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Original Research Paper

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BENEFICIARIES' PERSPECTIVE IN REDUCING CHILD DEATHS DUE TO MALNUTRITION IN TRIBAL DISTRICT OF MAHARASHTRA: A QUALITATIVE STUDY

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ABSTRACT This study was an attempt to understand the perceptions of the beneficiaries towards various services provided by Government for reducing the problem of child deaths due to malnutrition and the challenges faced. Three talukas from Palghar were chosen based on the child malnutrition status in those talukas. A descriptive cross sectional, community-based study was conducted. Data was collected through focus group discussions conducted in representative and homogeneous samples of the beneficiaries, viz., adolescent girls, pregnant/lactating mothers, mothers with toddler/malnourished child, mother-in-law and husbands. It was found that the main challenges posed to the beneficiaries were category specific. The major challenges were poverty, lower education levels, socio-cultural beliefs, practices and problems in having a stable source of income for livelihood which leads to constant migration. The power dynamics regarding decision making in every household rests with either the males or the elderly of the family thus leaving very little scope for women of the family to make any choices about their own health or nutrition. Hence, these decision-making power dynamics are yet another major reason for driving malnutrition across the life course.

KEYWORDS : "perception"; "beneficiaries"; "malnutrition"; "child undernutrition"; "tribal district"

INTRODUCTION

Malnutrition has always been studied focusing on either of the below mentioned three broad groups although rapid global nutritional transition and living conditions are giving rise to the double burden of malnutrition wherein under and over nutrition have become two sides of the same coin. [1,4] But here we would stick to malnutrition that refers to deficiencies, excesses, or imbalances in a person's intake of energy and/or nutrients, since it is very commonly found mainly in the Lower Middle-Income countries and India is one of them. [1,2] The term malnutrition addresses 3 broad groups of conditions: [3]

- Undernutrition, which includes wasting (low weight-for-height), stunting (low height-for-age) and underweight (low weight-for-age);
- Micronutrient-related malnutrition, which includes micronutrient deficiencies (a lack of important vitamins and minerals) or micronutrient excess; and
- Overweight, obesity and diet-related noncommunicable diseases (such as heart disease, stroke, diabetes and some cancers).

Low weight-for-height is known as wasting. Low height-for-age is known as stunting. Stunting mainly signifies that the malnutrition is a chronic one. Children with low weight-for-age are known as underweight. A child who is underweight may be stunted, wasted, or both.

As of July 2020, the WHO South-East Asia Region is estimated to have more than 700 million children (0-19 years of age), including approximately 169 million under 5 years of age. The Region is home to more than one-third (52.6 million of 144.0 million) of stunted children and more than half of wasted children under 5 years of age (24.9 million out of 47.0 million) worldwide.[4] Stunting proportion according to base year 2017 as per National Nutrition Survey 2016-18 in India was 34.7%, of which 37% was from rural areas. Similarly, for wasting, the national proportion was 17.3% with 17.6% from rural areas. [5]

About 80 per cent of the 5 million chronically undernourished tribal children live in just eight states of Karnataka, Chhattisgarh, Gujarat, Jharkhand, Madhya Pradesh, Maharashtra, Rajasthan and Odisha. Tribal people in these states, have borne the maximum brunt of land alienation, displacement and poor compensation. About 40 per cent of under-five tribal children in India are stunted, and 16 per cent of them are severely stunted. Mild and moderate stunting is similar in tribal and non-tribal children. But severe stunting is higher (16 per cent vs. 9 per cent) in tribal compared to non-tribal children (CNNS 2016-18). [6]

Tribal children have higher levels of undernutrition compared to children of socially economically advanced sections. Similarly, income security of tribal peoples has been adversely affected by losses and access to productive resources (rights to forest or agricultural lands coupled with poor compensation). Debts are one of the main coping strategies, resulting in a hand-to-mouth existence for those affected. [7]

As per Census 2011, Palghar district has about 59% of its population residing in rural areas, [7] of which about 37.4% population resides in tribal areas. [8]

As per NFHS 4 data on Thane district of which Palghar is a part, 38.5% children under 5 years are stunted (height-for-age) 29.5% Children under 5 years are wasted (weight for-height), 8.9 % Children under 5 years are severely wasted (weight-for-height) and almost 40.3% Children under 5 years are underweight (weight-for-age). 54.1% Children aged 6-59 months were anemic. [9]

In November 2015, a cross sectional survey (called the SMART survey) was conducted in Jawhar, Mokhada and Vikramgad blocks of Palghar district to explore the prevalence of undernutrition in children. The Jawhar and Mokhada survey highlighted startling figures with rates of stunting at 70.8 %, wasting at 40.4 % and 9.1 % of children below 5 years of age being severely wasted. [10]

In view of above, this study was planned to understand the perception and awareness of the various beneficiaries about the services provided to reduce deaths due to child malnutrition and also to help understand the utilization of these services as well as the challenges faced by beneficiaries in availing these services.

