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Cultural beliefs associated with pregnancy and child birth among aimol tribe of Manipur

KH. RINGSUACHONG AIMOL **AND** MINOTI PHUKAN

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See end of the paper for authors' affiliations

KH. RINGSUACHONG AIMOL
Department of Human Development, College of Home Science, TURA (MEGHALAYA) INDIA
Email: aimol77@yahoo.com

ABSTRACT : Pregnancy and childbirth are important in the stages of life as they are associated with maternal and infant mortality and morbidity. Culture has a profound influence on beliefs and practices of pregnancy and child care. The present study aims at exploring the cultural beliefs of Aimol ethnic women of Manipur regarding pregnancy and child birth practices. Purposive sampling method was used to collect 128 women in the age group of 18 to 40 years. In-depth interview and focus group discussion methods were used to collect the data. Results showed that majority knew the positive impact of antenatal care and delivering at health facilities however, only 77 per cent had minimum recommended antenatal care while 27 per cent had below minimum recommended antenatal care. Majority had home deliveries and institutional deliveries were more for the first child birth than for the subsequent deliveries. A modern health care system was preferred over traditional healer however they also seek health care from traditional healer care called "maipa". Rearing of local chicken and drying of smoke fish for post delivery consumption were common practices on the other hand vegetables and pulses foods which are rich in proteins and vitamins were avoided for nearly one to three months due to food taboos.

KEY WORDS: Practices, Pregnancy, Childbirth, Aimol, Antenatal care

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Culture has a profound influence on beliefs and practices of childbirth. Cultural beliefs and traditions associated with childbearing touch all aspects of life in a given culture (Callister, 1995). Many culture bound syndromes are effectively managed through an informed knowledge of their cultural contexts and the background of patients (Erinosho, 1998). Some socio- cultural factors, which not only prevent women from getting out of their homes to utilize maternal health facilities, even in emergencies, but also prohibit them from eating certain foods, have been identified (Erinosho, 1998; Jafarey and Korejo, 1995).

Two ethnographic studies, focusing on pregnancy and childbirth in Guatemala (Berry, 2006; Callister and Vega, 1996) found that biomedical information about the dangers of birth failed to fit into the traditional cultural understanding of birth by indigenous women in Guatemala. Both studies found a strong desire among Guatemalan women to give birth at home surrounded by their families. The quality of their birth experience was highly influenced by where they gave birth. Most women preferred to remain in their villages and homes even when problems manifested during labor traditional cultural practices reflect values and beliefs held by members of a community for periods often spanning generations.

Women in Katolo were also found to be affected by cultural beliefs as regards to their nutrition and health. Food taboos determine their feeding habits during pregnancy (Peterson and Mubuu, 1997). These beliefs contribute to the underutilization of prenatal and childbirth delivery services at the hospitals and clinics. They also lead to delay in accessing services when a complication arises during pregnancy or birth. This is because an individual society views and manages childbirth dependent on the beliefs,

practices and values associated with reproduction, health, and the role and status of women (Lauderdale, 2003).

Every social grouping in the world has specific traditional cultural practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group, such as women. There is a dearth of scientific studies related to the customs and beliefs associated with pregnancy and child birth especially in a multi - ethnic state or country. An understanding of the traditional concepts of pregnancy, delivery and child care is necessary to avoid harmful practices and to build supportive links between the traditional and the formal health systems. Cultural beliefs associated with pregnancy care and childbirth among Aimol tribe have been little documented. Hence, the study was undertaken with an objective to explore the cultural beliefs associated with pregnancy and child birth among Aimol tribe of Manipur.

