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Original Research Article

Antenatal, intranatal and postnatal practices in Melghat tribal area: a qualitative study

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ABSTRACT

Background: Melghat, the hilly and forest dense area in the northeastern Maharashtra is the home of the Gond and Korku tribes. The maternal and child health indicators in Melghat are poor compared to other parts of Maharashtra. Apart from poor socio-economic development, traditions and social norms prevailing in the area also prevent people to seek reproductive health care. The current study tried to capture the perception of women in reproductive health regarding their practices during the antenatal, natal and postnatal period and reasons for not seeking medical advice during pregnancy or childbirth.
Methods: This qualitative study was conducted during September to October 2015 in the selected villages under three PHC areas of Melghat region, where we used in-depth, key informant interviews and focus group discussion with the purposively chosen participants, after taking verbal consent from them. All the interviews were audio recorded which were transcribed for doing the analysis. Ethical clearance was taken from institutional ethical committee.
Results: We identified different practices during the antenatal, natal and postnatal period in Melghat, which could be classified into common and deviant. Though some of the mothers go to health facilities for delivery but still there are many others who prefer home delivery due to poor health literacy, family customs, poor communication network, perception regarding quality of health care in government health facilities and more reliance on health seeking from unqualified health care providers and faith healers.
Conclusions: More emphasis should be given on counselling for increasing the awareness among the mothers and their families regarding institutional delivery, birth preparedness and maternal deaths in Melghat, along with improvement in quality of services at government health facilities and the inter-sectorial coordination.

Keywords: Melghat, Antenatal practices, Birth practices, Postnatal practices, Traditional customs

INTRODUCTION

Pregnancy is not a disease or illness. Yet more than half a million women and girls die every year because of pregnancy, childbirth, and unsafe abortions. The maternal mortality ratio (MMR) of India has declined from 437 in 1990-1991 to 167 per 100,000 live births in 2011-2013 period, which may be attributed to the different interventions of Government of India, which include programs to increase the rate of antenatal check-up of the pregnant women, increased institutional deliveries and better post-partum care.[1,2] But, despite all these efforts, little improvement has been achieved in different hilly and backward tribal areas in India. Mention worthy among them is the Melghat area of the Amravati District of Maharashtra, comprising of the Dharni and Chikhaldhara tehsils. The whole area was declared a tiger reserve and was among the first nine tiger reserves notified in 1973-74 under the 'Project Tiger'.[3] The inhabitants of Melghat are mostly tribal; a large majority of them are from the korku tribe. They earn their

livelihood from daily labor and rainy season agriculture.[4] These tribal people are primitive and marginalized from the development processes. Since 1977, 90% of Korkus and other tribes in Melghat region were below poverty level, which is far below the national average (around 40%) and national tribal average (around 60%).[5]

Though there is a declining trend of maternal deaths in Melghat from 209/ 1,00,000 live births during 2008-09 to 126/ 1,00,000 live births in 2014-15, the MMR in Melghat (126) is almost double the state average (68) in 2014-15.[6,7] According to the Department of Health and Family Welfare, Amravati district, the birth rate of Melghat is quite high (23.07) as compared to the whole district (14.56), but institutional deliveries account for only 44.12% of all the deliveries.[6] Apart from decreased institutional deliveries, decreased level of seeking antenatal care is another reason for the higher maternal mortality and morbidity in this area, which ultimately links to the higher child mortality in Melghat, as we know "a healthy mother can only bring forth a healthy child". Poverty, unavailability of good transport system, poor network connectivity are the important reasons contributing to the higher mortality indicators. Apart from these, there are a number of traditions and social norms prevailing in the area, which forbid them to fetch hospital services during the pregnancy, childbirth and in the post-partum period. This qualitative study is hence designed to develop an understanding of the general practices during the antenatal, natal and postnatal period in Melghat and to find out the reasons for not seeking medical advice during pregnancy or childbirth.

METHODS

In this qualitative study, we have used In-depth interview (IDI), Key Informant's Interview (KII) and Focus group discussions (FGD) which were carried out in the month of September to October 2015 in selected villages of the Melghat area under three Primary Health Centers (PHC) areas, namely Tembrusonda, Bairagad and Sadrabadi PHC. The study participants for the IDIs were the purposively chosen pregnant women, mothers who had given birth to a child within a year from the date of interview and had consented to be a part of the study and KIIs were conducted with the frontline health workers (ASHA, AWW, ANM and MPW).

