

Cultural Health Practices and its Impact on MCH Care: Perspective of Tribal Women of Himachal Pradesh (India)

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Abstract

Maternal and Child Health Care (MCH) is essential for achievement of Sustainable Development Goals. Delivering quality primary care to tribal populations is always challenging, which is the case in India. Cultural practices are often implicated in determining MCH care. This study aimed to explore the existing cultural health practices in tribal areas and its impact on MCH care among tribal women of Himachal Pradesh. In this exploratory study qualitative research approach was adopted. Women of reproductive age group (18-49 years) were selected through stratified sampling techniques from selected tribal areas of district Sirmour (Himachal Pradesh). Data was collected through Focused Group Discussion (FGDs) and Colaizzi method was used for data analysis. The study findings revealed inadequate exclusive breastfeeding, antenatal beliefs, faulty dietary habits, unhealthy practices, less exposure to sunlight, quack treatment and trans cultural issues. In addition, early marriages and inadequate usage of family planning deeply entrenched in cultural values and influence of traditional or spiritual healers etc. refrain them from adequately availing provisions of MCH. Maternal and child mortality is firmly related to certain cultural practices, which create constraints for women seeking maternal and child care. Hence, it is imperative to create awareness regarding impact of cultural practices on MCH care and need to address the health concerns among tribal women to reduce maternal & child mortality rate.

Key words: Cultural practices, Maternal and Child Health Care, Tribal women

India is home to many native people who are still untouched by the modern world's lifestyle practices. The tribal culture of India and their traditions and practices pervade almost all aspects of Indian culture and civilisation (Patro et al, 2012). Cultural practices, beliefs, and taboos are often implicated in determining the care received by mothers during pregnancy and child birth which are important determinants of maternal mortality (Chandra et al, 2016). 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. Remoteness and lack of modern amenities in tribal areas lead to less utilisation of maternal health care services which ultimately causes maternal and child mortality (Govt of India, 2011).

According to Census 2011, the tribal population of India is 10.43 crore, constituting 8.6 percent of the total population. Out of total population residing in the Indian Himalayan range, a little more than 51 percent belongs to a tribal community

(Chaudhary, 2012). As one of the Member States at the United Nations General Assembly Summit in September 2015, India committed to the 17 Sustainable Development Goals (SDGs). The goals stand at the three pillars of overall development-economic, social and environment. Of the targets laid down under SGD-3 "Ensure healthy lives and promote well-being for all at all ages"; 4 out of 9 targets specifically concern maternal and reproductive health (Babu et al, 2012).

Tribal culture and their belief in certain things make the concept of health and illness very interesting and a matter of great concern and priority. Their close relationship with the environment probably makes them believe in the supernatural power or God and Goddesses. The mother and children have been the most vulnerable group in tribal community. However, some issues pertaining to their reproductive, maternal and child health continue. To tackle these, adequate MCH care & services should be provided through Health Care personnel (Dubey, 1982).

Need of Study: According to a UNICEF study (2009), 61 percent of maternal deaths occur in tribal communities in India. The target of Sustainable

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Development Goals (SDG) set by United Nations aim at reducing the global maternal mortality ratio to less than 70 per 100,000 live births. About 99 percent of maternal deaths occur in developing countries and India accounts for the largest number. In the North Zone, the tribes of Jammu & Kashmir, Himachal Pradesh, Punjab, Uttarakhand, and Bihar come under this zone. Most of them need to focus on mother and children because they have high rate of infant, child and maternal mortality in the tribal areas (Registrar General of India, 2009). In Himachal Pradesh, people of the Gujjar tribe live in district Sirmour. They still follow the custom of early marriage where girls are married at 14-15 years and boys at 17-18 years (Govt of Himachal Pradesh, 2016; Ministry of Tribal Affairs, 2013-14). In terms of health indicators, children and women are more vulnerable than men. Baseline information about traditional new-born feeding practices and care during pregnancy of tribal communities is of importance in planning culturally sensitive care. Some cultural beliefs had a good impact on mother and child's health outcomes, whereas some were responsible for maternal and child morbidity and mortality (Shah & Dwivedi, 2013).

