CHAPTER VI

FINDINGS AND CONCLUSIONS
CHAPTER VI

FINDINGS AND CONCLUSIONS

The present study is carried out with a view to examine the influence of rural mother's value orientation in relation to children's ill health; and to examine the influence of socio-economic variables like type of family, size of family, caste and income etc. on the nutritional status of the pre-school rural children. More specifically the objectives of the study are as follows:

1. To examine the health status of the general population in the region under study with reference to mortality and morbidity trends;
2. To examine the socio-economic status of the pre-school rural children and their parents;
3. To understand the knowledge, awareness and practices of the rural mothers with regard to health care and ill health;
4. To examine the nutritional status of the pre-school rural children with reference to the degree and duration of malnutrition;
5. To analyse the relationship between social background variables, like age, sex, type of family, size of family, caste, income and age of the mother and nutritional status of the pre-school rural children; and
6. To examine morbidity status in relation to nutritional status of the rural pre-school children.

These objectives are pursued in four villages of Anantapur district in Andhra Pradesh. The four villages are Jayapuram, Cholasamudram, B. Pappuru and Duggumarri. A total of 70 mothers and their 83 children were contacted for collecting relevant information. Following is the account of major findings of the study.

FINDINGS:

1.1 Health care infrastructure-wise Anantapur district enjoys relatively better status in terms of number of health centres, number of beds available etc. It was found that for every lakh population 38 beds and 12 doctors are available. Similarly, there are 63 primary health centres and there are as many revenue mandals.

1.2 It was found that the infant mortality rate has been considerably reduced. The infant mortality
rate was 23.61 in 1981 which declined to 18.70 by 1985. Similarly, maternal mortality rate declined from 3.70 in 1981 to 1.64 by 1985. These two indicators reflect increasing better health care both in terms of infrastructure and the quality of services and there by relatively better health status. However this is marred by increase in birth rates which was 16.29 in 1981 and 18.06 in 1985.

1.3 The morbidity trends of Anantapur district population reveal vulnerability of the populace. It shows that the morbidity rate has increased from 4,772 in 1983 to 7,184 in 1987.

1.4 The district populace is affected more by such disease categories as infections and parasitic diseases; and diseases of respiratory system. A total of 44.75 per cent on an average over a period of 5 years were treated under these two categories.

1.5 Among the infections and parasitic diseases majority that is 57.41 per cent were found to be affected by intestinal infections.

1.6 An alarming rise was noticed with regard to venereal diseases which rose from 5 per cent in 1983 to that of 7.57 per cent in the year 1987. Similarly, Tuberculosis also has shown rising trends. Which rose
from 3.22 per cent in 1983 to that of 5.04 per cent in 1987.

1.7 The larger percentage of the patients suffered by the respiratory diseases are affected by such diseases as Bronchitis, Pluracy, Influenza and etc.

1.8 A substantial percentage of deaths, it was found occurred in the category of infections and parasitic diseases. Of the total deaths occurred during the period 1983 to 1987, 41.9 per cent deaths have been reported in this category. The next major reason was due to complications of pregnancy (12.69 per cent).

2.1 The villages under study were found to be devoid of infrastructure related to health and communication and are multi-caste villages.

2.2 The pre-school children under study represent scheduled caste and tribes (51.80 per cent); backward castes represent 39.75 per cent. 54.21 per cent are male children; 78.31 per cent of the children belong to nuclear families and 45.78 per cent of children belong to large sized families which comprise 6 and more members; 77.10 per cent of children's parents income is found to be less than ₹ 4,500 per annum.

2.3 57.14 per cent of households (mothers) are found to the landless and 19.99 per cent were observed
to be marginal and small farmers. Majority of the parents (both mother & father) are found to be involved in agricultural labour and the average annual income is Rs. 2,700.

2.4 The average age of the mothers is found to be 27.85 years. More than 50 per cent of the mothers experienced 2 to 4 conceptions only. Majority of the mothers were found to be illiterate.

3.1 It was noticed that overwhelming majority of mothers (90 per cent) believe that ill health is caused by fate. It was found that with regard to prevalence and commonness of illness among children mothers opinion was divided. It was noticed that a good majority of backward caste mothers (46.15 per cent) consider illness is common among children and they need not bother about it. 78.57 per cent of mothers do not have particular preference for seeking medical care.

3.2 It was noticed that situational constraints like lack of infrastructure, non-availability of qualified medicares continuously influence the mother's value orientation towards ill health. It was observed that mother's value orientation was diffused and affectively oriented.

3.3 The mother's awareness with regard to physical infrastructure like location of health centre is found
to be satisfactory. However, it was observed that their awareness with regard to services and para-medical staff personnel is poor. More than 40 per cent of mothers were not aware of the services and presence of Auxiliary nurse midwife, community health volunteer and dhai; 94 per cent of the mothers were not aware where immunization services can be obtained.

