Chapter-10

Conclusion
and
Suggestion
The present research work is about “Health status and problems of schedule tribe families” for which research had selected members of schedule tribe families from Tahseel Talbehat of district Lalitpur. Total numbers of 300 families were selected by random method of sampling so that out of the total the respondents of different back grounds castes, age groups, sex, educational standard, marital status the respondents will be.

In India, as several other developing countries, the health awareness of the people is adversely affected by several factors like environmental, malnutrition, illiteracy, reproductive habits, contraceptive practices, customs, traditional beliefs and lacunae in the health services of the country.

India is the country of caste in which schedule tribes have a big share, but they have mostly desprive of their fundamental rights since “Varna system” regulated. Though their contribution to nation is very large, they are not being allowed to share its fruit even after constant efforts of Government of India and so many of the social reformatory institutions. Yet the economic, social and health status of schedule tribes is still at the lowest ebb.

- **Sex:** Majority of 253 respondents (83.33%) were male and 47 respondents (15.67%) female.
Age: Majority of 66 respondents (22.00%) were in age group of 21-25 followed by 60 (20%) in 41-45, 59 (19.67%) in 31-35 respondents, 50 (16.67%) were in 36-40 followed by 31 (10.34%) in more than 46 and 17 (5.66%) viz. 15-20 and 26-30 age group.

Educational status: Majority of 204 (68.00%) respondents were illiterates followed by 64 (21.33%) literates, 27 (9.00%) primary school passed and 5 (1.67%) were junior high school.

Sub tribe: Majority of 166 respondents (55.34%) belonged Saharia, subtribe, followed by 75 (25.00%) Gond, 33 (11.00%) Adwasi and 26 (8.67%) were cole.

Occupation: Majority of 176 (58.66%) were wage earners, followed by 80 (26.66%) agriculture, 40 (13.34%) shopkeepers and 4 (1.34%) servicemen.

Monthly income: Majority of 246 respondents (82.00%) were under poverty line (BPL)

Marital Status: Majority of 216 respondents (72.00%) were married followed by 52 (17.33%) unmarried and 32 (10.67%) widow/widowers.

Age at marriage of husband and wife: Majority of 248 respondents (100%) husbands were performed child marriage.

No. of pregnancy: Majority of 83 respondents (33.66%) conceived 4 to 6 times.

Total fertility: Majority of 66 (27.00%) respondents wives performed 3 deliveries followed by 50 (20.00%) 2 deliveries, 30 (12.00%) 5 and 22 (9.00%), 18 (7%) 6th times and 12 (5.00%) 7 times.
• No. of live children: Majority of respondents an averagely had 4:1 live children.

• Residence conditions: Majority of respondents had utmost bad conditions of housing conditions.

• Source of information: Majority of 116 (38.67%) received health information from fairs, followed by 42 (14.00%) from T.V., 39 (13.00%) from health workers, 34 (11.39%) from community leaders 29 (9.67%) from advertisements, 23 (66%) from V.D.O and 11 (3.67%) from radio.

• Type of marriage: Majority of 262 (87.33%) respondents married their children in group.

• Age at marriage of children: 100 percent marriages were performed against the marriage Act, 1978.

• Pregnancy within year: majority of 205 respondents wives were conceive within year.

• Nutritive diet: majority of 186 respondents 62 percent provided poor nutritive diet to their wives during pregnancy.

• Health check up: majority of 219 respondents 73 percent did not seek health check of antenatal mothers.

• T.T. vaccination: majority of 209 respondents 69.67 percent did not immunized against tetanus toxidie during pregnancy.

• Spacing: majority of 192 respondents (64.00%) had no spacing between the births of two children.

• Extent of morbidity among women: majority of 193 respondents (64.33%) often fallen ill.
- Mortality: majority of 240 respondents (96.78%) told no maternal mortality during last year in their family.

- Nutritive status of children: majority of 135 respondents 45 percent told that their children were weak physically.

- Extent of child morbidity: majority of 176 respondents 58.66 percent told that their children often ill followed by 30.33 percent always.

- Health centre in area: majority of 278 respondents 92.67 percent told that there was no health centre in their area.

- Life expectancy rate: majority of 152 respondents told that life expectancy rate had been increased.

- Month of registration of pregnancy: The overall result reveals that respondents were unaware about the concept of early registration of pregnancy as was made essential to reduce maternal mortality rate and to diagnose any malformation.

- Health checkup visits during pregnancy: The overall observation reveals that 271 respondents (90.33%) were unaware about the number of visits for health check up during pregnancy period.

