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Maternal and Child Healthcare among Tai-Khampti Tribe of Namsai District, Arunachal Pradesh

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Abstract: Safe motherhood should be a priority in every country, state, society, and community. By improving the health of mothers and children, the health of the family and community can be improved. The well-being of both child and mother determines the health of the next generation and can help predict future public challenges for families, communities, and the health care system. Maternal mortality and Infant mortality are major threats to the developing status of a country. The Present study intends to examine the factors affecting the utilization of maternal and child healthcare services in the village and to identify the barriers to utilization of the healthcare services in the village based on empirical evidence from the field. This paper focused on the perception and knowledge of the tribal people towards maternal and child health care services.

The study reveals that there is a need to focus on the education level, medical facilities, and more awareness among the tribal people of the village. There is a need to introduce more clinics and facilities for HIV tests and ultrasound. Women should be motivated for institutional delivery and regular checkups during their pregnancy period. Proper supplementary diets should be advised to all pregnant women.

***Keywords*:** Tribal Women, Arunachal Pradesh, Pregnancy and Motherhood, Risk factor, Socio-economic, Health care services utilization.

Introduction

Maternal and child healthcare refers to the process of promoting and maintaining the health, safety and well-being of children and women of reproductive age. Improving the well-being of mothers, infants, and children is an important public health goal across the world today (Pertin and Degi, 2020). Reproductive health is a crucial

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part of general health and a central feature of human development (Srivastava and Chaudhry 2016, 29500-29503). According to a recent report, in 2022 most of the births by far were registered in India (23 million), followed by China and Nigeria (United Nations, Department of Economic and Social Welfare, 2022). Maternal morbidity and mortality are becoming a major concern in a developing country due to multiple factors contributing to it. Maternal and child healthcare is also included in the 4th and 5th-millennium development goals to improve and achieve proper maternal health conditions for all regardless of caste, gender, socio-economic status, and many other variables (Millennium Development Goals, 2018). Due to Multidimensional factors, Safe Motherhood is still a dream for much of India particularly for its rural and tribal population (Deb 2008, 137-141). There are many national programmes aimed at reducing mortality and morbidity. However, despite the existence of national programmes for improving maternal and child health care (MCH), maternal morbidity continues to be on the higher side, at an unacceptable level (Kavita et al. 2021, 69-72). Although high-quality health services and accessible health care have made maternal death a rare event in developed countries, these complications often cause fatalities in backward states and tribal dominated like Arunachal Pradesh due to lack of information and being illiterate but mostly due to lack of maternal and child health education especially among women (Pertin and Degi,2020). Tribal people are amongst the poorest populations and experience extreme levels of health deprivation (Dave, Mistry & Chaudhary 2019, 2239-2245). The fertility rate in the state was 1.8 children per woman, a decrease from 2.1 children per woman during National Family Health Survey-4 (NFHS-4) and the survey notes that 94 per cent of the pregnancies in the five years before the survey resulted in live births. The remaining six per cent accounted for abortions, miscarriages, and stillbirths (National Family Health Survey-5, 2019-21).

Improving the health status of women and children are must as they are mostly exposed to diseases and illnesses. Women and children together constitute 67.7 % of the country's population according to the 2011 census. So, it is a very important task for all to protect and ensure the safety and well-being of all the women and children in the country. The survival and well-being of the mother is a very important factor responsible for the development of a country India has made good progress in reducing maternal deaths in the last two decades. India's Maternal mortality ratio (MMR) has improved from 113 in 2016-18 to 103 in 2017-19 (State of World Population Report, 2022, https://india.unfpa.org/sites/default/files/pub-pdf/1_key_insights_india_final_web.pdf. Between 2000 and 2017 the global maternal mortality ratio (MMR) fell by 38%, from 342 deaths to 211 deaths per 100000 live births; this represents an average

annual rate of reduction (AAR) of 2.9% (UN, 2022, Sustainable Development Goals Extended Report 2022). India's MMR has fallen faster than the global decline and is on track to achieve Sustainable Development Goal 3 of an MMR below 70 by 2030 (Ministry of Health & Family Welfare, Govt. of India, Annual Report, 2021-22). It is estimated that around 47,000 mothers die every year due to multiple factors related to pregnancy and childbirth. Some of the major factors related to these deaths are Hemorrhage, sepsis, abortion, anaemia, etc.

