Socio – Cultural Barriers In The Adoption Of Safe Reproductive And Child Health Practices: A Case Study Among Tribals in Bastar

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ABSTRACT

Tribal groups are homogeneous and culturally rich in traditions. They have their own magico-religious health care system since time immemorial. The prevailing health care system has been found not only inadequate but also primitive in nature.

Maternal and child care are an important aspect of health care practices which are largely neglected among the tribal groups. On the basis of the studies of cultural values and social norms, the Anthropologists is in a position to explain to health personnel and administrators that how these traditional beliefs and practices conflicted with western medical assumptions; how socio-cultural factors influenced health, diseases; how cultural factors took care of health and cured illness; and how health and diseases are just aspects of total cultural patterns, which change in the company of broader and more comprehensive socio-cultural change.

In view of above, the study aims to identify the socio-cultural barriers in a tribal set up in adopting safe reproductive and child care practices and to suggest measures in planning the programmes in accordance with these understanding. The study is depended upon secondary and primary data both and selected areas are the villages of Bastar in Chhattisgarh.

In the present study, an attempt has been made to focus on knowledge, awareness and practices about health and its correlates among tribal women to identify the gaps of knowledge and to suggest a possible plan of action besides pointing out the debatable issues.

Key Words: Maternal, Child Health, Socio-Cultural Change

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Introduction

The tribal population forms 8.2 percent of the total population of India. About 84.33 million persons have been enumerated in the country (excluding Jammu & Kashmir) as Scheduled Tribes (2001 census). These tribal groups inhabit widely varying ecological and geo-climatic conditions (hilly, forest, tarai, desert, coastal regions etc.) in different regions throughout the country. They are distinct biological isolates with characteristic cultural and socio-economic background. Tribal groups are homogeneous and culturally rich in traditions. They have their own magico-religious health care system since time immemorial. The prevailing health care system has been found not only inadequate but also primitive in nature.

This study focused how socio-cultural and environmental factor influenced to Maternal & Child health among the Halba tribal community of Madpal village of Bastar district, Chhattisgarh.

Combined with information on childhood mortality, this information can be used to identify women and children who are at risk because of nonuse of health services and to provide information that would assist in planning interventions to improve maternal and child health.

Maternal and infant deaths are sizeable but the advantage here is that they can be prevented merely by more intensive utilization of existing rural health infrastructure. Policy and implementation must keep steady focus on key items such as improved institutional deliveries better trained birth attendants and timely antenatal screening to eliminate anaemia and at the same time isolate cases needing referral or other targeted attention. After all Chhattisgarh has by such methods ensured closed to maximum institutional deliveries backed by a functional referral. Firm administrative will and concurrent supervision of specified screening tasks included in MCH services can give us a window of opportunity to dramatically bring down within a few years alarming maternal mortality currently one of the burning topic (NFHS, 2010).

It is the accepted that due to geographical factors, certain area of Bastar are more fertile than others. Some areas are favoured with regular monsoon rain, where as other are arid uplands or drought prone areas. Naturally nature of problems differs from place to place. Just to overcome difficulties, Government of India had set up the Planning Commission (1950). Human resources had to be mobilized to utilize the maximum physical resources training and orientations were needed to reshape the mentality. Naturally full fledged maternal and child

health care as well as development activities were in operation not only in this part but all over the country. Beside anthropological investigation was given priority just to diagnose the problems to overcome them and to see smooth health care delivery systems for mother and child to reach the goal.

It has been stated that in India, tribals (those who are scheduled) are distributed at varied zones with different types of interactions with many types of people having different socio-economic status. As the groups of people are to articulate with many situations, we find different types of bending and angularities in their life style. So, problems differ from place to place as well as from group to group. Under such situation question of health care delivery as well as welfare and care is not easy. It requires systematic study as well as the understanding of the people and their mentality (Kolay, 2001).

Material & Methods

The present study was conducted among the Halba of Chhattisgarh. The data were collected from the Madpal village of Bastar district. The sample size of the present study comprised of 70 Halba families. The data were collected using a semi-structured schedule followed by focus group discussion and case studies method. Ante-natal, natal and post-natal care data were collected by pregnancy enumeration.

Study Area

The data were collected from tribal multiethnic village Madpal under Bastar Block as well as the district of Chhattisgarh. The state lies at 17°46' N to 24°5'N latitude and 80°15' E to 84°20' E longitude Bastar district -the largest district of Chhattisgarh-covers an area of 17020 sq. km and lies between North latitudes 18°38’8.5” and 20°11’40.56” and East longitudes 80°39’47.12” to 82°14’51.29” with population of 1302253 as per 2001 census. The population of the district is 1,302,253 (2001 census). 70% of the district's population are tribals (adivasis). Where as in 1981 Bastar had a population of 1,842,854 with 1,249,197 of the residents being members of scheduled tribes.

