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Health and Nutritional Status of Tribal Population in Two Districts of Madhya Pradesh

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Introduction

The state of Madhya Pradesh is characterized by a very large tribal population. At the time of 1991 population census, the tribal population in the undivided Madhya Pradesh was 15.40 million which was more than 23 per cent of the total population of the state; the corresponding information from the 2001 population census is not yet available. The state of Madhya Pradesh, as it existed at the 1991 population census has since been divided into the states of Chhattisgarh and Madhya Pradesh. Information available from the 1991 population census indicates that the tribal population in the new state of Madhya Pradesh was 9.68 million in 1991 which was almost one fifth of the population of the state. In terms of numbers, the new state of Madhya Pradesh still has the largest tribal population in the country.

Within Madhya Pradesh, the tribal population is almost entirely concentrated in its southern part, the region south of the river Narmada. Highest concentration of tribal population, according to the 1991 population census, is in district Jhabua where tribal population accounted for more than 85 per cent of the population of the district in 1991. In Dhar and Mandla districts, on the other hand, tribal population constituted more than 50 per cent of the population of the district. There were 11 districts in the state in 1991 where the tribal population accounted for more than 20 per cent of the population of the district.

Tribal people are popularly known as forest people. Since ages, they have been nestling away from the historical 'perennial and nuclear areas' and placed in relatively isolated niches. This historical settlement pattern seems to have bearings even today, There is ample evidence to suggest that the social and cultural value system including values and status accorded to females is very significantly different in tribal communities than in the non tribal communities, especially communities which have a very rigid caste system. Over generations, tribal communities have preferred to remain isolated from the main streams of social and economic development and have remained confined to forests which continue to be their main source of the livelihood even today.

This paper analyses the health and nutritional status of tribal population in Jhabua and Dhar districts of Madhya Pradesh and explores their health seeking behaviour. Information about health and nutritional status of tribal population is

usually available through nationally representative surveys like National Family Health Survey. Information available through these surveys provides, at best, only a macro view of the situation and that too in a residual context only. Such surveys are not designed to analysing the health and nutrition status of the tribal population and exploring their health seeking behaviour. In order to understand the specific health and nutritional needs of the tribal population in the right perspective, it is imperative that health and nutrition needs of the tribal people are assessed and analysed at the local level so as to plan and implement programmes that can address the felt needs of the people.

Data and Method

The present paper is based on the information collected through a survey of 300 tribal families in Jhabua and Dhar districts of Madhya Pradesh and focus group discussions with the representatives of tribal communities in these districts. The families surveyed were selected through a multistage sampling approach from 15 villages in one development block in each district selected randomly. Information from all the families surveyed was collected on the basis of a pre-designed and pre-tested information schedule from the head of the household as well as from one pregnant female in the family if there was one at the time of the survey. The lay reporting of health information methodology developed by the World Health Organization (WHO, 1978) was used for identifying the morbid conditions. On the other hand, the nutritional status of children of the families surveyed was assessed by following the guidelines and methodology developed by the United Nations (United Nations, 1986).

In addition to the household interviews, focus group discussions were also organized in all those villages where the household survey was carried out. Selected representatives of villages, numbering 10-15 including elected representatives of the people, government functionaries in the village and representatives of social services organizations functioning at the village level were invited to participate in the focus group discussions. The supervisor for the field survey acted as the facilitator for focus group discussions.

Characteristics of Families Surveyed

Basic features of the families surveyed are summarised in table 1. Majority of the families surveyed belonged to the lowest social and economic strata of the society. Primary occupation of almost 9 out of every 10 families surveyed was agriculture. Average annual per capita income of the families surveyed was Rs. 2448 at current prices with almost one fifth of the families having an average annual per capita income of less than Rs. 1000 at the prevailing market prices; there were only about 5 per cent of the families surveyed where the average annual per capita income at current prices was more than Rs. 6000.

Extremely poor living conditions of the families surveyed is also reflected through the family belongings. Most common family belonging in the families surveyed was the bicycle which was available in more than one fifth of the families whereas the electric fan was available in about 15 per cent of the families surveyed. By contrast, colour television and refrigerator was available in less than 1 per cent of the families surveyed. Similarly, houses of more than 90 per cent of the families surveyed were mud houses and there was no separate kitchen. There was no latrine in two third of the houses and 58 per cent of the houses surveyed had no electricity.