METHODOLOGY

Descriptive cross sectional, community-based qualitative study was conducted during August 2019-February 2020 among beneficiaries from three talukas in Palghar District predominantly with tribal population in the state of Maharashtra. The three talukas, viz., Jawhar, Mokhada and Dahanu were chosen based on the child malnutrition status. Keeping the district as sampling unit, multistage stratified purposive sampling technique was used for selecting the participants. After the selection of the three talukas, Sub-district hospitals (SDHs) catering to those three districts were identified. Subsequently, all of the PHCs in the above-mentioned talukas were selected and two sub-centres from all the selected PHCs were randomly chosen. Eventually, the frontline health workers, viz., Accredited Social Health Activists (ASHAs), Anganwadi workers (AWWs) and Auxiliary Nurse Midwives (ANMs) working under the chosen sub-centers were selected and the beneficiaries served by them were the ones that participated in the Focus group discussions (FGDs) which were conducted by a four member team comprising one facilitator, two Recorders and one observer. The Ethical clearance for conducting the study was obtained from Institutional Ethics Committee.

FGDs were conducted with each category of beneficiaries in each taluka (1 FGD per beneficiary category per taluka).

Table 1: FGD details:

Sr. No.	Participants	Total no. of participants in all FGDs
1	Pregnant, lactating mothers	24
2	Mothers with toddlers or malnourished child	25
3	Adolescent girls	28
4	Mothers-in-law	26
5	Husbands	25

Data management and analysis

Qualitative data in the form of FGDs with the help of guiding documents and tape recorders was collected by the field teams. The FGD transcripts were transcribed in local language so as to capture the spoken part of discussions as well as the general feel of the discussions. Both handwritten notes and audio records were used for transcription. Transcripts were translated into English. Domains were identified on the basis of responses that conveyed homogenous perceptions and qualifiers and adjectives were used for semi-quantitative expressions of observations.[11]

Study findings and Discussion

It was found each category of beneficiaries had different set of challenges while accessing and availing the services available to them. All the participants readily agreed to participate in the study. The study findings can be described under three main headings-

a) Awareness, b) Utilization, c) Challenges

Table 2: Awareness amongst beneficiaries:

Beneficiaries	Awareness
Adolescent girls	• Sanitary napkin program (Asmita Yojana)- **50-74%** participants. • ASHA of their area; Kishorvayin Baithak- **<25%** participants.
Pregnant and lactating mothers	• ASHA of their area and the services provided by ASHA- **≥ 90%** participants • Amrut Ahar Yojana; Maher Ghar Yojana; PMMVY; JSY; importance of institutional deliveries; family planning services- **50-74%** participants.
Mothers with toddler/ malnourished child	• Services provided by Govt for under 5 children at AWC; provisions of services for children by ASHA; NRC and services provided there- **50-74%** participants. • Amrut Ahar Yojana; JSY- **25-49%** participants.
Mothers-in-law	• Services provided by ASHA; services provided for women and children at AWC- **50-74%** participants. • Family planning methods; NRC and services provided there- **25-49%**
Husbands	• Provision of health education, IFA tablets by ASHA; services provided for pregnant women and children at Anganwadi- **50-74%** • Provision of cash benefits to women after delivery- **<25%** participants

It was found that most of the adolescent girls, pregnant/ lactating mothers and mothers with toddler/malnourished child were aware of the various schemes and facilities available for them and malnourished children. This can be mainly attributed to the fact that they themselves are all direct beneficiaries and also because health education in the form of 'mata baithak' and 'kishorvayin baithak' are conducted on a frequent basis by grassroot level healthcare workers. But when it came to husbands and mothers-in-law, the scenario changed drastically. Most husbands were mainly aware of the schemes with monetary benefits whereas approximately just half the mothers-in-law were aware of the facilities available. The main reason for this could be that husbands, being the bread winners and constantly on the move for employment and earning livelihood, are mostly concerned mainly about monetary aspects since poverty is one of the major drivers of malnutrition in tribal population.[12] Likewise, mothers-in-law have lower level of education and old beliefs which makes them turn a blind eye and have an untoward attitude for the activities actually carried out for the above-mentioned beneficiaries.

