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Obstacles to Acquire Modern Medical Institutional Facility with Special Reference to Maternal Health Care among Tribals of South Bastar in Chhattisgarh

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Abstract

Introduction: The Maternal Mortality Ratio of Chhattisgarh is 269 (SRS 2010-11) which are higher than the National average (178). If we analyze the state wise data of MMR we found that Chhattisgarh is fourth in position amongst all states of India. Maternal and child health care is an important aspect of health seeking behaviour which is largely neglected among the tribal groups (Basu et al., 1990). It has been seen that inspite of a lot of government incentive programmes for women health care and development, some obstacles create obstruction to acquire modern medical institutional facilities. It is a burning concern for the development because the problems of tribal women differ from a particular area to another area owing to their geographical location, historical background and the processes of social change (Chauhan, A., 1990).

Objectives: The study concerned with the objective of understanding the gap between government modern health facilities and tribal women with special reference to maternal health care.

Study Area: For the study purpose tribal dominating villages of south Bastar, Chhattisgarh was selected. Chhattisgarh is known as 10th largest state of India where Bastar is known as its rich and uniqueness of bio-cultural diversity in the whole world.

Methodology: Random sampling technique was the key instrument for selecting sample as well as Snowball sampling is also used to identify a few households where maternal and infant related problems occurred through some key informants in the village and ask each of them to identify households where maternal problems have occurred. Questionnaire on different variables of knowledge, attitudes, belief and opinion about government health institution were organised by direct interview. Along with above semi participatory observation was strength for the data collection.

Result: The findings stated that the acceptance of modern institutional health facilities is poor amongst tribal people. In addition, a lot of females suffered from ill health due to pregnancy and childbirth in the absence of a well defined concept of health consciousness.

Conclusion: The health problems of mothers arise as a result of synergistic effects of malnutrition, poverty, illiteracy, unhygienic living conditions, infections and unregulated fertility. Apart from that superstitious beliefs play an essential obstruction to acquire modern medical facilities. At the same time, poor infrastructure and ineffective public health services is also responsible for low inadequate obstetric care.

Keywords: Maternal mortality; Seeking behavior; Modern medical institutional; Tribal women; Superstitious beliefs.

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INTRODUCTION

Independent Commission on Development and Health in India, 2008 considered Chhattisgarh as the worst state regarding availing status of institutional health facilities and the poor status of institutional maternal health care. It has been revealed in the report that only 7.5 percent births in institutional in rural and tribal areas of Chhattisgarh. Apart from that according to Public Health Foundation of India 2015, stated that the prevalence of anemia among married women (15-49 years) and children (0-5 years) are 59.4 percent and 55.9 percent respectively which is higher than that of national rate whereas International Food Policy Research Institute, 2015 reported that 71.2 percent children (0-5 years) and 63.7 percent pregnant women are severe anemic in Chhattisgarh.

It has been seen that inspite of a lot of government incentive programmes for women health care and development some obstacles like common beliefs, customs and practices connected with health and disease have been found to be intimately related to the treatment of disease by avoiding government institutional health facilities. It is necessary to make a holistic view of all the cultural dimensions of the health of a community. In most of the tribal communities, there is a wealth of folklore related to health. Documentation of this folklore available in different socio-cultural systems may be very rewarding and could provide a model for appropriate health and sanitary practices in a given eco-system. Maternal and child care is an important aspect of health seeking behaviour which is largely neglected among the tribal groups (Basu et al., 1990). Among tribals as well as rural, the status of women relating to their socio- cultural problems, their economic rights, their participation in management, their access to employment, food, health, etc. But these issues have not been properly focused in relation to the tribal women and their health related issues by government. There are only a few studies on the status of tribal women in India (Mann, 1987; Singh, Vyas & Mann, 1988; Chauhan, 1990). Thus the study of tribal women cannot be ignored specially regarding maternal health care practices. It becomes important because the problems of tribal women differ from a particular area to another area owing to their geographical location, historical background and the processes of social change (Chauhan, 1990).

