CHAPTER – 6
FINDINGS AND CONCLUSION

The findings of the health status of rural households reveal the following facts. The possession of high level health status occupies the first position among the selected respondents in the study area; possession of low health status, the second; and possession of medium health status, the last. In general respondents of Nerkunam village and Mambakkam village have relatively high level health status, indicating their physical, mental and social well being consequent upon good socio-economic condition. The low health status is quite common among the respondents of Kalathur village and Athur villages, due to low socio-economic status.

It is observed that rural households from the highest income group mainly have high health status, consequent upon taking adequate nutrition and health care practices. In general, rural respondents from the low income group have low health status. This is due to taking inadequate nutrition and inadequate health care practices. The low income rural respondents have low capacity to make use of available health care facilities and services in their rural areas and they have low user fee paying capacity in utilizing the health care services.

It could be seen from the result of the study that rural government employee respondents occupy the first position with respect to possession of high health status. This is due to their educational status and income status. In general, rural labour groups’ respondents have low health status consequent upon low level education and low level income. The rural labour group respondents have less health awareness and
they are not in a position to utilize the available health services and health facilities from the government schemes.

The result of education wise analysis reveals the following facts. Degree level and secondary level educated respondents have high health status. Educational attainment enables them to undertake better health care practices; usually educated rural people have more household income and this status enables them to take required nutrition and medicine towards their health care practices. In general, illiterate rural and primary level educated rural respondents have low health status consequent upon lack of awareness about health care practices. Usually they belong to the poor households; so, they are not able to take the required nutrition and health care practices.

The findings of anthropometric measurement of rural households reveal the following facts. One fifth of the rural respondents have a height of below 145 cm. They are considerably found in Kalathur village, Athur village and Annangal village. In this study, an average body mass index is estimated at 21.08 and it is supposed to be the national average. The body mass index is quite low among the rural respondents of Kalathur village, Athur village and Annangal village. This is due to low physical growth consequent upon under-nutrition. In general, high body mass index of above 20kgm$^2$ is quite common among the rural respondents of Nerkunam village, Mambakkam village and Kalpattu village, indicating better status of physical growth.
It is observed from the result of the study that the average height of low income group rural respondents is quite low and it is quite high among the high income group rural respondents. It could be noted that the body mass index of low income group rural respondents is below the national average and it is considerably above the national average among the high income group rural respondents. The body mass index depends on physical growth consequent upon taking balanced nutrition. In general low income group rural respondents consume less nutrition, which results in low growth of body mass index. The high income group rural respondents consume adequate nutrition and it results in better growth of body mass index.

It could be seen from the results of the study that the average height of rural labour group respondents is quite low and it is quite high among the rural government employee group respondents. It could be noted that the body mass index of rural labour group respondents is below the national average and it is considerably above the national average among the other groups of rural respondents. In general rural labour group respondents are poor and they are under-nourished. So, they have less physical growth and ultimately low body mass index. In general rural respondents of other groups have considerably better nutrition consequent upon economic status and it enables them to have body mass index of above national average.

The result of education wise analysis shows that average height of rural illiterate group respondents is quite low and it is quite high among the educated group respondents. It could be noted that body mass index of illiterate group rural respondents is below the national average and it is considerably above the national average among the other groups of rural respondents. In general rural illiterate
respondents are poor and they are undernourished. So, they have less physical growth and ultimately low body mass index. In general rural respondents of other groups have considerably better nutrition consequent upon economic status and it enables them to have body mass index of above national average.

