

Health Situation in Darbha Block, Bastar District—A Study

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Uncovering, documenting and understanding the existing health conditions in the Darbha block, Bastar district, the study highlights the preferences and practices of the community on the one hand and explores the reasons for the deteriorating health conditions of the community on the other

CONTEXT

PRADAN began its operations in Bastar district in September 2009. The organization conducted an initial survey of the area and after interactions with the various stakeholders such as the community, the government, banks, other NGOs and traders, it zeroed in on two blocks, namely, Darbha and Bastanar. PRADAN's plan was to focus on social mobilization by forming Self Help Groups (SHGs) and clusters on a saturation basis in the blocks of Darbha and Bastanar by 2010–11.

The study collected data of the SHG members, using various parameters such as resources, health, sanitation, and access to rights and entitlements. The data would help build a perspective of the area and help PRADAN become familiar with the current state, using baseline survey methods. The team extended its outreach to 32 villages (30 of them in Darbha block) of 17 *gram panchayats* and 86 hamlets. It set three primary goals for 2010–11. First, to cover 4,500 families in the SHGs (300 SHGs) and help promote livelihoods that would ensure an additional six months of food (cash/grain), providing thereby round-the-year food security; to ensure an additional Rs 15,000 income in cash from other sources in a sustained manner and to help reduce the dependence on existing livelihood sources. Second, the team aimed at helping to deploy the extra income productively. Third, to assist—directly and indirectly—in addressing the well-being and the issues of women's rights.

During the course of the study, the team realized that illness and health problems of the SHG members were obstacles to achieving their goals. The importance and magnitude of the health problems in the area led the team to focus on health issues as a separate goal. In order to form, deploy or assess any intervention strategy, the team had to understand the existing health status, conditions, problems, facilities and the overall health scenario of the community. Hence, the aim of the baseline study was to understand the existing state of people's health in the area, in order to make interventions more effective.

OBJECTIVES

The objectives of the study were to:

- ♦ Understand the prevailing health conditions in the community, in terms of parameters such as sources of food and drinking water, hygiene and sanitation habits, prevalence of diseases, status of reproductive services and awareness levels among people.
- ♦ Identify and explore the major health problems and issues existing in the community as well as the possible factors causing them.
- ♦ Develop standard indicators related to health that will help in deciding the nature and type of intervention as well as in assessing the impact of the intervention.

METHODOLOGY

Quantitative/Qualitative Research

The nature of the research study was both descriptive and explorative. On the one hand, it aimed at revealing, documenting and understanding the existing health conditions, preferences and practices of the community; on the other hand, it aimed at finding the processes and linkages behind these existing conditions and practices. Accordingly, the type of data used to obtain information was both quantitative and qualitative. There was an effort to get some objective data, based on numbers and some close-ended questions, to identify the status and trends across the community, which could be used

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PRADAN currently operates in 20 *panchayats* of Darbha block, involving 34 villages, and covering 165 SHGs and 2,210 households approximately. A sample survey was undertaken in six *panchayats*, involving eight villages and covering 18 SHGs and 210 households as respondents (eight of them being non-SHG members).

The total population of the 210 households (including all family members) was 977. The six *panchayats* so covered were further clubbed into four clusters.

The area for the sample survey was purposively chosen, that is, the sampling technique was purposive, based on various factors such as:

- (i) Accessibility of the areas. The areas chosen were more accessible to the Community Service Providers (CSPs—local residents, who act as mediators between PRADAN and the local community) of PRADAN. CSPs also assisted in the survey as translators.
- (ii) The fact that time and language constraints restricted the researcher from undertaking random sampling and from covering a similar number of households.

Similarly, the clubbing of *panchayats* into clusters was done purposively, for the following considerations:

- (i) Koinar and Chitapur are the smallest and largest clusters, respectively, in terms of area.

- (ii) Chindavada and Chitapur are the smallest and largest clusters, with a population of 205 and 899 households, respectively.
- (iii) The forest coverage is low in Chindbahar (0.5 per cent) and Koinar (1.8 per cent) whereas Chindavada (17 per cent) and Chitapur (42 per cent) have higher forest coverage.
- (iv) Koinar and Chindavada are the closest and farthest, respectively, from the nearby town of Jagdalpur.

The objective was to first observe whether there were any differences in various health parameters among the clusters and then to

explore whether the above characteristics of the clusters influenced the observed outcome. After the sample area was identified, a structured questionnaire (comprising both open- and close-ended questions) was designed for the survey, to obtain data on the indicators mentioned earlier.

FINDINGS AND ANALYSIS

1.1 Household Profile

A. Almost all the households surveyed had their own *kuccha* houses (Tables 1 and 2).

Table 1: Land Type

| | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|--------|------------|--------|------------|----------|-------|
| Own | 46 | 49 | 58 | 56 | 209 |
| Rented | 1 | 0 | 0 | | 1 |
| Total | 47 | 49 | 58 | 56 | 210 |

Table 2: Housing Type

| | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|---------------|------------|--------|------------|----------|-------|
| <i>Kuccha</i> | 44 | 49 | 58 | 54 | 205 |
| <i>Pucca</i> | 2 | 0 | 0 | 2 | 4 |
| Others | 1 | 0 | 0 | | 1 |
| Total | 47 | 49 | 58 | 56 | 210 |

B. Approximately 88 per cent of the households belonged to the Scheduled Tribe (ST) category and eight per cent to the Scheduled Caste (SC) category. A majority of the households in

Chindavada and Chitapur were STs, whereas most of the households in Chindbahar and Koinar were SCs (Table 3).