The Aimol is one of the 33 indigenous Scheduled Tribes of Manipur and are concentrated in thickly in eleven villages of Chandel district and sparsely in three villages of Senapati and Churachanpur districts of Manipur. The term "Aimol" is derived from two words *viz.,* "Ai" and "Mol". Ai is a medicinal plants (black turmeric) used for treatment of a sick and to perform *doi* for offering deities while mol or mual means spur of hills. Ai was grown in the spur of hills where the Aimols made their settlement. So, the people who inhabited in that spur of hill where Ai was grown are known as "Aimols". *Doi* was performed before Christianity comes however with the preaching of Christianity, the practice of *"Doi"* was prohibited and is no longer practiced. They have their own distinctive cultural tradition- customs, beliefs, social system, language (Aimol dialect) clothes, songs and musical instruments etc. Aimol society is mainly divided into four clans which are further divided into many sub clans. Agriculture is the main occupation, particularly plantation of paddy (rice). Marriage is endogamous but outside one's own clan. Monogamy is the only accepted form of marriage. The children usually set up their own family after their marriage of one year or even before first anniversary (also called *Inbingchum*). They are patrilineal *i.e.* descent and inheritance is traced through father's side. Paying bride price in the form of animal like pig or cow and distribution of sugar and milk powder to all the bride's family relatives and friends (the number of kilogram of sugar and milk powder decided by a girl family) is a common practice among Aimol. Love marriage is commonly practiced and mate selection usually done by self however marriage proposal should always come from boy's side. In case of divorce, the elders of clans and village administration would dissolve the matter. Premarital sexual relations are against the religion and societies.

■ RESEARCH METHODS

Multi - stage sampling design study was adopted for the study. The study was conducted in Tengnoupal block of Chandel district. Ten out of eleven villages of Aimol were selected purposively based on the availability of the Aimol tribe and from these villages a total sample of 128 Aimol women in the age group of 18 to 40 years having at least one living child of 1year to 6 years child were randomly selected for the study. A self - structured interview scheduled was developed to elicit specific information. The scheduled includes background information and customs and practices with regard to pregnancy and child birth. In-depth interviews were conducted to collect the primary data by visiting the household of each participant between August 2012 and December 2012. The data were analyzed using percentage.

■ RESEARCH FINDINGS AND DISCUSSION

Data on socio-cultural practices on pregnancy and child birth related to antenatal, intra natal and postnatal care are given under the following heads:

Antenatal visit:

Antenatal care is essential to reduce the morbidity and mortality among newborn babies and pregnant women. Minimum recommended antenatal care was conceived as at least 3 to 4 visits to the ANC provider with 2 tetanus injections and 100 tablets of iron and folic acid. In order to understand whether the women had received minimum recommended antenatal care during pregnancy, information was collected related to number of antenatal visits, tetanus toxoid injection received, and supplement of iron folic acid tablets and timing of the first antenatal visit. Majority (98%) had antenatal check up during pregnancy, however, only 16 per cent had above minimum recommended antenatal check up. Fifty five per cent had minimum recommended antenatal check up while 27 per cent had below minimum recommended antenatal care and two women had no antenatal health check up during pregnancy. Similar result was also found in other studies by Mathew *et al.* (2001) and Metgud *et al.* (2009). Further, it was noted that only 50.41 per cent had their first visit during first trimester of a critical period while 37.09 per cent and 12.50 per cent seek late antenatal care from second and third trimester, respectively. This shows that the supplementation of iron and folic acid tablets were missed out for at least three months which may affect the health and wellbeing of both the mother and the child. The main reasons cited for irregular visit were lack of proper road connectivity and transportation, unable to afford the expenditure while some felt unnecessary unless one has complication because they belief that pregnancy is a natural process. Pregnant women were more concerned about the chances of miscarriage that may happen by travelling in bad road. This is one factor why the respondent's women had less than minimum recommended antenatal check up. The finding is in line with Titaley (2010) that in rural zones of

Indonesia, distances and cost of transportation were factors associated with difficulty in access of antenatal services. It was noted during focus group discussion that they mainly visit the health facility when they were feeling unwell. This knowledge gap needs to be addressed by community health workers and researchers.

Majority (82%) had two doses of TT, 72 per cent took all the IFA tablets while the rest did not consume the complete doses. This indicated that although majority had recommended antenatal visit, still more than 27 per cent did not take full antenatal care package ($\geq$ 3 AN visits, TT_2 / TT_1 as booster and regular IFA tablet intake). Similar observation has been found in rural area of north Karnataka by Metgud *et al*. (2009). Reason expressed for non-intake of all the IFA tablets were the size of tablet was big, some forgot while few worried that baby would be too healthy which may create labour problem for having normal delivery and other reason included were change in the colour of the stool and constipation.

Sources of antenatal care:

The availability of reproductive health services does not necessarily ensure access. While knowledge and awareness are critical, the types of health care services available, provider attitudes and facility opening hours were amongst the most important factors that determined whether women sought health care (UNPFA, 2011).

