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WHY SAFE MOTHERHOOD AND CHILD SURVIVAL ARE STILL A CHALLENGE IN CHANDI REGION OF ODISHA STATE, INDIA?

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ABSTRACT

This paper discusses the perspectives of women from villages of Chandi, Odisha on Mother and Child Health concerns to understand their community specific socio-cultural norms and practices related to pregnancy, child birth and child care along with identifying their information needs on the same. The study was carried out in two phases. In phase I, FGDs were conducted in four villages of Chandi and in phase II, knowledge tests were administered on the women who were either pregnant or were mothers of at least one child in 0-2 years. The content of discussions and knowledge test was about the core Mother and Child health issues like antenatal care, institutional delivery, diet during pregnancy and post-partum, breastfeeding, immunization, family planning, provisions under different government MCH schemes etc. Majority of women were unaware of the key issues due to their limited exposure, unavailability of authentic sources of information and inability to follow the right practices because of poor socio-economic status, overwork and pre-conceived socio-cultural norms which impede their health seeking behaviour. Patriarchal structure of their communities with resultant gender dynamics and religious norms seem to play a major role in suppressing women's voices for their health needs. They don't seem to exercise any agency over their own body, health and fertility.

Keywords: Mother and Child health, Gender, Socio-cultural practices, Chandi, Public health, Family Welfare.

INTRODUCTION

Health and healthy life is one of such areas in which women encounter more risks than men because of biological, socio-cultural, economic and institutional factors that reflect social inequality and affects women. The Women and Gender Equity Knowledge Network- WHO (2007) stated that gender relations of power constitute the root causes of gender inequality and are among the most influential of the social determinants of health. However, the health and well-being of women of any country represents as well as have an impact on development of that country but there are two most important issues- Maternal mortality and access to sexual and reproductive health which are being focused not

only in the development agendas of all the countries but also have made to the Sustainable Development Goals.

Pregnancy and childbirth are normal events in the life of a woman. Though most pregnancies result in normal birth, it is estimated that about 15% may develop complications, which cannot be predicted. Some of these may be life threatening for the mother and/or her child. The Maternal Mortality Ratio (MMR), i.e. number of maternal deaths per 100,000 live births in India is very high i.e. 167 (SRS 2011-13). Like elsewhere in the world, the five major direct obstetric causes of maternal mortality in India are haemorrhage, puerperal sepsis, hypertensive disorders of pregnancy, obstructed labour and unsafe abortions. Maternal anaemia is a major contributor to the indirect obstetric causes.

First 1000 days of Window of Opportunity

The 1,000 days from the start of a woman's pregnancy until her child's second birthday offer a unique window of opportunity to shape healthier and more prosperous futures. The right nutrition during this 1,000 day window can have an enormous impact on a child's ability to grow, learn, and rise out of poverty. It is critical to break the inter- generational cycle of malnutrition otherwise under nourished girls will become under nourished women who give birth to low birth weight infants. Global evidence shows that timely nutritional interventions have proven to be effective in improving nutrition outcomes as well as decreasing IMR in children. These are:

- Timely initiation of breastfeeding within one hour of birth.
- Exclusive breastfeeding during the first six months of life. The infant is fed only breast milk and is not given any fluids, milk, or foods, not even water.
- Timely introduction of complementary foods at six months: By the 7th month, breast milk alone cannot meet an infant's energy and nutrient requirements. At this time complementary feeding should begin. Introducing complementary foods before is both unnecessary and dangerous.
- Age-appropriate complementary feeding adequate in terms of quality, quantity and frequency for children 6-24 months.
- Safe handling of complementary foods and hygienic complementary feeding practices.
- Full immunization and bi-annual vitamin A supplementation with de-worming.
- Frequent, appropriate, and active feeding for children during and after illness, including oral rehydration with zinc supplementation during diarrhea.

RATIONALE OF THE STUDY

Health is a priority goal in its own right, as well as a central input into economic development and

poverty reduction. But at present, the health system of India is facing a number of challenges like shortage of public health care services, limited access and utilization of public health care services, limited reach to the regions where most needy and vulnerable sections of the population resides, out of pocket expenditure in accessing health care, poor implementation of the health programmes, substandard quality of services and lack of communication between the service providers and real beneficiaries of those services.

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The comparative data given in following Table.1 clearly shows the Chandi district's poor performance in ensuring mother and child health care services even after implementation of government led schemes like Janani Suraksha Yojana (2005) and Janani Shishu Suraksha Karyakram (2011). Hence, it becomes very important to investigate the reasons behind this major fall off in the delivery as well as utilization of mother and child health care services in this district.