"'Lasikaran' (vaccination) is done at Anganwadi and food is provided for both, children and pregnant women there."
- (Mother with toddler in an FGD)

"We are told about 'paali' (menstruation) and hygiene to be maintained during those days at the Kishorvayin Baithak and we are also advised about always maintaining personal hygiene and eating healthy food."
– (Adolescent FGD participant)

Table 3: Utilization of available services by beneficiaries:

Beneficiaries	Utilization
Adolescent girls	• Receiving deworming tablets 6 monthly from ASHA- **75-89%** participants. • Receiving sanitary napkins; receiving health education including menstrual hygiene advise; daily nutritious lunch- **50-74%** participants.
Pregnant and lactating mothers	• Receiving nutritious lunch from AWC; ASHA helping with ANC registration as well as providing help during delivery- ≥ **90%** participants. • Receiving monetary benefits under JSY, PMMVY- **50-74%** participants. • Receiving health education, immunization and other medical services at nearby PHC- **50-74%** participants
Mothers with toddler/ malnourished child	• Provision of nutritious food for children and pregnant ladies at AWC- **50-74%** participants. • Reception of cash benefits from JSY, PMMVY and also at NRC during their child's treatment- **75-89%** participants.

Mothers-in-law	• Health education, IFA tablets for ANC and PNC mothers provided by ASHA; availing services provided at NRC; availing services for children at AWC- **50-74%** participants
Husbands	• Utilization of barrier contraceptives for family planning- **25-49%** • NSV as a terminal method of contraception on completion of family- **<25% participants**

In terms of utilization, it was found that most of the beneficiaries: adolescent girls, pregnant/lactating mothers and mothers with toddler/malnourished child, were availing services like nutritious meals, vaccination and medical care; health education and kindergarten facility; NRC; provision of sanitary napkins and IFA tablets for adolescent girls. This is seen mainly because they are constantly being counseled and made aware of the facilities available and their health benefits by frontline workers by means of home visits and 'Baithaks'. Approximately half the husbands utilize family planning services, mainly utilization of barrier contraceptive ('Nirodh') and very few husbands had undergone NSV for terminal method of contraception on completion of their family. This is because of misconception of associating sterilization methods to lesser manliness/virility in a man and lower levels of education help propagate this notion even more. Majority of mothers-in-law expressed that their daughters-in-law avail the services provided at Govt hospitals but rest of them admitted to have been going to traditional healers (bhagats) for minor and major ailments rather than going to hospital. Lot of superstitious beliefs are still deeply imbibed in their minds and lower levels of education, illiteracy in some cases, contributes to keep these deeply rooted superstitions alive in their minds.

"We receive 'raktavadhichya golya' (tablets that help improve Hb/IFA tablets), 'jantaachya golya' (deworming tablets) and 'poshak ahar' (nutritious lunch) at Anganwadi."

-(Adolescent FGD participant)

"I preferred to use 'taambi' after delivery as a family planning method."

-(Pregnant/lactating mothers FGD participant)

"There is no need for going to the hospital for delivery because I've myself had all four of my kids by conducting delivery at home.

-(Mother-in-law FGD participant)

Table 4: Challenges faced by beneficiaries while availing services:

Beneficiaries	Challenges
Adolescent girls	• Irregular sanitary napkin supply- **50-74%** participants. • Discomfort discussing health problems, especially regarding menstruation, with a male doctor- **25-49%** participants
Pregnant and lactating mothers	• Unavailability of round-the-clock obstetrician, pediatrician at RH; poor connectivity making referral to higher centres undesirable and causing out of pocket expenditure; lack of sonography facility at RH- **50-74%** participants
Mothers with toddler/ malnourished child	• Delay in receiving monetary benefits under various Govt schemes; loss of wages during completing formal procedures for encashing monetary benefits from Govt schemes- **<25%** participants. • Out of pocket expenditure incurred on medicines due to their unavailability at Govt hospital- **<25%** participants.
Mothers-in-law	• Availability of lesser health manpower at nearby Govt hospitals; non-inclusion of traditional healers in Govt healthcare system- **<25%** participants.
Husbands	• Availability of lesser doctors for procedures like Caesarean section at nearest Govt hospital- **75-89%** participants. • Problems and expenditure in traveling to higher centres on referral; unavailability of facility of sonography- **50-74%** participants

