Fact of Maternity Practices Among the Tribal Communities: A Special Reference of Santal Society

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Abstract- ***The Santals in the world has a very rich Socio-Cultural heritage. Their lifestyle is marked by several rituals, myths, taboos, rites, and fundamental event connected with various stages of life. These myths and rituals are mainly connected with Santal traditional practices like animism, Naturalism, Bongaism, etc. Santals celebrate their rituals in every stage of life. Around the world, people celebrate the birth of a new baby. Women re blessed to rare a new life in their womb and is accepted by the society as well and hence a safe Maternity is the right of all women. Among the primitive societies, particularly among the Santals, a child birth is regarded as very important and crucial however for a women, the period of pregnancy and childbirth is a journey full of taboos and myths that sometimes become dangerous for both the maternal and child health.***

I. INTRODUCTION

Santals are the linguistically largest tribal group in India as well as in the world. They are still maintaining their language, culture and tradition and are therefore recognized as a separate community. Although they have changed their traditions and culture in least places, which is rarely observed in other tribal groups. Santals are the preserver of ancient language and culture known as Kherwari (Santali) which flourished in the very ancient time, long before the emergence of Vedic culture and civilization. They are largely concentrated in Odisha, Bihar, Jharkhand and West Bengal. More than seven million people are considered as Santal in India. Their primary occupation is agriculture and daily wage earner though there is an increasing move among youth towards better education and self-income generating activity.

This research has focused on maternal health practices among tribal societies. Utilization of resources is lowest among tribal groups than any other community in India due to the long distances from quality health services and their unavailability, cultural barriers, low educational level of women, and economic inequalities, etc. Worldwide, Maternal mortality is unacceptably high. About 2,95,000 women died during pregnancy and childbirth in 2017. (Gliozheni) Every day in 2017, approximately 810 women died from preventable causes related to pregnancy and childbirth in less developed countries, but skilled and quality care before, during, and after childbirth can save the lives of women and newborns. The Santal community holds a high richness of myths and taboos. Therefore, despite improvement in infrastructure and bridging the access-gap in health care, their cultural barriers could not be ignored.

As per the Sample Registration System (SRS) report by Registrar General of India (RGI) for the last three years, Maternal Mortality Ratio (MMR) of India has reduced from 130 per 100,000 live births in SRS 2014-16 to 122 in SRS 2015-17 and to 113 per 100,000 live births in SRS 2016-18 (WELFARE).

The Government is focusing to bring down the rate of maternal mortality. It has been to address the actual causes of mortality and morbidity among women, and deliver solutions to eliminate these causes. The emphasis has been on ensuring a continuum of care to address maternal and child health in a holistic manner, by providing excellent healthcare facilities to pregnant women.

II. METHODOLOGY

This study is focused on the old myths and taboos practices by the Santals during pregnancy and motherhood, particularly the post-partum period of a mother. For the purpose of this study, number of articles have been reviewed, where traditional practices during maternity period of a women were focused. Books describing cultural beliefs and

customs of Santals have been studied. Secondary data has been collected from the Planning Commission of India and Rural Health Statistics. Other sources include International and Local newspaper reports and records, electronic media records, articles, NCRB database, NGO reports and documentaries.

III. OBJECTIVES OF THE STUDY

1. To determine the tribal cultural-myths and believes practices during maternity.
2. To assess the accessibility and availability of health care among the tribal communities.
3. To determine the work engagement of the tribal women during pre-natal and post-natal period.
4. Causes of high maternity death among the tribals

Santal women in remote areas are less likely to receive adequate health care. The major factors that prevent these tribal women from receiving or seeking care during pregnancy and childbirth are:

- Cultural Myths, Beliefs and Practices
- Poverty
- Distance from health facilities
- Lack of information/awareness
- Inadequate/poor quality health services

Cultural Myths, Beliefs and Practices

A Santal pregnant women obey certain taboos and rule to attend some social evils and unlucky incidents to save herself and her baby from the displeased soul of the dead, witchcraft, spirits, etc. She is not allowed to go anywhere because as per myths her life will be dangerous when the sun is not directly overhead, she does not go anywhere after the sunset. The pregnant Santal woman is not allowed to go alone to the forest, jungle or hill, cross the river, or attend to the death house. A pregnant woman can't do any hard work, however, in recent trends due to poverty, pregnant women are engaged as a daily wage earner in construction sites, agriculture fields, mining, etc.