- T.T vaccination to mother during pregnancy: Majority of 209 respondents (69.67%) were aware about number of tetanus toxide vaccination during antenatal period.

- First feeding time: The overall result reveals that 267 respondents (81.00%) were not aware about first feeding time of new born baby.

- Six-killer disease of infants (0-1 yrs): Majority of 233 respondents (77.67%) were aware about tetanus and 224 respondents (81.33%)
were aware about pertussis as killer diseases of infants. On the other hand 269 respondents (89.67%) were not aware about whooping cough as fatal disease, followed by 200 respondents (66.67%) about measles, 201 respondents (67.00%) about polio and 239 respondents (79.67%) about tuberculosis.

- **Immunization schedule:** The overall observation of the result reveals that an averagely (48.00%) respondents were not aware about immunization schedule.

- **Causes of Diarrhoea:** The overall observation reveals that majority of 179 respondents (59.67%) were unaware about causes of diarrhea.

- **Prevention of diarrhoea:** The overall observation of result reveals that majority of 211 respondents (70.33%) were unaware about prevention of diarrhoea.

- **Home treatment of diarrhoea:** Majority of 201 respondents (67.00%) were not aware about home available treatment of diarrhoea. On the other hand 180 respondents (60.00%) were aware about O.R.S. treatment of diarrhea.

- **Causes of malnutrition:** Majority of 210 respondents (70.00%) told that “poverty” was cause of malnutrition. 190 respondents (63.33%) told that “poor intake” was cause of malnutrition, 180 respondents (60.00%) told lack of nutrition education, 179 respondents (59.67%) told malaria was cause and 35 respondents (11.67%) told that Mensuration among women was also cause of malnutrition.
• Ladies F.P. contraceptives: Cent percent respondents were aware about tubectomy operation. 181 respondents (60.37%) aware about loop / copper-T, insertion, 180 respondents (60.00%) about oral pill and 61 respondents (20.33%) were awarded injections.

• Medical termination of pregnancy (M.T.P.) services: Majority of 200 respondents (66.67%) were unaware about medical termination of pregnancy. The overall observation of the above table reveals that 237 respondents (79.00%) were unknown about medical termination of pregnancy services.

• Breast feeding as family planning contraceptive: The overall observation of result reveals that majority of respondents were not aware about breast feeding as family planning measure.

• AIDS: Majority of 171 respondents (57%) replied in can’t say while 74 respondents (24.67%) were quite unaware about AIDS disease. Only 55 respondents (18.33%) were known to AIDS disease. The overall observation of this above result reveals that majority of respondents were unaware about AIDS disease.

• Transmission channels of AIDS: Majority of 241 respondents (80.33%) were aware that blood was channel of AIDS infection. On the contrary 239 respondents (79.67%) were unaware about needles and syringe as channel of transmission followed by 191 respondents (63.67%) were unaware about Illegal sex and cent percent about mother placenta. Over all observation reveals majority of respondents were unaware about channels of AIDS transmission.

• Symptoms and signs of tuberculosis: Overall observation of result reveals an averagely (77.00%) awareness of respondents about sign and symptoms of tuberculosis.
• Prevention of tuberculosis: Overall observation reveals that majority of 167 respondents (55.67%) were not known about prevention measure of tuberculosis.

• Functioning of DOT centers: Overall observation reveals that majority of respondents were unaware about functions of DOTS centre.

• Motivation to others for using Health programmes: Majority of 188 respondents (62.66%) answered negatively, followed by 80 respondents (26.67%) in “Some time” and 32 respondents (10.67%) in “Always”. The overall observation of the result reveals that the attitudes of respondents towards present health programmes were negative.

• Utilization of Health Service by respondents: The overall observation reveals 43 per cent respondents utilized present health service provided by primary health centre (PHC), community health centre (CHC) and sub centre (SC).

• Level of satisfaction about health programme/service: The overall result reveals “No satisfaction” about health programmes and schemes in respondents.

• Opinion about Continuation of health programmes: Majority of 201 respondents (67.00%) replied in affirmation, On the other hand 99 respondents (33.00%) were such who said can’t say.

• Individual factors: An averagely 58 percent individual factors smoking, alcoholism and Tobacco influence health of people.

• Uncontrolled reproduction: An averagely 58 percent uncontrolled reproduction influenced health of respondents
- **Social factors:** An averagely 56 percent respondents told that social factors lack of health services, workers, consciousness and community education influenced health status.

- **Illiteracy:** An averagely 69 percent illiteracy of respondents influenced health of family members.

- **Economic factors:** Majority as well as an averagely 84 percent economic factors influenced health status of respondents.

