CHAPTER - VI

CONCLUSION
A. MATERNAL HEALTH DURING ANTENATAL STAGE:
A1. Incidence of Health Complications:

The Ganda Women experienced episodes of Vomiting (80%), Visual Disturbance (29.37%), swelling of Hand and Feet (26.25%), Severe Headache (25.62%) etc. during course of pregnancy. Except in case of foetus movement, majority of them did not approach any medical professional for treatment.

A2. Incidence of Malnutrition:

As per BMI, 16% of the studied pregnant women were found malnourished of which 14% fall in mild malnutrition category and 2% show moderate degree of malnutrition.

A3. Incidence of Anaemia:

Almost every (98%) studied Ganda pregnant women is found anaemia. Among them 34% and 16% show moderate and severe categories of Anaemia, respectively.

B. MATERNAL HEALTH DURING INTRANATAL PHASE:

B1. Incidence of Delivery Complications:

The studied Ganda women experienced prolonged labour (32.5%), excessive bleeding (24.38%), interprated pain (23.03%) etc. during Intranatal Phase.

C. MATERNAL HEALTH DURING POSTNATAL PHASE:

C1. Incidence of Health Complications:

The studied Ganda mother suffered from excessive bleeding (23.75%), convulsions (45%), lower abdomen pain (35.62%), delayed milk secretion (20%) etc during lactating period.

C2. Incidence of Malnutrition:

Almost half (46%) of the studied lactating women are found malnourished out of which 24.66% and 8% fall in moderate and severe degree malnutrition, respectively.

C3. Incidence of Anaemia:

Majority (87%) of the studied Ganda lactating women are found anaemic. Among them, 54% and 9% fall in moderate and severe categories, respectively.
D. HEALTH OF CHILDREN (0-2 YEARS)

D1. Incidence of Shunting (HAZ):

Z-score analysis shows 9.85% incidence of mild degree of shunting while 2.39% show its severe expression.

D2. Incidence of Under Weight (WAZ):

Z-score analysis reveals incidence of 6.58% mild degree of under­weight, while 2.99% shows its severe expression.

D3. Incidence of Under Wasting (WHZ):

Z-score analysis show 3.59% incidence of wasting among the studies children.

D4. Incidence of Malnourishment (Kanawati and McIarance Index):

According to the Kanawati index almost (49.10%) studied children are found malnourished.

D5. Incidence of Malnutrition (Ghosh and Tejswani):

According to the Index almost half (49.10%) studied children are found malnourished.

D6. Incidence of Malnutrition (Jelliffe Index)

As per the Jelliffe Index, around 85% of Ganda children are found malnourishment. Almost half (41.9%) of them express severe degree of malnourshment.

D7. Incidence of Malnutrition: Clinical Sympton:

Prevalence of Conjunctival Xerosis (10.62%), reveal Vitamin A deficiency. Similarly, incidence of Cheilosis (11.28%) and Pallagrous Dermatosis (11.25%) are indicative of Riboflavin and Niacin deficiency. Vitamin C deficiency is indicated by presences of Swollen and Bleeding gums (15.00%) among studied children.

D8. Incidence of Birth Complication:

The studied Ganda children show the presence of low birth weight (33.13%), infectious chord (22.5%), Jaundices (21.25%), Cold body (6.87%) and so on.
D9. Incidence of Infectious Diseases (Last Days)

The studied Ganda children are found suffering from Cold and Cough (76.88%), Breathing Trouble (35.12%), Fever (30.12%), and Malaria (22.5%).

D10. Incidence of Diarrhoea and its Management:

High incidence of diarrhoea and vomiting is recorded among studied Ganda children. Repeated occurrence of episode is reported in 68.90% cases. Though medical professional was consulted in recorded cases, use of oral rehydration was rather limited (38.75%).

D11. Growth Pattern:

i. Boys are found both taller and heavier with greater Head Circumference, greater Chest Circumference to those of girls for all age groups, under consideration. In case of Triceps skinfold, however, boys are ahead at 3+ and 6+ months, while they are behind at 0+, 9+ and 12 months age groups.

ii. In weight, the Ganda boys are found lighter between 0+ and 3+ months and heavier from 0+ months to 12+ months in comparison to that of ICMR standards. In comparison to that of NCHS standards, the Ganda children are lighter for all age groups, under consideration.

iii. In head circumference, the Ganda boys have shorter values of the dimension between 0+ and 9+ in comparison to that ICMR standards. Head circumference of the Ganda children is shorter for also all months groups, under consideration.