The findings of rural households’ child immunization behaviour indicate the following facts. Most of the respondents have given BCG immunization during the six weeks timing after the birth of their children. It could be noted that 79 per cent of the respondents have given first dose of DPT immunization during the time of six weeks after birth of their children and it has shown mild decline during the second dose and third doses of DPT immunization during the tenth week and fourteenth week after the birth of their children respectively. In this, study about 79 per cent of the respondents have given oral polio vaccine on time of six weeks after the birth of their children and polio vaccine given level has declined in second dose and third dose in the prescribed time of tenth week and fourteenth week after the birth of their children respectively. The hepatitis ‘B’ immunization has been given by majority of the respondents during the first two stages and it has declined during the third stage. More than half of the respondents have given measles immunization with vitamin A during the time of ninth month after birth of their children and they have also given DPT booster immunization with vitamin A and Oral Polio vaccine with vitamin-A during the 16-24 months after birth of their children.

The result of income wise analysis shows that lowest income group respondents lag behind others regarding immunization of their children on time. It
could be observed that rural labour group respondents lag behind others with respect to provision of all immunization to their children in the right time.

The findings of rural households’ child treatment behaviour indicate the following facts. The respondents have given first order priority of admitting their children in hospital during the time of severe fever, cold, dysentery and diarrhea; the second; they admit their children in hospitals when they suffer from chest pain and difficulty in breathing and lastly they admit children in hospital, during excessive sleepiness and convulsions timings.

It could be observed that high income group rural respondents admit their children in hospital during the time of severe fever, cold, dysentery and diarrhea and low income group rural respondents mainly admit their children in hospital during the time of difficulty in breathing and chest pain. It could be noted that rural government employee group respondents and rural private employee group respondents admit their children in hospital during the time of severe fever, cold and dysentery.

The result of education wise analysis shows that rural respondents with high educational attainment admit their children in hospital during the time of severe fever, cold, dysentery and diarrhea and illiterate group rural respondents admit their children in hospital only during the time of difficulty in breathing and chest pain.

The findings of child nutrition during the time of dysentery and diarrhea indicate the following facts. It could be noted that 50 per cent reduction in dosage of food given to the respondents’ children during the time of dysentery and diarrhea ranks the first order; 75 per cent reduction in dosage of food given to the respondents’
children during the time of dysentery and diarrhea, the second; regular dosage of food given to the respondents’ children during the time of dysentery and diarrhea the third; and 25 per cent reduction in dosage of food given to the respondents’ children during the time of dysentery and diarrhea, the last.

The findings of income wise analysis show that high income group rural respondents have given 50 per cent reduction in dosage of food to their children during the time of dysentery and diarrhea. In general regular dosage of food given is considerably found among the low income group rural respondents. It could be observed that rural government employee group respondents and rural private employee group respondents have given 50 per cent reduction in dosage of food to their children during the time of dysentery and diarrhea. In general regular dosage of food given is considerably found among the rural labour group respondents.

The result of education wise analysis shows that degree level educated rural respondents and secondary level educated rural respondents have given 50 per cent reduction in dosage of food to their children during the time of dysentery and diarrhea. In general regular dosage of food given is considerably found among the illiterate group rural respondents.

The findings of household hygiene behaviour indicate the following facts. The proper removal of dust and debris from the households rank the first order sanitation practices among the rural households in the study area; safe disposal of infant excreta, the second; cleaning latrines and using sanitary latrines, the third; proper cleaning of house floor and wall, the fourth; proper washing and protection of utensils, the fifth;
and proper washing room and home environment, last. In general, majority of the rural households of Kalpattu village, Mambakkam village and Nerkunam village have the practice of cleaning and using latrines, safe disposal of infant excreta, proper washing and protection of utensils, proper washing room and home environment and proper removal dust and debris from the households.

It could be observed from the results that majority of the rural labour group respondents have no domestic sanitation practices such as cleaning latrines and using sanitary latrines, safe disposal of infant excreta, proper washing and protection of utensils, proper cleaning of house floor and wall, proper washing rooms and home environment and proper removal of dust and debris from the household. In general majority of the rural private employee group, farmers group and most of the government employee group respondents have all the domestic sanitation practices.

