CHAPTER - 7

SUMMARY AND CONCLUSION

7.1 Profile of the Population
7.2 Birth Related Practices
7.3 Knowledge and acceptance of T.T. Vaccing and Iron and Folic Tablets for Pregnant Women.
7.4 Immunization of Children
7.5 KAP regarding Family Planning
7.6 Tribal transformation and acceptance of MCH and Health Seeking Behaviour.
7.7 Recommendations
Summary and Conclusions

Non-acceptance of health services, particularly of preventive services like MCH and health seeking behaviour has been emerged as very significant problem particularly in developing countries like India and underdeveloped, backward countries. As discussed in Chapter one that organisations like WHO and social scientist M.E. Khan has raised their serious concern over this issue and need of microlevel studies have been emphasised by them considering the diversified socio-cultural background of different communities.

The present study is on the different aspects which reflect in practices in accepting the MCH and health seeking behaviour among the Kol population of Panagar block of Jabalpur district. The study is based on 200 household which are spread over 10 villages in Panagar block of Jabalpur district covering a population of 1230 persons, for in-depth study of various aspects of MCH 70 case has been studied. The data has been analysed on household characteristics, population characteristics, birth related practice sociocultural correlates of MCH, health seeking behaviour and transformation in sixth chapter. Summary of the main findings :-
7.1 PROFILE OF THE POPULATION:

The study of population profile indicated 44.5 percent the surveyed households are nuclear. About 67 percent houses are Kuccha type. Only 8.5 percent households have land of 5 acres or less, and 66.5 percent households are landless. About 47.5 percent of the households have annual income between Rs. 6401-11000. The average size of the household is 6.1 persons.

About 66 percent of Kol households are engaged in labour work as the main occupation. Literacy level among the households is very low (20.5 percent) in which majority (12.5 percent) of the literate households are educated up to primary level.

Regarding the martial status of the households among Kol, 89 percent are married and other 11 percent fall in the category of unmarried, separated, widower etc. The average age of marriage among the households of Kol Tribe is 13.71 years.

Almost to 52 percent households electricity is available and 48 percent households are using kerosine lamp as source of light. Among the surveyed households only 10 percent avail the drainage facility. Only 8.5 percent of the households have the proper defecation facility that is, Latrine blocks. Majority of the households fall in the age group of 30-34 years. Regarding the number of rooms in a house about 48.5 percent of the households have 2 rooms. Regarding water availability only 58 percent of the population has access to the hand pumps.
From the population characteristics it is observed that, the percentage of population in the age of 15-59 years, which is called working group population, was 54.39 percent in which 56.53 percent are males and 52.32 percent are females. The sex ratio is more in young age group (1137.9) which is higher than elder age group (1096.8). The overall dependency ratio dependent population (0-14 and 60+ years) to the working population (15-59 years) is 83.9 percent. The index of ageing is very low 13.2 percent and high young dependency ratio also suggests high mortality and high fertility levels prevailing in the population, from the population characteristics it is observed that mean age at marriage for males and females is 16.03 years and 14.9 years, respectively.

Only 14 percent of the Kol population is literate and 7.72 percent of population is educated upto primary level. Majority of population is illiterate 85.93 percent and illiteracy is more (40.40 percent) among the females. Among the working population it is observed that 30.41 percent is occupied by Labour as a main occupation, in which 51.46 percent males and 51.38 percent females belonging to 15-59 years of age are engaged in Labour works.

7.2 BIRTH RELATED PRACTICES:

Occurrence of pregnancy and birth is taken as a natural and common event and a wish of God. When the menstrual period is delayed by a month or so the woman identify herself as being pregnant. There is no change in the status of woman during pregnancy and she continue to do her daily routine work. Pregnant woman take the same food which is taken by other family members. No special diet is given during pregnancy, but a few food items are avoided during pregnancy.
No special care is given during the prenatal period. Only 14.3 percent pregnant woman received ante natal care during the pregnancy period. Pregnant woman is not permitted to see the eclipse, it is believed that it may harm the child in the womb.

About 22.8 percent pregnant women avoid consuming Tomato, Beans, Urad dal, Brinjal and vegetables, which are considered to be causing cold, and stale food particularly during the 8th month of pregnancy. These food items are considered to be harmful for the pregnant women, which can affect the health.

During pregnancy period Kol women do all kinds of work i.e. household as well as out side work. Only 5.7 percent women stopped doing certain physical activities like bringing fire wood from forest, fetching water from distant places for 15-20 days before delivery.

