

## **CHAPTER-VI**

### **DISCUSSION AND CONCLUSION**

This chapter deals with discussion on the findings, suggestions proposed, conclusion and the implications of the findings of the study for Social Work Services, Social Work Trainees and Social Work Research.

#### **Discussions**

Under this section, the findings from the analysis of various data are being discussed below under the following headings

#### **1. Discussion on Maternal Health**

##### **a) Safe Motherhood**

It had been observed that nearing cent per cent of the women beneficiaries were mother beneficiaries, who had given birth to one or more children out of total 360 women beneficiaries interviewed under the study. Out of these mother beneficiaries, half of them had attained the first pregnancy at the age of 10-22 years and one fifth of them had attained at an age below 18 years. The average age of first pregnancy among these mother beneficiaries is 21.17 years. These shows that still there are more than 20 per cent of women in rural areas out of every 100 mothers remains at risk during the birth of their first child as against the 16 per cent in Assam. (NHFS-3). This points out the necessity of more concentrated efforts in the area of increasing the age of pregnancy and age of marriage in Barak Valley.

The ANMs/LHVs visit to the mother beneficiaries, all most all of these beneficiaries were visited by ANMs or LHVs during pregnancy and more than two third of them were visited by ANMs/LHVs once in a month. On medical check-ups during pregnancy, below half of them the beneficiaries had gone for two times medical check-ups during their pregnancy period and only one fifth per cent gone for three times. This shows that the number of women going for three antenatal check-ups as recommended under RCH Programme is far low than the number in all Assam which is 36 per cent(NFHS-3). The present study in the three districts of Barak Valley revealed had a poor coverage when number of Antenatal check ups was compared with NFHS-3 data of Assam. As per RCH program all the districts should have achieved at least 100 per cent coverage of 3 Antenatal Check ups.

Out of the 345 mother beneficiaries, all of them had been immunized by TT and high majority of them had taken Iron and Folic Acid tablets during their pregnancy and took more than 100 tablets. As regard to the intake during pregnancy is concerned all of them took green leafy vegetables, pulses, fruits, and milk during pregnancy. These findings indicate the improved coverage of TT immunization for women

It was also found that incase of place of delivery of child birth, out of the 345 mother beneficiaries, majority of them had given birth to one or more children at home with one third attended by trained Dai followed by almost same number of them attended by Village Dai. As far as practice of safety measures during delivery at home is concerned a high majority replied positively on the

practice of safety measures during delivery at home. These findings in comparison to the data of NFHS-3, shows the difference in the institutional delivery, where in Assam 23 per cent of the births are institutional as against the 15 per cent in found by this present study in Barak Valley region pointing towards the improvement needed.

It is also seen that two third of the mother beneficiaries had started breast feeding to their new born child immediately after birth and high majority preferred breast feeding as and when the new born required or demanded. During their lactating period almost all of these mother beneficiaries took fresh Vegetables, fruits, milk and others in their nutritional intake. It is recommended under the RCH Programme that every women should start breast feeding their newborn immediately after birth, but the present study reveals that still there is more than one third of women do not comply to that.

#### **b) Nutritional Anaemia**

The intake of Green leafy vegetables, Cereals, Pulses, Lemon/Orange, Meat during pregnancy by the mother beneficiaries was found high and at the same time the intake of Wheat, Ragi, Jowar, Bajra, Pulses, Meat, Leaves, cereals by the family members in the age group of 0-19 years was also high. It is also found that leaving ten out of 100 beneficiaries given green leafy vegetables in the weaning of food during infancy to their children, which are helpful to avoid nutritional Anaemia. But, at the same time a very low number of the beneficiaries received 50-100 Iron and Folic Acid tablets (small) for their children of age 1-5 years. These make it clear that though the intake of food

favorable for avoiding and prevention the Nutritional Anaemia among pregnant women and children is quite satisfactory, but the possibilities of children getting Anaemic can not be ruled out as the coverage of Children aged 1-5 years by IFA tablets is very low.

