A Qualitative Study on Maternal and Child Health Practices among *Baiga* Tribe of Madhya Pradesh State in Central India

D. Kumar[1], A.K. Goel[2], V. Ghanghoria[3], P. Ghanghoria[4]

[1]Scientist D, [2]TA (Research): National Institute for Research in Tribal Health (Indian Council of Medical Research), Nagpur Road, Jabalpur, [3]Assistant Professor (Obst. & Gyn.), [4]Assistant Professor (Paed.), NSB Medical College, Jabalpur

***Corresponding Author:**
Email: dk2508@rediffmail.com

Abstract

Introduction: Health improvement for the tribal and their delivery system cannot be the same because of cultural pattern, lifestyle and health seeking behavior of tribal population. Maternal and child health care practices observed to be poor among particularly vulnerable tribal groups (PVTGs) in India.

Methods: Focus Group Discussions (FDS) were conducted among ever married women aged 15-49 years. Areas explored included disclosure of pregnancy status, access barriers, perceptions about existing maternal and child health (MCH) services and influencing factors for utilization of traditional health care facilities. Content and thematic analysis was used to identify common responses and ideas.

Results: Twelve FDGs were undertaken by trained investigators one in each village. Participants were identified through the Accredited Social Health Activists (ASHAs) residing in the same village. It was observed that few women are disclosing their pregnancy status to their family members after first trimester; women have many wrong perceptions about safe delivery and abortions. Due to lack of transport facilities and poverty they felt seeking health care was difficult and costly.

Conclusion: This study demonstrates that *Baiga* is one of the PVTGs residing in dense forest in central India have low awareness and underutilization of MCH services.

Key words: Particularly Vulnerable Tribal Groups, Tribal Population, Indigenous Health System, Maternal and Child Health, Rural Practice, Forest and Interior, Remote Area

Access this article online	
Quick Response Code:	**Website:** www.innovativepublication.com
	DOI: 10.5958/2394-2738.2016.00003.0

Introduction

Millennium Development Goal (MDG) five is focused on reducing maternal mortality rate (MMR) and achieving universal access to reproductive health care. Under MDG 5, India has committed to reducing maternal mortality to 108 deaths per 100,000 live births by 2015. India has made extensive efforts to reduce maternal mortality and to increase access to reproductive health care. However, the progress made has been uneven and inequitable, that is highest MMR in Assam (390) and the lowest in Kerala (81).[1] As per Third National Family Health Survey conducted during 2005-06, reported that infant mortality (IMR) rate was higher among tribal population (62.1) as compared to the national average (57.0).

About 99% of maternal deaths occur in developing countries and India accounts the largest number. India's MMR is estimated to be 254 per 100,000 live births.[2] It is estimated that two thirds of these deaths take place in the tribal dominated states of Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttaranchal and Uttar Pradesh. Madhya Pradesh state covers 21% tribal population, residing in dense forest and hilly areas. They are mainly concentrated in southern part of the state and their lifestyle, culture and customs most resembles the Hindu religion though they still strongly believe in orthodox traditions. According to a UNICEF study, 61% of maternal deaths occur in tribal communities in India.[3] Studies also done in different parts of Madhya Pradesh among different tribal population reported that higher maternal mortality.[4,5]

The National Institute for Research in Tribal Health (ICMR), Jabalpur, Madhya Pradesh has conducted a series of studies to measure the scale of tribal health problems and to recommend measures to improve their health conditions. In this link we also undertook studies to improve the maternal and child health (MCH) care practices among tribes in Madhya Pradesh. The current communication we describes the qualitative findings of the study on perceived barriers of utilization of maternal and child health care practices among Baiga women in terms of (1) disclosure of their pregnancy status to the family members, (2) modern treatment access barriers, (3) wrong perceptions about the prenatal care, (4) perception about the available MCH services and (5) pushing factors for utilizing services of traditional healers.

Methods

Setting: Dindori district of Madhya Pradesh in central India is a tribal district, 95% of the total population lives in rural areas and 65% were tribal population namely Baiga, Kol, Pardhan, Dhula, Bhoomia and Agaria. Bahu Lamsena, Jadoo-Tona, Jhada-Phooki and alcoholism are co-tradition of this people's life. Dindori district still ranked as a backward district of India based on the following indicators: population living below poverty line, low productivity, very backward pockets of habitations, poor health and educational facilities in respect of the national and international averages.