There have been several studies on the status of women relating to their socio-cultural problems, their economic rights their access to employment, food, etc. But these issues also need to be reviewed in the light of changing socio-economic conditions, especially with a focus on Tribal women (Rani and Ramana, 2016). Exploitation and marginalization of tribals have been intensified due to India's rapid economic growth. Sustainable and subsistence tribal livelihood is under threat from the flow of global and local capital in the exploitation of their physical environment (Mushooq, 2012).

There is a need to make a review of the tribal situation. The development strategy would require an intensive approach to tribal problems. These achievements are a matter of satisfaction as various development plans, policies and programmes have brought forth a perceptible improvement in the health and socio-economic status of Schedule tribes (Kaur, 2020).

In many places, especially in rural areas, women are always burdened with all the household chores as well as outside chores. Even during pregnancy, they need to. medical institution or assisted by a skilled health professional. Childbirth-related problems, such as haemorrhage and prolonged labour are difficult to predict. It is important, therefore, that each pregnancy is attended by a skilled birth attendant (Paul and Chellan 2009, 297-314). Geographic difficulties in accessing healthcare facilities are an important factor contributing to high MMR among women living in remote areas, especially tribal women (Basu and Jindal 1990, 19-39). Education plays a very important role in Maternal health status. Educated women tend to receive more proper and efficient facilities during their pregnancy as they what is best for their health and their baby's health as well. The women residing in the rural area have poor education levels because of which they don't have any knowledge of proper care and the facilities to be received during their maternal stage. The role of the male member of the family is also an important factor. The male members should engage themselves more in providing proper facilities for a safe and healthy pregnancy. Mother's health during and after pregnancy determines the health status of the child born. So, the health of the mother should be given proper attention.

Keeping in view the above facts, the present study is conducted in Village Chongkham of Namsai district, Arunachal Pradesh amongst the Tai-Khampti tribal women. The Tai-Khampti tribe is one of the major tribes of Arunachal Pradesh among the twenty-six major tribes and a number of Sub-tribes (Goken, 2021). Tai-Khampti are followers of Theravada Buddhism.

Research Aims and Objectives

The aims and objectives of this study are to access the knowledge regarding maternal and child healthcare services available among the antenatal women of the village area, to understand the utilization of maternal services by the village people and to understand the reproductive health status of the tribal women of the village area.

Materials and Methods

The data consists of 150 subjects, which comprise Tribal women of the Namsai district of Arunachal Pradesh. The study was carried out in a village named Chongkham, Namsai district, Arunachal Pradesh of Northeast India. Northeast India is a place of various tribal and Ethnic groups. According to census 2011, Chongkham village has a total of 115 families residing there. Chongkham has a population of 562 of which 295 are males and 267 are females. The population of children with age 0-6 is 100 which makes up 17.79 % of the total population of the village. It is home to about 145 tribal groups. Chongkham is a town and subdivision in the Namsai district of Arunachal Pradesh state in India. The participants were women of reproductive age. The schedule and interview method were used for conducting the survey. The Interviews were carried out at home. The questionnaire consisted of 27 questions. Pregnancy information and child healthcare were recorded by the participants. All the subjects belong to the Buddhist religion. Basic background information was taken on each subject including the age of the mother, Place of birth, Economic status of the family total family income, healthcare facilities, complications during delivery, number of antenatal visits, awareness regarding complications during delivery, breastfeeding and immunization, immunization of baby, etc. Approval for the survey was taken from the village head i.e., gaon bura. The purpose of the research study was explained to him. The study purpose was also explained to study participants and consent was taken before conducting the survey. The data collected was only used for research purposes.

