



Maternal Health Care Seeking Trends Among Tribal Women: A Review

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DOI: 10.31080/ASNH.2024.08.1470

Received: November 05, 2024

Published: November 27, 2024

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Abstract

Sociological and Anthropological studies of tribal health provide a wealth of ethnographic information about aspects of their cultural practices, perceptions, and behaviours. Most of these studies are at the micro research level emphasis on individual tribes or state specialised tribes. However, very less anthropological research goes beyond behavioural and cultural contexts but they fail to develop a larger horizon of interdisciplinary approach to issues of socio-cultural, party-political and environmental factors with the obtainability, approachability and convenience of health care services to understand the well-being and diseases of tribal populations, particularly maternal and child health. Almost every state in the nation has tribes, with the exception of Pondicherry, Chandigarh, Haryana, Delhi, and Punjab. Within a community, a tribe is a social division made up of and bound by strong links to one another on the social, political, and/or familial levels, creating a tiny, homogeneous group with a shared dialect and culture. There is a need to distinguish and identify tribal heterogeneous groups to develop realistic family related health planning policy based on the daily living needs of the reproductive health of the tribal women and infants and targets to reduce Maternal and infant mortality rates. In this respect, this review has been carried out to explore the trends in health care seeking trends among tribal women in the rural and urban areas of different states in India.

Keywords: Maternal Health; Tribal Women; Health Culture; Health Policy

Introduction

Scheduled Tribes Population

The 1981 census reported 427 Scheduled Tribes with about 50 million people, or 7.76% of India's total population. They are found in many states and inhabit a variety of ecosystems. About 65% Tribes, with less capital than clans, receive monthly income 40/- and over 82% of the tribals have an income of less than Rs. 60/- compared to the national level of Rs. 70/-. The economies of most tribes depend primarily on forestry, pastoralism and primary agriculture. More than 93% of tribes participate in these activities, compared to the national estimate of 73%. The tribal literacy rate is very low at 11.3% for both males and females compared to the national estimate of 36%. They live in contrasting environments in different isolated areas with wide differences in nutritional health. Most of them rely on simple farming methods to produce rice and other crops, including millets and some green leafy vegetables.

A significant number lives on cultivated tubers. Some people collect various products such as wild roots, fruits and honey. Forest dwellers hunt animals and birds to supplement their staple diet. Addressing the health of tribal women and children requires consideration of several aspects, including their geographical location, position in the development continuum, literacy level, economic base, political participation, level of integration and assimilation, external institutions and factors affecting them life [1].

About health and health culture

A state of whole physical, mental, social, and spiritual well-being has been described as health; it is not just the absence of illness or disability (WHO). Health is man's natural condition and the outcome of living in line with natural laws pertaining to the body, mind, and environment. It allows man to live a socially and economically productive life. It has also been acknowledged that health is influ-

Census year	Population			Decadal Growth Rate		
	Total	Rural	Urban	Total	Rural	Urban
1961	3,01,20,184	2,93,57,790	7,72,394			
1971	3,80,15,162	3,67,20,681	12,94,481	26.2	25.2	67.6
1981	5,16,28,638	4,84,27,026	32,01,034	35.8	31.9	147.3
1991	6,77,58,380	6,27,51,026	50,07,354	31.2	29.6	56.4
2001	8,43,26,978	7,73,39,335	69,87,643	24.5	23.2	39.5
2011	10,42,81,034	9,38,19,162	1,04,61,872	23.7	21.3	49.7

Table 1: The population of scheduled tribes in India 1961-2011.

Source: Census of India.

enced by medical care as well as by the total integrated development of society, which includes social, political, cultural, economic, and educational aspects. Socioeconomic level, family structure, habits, beliefs, lifestyle choices, and utilisation of accessible medical facilities all have an impact. In actuality, a person’s health determines his fate and affects all of his actions.

With the promotion of primary health care as part of the new international development plan for the 1980s and beyond, “Health for All” has been accepted as the aim by the year 2000. The Government of India, a signatory to the Alma Alta Declaration that was endorsed by UNICEF and WHO, developed a national policy in 1983 with the goal of achieving Health for All by the year 2000. It aims to lower the average family size from 4.3 to 2.3 children, the death rate from 15 to 9, and the birth rate from 100 to 60. Primary health care is described as necessary medical treatment based on workable, ethically sound, and socially acceptable practices that are widely accepted by members of the public, families, and the nation. (ICMR).

