Volume 28 June 2022
Indian Journal of Biological Sciences
(A Peer Reviewed Journal)
ISSN 0972-8503
http://dx.doi.org/10.62424/ IJBS.2022.28.01.06

Assessment of Knowledge, Attitude and Practice Levels of Family Welfare at Rural Sector of Paschim Midnapore

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Abstract

This present study investigates the knowledge, attitude and practice (KAP) levels regarding family welfare at rural sector of Paschim Midnapore. Through a comprehensive survey conducted among household in the region, supplemented by qualitative interviews with key stakeholders, the study explores the multifaceted dynamics influencing family planning, maternal healthcare and child-rearing practices. Study population consists of pregnant and lactating mother (19-30 year of age), child (5-12 year of age) and guardians (25-60 year of age) covering husband, father, mother etc. The sample size was 200 mothers, 150 children and 50 guardians. Baseline data was collected in the month of January-February 2023. Findings reveal a diverse range of factors impacting KAP dynamics, including socio-cultural norms, access to healthcare services and levels of education. Data presented that in all of the said domains, above three indicators i.e. KAP about family welfare are inadequate in most of community population. Notably, the research identifies both the barriers and facilitators to the adoption of positive family welfare practices within the community. By elucidating these dynamics, this study contributes valuable insights for the development of targeted interventions aimed at improving family welfare outcomes in rural Paschim Midnapore, thereby fostering sustainable development and community well-being.

Keywords: Family welfare, KAP, Paschim Midnapore, Maternal health, Child health

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Introduction

Family welfare encompasses a broad spectrum of initiatives aimed at promoting the health, well-being and prosperity of individuals and families within a community. As its core lies the triad of knowledge, attitudes and practices (KAP), which collectively shape the landscape of family welfare interventions (**Wani et al.,2019**). Understanding the intricate dynamics of KAP regarding family welfare is crucial for designing effective programs and policies that address the diverse needs and challenges faced by families, particularly in rural areas (**Fataar,2020**).

Knowledge serves as the foundation upon which attitudes and practices are bulit. In the context of family welfare, knowledge encompasses awareness and understanding of issues such as the family planning, maternal and child health, nutrition, hygiene and reproductive rights. Attitudes, on the other hand, reflect individuals mindset, beliefs, perceptions and values regarding these issues. Positive attitude are essential for fostering supportive environments conductive for adopting healthy practices and seeking necessary healthcare services. Finally, practices encompass the contraceptive behaviours and individual centric action and families undertake in relation to family welfare, including prenatal care, childbirth practices, child-rearing, personal and family hygiene as well as sanitation along with preventive health behaviour (**WHO,2011**)

In rural settings, where access to healthcare services and educational opportunities are be limited, understanding the KAP dynamic of family welfare becomes even more critical. Socio-cultural factors, economic constraints and infrastructural challenges often intersect to shape individuals and communities perceptions and behaviours regarding family welfare practices (**Coombs et al., 2022**). Moreover, disparities in knowledge, attitudes and practices may exist within and across communities, influenced by factors such as gender, age, socioeconomic status and cultural norms.

By unravelling the complexities of KAP surrounding family welfare, researchers, policymakers and practitioners can develop targeted interventions that address the specific needs and preference of rural populations (**Mahadeen et al., 2012**). From this context, this survey aimed to explore the degree of KAP among mothers, children and guardians at rural sector, Paschim Midnapore.

Methods and materials

Study design

Four blocks from the Paschim Midnapore district were selected from random sampling method namely Midnapore sadar, Salbani block, Garbeta III block and Chandrakona I block. From the selected blocks, panchayet followed by villages were also selected by same simple random sampling method. Selected villages were considered for data collection from the targeted individuals by random sampling.

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Data collection

Questionnaire was framed to estimate KAP level on 3 major domains for mother: Pregnancy nutrition, site of delivery, and contraceptive, three major domains for child namely Child education, child labour, and child vaccination. Three major domains for guardian: Antenatal care, family size and birth spacing. Cross sectional study was done among 200 mothers, 150 children and 50 guardian.
Area sampling method followed by random sampling method was followed.
Scoring method for KAP schedules:

Knowledge score by Mother	**Attitude score by Mother**	**Practice score by Mother**
Correct answer- 1 Wrong answer-0	Strongly disagree (SD)-1 Disagree(D)-2 Undecided (U)-3 Agree (A)(-4 Strongly agree (SA)-5	Yes-1 No-0
Total score- 20	Total score- 60	Total score- 12

Knowledge score child	**Attitude score child**	**Practice score child**
Correct answer- 1 Wrong answer-0	Strongly disagree (SD)-1 Disagree(D)-2 Undecided (U)-3 Agree (A)(-4 Strongly agree (SA)-5	Yes-1 No-0
Total score- 15	Total score- 40	Total score-15

Knowledge score guardian	**Attitude score guardian**	**Practice score guardian**
Correct answer- 1 Wrong answer-0	Strongly disagree (SD)-1 Disagree(D)-2 Undecided (U)-3 Agree (A)(-4 Strongly agree (SA)-5	Yes-1 No-0
Total score- 20	Total score- 40	Total score-20

Grading of KAP level according to correct answer score:

Grade	**Knowledge**	**Attitude**	**Practice**
<50%	Inadequate	Poor	Unhealthy

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51-75%	Moderately adequate	Good	Normal
76-100%	Adequate	Very good	Health friendly

Results

Level on pregnancy nutrition covering KAP domains focused that 60% of mothers had inadequate knowledge, 52.5% mothers had poor attitude level, 68% mother followed unhealthy practices. Out of the samples, about nutrition care during gestational period 25% mother had moderately adequate knowledge, 28.5% mother had good attitude level, 21.5% mother had normal level practices. Only 15% mother had adequate knowledge, 19% mother had very good attitude level, about 10.5% mother followed health friendly practices (Figure 1).