Results

In the present study, each participant was asked about their pregnancy and the problems they faced during delivery. The detailed characteristics of the study participants were presented in Tables 1, 2 and 3. It was observed that the majority of the study participants were aged 19 to 30 years. Few were of age 31 to 40 years. As it was a village consisting of Tai people, so all the study participants were Buddhists. The majority of the women interviewed were housewives. 16 per cent of participants interviewed were engaged in farming activities along with their husbands or other family members. The village is famous for paddy and rice cultivation so most of the women of the village are engaged in farming. Chongkham was once known as the richest village in Asia, thanks to its abundant natural wealth that included timber forests and tea estates. Few families own these tea estates. Very few women were engaged in the private or government sector as they must travel to Namsai district or Tezu. Some women were engaged in small businesses like they sell their homemade goods like pickles, traditional dresses (Gale), things made from bamboo like baskets, etc. majority of the women had children of more than three. The demographic features of the studied mothers are stated in the following Tables 1, 2, and 3.

Table 1: Distribution of Mothers based on Religion and Age group

Religion	*Mothers Age (in Year)*				*Total*
Buddhist	*Below 18*	*19-30*	*31-40*	*Above 41*	
150	0	90	55	5	150
100.00	0.00	60.00	36.6	3.33	100.00

Table 2: Distribution of Mothers based on Occupation of the Mothers

Housewife	*Farmer*	*Govt. Job*	*Private Sector*	*Other*	*Total*
95	25	10	5	15	150
63.33	16.66	6.66	3.33	10.00	100.00

Table 3: Distribution of Mother based on No. of Children

Number of Children of the Mothers				*Total*
1	*2*	*3*	*3+*	
7	18	95	30	150
4.66	12.00	63.33	20.00	100.00

Most of the women in the village were not aware of the contraceptive methods or other birth control measures and many of the women gave birth to their first child at

a very young age. More than 50 per cent of the women gave birth at the age of 21 to 25. This data shows that most of the women were married at a very early age. When asked about the health centre and related variables it was found that more than 50 per cent of women gave delivery at the government health centre. Only 13 per cent of women gave birth at the private health centre and 23 per cent gave birth at home. The government health centre is in the village locality, so it takes less than 30 minutes for nearby village people to reach the health centre, so they were not able to go to the clinic for delivery. It takes like 30 minutes to 1 hour for some pregnant women to reach the health centre and approximately 1 to 3 hours for a few women to reach the health centre. More than 50 per cent of women visited the health clinic 4 to 5 times during the pregnancy period and 10 per cent of women visited the clinic more than 5 times, a few women visited the clinic only 1-3 times during their pregnancy period.

There is only one government hospital/clinic in the village locality so the people living far away had to travel long distances to consult doctors so many gave birth at home. When asked about the reason many of the women said that they do not find it helpful to deliver at the clinic and many did not have any knowledge about the complications during delivery that can be handled well by nurses or doctors or any skilled birth assistance. The majority of women received almost all the facilities like tetanus vaccine, blood testing, ultrasound, and sonography. It was observed that 66 per cent of pregnant women received Ultrasound and sonography at the health clinic and nutritional status was done for 80 per cent of women, HIV/STD testing was not done at a very low number. Tetanus vaccines were given to 91.3 per cent of women and blood testing was done for 66 per cent of women. Earlier there were no such facilities at the hospital but after the renovation of the hospital in 2020, the government introduced many other departments for testing and nurses and doctors were appointed. The women who gave birth recently received all these facilities. Women who gave birth earlier did not receive all these facilities. The study documented that earlier there was a lack of transport services or a long way to walk to reach facilities due to poor road connectivity and demand for higher transport charges. Another factor identified with earlier deliveries was the lack of access to specialists and diagnostic facilities in healthcare facilities.