Total 16 IDIs were conducted with the purposively chosen study respondents who could provide rich, relevant and diverse information pertinent to the research objectives. 14 KIIs were conducted to understand the health provider's perspective regarding the community's response during their antenatal, intra-natal and postnatal period. Apart from this, we have also conducted 5 FGDs (Focus group discussion) with the pregnant, postnatal and lactating mothers of the study area, for which a separate tool guide was prepared beforehand. Each FGD was conducted with an average of 8-10 purposively chosen women in locations chosen by the participants. During the FGDs, along with the interviewer, a social worker and a local volunteer were also present, who helped in taking the field notes, audio recording of the proceedings and drawing the sociogram.

All the interviews were conducted in Hindi, which the participants understood. Each of the IDI, KII and FGD continued for around 40 to 60 minutes. Interviews were taken till there was saturation of information and no new information came up. The persons conducting the interviews and the FGDs were trained in qualitative research methods. All the interviews and FGDs were audio recorded and were conducted after taking verbal consent from the participants.

The study was conducted after getting approval from the Institutional Ethics Committee, MGIMS.

RESULTS

After analyzing the transcripts obtained from the audio recording of the IDI, KII and FGD, we could classify the practices in the Melghat area into common, deviant and change in practice, where the deviant practices include both positive as well as negative deviance, that are being practiced before, during and after child birth, which are mentioned in Table 1.

Agriculture or working as migrant laborer are the main sources of income for the tribal population of Melghat. "*Here the pregnant mothers work in the field even during their last trimester of pregnancy*" (said an ANM), where they are engaged in hard physical labor. Many of the families reside in the fields for months together, which is quite far away from the village. As a result of regular counseling by different health workers, it is now found that many of the mothers have started avoiding going to the field, at least in the later part of pregnancy. Migration of the whole family, including the pregnant mothers, to the cities for cheap labor is a common observation in the whole area. As a result of this, the "*pregnant mothers miss their regular antenatal checkups*" (ASHA), though now, in few families a change in practice is noticed, where "*only the males migrate for earning wages*" and they don't take their pregnant wives with them, so that she can receive regular antenatal check-ups. Most of the mothers who continue antenatal checkup take IFA (Iron and folic acid tablets), but there is a belief in the society, that *"IFA tablets make the baby big, which causes problem in delivering the child"*. As a result of which, many mothers don't take IFA tablets at all throughout the whole pregnancy, though they are being regularly told about the importance of consumption of IFA tablets by the ASHA/ANM, who also ensure regular supply of the same. Quite a few of the inhabitants of Melghat have started understanding the importance of antenatal check-ups, as one of the participants in the FGD said; "*when I was pregnant I went to the Anganwadi Center every month for the nurse to check me. She (the nurse) told me to take more food, as now I have to eat both for myself*

and my baby". Many of the participants nodded to her statement showing their agreement to the comment. Now "*more than half of the antenatal mothers receive ANC checkups*" in the sub-center or anganwadi center, said by an ANM of a village.

Table 1: General practices during the antenatal, natal and postnatal period in Melghat.

Common practices	Deviant practice	Change in practice
Practices during pregnancy		
Pregnant mothers work in the field till the end of last trimester	Few women have started avoiding going to the field to work, during their pregnancy (*Positive Deviant*)	Gradual improvement is seen in in the consumption of IFA tablets.
Most of the families (including pregnant mothers) migrate to far away cities to earn the livelihood	In few families, only males migrate to earn money, while the pregnant mother stays in the village to attend the ANC services (*Positive Deviant*).	More than half of the antenatal mothers receive at least one ANC
Most of the mothers avoid consuming Iron and Folic acid (IFA) tablets		
Practices during delivery		
Home delivery by *dai* (traditional birth attendant) is preferred	Some home deliveries are conducted by ANM (*Positive Deviant)*	Now around half of the deliveries are conducted in the health facilities
Post-partum practices		
Breast feeding is initiated only after giving the first bath to the baby	Some of the families have started delaying the first bath to the child (*Positive Deviant)*	They allow the ASHA to come in their house to assess the newborn.
They don't allow the outsiders to enter the house for first 7 days	In more than half of the families, mothers start going to the field as the baby turns two months old. (*Negative Deviant)*	
Preference for health care seeking		
People have more faith in the traditional healers (*Bhumkas/Bhagats*) than the scientific system of medicines.	Few people have stopped going to the traditional healers (*Bhumkas*)	Mothers have now started coming to the hospital for treatment purposes.
	Very few of them deny to go to hospital although the ambulance is at their door step to transfer them to the hospital (*Negative Deviant*)	Majority of the pregnant mothers take part in the VHNDs and in the immunization sessions, though, they have to be reminded by the frontline workers.
Feeding practices		
Almost all mothers practice exclusive breast feeding	In some families where child deaths were reported, the baby wasn't fed for first two to three days (*Negative Deviant)*	Early initiation of breast feeding is now practiced throughout Melghat.
Cost of care		
Most of them don't have to spend for delivery and their treatment	They go to hospital on their bikes when ambulances aren't available (*Positive Deviant)*	Few people go to private doctors around Dharni

Home delivery is still preferred in most of the houses. Poor roads, difficult terrain and unavailability of vehicles at the time of emergency, forces them for conducting deliveries at home by the "*dais*". Beside these, there were many other factors, for which they avoid hospital delivery (Table 2). However, women reported that the proportion of home deliveries conducted by the ANM has increased. Over time, understanding of women regarding importance of institutional delivery has improved. However, they prefer the sub centers to PHC for delivering their child, due to distance of the health facility from their village. The ANM stays in the center and most importantly the women is sent back home on the day of delivery. One of the ASHA said, "*Now more than half of the deliveries are being conducted in the health facilities*". A participant of the IDI told us, "*We now call the ASHA when the pain starts. And the ASHA calls for the ambulance*". Another participant added to it, "*Last month, during the time of delivery of my sister-in-law, as vehicle was unavailable, my husband took her on his bike to reach the hospital*". It proves that people at Melghat

unlike earlier times, in spite of un-availability of proper infrastructures, are willing and gradually getting motivated towards attending public health services during emergencies, especially for the deliveries.

Table 2: Reasons for not preferring health facilities during pregnancy or childbirth.

S. no.	Reasons
01	Loss of wages as a result of prolonged hospital stay
02	There exists problems in transportation due to poor road connectivity
03	Ambulance often doesn't come in time, especially in the night hours.
04	Social norms cannot be followed on time, like bathing the newborn soon after birth, worshipping and burying the placenta near their home and burying the umbilical cord next to the house etc.
05	The hospitals don't discharge the mother soon after the delivery; they have to stay for minimum 2 days.
06	Most of the time, the pregnant mothers are referred from the PHC to the CHC, sub-divisional hospital or the district hospital, that are located at quite a faraway place from the village.
07	Increased expenditure for the household as a result of prolonged hospital stay, as regards to the food and the accommodation of the patient's relatives.
08	The dai (Traditional birth attendant) and the Bhumka (traditional healer) are available in the village at any hour of the day for conducting the delivery and treatment purpose respectively.
09	Privacy is not maintained, if delivered in the primary health centers.
10	Injections and saline are always injected, once they are admitted to the hospital for delivery.
11	Mother in laws are generally the ones, who take decision as to where her daughter-in-law would deliver, and in most of the cases, they advice them for home delivery.

Breast-feeding is usually started soon after birth, after giving the first bath to the baby. "*After conducting the delivery, we advise the mother to give the 'cheek dudh' (colostrum) to the baby soon after cleaning the newborn*," said one of the dais in a village. They don't allow any outsiders to enter their home during the first few days after delivery, as one of the participants mentioned, *"to protect the newborn from an evil eye, we do not allow strangers to visit the child for first 7 days"* but they allow the ASHA, who is a resident from their own village to enter their home. The ASHA assesses the newborn's health status, take anthropometric measurements and asks regarding any problem faced by the mother in feeding and rearing the new one. She also checks if the baby is breastfed properly. Later, the ASHA advises the mother for timely immunization of the child and advises the mother on nutrition and hygiene.

People in the Melghat area still believe the traditional healers, called "*Bhumka"* or "*Bhagat*" for the treatment of their ailments. Easy availability and cheap means of treatment might be a reason for such a faith. A participant in the IDI commented, *"We go to the Bhumka baba, as they not only treat us but also worship for our wellbeing."*

A pregnant mother from the FGD added, *"We go to hospital only when Bhumka tells us to go"*. An ANM informed that quite a good number of the inhabitants have stopped going to the traditional healers. They went to the sub centers for minor ailments also. The ANM confirmed this, when she said, *"Many people first come to us for treatment now".* On the contrary, there are a few of them, who refuse to take medical advice or go to hospital, even when the ambulance is standing at their doorstep. While discussing the reasons for not going to the PHCs during delivery, a mother of a 6 months old child said, "*We do not like to go to government hospitals (PHC), as they always refer the pregnant women to Achalpur (CHC) or Dharni (Sub divisional Hospital),* which is around 100 km from the village. *And if we deny to take our patients (pregnant women) to those hospitals, they (the PHC people) don't treat us and ask us to go back to our home".*

Now, coming to the feeding practices, the pregnant women take meal two to three times a day. They do not take any extra diet during their pregnancy nor do they take any seasonal fruits or snacks in between. Breast-feeding was started quite early, but in many families, *ghutti* was also given along with breast milk to the newborn. The mothers lack in knowledge as to when they should start complementary feed for their child. For a significant proportion of infants complementary feeding was delayed. Complementary feeding is mostly started with diluted cow's milk, dal water and rice water, which is later, shifted to Khichdi, bhakar (Joyar roti) and dal. In some families where child deaths were reported, it was found that the baby was not fed for first 2/3 days after birth. As the mothers had to go to field for work, the baby was being taken care by the elderly member of the family like grandmother. In many families, the elder sibling, who was just around 6-7 years old himself, was taking care of her younger sibling and was responsible for the child's feeding. Colostrum was given to all newborn children without being discarded. All the pregnant, lactating mothers and children regularly went to the anganwadi center for supplementary nutrition in the form of 'take home ration' (THR) or khichdi.

In majority of the cases, no cost had to be borne by the family members for the delivery and treatment purposes,

if the deliveries were conducted in hospitals. Ambulances from the PHC arrive to the doorstep to take the pregnant mother in labor to hospital, once the ASHA calls the PHC, although mobile network connectivity is still an issue in those hilly terrains. During the hospital stay at the time of delivery, 2-3 family members accompany the pregnant mother and they need to bear cost for their transport and stay in the hospital. One of the participants said, *"In hospital, food is given only to the patient and not to her relatives; so buying food for ourselves becomes a problem for us".* Though they have to spend the money from their own pocket, still few people prefer to go to private practitioners at Dharni for their investigations, ANC and treatment purpose, related to the pregnancy.

DISCUSSION

The present qualitative study tried to find out the general practices during the antenatal, intranatal and postnatal period in the Melghat area, where we have found, there has been a gradual improvement in seeking the regular antenatal care in the village, although migration along with families to far away cities and residing in the farming land during harvesting carries a negative impact on the overall ANC care. Although coverage with tetanus toxoid immunization during pregnancy is good, there are issues related to availability, distribution and consumption of IFA tablets.[8] At community level, people believe that consumption of IFA tablets will result in larger sized babies and will cause difficulty in normal delivery. Decreased IFA consumption coupled with poverty and unavailability of iron rich food items in diet result in high prevalence of anemia, mostly iron deficiency anemia among the pregnant mothers.[9] Further, displacement from their traditional forest homes[5] and natural source of food; and lack of livelihoods make the inhabitants of Melghat to get dependent on the public distribution system (PDS), where they get polished rice and cereals. This has replaced their diverse dietary food regime resulting in increased cases of micro and macronutrient deficiency among the pregnant mothers.[10] In such a scenario, the THR supplied to the mothers from the Anganwadi centers via ICDS scheme has proved to be beneficial in preventing further deteriorating of their health status. We need to strengthen our nutritional counseling and education strategies for the pregnant mothers. Apart from that, establishing kitchen gardens and providing a wider range of diverse food supply through the PDS may help in curtailing both macro and micro nutrient deficiencies during pregnancy and childbirth.