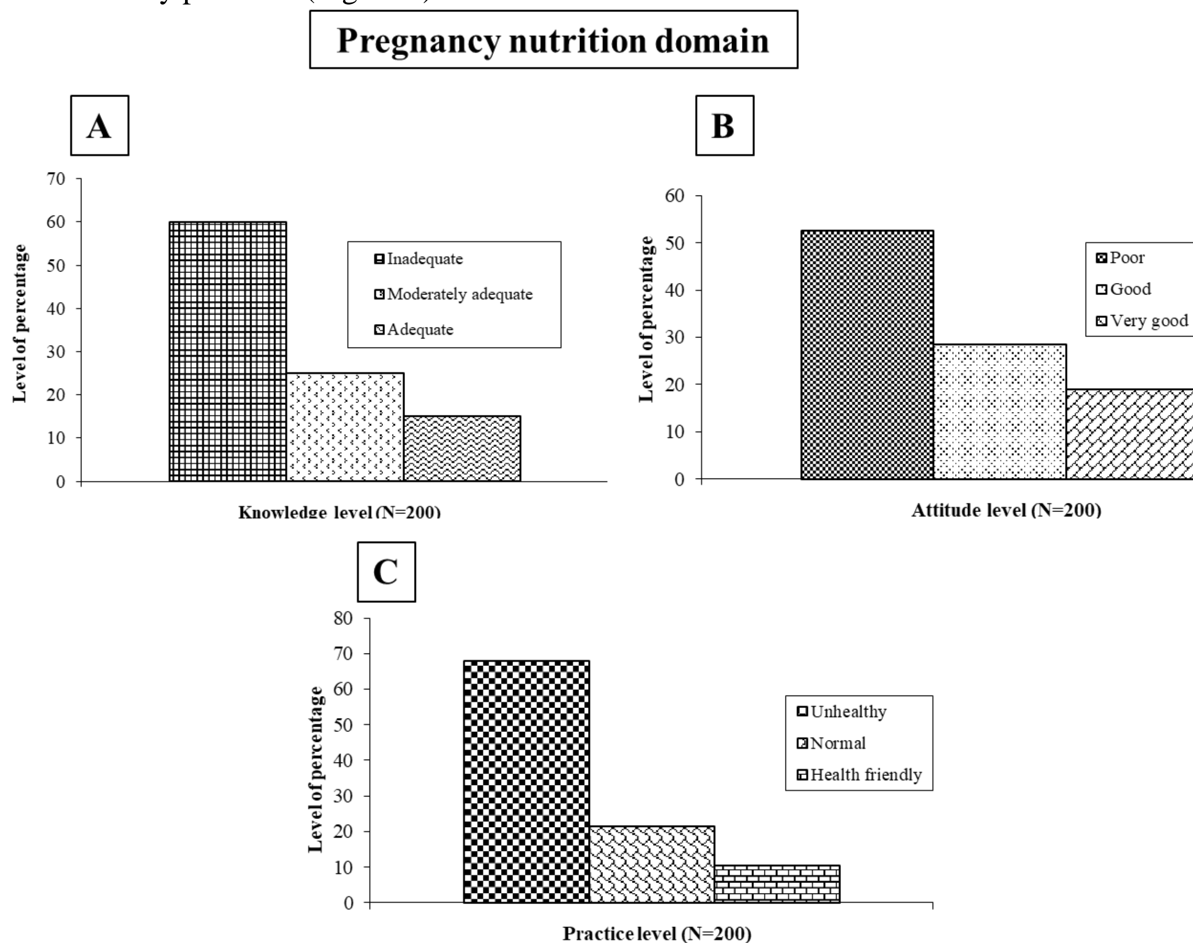

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Figure 1: Graphical presentation of KAP about nutritional requirement in pregnancy period among mothers. (A) represents knowledge level of mothers, (B) showing attitude level of mothers, (C) demonstrates the practices of mother in this domain.

About the site of delivery of pregnant mother, the study reported that 41% mothers had inadequate knowledge, 28.5% had poor attitude, 58.5% mothers followed unhealthy practices on this domain. It also noted that 20.5% of the target population had moderately adequate knowledge, 35.5% had good attitude level, 21.5% mothers had normal level of practices about the said domain. Beside this, 38.5 % mothers had adequate knowledge about this domain, among all 36 % mothers had very good attitude and 20 % mothers followed health friendly practices (Figure 2).