Study area: This study was undertaken in Dindori district of Madhya Pradesh during May 2013 to April 2014. It was conducted among one of the PVTGs (*Baiga* tribal) of population. Twelve villages were selected from all three tribal denominated blocks based on applying probability proportional to size (PPS) method.

Study population: This study conducted among ever married *Baiga* tribal women aged 13-49 years. The inclusion criteria were (1) women recently delivered a baby; (2) currently pregnant; (3) newly married women; (4) those who are willing to give consent and participate voluntarily. The participants were excluded who are not eligible for inclusion criteria; not willing to participate and women aged more than 49 years; and guests from other villages.

Data collection and analysis: Focused Group Discussions (FGDs) as a tool to collect data. Trained Investigators conducted the FGDs in each village after obtaining verbal consent having informed them the purpose of the study. All the participants were told about the confidentiality of the data collected from them and also about their right to withdraw from the study any time. Each FGDs consisted an average twelve ever married women and it took about two hours to complete. Their participation is voluntary and there is no monetary compensation provided to them. Discussions focused on information related to disclosure of pregnancy status to the family members, access barriers on free government MCH facilities, perceptions about their prenatal care and existing available MCH services and influencing factors for utilization of traditional health care facilities. An interview guide was used for to achieve consistency. The discussion was documented by the principal investigator on the interview template and analyzed manually.

Ethical approval: This study was approved by Scientific Advisory Committee and Institutional Ethics Committee of Regional Medical Research Centre for Tribals (ICMR), Jabalpur.

Results

Coverage: Of the 242 screened, 92 (38%) were eligible to include, 84 (91%) given consent and participated this study. Eight women were not able to participate due to their urgent work.

Perceived barriers of utilization: Table 1 describes the perceived barriers of utilization of MCH services. It was observed that few women not disclosing her pregnancy status to her husband, her mother-in-law and others for first trimester. However, they feel relatively free to discuss with elderly women after completion of first trimester.

Access barriers on MCH facilities: Of the twelve villages, three villages are located in top of the hills and for any reason they have walk long distance and difficult terrain by on foot. There is no PHCs located in these and they need to travel around 8-9 kms to PHCs from these villages are. These people are isolated and community health providers allotted by government is ASHA/Anganwadi. These community health workers are residing in different village and majority of ASHAs are from other communities.

Table 1: Perceived barriers of utilization of maternal and child health care services

Focus points	Results
Disclosure of pregnancy status to the family members	• Few women not disclosing her pregnancy status to her husband in first trimester • Few women not disclosing her pregnancy status to her mother-in-law and others in first trimester • Free to discuss with elderly women after 3-4 months • After disclosing to the family they are happy but not provided special care from husband • After disclosing to the family they are happy but not provided special care from family members also • Family is allowed to continue to do hard work
Access barriers on MCH facilities	• 3 villages are located in top of the hills • 4 villages are connected with poor mud roads • Distance to PHC is about 8 to 9 kms • Once in a day transport is available in few villages • No PHCs located in these 12 villages • Majority of ASHAs are from other communities
Perceptions about the prenatal care	• Pregnancy is natural phenomena • No need for special care and medicines • Work hard to get normal delivery • Use liquor for safe abortion
Perception about the available MCH services	• Marjory not aware about MCH services • ANM visit is not adequate • Fear about immunization • Not provided supplementary food • Home delivery is a safe
Reasons for utilizing traditional healers	• Easy access • Cheaper or less cost • Same community/ relatives • Herbal medicines • Strong believes

Perceptions about the prenatal care & available MCH services: It was a notice that the group expressed pregnancy is natural phenomena, why they need for special care and medicines. Also they perceived that hard work is a factor for normal delivery and family members are encouraged and forced pregnant women to do hard work to get safe delivery. It was also reported that they are very comfort with traditional healers due to easy access, less cost and they will provide only herbal medicines. The views on believes reported by the women regarding MCH services provided in Box 1.