- **Cultural factors:** An averagely 60 percent of respondents cultural factors – T.B is curse of god given hereditary and leprosy is result of old sins etc influenced health of community.

- **Myths Influence:** An averagely 79 percent myths- Baby suffers by evel eye, Eye cures by Jharfooq and black spot on forehead prevents from evil eye. Influenced health of family.

- **Psycho-factors:** Majority of respondents told that tensions and anxiety and stress influenced health of family.

- **Nutritional factors:** An averagely 83 percent nutritional factors were responsible for bad effect on family health.

- **Religious factors:** An averagely 73 percent religious factors badly influence the health of family as fast, god’s anger.

- **Problem of personal hygiene:** Majority of 198 respondents (66.00%) were suffering from problem of personal hygiene. Viz 43 (14.33%) by pertuisis in head followed by 52 (17.33%) lice in clothes, 71 (23.67%) scabies and 32 (10.67%) ear infection

- **Problem of RTI / STI:** Majority of 167 respondents (55.67%) were suffering of reproductive and sexually rack infections such as 43
(14.34%) from Etching in Vagina, 37 (12.33%) from R.T.I., 34 (11.33%) from apses on penis, 27 (9.00%) soiling in thy and 26 (8.67%) from puse discharge from urinals.

- Maternal health problems: Majority of 177 respondents (59.00%) respondents family members were anaemic, followed by 227 (75.00%) told more morbidity, 25 (8.33%) told problem of mortality and 31 (10.33%) problem of abortion. That is to say (51.00%) maternal health problems.

- Problems of child health: Majority of 174 respondents (58.00%) told child health problems in their families. Oat of which 86 (28.67%) of vaccination, 45 (15.00%) of Diarrhoea and 43 (14.33%) of fever

- Problem of warm infestation: An averagely 52 percent respondent’s children were suffering from warsms infestation.

- Problem of nutritional deficiency: An averagely (50.33%) respondents told that their women and children were malnourished along with scabies in teeth and night blindness among children.

- Problems related to communicable diseases: 135 respondents (45.00%) had problem of communicable disease infections. Out of them 20 (6.67%) from tuberculosis, 9 (3.00%) leprosy, 3 (1.00%) filarial and 103 (34.33%) from malaria.

- Problems of environmental sanitation: 133 (44.33%) told problem of air population, 119 (39.67%) of safe water supply, 105 (35.00%) of daily disposal of waste.

- Eye Health Problems: 149 (49.67%) told eye health problems
among respondents. Out of them 42 (14.00%) suffering from Pain in eyes, 38 (12.67%). Etching in eyes, 24 (8.00%) squint as well as cataract in eyes and 21 (7.00%) red eyes problems.

- **Dental Health Problem**: Majority of 178 respondents (59.33%), told dental problem. Such as 90 (30.00%) piarrhoea, 43 (14.33%), bad smell in mouth, 31 (10.33%) scabies in teeth’s and 14 (4.67%) soars in through.

- **Problems related to life style**: Majority of 241 respondents (80.33%) was smokers and 189 respondents (63.00%) were drinker among respondents.

- **Population problems**: 65 percent respondents told population problems. In which 184 (61.67%) had large family size, 248 (82.67%) inadequate residence, 180 (60.00%) dress, 59% percent education of children and 66.67 percent education of children and 66.33 percent imbalance diet.

- **Staff position of H.I.E.C.**: chief medical officer of district Jhansi told that (83.30%) posts of an averagely were vacant of health education unit of department.

- **Training status of health educators**: District health information and education officer told that are averagely (84.20%) status was untrained in health education units.

- **Educational aids conditions**: According to district health information and education officer an averagely (67.00%) educational equipments and instrument were not in working order.

- **Nature of financial allocation**: District health information and
education officer told that budget allocation and supply for health education activities was irregular or on demand.

- **Extent of budget sanction:** District health education cum information officer told meager budget sanction by state for health IEC activities in area.

- **Health IEC activities:** According to district information and education officer told that merely (30.30%) IEC activities achieved against annual target of programme.

- **Interpersonal communication on health:** Majority of 262 respondents (87.33%) did not communicate in their families on health matters.

- **Status of IEC activities:** Majority of 213 respondents (71.00%) valuated inadequate status of health IEC activities in area.

- **Creditability of health functionaries:** Majority of 84 percent respondents told that Doctors were maximum credible, health worker female and male on second rank and traditional birth attendants were in third rank.

- **Respondent’s participation:** Majority of 187 respondents (62.33%) told that did not participate in health IEC activities as and when organized.