In the 300 families covered during the survey, 1698 individuals were enumerated. This gives an average size of approximately 5.66 individuals per family. Out of the 1698 individuals enumerated, 824 were females which give a sex ratio of 943 females per 1000 males. According to the 2001 population census, the sex ratio of the combined population of Jhabua and Dhar districts was 970 females for every 1000 males which indicates that there was some under enumeration of females in the survey.

The age-sex pyramid of the population surveyed was typically triangular is shape which reflects persistent high fertility and high mortality conditions. More than 14 per cent of the population surveyed was below 5 years of age while only about 3.5 per cent was above 60 years of age. As the result, the dependency ratio was 931 dependents for every 1000 working age people. There were 835 young dependents (persons below 15 years of age) and 96 old dependents (persons above 55 years of age) for every 1000 population in the age group 15-54 years. Similarly, the child-woman ratio was 649 children of 0-4 years of age for every 1000 women in the age group 15-44 years. The births and deaths

reported during the survey, on the other hand, indicate a crude birth rate of 30.62 live births for every 1000 population per year, a crude death rate of 13 deaths for every 1000 population per year and an infant mortality rate of 96 infant deaths for every 1000 live birth per year.

As regards education, more than 74 per cent of the population surveyed was found to be illiterate, the proportion being 87 per cent in case of females. Slightly more than one fifth of the population with age 6 years and more had been found to have ever gone to school. In females, this figure was less than 9 per cent. Just five per cent of the population above 6 years of age had education at least up to the high school level. In males, this proportion was 8.28 per cent but in females, this proportion was only 1.61 per cent which shows that mass illiteracy conditions prevailed in the surveyed families.

Morbidity among Children

Information about current sickness and sickness during one month prior to the survey was collected for all children below five years of age. About one in every five children surveyed were found to be sick at the time of the survey whereas more than 40 per cent of the children surveyed were found to have fallen sick during one month prior to the survey. The proportion of children found sick at the time of the survey or the proportion who were sick any time during one month prior to the survey was found to be slightly higher in male as compared to female children. Fever, resulting primarily from malaria, was the main cause of sickness among children. In case of children found sick at the time of survey, almost 70 per cent were suffering from fever normally associated with Malaria; this proportion was almost 90 per cent in children who were reported to be sick during one month prior to the survey. In addition to fever, cough, normally associated with acute respiratory infections, was found to be the second most common cause of morbidity in the children surveyed. More than 8 per cent of the children who were sick at the time of the survey were having cough and associated symptoms and this proportion was substantially higher in male than in female children.

In general, the sickness reported in children surveyed was short duration sickness. In case of more than 42 per cent of the children who were sick at the

time of the survey, the duration of sickness was reported to be of less than 7 days. In only about 30 per cent of the children who were sick at the time of the survey, it was reported that the ailment was persisting for more than 15 days. The duration of sickness reported during the survey has been found to be substantially longer in male than in female children. More than 40 per cent of the male children found sick at the time of the survey were reported to be sick for more than 15 days. This proportion was only 16 per cent for female children.

In addition to the information on current sickness and sickness during one month prior to the survey, specific information related to diarrhoea, high fever and acute respiratory infections was also collected during the survey. Information available from different sources suggests that these morbid conditions are the most common morbid conditions in children and are the major causes of childhood mortality. In the present survey, more than one fifth of the children below 5 years of age had at least one bout of diarrhoea, 43 per cent had high fever and 44 per cent had cough sometime during one month prior to the survey. In case of children who had diarrhoea, total days of diarrhoea ranged between 1-3 days in almost half of the children whereas in about 28 per cent it lasted for more than 7 days. On the other hand, in almost 80 per cent of the children who had high fever during the one month prior to the survey, the fever was associated with shivering while in case of 44 per cent of these children, high fever was associated with convulsions also. Similarly, among children having cough, more than two third had breathing problems whereas whooping cough was reported in 36 per cent of the children.

Nutritional Status of Children

The nutritional status of all children below 5 years of age identified during the survey was assessed on the basis of their height and weight. The height and weight of the child was used to estimate three indexes: weight-for-height, height-for-age and weight-for-age commonly used for measuring the nutritional status of children. The weight-for-height index is generally used as an indicator of "wasting" and is more commonly known as the body mass index. The height-for-age index, on the other hand, is the commonly used indicator for "stunting" in children whereas the weight-for-age is a composite indicator of wasting and

stunting. Weight-for-age is also the most widely used indicator for assessing the nutritional status. Once the three indexes were calculated for all children, they were compared with the corresponding values of a reference population by calculating the 'z' scores and estimating the proportion of children who fall below a given 'cut off' value of the 'z' score. The proportion of children falling below the cut off value of the 'z' score gave the prevalence of malnutrition. The data assembled by the United States National Centre for Health Statistics (United States, 1976) was used as the reference for estimating the prevalence of malnutrition following the recommendations of the World Health Organization (Waterlow, at. el. 1977) and the cut off value of the 'z' score for estimating the prevalence of malnutrition was taken to be 2 for all the three indexes of nutritional status as suggested in the guidelines developed by the United Nations for assessing the nutritional status (United Nations, 1990).

