AWARENESS AND ATTITUDE OF TRIBES AND HEALTH CARE PROVIDERS REGARDING *RCH* SERVICES

THESIS SUBMITTED FOR THE AWARD OF THE DEGREE OF
DOCTOR OF PHILOSOPHY
IN
ANTHROPOLOGY

By
Mr. O.S.V. D. PRASAD

Under the Guidance of
Prof. R. SAMBASIVA RAO, Ph.D.
Research Director
&
Prof. Ch. BAPU HARANATH, Ph.D.
Joint Research Director

DEPARTMENT OF ANTHROPOLOGY
ANDHRA UNIVERSITY
VISAKHAPATNAM

2012

Maternal health services have a potentially critical role in the improvement of reproductive health. The use of health services is related to availability, quality and cost of services as well as the social structures, health beliefs and personal characteristics of the users. According to the World Health Organization (WHO), over half a million women die each year from complications of pregnancy or childbirth. Most maternal deaths occur during childbirth and the presence of trained medical staff could greatly reduce this number.

During the International Conference on Population and Development (ICPD) held in Cairo in 1994, governments from around the world endorsed the need to promote and protect the rights of adolescents to reproductive health information and care. However, the situation in many countries may not reflect this recognition. In some low income countries where fertility rates are high, teenage pregnancy and early marriage are common. For instance, the proportion of teenage women who are mothers or currently pregnant is highest in sub-Saharan Africa (20–40%). As a result, pregnancy and childbirth are the leading cause of death among women adolescents. Compared to adult mothers, adolescent mothers are at increased risk of poor maternal and infant outcomes such as maternal and infant death or having an infant who is of low-birth-weight. In sub-Saharan Africa, even when services are available, many pregnant women come late for ANC and many attend only once thereby limiting the quality of care provided. This hampers the delivery of effective antenatal care (ANC) screening and treatment programs, potentially contributing to the high maternal morbidity and mortality. Young people in particular are reluctant to seek health service for their sexual and reproductive health needs. Included among the many barriers are restrictive laws and policies, judgmental health workers and a lack of training in and understanding of adolescent reproductive needs. There is fear among adolescents of humiliation or having to respond to unpleasant questions and procedures. Furthermore, there is lack of respect, privacy and confidentiality within the health care system.

The health of women is a human right issue and is a fundamental pillar for progress in low income countries. In spite of the continued efforts paid by the Central and State governments some sections of the people, particularly the tribals are not fully aware about the health services which were provided to them. The other important aspects which were keeping them away from these services are Illiteracy, Poverty and inaccessible health facilities. The traditional beliefs and misconceptions about modern medicine also play a major role in keeping them in dark.

The present study is aimed at the tribal areas of Vizianagaram district to evaluate the perceptions and practices towards reproductive and child health. Efforts have been made to collect information about the demography and some of the health aspects of tribal women, i.e.

about age at menarche, age at marriage, fertility, mortality, morbidity, adolescent reproductive health, antenatal care, delivery practices, postnatal care, breast feeding, birth spacing, immunization, reproductive tract infections and involvement of men in reproductive health.

REVIEW OF LITERATURE:

Adolescent reproductive health:

Nearly 98.0% of tribal girls in Vizianagaram and 62.2% of school going girls in Nellore are menstruating regularly with out any problem (Sambasiva Rao, 2008 and Muni Susmitha, 2007). The rural women in Bangladesh, Nepal and Even in India use reusable cloths to absorb the menstrual blood (Ahmed and Yesmin, 2008; Dasguptha and Sarkar 2009 and Dhingra and Kour 2009). In the studies reported from Thane district of Maharstra (Khanna et al., 2005; Quazin et al., 2006) more than 3/4th of girls in the rural areas are using cotton cloths and also reusing them after wash. Leena (2005) carried out a survey among college students of Mumbai and reported that majority of boys know what a condom is and that it could be procured from chemists or from paan shops, but knowledge of condoms is extremely low among younger girls as compared to older girls.Premarital sexual relations are rarely practiced in tribals and are tolerated among Yerukulas, Jatapus, Lambadis and Yanadis of Andhra Pradesh and Soligaru of Mysore State (Haimendorf, 1943; Roy Burman, *et.al.*, 1961; Prasad Rao, 1971).

