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Sub-Tribal Communities and Maternal Mental Health: A Sociological Lens on Perinatal Challenges in Manipur

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Abstract: Perinatal mental health has emerged as a critical public health concern globally; however, it remains inadequately explored within the socio-cultural contexts of India's Indigenous and tribal communities. This paper offers a theoretical and review-based analysis of perinatal mental health issues among sub-tribes in the Churachandpur district of Manipur, which is one of the ethnically diverse regions in Northeast India. Drawing on sociological theories of health, illness, and care—particularly symbolic interactionism, structural functionalism, and intersectionality—the paper critically examines how socio-cultural norms, gender roles, kinship systems, marginalization, and access to healthcare shape maternal mental health experiences in the perinatal period. By reviewing existing literature and regional studies, the paper foregrounds the need for culturally sensitive frameworks and mental health interventions that consider the lived experiences and realities of tribal women. It also highlights the gaps in research and policies connecting indigenous communities in Northeast India, advocating for a more inclusive and decolonized sociological engagement with maternal health.

Keywords: Gender, Indigenous communities, intersectionality, Manipur, Maternal Care, Northeast India, Tribal women, Perinatal Mental-health, Sociology of Health, Tribal women

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Introduction

"India is categorised as a lower-middle income country according to the World Bank's Country Classification" (The World Bank, 2023). It is the world's most populous nation (United Nations, 2023a). India is currently home to 18% of the world's population. In India, women make up 48% of the population. Research has shown that India has a high prevalence of mental health problems, as per the record of "Indian State- Level Disease Burden Initiative, about 197.3 million people in India suffered from mental health issues in the year 2017, which is roughly every seventh Indian affected with varying degrees of severity" (Sagar et al., 2020). "Out of which, Indian women had a higher percentage prevalence of anxiety and depression (3.9%) than men (2.7%). The "SDG 2030 Agenda" (Ali et al., 2020) has India as a signatory. To lower maternal and newborn mortality, the Indian government has guaranteed to provide all mothers and newborns with high-quality care. However, noticeable disparities between states have been observed in terms of maternal health care service utilization, distribution, and accessibility. One of the most crucial aspects of maternal health is mental health, or perinatal mental health. Meeting women's "physical and mental health needs during this vulnerable period is the fundamental duty of any maternal care system, according to the World Health Organization's Nurturing Care Framework" (WHO, 2018). The mental health during this period has been integrated into the "regular maternity care policy and guidelines in high-income countries; however, this has been ignored in low and middle-income countries" (Rahman et al., 2013)

The period from pregnancy spanning to the first year of postpartum can be challenging and stressful, not only for the "women but also for their intimate partners due to the physiological and psychological changes. One of the most common morbidities during this period is the perinatal mental disorders" (PMDs) (Howard & Khalifeh, 2020). "PMDs are categorised into two types: Perinatal Common Mental Disorders (PCMDs) such as depression, anxiety, somatoform and adjustment disorders, and Perinatal Severe Mental Health Disorders (PSMDs)"

(Fisher et al., 2012). schizophrenia, psychosis, and affective psychosis are the most common morbidities. These mental disorders affect the mothers' "productivity and health outcomes and have a long-term impact on the overall development of the child" (Jones et al., 2014).

"Perinatal mental health is recognized as a significant factor in determining early childhood development, maternal mortality, and birth outcomes of the foetus" (World Health Organization, 2022). Studies have shown that low-and middle-income countries (LMICs) exhibit higher prevalence due to various vulnerabilities like marital or familial issues, financial burden, complications during pregnancy, and other social adversity (Gavin et al., 2005). "Further, culturally influenced gender-based risks make women more likely than men to experience non- psychotic mental disorders" (Chandra & Satyanarayana, 2010). However, despite the high prevalence, mental health problems during the perinatal period remain ‚unrecognized' and ‚unaddressed' (Geyale et al., 2016). Unrecognition of the perinatal mental health problems can be a pressing concern in LMIC due to the stronger associated adverse outcomes.

Recent studies in India (Sidhu et al., 2019; Seshu et al., 2021) have estimated the prevalence of perinatal depression from 14 to 24% and pregnancy-related stress and anxiety to be 30.9% (Aneja et al., 2018) and 23% (Jyothi et al., 2020) of all pregnancy-related disorders in 2020.