There are other taboos like, the husband of the pregnant women is not supposed to kill any animals or breaks an egg. He is not allowed to attend funeral ceremonies and cremation or touch dead bodies. He is deprived from eating non veg, particularly flesh or meat. There are myths to determine the sex of coming child. For instance, if mother's appearance is sick and particularly if the mother gets thin around the neck, *it indicates that she will have a male child.*

When the pain starts of the santal women, the pregnant woman is shifted to a separate room, where only female is entered. The Dhai Budhi (Midwives) is appointed there for the delivery. *They are untrained but according to their myths,* Dhai Budhi plays the most important role in the delivery of the child. Other married women are gathered to help to the pregnant woman. Special measures are taken if delivery proves to be complicated. *An Ojha is called for the solution of problems.*

The umbilical cord of a new born child can cause bacterial infection if not properly taken care of. It can cause newborn sepsis and other morbidity and even result in child mortality. According to their myths Dhai Budhi (Mid-Wife) cut the umbilical cord with the help of oysters. In such cases maintenance of hygiene is very poor.

Poverty

Poverty during pregnancy and motherhood affects the child health outcomes. According to 2011 census, 114 million Scheduled tribes are living in Below Poverty Line. Poverty has consistently been found to be a powerful determinant of delayed cognitive development in children. Behavioral problems among children and adolescents are strongly associated with maternal poverty.

Percentage of ST Population who are Below Poverty Line during 2009-10 and 2011- 12 (India) *(Tendulkar Methodology)*

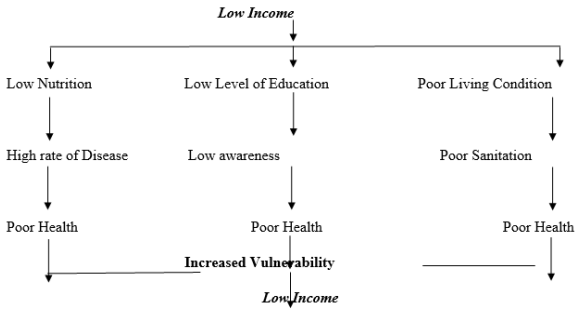
Sl.No.	*State*	*Rural*	
		2009-10	*2011-12*
1	*Andhra Pradesh*	*40.2*	*24.1*
2	*Assam*	*32.0*	*33.4*
3	*Bihar*	*64.4*	*59.3*
4	*Chhattisgarh*	*66.8*	*52.6*
5	*Gujarat*	*48.6*	*36.5*
6	*Himachal Pradesh*	*22.0*	*9.5*
7	*Jammu & Kashmir*	*3.1*	*16.3*

8	*Jharkhand*	*51.5*	*51.6*
9	*Karnataka*	*21.3*	*30.8*
10	*Kerala*	*24.4*	*41.0*
11	*Madhya Pradesh*	*61.9*	*55.3*
12	*Maharashtra*	*51.7*	*61.6*
13	*Odisha*	*66.0*	*63.5*
14	*Rajasthan*	*35.9*	*41.4*
15	*Tamil Nadu*	*11.5*	*36.8*
16	*Uttar Pradesh*	*49.8*	*27.0*
17	*Uttarakhand*	*20.0*	*11.9*
18	*West Bengal*	*32.9*	*50.1*
	All India	*47.4*	*45.3*

(Source: - Planning Commission

According to the Planning Commission in India, about 45 percent of the ST population lives below poverty line. States that retain a high percentage of the Scheduled Tribe population also have a high percentage below the poverty line. India's West Bengal, Jharkhand, Odisha and Bihar have a large population of Scheduled Tribes, hence their poverty also high.

The below mentioned graphical presentation shows the poverty impact resulting in poor health condition:



Above graphical presentation helps us to identify appropriate reasons for Poor Health

Reproductive health is closely related to the nutritional status of a country. It is the biological differences and the conservative gender roles and taboos between women and men that places women at higher risk for malnutrition and mortality.

The scenario of Tribal Health in India

According to NFHS-3

- 21.1 % of teenage tribal girls had begun childbearing.
- 65% of Tribal women in the 15-49 years age group suffer from anemia. (Aanemia are assessed to be responsible for 17-46% of cases of maternal death.)