Poor socio-economic status and resulting poor nutritional status of women and high prevalence of infectious diseases as well as the poor health care delivery system are the most important reasons for poor reproductive outcome. However, it is noteworthy that practices during pregnancy and childbirth are gradually improving. The ANMs trained in midwifery conduct deliveries in the sub centers, which is quite acceptable among the tribal population and has increased the rate of institutional deliveries in Melghat. But the ANM can do very little to save the life of the pregnant mother unless the ANM is well supported by a fully functional health system throughout 24×7 hours, which includes an adequate supply of essential infrastructure, necessary for managing obstetric emergency and referral system for different intranatal and postnatal complications like hemorrhage, obstructed labor or hypertensive disorders in pregnancy. But absence of good roadways, unavailability of easy transportation and poor network connectivity to call the ambulance prove to be a barrier in timely referral of the mothers to the hospital on time, resulting in increased number of home delivery in the tribal population increasing the mortality and morbidity by leaps and bounds.

Teen-age pregnancy, due to the social norm of early marriages and lack of opportunities for adolescent boys and girls is another issue in the Melghat area. Further, the adolescent mothers seldom visit the health centers for their checkup or delivery due to social and cultural deprivation. Moreover, safe abortion services are yet not available in the village level and the primary health center is the first place to receive MTP services. So, they often take advice from the elderly in the family, traditional birth attendants and unqualified private practitioners in the village.

ASHA and AWW act as a link between the community and the health care system and provide the community access to information to improve the health seeking practices. Coming from the same community, ASHA and AWW are well aware of the traditional norms and practices prevalent in the area and also have more acceptability among the community members. The ASHA not only call the pregnant mothers for attending ANC services but are also involved actively in counseling the mother regarding nutrition and birth preparedness and rendering health education. She is trained to detect danger signs early and initiate quick referral of the mothers to the nearest hospitals using the 108 ambulance services. ASHA also escorts the mother to the hospital and usually stays there till she gets discharged. Under the Home-based Newborn Care, ASHA is expected to provide home visits during the post-partum period, which not only would help early detection of complications for both mother and the baby during the post-partum period, but also help in building confidence of the community. Also, we found the *'Bharari Pathak'* and '*Phirte Pathak'* schemes (Mobile Medical Unit), run in the Melghat area, are doing excellent work, where doctors (usually trained in alternative system of medicine) get opportunity for frequent village visits. We heard several stories of how they were catalytic in early referral to higher facilities in case of danger sign.

Provision of quality medical care in the PHC, which cater for a population of around 20,000 in Melghat area, is another issue that came up in the FGDs. Some of the posts of doctors and paramedicals were vacant and several of the staff who were posted, considered posting

in Melghat area as punishment posting which usually reflects during health care provision. Additionally, the non-availability of essential drugs and equipment, inadequate infrastructure forces the PHC medical officer to refer the pregnant mother to higher referral centers, which creates a lot of problem for the poor family members of the pregnant mothers, which ultimately decreases their belief on the health system. So, they prefer going to the traditional healers and the *dai.* Though the approach now is to bring all deliveries to the institutions, large proportion deliveries continue to happen at home in Melghat area and these are mostly conducted by traditional birth attendants (TBAs). TBAs were trained long back to conduct vaginal delivery, with the emphasis on institutional deliveries now, there is no system for their handholding and continuous monitoring and support. Besides this, training the traditional healers for providing the basic health care with availability of essential drug kit may prove to be a saviour in few remote pockets in Melghat.

In Melghat area, joint family is the norm, where the say of the mother-in-law is still regarded to be final, in regards to cases of maternity and childbirth. On the contrary, the younger mothers or the newly wed women were more receptive and listened to the health workers in matters of their health and contraception. There is need of strategies to reach both would-be parents and the older generation and make them understand the benefits of institutional deliveries and other practices during pregnancy and childbirth.

It needs to be mentioned here that the current study was conducted with selected participants in three PHC areas using qualitative methods, and therefore, the results cannot be generalized to other tribal and non-tribal population.

CONCLUSION

Irrespective of gradually increasing antenatal care seeking and institutional deliveries, poor availability of easily accessible and affordable health care services for delivery result in large number of home deliveries in the Melghat area. This is also negatively influenced by the different traditional beliefs and practices of the tribal population. As these beliefs and practices are the integral part of the *gond* and *korku* culture, culturally sensitive tailored interventions along with development of roadways, improved network connectivity and better quality of care at the health facilities are the crying needs for improving the MCH services in the Melghat area. Last but not the least, strategies for empowering families and pregnant mothers with the information of birth preparedness and early identification of danger signs should be also taken into account.

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