OBJECTIVES

In this study, we intend to do an in-depth decentralized analysis of Rural India's primary health care delivery system at the district level because it is really worrying, that inspite of investment in infrastructure, they are virtually nonperforming; and where the availability of infrastructure is strikingly low, and situation is naturally bleaker especially for maternal health care in rural and tribal areas.

Study Area

Chhattisgarh, is a state in central India. It is the 10th largest state in India, with an area of 135,194 km2 (52,199 sq mi). With a population of 25.5 million, Chhattisgarh is the 16th most-populated state of the nation where Bastar and Dantewada in south Chhattisgarh are the most illiterate districts.

The ***Dantewada*** district ranks 16th in the State in terms of population size. The percentage of Scheduled Castes population to total population is 2.4 whereas, that of the Scheduled Tribes population is 76.9. Apart from that Dantewada is a beautiful district situated in southern Bastar region of Chhattisgarh state and it is connected with Jagdalpur the nearest town, by State Highway No.16.

Kuwakonda is a Tehsil and development block head quarter of Dantewada District of Chattisgarh State, India. It is less populated area. For study purpose three villages Nakulnar, Potali and Sameli were selected.

Nakulnar is a Village in Kuwakonda Tehsil in Dantewada District of Chattisgarh State, It is located 19 KM towards South from District head quarters Dantewada. 4 KM from Kuwakonda. 329 KM from State capital Raipur. In this village total 330 families residing. In Nakulnar village population of children with age 0-6 is 238 which makes up 11.61 % of total population of village. Average Sex Ratio of Nakulnar village is 1096 which is higher than Chhattisgarh state average of 991. Child Sex Ratio as per census, 2011 is 803, lower than Chhattisgarh average of 969.

Potali is a medium size village located in Kuakonda of Dantewada district, Chhattisgarh with total 431 families residing. The village has population of 1733 of which 804 are males while 929 are females as per Population Census 2011. The population of children with age 0-6 is 286 which makes up 16.50% of total population of village. Average Sex Ratio of Potali village is 1155 which is higher than Chhattisgarh state average of 991. Child Sex Ratio for the Potali as per census is 946, lower than Chhattisgarh average of 969. Potali village has lower literacy rate

compared to Chhattisgarh. In 2011, literacy rate of Potali village was 41.74% compared to 70.28% of Chhattisgarh. In Potali Male literacy stands at 52.82% while female literacy rate was 32.53%.

The ***Sameli*** village has population of 1768 of which 842 are males while 926 are females as per Population Census 2011. In village population of children with age 0-6 is 294 which makes up 16.63% of total population of village. Average Sex Ratio of Sameli village is 1100 which is higher than Chhattisgarh state average of 991. Child Sex Ratio for the Sameli as per census is 922, lower than Chhattisgarh average of 969. It has lower literacy rate compared to Chhattisgarh. In 2011, literacy rate of Sameli village was 34.26% compared to 70.28% of Chhattisgarh. In Sameli Male literacy stands at 46.59 % while female literacy rate was 23.44%

Table 1: Study Area with Household and Population

State	District	Block	Tribal Village	Number of Household	Population					
					Male		Female		Total	
					No	%	No	%	No	%
Chhattisgarh	South Bastar, Dantewada	Kowakonda	Nakulnar	35	69	30.80	76	35.19	145	32.95
			Potali	35	72	32.15	67	31.02	139	31.59
			Sameli	35	83	37.05	73	33.79	156	35.46
Total	105	224	100	216	100	440	100			

METHODOLOGY

Random sampling technique was the key instrument for selecting sample as well as Snowball sampling is also used to identify a few households where maternal and infant related problems occurred through some key informants in the village and ask each of them to identify households where maternal problems have occurred.