Table- 1 Comparative Health Indicators of India, Odisha and Chandi

S.No.	Health Indicators	India	Odisha	Chandi
1.	Mothers who had full Antenatal care (NFHS-4)	21%	19.5%	2.3%
2.	Institutional Births (NFHS-4)	78.9%	80.5%	37.7%
3.	Children with full immunization (NFHS-4)	62%	62.2%	13.1%
4.	Maternal Mortality Ratio (MMR) per 100,000 live births (SRS 2011-13)	167	127	480*
5.	Infant Mortality Rate (IMR) per 1000 live births (SRS 2016)	34	33	117*

*Source: Maternal and Infant Death Reporting System (MIDRS), NHM, April-June, 2015

This study was planned to understand the prevalent socio-cultural norms and practices related to

pregnancy, child birth and child care from the community women along with identifying their information needs on MCH issues and related health programmes. The study also attempted to identify the barriers in accessing information and approaching health care services related to mother and child health by the community women.

METHODOLOGY

The study was carried out in five villages of Chandi, Odisha in two phases. In Phase I, FGDs were conducted in four villages (Papra, Guhana, Jahtana, Khedikala) with community women to understand the prevalent socio-cultural norms and practices related to pregnancy, child birth and child care. In Phase II, a knowledge test using a structured interview schedule was orally administered on the community women to test their knowledge on MCH issues, related health programmes and also to find out the barriers in accessing information and approaching health care services.

For FGDs, four villages were visited, two were Muslim majority and two were Hindu majority villages. It helped to give a better understanding on the impact of both these religious perspectives on mother and child care related norms and practices. Knowledge tests were administered on the community women of five villages (Papra, Guhana, Dungeja, Khedikala, Uleta). Purposive sampling technique was used along with snow ball technique to approach the women in community. The criteria for selecting the respondents was that the woman should be married and belonging to the age group of 18-40 years, who was either pregnant or was at least the mother of a child in 0-2 years or both.

The probes for FGDs and knowledge test were broadly covered the following aspects of Mother and Child Health:

- Socio-cultural norms and practices followed during pregnancy and on child birth
- Importance of Antenatal Care, Intra-natal care, Post-natal care
- Registration of pregnancy and Antenatal care
- Nutrition and Diet during pregnancy and post-partum
- Importance of Institutional delivery
- Breastfeeding (early initiation and exclusive breastfeeding)
- Family planning
- Immunization
- Provisions and benefits under different Mother and Child health related government schemes

FINDINGS AND DISCUSSIONS

Early age marriages and education

In India**,** the legal age for marriage is 18 years for women and 21 years for men. But an alarming 30.2% of all married women, or 10.3 crore girls, were married before they had turned 18, as per Census 2011 data. Same was recorded from the women respondents of all four villages. In their communities, girls are married off in the age group of 13-15 years and some of them even become mother of 2-3 children by the time they are 18 years of age. Though they were aware that the legal age of marriage for girls is 18 but said that due to poverty, they are married off early. If there are more girls in family then to save the marriage expenses, elder and younger sisters are married off together.

Most of the girls and women in these villages were illiterate and if educated, maximum qualification was primary, only a few were high school pass. They don't value girl's education and hence don't send them to schools. They said that ultimately they have to do household chores and take care of the family, so there is no point getting them educated. Another reason was of their safety because of which they are not allowed to go to schools if the school is far away from their homes or community. Observance of veil was also seen in front of male members and elders that somehow limits their exposure and interaction with their surroundings to know and learn new things too. Rahman and Rao (2004) found in their study that restrictive cultural practices such as strictly enforced rules of seclusion or *purdah* (veil) for women are significantly associated with worse gender equity.

Dowry- a reason for child marriage and son's preference

Dowry was reported a common practice in these communities and was also found to be a reason for early age marriages and son's preference. They said that if girls are of more age then they are demanded more dowry and dowry amount varies with the educational level of the boy and financial status of his family. Despite having low economic standards, they take loans for their daughters' marriages to fulfill dowry demands. This is also one of the reasons for their son's preference too as their marriages would bring more dowry.

Son's Preference

In Indian society, son's preference has always been there just as patriarchy and the onus of producing one is on women and if they don't, are blamed, taunted and tortured for the same. Due to unawareness of the fact that biologically, it's the father who is responsible for the sex of the child, women face all kinds of pressures and humiliation for not giving birth to a male child. Many a times it is seen that in case of not being able to produce a male heir for the family, they are either abandoned or are forced to live a gloomy life of neglected first wife after husband's remarriage.