Table 3: Caste Distribution (in Percentage)

| | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|---------|------------|---------|------------|----------|----------|
| SC | 9 (19) | 7 (14) | 0 | 0 | 16 (8) |
| ST | 36 (77) | 40 (82) | 57 (98) | 52 (93) | 185 (88) |
| OBC | 2 (4) | 2 (4) | 0 | 0 | 4 (2) |
| General | 0 (0) | 0 (0) | 1 (2) | 4 (7) | 5(2) |

C. Approximately three-fourths of the households had BPL cards. Most of the

households in Koinar and Chitapur had BPL cards (Table 4).

Table 4: BPL Card Holders (in percentage)

| | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|-----|------------|---------|------------|----------|----------|
| Yes | 34 (72) | 43 (88) | 32 (55) | 52 (93) | 161 (77) |
| No | 13 (28) | 6 (12) | 26 (45) | 4 (7) | 49 (23) |

D. The primary occupation of about half the households was agriculture and the others relied upon wage labour. A majority of the households in Chitapur and Koinar depended

primarily upon agriculture and wage labour, respectively, whereas in the other clusters there was an equal dependence on both agriculture and wage labour (Table 5)

Table 5: Occupational Distribution

| | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|--|------------|---------|------------|----------|----------|
| 1. Farming, Animal Husbandry & collections | 27 (47) | 8 (15) | 57 (51) | 44 (79) | 136 (49) |
| 2. Self-employed | 5 (9) | 1 (2) | 0 | 0 | 6 (2) |
| 3. Service | 0 | 0 | 0 | 0 | 0 |
| 4. Wage labour | 22 (38) | 45 (82) | 54 (490) | 12 (21) | 133 (48) |
| 5. Others | 4 (7) | 1(2) | 0 | 0 | 5 (2) |

E. Around 73 per cent of the total household population was found to be illiterate (could not read or write) and 18 per cent had received primary education. The least illiterate and the most educated (secondary or more)

households were in Chindbahar whereas in Chindavada and Chitapur most of them were illiterate and no one had received secondary education (Table 6).

Table 6: Educational Status of Household Population

| | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|------------|------------|----------|------------|----------|----------|
| Illiterate | 147 (59) | 173 (74) | 198 (83) | 156 (75) | 674 (73) |
| Can sign | 4(2) | 5(2) | 0 | 0 | 9(1) |
| Primary | 47 (19) | 37 (16) | 32 (13) | 52 (25) | 168 (18) |
| Secondary | 27 (11) | 9(4) | 4(2) | 0 | 40 (4) |
| >Secondary | 25 (10) | 9(4) | 4(2) | 0 | 38 (4) |

1.2 Food and Nutrition

A. The daily food intake of all the households was mainly rice and rice porridge, a high source of carbohydrates. There was found to be a deficiency of other nutritional elements

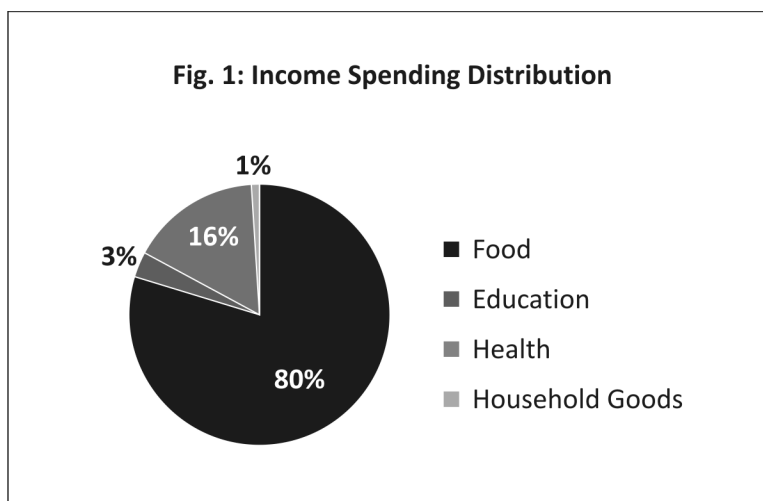
such as proteins and vitamins, owing to the dietary habits of the households. Moreover, rice porridge was consumed frequently in a day as a substitute to drinking water.

B. About 80 per cent of the income of the households was spent on food followed by 16 per cent on health. The people of Chitapur spent the largest share of their income on food.

Among the four clusters, the relative spending on health was the maximum in Chindbahar (Table 7 and Figure 1).

Table 7: Income Spending Pattern

| | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|-----------------|------------|--------|------------|----------|-------|
| Food | 40 | 39 | 51 | 54 | 184 |
| Education | 4 | 1 | 2 | | 7 |
| Health | 16 | 10 | 10 | 1 | 37 |
| Household Goods | 1 | 1 | | 1 | 3 |



C. The majority of the households primarily depended on the market for their food whereas one-third of them depended on self-

produce and 14 per cent bought their food from a ration shop (Table 8).

