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Research Article

# Assessment of Health Problems, Needs and Cultural Beliefs of Women in a Rural Area of Karnataka, India: A Participatory Rural Appraisal Method

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## Abstract

*Introduction:* Mothers and children are not only a vulnerable group but even a major group consuming health services. In Indian society, Mother and child health (MCH) is surrounded by a wide range of customs and beliefs. Possible attention is necessary to focus on wrong practices and beliefs to prevent health systems to suffer from inefficiency and poor utilization. One of the methods to involve community in identifying and analyzing the problem is participatory rural appraisal (PRA), which helps in drawing framework to understand, analyze and develop programs with communities.

*Objectives:* (1) To determine the health problems and needs of women in a rural area. (2) To assess the cultural beliefs related to mother and child health in the rural community.

*Methodology:* Participatory rural appraisal (PRA) was conducted with women of a rural village, Giriyapura in Davangere taluk. The methods used in the PRA technique were village mapping, village transect, and focus-group discussion. All the women of the village were informed about the objective of the study and those who came voluntarily (n=37) to participate were included in the study.

*Results:* PRA resulted in empowering community involvement among the participants. The participants took charge of identification of health problems and their perceived causes for the same. The health needs were identified and prioritized. Need of transportation was the main priority of the participants. Cultural practices related to mother and child health were charted out.

*Conclusion:* The most important perceived need of villagers was transport facility. Many cultural beliefs surrounded the mother and child health, of which some were unscientific. PRA was successful to an extent in obtaining information about health problems and needs of the community.

**Keywords:** Participatory rural appraisal, Health problems, Needs, Cultural beliefs, Women



## Introduction

Mothers and children constitute a large priority group in any community. In India, women of the child-bearing age (15–44 years) comprise 48% and children under the age of 14 years constitute 27%; together they constitute 75% of the total population.[1] By virtue of their numbers, they are not only a vulnerable group but even a major group consuming health services.[2] Huge and strategic investments are being made by the government of India to provide services to improve mother and child health. There is emphasis on establishing the 'continuum of care' through integrated delivery of services in various stages of life through mother and child health programs under the National Health Mission (NHM). These services are made available at all levels – from home, community, to

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hospitals. To keep the spirit of continuum of care, home-based newborn care has been linked for early diagnosis of danger signs and prompt referral to save lives.[3,4]

Even with many planned health services, it is difficult to reach the health goals without community participation. In Indian society, mother and child health (MCH) is surrounded by a wide range of customs and beliefs. Influential factors such as socioeconomic status, education and individual experience and choices vary from family to family. Lack of knowledge, prevailing misconceptions, social factors, cultural beliefs contribute to wrong practices causing impaired health.[5]

Possible attention is necessary to focus on wrong practices and beliefs to prevent health systems to suffer from inefficiency and poor utilization. Thus, it becomes important to unveil the cultural beliefs at community level that affect mother and child health. One of the methods to involve community in identifying and analyzing the problem is participatory rural appraisal (PRA), which helps in drawing framework to understand, analyze and develop programs with communities.[6] Hence, the present study was undertaken to determine the health problems and needs of women in a rural area and to assess the cultural beliefs related to mother and child health in the rural community.

## Methodology

1. **Study design and the participants**: Qualitative study using participatory rural appraisal (PRA) technique.

- **PRA technique:** This is a qualitative method developed with consideration for a bottom-up approach than top-down approach. It uses experiences shared by local people and intends to enable local communities to conduct their own analysis, plan, and take action.

Three methods were used in the PRA technique: Village mapping, village transect, and focus-group discussion. This was carried out by a team consisting of a facilitator assisted by a postgraduate, six interns, and a medical social worker. All the members in the team were trained before carrying out the PRA technique. The sessions were conducted within the community at Anganwadi of the same village except for village transect (which was conducted by having a walk with some participants). The PRA activities were carried out by a facilitator who engaged the community people by asking questions and discussing with them. The facilitator was helped by other team members to take notes of the discussion and to draw diagrams on sheets. At the start of the session, the participants were introduced about the PRA to initiate participation and were explained the purpose and schedule of conducting different methods of PRA. On each of these methods conducted with the community, chalks were used to draw different maps and diagrams on the ground. The participants used materials such as leaves, straws, flowers, pebbles, sticks, papers, seeds to represent different locations on the map. At the end of all the PRA activities, health education about the mother and child health was given to the participants. Following are the PRA methods used:

- **Village mapping**: Participants of the community were involved in drawing a map of the village to get information of village layout and infrastructure. This was done mainly to establish a rapport with the community and to know the layout of the village. Two women and two adolescent girls participated in outlining the village map. The participants took 30 minutes to draw the village map.
- **Village transect:** This was an observatory walk conducted with four informants (two women and two adolescent girls) of the village. The layout of the village was observed and the social aspects were examined. Houses were visited to have a look for water supply and sanitation. It took an hour to finish the transect walk in the village.
- **Focus-group discussion:** 37 females of different ages between 19 and 55 years participated in this activity. The objectives of the study were explained to them and the participants were asked to identify and analyze various health problems related to women and their perceived reasons for the same. Sanitation, education, drinking water facility, and cultural practices related to mother and child health were discussed.

