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Maternal Health of Tribal Women in West Bengal, India: A Sociological Case Study

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Abstract:
This study investigates the intricate sociocultural, economic, and institutional elements influencing maternal health among tribal women in India, who constitute 8.6% of the country's population. In spite of numerous government initiatives, tribal populations continue to experience significant maternal health difficulties due to persistent poverty, restricted access to healthcare services, low educational attainment, and deeply entrenched patriarchal systems. Through participatory observation, structured surveys, and detailed interviews, the study documents the personal experiences of tribal women, concentrating on their health-seeking behaviors and the obstacles they encounter in accessing institutional care.

By utilizing case studies and applying sociological concepts—including Bourdieu's notion of cultural capital, Galtung's theory of structural violence, Foucault's idea of biopower, and Crenshaw's framework of intersectionality—the research investigates how systemic disparities influence women's health outcomes. The results show that inadequate education, premature marriages, gender-based discrimination, and insufficient healthcare infrastructure contribute to elevated rates of maternal mortality, undernutrition, and restricted reproductive rights. While initiatives like Janani Suraksha Yojana and ASHA worker programs have demonstrated some effectiveness, there remain significant deficiencies in implementation and distribution of resources.

The study underscores the importance of Accredited Social Health Activists (ASHAs) as crucial intermediaries, but points out that their influence is restricted without adequate structural support. It also critiques the gap between conventional childbirth methods and biomedical healthcare, advocating for healthcare models that are sensitive to cultural contexts. Ultimately, it posits that the maternal health inequities faced by tribal women are not simply medical problems but mirror wider social injustices. To tackle these issues, it is essential to implement integrated strategies that respect cultural practices while bolstering healthcare systems. This research enhances the understanding of how social factors influence maternal health and highlights the pressing need for policy reforms that are specifically designed for the distinct requirements of India's tribal populations.

Key Words: *Tribal Women, Maternal Health, Healthcare Access, Cultural Practices*

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I. INTRODUCTION

Approximately 104 million Indians are tribal, making up 8.6% of the country's overall population. Every Indian tribe is a member of a distinct sociocultural and linguistic group. They also differ in terms of economic, educational, cultural, and political development. Their cultures are not the same. Every kind of tribal person lives in a condition of absolute poverty. Additionally, they do not have enough or easy access to essential health services. As a result, compared to the non-tribal population, the overall health of the tribal community and the maternal health of tribal women are extremely poor. Therefore, the health of indigenous people, and especially tribal women, requires careful consideration and care (Kumar *et al.,* 2020).

The health of a country is a reflection of the health of its citizens. India is a developing country with low maternal health status and high rates of maternal death and morbidity. Given that childbirth is a vital aspect of human life, all women have the fundamental right to protection during this period **(**Bandyopadhyay, 2011).

However, policy makers, administrators and researchers have always considered maternal health in India to be a difficult issue. Complications and maternal mortality are common in India (NFHS, SRS, WHO). One reason for this is the underutilization of maternal health services, but maternal health culture is also lagging behind. This has been the subject of numerous studies, investigations and reports conducted across India. On the other hand, culture is a way of life; it regulates and directs the life of the community and provides a specific way of adopting and operating social institutions. Motherhood is an important social (and biological) event in society,

just like marriage, death, and festivals. It has a long history of cultural regulation, especially among tribal communities, and is an important demographic feature that provides evidence of the emergence of human society (Anil, 2025).

A woman's general health and her position in society are greatly influenced by her maternal health, which reflects both the biological demands of pregnancy and childbirth as well as the sociocultural factors that influence these experiences. Pregnant women in many poor countries face a variety of barriers due to a lack of support networks and quality healthcare, which are exacerbated by socioeconomic inequalities, cultural norms, and deeply held beliefs. The journey from conception to birth can be dangerous in circumstances where women are susceptible to difficulties and adverse outcomes, even though pregnancy is not an illness (Akram, 2014).