No special preparation is done for delivery. Delivery is conducted in a separate room away from kitchen and holy places. When women is experiencing labour pains, she is given hot tea without milk. Delivery is conducted by untrained dai. Only 12.9 percent women told that at the time of delivery they took help from trained dais. Delivery is conducted in sitting position, delivery occurs easily and with reduced pain. After delivery the naval cord is cut by new blade (55.7%), old blade (30.0%), sickle (12.9%), Axe (1.4%). After cutting the naval cord mustard oil (74.3%) is applied. Haldi (15.7%) is also applied in some case.

After delivery, the new born baby is given bath by warm water and soap (if available), after that baby is massaged with mustard oil. The mother
is also given bath with warm water and soap (if available) and mustard oil is applied and she is exposed to the Ajwain fumes which give warmth to the mother. Mother breast feed the child after 3 days of delivery (90.0%) and 87.1 percent mother discard colostrum, they have the concept that the colostrum is very heavy and it is difficult to the infant to digest it.

After delivery mother is given Harrira to drink after one or two hours of delivery Harrira is a special liquid diet prepared for mother after delivery. Harrira is prepared from Jaggery, Haldi, Ghee, Saunth, Kali mirch and Ajwain. Mother is given Haldi and Kudai (a kind of millet) Rice, Maize, Chilli, Masur, Urad and Sour foods are restricted to eat for about one month after delivery.

Women start doing all her routine work after 6th day (chatti ceremony). The supplementary food is given (37.1%) to the child from 6th month onward.

While studying the relation of socio-cultural characteristics with birth related practices prevailing in Kol tribe, it is found that pregnant women who receive the ante natal care varies according to literacy of husband. It is 45.5 percent in literate husband and 8.5 percent in illiterate husbands. Rest during the pregnancy time of women on the basis of family income is 31.4 % in <Rs. 5000 and 42.9 percent in Rs.5000 +. In income group of < Rs. 5000 the delivery care and preparation for delivery is 22.9% and it is 40 % in case of income group of Rs.5000 +. Colostrum is discarded by mother is very high in case of illiterate husbands i.e. 96.6 and in literate it is 54.5 percent. Bathing child with soap and massage with mustard oil practice is high among nuclear family (44.4 %) and it is 29.4 percent among joint family.
7.3 KNOWLEDGE AND ACCEPTANCE OF T.T. VACCINE AND IRON FOLIC TABLETS FOR PREGNANT WOMEN.

Knowledge and advantages of T.T. Vaccine was low in study population. But the knowledge and advantages of iron and folic tablets is higher as compared to T.T. Vaccine. For example only 32.9 percent had knowledge of advantages of T.T. Vaccine and it is 67.1 percent in regard to iron and folic tablets. Thus majority of the people are not aware about the advantageous aspects of the vaccines. It reflects that there is high level of ignorance among the study population.

The analysis indicates that the literacy of husband regarding knowledge of T.T. and iron tablets is higher among literate husbands as compared to illiterate husbands. This shows positive association of advantages of vaccine and iron tablets with knowledge.

It is observed that there is low acceptance of T.T. Vaccine and iron and folic acid tablets. The required number of doses taken for T.T. Vaccine was 31.4 percent and for iron and folic tablets it was only 8.6 percent. The acceptability is very low than acceptance of in M.P. and India. Strictly speaking if we consider acceptance irrespective of required number of doses than acceptance for both T.T. Vaccine and iron tablet in study area was almost equal of Madhya Pradesh.

Ignorance and misconception have been emerged as major causes for the low intake of T.T. Vaccine and iron, folic tablets. As it has been observed that those mothers who are aware about advantages of MCH care majority of them have taken vaccine and tablets. Knowledge about number of
doses to be taken is absent which is likely to be responsible for low intake of T.T. Vaccine and iron tablets. This indicates positive association of knowledge with acceptance.

Observation on socio-cultural characteristics revealed that in case of literacy of husband there is positive association with acceptance of T.T. Vaccine (63.6 %) and iron tablet (27.3%) but type of family have not shown any positive association with the acceptance for T.T. Vaccine but in case of iron and folic tablet it is higher among the nuclear family. In income group of Rs.5000+ the acceptance of iron and folic tablet is high 17.1 percent.

