CHAPTER XIV

SOME OTHER FINDINGS AND GENERAL ANNOTATION ON THE STUDY

FINDINGS

As mentioned in the previous chapter there are some other findings observed in the data of this study. These findings did not have any direct influence on the data required for testing the hypotheses. Nevertheless these findings require to be mentioned. A very comprehensive discussion is not possible because in the absence of similar research work done in India, there are no terms of reference in relation to which a discussion can be expended.

These findings have been enumerated further along with the investigator's own remarks on the findings.

1) Accessibility (Table 3)

For 19 units out of the sample of 30 units i.e. 63.33% the major difficulty was accessibility to a central place like Wai where a special school existed. Either there was the problem of frequent and direct buses or there was the question of expenses to be incurred. In most villages the frequency of direct buses came to less than three per day. For two units from villages which had many frequent direct buses the monthly cost of transport averaged to Rs. 50 per month which is beyond the amount which a villager desires to afford for the sake of education.
2) Availability of referring agencies (Table 4)

Maximum number of referrals were sent by the local school teachers. Out of the referrals received from them 70% were incorrect referrals.

The first part of this statement may seem to indicate that the school teachers can be made good use of in locating mentally retarded individuals from various parts of rural regions. Unfortunately, amongst the teachers, the primary school teachers who are mostly employed by the Zilla Parishad already have additional assignments. Besides teaching in the school, they have to function as agents for registering cases for family-planning operations. Towards the end of the financial year of the government this work becomes the major-occupation of most of the Principals and senior teachers from the village primary schools. There is a pressure from their superiors to register cases for operation in order to complete the set target for the District.

Besides this additional work in remote areas the village teacher is also assigned the work of collecting and delivering mail and selling postal stationary. At the time of census work these teachers are expected to work as census assistants. The secondary schools teachers are employed mostly by private educational trusts and have their own set of responsibilities to complete.

The primary teachers does come in close contact with the children in the village hence if they are allowed to concentrate their full attention only on educational
activities for the children it will be possible for them to identify more children with mental retardation and probably at an early age.

The high portion of incorrect referrals indicates the need to give relevant information to the teachers. The syllabus of teachers' training programme do not include any lecture on mental retardation. Hence the teachers inadvertently referred even children with behaviour problems as those with mental retardation.

The volunteers of National Service Scheme sent a high number of referrals, 66% of which were incorrect referrals.

The youths from the National Service Scheme are indeed a good resource for spreading awareness and identifying mentally retarded individuals from the villages. As a college-going (studious) young man usually the volunteer receives a certain respect from the villagers. The volunteer too is enthusiastic to do his work because the National Service Scheme is an extra curricular activity of importance in terms of getting a job in future.

Of course it will be essential to provide such volunteers with some basic training which will enable them to detect the individuals more correctly. Thus they will economize their efforts, prevent the disappointment of those referred incorrectly and avoid being indiscriminate in referring even those who are not really mentally retarded.
The number of referrals received from General Practitioners was very low (9.52% of the total referrals). Only 33% of these were correct referrals.

Actually all these referrals were received from only one General Practitioner. This doctor himself had a child with a disability. The incorrect referrals sent by him were not incorrect because of the conditions but the age of the individuals referred was more.

It is difficult to establish why such a low number of referrals were received from the General Practitioners. On explanation given by a doctor himself is that their work in rural area is mainly directed towards curative treatment. Much of their high patient load demands quick symptomatic relief and the patients seldom contact the doctor again until another acute ailment forces them to. Thus the General Practitioners can hardly pay attention to the rehabilitation needs of the concerned patients.

The investigator also observes that during their training the doctors get very little information on mental retardation. Under the circumstances described in the previous paragraph they do not get the scope to develop their information regarding the rehabilitational needs and means to meet them.
3) Incidence of risk factors. (Table 11)

There is a markedly higher incidence of children having Biological factor as the reason for mental retardation.

This is a very important finding from the viewpoint of planning a prophylactic programme which will deter the incidence of children with mental retardation.

Biological risk factors are more preventible. Proper ante-natal care, good obstetric management and vigilant post-natal care can avoid the occurrence of Biological risk affecting development.

As the case-histories indicate in ease of thirteen out of fifteen children with Biological risk factors the occurrence of the risk could have got prevented.

