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Cultural Beliefs and Practices Affecting the Utilisation of Health Services during Pregnancy

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Abstract

The present study was carried out to study the beliefs, actual dietary intake of pregnant women and ante-natal care in three villages of Haryana in India. Dietary intake was found to be maximum in village covered by ICDS.Utilisation of health services was affected by availability of health centres in the premises of village, availability of staff, awareness about the existing health services and patient's satisfaction.

In India, girls are married off at a young age, sometimes as low as 9-11 years. It is note-worthy that about 43% of all female deaths are of girls between fifteen and twenty years of age and the causes of maternal mortality are pregnancy complications, early pregnancy, abortion, deaths due to bleeding anaemia etc. Early marriage, early conception, negligible antenatal care, general negligence of women and low social status, all lead to increased mortality rates.

Objectives of the study

1. To find out the age at marriage and age at first conception.

2. To study the dietary practices prevailing in the area.

3. To calculate the dietary intake during pregnancy.

4. To study the kind of antenatal care the pregnant woman is getting and lastly the rituals taking place during this period.

Information on the age at first conception was collected from the respondents by asking them when they conceived first after Gauna. Local language was used to draw this information 24 hours recall method was used to collect the information on dietary intake

Method

The present study was was carried out in three villages of Haryana, namely Aurangabad, Mitrol Kalsara. Village Aurgangabad is vested with a PHC (Primary Health Centre) and caters health services to village Mitrol too. In village Kalsara, there is a subcentre and it is covered by ICDS Intergerated Child Development Services) block Hathin. Lactating women with second pregnancy were taken as the subjects of the study. Primipara women were not inclued in the study. In village Kalsara and Mitrol all houses were visited to get the subjects, whereas in village Aurangabad, which is a big one, every alternate house was visited. In village Aurangabad and Kaisara 50 each and in village Mitrol, 52 subjects were selected. A detailed pretested schedule was prepared to get the information.

Observations and results

Average age at marriage for girls in the three villages is found to be 14.6 years ranging from 11 -20 years Table I.

Table I.: Age of the girls at marriage and at the time of gauna

Villages	N	Age at marriage(in years)	Age at gauna(in years)
Aurangabad	50	14.9 ± 1.3	15.4 ± 1.2
Mitrol	52	14.7 ± 1.7	15.5 ± 1.7
Kalsara	50	14.3 ± 1.6	15.5 ± 1.6

Marriage may take place even before the girl attains puberty. After the marriage, a girl continues to live with her parents for a period ranging from zero to 3-5 years. She joins her husband after menarche. "Going to her husband" is related with a ritual known as *gauna.* The average age at *gauna* in the subjects is 15 years Table I.

It has been observed that due to Government-launched family planning programmes in India, the number of paras has come down to 3 compared with 7 in case of elderly ladies in the villages Table II.

Table II: Average number of children born to mothers, mother-in law and respondents

	Average number of childern born to		
Village	Mothers	Mother-in-law	Respondents
Aurangbad	8 ± 1.3	8.8 ± 1.3	4.0 ± 0.9

Mitrol	8 ± 1.2	8.5 ± 1.5	4.8 ± 1.2
Kalsara	7.9 ± 1.2	9.1 ± 1.6	3.6 ± 0.8

Various studies in India have pointed out that parents consciously wanted more children until they were reasonably sure that at least two sons would survive up to adulthood. In our study the idea of having two sons and two daughters is accepted by many but very few preferred to have only two children. Young mothers were willing to have small family but dared not speak out in front of mother-in-law who produced a large number of childern during their reproductive span. Change in appetite during pregnancy was common phenomenon and this change is related with presence of nausea. In the area, intake of milk, dalia, green leafy vegetables is thought to be good for growth of foetus. It was observed that poor women knew what they should eat during pregnancy but as they could not afford it, they statisfied themselves with chapati and little vegetables.

Women in all the three villages developed craving for citrus foods (Tamarindus indica), raw-mango (Mangifera indica), guava (Psidium gugava), ber (Zigyphusjujuba), jamun (Syszyquim cumni), tomato (Lycoperslcum exculenum), red chillies, butter milk and pickle of all kinds. A few craved for sweets, Aversion towards certain foods like pulses, chapatis, fried foods during pregnancy is also noticeable. Craving for like inedible substances like chullah (cooking stove made of mud) ash, chullah mud, and chullah ash and clay is found to be common in 26%, 46%, 12%. and 16% of the respondents respectively. From the medical point of view, experts opine that energy requirement of woman increases when foetus grows in her womb. Gopalan et. al. (1989)[1]advised an extra intake of 300 Kcals during pregnancy, whereas villagers in the study area do not believe that pregnant women require additional foods. There is no difference in dietary intake when compared with nonpregnant state. The dietary intake is found to be below ICMR recommendation Table III.