Observation: Result & Discussion

Maternal and child health care practices among the Murias of Bastar have not improving steadily. The Halba generally take no significant pre-natal care in the house, nor do they do so in the PHC, it is revealed that the average of ante-natal and post-natal care is very poor in all the Halba communities under study, living in close proximity. The Halbas, who are served by Primary Health Center or Subsidiary Health Center, are in a better position to have health and nutritional services than those living in remote areas. It is also seen that the Halbas generally received pre-natal and post-natal care only if they suffer from severe illness during pregnancy and lactation period. It is due to the belief that delivery of the children is a normal process which does not require any special care (Kolay, 1997).

Table 2: Conducted the delivery

S. No.	Conducted	No.	%
1	TBA	1	1.85
2	Untrained TBA	35	64.81
4	Mother-in-law	5	9.26
5	Elderly ladies	2	3.70
6	LHV/ANM	4	7.41
7	Doctor	6	11.11
8	Any other	1	1.85
Total		**54**	**100**

During the fieldwork 48 women were found to have at least one birth and 16 women were found to be currently pregnant during last two years in Madpal village. It was observed that 87.14 percent women registered for ante-natal services during pregnancy, majority number 48.57 percent registered which 1st trimester followed by 40 percent registered 2nd trimester and 10 percent are not registered of any month during pregnancy.

As far as 90.47 percent women take ante-natal care during pregnancy from AW, 95.38 percent pregnant women get immunized for TT either through Anganwari Workers (AWs) or ANMs or Govt. hospital. Most of the women consume Iron & folic acid tablets during pregnancy.

An inquiry was made about place of those women who have had any birth during last two years table-1 presents data on the place of assistance received at the time of delivery. The analysis indicated that a less number of deliveries (3.70 percent) were institutional (at PHCs).12.96 percent deliveries were conducted at Government hospitals. Significant proportions (83.33 percent) of all deliveries were conducted at home.

Table 1: Place of Birth

Place	No.	%
Home	45	83.33
PHC/SC	2	3.70
Govt. Hosp	7	12.96
Total	**54**	**100**

It has been found that delivery mostly takes place in their house, rather than in health centers. It is reported by the key information that delivery in house is better, because in the house family deities and ancestral spirits can protect the mother and the child from the evil sprits (Kolay, 1997).

Table 2 shows that 64.81 percent of deliveries were conducted by untrained TBA While 1.85 percent by traditional birth attendants. The women belonging to Mahara (Swin) caste traditionally perform the activities of a midwife. Many Halbas believe that such a women or midwife is better than a trained dais.

Table 3 present natures of complications experienced by CMW during at the time and after delivery. The analysis of the data shows that 54.55 percent of the women have had some complications during delivery, 66.67 percent of had some complications at the time of delivery. Bleeding from vagina was the most common problem reported during pregnancy (36.67 percent) followed by odema (23.33 percent) no foetal movement, giddiness and fever were other complications which were experienced by the Halba women during the pregnancy. At the time of delivery the following problems were encountered with varying which are long labour pain was most common problem (50 percent) followed by bleeding from vagina (28.13 percent), baby stuck (9.38 percent). Bag burst early, delayed Placenta were other problems which were experienced by CMW at the time of pregnancy. Of those mother who have had complication during delivery, 44.12 percent of the mother sought treatment from *dai*. While 29.41 percent of the mother sought home remedies for the problems they experienced after delivery, 11.76 percent consulted Government doctors, 8.82 percent only PHC and 2.94 percent only privet doctors.

Table 3: Percentage of Halba Women* who had Complication during, at the time and after Delivery

Nature of Complication	**Number of Women (in percentage)**
Complications during delivery	54.55
Type of complications during delivery	
Giddiness	3.33
Swelling of face/legs (Odema)	23.33
Fever	13.33
Bleeding from vagina	36.67
No foetal movement	23.33

Percent of women who had complications at the time of delivery	66.67
Type of complication at the time of delivery	
Bag burst early	3.13
Baby stuck	9.38
Long labour pain	50.00
Placenta delayed	3.13
Bleeding from vagina	28.13
Any other	6.25
Source of treatment after post delivery complication	
Govt. Hospital	11.76
PHC	8.82
Pvt. Doctor	2.94
Home remedy	29.41
Dai	44.12
No Treatment Sought	2.94
Percentage of women who had satisfied with the treatment	73.53

**Currently Married Women (CMW) who have had a delivery during last 2 years*

Table 4 shows that for the majority of the informants (84.62 percent) blade was the only material used for severing the umbilical cord. Its use is extensive among the Halba. About (13 Percent) of the Halba mothers mentioned of using scissor for cutting umbilical cord.