The sociological relevance of case studies on maternal health of tribal women is to illuminate how intersecting social factors influence health outcomes and access to care. These studies move beyond biology to analyze how social determinants such as poverty, cultural beliefs, geographic isolation, and systemic discrimination create and perpetuate health disparities.

Case studies are sociologically relevant because they provide rich, contextual information necessary to develop culturally sensitive and effective solutions. Insights from these studies can inform policymakers on how to design culturally appropriate health programs that meet the needs of specific communities rather than adopting a one-size-fits-all approach. Educating health professionals about the cultural nuances and challenges of tribal communities can increase respect and build trust, improving the quality and uptake of services. By revealing the root causes of health disparities, the case studies emphasize the need for broader interventions to address not just biological symptoms, but also the social, economic, and political factors that affect tribal women.

II. MATERIAL AND METHODS

Data was gathered through participatory observations and a maternal health questionnaire designed for tribal women, which included social demographic information such as age, marital status, tribal affiliation, monthly household income, education level, family structure, housing conditions, sources of drinking water, and dietary habits. This questionnaire was created after a thorough review of similar studies. Initially, the questionnaire was drafted in English and subsequently translated into the local language, Bengali.

Moreover, interviews were conducted with tribal women to allow them to express their concerns in their own words. The discussions were transcribed for documentation. This methodology allowed the researcher to connect intimately with the participants and capture direct narratives of customary practices. Significant case studies were created to highlight important elements of maternal healthcare, focusing on the lived experiences and cultural values of the community.

III. RESULTS AND DISCUSSION

This chapter outlines the theoretical framework used to explore the maternal health experiences of marginalized tribal women, illustrated by various case studies. A range of sociological frameworks that focus on issues of gendered discrimination, structural inequality, and government healthcare interventions are employed to contextualize this analysis. The chapter establishes a comprehensive structure to illustrate how overlapping social, economic, and institutional elements influence maternal health by discussing critical concepts such as Bourdieu's theory of capital, Galtung's notion of structural violence, feminist theories related to patriarchy and standpoint, Foucault's concept of biopower, Lipsky's theory of street-level bureaucracy, intersectionality, and Sen's capability approach.

Education, Cultural Capital, and Social Mobility

In the analyzed case studies, education consistently appears as a key factor impacting women's lifestyle. Due to academic failure, financial hardship, and insufficient family support, women such as Shibani and Kajol (Case study subject) abandoned their education prematurely, missing chances to elevate their social standing. This pattern of inequality can be understood through Pierre Bourdieu's idea of cultural capital, which suggests that education provides individuals with the symbolic power to navigate institutions and assert their rights, in addition to gaining knowledge (Bourdieu, 1986). Even when women like Pratima obtain an education, patriarchal barriers and a lack of resources restrict their ability to translate educational success into social or economic capital, thereby maintaining cycles of immobility. In the absence of such capital, marginalized women remain dependent on low-wage agricultural or migratory work.

In terms of health-seeking behaviours, women from Scheduled Tribes (ST) in India display notably lower literacy rates compared to the national average (Ministry of Tribal Affairs, 2014). According to NFHS-5 data (IIPS & ICF, 2021), ST women are less inclined to utilize institutional delivery and prenatal care services than other demographic groups. The WHO Commission on Social Determinants of Health (CSDH, 2008) identifies education as a vital structural factor impacting health, while the UNESCO Global Education Monitoring Report (2020) points out systemic obstacles to education for girls from minority backgrounds. These patterns are evident

in the high rates of early school dropout among indigenous girls globally. All of this information points to the local and global nature of educational exclusion among indigenous women, which affects their mobility, health, and life chances.

Poverty, Migration, and Structural Constraints

The stories highlight how poverty shapes maternal health outcomes as a systemic and persistent problem. In line with Johan Galtung's theory of structural violence, which holds that social structures systematically restrict access to resources required for survival and well-being, families frequently rely on daily wage labor, subsistence farming, or seasonal migration to brick kilns (Galtung, 1969). This violence is best illustrated by the cases' recorded newborn death, avoidable comorbidities, and maternal undernutrition. Economic survival takes precedence over women's reproductive work from a Marxist political economy standpoint. Migration, although a means of subsistence, frequently isolates women from local healthcare systems, increasing maternal fragility (Marx, 1867/1976; Mosse, 2018).

