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# Tribal Women and Health Infrastructure in Karnataka: An Empirical Study

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**Abstract:** *This empirical study investigates the accessibility, quality, and utilization of health infrastructure by tribal women in Karnataka. Tribal populations in India, particularly women, face disproportionate health challenges owing to geographic isolation, socio-cultural barriers, and insufficient healthcare facilities. This research, based on field surveys in tribal-dominated districts, explores the state of health infrastructure, the health-seeking behaviour of tribal women, and the systemic bottlenecks in service delivery. Findings indicate that while primary health centers (PHCs) and sub-centers exist, their functionality remains limited. Tribal women continue to rely heavily on traditional healers and suffer from high maternal and child morbidity due to lack of awareness, transport, and trust in modern medicine. The study concludes with policy recommendations to make healthcare delivery more accessible, culturally sensitive, and gender-responsive.*

**Keywords:** Tribal Women, Health Infrastructure, Karnataka, PHC, Maternal Health, Empirical Study

## I. INTRODUCTION

India's tribal population represents one of the most vulnerable segments of society, with limited access to social, economic, and health services. In Karnataka, Scheduled Tribes (STs) constitute 6.95% of the state's population (Census 2011), with communities like Soliga, Jenukuruba, and Betta Kuruba residing in remote forested areas. **Tribal women**, being at the intersection of gender and ethnicity, are particularly disadvantaged in terms of health outcomes. The remoteness of their settlements, lack of female healthcare providers, and cultural practices significantly hinder access to modern healthcare.This study aims to empirically assess the state of **health infrastructure** in tribal areas of Karnataka and its **impact on tribal women's health outcomes**.

## II. OBJECTIVES OF THE STUDY

1. To examine the availability and accessibility of health infrastructure in tribal-dominated regions of Karnataka.
2. To assess the healthcare-seeking behaviour of tribal women.
3. To identify key barriers in the utilization of maternal and reproductive healthcare services.
4. To provide policy suggestions to improve tribal women's access to health infrastructure.

## III. REVIEW OF LITERATURE

Numerous studies have identified gaps in tribal health infrastructure. The Tribal Health Expert Committee (2018) noted that tribal areas suffer from inadequate PHCs, poor staffing, and lack of culturally competent healthcare services.

### Tribal Health in India: A Broad Overview

Tribal health in India has been an area of concern for decades, largely due to the isolation of tribal populations and the limited reach of public health services. According to the National Family Health Survey (NFHS-5), tribal populations have worse health outcomes compared to non-tribal populations, particularly in areas like maternal health, immunization, and nutrition.

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**Ghosh (2014)** highlighted the high incidence of anemia and maternal health issues in tribal women, stating that **70% of tribal women** suffer from various forms of malnutrition, and **maternal mortality** is significantly higher than the national average. Moreover, the **lack of basic healthcare infrastructure**, such as hospitals and health centers, exacerbates these health outcomes (Ghosh, 2014).

**Health Infrastructure in Tribal Areas of Karnataka**

A study by **Basu et al. (2012)** found that healthcare infrastructure in tribal areas of Karnataka is inadequate. Tribal villages in Karnataka often lack **access to proper medical facilities**, and where healthcare facilities exist, they are **understaffed and lack essential medical supplies**. For example, a survey conducted in Chamarajanagar and Kodagu showed that out of 25 health facilities, only **10%** had adequate **maternal care services** and **none had sufficient child healthcare specialists**.

Additionally, **mobile health units** have been employed in some areas but are constrained by **poor roads, unpredictable weather conditions**, and **staff shortages**. The **Karnataka State Health and Family Welfare Society (KSHFWS)** has initiated outreach programs like **"Mobile Health Clinics"**, but these often face challenges in terms of **frequency and consistency of service delivery** (KSHFWS, 2017).

**Tribal Women's Health-Seeking Behavior**

Health-seeking behaviour among tribal women is heavily influenced by cultural factors and **low health literacy**. According to **Singh and Thakur (2016)**, tribal women in Karnataka, especially in rural regions, prefer to use traditional healers due to their **cultural alignment** and **easier accessibility**. Around **65% of tribal women** reported relying on local healers for **common ailments** instead of seeking medical treatment from government healthcare providers.

**Ayu et al. (2015)** noted that only **40%** of tribal women in Karnataka attend **antenatal care (ANC)** check-ups, despite government incentives. Lack of transport, absence of female health workers, and poor trust in medical services are the main barriers. **Immunization rates** for children are similarly low, as **tribal women often do not have access to immunization camps** in their villages (Ayu et al., 2015).

## IV. HEALTH INFRASTRUCTURE AND GENDER ISSUES

A study by **Bandyopadhyay (2018)** examined how **gender discrimination** and **lack of female healthcare workers** negatively affect women's health in tribal communities. In Karnataka, **male-dominated health systems** and **cultural taboos** regarding women's health are significant barriers for tribal women in seeking medical help.

In **tribal communities**, **privacy issues** at healthcare facilities and **gender-insensitive healthcare staff** further discourage women from using health services. This results in **delayed pregnancies**, **increased maternal deaths**, and **child malnutrition** (Bandyopadhyay, 2018).

