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TRIBAL MATERNAL MORTALITY AND SAFE MOTHERHOOD PROGRAMME IN INDIA

SNIGDHA SAMADARSANI
Ph.D Scholar in the Sociology Department, Central University of Orissa, Koraput,
Email: snigdha25aug@gmail.com
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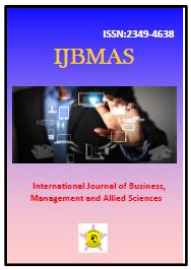

ABSTRACT
Mortality refers to the state or condition of being subject to death or the relative frequency of deaths in a specific population. Maternal mortality is the death among women aged between 15-49 years while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes per 100 000 live births. The maternal mortality represents the risk associated with each pregnancy, i.e. the obstetric risk. It is also a Millennium Development Goals (MDG) indicator. It has shown a decline from 212 in 2007-09 to 178 in 2010-12 and in Odisha it decline from 258 in 2007-09 to 235 in 2010-12, as per Sample Registrar Survey of India. Maternal mortality was reported to be high among various tribal groups but no exact data could be collected. They are strong faith in culture, custom, depend on traditional methods and prefer to give birth at home rather than any health centre. The paper is based on secondary source of data, design by both qualitative and quantitative data. The main objective of this paper is to find out the causes behind the high tribal maternal mortality and secondly to discussed Government Safe Motherhood Programme in India. The study found that early marriage, spacing between two pregnancies, primitive and unhygienic practices for parturition, anaemia, partum haemorrhage, septic abortion, rupture uterus, high birth rate, less consumption of iron, vitamin and calcium, taking alcohol, hard physical work etc. are the main causes of tribal maternal mortality. Some important Government Program for Safe Motherhood in order to reduce maternal and infant mortality are Reproductive and Child Health (1994), Janani Suraksha Yojana/ NRHM (2005) , Janani Express Yojana(2006), Yoshoda Scheme (2008), Janani Shishu Suraksha Karyakarma (2011), White Ribbon Alliance (2012), Mamata Scheme (2012). The paper concluded that safe motherhood programme should work properly and reach properly in the tribal areas in order to reduce maternal mortality.
Key words- Maternal Mortality, Tribal, Safe Motherhood Programme, India

Introduction

Mortality refers to the state or condition of being subject to death or the relative frequency of deaths in a specific population. Maternal mortality is the death among women aged between 15-49 years while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes per 100 000 live births. The maternal mortality represents the risk associated with each pregnancy, i.e the obstetric risk. It is also a Millennium Development Goals (MDG) indicator. It has shown a decline from 212 in 2007-09 to 178 in 2010-12 and in Odisha it decline from 258 in 2007-09 to 235 in 2010-12 as per Sample Registrar Survey of India. Maternal mortality was reported to be high among various tribal groups but no exact data could be collected. They are strong faith in culture, custom, depend on traditional methods and prefer to give birth at home rather than any health centre.

Review of Literature

Chauhan, et.al (2011) conducted a study on **"Rural Epistemology of Maternal Mortality in Tribal Women from Bastar, Chhattisgarh, India".** They found that majority maternal mortality was noted in the age group between 19-35 years. Maximum number of patient had a low education status and among them majority are engaged as a labourer than farmers with street beggar. Majority of them belong to the lower socio- economic status. They also found that chief causes of maternal mortality were found to be unhygienic and primitive practices for parturition, taking alcohol during pregnancy, no specific nutritious diet is consumed, continuing their regular activities and also a majority deliveries are conducted at home attended by elderly ladies of the household.

Chauhan, et.al (201) conducted a study **"Maternal Mortality among Tribal Women at a Tertiary Level of Care in Bastar, Chhattisgarh". They found that main cause** tribal maternal mortality also occurred due to reduced their food intake because of simple fear of recurrent vomiting and also to ensure that the baby remain small and delivery may be easier. The consumption of iron, calcium and vitamins during pregnancy is poor. The habit of taking alcohol during pregnancy has been found to be usual in tribal women and almost all of them are observed to continue their regular activities including strenuous physical work during advance pregnancy. They preferred to give birth at home rather than any health centre. No specific precautions are observed at the time of conducting deliveries which resulted in an increased susceptibility to various infections. Services of paramedical staff are secured only in difficult labour cases.