The result of education wise analysis shows that majority of the rural illiterate group respondents have no domestic sanitation practices such as cleaning latrines and using sanitary latrines, safe disposal of infant excreta, proper washing and protection of utensils, proper cleaning of house floor and wall, proper washing of rooms and home environment and proper removal of dust and debris from the household. In general majority of the private secondary level educated and higher secondary level educated rural respondents have all the domestic sanitation practices.

The result of income wise analysis reveals that majority of the rural lowest income respondents and also respondents in the income group Rs. 3001-6000 have no domestic sanitation practices such as cleaning latrines and using sanitary latrines, safe
disposal of infant excreta, proper washing and protection of utensils, proper cleaning of house floor and wall, proper washing of rooms and home environment and proper removal of dust and debris from the household. In general majority of the high income rural respondents have all the domestic sanitation practices.

The findings of personal hygiene behaviour of rural households reveal the following facts. Taking fresh vegetables ranks the first order personal hygienic practices among the rural households in the study area; proper washing of cloth, the second; regular use of toilet soap, the third; washing hand before eating, the fourth; taking fresh food, the fifth; endorsing household members to follow healthy practices, the sixth; boiling water before drinking, the seventh; and proper protection of food from flies and insects the last. In general, majority of the respondents have not followed the practice of endorsing household members to follow healthy practices, boiling water before drinking and proper protection of food from flies and insects. Majority of the rural households of Kalathur village, Athur village, Annangal village and Kalpattu village follow all the personal hygienic practices in contrast to rural households of Mambakkam village and Nerkunam village.

It could be observed that rural government employee and private employee households mostly practice personal hygiene practices such as regular use of toilet soap, washing hands before eating, proper washing of their clothes, taking fresh food, taking fresh vegetables, boiling water before drinking, proper protection of food from flies and insects and endorsing household members to follow healthy practices. In general labour group respondents lag behind others in following all the hygienic practices.
The result of education wise analysis shows that secondary level and higher secondary level educated rural households practice personal hygiene practices such as regular use of toilet soap, washing hands before eating, proper washing of their clothes, taking fresh food, taking fresh vegetables, boiling water before drinking, proper protection of food from flies and insects and endorsing household members to follow healthy practices. In general illiterate group respondents lag behind others in following all the hygienic practices.

It is observed from the result of the study that highest income group respondents and respondents in the income group Rs.9001-12000 practice personal hygiene practices such as regular use of toilet soap, washing hands before eating, proper washing of their clothes, taking fresh food, taking fresh vegetables, boiling water before drinking, proper protection of food from flies and insects and endorsing household members to follow healthy practices. In general lowest income group respondents lag behind others in following all the hygienic practices.

It could be seen clearly from the above discussion that more than half of the rural households have personal hygiene problems such as head lice, problem of teeth and problem of dandruff. Majority of the rural households of Mambakkam village and Nerkunam village have personal hygiene problems like head lice, problem of teeth, problem of dandruff, problem of skin, problem of bad breath, problem of ear wax, problem of nails growth, and problem of feet hygiene.

It could be observed that more than two third of the rural labour households have all personal hygiene problems and majority of the farmer households have all
personal hygiene problems. In general, most of the rural government employee households and majority of the rural private employee households are free from personal hygiene problems.

It is observed from the education wise analysis that more than two third of the rural illiterate households have all personal hygiene problems. In general, most of the higher secondary level educated rural households and majority of the secondary level and primary level rural households are free from personal hygiene problems.

It could be seen clearly from the above discussion that more than two third of the lowest income rural households have all personal hygiene problems and majority of the farmer households have all personal hygiene problems. In general, most of the highest income group rural households and majority of the households with the income of Rs. 9001-12000 are free from personal hygiene problems.

It could be noted that rural households rate first order cause of diarrhea in terms of children consuming contaminated food; intrusion of evil spirit on the child body, the second; dirtiness and soil eating habit of children, the third; taking huge quantity of food, the fourth; and taking hot and cold food, the last. In general rural households of Kalpattu village, Mambakkam village and Nerkunam village believe that diarrhea is caused by intrusion of evil spirit in the child body.

