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Quotidian Beliefs and Practices in Maternal and Child Health Care: An Empirical Study Among the Irula Tribe of Tamil Nadu

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Abstract

The present paper explores the cultural context of maternal and child health (MCH) care practices and beliefs of Irula tribes. It identifies the factors and analyses the pattern of their domiciliary deliveries and neonatal care among Irula, which is one of the PVTGs (Particularly Vulnerable Tribal Groups) in Tamil Nadu. The paper adopted a descriptive research design based on the pilot survey and ethnographic fieldwork. It examines the health care beliefs and practices relating to maternal and neonatal care connected with a holistic view of the Irula community's cultural dimensions. The paper also demonstrates the factors for domiciliary deliveries, non-utilization of prevailing state's health interventions, and incentives for maternal and child health care services among the Irulas. Keeping in view the aforementioned argument, an empirical study was carried out in six Irular settlements of Villupuram district in Tamil Nadu.

Keywords

Beliefs and practices, Irulas, maternal and child health care, PVTGs, Tamil Nadu

Introduction

In any society, the significant factors which influence maternal and child health (MCH) care practices are the social beliefs, cultural practices and perceptions, and prevailing economic conditions of the area. Added to these, lack of awareness about personal health and hygiene, the impact of demographic scenarios, and natural and occupational vicinity on a woman's health and well-being are also of paramount importance in the sociology of health and hygiene literature. There is a plethora of research on MCH care

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on various social groups.[1] But, there is a gap or lacunae of literature about the MCH care of PVTGs. Rather, as vividly viewed by Scambler (2012: 46–47), there is a wider gap in the literature of the sociology of health. The persistence of inequality is visible in the sociology of health. According to the Trends in Maternal Mortality (2000 to 2017) analysis (WHO, 2019a), there is a nexus between various socioeconomic indicators that influence mothers and children's maternal and new-born health. Various life-saving evidence-based interventions can improve maternal and neonatal health and survival across the continuum of care. Including quality antenatal care, skilled care during birth, postnatal care for both the woman and her baby, and essential new-born care (WHO, 2019b).

India has the second-largest concentration of tribal population in the world. According to the Census of India, 2011, the tribal people of India are 8.6 percent of the country's total population. There are 705 tribes speaking more than 100 languages and dialects that have been specified as Scheduled Tribes in 26 states and 4 Union Territories of India (Verma, 2017: 15). The Draft National Tribal Policy, 2006 has recorded 698 Scheduled Tribes in India (Srivastava, 2008: 29). The Xaxa committee[2] (2014) identified from its study that there are 693 Scheduled Tribes in India. In 1975, the Government of India undertook an initiative to identify few tribal groups that are more vulnerable than the others. These groups are considered as a separate category as PVTGs. The government has declared 52 such groups as PVTGs. Later, in 1993 an additional 23 groups were added to the list, making it a total of 75 PVTGs out of 705 Scheduled Tribes. These PVTGs spread over 18 states and one Union Territory (Andaman & Nicobar Islands) (2011 census). As per the 2011 census, these 75 PVTGs had a total population of 1,702,545. The majority of the PVTG population lives in the six states of Maharashtra, Madhya Pradesh, Chhattisgarh, Jharkhand, Odisha, Andhra Pradesh and Tamil Nadu. Odisha has 13 PVTGs, the most significant number for any state. Even within the groups labelled PVTGs by the state, there is considerable differentiation, most obviously concerning size—there are 19 groups with fewer than 1,000 persons and eight groups with more than one lakh.

The vulnerability of the PVTGs primarily stems from the loss of their traditional livelihoods, habitats and customary resource rights through the gradual exploitative intrusion of the market and state into their areas in the form of industrial projects, conservation efforts, tourism, the forest bureaucracy and so on. The groups most under threat have been identified as the Shompens, Sentinelese and Jarawas of the Andaman Islands; the Bonds of Odisha; the Cholanaickans of Kerala; the Abujh Marias Chhattisgarh and the Birhors of Chhattisgarh and Jharkhand. Some PVTGs such as the Paudi Bhuiyan in Odisha are still not included within the list of STs.

The PVTGs are more vulnerable among the tribal groups with the characteristic features of declining or stagnant population, low-level literacy, pre-agricultural level of technology and a subsistence level of the economy (Mathew & Kasi, 2021; Misra, 2016). They inhabit different ecological and geo-climatic conditions. They demonstrate a unique identity and other lifestyles and cultures with poor infrastructure and administrative support. Though the Government of India has introduced various health schemes, the health condition of tribes is very despicable in general and maternal and child healthcare in particular. Numerous contributing factors cause poor health conditions of the tribes, such as inadequate health personnel, inaccessibility to health care, poor health infrastructure and geographical settlement. There are further worsened and complicated by poverty, illiteracy, lack of awareness about the diseases, lack of safe drinking water, poor sanitation, age-old cultural practices about cures and ailments, irrational traditional belief systems, etc.