Antenatal:

Suman and Asari (2001) have observed that 58.6% tribals of Tamilnadu have received antenatal care and 87.8% women have utilized the immunization services provided by the PHC. About 89% of the pregnant women in rural India availed antenatal visits of which 62% had received three or more ANC visits (Singh et al., 2002). About 62.0% of households of Muthalamada village, Kerala in both Scheduled Caste and Scheduled Tribes had regular antenatal checkups by doctors. 30 .0% of deprived sections did not go for any specific antenatal care while 37 percentage among non deprived consulted doctor only during illnesses (Brahmaputhran, 2003). Many researchers are also observed about the antenatal care during pregnancy period (Maiti et al., (2005); Gandhi Manav Kalyan Society, 2007; Roy et al., 2010; Roumi Deb, 2008). Mallikarjuna Rao (2008) indicated that about 87.0 % of the tribal women in Andhra Pradesh were registered for antenatal check up either by Auxiliary Nurse Midwife (65.0 %) or through anganwadi worker (15.2 %). The Koya tribal women were reported that they had received the first dose of TT injection between 2nd and 8th month, but 90% have received it between 3rd and 5th month. 77% of the respondents have received the 2nd dose of TT injection between 5th and 7th month of pregnancy. About 64% have received their 3rd dose of

TT injection between 6th and 9th month of pregnancy. It is evident from the results that these tribal women have not received the TT injections during the recommended period of pregnancy and the health workers have not maintained one month gap between 1st and 2nd dose of TT injections (Sambasiva Rao et al , 2011).

Natal:

In 2001, Potter and others carried out a study in Brazil and reported that the proportion of women wanting to deliver vaginally was over 80 percent, except in cases where the woman had had a previous cesarean delivery where it was around 44 percent. Most rural western Kenya women (83%) delivered outside of a health facility. Of these, 80% delivered in their own house, 18% in the house of a TBA and 3% on their way to a health facility (Anna van Eijk et al., 2006). In Asia an average of about one-fourth of pregnant women delivered in a medical facility. The range across countries is wide, from 10% or fewer in Bangladesh, Cambodia, and Nepal to 62% in Vietnam (USAID, Population reports, 2003). Out of 26 million babies born annually in India, 65% are delivered at home and more than half by semi skilled and un-skilled traditional birth attendants (National commission on population, GOI, 2000). The traditional delivery practices were elaborately studied by Gouri Kumra (2006), Phanidhar Sarmah (2006), Murthy (2006), Meera Ramanatham (2006); Umamani (2006), Roy et al (2010) and Pandey et al., (1997 and 2001) on different population of India. Home deliveries in different districts of Andhra Pradesh were reported by various researches as 61.48 % in rural areas of Guntur district (Pravin, and Keerti, 2010), 14.3 % in Guntur and Krishna Districts (SERP, 2006), 7.7 % in urban slums of Visakhapatnam (Swamy, 2009), 34.5 % in tribal areas of west Godavari district (Sambasiva Rao et al., 2011), 79% in tribes of Vizianagaram district (Sambasiva Rao, 2008), 85.0% in tribes of Andhra Pradesh (Mallikharjuna Rao, 2008) and 71.7 % in tribal women of Visakhapatnam district and 6.4 % in slum women of Visakhapatnam (Sambasiva Rao, 2008a).

Postnatal:

Pakistan Demographic and Health Survey (PDHS, 2006-07) shows that in the five years preceding the survey, two-fifths (43 percent) of women received postnatal care for their last birth. Khanam and Akanda (2007) have reported that post natal complications like haemorrhage, pelvic pain, fever more than three days, headache etc are significantly associated with the delivery attendance among rural Bangladesh. Majority (60 percent) of Todas and Kurumba women received postnatal care as reported by Suman and Asari (2001). During Post partum period 96.5% of the tribal mothers of Vizianagaram district had the routine checkups by

Doctors, Nurses, ANMs and TBAs. Mostly they received advises on breast feeding, care of the new born and also about birth control in certain instances (Sambasiva Rao, 2008).