Methodology

The paper is based on secondary source of data, design by both qualitative and quantitative data. The main objective of this paper is to find out the causes behind the high tribal maternal mortality and secondly to discussed Government Safe Motherhood Programme in India.

Results and Discussion

Classification of Maternal Mortality

There are four types of maternal mortality discussed below

a) **Direct Obstetric Deaths:** Those resulting from obstetric complications of the pregnancy state (pregnancy, labour and the puerperium) from intervention, omissions, incorrect treatment or from a chain of events resulting from any of the above.

b) **Indirect Obstetric Deaths:** Those resulting from previous existing disease or disease that developed during pregnancy and which was aggravated by physiologic effects of pregnancy.

c) **Coincidental Maternal Mortality:** Deaths from unrelated causes which happens to occur in pregnancy or the puerperium.

d) **Late Maternal Death:** Women from direct and indirect obstetric causes, more than 42 days but less than 1 year after termination of pregnancy.

Causes of Tribal Maternal Mortality

Marriage Practices: Endogamy (marriage within the group of birth), Exogamy (outside the own group) and Consanguineous marriage practices are present in India. Consanguineous marriage is a marriage between individual who are same kinship or closely related to each other. Among the tribal this type of marriage found higher than the other (Vidyarthi, L.P &Rai, B.K.,1977). It is also resulted abortion, still births, miscarriage, neo natal death, infant and juvenile death, physical and mental imperfection. They also preferred and practices cross cousin marriage. This type of marriage avoid bride price and females are well treated in their in- laws house. **Early Age of Marriage and Pregnancy:** In tribal area after puberty girl get married as per social value. Among them virginity of a girl or boy was not important. They are permitted to pre-marital sex relation because it is a training act of love and sex life; and often ended in marriage. Due to early marriage girl is not suitable enough physically and mentally to become pregnant. So, young mother faces miscarriages, abortions and still births; and also suffer from high blood pressure, difficulty in delivery and anaemia. (Basu,1994). **Ante- Partum Haemorrhage:** In tribal area the scope of diagnose placenta prevail is limited. Even many mothers do not take vaginal bleeding during pregnancy seriously. This can lead to huge blood loss and death. **Eclampsia:** Generally tribal mother are not regularly coming to antenatal clinic, often have undiagnosed hypertension or pre- eclampsia. Suddenly eclampsia may cause tribal maternal mortality. **Post-Partum Haemorrhage (PPH):** Post-Partum Haemorrhage **(**PPH) mainly occurs in home delivery or delivery by untrained birth attendant and the main causes are uterine agony and retained placenta. Tribal women are more preferred to home delivery than institutional deliveries, so they face PPH. **Septic Abortion:** It occurred mainly due to unwanted pregnancy or use of female feticide mainly by untrained person. Some septic abortion may be result of domestic violence, unhygienic and primitive practices for parturition among tribal women. **Anaemia:** Tribal women are more suffer from anaemia. So, severe anaemia can cause death particularly when other complications are also there among tribal pregnant women. **Rupture Uterus:** It occurs may be due to post caesarean section pregnancy among tribal women. **High Birth Rate and Fewer Gaps between Pregnancies:** Birth rate among tribal areas is very high and there are very less gap between the two pregnancies. This may lead to low birth weight of newborn and also high rate of prenatal, neonatal, infant mortality and maternal mortality occurred.

Besides the above causes tribal maternal mortality also occurred due to reduced their food intake because of simple fear of recurrent vomiting and also to ensure that the baby remain small and delivery may be easier. The consumption of iron, calcium and vitamins during pregnancy is poor. The habit of taking alcohol during pregnancy has been found to be usual in tribal women and almost all of them are observed to continue their regular activities including strenuous physical work during advance pregnancy.

Safe Motherhood Programme in India

Safe motherhood refers to a women's ability to have a safe and healthy pregnancy and delivery. The goal of safe motherhood is to ensure that every woman has access to a full range of high quality, affordable sexual and reproductive health services especially maternal care and treatment of obstetric emergencies to reduce deaths and disabilities.

11th April, which is the birth anniversary of Smt. Kasturaba Gandhi, is being celebrated every year as National Safe Motherhood Day from 2003 onwards.

The key interventions included safe motherhood program were immunization for pregnant woman, prevention and treatment of anaemia, antenatal care and early identification of maternal complication, delivery by skilled personnel, promotion of institution delivery, management of obstetric emergencies and Birth spacing.