The participants were asked to help us to identify institutions/persons that were important in their community to provide health-related services through a Venn diagram. The group was then asked to prioritize health needs in the village. The discussion lasted for nearly two hours. A digital voice recorder was used to record the discussion which was then transcribed precisely by the facilitator.

2. **Study Setting:** Giriyapura village belonging to PHC, Lokikere, Davangere taluk, Davangere district, Karnataka. The village is located 4 km away from PHC, Lokikere. The village consisted of 137 households with population of 833 (400 males, 382 females and 51 under-five children. Majority of the villagers belonged to Hindu religion.
3. **Study population**: Local women of the same village.
4. **Study duration:** 2 months ( Jan 2018 to Feb 2018).
5. **Consent prior to study:** Informed verbal consent was taken from all the voluntary participants.

## Results

1. **Village mapping:** Giriyapura is a small village belonging to PHC, Lokikere in Davangere taluk. The village had a government primary school, an Anganwadi center, a temple, an overhead water tank, and four hand pumps (Fig. 1).



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**Figure 1.Mapping of Giriyapura Village**

2. **Water supply:** There was only one well for the whole village till the year 1985, from where water was used for domestic purpose and for drinking. Later, hand pumps were installed. Presently, there were four hand pumps in the village. In addition to the open well, there was an overhead tank from where water was supplied to other water tanks, which was utilized for domestic and drinking purpose.
3. **Sanitation:** About 90% of the houses had toilets in their houses. Old-age people preferred going out to open fields for defecation. Remaining 10% of houses did not have toilets, they went to the fields. There were no public toilets in the village.
4. **Waste disposal:** The waste was segregated at household level and was dumped in dump yards near their houses. Later, it was cleared by dumping it in the dump yards outside the village.
5. **Village transect:** The information collected in the social map was confirmed by the village transect. During house visits, we observed that Chula was the main source of cooking, but some houses also had gas stoves. Dried cow dung and dried sticks were used as cooking fuel. Most of the houses were pucca. There were cattle sheds in most of the houses. The most common occupation of villagers was agriculture.
6. **Focus group discussion:**

**(a)** The participants were asked to describe health-related problems occurring in different seasons and age groups and perceived factors responsible for the same (Tables 1 and 2).

**Table 1.Health Problems Being Faced by Women and their Perceived Causes**

| Age (Years) | Health Problem Being Faced | Perceived Causes of Health Problems |
|---|---|---|
| 19–25 | Anemia, gastritis, lower back pain, infertility, jaundice | Food habits, drugs |
| 26–40 | Joint pain, burning micturition | Due to eating chilies, spicy food, heat |
| 41–60 | Joint pain, asthma, hypertension | Dust, due to consumption of pickle and salt |
| >60 | Diminution of vision, hypertension, diabetes mellitus | Due to aging |

**Table 2.Health Problems Being Faced by Women in Different Seasons**

| Season | Health Problems Being Faced |
|---|---|
| Summer | Diarrhea, fever, chicken pox, dehydration |
| Rainy | Fever, cold, cough, dengue, malaria |
| Winter | Fever, cough, cold |



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**(b) Cultural practices:** Women of the village also gave information about the practices followed:

- Marriage of girl child was preferred to be done after 18 years of age.
- During eclipse, pregnant women were not allowed to cut vegetables and fruits and they were not allowed to go out of the house. If not done so, people thought babies would be born with deformities.
- Lactating women were not allowed to consume sour food, sesame, papaya, coconut water, sweet potato, banana, green chilies for the first 3 months. If any of such stuff was consumed, it was believed that the baby's stomach would get upset.
- A pregnant woman was not restricted from her daily activities till delivery. It was believed that a woman who was physically active would have normal vaginal delivery.
- Following delivery, women were not allowed to have curd and butter milk. People believed that by consuming curd or butter milk, the mother's milk would get spoilt.
- Mother and the baby were kept in a dark room till 3 months to protect them from evil eye.
- Colostrum was not discarded and was fed to the baby.
- Pre-lacteal feed like honey and sugar water was given to the babies.
- Postpartum mother was given a lot of garlic to increase amount of milk secretion.
- Lactating mother was not allowed to drink more water. The reason for this what they believed was mother's milk would get diluted.
- Exclusive breastfeeding was not followed for 6 months. Complementary feeding was started at 4–5 months thinking that the mother's milk would not be sufficient for the baby to grow.
- Babies were applied kajal to eyes, cheeks, hands, abdomen, and legs to prevent from evil eyes.
- Nothing was applied to the umbilical cord.
- Immunization was followed as instructed.
- Girl child education was considered important. The group was of the opinion that an educated girl could understand the things well in the society.
- There was no blind belief about contraception methods and women were of the opinion that a family should not have more than two children.
- Social problems like alcoholism and smoking were seen among men of the village. Smoking was more than half cent among men.

**(c) Venn diagram**

The participants were asked to write names of institutions/ groups/health-related persons found in the village on cardboards provided to them and to draw circles on the ground. They were allowed to discuss for each organization how important it was for them and they were instructed to place the most important one which/who provided the best service to them in the inner circle. The middle and outer circles were for the good and unsatisfactory services provided respectively. The space outside the outer circle was for poor services (Fig. 2 and Table 3).