It is observed that farmer respondents and government employee respondents feel that diarrhea is caused by taking contaminated food and labour households believe that it is caused by intrusion of evil spirits in the body of children.
It is seen from the result of education wise analysis that secondary level and higher secondary level educated respondents feel that diarrhea is caused by taking contaminated food and illiterate households believe that it is caused by intrusion of evil spirits in the body of the children.

It could be seen clearly from the above discussion that highest income group respondents and respondents in the income group Rs.9001-12000 feel that diarrhea is caused by taking contaminated food and households in the income group Rs. 3001-6000 believe that it is caused by intrusion of evil spirits in the body of children.

The findings of rural households’ place of health care seeking indicate the following facts. It could be noted that rural households’ always prefer primary health centers and government hospitals for seeking health care services and rank first as their choice, taking health care in private health centers the second; taking health care in Ayurvedic and Siddha hospitals, the third; sometimes taking health care in primary health centers and government hospitals, the fourth; and taking health care with the traditional spiritual man, the last. In general majority of the respondents of Kalathur village, Athur village and Annangal village take health care mostly in primary health centers and government hospitals.

It is observed that labour households take health care considerably from their traditional spiritual men and Ayurvedic and Siddha hospitals.

It is seen from the results of the study that illiterate and primary level educated rural households take health care considerably from their traditional spiritual men and/or from Ayurvedic and Siddha hospitals. It could be noted that lowest income group
and rural households in the income group Rs.3001-6000 take health care considerably from their traditional spiritual men and Ayurvedic and Siddha hospitals.

The findings of respondents’ health belief indicate the following facts. It could be noted that the respondent’s rate high level beliefs on occurrence of diseases with reference to spirit sent through witchcraft, super natural wrath, and displeasure of super natural elements, intrusion of spirit and low quality food. The respondents rate moderate level beliefs on occurrence of diseases with reference to anger of god, deficiency in food taken, excess manual power, breach of taboos, changes in weather, displeasure of family deity, drinking polluted water, inadequate immunization, non-fulfillment of obligations towards mahes and anathema. The respondents rate low level beliefs on occurrence of diseases with reference to lack of hygiene behaviour, eating old food, fate/ karma, influence of occultism and eating uncooked food.

It is observed from the result of the study that the illiterate respondents occupy the first position with respect to overall beliefs on occurrence of diseases. A similarly belief was held by the labour group and the lowest income group respondents.

The findings of common health problems among the rural households indicate the following facts. The rural households have common health problems relating to fever, malnutrition, dysentery, malaria, itching and diabetes. Some of the households have health problems of body swelling, chronic pain, jaundices, hysteria, syphilis and gonorrhea, leprosy, typhoid, scabies, measles and high blood pleasure. It could be noted that rural households of Mambakkam village and Nerkunam village have mostly common health problems of fever, chronic pain, malnutrition, dysentery, diabetes, itching, malaria, measles and high blood pleasure. In general, rural
households of Kalathur village and Athur village have fewer incidents of common rural diseases. It is observed that rural labour households are prone to many common diseases: following rural farmer households, rural private employee group, and rural government employee group.

It could be noted that rural illiterate households are prone to many common diseases followed by primary level educated households, the secondary level educated rural households, and higher secondary level educated rural households.

From the field observation it is also evident that in the all the villages the majority of the respondents have pointed out that the health inequalities can be narrowed down only by providing proper health education, creating awareness about healthy lifestyle practices and by improving the economic status of the rural population.

The income wise analysis reveals the lowest income rural households are prone to many common diseases; than others with higher income level. Thus from the results of the study it is clear that cultural practice of the rural community members have a distinct say on their health and health related issues. More significantly it is evident in terms of their belief about diseases and treatment procedures. The study results highlight how the health seeking behavior of the village community is influenced by their culture of the people of Kancheepuram District.