



Maternal Health in Tribal Areas: An Advocacy Dialogue
**Organized by National Alliance for Maternal Health and Human
Rights, India**
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Call to Action

Maternal mortality continues to be a serious health challenge for India despite its ambitious programs to incentivize institutional deliveries, strengthen health systems, remove financial barriers and implement regular tracking systems in high-focus states. The data on maternal mortality reflects the gender and other social biases against women who seek care. Data from the third National Family Health Survey shows that the all-India average of women delivering with a skilled attendant during childbirth is 46.6% but in comparison the figure for tribal women is 25.4% (NFHS-3 of 2005-06). According to UNICEF (MAPEDIR 2009), although they may make-up a small part of the general population, tribal communities had a disproportionately large proportion of maternal deaths.

The National Advocacy Dialogue on ‘Maternal Health in Tribal Areas’ held on 20th-21st August in New Delhi brought together 70 civil society activists, NGO representatives, researchers, media persons, health practitioners working with tribal communities from 11 states of India, as well as 15 key officials including three Members of Parliament, representatives from the Ministry of Health and Family Welfare (MoHFW), Government of India and the MoHFW Committee on Tribal Health.

The presentations, sharing of experiences and discussions on the first day of the dialogue highlighted that:

- a) The exclusion and marginalization of tribal communities is not limited to geographical isolation but a host of other factors. Their context is of economic marginalization usually through poorly paid informal labour in hazardous occupations, leading to poverty, hunger and extreme deprivation. Though the recent ‘Reproductive, Maternal, Newborn and Child Health Approach’ (RMNCHA, MoHFW 2014) did recognize specific vulnerability of communities in ‘hard-to-reach areas’ due to geographical isolation, policies also need to address the marginalization owing to political, social and economic factors that are contributing to tribal deprivation.
- b) Studies show that tribal communities experience social exclusion and alienation from the health system. However, despite this, where health services are of good quality and sensitive to their needs, the usage of the formal health system has increased as

much as five fold, which indicates that tribal communities are not averse to utilizing modern medicine. In areas where tribal groups have actively participated in community-based monitoring of health services, their participation has actually brought them closer to the health system.

- c) Tribal blocks are severely under-served in terms of health infrastructure and workforce, since skilled health workers are often unwilling to move into tribal areas, and quality of services continues to be a concern. The ill-equipped public health system and weak referral linkage often compels these poor families to seek care at the private sector. The unregulated private sector tends to be extremely exploitative (both in terms of irrational procedures, coercion and high out of pocket expenses).
- d) On the other hand, although home births are common among tribal communities, they are being overlooked by the health system with no provisions for ensuring women's safety.
- e) The high prevalence of anaemia (nutritional as well as sickle cell anaemia), malaria (especially falciparum malaria) and malnutrition in tribal communities contributes to the risk of bleeding to death with an obstetric complication. With blood transfusion not easily available in rural areas this becomes a major cause of death.
- f) Regarding budgetary resources, data shows that the emphasis on demand-side financing (JSY) has starved the health system of resources needed for strengthening services. In addition, the potential of the Tribal-Sub Plan approach to budgeting has not been effectively utilized.
- g) Some tribal communities have a very sophisticated system of healing and traditional practices for maternal health, several of which are beneficial to women. These have not sufficiently been documented or acknowledged by the formal health system, nor included within AYUSH.

Recognizing that the Xaxa committee report has highlighted the poor access of tribal communities to maternal health services, we, the civil society participants from 30 organisations and 11 states of India would like to make the following four key recommendations for improving maternal health in tribal areas:

- A. Strengthen health systems, including deployment of skilled human resources and availability of EmoC services**
- B. Ensure rigorous planning and monitoring with participation of local communities**
- C. Address Social Determinants of Maternal Health among Tribal Communities**
- D. Integrate those tribal health practices that have been found to be beneficial**

We strongly recommend that the **Tribal Sub-Plan component** of Ministry budgets be directed towards projects that draw from the following recommendations.

A. Strengthen health systems, including deployment of skilled human resources and availability of EmoC services:

Maternal health services should be embedded in the provision for the full range of comprehensive primary and secondary health care available very close to the community. The full package of such services must be carefully documented, made known and legislated to make it a justiciable right of the tribal people.

Basic standards of quality health care services must be ensured in tribal areas with adequate monitoring. All facilities must have clean labour rooms, availability of water and functioning toilets, ability to handle deliveries, provide emergency obstetric care – based on the level of facility.

