CHAPTER - VI

Findings & Conclusion :-

This is a sociological study. The study concerned with health behaviour, beliefs and practices and health culture in rural areas. It tries to see how far health related behaviours influenced by caste, community, economic level of family education and such other factors. Knowledge about the health services provided by primary health centre and its staff, understanding attitudes, beliefs and practices towards PHC. In the foregoing chapters the details about the nature of illness prevalent among people and health belief of people and also to study the nature and place of treatment.

The acceptance of people in rural areas of Maternity Child health care services and other health services provided by the PHC.

The main finding emerging from the analysis put together in this chapter.

Most sample families are native of the villages and since generations however few migrates (2.8%) were settled in the villages.

In the sample villages dominant caste is Patidar (Patel) 35.8% and Rajput/Thakor (31.3%). In Hadgud village dominant caste is Muslim (82.1%) and Raput/Thakor (15.7%). In Hadgud, Jitodia and Meghwa villages has no Brahmin community. In Mogari village 5.8% households from Brahmin community.
Napad village dominant caste is Patel (24.7%) and Christian (13.5%) And in Gana village out of 50 sample households 11 (22%) and 9 (5.3%) are from schedule caste.

The sample households all Brahmin (100%) were resided in Brahminvas. While Patidar (99.%) were resided in Patelvas, and all Thakor were resided in Thakorevas. Schedule caste households resided in Harijanvas, and Muslim households were resided in Muslim vas.

The sample house holds 26.2% has educational qualifications 7th standard completed 19.3% were S.S.C. passed, 14.3% HSC and 5.5% were degree holders. And only 2.7% having post graduate qualifications. Only 5.2% were illiterate. It indicates that head of the family in majority were literate.

In Sample families 1.8% are Brahmin out of them 9.1% are post graduate and 18.2% are graduate, 36.4% are HSC and 27.3% are S.S.C. and no illiterate in the community. In Patidar caste out of 215 (35.8%) respondents 12 (5.6%) are post graduate 27 (12.6%) are graduate and 54 (25.1%) are HSC and 52 (24.2%) are S.S.C. only 1 (0.5%) are illiterate in the community. Out of 45 (7.5%) respondents of lower caste 19 (42.2%) are illiterate.

It is observed that in Jitodia and Hadgud village no body is illiterate. It indicates that literacy level is high in high caste community and low in lower caste community. It was
also observed that low income group higher the illiteracy and high income illiteracy is low.

In sample families out of 14 (2.3%) respondents were illiterate, among them 7 (50%) were from poor income group 4 (28.6%) from middle income group 2 (14.3%) from higher middle group and only 1 (7.1%) respondents from higher income group.

It was observed that 42.8% respondents has no land and they were working as land less labourer in the farms of land food. In sample families 32% are having up to 5 acre land, 11.5% has 5-10 acre land and 11.5% has upto 15 acres land and 0.7% has above 25 acre land. Only 2.2% respondents are doing whitecollar job.

The majority sample families (60%) were medium sized (having 5-8 members in the family) 29.2% were small sized (upto 4 members in the family) and 15.5% were large sized families (more than 8 members in the family).

It was observed that majority of the families were nuclear type. 43.5% respondents were nuclear having husband wife and unmarried children in the household family.

It indicates that society is dynamic and high joint families are broken and nuclear families are increasing.

The sample families 67 (11.2%) joint families were low joint families and 91 (15.2%) families each were medium and high joint families. Compared to the total 600 households 11 (1.8%) respondents from Brahmin community. Out of them 6
(54.5%) were nuclear and 2 (18.2%) were joint family. It shows that in Brahmin community joint families were less and comparison to Patidar, Muslim and Rajput community. It is observed that higher joint families were divided in a small families. In Napad village 88 (51.8%) house holds were living in medium joint family and in Gana 40% house holds were living in medium joint family. 91 (15.2%) sample households were living in Navali village. In the comparison of other village in Jitodia 56.7% households were living in a small family.

Major occupation of the people in all the sample villages was agriculture farming. It was found that out of all the sample house holds only 7 (1.2%) households having 25 acre land and they were doing farming. Land is fertile and cash crop is produced, 14.8% house holds were middle farmers having 6 to 26 acres land for agriculture farming. 37.2% households were landless labourer and they were working as agriculture labours. Only 13 (2.2%) house holds were doing white collar job. And 43 (2.8%) households were doing Blue collar job also along with farming.

It was found that out of total sample house holds 42 (7%) respondents were living below poverty line i.e. Rs.3600/- and 234 (29%) house holds were found poor (Rs.3600-9000), 217 (36.2%) were found in middle income group (10000-25000) 76 (12.7%) were found in higher middle income group (26000-35000) and only 31 (5.2%) househols were found higher level (above Rs.35000 per year). In Navali village nobody were below
poverty line. While out of 170 (28.3%) sample households 19 (11.2%) were found in Napad village people were living below poverty line. 83 (48.8%) respondents were living in poor condition.

Out of 600 sample respondents 215 (35.8%) are from Patidar caste out of them 18 (8.4%) are living below poverty line. While 188 (31.3%) respondents from Thakor community out of them 108 (57.4%) are living below poverty line. 535 (5.8%) respondents are from schedule caste people out of them 18 (51.4%) are living below poverty line.

