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Antenatal care among schedule Tribes of Jammu and Kashmir: Some Comparative observations from NFHS-4 and NFHS-5

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Abstract

Antenatal care is an essential safety net for healthy motherhood and childbirth, where the well-being of both the mother and child can be monitored. It is well established that those women who undergo full antenatal care check-up and give birth in a medical institution or whose delivery is attended by trained paramedical persons promotes child survival and reduces maternal mortality. World Health Organization, in its World Health Report 2005, suggests that poor maternal conditions account for the fourth leading cause of death for women worldwide, after HIV/AIDS, malaria, and tuberculosis. This paper is based on the secondary in General and data sources provided by National Family health services (NFHS-4 and NFHS-5) in Particular .This paper identifies the changes on Antenatal care among schedule Tribes that have occurred within these factsheets. The data shows that antenatal care differs with the socio-cultural background like nutritional status, age, caste, Place of Residence. Having a comparison of both NFHS-4 and NFHS -5. Anaemia is very important for safe motherhood in the State. Data gives us a clear picture that Anaemia is decreases in NFHS -4 and also NFHS-5 in Jammu and Kashmir. Because women not consuming iron folic acid tablets for 100 days according to NFHS-5 that West Bengal showed the most significant increase whereas Jammu and Kashmir were negligible. Although Jammu and Kashmir was seen to be performing better than some poor performing states like Bihar, Uttar Pradesh and Kerala. Basic antenatal care components are effective means to prevent a range of pregnancy complications and reduce maternal mortality.

Keywords: Antenatal care, Schedule Tribe, Nutritional Status, Jammu and Kashmir

Introduction

Reproductive health is well recognized that in patriarchal setting such as in India, hierarchical gender relations and unequal gender norms impact women`s sexual and reproductive health and choice and act as significant obstacles to access services and facilities. Equally, the achievement of good sexual and reproductive health may be inhibited by such structural factors as poverty and malnutrition, early marriage, inadequate educational and health systems. Gender roles that perpetuate the ‘culture of silence ‘inhibit women from communicating a health problem or seeking prompt treatment unless it inhibits them from carrying out their daily chores. This ‘culture of silence ‘is even more pronounced for gynecological and reproductive morbidity

that are so closely linked with sexuality. [1]Antenatal during pregnancy is important for the health of the mother and development of the unborn baby and helps to link the woman and her baby with the formal health system, increases the chance of using a skilled attendant at birth and contributes to good health through the life cycle. Globally, about 800 women die every day due to causes related to pregnancy and child birth and 20 percent of these women are from India. [2] Maternal mortality is higher in women living in rural areas and among poorer communities. Skilled care before, during and after childbirth can save the lives of women and newborn babies (WHO, 2014) [3] World Health Organization and UNICEF recommend minimum of four antenatal care visits (United Nations 2008) [4] Antenatal care plays important role in reducing health risk from mother and her child and contributes in healthy pregnancy outcome [5] Maternal health is an important indicator of women`s health and status. The world health organization (2009) in women and health: Today`s evidence and tomorrow`s agenda. [6] Maternal health refers to the state of complete physical, mental, and social well-being of women during pregnancy, childbirth, and the postpartum period .While motherhood is often a positive and fulfilling experience, for many women it is associated with suffering, ill health, and even death. [7] Improving maternal health is one of the Millennium Development Goals (MDG) adopted by international community in 2000[8]

Pregnancy is considered as a normal and natural phenomenon by most tribal groups and no special care is given to ladies during pregnancy. Non-utilization of antenatal care (ANC) by tribal mothers, as they do not consider having a check-up necessary during pregnancy. Tribal women in Kashmir (gujjar and bakkarwal) are at high risks related pregnancy and child bearing[9].It is noteworthy that among the three components of HDI, Jammu & Kashmir performs better than the national average on Income Index and Education Index but Health index of Jammu & Kashmir is below the national average and far below than Kerala. Looking at the sex ratio in Indian states, Jammu & Kashmir has the second worst sex ratio i.e. only 883 females per 1000 males in 2011[10].

The Gujjars and Bakerwals, the third largest ethnic group in Jammu and Kashmir after Kashmiri and Ladakhi, constitute more than 20 per cent population of the State. They are the state's most populous Scheduled Tribe contains the population of more than 20 lakh as per the 2011 census and one fourth of them are living nomadic life. Out of the total nomadic Gujjar and Bakerwals, 66 percent population of nomad Gujjar-Bakerwals who fall under Scheduled Tribe groups in the state of Jammu & Kashmir are living Below Poverty Line, revealed by a survey conducted by Tribal Research and Cultural Foundation (TRCF), a frontal organization working for the cause of Indian tribes [11] The literacy rate of Jammu and Kashmir is only about 68.7 percent against the national literacy rate of 74 percent in 2011.Based on extensive review of literature and secondary analysis of data provided by the National Family Health Survey-4 (NFHS-4)and National Family Health survey-5 (NFHS-5) the present paper looks at the issues related to antenatal care in schedule Tribes of Jammu and Kashmir some comparative observation from NFHS-4 and NFHS-5.