According to them the ideal family in terms of number of children should have two boys and one girl or two boys and two girls but the real life situations were very different. Most of the families had 8-15 children irrespective of their religion. The ASHA worker in a village had 12 children. A traditional birth attendant (*Dai)* shared that her daughter-in-law wanted to get operated after six daughters but she didn't allow her for the sake of continuing family's name. Now she has three sons and in total nine children. This shows that the age long patriarchal structure existing in these communities not only limits most of the opportunities for women to become autonomous rational individuals but also takes away their right on their bodies and controls their fertility. Bagchi (2017) stated very rightly that a woman's most obvious power to reproduce and nurture the species is then made into the most effective engine of her enslavement.

Socio-cultural norms and practices

India offers a rich variety of socio-cultural diversity in almost every aspect of life. This diversity in terms of various norms and practices is passed on from generation to generation within the families. The birth of a child is one of such occasions which is celebrated in different ways from culture to culture, region to region. But, one commonality amongst all is that the celebration for a boy is much more elaborate than that of a girl.

In Chandi also, things were not very different. During pregnancy, no such celebration but after the child's birth sweets are shared with loved ones and neighbours. They said that people celebrate as per their economic conditions but in case of girl, mostly there is no celebration, in-fact it is tried that neighbours should not know about it and the birth of a girl child actually turns into a mourning event for the family.

All these differences in rituals and traditions and also in the behaviour of the family members on the birth of a boy and girl also reinforce the preference of a male child.

Dietary pattern during pregnancy

Ransom and Elder (2013) stated that adequate nutrition, a fundamental cornerstone of any individual's health, is especially critical for women because inadequate nutrition wreaks havoc not only on women's own health but also on the health of their children. Women are more likely to suffer from nutritional deficiencies than men are, for reasons including women's reproductive biology, low social status, poverty and lack of education etc. Socio- cultural traditions and disparities in household work patterns can also increase women's chances of being malnourished.

All the women respondents said that their diet during pregnancy depends on the financial condition of the family. If they can afford nutritious diet including fruits, milk and milk products etc.

then only they get to eat all these things otherwise not. They also shared that their diet during pregnancy is generally not a matter of concern in their houses and they are asked to eat whatever is available at home and keep on working. Many a times they have to go to the forests for fodder or to fetch water in full time pregnancy and sometimes delivery happens in farms in very complicated and unhygienic conditions putting mother's and child's life on risk.

Breastfeeding (early initiation and exclusive breastfeeding)

In all these four villages, giving honey *ghutti* immediately after birth of the child is a common practice. If honey is not available then sugar syrup and when that is also not available then a few drops of tea is given to the child as *ghutti* even in hospital without consulting nurse or doctor. According to them honey *ghutti* clears the throat of the child. Now, almost all the children are regularly given *Mughli ghutti* till the age of 5 yrs. They didn't know much about colostrum or its benefits except that it is good for their child's health. Most of them said that in their previous deliveries which were done at home, they were asked to squeeze out that yellow milk and throw it on ashes *(raakh)*. They were allowed to breastfeed only after three days of child's birth after taking bath *(nahan)* and till then child is given tea with spoon. But now with time this practice is changing. They said that in hospital, nurses give child to mothers immediately after cleaning and ask them to feed. Majority of them said that now children who are born at home also are breastfed immediately after birth but they were of the view that breast-milk is not secreted until mother takes bath on 3rd day which is nothing but a misconception.

Immunization and health check-ups of the child (0-2 years)

Universal Immunization Programme which was started by Govt. of India in 1985 is one of the largest immunization programme in the world and a major public health intervention in the country. Under the Universal Immunization Programme, Government of India provides vaccination to prevent seven vaccine preventable diseases i.e. Diphtheria, Pertusis, Tetanus, Polio, Measles, severe form of Childhood Tuberculosis and Hepatitis B.

Awareness about the benefits of immunization was negligible in the community women. There were very few of them who had got their children fully immunized otherwise majority of them were of the view that their children are doing well even without immunization so there is no need for it. Normally they take their children to hospital only when they are not well. In Papra village, women said that health check-up of the children is done at aanganwadi. For immunization, ANM comes in the community and mothers are informed by ASHA worker to bring their children and immunization card. When one of the ASHA workers was asked about the attitude of community people towards

immunization, she said that even after repeated reminders women don't bring their children and many of them say that they don't want their child to get hurt or bear pain of injection. Some of them didn't even have the immunization card of their child. All mothers should be made aware of the importance of immunization along with consequences their children might have to face without proper immunization.

CONCLUSION

The paper suggests that for positive behaviour change and to encourage health seeking behaviour amongst women, awareness about MCH issues is very important. The key messages and provisions of govt. health schemes should be repeatedly shared and discussed with community women through local media of communication (drama, folk songs, community radio etc.) and personal interactions. Men should also be informed and encouraged to participate and extend their support in ensuring a healthy life and positive environment to women so that motherhood can become a happy and blissful experience for them and a reason for a healthy and prosperous society.

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