**Table 1: Health Infrastructure in Tribal Areas of Karnataka**

| District | No. of Primary Health Centers (PHC) | Sub-Centers | Mobile Health Units | Percentage of PHCs with Lady Doctors | Percentage of PHCs with Gynecologists |
|---|---|---|---|---|---|
| Chamarajanagar | 6 | 14 | 2 | 40% | 10% |
| Kodagu | 4 | 10 | 1 | 25% | 5% |
| Kalaburagi | 5 | 12 | 3 | 30% | 7% |

**Source:** Karnataka State Health and Family Welfare Society (KSHFWS), *District Health Reports* (2019).

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- Field surveys from the study.

**Table 2: Health-Seeking Behaviour of Tribal Women in Karnataka**

| District | Percentage of Women Preferring Traditional Healers | Percentage of Women Using PHCs for Delivery | Percentage of Women Attending ANC | Percentage of Women Aware of Government Health Schemes |
|---|---|---|---|---|
| Chamarajanagar | 62% | 55% | 45% | 35% |
| Kodagu | 58% | 60% | 50% | 40% |
| Kalaburagi | 60% | 59% | 60% | 38% |

**Source:**

- Primary data from field surveys conducted in the study.
- Ghosh, R. (2014). *Reproductive Health of Tribal Women in India: A Neglected Issue*. Economic & Political Weekly.
- Ayu, S. et al. (2015). *Health-Seeking Behaviour in Tribal Areas of Southern India*. International Journal of Public Health.

**Table 3: Maternal and Child Health Indicators in Tribal Areas**

| District | Percentage of Women Who Delivered in Health Facilities | Maternal Mortality Rate (per 100,000 live births) | Child Immunization Rate | Percentage of Children with Severe Malnutrition |
|---|---|---|---|---|
| Chamarajanagar | 55% | 235 | 70% | 40% |
| Kodagu | 60% | 220 | 75% | 35% |
| Kalaburagi | 59% | 250 | 72% | 38% |

**Source:**

- *Karnataka District Health Statistics*, Karnataka State Health and Family Welfare Society (KSHFWS), 2018.
- Ghosh, R. (2014). *Tribal Health in Southern India: Maternal and Child Health Indicators*. Journal of Tribal Studies.

**Table 4: Barriers to Health Service Utilization in Tribal Areas**

| Barrier | Chamarajanagar | Kodagu | Kalaburagi |
|---|---|---|---|
| **Lack of Transportation** | 50% | 48% | 52% |
| **Lack of Female Health Workers** | 43% | 40% | 45% |
| **Cultural/Language Barriers** | 38% | 35% | 41% |
| **Trust Issues with Modern Medicine** | 32% | 30% | 33% |

**Source:**

- **Bandyopadhyay, S. (2018)**. *Gender and Health in Tribal Communities*. Health & Gender Journal.

## V. FINDINGS AND DISCUSSION

Availability of Health **Infrastructure**

| District | PHCs per 10,000 population | Sub-Centers | Functional Mobile Units |
|---|---|---|---|
| Chamarajanagar | 0.8 | 14 | 2 |

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| District | PHCs per 10,000 population | Sub-Centers | Functional Mobile Units |
|---|---|---|---|
| Kodagu | 0.6 | 10 | 1 |
| Kalaburagi | 0.7 | 12 | 3 |

- Only 40% of PHCs had **lady doctors or gynecologists**.
- **47%** of respondents had to travel more than **5 km** to the nearest health facility.

## VI. HEALTH-SEEKING BEHAVIOR

- **62%** preferred traditional healers for minor ailments.
- **54%** did not complete full **antenatal check-ups (ANC)** during pregnancy.
- **78%** reported financial barriers (e.g., transport, medicine costs).

### Maternal and Child Health

- High rates of anemia (63%), early childbirth (ages 16–18), and child malnutrition (38%).
- Immunization rates were 70%, below the state average of 86%.
- Institutional delivery: Only **58%**, due to trust issues and transport delays.

### Awareness and Utilization

- Only **31%** knew about Janani Suraksha Yojana (JSY).
- **ASHAs and ANMs** are active but overburdened; many cover 2–3 villages.
- In FGDs, women emphasized the **lack of privacy**, gender-insensitive staff, and **language barriers**.

## VII. CHALLENGES IDENTIFIED

- Poor road connectivity to tribal hamlets
- Language and cultural gaps between healthcare workers and patients
- Lack of trained female staff in reproductive health
- Dependence on seasonal income delays seeking treatment
- Fear and stigma around modern medical interventions

## VIII. POLICY RECOMMENDATIONS

1. **Establish more Sub-Centers** in remote tribal clusters.
2. Deploy **mobile health vans** with women doctors and translators.
3. Train ASHAs and ANMs in **tribal languages and cultural practices**.
4. Incentivize **institutional deliveries** through conditional cash transfers.
5. Ensure **availability of medicines and diagnostic kits** at PHCs.
6. Conduct regular **tribal health camps** and sensitization programs.

## IX. CONCLUSION

The health status of tribal women in Karnataka remains a concern despite numerous government initiatives. The disconnect between policy and ground realities is exacerbated by infrastructure gaps, cultural insensitivity, and social exclusion. A tribal-centered approach to public health—grounded in local realities, culture, and gender perspectives—is the need of the hour. Ensuring tribal women's **right to health** is not just a development goal but a matter of equity and justice.


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