Breast feeding:

Traditionally in Turkey almost all women breastfeed, however one study conducted in Istanbul reported that although 97% of women initiated breastfeeding, only 47% of women were exclusively breastfeeding at one week (Neyzi et al., 1991). Most of the mothers (52.6 per cent) initiated breast feeding within 1-6hours of birth and only 6.3 per cent co initiate breast feeding within 1 hour of birth. There were 32.6 per cent who reported initiating breast feeding after 24 hours of birth. Family restriction (38.8 per cent), followed by social customs and religious beliefs prevalent in the community (25.2 per cent), were mainly found to be responsible for the delay in initiating breast feeding (Kumar et al., 2006). A recent study from rural Ghana (Karen Edmond et. al., 2006) (based on 10,947 breastfed singleton infants) has shown that initiation of breastfeeding within the first hour of birth could reduce neonatal mortality by 22%. This effect was seen independent of exclusive breastfeeding. The studies by Bhardwaj and Tungdim (2010); Swamy (2009); Sinhababu and Apurba, (2010);Srivastava et al., (1994) and Sethi et al., (2003) also reported high prevalence of giving pre lacteal feeds in different populations.

Immunization:

The vaccination status in the tribal children of Netrakona district, Bangladesh was satisfactory in relation to National coverage, but the vaccination status of the tribal mothers was not satisfactory in our national context (Rahman et al., 2006). The results showed that there was low immunization coverage (46%) in the Butere-Mumias district, Kenya, below the expected levels of 90%. The drop out rate was noted to be high (40%) above the expected rate of below 10% (Rose and Mutuku, 2005). Pandey & Tiwary (2001) reported that the Hill Korwas have no knowledge about immunization of the children. It was observed in their study that only 2.5% had received BCG, 2% received DPT and polio vaccines and only 1% were vaccinated against measles. For the Andhra Pradesh state as a whole, the coverage of full immunization was 82.7 percent which is on par with the PATH (2005) and IIHFW (2004) study of 71.4 percent. However, the NFHS-3 (2005-06) study recorded the coverage of full immunization as 46 percent (43 percent in rural and 57 percent in urban areas).

Family planning:

In West Bengal 49.1% of Hindus, 28% of scheduled caste and scheduled tribe and 19% of Muslims accepted any form of contraception as reported by Biswas (1989). More Mahali

women (about 54%) of West Bengal tended to accept family planning practices and preferred small-sized families more than Santhals (Bagchi and Anuradha, 2005). In Saharia tribe of Madhya Pradesh , they are not aware to adopt any family planning contraceptive methods (Ranjan and Kapoor, 2003). Naidu (1979) in his study of family planning acceptance among the Juang and Bhuyan dominated block, Bansal in Keonjhar district of Orissa, has found that the rate of family planning acceptance is very low.

Sexual health:

As per WHO (2007) More than 340 million new cases of sexually transmitted bacterial and protozoal infections occur throughout the world every year. The annual incidence rate of STIs in India was over 5%, and most regions of the country have relatively high levels of STIs (NACO, 2006). In a study conducted in Haryana village, 89% of the women who had symptoms of RTIs did not consult anyone for their treatment (Aggarwal et al., 1999). According to Nathalie Broutet, WHO (2010) the Prevalence of HIV and STIs in sex workers of Kakinada, Andhra Pradesh estimated as Trichomonas vaginalis (43.4%), Neisseria gonorrhoeae (11%), Chlamydia trachomatis (4.6%), A. sifilide (31.2%) and HIV (42 %).

Involvement of men in reproductive and child health

There are several reports confirming the inefficacy of reproductive health programmes with regard to the role of men (Cairo conference, 1994; fourth world conference on women , 1995). Needs assessments conducted in Kenya and Mexico showed that men's attitudes towards reproduction was an important factor in efficacy of family planning (Planned Parenthood Association of South Africa, 2001). In a survey conducted in Indonesia it was shown that neglecting the man's role was the main cause of family planning failure, either in selection or continuation of contraception use (Indonesian Family Planning Association, 2005). A study conducted in Mumbai by Bhalerao et al. (1984) found that involving husbands in antenatal care counseling significantly increases the frequency of antenatal care visits, significantly lowers perinatal mortality, and pays dividends even among uneducated and low socio-economic groups.

OBJECTIVES:

Main objective:

The main objective is to evaluate the awareness, attitude and practices of tribal people and also the health care providers towards the various issues of reproductive and child health.

Specific Objectives:

- To examine the demographic profile of the tribes.

- To understand the awareness, attitude and practices of
  - antenatal care
  - Natal and postnatal care
  - Newborn care
  - Immunization and Family planning
  - Adolescents towards reproductive health
  - Men in reproductive and child health issues
- To assess the awareness levels of the health care providers towards RCH services.