Considering the geographic location of Palghar and the customs and traditions there, the very beginning of the challenges was from the fact that the people have to do heavy physical activities throughout the day. At the same time nutrition is inadequate mainly because of restricted access to nutritious food items and also due to poverty, constant migration for livelihood which again provides meagre income. All these factors have an adverse impact on the attempts made to tackle child undernutrition through NRCs; provision of nutritious meals for adolescents, pregnant women and children at AWC, and THR for mothers with toddler/malnourished child. Also, connectivity to higher referral centres is also hampered because of the remote location of the blocks/talukas under study.[14] The lower level of education of the mothers also contribute to their child's malnutrition. [13, 15]

At household level, the prevalence of patriarchal system, does not give women and adolescent girls the liberty to take decisions about their own health and nutrition since the decision makers are usually the bread-winner men in the family, i.e., their husband or elderly member in the family who is, usually their mother-in-law. The socio-cultural practices also restrict access to proper nutrition for children and women.[15] It also reflects in the ways that the food is prepared for babies and pregnant women as mostly traditional ways are used for this. [13]

Alcohol addiction ('mohachi daaru') is another factor which is seen not just amongst men but women as well, and this usually leads to negligence towards their own as well as their child's health and nutrition.

Firm belief in traditional healers is yet another major hurdle when it comes to challenges at social level. This was more evident in discussions with mothers-in-law. They firmly believe in the old ways of treatment by traditional healers and less so for hospitals and doctors. Majority of the mothers-in-law expressed that they go to the hospitals infrequently and the need to include these traditional healers in to the existing healthcare system so that people can easily access whichever modality of treatment they wish to choose. Approximately half of them believe in local socio-cultural norms like that of withholding nutritious foods from the diet of pregnant women and instead putting them on bare minimum diet that is usually recommended to them by the traditional healers.

"My grandchild had fever recently, so we took him to a nearby 'bhagat' (traditional healer) and he cured the kid in 2 days. There was no need for us to go to the hospital."

-Mother-in-law FGD participant

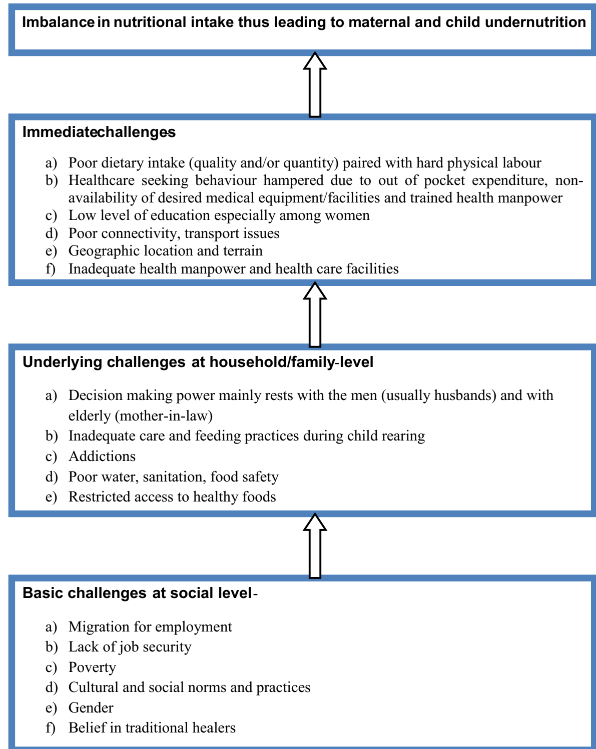
"There are a smaller number of doctors and usually no specialists available at govt hospital and so we are sent to other faraway hospital which take long time to reach due to poor roads. We also have to spend money to take our patient there when ambulance is not available."

-Husband FGD participant

Figure 1 represents the major challenges identified that lead to child malnutrition at different levels, namely, social and

household levels as well as the immediate challenges.