Questionnaire on different variables of knowledge, attitudes, belief and opinion about government health institution were organised by direct interview. Interview schedule and interview guide were the two specific techniques used to collect data. Those who participated in the study were woman and head of the household, Anganwari workers, PHC workers, traditional medicine men (*Sirha/Guniya*), and private practitioners working at selected villages and health functionaries working at Community Health Centre (CHC) Dantewada. Semi participatory observation was strength of the data collection. Information was also collected from secondary sources especially from records which provided by PHC, CHC and DLHS-3 and SRS reports. Field work was carried out during January to December 2015. For justification of the primary data 3 point scale (low, medium, high) has been developed for socio-cultural issues in the tribals' community.

RESULT AND ANALYSIS

Status of Acquiring Modern Medical Facility

In the new sample from 2004, the options on types of medical attention received before death have been modified to capture the death occurred specifically at private hospital/nursing homes. The new options include 'Government Hospital', 'Private Hospital', 'Qualified Professional', 'Untrained Functionary' and 'other' the options for the sample based on 1191 sample were 'institutional', Medical attentions other than institution', and 'No medical attention', Statement 58 given below percents the percentage distribution of deaths by type of medical attention received before death for India and bigger States separately for rural and urban areas for the years 2009. At the National level, 17.7 per cent of the deaths occurred at Government Hospital and varies from 14.8 per cent in rural areas to 28.2 per cent in urban areas.

Table 2: Percent Distributed of Deaths by type of Medical Attention Received before Deaths by Residence

Place	Government Hospital			Private Hospital			Qualified Professionals			Untrained Functionary and Others (Sirha/Guniya)		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
India	17.7	14.8	28.2	12.3	10.3	19.5	37.9	38.6	35.1	32.1	36.3	17.3
Chhattisgarh	17.0	13.8	35.7	8.7	7.7	14.6	30.0	28.5	39.0	44.3	50.0	10.7
Dantewada, South Bastar	-	9.8	28.7	-	2.6	8.4	-	4.2	14.7	-	72.5	42.5

Source: *SRS,2009*

Table 3 depicted the maternal health care status in both rural and urban areas and a comparison is made between Chhattisgarh state and its Dantewada district. About Antenatal Care (ANC), it has been found that 78.5 percent pregnant women registered themselves in Dantewada which is slightly greater than total registered pregnant women (77.4 percent) in Chhattisgarh. Overall the statuses of registration for ANC checkup in first trimester, and frequency of having TT injection are better in state level as well as in district level. It is noted about the consumption of IFA for 100 days (Dantewada; rural: 29.0 percent, urban: 26.1 percent and Chhattisgarh; rural: 24.0 percent, urban: 28.6 percent), status of full Antenatal Checkup (Dantewada; rural :21.5 percent, urban:23.0 percent and Chhattisgarh; rural: 19.0 percent, urban: 25.4 percent) are significantly less in both areas of rural and urban in Dantewada and Chhattisgarh. The acceptance of Pathological test like Hb analysis, among rural area of Dantewada is less prevalent while it is higher in urban areas of Dantewada. Delivery health care status in rural areas of Dantewada is gradually miserable in condition because in rural areas home delivery is more prevalent than institutional delivery. It is also observed that delivery care and post natal care are highly affected and controlled by socio-cultural practices in tribal and rural areas of Chhattisgarh. No specific precautions were observed at the time of conducting deliveries which resulted in an increased susceptibility to various infections. Admittedly, extremes of magico-religious beliefs and taboos aggravated the problems.

Table 3: Comparative Study between Dantewada and Chhattisgarh according to Maternal Health Care Practices