Information available through the present survey indicates that almost 21 per cent of the male and 17 per cent of the female children in the surveyed families were found to be 'wasted' at the time of the survey meaning that they were having significantly lower weight-for- height index than the reference population. Wasting is the best indicator of current and acute malnutrition in children. When the food intake is significantly reduced or infection is sufficiently serious, weight-for-height is the first indicator to be affected.

One known cause of the wasting or low weight-for-height index in children is a food intake inadequate to meet the energy needs of the child as in case of starvation or in a situation such as an infection in which increased energy requirements are not met. Another cause of wasting is the inadequate utilization of available energy because of mal absorption of foods as in case of fever and diarrhoeal diseases. In the families surveyed, very high prevalence of fever has been reported currently as well as in the past. It appears that a primary reason for a very high proportion of malnourished children in the families surveyed is the prevalence of fever.

The prevalence of stunting in the surveyed children, on the other hand, was found to be very high - almost 72 per cent in male and 63 per cent in female children surveyed. Similarly, almost 72 per cent of male and 55 per cent of female children were found to be having lower weight-for-age as compared to the

reference population. Main reason for very high values of these indexes appears to be the reference population used for the purpose of comparison. As remarked earlier, the reference population used for comparison is the American population. There is evidence to suggest that the height of an average Indian is substantially lower than the height of an average American. Because of this difference, the average value of height-for-age in the reference population is much higher.

Causes of stunting, however, are not very clear. Stunting is not as sensitive to serious inadequacies in the food intake as is wasting and seems to be the last indicator to be affected, if affected at all, in situations of acute starvation. There are evidences where a significant increase in the prevalence of stunting has been reported without any significant increase in the prevalence of wasting. As such, non nutritional causes such as genetic effects, social and economic conditions, etc. have also been attributed as some of the causes of stunting.

Like the height-for-age, the weight-for-age is also not a good indicator of malnutrition in children because it is a composite indicator of wasting and stunting. A short child with a normal weight-for-height may have a low weight-for-age or, conversely, a tall, wasted child may have a normal weight-for-age. Moreover, this index does not tell whether the observed malnutrition is due to wasting or due to stunting. The weight-for-age index is also sensitive to the reference population used for the purpose of comparison.

Health Status of Women

During the survey, especial emphasis was given on the information related to the health status of women. The respondents were specifically asked whether any female above 5 years of age was having any health related complication or problem at the time of the survey. In addition, the respondents were also enquired about any pregnant female in the family. When any female in the family was reported to be pregnant, a detailed pregnancy history was collected by interviewing the pregnant woman herself. Similarly, when any female in the family was found sick, detailed information was collected about the nature of the problem and the type of medical assistance received by the sick female. It may however be pointed out that the response received was significantly influenced by the prevailing perceptions about sickness and morbidity, particularly of

women. It is well known that there are many disease conditions which are not perceived as morbid conditions by the people but which require medical attention and treatment, especially in traditional societies characterized by high morbidity and mortality levels are high and where general awareness about morbidity and their causes is low.

In the present survey, about 7 per cent of the females with at least 5 years of age were reported to be sick at the time of the survey. In the absence of proper investigation and diagnosis, this proportion may be viewed as an indication of the prevailing levels of morbidity in females of the surveyed families. Even more important is the observation that most of the reported morbidity was concentrated in the reproductive age group - of the total females reported to be sick at the time of the survey, more than 85 per cent belonged to the reproductive age group. On the other hand, more than 70 per cent of the reported sickness in females was due to two widely prevalent causes of morbidity - fever and pain in the abdomen. Fever alone accounted for half of the reported sickness in females above five years of age and this pattern is very similar to the pattern of morbidity observed in children below 5 years of age, either male or female. In addition, leucorrhoea and asthma were reported in about 10 per cent of the females who were reported to be sick at the time of the survey.

During the survey 24 women were identified who were reported to be pregnant. These women were requested to report all problems and complications that they were facing as the result of the pregnancy. Two third of these pregnant women reported that they were having problems and complications as the result of the pregnancy. Most of the pregnant women reported more than one problems and complications as the result of the pregnancy. The most common problem reported by pregnant women was weakness, closely followed by pain in the body and in the lower abdomen. In general the rate of pregnancy related complications in the women surveyed was very high despite the fact that general perception of females about reproductive health problems was poor. There was a general belief among the pregnant women surveyed that pregnancy is always associated some problems and complications. These women were of the view that normally problems and complications associated with pregnancy were not regarded as serious enough for any attention or treatment.

Patterns of Treatment and Care

An important component of the health and nutritional status of any population is the patterns of treatment and care which is more popularly known as the health seeking behaviour. During the survey, information about treatment and care of the sick was collected for all those who were found sick at the time of the survey. Issues related to treatment and care that were covered during the survey included breast-feeding practices, immunization status in women and children, nature of treatment during diarrhoea, fever and respiratory infections in children, patterns of treatment in women and children found sick at the time of the survey and attention and care during pregnancy. This section presents an overview of the situation that prevailed in the families surveyed.

Breast-feeding. Breast-feeding among the children surveyed was found to be nearly universal and quite prolonged. Nearly half of the children below 5 years of age were breast-feeding at the time of the survey. Among those who were not breast-feeding at the time of the survey, only 4 per cent were never breast fed whereas in more than one third, breast-feeding lasted for more than 18 months.

Immunization. There was some substantial variation in the coverage of children below 5 years of age by different vaccines. Highest coverage of children was found to be in case of the first dose of oral polio vaccine. More than 78 per cent of the children below 5 years of age in the families surveyed were reported to have received the first dose of oral polio vaccines. The coverage of the second dose of oral polio vaccine was also very high; there was a drop of just 1.4 per cent between the first and second dose of this vaccine. But the gap between the second and third doses was found to be very large; while nearly 77 per cent of the children surveyed were found to have received the second dose of oral polio vaccine, this proportion was only 68 per cent in case of the third dose of the vaccine. Similarly, more than 72 per cent of the children surveyed had been found to have received the BCG vaccination.

Unlike the oral polio vaccine, the coverage of children below 5 years of age by the DPT vaccine has been found to be substantially lower; only about 56 per cent of the children surveyed were found to have received first dose of DPT vaccine and this proportion for the third dose of the vaccine was only about 47

per cent. Lowest coverage, however, had been found to be in case of measles vaccination; less than 40 per cent children below 5 years of age surveyed were found to have received the measles vaccination.

Sex differentials in vaccination of children in the surveyed families has been found to be quite interesting. In case of first doses of oral polio vaccine and DPT vaccine, the coverage rate was found to be higher in male than in female children. At the same time, the drop out between first and third doses of the same vaccine has also been found to be higher in male than in female children. As the result, the coverage rate of the third dose of both oral polio and DPT vaccines has been found to be higher in female as compared to male children. The drop out rate between first and third dose of oral polio vaccine was almost 17 per cent in male children but only about 9 per cent in female children; the corresponding proportions were 19 per cent and 12 per cent respectively for the DPT vaccine. On the other hand, the coverage rate of BCG vaccine was marginally higher while that of the measles vaccine was substantially higher in female as compared to male children.

Treatment of sickness. A clear preference for a private doctor/hospital for the treatment of current and past sickness in the surveyed families was very much evident from the survey. In children below 5 years of age found sick at the time of the survey, more than 47 per cent were being treated at some private facility either in the village or in the nearby village/town. In case of children sick in the one month prior to the survey, this proportion was almost 63 per cent. In specific cases of diarrhoea, fever and coughs also, the preferred place of treatment was private health care facility.

Another important feature of the treatment pattern that was observed during the survey is that a very substantial proportion of population who was found sick at the time of the survey or was sick during one month prior to the survey had either no treatment at all or some home treatment only. Among children below 5 years of age who were found sick at the time of the survey, this proportion was more than 37 per cent whereas in children who were sick sometimes during one month prior to the survey, this proportion was almost 20 per cent. On the other hand, three fourth of the women reported to be pregnant at the time of the survey and having some complications associated with

pregnancy were found to be having no treatment and care for the problems that they were facing as the result of the pregnancy.

Since reproductive health is a major contributor to the over all health status of women, detailed information about care and attention during pregnancy was collected from women reported pregnant at the time of the survey. The situation that emerged in the surveyed families may be termed as alarming. Two third of the women reported to be pregnant at the time of the survey had no antenatal examination whereas only one fourth were examined only once during the pregnancy. Similarly, three fourth of the pregnant women had no tetanus toxoid immunization while blood pressure was measured and urine was examined respectively in less than 20 per cent and less than 5 per cent.