Table 8: The Main Source of Goods

| | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|--------------|------------|--------|------------|----------|-------|
| Self produce | 16 | 14 | 33 | 54 | 117 |
| Market | 38 | 32 | 52 | 50 | 172 |
| Ration shop | 6 | 12 | 19 | 13 | 50 |
| Forest | 6 | 7 | | | 13 |

D. In case of food shortage, approximately two-fifth of the households borrowed from the moneylender and about one-fifth borrowed from SHGs or they migrated to other places for work. In Chindbahar and Chindavada, the majority of them were dependent on moneylenders; in Chitapur on the SHGs and in Koinar on working outside the village.

Anganwadi Centres (AWCs) in Darbha Block

AWCs are the chief nodal agency across the villages and cities for the delivery of health services under the Integrated Child Development Services (ICDS) Scheme of the Ministry of Women and Child Health. The scheme has been in existence in the country for three-and-a-half decades, with an aim to specifically promote and support the health of Pregnant and Lactating Mothers (P&LM) as well as children up to six years of age, through the provision of services such as supplementary nutrition, immunization, health check-ups, referral services, pre-school informal education and health and nutritional education.

The Darbha block has 72 villages that have been classified into six sectors, comprising 172 AWCs. The AWCs are spread out very unevenly across the villages, with some of the villages without an AWC whereas some have 10 to 20 AWCs. Whereas some of this is due to demographical differences, a large part is also due to the difficult topography (forests, lack of connectivity), administrative and security reasons. Around 5,500 children up to six years of age are enrolled in the AWCs in the entire block, with 900 on an average in each sector. Each AWC is run by an honorary *anganwadi* worker (AWW) supported by an honorary

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Anganwadi Helper (AWH), both of them being women, who are paid Rs 2,000 and 1,000 per month, respectively. Both are selected through some pre-defined minimum criteria such as being local residents of a village, residing near an AWC, and having completed eight years of formal schooling in the case of an AWH and 12 years in case of an AWW. The task of the AWH involves preparing, cooking and serving food besides maintaining the cleanliness of the place and helping the AWW in other services. The AWW, on the other hand, supervizes the former, arranges the food, immunization and other services, and prepares and sends the monthly report of its activities to the block office.

The multiple functioning of the AWCs is supported by several stakeholders. First, as part of the supplementary nutrition programme, cooked food is given to children aged between the ages of three and six years and packaged food (ready-to-eat), introduced last year, is given on two days (Tuesdays and Fridays) to children up to three years of age as well as to the P&LM. The services of womens Self Help Groups (SHGs) are hired through some contractual procedures. They are engaged to supply the raw material for the food to be cooked and the finished ready-to-eat packaged food. One SHG can cover a maximum of 20–25 AWCs for a three-year period. Second, at the local sub-health centre, the auxiliary nurse & mid-wife (ANM) and *mitanins*, together with the AWW, arrange and provide immunization and health check-up programmes. They also facilitate the enrolment of new children in the AWC, and impart health and nutritional education to the P&LM.

Challenges in the Functioning of the AWCs

The supervisors identified two main problems in the effective functioning and monitoring of the AWCs. First, most of the AWWs are old and not educated enough. Therefore, there is no timely preparation of the report with the requisite information. Many times, the report of an individual AWC has had to be made in the block office by the supervisors themselves because they had to send the report to the district office at the stipulated time. Second, the local people are not very aware, educated or motivated. They, therefore, do not send their children daily to the AWCs; hence, the problem of low enrolment and attendance of children.

With regard to the poor malnutrition status of Darbha block (which was recently reported to have the worst cases of malnourished children compared to all the other blocks of the Bastar district), the supervisors blamed the technical changes in the method of identifying and counting malnourishment levels among the children and the resultant reporting errors by AWWs, based on the new criteria. The shift from the earlier single category to the now three categories of low, medium and highly malnourished was jointly enumerated by AWWs without their classification, which then led to the large increase in the malnourishment cases.

Case Study: Koinar

The village has seven hamlets, but no separate AWC of its own. Instead, one of the houses of an old widow is rented for Rs 500 per month, which sometimes acts as both a kitchen and a place to serve food, although many times the AWH prepares the food in her own house and serves it in the rented house. The AWH we talked to was quite old, probably in her late 50s, although she couldn't tell us her exact

age. She didn't seem too educated, although she has been working as an AWH for almost 15 years and receiving a payment of Rs 1,000 per month almost on a regular basis. She told us that hardly 15 children are enrolled at the AWC and about eight to ten of them come on alternate days, as and when cooked food is served, which is the only provision of supplementary nutrition by the AWC. When asked what the reason was behind the low enrolment and attendance rates, the response was familiar—non-interest shown by the villagers. Among the items of cooked food, the AWH told us that rice, millet and a vegetable were served. With regard to the status of other services that the *anganwadis* are supposed to provide, the AWH seemed unaware of them. Instead, she directed us to meet the AWW for further information because the latter was in charge of them and was authorized to give any information. However, we found that the AWC is non-existent and non-functional in the village.