This study aims to fulfill the following objectives:

- To observe the antenatal care statistics in schedule Tribes of Jammu and Kashmir from the surveys NFHS-4and NFHS-5
- To identify the changes on antenatal care in Schedule Tribes of Jammu and Kashmir.

Methodology

This is a review paper based on secondary sources and analysis of data provided by National Family Health Survey (NFHS-4) collected information from a nationally representative sample of 723,875 households eligible women age 15-49 and 122,051 men age15-54 from 2015-16.Whereas National Family Health Survey -5 (NFHS-5). Fieldworks for India was conducted in two Phase Information Gathered from 636,699 households, 724,115 women, and 101,839 men. These surveys are the backbone of policies and programmes as they help to portray a picture of how well a society is performing on different indicators of health.

Literature Review

Antenatal care during pregnancy is important for the health of the mother and development of the unborn baby and helps to link the woman and her baby with the formal health system, increases the chance of using a skilled attendant at birth and contributes to good health through the life cycle. Globally, about 800 women die every day due to causes related to pregnancy and child birth and 20 percent of these women are from India. World Health Organization and UNICEF recommend minimum of four antenatal care visits (United Nations 2008). Pregnancy is considered as a normal and natural phenomenon by most tribal groups and no special care is given to ladies during pregnancy. [2]

Improving maternal health is one of the three health related goals out of the eight Millennium Development Goals (MDGs) that were established following the Millennium Summit of the United Nations in 2000, under the United Nations Millennium Declaration [4] This disparity is even visible within countries between people with high and low income and between people living in rural and urban areas. It is a mere indication of inequalities in access to maternal healthcare services and highlights the gap between the rich and the poor.[7] As per NFHS-3 (2005-06) reports 61.9 percent of ST women were being found receiving TT injection. In terms of consumption of IFA tablets 31.1 percent have consumed Iron and folic acid tablets which is higher than that reported by NFHS-3 (2005-06) i.e. 17.6 percent. In terms of utilization of benefits during pregnancy only one third (33.5 percent) of respondents have got benefitted by supplementary food and 38.9 percent have received health check-ups and health and nutrition education from Anganwari /ICDS center during their last pregnancy. Only 26.7 percent women are being informed about financial assistance/help and support during delivery under JSY among

which only 7.3 percent have actually got benefitted by free transport, medicine and baby care. Some other studies have also reported failure of JSY in achieving its goals. [2]

According to NFHS-3, antenatal care (ANC) refers to pregnancy-related health care, which is usually provided by a doctor, an Auxiliary Nurse Midwife (ANM), or another health professional. Ideally, antenatal care should monitor a pregnancy for signs of complications, detect and treat pre-existing and concurrent problems of pregnancy, and provide advice and counseling on preventive care, diet during pregnancy, delivery care, postnatal care, and related issues. The main purposes of antenatal care are to prevent certain complications, such as anemia, and identify women with established pregnancy complications for treatment or transfer. [13] The 1992–1993 Indian National Family Health Survey showed that only 64% mothers received antenatal check-ups and this increased marginally to 65% in 1998–1999. This lack of improvement occurred despite governmental and non-governmental efforts to strengthen service delivery, and is likely to contribute to the continuing high maternal mortality in the country.

Five Year Plan

In India, antenatal care initiatives began in 1951 with the implementation of the First Five Year Plan (1951–1956). However, a lack of rural health infrastructure, and a focus on family planning using a clinic based approach limited the benefits to rural women. In the Third Five Year Plan (1961–1966) an extension approach to family planning was adopted with recruitment of auxiliary nurse midwives (ANMs) and Health Assistants. This provided rural women access to some elements of antenatal care. However, it May be noted that these programmes were primarily geared to family planning service provision. During the Fifth Five Year Plan (1974–1979) maternal and child health services (MCH) were integrated with family planning services and a new Programme entitled 'Family Welfare' was introduced. This gave impetus to provision of maternal health services in rural areas. In the Seventh Five Year Plan (1985–1990) a Universal Immunization Programme (UIP) was implemented, greatly increasing pregnant women's access to tetanus toxoid vaccination. Following the recommendations of the International Conference on Population and Development in 1994, in 1997 the Government of India launched the Reproductive and Child Health (RCH) Programme for implementation in the Ninth Five Year Plan (1997–2002). Twelfth Five Year Plan (2012-2017) is important to note here that Integrated Child Development (ICDS) programmes introduced in 1975 in selected districts also provided women with access to antenatal care. To reduce maternal and infant mortality, institutional deliveries are being promoted by providing cash assistance to pregnant women under Janani Suraksha Yojana (JSY). Though institutional deliveries have increased in rural (39.7 to 68 per cent) and urban areas (79 per cent to 85 per cent) over the 2005–09 period, low levels of full Ante-Natal care (22.8 in rural, and 26.1 in urban in 2009, CES) and quality of care are areas of concern.[13]