Healthcare providers should enhance their knowledge of the area-specific cultural practices to provide better maternal and child health services to promote their health status. This study aimed to explore the existing cultural health practices in tribal areas and its impact on MCH care.

Review of Literature

Contractor et al. Sana (2019) explored their experiences with pregnancy and childbirth among mothers of Rayagada district of Odisha. Methods included in-depth interviews with women, traditional healers and formal health care providers and outreach workers, observations in the community and health. Traditional health providers who are important stakeholders have not been integrated into the health system. Despite the immense difficulties that women face, they do access health facilities, but barriers of distance, language, cultural inappropriateness of services, and experiences of gross violations have further compounded their distrust.

Omer et al (2021) revealed that the delay in seeking care and the potentially resulting maternal mortality is more likely to occur in South Punjab, Pakistan. Data was collected through FGDs and thematic analysis was done. Poor socioeconomic status, limited knowledge about maternal care, early marriages and lack of family planning and financial constraints among rural people were the main barriers to seeking care. The preference for traditional birth attendants results in maternal deaths.

Objective

The study sought to explore the existing cultural health practices in tribal areas and its impact on MCH care among tribal women of Himachal Pradesh.

Methodology

A qualitative research approach and ethnographic research design was used to explore the impact of the cultural practices on MCH care among women of reproductive age group (18-49 years) residing in tribal areas of district Sirmour (Himachal Pradesh) during year 2020-21. Majority of tribal population were residing in Nahan and Paonta Sahib blocks of district Sirmour (DLHS-4) (Ministry of Health & Family Welfare, 2017). Participants belonged to Gujjar tribe having Hindi as their local language. They were selected through a probability stratified sampling technique from each stratum (10 villages) till data saturation. Total sample size was 84.

Inclusion criteria

1. Women of reproductive age group between 18-49 years who were residing in the selected tribal areas.
2. Women who were willing to participate in the study.
3. Women who were able to understand Hindi language.

Exclusion Criteria

1. Women who were mentally retarded or mentally ill.
2. Women who were not available at the time of data collection.

Ethical consideration was maintained during data collection i.e., formal permission was obtained from concerned authority and written informed consent was taken from the participants. Secondary data was taken from previous literature, books, policy document, records & reports, online databases & websites, journals, etc. Primary data was collected from the beneficiaries, i.e., women of reproductive age group (18-49 years). Ten focused group discussions (FGDs) were conducted with 8-10 participants from each village for 30-40 minutes. ASHAs and Anganwadi workers were present during the discussions in order to make the beneficiaries more comfortable.

Primary data were analysed with Colaizzi procedural steps and N-Vivo software. The different issues affecting MCH services utilisation have emerged as significant themes from the data (FGD transcripts, notes, field observations). Finally, both the predetermined and emerged

themes were pooled together to address the research question.

Results & Discussion

Socio-demographic variables of women are shown in Table-1.

Table 1: Frequency & percentage distribution of demographic variables of women (N=84)

S. No.	Demographic variables	Frequency (n) (%)
1	Age (in years)	
	a) 18-24	26 (31)
	b) 25-31	31 (36.9)
	c) 32-38	22 (26.2)
	d) 39-45	05 (5.9)
2	Religion	
	a) Hindu	54 (64.3)
	b) Muslim	30 (35.7)
3	Educational status	
	a) Pre-literate	26 (31)
	b) Primary	10 (11.90)
	c) Middle	22 (26.2)
	d) Secondary	12 (14.3)
	e) Senior secondary	08 (9.6)
	f) Graduate & above	06 (7.2)
4	No. of living children	
	a) None	07 (8.3)
	b) 1	12 (14.3)
	c) 2	24 (28.6)
	d) 3	20 (23.8)
	e) >3	21 (25)
5	Occupation	
	a) Home maker	73 (86.9)
	b) Own business	02 (2.4)
	c) Govt employee	03 (3.6)
	d) Private employee	02 (2.4)
	e) Labourer	04 (4.7)
6	Monthly income (in Rs)	
	a) 5571 and above	06 (7.1)
	b) 2586-5570	12 (14.2)
	c) 1671-2785	31 (36.9)
	d) 836-1670	24 (28.6)
	e) <836	11 (13.2)

