COMMUNITY SERVICE PROJECT

"A STUDY ON MALARIA DISEASE"

Submited in the partical fulfillment for BSc(CBZ) intership

(Batch 2022-23)

Submited by

SIRAGAM.ROHINI

(Reg No:- (720122205046)

BSc(CBZ). II-SEMISTER

Under the mentorship of

Dr. **S.APPALA NAIDU**

Lecturer in Zoology

Government Degree College

Bheemunipatnam

Visakhapatnam(Dist) 531163

SVLNS DEGREE COLLEGE

BHEEMUNIPATNAM

Dept of Zoology

Bheemili: 531163 , Visakhapatnam (Dist). Accredited with B grade by NAAC

CERTIFICATE

Certified that this project report titled **" A study on "Malaria Disease"** is the bonafide work of SIRAGAM ROSHINI **(Reg No:** (720122205046) who carried out the project work under my Supervision

Certified further, that to the best my knowledge the work reported here in does not from part of my any other project report or dissertation on the basics of which a degree or award was conferred on an earlier occasion on this or any orther candidate

Mentor

Dr. S.APPALANAIDU

Date: _____

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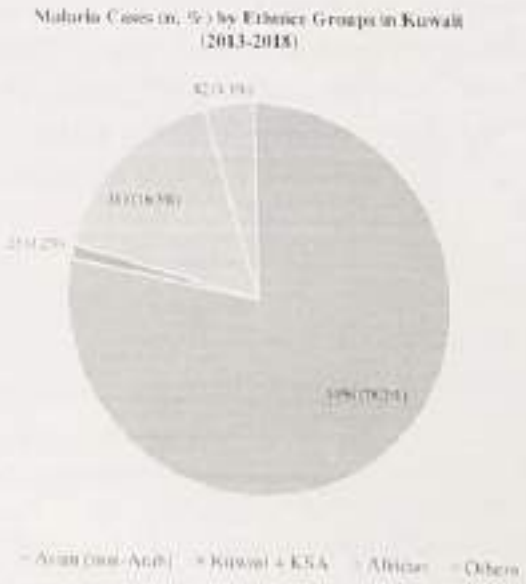
Introduction:

Malaria is a vector-borne infectious disease caused by protozoan parasites. Malaria is a very widespread disease in the tropics and subtropics regions of the world including Africa, South Asia, and South and Central America, affecting over 650 million people and killing 1 to 3 million. Over half affected and killed are young children in Sub-Saharan Africa. This disease is an enormous public-health problem because it only takes one bite by a mosquito infected with parasites that causes this infectious disease to become apart of a humans body. Malaria cannot be transmitted from one person to another by just standing next to them you have to have contact with them.

Population of Bheemunipatnam

Particulars	Density	Male Population	Female Population	Total Population
Rural	786 /sqkm	28,687	28,067	56,754
Urban	2,504 /sqkm	28,721	30,874	59,595
Total	1,212 /sqkm	57,408	58,941	1,16,349



Community Awareness Service

Expanding traditional medicine (TM) coverage in health care is a priority in Vietnam. Continuous medical education (CME) plays an important role in ensuring the quality of TM. However, evidence about TM CME in TM practitioners in Vietnam is insufficient. This paper aimed to evaluate the awareness, practice, and demands on TM CME among TM providers in district hospitals of Vietnam. This cross-sectional descriptive study was performed at the district level at TM hospitals and TM departments of general hospitals in Thanh Hoa Province. Demographic characteristics, awareness, practice, and demand for TM CME were collected via face-to-face interviews. Descriptive statistics and multivariable logistic regression models were applied to examine the factors associated with awareness, practice, and demand for TM CME. The majority of the respondents had ever heard of TM CME (87.5%). Only 60% received TM training in the last five years. Most respondents had a demand for CME (86.8%). The non-Kinh ethnic group (OR = 0.2, 95% CI: 0.1–0.8) and people who had a temporary contract (OR = 0.2, 95% CI: 0.1–0.7) were less likely to be ever heard about TM CME. Higher levels of education (college, OR = 14.1, 95% CI = 1.0–195.9; undergraduate, OR = 9.1, 95% CI = 1.9–44.6) are more likely to be ever heard of TM CME than the vocational training group. Those who regularly update their knowledge are more likely to have heard about TM CME (OR = 7.7, 95% CI = 2.8–21.7) and are more likely to have demands on TM CME (OR = 3.7, 95% CI = 1.2–11.5). Those who had heard about TM CME were more likely to take these courses in the last five years (OR = 6.9, 95% CI = 2.5–18.8). However, this result was the opposite for people with more years of experience (OR = 0.9, 95% CI: 0.8–0.9). There were limited awareness and participation in TM CME but was a high need for CME among TM providers at district hospitals in Vietnam. Promoting lifelong learning and providing promptly supports would be potential to increase the TM CME demands and participation among TM providers.

