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A Descriptive Study to Identify the High Risk Families in Terms of Health and Assess their Coping Strategies in a Selected Community of Kashmir

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Abstract

It is well known that the course of family life is not always smooth. The present study is a descriptive study to identify the high risk families in terms of health and assess their coping strategies in a selected community of Kashmir. *Objectives*: To identify the high risk families in terms of health in a selected community, to assess the coping strategies of the families and to establish relationship between coping strategies and risk status of families. *Methods:* Descriptive cross sectional survey design was adopted with a sample of 100 families. The data was collected through systematic random sampling. A structured interview schedule on internal and external environment for identifying high risk families, Aggarwal, O.P. et al, a standardized tool for identifying socio-economic status of the families, Rating scale for assessing coping strategies of families and Pro forma for Anthropometric observation and haemoglobin estimation for identifying obesity, malnutrition and anaemia was used. *Result:* The findings revealed that 38% of the families were high risk and 62% were in the category of low risk. Majority of the families i.e., 83% had adequate coping strategies and 17% of families had inadequate coping strategies. There was a significant relationship between risk status of families and their coping strategies as obtained by Chi-square at 0.05 level of significance.

Keywords: Malnutrition; Anaemia; Haemoglobin Estimation; Obesity.

Introduction

Success in family life comes from avoiding difficulties or problems, but rather facing them squarely and coping with them effectively.

According to Pedro [1] "Opportunity is embedded in the potential for the growth and positive changes that promote resilience and healthy outcomes for the family members. Family structure, functions and values are experiencing unprecedented changes throughout the world. The impact of globalization, urbanization, migration and social transformation are among the contributing factors for these changes.

As discussed by Carson and Chowdhary [2] Indian families need become better informed on how they can be more effective in handling internal problems and confronting external demands or changes.

Hence, families need to have a new deal that ensures their economic and social security, general health and wellbeing.

World Health Organization [3] reported that low income populations are most affected by risks associated with poverty, such as under nutrition, unsafe sex, unsafe water, poor sanitation and hygiene and indoor smoke from solid fuels; these are the so called "traditional risks". As life expectancies increase and the major causes of death and disability shift to the chronic and non-communicable, populations are increasingly facing modern risks due to physical inactivity; overweight and obesity and other diet related factors; and tobacco and alcohol related risks. As a result, many low and middle income countries now face a growing burden from the modern risks to health, while still fighting an

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unfinished battle with the traditional risks to health and impact of these modern risks varies at different levels of socio economic development.

Understanding the role of these risk factors is important for developing clear and effective strategies for improving global health.

According to WHO [4] violence against women is present in every country, cutting across boundaries of culture, class, education, income, ethnicity and age. Studies estimate that worldwide between 20 and 50% of women have experienced physical violence at the hands of an intimate partner or family members.

Domestic violence is a complex problem and there is no one strategy that will work in all situations. To begin with, violence may take place within very different societal contexts and the degree to which it is sanctioned by a community will naturally influence the kind of strategy needed. Considering the interconnections between the factors responsible for domestic violence, gender dynamics of power, culture and economics strategies and interventions should be designed within a comprehensive and integrated framework.

According to Park [5], poverty is the most obvious problem in India. There is almost one third of population below poverty line which is at highest risk of communicable and non communicable diseases resulting in heavy mortality. The foremost reasons for poverty in India are perceived as lack of employment schemes, lack of land possession, undernourishment, lack of housing and lack of education.

Park [5] stated that malnutrition is the most widespread condition affecting the health of children. Scarcity of suitable foods, lack of purchasing power of family as well as traditional beliefs and taboos about what the baby should eat, often lead to an insufficient balanced diet, resulting in malnutrition. At present in India 65% children less than 5 years of age are under weight.

Stanhope and Lanacaster [6] stated that alcohol is the oldest and most widely used psychoactive drug in the world. Alcohol abuse ranks third following coronary diseases and cancer as the major cause of death in the United States.

According to World Health Organisation [7], Iron is critically important in muscle, brain and red blood cells. Iron deficiency may occur at any age if diets are based on staple foods with little meat, or people are exposed to infections that cause blood loss; young children and women of child bearing age are most commonly and severely affected. An estimated 41% of pregnant women and 27% of preschool children worldwide have anaemia caused by iron deficiency.

Thus keeping this in mind the present study was designed with the following objectives:

- To identify the high risk families in terms of health in a selected community.
- To assess the coping strategies of the families.
- To establish relationship between coping strategies and risk status of families.

Materials and Method

Research design adopted for the study was crosssectional survey research design.

Variables of the study are:

1. Socio-economic status
2. Family organisation
3. Family environment
4. Child health status
5. Adult health status
6. External environment, socio political environment
7. Anthropometric measurement
8. Hb estimation
9. Coping strategies within the families.

Setting of the Study

The present study was conducted in H- 16, Sangam vihar (Pilot study) and families residing in the urban resettlement, Boat colony of Bemina, Kashmir (Final study).

