

Child Health Care Practices among the Tribes of Visakhapatnam District

Dr. N.Srinivas

Post-Doctoral Fellow (UGC) Dept. of Anthropology, Andhra University Visakhapatnam

Date of Submission: 05-02-2018

Date of acceptance: 24-02-2018

I. INTRODUCTOION

Reproductive and child health (RCH) approach means a holistic and integrated approach of contraception issues, maternal health issues. RCH has been defined as 'people have the ability to reduce and regulate their fertility, women are able to go through pregnancies and child delivery safely, the outcome of pregnancies is successful in terms of survival and wellbeing and couples are able to have sexual relationship free of fear of pregnancies and of contracting diseases (Basic guide to RCH programme, 2007). Reproductive health is defined by World Health Organization (WHO) as a state of physical, mental and social well-being in all matters relating to the reproductive system and is not merely the absence of disease or disorders associated with the reproductive process. The specific objectives of the RCH are reduction of maternal, peri-natal, infant and childhood mortality and morbidity: According to NFHS-3 (2005-06) institutional deliveries 17.7%, home deliveries 80%, Antenatal care 70.6% and 55% of Tribal women use contraception methods in tribal areas of the country. Indian Government has introduced many programmes to reduce the Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR). Particularly in RCH-1 and RCH-2 main focus was given to mother and child health to reduce the mortality rate and also the morbidity levels by improving the services such as Antenatal checkups, Promoting institutional deliveries, Immunization, Birth control measures etc. It was observed that comprehensive area specific health studies were limited Even under the National Rural Health Mission main attention has been paid to improve the health of mother and child in 18 states, which were identified on the basis of maternal and infant mortality rates. In spite of launching many programmes we have achieve only a little in reducing the maternal and infant mortality. Many gaps and limitations have been identified through review of many programmes by the planning commission at the end of 10th plan and decided to improve the health services (by improving antenatal care and perinatal care and by promoting institutional deliveries and also by introducing newer vaccines like Japanese encephalitis vaccination and for others basing on disease burden or recommendation by the experts. Detailed information was need on food habits of pregnant woman, lactating mothers and their nature of work load, the distribution of food within the pregnant and lactating mothers and its effects on the nutritional status of those woman, the complications of pregnancy and of child birth, maternal mortality, birth weight of children, infant and childhood mortality, nature of maternal and child health care practices, attitude towards antenatal, natal care. The present study also aims to identify the various problems in different settings with regard to maternal health care practices and facilitates the future researchers to take-up effective interventions. Tribal groups have developed strong magico-religious health care systems and they wish to survive and live in their own style. They live and interact within their own homogenous and culturally firm system wherein common beliefs, customs and practices connected with health and disease has been found to be intimately connected with the treatment of disease. It is necessary for health functionaries not only to have knowledge about the culture and society of tribal people and the socio-cultural dimensions of their health and family welfare systems, but to examine constraints for the acceptance of modern health care facilities. The inadequate nature of facilities in many tribal areas, lack of respect for indigenous culture, lack of attention given to patients are the main factors responsible for the non-acceptance and distrust of tribal people towards modern medicine. Anthropological, sociological studies covering different facets of the society are urgently needed to understand some of the real health issues prevailing among the tribal populations. Health status of the tribals in lower and inferior compared to that of the general population. Several studies have suggested higher infant mortality rate, higher fertility rate and greater malnourishment. It has been seen during the last three decades that the increase in the per capita income was associated with improved health indicators and there were also some evidences that economic decline had some association with the decline in health indicators. On almost all the indices of health, the status of tribals was poor. The report of the working group on Development and Welfare of ST during Eight Five Year Plan (GOI, 1989) indicated that diseases like goiter, yaws, malaria and

guineawarm were endemic in tribal pockets. Basu (1991) reported an alarmingly high incident (32%) of sickle cell disease among the Adiyam tribal group of North Waynad, Kerala.

Objectives of the Study

- 1) To examine the maternal care practices of tribal women of Visakhapatnam district during antenatal, natal and postnatal periods.
- 2) To document the health problems encountered by tribal women during pregnancy, delivery and post natal stages.
- 3) To explore the neo-natal care and breast feeding practices in tribal situation.