1. Deployment of Skilled Human Resources

- a) Mapping of health facilities in tribal areas must be carried out to identify the closest facility which is easily accessible based on geographical conditions (specifically in hard-to-reach areas). These facilities like health sub-centers, PHCs, or satellite centers, should be made functional on a priority basis as Level 1 Delivery Points to manage normal delivery with necessary backup of referral transport facilities and essential medicines.
- b) Given the cultural and geographical context of most tribal areas in the country, a special Action Plan also needs to be made to ensure safe home births where skilled birth attendants are available to manage normal deliveries and identify complications in the community.
- c) Skilled workforce must be stationed in these accessible service delivery points and the health workers stationed must be able to manage normal delivery and identify complications. They need to be backed up by essential medicines and telecommunications with higher referral centers, responsive consultation and possibility of referral, and constant refresher trainings. Use of Misoprostol or Oxytocin must be part of the kit given to the frontline workers (SBAs and ANMs) to help Active Management of Third Stage of Labour and reduce Post-partum Haemorrhage.
- d) In order to reduce the alienation and enhance communication with the tribal communities, facilitate local ownership, and promote staff retention, tribal youth must be trained and recruited into the health workforce. Proactive efforts (scholarships and other opportunities) are needed to enhance the skills of local

communities so that they are available to provide services. Additionally, women from tribal communities should be locally recruited as ANMs and ASHAs. Sensitization of all health care providers to specific concerns of tribal communities, their health and culture should be integrated into health worker curriculum. Beneficial health practices from traditional practices must be documented and integrated into the training curriculum of these health workers.

2. Ensure availability and accessibility of EmOC

- a) Specialists must be recruited and designated FRUs must be urgently operationalized in underserved areas to be able to respond to emergency obstetric complications as per standard protocols. Since specialists are required for managing emergency care, graduates of government medical colleges must be provided incentives¹ to work in underserved areas, using a hub-and-spoke model. Training of doctors on CEmOC and LSAS and posting them in tribal areas will ensure continuum of care and prevention of leakage into the private health sector.
- b) In addition, AYUSH medical officers may be trained in conducting normal deliveries and in identifying complications, while MBBS doctors may be allowed to perform C sections or to give anaesthesia for emergency LSCS after completing special training courses. Training on BEmOC is especially needed for MOs at 24x7 PHCs.
- c) Blood transfusion services which are a critical life-saving component must be immediately instituted in the District Hospital and FRUs. Information on the availability and use (number of units of blood) of the Blood Banks/Blood Storage centres must be uploaded on websites at least monthly. Unbanked Blood Transfusion must be decriminalized and legalised with appropriate regulation in order to ease access to blood in case of emergencies.
- d) Because sickle cell anaemia as well as falciparum malaria are highly prevalent in tribal communities, it is imperative that women be screened for sickle cell anaemia and malaria be identified in the antenatal period. For malaria, appropriate treatment must be provided as per standard treatment guidelines. For sickle cell anaemia, treatment should be provided as per standard protocols along with regular follow up, counselling, and screening of the entire family. In addition to this, TB and silicosis have also been reported as occupational hazards among communities working in stone quarries. Similarly many tribal women are agricultural and forest workers and are susceptible to snake/rodent bites.

¹ The govt can sponsor postgraduate training in Family Medicine for their existing graduate medical officers

Provisions must be made to address these in terms of preventive measures as well as treatment.

- e) Free and reliable transport should be made available. Various models of decentralised transport system need to be deployed based on the context. The state supported vehicles need to be available at a central, easily accessible point, in order to save time. In case of complications in home births, sufficient back up must be provided to reach an appropriate FRU for management of the complication. Similarly intelligent inter facility transfer needs to be established so that a woman with an obstetric complication directly reaches the appropriate hospital rather than be shifted from one hospital to other.
- f) The Mother and Child Tracking system needs to be made more foolproof so that record of each mother is readily available to entire chain of providers at different levels.
- g) Looking at the geographical conditions for safety of women during their ante and post natal period each EmOC center should be provided with resource support for “MamtaGhar” waiting room/ transit home for pregnant women. In places where such a facility exists, more effort must be put into informing communities about its purpose, provisions and advantages, thereby facilitating utilization.
- h) There should be a Patient Help desk at EmOC centers which displays prominent information and is, staffed by those who can speak the local language (perhaps a social worker).
- i) The above mentioned services must be strengthened within the public health system as far as possible. If services are outsourced in the spirit of public-private partnership, not-for-profit/charitable hospitals need to be involved as opposed to for-profit private providers

B. Rigorous planning and monitoring with participation of local communities:

- a) Seeing that there are location-specific and community-specific issues for tribal populations as well as a strong influence of the social determinations of health, we recommend that planning be decentralised to the greatest extent possible and budgets be made flexible to respond to local needs, preferably with involvement of mass-based organizations of the poor, who best represent the interests of local tribal communities.
- b) CBOs can be involved in massive public education programmes so that tribal communities are aware of their entitlements from state services.