METHODOLOGY:

The present study is aimed to evaluate the perceptions and practices towards Reproductive and Child Health among Gadaba and Konda Dora tribes of Vizianagaram district. Systematic sampling procedures were followed in the selection of the sample size from different tribal mandals of Vizianagaram district.

(2-35 -2011)

The scheduled tribal population of Vizianagaram district is 2,14,839 according to 2001 census constituting 22, 49,254 (9.55%) to the total population of the district. The most predominant tribes in Vizianagaram district are Gadaba, Jatapu, Konda Dora, Savara, Mukadora, Mannedora and Bagata, of which Gadaba, Savara, are relatively primitive in their lifestyles.

Sample:

The study was carried out in 4 tribal mandals which were selected at random from a total of 8 tribal mandals of the district. Under the 1st stage of stratification 4 tribal mandals namely **Srungavarapukota, Pachipenta, Saluru and Gummalakshmipuram** were selected at random. In the second phase of stratification, 10 villages from each mandal were selected. Thus, 40 villages in total were selected for the present study; from each village 12 nursing mothers who were in the age range between 15-49 years are considered as the respondents. In total, 480 nursing mothers were selected for the present study. As the husband has the major role in providing the care to the wife; so they are also considered as the valuable respondents in the present study. A total of 280 men were included for the present survey and are selected randomly i.e. seven members from each village are included. As the stakeholders of the health services both men and women who are in the eligible age group are selected to assess their awareness, attitude and practices regarding the care provided to the mother and child. Further, to study the adolescent health situation a sample of 100 boys and 100 girls were purposively selected from all the four mandals.

On the other hand the health care providers at PHC level are also included in the survey to have a comprehensive idea about the quality of health services they are providing to the tribal mothers and children. Thus, the medical officers (4) of the concerned PHCs (1 from each mandal). 5 ANMs (5×4=20) and 5 birth attendants (5×4=20) (both trained and untrained) from each PHC area are included in the study.

Sample design:

Stake holders

Tribal Mandals (8)

1st Stage of Stratification

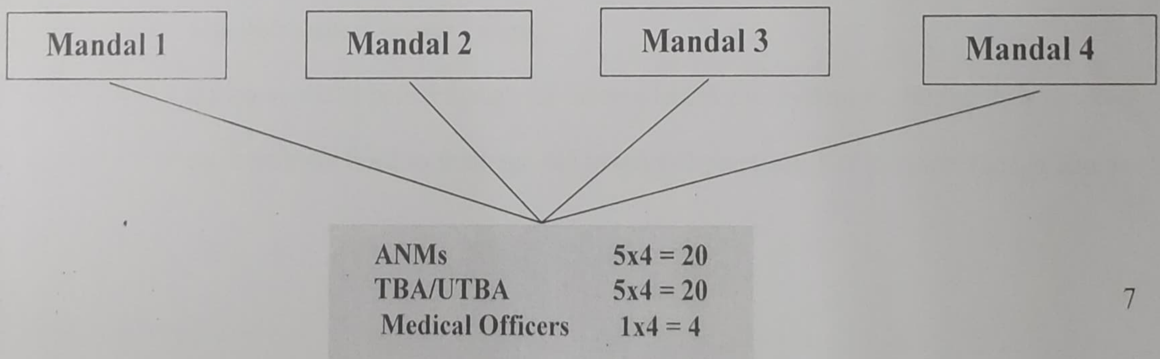
4 Tribal Mandals

Mandal-1 S.kota	Mandal-2 Pachipenta	Mandal-3 Saluru	Mandal-4 G.L. Puram
10 Villages	10 Villages	10 Villages	10 Villages
From each village 12 Nursing Women 7 Men	From each village 12 Nursing Women 7 Men	From each village 12 Nursing Women 7 Men	From each village 12 Nursing Women 7 Men
12x10 = 120	12x10 = 120	12x10 = 120	12x10 = 120
7x10 = 70	7x 10= 70	7x10 = 70	7x10 = 70

2nd Stage of Stratification

From each Mandal 25 adolescent girls (4 x25=100 girls) and 25 adolescent boys were selected (4 x25=100 boys)

Health Care Providers



The individual questionnaire listed all usual residents in each sample household. Basic information was obtained on the characteristics of each person listed, including age, sex, marital status, education and occupation. In addition, the household questionnaire collected information on household conditions. Data pertaining to a variety of health indicators such as age at menarche, age at marriage, adolescent reproductive health, antenatal and postnatal care, delivery care, child immunization, contraception, reproductive health problems, sexually transmitted diseases and HIV/AIDS awareness, involvement of men in reproductive and child health and involvement of health care providers in RCH activities are collected through interview method.