II: Qualitative Analysis of Women's Perspective

Cultural Practices: Cluster of themes

After careful analysis of the transcript of the FGD, themes and sub themes were formulated. A total of 40 responses evolved from the data of FGD. Out of these, 36 meanings were derived because some of the study's responses were not exclusive but were interconnected and overlapping. The responses were grouped under various sub themes under the main 7 themes.

Main themes have been shown in Fig 1.

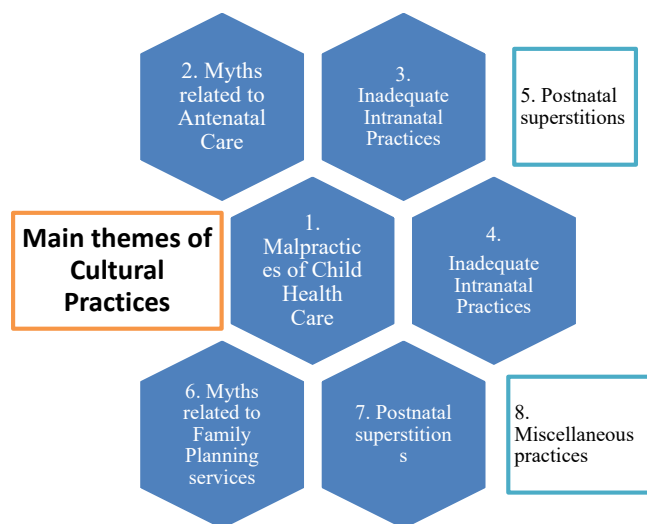


Fig 1: description of themes.

1. Malpractices in Child Health Care

Inadequate exclusive breastfeeding: Exclusive breastfeeding means the infant will receive only breast milk; no other liquid or solid is given. Beneficiaries reported that they have given salty water, honey and Janma-ghutti (Ayurvedic tonic) to their children immediately after birth rather than first feed of colostrum. For the management of diarrhea, they used to prepare a solution with Ajwain (ajwan caraway, bishop's weed), Harar (Terminaliachebula), and Tulsi leaves (Holy Basil) for the drinking by the children instead of using ORS.

Traditional practices: There are numerous practices based on the theories, beliefs, and experiences indigenous to different cultures and traditions. Beneficiaries reported some traditional child care practices which are followed by Muslim religion only.

Hazaan ceremony: In Muslim culture, Hazaan practice was followed for children, i.e., piercing in both ears after seven days of birth during hospital delivery and after 3-day in home delivery, which has no significant relation to health deteriorating conditions.

Wearing of Taweez (magical ornament): A Taweez is a locket that is generally associated with Islam, although wore by Hindus also. It usually contains verses from the Quran or other prayers and symbols inscribed on the metal portion of the Taweez. Beneficiaries reported that Taweez is mandatory to be put in the neck of the child to be prevent them from diseases.

Circumcision practice: In Muslim culture, they follow the aseptic technique of circumcision in which children under the age of 3-5 years has to undergo Sunnat (circumcision), i.e., removal

of the foreskin from human penis using aseptic techniques without sterilised blades and then applying cow dung on the wound, etc. which is causing infection and delay wound healing.

