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DETERMINANTS OF HEALTH STATUS AND HEALTHCARE-SEEKING BEHAVIOUR AMONG TRIBAL WOMEN IN ANDHRA PRADESH: A CRITICAL ANALYSIS

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Abstract

Tribal populations in India, particularly Scheduled Tribes (STs), face distinct multi-layered vulnerabilities due to geographic isolation, socio-economic marginalization, and strong adherence to traditional beliefs. Among these communities, tribal women experience a pronounced "triple burden" of disease, compounded by gender disparities and unique reproductive health challenges. This paper investigates the primary health determinants, maternal mortality trends, and healthcare-seeking behaviours among tribal women in Andhra Pradesh—specifically focusing on newly formed ITDA (Integrated Tribal Development Agency) regions like Alluri Sitarama Raju (ASR) and Parvathipuram Manyam districts. Despite Andhra Pradesh tracking significantly better than the national average in overall Maternal Mortality Ratio (MMR), a recent upward tick highlights persistent structural barriers in remote habitations. This study outlines critical interventions, localized government strategies, and policy recommendations to bridge the equity gap.

Keywords : Health , Healthcare, Behaviour , Tribal, Women ,Andhra Pradesh

1. Introduction

The state of Andhra Pradesh is home to a diverse tribal population (comprising communities such as the Chenchus, Koyas, Kondareddis, Yanadis, and Savaras), mostly concentrated in the Eastern Ghats and coastal hilly terrains. Globally and nationally, the health of indigenous women serves as an unyielding metric for systemic healthcare equity.

Tribal women navigate a fragile ecological and nutritional landscape. Their status is impacted heavily by early marriage, high parity, heavy physical labor, and a historical distrust of institutionalized modern medicine. While Andhra Pradesh has made significant strides under the National Health Mission (NHM), recent sample registration surveys point out that regional imbalances—especially in access to emergency obstetric care—continue to disproportionately affect tribal pockets.

2. Review of Literature

Historical literature categorizes the health issues of tribal women under three major brackets: Nutritional deficiencies, Reproductive tract morbidities, and Infectious/Vector-borne burdens.

The Nutritional Paradigm: Studies consistently reveal a high baseline of micro-nutrient deficiencies. According to epidemiological cohorts, anemia prevalence among tribal lactating mothers often exceeds 60\% \text{ to } 75\%, severely impacting both maternal survival and neonatal outcomes.

Socio-Demographic Interlinks: Lower literacy rates, early age at menarche combined with underage marriages (<18 years), and lack of decision-making power inside the household act as social determinants that limit a woman's capacity to seek timely clinical help.

The "Three Delays" Model: Thaddeus and Maine’s framework on maternal mortality heavily applies to Andhra Pradesh's tribal topology:

Delay in the decision to seek care (due to reliance on Registered Medical Practitioners (RMPs) or traditional healers).

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Delay in reaching the healthcare facility (due to difficult hilly terrain and lack of all-weather transport).

Delay in receiving adequate care at the facility (due to human resource shortages in primary health centers).

3. Key Health Challenges Facing Tribal Women in Andhra Pradesh

A. Severe Maternal Morbidity and the Referral Dilemma

While the state's overall MMR performs strongly against national metrics, remote tribal districts tell a different story. Recent health audits show that a vast majority of maternal deaths occur during transit—either while moving a patient from a community health center to a tertiary hospital, or following an emergency referral across multiple facilities.

Table No.1

Particulars of tribal women health

Primary Medical Cause	Contribution to Tribal Maternal Mortality	Underlying Systemic Factor
Postpartum Hemorrhage (PPH)	~25% – 30%	Severe baseline anemia, lack of immediate uterotonics in sub-centers
Hypertensive Disorders / Eclampsia	~35% – 40%	Poor antenatal screening, late identification of high-risk pregnancies
Puerperal Sepsis	~10% – 15%	Home deliveries conducted by untrained local hands under unhygienic conditions

B. Genetic and Lifestyle Vulnerabilities

Apart from reproductive health, tribal women exhibit localized genetic risks, specifically Sickle Cell Anaemia and Thalassemia. Furthermore, there is an ongoing epidemiological transition; lifestyle-related chronic conditions like hypertension and osteopenia are rising among older tribal women, complicating the existing infectious disease burden (Malaria, Tuberculosis).

4. Healthcare-Seeking Behaviour and Cultural Dynamics

Understanding why tribal women bypass public health systems requires analyzing the cultural fabric of these indigenous societies:

Role of Traditional Healers: In many tribal habitations, spiritual rituals and herbal formulations from community elders are trusted far above modern clinical settings. Western medical systems are often perceived as alien or intimidating.

The RMP Network: Unlicensed Registered Medical Practitioners (RMPs) are often preferred over public facilities because they are geographically accessible, offer immediate credit for medical expenses, and match the local language and cultural comfort.

Frontline Catalyst (ASHAs and Anganwadis): Accredited Social Health Activists (ASHAs) from within the tribe have proven to be the most vital links. Where ASHAs are actively trained, trust in institutional deliveries and uptake of Iron Folic Acid (IFA) supplementation scales up drastically.

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5. Government Interventions and Innovations

Andhra Pradesh has implemented highly targeted strategies to address these challenges:

Birth Waiting Homes / Pregnant Women Hostels: Initiated in several ITDA areas, these residential structures house tribal pregnant women from remote hill-top villages 15 to 30 days prior to their delivery date. Providing free nutrition, regular check-ups, and cultural accommodations has successfully dropped maternal and infant mortality rates to zero in specific clusters.

Dr. YSR Aarogyasri & Talli Bidda Express: Financial protection through comprehensive cashless insurance covers high-risk surgeries, while dedicated transport systems try to combat the "second delay" of navigating difficult terrain.

Anemia Mukt Bharat & Tribal Sub-Plan Funds: Enhanced distribution of 180 days of IFA tablets alongside culturally adapted cooking awareness programs aimed at restoring dietary diversity.

6. Recommendations and Conclusion

Policy Recommendations

Strengthening the "Golden Hour" Transport: Deploying specialized, smaller off-road emergency vehicles (4x4 ambulances) capable of navigating narrow, unpaved hilly tracks.

Standardization of Referral Pathways: Over 80\% of transit deaths involve multiple facility shifts. Implementing a strict, single-point tertiary dashboard communication can prevent critical delays.

Integration of Traditional Medicine: Training traditional birth attendants (Dai) and local healers to identify high-risk symptoms early, converting them into referral allies rather than structural rivals.

Decentralized Diagnostics: Equipping tribal sub-centers with point-of-care testing kits for hemoglobin, blood pressure, and sickle cell traits to ensure early detection.

Conclusion

The health of tribal women in Andhra Pradesh cannot be improved through a purely medical approach; it requires a socio-cultural and geographical solution. While current models like birth waiting homes show remarkable success, the rising trend of maternal mortality during inter-hospital transit highlights a critical need to strengthen rural infrastructure. By focusing on targeted, decentralized, and culturally sensitive health policies, Andhra Pradesh can close its regional equity gaps and secure sustainable well-being for its tribal communities.

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