It was also found in the present study (Fig.1) that even though the nearest accessible health centre for Aimol tribe is public healthcare system (PHC-sub centre) which ranges from nearest half to 2 kms however, majority of the Aimol women (78%) still sought health care more from non - public health facilities like private hospital/ clinic for antenatal care than public health facilities.

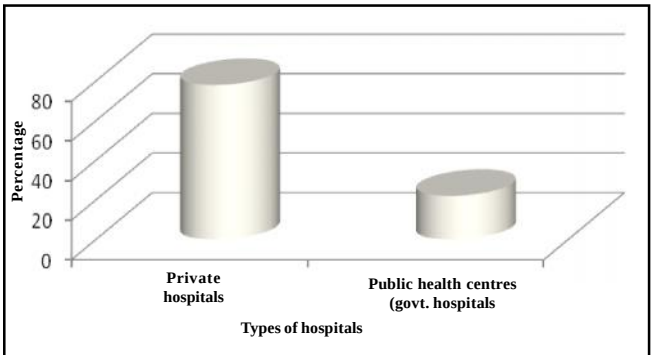

Fig. 1: Source of antenatal care for respondents according to communities

The factors highlighted for seeking health care more from private hospitals and clinics over public health service PHC (sub centre) among Aimol were lack of proper infrastructure, irregularity of health providers in the PHC especially doctor, poor quality of service, lack of essential drugs, non - availability of medical shop or drug stores in the area, non - availability of public transport facility and poor attitudes of health workers. It was observed that there was not a single pharmaceutical store located in and around Aimol area near PHC (sub centre). In the absence of such vital facilities, people were reluctant to visit sub centre although its distance was accessible to them. Most of the Aimol respondents expressed that it was more convenient to go at town or cities as they get medical stores and also felt more satisfied with the quality of care at private clinic. Another factor was attitude and perception of the people towards PHC sub centre. Many women revealed that there was one doctor posted earlier in the Aimol PHC sub centre who is presently serving in Kakching town of Community Health centre. They went to seek health care from him when he was serving in PHC sub centre however, when he was posted in community health centre in town, they all went to the same doctor for health care. This shows that environment is influencing the attitude and perception of people that inhibit access to health services.

This study is in line with the finding of Negi *et al*. (2010) in their study on Antenatal care among Tribals of Chhattisgarh and Jharkhand where the utilization of ANC services was low among ST women in Jharkhand as compared to Chhattisgarh. It can also be observed that ST women in Chhattisgarh availed ANC facilities more from public health centers whereas in Jharkhand, more women go to other health service providers. The substantial variation in utilization of maternal services among tribals and non-tribal women may be due to striking differences in health-seeking behaviour of people across socio-economic groups on the demand side and access barriers on the supply side. The result suggests that public health systems services in rural areas are poor in quality due to lack of infrastructure and inadequate manpower. Further, they also depended on the traditional healers called maipi maipa for various treatments.

Birth preparedness:

Majority of Aimol women reported that they prepared some things for childbirth in advance just one or two months ahead such as buying fresh fish in bulk and smoke dried them and rearing of chicken preferably black hen because black hen has more nutrition as compared to other colour chicken. Boiled chicken with salt and rice was served to a mother to compensate blood losts at the time of delivery. Also, nappies, baby dresses and knitting socks sweater etc. were kept ready. This result is in contract with the Assamese women of Kamrup district where 86 per cent had no preparation for their deliveries due to traditional beliefs and superstition (Das, 2000).

Intra-natal services:

Services during intra natal period include the place of delivery, type of birth attendant and management of

complication during pregnancy. The data on intra-natal services are presented under the following heads:

Types of delivery:

It was found that majority of the respondents (89 %) had normal delivery for the last child born preceding the survey while few (11%) had undergone caesarian delivery.

Place of delivery:

It was also observed in the present study (Table 1) that for the first child birth 56 per cent of the respondents had institutional deliveries while 44 per cent had home delivery. However, after the first delivery, the subsequent deliveries tend to be more from non-institutional as the number of percentage at home delivery has shown to increase for subsequent deliveries. The percentage of the second, third, fourth and above deliveries were 71 per cent, 76 per cent and 82 per cent, respectively which indicate unsafe deliveries. The reasons for home delivery were mainly due to inability to afford for cost involvement and another reason may be they become more confident to deliver at home as there are two local ANM in the areas who assisted in delivery on payment basis.