Traditional medicine (TM) has been encouraged to develop and become increasingly popular worldwide [1–3]. In many countries, such as India, China, and many other parts of Asia, TM can be concerned as folk medicine or alternative medicine [4]. TM practitioners may have undergone formal training or have accumulated only folk experiences or inherit heirloom remedies. Consequently, there is no uniformity in qualifications among TM practitioners. According to the World Health Organization (WHO), a large proportion of TM practitioners have low educational levels [5]. In addition, many TM workers received inadequate training for their practices [6]. Since using natural herbs has many potential risks associated with adverse reactions or drug interactions [7, 8], TM practice cannot solely rely on the traditional experience or beliefs [9]. Therefore, all of TM workers, including those who had undergone formal training, also need to update their knowledge or undergo additional intensive training regularly.

Recommendations

The regulation and registration of traditional medicines (TM) continues to present challenges to many countries regardless of the fact that an increased number of the population utilises TM for their health care needs. There have been improvements in the legal and policy framework of South Africa based on the WHO guidelines. However, there are currently no guidelines or framework for the registration of TM in South Africa. This article reviews literature and existing guidelines of specific countries and regions and makes recommendations for South African guidelines.

Traditional medicines (TM) and plant-based remedies are widely used in Africa. It has been estimated that 80% of the African population relies on traditional forms of medicine to meet their healthcare needs (World Health Organisation (WHO), 2004). Worldwide the trend has also shifted towards the use of TM due to concerns about the costs, invasiveness and potential for toxicity of conventional mainstream remedies (Cowan, 1999). Most of these TM are not well-researched, poorly regulated, may contain adulterated products, and may produce adverse effects (Mills et al., 2005). Traditional medicines are defined as the sum total of knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in prevention, diagnosis, improvement or treatment of physical or mental illnesses (WHO, 2001). Over the last fifteen years the safety and efficacy of TM, as well as quality control, have become important concerns for both health authorities and the public (WHO, 2005).

Conclusion

Approximately one-third of adults in the United States use complementary and alternative medicine (CAM) yet less than 40 percent disclose such use to their physician and other health care providers. Women are more likely than men to use CAM therapies; use appears to increase as education level increases; use patterns vary by race, depending on the type of CAM therapy considered; and those who use CAM generally use more than one CAM modality and do so in combination with conventional medical care (Barnes et al., 2004; Eisenberg et al., 1998; MacLennan et al., 2002; Ni et al., 2002; Wolsko et al., 2002; Wootton and Sparber, 2001). Some forms of CAM are being incorporated into services provided by hospitals, covered by health maintenance organizations; delivered in conventional medical practitioners' offices, and taught in medical, nursing, and other health professions schools. Insurance coverage of CAM therapies is increasing and integrative medicine centers and clinics are being established.

What do patients and health professionals need to know to make good decisions about the use of health care interventions, including CAM? Of primary importance is determining that they are safe and effective. Cost-benefit and cost-effectiveness may be important to both the individual and to society. In this report, the committee has recommended that the same principles and standards of evidence of treatment effectiveness apply to all treatments, with the understanding that certain characteristics of some CAMs and some conventional medical interventions make it difficult or impossible to conduct standard randomized controlled trials. For these therapies, innovative methods of evaluation are needed as are measures and standards for the generation and interpretation of evidence.

The committee believes that it is necessary and desirable to use a variety of study designs to research CAM therapies. Given the limited funding, the committee suggests that the following criteria be used when considering the CAM therapies to be selected for testing. No intervention will meet *all* criteria, and a therapy should not be excluded from consideration because it does not meet any one particular criterion, for example, biological plausibility.

Ideally, potential new treatments go through a series of scientific challenges that, if met, lead to acceptance of the test or treatment and integration into clinical practice. Many CAM therapies and many conventional medical therapies, however, are already in widespread use without such validation. The committee therefore concluded that, in addition to research aimed at determining efficacy and uncovering mechanisms of action, research aimed at investigating what is occurring in practice (that is, effectiveness) is also needed. This report proposes that such research be conducted within a research framework with four major components: practice-based research networks, a sentinel surveillance system, CAM research centers, and input from national surveys.

S.V.L.N.S. GOVERNMENT DEGREE COLLEGE
BHEEMUNIPATNAM- VISAKHAPATNAM

Community Service Project Survey Questionnaire

Respondent Number	1		

PART A: SOCIO-ECONOMIC AND DEMOGRAPHIC PROFILE

Village Name.. Beemili (Village)

House No/Flat No..... 7-72

Name of the Respondent: Paila. Ravindhra

Address: Beemili (Village) Beemuni patanam (Mandalam)
Visakhapatanam (Dist) - Andhrapradesh (State)

1. Sex: ✓ Male Female

2. Age (in completedyears) 60 years

3. Religion: HINDU **4. Cast:** B.C.D **5. Sub Caste** Yaadav

6. Do you have a Phone:

✓ 1. Yes. 2. No

If yes, Number:

7. Do you have a Mobile:

✓ 1. Yes. 2. No

If yes, Number:

8. Do you have transport?

❑ 1. Car 2.Jeep 3.Tractor

❑ 4. Bullock Cart ✓ 5. None

Average consumption of fuel per month .....