In villages Kalsara, supplementary nutrition is provided to pregnant women like soya panjiri, cookies etc. providing a total energy of 500 Kcals and 20 gms of protein. These add to the dietary intake of pregnant women in village Kalsara which has the highest average dietary intake among pregnant women, viz 2439 Kcals. Average dietary intake in women belonging to upper caste is much more i.e. 2387 Kcals when compared with lower caste counterparts, i.e. 1786 Kcals in all three villages (Table IV).

Table III.: Dietary intake pregnant women

Villages	**N**	**Energy intake (Kcals)**

Aurangabad	26	2034 ± 556
Mitrol	23	2161 ± 475
Kalsara	28	3439 ± 358

Table IV.: Differences in dietary intake amongst higher and lower castes

Villages	N	Upper caste	N	Lower caste
Aurangabad	12	2364 ± 329	14	1705 ± 426
Mitrol	11	2471 ± 273	12	1792 ± 698
Kalsara	17	2326 ± 367	11	1862 ± 577

Women were found to be very casual about their food intakes. They were not about eating additional food during pregnancy. Jat women in three villages have been observed drinking milk varying between 250-750 gms/day which is an adequate amount during pregnancy. The same amount is taken when they are not pregnant. The main reasons behind the milk consumption is that Jats own cattle and milk is generally not sold.

Intentionally reduced dietary intake during pregnancy has been reported in Taimilnadu (Rose 1970)[2]. Purohit (1973)[3]also observed less food intake due to the fear of big foetus, causing obstruction and pain during delivery. Among the present respondents, a few were following this advice.

All the ante-natal care in these villages is in the form of rituals directed towards a handsome, healthy male child. Care of the ante-natal women has medical implications e. g. restrictions regarding eating certain foods and avoiding others, have medical implications. Medical care during childbirth is obtained from the traditional dai or ANM or doctor

In village Aurangabad, where there ia a PHC, nearly 50% women had gone for ante- natal checkup, whereas in village Mitrol, 27% had gone. In village Kalsara, where there is 84% had gone for ante-natal checkupTable V.

Table V.: Number of female who went for ante-natal check-up

Villages	No. of females went for ante-natal check up	%	No of females didn't go	%
Aurangabad	25	48	26	52
Mitrol	14	27	38	67
Kalsara	42	84	8	16
Total	80	53	72	47

In village Mitrol, only 27% pregnant females went for ante-natal cheek up. The main In reason behind this was , absence of multipurpose worker for a long time in the village. Therefore most of the women were ignorant about the kind of availability of health services at PHC. There was none from health or social welfare side to educate and motivate them. A strong belief prevalent amongst these women was that the poor were not attended at PHC. They hardly felt the need of visiting PHC during pregnancy unless there was some complication. In Aurangabad village, most of the PHC staff was residing in the village itself and also the PHC was inside the village for a number of years, so people were aware about the availability of health services and used to visit PHC quite frequently.

In Aurangabad, out of a total of 50 women interviewed, 22 (44%) availed antenatal services at PHC and the rest went to private doctors. In village Mitrol, 13 (25%) out of 52, had gone to PHC and in village Kalsara, 84% went to the subcentre for ante-natal check up. This high percentage reflects that most of the pregnant women visited anganwadi to get the available services Table VI.

Table VI.: Place of ante-natal check up

Villages	N	PHC	Subcentre	Private Dr.
Aurangabad	24	22	Nil	2
Mitrol	14	12	Nil	1
Kalsara	42	nil	42	Nil
Total	80	35(44%)	42(52%)	3(4%)

There is a general practice that immediately after the delivery some doctor (as named by the villagers) is called at home and both the mother and child are given Tetanus Toxoid (TT). Even if the mother has taken complete dose of TT, she may be given another shot after delivery. Though ANM may advise them not to go for third shot yet they wont follow her advice. All the elderly ladies have been found to believe that tetanus toxoid given just after delivery is more effective, otherwise child may get tetanus.

Tetanus toxoid coverage in case of pregnant women is 78% in the field area. 37 females got TT just after delivery, 67 got it before and 16 got before as well as at the time of delivery Table VII.

It is customary to get tetanus toxoid immunisation just after delivery and not before. This is the reason that neonatal mortality due to tetanus is significantly high as compared to village Aurangabad and Kalsara. There is a need to ante-natal care and immunisation against tetanus. Ante-natal check up coverage was maximum in village Kalsara because of constant motivation by AWWs and ANMs.

Table VII.: Time of TT administration

Villages	Before delivery	Just after delivery	Before and at the time of delivery	Total
Aurangabad	16	14	9	39
Mitrol	10	21	6	37
Kalsara	41	2	1	44
Total	67	37(31%)	16(13%)	120

References

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