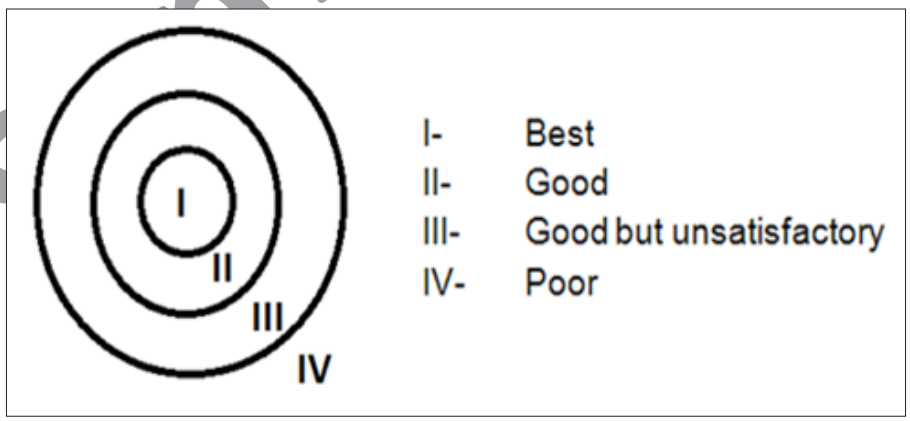


**Figure 2.Venn Diagram**

**Table 3.Ranking of Services Provided by the Participants**

| Ranking | Organizations/ Institutions/ Groups/ Health-Related Persons |
|---|---|
| I | ASHA worker, Anganwadi worker, PHC medical officer, gram panchayat member, junior health worker female (JHWF) |
| II | School and staff |
| III | Health assistant – male |



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**(d) Ranking**

The women in the focus-group discussion listed out the problems in the village. Among the listed problems, priority was given to need for transportation facility. The village had no government bus facility; only two private tumtum vehicles were available. The next problem in the list was hospital facility as the PHC was 4 km away from the village. The women found it difficult for pregnant mothers to travel because of lack of transportation. Though ASHA and Anganwadi workers provided the essential healthcare services, they could not meet the health demands of the women. Another problem figured out was public purified drinking water supply (Table 4).

**Table 4.Ranking to Prioritize Health Needs of Women of Giriyapura Village**

| Ranking | Health Needs |
|---|---|
| 1 | Transportation to health facility |
| 2 | Health center in the village |
| 3 | Drinking water facility |

## Discussion

Participatory rural appraisal has become the new development tool, which is being used in every aspect of community development where involvement of people is present. It comprises a series of techniques, which use knowledge and skills of local people to learn about the local conditions, to identify local development problems, and helps to raise knowledge to plan appropriate solutions to them.[7,8]

PRA provided a vehicle to initiate an interaction and planning at community level with community people as the assets. The people got an opportunity to draw out the important and relevant factors in their living settings. The different methods in PRA technique created a community-empowering environment to point out the context and reasons to various issues raised within the community.

The community members participated actively in the event. They initiated discussion on what practical measures could improve the situation. According to them, transportation was the major facility that was needed by all. The villagers used private or their own vehicles for transportation. To solve this, they came up with the idea to request for bus facility to Road Transport Department under the leadership of the gram panchayat member. For drinking water problem, currently they planned to get water from Lokikere village, where public filtered water distribution system was present and for a long-term benefit, they decided to request for purified drinking water facility in their village to the gram panchayat. The lack of healthcare facilities would depart if transportation facility was provided. Meanwhile, the community people were asked to utilize JHWF, ASHA and Anganwadi workers for healthcare facilities.

The community's perception related to mother and child health was surrounded by numerous cultural beliefs. Many practices were followed blindly. But the community's accent towards marriage, girl child education, and immunization pointed to the importance given to children. There was a need for dissemination of information and education regarding mother and child health and to promote healthy practices. At the end of the session, the group was enlightened about the wrong practices followed, and health education regarding promotion of health and prevention of diseases in mother and children was given.

Thus, it is essential to know timely and accurate information for health services to meet the needs of the population. These appraisal methods, when done well, encourage people to participate and also provide reliable and valuable information on health status, knowledge, attitudes, and practices.[9]

## Conclusion

In our study, we found that the women of the village under study were capable of collecting and analyzing information. The most important perceived need of villagers was transport facility which would reduce the physical and economic burden to a great extent and will also help for easy approach for antenatal mothers and children to avail primary healthcare services. Many beliefs surrounded the mother and child health, of which some were unscientific. Lack of knowledge, prevailing misconceptions, and cultural taboos significantly contributed to undesirable practices in mother and child care. Thus, PRA was successful as a powerful means of involving community in identification and analysis of problems.

## Recommendation

Various and frequent IEC activities at community level are desirable mainly involving adolescent girls, pregnant and lactating mothers, and elderly women as they play a vital role in rearing children and other healthy practices.

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**Conflict of Interest:** None

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