Antenatal care in Jammu and Kashmir

According to NFHS-3 the percentage of Antenatal Care visits by women in Jammu and Kashmir is better than the national average. In Jammu and Kashmir 84.6 percent women had at least one ANC visit and 73.5 percent had three or more ANC visits. Besides, 54.8 percent women had an ANC visit in first trimester. At the national level these figures were found to be 76.4 percent, 52 percent and 43.9 percent respectively. Although Jammu and Kashmir was seen to be performing better than some poor performing states like Bihar (one ANC visit=34.1 percent & 3 or more ANC visits= 17.0), Uttar Pradesh (one ANC visit=66.0 percent & 3 or more ANC visits= 26.6) etc., it was far behind from the better performing states like Kerala (one ANC visit=94.4 percent & 3 or more ANC visits= 93.6) and Tamil Nadu (one ANC visit=98.6 percent & 3 or more ANC visits= 95.9) The NFHS-3 data also suggests that there are multiple sources of receiving the ANC services both at national level and in Jammu and Kashmir. As compared with the national average where 50.2 percent women received their ANC from doctors, 23 percent received from ANM/Lady Health Visitor (LHV)/nurse, 1.2 percent women from Dai/ Traditional Birth Attendant (TBA) and 22.8 percent received ANC from no one, majority of women (77.2percent) in Jammu and Kashmir received their ANC from doctors, 6.2 percent from ANM/LHV/nurse, 1.1 percent from Dai/TBA and 14.7 percent from no one. However in Kerala 98.1 percent and in Bihar only 22.5 percent women received their ANC from doctors. According to NFHS-4 in Jammu and Kashmir 90.9 percent women had at least one ANC visit and 81.3 had three or more ANC visit in first trimester. In Jammu and Kashmir where 81.8 percent women received their ANC from doctors, 8.6percent received from ANM/Lady Health visitors (LHV)/nurse, 0.6 percent women from Dai/Traditional Birth attendant (TBA) and 7.6 percent from no one. [12] Whereas NFHS-5 Mothers who had an antenatal check-up in the first trimester received 86.6% it clearly showed to increase from NFHS -4, where Mothers who had at least 4 antenatal care 80.9% received.

Discussion

Antenatal care is an important component of Reproductive health that not only determines the outcome of pregnancy but plays vital role in maintaining health of mother and can be an important tool in diagnosing and preventing risks during pregnancy. Available health services among studied group has been observed in this study and the characteristics of individual factors like age, income ,residence ,caste ,religion number of previous pregnancies and the health system available to them and education level play a role in determining whether they seek appropriate services. Gujjar and Bakkarwal of Jammu and Kashmir due to illiteracy, orthodoxy these allied factors responsible during antenatal care. Caste, urban and rural residences were all found to be associated with quality of antenatal services received by different groups in India. Rural women have considerably lower maternal healthcare services utilization than the urban women. [7]

4.1 ANC check-ups:

In NFHS-4 and NFHS-5 survey, women were had at least three visits for ANC checkups, received at least one TT injection and consumed 100 IFA tablets /syrup [7].The key reasons for the prevalence of home deliveries assisted by Traditional Birth attendant in villages (TBAs) are the family trust on Traditional birth attendant due to orthodoxy of women, their desire to follow the rituals regarding birthing and easily accessibility of Traditional Birth Attendant within the community. In every village, women received poor utilization of antenatal care services.

Table 1.ANC indicators according to NFHS-4 and NFHS-5

Source of Data	**Percentage who had at least 4 antenatal care visits**	**Percentage with an ANC visit in first trimester**	**Percentage with full ANC**
NFHS-4 (2015-2016)	51.2	58.6	N.A
NFHS-5 (2019-2021)	58.1	70.0	N.A

(All figures in Percentage)

Table 2.ANC indicators by Jammu and Kashmir according to NFHS-4and NFHS-5

State and source of Data	**Percentage who had at least 4antenatal care visits**	**Percentage with an ANC visit in first trimester**	**Percentage with full ANC**
J&k(NFHS-4)	81.3	76.7	N.A
J&K(NFHS-5)	80.9	86.6	N.A

(All figures in percentage)

The NFHS-4 and NFHS-5 gives us a detail of the ANC indicators of India in General and particular in Jammu and Kashmir state as shown in Table 1and 2. In Jammu and Kashmir the NFHS-4 percentage who had at least 4 antenatal care visits is 81.3 percent and 76.7 percentage with an ANC visit in First trimester. In NFHS-5 percentage who had at least 4 antenatal care visits 80.9 and 86.6 in percentage with an ANC visit in first trimester. All ANC indicators were found to be more than national average as mention above in Table 1 according to NFHS -4 and NFHS-5respectively.