Study Design

- 1) The study design was cross-sectional and was done in 2 stages. In the 1st stage, five tribal mandals are selected at random out of eleven mandals.
- 2) In the 2nd stage of stratification, 20 villages from each mandal one considered at random. Thus, 100 villages from the tribal area are identified and 5-10 nursing mothers are selected at random as respondents for the present study. In total, 853 nursing mothers (whose children must be in lactating stage) comprise the sample.
- 3) A pre-tested, semi-structured questionnaires were prepared to get data from lactating mothers and also in-depth interviews with regard to the women's perception towards many RCH components are also conducted to increase confidence in the validity of data collected by quantitative method.
- 4) The area constitutes mainly tribal populations like Kondh, Konda dora, Nooka dora, Poraja, Manne dora, Kotia and others.
- 5) The population of Visakhapatnam district is 42.90 lakhs as per 2011 census (after bifurcation 13 districts) and constitutes about 8.6 % of the population of the state.

The sex ratio of the district is 1006 females per 1000 males, which is higher than that of the state average of 993. A total of 853 lactating mothers having children ≤60 months of age were interviewed in their respective homes to assess Practices carried out in the *i)* antenatal, *ii)* intra-partum, and *iii)* postnatal period up to 2 months.

Table -1: Back ground characteristics of tribal women

Characteristics (N=853)		Per cent
Age		
15-19 years	115	13.48
20-24 years	503	58.97
25-29 years	202	23.68
30-34 years	30	3.52
35-39 years	3	0.35
Education		
Illiterates	507	59.44
Primary	233	27.43
Secondary	98	11.49
Higher	15	1.76
Occupation		
House wife	68	7.97
Coolie	236	27.67
Agriculture	165	19.34
Agriculture and coolie	352	41.27
Petty business	11	1.29
Working in NGO	11	1.29
Student	2	0.23
Teacher	7	0.82
CHW	1	0.12

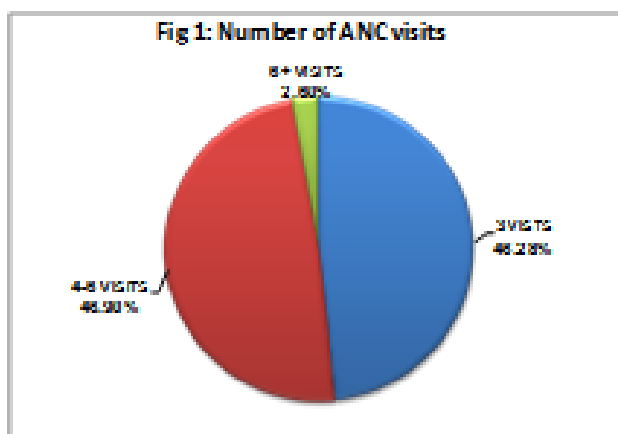
Several important background characteristics of women like age and their marital status, education, and occupation details are given in Table-1. About 59.0 per cent of women are in the age group of 20-24 years followed by 23.6 percent in the age group of 25-29 years and 13.5 percent in 15-19 years age group. It is clear that the women in the sample were concentrated more in the age range of 15-29 years. The mean age of the study sample is 22.74±3.26Yrs.

Number and Timing of Antenatal Care Visits and ANC provider:

Table - 2 : Percentage of women who received antenatal care

	Number	Per cent
Ante natal checkups (N=853)		
Yes	807	94.61
No	46	5.39
Number of ANC visits (N=806)		
1	3	0.37
2	31	3.85
3	373	46.28
4	235	29.16
5	120	14.89
6	23	2.85
7	10	1.24
8+	11	1.36
Number of months pregnant at the time of first ANC visit (N=806)		
<3	293	36.35
4-5	368	45.66
6-7	122	15.14
8+	23	2.85
ANC provider (N=806)		
Government doctor	201	24.94
Private doctor	1	0.12
Govt. and private doctor	6	0.74
ANM/Health worker	118	14.64
ANM and Government doctor	480	59.55

