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Prevalence and outcome of consanguineous marriage in selected community area

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ABSTRACT

Objectives

To determine the prevalence of consanguineous marriage in our region. To identify the socio economic and demographic determinants of consanguineous marriage. To evaluate prevalence knowledge of couples of impact kind of this marriage.

Methodology

Quasi experiment method used to 100 samples for knowledge about prevalence of consanguineous marriage collected tools for demographic variables

Findings

60% knowledge for prevalence of consanguineous marriage

Keywords: Assess knowledge, Consanguineous marriage, Demographic variables.

INTRODUCTION

Community health nursing relies heavily on the systematic process of designing and delivering health services and nursing care to improve the health of the entire community. Community health nursing is a specialty in nursing. According to the **American Nursing Association** (ANA), public health nursing is the practice of promoting and protecting the health of populations using knowledge from nursing, social and public health sciences (Waldorf, 1999). The primary goal of community health nursing is to help a community

protect and preserve the health of its members, while the secondary goal is to promote self-care among individuals and families. In the health-care reform environment, the community health nurse will probably continue to care for individuals and families, particularly high-risk clients and those with communicable diseases. Community health nursing involves the identification of high-risk aggregates in the community, and the development of appropriate and workable policies and interventions to ensure accessible services for all groups of the population. Community-based

nursing covers nursing care provided to individuals are delivered by health care providers.

The **World Health Organization** defines health as “a state of complete physical, mental and social well being and not merely an absence of diseases or infirmity”. The maintenance and promotion of health is achieved through different combination of physical, mental, and social well being together something referred to the “health triangle”. Systematic activities to prevent or cure health problem good health in humans. The term community health nursing is synonymous with public health.

Consanguinity or marriage between a man and woman who are related by blood is a global health issue with a variety of distributions and occurrence rates around the world. Consanguineous marriage is defined by human geneticists as the unions of second cousins (fourth degree relatives) or closer relatives. It is recently estimated that 20% of human populations live in communities with a tendency toward endogamy and globally 8.5% of all children have consanguineous parents. The prevalence of consanguineous marriage varies widely between and within countries. Although consanguinity is declined dramatically in many of western communities is still prevalent in parts of Middle-East, and India.

Additionally there is a growing evidence that supports the association between parent’s consanguinity and complex, multi-factorial adult diseases in off-springs including Alzheimer’s disease, hypertension, cardio vascular disease, stroke, cancers, depression, asthma, gout, epilepsy, osteoporosis, and peptic ulcer . On the other hand consanguineous marriages are related to various social problems for families and the community including domestic violence and infertility in couples, and illicit drug abuse in children. In several studies different factors are detected as the predictors for consanguineous marriage such as socioeconomic status, educational level, location and size of the area, and people’s attitude. Better understanding of these factors can help us in implementation of appropriate interventions to prevent this health problem. Considering three main objectives

It is estimated that one billion of the current global population live in communities with a preference for consanguineous marriage (Bittles and Black 2010a; Modell and Darr 2002).

Consanguineous marriage is traditional and respected in most communities of North Africa, Middle East, India and West Asia, where intra-familial unions collectively account for 20–50+% of all marriages (Bittles 2011; Hamamy et al. 2011; Tadmouri et al. 2009) [Fig. 1]. Primary health care providers in communities with high consanguinity rates may be confronted by situations where they are asked to provide preconception counseling to consanguineous couples. In such countries and communities where cousin marriages are customary, many young couples nowadays present to health care providers seeking a scientifically sound answer to their questions including: “Will our children be physically or mentally abnormal?” “How can we minimize the risks for having affected children?” Reports have indicated that there may be inconsistencies in counseling for consanguinity among health care providers (Bennett et al. 1999). It is important that primary health care providers, specifically in highly consanguineous communities, have clear evidence-based guidelines in counseling a consanguineous couple to minimize their risks for having affected offspring. This review aims to portray the definition and current global trends of consanguinity, and propose simple guidelines for preconception counseling related to consanguinity based on published studies of health burden and social benefits of consanguinity. Such data could guide health care providers and help consanguineous couples take informed decisions regarding their reproductive choices.

MATERIAL AND METHOD

A sample of 60 were selected by convenient sampling techniques. The descriptive study was conducted during a one week period. Data collection was conducted in Nemam. After getting permission from the village panchayat. Self-structured questionnaire was used to collect data. The study investigators explained to the adults about the study’s objectives, rational and requirement of consent to participate in the study. The investigators then provided instructions for filling the questionnaire, and then guided the adults. Understanding of each question was checked by asking the adults to repeat the meaning. During the filling of questionnaires, the investigators helped throughout and helped

simplifying the meaning of each question, clarifying doubts and checking for completeness of filling up the questionnaire Chi-square test was used to test the association between categorical variables.

Ethical consideration

The project has been approved by ethics committee of the institution. Informed consent was obtained from participants before initiating the study.

- The tool consist of two groups: Group 1 and Group 2
- Section A: Part 1: Demographic variables.
- Part 2: Community variables

PART1: Demographic variables

Group 1: Demographic data which give baseline information obtained from patients such as age, sex, Education, Occupation, religion, residence, marital status, type of family and socio economic class.

PART 2: Community variable

Group 1:The clients of consanguineous marriage data which gives baseline information obtained from consanguineous marriage women such as :age of marriage, type of marriage, degree of consanguineous marriage ,history of LSCS, number of birth, history of congenital defeat, history of abortion, history of prolonged labour, history of infertility, reasons of preference, disorders, history of treatment of infertility .

Score interpretation

- Inadequate knowledge: 1-7
- Moderate knowledge: 8-14
- Adequate knowledge: 15-20

Procedure for data collection

Data collection was conducted at rural village after getting permission from the village head. The sample were collected by using purposive sampling, a total of 100 samples were selected included both married female, the self-administrated question was given and the knowledge was assessed.

RESULT

Frequency and percentage distribution of demographic variables of rural peoples at MAPEDU N=(100)

S.NO	DEMOGRAPHIC VARIABLES	FREQUENCY	PERCENTAGE
1.	AGE?		
	a) 18-25	42	42%
	b) 26-35	42	42%
	c) 36-45	16	16%
	d) 45 and above	-	-
2.	GENDER?		
	a) Male	-	-
	b) Female	100	100
3.	OCCUPATION		
	a) Not working	36	36%
	b) Cultivator and daily wages	31	31%
	c) Other workers	33	33%
4.	RELIGION		
	a) Hindu	34	34%
	b) Muslim	46	46%
	c) Christian	20	20%
	d) Others	-	-
5.	RESIDENCE		
	a) Rural	100	100%
	b) Urban	-	-
6.	MARITAL STATUS		
	a) Married	100	100%
	b) Unmarried	-	-
7.	SOCIO ECONOMIC CLASS		
	a) Middle class	37	37%

b) Lower class	43	43%
c) Upper class	20	20%

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