- **IEC centre in area:** 300 respondents (100.00%) told that there was no information, education and communication centre of health.
SUGGESTIONS/RECOMMENDATIONS

1. Policy & Legislation:

The present national policy on health needs revision and here is a clear and established need for a separate national health policy for schedule tribes. In addition, every state should set up a state commission for the protection of rights of the schedule tribes at the state and district level. There is also a clear and established need for an effective national legislation to deal with barriers in the way of dream “Health for all”.

The proposed legislation should address all forms of abuses i.e. physical, mental and sexual. It should also look at mechanism of reporting and persons responsible for reporting about the evaluation process of health services.

2. Protocols:

In order to enhance the standard of health care there is a need to develop standard protocols on schedule tribe family’s health protection mechanisms at district, block and village levels, defining roles and responsibilities of each individual and agency. Such protocols should also by down standards and procedures for effective health care services delivery including preventive, statuary, care and rehabilitation services for all of the age groups of schedule tribe families. An effective community based monitoring mechanism needs to be put in place to ensure accountability at various levels. Monitoring should be based on indicators of performances such as quality of health services and level of satisfaction by the community.

3. Schemes:
So far schedule tribe families health has been dealt with a piecemeal and dilatory way with allocation of minimum resources reacting out to a miniscale numbers of schedule tribes in difficult circumstances. The result of the study point to the need for a national scheme, such a scheme should identify vulnerable families, prevent vulnerabilities and provide services to those who are in actual need. The scheme should strengthen statutory support services under the jurisdiction. With the allocation of adequate finance and human resources, the scheme should help to create a protective environment for schedule tribe families through strong health services delivery mechanisms and effective interventions.

4. Outreach and support services:

The study has revealed that schedule tribes have their great importance in growth of the nation. They have a sharp skill in handicraft, herbs and plants, medicines, agriculture, building construction etc. but due to lack of their out reach and support services and due to their illiteracy their skills are not accountable. It is essential to provide outreach and support services to them through education, vocational skills, economic and moral support So that they can reduce their vulnerability and enable them to sustain them selves.

5. Shared responsibilities:

Schedule tribe family’s health protection is a shared responsibility and for any intervention to be effective there should be synergy between efforts being made by different stakeholders to address the issue. There is a need to create a mechanism that will make such synergy possible. These may include health care mechanism at village, block, district and state
levels which involve the beneficiaries, elected representatives of rural and urban local bodies, aanganwadi workers, medical practitioners, social workers, all related agencies to health, administrative bodies and the media.

6. Capacity building:

Schedule tribes have a lot of skills in various means of life regarding to their livelihood, health prevention and protection, agriculture etc. but due to lack of awareness and lack of risk taking capacity they are not able to lift from their down trodden situation.

There is need to furnish their skills through education various schemes and policies so that they can help them to upgrade their health, education, economic status, political status, livelihood, nutritional status as well as their source of earnings.

7. Advocacy and awareness:

The media should be used to spread awareness on health status and problems of schedule tribe families. Debates and discussion with participation of focused group can be a regular feature on electronic media in order to enhance stakeholder's knowledge and sensitivity on health care issues of schedule tribe families. While media coverage on health status and problems of focused community is desirable, it is essential that this coverage is done in such a way that it prescribes high ethical standards of reporting such as avoiding disclosure of identify of the causes of health problems and the various barriers in providing the health services. All these measure will reduce the health problems of schedule tribe families and will help them to upgrade their health status. The ministry of information and broadcasting and media self regulatory
authorities should take necessary action to develop ethical standards for the media and to implement them.

8. Research and documentation:

There is a need to do research at National level on health status and problems of focused group in order to strengthen their health status. This research could include:

- Living condition of schedule tribe families
- Health and education status of schedule tribe families
- Health problems among the schedule tribe families
- Various factors responsible for the health problems
- Impact of the health problems on the life of schedule tribe families
- Govt. efforts and their results to reduce the health problems of schedule tribe families
- Identify the various barriers in implementation of the various programmes to upgrade the health status of schedule tribe families
- Knowledge, attitude and utilization of health services and schemes among schedule tribe families
- Neglecting of health issues by the stake holders good practices in reducing the problems should be documented and shared to facilitate qualitative improvement at all levels and it must be appreciated by all.

9. Participation:

Schedule tribe family's voice need to be heard by everyone. All for addressing issues of health status & problems should have adequate
schedule tribe’s representation with the opportunity for them to express their views. It will help them to find out their problems and will help to change their habits causing their health problems as well as help policy makers to make policies and launch schemes and programmes directly related to the schedule tribe families.