Persons involved in home delivery:

Safe delivery is defined as institutional deliveries plus deliveries conducted at home but by skilled staff and do not include deliveries by trained birth attendant (dais) Park (2007). But the international definition of skilled attendants disqualifies either the trained birth attendants (TBAs) or the 18-months trained Auxiliary Nurse Midwives (ANMs) (NCMH background papers, 2005). Among women who had home delivery (Table 2), 15 per cent of the births were assisted by elders of home, friends and relatives in unhygienic manner without any assistance of trained birth attendant while majority (85 %) were assisted by a local ANM or a nurse. Similar observation has been made by Garg *et al*. (2010) in rural Punjab where about two-thirds (66.1%) of the deliveries were found to have taken place at home. The most common reasons cited for home delivery were traditional attitude (86.2%) and economic reasons (13.4%). Although most of them possessed the positive benefits hospital deliveries since it involved the cost of expenditure, many could not afford for institutional deliveries.

Feeding practices:

Promotion of early initiation of breastfeeding has the potential to make a major contribution to the achievement of the child survival millennium development goal. As per the recommendation of UNICEF (2011), breast feeding should be initiated within a half-hour of birth instead of waiting several hours as is often customary. In the present study, cent per cent breast fed their babies however, the initiation and duration of breast feeding varied. Cent per cent mothers who had normal delivery breastfed their children immediately or soon after birth. On the other hand, those mother who had caesarian deliveries breastfed within a day of birth (6%) or after one day of birth (5%). The reasons stated were unable to produce milk immediately after birth, difficult to move their bodies. Pre - lacteal feeding was reported among late initiation of breast feeding mothers. Water, commercial milk and honey were given in substitution of breast milk for late initiation of breast milk. They were given either in cotton by soaking water or by dropper or spoon without sterilization. Majority of the selected respondents knew the importance of colostrums as it is evident from the results that majority of the respondents (96%) had given colostrums to their children.

Pre-lacteal feeding:

The practice of pre-lacteal feeding is still predominant among Aimol women. The most commonly offered pre-lacteal food were sugar water, honey, commercial milk powder. The practice of offering pre-lacteal feeds to the newborns is at minimal level in the states of Kerala (10.8%), Sikkim (12.3%) and Arunachal Pradesh (16.7%). The pre-lacteal

Table 1: Place of deliveries by respondent women

Place of delivery	1st delivery (n=128)	2nd delivery (n=93)	3rd delivery (n=55)	4th delivery (n=34)
Institutional	72 (56.00)	27 (29.00)	13 (24.00)	6(18.00)
Home delivery	56 (44.00)	66 (71.00)	42(76.00)	28(82.00)
Total	128	93	55	34

Table 2: Distribution of persons involved in home delivery

Person involved	Number (n=72)	Percentage (%)
Elders of home/local dias	11	15.00
ANM with elders	61	85.00
Total	72	100.00

feeding is most common in Bihar (90.6%), Uttar Pradesh (86.0%), Rajasthan (71.6%) and Jharkhand (66.3%) as per NFHS-3 (IIPS and Macro, 2007).

Age of introduction of weaning to the child:

Majority of the respondents (91.2%) started weaning at 6 months. However, there was also report of early weaning as well as delayed weaning. Early weaning was initiated as they felt they could not produce sufficient milk for their children.

Postpartum visits:

The postpartum period is a very special phase in the life of a woman and her newborn. The Reproductive and Child Programme recommends that women who do not deliver in an institution should receive three postpartum visits during which they will be provided with advice on family planning. However, in the present study, visit by government health services after delivery was nonexistent. At the same time, the selected respondents also did not use postnatal services unless the mother or the newborn faced any serious problems. Similar observation has been made by Santhya (2004). Therefore, in the effort to improve reproductive health care services, there is an urgent need to improve the postpartum services.

Postpartum care on cutting of umblical cord:

Most of the women who had home delivery cut the umbilical cord either by using a sharp clean bamboo called *"rua"* or razor blade and used a black and red thread to tie the umbilical cord in order to prevent the new born baby from evil spirit. After giving birth, the baby was given a bath with luke warm water.