IMPORTANT FINDINGS:

According to the objectives aimed in the present study entitled ***"Awareness and attitude* of tribes and health care providers regarding *RCH* services".** The data are collected and analyzed statistically to obtain the results which are discussed accurately. The analysis in the present study is summarized in the prior lines and also the conclusions are drawn accordingly.

The tribal groups which are included in the present study are genetically distinct. Some of the cultural characteristics shows the affinity with each other and are having more or less similar socio-economic back grounds. The status of health care in the tribal groups is largely governed by prevailing beliefs and practices followed by the people. In an anthropological perspective, the health care is commonly linked with the cultural practices; in some aspects they are deep-rooted. It needs behavioural change in the community to avail the modern health care services, so that these practices are likely to be more productive. These tribal populations are still following their traditional practices related to health. In the present study an attempt has been made to understand these practices in socio-cultural context and also examines how it will be rewarding and helpful in tuning up the care practices suiting to their needs.

- Adolescent boys and girls have some knowledge about puberty and are having premarital sex relations to some extent. Usually they discuss the sex related matters with their respective peer-groups.
- During antenatal period though the modern health care system is offering their services are mostly confined to their age old traditional practices. For instance, though almost

all the pregnant women were supplied with IFA tablets, majority are not consuming them due to various reasons.

- Even for the utilization of antenatal care services, majority of the pregnant women are not visiting the PHCs or sub-centres due to various barriers like lack of road and transport facilities and all the necessary tests are not conducting at the health facilities and other cultural beliefs are the reasons expressed by them.
- Still they are practicing the home deliveries, because these are convenient for them to deliver at home with the help of either elderly women of the household or the traditional dai of their village. Lack of proper infrastructure, non-availability of the medical officers and attitude of the health workers forced these women not to avail the institutional delivery facility.
- For the treatment of severe health complications, during pregnancy and postnatal periods, majority of the women are attending the PHCs and some of them are approaching the traditional healers.
- The deep-rooted traditional beliefs and misconceptions are observed with regard to cord care, in delaying the initiation of breast milk, discarding of colostrums and introducing the pre-lacteals to their babies.
- The duration of lactation on average extends upto 30 months in these tribals.
- Immunization coverage is much better when compared with other tribal and rural populations in India.
- Regarding family planning, most of these tribal people are not willing to go for sterilization. More particularly the men are reluctant to go for vasectomy surgery because of false beliefs.
- Though a considerable number of these tribal people are having pre and extra marital sex relations with multiple partners, they are not using the condoms to prevent the transmission of RTIs. And hence, the RTI/STI symptoms are more prevalent among these people.

- The tribal men are also having some knowledge regarding the reproductive and child health services and also involved in participating various RCH events.
- In tribal areas, the health care providers particularly the ANMs are over loaded with many target oriented programmes apart from routine duties. The area and the target population specified for each sub-center are more and also the man power in the health care system is very discouraging. The medical officers are not residing at their respective PHC areas and are not available not only in emergency situations but also their presence is irregular in many health facilities. Providing the treatment on one hand and creating awareness about the health and motivating the tribals to avail the reproductive and child health services on the other hand is an essential task to the medical officers to improve the reproductive and child health status among the tribal communities.

— End —

CHAPTERIZATION:

The present study report has been organized in to different chapters. ***Introduction*** is the first chapter which deals with the meaning and different components of reproductive and child health and their importance in the effective implementation of RCH programme. The second chapter, ***Review of literature*** *describes about* various studies carried out by different researchers were elaborately reviewed in this chapter ***Materials and Methods*** is the third chapter, which encompasses the details about the area and the people under study, sample design and the components are also included along with aims and objectives. The fourth chapter- ***Results and Discussion***, in this chapter the interpretations were made according to the results achieved in the present study. The results of the present study are compared and discussed in the light of other population data available on this subject. ***Summary and Conclusions*** is the last chapter, in this total study was summarized and the conclusions were drawn according to the results achieved in the study. At the end of the report, the studies referred in the present report were also listed in an alphabetical manner.