%)	31 (16%)	12 (06%)
3	Legs	28 (14%)	39 (20%)	88 (43%)	30 (15%)	15 (08%)
4	Hair	22 (11%)	55 (28%)	84 (41%)	29 (15%)	10 (05%)
5	Wounds	28 (14%)	41 (21%)	88 (43%)	25 (13%)	18 (09%)

The above table displays the health status of the anganwadi children with respect to cleanliness in the tribal area. Among the total of 200 anganwadi children, with respect to the cleanliness of dress, 30 (15%) responded very clean, 44 (22%) responded clean, 81(40%) responded sometimes clean, 34 (17%) responded rarely clean and 11(06%) responded as never clean. With respect to the cleanliness of hands, 37 (19%) responded very clean, 48 (24%) responded clean, 72 (35%) responded sometimes clean, 31 (16%) responded rarely clean and 12 (06%) responded as never clean. With respect to the cleanliness of legs, 28 (14%) responded very clean, 39 (20%) responded clean, 88 (43%) responded sometimes clean, 30 (15%) responded rarely clean and 15 (08%) responded as never clean.

With respect to the cleanliness of hair, 22 (11%) responded very clean, 55(28%) responded clean, 84 (41%) responded sometimes clean, 29 (15%) responded rarely clean and 10 (05%) responded as never clean. With respect to the cleanliness of wounds, 28 (14%) responded

very clean, 41 (21%) responded clean, 88 (43%) responded sometimes clean, 25 (13%) responded rarely clean and 18 (09%) responded as never clean. It can be inferred from the above that, most of the anganwadi children (i.e. four tenth of the sample) were maintaining cleanliness of dress, hands, legs, hair and wounds for a short period of time.

Findings

1. Most of the anganwadi children (i.e. nearly less than half of the sample) were frequently exposed to cold and fever when compared to other common illness like cough and skin infections.
2. Most of the anganwadi children (i.e. nearly half of the sample) were maintaining personal hygiene like cleanliness of teeth, ears, nose, eyes and skin for a short period of time.
3. Most of the anganwadi children (i.e. four tenth of the sample) were maintaining cleanliness of dress, hands, legs, hair and wounds for a short period of time.

Conclusion

Good health supports successful learning. Successful learning supports health. Education and health are inseparable. Early childhood stimulation attempts to provide learning opportunities to the child so as to enhance her development. However, the learning experiences need to be so planned that they are in accordance with the child's maturational status: This stimulation should be provided from early infancy. By and large, stimulation comprises activities that involve a close interaction “between the child and the caregiver”. The basis of these activities is a warm, loving relationship between the child and the caregiver. The early childhood years set the foundation for life, ensuring that children have positive experiences and that their needs for health, stimulation and support are met, and that they learn to interact with their surroundings.

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