Understanding Social, Cultural and Political Determinants of Maternal and Child Health: A Medical Anthropological Study of the Kondareddis of East Godavari District, Andhra Pradesh

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ABSTRACT: Understanding maternal and child health from critical medical anthropological perspective reveals that maternal and child health (MCH) status is a result of complex interplay of social, cultural and political factors. This paper aims to explain the role of social, cultural and political factors in determining the MCH status among the Kondareddis. Fieldwork was undertaken for a period of 25 days among the Kondareddis of Busigudem village, East Godavari district, Andhra Pradesh. The methods of participant observation, schedules, in-depth interviews and case studies were employed. The data obtained were analysed using content-analysis method. The results revealed that social and cultural elements influence the reproductive behaviour and health care practices. There exists a trend towards maximization of reproductive functions. However, this trend runs counter to the health of the woman. In addition to the social and cultural factors, the article discusses the negative impact of state interventions in the form of development programmes and welfare schemes on the MCH Status. Results indicate the need to establish vertical links between factors operating at micro level to larger social, cultural and political forces operating at macro level.

INTRODUCTION

Human reproduction is a bio-cultural phenomenon. Reproduction is an important process in any community for its perpetuation. The key factor for a healthy society lies in the health of women and children. Hence, maternal and child health (MCH) is an important aspect for healthy perpetuation of the society. According to (WHO, 2022), maternal health refers to "health of the women during pregnancy, childbirth and postpartum period". Looking at maternal and child health from medical anthropological perspective suggests that the health of the women and children is determined by both biology and culture. Culture provides opportunities to cater to individual needs of the human being as functionalists would argue. Also, every society culturally patterns and influences its members' reproductive behaviour and health care practices. In the sense, that culture shapes the beliefs and practices surrounding menstruation, prescriptions on the circumstances

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under which pregnancy may occur, the prenatal and postpartum practices, availing health care services etc (Browner and Sargent, 2011). Further, understanding MCH from critical medical anthropological perspective suggests that maternal and child health status of a community is a result of complex interplay of social, cultural, ecological, economic as well as political factors.

In any given community, women and children approximately constitute 70% of the population especially in developing countries. It was recognized that maternal and child health plays critical role in economic growth and development in developing countries. Accordingly, mothers and children receive highest priority in the health services planning (Shankar and Thamilarasan, 2003). One of the eight millennium development goals adopted at the Millennium Summit is to reduce maternal mortality rate and improve maternal health. According to WHO, about 830 women die from pregnancy or childbirth-related complications around the world every day. Maternal mortality rate (MMR) which refers to the annual number of female deaths per 100,000 live births, is an important indicator of maternal and child health status and quality of health care services in a country. Globally, MMR in 1990 was estimated to be 400, which translates into about 5.4 lakh women dying each year. In India, in 1990, MMR was very high marking 600 women dying during childbirth per thousand live births which meant nearly one and half lakh women dying every year contributing about 27 percent of the global maternal deaths. Global MMR has reduced to 210 in 2010 and MMR in India has declined to 178 per hundred thousand live births in 2011 contributing to 16 percent of global maternal deaths. These statistics reveal a decline in the maternal mortality rate; however, India has a long way to go to achieve minimum maternal deaths.

Health of its citizens has been a major concern of Indian government since independence. In particular, to improve tribal health has always been a primary concern. Accordingly, various programmes have been devised by Indian government that aimed at reducing maternal, perinatal, child mortality and morbidity rates, providing prenatal and postnatal health services, ensure safe child birth, family planning care and paediatric care in infancy. The first MCH services were introduced in early 1900's, when maternity care services improved and rural midwives and birth attendants received training. From then, it has increased its magnitude accommodating and adding various elements of health services required for women and children. The current programmes have incorporated the elements of community participation which is crucial in availing and utilising the services (Singh, 1997). The significance of health care programmes, accessibility and its utilisation has resulted in plethora of research work, academic literature over the past few decades. These studies have identified and brought into light, the health requirements of women, reproductive health problems, nutritional needs of children and accessibility of services issues etc. However, very few studies on health care and studies on reproductive health have incorporated socio-cultural and political dimensions of MCH.