Actually mental retardation caused by even Established and Environmental risk factors is preventible. But in rural health care services in India there is a paucity of sophisticated equipment and laboratory procedures to detect mental retardation ante-nataly. Hence mental retardation caused by Established risk factors is difficult to prevent. The incidence of mental retardation owing to Environmental factors, as indicated by the data, is very insignificant.

The Biological risk factors can surely be prevented in rural areas much the same way as it can be done in the urban areas. Preventing Biological risk factors
does not require much sophisticated equipment or scarcity available scheduled form of chemotherapy or major surgical intervention. It requires good clinical acumen and proper means for social education against general ignorance. A socially conscientious doctor can have both these requirements developed even when working in rural areas.

4) Incidence of Drop-out (Table 11.)

i) The mean age of fathers from DROP-OUT sample units is markedly higher than that of fathers from ALL units and also TRAINED units.

ii) The mean age of mothers from DROP-OUT sample units is higher than that of mothers from ALL units and also TRAINED units.

iii) The mean educational score of fathers from DROP-OUT sample units is markedly lower than that of fathers from ALL units and also TRAINED units.

iv) The mean educational score of mothers from DROP-OUT sample units is lower than that of mothers from ALL units and also TRAINED units.

v) The mean income of DROP-OUT sample units is markedly lower than that of ALL units and also TRAINED units.

vi) The mean number of children per family in the DROP-OUT sample units is higher than that in ALL units and also TRAINED units.

vii) Families forming the DROP-OUT sample units live predominantly as nuclear families.
Although factors such as age of father and mother, educational level of father and mother, income of the family, number of children in the family and type of families seem to have influence on the decision to participate in the programme, once having consented there is no further correlation observed between these factors and the performance of the parents.

5) Tendency for availing different means of cure

(Table 20A)

70% of the units had availed medical or surgical means of cure.

45% of the units had also availed para-medical means of cure.

30% of the units had availed occult (para-psychological) means of cure.

It should be noted that this information was collected after having built-up acquaintance and at the end of the study. Hence it can be considered as highly reliable.

It is indeed encouraging to note that the rural parents tend more to avail scientific means of cure than availing occult means.

THE STUDY

In general the study turned out to be a straight-forward one after the organization for conducting the research got established in accordance with the objectives laid down. It had ample opportunity to collect much relevant
and non-relevant data. While the relevant data assisted in examining all but one hypothesis, the non-relevant data assisted in acquiring interesting and pertinent information about the rural community.

The fact that there was no adequate opportunity to assist in examining hypothesis 5 is in a way a shortcoming of this study though not a major one.

Although the issue investigated was complex the method for investigating it had to be kept very simple. There was obviously a limitation on the design of research because either a large sample could be taken nor could the sample selected be divided into experimental and control group. Fortunately this proved to be helpful in eliminating some short-comings which Berkowitz had pointed out when reviewing other similar studies. It was possible to adequately control and measure the form of intervention. A follow up visit at the mean rate of one visit every third week could be made.

The tools utilized for assessing change in the child as well as in parents proved to be very useful. Yet it leaves the investigator with a feeling that besides these reliable and valid tools some tool either designed or adapted but standardised on Indian population should have been utilized to double-check the pre and post test levels. It is frustrating to realise that no such tool was available. It must be noted that the investigator did not favour the idea of utilizing
tests which measure Global Intelligence. Such tests are of course available.

Owing to the magnanimity of the volume of description required for giving all details of training, those have been condensed in this thesis. This is likely to leave the reader with an impression that the details of training are not given satisfactorily. This has happened not due to any design limitation but strictly due to space limitation.

Another point which is likely to draw some criticism is the duration of actual intervention. The total study took nearly five years out of which only nine months were used for actual intervention. Initially it was planned to do the intervention over one full year. But after the acquaintance with the region and community developed it became apparent that the three months of rainy season must get excluded from the period of intervention. The first reason for this is the difficulty encountered in using any form of road communication, which incidently is the only mode of communication available here, during the rainy season. Secondly this season is of great importance to the farming community. During this season the entire attention of the farmer is towards his farming. One farmer, while emphasizing the importance of rains to them told the investigator in a slightly exaggerated manner that if there occurs a death in a
farmer's house on the day when sowing is to be carried out the corpse is kept unattended until the farm chores are completed.

Thus it was no use visiting many of the samples during the three months of rainy season. The investigator now feels that it would have been perhaps interesting to note how the parents resume their work with the children once they become relatively free again after the rainy season.

The parents accepted the study very well. Their opinions about the study are given in Table 20 A.

REFERENCE