A community with 100,000 residents is defined as having a “Community Health Centre” with Primary Health Centres serving 30,000 people, a Sub-Centre for every 5,000 people, and a village or neighbourhood service for every 2,000 people. The community now forms the centre of the system rather than its perimeter. From this foundation, the health services expand to the district and regional levels, offering additional highly specialised and specialist services. It is intended that the community and the health services would form a tight cooperation [2].

The phrase “health culture,” refer to cultural perspectives, the cultural interpretation of health issues that the community faces, and health behaviours in relation to the different cultural tools that the community has access to and can use. The idea is used to highlight the importance of comprehending health-related behaviours in the community, the accessibility and availability of healthcare facilities, and the cultural significance and views on health issues as a cohesive whole. It is argued that a community’s perceptions of health issues, its overall condition of health and illness, and its reaction to the different institutions that exist to address these issues together constitute an integrated, interdependent, and integrating

whole. It is a subcultural complex that may be referred to as the community’s health culture [3].

Its emphases on the various facets of health care systems and their operation. Anthropologists are just as interested in the cultural representations of health and illness as they are in their social causes and effects. But the application of ethnography to comprehend health, sickness, and medical care is what most distinctively defines the anthropological approach. The organisation, narration, contestation, and overall social trajectory of individual and collective realities are brought together by anthropological perspectives on health [4].

There are reports of high maternal death rates among different indigenous tribes. Research on health care methods for mothers and children is mainly disregarded in different indigenous communities. The majority of anthropological ethnographic research identify “unhygienic practices,” “lack of awareness,” “fatalistic or irrational unscientific view,” “illiteracy,” and failing to seek appropriate medical attention as the causes of their poor health. As a result, the strategy is “reductionist,” blaming the victims’ cultural traditions. Fewer studies have connected the poor health to more significant economic, political, ecological, and developmental challenges than only these culture-centric approaches and behavioural recommendations [5].

Maternal-child health and family planning

By using an integrated primary health care strategy, maternal and child health care and family programmes enhance the health of women and children. In India, there are still many newborn deaths, particularly among the tribal population. Emphasis must be placed on the usefulness of studying traditional systems as a system of values, beliefs, knowledge, objects, tools, and skills as well as how roles and activities are organised and how they relate to other demands. Anthropologists and other social scientists have studied child malnutrition extensively, but pregnant mothers have received less attention. The decline in women’s health is caused by numerous socio-cultural and economic issues, such as unequal access to food. Research on the underutilization of health services ought to be given top priority [1].

Maternal health scenario

The death rate among mothers is merely the beginning. Other unfavourable outcomes that affect adolescent females include prenatal and neonatal mortality, which is much higher among adolescent moms than it is among women in their 20s and 30s. Comparably, a number of facility-based research indicate that teenage girls experience greater rates of pregnancy-related issues than older women do, including eclampsia, pregnancy-induced hypertension, intrauterine development retardation, and early delivery [6,7].

In a Study, Basu, *et al.* argues that maternal morbidity and mortality rates are high due to early marriage, subsequent pregnancies that are accompanied by inadequate calorie intake and inaccessibility, and underutilization of medical resources. Thus, early mating and ongoing cycles of pregnancy and nursing lead to “maternal depletion.” Uninterrupted overwork and an inadequate food cause cumulative illnesses such as anaemia, general malnutrition, early ageing, and early mortality [8].