Variables	Condition	Dantewada			Chhattisgarh		
		Total	Rural	Urban	Total	Rural	Urban
ANC	Currently Married Pregnant Women Aged 15-49 years Registered for ANC	78.5	78.2	84.7	77.4	76.4	81.9
	Mothers Who Received Any Antenatal Checkup	90.1	89.9	91.4	91.4	90.8	93.7
	Mothers Who Had Antenatal Checkup in First Trimester	43.6	38.4	77.4	69.9	67.9	78.2
	Mothers Who Received 3 or More Antenatal Care	62.3	58.9	84.4	64.2	61.0	77.6
	Mothers Who Received at least One Tetanus Toxoid (TT) Injection	89.6	89.4	91.4	91.1	90.6	93.4
	Mothers Who Consumed IFA For 100 Days or More	28.7	29.0	26.1	24.9	24.0	28.6
	Mothers Who Had Full Antenatal Check-up	21.7	21.5	23.0	20.2	19.0	25.4
	Mothers Who Received ANC From Govt. Source	46.2	48.1	33.9	43.2	43.5	41.6
	Mothers Whose Blood Pressure (BP) taken	80.0	78.3	91.4	77.9	75.7	87.5
	Mothers Whose Blood taken For Hb	46.6	41.2	82.3	55.2	50.1	77.0
	Mothers Who underwent Ultrasound	33.7	29.4	61.9	31.1	25.7	54.2
Delivery Care	Institutional Delivery	47.8	44.4	70.3	40.4	35.7	60.5
	Delivery at Government Institution	38.0	40.1	23.7	29.6	29.6	29.7
	Delivery at Private Institution	9.5	4.1	44.6	10.4	5.8	30.3
	Delivery at Home	52.0	55.4	29.7	59.4	64.1	39.4
	Delivery at Home Conducted by Skilled Health Personal	22.0	19.4	53.2	44.1	42.2	57.3
	Safe Delivery	55.6	52.0	79.4	56.9	52.2	77.3
	Caesarean Out of Total Delivery taken Place in Government Institutions	6.2	5.5	14.1	9.6	8.2	15.6
	Caesarean Out of Total Delivery taken Place in Private Institutions	23.0	20.1	24.7	36.9	38.3	35.8
Post Natal Care	Less than 24 hrs. Stay in Institution After Delivery	32.4	37.0	13.7	35.4	37.5	30.2
	Mothers Who Received Post Natal Checkup Within 48hrs. of Delivery	60.9	56.8	88.0	69.5	66.0	84.5
	Mothers Who Received Post-Natal Check-up With-in 1 Week of Delivery	65.5	61.7	90.9	74.8	71.9	87.5
	Mothers Who Did not Received Any Post Natal Check-up	*30.4*	*33.8*	*7.9*	*20.9*	*23.4*	*10.3*
	New Born Who Were Check-up Within 24hrs. of Birth	*56.4*	*53.0*	*79.1*	*64.2*	*60.7*	*79.5*

Source: DLHS-3ww

Overall, more than 70 percent of the deliveries were conducted at home attended by elderly ladies of the household in tribal communities in Kowakonda, Dantewada. Acceptances of institutional delivery, vaccination among pregnant women are very poor in position because of some socio cultural reasons and poor performance of institutions. Services of paramedical staff were secured only in difficult labour cases. In tribals area of Dantewada maternal mortality directly related to pregnancy and childbirth was found to be appreciably high among the tribal population groups by traditional way. In addition, a lot of females suffered from ill health due to pregnancy and childbirth in the absence of a well defined concept of health consciousness.