Observations from Focus Group Discussions

In addition to the quantitative information on the health and nutritional status of the population collected on the basis of household survey, focus group discussions were also organized in all villages where the household survey was carried out. The primary purpose of organizing the focus group discussion was to provide the qualitative supplement to the quantitative information collected through the structured interviews. These focus group discussions focussed on the following broad topics:

- diseases and morbid conditions prevalent in the village.
- reasons for prevailing health and nutrition situation.
- availability of health care facilities in the village and nearby villages.
- Means of transport.
- Nutritional status of children and factors associated with given nutritional status.
- Occupation and employment opportunities in the village.

Main observations of the focus group discussions are summarized below:

i. The disease profile that emerged from the focus group discussions was very similar to that emerged through the household survey. Fever, mostly associated with Malaria was found to be the most widely prevalent morbid condition in the villages surveyed.

ii. The villagers were not having any clear idea about the prevailing nutritional situation. However, the over all view was that the lack of adequate diet was the main cause of poor nutritional status.

iii. In a number of villages, availability of safe drinking water was a major problem. This observation is supported by the fact that diseases of digestive system emerged as an important cause of morbidity in the household survey also. Hand pumps were reported to have been installed in most of the villages but the use of the hand pumps was not popular as water from even hand pumps was not found safe for human consumption. At some places, villagers were quite concerned about the near total neglect of traditional, time tested concepts of traditional, time tested ways and means of conserving and protecting water.

iv. Most of the participants in the focus group discussions were nearly totally ignorant about the need of balanced diet and proper dietary habits to combat malnutrition. Moreover, there were very limited options for improving the availability and quality of he food as the agriculture in the surveyed villages was traditional and the poverty was rampant in the villages surveyed.

v. Availability of basic minimum health care facility in every village was another issue that was raised by the villagers during the focus group discussion. Villagers were quite critical about the inability of the public administration to provide even the basic minimal health care facilities in the villages surveyed.

vi. Males were nearly totally indifferent about the health related issues specific to females. There were very few participants in the focus group discussions who were really concerned about the health of women. Involvement of males in addressing female health issues, especially, reproductive health issues, emerged an important concern.

Conclusions

The findings of the survey presented and discussed in the forgoing pages provide some very valuable insight into the health and nutrition status of the tribal population of Jhabua and Dhar districts of Madhya Pradesh. It is clear from the information generated through the survey that the process of transition in the

health and nutritional status of tribal population in the two districts is extremely slow despite all investments in the health sector. It appears that focussed efforts to accelerate the process of social and economic development are strongly needed to accelerate health transition in the population surveyed.

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Table 1 Basic characteristics of families surveyed.

Number of families surveyed		300
Average annual per capita income at market prices		2448
Proportion of families having average annual per capita income of less than Rs 1000 at market prices		19.21
Family belongings		
	Pressure cooker	4.62
	Electric fan	14.85
	Bicycle	21.12
	Motor cycle/scooter	4.62
	Radio/Tape recorded	8.91
	Stitching machine	4.95
	Television (B/W)	7.92
	Television (colour)	0.33
	Telephone	0.66
	Refrigerator	0.66
	Car/Jeep	0.33
	Tractor	0.66
	Water pump	1.32
	Thrasher	0.66
	Bullock cart	8.25
Type of house		
	Kuchcha	92.08
	Pucca	4.29
	Semi Pucca	3.63
Proportion of houses having separate kitchen		8.58
Proportion of houses having electricity		58.09
Source of drinking water		
	Tap/well/hand pump in the house	18.14
	Public tap/well/hand pump	72.93
	Others	7.92
Proportion of houses having latrines		34.22
N		300

Table 2 Characteristics of population surveyed

Total population surveyed		
	Total	1698
	Male	874
	Female	824
Average family size		5.7
Sex ratio of population surveyed (F/M)		943
Dependency ratio		
	All	931
	Young	835
	Old	96
Child-woman ratio		646
Crude birth rate		30.62
Crude death rate		13.00
Infant mortality rate		96.00
Proportion of population above 6 years ever gone to school		
	All	25.71
	Male	37.79
	Female	12.88
Occupational structure		
	No work	45.31
	Agriculture	39.35
	Labour	12.22
	Business	2.06
	Service	0.92
	Others	0.14

Table 3 Morbidity and nutritional status of children below 5 years of age.