### **c) Adolescent Reproductive Health**

The study exhibits that two third of the beneficiaries had no education and knowledge on safe sex, STIs, RTIs, STDs and only 31.94 per cent received such knowledge and education from ANMs/LHVs. On the frequency of conduction of adolescence girls meeting by ANMs/LHVs, more than half of the beneficiaries refused of conduction of such meeting. But, it is encouraging to note that no beneficiary found suffered any kind of sexual infections or disease. The RCH Programme has been strongly focusing on adolescents reproductive health and awareness on RTIs/STIs/STDs/HIV/AIDS among the all people special among women in the reproductive age group. The NFHS-3, found that in Assam more than 65 per cent of married couple aware of HIV/AIDS, RTIs, STIs and STDs and compare to that the awareness level in Barak Valley is below the half of that of Assam giving the hints of lot of efforts need to be taken in this area of public health.

### **d) Gender Issues**

To avoid discrimination based on gender, the RCH Programme has been trying a lot to motivate people to equal health care to their all children. The study also found that from mothers side there was no such discrimination except only a

very negligible number of family members of the beneficiaries favors male child for being productive in future as against female child. In case of all mother beneficiaries, no body of them went for sex identification during their pregnancy.

## **2. Discussion on Child Health**

### **a) Mortality Rate and breast feeding**

In terms of no. of children given birth by mother beneficiaries was 1349 till the day of interviewed and among them almost half had given birth to three and more children. Out of these children 41 children died within the age of 5 years and majority of them died at home. 75 per cent of the died due to fever and other diseases unknown to the beneficiaries. By calculating the number of infant deaths and child deaths in last one year fro the day of interview, it was found that IMR and CMR were 81 per cent and 41 per cent respectively, which are much higher than both the national and all Assam level.

In case of length of breast feeding to children, just above half of the mother beneficiaries continued breast feeding to their children up to 6 months, where as in all Assam level more than 63 per cent of mothers exclusively breast feed their children up to the age of 6 months. This reflects the low achievement in inculcating the breast feeding habits among the mothers of Barak Valley.

### **b) Nutrition**

While talking about the giving nutritional food to children, fifty per cent of the mother beneficiaries started giving semi-solid food to their children at the age of 4-5 months It was also observed that nearly all of them were giving nutritious

food such as cereals, dal, vegetables, fruits, oils, fresh food, eggs, nuts, milk and milk powder to their children in the age of 1-2 years and high majority of them were giving equally mixed food to their children of 3-6 years of age. As per the data of NHFS-3, in Assam 59 per cent of children received semi-solid food in the age of 4- months, but, in Barak Valley the performance is low.

### **c) Newborn care and Childhood diseases**

It had been found that incase of practice of safety measures such as clean hand, surface, razor blade, cord tie and clean cord stump during delivery at home, the high majority of them replied positively with maximum forty per cent attended by trained Dai and a very negligible portion of them attended by doctors or any other health functionaries. Compare to that in Assam 31 per cent of birth assisted by doctors/LHVs/ANMs. (NFHS-3).

The study also revels that only 10 out of 100 mother beneficiaries took all required care to the new born babies. A huge majority of the mother beneficiaries did not kept their new born babies in close contact with them to prevent hypothermia. Almost one fifth of the mother beneficiaries given birth to one child each with birth weight less than 2500 gms and more the two third of them were treated at PHCs and civil hospitals.

In connection to knowledge received from on spacing of birth, it was found that the below half of the beneficiaries received the knowledge and education from the ANM and more than half of the beneficiaries received the education on new born risks from the ANM/LHV.

It has also been discovered that 41 children of their families suffered from Acute Respiratory Infection (ARI). Out of these 41 children, nearly two third of them suffered from fast breathing and rest suffered from chest drowsing and both respectively and majority of them consulted doctors for the treatment. Talking about the education on the precautionary measures to be taken at home to the child with pneumonia such as keeping the infant warm and away from draught, exclusive breast feeding up to 4 months of age, DPT and Measles vaccination at the appropriate age and hand washing while feeding and touching the child, the 100 per cent of the beneficiaries replied that they had received such education from ANMSs/LHVs.

