CHAPTER - 7

Summary and Conclusion
SUMMARY AND CONCLUSIONS

7.1. Introduction

This chapter summarizes the results of the present study carried out among the four tribes namely Irula, Kota, Paniya and Toda, primitive tribal population inhabiting in the Nilgiri District of Tamil Nadu. There are several studies available on various aspects of socio-cultural anthropology of the tribal people of India. But very few attempts have been made to study their demographic behaviour. Thus in the present study an attempt was made to understand the reproductive health status of four primitive tribal groups in terms of their demography, health and education. This study explores the reproductive health status of tribal women in relation to sex ratio, age at marriage, fertility, maternal and child health care practices among the four primitive tribes.

These four tribes are different endogamous tribal populations living in similar ecological conditions. The social structure, economic organization and cultural identity among these groups have helped in identifying them as primitive tribes in Nilgiri Hills. In view of their social and cultural diversities and economic inequalities in their way of life it is interesting to study their demographic profile among these four selected groups.

The main focus of the present study was to understand the levels and differentials of fertility among these four selected primitive tribes from a critical medical anthropology perspective. The specific objectives of the present study were:

- To study the demographic, socio-economic and ecological, aspects affecting the reproductive health status of the four primitive tribes.
To understand and make a comparative study on the impact of various biological variables like age at menarche, age at marriage, age at first conception and various socio-cultural variables like economic status, occupation, education, consanguinity, family size, type of marriage and abortion affects on fertility among four primitive tribes.

To study the levels and differentials of fertility among the four primitive tribes.

To understand the maternal and child health care practices and to know the extent of awareness and adoption of family planning methods and to ascertain their preference for type of medicinal system.

To formulate future strategies for the development of the reproductive health status among the tribes.

In order to conduct this study efficiently a pilot study was conducted for the period of two months from November – December 2004, with an aim of locating this tribal population, to establish rapport, make arrangements for final round of field work and to assess the suitability of the prepared schedule relevant for the study. The final intensive fieldwork was conducted from the month of January 2005 to June 2006. The data were collected from 51 tribal villages constituting 698 households with the total population of 3158 were covered for the present study. For selecting the sample it was decided to adopt three levels of strata. The first was selection of the tribes and taluks. At the second level villages were selected on the basis of their proximity. At the third and lowest level the households bearing on the women with reproductive span were selected to understand the demographic profile, which includes the distribution of age, sex, economic status, occupation, education and more focus were given among the tribal women’s to understand their fertility rates. The unit selected for the demographic study consisted of 715 ever-married women, belonging to age groups varying between 12-55.
years have been identified for an in-depth interview. The mean age of the women selected for the present study was found to be 27.99.

The data was collected with the help of a structured interview schedule prepared exclusively for this purpose. Besides using structured interview schedule, participant observation method was also employed for data collection. The information gathered included cultural and social aspects covering education, family size, family type, age at marriage, birth history of a woman, abortion, birth interval, occupation, income, perception of infant and health care practices among these four primitive tribes. The analysis was done using computer facility. Besides extensive tabulations, some statistical analysis was applied to find out the variation explained by each independent variable. The present study and its findings are presented in seven chapters.

7.2. Demographical and socio-economic conditions of the four primitive tribes

The social background of all the four tribes from the study area shows that all of them are all below poverty line. Most of them are still living in thatched and tiled houses. In the name of development, the traditional houses are slowly replaced by the asbestos sheet houses and tiled houses, which are not suitable for the cold as a good thermo resistant material. It is observed that the Toda population is suffering from cold and lung infections possibly due to change in the housing material. The number of houses that electrified on an average does not exceed 25 per cent. The ventilation facilities are not proper. Most of the houses are provided with single window made out of cement.

Supply of safe hygienic potable water is always a problem in tribal areas much loss than in the Nilgiris. A majority of the tribes in the study area are depending on tap water, well water and spring water. Only a small fraction of them is depending on bore
wells and canal water. Out of the total households 698, only 18 households are provided with water in their houses through the tap water distribution system. Drinking water quality is very poor and most of tribes do not have the containers to preserve the water. During summer months the tribal faces acute problems of drinking water. Toilet facilities are not available to all the four tribes, out of 698 households studied, only 2.0 percent of the households have the toilet facilities and the rest of 94 per cent of them are using open field for their toilet and only 0.7 percent of them are using the public toilets.

The socio-economic conditions of all the four tribes are far from satisfactory, however, relative basis the Toda and Kota economic status are better than the Irula and Paniya tribe. Majority of the Paniya are working as daily wage labourers, their economic status and living conditions are very poor. Only 63 per cent of the tribes are in the possession of their own land. The rest of them work as daily wage labourers as their chief occupation.