Case Study: Chindbahar

This six-hamlet village is covered by two AWCs—each of them located at two ends of the village. The AWC that we visited is located in Khaspara, the hamlet just at the entrance of the village. The semi-*pucca* centre is surrounded by a primary school (part of its vacant outer space serves as an *angandwadi* kitchen), the village *panchayat* office, a ration shop, a grocery shop (run by the husband of the AWW) and some *kuccha* houses in the midst of a solitary *pucca* house, which we found later to be the house of the AWW we were to meet. However, before meeting the AWW, we happened to meet her son, who worked as a distributor of a private health insurance company for the entire Bastar district. He volunteered information about his area of operation, the failure of the government-

sponsored nation-wide health insurance scheme called Rashtriya Swasthya Bima Yojana (RSBY) and the need for awareness about private insurance in the village. This would help strengthen his business as well as perform social service. In the one year that he had been operating in the village, he had so far made around 60 customers. He also wanted us to help him market his product through some association.

The AWW of the centre is a 50-year-old lady, who has been working for the last 20 years along with an AWH. The AWW and the AWH were being paid an honorarium of Rs 1,500 and Rs 750 per month, respectively. Although 26 children were enrolled in the AWC, only 12 of them were present on an average on any given day. The timings of the centre had been changed to between 7 and 11 a.m. from the earlier 9 a.m. to 12 p.m. The AWW complains that the children continue to follow the earlier timings. The AWC serves cooked food daily

to children between three and six years, and provides packaged (ready-to-eat) food (called snacks) twice in a week to children up to three years as well as the P&LM. The cooked food comprises rice, millet and one vegetable such as brinjal or potato; the packaged food includes wheat and various sorts of local grains. The ingredients for the cooked food and the packets of ready-to-eat food are both purchased from two local women SHGs. The AWW told us that in case of delay in payments and fund shortages, the SHGs often contributed voluntarily to meet the daily food requirements for the AWC.

The AWW told us that the AWC works in collaboration with the nearby sub-health centre and the *mitanins*, for immunization and providing health education to the people. They identify and inform the people regarding the importance of vaccination and also provide the required doses on time. The AWW said she had noticed a significant increase in awareness



A health training in progress.

among the villagers, over the years, regarding the need for immunization although there had not been any significant changes in health practices.

As far as the AWCs' role in pre-schooling and non-formal education was concerned, teaching resources and material were available; however, the AWW regretted being unable to devote the necessary time to teaching, both due to her health and other household work. Health check-ups were also quite sporadic. The AWW said that there was only one malnourished child in the centre, who was later sent to the sub-health centre

for referral services because he was very weak and suffered from diarrhoea. She also told us that all the children are weighed on a specific day of every month although she finds it difficult to weigh them. She observed that the interest in and reliance of the villagers on the AWCs for supplementary nutrition had been declining over the years.

B. Half the households spent one-hour collecting drinking water and two-fifths took half an hour or less. In Chindavada, most households took less than half an hour whereas the Koinar households spent maximum time collecting water (Table 10).

Table 10: Average Time Taken to Collect Drinking Water

| | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|--------------------|------------|--------|------------|----------|-------|
| 30 minutes or less | 16 | 9 | 58 | 2 | 85 |
| 1 hour | 35 | 26 | 4 | 54 | 119 |
| 2 hours | 2 | 10 | 0 | | 12 |
| 4 hours | 0 | 3 | 0 | | 3 |

C. Approximately 95 per cent of the households did not treat the water before drinking it. Of the five per cent of households that treated the water, half was in Chindbahar.

They treated the water either by boiling it or passing it through a cloth filter (Tables 11, 12 and Figure 2).

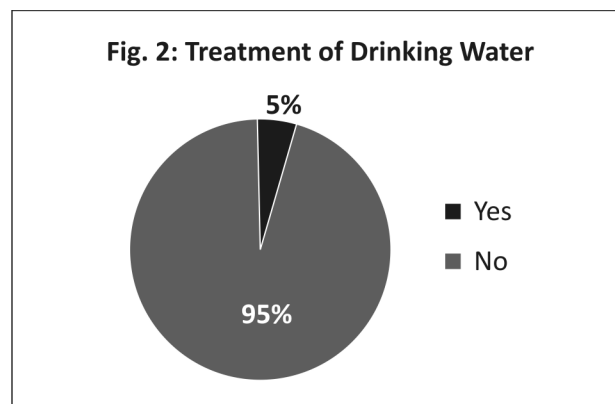


Table 11: Treatment of Drinking Water

| | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|-----|------------|--------|------------|----------|-------|
| Yes | 5 | 1 | 3 | 1 | 10 |
| No | 42 | 48 | 55 | 55 | 200 |

Table 12: Method of Treatment of Drinking Water

| | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|--------------|------------|--------|------------|----------|-------|
| Boiling | 0 | 1 | 3 | 1 | 5 |
| Cloth filter | 5 | 0 | 0 | | 5 |

3.4 Sanitation

A. One-fourth of the households surveyed washed their hands after defecation whereas two-fifths washed their hands before eating. Among the four clusters, most of the households in Chindbahar washed their hands after defecating whereas very few did so in Chitapur (Table 13, Fig. 3).