Table 4 :Instrument use for cutting the cord

Used Instrument	No.	%
Blade	44	84.62
Scissor	7	13.46
Any other	1	1.92
Total	**52**	**100**

Table 5 present position at the time of delivery an expectant mother would sitting with hand holding by other women is mostly (50 percent) apply by them and 32.69 percent expectant mother position in squatting by pressing by grasping the rope tightly in both hands .

Table 5 :Position of Delivery

Position	No.	%
Sitting with rope	17	32.69
Sitting with hand holding by other	26	50.00
Sitting with knee	1	1.92

Lay	8	15.38
Total	**52**	**100**

It was observed that 56.60 percent of the expectant mother did not consume any specific diet during pregnancy and 43.40 percent expectant mothers were consumes specific diet during pregnancy. 84.91 percent of the women were found to perform hard work (cutting woods, carrying woods, bringing water, Lifting heavy articles etc.) even during last trimester. There is a common belief that colostrums are widely discarded in India. National Family Health Survey (NFHS-1999) data states that 62.8 percent mother respectively squeeze the first milk from the breast before initiating breast feeding. As per as child care practices is concerned among the Halba, plain water, honey, jiggery water to the child, during the very first day of birth. The Halba believe that breast milk of the lactating mother just after delivery is bad for health of new-born. Thus, the infants are deprived of getting the necessary for which is helpful for a new born baby to develop immunity against communicable diseases. It can be seen from the table 6 that 58.82 percent infants get their first feed as mother's milk without colostrums. 27.45 percent Halba mother have knowledge about colostrums and knew that it should be given. 27 percent of women breast feeding were initiated within 2 hrs followed by 23 percent breast feeding start 12- 24 hrs after the delivery. It also shows the distribution of Halba mothers according to their responses on time for starting supplementary feeding. There is maximum concentration of responses in supplementation child age between 10 to 11 month more than 62 percent of the mothers introduce semi-solid or solid food after the child is above 10 months year old. The data also reveal that, some mothers supplementation their child is 8 to 9 month year old (37.5 percent). As per as initiation of supplementary diet by Halba women are rice and rice-starch form the main food for the babies *(paz)*. Cooked rice and mixed dal (pulse), vegetables, milk, dalia, etc.

Table 6: Childcare Practices among the Halbas

Childcare practices	Percentage
First feed given to new born (n = 51)	
Colostrums	27.45
Plain water	3.92
Jaggery water	1.96
Mother's milk without colostrums	58.82

Honey	7.84
Age at Supplementary diet given (n = 16)	
8 - 9 month	37.5
10 - 11 month	62.5

Immunization is a National Health Progremme in India. All children under the age of six years are to be immunized against six serious and preventable disease (childhood tuberculosis, pertussis (whooping cough), tetanus, poliomyelitis, measles and Diphtheria in crucial for reduction of infant mortality. This programme is carried out in all government hospitals, dispensaries and Primary Health Centers. Children bellow the age of one year are given three doses of DPT (against diphtheria, whooping cough and tetanus), three doses of polio(against poliomyelitis), one dose of measles and B.C.G. each (against measles and T.B.). At the age of 18 to 24 months booster doses of DPT and polio are given. The schedule that tells us when and how many doses of each vaccine are to be given is called immunization scheme. It is seen from table 7 that Halbas are highly motivates for immunization programme. More than 81 percent of the children have been vaccinated for DPT, Polio and BCG. Performance in administration of vaccination for measles and vitamin-A prophylaxis needs further strengthening of the efforts in this direction. Incidentally, government institution is the primary source of vaccination is more than 99.48 percent of cases. By and large immunization coverage is satisfactory in Halbas of Bastar district.

Table 7: Status of child Immunization among Halbas

Vaccination	Percentage
1.DPT (n=49)	
a. Yes	81.63
b. No	18.37
2.Polio (n=49)	
a. Yes	81.63
b. No	18.37
3.BCG (n=48)	
a. Yes	83.33
b. No	16.67
4.Measles(n=49)	
a. Yes	65.31
b. No	34.69
5.Vitamin A(49)	
a. Yes	85.71
b. No	14.29

As far as family planning method is concerned for appropriate spacing the children in such a way that the women conceive with minimum risk of her as well as

offspring's life and health. (Kolay,2005). Most people are not aware (20.51 percent) IUD//Loop/CUT method. Most of them knowledge about Oral pills 19.81 percent followed by above 16 percent knowledge about vasectomy and tubectomy.