It is observed that throughout the world, people have particular folk definitions for body's form and function by which we can understand their health behaviour. In the domain of human reproduction, this illuminates fertility related beliefs and informs about the management of labour. According to MacCormack, the idea of "natural fertility" is shaped by the residence patterns followed in the community. Also, women's culturally prescribed diet, length of lactation, suckling patterns, knowledge of indigenous or western contraceptive techniques are some variables that modify fertility. In reality, the concept of "natural fertility" and "natural childbirth" are cultural constructs (MacCormack, 1982). In specific, maternal and child health problems in tribal areas need to be approached as well as addressed in a holistic manner. This is because, influence of social circumstances, social roles, attitudes, practices, beliefs of tribal people about reproductive behaviour directly influence maternal health and child health.

Therefore, it is significant to understand socio-cultural dimensions of reproduction. Besides this, the government interventions in the form of development programmes and welfare schemes indirectly affect the health status of the people. Hence, to understand the socio-cultural and political factors is necessary to gain a holistic understanding of health of the people.

Accordingly, this paper seeks to understand the

maternal and child health status of the Kondareddis of Busigudem village, East Godavari district, Andhra Pradesh. Also, it attempts to demonstrate the factors affecting the health status of the people. Kondareddis are a designated scheduled tribe who live in the state of Andhra Pradesh. The present study has been conducted in the village of Busigudem which is located in East Godavari district, Andhra Pradesh.

METHODOLOGY

Anthropological methods and techniques have been employed to undertake the study. Throughout my fieldwork, I had been a participant observer in the village, consciously sensing all the events taking place around. Participant observation helped me in understanding the day to day activities of the people in their natural setting. Participant observation is a continuum in which the levels of participation with the people and involvement in the activities vary depending on the researcher and the situations in the field. For most of the time, I was an active participant with the people in the village. This helped me gain a deep understanding into the cultural behaviour of the people through 'emic' perspective. On the second day of my fieldwork, along with twenty four other team members and local people, I had undertaken a transect walk in the village. We had explored the village and had identified the main landmarks which included the number of streets, number households, PHC sub-centre, Church, Rachabanda (a place where meetings of villagers take place), main water sources, fields etc. The same were mapped to give pictorial representation of the village. For the next five days, we had divided ourselves into groups of five each and conducted household survey using schedules. Household data so collected had given a basic understanding of the community and members. This process helped me in identifying my key informants. Moreover, it had aided me in establishing rapport with the villagers. As I understand, rapport establishment is a process that takes place throughout the period of fieldwork. Rapport establishment particularly aided me to talk about sex taboos, indigenous child spacing methods, family planning methods and the community participation in various governmental health initiatives. Schedules have been administered to collect obstetric histories of women. This provided me with quantitative information. Quantitative data so collected is a significant component based on which qualitative analysis has been made. In-depth interviews were conducted using semi-structured interview schedules which contained open-ended questions. Questions were addressed to the identified stakeholders and key informants (women, their kin and the health officials) to gather meaningful information regarding my topic. Questions were constantly improvised based on the conversations with the respondents and situations evolved in the field. This helped me to elicit the cultural beliefs regarding child birth. Content analysis was employed to analyse the data and identify the major patterns. Further, a holistic approach to analyse the maternal and child health status aided me to identify the political factors determining it.

STUDY AREA: VILLAGE PROFILE

The study area, Busigudem village is located in coastal Andhra region. It comes under the territorial division of Rampachodavaram mandal, East Godavari district, Andhra Pradesh. It is surrounded of hilly tracts. The total population of the village is 583, out of which, the female population accounts to 312. The data suggests a sex ratio of 100:122, which says for every hundred males, there are one hundred and twenty two females. The total number of families in the village is 131, out of which 93 families are Kondareddis. While Kondareddis constitute 71% of the total population, other ethnic groups in the village namely Konda Kapus, Konda doras, Konda Kammaris, KoyaDoras, Valmiki, Padmashali, SettiBalija and Mangali constitute of 29% of the total population. The settlement patterns of the village are in a linear fashion along the road. The houses are situated along the road, on either side of the different hamlets. Telugu is the mother tongue of the Kondareddi. They have an accent which is different from other areas.

Agriculture is the main economic activity among the kondareddies. They indulge in *kondapodu* or hill cultivation. In earlier days, they used to produce different kinds of millets which formed their staple diet. With the introduction of *jeedimamidi* or cashew saplings by the government in 1984, the extent of millets cultivation has reduced. Government introduced cashew saplings in order to increase the

economy of the tribals. Now, their main source of income comes from cultivation of "jeedimamidi" cultivation. This shows a shift from food crops to cash crops. In the Busigudem village, there exists Panchayat system which reflects their political system. Two types of Panchayat exist namely formal and informal. The informal panchayat is formed by four village elders which mainly solves conflicts relating to villagers such as land disputes, family disputes, inter village disputes. The formal Grama panchayat is jointly formed by three neighbouring villages namely Busigudem, Chilkamamidi, Kothapakala. In the formal panchayat, work related to implementation of government projects, development programmes, welfare schemes etc are primarily dealt with.

The first choice of health care in the village reserves to ethnomedicine. The ethnomedical practitioner is referred to as *Vejju*. He treats illnesses with the help of *chekkamandulu* (herbal medicine), prayers and other magico-religious practices. In the village, there is one PHC-subcentre. The Primary Health Centre (PHC) is located in Vadapalli which is about 10 kms away from the village. People of Busigudem prefer ethnomedicine to biomedicine. The trend of health seeking behaviour is first home remedies, then ethnomedicine and only if and when the condition persists or worsens, biomedical care is sought. Malaria was found to be endemic in the village. It is said that people in the village get affected by malaria at least once a year. The younger women were observed to be anaemic. Malaria can be one direct cause for that. Besides this, the dietary pattern of people plays a key role in the health of the people. There has been a shift from millets to rice as staple food among the people of Busigudem which can be another reason for low Hb count among the people. Other acute illnesses such as Diarrhoea, typhoid, jaundice, tuberculosis, paralysis are prevalent in the village. There are two Auxiliary Nurse Midwifery (ANM)s in the village. They act as medium through which awareness is created among people about government's health initiatives and play a key role in delivering institutionalised health care. During pregnancy, Iron folic tablets are distributed by the ANMs. ANMs keep a record of all the pregnant women in the village and refer them to the hospital in Rampachodavaram. Although home delivery is preferred, institutional deliveries were observed to be increasing in the village. People are aware of Sexually transmitted diseases (STDs) and also family planning methods, both temporary and permanent.

Religion and ritual play a significant role in the lives of Kondareddi. They worship many deities for obtaining their blessings for a healthy and prosperous life, and for a good harvest. Kondareddis worship their local deity called *"Gangalamma thalli"*. Seasonal festivals are performed, many of which are offering of newly harvested grains, fruits etc., to God. In specific, certain fruits and vegetables are consumed only after performing a ritual. This marks the ripening of the fruit or vegetable which is available in the season.

Development of tribal areas in all aspects is one of the major concerns of government of India. The government has established the Girijan Cooperative Corporation (GCC) to empower and to improve the economic conditions of the Kondareddi people. The GCC buys minor forest produce collected by Kondareddi and sell rice, sugar and other provisions necessary for households at a subsidized rate. Several development projects such as lift irrigation schemes, primary and secondary schools, co-operative societies to provide financial assistance and loans, empowerment of women through DWCRA groups have been implemented by the government. The government of Andhra Pradesh in 1984 introduced cashew plantations in Busigudem and the nearby villages to improve the economic conditions of the tribals. This has been widely availed and a successful development programme in the village. Almost all the households in the village were found to avail the toilet system introduced by "Swacch Bharat" mission by the government.

RESULTS

Obstetric History and Morbidity among Women

Schedules regarding obstetric history have been administered to 24 married women. The data acquired, revealed that firstly, the mean age at first marriage of women is 16.1 years. Secondly, mean spousal age difference is 3.75 years. Thirdly, mean spacing between marriage and first pregnancy is 1.3 years. Fourthly,

the average gap between successive child births to be 2.22 years. It is observed that 24 women have conceived 82 times in total (Table 1). Out of 82, 71 normal births have been recorded. Reproductive wastage in terms of miscarriage, still births and abortion has been recorded to be 9.04%. Miscarriages are reported high during the third conception. Abortion is rare and is generally not preferred by the Kondareddi women. Malaria and anaemia are the most prevalent health conditions during pregnancy (Table 2). The pie chart (Figure 1) shows that anaemia is reported to be the highest during the third pregnancy. It can be said that malaria occurred during pregnancy plays a major role in the loss of immunity to women and results in anaemia. The increased morbidity in turn makes the women unprepared to deliver healthy children. Further, it results in the loss of immunity in the children born.

TABLE 1

Distribution by outcomes of pregnancies of different order

Child no. later	Live births	Still birth	Miscarriage	Abortion	Born alive but died
1st child	23		1		
2nd child	23		3		
3rd child	15	1			
4th child	6			1	
5th child	2				1
6th child	2				
7th child		1			1
8th child			1		1
Total	71	2	5	1	3

Source: Author's original data

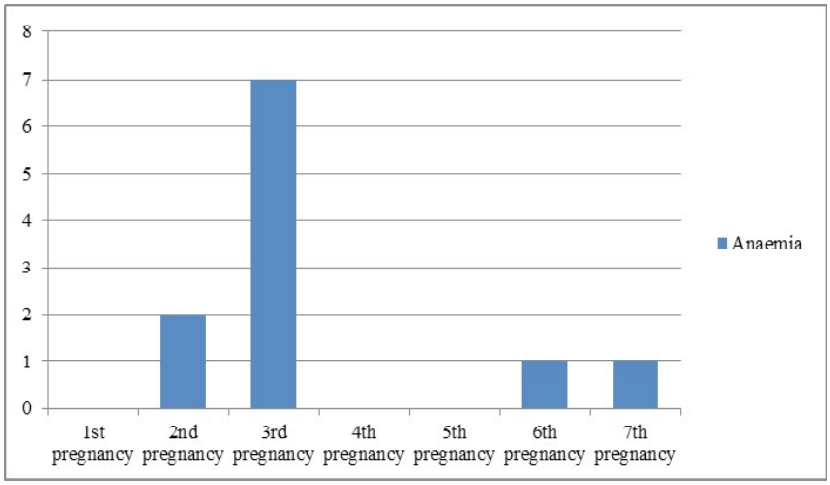
TABLE 2

Reproductive morbidity among women

Nature of illness	1st pregnancy	2nd	3rd	4th	5th	6th	7th	Total
Cold and cough	2	1	1					4
Fever	2	2	2	1				7
Malaria		2	4			1	1	8
Typhoid		1						1
Anaemia		2	7			1	1	11
Jaundice			2					2

Source: Author's original data

Figure 1: High incidence of anaemia during third pregnancy



Source: Author's original data

Social and Cultural Determinants of MCH

In tribal areas, besides the obvious biological determinants, indigenous explanations regarding fertility, conception and child birth play a significant role in determining the maternal health status. Further, it was observed that women have got severely anaemic during their third pregnancy (Table 2). The majority of the sample includes women from the age group of 18-45 years and the older women (45-60) interviewed have not reported any such cases. This implies that anaemia is prevalent among the women of reproductive age.

Social Significance of Child Birth

Society, according to Ernest Geller refers to "sets of relationships between people" (Geller, 1963). Social significance refers to all the activities that are important to the society for the perpetuation of the relationships between people and thereby the society as a whole. In any society childbirth is essential for its continuity and hence, carries a great social significance. Given this background, people in Busigudem attach high importance to child birth both at the level of society and individual level. At the level of society, child birth is important for procreation of the relationships between people and the continuity of their lineage.

At individual level, a newly married couple wants to have more number of children for economic, social and psychological security. More number of children in a family gives the parents psychological security. More number of children in the family is directly proportional to the amount of work shared within the family amongst the members of the family. Hence, they are considered as an economic asset. However, the girl children are considered to be an economic asset only till they get married off to her husband.

In particular, there exists a preference for male child. Kondareddis is a patrilineal society. A couple wants to have male children for the following reasons. Firstly, for *"thalakorivipettadam"* or to do their parents' last rites. Secondly, to carry forward the family's *"intiperu"* or the surname to the future generations. Thirdly, to take care of the parents' property and lastly, for economic security. Kondareddis is a patrilineal society and follow patrilocal and neolocal pattern of residence. Therefore, when a man in the family gets married, the woman comes to stay with the husband along with her in-laws at in-laws' house. She works in their fields and takes care of the house on a daily basis. This suggests that there is an addition of human power to the family and working hands to the field. Kondareddis own *"jeedimamidithotalu"* or the cashew plantations in large numbers. Hence, they require human power for the cultivation of the same on hills. Women largely contribute in the areas of weeding, spading, clearing the forests etc. Therefore, male member in the family implies more economic security to Kondareddis as they bring a new member to the family.

Cultural Significance of Child Birth

Reproduction and the related activities are culturally patterned in given society. These include beliefs and practices related to menstruation, cultural prescriptions of who may legitimately produce children, practices during child bearing and child-rearing including child spacing, lactation period and child care. Most importantly, culture plays an important role in defining 'womanhood' and the idea of 'womanhood' as perceived by the society. Among the Kondareddis, to have children acts as a status symbol to the whole family. In case of infertility, the couple is taunted by the villagers. In specific, the woman is less respected for not being able to conceive. This also reinforces that the idea of *"womanhood"* among the Kondareddis largely depends on 'her' capacity to reproduce children. The notion of prestige is associated with the couple's ability to conceive.

Political determinants of MCH

Political economy approach to health urges one to understand the many economic, political and historical forces that shape the contemporary health problems in order to get a holistic perspective of the health condition (Minkler *et al*., 1994). To understand health conditions as a result of complex interplay of economic and political factors aids in locating the determinants of the same. State interventions in terms of development programmes and welfare schemes are observed to have a great impact on MCH status. In 1984, the government of Andhra Pradesh had introduced *'Jeedimamidi'* or cashew plantations in the tribal areas of the state with the motive to increase

the economy of the tribals. Kondareddis are primarily horticulturalists who indulge in low intensity farming. They practice *'kondapodu'* or hill cultivation. They cultivate different kinds of millets on the hills namely *Kandulu* (Lentils), *Alasandelu* (Bengal gram), *jonnalu* (Sorghum), *ragi* (Finger millet), *chamalu* (Foxtail millet) etc. Millets used to be their staple food and were cultivated on a large scale. With the introduction of cashew plantations, there was a shift from subsistence farming to commercial crops. These crops yielded more income and people started to cultivate them in huge numbers. Amount of land used to cultivate cashew had multiplied. Consequently, there took place reduction in the extent of millets cultivation.

Coupled with this, a welfare scheme called "Kilo Rice at Rs.2" as part of Public Distribution System(PDS) has been revived in 1994 by the then Chief Minister N.T. Rama Rao in Andhra Pradesh. It has become prominent at those times which continued till today. The aim of PDS is to provide food grains at subsidized prices to the vulnerable sections of Indian society. People of Busigudem village have been availing rice through this scheme. Through this scheme, the distribution of rice, oil etc takes place on monthly basis. With the introduction of one kilo at Rs 2, people started taking rice for it is available at a cheaper rate and is easily available through PDS. One disadvantage associated with millets is the post-harvest processing. Milling used to be done manually and is considered to be a tedious task in present days. Gradually, there had been a shift in their staple diet from millets to rice. Millets contain high content of nutrients including vitamin B, Calcium, iron, potassium, zinc, magnesium and fats. Rice, on the other hand, is rich in carbohydrates. White rice provided at PDS is over-processed and no longer contains beneficial nutrients because its husk and bran are removed. Essentially, the grains are made of sugar and contain empty calories. Consumption of this on a daily basis can lead to chronic diseases such as diabetes. Rice does not contain Iron in contrast to millets. The major source of Iron used to come from millets which is replaced by rice. Now, their diet also includes increased consumption of *'nukalu'* or broken rice bought from the market. The older women reported that vegetables consumed these days are grown using fertilizers and are not good to health. Their dietary patterns have considerably changed making them unhealthier.