Scheduled Tribe (ST) women in India are substantially less literate than the national average when it comes to health-seeking habits (Ministry of Tribal Affairs, 2014). NFHS-5 figures show that ST women are less likely than other groups to seek prenatal care and institutional delivery services (IIPS & ICF, 2021). Education is a key structural determinant of health, according to the WHO Commission on Social Determinants of Health (CSDH, 2008), and systemic impediments to education for minority girls are highlighted in the UNESCO Global Education Monitoring Report (2020). The early school dropout rates among indigenous girls around the world are indicative of these tendencies. These statistics all demonstrate how indigenous women's educational marginalization affects their mobility, health, and life opportunities on a local and global level.

Patriarchy, Gender Norms, and Intra-household Inequality

In the case studies, patriarchal institutions have a major influence on maternal health outcomes. Women experience gendered hierarchies in food allocation, where women eat last, reproductive coercion, such as pressure to have male heirs, and mobility limits. These interactions are consistent with Sylvia Walby's theory of patriarchy, which sees domestic production as a primary site of women's subordination (Walby, 1990). From a women's perspective, undernutrition during pregnancy, resistance to institutional delivery, and limited autonomy in health decisions—all of which are often accepted in households—become apparent manifestations of structural inequality. This is another way that feminist standpoint theory illuminates how these women's everyday experiences highlight systemic gendered oppression (Harding, 1991).

In India, son preference and intra-household food inequities are well recognized to systemically affect maternal and child health (Das Gupta, 1987). Women in rural and ST homes generally do not have the power to make their own healthcare decisions, according to NFHS-5 statistics (IIPS & ICF, 2021). These patterns are seen globally: the UNICEF Gender Equality Report (2017) highlights discriminatory practices that hinder maternal nutrition and access to healthcare, while the UNFPA (2020) emphasizes that a lack of reproductive autonomy is a barrier to achieving SDG 5 (Gender Equality). When taken as a whole, these findings demonstrate that maternal health disparities are not just medical problems but also deeply rooted effects of patriarchal household practices and broader societal norms, both domestically and globally.

Maternal Health, Policy, and Institutional Barriers

The Indian government has introduced welfare initiatives such as the Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK) to promote institutional childbirths and reduce maternal mortality (MoHFW, 2011). However, women frequently face inconsistent availability of iron tablets and folic acid, refusals of hospital admissions, and inadequate ambulance services. Some women dealt with underweight pregnancies, high-risk deliveries or experienced child loss attributed to negligence and delays. Although initiatives like JSY, JSSK, and Bangla Matri are in place, many respondents report not receiving or inconsistently obtaining cash incentives, revealing a gap between the intended policy outcomes and actual implementation.

In this context, Michel Foucault's concept of biopower is particularly relevant as it highlights how the state attempts to regulate reproductive health through laws and conditional incentives (Foucault, 1978). Nonetheless, systemic inefficiencies and inadequate local implementation hinder marginalized tribal women from accessing their guaranteed entitlements, leading to an unequal exercise of biopower. As noted by Marmot (2005), the framework of health disparities illustrates that maternal health is influenced by factors such as geography, poverty, caste, and gender. The vulnerability of these groups is further exacerbated when institutional obstacles intersect with existing social disadvantages. Similar challenges are observed worldwide: the WHO's Trends in Maternal Mortality report (WHO, 2019) indicates that maternal health initiatives often fail to reach underserved populations, highlighting the necessity for state involvement in global reproductive health efforts.

To realize fair maternal health results, the experiences of Shibani (Case study subject) and other tribal women highlight not only local institutional limitations but also broader global governance challenges.