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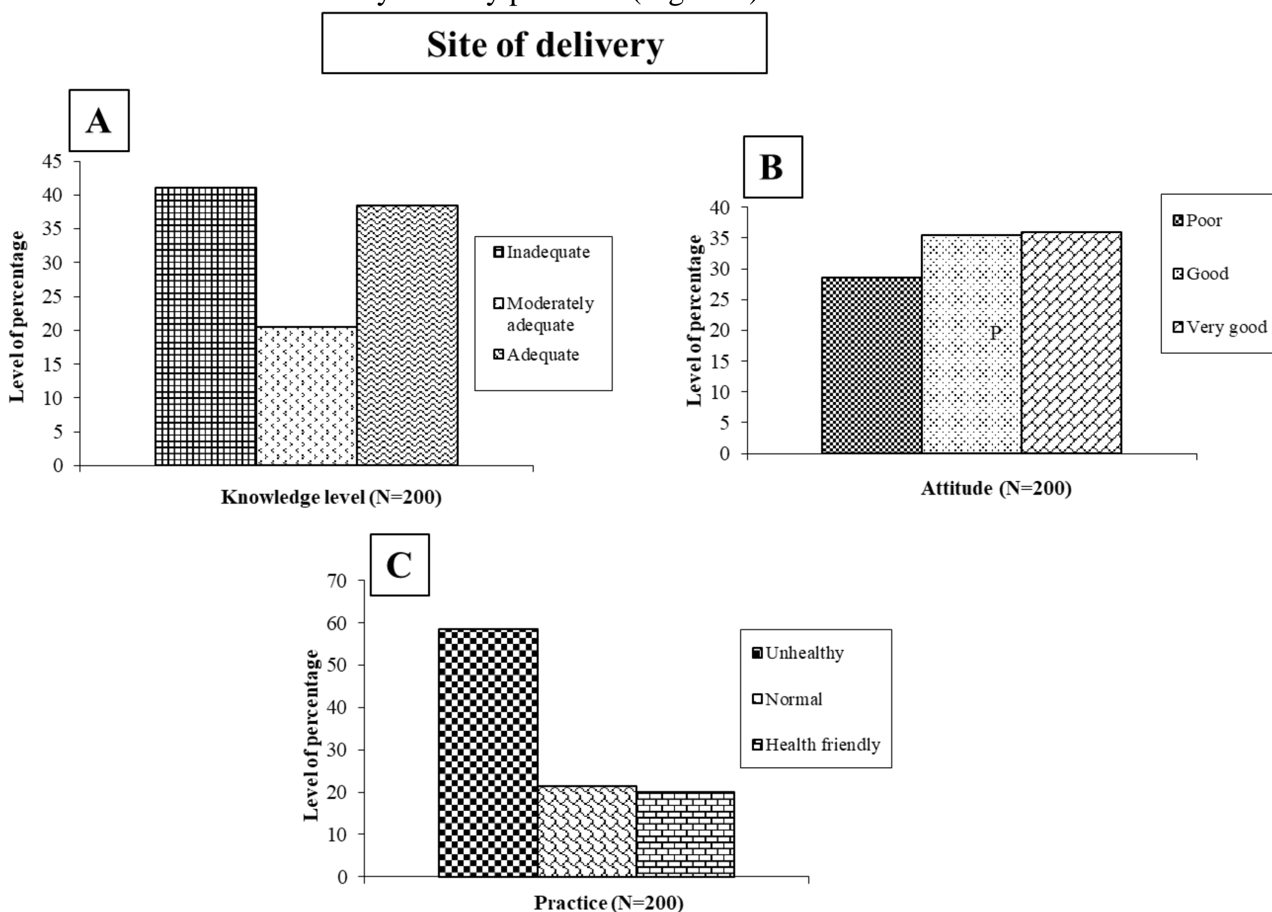
Figure 2: Representation of KAP level about the site of delivery among mothers. (A) represents the scenario of knowledge level, (B) showing the attitude level towards the said domain, and (C) is the practices followed by mothers by site of delivery.

The scenario about contraceptive domain in the target group also noted that 28.5% mothers had inadequate knowledge, 42.5% poor attitude level, 66.5% mothers follow unhealthy practices about this. In contrast, 31.5% mother had moderately adequate knowledge, 28.5% had good attitude level, 17.5% mother supplant normal practices, 40% mother had adequate knowledge, 29% mother had very good attitude level and 60% mother had healthy friendly practices (Figure 3).