In 1993, *Bhatia and Cleland* conducted a cross-sectional survey in the state of Karnataka rural and urban districts. Study covered 3595 married women under 35 who had at least one kid under five were included in the poll. Throughout their most recent viable pregnancies, nine out of ten women had at least one prenatal consultation. The majority of consultations were with physicians, while the primary health care system’s paramedical staffs were rarely used. Of the total respondents, 38% (57% in urban areas and 29% in rural areas) gave birth in a hospital, with the bulk of these institutional deliveries taking place in private facilities. The findings indicated that over 30% of hospital deliveries involved surgical interventions. Because less than one-fifth of the moms got a postnatal visit, there was a clear disparity in the care provided throughout pregnancy and after delivery. Even though self-reported morbidity in the six weeks following labour was fairly high, less than one in five of all respondents obtained a postnatal check. Thus, it would seem that there is a significant Gap in Karnataka’s maternal health services that needs to be looked at more. In rural areas, there was little involvement of the paramedical staff services offered by the primary health care system. Thus, a comprehensive review of the paramedical staff’s involvement in the delivery of maternal health care at health centres and subcentres is required [9].

K. Sujata Rao (1998) conducted research in Andhra Pradesh and found that the primary reason of the tribal people’s poor health is poverty, which is exacerbated by a number of variables including lack of access to wholesome food, iron, protein, and micronutrient deficiencies. The state’s maternal mortality rate (MMR) is 4 per 1000, whereas the national rate is eight. The state’s infant mortality rate (IMR) is 72 per 1000, while the national rate is between 120 and 150. Thus, inadequate housing, inadequate infrastructure,

high rates of absenteeism and vacancies, and a lack of qualified and trained labour are the causes of the subpar health care services, which in turn contribute to the subpar health of the tribal population in that area [10].

Another cross sectional study conducted by *Maharatna* in two rural areas of West Bengal i.e. Nandura (Birbhum district) and Khatra (Bankura district). The study showed divergent patterns of reproduction behaviour and how it changes for a same tribe (the Santals) in two different places, as well as for those of lower caste in one area. According to the study, compared to their tribal counterparts in a region from which the Santals do not migrate, the seasonal migrants not only exhibit low fertility but also appear to be far ahead in terms of contraceptive methods and fertility transition. In fact, the study reported that even non-migrant lower caste (nontribal) people, who have undergone mass sterilisation, are not able to achieve fertility as low as that of the seasonally migrant Santals. Instead, they appear to be more mature and motivated users of contraceptives (e.g., oral pills and condoms). The main take away from this study is that seasonal migration plays beneficial functions in speeding up the fertility transition, for example by raising earnings and goals and promoting social connections and the spread of information, concepts, and motivation about family planning. The study suggested with immediate policy recommendation to encourage the increase of seasonal migration and mobility (such as building a transport network and providing for the education of migrant households’ children). However, it argues that this should in no way be seen as a substitute for longer-term initiatives aimed at permanently and fairly developing the underdeveloped areas from which people must migrate on a seasonal basis [11].

Balgir (2006), discussed in his study that the state of Orissa holds a special place on the tribal map of India. It is home to 62 scheduled tribes, including 13 primitive tribes, with a combined population of approximately 8.15 million people, or 22.3% of the state’s total population according to the 2001 Census. The study reported that the major causes of the poor health in Orissa’s tribal communities are widespread poverty, illiteracy, malnutrition, a lack of sanitary conditions and safe drinking water, inadequate maternity and child health services, ineffective coverage of national health and nutritional services, etc. [12]. The health care delivery services in tribal communities, particularly in Orissa, are still inadequate despite the tremendous advancements in preventive and curative medicine. These services need to be strengthened and improved in accordance with recommended guidelines in order to meet the ambitious goal of universal health coverage in India [12].

According to Rao, *et al.* (2006), the ‘Sahariya Tribes of Rajasthan’ follow a diet that consists of cereals, millets; consumption of milk, legumes, jaggery, and other foods is lower than recommended dietary intakes (RDI). While the intake of other nutrients, including

fat, vitamin C, folic acid, vitamin A, and riboflavin, is below average, the intake of protein, iron, calcium, and thiamin is comparable to the required level. Study showed that the Sahariya tribe's nutritional intake was superior to that of the other drought-affected areas. While the study paints a clear picture of the Sahariya people's nutritional health, there are some nutritional deficiency illnesses that can be identified in them. Further reported that approximately 4% of the baby was malnourished and that the same percentage had conjunctival xerosis. The investigation also showed that prematurity is the primary cause of neonatal death, whereas infectious diseases are the predominant cause of adult death [13].