Table 2 shows the percent distribution of mothers who had a live birth by the number and timing of antenatal care visits for their most recent birth. An overwhelming proportion of mothers (94.6 percent) received any form of antenatal care during their last pregnancy. About 46.28 per cent of mothers had three antenatal care visits, 29.16 per cent had four visits and 14.89 had five visits (Fig-1)



Only 4.22 percent of women had 1-2 visits. The median frequency of antenatal care visits either at home or elsewhere is 4.0. About 36.35 per cent of mothers had their first antenatal care visit in the first trimester of pregnancy and another 45.66 percent had their first visit during their fourth or fifth month of pregnancy (Table-2). Around 15.14 percent of women had their first antenatal care when they were six or more months pregnant. Around 59.55 percent of mothers had received antenatal care from the government doctor or ANM, while 24.94 per cent of mothers received from government doctor and 14.64 per cent of mother received antenatal care from both ANM or health worker.

Health Problems during Pregnancy:

Table 3: The Health problems of the pregnant women

Health problems (N=455; 53.87%)	Number	Per cent
Swelling of hands and feet	124	27.25
Paleness	73	16.04
Weakness and tiredness	183	40.22
Dizziness	13	2.86
Visual disturbances	38	8.35
Vaginal Bleeding	15	3.30
Convulsions	4	0.88
No movement of foetus	2	0.44
Abdominal pain	3	0.66

As shown in above Table and, the pregnancy-related health problems most commonly reported are weakness and tiredness (40.22 percent) and swelling of the legs, body, or face (27.25 percent). About 16.04 percent of mothers had paleness while 8.35 mothers had visual disturbances. Only 3.30 percent of mothers had vaginal bleeding.

Table 4: Status of IFA tablets consumption and TT injections

Components of Antenatal care	Number	Per cent
Received IFA tablets (N=853)		
Yes	846	99.18
No	7	0.82
Taken the tablets (N=846)		
Yes	661	78.13
No	185	21.87
Consumed tablets(N=185)		
≤30	119	64.32
31-60	65	35.14
61-90	1	0.54
Received TT injection (N=853)		
Yes	851	99.77
No	2	0.23

Table 4 shows that 99.18 percent of mothers received IFA supplements for their most recent birth. Overall, only 78.13 percent of women consumed IFA for at least 90 days. Reasons cited by mothers for not consuming appropriate number of IFA tablets included 1) a feeling of dizziness/ nausea/ palpitation/ smell/ bitter 2) belief that the tablet is hot, become weak, burning sensation, reduction in milk production and over growth of the baby 3) some women mentioned – “*there is too much work at home and no time to think of oneself, so we forget eating the tablet*”.

To prevent the infections caused during delivery time due to unhygienic practices and also in case of episiotomy, Tetanus Toxoid (TT) injection will be given to the pregnant women. It also takes-care the newborns against neonatal tetanus due to improper care provided in cutting the umbilical cord.

The present tribal women were provided with 2 TT injections during the pregnancy period are 99.7 percent.

Ideally it was suggested that the pregnant women should attend the antenatal clinic once a month during the first 7 months, twice a month in 8th month and once a week in the next month

NATAL CARE:

Approximately 53 million women in the world give birth at home each year without the help or benefit of a skilled delivery attendant (Sibley & Sipe, 2003). Bindu (2005) extensively studied the delivery pattern and associated practices existed among Kurumbar, Irular, Panian and Mullu Kuruman tribes of Kerala. Deb (2008) has reported more home deliveries as the absence of delivery facilities in the nearest PHCs in the East Khasi hills of Meghalaya.

Table - 5: Percentage of women in relation to place of delivery, birth attendant and type of delivery.