Box 1. Women's statement on MCH services

- "When I was pregnant I didn't tell to anybody and not taken any medical check-up upto four months"
- "Delivery at our home is very safe, since Dai or elderly women are available at my village and they will assist for normal delivery"
- "When I was pregnant, I asked my mother-in-law, can I go for antenatal check-up" she replied saying "No need, it is natural phenomena"
- "When I was pregnant, I was looking alright, Why I have to go to hospital, Am I sick person to go to hospital for check-ups"
- "Need to open a Bank Account to get incentive money Rs 1400 for institutional delivery. I don't have Rs 500 to open a Bank Account, I need time and money to travel to Bank. This is not easy for me"

Discussion

The salient finding from this study was disclosure of pregnancy status to the husband and family members. It was reported at my that few women are disclosing their pregnancy status to their family members after first trimester. They said that if they were pregnant, the disclosure of pregnancy is a not a very joyful moment that is a natural and they never thought of intended or unintended pregnancy. They are not surprised about pregnancy since they didn't use any family planning methods; it was always expected that she will get pregnant some point of time and they will come to know automatically. They didn't feel like sharing this information to the family members. The reason may be due to lack of awareness on importance of prenatal care. Other reason is, if they disclose, there is no special care and support from family members. Some time they don't know whether it is delayed menstrual period or pregnancy. They are waiting upto 3-4 months to confirm pregnancy themselves without any test and to share with others. There is a paucity of information on this aspect from India particularly among tribal population. However, this finding can be substantiated with findings that most of tribal women failed to receive full antenatal care (ANC) because of late registration of pregnancy.[6,7] The disclosure of pregnancy to the family and the reactions this triggers, contemplating deliberations regarding the desirability of the pregnancy, as well as the subsequent management of its repercussions was studied among middle-class families by Federal University of Rio de Janeiro, Garamond in 2005.[8]

Tribal women have many wrong perceptions about safe delivery and abortions. There is a need to advise tribal women to reduce hard work and rest during pregnancy. Also the habit of taking alcohol during pregnancy for safe abortion should be discouraged. Primitive practices of tribal population to be discarded and necessary health education should be imparted. Maintenance of personal hygiene in connection with childbirth, abortion or menstruation should be properly explained in order to improve maternal and child health. The similar findings were reported from tribal population of Kolli hills at Nammaka district, Tamilnadu.[9] The current study area also covered tribal population of hills areas.

It was observed that tribals have deep knowledge about the indigenous method of MCH care services. The interference of supernatural agency is particularly strong in the context of health and disease. The dependency on supernaturals is responsible for the non-acceptance of modern medicine. The decision about the nature of treatment taken at the community level is traditional health care system. It is based on their deep observation and understanding of nature/herbal medicines. Traditional healers are staying in nearby village and they belong to same caste. It was reported that easy to access this people at any time with less cost. Fee to the healer is not necessarily in term of money, it can be any kind. It was noticed that mothers were not accepted antenatal care during their pregnancy due their misperception on 'not necessary and customary'. A study done in developed state Kerala, it was found that tribal women who did not utilize one or more of maternal health care services were of the opinion that ANC and delivering at the hospital were unnecessary (5.7%). They believed that medicines and injections are harmful to health and will cause other health problems. They never consulted hospitals for any diseases. [7]

Other issue was due to lack of hospital facilities and transport facilities, people in this area need to walk a long distance on foot, so most of the women are not going for check up for health centres. Generally delivery among tribal women used to take place in their home with the help of their relatives. Due to the same

reason ANM also not able to visit these villages very regularly. Many of these tribal women were engaged in agriculture and forestry since they are illiterates and unskilled. As a result, these women were working in the hill areas as a daily wage earner or work for their own food collection. Their working hour is more than 10 hours a day. The similar finding was reported from south Indian tribes that about 86% deliveries performed at their home and three fourth of deliveries conducted by untrained Dais and other untrained persons in tribal women in Kolli hills.[9] This evidence corroborate with the findings reported on tribal areas have high neonatal mortality of around 43 per 1000 and contribute to 65% of all infant deaths in those areas.[10,11,12]

The main reason stated by tribal women who wanted to utilize the services but not able to utilize due to lack of availability of public transport facilities in their area. This made seeking health care difficult and expensive. This was a major barrier to institutional delivery and few women delivered before the hired vehicle reached home. The other reasons for under-utilization by tribal women were rude and unfriendly behavior of staff in government hospitals and financial constraints. Though, treatment was free in government hospitals, expenditure incurred were expenses of the person accompanying pregnant mother to the hospital, stay and food.

