

Original article

A STUDY TO ASSESS THE LEVEL OF LIVING AND AWARENESS AND PRACTICES REGARDING MCH CARE IN A REMOTE TRIBAL VILLAGE OF UDAIPUR DISTRICT

Arun Kumar¹, Shalabh Sharma², Chandra Prakash Sharma³, Suresh Chandra Meghwal¹

Financial Support: None declared
Conflict of interest: None declared
Copy right: The Journal retains the copyrights of this article. However, reproduction of this article in the part or total in any form is permissible with due acknowledgement of the source.

How to cite this article:

Kumar A, Sharma S, Sharma CP, Meghwal SC. A Study to Assess the Level of Living and Awareness and Practices Regarding MCH Care in a Remote Tribal Village of Udaipur District. Natl J Community Med 2013; 4(2): 318-320.

Author's Affiliation:

¹Resident; ²Professor; ³Tutor, Department Of Community Medicine, R.N.T Medical College, Udaipur, Rajasthan

Correspondence:

Dr Arun Kumar
Email: dr.arun.barath@gmail.com

Date of Submission: 16-01-13

Date of Acceptance: 13-05-13

Date of Publication: 30-06-13

ABSTRACT

Introduction: Cultural patterns, lifestyle and health seeking behavior of tribal population observed to vary a lot in previous studies. Health awareness and the level of living observed to be poor among tribal people.

Objective: Present study was done in order to assess the level of living with emphasis on awareness and prevalent practices regarding Maternal and Child Health care among the tribal population of a remote village.

Methodology: A family based community health survey was done in a tribal village Bakhel of Udaipur. Data collected by observation on a pre designed and pre structured interview schedule of mostly female heads of all the families consented.

Results: Only 20% of male heads are literate and female literacy much lower, 60 s% families preferred to deliver at home, 62% of families had no knowledge about child immunization, 61% of children found to have some grade of malnutrition.

Conclusion: Most of the tribal villagers are Illiterate; have poor awareness regarding availability of MCH services, routine immunization and family planning methods.

Key-words: Community health survey, MCH, Tribal

INTRODUCTION

The cultural patterns and the life style of the tribes vary a lot, and so does their health seeking behaviour. Many attempts have been made to document the health seeking behaviour of the tribal's in India. Of late, some attempts have been made to study it among the tribals of Madhya Pradesh and Orissa.^{1,2}

Present study is based on Bakhel, a tribal village which comes under gram panchayat Mandva and block Kotda of Udaipur district, state Rajasthan. It is about 2 kilometers from Mandva PHC and about 24 kilometers from CHC Kotda.

There are about 250 families residing in a very scattered manner in five different hamlets

/Phalla's in the village with a total population around 1200.

Taking cognizance of a report about some child deaths in the village in 2011 a family based community health survey was done in order to collect baseline information on basic components of level of living and also to get information related to health status of residents and in particular women and children of 0 to 6 years age group.

MATERIAL AND METHODS

A Cross Sectional Survey Design was utilized as study design. All families after obtaining informed consent were included in the survey .A

set of Four teams were constructed for the survey .Each team had one resident doctor, one or two members from local Non Governmental Organization Hunargarh and at least one local female resident of the village. Taking in consideration demography of the area and time required to collect the data, each team was given target of interview at least 60 families. Data collected by observation on a pre designed and pre structured interview schedule of mostly female heads of the families. Anthropometric data collected from all children of 0 to 6 years age group using weighing machines and inch tapes which were carried separately by each team.

RESULT AND DISCUSSION

In our study most of families were quite large with a mean family size of 6.7 which is bit more than mean family size of 5.4 as estimated by DLHS-3 for rural population in Rajasthan³. Mean age of female marriage is 16.5 years almost similar to DLHS3 data of 17.1 years³.

Majority of families were residing in kutcha houses made of mud and cow dung smeared floors with thatched roofs. 75% houses were in overcrowding category as per definition⁴. Ventilation and lighting problem is also prevalent in majority of houses. No electricity in whole village. No separate kitchen in any of the houses.85% families utilizing well as source of drinking water with no disinfection practice. In contrast to our finding, DLHS-3 reported 78.1% of the rural households in Rajasthan utilizing improved source of drinking water³.

Table 1: Health awareness and health seeking behavior among tribal families

Key Issues	Families (%)
Institutional delivery	100(40)
Unawareness about child immunization	155(62)
Unaware about family planning methods and available services	148(59)
Unaware about antenatal checkup	133(53)
Unaware about IFA tablets	130(52)
Unaware about antenatal TT injection	110(44)
Unaware about services rendered by Anganwadi center	123(49)
Unawareness about HIV/AIDS	240(96)
Treatment seeking behavior(local quacks)	213(85)

Illiteracy is a big concern; only 20% of male heads are literate and female literacy much lower

in contrast with the findings of NFHS3 where 55% of the rural women found literate⁵. Family heads are responsible for most of family decisions including utilization of health services too. Thus illiteracy has a negative impact on health aspect of residents of the village.