Characteristics	Number (853)	Per cent
Place of delivery		
Home	612	71.75
Govt. health facility	231	27.08
Private nursing home	10	1.18
Birth attendant (Home) (717)		
ANM/Nurse	25	3.5
UTBA	117	16.32
TBA	215	29.99
Elder woman	485	67.64
Doctor	1	0.14
CHW	10	1.39
Type of Delivery		
Normal	780	91.44
Manipulated	4	0.47
C-section	26	3.05
Forceps	6	0.70
Episiotomy	37	4.34

In the present study, Table shows that 71.75 per cent of deliveries were conducted at home facility while 27.08 per cent of deliveries were conducted at government health facility. Only 1.17 per cent of deliveries were conducted private nursing home. Majority of home deliveries were conducted by elder women (67.64 per cent) followed by TBA (29.99 per cent) and UTBA (16.32 per cent). Around 91.5 per cent of births were delivered by normal and 4.34 per cent were delivered by Episiotomy. Only 3.0 per cent of births were delivered through Caesarean section. It is important to note that, maximum percentage of the pregnant women depend upon the traditional dais (untrained birth attendants) or elderly women for delivery

Newborn Care:

The recent estimates (Black, et.al., 2003) shows that out of 3.9 million neonatal deaths that occur worldwide, all most 30% occur in india. the current neonatal mortality Rate of 44 per year for 1000 live births, accounts for nearly two thirds of infant mortality and translates into at least 2 new born deaths for every minutes somewhere in this waste country (RGI, 2004).

Child's weight at birth:

Birth weight is an important indicator of a child's vulnerability to the risk of childhood illness and chances of survival. Low birth weight (LBW), defined as a birth weight < 2500g, is indisputably a very important indirect cause of death in neonates the world over. W.H.O estimates that 16% of newborns or nearly 20 million are born low birth weight (LBW) each year. Overall estimates indicate that around eight million LBW babies are born in India every year, i.e. around 40 percent of the global burden of LBW infants (Saving the newborn lives, 2001). LBW babies are at a higher risk of asphyxia, sepsis, hypothermia and feeding problems. LBW babies lag behind in somatic growth and have sub-optimally developed humoral and cellular immunity. Common illnesses like diarrhoea, respiratory infections, measles and skin diseases are more severe and of a longer duration in these babies (Bang, et.al, 2001).

Table -6: Birth weight of the New Born

Birth rate of the New Born	Number	percent
≤ 2.0 kgs	132	17.74
2.1 – 2.4 kgs	73	9.81
2.50 kgs	314	42.20
2.6 – 3.0 kgs	217	29.17
≥ 3.1 kgs	8	1.08
Total	744	100.0

For the present study, weight of the new born was collected from health card or from the mother's memory (recall). Among children for whom birth weight was reported, 27.55 percent had a low birth weight, that is, they weighed less than 2.5 kilograms and presented in Table-12. It is well established that care of the mother during antenatal and delivery period; and provision of essential care to the new born at birth and during the neonatal period can reduce neonatal and infant mortality rates. Under Child Survival and Safe Motherhood Programme and now under the RCH programme, the intervention aimed at improving survival of infants during the prenatal and neonatal period are being taken.

Interventions for improving survival of newborns are

- Ensuring antenatal care to all pregnant women
- Promoting safe delivery practices
- Providing essential care to all newborns
- Identification and referral of newborns "at risk".

Most families in the study population follow the customary practice of bathing the baby immediately after birth. As per modern health care practices it is an unhealthy practice. Bathing can lead to hypothermia which may be fatal during summer months. Bathing (Luke warm) is not recommended till the child is at least one week old. The new born should be received at birth in a dry, warm and clean cloth. After drying the new born, the wet cloth should be discarded (to prevent hypothermia) and the baby wrapped in a clean and dry cloth. The head of the baby should be wiped first. Clean the eyes with a soft clean cloth or cotton swab using one for each eye. Clean the eyes from the medial to the lateral side. Do not apply any eye drops or *kajal* to the eyes. Keep the child warm by wrapping in enough cloths and keeping her close to the mothers' body. The room where the new born is kept must be warm enough. These are the healthy practices recommended by modern healthcare system.