Nutritional standards among all four tribes are very poor. The Kota, Irula and Paniya are non-vegetarians whereas the Toda are lacto-vegetarians. The demographic data show that female sex ratio is higher in Kota and Toda groups. The Irula and Paniya groups show less the female sex ratio. The literacy level is very low among the Paniya tribe, 58 per cent of them are illiterates followed by 41 per cent of Irula, 23.6 per cent of Kota and 10.9 per cent of Toda.

All the four tribes prefer nuclear type of families. Out of 698 households surveyed 541 (77.5 per cent) nuclear families and 148 (21.2 per cent) joint family types. Traditionally all the four tribes have a special preference to have their own ethno-medicine during earlier period. Owing to the impact of modernization and expansion of allopathic medicine reached through the Primary Health Centers. All the four tribes now show preference to allopathic medicine (61.5 per cent) and only 7.3 per cent prefers to
have the native medicine. From the data, it is observed that the first line of treatment after falling sick consultations with the local Vaithiar (medicine man).

An emic perspective in regard to relative notion of “Cleanliness” and “Hygiene” was adopted in this study. Anthropologists cannot judge other cultures according to etic standards. In this regard it was found that each tribe has logical reason for the way they approach cleanliness. For example among the Irula and Paniya it was found that their work as daily wage labourers makes it exceeding different to ever find to time to wash work garments. Also, for some not frequently washing clothing meant the clothes felt warmer in the Nilgiri cool climate.

7.3. Maternal and child health care practices

Age at menarche is very crucial phase in the life cycle ceremony of a girl. It is evidenced from the data many girls attain puberty at the age of 14 irrespective of their tribal affiliation. After attainment of puberty, the commencement of regular menstrual periods is observed by 76.1 per cent of the women. 24.3 per cent of the women reported that they are having pain during their menstrual periods. 21.2 per cent of women reported that they are having irregular menstrual periods in all the tribes extending to 4-6 days.

The total effectively reproductive population size in all the four tribes remains of 962. The distribution of age groups of reproductive population gives a mixed trend. The highest reproductive population is in the age group of 25-29 years. The data on age at conception shows the age at first conception is 15-19 years.

These findings show all the four tribes have a preference for home delivery. As 75 per cent of them prefer their homes for facing the labour ordeal in the company of their near and dear and only 2 per cent utilized the services of the Primary Health Centre. Among Irula, it was also show that men play a significant role in delivery.
Infacts and it is hoped that future studies can examine the cultural content of these practices and knowledge.

Out of 845 deliveries recorded, 548 deliveries have been attended by the local untrained women, close relatives and neighbours. Only 93 deliveries have been conducted by the midwife in the PHC. Different delivery postures are noticed among the tribes. 52.3 per cent of them are following labour, 21.3 per cent of them observing squatting methods, 13.3 per cent are following back side and 4.5 per cent of them are observing using on back with legs rising.

The instrument used for cutting the umbilical cord also varied from tribe to tribe. A majority of them uses the new blade as an instrument to cut the umbilical cord. For tying the cord they are using the thread, cloth and bandage. The incidence of abortion was negligible (1.5 per cent).

There is a general consensus for small family size among all the four primitive tribes. The data show 58.6 per cent of the sample population are interested to adopt the methods to limit their family sizes. The data 40.9 per cent of them accepted for family planning operations.

Among the study tribes not much age gap is observed between couples. There was no discrepancy in the sex ratio. Only 18.6 per cent of the tribes practiced consanguineous marriages. The frequency of intercourse among the selected primitive tribes was (34.8 per cent) having 3 intercourses in a week.

7.4. Demography and socio-cultural factors influencing marriages

Among the four selected primitive tribes Kota girl’s menstrual age is slightly lesser than the other three primitive tribes. However, among other tribes the observed difference is very small. The mean age at menarche among Paniya and Toda girls has been gradually decreasing from 14.16 - 13.33 and 14.0 – 12.67 respectively. This slight
difference in the menarcheal age noted among these four tribes may be due to socio-economic, environmental and nutritional factors.

Data on mean age at marriage of all the four selected primitive tribes by the current age indicates that the Toda girls marry little earlier than the other three tribes. The age at marriage ranges from below 14 years to 30 years for all the tribal groups showing an average of 18.4 for Irula, 19.6 for Kota, 18.8 for Paniya and 16.1 for Toda. All together the mean age at marriage for all the four tribes is 18.4 years. This clearly show that Toda marry earlier than the other three primitive tribes. Moreover among the Toda tribe 29.3 per cent of them had their formal marriage, after one year of puberty, whereas in the other three tribes had their formal marriage after 5 years of puberty. The tendency of marrying immediately after puberty is common among older women. The differences in the age at marriage of women immediately after puberty are common among older women.