ASHA Workers as Mediators of Change

Accredited Social Health Activists (ASHAs) play a crucial role in facilitating communication between state healthcare systems and marginalized families in all instances. Michael Lipsky's concept of street-level bureaucracy, where frontline workers adjust state policies to fit local contexts, is illustrated by their involvement in promoting hospital births, providing nutritional guidance, coordinating ambulance services, and informing families about welfare benefits—often facing resistance, disrespect, or skepticism from family members. Research from India indicates that ASHAs have significantly boosted the rates of institutional births and prenatal care utilization (Scott and Shanker, 2010). Nevertheless, their effectiveness is hampered by systemic issues such as inconsistent incentives, inadequate training, limited authority, and insufficient resources (Nandi & Schneider, 2014).

ASHAs serve as brokers of social capital, linking families to institutional networks, and often provide the only means for women in tribal areas to access formal healthcare services (Putnam, 2000). Community health worker programs worldwide display comparable trends: they play a crucial role in addressing disparities in maternal and child health (UNICEF, 2019) and achieving universal health coverage (WHO, 2018), yet their effectiveness remains fragile without adequate structural support. Therefore, the crucial role of ASHAs highlights the limitations of relying solely on individual actors to bridge systemic gaps in healthcare accessibility, as well as the transformative potential of health interventions rooted in the community.

Health, Nutrition, and Structural Violence

The vulnerabilities faced by tribal women are intensified by recurring issues highlighted in the examples, including maternal undernutrition, a lack of nutrient-rich foods, and biases in food distribution within households. To understand how factors like caste (tribal identity), class (poverty), and gender (patriarchal structures) intertwine to produce complex forms of disadvantage, the concept of intersectionality serves as a valuable framework (Crenshaw, 1989). These health disparities arise from intersecting social marginalizations rather than existing along a single dimension of oppression. Simultaneously, Amartya Sen's capabilities approach emphasizes the importance of assessing health outcomes through the lens of well-being and the achievement of substantive freedoms (Sen, 1999). Beyond simply reflecting a lack of resources, barriers to institutional care, transportation, and nutritional access also deny women of their ability to live healthy and dignified lives.

Although evaluations of government nutrition initiatives like ICDS reveal persistent service shortcomings in remote and tribal regions (NITI Aayog, 2015), NFHS-5 data shows that tribal women in India experience some of the highest rates of anemia and maternal mortality (IIPS & ICF, 2021). The conceptual framework on malnutrition by UNICEF/WHO links insufficient access to food, healthcare, and social protections to long-term maternal health challenges (UNICEF/WHO, 2017), aligning with the elevated incidence of anemia and underweight pregnancies faced by women in marginalized communities globally (Global Nutrition Report, 2021). Shibani's (Case study subject) situation exemplifies how systemic economic deprivation and prevailing patriarchal standards intersect to restrict women's agency and potential.

IV. CONCLUSION

The profile of the respondents illustrates their dire situation, particularly linked to their economic conditions, levels of poverty, cultural context, and the challenges related to motherhood they currently face. Most respondents lack basic household amenities and live beneath the poverty threshold. The mean age for first-time pregnancies is 18 years, while the average marriage age is 17.4 years. The community generally encourages pregnancy within the first year of marriage. This research also underscores the significant influence of traditional midwives, dietary practices, and spiritual ceremonies, revealing the intricate interplay of cultural traditions and beliefs surrounding pregnancy and childbirth. While these customs hold substantial cultural significance, they often clash with modern medical practices, potentially endangering the health of both mothers and infants. To ensure safer delivery experiences, maintain cultural identity, and safeguard the health of both mother and child, it is essential to bridge the gap between traditional practices and medical knowledge. A collaborative approach can harness the benefits of modern healthcare advancements while honoring these customs. This comprehensive approach highlights that maternal health in marginalized tribal communities is a social issue rooted in institutional failures, structural poverty, and patriarchal oppression rather than solely a biological concern. Although community health professionals embody the transformative potential of welfare-state initiatives, systemic disparities continue to constrain women's health outcomes.

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