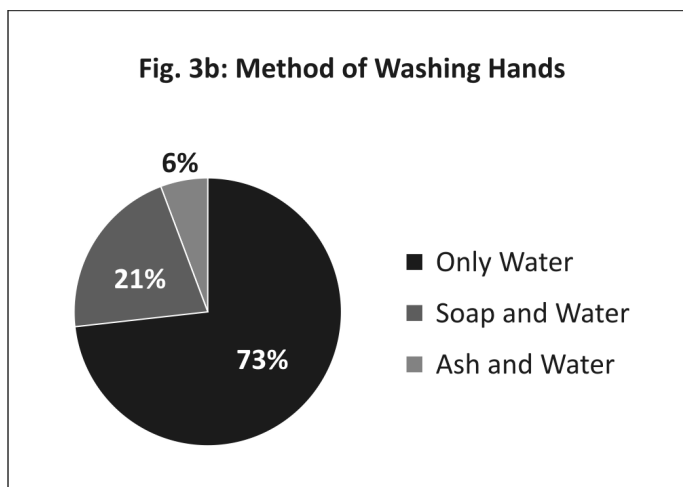
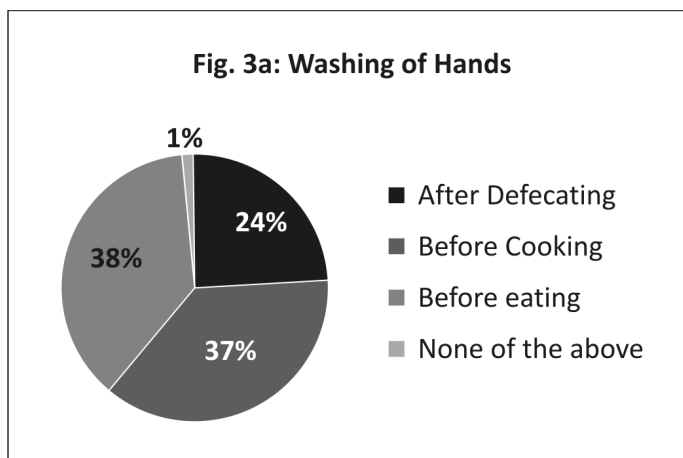
B. Most of the households washed their hands only with water. Only 21 per cent used soap. Almost all the households in Chindavada washed their hands only with water whereas Koinar had the maximum soap users. (Table 14, Figures 4 a and 4 b).

Table 13: Washing of Hands

| | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|-------------------|------------|--------|------------|----------|-------|
| After defecating | 43 | 46 | 32 | 5 | 126 |
| Before cooking | 47 | 46 | 54 | 45 | 192 |
| Before eating | 47 | 46 | 58 | 45 | 196 |
| None of the above | 0 | 3 | 0 | 5 | 8 |

Table 14: Method of Washing Hands

| | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|----------------|------------|--------|------------|----------|-------|
| Only water | 42 | 41 | 58 | 49 | 190 |
| Soap and water | 7 | 41 | 0 | 7 | 55 |
| Ash and Water | 2 | 6 | 0 | 7 | 15 |



C. All the households defecated in the open and most of them did so in an undesignated area. Only three per cent of them defecated

in a designated open area in Chitapur (Figure 15).

Table 15: Place of Defecation

| | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|------------------------|------------|--------|------------|----------|-------|
| Designated area | 0 | 0 | 0 | 7 | 7 |
| Undesignated open area | 47 | 49 | 58 | 49 | 203 |

D. Most of the households threw waste outside in an undesignated area. One-fourth of them buried the household waste.

Reproductive and Child Health

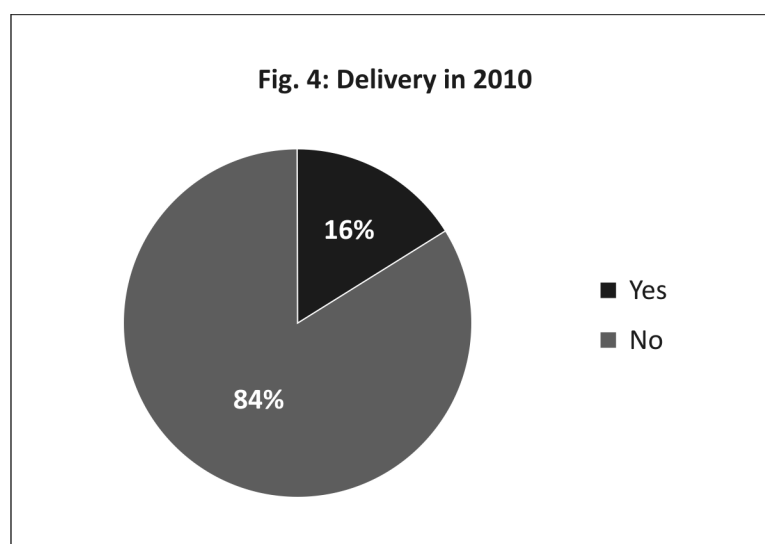
A. Of the total households surveyed, 84 per cent had not had a birth of a child in the

previous 12 months; in the remaining 16 per cent, a child had been born in that period. Chitapur had the maximum number of births among the clusters; in the other three clusters,

there were three households each in which a child had been born. Chindavada had the highest number of households (55) among the clusters without any births (Table 16).