Women in particular require high amount of Iron to compensate blood loss during menstruation and to compensate increased blood supply during pregnancy (Luke, 1991). Iron helps form the placenta, an essential part of the womb. The iron supplied to the child during pregnancy also needs to last her for six months after birth. So not only is iron aiding in development, but the child is storing it up for later. Therefore, it plays a key role in healthy child development. As rice does not contain Iron and as is being consumed in large quantities, it has led to reduction in the haemoglobin levels of women. The ANMs in the village reported that the average Hb count of the women is 8, which is very less. Further, it observed that the pre-natal care taken by the pregnant woman and given by the family members is not strictly observed as compared to post-natal care. The older women often criticized the younger generation for not consuming the prescribed food during pregnancy such as jaggery, green leafy vegetables, drumstick curry etc. A majority of women do not consume the Iron tablets given by the ANMs. All this together, has resulted in increasing rate of anaemia among the women. Also, shift in the dietary pattern had led to development of new health conditions such as hypertension and diabetes reported among the older people (45-60 years) in the village.

Therefore, state interventions, in the process of achieving the directed change, result in structural changes which act as an impediment to people's health. Although cashew plantations increased the economy of the people of Busigudem and also, rice, oil and vegetables being available at subsidized prices, this only created dependency on the state. This in turn affected the community's efforts to keep the members or themselves healthy. Women and the children are the worst affected in this scenario.

DISCUSSION

By employing critical medical anthropological approach, this research attempted to explain the social, cultural and political factors that affected the maternal and child health status among the Kondareddi women. Findings of the Study posit that anaemia is reported to be the highest among the

Kondareddi women during their third pregnancy. About 45% of the women of reproductive age reported anaemia. The study shows a significant relationship between social expectations, cultural patterns, state interventions and anaemia. At the family level, there exists aneed for a definitive biological male heir to look after the parents' property, firstly, to carry forward their lineage and secondly, to look after the parents in their old age. Further, infertility is often associated with taunts and low prestige. Both the social and cultural significance of child birth imply that there exists a trend towards maximization of reproductive functions of women. However, this trend runs counter to the health of the woman. The preference for male children in the family acts as a burden on woman's health. Moreover, more number of children results in the loss of immunity to women. Loss of immunity takes place due to frequent and more number of conceptions. In addition, the morbidity analysis reveals that there exists high prevalence of malaria in the village. Women get affected by malaria at least once a year according to the reported rate of malaria and the ANMs in the village. This also results in the loss of immunity among women. This coupled with frequent conceptions acts as a major impediment to maternal as well as child health.

Reddy, (2008) identified the need to study the health of the tribal women from interdisciplinary approach. She urges one to go beyond culture-centric approach and study health conditions linking to larger economic, political and developmental issues (Reddy, 2008). Studies indicate that anaemia is highly prevalent among the tribal women of reproductive age (15-49 years) (Kamath et al., 2013),(Shrinivasa *et al*., 2014), (Rohisha *et al*., 2019). In the current study, more than 45% women of reproductive age reported anaemia. (Abiselvi *et al*., 1983) identified anaemia to be a social problem. Low socio-economic status, illiteracy and lower level of education, tobacco consumption adversely affect the maternal and child health (Ismail *et al*., 2017), (Batool *et al*., 2010).In addition to these studies, the current study confirms that the need for a definitive biological male heir, the notion of prestige associated with fertility, the idea of womanhood and state interventions in the form of development programmes and welfare schemes negatively impact the maternal and child health status.

CONCLUSION

The present study indicates that the factors affecting the MCH status are all interlinked. Hence, future studies must establish vertical links between social groups operating at micro level to larger social, cultural and political forces operating at macro level to gain a holistic perspective of maternal and child health status. The study further recommends the re-introduction of millet-based diet among the Kondareddis to combat anaemia and improve the status of maternal and child health.

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