4.2 Antenatal care and Nutritional status:

Food is very important factor that has an impact on women's health. A woman who eats balanced diet doesn't suffer from Anaemia. The state of maternal nutrition is one of the important environmental factors which might be expected to influence the course of pregnancy. Their nutritional status was possibly reflected in the high percentage of premature termination of pregnancy. The vast majority of the pregnant subjects complained of long-standing general weakness, fatigability and vague body pains. During pregnancy a women has increasing demands for energy both for her and the growing foetus.

Anaemia is a major health problem in India, especially among women and children. Anaemia can result in maternal mortality, weakness, diminished physical and mental capacity, increased morbidity from infectious diseases, perinatal mortality, premature delivery, low birth weight, and (in children) impaired cognitive performance, motor development, and scholastic achievement.

Table 3. Percentage of an Anaemia and IFA intake for 90 days as per NFHS-4and NFHS-5

Source of Data	**Any Anaemia (<12.0 g/dl)**	**Percentage who took IFA for at least 90 days**
NFHS-4(2015-2016)	53.1	30.3
NFHS-5(2019-2021)	57.0	44.1

(All figures in percentage)

Table 4.Percentage of an Anaemia and IFA for 90 days by Jammu and Kashmir as per NFHS-4 and NFHS-5

State and Source of Data	**Any Anaemia (<12.0 g/dl)**	**Percentage who took IFA for at least 90 days**
J&K(NFHS-4)	49.4	30.2
J&K(NFHS-5)	65.9	29.8

(All figures in Percentage)

The NFHS-4 and NFHS-5data gives us a detail of any Anaemia and percentage who took IFA for at least 90 days it is clear that more than half women in Jammu and Kashmir 49.4 percent of Anaemia in NFHS-4 and 65.9 percent of Anaemia in NFHS-5 it clearly shows that percentage of Anaemia in NFHS-4 is decreases. However, in NFHS-4 the IFA tablet for at least 90 days is 30 .2 and 29.8 percent in NFHS-5 slightly decreases in NFHS-5.Anaemia is particularly high for Hindu women, women from the schedule caste, and women in the two lowest wealth quintiles. Women who are pregnant or breastfeeding are also more likely to have Anaemia than women who are neither pregnant nor breastfeeding [12].

4.3 Antenatal care and Caste:

Important element of Antenatal care includes the provision of iron and Folic acid (IFA) tablets to pregnant women. The different Caste in NFHS-4 and NFHS-5 data who took IFA for 90 days or more only 28.6 percent SC,26.8 for ST,and 30.2 for OBC and 33.6 in others those who received both or more TT injections 82.4 for SC ,79.0 for ST and 82.8 for OBC and 85.5 in others. The two surveys gives us a detail antenatal care component but in NFHS-5 is slightly increased in IFA and TT injections. Besides this percentage of women from different caste took these elements for ANC show decreased in SC and slightly increase in ST and other backward classes respectively. Table 5

Table 7. Percentage of women who took IFA tablets and received TT injections as per caste by Jammu and Kashmir.

Caste	Took Iron Folic Acid (IFA)for 90 days or more		Received two or more TT Injections	
Source	NFHS-4	NFHS-5	NFHS-4	NFHS-5
Schedule caste	28.6	46.3	82.4	80.6
Schedule Tribe	26.8	22.6	79.0	79.3
OBC	30.2	22.0	82.8	86.3
Others	33.6	28.9	85.5	85.6

(All figures in percentage)

Conclusion

Thus our study highlights the existing literature on Antenatal care especially in tribal areas for bringing out the positive changes toward antenatal care services which will surely help in improving the reproductive health status of tribal population. Several Factors that are associated with increased risk of maternal deaths are age at marriage /Delivery, Space between births, economic condition, post-partum care etc. and the evidences provided by the NFHS-4 and NFHS- 5 data suggest that these factors are important for Antenatal care in Jammu and Kashmir. Maternal health must be recognized as a key development issue by the developing countries and must commend to increasing the quality and accessibility of reproductive health care. This can be done by expanding and improving health systems, addressing social and cultural factors that may discourage some of the most vulnerable women from seeking care. Also the woman must be

educated about her health and about the importance of proper care during pregnancy and childbirth.

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