In the second and third world nations, access to maternity and postnatal care is impoverished among tribal people due to the prevalence of acute poverty, traditional community beliefs and cultural perceptions in their vicinities. Several studies (Balgir, 2011; Basu, 1993; Mahapathro, 2000; Meena, 2014; Mishra, 2012; Sachdev, 2012; Singh, 1998; Sogarwal & Dwivedi, 2008; Varma & Shah, 2014) have revealed that

the socioeconomic, socio-cultural and socio-biological norms have a more significant impact on the health status of the tribal women. These are concerning sex ratio, age at marriage, fertility, mortality, life expectancy, nutritional quality, maternal and child health care practices, sexually transmitted diseases (STDs), genetic disorders, etc. In India, the tribal communities have strong roots in different institutions such as marriage, family and kinship. The family is the most important social unit in which a woman's role and participation are crucial. Once the woman enters the in-laws' home after marriage, she is well acquainted with the folk culture, norms, beliefs and traditional practices. The young girls and women have been socialized, and the cultural practices have been transferred through intra-generation and inter-generation. These conventional practices continue from one generation to another. Among tribes, the lifestyle, dietary pattern, social, cultural and health behaviour are prescribed by deep-rooted traditions and community norms.

The tribes of India, due to their varied and distinct features of mode of living, are prone to various health problems. These health issues were primarily dealt with by a traditional indigenous health practitioner (locally known as *Dayi*) or by the primary health centre's medical staff. Balgir (2006) has emphasized in his report that tribes are victims of communicable and non-communicable diseases, including silent killer genetic diseases, anaemia and reproductive health problems. They are highly prone to tuberculosis, hepatitis, STDs, malaria, diarrhoea and dysentery, jaundice, parasitic infestation, viral and fungal infections, conjunctivitis, scabies, leprosy, cough and cold, HIV/AIDS, etc. The cycle of ill health across generations creates a complex interplay between the biological, social, economic and cultural aspects and can be reactivated at any point in time. Earlier, Basu and Jindal (1990) reported that the tribes need special attention, especially the primitive tribal groups (PTGs), due to their specific geographical location, habitat pattern and ecological terrain. They are more vulnerable, especially to prevalent genetic disorders like sickle cell anaemia and STDs. Several other research studies report more or less similar kinds of health problems and diseases. These include anaemia, vaginal discharge, swelling of feet, malaria, premature delivery, irregular menstrual cycle and irregular vaginal bleeding which were common among the tribal women (Agarwal, 2013; Balgir, 2011; Islary, 2014; Mishra, 2012; Mishra et al., 2013; Panda & Guha 2014; Sachdev, 2012). Thus these health problems will affect maternity and maternal health among the tribal women of India to a large extent.

Women are subject to particular health risks due to inadequate responsiveness and lack of services to meet health needs related to sexuality and reproduction. In the context of reproductive health, tribal perspectives should be understood in terms of perceptions, culture and belief system, and they are considered vital determining factors that influence their health and hygiene practice. Health problems and health practices of tribal communities have been profoundly influenced by the interplay of complex social, cultural, educational, economic and political practices (Balgir, 2006).

Health care is one of the most important human endeavours to improve the quality of life, especially for tribal people (Balgir, 2006). Both health and treatment have a vital role in the socio-cultural, demographic, ecological and economic functioning of a society. The tribal population is particularly vulnerable to undernutrition because of geographical isolation, socioeconomic disadvantage and inadequate health facilities (Maharatna, 2005).

Researchers believe that health is an essential aspect of the tribal community. Socio-cultural beliefs and practices highly influence perspectives on health status. Irula women of the study areas are not an exception to this phenomenon. The Irula women are highly illiterate, ignorant, exploited and are inhumanly treated in the study area. Keeping these facts and ethnographic observations in view, an attempt has been made in the paper to understand the relevant aspects of traditional health-seeking behaviour through the lens of their social structure, culture, food habits, and maternal and child healthcare practices.

Methodology

Ethnographic fieldwork was carried to get first-hand information in the six selected settlements of Anjancherry, Appambatti, Thindivanam, Gingee Fort, Singavaram and Olakur based on the pilot study. The sample consists of 20 households from each Irula settlement, making a total of 120 families.

The paper adopted a descriptive research design. It describes the socio-cultural pattern and economic conditions of the Irula[3] tribes. Also, it aims to describe the health issues related to maternal and child healthcare practices among the Irula tribes of these settlements in the Villupuram district. It also describes the traditional tribal medicinal practices highly prevalent among the Irula tribal settlements of the study area. Further, the paper also used an interview schedule in Tamil and later translated it into English for the researcher's convenience and data analysis. The interview schedule consists of structured statements and close-ended and open-ended questions to examine various aspects. These include social and cultural elements, occupations and income, education, family size, and family type, age at marriage, pregnancy and delivery, place of delivery, abortion and infant mortality, the health status of mother and infant, traditional beliefs and practices related to maternal and new-born care of the respondents.

The primary data has been collected with a field guide based on the interview schedule, observations and focused group discussions. The respondents selected for the study were pregnant women, mothers of children below three years and lactating mothers. The secondary data has been collected from various books, articles, reports, newspaper articles, internet databases, visits to different libraries and relevant documents from the Irula Tribal Women's Welfare Society (ITWWS) and local NGO—PIPS (Pazhangudi Irular Pathukappu Sangam) Thindivanam. This NGO is working for the upliftment of Irulas in the Villupuram District.

State of the Irula Tribe in the Study Area

The Irula tribe forms a part of aboriginal tribes sporadically settled in the South Indian state of Tamil Nadu. It is one of the PVTGs of Tamil Nadu. The word 'Irula' comes from the root word of '*Irul*', which means darkness or night. They are one of the major tribes of Tamil Nadu who trace their ancestors to the Dravidian family. The Irulas constitute 23,116 households in Tamil Nadu. Sathyanarayanan mentioned that the Irula comprise the second largest Scheduled Tribe. As per the 2011 census, the Irula has a population of 189,621 in Tamil Nadu. They are mainly concentrated in the Chengalpattu, Dharmapuri, Kanchipuram, Tiruvannamalai, Thiruvarur and Villupuram districts of Tamil Nadu (Padmavathi & Saradha, 2014; Sathyanarayanan, 2016).

The Irulas in the Villupuram district are extremely poor and struggle for their day-to-day survival. The majority of Irulas are landless people, but they are familiar with their skill of snake catching. People in the study areas informed us that the Irula is an expert in catching deadly snakes. Irulas eke out their livelihoods through the hunting of small ruminants in the nearby forest areas. They also earn their livelihoods by catching snakes and rats, and selling firewood, honey and bee wax. Due to the Wild Life Protection Act, 1972, the Irulas lost their traditional occupation, and they slowly turned into agricultural labour in the study areas. It is apt to mention Jahanara's (2008) report, which found that 73 percent of Irulas live below the poverty line (BPL), and less than one-third were of lower socioeconomic status. Only 3 percent of them belong to the middle-level socioeconomic status. In the study area, Irulas are facing rampant malnutrition.

In the study area, most of the Irulas are nomadic[4] (frequently travel from one place to another with temporary settlements) and face many health problems due to a lack of infrastructure facilities such as

proper housing, drinking water and drainage facilities. So, it would not be easy to maintain hygiene as informed by one informant of the Irula during our interaction. The huts they live in do not have adequate shelter facilities. There is a cycle of poverty and deprivation associated with the lower position and landless status of the tribe. In recent years, the Irulas have started living in plain lands by doing agricultural activities and are dependent on wage earnings in the outskirts of villages and semi-towns. The village heads marked boundaries for the Irulas and consider them untouchables. They are denied work because of their lower status and position in the area, due to which they live in appalling conditions and eat whatever they get in the place they live, like rats, snails, crabs and turtles. They continue to live in conditions of extreme poverty, and they are not even able to meet their food demands twice a day. Due to poverty, pregnant women, expectant and lactating mothers are not properly taken care of, which has resulted in poor mother and child health. Due to these precarious situations, they believe in and prefer to visit local religious-magical practitioners in case of any illness. These priests perform the rituals and suggest sacrificing an animal to cure or appease a God or any ill spirit.

Among the various factors influencing health of Irulas are belief systems, accessibility and affordability of health services; essential determinants for improving health. The Infant Mortality Rate, Maternal Mortality Rate, Neo-Natal Mortality Rate and Under-5 Mortality Rate among these tribes have not improved despite central and state government initiatives, incentives and institutional care. The young Irula girls enter the reproductive age with early marriage as victims of undernourishment and anaemia and face more significant health risks due to frequent pregnancies and abortions, unsafe deliveries, and sexually transmitted diseases. The low social status of Irula women and community attitude towards pregnancy, not considering any medical treatment or nourishment and care, hinder efforts to deliver antenatal services, making these women and children more vulnerable (Basu, 1993). Significant inequities in health and access to health services continue to persist among the Irulas. Therefore, it is critical to ensure health and healthcare services for these people and assure quality healthcare.

A few of the Irula women working with the ITWWS spoke about the state of Irula women in their vicinities. Irula women have minimal to no power in the decision-making process and are discriminated against and exploited virtually at every level of society. They experience prejudice and violence within their home and community. Many women suffer awful health conditions due to early marriage and childbirth and lack of trained assistance available within the community (Irula Tribal Women's Welfare Society, 2007). Similarly, teenage tribal mothers are at increased risk of having pre-term deliveries, stillbirths, maternal mortality, morbidity and neonatal deaths (Spear, 2002).

An attempt is made in the paper to depict the socioeconomic conditions, illness, and diseases, the status of maternal health condition, breastfeeding, prenatal and antenatal care during pregnancy and delivery time, family planning, etc., of the Irula tribe. Therefore, the paper aims to explore the Irula women's perceptions and practices related to pregnancy, domiciliary delivery and childbirth. Among Irulas, the proportion of home deliveries continues to be comparatively higher than the general population, despite the incentives provided by the state.

Empirical Observations from the Study Area

In the study area, the Irulas approach childbirth as an everyday event. Pregnancy and childbirth are perceived as natural processes, not requiring much external intervention. They follow their own community rules, cultural beliefs and traditional practices. There are various typical conventional health care beliefs and practices concerning pregnancy and childbirth among the Irulas. In the Irula community, women's pregnancy and childbirth are considered auspicious ceremonies after marriage.

During the seventh, eighth and ninth months of pregnancy, the Irula conduct traditional formalities and serve nutritious food. They do not send their pregnant women to their parent's house for delivery, as is the case with other communities in the study area.

Maternal and child health (MCH) services during pregnancy and delivery were reportedly poor among the Irulas due to traditional solid beliefs and trust in *Dai*s. Preference for home delivery is the mandate for performing some rituals. These ritual practices and traditional beliefs within the community led to unhygienic cord care practices. They include delay in bathing mother and baby, unhygienic baby cleaning process, delay in breastfeeding initiation and the absence of a colostrum feeding practice.

The Irula girls and women strongly believe that there is no need to visit any primary health centre (PHC) or hospital for a health check-up during pregnancy unless there is a health complication. They are against having iron and folic acid tablets and tetanus toxoid (TT) injections. In their opinion, the iron tablets increase the weight of the foetus, thereby making natural delivery difficult, and these tablets contain heat, which leads to abortions of the foetus. These young pregnant ladies are never allowed to undergo abdominal examination by auxiliary nurse midwives (ANMs) due to the superstitious belief that their touch might lead to stillbirth or abortion.

The young pregnant women allow only the midwife to do an abdominal examination and get advice to avoid some food items. They include papaya, mango, banana, brinjal, mint, *yel* (Sesame seeds), red dal, and pig meat considered to produce heat and, therefore, harmful to the foetus. These pregnant women underfed themselves to ensure a tiny baby and easy delivery and have no concern about the mother's fever and swelling of the face, feet and hands. They believe in evil demons, wear neem leaves in their hair, and keep metallic hooks, chilies, lemons, etc., at the threshold that are generally used to deter evil spirits from pregnant women. During the first delivery, the husbands of these Irula pregnant women will not cut their hair till the baby is delivered. They also believe that they get blessings for a healthy baby and natural delivery by praying to God.

Among the Irulas, significant reasons for home delivery include strong faith in *Ambattachchi* or Traditional Baby Attendants (TBAs) or midwifery[5] and the delivery will take place in a squatting position, and women are allowed to walk around in between contractions and get labour pain for an easy natural delivery. After delivery, the *Thoppul Kodi* (umbilical cord) of the child was cut with a sharp instrument locally known as a bamboo stick or new blade. They bury it in the back courtyard of their house to ensure its safety from wild animals, birds, human beings, witchcraft and other sources of harm to the infant. Later, they wanted to bury the *Nanchukodi* (placenta) inside the household boundary, which symbolizes the survival of the new-born and the attachment of the child to the house and family. The baby is wrapped in a white cotton cloth, and the skin is rubbed for cleaning of vernix. They believe that putting *Yenna* (oil), *Manjal* (turmeric) at the *Thoppal Kodi* (Cord stump) prevents early drying of the cord and entry of air into the baby's stomach.

Irulas give a bath to the baby immediately, but the women take a bath after six days of delivery. The delivery process is to be 'impure', and the mother will give the sacred bath on the seventh day. This ritual is popularly known as *theetu yedupanga*, which means removing the delivery attached pollution of the family. Dry cow-dung cakes are burnt in a container and kept near the fire or under the mother's cot to maintain a temperature that provides warmth for both mother and the new-born. The Irula mothers never initiated immediate breastfeeding, but most of them feed honey, jaggery and sugar water, ghee and cow milk, with the help of *dai*s. As per the beliefs of Irulas, they do not give colostrum milk to the new-born. They believe that during pregnancy, a woman does not menstruate, and this lousy blood (*Ketta rattan*) is mixed up with breast milk and thickens it, and once fed to a child, it attaches to the intestine of the child and causes indigestion with pain in the stomach leading to diarrhoea. Similarly, it is believed that lactating mothers should not eat cold, hot and spicy foods because it makes her blood and breast milk

cold and hot, and the new-born get a cold, cough and stomach ache, causing dysentery. Irula women do not have eggs during breastfeeding as they believe that the child cannot speak fast by eating eggs. Few Irula mothers continue their breastfeed until the birth of the next child. The women are allowed to rest only for 15 days after delivery and then go back to work for their survival, which results in the majority of the infants being malnourished.

Irulas are specialists in traditional herbal medicine and healing practices. After the delivery, the new-born is provided with an oil massage and a regular bath. Due to water shortage, if the baby is born during summer, a bath will be given once in three days. Most of the Irula parents do not provide a complete vaccination to their kids. If the baby gets a fever, they apply *Tulasi* and *Manjal* (turmeric and basil leave paste) to the whole body and give a bath. They believe that the fever will get cured for three days and pray for their *kula devata* (family deity). They apply oil on the baby's head to reduce cold and cough. If the health condition is severely affected, they visit local 'Irula *vaidyar*s' (community doctors). Most women practice traditional healing systems and take medicine in the form of medicinal herbs and a black neck thread, which has a metal pendant called *Thayattu*. They believe *Thayattu* will cure the disease and improve the health of a child. Sometimes these traditional healers demand the offering of an animal to their family deity to resolve issues related to health and family problems. The Focused Group Discussions enumerated the strong presence of cultural practices and traditional beliefs rampant among the Irulas influencing the non-utilization of Mother and Child Health Care services provided by the state.

The government of Tamil Nadu has initiated a model that prescribes institutional childbirth for all the deliveries and promotes it through a conditional cash transfer scheme popularly known as Dr Muthulakshmi Maternity Benefit Scheme. The Tamil Nādu state's Health and Family Welfare Department has enhanced the financial assistance to poor pregnant women from ₹12,000 to ₹18,000. This scheme provides financial aid to poor expectant mothers above 19 years for two pregnancies. It is strengthened with a Nutrition kit to reduce the maternal mortality rate (MMR) and infant mortality rate (IMR). This scheme also aims to provide optimal nutrition for pregnant and lactating women and compensates for the wage loss during pregnancy. Despite this financial assistance, the Irula women prefer to do domiciliary deliveries due to a lack of faith in institutional deliveries and strong beliefs in their cultural practices and knowledge of their *dais*.

Data Analysis and Discussion

Marriage is conducted in the temple of the bride's hamlet. In this marriage, 12 clan people have to touch the *tali* (holy badge), and they believe that this makes the couples live happily and proudly. The Irula tribes are very innocent, they do accept love marriages, and remarriage is also acceptable in their society. The Irula parents generally try to arrange and conduct early marriages for young girls, especially after two or three years of attaining puberty.

Table 1a shows that the Irulas conduct marriages at a very early age and believe late marriages will create many difficulties in finding a suitable groom and complications in pregnancy and childbirth. Suppose the parents neglect to conduct an early marriage for young boys and girls. In that case, there is a fear in the community that it may lead to eloped marriages such as inter-caste and inter-religious marriages. The young Irula girls also accept union at an early age based on cultural aspects of their community and start their own family. It is indicative from the table that a majority of 41.67 percent got married at the age of 15–19 years, followed by 36.67 percent between the ages of 20 and 24 years. While 14.17 percent got married at the age of 25 and 29 years, only 7.50 percent were married at the age of 30 and above as part of remarriage, inter-caste and eloped marriages.

Table 1a. Age at Marriage Among Irulas.

Age at Marriage	Frequency	%
15–19 years	50	41.67
20–24 years	44	36.67
25–29 years	17	14.17
30+ years	9	7.50
Total	120	100.00

Source: Field survey.

Table 1b. Age at Delivery Among Irulas.

Age at Delivery	Frequency	%
16–18 years	49	40.83
19–21 years	32	26.67
22–24 years	14	11.67
25–27 years	12	10.00
28–35 years	13	10.83
Total	120	100.00

Source: Field survey.

Within this tribal community, early marriages have resulted in early pregnancies' among young girls. The cultural and traditional practices are handed down as a family legacy to these young couples. It was found that no newlywed couple had taken any preventive measures to postpone their conceiving with diverse reasons such as illiteracy, unawareness, nomadic lifestyle, lack of belief in institutional health care and a strong belief in their cultural practices.

It is evident from Table 1b that about 40.83 percent delivered their first child at the age of 16–18 years, followed by 26.67 percent who gave birth at around 19–21 years of age. Approximately 12 percent of the respondents were happy to give birth at 22–24 years. Out of 120 respondents, only 25 respondents gave birth at 25–35 years of age. Among this category, they gave birth to a second and third child during the data collection. Some respondents felt that either postponing or aborting a baby is a sin because these young ladies strongly believe that becoming a mother is a blessing from God. Most of them are unaware of preventive measures to avoid pregnancy, as they consider pregnancy a boon to women and motherhood. Moreover, these young women strongly believe that delivering a child is bliss to the family and the community.

Among the six Irula settlements, most young women never complained about serious health complications during their pregnancy (Table 2). The majority of (28.33 percent) the respondents informed us that they had fever, followed by (23.33 percent) weakness due to anaemia. Around 21 percent experienced abdominal pain and 16.67 percent had swelling of hands and feet. Only 10.83 percent of them experienced frequent vaginal bleeding during the pregnancy and prepartum period. They gave various reasons that these health problems were due to some sins committed in their previous life, the anger of family deity, *Kanu dishti* (bad eyes or evil eyes), the effect of black magic, etc. Despite all these health issues, they were hesitant to go to the hospital for health check-up, never allowing ANMs to check their abdomen, and avoiding having iron and folic acid tablets.

Irulas approach childbirth as a regular event. Pregnancy and childbirth are perceived as natural processes, not requiring much external intervention (Table 3). Out of 120 respondents, a majority of 70 (58.33 percent) have undergone home deliveries. Utilization of MCH services during pregnancy and

Table 2. Health Problems During Pregnancy.

Health Problems During Pregnancy	Frequency	%
Abdominal pain	25	20.83
Fever	34	28.33
Anaemic	28	23.33
Swelling of hands and feet	20	16.67
Vaginal bleeding	13	10.83
Total	120	100.00

Source: Field survey.

Table 3. Place of Delivery.

Place of Delivery	Frequency	%
Home	70	58.33
PHC	35	29.17
Hospital	15	12.50
Total	120	100.00

Source: Field survey.

delivery were reportedly poor among Irulas, and preference for home delivery is tied to the mandatory nature of some rituals that need to be performed.

This has resulted in only 35 respondents, with 29.17 percent who had gone to a nearby PHC for their delivery. Unless there is an emergency or complications during the delivery, they prefer to visit the hospital with the advice of traditional *dai*s, and only a few (12.50 percent) of the pregnant women prefer to go to the hospital for their deliveries.

The young pregnant women of the Irula community always seek good support. They prefer to take the help of a birth attendant from the community and their neighbours during the delivery time (Table 4). A majority of 51.67 percent of birth attendants were traditional *dai*s, followed by 15 percent of pregnant women supported by a trained birth attendant. Around 13.33 percent of ANMs are recorded as birth attendants. Ten percent neighbours and 10 percent of doctors were used as birth attendants during the delivery.

Out of 120 respondents, only 39 percent of women have undergone family planning after having 3 to 4 children. While a majority of 61 percent of respondents have not experienced any family planning, though they have an average of 2 children each as they strongly believe children are blessings of God.

Table 5 provides information about traditional beliefs and practices among young Irula pregnant women. Only 35 respondents had Iron and Folic Acid (IFA) tablets, while 85 respondents expressed that they are harmful to health. A majority (37 percent) of the respondents said that burying the placenta and the umbilical cord is an important ritual. This safeguards new-borns from evil powers, followed by 23 percent who shared their opinion that colostrum is spoilt blood which was a result of impure blood. Around 18 percent opined that IFA tablets and TT injections were harmful. In their view, the iron tablets increase the weight of the foetus, thereby making natural delivery difficult, and these tablets contain heat, which leads to abortions of the foetus. A few participants of 13.33 percent believed that hospital delivery would detach the emotional bond between new-borns and home, followed by 9.17 percent who opined that an ANMs touch leads to abortion.

Table 4. Birth Attendant.

Birth Attendant	Frequency	%
Traditional *dai*s	62	51.67
Trained Birth attendant	18	15.00
Neighbour	12	10.00
ANM	16	13.33
Doctor	12	10.00
Total	120	100.00

Source: Field survey.

Table 5. Traditional Beliefs and Practices Among Irulas.

Traditional Beliefs and Practices	Frequency	%
ANM touch leads to stillbirth or abortion	11	9.17
Home delivery is only safe	19	15.83
Buying of placenta and umbilical cord	25	20.83
Discomfort with hospital provisions	21	17.50
New-born attachment with home	16	13.33
Colostrum is spoilt blood	28	23.33
Total	120	100.00

Source: Field survey.

Table 6. Reasons for Home Delivery Among Irulas.

Sl No.	Reasons for Home Delivery	No. of Respondents	%
1	Scared of medical tests	10	8.33
2	Communication problem	11	9.17
3	Financial problem	7	5.83
4	Scared of C-section	17	14.17
5	Provision of warmth to mother and new-born	12	10.00
6	Distance and transportation problem	15	12.50
7	Belief in *dai*s	17	14.17
8	Different food in hospitals	11	9.17
9	Attendant is not allowed in hospital	9	7.50
10	Mandated rituals	11	9.17
Total		120	100.00

Source: Field survey.

Table 6 describes the opinions of Irulas regarding their preference for home delivery and various reasons for home delivery. An equal percentage (14.17 percent) of respondents opined that they were scared of the C-section and had firm belief and trust in the *dai*s, followed by 12.5 percent who feel that the hospital is far away and transportation is a significant issue. About 10 percent of the respondents opine that they do not provide warmth to mothers and new-borns at the hospital. In home delivery, Irulas keep a warm fire that burns with cow dung cakes close to the delivery cot. Around 9.7 percent of them have shared their experience that there is a communication problem. Hospitals do not allow an attendant. Further, the food they distribute is different from the Irula's food. The remaining (22 percent) gave other

Table 7a. Irula Mother's Initiation of Breast Feeding.

Sl No.	Initiation of Breast Feeding	No. of Respondents	% of Respondents
1	Within one hour	8	6.67
2	2–6 hours	22	18.33
3	7–12 hours	29	24.17
4	Next day	34	28.33
5	Third day	27	22.50
Total		120	100.00

Source: Field survey.

Table 7b. Reasons for Delay in Initiation of Breastfeeding.

Sl No.	Reasons for Delay in Initiation of Breastfeeding	No. of Respondents	% of Respondents
1	No milk secretion	28	23.33
2	Due to C-section	14	11.67
3	Colostrum is spoilt blood	55	45.83
4	Sickness of the mother/new-born	23	19.17
Total		120	100.00

Source: Field survey.

reasons that mandated rituals, fear of medical tests and financial problems restrict them from having a home delivery.

Irula mothers never initiate immediate breastfeeding, but most of them feed honey, jaggery and sugar water, ghee and cow milk, with the help of s. Only 6.67 percent have fed their babies within an hour, followed by 18.33 percent who started feeding after 2 to 6 hours of delivery (Table 7a). A majority of 28.33 percent fed their babies the next day of the delivery, around 24.17 percent initiated feeding between 7 to 12 hours after delivery. As per the beliefs of Irulas, colostrum milk was not given to the new-born because they believe that during pregnancy, a woman does not menstruate, and this spoilt blood (*Ketta rattam*) is mixed up with breast milk and thickens it, and once fed to the child, it gets attached to the intestine of the child and caused indigestion that leads to stomach pain and diarrhoea. About 22.50 percent had initiated feeding on the third day of their delivery with the opinion that colostrum is spoilt blood.

The Irula mothers come with various reasons for the delay in breastfeeding (Table 7b). Around 12 percent explained that it is due to the C-section, followed by 19.17 percent who said it is due to the ill-health of the mother or new-born. Around 23.33 percent shared that they did not get milk secretion, and a majority of 45.83 percent of them delayed with the belief that colostrum is spoilt blood. But most of them continued their breastfeeding till the birth of the next child.

Table 8 explains that the new-born is provided an oil massage and a regular bath after the delivery. Only 9.17 percent have given complete vaccination, while the rest of the Irula parents did not provide a full immunization for their kids. Around 15 percent of respondents have shared that they have given an immediate bath, 16.167 percent stated that they had offered thermal heat to the baby, followed by 28.33 percent who have given effective skin massage to avoid infections. A majority of them shared that their babies were given BCG vaccination with ANMs initiative from nearby PHC. The Focused Group Discussions enumerated the strong presence of cultural practices and traditional beliefs, which are

Table 8. Irula's Neonatal Healthcare Practices.

Sl No.	Child Healthcare Practices	No. of Respondents	% of Respondents
1	BCG vaccination	37	30.83
2	Complete vaccination	11	9.17
3	Skin massage	34	28.33
4	Thermal care	20	16.67
5	Immediate bathing	18	15.00
Total		120	100.00

Source: Field survey.

rampant among Irulas influencing the non-utilization of the state's Mother and Child Health Care services.

Conclusion

To sum up our paper, it is pertinent to state that majority of the Irula women in the study area work in the unorganized sector as daily wage labourers, brick kiln workers, and construction labourers. It is found that even in the late stages of pregnancy, these women continue to work to support their families and employer. In the study area, the Irula community struggles with poverty, illiteracy, lack of awareness about their rights and entitlements, and lack of access to basic amenities such as housing, clean drinking water and landlessness, which usually affect women's care during pregnancy and health care. It was evident from the field observation that due to lack of proper infrastructure in the areas inhabited by the Irulas, literacy levels and awareness about their health and sanitation is also very poor. This indicates the state of Irulas in the social and economic status in the area and same is leading to discrimination in their neighbourhoods. Because of their illiteracy and not aware of the MCH services available in the area, their age at marriage is at very young age. This is further aggravated their health situations and leading to immature pregnancies among the Irula girls and women. Government should sensitize the Irula pregnant girls and mothers to go for deliveries in the government hospitals as against home deliveries which they practice even now in the study area. Further, the findings from the study also show the deprived state of health condition of young Irula women and their children. However, it is indicative to state that traditional beliefs and practices affirm gender biases regarding new mothers and their care. These beliefs and practices are evidence of their illiteracy and backwardness. To address the health needs of these 'young Irula mothers', the government and civil society have to work closely towards the optimal utilization of health services, gender equity norms in neonatal care, removal of harmful healthcare practices and reducing the incidence of poverty to improve the lives of Irulas in the state of Tamil Nadu. The study has also found that the health of women in the community can be improved by health education and providing health services in the community. NGOs and government programmes should address the issues that arise from the cultural practices of the tribal population, especially in maternal and child health care. There is a need for examining every component of the tribal society to deliver health care services that should be accommodative to the existing community social norms.

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Notes

1. MCH occupies impeccable importance in the literature of the sociology of health and medical anthropology in India and elsewhere. But, scant literature is available on MCH among the tribes of India. However, there are umpteen works available on the sociology of health and health-seeking behaviour, and health and illness. For further information and analysis see, for instance, the works of Bowes & Domokos (1996); Das et al. (2020); Debnath (2021); Ettorre (2010); Hirst & Hewison (2001); Mackintosh & Armstrong (2020); Nagla (2018); Pandey & Lakra (2000); Pandey & Tiwary (2001); Sarmah & Dutta (2018, 2019); Sengupta (2019); Sujatha (2014, 2017) and Tamilarasan (2017).
2. The Government of India constituted a High-level Committee under the Chairmanship of Prof. Virginius Xaxa in the year 2013. The committee was mandated to examine the socio-economic, educational and health status of tribal communities. The committee had been given one year's time to submit its recommendations. The committee carried its work and studies on five critical issues related to the tribal people of India: livelihood and employment, education, health, involuntary displacement, and migration, and legal and constitutional matters. The committee has recommended appropriate interventional measures to improve the conditions of the tribal people of India and submitted its report to the government in May 2014.
3. The term 'Irula' has its original root in the Tamil term *irul* which means blackness or darkness. This might have been used in reference to the darkness of jungles or forests of which Irula people have been inhabiting since the beginning as mentioned by different scholars who carried their studies on the Irulas of Tamil Nadu. For instance, refer to Perialwar (1997); Sathyanarayanan (2016); and others.
4. Nomadic communities practice a range of occupational activities in order to eke out their livelihoods. They include; pastoralists, hunter-gatherers, shepherds, cowherds and hunters of small ruminants, entertainers including dancers, acrobats, snake charmers and monkey trainers. For a further anthropological and sociological understanding of nomadic communities, refer, for instance, Bokil (2002); Devy (2000); Dutt (2004); Rao & Casimir (2003); Xaxa Committee (2014); and among others.
5. The role of midwifery or midwives is crucial and has sociological significance in the sociology of health and maternal health systems. For more sociological engagement and discussion on midwifery or midwives, see the works of Bowler (1993); Benoit et al. (2005); De Vries (2004) and Kamal et al. (2015).

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