Population

In the present study, population comprised of families residing in the urban resettlement, Boat colony of Bemina, Kashmir.

Sample Size

Total sample size was 100.

Sampling Technique

In the present study the sampling technique adopted was Systematic Random sampling technique.

Data Collection Tools and Techniques

In the present study, the researcher developed and used a structured interview schedule.

Structured Interview Schedule

It was divided into four parts:

Part-I consisted of 22 items related to the Socio economic status for the family.

Part-II consisted of 40 items related to External and Internal Environmental risk assessment scale.

Part-III consists of 3 items related to Anthropometric observation and haemoglobin estimation.

Part-IV is related to Rating scale to assess their coping strategies.

The structured interview schedule was translated into Kashmiri language.

Ethical Considerations

Ethical permission to conduct the study was taken from Institution Review Board Jamia Hamdard.

Analysis of the Data

The data was tabulated in Microsoft Excel Spread sheet and the analysis was done using descriptive and inferential statistics and Chi-square test. The level of significance was kept at 0.05 level.

Results

The findings were organized under the following sections:

Section-I: Findings Related to Frequency and Percentage Distribution of Subjects by their Socio-Economic Status.

Majority of the families i.e. 91% of families had poor social status. None of them belonged to upper high, high, upper middle and below poverty line (Table-1).

Table1: Frequency and Percentage Distribution of Socio Economic Status among Families **n = 100**

Socio- economic status	Frequency / Percentage
Lower middle	9
Poor	91

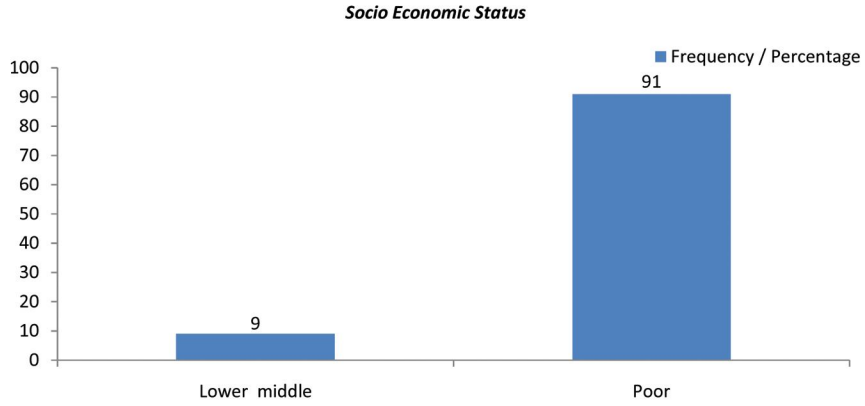

Fig. 1: A Bar diagram showing the percentage distribution of families by their socio economic status

Section-II: This Section Describes the Findings Related to Internal and External Family Environment.

Majority of the families i.e. 76% had occasional fights within their families, 13% had congenial relationship and 11% had fights that resolved easily. Majority of women i.e. 76% had congenial relationship with their in laws, 23% with occasional fights and 1% had fights that resolved easily. All families had only one working spouse. Majority of the families i.e. 77% responded that they sometimes spend free time with each other, 21% said most of the times and 2% very rarely. Data also reveals that 48% had very rare punitive discipline, 48% families sometimes used punitive discipline and 4% families had no punitive discipline within their families. Maximium number of families i.e. 62% sometimes had meal together, 36% very rarely and 2% had most of the times. Majority of the family heads i.e. 70% did not involve family members in decision making, 26% involved them rarely and only 4% involved them sometimes in decision making. 93% of the family members were not abused physically, 3% were abused rarely and 4% were abused only sometimes (Table 2a).

Table 2a: Frequency and percentage distribution of the families according to their family environment

S. No	Items on family environment	Frequency/ Percentage
1.	Relationship with family	
	a) Congenial	13
	b) With occasional fights	76
	c) At times fights but resolves easily	11
2.	Relationship with in laws	
	a) Congenial	76
	b) With occasional fights	23
	c) At times fights but resolves easily	01
3.	Working status of the spouses	
	a) Only one working parent	100
4.	Family members spending free time with each other	
	a) Most of the times	21
	b) Sometimes	77
	c) Rarely	02
5.	Punitive discipline in the family	
	a) Never	04
	b) Rare	48
	c) Sometimes	48
	d) Most of the times	-
6.	Having meals together	
	a) Most of the times	02
	b) Sometimes	62
	c) Rarely	36
7.	Head of the family involves other family members in decision making	
	a) Sometimes	04
	b) Rarely	26
	c) Never	70
8.	Family members being abused physically	
	a) Never	93
	b) Rarely	03
	c) Sometimes	04

Table 2b: Frequency and distribution of the families according to their external environment