Table 16: Delivery Taken Place in the Previous 12 months (in 2010)

| | | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|----------------|-----|------------|--------|------------|----------|-------|
| Births in 2010 | Yes | 3 | 3 | 3 | 20 | 29 |
| | No | 44 | 46 | 55 | 6 | 151 |

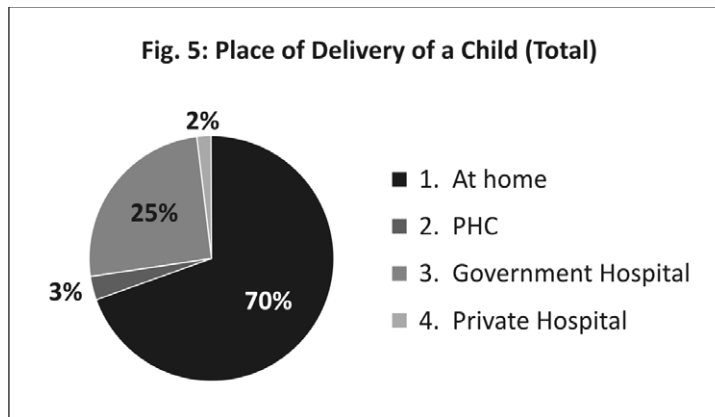


B. Of the surveyed households, 70 per cent of the women had their delivery at home, 25 per cent at the government hospital, 3 per cent at a Primary Health Centre (PHC) and 2 per cent at a private hospital. The most common place for the delivery of a child was at home

followed by in government hospitals. Very few people went to the PHC or private hospitals. At Chindavada, the delivery most often took place at home; Koinar was the only cluster where women also relied on a private hospital to deliver their babies

Table 17: Place of Delivery

| | | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|--|------------------------|------------|--------|------------|----------|-------|
| Where did the delivery take place?/ Where is a baby usually delivered in your family? | 1. At home | 36 | 33 | 57 | 49 | 175 |
| | 2. PHC | 0 | 1 | 0 | 7 | 8 |
| | 3. Government hospital | 25 | 14 | 11 | 14 | 64 |
| | 4. Private hospital | 0 | 5 | 0 | | 5 |

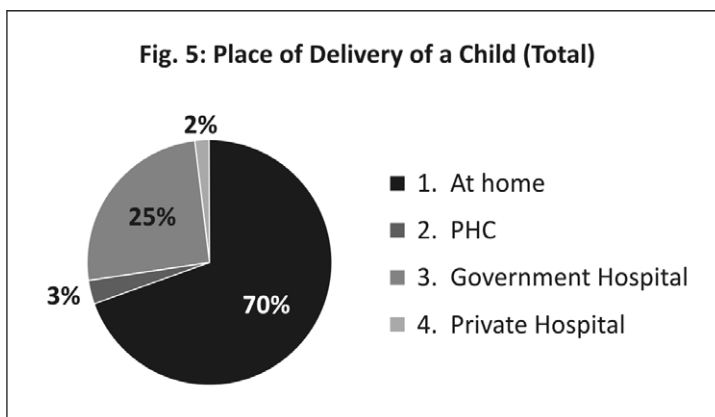


C. Of the 210 households surveyed, 33 per cent gave birth with the help of an untrained birth attendant, 25 per cent with the help of family members, 22 per cent with the help of the *mitanin*, 18 per cent with the help of an ANM and 2 per cent with the help of neighbours. In Chitapur, family members assisted in the

birthing process; in Chindavada, an ANM assisted; in Koinar, untrained birth attendants assisted in the process; and in Chindbahar, untrained birth attendants and *mitanins* often assisted in the delivery of babies. Of the four clusters, only in Chindbahar did women take help of neighbours.

Table 18: Support during Delivery at Home

| | | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|-------------------------------------|------------------------------|------------|--------|------------|----------|-------|
| Who helped in the delivery at home? | 1. Family Members | 0 | 0 | 4 | 56 | 60 |
| | 2. Untrained birth attendant | 22 | 39 | 15 | 3 | 79 |
| | 3. <i>Mitanin</i> | 25 | 13 | 13 | | 51 |
| | 4. ANM | 0 | 0 | 43 | | 43 |
| | 5. Neighbours | 4 | 0 | 0 | | 4 |

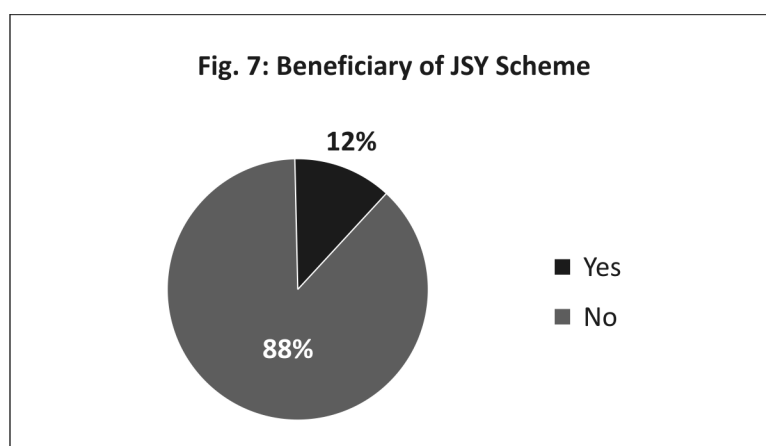


D. Only 12 per cent of the surveyed households benefited through the government scheme called Janani Suraksha Yojana (JSY). The other

88 per cent were not a part of the JSY. The scheme benefited the people of the Chitapur and Chindavada clusters the least.