For children under 5 years of age suffered from diarrhea, a significant number nearly half of the mother beneficiaries replied that their one or more children suffered the same and out of them only forty per cent of them treated at PHCs. On asking about the getting education from ANMs/LHVs about increased quantities of fluid to the child and continued breast feeding during diarrhea, all the beneficiaries replied positively. But, on early signs of dehydration the response was nil and only near to twenty per cent of them learnt how to prepare ORS and its doses from ANMs/LHVs.

Among the mother beneficiaries, only ten per cent of all the mother beneficiaries reported with one of their children suffered from Vitamin-A deficiency. Out of all the mother beneficiaries near to half of them took care of their children in consumption of Vitamin-A rich food and exclusive breast feeding.

## **Immunization**

In respect to the immunization, a very high majority of the mother beneficiaries replied that all of their children were immunized and they came to know about immunization from mass media followed by from ANMs/LHVs. As far as complete immunization by the all doses of BCG, DTP, Polio, TT and Measles only fifty per cent of the replied positively and above half of them were immunized at PHC/HSC. I

In comparison to the data of NFHS-3, in all aspects the in this part of Assam, the performance and impact of RCH Programme on the various issues of newborn care, childhood disease control and immunization

### **3. Discussion on Contraceptives and Family Planning**

About family planning, half i.e. 52.50 per cent of the beneficiaries know about family planning and its various methods. Out of them 45.50 per cent and 39.68 per cent of the beneficiaries received knowledge and education from ANMs/LHVs and PHC doctors/staff respectively. As far as adoption of any family planning methods, only 13.04 per cent of all the mother beneficiaries went for the same and out of these 42.86 per cent, 30.16 per cent, and 8.16 per cent 6.12 per cent, 4.08 per cent of them adopted Oral Pills, Condom/Nirodh, IUD, Vasectomy and Tubectomy respectively. This study thus indicates that the family planning in this rural part of Assam is still not adopted by the beneficiaries/eligible couples up to the desired level as against 56 per cent of eligible couple found using any methods of family planning in Assam. (NFHS-3).



## CONCLUSION

We have discussed all the findings and observations of the study on impact of RCH Programme in Barak Valley, Assam and this discussion leave enough room for improvement both at planning and implementation level

**To conclude, the following points can be highlighted-**

- Though the awareness level of people have been increased by the implementation of RCH Programme in rural areas, but the achievements in respect to different health indicators are lower than the set goals. This because people in rural areas are still not able to recognize the benefit of good health and its impact on their socio-economic development. Another reason behind this is that rural people are also more dependent on traditional health practices and believes.
- The people are accepting the different services, when it is offered to them or when health functionaries are reaching to them. These people in rural areas are lacking knowledge and interests for health and hygiene and that's making them reluctant in approaching health services when needed and in general.
- The adaptation of family planning methods by male is far below than females. This factor is as a result of decision making power with the male member and the belief that the sterilization of male affects the working capacity.

- More than 60 per cent of the beneficiaries are not aware of safe sex, STDs, STIs, RTIs and HIV/AIDS. Health functionaries providing education on the same is also not satisfactory. These rural communities are with the attached taboos that sexual issues are not the topic of open discussions preventing them from receiving knowledge and information on sexual health.
- Intake of Iron and folic acid tablets by children and new born care knowledge are very negligible. Child health care is still a neglected side of rural health as people are not very much keen to upgrade themselves on children upbringing and development rather believing that it is natural process to follow.
- Community ownership of health intervention yet to generated and mobilized among the communities. Health Care facilities available in rural areas are not fully utilized by the community people as the find it as responsibility of the government. This because of deleting from their thinking that these facilities are meant for them and they need to take active part in their smooth management.
- The manpower resources are not adequate and the overloading on the existing human resources is affecting the overall performance. It has been seen that specially in rural areas health functionaries are working far more than the set norms. This because of high concentration of health manpower in urban areas and low interest of working in rural areas.

## SUGGESTIONS

Based on the findings of the study, following suggestions can be forwarded for better implementation of the programme in near future.