7.4 IMMUNIZATION OF CHILDREN:

It is observed that the overall immunization status was poor among the children for all the vaccines i.e.B.C.G., D.P.T. and Polio. Coverage of Polio vaccine was comparatively higher than the other 44.9 percent children received polio vaccine irrespective of the number of doses. Higher awareness about Polio vaccine is due to special campaign for polio vaccination carried out in the area.

It is worth mentioning that majority of the population is ready to get their children immunised. But the Government has not prepared solid background because people are not aware about real benefits for vaccination which discourages to the people towards immunization. People do not have clear and correct perception of immunization.

The low awareness and ignorance leads to different attitude towards immunization of children in the population studied. This is very well reflected in low and irregular acceptance of these vaccines. The percentage of
children immunised with B.C.G., D.P.T. and Polio vaccines was 15.6, 23.9 and 44.9 respectively (irrespective of dose schedule). Those who have required number of doses the percentage goes down to very low level.

The acceptance of immunization for the children is higher among the literate father. This shows a very high association with the acceptance of these vaccines.

Higher acceptance of these vaccines is observed among the children belonging to joint households as compared to the children of nuclear households.

Acceptance of immunization for the children is higher in the income group of Rs.<5000 for B.C.G., D.P.T. and Polio as compared to the income group of Rs. 5000+.

7.5 KAP REGARDING FAMILY PLANNING:

While studying the knowledge about family planning about 48.6 percent respondents were aware about family planning.

Knowledge regarding permanent methods of family planning is high. It is 44.3 percent in which 12.9 percent respondents mentioned vasectomy and 5.7 percent reported about tubectomy, and knowledge regarding both VT and TT collectively reported about 25.7 percent as permanent methods. But knowledge of temporary methods is very low 4.3 percent.

The case studies have revealed some negative factors which have bearing on the acceptance of family planning, such as fear of death due to
operation, desire for more children, lack of proper motivation, vasectomy makes
the man physically weak, fear of death of children and son preference.

Adoption of family planning is very low (14.3%). About 11.4
couples have adopted permanent methods of family planning in which 10 percent
adopted vasectomy and 1.4 percent adopted Tubectomy. It is only 2.9 percent
reported use of temporary methods. Actually speaking it is very low in regard to
percentage of acceptors in M.P. (27.1 %).

Among the Kols the concept of family planning, only 30 percent
respondents said family planning means "small family". And 18.6 percents
respondents expressed that it is Harmful to health.

In regarding to the Adoption of the family planning there is
lack of proper motivation to the couples. The number of couples motivated by
Health workers is very less, it is 14.3 percent. And majority of decision regarding
the practice of family planning methods are taken by husbands and wife (10%).

In general they have favourable attitude towards family planning
but they have some reservations and fear about methods of family planning
which definitely influence acceptance of family planning. So proper knowledge
and motivation should be given by the health workers. Health workers should
clear the misconceptions regarding methods of family planning.
7.6 TRIBAL TRANSFORMATION AND ACCEPTANCE OF MCH AND HEALTH SEEKING BEHAVIOUR.

The study on tribal transformation that the distance of village from the P.H.C. has been a strong factor for acceptance of MCH and health seeking behaviour. Tribal transformation and distance from P.H.C. is inversely associated with the acceptance, that is acceptance of MCH and other aspects of health seeking behaviour increases as the distance decreases.

Regarding the Antenatal care, it is observed that food avoided during the course of pregnancy varies from distance nearer to the P.H.C. and far from the P.H.C. Regarding the physical activities like fetching the water, doing straineous works etc. are more characterised in the villages away from the P.H.C. (91.4%) where as in villages near from the P.H.C. it is 85.7 percent.

It may be pointed out that the preparation for delivery is done in the villages near to the P.H.C. is 40 percent and for distant villages the percent of preparation for delivery is less 17.1, just half of the former. This shows that the knowledge and practice regarding delivery and related aspect is less among the villages which are situated away from the P.H.C. and do not avail health services properly.

It is observed that cleaning and bathing of new born baby with soap it is 45.7 percent in villages near the P.H.C. and it is 28.6 percent in villages away from P.H.C. This shows the lack of awareness about hygienic among the population which are residing away from the P.H.C. And it is seen that maximum of the respondents away from the P.H.C. simply clean the new born child with only warm water (71.4 %).
Majority of population irrespective of distance from P.H.C. discard colostrum as they have the concept that colostrum is very heavy so that a new born baby will not digest it. That's why breast feeding, in Kolis starts after 3 days, before the cow milk is given to the new born baby.

