Chapter – VII

CONCLUSIONS AND SUGGESTIONS

7.1 FINDINGS

7.2 SUGGESTIONS
Basing on the analysis made in the previous chapters, the following are conclusions have been drawn.

7.1 FINDINGS

1. As per the analysis statistical data, it is found that majority of the sampled pregnant women, husbands of the respondent women and the other members in the families of the respondent wish to have female child, which is a welcoming revolutionary change in the human attitude towards girl children. However, it is observed that majority of the respondents have felt, to have a female child is economic burden, besides orthodox traditional outlook.

Husbands of the majority of the respondent pregnant women were desired for sons since they felt that to have a girl child is a financial burden. Yet, they do not have any hard negative attitude. It is to be noted that the other members in the families of respondent women have negative attitude towards girl children. It is due to (perhaps) their orthodox traditional customs.

It is evidently observed that the respondents of all the categories feel that to have female child is overburdened with financial troubles.

2. Regarding the attitudes of the members of the families of the respondent pregnant woman, it is found that even though majority of them want to have female child, it is mere out of their heart's wish desire. It is also found still there is a remarkable percentage of them do not want girl children since they feel it as
financial burden. Moreover, they have desire for a boy and more over they are superstitious to follow blind traditional customs.

3. Regarding the Balika Samrakshana Programme, it is observed from the responses of the medical staff concerned, that this programme is not being implemented properly. As it is observed, it is due to improper grant of funds from the government. It is further found that the amount worth Rs.5,000/- under this programme is not being got deposited immediately after the female child is born due to lack of funds. And so the people below poverty line are not getting benefitted from this programme.

It is surprising to find that about two-thirds of the respondents even do not know about Balika Samrakshana Programme. Further, it is found that only 4 of the respondents have got benefitted from this programme.

4. It is miserable to find that most of the respondents about 90 per cent are not aware of the Bhagyasri Samruddhi Yojana Scheme. Among the respondents who are aware of this programme do not know even about the details of monetary benefit afforded under this programme. Further, it is a surprise to note that no respondent has secured monetary benefit under this programme.

5. Regarding the Rajarajeswari Samruddhi Yojana Programme (Scheme), it is found from the responses of the respondent pregnant women, that about one-fourths are unaware of this scheme. More than 93 per cent, the respondents who are aware of this programme do not know about the details of monetary benefit
that is being afforded under this programme. And it is clearly observed that no respondent family or no respondent member has got registered under this programme.

6. Regarding Kishore Balika Scheme, it is found that about 86 per cent of the respondents do not know about this programme and only 14 per cent of the sample know about the measures of health care propagated through this programme but only 10 per cent respondents have got benefited from this programme.

7. Regarding 'Adolescent Girl Programme', it is found that two-thirds of the respondents are aware of the programme. They got benefit from this programme by getting iron folic tablets. Among these respondent, about 80 per cent were received the tablets twice and each time have received 130 tablets pack.

8. With regard to Bridge School, it is striking to notice from the data that only a negligible 5 per cent of the respondents who are aware of Adolescent Girl Programme also know about this school. Further, it is observed from the responses of these 21 respondents, that Bridge School is very useful to adolescent girls. But they felt that the time schedule of school is not convenient and the teachers are not punctual.

9. With regard to Integrated Child Development Services, it is found that about 72 per cent of the respondents know about this ICDS Project and the remaining are unaware of this programme. Among these unawared respondents, majority of
them are the natives of Telangana region followed by Andhra and Rayalaseema regions. From this, it is clear that this programme is being implemented properly and effectively. Further, it is observed that the medical staff members are discharging their duties sincerely by paying visits to the houses of the respondents regularly.

10. As per the responses of the respondent medical staff regarding the ICDS project, it is found that ICDS project provides satisfactory service to the children and they have expressed complete satisfaction for the service they render under this programme.

11. It is observed that the most important factor that change the attitude of a women to bear a girl child is her level of education and her husband’s education and financial status of the family. Women with high academic degrees and having substantially good financial status prefer to bear a girl child.

12. Women at lower age groups are willing to have girl child while women in higher age groups are not interested to have a girl child.