Table 19: JSY Scheme Benefits

| | | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|--|-----|------------|--------|------------|----------|-------|
| Were any benefits of the Janani Suraksha Yojana(JSY) availed of? | Yes | 6 | 4 | 1 | 7 | 18 |
| | No | 41 | 45 | 45 | 2 | 133 |

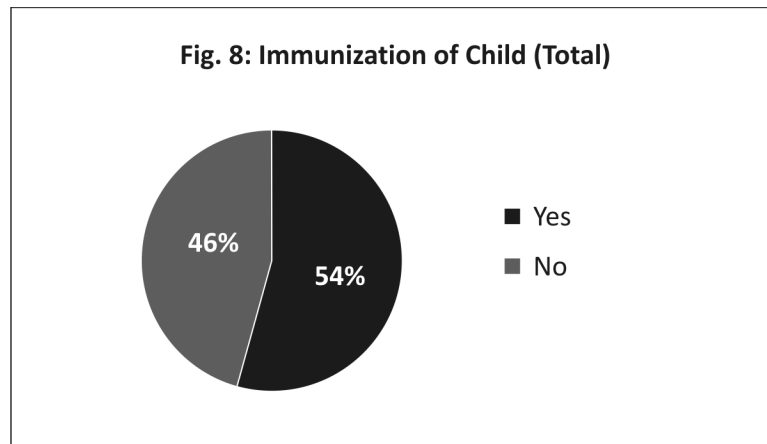


E. The study on the immunization of children found that 54 per cent of the surveyed households had their children immunized but the other 46 per cent had not. Chitapur cluster

led with the highest number of immunizations of children and Chindavada had the lowest rate.

Table 20: Immunization of Children

| | | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|----------------------------------|-----|------------|--------|------------|----------|-------|
| Are children under-5 vaccinated? | Yes | 38 | 18 | 2 | 56 | 114 |
| | No | 9 | 31 | 56 | | 96 |

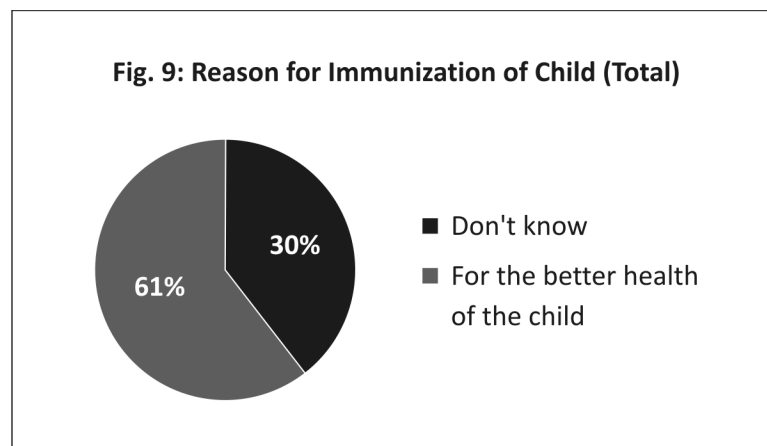


F. Only 61 per cent of the people were aware of the reasons for immunization. In Chindavada, none of the households surveyed knew why

immunization had to be done. In Koinar, on the other hand, most of the households were aware of the reason.

Table 21: Reason for Immunization of Children

| | | Chindbahar | Koinar | Chindavada | Chitapur | Total |
|-------------------------|------------------------------------|------------|--------|------------|----------|-------|
| Why vaccinate children? | Don't know | 13 | 1 | 2 | 29 | 45 |
| | For the better health of the child | 25 | 17 | | 27 | 69 |



G. The *mitanin* helps the women in the birthing process in the village. She also helps take women to nearby hospitals for their delivery. She helps the doctors and the villagers in immunizing the children in the village.

CHINDBAHAR

The village has around 10 *mitanins*, at least one in each hamlet. Radhamani, the *mitanin* we interviewed, was from Khaspara. She was in her early thirties and she had been working as a *mitanin* for the last seven years. She was responsible for three villages. She was trained for three months when she was appointed and continues to go for short training programmes occasionally and for meetings of all the *mitanins*, once a month. As a *mitanin*, her main role is to support pregnant women both during and after the delivery of a child. She also looks after and arranges for the immunization of both the pregnant mothers as well as the newborn child. In order to perform this task, she associates with the AWCs and the sub-health centre of the village. Besides, she is also involved in spreading awareness and information, regarding the health and nutritional education to the P&LM. She is supposed to receive Rs 2,000 per month for her services from the government but according to her, she often receives her remuneration either quarterly or half-yearly. She said that the initial years were quite difficult for her because the work was new and the people were not aware and cooperative. Earlier, she said, she had to convince them to go for vaccinations, but over the years, the awareness levels have increased and many people voluntarily come to her for help at the time of delivery and vaccination. Overall, she finds the work quite challenging and satisfying.