Table 4: Maternal Health Care Status in South Bastar Dantewada

Name of SHC	Total Population	Women Population (15-49 years)		ANC	Vaccination and Delivery Status						Live Birth
		Total	Pregnant Women		TT1	TT2 or Booster	IFA Tablet	Anemia	Institutional Delivery	Home Delivery	
Kuakonda	3557	610	149	64.43	44.97	64.43	64.43	41.61	28.86	51.01	95.30
Nakulnar	3760	645	169	60.36	42.01	60.36	60.36	38.46	42.01	57.99	98.82
Mailawada	3908	671	106	100.00	69.81	100.00	100.00	64.15	22.64	77.36	100.00
Gadhmiri	3467	595	99	94.95	66.67	94.95	94.95	60.61	29.29	70.71	85.86
Palnar	5164	886	140	99.29	70.00	99.29	99.29	63.57	23.57	76.43	90.00
Maharahaurnar	3757	310	103	98.06	68.93	98.06	98.06	63.11	24.27	75.73	97.09
Tikanpal	2578	334	87	80.46	56.32	80.46	80.46	51.72	39.08	60.92	100.00
Kalepal	2583	443	70	100.00	74.29	100.00	100.00	64.29	24.29	75.71	100.00
Potali	2687	443	89	82.02	52.81	82.02	82.02	51.69	38.20	61.80	100.00
Aranpur	1278	461	78	44.87	65.38	44.87	44.87	28.21	66.67	33.33	92.31
Burgum	3509	219	45	211.11	53.33	211.11	211.11	135.56	28.89	71.11	100.00
Sameli	2178	603	95	62.11	69.47	62.11	62.11	40.00	47.37	52.63	100.00
Madenda	9291	374	59	69.49	69.49	86.44	86.44	61.02	33.90	66.10	98.31
Rampur Camp	10167	1594	251	100.00	70.12	109.56	109.56	70.12	16.33	83.67	100.00
Gajraj Camp	3179	1745	275	100.00	69.82	31.27	31.27	20.00	37.09	62.91	100.00
Kodenar	988	545	86	100.00	69.77	31.40	31.40	19.77	46.51	53.49	100.00

Source: CHC Report, 2014-15

Poverty by Low level Occupation

Table 5 stated that in study villages had only five kinds of occupations were prevalent i.e agriculture, household workers, mining workers, daily waged labour and government service. In all 3 hamlets, majority of the respondents are daily waged labours and their income status is very low. It has been observed that only 2.86 percent respondents are in government service and no government worker is found in Potali and Sameli village. The one of the most vulnerable part of the villages is that there is less frequency of agriculturist because the areas are covered with forest. The study villages Nakulnar, Potali and Sameli are nearby the National Mineral Corporation Limited. By this reasons local people of the corporate affected areas are beneficiaries from the organisation by work. In this way illiterate and some literate people are working in the organisation as daily waged labour and mining workers. This assistance of corporate group generating minimum level of income status among tribals communities. It is depicted in table 5 that majority of the respondents come under Rs. 50001-100000 income range annually.

Table 5: Occupation and Income Status of Head of the Household

Occupational Status	Nakulnar	Potali	Sameli
Agriculture	1 (2.86)	2 (5.71)	4 (11.43)
Household Workers	3 (8.57)	1 (2.86)	1 (2.86)
Mining Workers	7 (20.00)	3 (8.57)	3 (8.57)
Daily Waged labour	23 (65.71)	29 (82.86)	27 (77.14)
Government Service	1 (2.86)	-	-
Total	**35 (100)**	**35 (100)**	**35 (100)**
Annual Income Range (in Rs.)			
>25,000	7(20.00)	2 (5.71)	2 (5.71)
25001-50000	2 (5.71)	3 (8.57)	10 (28.58)
50001-100000	20 (57.14)	27(77.15)	21 (60.00)
100001-150000	5 (14.29)	3 (8.57)	2 (5.71)
150001<	1(2.86)	-	-
Total	**35**	**35**	**35**

Source: Primary Data

Low literacy

When we specially analysed the women literacy status, it is significantly very less and need urgent attention from the government because education helps in generating awareness, makes an individual well informed about the overall changes taking place all around, liberates its mind from ignorance, sharpens it for logical thinking, mobilizes and generates capacity building, and thus increases the ability to understand the problem and to take effective decision, and thus one of the key determinants affecting the autonomy of any individual. Table 6 shows that only 38.16 percent women in Nakulnar, 10.44 percent women in Potali and 5.47 percent women in Sameli are literate and education level is also very poor. It has been observed that no women in all three villages are obtained high school, higher secondary school and graduation level education. Thus due to lack of awareness and illiteracy, the autonomy level of tribal women, in case of community participation is also low. They are not aware about new things happening around them as a result they act as mere spectator and don't play a lead role in community matters.