3.4 It was noticed that voluntary organizations are helpful in promoting better awareness, particularly among weaker sections.

3.5 None of the mothers, it was found, lack scientific health-practice knowledge with regard to treatment of basic common ailments like loosemotions and vomittings (Diarrhoea), cuts and burns and constipation etc. They also lack knowledge about balanced diet and immunization, particularly with regard to booster supplementation.

3.6 A high majority of mothers (72.86 per cent) leave their children at home when they leave for work. It was also found that a large percentage of mothers (38.57) leave their pre-school children under the care of their elder children; similarly, 24.28 per cent of mothers leave their children under the care of their parents-in-laws.
3.7 Despite the lack of knowledge and awareness it was noticed that 97.14 per cent of the mothers have immunized their children. This was due to the delivery of immunization services at the door step and due to the efforts of voluntary organizations working in these villages.

3.8 It was noticed that the mothers had scant regard for domestic hygiene and sanitation, a small percentage use mosquito nets to prevent malaria and Japanese encephalities.

3.9 The mothers were found to be primarily dependent on home remedies, village magic man's intervention. They seek a qualified medical care only when it is freely available or as a last resort.

4.1 Majority of the pre-school children under study (55.42 per cent) were found to be moderately malnourished and 18.07 per cent suffer with severe degree of malnutrition; none of the children, it was observed, nutritionally normal as per Gomez grading; age-wise severe degree of malnutrition was noticed in the 2+ years age group (26.66 per cent); moderate degree of malnutrition was found more in the case of 3+ years age group (82.75 per cent); and mild degree of malnutrition was noticed both in 2+ and 4+ years age group (46.66 and 45 per cent respectively).
4.2 Severe degree of malnutrition was noticed more in the case of girls (26.3 per cent) than boys. This situation is reverse in the case of moderate and mild forms of malnutrition.

4.3 With regard to 'Duration of malnutrition' a prepondering majority of the children (85.54 per cent) were found to be suffering with long duration malnutrition (stunted). The nutritional grading was done by adopting Waterlow's classification.

5.1 The relationship between age and malnutrition was found to be insignificant. Similarly sex difference, it was found, has no significant bearing on the nutritional status of the pre-school children.

5.2 Statistically significant association between type of family and the nutritional status is observed. It was found that the children of the joint families enjoy relatively better nutritional status than the children of nuclear families.

5.3 It was observed that there is a statistically significant relationship between size of family and the nutritional status. The test of significance revealed that the children of the large sized families enjoy relatively better nutritional status than the others.
5.4 It was found that nutritional status of the pre-school rural children is significantly dependent on their mother's age. Children belonging to older mothers (more than 30 years age) are found to be in advantage with reference to nutritional status.

5.5 It was noticed that caste background has no statistically significant influence on nutritional status of the pre-school children.

6.1 It was observed that 55 per cent of the children suffer with more than one ailment and thus high morbidity.

6.2 It was noticed higher incidence of morbidity among the children who suffer with severe degree of malnutrition.

CONCLUSIONS:

The findings of the present study lead us to arrive at the following broad conclusions. At the outset it may be mentioned that in view of the restricted size of the study, the validity of the generalizations are highly restricted and contextual in nature. However, it is hoped that these generalizations would form a basis for further investigation.

Our first conclusion is that inspite of increasing trends of urbanization, modernization, expansion of
health care delivery infrastructure the mother’s conception of illhealth is tradition bound. They still believe ill health is caused by fate.

The second conclusion is that the mother’s value orientation in relation to ill health is diffused and affective. Such value orientation is understandable in view of the socio-economic, cultural environment and the situational constraints in which these people live in. The diffused value orientation naturally has negative consequences on child care.

The third conclusion is that the positive influence of joint families and larger families on nutritional status is significant. In a society which is undergoing, rapid transformation in terms of rapid and greater nucleazation of families and emphasis on small family norm such trend assumes significance. In other words in the years to come, in the absence of joint and larger families the burden of the child care will be greater on part of the State. Any failure to provide an alternative social infrastructure for the care of the child will result in neglect of the child.

Our fourth conclusion is that the population groups which are homogeneous in terms of their social disadvantage and povery, the factors like caste hierarchy
variations and minor variations in the income levels do not influence the nutritional status positively.

Our fifth conclusion is that pre-school rural child is most neglected child. The poor knowledge and awareness of scientific health practices of the mothers and their irrational health practices due to situational constraints have adverse effect on pre-school child's health and nutritional status.

Finally, it may be said that the long duration of malnutrition (stunted) among the rural children is a clear reflection and index of social deprivation experienced by these children.