S. No	Items of External Environment	Frequency / Percentage
1.	Type of house	
	a) Pucca with 2 rooms or more, kitchen & bathroom	85
	b) Semi pucca with 2 rooms, kitchen & bathroom	02
	c) Pucca with 2 rooms, no kitchen, no bathroom	10
	d) Kacha with one room, no kitchen, no bathroom	03
2.	Kind of ventilation in the house	
	a) Two windows in room	06
	b) One window in a room	93
	c) No window, only a door	01
3.	Kind of drinking water in family	
	a) Boiled / chlorinated water	18
	b) Untreated tap water	82
4.	Kind of latrine in the house	
	Service type	100
5.	Disposal of refuse	
	Open space	100
6.	Kind of drainage system in the house	
	Closed inside and open outside	100
7.	Having rodents and arthropods in the house	
	a) none of the above	03
	b) One of them is present	43
	c) Two of them is present	54

Among 100 families, 85% had pucca house with 2 rooms or more, kitchen and bathroom, 2% semi pucca with 2 rooms, kitchen and bathroom, 10% pucca with 2 rooms, no kitchen, no bathroom and 3% had kacha with one room, no kitchen and no bathroom. 6% families had 2 windows in a room, 93% had one window in a room and 1% had no window, only a door. Majority of families i.e. 82% were drinking tap

water directly and 18% boiled water. All these families were disposing the wastes in an open space. All the families (100%) had closed inside and open outside drainage system. Majority of the families i.e. 54% had rodents and arthropods in their houses, 43% had only arthropods in their houses and 3% only had none of them present (Table 2b).

Section-III: This Section Describes the Sample Characteristics in Terms of Malnutrition, Obesity and Anaemia of the Family Members.

Among the population of 614, 1.46% of the children are malnourished, 4.56% are obsessed and 18.72% are anaemic (Table 3).

Table 3: Frequency and percentage distribution of anthropometric observation and haemoglobin estimation of the total population

S. No	Nutritional Status	Frequency	Percentage
1.	Malnutrition among children	09	1.46
2.	Obesity among adults	28	4.56
3.	Anaemia with Hb≤ 8 gm	115	18.72

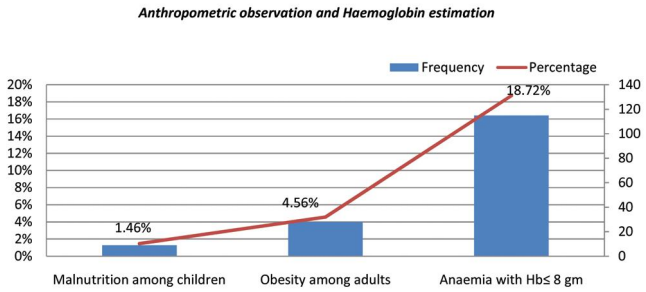

Fig. 3: A cylindrical diagram shows the frequency and percentage distribution of anthropometric observation and haemoglobin estimation of the total population

Table 4: Mean median and standard deviation of coping strategies scores of families

Variable	Minimum possible scores	Maximum possible scores	Range of obtained scores	Mean	Median	Standard deviation
Coping strategies	0	40	29-37	32.44	33	2.124

Table 5: Relationship between risk status of the families and their coping strategies by Chi-square

Selected variable	High risk	Low risk	X^2
Adequate coping	26	57	9.23
Inadequate coping	12	5	

X^2 (1) = 3.84, p d" 0.05, significant at 0.05 level.

Section- IV: This section describes the families according to their coping strategies, mean, median and standard deviation of coping strategies scores of families were computed for describing coping strategies of families.

This shows that the mean score of the coping strategies of high risk was found to be 32.44; median was 33 with the standard deviation 2.124. The close value of the mean and median indicates the distribution to be normal (Table-4).

Section-V: This section describes the findings related to relationship between risk status of families and their coping strategies

This shows that the Chi-square value is significant at 0.05 level. Therefore, it indicates a significant relationship between the risk status of families and coping strategies (Table 5).

Discussion

The present study dealt with the high risk families and their coping strategies in terms of health and findings revealed that only 38% of the families were high risk though their socio economic status was poor.

The findings revealed that the adult population was smokers. Individuals with no education are 2.69 times more likely to smoke and chew tobacco than those with post graduate education.

The external environment of the families was very poor. These families had outside open drainage system with service type of latrines. Therefore people living in this locality are more vulnerable to diseases. Hygiene practices were found to be bad in terms of water collection and storage. Sanitation facilities and practices were also poor with 88.3% of the population still relying on unimproved pit latrines and children less than 5 years defecating outside the latrines, whilst 10.7% of the population still uses the bush. Poor waste management was also found to be a recurring problem.

The study findings indicated that the majority of the families i.e. 63% were known cases of hypertension including adult females.

It was also found that the majority of the female adolescent girls were anaemic and also the female adults were obese. Obesity was not found in children.

The population among 100 families comprised of 614 which indicates family size of 6.1 which is much above the national average i.e. 2.6 according to the 2008.

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