MITANIN

The village has two *mitanins*, residing in two different hamlets—Maryapara and Schoolpara. The *mitanin* that we interviewed belonged to Maryapara and has been a *mitanin* for the last five years. She looked to be in her late twenties and had a small family—she, her husband and their small infant. Farming is her family's primary occupation; being illiterate, she treats being a *mitanin* more as a community service than a profession. Her work mainly involves supporting the nurses of the hospitals in a monthly immunization programme by taking the pregnant women to them and also supporting the pregnant women at the time of delivery, either in their homes or facilitating their travel to the nearby hospital. Apart from this, she also keeps medicines for common ailments such as fever, diarrhoea, stomach pain and cough, which someone brings to her from the Darbha hospital (Community Health Centre) on a weekly basis and which she distributes to the patients on demand, free of cost. She also works along with the *Sirah Gunias* in almost most of her tasks. She said that she had received some training for about a year for these tasks at Darbha and Tiratgarh. She also said that she does not receive any fixed monthly remuneration for her service from the government although she does receive Rs 100–300 for her training and Rs 350 per delivery of every pregnant woman taken to the hospital from nearby villages. Based on her experience so far, she finds her work difficult at times because she has to travel around the villages, often on an empty stomach. Her one complaint was that she does not receive enough money for the work.

The village has four or five *mitanins* located in the different hamlets. Sukhmani, the *mitanin* we interacted with, was in her late twenties and has been working part-time as a *mitanin* for the last three years. She initially received training and now visits the nearby village of Chingpal with other *mitanins* of the area, to attend the annual meeting. As a *mitanin*, she helps pregnant women during their delivery and provides vaccination services to them as well to the newborn child, although without any support from the AWCs or the sub-health centre because there aren't any in the village. Sukhmani complained that she had not received her dues for the last six months and though she had lodged several complaint she had not got any response. The lack of incentive has begun to show and she has begun to show disinterest in her work.

Conclusion

The nature of the research study conducted was both descriptive and explorative. On the one hand, its aim was to uncover, document and understand the existing health conditions, preferences and practices of the community; on the other, it aimed at finding the possible processes and linkages that have led to the these health conditions and practices of the community. The data used to seek and obtain information for the above was both quantitative and qualitative. Data were collected primarily through surveys, interviews, observations, etc., and through secondary sources such as the Handbook.

Our research was conducted in collaboration with PRADAN. PRADAN began its operations in Bastar district in September 2009; after an initial survey of the area and interactions with the various stakeholders such as the community, the government, banks, other NGOs and traders, it zeroed in on two blocks namely Darbha and Bastar. PRADAN planned to focus on social mobilization by forming SHGs and clusters on a saturation basis in the blocks of Darbha and Bastar. Our research was based on the study of the household profile, food and nutrition, drinking water, sanitation, reproductive and child health practices in the

clusters of Chindbahar, Koinar, Chindavada and Chitapur.

Almost all the households surveyed had their own house and lived in *kuccha* houses. Around 88 per cent of the households belonged to the Scheduled Tribe (ST) category and 8 per cent to the Scheduled Caste (SC) category. Around 73 per cent of the total household population were illiterate (could not read and write) and 18 per cent had received primary education. Amongst the four clusters, the households in the area of Chitapur spent the maximum share of their income on food. The primary occupation of about half of the households was agriculture and the other half relied upon wage labour, due to poor economic conditions and lack of higher education.

The daily food intake of all the households was mainly rice and rice porridge, both high sources of carbohydrates. The diet of the households was found to be deficient in nutrients such as proteins and vitamins. Rice porridge was consumed frequently in a day by the households as a substitute for drinking water. AWCs are the chief nodal agency across villages and cities for the delivery of health services under the Integrated Child Development Services (ICDS) Scheme of the Ministry of Women and Child Health.

About the reproductive health of the women, in 84 per cent of the households surveyed, there had been no births in the previous 12 months; in 16 per cent of households surveyed babies had been born in that period. Of the surveyed households, Chitapur had the maximum number of births. Three other clusters had three households each where a birth had taken place. Chindavada had the highest number of households (55), in which no birth had taken place.

There was found to be a high mortality rate in these clusters because:

1. Births in 70 per cent of the households took place at home.
2. Only 25 per cent of the households had used the government hospital facilities and 3 per cent had utilized the PHC.
3. Just two per cent of the deliveries took place in the private hospital.

All the four clusters lived in kuccha houses; they were mainly dependent on rice for their nutritional needs; spent most of their income on food; spent much less on health; for the delivery of their children, they relied mostly on help from mitanins and preferred to have their children delivered at home

At Chindavada, most of the births took place at home; Koinar was the only cluster where women also relied on the private hospital for the delivery of their babies. At Chindbahar most of the deliveries took place with the help of untrained birth attendants or *mitanins*.

It was found that there was inadequate nutrition and the sources of drinking water were poor and unhygienic because a majority of the households obtained their drinking water from a hand pump. Only households in Chindavada relied on water from the stream.

In the final analysis, the study concluded that the households of all the four clusters lived in *kuccha* houses; they were mainly dependent on rice for their nutritional needs; spent most of their income on food; spent much less on health; for the delivery of their children, they relied mostly on help from *mitanins* and preferred to have their children delivered at home.