Data provided among ever married women ages 15-49 years clearly indicates that over 45.41 per cent of Irula women and 73.88 per cent of the Paniya women are illiterates. Among the literate women a majority of them have one to five years of schooling. It is found that the education showed a strong negative association with age at marriage among these two tribes. Whereas, no illiteracy among the Toda tribal women.

The hypothesis that the higher the education, the higher will be the age at marriage of girls does not fully fit into Toda. This may be because among these communities marriage is definitely a priority over education and the result is tribal boys and girls enter marital life at an early age without any education is strong positive association with age at marriage among certain tribes.
Like education, the family type also does not show any significant difference in the age at marriage among the Nilgiri tribes. Data clearly indicates that over 74.83 per cent of all the tribes are belonging to nuclear families. The nuclear families are more among Irula tribe mainly because they got government quarters.

7.5. Fertility measures among the four primitive tribes of Nilgiri Hills

The CBR and GFR for Toda population are very low when compared to other two tribes in the Nilgiri Hills. When the ASFR for the different age cohorts is compared it is observed that the peak reproduction in the present population is reached in the year's age cohort 20-24 years followed by 25-29 years. Further 35-39 age cohorts show lower ASFR than that of 40-44 age cohorts. This may be due to small number of mothers in this age group. However in the present population active reproduction period is found to extend between 15-39 years. The age cohort wise distribution of fecundity among the tribal women reveals that 93.59 per cent.

The mean number of conception and live births with age expects from the age cohort of 20-24 to 35-39 years, which, however decreased at 45-49 years of age. The mean numbers of conceptions and live births for those supported to have completed families. When mean number of conceptions and live births for each woman in each age cohort was estimated, it was found to be within the range of 1.5 – 3.0 for each woman indicating that each woman has at least once conception or live birth as she passes through each age cohort. The mean number of live births showed a decline in mean live births, which, however, decreased at the later age cohorts.

The number of conceptions per mother in tribal woman varies from 0-12, with maximum number of women 28.1 per cent having two conceptions, followed by three
conceptions 26.3 per cent. 6.7 per cent of the women didn’t conceive these include both sterile and currently married women.

Distribution of age at menarche among all the tribal women reveals that the maximum number 39.0 per cent of tribal women attained menarche at the age of 14 years followed by 15 years (21.7 per cent).

Distribution of fertility vis-à-vis age at menarche among tribal women reveals that the mean number of conceptions and live births are higher among the women who had menarche between 13-14 years of age followed by those with menarcheal age between 15-16 years of age, the women who had menarche between 11-12 years of age are fund to have lower mean values for conceptions and live birth respectively. Thus, tribal women who had menarche between 11 to 16 years of age are found to have highest fertility.

Distribution of age at marriage among the tribal women reveals that maximum number of females married at the age of 18 years (18.18 per cent) followed by at 20 years (16.50 per cent). The range of variation is 11 to 30 years. The mean age at menarche for the Irula, Kota, Paniya and Toda women are found to be 18.41, 19.56, 18.79, 16.01 years respectively. In India according to the Marriage Act, the minimum age at marriage prescribed for female is 18 years. The present study shows that the Toda age at marriage for females are less in compared with the other three tribes and the marriage act.

Distribution of fertility vis-à-vis age at marriage among tribal women shows that those women who married before 12 years of age have higher fertility, while those who married at the age of 17 years and above have lower fertility. Thus the present study shows that the fertility of the tribal women is inversely proportional to the age at marriage as is observed in most Tamil Nadu population.

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A majority of tribal women experienced their first conception before 19 years of age. The ranges of variation among tribal women are below 14 years to 24 years. The mean age at first conception for the Irula, Kota, Paniya and Toda women are found to be 18.79, 18.29, 18.33, 15.94 years respectively.

The distribution of fertility vis-à-vis age at first conception among tribal women reveals that there is not much variation in the mean number of conceptions and live births with respect to the distribution of age at first conception among the tribal women. It is generally expected that lower age at first conception may lead to raised fecundability or raised fertility, but the Toda women didn’t appear to show such variation either in mean number of conceptions (fluctuating between 3.0 and 3.3) or in mean number of live births (fluctuating between 2.8 and 3.0).

7.6. SUGGESTIONS AND RECOMMENDATION

There are many policy issues that the government of Tamil Nadu need to consider if it wants to care for the tribal people in the Nilgiri hills, in view of their overall socio-economic development. In order to reproductive health, some specific measures that the government may have to consider, as integrated component of socio-economic development strategy should include:

- 45.1 per cent of the tribals are consuming unprotected water from river, pond, spring, well and canal. Government should provide the safe drinking water through tap or bore well to all the tribal villages.
- Only 41.08 per cent of the tribal houses are electrified, it is suggested that the Government should make arrangements to provide at least one-light service electrification to all the tribal households.
- The literacy level of the primitive tribes in Nilgiri hills are very poor, specifically the Paniya tribe; this is because they were highly isolated from
mainstream of life and there is very little infrastructure for formal education in their settlement.