Table 6: Literacy Status of the Respondents

Education Status	Nakulnar			Potali			Sameli		
	Male	Female	Total (%)	Male	Female	Total (%)	Male	Female	Total (%)
Illiterate	9 (13.05)	47 (61.84)	56 (38.62)	20 (27.77)	60 (89.55)	80 (57.56)	30 (36.14)	69 (94.53)	99 (63.46)
Literate	60 (86.95)	29 (38.16)	89 (61.37)	52 (72.23)	7 (10.44)	59 (42.44)	53 (63.86)	4 (5.47)	57 (36.54)
Total	69 (100)	76 (100)	145 (100)	72 (100)	67 (100)	139 (100)	83 (100)	73 (100)	156 (100)
Primary School	19 (21.34)	17 (19.10)	36 (40.45)	30 (50.84)	5 (8.47)	35 (59.32)	30 (52.64)	4 (7.01)	34 (59.65)
Middle School	12 (13.48)	12 (13.48)	24 (26.96)	15 (25.43)	2 (3.38)	17 (28.82)	22 (38.59)	-	22 (38.59)
High School	11 (12.35)	-	11 (12.35)	7 (11.86)	-	7 (11.86)	1 (1.76)	-	1 (1.76)
H. S. School	15 (16.86)	-	15 (16.86)	-	-	-	-	-	-
Graduation and Others	3 (3.38)	-	(3.38)	-	-	-	-	-	-
Total	60	29	89	52	7	59	53	4	57

Source: Primary Data

Poor Institutional Facility

There is lot of dominating reasons in the study villages which are making hurdles for availing institutional health facilities. When we established the 3 point scale to examine respondents opinion about the acceptance and availing rate of institutional health care delivery, the large percentage of the respondent comprises in high frequency by answering that the lacking of institutional vehicle, long distance of hospital from their residence, absenteeism of doctors and health facilitators and their bad behave, untidiness surrounding of hospitals are common in local health institution. Another but significant observation is that female doctors for p women are yet not appointed in the areas because of naxlite areas no female doctor wants to come and give service.

Table 7: Institutional Facility

Status	Nakulnar (n= 70)			Potali (n= 70)			Sameli (n= 70)		
	Low	Medium	High	Low	Medium	High	Low	Medium	High
Lack of Vehicle	10 (14.29)	21 (30.00)	39 (55.71)	3 (4.29)	2 (2.85)	65 (92.85)	1 (1.42)	6 (8.57)	63 (90.00)
Bad Behave of Health Providers	3 (4.29)	20 (28.57)	47 (67.14)	5 (7.14)	36 (51.42)	29 (41.42)	12 (17.14)	37 (52.85)	21 (30.00)
Long Distance of Hospital	14 (20.00)	27 (38.57)	29 (41.42)	15 (21.42)	23 (32.85)	32 (45.71)	3 (4.29)	27 (38.57)	40 (57.14)
Absence of Doctors & Others Health Providers	1 (1.42)	10 (14.29)	59 (84.28)	2 (2.85)	27 (38.57)	41 (58.57)	3 (4.29)	11 (15.71)	56 (80.00)
Unavailability of Medicines	4 (5.71)	27 (38.57)	39 (55.71)	14 (20.00)	29 (41.42)	27 (38.57)	11 (15.71)	27 (38.57)	32 (45.71)
No Cleanliness in Govt. Hospitals	9 (12.85)	37 (52.85)	24 (34.28)	13 (18.57)	26 (37.14)	31 (44.28)	3(4.29)	36 (51.42)	31 (44.28)
No Female Doctor in Hospital	-	-	70 (100)	-	-	70 (100)	-	-	70 (100)

Source: Primary Data

Trained doctors typically refuse to live in rural areas due to the lack of: educational opportunities for their children, transport, and recreational facilities. In addition, drugs and supplies in the government PHCs are often lacking. World Health Organisation, 2008 showed that the coverage of PHCs was essentially limited to people living within a radius of about two miles. The government of India tried to address these problems by launching the community health volunteer scheme in 1977. However, these health workers could not meet the needs of rural populations that had increasingly begun to demand "proper medical care" characterized by access to "doctors" and "western medicines." Consequently, unqualified private providers found a niche market and began to provide these services demanded by the rural population. (Prakasamma, 1993)

The growth of informal private health providers in India, especially in rural areas is attributable to a complex set of factors such as the lack of alternative and affordable health services and the popularity of the care that they provide. Compared to their urban counterparts, rural populations in India have very limited choice in terms of health services. As the government health system in India is beset by problems of physical distance, long waiting times, unavailability of doctors, the rural private practitioner is by default, the de facto primary care provider.