Table – 7: New born care practices in tribal population

New born Care(N=872)	Number	percent
Given bath to child immediately after birth		
Yes	420	56.50
No	324	43.60
Clean the air passages of new born		
Yes	744	100.00
No	-	-
Clean by using		
Coconut oil and cloth	743	99.90
Cotton / soft cloth	1	0.10
Clean the eyes of the new born		
Yes	742	99.80
No	2	0.20
Clean by using		
Sterile cloth	68	9.14
Unsterile cloth	614	82.53
Cotton	61	8.20
Towel	1	0.10
Steps taken to keep the new born warm		
Wrapped in cloths	3	0.40
Kept beside the mother	1	0.13
Wrap and kept beside the mother	740	99.46
Idea about premature baby protection		
No idea	454	61.00
Wrapped in clothes	218	29.30
Kept beside the mother	7	0.94
Wrapped and coal heat protection	42	5.64
Wrapped and kept beside the mother	8	1.08
Wrapped and coal heat	15	2.01
Kept under the bulb for heat	1	0.13

But about 56.5 per cent of tribal new born babies were bathed with lukewarm water immediately after birth. About cent per cent of the birth attendants (100.0 per cent) were cleaned the air passages of new born with coconut oil and cloth (99.9 per cent). Around 82.53 per cent of birth attendants used unsterile cloth to clean the eyes of new born while only 9.14 per cent of birth attendants were cleaned the eyes of new born with sterile cloth. To keep the new born warm, 99.46 per cent of families wrapped the baby (top and bottom) with a cloth and kept beside the mother. Around 61.0 per cent of respondents had no idea about premature baby protection (Table-7).

Breast feeding

The Government of India recommends that initiation of breastfeeding should begin immediately after childbirth, preferably within one hour (Ministry of Women and Child Development, 2006). Early initiation of breastfeeding is encouraged for a number of reasons. Mothers benefit from early suckling because it stimulates breast milk production and facilitates the release of oxytocin, which helps the contraction of the uterus and reduces postpartum blood loss. The first breast milk (colostrums) is highly nutritious and has antibodies that protect the newborn from diseases. Late initiation of breastfeeding not only deprives the child of valuable colostrums, but becomes as on introduction of pre-lacteal feeds (that is, something other than breast milk) like glucose water, honey, *ghutti*, animal milk, or powdered milk that are potentially harmful and contribute to diarrhoea in the newborn.

Table – 8: Initiation of breast milk and the reasons for delay in the initiation

Initiation of Breast feeding	Number	Percent
Initiation of B.F		
With in 1 hour	711	83.35
Firstday within 2 – 6 hrs	78	9.14
First day within 7 – 12 hrs	22	2.58
Second day	34	3.99
Third day	5	0.59
After 3 days	3	0.35
Reasons for delay in initiation of B.F. (N=63)		
Advise of elder women of the family	6	9.52
No milk production	17	26.98
Ill-health of the mother	9	14.89
Due to C – section	27	42.86
Ill-health of the new born	4	6.35

Early initiation of Breast feeding

WHO recommends that BF should be initiated within an hour of birth and nothing should be given to the infant before beginning to breast feed (WHO, 2003). However, in the present study, only 83.35 per cent of the mothers have initiated breast feeding within an hour of birth while 9.14 per cent of the mothers initiated breast feeding to their newborns within 2-6 hours of birth. Only in 7.51 per cent of cases children were breast fed after 6 hours (Table-8).The major reasons for delayed initiation of breast feeding was no milk production (26.98 percent) -*mothers own perception after hearing from other members of the community* that milk lets down the mother's breast after 3 days of birth and ill health of the mother (14.89 per cent). Advice of elder women in the family (9.52 per cent) was another reason for delaying breast feeding initiation.

Recommendations:

- ❖ Every tribal woman should be motivated to visit the health facility to get all the necessary antenatal care services.
- ❖ Though the IFA tablets are properly distributed to the pregnant women in the present study population, they are not consuming these tablets because of various reasons. It is the job of the healthcare providers to educate the community regarding the importance of IFA tablets and negative consequences of anaemia.
- ❖ The health workers should motivate the tribal women to have institutional delivery by explaining the benefits of having better infrastructure and skilled (medical) supervision during delivery time and also the risk factors to be faced at home delivery. Training should be provided to the traditional dais and also to the tribal women who are performing deliveries and they also may be provided with delivery kits.