There are also many schemes and programs are lunched to reduce and control the maternal mortality rate and also improve the standard of maternal health. Some important Government Program for Safe Motherhood in order to reduce maternal and infant mortality are Reproductive and Child Health (1994), Janani Suraksha Yojana/ NRHM (2005) , Janani Express Yojana(2006), Yoshoda Scheme (2008), Janani Shishu Suraksha Karyakarma (2011), White Ribbon Alliance (2012), Mamata Scheme (2012).

a) Reproductive and Child Health (1994)

Reproductive Child Health program was launched in 1994. The RCH are two phases, RCH- 1 in 1997 and RCH-2 in 2007. Main aim of this programme is to treatment women reproductive tract infections (RTIs)/sexually transmitted diseases (STDs), establishment of blood-storage units, referral transport, and access to safe abortion. To provides skilled attendant for birth care.The RCH program incorporated additional nursing staff for the PHCs for round-the-clock maternal health services and staff incentives for night-time institutional deliveries. All these new efforts were added without increasing human resources in management at the central or lower levels.

b) JananiSurakshaYojana/ NRHM (2005)

In 2005, the Government of India's Ministry of Health and Family Welfare (MOHFW) launched the National Rural Health Mission (NRHM) with a strong commitment to reduce maternal and infant mortality. It provides universal access to public health services, prevent and control communicable and non communicable diseases. It also ensures population stabilization, maintain gender balance and revitalize local health traditions.

A core feature of the NRHM is Janani Suraksha Yojana (JSY) - (In Hindi Language; Janani = Mother, Suraksha =Protection, Yojana. The main objective of the JSY is to reduce maternal and neo-natal mortality. It tries to achieve this by promoting institutional delivery, making available quality maternal care during pregnancy, delivery and in the immediate post-delivery period along with appropriate referral and transport assistance. The scheme is sponsored fully by the Central government. The JSY is a conditional cash transfer scheme a woman is paid money if she delivers her baby in a medical facility in government health centres, like sub centres (SCs), Primary Health Centres (PHCs), Community Health Centres (CHCs) or general wards of district or state hospitals, government medical colleges or accredited private institutions. In JSY, ASHA (Accredited Social Health Activist) plays an important role to promote institutional delivery in rural and tribal areas.

c) Janani Express Yojana(2006)

The Janani Express Yojana is providing emergency transportation facility to expectant mothers, sick infants and BPL families in rural areasso, as to enable them to avail adequate healthcare facilities on time. The infant and maternal mortality rate in Madhya Pradesh (M.P), Orissa have been amongst the highest in the country as a result of which schemes like the JananiSurakshaYojana (JSY) for promoting safe institutional deliveries acquire utmost importance. For JSY to produce results, it has to be accompanied by various supporting factors primary among which is an adequate referral transport service which can transfer expectant women to a medical facility on time. Recognizing the importance of such a transport service, the Government of Madhya Pradesh, Orissa , have launched the Janani Express Yojana (JEY).

Under JEY, pregnant women, sick infants and BPL families can call a call centre and request for a vehicle to take them to the hospital at crucial emergency moments and drop them home after

treatment. Call centre operators forward patients requests for transport to the drivers of ambulances that are usually stationed at government hospitals, community health centers (CHCs) and primary health centers (PHCs). The drivers then ensure that patients are transported to the nearest medical facility on time.

Operational since 2006, JEY has significantly increased the rate of institutional delivery in M.P, Orissa, Rajastan by providing transport services to expectant mothers and ensuring that they are given adequate care on time. A primary reason for JEY's success is a tight monitoring mechanism through an offline software that stores all the details of beneficiaries like name, address, village, time of call, arrival time of ambulance, response time etc. The maintenance of such a robust database makes drivers and call centre operators perform their responsibilities without any delay. The existence of such data also ensures that periodic reports can be sent to higher officials for their review and monitoring. Very soon, the offline software will be converted into a real time online monitoring system which will facilitate regular monitoring by district and state officials.

d) Yoshoda Scheme (2008)