Self Decision Making Problem among Tribals' Women

The study reveals that females enjoy a lot of autonomy pertaining to social issues. They take decisive role regarding visiting relatives and kin, whereas decision regarding to children's education were taken care of by their elder family members. The result is almost uniform in the entire study area i.e. in all three hamlets. The tribal societies traditionally give lot of autonomy to women in family related matters but cultural practices and reproductive and child health related decision is only taking by priest of the community and elder member of the family. These findings are similar to the finding of other studies (Soni & Jindal, 1983; Bala & Moonga, 2004). The important point arising from the finding was that females in the study area were not ignored in the decision making related to social aspects. The females take independent decision related to treatment of sick persons, visiting relatives and friends and daily cooking whereas elders and priests decision is taken for children care, maternal health related care.

Table 8 depicted that majority of the respondents (76.32 percent in Nakulnar, 79.11 percent in Potali and 82.19 percent in Sameli) amongst both literate and illiterate women do not take self decision regarding antenatal and delivery related care and practices. The overall finding shows that the tribal women have low decision making power at child and maternal health related issues because of superstitious believe among tribals' communities whereas they can take major decision at their household level. Their decisions are mostly affected by their education and employment status. It is ever seen that literate women have more decision making power than illiterate women.

Table 8: Opinion of Tribals Women Regarding Self Decision Towards Maternal health Care

Literacy Status of Women	Nakulnar (76)		Potali (67)		Sameli (73)	
	Yes	No	Yes	No	Yes	No
Illiterate	7 (9.21)	40 (52.64)	11 (16.41)	49 (73.14)	10 (13.70)	59 (80.82)
Literate	11 (14.47)	18 (23.68)	3 (4.48)	4 (5.97)	3 (4.11)	1 (1.37)
Total	18 (23.68)	58 (76.32)	14 (20.89)	53 (79.11)	13 (17.81)	60 (82.19)

Source: Primary Data

Superstitious Believe and Lack of Awareness about Diseases among Tribals

Lack of awareness and illiteracy generating superstitious believe among tribals about any kind of disease and also for maternal health problems. Majority of the respondents comes under highly administered that health problems, any kind of diseases and problems amongst pregnant women are the impact of evil spirit, Sin of Life, curse of deities and effect of witchcraft and it can be cured by only priest and local healers (Sirha/guniya).

Table 9: Believe about Diseases and Bad Health Status in the Study Villages

Status	Nakulnar (n=70)			Potali (n=70)			Sameli (n=70)		
	Low	Medium	High	Low	Medium	High	Low	Medium	High
Bad Health and Disease are curse of Deities	11 (15.71)	11 (15.71)	48 (68.57)	2 (2.86)	15 (21.42)	53 (75.71)	2 (2.86)	11 (15.71)	57 (81.42)
Believe on Evil Spirit	10 (14.28)	7 (10.00)	53 (75.71)	3 (4.28)	24 (34.28)	43 (61.42)	2 (2.86)	19 (27.14)	49 (70.00)
Believe that Disease and Relevant Problems are Sin of Life	10 (14.28)	13 (18.57)	47 (67.14)	3 (4.28)	9 (12.85)	58 (82.85)	3 (4.28)	7 (10.00)	60 (85.71)
Disease and Health related problems can be Cured by Worship	3 (4.28)	14 (20.00)	53 (75.71)	2 (2.86)	1 (1.43)	67 (95.71)	1 (1.43)	6 (8.57)	63 (90.00)
Village Priest have power to cure Disease	3 (4.28)	9 (12.85)	58 (82.85)	2 (2.86)	7 (10.00)	61 (87.14)	2 (2.86)	5 (7.14)	63 (90.00)
Disease is the effect of Witchcraft	5 (7.14)	16 (22.85)	49 (70.00)	2 (2.86)	6 (8.57)	62 (88.57)	2 (2.86)	9 (12.85)	59 (84.28)