- ❖ Giving bath to the newborn is an unhealthy practice prevailed more in tribal areas which will lead to more and more complications (hypothermia) and hence the community should be provided with proper education. Awareness should be created to the mothers in protecting the pre-term and hypothermia effected babies.
- ❖ The importance of early initiation of breast milk, the negative aspects of pre-lacteals, the importance of colostrums and exclusive breast feeding should be explained to all the prospective mothers during antenatal period.
- ❖ Proper guidance should be provided to the pregnant women regarding the diet, rest during day time, personal hygiene, family planning, child immunization, reproductive track infections, sexually transmitted diseases, general health problems and the complications of pregnancy.
- ❖ The Primary Health Centers (PHCs) in tribal areas should be equipped with the required infrastructure including the emergency obstetric care and essential newborn care. The services should be provided 24 hours a day and facilities may be improved to
- ❖ Transport the patients to the first referral units.
- ❖ The skills of the healthcare providers should be improved in attending the complicated deliveries, medically terminated pregnancies, in protecting the pre-term, low birth weight, hypothermia babies and also those who suffer from acute respiratory disorders.
- ❖ Sufficient man power should be appointed at each health facility along with the essential medicines at each health facility.

REFERENCES

- [1]. Bang AT, Bang RA, Baitulae S, Deshmukh M, Reddy MH. (2001). Burden of morbidities and the unmet need for health care in rural neonates –a prospective observational study in Gadchiroli, India. *Indian Pediatrics* 38; 925-65.
- [2]. Basic guide to Reproductive & child health Programme (2007). Dept of Health and Family Welfare, Govt of India, 2007.
- [3]. Basu SK, (1991). Genetic and socio cultural determinants of tribal health: Bastar tribal group of Madhya Pradesh. Cultural and Environmental dimensions on health (ed), Buddhadeb Choudhury, New Delhi. Inter-India publications.
- [4]. Bindu,S. (2005). Social structure, child-rearing practices and behaviour pattern among the tribes of Kerala, Unpublished Ph.D. Thesis, Department of Anthropology, Pondicherry University, September.
- [5]. Black R.E., Morris SS, Bryce J (2003). Child Survival I : where and why are 10 million children dying every year? *Lancet*, 361:2226-2234.
- [6]. Census of India (2011). Government of India, New Delhi.
- [7]. Deb Roumi, (2008). Utilization of services related to safe motherhood among the tribal population of East Khasi hills (Meghalaya): An overview. *Kam Raj enterprises, Ethno-Medicine*, 2(2):137-141.
- [8]. GOI (1989). Development and Welfare of ST during Eight Five Year Plan. The working Group report of the planning commission, health care delivery services in rural and urban areas – policies and perspectives, June.
- [9]. Ministry of Women and Child Development (2006). National guidelines on infant and young child feeding. New Delhi: MOWCD (Food and Nutrition Board), Government of India.
- [10]. NFHS-3 (2005-06). National Family Health Survey, Rajasthan. Mumbai, India: International Institute of Population Sciences & ORC Macro, 2007).
- [11]. Registrar General of India (2004). Sample Registration System, Statistical report. New Delhi: Office of the Registrar General, India.
- [12]. Saving Newborn Lives (2001). State of the World's Newborns.
- [13]. Washington DC: Saving Newborn Lives, Save the Children.
- [14]. Sibley, L. and Sipe, T. (2003). What can a meta-analysis tell us about traditional birth attendant training and pregnancy outcomes? *Midwifery*, 20, 51-60.
- [15]. WHO (2003). Working with individuals, families and communities to improve maternal and neonatal health. Geneva, World Health Organization press, 2003; pp32-34. Available from: URL: http://www.who.int/reproductive-health/publications/RHR_03_11/ifc_03.pdf. Accessed April 1, 2004.

IOSR Journal of Pharmacy (IOSR-PHR) is UGC approved Journal with Sl. No. 5012

Dr. N.Srinivas" Child Health Care Practices Among The Tribes Of Visakhapatnam District. ”
IOSR Journal of Pharmacy (IOSRPHR), vol. 8, no. 2, 2018, pp. 01-09