In terms of health expenditure, the burden of health care spending is greatest among those living in rural and economically poor areas, with members of scheduled tribe caste being the most affected by health care spending.[13] One of the most recent government-sponsored initiatives to improve health care access among poor includes a state government funded health insurance scheme called the Rashtriya Swasthiya Bima Yojana (RSBY) is called "Health Insurance for the Poor". It works by sharing the risk of a major health catastrophe by pooling the risks across many households. National Rural Health Mission scaled-up of public spending to 2-3% of GDP for vulnerable populations residing in key geographic areas to the implementation of a conditional cash transfer scheme to encourage institutional safe deliveries. It's targeted to reduce IMR and MMR in key geographic areas. Tribal women are willing to go for institutional deliveries so that they can get financial incentives. However, the women are not going for institutional deliveries due to difficulties like lack money and distance to opening savings Bank Account. Also the felt opening account in the Bank is expensive task.

Conclusion

Habitually tribes live in areas with scarce resources, follow traditional norms, socially and economical weak, and conservative in nature. This needs lot of efforts to change their behavior, modify their life style and improve their overall quality of life. Over a decade of research and experience in addressing maternal health has made it clear that safe motherhood initiatives are cost-effective, ensuring high social and economic returns at low cost. It was proven that interventions to improve maternal health are also feasible, even in poor settings.[14] However, much work has yet to be done to assure maternal health for women in backward tribal areas in order to receive the care they need to be safe and healthy throughout pregnancy and childbirth.

References

1. Linda Sanneving, Nadja Trygg, Deepak Saxena, Dileep Mavalankar, Sarah Thomsen. Inequity in India: the case of maternal and reproductive health. Glob Health Action 2013;6:http://www.globalhealthaction.net/index.php/gha/article.
2. Registrar General of India. Special Bulletin on Maternal Mortality in India 2004–06, Sample Registration System. New Delhi: Registrar General of India, 2009. www.censusindia.gov.in.
3. UNICEF. Maternal and Perinatal Death Inquiry and Response, 2009. www.mapedir.org.
4. Prabha Chauhan, VKS Chauhan, Praveen Shrivastava. Rural Epidemiology of Maternal Mortality in Tribal women from Bastar, Chhattisgarh, India. Int J Biol Med Res 2011;2(4):1106–1109.
5. Ministry of Tribal Affairs Statistics Division, Government of India. Statistical profile of Scheduled tribes In India 2010. www.tribal.nic.in.
6. Deb R. Utilization of services related to safe motherhood among the tribal population of East Khasi Hills (Meghalaya): An overview. Ethno-Med. 2008;2:137–41.
7. Jinu Annie Jose, Sonali Sarkar, S Ganesh Kumar, Sitanshu Sekhar Kar. Utilization of maternal health-care services by tribal women in Kerala. J Nat Sci Biol Med 2014;5(1):144–147.
8. Elaine Reis Brandao. Sexulaity, culture and politics – A South American reader: Disclosure of teenage pregnancy in middle-class families: tensions and dilemmas. Latin American Centre on sexuality and human rights. Federal University of Rio de Janeiro, Garamond in 2005. http://www.clam.org.br/uploads/publicacoes/book2/14.pdf.
9. S Srinivasan, P Ilango. Reproductive health care of tribal women in Kolli hills at Nammaka district, Tamil Nadu. SLAP Journal of Social Science 2013;3:http://papers.ssrn.com.
10. Basu S. Health status of tribal women in India. Social Change 1993;23(4):19-39.
11. Basu S. Dimensions of tribal health in India. Health and Population Perspectives and Issues 2000;23(2):61-70.
12. Babu G, Ramachandra S, Garikipati U, Mahapatra T, Mahapatra S, Narayana S, Pant H. Maternal Health Correlates Of Neonatal Deaths In A Tribal Area In India. The Internet Journal of Epidemiology 2012;10(2):http://ispub.com/IJE/10/2/14442.
13. Balarajan Y, Selvaraj S, Subramanian SV. Health care and equity in India. Lancet 2011;377:505-515.
14. World Bank. Safe Motherhood and Maternal Health. Http://web.worldbank.org/ website/External/ Topics/ Exthealth Nutrition and Population.