2. Myths related to Antenatal Care

Antenatal beliefs: Women are isolated for 11 days in a room during the religious event (Pooja) and her presence considered as Sutak (bad) for the village during Pooja. In Muslim culture, during Roza time, they have to keep fasting continuously for days. Some of them have omitted vaccination during fast because of fear of Allah's (God) punishment in the form of illness.

Inadequate dietary practices: Primitive practices of the tribal population to be discarded and necessary health education should be imparted. There is no specific attention given to the food during pregnancy. They are eating less quantity of fruits because of cost and unavailability.

Unhealthy practices: In some areas, women smoke tobacco smoking during pregnancy because of their habitual and ancestral practices (Fig 2). They smoke tobacco through a pipe that brings smoke through a container of water before it is breathed in (known as Hukka). Smoking, chewing tobacco and alcohol consumption is high among tribal population. It was noticed that most of women had not accepted antenatal care during their pregnancy due to their misperception of 'not necessary' and 'customary'. "We are smoking (Hukka) during pregnancy time also, now we are habitual, cannot change our habit".



Fig 2: Hukka (pipe for smoking tobacco) for females.

3. Intranatal practices: During home delivery, immediately after birth, the new-born baby is wiped with clean cotton cloth. After giving honey or Janamgutti, the baby is put on the mother's breast, whereas the mother is also given hot tea with Jaggery. After six days of delivery, the cord and placenta were buried underground. It is usual for them to migrate to their mother's house for delivery. Among Hindus, most prefer hospital delivery by trained health care personnel whereas Muslim beneficiaries prefer home delivery.

4. Myths related to Post-natal Care:

Respondents reported that during post-natal period, they have to follow certain specific practices regarding diet, hygiene, and rest to keep herself and her baby healthy.

Less exposure to sunlight: Beneficiaries reported that there was no exposure of mother and child to sunlight (outside room) at least for 1 month & 15 days, i.e., they are isolated in a room for six weeks.

Inadequate dietary practices: In the post-natal diet, they have eaten moong daal and chapatti for one month and Desi ghee Halwa for 3 days. Boiled water was given to the mother with ajwain, Ghee, and Jaggery for a drink. Only one-time, chapatis in food were given to them because they believe that if they eat more chapatis, it will increase the size of abdomen. Intake of rice, buttermilk, milk, curd, and chillies is avoided during the post-natal period.

Personal hygiene: Inadequate personal hygiene practices related to bathing and teeth cleaning etc. due to cultural beliefs. "After 40 days, we use to take a body bath with warm water & neem leaves with our children, and changed clothes. In our Muslim culture, mother and child bath is allowed after 1 week or 1 month."

5. Post-natal superstitions: Superstitions are the cultural beliefs for prevention of mother and children from supernatural powers and diseases. "After the birth of a child, if you want to see mother and child, you have to stand in front of Rakh (sand) kept outside their room, and then you can enter inside so that we can prevent a child from supernatural [evil] powers. We are keeping one vessel with wheat, knife, and onion under mother & child's bed to prevent supernatural powers responsible for child mortality (Fig 3 & 4).

6. Myths related to Family Planning Services

Inadequate utilisation of Family Planning methods: Muslim women reported that males are not adopting vasectomy because they believe it will cause physical weakness and reduce energy to work in fields. Few of them are not using any family planning methods because they think children are God's gifts. Beneficiaries reported that if they undergo surgery, then they will be deprived of God's blessing. "Zanat nhi milte, Namaz nhi lagegi, Operation karwana Gunah hota hai."

7. Miscellaneous Practices

Quack treatment: Cultural belief and traditions are followed for the management of infertility & fibroid uterus which is responsible for the



Fig 3: Rakh kept outside room



Fig 4: Wheat, knife and onion under mother & child's cot.

non-acceptance of modern medicine. “During infertility and fibroid uterus development, we are going to local Baba for Jhada or Muslim Elaaz, not preferring medical treatment.”

Gender issues: There was under-utilisation of obstetrical and gynaecological services from Govt hospital due to gender issues of health care personnel (physician). In Muslim culture, the family does not allow females to visit male gynaecologist and obstetrician.