It was observed that in the villages houses are located in different residences are on the basis of caste system. Out of 600 respondents 335 (55.8%) having Pucca houses for residence 122 (20.3%) respondents having Kachcha houses and 89 (14.8%) were not having facility of electricity and water facilities, 32 (5.3%) respondents having facilities like pucca house with water and latrine facilities.

The Kachcha houses were made of both mud and bricks. Their living condition was not hygienic as their cattle were rared around their living houses. They were having safe drinking water facilities from water works – tanks – tape water. Stand post is available.

As shown above significant characteristics, socio-economic, educational and occupations condition of the households. I shall present health related aspects health beliefs, perception identified and utilisation of health programmes.
Except for education and caste health adoption is not predictable in terms of social status, economic position and leadership behaviour of the people. Educated people are more likely to adopt health practices than the less or uneducated ones. People of higher caste status are better adopters of health practices than others. The potentiality of adoption of health practices thus lies more among the educated and high caste people. Therefore, such persons may be contacted and persuaded initially for creating conducting atmosphere for health adoption as social acceptance is a strong motivating factor.

The sample families 30.8% has visited Primary Health Centre for treatment of fever and minor ailments. Only 1.2 percent respondents have visited near by Ayurvedic doctor and only 0.8% of sample families have visited private practitioners for treatment.

15.8 percent of sample families are in the opinion about the services of the PHC is satisfactory and they are getting good services at the time of emergency and deliveries and operation for family planning.

Generally no specifically dietary rules are observed during the early stages of pregnancy. People are aware that pregnant women need more nutritive food. Majority sample families (75%) have expressed their views that pregnant women need more nutritive and light food such as green leafy vegetables, dal, rice, chapati etc. It shows that awareness is
created through primary health centres staff.

It is encouraging to note that the people are protecting their children against six killer diseases. 92% sample families have expressed that their children are immunised against six killer diseases like Tuberculosis, BCG, Diptheria Pertuses & Tetanus – DPT, Polia and measles. So immunisation programme has impact among the people.

It is also observed that people are aware and knowing the importance of breast feeding. 79.7% respondents have expressed their views that up to the period of one year breastfeeding should be continue to their children.

Most of sample families (69%) have expressed their views that after six months of age of their children they are practicing weaning – by introducing of solid and semi solid food like khichadi, Milk, Dal, loof mashed vegetables etc.

The sample families 40.3% expressed their views about additional services like X-Ray facilities Anti-Rabic infection and Opthalmic services should be rendered by the PHC. So this is the felt need for additional facilities at the PHC is required.

It is observed that higher income group people are taking treatment from the private practitioners and low income group and low middle class people are taking treatment from the PHC.
It is observed that the tendency is to try home medication in the initial stages of illness in the poor and low income group of people.

It was observed that to be a common practice for relatives, friends, and neighbours to offer advice about where to go for treatment and also about home medication. But within the family the male, head of the family had the decisive say in seeking treatment for serious and chronic ailments of children. The mothers initiative was comparatively more through husbands approval was invariably secured.

Allopathic system of medicine was found to be the most popular. The preferred was Ayurvedic system. It was observed that people of lower economic status preferred more indigenous system of medicine than the medium and higher strata of population who indicated more preference for modern medicine.

Majority of sample families 96.8% have reported that safe drinking water is available from water works - tank through tapes. Only 12 (2%) respondents availing drinking water from wells.

A basic purpose of water supply improvement is to provide adequate quantity of safe water for human use, primarily for drinking. Almost 95% sample families are using tape water after filtration. And 3.2% respondents has reported that they are using tape water after disinfecting and most of the families had stored drinking water in clean
earthen/braso pitcher which were properly covered.

As for the disposal of the waste water was concerned, few soakage ots were constructed (1.2%) sample families has reported that they have constructed soakage pots for waste water. 67.3% sample families has reported that they are still disposing waste water in the lanes. As the quantity of the waste water has less as individual families were concerned they have no major problem of water logging in these villages.

In this study the author took on PHC Navali of Anand Taluka in Kaira District, as a case study and applied the KAP survey technique. For the purpose of study PHC village Navali, three sub centre, villages Jitodia, Gane, Napad and three villages nearby Navali PHC was selected. At present except 2 villages namely Vaskhilia and Meghwa all other villages having facilities of sub centres. It shown that health services are strengthen in these villages of Navali PHC area.

In the post study 77.7% respondents had knowledge about the services rendered by PHC. In Present study 98% respondents has knowledge about the various services rendered by PHC. It shows that knowledge about the services rendered by the PHC is increased among the people.
Suggested steps to mitigate short comings revealed by the study are as follows :-

1. Restoration of health - bridging the gap between provider and users - what is expected of and what impact PHC is actually making should be bridged - suitable steps both technical & administrative may be taken up.

2. Felt need of the community for the provision of medical aid to provide integrated health care, where curative services were envisaged to supplement preventive measures.

3. As regards, Common communicable diseases community must be weaned from reliance on medical aid - and 100% immunisation coverage of infants.

Administrative steps which merit consideration are :-

4 To enact a legislation for compulsory registration of professional trained village Dais.

5 To ensure that statutorily Medical Officer of PHC acts as Health officer of all villages.

6 Supervision should be strengthen sub centres and other activities of National Programme.

7. To make reasonable and separate budgetary provision for health education, Publicity and training programmes.
8. To provide, by various means, desirable rural living conditions in health centres for the medical and para medical staff.