E. Acceptance of MCH Programmes

E1. Antenatal Check-Ups: More than three-fourth (77.5%) of the Ganda pregnant women are found to have undergone their antenatal checkups. Almost all (98.38%) of them got check-ups from Govt. Medical professional. Around 55% of them got more than 3 antenatal check-ups, as prescribed.

E2. Intake Pattern of IFA Tablets: Only little less than two-fifth (38.75%) of the pregnant women are found to have taken IFA tablets. Only 29.03% of them completed the full course of 100 tablets. Almost two-third 64.51% of those taking IFA tablets reported to have bought from chemists.
E3 T.T. Injections: High proportion (73.75%) of Ganda pregnant women received T.T. injections. Similar proportion (76.27%) of them got full dose of 2 injections.

E5. Bio-Chemical Tests: Only 25.62% and 32.87% Ganda pregnant Ganda women got their blood and urine tests done. X-ray/Sonography is also done in just 24.37% cases.

E6. Incidence of Institutional Deliveries: Majority of deliveries in the studied area took place at homes. More than half (53.48%) of them do not think that it is necessary to go for institutional deliveries.

E7. Delivery Assisted by Medical Professional: Only 8.5% of deliveries in the studied field found assisted by medical professional. In absence of any traditional mid-wife in the area, senior ladies assisted home deliveries.

E8. Use of Antiseptic: Antiseptic was applied at cut pont of umbilical cord only in 26.25% cases.

E9. Immunization Status: The incidence of fully immunized children is found in low proportion (10.25%). Majority of children are found being partially immunized. Maintainance of cord is found to be just 26%.

F. Impact of Soci-Economic Factors on Acceptance level of MCH Programmes.

F1. Antenatal Check-Ups: It is seen that education, occupations, parity and income influence acceptance level of Antenatal Check-ups. It is also found that the family type does not effect acceptance level of the variable, significantly.

F2. T.T. Injection: In case of receiving two T.T. injections, family, occupation and parity are found having significant influence. Education and income do not appear to be influencing factors in receiving T.T injections.

F3. Intake of IFA Tablets: In case of IFA intake patterns only family and parity variables are found having significant influence. Other factors, namely education, occupation and income do not influence intake pattern of IFA tablets.

F4. Institutional Deliveries: In case of institutional deliveries, only income is found to have significant bearing.
**F5 Body Mass Index:** In case of nutritional status, occupation and family type are found to have positive association, other social variables, namely education, parity and income do not contribute to one's nutritional status, significantly.

**F6 Oral Rehydration Therapy:** In utilization of ORS therapy, family, occupation, parity and education are found to have significant association.

### 6.3. RECOMMENDATIONS:

i. Effective interaction should be developed with potential beneficiaries to identify the specific factors responsible for not accepting MCH programmes fully to be followed by appropriate remedial measures.

ii. Adult education centers should be opened in slums to educate them about MCH programmes, importance of balanced food, hygienic practices etc.

iii. Ground medical staff should be strengthened to follow up various MCH programmes.

iv. Adolescent girls (12-18yrs) should be targeted for imparting appropriate knowledge about need of small families, family planning devices, adequate gap between two pregnancies, MCH programmes.

v. Slums should be provided basic infra-structural amenities, like drainage, disposal of kitchen refuse and waste material.

vi. Slums should be provided with proper health facilities backed by competent and sufficient staff to reduce their dependence on unqualified fake medical professionals. Till then, mobile medical van service may be extended.

vii. There is a need of setting up of a referral unit in slums. Which should be linked with PHC and district hospitals. It should be responsibility of the referral unit to transport the emergency cases of mother and newborn babies to hospitals equipped with handling such cases.

viii. Most of the government programmes are focused on SC and ST populations. Since health condition of slum dwellers are worse to that of Rural areas in some respects, there is urgent need for some specific programme targeting urban slums.