Source: Primary Data

Believe in Local Healer/Sirha/Guniya

Traditional practitioners in Bastar treat diseases holistically. The all family members and even community are evolved in healing practices. Indeed the healer often plays a much wider social role than merely providing health care. So, we can say that the traditional healers are not only a medicine man while they are a religious consultant and adviser for all. In this sense traditional and modern health care workers are not directly comparable. Patients consult traditional healers for several reasons. First patients may feel more comfortable with local healers who are familiar with the socio-cultural context; second traditional health services are usually more ascendable than modern care. Moreover, according to them modern health care providers are often unsympathetic and unresponsive the concerns and need of patients, therefore they prefer to go to traditional healers.

Popularity and Impact of Untrained Private Practitioners

Unqualified private health providers are the primary sources of initial ambulatory care for the rural poor in India. In fact, they are often the first point of contact that the poor have with the health system. In four studies, rural private providers were found to be the mainstay of rural medical care, consulted first (and exclusively in most cases) for 60-80% of illness, especially for women and children. The existing network of rural practitioners is the de facto primary health care system of rural India (Rohde & Viswanathan, 1995).

Private providers have a comparative advantage because they are close to the community, both geographically, and socially. Private providers are also trusted by the community, so collaborating with them presents a unique opportunity to increase patient acceptance of care, such as family planning and reproductive health services. Past research has shown that clinic franchising programs that encourage providers to form ties with their local communities and promote family planning among existing clients may have better outcomes (Field Briefings, 1992; Foreit, 1998).

RECOMMENDATION

- In institutional level there is urgent need of female doctor in PHC level in tribals areas of Chhattisgarh.
- The status of infrastructure of Health institutions are not up to the mark so government should take proper management action to develop infrastructure health facilities like vehicles, operation theatre, labour room and a separate and hygiene women wing for delivery care.
- Illiteracy is the big factor of the failure of any government programmes among tribals' areas so awareness campaigning at grass root level because illiterate person cannot understand printed leaflet and any kind of advertisement. They can be awarded when the awareness tools will be include in their social cultural education because it is ever seen that formal education in not accepted by tribal but their social education like ghotul (among Maria tribe) is the part of their life.

- There is a need of strict rules for untrained private practitioners who are especially selecting illiterate areas to create their income web by exploiting simple tribals' people.

Apart from above recommendation if government promote and support cultural assumptions and values as well as patients expectation for institutional maternal health care by traditional method of treatment, will improve the acquiring rate of modern medicine facilities because the all traditional factors lend weigh to acknowledging the role and importance of traditional healer in tribal communities.

CONCLUSION

It can be conclude that modern institutional health facilities are still not prevalent among tribals in modern era because tribal groups are homogeneous, culturally firm, have developed strong magico-religious health care system and they wish to survive and live in their own style wherever Maternal and child health care practices were found to be largely neglected in tribal communities. Overall observation said, expectant mothers to a large extent were not inoculated against tetanus. From the inception of pregnancy to its termination, no specific nutritious diet was consumed by women. On the other hand, some pregnant tribal women reduced their food intake because of the fear of recurrent vomiting and also to ensure that the baby may remain small and the delivery may be easier. The consumption of iron, calcium and vitamins during pregnancy was poor. The habit of taking alcohol during pregnancy was found to be common among the tribal women of South Bastar and almost all of them continued their regular activities including hard labour even during advanced pregnancy. So there is a need of awareness and advocacy by local sirha/guniya for promoting to acquire modern maternal institutional health care facility.

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