Regarding the immunization status of children, there is less difference in knowledge and acceptance. Actually their is lack of knowledge regarding Vaccination of children. Only in Polio the acceptance is high in comparison to B.C.G. and D.P.T. because of Government schemes.

Maternal and child health services in regard to distance is very important. The health worker visit villages regularly which are near to the P.H.C. (88.6 %) and the visit of health worker’s percent decreases with increases in the distance from the P.H.C. As the village is not easily approachable and when the health workers reaches the village, the maximum population is gone for their occupational jobs.

Children are immunised (42.9 %) in the villages near to P.H.C. and the percent (22.9 %) is half of the former as it is far from the P.H.C. In regard to the iron and folic tablets also the situation is same.

When some complication arises for pregnant women as P.H.C. is near they can easily approach but still percent is less and in case of villages away from the P.H.C. it is negligible (2.9 %). Actually Kol tribe believes in Gunia's and in traditional system.

In context to family planning the percent is very less who practices these methods. But it is even very less among the respondents away from P.H.C.
7.6 HEALTH SEEKING BEHAVIOUR AMONG THE KOLS:

Amongst the Kol tribes health seeking behaviour is quite far from the satisfactory level. The modern scientific means available are still to reach them and whatever available at block level is yet to be fully accepted by the majority. Still they believe in old traditional methods of "Gunias and Tantriks". That is if a dog bites a person, they would prefer to go to Gunia rather than nearby P.H.C. So is the in event of diseased, pregnant women or delivery cases. The reasons for such health seeking behaviour is lack of wide publicity and non provision of sufficient number of P.H.C. in the area of approachability. Provision for sufficient P.H.C. with adequate facilities will definitely improve the health seeking behaviour of the tribes.

The figure represents the complex nature of MCH and Health seeking behaviour and the factors influencing acceptance. The Pictorial representation explain in brief as to How the number of factors affect MCH and Health seeking behaviour, it will be clear from the figure that the unfavourable factors or illiteracy, financial status, tribal environment i.e. belief traditional values & customs affecting the acceptance of the modern practices. Also one of the significance factor is PHC, non-availability of the PHC services and the approachable distance. It also brings out that poor network of the mass media is also responsible to great extent is extension to modern facilities and practices in the remote corners.

In the figure remedial measures have been suggested to improve the acceptance of MCH and Health seeking behaviour. The utmost measure shown in intensive educational programme for males and females, and intensive health education programme for all. Role of mass media is also very important to make the people aware of the modern facility available and their better effects.
Fig.: MCH and Health Seeking Behaviour with reference to Socio-Cultural Environment and Remedial measures
And the most important point regarding MCH is that trained Birth attendants should perform the delivery work. When the delivery is perform by untrained dais and with no child immunization, it may results in infection to the mother, child and further deterioration of health. To achieve better MCH practices firstly, for untrained dais a minimum training programme should be planned and executed. Secondly, PHC services are to be improved drastically by providing PHC in such a manner that every village within 5 kms is covered.

7.7 RECOMMENDATIONS:

On the basis of the study it is observed that the Kol tribe still are using traditional methods number of irrational beliefs and unscientific practices in case of MCH and health seeking behaviour. Due to such practices the infant mortality is quite high. Inspite of the different programmes regarding MCH & Health seeking behaviour by the government, the tribes at a remote distance are deprived of basic MCH care and facilities. On the basis of field observations following recommendation are made:

1. All out efforts should be made to cover all villages by PHC centres with approachable distance so that the population take the benefit of the Government medical schemes. Acceptability and availability go together this has been observed and conformed in case of polio vaccine programme. It has been quite popular because of easy approachability.

2. An evaluation should be chalked out to register the pregnant women and adequate arrangements be planned to provide ANC, PNC and natal services a check list should be kept to see that registration and the services planned are done as required.
3. Medical camps should be organised at least weekly at a convenient place where villages and health personnel can have interaction. The occasion can also be utilised for immunization of children and registration of pregnant women.

4. Majority of deliveries are still being conducted by untrained dais in the villages. These untrained dais should be given short term training regarding Birth related practices and should be provided kit & iron, folic tablets. They should be taken as linked person between the mother and Health officials.

5. More stress should be given to improve literacy among females particularly among the young females to make them able receive and understand on MCH services;

6. Network of radio/television is very effective media to disseminate information should be strengthened in remote areas. This will definitely improve the acceptability of MCH & Health seeking behaviour.

7. Some sort of monitoring system of the on going MCH and health seeking programme should be evolved to see efficacy and to modify as required.