Rani., *et al.* (2007), in their cross-sectional survey in Jharkhand on the prevalence of maternal healthcare seeking among married adolescent tribal females among Santhal, Oraon, Munda, constitute 26% of the state. The study's demonstrate that few mothers seek medical attention. A significant fraction of females was given no prenatal care; almost all gave birth at home, and just a tiny percentage had a postpartum examination. The results are meant to guide the creation of policies and programmes that meet the maternity and child health requirements of this population in the nation. They are based on a primary survey conducted in the state's Lohardagga district of Jharkhand. The findings of such several research carried out in India indicate that teenage girls are more likely than adult women to experience unfavourable consequences for their mother and child's health [14].

In a study, Singh (2008) documented that most tribes knew very little about family planning and were unaware of the RCH. Almost two-thirds of the population used contraceptives, despite the extremely high rates of use of condoms, oral tablets, contraceptives, and safe periods [15].

Misra., *et al.* (2014), carried out a cross-sectional community-based study in Bankura district of West Bengal. The study objective was to determine the socio-demographic parameters impacting the contraceptive behaviour of eligible tribal couples in Taldangra Block, Bankura, West Bengal, as well as the reasons behind their nonusage of contraceptive techniques. In the study population, there was a trend towards an increase in contraceptive use as parity increased. The results reported that the highest percentage of educated couples, women in their thirties (ages 30-35), and mothers of two or three living children used contraceptives. In conclusion, raising the educational attainment of tribal women would delay marriage and make it easier for them to have a suitable and long-lasting family size [16].

In Paschim Medinipur district of West Bengal", a study was conducted by Bepari., *et al.* (2015), on nutritional and health status of adult Lodha women. The study adopted 240 women (120 from the Lodha group and 120 from the General community) between the

ages of 18 and 45 were chosen at random from several villages in the Nayagram block of the Paschim Medinipur. The questionnaire method was used to assess the socioeconomic status. Standard techniques were used to measure the body dimensions, blood pressure, and haematological markers. The findings indicated that the Lodha women are members of a low socioeconomic category. The risk of undernutrition was significantly and roughly eleven times higher among Lodha women than it was among women in ordinary groups, and the frequency of undernutrition was extremely high (80%). Blood pressure data also showed a similar pattern. Thirty-six percent of Lodha women had hypotension. Approximately five times more often than women in normal groups, Lodha women had an extremely high frequency of anaemia (91.67%). The WBC count of Lodha women is substantially greater than that of the overall population [17].

Srivastava and Sahu (2021), conducted a study in Uttar Pradesh, found that due to scarce resources and the predominance of "traditional culture," third world countries are constantly at risk of having high rates of maternal and infant illness and mortality. Positive outcomes at birth can only be guaranteed by appropriate prenatal care (ANC). The main objectives of the study are to identify how local culture affects prenatal care and related visits by learning about the importance of ANC visits and the emic perspective on pregnancy in the chosen villages (Bakshi ka Talab development block, district Lucknow), as well as the socio-cultural factors that lead to underutilization of ANC services. Both observation and interviews have been used to gather data. The findings conclude that while a person's personal experience, socio-demographic characteristics, accessibility, and availability of health resources, among other things, are relevant in prenatal care, people's customary knowledge and social networks are still invaluable and should be prioritised by medical professionals in order to decrease the underutilization of ANC services [18].

Conclusion

To improve the health of the indigenous people, a multidisciplinary approach is required. Gaining a deeper comprehension of their living circumstances and placing women at the forefront of development are imperative.

There are numerous pressing issues that require consideration. Maternal malnutrition, nutritional anaemia, pregnant women's nutritional status and the nature of their workload, food distribution within the family and its impact on women's nutritional status, complications during pregnancy and childbirth, parturition practices, maternal mortality, childbirth weight, infant and childhood mortality and their sex differences, types of maternal and child health care practices, attitudes towards family planning, etc. all require detailed information. A database pertaining to every tribe must be created.

Primary healthcare in tribal regions needs to be rethought and redesigned. Issues such as burns, accidents, Sick Cell illness, malaria, tuberculosis, leprosy, STDs, and endemic goitre may require extra care.

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