Placenta disposal:

With regard to disposal of placenta, almost all the respondents irrespective of institutional or home delivery, the placenta was buried deep down into the earth by the family members within the courtyard of the house. In case of institutional delivery, the placenta was collected in a small earthen pot and brought home to bury. The practice had been passed from generations and main reason was not known however few belief that the placenta was buried so that the child has attachment with home in future.

Dietary pattern:

Most of the respondents reported to consume more amount of food than normal after birth as it was felt that body needs more nutrition for baby and mother, however the number of meal taken was similar to normal trend practices among the people of Manipur. Usually meal was taken twice a day with tea and snack in between meal.

Types of food consumed and restriction during postpartum:

Food recommended:

Local reared chicken or smoked meat like pork, beef, dried or smoked fish with onion or zinger for a period of nearly one to three months or more. However, vegetable like colacosia were added after 20 days with chicken or fish. Method of cooking is boiling without seasoning or frying.

Food avoided:

All kinds of pulses and legumes, sour food, bitter food like bitter gourd, *suangkha/nongmangkha* (local name). All kinds of fatty food and spicy food including oil/fried food and vegetables such as cabbage, cauliflower, mustard, pumpkin and sour fruits such as lemon, star fruits, pineapple. belief that certain foods considered harmful to the unborn baby should be avoided.

Cultural beliefs:

Meat and fish products are nutritious. Colacosia stem is rich source of iron, pulses and legumes and vegetables like cabbage, cauliflower, mustard leaves and pumpkin are gas producing foods like gas constipation and headache. Bitter foods prevent milk production, fruit may cause diarrhea to infant.

Health and hygiene practices:

With regard to postpartum care, almost all of them followed a custom of bath restriction and washing of hair for the duration of 30 to 20 or 15 days for first and consecutive births. The woman had to tie her abdomen with a small traditional cloth called *puante* or any cloth and had to cover her head intact and combs her hair only when she removes her cloth for washing hair.

With regard to vulval and perineal hygiene, most of the respondents reported to wash their vulval or perineal area every day for 15 to 20 days or till proper healing of the area with warm water and dettol by padding with clean cloth in order to prevent from infection. This was also viewed by Thi *et al.* (2012) among Vietnamese mothers in Anthi district of HungYen province.

Behavioural precautions:

Most of the respondents especially those who had caesarian confined themselves in the bed room for nearly a month looking after baby and also restricted movement like going outside and doing household work due to fear that the stitches may not heal completely while such restriction are less in case of women who had normal delivery.

As far as postpartum sexual is concerned, traditionally it is believed by elders to abstain from sexual contact for at least four months, for it was felt that scar of vulval or perineal takes around four months to completely heal. Therefore, sexual contact before healing of scars may lead to reproductive tract infection in future. However, this tradition

was not strictly followed by all respondents. Most respondents hesitated to reveal the answer pertinent to this question due to embarrassment.

Ritual after birth:

Among Aimol tribe, there is a simple ceremony called *"nainu juh inn" nai* means infant baby, *ju* as wine and *inn* means drinks. Before Christianity, wine was a common drink and usually those who assisted in delivery including traditional birth attendant, elders of family members and few friends are offered wine and chicken chutney (chicken boiled and plantain stem) to welcome the arrival baby in this world in general and family in particular and to symbolize successful delivery performance. This tradition is still followed but wine is replaced by tea and chicken or other red meat because consumption of wine or local bear is restricted as per Christian religion.

Conclusion and recommendation:

Traditional beliefs and practices have some beneficial effects like covering of head, warming of back near heater or firewood, wearing warm clothes and abstinence of sex for certain period. It also has potential harmful or negative effects to the mother and child health like avoidance of rich nutritious food such as vegetables, fruits and pulses. Rural Public Health Centres need to be equipped with proper infrastructure and manpower so that they can attract the services render by them. Provision of medical shops need to be made available at rural health centre where accesses for transportation are limited.

Authors' affiliations:
MINOTI PHUKAN, Department of Child Development and Family Relations, Faculty of Home Science, Assam Agricultural University, JORHAT (ASSAM) INDIA

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