The scheme was launched in the country after success of "JSY" with an objective to bring a change in the post natal care. Under this,yosoda would stay in hospital for 48 hours and take care of new born child and also look after the mother. The Orissa Government implement 'Yashoda' scheme for taking care of newborn babies across nine districts in the State. According to a statement released by the State Health Department, it was launched in Sambalpur, Angul and Jharsuguda district. While 12 Yashodas were appointed in each of the district headquarter hospitals of Sambalpur and Angul, nine were absorbed in Jharsuguda district hospital. Other districts, which will be covered, are Balasore, Keonjhar, Koraput, Rayagada, Malkanagiri and Kalahandi.

e) Janani Shishu Suraksha Karyakarma (2011)

The UPA Chairperson Smt Sonia Gandhi on 01.06.2011 launched the national initiative of Ministry of Health and Family Welfare, Government of India, the Janani Shishu Suraksha Karyakram (JSSK). Smt Gandhi noted that tremendous improvement in health care services has occurred under the initiative of National Rural Health Mission started since 2005 and the new initiative of Janani Shishu Suraksha Karyakram is but a step further in ensuring better facilities for women and child health services and every needy pregnant woman coming to government institutional facility. The new initiative of JSSK would provide completely free and cashless services (free Provision of Blood, Free Transport from Home to Health Institutions, Free Transport between facilities in case of referral as also Drop Back from Institutions to home after 48hrs stay) to pregnant women including normal deliveries and caesarean operations and sick new born up to 30 days after birth in Government health institutions in both rural and urban areas. JSSK supplements the cash assistance given to a pregnant woman under Janani Suraksha Yojana and is aimed at mitigating the burden of out of pocket expenses incurred by pregnant women and sick newborns.

f) White Ribbon Alliance (2012)

India has been working to facilitate policy review and is advocating for a comprehensive national safe motherhood policy at the national and state level. The alliance aims to scale up social accountability, track resource utilization against allocation, and standardize maternal health information kits. Surviving childbirth is a fundamental right of every woman. On 26th March, 2012, the White Ribbon Alliance for Safe Motherhood of India, held a special concert to increase public awareness on the need to prevent maternal death, where nationally renowned musician ShubhaMudgal released a song dedicated to Safe Motherhood.

g) Mamata Scheme (2012)

Taking a leaf out of the Muthulakshmi Reddy Memorial Maternity Assistance scheme of Tamil Nadu government, Orissa would launch a maternal benefit scheme from September, 2012 in which over 7 lakh rural women would get financial assistance before and after childbirth. Chief minister Naveen Patnaik,undertook a reviewed meeting of the development of women and child.The program called "Mamta" in Odisha would provide Rs.5,000 to each rural women to enable the pregnant and lactating women to have nutritious food as well as compensate the wage loss owing to their inability to work during the period of pregnancy. But unlike the Tamil Nadu scheme, the Orissa scheme is fairly liberal and open to women irrespective of their APL and BPL status. However, women government employees have been excluded from the scheme. Although India has a Maternity Benefit Act, in reality most Indian women do not get any maternity benefits as the legislation does not apply to the unorganized sector. The majority of working women in the country work until the last stages of pregnancy and get back to work soon after delivery to avoid loss of wages. The money will be given in four instalments and will have to be used strictly for the mother's antenatal care and the baby's immunization with focus on Measles vaccination of the child. The first instalment of Rs 1500 will be given after six months of pregnancy with registration and vaccination in an Anganwadi centre. The second instalment of Rs 1500 will be paid when the new born is 3 months old with registration and appropriate vaccination of the child. The 3rd and 4th instalment of Rs 1000 each will be availed when the baby is six and nine months old with appropriate vaccination and new born care. This scheme will be applicable for the first two pregnancies. According to the scheme Rs 5000 will be given to each pregnant woman in four instalments.

Conclusion

The study found that early marriage, spacing between two pregnancies, primitive and unhygienic practices for parturition, anaemia, partum haemorrhage, septic abortion, rupture uterus, high birth rate, less consumption of iron, vitamin and calcium, taking alcohol, hard physical work etc. are the main causes of tribal maternal mortality. Some important Government Program for Safe Motherhood in order to reduce maternal and infant mortality. These programme major factor in enhancing access to public health institutions and help bring down the Maternal Mortality and Infant mortality rates. Presently it is noted that, out of pocket expenses and user charges for transport, admission, diagnostic tests, medicines and consumables, caesarean operation are being incurred by pregnant women and their families even in the case of institutional deliveries. The paper concluded that safe motherhood programme should work properly and reach properly in the tribal areas in order to reduce maternal mortality.

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