Children below 5 years of age	All	Male	Female
Found sick at the time of the survey	20.63	21.52	19.53
Fever	*14.34*	*15.19*	*13.28*
Cough	*1.75*	*2.53*	*0.78*
Abdominal pain	*1.05*	*1.90*	*0.00*
Others	*3.49*	*1.90*	*5.47*
Sick during one month prior to the survey	41.26	42.41	39.84
Having diarrhoea during one month prior to the survey	26.22	25.32	27.34
Total days of diarrhoea			
1-3 days	*47.30*	*50.00*	*44.12*
4-7 days	*24.32*	*25.00*	*23.52*
> 7 days	*28.38*	*25.00*	*32.35*
Having high fever and associated symptoms during one month prior to the survey	43.36	44.30	42.10
High fever with shivering	*34.26*	*37.34*	*30.47*
High fever with convulsions	*19.23*	*21.52*	*16.41*
Having acute respiratory infections during one month prior to the survey	44.06	46.20	41.41
Breathing problem	*33.22*	*36.71*	*28.91*
Whooping cough	*16.08*	*17.72*	*14.06*
Nutritional Status			
Proportion “wasted”		20.89	16.50
Proportion “stunted”		71.56	62.92
Proportion low weight-for-age		71.85	54.95

Table 4 Patterns of morbidity in females above 5 years of age

Proportion of women reported sick at the time of the survey		6.91
Pattern of sickness		
	All	*100.00*
	Fever	*47.62*
	Leucorrhoea	*9.52*
	Pain in abdomen	*23.81*
	Asthma	*9.52*
	Blood Pressure	*4.76*
	Others	*4.76*
Age pattern of sickness		
	All	*100.00*
	5-14	*9.52*
	15-49	*85.71*
	50 and above	*4.76*

Table 5 Complications associated with pregnancy.

Complications	Proportion of pregnant women
Bleeding	37.50
Weakness	66.67
High blood pressure	33.33
Swelling in the feet	45.83
High fever	54.17
Bad discharge	45.83
Pain in the back and the body	62.50
Pain in lower abdomen	62.50
Anaemia	45.83
Convulsions	54.17
Breach delivery	33.33
Others	41.67

Remarks Figures do not add to 100 as multiple complications were reported by the respondents.

Table 6 Management and treatment of sickness in children below 5 years of age.

Particulars	All	Male	Female
Current sickness			
Taken to Vaidya/Hakeem	3.38	0.00	8.00
Taken to private doctor/hospital	47.36	55.88	36.00
Taken to government doctor/hospital	10.17	2.94	20.00
No treatment/home treatment	35.29	38.24	36.00
Sickness during one month prior to the survey			
Taken to Vaidya/Hakeem	0.79	0.00	1.85
Taken to private doctor/hospital	62.99	60.28	66.67
Taken to government doctor/hospital	15.75	12.33	20.37
No treatment/home treatment	19.69	26.03	11.11
Management of diarrhoea			
Proportion given ORS	25.33	22.50	28.57
Proportion continued breast-feeding	49.12	54.84	42.31
Proportion taken to Vaidya/Hakeem	2.67	0.00	5.71
Proportion taken to doctor/hospital	73.27	72.50	74.29
Treatment of high fever			
Proportion taken to Vaidya/Hakeem	0.00	0.00	0.00
Proportion taken to doctor/hospital	84.67	84.82	85.19
No treatment/Home treatment	15.33	15.72	14.81
Treatment of ARI			
Proportion taken to Vaidya/Hakeem	1.59	1.37	1.89
Proportion taken to doctor/hospital	76.19	76.71	75.47
No treatment/Home treatment	22.22	21.92	22.64

Table 7 Management and treatment of sickness in women

Particulars	Proportion
Management and treatment of sickness in all women	
Consulted Vaidya/Hakeem	4.76
Consulted/attended private doctor/hospital	42.86
Consulted/attended government doctor/hospital	14.29
No treatment/Home treatment	38.10
Management and treatment of complications related to pregnancy	
Consulted Vaidya/Hakeem	0.00
Consulted/attended private doctor/hospital	12.50
Consulted/attended government doctor/hospital	12.51
No treatment/Home treatment	75.00
Antenatal examination during pregnancy	
Three times and more	4.17
Less than three times	25.00
No examination	66.67
Tetanus toxoid during pregnancy	
Two doses	4.17
One dose	16.67
None	75.00
Pregnant women having blood pressure check up	16.67
Pregnant women having urine examination	4.17