Figure 1: Major challenges identified that lead to child malnutrition:



CONCLUSION:

This study has thus shown that even though there are many services provided and awareness generation done, the problem of malnutrition continues since it is time that all the awareness generation activities are not to be kept restricted just to the beneficiaries. It should also be for the family members of the beneficiaries who ultimately act as the decision makers, viz., husband and mother-in-law. Their increased awareness can lead to effective utilization of various services available for the beneficiaries.

It is time now that the formal education levels must go up especially for adolescent girls who are going to be future mothers. The migration for livelihood must be minimized by employment generation at local levels so that the tribal people can settle down at one place and lead a stable life. Intensifying de-addiction awareness and referral for the same might help control harm due to addictions to some extent. Inclusion of traditional healers in the existing healthcare system might help considering how dais (traditional birth attendants) were trained and introduced in the health system thus making even home deliveries safer than earlier. Nutrition education is an important part for every member of each household so as to ensure that adolescent and child malnutrition do not occur. Thus, Village Health and Nutrition Day is a necessary activity that needs to be carried out regularly. It is also necessary to keep a check on the tendency of people to deliberately make their child malnourished in order to get monetary benefits in lieu of treatment at NRC.

Above all, it is the need of the hour that policy makers take into consideration the views and needs of the people living in tribal areas in order to form the policies that can actually help tackle the root problem of malnutrition and various other factors that lead to malnutrition through life cycle approach.

REFERENCES:

1. Lower middle income | World Bank Data. (2021). Retrieved 3 March 2021, from https://data.worldbank.org/country/XN
2. Tzioumis, E., & Adair, L. S. (2014). Childhood dual burden of under-and overnutrition in low-and middle-income countries: a critical review. *Food and nutrition bulletin*, *35*(2), 230-243.
3. World Health Organization. (2017). Assessing and managing children at primary health-care facilities to prevent overweight and obesity in the context of the double burden of malnutrition. *WHO. World Health Organization*.
4. World Health Organization. (2020). The double burden of malnutrition: priority actions on ending childhood obesity.
5. Fact sheets - Malnutrition. (2021). Retrieved 3 March 2021, from https://www.who.int/news-room/fact-sheets/detail/malnutrition
6. Tribal nutrition. (2015). Retrieved 3 March 2021, from https://www.unicef.org/india/what-we-do/tribal-nutrition#:~:text=About%2040%20per%20cent%20of,of%20them%20are%20severely%20stunted.&text=9%20per%20cent)%20in%20tribal,of%20them%20are%20severely%20stunted.
7. Palghar Taluka Population, Religion, Caste Thane district, Maharashtra - Census India. (2011). Retrieved 3 March 2021, from https://www.censusindia.co.in/subdistrict/palghar-taluka-thane-maharashtra-4163
8. Districtwise Total & Tribal Population. (2011). Retrieved 3 March 2021, from https://trti.maharashtra.gov.in/index.php/en/districtwise-total-tribal-population#:~:text=Districtwise%20Total%20%26%20Tribal%20Population%20as%20per%201991%2C,%20%208132%20%2034%20more%20rows%20
9. National Family Health Survey - 4 2015 -16 District Fact Sheet Thane Maharashtra. (2016). Retrieved 3 March 2021, from http://rchiips.org/nfhs/FCTS/MH/MH_FactSheet_517_Thane.pdf
10. Action Against Hunger Palghar. (2015). Retrieved 3 March 2021, from https://www.actionagainsthunger.in/our-work/maharashtra/palghar
11. Nujum, Z. T., Remadevi, S., Jose, R., Nirmala, C., Rajmohanan, K., Indu, P. S., & Nair, S. M. (2013). Evaluation of coverage and compliance to Mass drug administration (MDA) for lymphatic filariasis elimination–A qualitative study. *Acad Med J India*, *1*.
12. Narain, J. P. (2019). Health of tribal populations in India: How long can we afford to neglect?. *The Indian journal of medical research*, *149*(3), 313.
13. Dey, U., & Bisai, S. (2019). The prevalence of under-nutrition among the tribal children in India: a systematic review. *Anthropological Review*, *82*(2), 203-217.
14. Shirisha, P. (2019). Socioeconomic determinants of nutritional status among 'Baiga'tribal children In Balaghat district of Madhya Pradesh: A qualitative study. *PloS one*, *14*(11), e0225119.
15. Sonowal, C. J. (2010). Factors affecting the nutritional health of tribal children in Maharashtra. *Studies on Ethno-Medicine*, *4*(1), 21-36.