Table 8 :Level of Awareness of FP methods among Halbas

S. No.	Type of Contraceptive Method	Responses			
		Yes		No.	
		No	*%*	*No*	*%*
1	Vasectomy	53	16.67	17	5.45
2	Tubectomy	52	16.35	18	5.77
3	Nirodh	57	17.92	13	4.17
4	IUD/ Loop/ CUT	6	1.89	64	20.51
5	Oral pills	63	19.81	7	2.24
6	Rhythm/ safe period	20	6.29	50	16.03
7	Abstinence	20	6.29	50	16.03
8	Withdrawal	38	11.95	32	10.26
9	Any other	9	2.83	61	19.55
Total		**318**	**100**	**312**	**100**

Table 9 present current users of various contraceptives method among Halba. This table reveals that 26.66 percent of the total respondents were not using any contraceptive methods. It can be seen from the table that Halba couples are very highly aware about terminal contraceptive methods as well as spacing methods. Awareness about VT and TT was found to be 16.36 percent and 5.45 percent respectively. However, most of them are aware about nirodh, IUD/Loop/ CoT, oral pills, abstinence and Rhythm/ safe period as methods for avoiding conception.

Table 9: Current use of Family Planning methods among Halbas

Contraceptive Method	Currently using	
	Number	Percentage
a. Any method	55	73.33
b. None	20	26.67
Total	**75**	**100**
a.VT	9	16.36
b. TT	3	5.45
C. Nirodh	13	23.64
d. IUD	1	1.82

e. Oral pills	21	38.18
f. Abstinence	7	12.73
g. Rhythm/ safe period	1	1.82
Total	**55**	**100**

Summary, Conclusion & Suggestions

In summary it can be inferred that Halba of Bastar are at different stage of demographic transition. Although they are lagging behind Indian National Population, a comparison with past studies on tribal health indicates that Halba are slowly but gradually progressing for better future. Morbidity trends among them are quite mixed up. Halba had very strong preference for utilizing the services of traditional healers. There were a number of private practitioners practicing in this area. Government health providers were doing stupendous job in Bastar district. However, scattered population, poor transportation/ connectivity and vacant position at various levels hamper effective health care delivery. It may be highlighted that Halba reveals neither literate nor economically affluent.

It would be worthwhile to state here that besides progressive measures of economic and social development (including sturdy transport connectivity) placement of and the role of health providers are the most important factors in improving health status of the tribal groups in India. Among the health providers the Government health providers are the key players. I say that the job of primary health care providers is stupendous. They are catering to a large segment of the society remarkably well. The primary health care delivery model now functioning under Government of India is doing fairly well. It should be understood that it provides enough width for some amount of regional variability within certain limits. There is no need for any policy of programme shift at this juncture, because the model has not been exploited to its full potential. It is therefore recommended to strengthen the existing set up of the programme for better service out put.

Halba of Bastar have specific problems, some of are inbuilt problems of communities and some are imposed upon them which jeopardize their overall development and progress inclusive of their health. Therefore, the health care delivery system should be such designed for Halba specific group of Bastar that it caters to their specific needs and problems by bringing their personal involvement. Simply increasing the number of health care facilities and technical manpower is not going to solve the problem. Research studies should be directed towards

understanding their knowledge and concept of health, felt needs for promoting and ensuring greater acceptance of purposeful modern health care practices.

The following strategies, if actively pursued could go a long way towards improving health and overall development not only the Halba of Bastar but also all tribal population of India:

- Positive Halba tribal culture/values, traditional skills should be encouraged and inducted into the mainstream of life.
- Study of nutritional status and physical growth among Halba children should be carried out for an effective strategy to plan nutrition intervention programmes.
- Hundred percent immunizations for pregnant mothers and children below five years must be targeted.
- Health education should be imparted by the local people (preferably women) with guidelines provided by health functionaries. It can also be imparted through distribution of leaflets and playing of audio and where possible video cassettes, preferably in local dialects at weekly markets, ghotuls and schools etc. Health Education through community participation.
- Organization of short-term orientation courses on Halba culture for health workers at district and sub-divisional headquarters.
- Training of Halba girls as nurses midwives to generate better response.
- Mobile health Teams should be formatted to provides more coverage. Tribal "Hatts" can be taken as the focal point of the activity.
- Local community leaders, clan chiefs must be involved in the decision making process, in which Halba women must also be included.
- Female health personnel should be increased, particularly in Halba, to provide the effective health services to mother and child.
- Establishing or updating national policy and standard for midwifery practice for maternal and newborn care, family planning including post-abortion and induced abortion care (where not against the law), and developing a combination of regulatory measures to support these policies and standards.
- Encouraging home/family, community-level practices that promote maternal and newborn health, and fertility regulation.

- Help Halba pregnant women to reach the relevant facility promptly especially during complications.

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