Regarding hygiene aspect none of the family had separate bathroom or sanitary latrine within the house, whereas DLHS3 found that 12.9% rural households have access to toilet facility³. 81% of families had history of individual smoking, consuming handmade local liquor known as Mahudi or having habit of chewing tobacco or gutkha but GK Mini et al found that 10.8% of tribal population have habit of smoking and chewing tobacco and 24.1% found to be indulged in alcohol consumption⁶.

Most of families i.e. 60% preferred to deliver at home with the help of family member or untrained birth attendant, DLHS3 also found that to be 58.4%³. In spite of the presence of Aanganwadi center in the village 49% families reported to be unaware of any MCH services being provided in their area. 59% of families were totally unaware of any family planning method and services and even not heard about condoms. 41% families had the awareness but not practicing because of fear of side effects or not having knowledge about their availability. Most people relate family planning services to female sterilization only.

62% of families had no knowledge about child immunization.38% of families were aware about immunization but only13% children had BCG scar marks but no immunization card made available to them, whereas as per DLHS3 reported 81.6% rural children having received BCG³.Residents not aware of any planned immunization session in their area and mobilization by ASHA/ANM of the area found to be negligible.

Regarding child rearing practices, weaning started at mean age of around 11 months with roti. This may be responsible for the malnourishment of children .Regarding food practices majority of families reported to use wheat and maize flour. Green vegetables and pulses used mostly once a week,80% families consume non iodized salt while cooking . Majority of families do not have access to milk and milk products.

For the sake of treatment of minor illnesses like fever, respiratory tract infections , diarrhea, 85% families prefer to visit private practitioners

/quacks. Reason for not utilizing health services was the faith these tribal people have in the traditional healers like the *bhopas* (faith healers) and herbalists.

In 96% of families no one even heard about HIV AIDS. This is in contrast to DLHS3 where 46.4% of rural household at-least heard of this dreadful disease³.

Table 2: Distribution of children (0-6yrs) by their anthropometric measurements (weight for age)

IAP Classification (wt for age)	Children (%)
Normal	131(39)
Grade I (Mild Malnutrition)	70(21)
Grade II (Moderate Malnutrition)	108(32)
Grade III (Severe Malnutrition)	17(5)
Grade IV (Very severe Malnutrition)	10(3)

Table 2 depicts analysis of Anthropometric data collected of the children present at home during survey. Total 336 children of 0 – 6 years age group examined for weight and height. As per IAP classification (wt. for age), 61% of them found to have some grade of malnutrition, this is almost similar to findings by Yadav Rajiv et al where 70% Bharia tribe preschool children found malnourished⁷ although a report by GP Katiyar et al showed 90.8% prevalence of PEM in rural children⁸.

During last year total 20 deaths reported, out of them 16 deaths were in 0 to 10 year age group, probably complicated malaria like illness and pneumonia were responsible. No child found to suffer from any vaccine preventable disease during survey period.

CONCLUSION AND RECOMMENDATIONS

Our study revealed that most of the tribal villagers are illiterate, have poor awareness regarding availability of MCH services, routine immunization and family planning methods. Looking to the under utilization of services by the community, organizing fortnight mobile camps in such remote and inaccessible areas should be considered to render on site essential medicines, immunizations, vitamin A administration and family planning services. Further multi-centric studies in tribal areas needed to assess the gravity and reality of problem.

REFERENCES

1. Meerambika Mahapatro, A.K. Kalla. Health seeking behaviour in a tribal setting. Health and Population- Perspectives and Issues.2000;23(4):160-9.
2. Basu S. Socio-cultural and environmental perspectives on morbidity and mortality pattern of the scheduled tribes. Tribal Health Bulletin.2007;13(1&2):1-10.
3. DLHS3, Fact Sheet Rajasthan. Available at: <http://www.jsk.gov.in/dlhs3/rajasthan.pdf>. Assessed on July 14th,2012
4. K Park. Park's Textbook of Preventive and Social Medicine, 22nd ed. Jabalpur: Bhanot Publishers; 2013. p 698
5. NFHS-3, Summary of Findings. Available at: <http://www.nfhsindia.org>. Accessed on July14th,2012
6. Mini G.K, Moli GK. Life style indicators among tribes in India. Tribal Health Bulletin. Jan & July 2005 ;vol II(1&2):3.
7. Yadav Rajiv, Roy J. Nutritional status of preschool children among Bharia tribe of Patakot, M.P. Tribal Health Bulletin. 2005; 2(1&2):14.
8. Katiyar GP, Gupta SK, Reddy DCS. Epidemiological determinants of PEM in under five rural children. Ind Jr. Prev & Soc. Med.1987;18:198.