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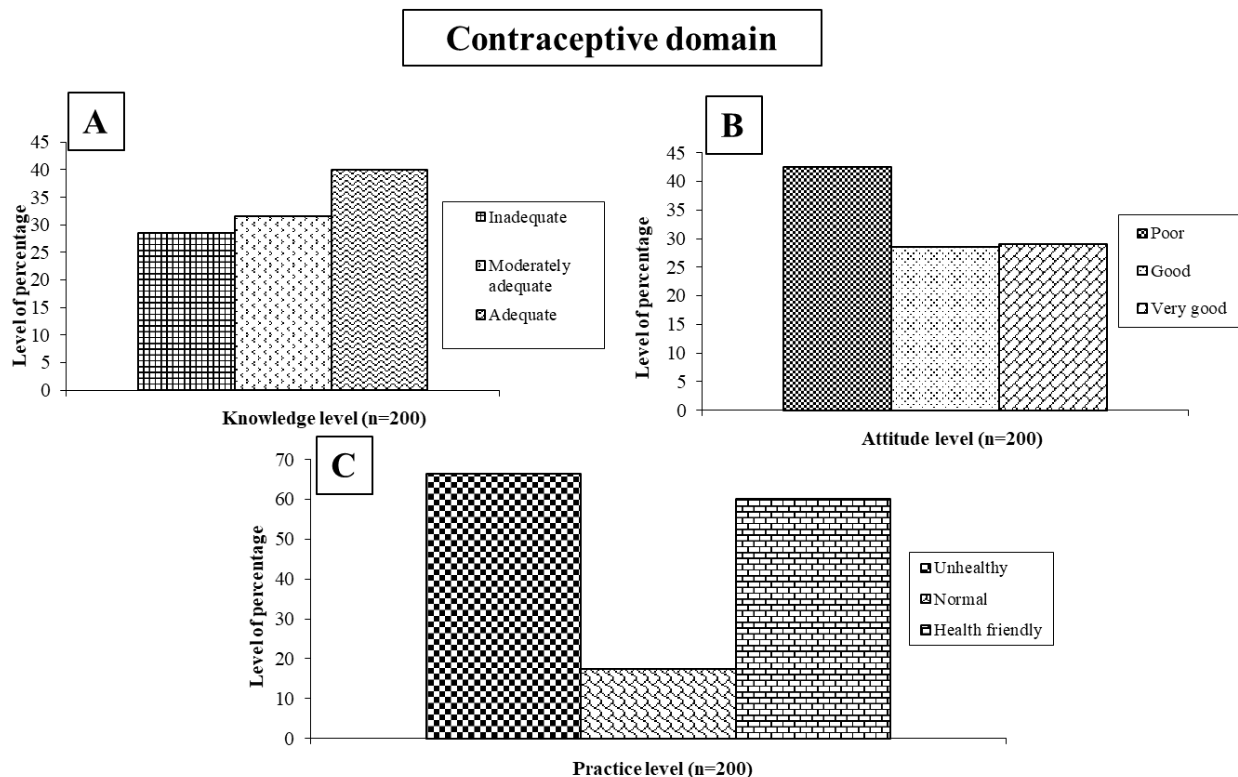

Figure 3: Representation of KAP level focusing contraceptive domain among mothers. (A) Each column showing knowledge level of the mothers, (B) represents attitude level of among mothers, (C) showing the level of practices followed by mothers.

In child education domain KAP level study among the target group focused that about 36% target groups had inadequate knowledge, 44.66% had poor attitude, 49.33% had follow unhealthy practices about this field. About 34% child had moderately adequate knowledge, 34.66% had good attitude, 28% child had very good practices. About 30% child had adequate knowledge, 20.66% child had very good attitude and 12.66% child had healthy friendly practices (Figure 4).

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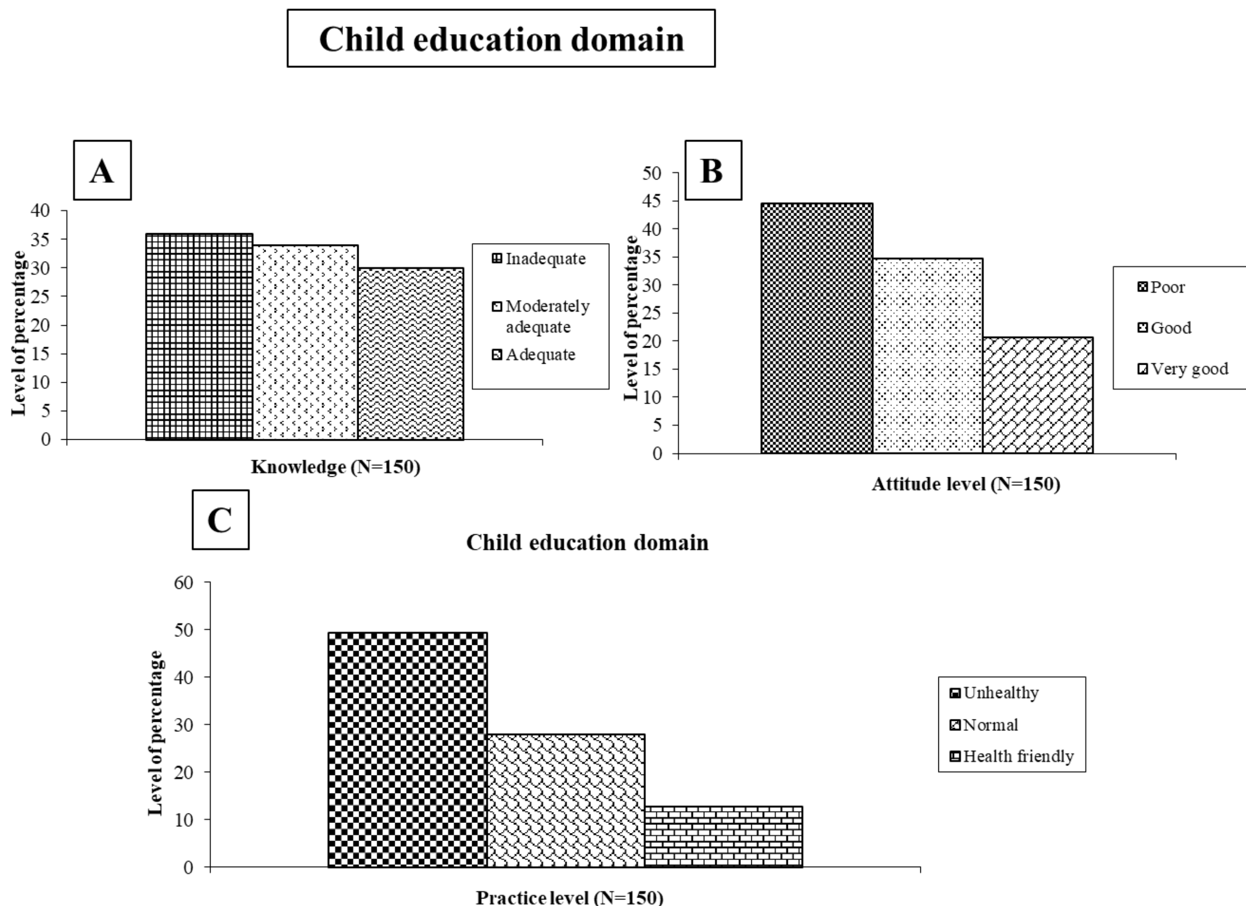