- Grants to GTR schools must be enhanced keeping in mind to the present days costs. Frequent inspection by the authorities will improve the standard of the children’s education and it will avoid corruption and exploitation.

- The tribal habitations are still didn’t get any benefits from the state government. Therefore, proper infrastructure facilities should be provided, so that they could be linked with the mainstream, which will go a long way to develop their socio-economic conditions.

- To bring the tribal children to the mainstream, the school curriculum should be designed according to their culture, dialect and local environment and also in respect to teachers inputs like teaching and training should be modified related to tribal culture.

- To uplift the tribal economy the government has to create awareness about the tribal development programmes in the tribal villages and make them to use the welfare measures. The tribal village head has to be educated regarding the economic empowerment provided by the government.

- Women’s education should be improved. They should be given more opportunities to continue with education for many years. This will lessen entry into marriage at an early age, as is the case at present. In addition, adequate education among women would act as a catalyst in changing their attitudes which currently favor larger family sizes. Furthermore, adequate education will prepare women to engage in gainful employment outside the home.

- Women’s social status should be improved to enable them to participate at all levels in the socio-economic development activities.
• The public distribution system should be made effective.

• Strong educational campaigns should be mounted to educate and persuade the population to accept the benefits of small family size. Means of achieving small family size should be made available.

• Existing programs for the tribals need to be strengthened and improved to achieve their desired objectives. However, attention should also be given to reduce problems of fertility where it exists.

• The tribes, though different in their ecological and culture setting were found to suffer from almost all the deficiency diseases. This was due to the lack of a balanced diet in their consumption pattern. Though the natural resource was available in abundance in the tribal areas, the tribals did not know the nutritive value of it. So, awareness should be created among the tribes on the nutritive value of the local food resources.

• Training programmes should be designed in schools in such a way that it should give scope for tribal talents and put them in proper use. Education with artisan works, tribal ethno-medicine, gardening etc., has to be educated to tribal children’s interest, which will evoke their livelihood in future.

• Tribal diets are generally deficient in calcium, vitamin A, vitamin C, riboflavin and animal protein. Steps to be taken to provide Iron, Calcium and vitamin tablets through the Primary Health Centres and Anganwadi Centres. Under nutrition is higher in tribal areas, it is particularly high among children. The prevalence of under nutrition is about the same for girls as for boys.

• Family Health Welfare Programme has to be implemented in the tribal villages, and periodically health camp has to be conducted in the tribal villages. Many
Primary Health Centres in the tribal villages are not properly maintained with adequate medicines and equipments.

- Health workers are the backbone of any medical systems and a mode of contact between the tribals and the medicinal people. The data shows there is a lacuna in the functioning of the Health Workers in tribal villages. This framework should be strengthened.

- Mother and child health and family planning should be integrated, wherever possible, in other sectoral areas within the framework of rural and urban development programs. Special attention should be given to birth-spacing and to a significant reduction of infant and child mortality, which are important determinants of fertility.

- It is observed in the field that Anganwadi Centres and EGS Centres are not functioning in the tribal villages. So it is suggested to open the Anganwadi Centres and EGS Centres in all the tribal villages for the nutritional supplement.

- The place of delivery should be shifted from home to PHC and delivery should be conducted by trained and experienced persons.

- Nutritional and health education should be imparted in the tribal local dialect preferably using audio-visual materials.

- Awareness needs to be created among the Paniya tribe regarding the adverse effects of excessive intake of alcohol and the use of tobacco / drugs by the Health Workers.

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- Primary Health Care Centre is the very important in the tribal area. So it is suggested to strengthening the Primary Health Centres in tribal remote villages.
Proper awareness for mother – child immunization should be generated and its importance to be explained both in health and disease conditions.

The government should encourage the primary health centre staff to work with traditional medical practitioners, school teachers, gram panchayat members, and voluntary organizations to work out strategies for the tribals.

The Anthropologist can play an important role in planning, implementing and following up health care and health education programmes for the welfare of the Tribes. Whatever is planned should be implemented and what is implemented should be followed up to know the success and the failure of the programmes. Most of the time programmes are only planned but not implemented and even if implemented not followed up. The health programmes should be planned along with people implemented with people and followed up with people so as to promote community participation.

Finally this thesis may be utilized not only promotive, preventive and curative health measures, including health education, but also to improve the economic status of the Tribes. The latter can include employment schemes, handicrafts, agricultural improvements, animal husbandry etc., and also starting of Self Help Groups and Youth clubs.

Finally it is recommended that the state should appoint the Anthropologists as Field Officers/Welfare Officers to evaluate and monitoring the implementation of the schemes in the tribal villages. This will ensure that the program remain effective and culturally sensitive.