When interviewed about the antenatal care received it was found from the interview that 53 per cent of women received proper antenatal care and 70 per cent of women did not receive proper antenatal care. The study depicted that 30 per cent of women visited the clinic 3 to 4 times for antenatal care, and rest 30 per cent of women visited the clinic one to two times and the other 5 per cent visited the clinic more than

four times for antenatal care. 53 per cent of women consumed 51 to 75 iron and folic acid tablets during their period of pregnancy and 46 per cent of women received more than 75 tablets, 93 per cent of women took supplementary food for 1-3 months during their pregnancy period. Only 6 per cent of women consumed supplementary food for 4 to 5 months. Almost all the pregnant women received two tetanus injections during their pregnancy at the health clinic. When asked about the reason why they did not receive antenatal care many participants answered that they did not find antenatal care important. This shows the lack of awareness among the study participants about the importance of antenatal checkups. Some women said that it was difficult for them to travel to the clinic for checkups and that they were not accompanied by their husbands or other family members. Women who gave birth at home did not visit the clinic for checkups as they were afraid of mistreatment by the healthcare staff. Many women were happy with the health facilities, but some women reported negative experiences such as low awareness, lack of communication and scarcity of necessary facilities in hospitals. However, few women reported positive experiences like the role of community workers. One such community health worker employed by the Ministry of Health and Family Welfare (MOHFW) as part of India's national rural health mission (NRHM) is an Accredited Social Health Activist (ASHA). It was reported by many women that ASHA provided money to poor groups of pregnant women and iron and folic tablets at a free rate. The awareness among study participants is presented in Table 4. It is observed from the table that 80 per cent of women knew the nutritional supplement during the pregnancy period. Other 20 per cent of women were not aware. Almost all (96 per cent) of women were aware of proper breastfeeding for the baby and the rest 3 per cent of women were not that aware.

Almost all the women were aware of the immunization of the newborn baby as this knowledge was provided by every nurse and staff in the hospital. The study revealed that 93 per cent of women were aware of the complications faced during pregnancy and the delivery period and few did not have any knowledge about the complications that can be faced during the pregnancy or delivery time. It was reported that many things were notified by the health staff but the women who gave birth at the home of them were not aware of proper immunization for the baby and some were informed by the elder people in their family or other relatives who gave birth at the hospital. The traditional practice was almost like the practice done by other religions. The food and other things prohibited were also like the Hindu religion. It was clear that almost all the women were aware of basic things related to their pregnancy. Women (93 per cent) received their post-maternal checkup. Most of the women visited the clinic one

to two times after giving birth to a child for a postnatal checkup. All the babies were immunized regularly after birth. Even the women who gave birth at home immunized their babies after

Table 4: Awareness among the Studied Participants and Number of Antenatal Visits

Variables	*Respondent*		*Total*
	Yes	*No*	
Awareness about supplementary nutrition	120 80.00	30 20.00	150 100.00
Awareness about breastfeeding	145 96.6	5 3.33	150 100.00
Awareness about any emotional change after birth	110 73.33	40 26.6	150 100.00

Conclusion

Maternal and child healthcare is one of the most concerning factors in a developing country like India. The health status of women in a country depicts the developing status of the country. The risk of maternal and infant mortality and other complications can only be overcome by giving access to quality. From the above foregoing discussions, it is evident that maternal education level, availability of health personnel and facilities, and perception of women, do act as barriers to utilization of maternal and child health care services in the study area in particular. From the present study, it is clear that there is a need to focus on the education level, medical facilities and more awareness among the tribal people of the village. There is a need to introduce more clinics and facilities like testing for HIV, and ultrasound. More emphasis should be given to low-income and low-status women. The importance of breastfeeding should be explained to all women during delivery. Women should be motivated for institutional delivery and regular checkups during their pregnancy period.

Moreover, in the present study, it was found that the traditional delivery system plays a significant role in the village. These tribal people are isolated, and the community provider allotted by the government is ASHA. During the survey, many of the women said that they were very dissatisfied with the facilities provided at the health clinic while some of the women were okay with the services provided. Women who gave birth at home gave the reason of fear of mistreatment and this should be overcome otherwise they will continue to give birth at home, and it may increase the rate of maternal and infant mortality. The government should take more initiative at the village level.

Campaigns through medical staff and educated people should be utilized for awareness of the importance of maternal and child healthcare and the identification of risk factors for everyone in the village.

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