- c) Local community-based organizations (CBOs) including women's groups should be actively involved in the need identification, problem prioritisation, planning and community-based monitoring of health interventions. Regular periodic meetings between the Medical Officer In-charge with local women's organizations, especially to discuss grievances of tribal users, cases of adverse outcomes and maternal deaths. This will help to build communication and trust between the providers and community, and complete the accountability loop.
- d) Reports of the meetings of the Maternal Death Review Committees, including the analysis of maternal deaths as well as action taken reports, must be made public.
- e) Women's group leaders and local elected leaders of tribal communities should be involved on the hospital management Committees (like the Rogi Kalyan Samitis).
- f) In order to identify underserved areas requiring greater attention, all data must be disaggregated by social characteristics. This will help to ascertain which communities/areas are being neglected and allow special mechanisms to be put in place for addressing their specific problems.

C. Address Social Determinants of Maternal Health among Tribal Communities:

A holistic approach to addressing maternal health in tribal areas requires that a range of issues that affect the lives of tribal communities be addressed as well. Different departments must work in convergence at all levels, so that efforts complement each other. We recommend:

- a) Implementation of various laws and schemes apart from just those of the health department – eg. Panchayat (Extension to Schedule Areas) Act, 1996 and Forest Rights Act, 2006 - are required in order to truly address this very complex problem. In order to allow tribal communities to avail of their entitlements, tribes who have not been listed must be included.
- b) Poverty and chronic hunger can be addressed by having a robust social and food security system in place. There needs to be automatic inclusion of tribal, PVTGs in all food, health and social security schemes that would provide a safety net, as most of them are unorganised sector workers with no wage and insurance safety.
- c) In addition to the cereal based PDS we strongly recommend inclusion of nutrient rich traditional crops such as eggs, oil, local millets (such as jowar, bajra, ragi) along with pulses, to fill the nutrition gap. Emphasis should be on preserving biodiversity and local procurement, which could enhance livelihoods for local communities.

- d) While it is imperative to focus on prevention of malnutrition, and increasing food security rather than medicalising malnutrition, treatment for severe malnutrition must be made readily available when required. To this end, Nutritional Rehabilitation Centres must be strengthened on priority basis in tribal blocks.
- e) Immediate implementation of the maternity benefits on priority basis for tribal communities as universal and unconditional entitlements, as well as implementation of all other provisions of the NFSA 2014. Maternal and child health care services at every worksite would contribute in reducing emergencies among pregnant women and infants.

D. Integrate those tribal health practices that have been found to be beneficial

Local tribal maternal health practices need to be recognized in keeping with the U.N. declaration on the Rights of Indigenous Peoples (UNDRIP) 2007. They must be studied and integrated into both provider training and practice.

- a) There is a need to document traditional folk medicine, diet and midwifery practices in different communities. There must be more studies of ethno-medicine practices with subsequent recognition of practitioners. Integration of well established Tribal/Ethno Medicine disciplines into AYUSH must be considered.
- b) Protecting and encouraging consumption of edible leaves, flowers, roots, stems which provide iron, calcium, protein, through promoting home herbal gardens and community herbal gardens, where they are easily accessible.
- c) Different tribal areas and their health problems should be studied (within tribal belts of India) while also trying to understand the underlying reasons, and investigate what health services are acceptable for different tribal groups.
- d) Recognizing beneficial/more acceptable practices (such as birthing positions, presence of a birth companion, traditional diets) related to maternal health and incorporation of the same into training of providers as well as integration into formal health service delivery.

Endotes

i A 'hub and spoke' model has the doctors and specialists based at a central point such as a CHC where EmOC is available, but they fan out every day by rotation into the peripheral health centres and ensure that skilled care is also available there. By staying together most of the time at the 'hub', the isolation and loss of motivation of these highly educated and skilled personnel can be avoided. There needs to be excellent communications and transport facilities to ensure mobility of the doctors to the centre where they are needed most. At peripheral centres, there should be an SBA, a Pharmacist and at least an AYUSH doctor with telemedicine back-up for diagnostic and telecom and transport back-up for referral.