- Create awareness among community, increase community support and male involvement thereby family is mobilized for institutional deliveries
- Involve PRIs, CBOs and NGOs. Chalk out strategies to involve these agencies
- Enhance accessibility and availability to skilled birth attendants
- Need to create conducive environment whereby all the pregnant women are encouraged to go for institutional deliveries
- Promote public private partnership
- Provide referral linkages and transport facility for referral transport
- Comprehensive training and skill enhancement of health personnel's managing primary health facilities..
- Involve ICDS AWWs actively in education, motivation activities, these should be reviewed regularly
- Out reach work in the community should not be for service provision but education and motivation.
- Create awareness among the community on exclusive breast-feeding.
- Strengthen immunization; the routine immunization clinics should not be disturbed.
- Invite adolescent girls to mothers meeting
- Condoms should be available to unmarried also

- Develop special strategy to reach school going and out of school adolescents
- Involve NGOs, CBOs in educating adolescents
- Expand the choice of method and its accessibility and availability. Regular uninterrupted availability of contraceptives should be ensured
- There is a need for change in contraceptive for a couple over time period, hence make it available as per their need.
- Temporary method should be given as a prescription form, it should be given to couple right at the beginning, not after they have completed their desired family size.
- More political commitment is required.
- Ensure provision of women friendly RTI/STI treatment.
- Expand access for quality RTI/STI services .
- Strategies for strengthening BCC have to be worked out
- Streamline the training procedure, does the training programme lead to improve output,
- All training should focus on capacity to interact with individual, in groups, with adults
- Key persons should be identified and trained in the early years of their service. Widen the network of hospitals that are providing 24-hrs services in rural areas.
- Bring in Panchayati Raj Institutions and make them more accountable.
- BCC should be for all level of staff not for community only .
- Focus has to be done on quality service.

- Strategies to be tailored to meet needs of the community.
- Develop service delivery plans locally \_ Mapping facilities, educate facilitators involving PRIs, CBOs and find local solutions.
- Out-reach services should be increased to increase the coverage.
- In school curriculum of elementary level education should include more and more health topics.
- Measures should be taken hassle free service delivery in health institutions.
- Indigenous system of medicines should be promoted to benefit more rural people.

## **IMPLICATIONS FOR SOCIAL WORK PROFESSION**

For Social Work education, training and research, the study gives the following scope of concentration and future trends of learning

- More and more training needed to work in the field of rural health care on behavioral change communication and community organization.
- Learning of management skills and techniques such as health care management, hospital administration by the students wish to work in health sector.
- Social work researches need to be carried out in the areas of Human Resource Planning and management in rural and primary health care system.
- Shortfalls and lacunae in the primary health care system pave the way for social work students to be placed in there for training and improvement of the same at community level.
- A separate subject is suggestive to be introduced on Primary Health Care to make the future students well versed with the skills and techniques required to work in the area of rural health care.
- As the social work professions mainly concentrate on rural development and the rural health care is an integral part of rural development. This makes it very much essential that field work

curriculum of Social Work Education need to have compulsory field work training in rural health care arena.

- It has been seen that no more the rural health facilities remains the sole responsibility of Government or higher authority. This leads to the focus point that local self governmnt/PRI's role in the planning and implementation of these services. Here it gives the scope for social worker to get involved as facilitator or as a catalyst to help these institutions in the process of planning and implementation of Rural Health Care Services.
- Non-Government Organizations need to be motivated to give more focus on Health Care apart from the income generation activities. Thses NGOs can be helped by the trained social workers in developing comprehensive and holistic programmes/projects on RCH or rural health care in general.
- Social Worker with their training and knowledge need to find out the factors responsible for low achievement in rural areas in case of RCH and provide effective plans and strategies to minimize the lacunae and improve the performance.
- One of the major areas where social workers can contribute to the better achievements in the field of rural health care is the implementation. Social Workers working both at government and non-government sectors should contribute in developing more community friendly implementation plans.

- There is lot of room for initiating policies that makes RCH services more accessible and affordable. These policies need to be initiated from the beneficiary point of view. Here social workers can play the role of policy initiator by influencing appropriate authority. While developing such policies, social workers can play the vital role of developing community profile, assessing community needs and resources that will be the key areas of focus.
- As community workers, social workers can also facilitate in establishment and effective maintenance of groups within the community that are interested in the overall community development.
- Social Workers by collaborating with the other agencies, professions and departments to bent them for taking initiatives in RCH activities in rural areas can play a vital role.