The rapid survey on children 2013-14 stated that-

- More than 30% ST women in the 20-24 years age group are married before they turn 18.

Almost 50% of adolescent ST girls between the ages of 15 to 19 years are underweight or have a BMI of less than 18.5

The scenario of Public Health Infrastructures related with delivery

The public health infrastructure means the number of health institutions, health professionals and other personnel-related with delivery and the overall arrangement for delivery of various health-related services.

Preventive and promotive services are mostly delivered in the public sector. In rural areas, such services are provided by the Sub-centers (SC), the Primary Health Centers (PHC) and the Block Primary Health Centers (BPHC). The BPHCs with at least 30 beds are generally declared as Rural Hospitals (RH) and have facilities better than the BPHCs. The BPHC and the RH have otherwise similar functions and are headed by the Block Medical Officer of Health (BMOH). All primary health care services in rural areas are delivered by the RH/BPHC, PHC and the SC.

Total number of sub-centers in India is 31273. However as per rural health statistics- 6503 sub-centers are required. Similarly, 1204 PHC (Primary Health Center) is required for better services in rural areas.

Lack of information/awareness

Local beliefs, customs, and practices have obstructed health care delivery to the tribals. However, acceptance of modern medicine is found to be increasing among tribals in recent years. The Government of India and State government launched

various schemes and policies but lack of communication and literacy results in the lack of information among the tribals. Many tribal families do not know about the benefits of those schemes. Some of the important schemes, particularly focusing on Maternal Child Health are as follows:

Janani Suraksha Yojona- The JSY has been launched under NHM with the vision of reducing MMR and IMR and increasing institutional delivery of pregnant mothers from BPL families. As indigenous peoples practice orthodox culture during childbirth, they ignore going to the hospital, and prefer non-institutional delivery with the help of traditional unskilled nurses called the "Dai Ma" instead of doctor/qualified nurse. The strategy adopted has been promoting early registration, identification of risk pregnancies, ensuring three ANCs and four PNCs. Providing referral transport free of cost for promotion of institutional delivery is another important objective. Women above 19 years and belonging to SC, ST and BPL families are covered under the JSY for providing financial benefit.

Village Health and Nutrition Day: - The purpose of the VHND is to extend services related to nutrition and health, particularly of the mother and child, to the village level by bringing all services given by the

ICDS center on fixed days. The VHND is generally organized in selected ICDS centres of sub-centres on fixed days.

Rogi Kalyan Samiti:- One committee, named Rogi Kalyan Samiti, is formed for each hospital for the involvement of all stakeholders like elected representatives, officials from general administration, doctors and nurses from the hospital etc. is formed for supervising the functioning of the hospital, particularly from the point of view of services being delivered and to the patients.

Improving Neonatal Care: - As mentioned earlier the reduction of IMR is largely dependent on reduction of neonatal morbidity. In order to prevent neonatal death, there is need for improving more home-based neonatal care through training of the ASHA and improving level of awareness of the mothers so that they can assess the risk and take the baby to the hospital for which no cost has to be incurred.

Promoting institutional delivery and safe motherhood: - Earlier it was mentioned that as indigenous people practice orthodox culture during childbirth, they ignore going to the hospital. They depend upon unskilled "Dai Ma" instead of doctor. Improving safety of motherhood requires many steps starting from proper ANC, PNC and institutional delivery with time-to-time immunization. One major drive under NRHM is to improve access to institutional delivery for the safety of the mother and the newborn. Around 71% of deliveries in West Bengal during the period 2010-11 were conducted in institutions or in presence of skilled birth attendants.

CONCLUSION

Improving Health infrastructure and bridging the access-gap are essential, but the cultural barriers cannot be ignored. Studies show that while the concept of deities and their effect on health is widespread among tribal communities, their acceptance of modern healthcare depends on its availability and accessibility. Policy makers, planners and care providers also need to think about the resources of the health care system, and to keep in their mind about the unique customs, values, beliefs and traditions of the tribal society, pursuing in the maternal health practices along with their isolation and remoteness. Therefore, a "differential approach" must be launched for tribal areas, with different norms for establishing facilities to gear up the existing programs that suit their specific requirements.

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