Figure 4: Knowledge, attitude and practice level from the view point of child education domain among children. (A) is the knowledge level, (B) attitude towards education among children, (C) showing level of practices followed by children.

In child labour domain, about 44.66% child had inadequate knowledge, 48.66% children showed poor attitude and 59.33% followed unhealthy practices. Beside this, 28% children had moderately adequate knowledge, 28% had good attitude level and 28% children had very good practices. About 30 % children had knowledge, 20.66% children had very good attitude level and 12.66% child had healthy friendly practices (Figure 5).

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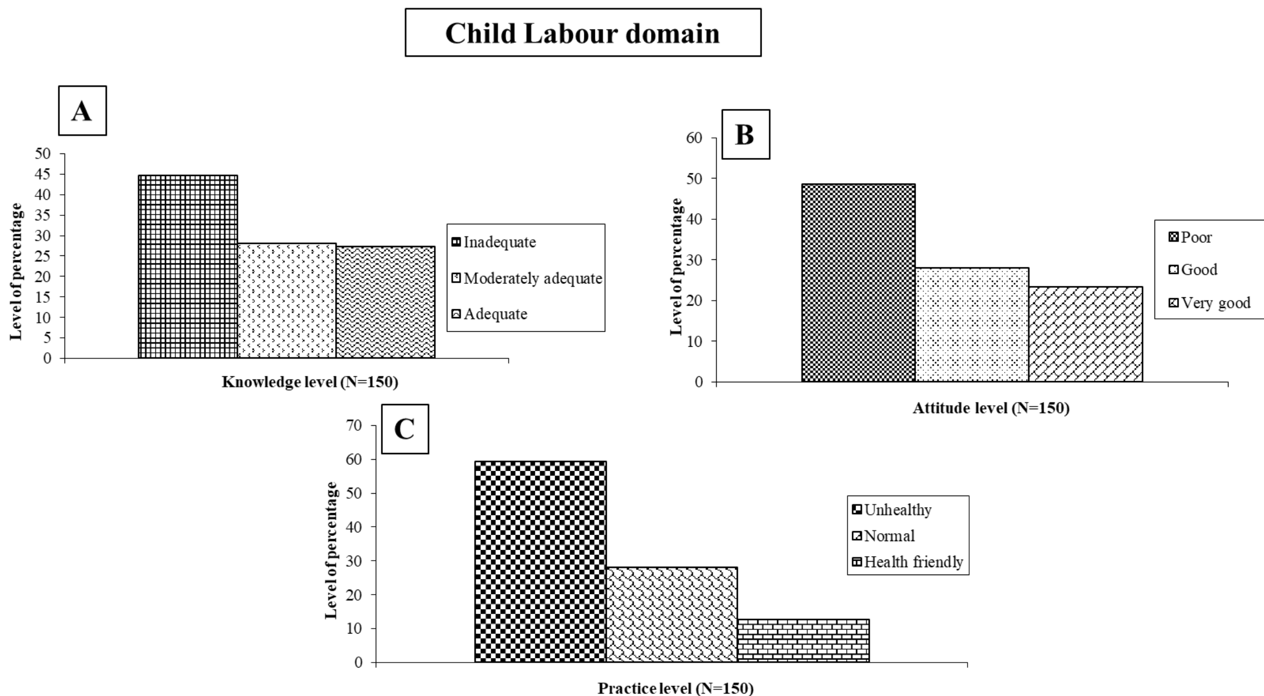

Figure 5: Bar diagrams represents the KAP level about child labour domain. (A) represents the knowledge level, (B) represents the attitude level, (C) represents the practice level among children

In child vaccination domain, among all the target group, 33.66% child had inadequate knowledge, 31.33% child had poor attitude level, 30% child had unhealthy practices. Similarly, about 43.33% child had moderately adequate knowledge, 30.66% child had good attitude level and 26% child had very good practices. About 57.33% child had

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adequate knowledge, 22% child had very good attitude level and 20.66% child had healthy friendly practices (Figure 6).