9. Education of the respondent:
Instruction: *TICK ONLY ONE*

❑ 1. Illiterate
❑ 2. Literate but no formal education
❑ 3. School up to 5 years (Class1-5)
❑ 4. School up to 6-9 years (Class 6-9)
❑ 5. SSC/HSC

10. Occupation of the respondent
Instruction: *TICK ONLY ONE*

❑ 1. Farmer
✓ 2. Wage labourer
❑ 3. Skilled worker
❑ 4. Petty Trader(shop keeper)
❑ 5. Self employed

❑ 6. Under Graduate
❑ 7. Graduate /Post Graduate (General)
❑ 8. Professional (Doctor, Engg. LLB,MBA)
❑ 9 Technical (Diploma/IT)
❑ 10 Others (Specify) _____

❑ 6. Service – Government
❑ 7. Service Private
❑ 8. Homemaker
❑ 9. Student
❑ 10. Retired
❑ 11. Unemployed
❑ 12. Others

11. Does the respondent's house have electricity? ***Instruction: OBSERVE AND WRITE***

1. Yes. 2.No

Average units consumed per month .....

12. Type of House

Instruction: OBSERVE AND TICK ONE

❑ 1. Hut
❑ 2. Semi Pucca
❑ 3. Pucca
❑ 4. Apartment
☑ 5. Independent house/Bungalow

13. Where do you get your Drinking Water?

Instruction: TICK ONLY ONE

☑ 1. Tap in the House
❑ 2. Common Tap
❑ 3. Hand pump / Bore well
❑ 4. Well
❑ 5. Tank/ Pond
❑ 6. Others: (specify):_____

14. What type of cooking fuel do you use

Instruction: TICK AS MANY AS APPLICABLE

☑ 1. LPG/Gas
❑ 2. Kerosene
❑ 3. Firewood
❑ 4. Gobar gas/bio fuels
❑ 5. Others: Specify:_____

No of cylinders consumed per year .....

15. What toilet arrangements do you have?

Instruction: TICK ONLY ONE

❑ 1. Private (in your own house)
❑ 2. Common (shared by others)
❑ 3. Open fields
❑ 4. Others: Specify:_____

16. Are there any persons with disabilities in the house?

Instruction: ***TICK ONLY ONE***

1. Yes. 2.No ✓

17. If yes, state nature of disability:

❑ 1.Visual
❑ 2.Speech

18. Currently are you member of a Self Help Group?

Instruction: TICK ONLY ONE

1. Yes. 2.No ✓

If yes indicate name:

Activity:

Is the group holding regular meeting:

1. Yes. 2.No ✓

Does the group have a Bank Account:

1. Yes. 2.No ✓

19. Currently are you a member of any social group, association etc? ***Instruction: TICK ONLY ONE***

1. Yes. 2.No ✓

If yes indicate name:

20. Indicate your economic status
Instruction: TICK ONLY ONE

- ❑ 1. BPL
- ❑ 2. APL
- ❑ 3. Red Card

21. Electrical appliances owned by the Household
Instruction: TICK AS APPLICABLE

- ❑ 1.Television Old/LCD/LED
- ❑ 2. Music player
- ❑ 3. Electric Mixer/Grinder/Food Processor
- ❑ 5. Air cooler
- ❑ 6. Washing Machine
- ❑ 7.Computer
- ❑ 9. Air conditioner
- ❑ 10. Refrigerator
- ❑ 11. Geyser
- ❑ 12. Fans number ....
- ❑ 13. Tube light LED/CFL/Incandescent Numbers .....
- ❑ Iron box
- ❑ Setup box/DTH
- ❑ Whether the appliances star rated Yes/No
- ❑ Any other.....

22.Family members

S No	Name of the family member	Relation with head	Age	Education qualification	Occupation	Blood Group
	Paila, Rudra	Husband	60		wage labour	'AB' positive
	Paila, Kumari	Duaghter	30		Housewife	'B' negitive
	paila, Rajesh	Son	25		shop keeper	'O' positive
	Paila, Bindu	daughter	18		Reading	'A' positive
	paila, Sindhuja	daughter	15		Reading	'AB positive

23. Name five most pressing problems faced by your community?
(Indicate *area and issue: e.g. Health, Epidemic, Environment, Pollution, Education, Drainage, Roads, Electricity, drinking water, sanitation, service delivery of Government Programmes etc*)

	Area	Issue
1.	Reddipatnam	NO
2.		
3.		
4.		

5.	

24. Property/ Land owned ..... (Area in Sq feets)
Agriculture land ....nil....
Crop cultivated .....nil.

PART – B

Village Profile:

Area Population: Beemunipatanam

District: Visakha Patanam

State: Andhra pradesh

Any other Information :

25. **Which of the following are there in the survey area: Provide a brief description, indicatingnumber, type etc.**

A) Anganwadi / Play School: ✓

B) Primary Schools:

C) Secondary Schools:

D) Colleges: ✓

E) Health Centre (PHC/CHC) :

F) Hospitals:

G) Youth clubs:

H) Sports clubs:

I) Environment clubs:

J) Village Knowledge Centre/Common Multi Media Centre/Common Service Centre:

K) Krishi Vigyan Kendra:

Name of the investigator: S. Roshini

Date:

Name of the supervisor: S. Ankel.

Date: