



INDIGENOUS MATERNAL HEALTH CARE: A STUDY OF POSTNATAL CARE AMONG THE SAVARA TRIBAL WOMEN IN ANDHRA PRADESH

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ABSTRACT

Disparities in formal postnatal care (PNC) persist among indigenous populations due to geographic isolation and deep rooted cultural beliefs. This study evaluates the traditional postpartum practices and PNC seeking behaviours among the Savara tribal community in the Srikakulam district of Andhra Pradesh, India. A multi stage stratified systematic sampling design was utilized to survey a cohort of nursing mothers aged 15–49 years across 95 interior villages. Quantitative field data was statistically processed using SPSS. The sampled population exhibits a young demographic profile (mean maternal age: 22.98 ± 2.76 years) alongside extreme maternal illiteracy (96.0%). While formal postpartum facility contact is high (96.7%), clinical utilization is primarily driven by seeking permanent tubectomy sterilization rather than holistic screenings. A major healthcare delivery gap exists; 44.7% of mothers received only verbal advice on breastfeeding and baby care, whereas critical physical medical examinations such as maternal breast exams (0.5%) were virtually absent. Furthermore, 38.0% of mothers reported severe complications like high fever and acute headaches, frequently resulting in delayed healthcare seeking behaviors. Standardized biomedical models fail to address indigenous context, causing routine diagnostic monitoring to remain dangerously underutilized during the critical early weeks of recovery. Public health strategies must transition from tracking sterilization targets to providing high-quality, physical postpartum home screenings via mobile clinics and frontline workers while integrating traditional birth attendants.

Keywords: Savara Tribe, Postnatal Care, Indigenous, Maternal health, Demographic, Healthcare, sterilization, breastfeeding, biomedical, Tubectomy.

Introduction:

Maternal and child healthcare remains a critical pillar of global public health, yet significant disparities persist in the utilization of formal postnatal care (PNC) services among indigenous populations. In India, tribal communities collectively designated as Scheduled Tribes often exhibit distinct health seeking behaviours shaped by geographical isolation, socio-economic challenges and deep rooted cultural belief systems. While national health policies like the Janani Suraksha Yojana (JSY) have successfully increased institutional delivery rates across rural landscapes, the critical postpartum period remains underutilized and frequently neglected within remote tribal pockets. Postnatal care is vital for preventing maternal mortality, managing complications and ensuring neonatal survival, making the documentation of indigenous postpartum practices essential for designing culturally competent healthcare interventions [1].

The Savara tribe, primarily inhabiting the rugged terrains of the Eastern Ghats in the Srikakulam and Vizianagaram districts of Andhra Pradesh (AP), possesses a rich ethno-medical and cultural heritage. Traditionally organized around extended kinship structures known as *Birinda*, the Savara lifestyle is deeply interconnected with the local forest ecology, which heavily influences their dietary habits and medicinal practices. In Savara society, pregnancy, childbirth and postpartum recovery are not viewed merely as biological events, but as profound transitions governed by strict cultural norms, communal rituals and specific taboos. Consequently, Savara women frequently rely on traditional birth attendants (TBAs), village elders and native medicine men for maternal care, rather than accessing formal government health facilities [2].

In AP, the Savara comprise around 5.14% of all tribal people. They can be found in the districts of Vizianagaram and Srikakulam, which form a continuous belt that borders the state of Odisha. The Savara are among the oldest tribes in AP. They are primarily found in the Palakonda hill ranges, which are a part of the Eastern Ghats and the districts of Srikakulam and Vizianagaram. They are also occasionally observed in the Vishakhapatnam area of AP. About 90% of the Savara population in AP lives in the districts of Srikakulam and Vizianagaram.

Their ancestry is Proto-Australoid. Based on physical attributes, the Savara habitat can be divided into two distinct zones: the hill towns and the foothill settlements. As the name suggests, most hill villages are found in mountainous regions, and many of them are now accessible by road. The second zone, which has fewer villages and a lower population than the first, consists of the Savara foothill communities along the Eastern Ghats [3].

The postpartum period in Savara culture is characterized by specific indigenous practices aimed at maternal healing, neonatal protection and social reintegration. Following delivery, mothers observe a period of ritual seclusion to shield the vulnerable newborn and herself from spiritual and physical ailments. This phase involves specialized ethno obstetric care, including the administration of traditional herbal decoctions, specific dietary restrictions to balance bodily "heat" and physical therapies supervised by experienced community matriarchs. While these practices offer holistic psychological and social support, certain customs such as severe dietary restrictions or delayed initiation of breastfeeding may present direct challenges to optimal maternal and neonatal nutritional outcomes [4].

Rationale for the Study:

Despite the cultural richness of these customs, there is a profound scarcity of empirical research focused exclusively on the postnatal experiences of Savara women in AP. Existing literature predominantly addresses broader tribal maternal health or focuses strictly on antenatal care utilization, leaving a critical knowledge gap regarding indigenous postpartum healing, neonatal care and the specific barriers preventing integration with institutional PNC services. Understanding these localized dynamics is imperative; imposing standardized biomedical models without acknowledging native wisdom often leads to community resistance and poor healthcare compliance [5].

This manuscript, aims to comprehensively document and analyze the traditional postpartum practices of the Savara community. The findings of this research intend to provide actionable insights for policymakers, public health workers and non-governmental organizations to develop culturally sensitive, integrative maternal healthcare frameworks that respect indigenous traditions while safeguarding maternal and neonatal health.

Methodology:

This study employs a multi-stage stratified systematic sampling design to comprehensively evaluate the postnatal healthcare practices of the Savara tribal community. The research was strictly delimited to the “Savara” scheduled tribe residing within the interior, mountainous terrains of the Eastern Ghats in the Srikakulam district of AP. The selection of specific study locations was guided by two primary anthropological criteria: distinct Savara demographic dominance and geographical accessibility.

TWO-STAGE SAMPLING DESIGN
Stage 1: Mandals & Villages <ul style="list-style-type: none"> • 6 out of 14 Tribal Mandals randomly selected • 95 interior villages selected (10-45 km from HQ)
Stage 2: Respondent Selection <ul style="list-style-type: none"> • 5 to 8 nursing mothers chosen per village • Total target age cohort: 15-49 years

The geographic and demographic selection followed a rigorous two-stage stratification process to ensure representative field data:

Stage One (Mandal and Village Selection): Out of the fourteen designated tribal mandals in Srikakulam district, six mandals were randomly selected. Within these six mandals, a total of 95 interior villages were mapped out. The majority of these chosen settlements are located deep within the Eastern Ghats, situated between 10 and 45 kilometres away from their respective mandal headquarters.

Stage Two (Respondent Selection): From each of the 95 sampled villages, a systematic cohort of five to eight nursing mothers aged between 15 and 49 years was selected to serve as primary respondents.

Following the completion of the field survey, the gathered data was systematically cleaned, coded and processed in accordance with the study’s analytical framework. Quantitative variables and field matrices were statistically analyzed using the Statistical Package for the Social Sciences (SPSS, version 11.0) to generate descriptive and inferential insights.

Results and Discussion:

Socio-demographic and economic profile:

The sampled Savara population exhibits a young demographic profile alongside a severe, critical deficit in formal education. The age of the sampled female respondents ranges from 19 to 36 years, with a high concentration of nursing mothers clustered tightly within the 19 to 30 age cohort, yielding a mean maternal age of (22.98 ± 2.76) years. Paternal ages are shifted slightly higher, ranging primarily between 25 and 36 years with a calculated mean age of (27.32 ± 2.78) years.

Maternal literacy is exceptionally low within the studied cohort, failing to meet baseline historical trends. The vast majority of the nursing mothers are completely illiterate (96.0%), while a meager (4.0%) have attained some primary school education. This maternal literacy level (4.0%) is

critically lower than the broader tribal female literacy baseline for AP (26.1%) recorded in the 2001 Census and drops below the (6.4%) literacy rate documented specifically for Savara cohorts in Srikakulam district. Paternal literacy is only marginally higher at (13.0%) [6].

Economic dynamics within the community are defined by standard dual income nuclear family structures dependent on manual labor. Labor market participation shows that (98.0%) of the women are employed as primary agricultural or contract laborers, with the collection and sale of fuelwood serving as their principal secondary source of income. Only an exceptionally small fraction found semi formal employment as Anganwadi workers or aayas (helpers).

Similarly, Savara men are heavily engaged as agricultural or contract laborers. However, paternal occupational profiles exhibit slightly more diversification, featuring small scale roles such as: Independent subsistence farming, Auto-rickshaw driving, Private security staffing, Artisanal welding and small-scale fishing. Household income streams are highly restricted, generated almost exclusively by the primary husband and wife working unit. The results are shown in Table 1 and Figure 1.

Table 1: Socio-demographic and Economic Profile of the Savara Tribal Households (N = Sample Size)

Socio-economic & Demographic Variables	Classification / Category	Frequency (f) / Mean \pm SD	Percentage (%)
Maternal Age (Years)	Range: 19–36 Years	22.98 \pm 2.76	—
Paternal Age (Years)	Range: 25–36 Years	27.32 \pm 2.78	—
Maternal Literacy Status	Illiterate	—	96.0%
	Primary Education	—	4.0%
Paternal Literacy Status	Illiterate	—	87.0%
	Literate (Any Level)	—	13.0%
Maternal Primary Occupation	Agricultural / Contract Labour	—	98.0%
	Semi-formal (Anganwadi/Aaya)	—	2.0%
Maternal Secondary Occupation	Fuelwood Collection & Sale	—	Prevalent
Paternal Occupational Profile	Primary: Agricultural / Contract Labour	—	Predominant
	Secondary / Diversified Roles	—	Minor
Family Structure	Nuclear (Husband-Wife Unit)	—	Predominant

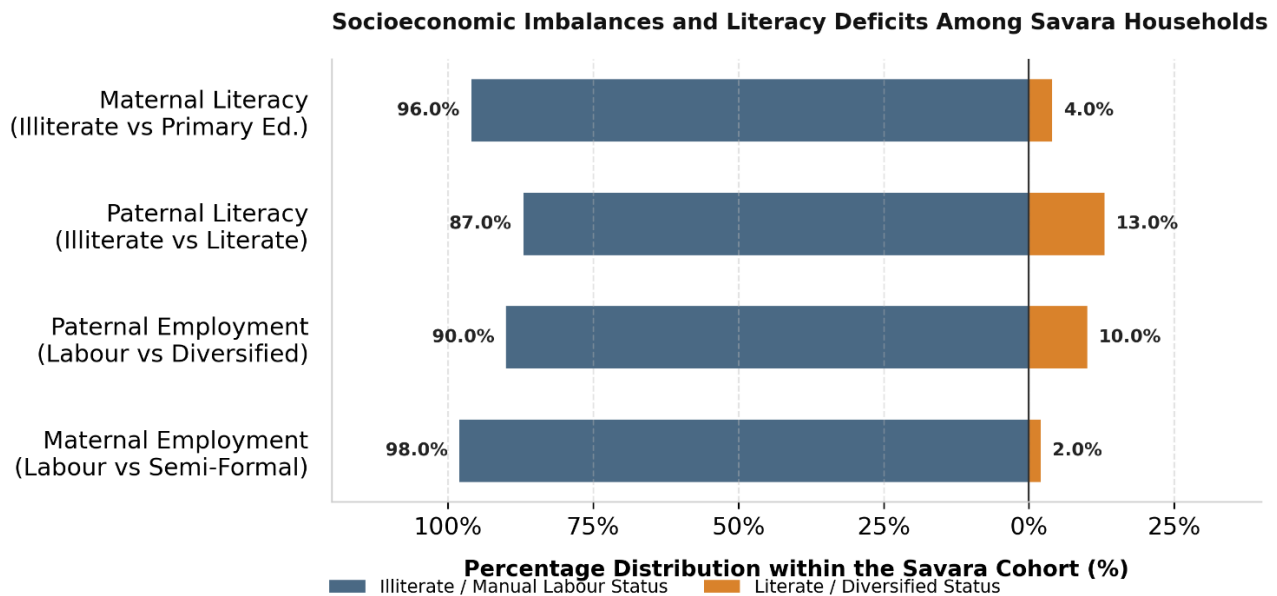


Figure 1. Horizontal diverging component bar chart generated which visualizes the socio economic disparities by aligning the dominant baseline vulnerabilities on the left against the minor progressive indicators on the right.

Postnatal healthcare seeking behaviour and complications:

While utilization of postpartum medical consultations is high within the cohort, care seeking is primarily driven by targeted maternal education and immediate health complications. A significant proportion of the sampled Savara women (97.0%) received some form of professional postnatal care (PNC) follow up after delivery. During these PNC evaluations, healthcare providers predominantly focused on counseling the mothers regarding optimal breastfeeding mechanics and general infant care. Additionally, clinical interactions included counseling on neonatal health, postpartum family planning and contraceptive options. Physical evaluations conducted during these sessions focused on examining the mother's abdomen and breasts to ensure proper uterine involution and address lactation related complications.

Clinical treatments during the postpartum window are primarily managed by the public healthcare sector, supplemented by home based supervision. Among the sampled mothers, (38.0 %) reported experiencing significant postpartum complications, with high fever and severe acute headaches identifying as the most common symptoms. Within this symptomatic sub cohort, the vast majority (92.0 %) sought and received medical treatment from physicians at government health facilities, while a minor fraction (8.1 %) utilized private medical practitioners. This institutional care structure was supported by community level outreach: Auxiliary Nurse Midwives (ANMs) routinely visited the respondents' homes two to three times during the early postpartum phase to monitor maternal recovery and supervise neonatal health.

Table 2: Postnatal Health Care Utilization and Type of Services Received (N = 600)

Maternal Health Variables	Frequency (f)	Percentage (%)
Postnatal Care (PNC) Status		
Received PNC	580	96.7%
Did Not Receive PNC	20	3.3%
Total	600	100.0%
Type of PNC Services / Counseling Received (n = 580)		
Advice on Breastfeeding (BF) only	40	6.9%
Advice on Baby Care only	128	22.1%
Advice on Family Planning (FP) only	33	5.7%
Combined: Advice on BF and Baby Care	259	44.7%
Clinical: Breast Examined with Advice on BF and Baby Care	3	0.5%
Comprehensive: Advice on FP, BF, and Baby Care	117	20.2%
Total (PNC Recipients)	580	100.0%

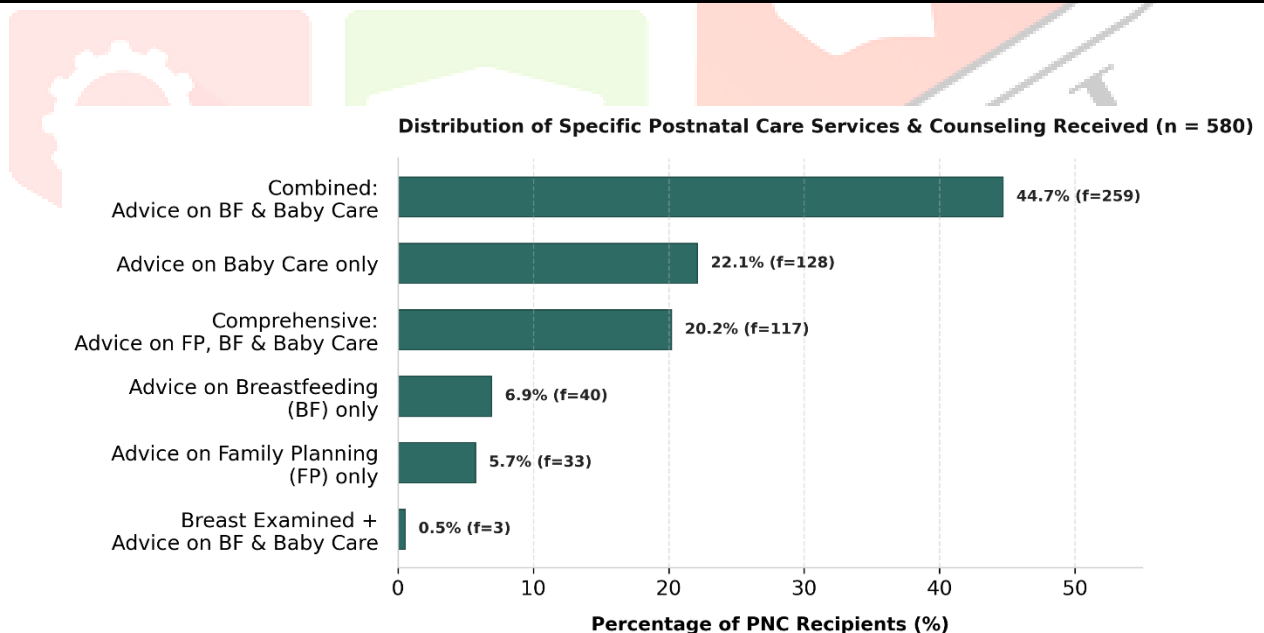


Figure 2.: Horizontal bar chart illustrating the specific types of postnatal care (PNC) services and counseling packages received by the Savara tribal community. The data highlights a distinct concentration on basic instructional counseling over clinical physical interventions, featuring an explicit combined breastfeeding and infant care advice utilization rate of 44.7% (f=259), contrasted against a critical maternal physical breast examination rate of only 0.5% (f=3).

The data in shows that while almost all Savara women (96.7%) receive some form of postnatal care, the actual medical checkups are very basic. Most mothers only receive verbal advice rather than physical medical exams. Specifically, the largest group of women 44.7%, (f=259) received basic advice

on breastfeeding and general baby care together, followed by 22.1% (f=128) who received advice only on how to take care of their infant. In sharp contrast, actual physical health checks are almost entirely missing. Only a tiny 0.5% (f=3) of the mothers had an actual physical breast examination by a health worker. This reveals a major gap in healthcare delivery, where giving verbal advice completely replaces necessary physical medical checkups. The results are shown in Table 2 and Figure 2.

A quarter of AP's women experienced postpartum problems, according to the District Level Household and Facility Survey (DLHS-3) (2007-08) survey. High fever (55.3%) is the most prevalent postpartum problem, followed by lower abdomen pain (36.4%) and heavy bleeding (32.7%). As a result, this survey closely aligns with the current study. Approximately three fourths (72.2%) of AP women who experienced postpartum problems sought care. High fever (7.1%), severe lower abdomen discomfort (2.7%) and urine incontinence (0.9%) were the postpartum problems reported in the Koya Doras of West Godavari district [7]. Massive bleeding (15.4%), high temperature (3.5%), convulsions without fever (0.2%), labour lasting longer than 12 hours (0.2%) and severe upper back pain (0.2%) are among the issues faced by the tribal women of Vizianagaram district [8].

In the six weeks following delivery, over 32.0% of Bhumija tribal women in Odisha experienced at least one health issue. Lower abdomen discomfort (14.5%), severe headache (11.9%), high fever (10.6%), heavy bleeding (7.5%) and convulsions (2.9%) are the postpartum problems that these women reported [9]. Accordingly, there is a substantial correlation between delivery attendance in rural Bangladesh and postnatal problems such as haemorrhage, pelvic pain, fever lasting more than three days, headache, etc. [10]. According to the Pakistan Demographic and Health Survey (2006–07), reported that the most frequent postpartum problems are severe headache (37.0%), high fever (26.0%), and blurred eyesight (21.0%) [12].

One of the ten Thai women reported seizures, incontinence, difficulty controlling bowel movements, oedema of the face and hands, and an unpleasant odour from vaginal bleeding. During childbirth and the postpartum period, haemorrhage is the primary cause of maternal death. PPH, or postpartum haemorrhage, frequently starts right after birth. The uterus's inability to contract or the placenta's retention for longer than 30 minutes following birth are the main causes [12].

Conclusion:

The investigation into the postnatal healthcare-seeking behaviour of the Savara tribal community in Srikakulam district reveals a highly specialized pattern of clinical utilization. While overall contact with formal health facilities during the postpartum period is nearly universal at 97.0%, this high rate is primarily driven by families seeking permanent family planning methods rather than comprehensive maternal health checkups. A significant majority of the respondents accessed formal healthcare services specifically to undergo tubectomy sterilization procedures.

Clinical utilization for acute maternal complications remains heavily restricted, frequently manifesting as delayed care seeking for severe late stage morbidities. Only a minor fraction (5.14%) of the sampled Savara women actively visited a health facility to manage immediate postpartum complications, such as lower abdominal pain, post-tubectomy septicemia, and severe uterine hemorrhage. Crucially, a distinct sub cohort of mothers only sought medical intervention well after the standard six week postpartum window had closed. These delayed presentations involved severe, unresolved clinical issues, including chronic postpartum hypertension, foul smelling vaginal discharge (indicative of reproductive tract infections), persistent lower abdominal pain, peripheral edema and urinary incontinence. This care seeking pattern highlights that while the community accepts surgical family planning, routine diagnostic monitoring for postpartum healing remains dangerously underutilized during the critical early weeks of recovery.

To improve maternal health outcomes healthcare strategies must transition from tracking sterilization targets to providing high-quality, physical postpartum screenings. Frontline workers (ASHAs and ANMs) should be mandated to perform vital physical checks, including monitoring maternal blood pressure, tracking temperature for early sepsis detection and conducting abdominal palpation during routine home visits. Furthermore, public health programs should deploy mobile clinics into interior Eastern Ghats villages and actively partner with traditional Dais to safely navigate ritual seclusion barriers. Finally, creating visual, non written health education materials is essential to communicate early postpartum warning signs to the 96% illiterate maternal cohort.

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