13. The impact of religion on the desire have a girl child has less importance. Husband’s occupation is found to be the last but one factor which influencing the attitude of reproductive women to bear a girl child.

14. The willingness or desire of family members to have a girl child is affected by the education of the couple and the income of the family, their age and nature of the
relation of respondent with her husband. In this case caste and religion factor is playing somewhat a better role than the wealth factor.

15. It is observed that awareness or lack of awareness regarding various Government Programmes are influenced by caste and religion. Wealth factor and relation factors are following the caste and religion factor.

16. The nature of the relationship of the respondent with the head of household emerged are of the important factors for caring the health of reproductive women and girl child.

17. The wealth factor occupied the last place which means this factor has very less influence on this group of women who were not aware of implementation of integrated child services program.

7.2 SUGGESTIONS

1. The study understood that the schemes implemented by the Government need to reach the targeted population and there should be proper and clear propaganda about the scheme/programme. Hence, it is suggested that while launching the programme a provision must be made in the funds allocated for the purpose for necessary propaganda.

2. The study also could understand that the officials and others who are responsible in propagating and implementing the programme are not taking whole hearted commitment in making the programme a success. In this connection it may be
suggested that before launching the scheme it is necessary to motivate the persons who involved in propagation and implementation, in such a way that they first of all convince themselves about the importance of the programme. Hence, it is suggested to conduct motivation and training programmes at different levels in such a way that they are given full information regarding the programme/scheme to be launched. Further, such training programmes should start at least 6 months to 1 year before the actual implementation of this scheme.

3. A general enquiry reveals, for example the pre-schools run by Anganwadi Centres, do not have that infrastructure necessary to improve the nutritional and psychological status of the children. This is very much clear from the fact that most of the respondents even though are aware of the provisions are not willing send their children to these Anganwadi Centres. Hence, it is suggested that full scale infrastructure facilities must be provided even before launching the programme. Also there must be continuous supply of consumables required in the programme.

4. It is found that the medicines and materials supplied by the Government are not reaching the targeted people for whom they are intended due to insufficient staff. So medicines and materials are through in the garbage due to expiry. Hence, it is suggested that the Government should initiate necessary steps that will ensure that the medicines and materials should reach the people for whom it was supplied.
5. Encouraging the medical staff for rendering best services to the people at micro level is needed. Hence, it may be suggested that incentives to the best workers, awards and rewards for best workers etc., will encourage the staff efficiency and productivity so that they will render optimum service to the best satisfaction of all and ultimately work for the success of implemented programme.

6. In the socio-economic sphere, there is a need to argue for an increased access to social, economic facilities — provision of better housing, quality health care, education, employment, economic independence of women, childcare facilities and community development projects etc., which may ultimately lead for removal of gender disparities.

7. A vast network of rural health institutions have been developed. Rapid expansion has, however, resulted in a considerable drop in the quality of functioning of health institutions. For several reasons, the quality of services and work done by various health institutions and by different categories of health personnel are poor, resulting in low credibility among the rural community. Moreover, for want of quality, the efficiency and effectiveness of the programmes and services has been limited and the objectives not fully realised. This is one of the main causes of non-utilisation and or under utilisation of health services and facilities by the people, especially the rural communities. Hence, a single window structure need for development of health facilities to girl children.
8. Organisation of health services has become complex, centralised and insensitive to the varying health felt-needs of the rural community. It is suggested that organisational set-up of health services needs reorganisation. While the health organization has grown tremendously in the past five decades, functionally the structure has not changed with the dynamic and divergent demands of effective health management. The middle-level management is weak because of the low status accorded to training in public health, epidemiology and health management and inadequate decentralisation of authority and resources allocation. The most important problem is the maldistribution of the health manpower/health human resources, both geographically and category-wise. Both technical knowledge and skills and motivation to serve the rural people fall short of requirements and expectations.

9. Equitable distribution of rural health care services for ensuring equity for health care should be ensured by the government. Location of health services and facilities should be such that these are easily accessible and available to the rural community. Greater importance is laid to the introduction of Multipurpose Workers’ (MPWs) Scheme and the Integrated Child Development Services (ICDS) which have brought a new ray of hope to the rural community.