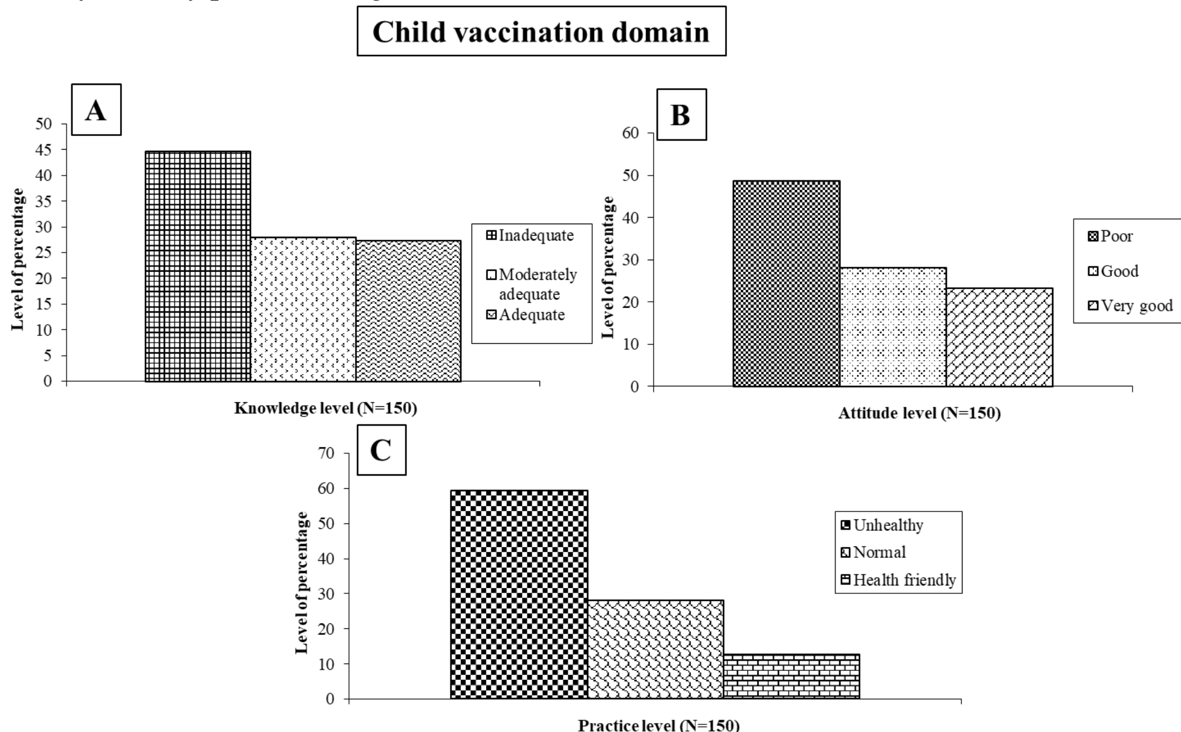

Figure 6: Data represents the KAP levels focusing child vaccination domain. (A) showing the knowledge level, (B) represents the attitude level and (C) represents the practice level of the children.

In antenatal care domain, about 46% guardian had inadequate knowledge, 56% guardian had poor attitude level and 20% guardian had unhealthy practices, 34% guardian had moderately adequate knowledge, 30% had good attitude level and 16% guardian had normal practices. Similarly, 66% guardian had adequate knowledge, 20% had very good attitude and 14% guardian had health friendly practices (Figure 7).

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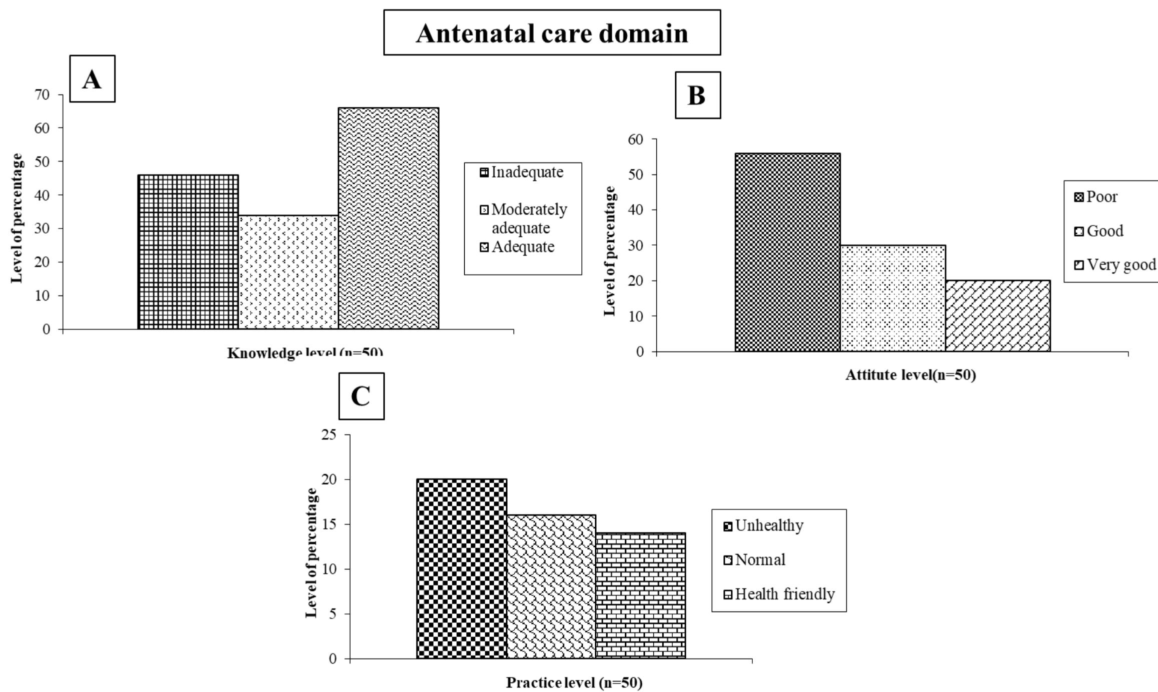

Figure 7: Knowledge, attitude and practice levels of guardian focusing antenatal care domain. (A) knowledge level of the guardian, (B) Attitude level towards antenatal care domain, (C) showing the level of practices followed by guardian regarding this domain

The present study shows 58% guardian had inadequate knowledge about the family size, 64% guardian had poor attitude and 74% guardian had unhealthy practices. Not only that, about 22% guardian had moderately adequate knowledge. 18% guardian had good attitude level, 14% guardian followed normal practices. About 20% guardian had adequate knowledge, 18% guardian had very good attitude level and 12% guardian had

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healthy friendly practices (Figure 8).

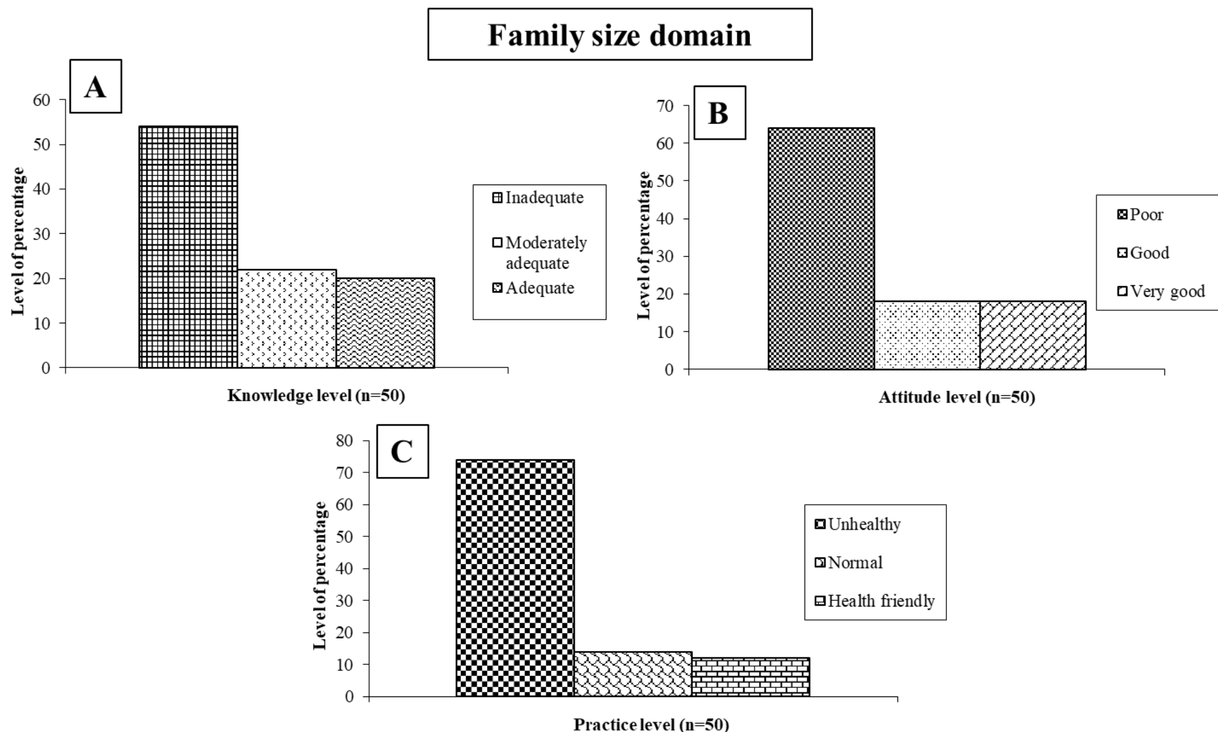

Figure 8: Graphical presentation of KAP level among guardian about family size. (A) Showing the knowledge level, (B) represents the attitude towards the domain, (C) reflects the level of practices regarding the same

In rural sector of Paschim midnapore, nearly 52% guardian had inadequate knowledge about birth spacing, 56% guardian had poor attitude level and 72% guardian followed unhealthy practices. Alongside, 30% guardian had moderately adequate knowledge, about 28% guardian had good attitude level. Similarly, 18% guardian had adequate knowledge, 16% guardian had very good attitude level and 10% guardian had healthy

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friendly practices level (Figure 9).