Discussion

Child Health Care Practices

The malpractice of inadequate exclusive breastfeeding has increased child morbidity and mortality. The irrational practice of squeezing out the mother's first milk deprives the new-born baby from nutrient-rich colostrum milk, which leads to risk for malnutrition. Children should be given Oral Rehydration Solution (ORS) during diarrhoea instead of the home prepared solution to maintain fluid and electrolyte balance for immediate effect. Application of Kajal in the eyes of children can cause minor eye problems such as irritation, discharge, and infections. The use of a non-sterilised blade and application of cow dung on the wound (after circumcision) has bad impact on children's health in the form of infection, bleeding, etc. Consistent to our findings, Contractor et al (2018) conducted a study and found similar results related to tribal women experiences with MCH services in Odisha (India).

Antenatal Health Care Practices

Most of Muslim beneficiaries prefer home delivery without supervision of trained/skilled health care personnel and they are missing the administration of tetanus vaccination during Roza (fasting days) which can make the mother and children prone to tetanus infection. Inadequate dietary

practices such as fewer intakes of fruits, no specific antenatal diet and smoking during pregnancy can cause poor pregnancy outcome such as LBW, pregnancy complications, malnutrition, iron deficiency anaemia etc.

Post-natal Health Care Practices

Exposure to sunlight is essential for mother and child to maintain the intake of vitamin

D inside body. They are not used to expose the mother and child to sunlight after delivery for 7 days, which leads to the development of nutritional deficiency diseases. Inadequate dietary practices can cause poor health outcomes for the mother and adversely impact the health of the breastfeeding baby. Boiled water with neem leaves with antibiotic/anti-infective properties used for bathing of mother and child may have good impact on health. However, they should maintain their hygiene regularly, not after a long period of time, to prevent infections.

Family Planning Services

Underutilisation of family planning methods and frequent childbirths can cause poor maternal health in terms of blood loss, anaemia, malnutrition, low birth weight babies, etc. Similar findings were found in a study conducted by Dehury Ranjit, Pati, Dehury Ashalata Parthsarathi (2018) regarding traditional practices and beliefs in post-partum care among tribal women in Maharashtra.

Implications

1. For provision of comprehensive services in community area, health care personnel have to provide transcultural care based on their traditional values and customs for effective usage of MCH services. These measures will reduce maternal and child morbidity and mortality for achievement of SDGs.
2. There is intensive need to involve community people in village health meetings and awareness campaigns in order to enhance their knowledge regarding impact of cultural practices on health of mother and child which is causing poor maternal and child health outcome.
3. Apart from facility-based care, community outreach would also strengthen health promotion and disease prevention. It should be

augmented by nurse practitioners in place of physician to provide essential drugs and basic diagnostic free of cost.

4. Targeted awareness campaigns should be organised which can be more fruitful in comparison with general campaigns. For effective communication, different audio-visual aids can be used.

Recommendations

- Qualitative study can be conducted to explore the tribal Govt initiative for promotion of tribal maternal and child health in India.
- Multicomponent interventional research can be performed on selected culturally impacted health problems of mother and child residing in tribal areas.

Conclusion

Tribal populations live in areas having scarcity of resources, inaccessible health care facilities. They follow traditional norms, are socially and economically weak and conventional in nature. This study was related to various myths, beliefs, and malpractices concerned with mother and child health care during the perinatal period. There should be awareness campaigns regarding exclusive breastfeeding practices, adequate personal hygiene, usage of ORS, healthy dietary habits, prohibition of smoking, preference to institutional deliveries, usage of family planning methods etc. to improve maternal and child health outcome.

Religious leaders are great motivators for their community. So, they should be involved by health care personnel during distribution of MCH services to enhance its utilisation and to promote safe motherhood which will ultimately help in achievement of Sustainable Development Goals.

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