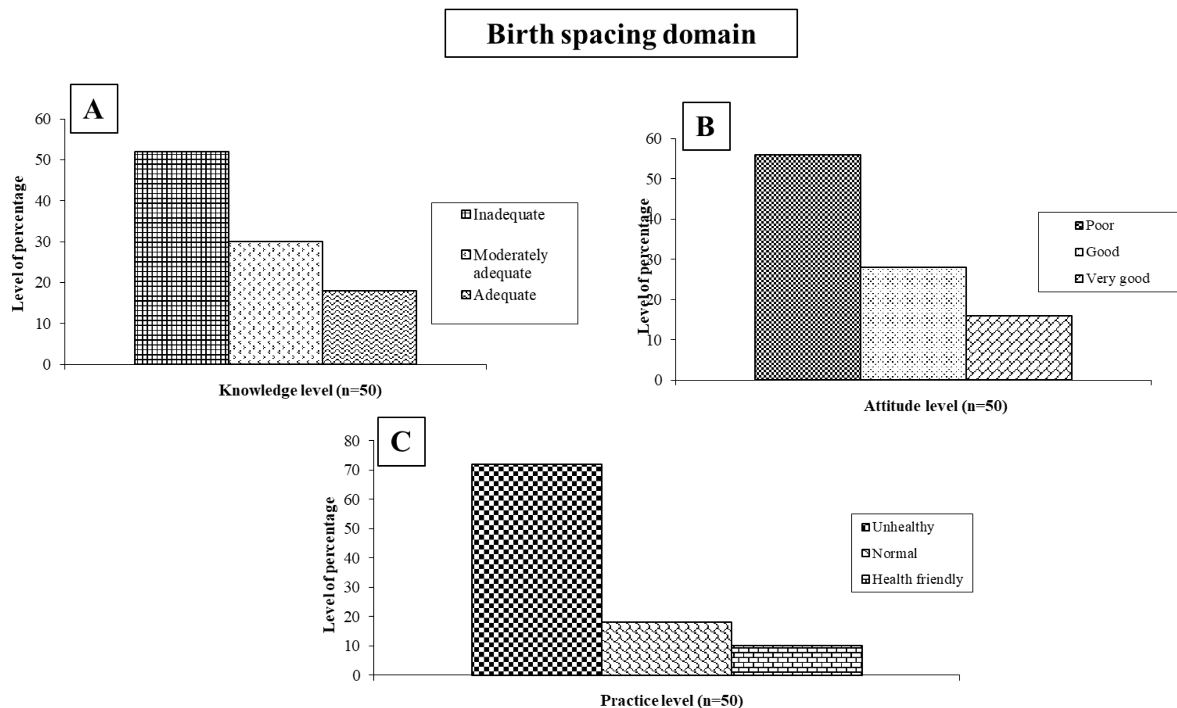

Figure 9: Knowledge, attitude and practice about birth spacing among guardian. (A) focuses the knowledge level about this domain, (B) shows the attitude level, (C) represents practice level

Discussion

In Paschim Midnapore, in spite the efforts given by government to improve family welfare, there persists a remarkable gap in knowledge, attitude and practices (KAP) in this domain among mothers, children and guardians. This disparity contributes to adverse health outcomes and impedes progress towards achieving optimal maternal and child health. Understanding the root causes and implicates of these challenges essential for developing targeted interventions and fostering positive behavioral changes within the community **(Araujo-Soares et al., 2019)**

A significant barrier in promoting family welfare in Paschim Medinipur is the pervasive lack of accurate knowledge among mothers, children, and guardians. Many individuals are unaware of the importance of family planning, proper maternal and child health practices and available healthcare practices and services. Misinformation and misconception about contraception, reproductive health and nutrition, further exacerbate the knowledge gap, leading to suboptimal health seeking behaviours and

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decision making. Lack of information delivery to the grass root levels through joint effort govt. and non govt. sectors are another important cause for such poor KAP in this domain of the targeted geographical areas. (**Ameyaw et.al,2022**)
The prevalence of unhealthy practices related to family welfare underscores the urgent need for intervention in Paschim Medinipur. Limited access to health-care services, financial constraints, and cultural barriers contribute to practices such as home births without skilled attendants inadequate immunisation coverage, and poor nutrition for mothers and children. These practices are not only jeopardize individual health but also perpetuate intergenerational cycles of poverty and ill health within the community. Literature support that community participation is one of the important tools for improving KAP in family welfare. This dimension is not so remarkable in this study area. (**Lassi.et.al,2016)**
Negative attitude towards family welfare, including family planning and maternal healthcare pose formidable challenges in Paschim Midnapore. Deep seated cultural beliefs, social norms, and gender disparities often influence attitudes the stigmatize discussion about reproductive health and discourage seeking timely medical care. These attitudes perpetuate harmful practices such as early marriage, low contraceptive use and inadequate prenatal care, contributing to preventable maternal and child mortality and morbidity. Periodic awareness deliberation for improving knowledge, attitude, and practice in family welfare domain is also mandatory which is not so noted in the concerned area**.**

Conclusion

In conclusion, addressing the challenges of inadequate knowledge, poor attitudes, and unhealthy practices in family welfare among mothers, children, and guardians in Paschim Midnapore requires a concerted effort from multiple stakeholders. By prioritizing education, behavior change communication, access to healthcare, and women's empowerment, it is possible to foster positive changes in KAP and improve health outcomes in the community.

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Volume 28 June 2022
Indian Journal of Biological Sciences
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