Perinatal mental health has become widely recognised in India; however, it has not been given satisfactory attention as it should be, concerning policy and healthcare provisions. Findings indicated that between 22 and 26 percent of Indian women suffer from depression during pregnancy, which is found to be higher among rural and marginalized women, due to factors like inadequate social support, intimate partner violence, and limited access to health care facilities. "These issues can be avoided with early detection and intervention to prevent the progression of symptoms and adverse outcomes" (Patel et al., 2015; Upadhyay et al., 2020). Nevertheless, perinatal mental health conditions are difficult to diagnose, since many women find it difficult "to disclose their symptoms due to the prevailing stigma and often due to the lack of knowledge about what qualifies as a mental health condition" (Alderdice, 2020).

Tribal communities make up almost "41% of the population of the northeastern Indian state of Manipur, which is home to a diverse range of ethnic groups. Each ethnic group has its own distinct identity, languages, customs, and kinship networks" (Hangshing, 2023). Despite the region's high literacy rates, the healthcare system is still unreliable and underfunded, especially in isolated tribal areas. Mental health receives little attention in maternal health services, which are frequently restricted

to basic prenatal care. Perinatal mental health is not only culturally and medically ignored in tribal communities. It is often interpreted through spiritual or moral frameworks rather than "psychological distress, wherein women are prevented from expressing their distress, burdened by the societal expectations of motherhood, resilience, and sacrifice" (Ngaithianven et al., 2019; Haokip, 2018). This cultivates an environment that indirectly encourages the internalization of emotional distress and the perpetuation of untreated mental health conditions. Thus, to understand how perinatal mental health condition is interpreted in the tribal communities, this paper utilizes sociological theories, specifically intersectionality, symbolic interactionism, and structural functionalism. This paper aims to provide a sociological analysis of the mental health issues that tribal women in the Churachandpur district of Manipur face during the perinatal period. It seeks to uncover the intersectant roles of gender, culture, social structure, and healthcare access in shaping women's mental health experiences during this crucial period. Understanding the perinatal mental health problems through the sociological perspective would enable an in-depth investigation of social determinants, rather than individual pathology, that contribute to perinatal distress. It will further provide a framework for developing culturally sensitive community-based interventions to bridge the gap between conventional belief systems and the formal mental healthcare services, which are predominantly essential in the Northeastern region of India, where political marginalisation, ethnic diversity, and developmental disparities come together to create hindrances for perinatal well-being.

Conceptual Framework

"Pregnancy-related emotional and psychological disorders, such as depression, anxiety, postpartum psychosis, and post-traumatic stress disorder, are referred to as perinatal mental health" (Stewart & Vigod, 2019). These conditions are primarily impacted by contextual and socio-cultural factors, particularly in marginalised populations, and are not only the consequence of biological vulnerabilities.

In order to comprehend the complexities of perinatal mental health experiences in the sub- tribal communities of Churachandpur district, it is imperative to move beyond the clinical and individualistic frameworks. Therefore, this paper draws on four interconnected sociological and anthropological frameworks: structural functionalism, symbolic interactionism, feminist intersectionality theory, and

medical anthropology. These approaches deliver a robust understanding of how social roles, cultural contexts, and interactions with the traditional care system, along with the formal mental healthcare system, influence the mental health of tribal women.

According to the Structural Functionalism, which was developed by "Talcott Parsons (1951), every element in the society plays a vital role in maintaining an equilibrium. According to this perspective, family is a crucial social institution responsible for nurturing and socialisation of future generations" (Parsons, 2017). The health care systems, including the maternal health care services, serve an important role in maintaining this equilibrium. However, when there is a disequilibrium in the social institutions, especially the mental health services, women are disproportionately affected. In tribal areas of Manipur, such as Churachandpur district, the inefficiency of the healthcare institutions creates a dysfunction in the family, which in turn jeopardises the stability of the larger community. This theory, thus, contextualises the perinatal mental health problems arising due to systemic breakdown rather than one's pathological condition. "The Symbolic Interactionism developed by Erving Goffman (1963) is centred on the everyday interactions and symbols through which people interpret their experiences. According to symbolic interactionism, mental illness is not just a biomedical condition, but a load of cultural meanings and social stigma, especially in tribal communities" (Carter & Fuller, 2015). Mostly, women in the tribal areas refrain from talking about their mental health problems for fear of being branded as socially inept or spiritually unclean. These attitudes and beliefs are so ingrained into their minds, particularly within the close-knit societies where there is a high level of community surveillance. This theory, therefore, emphasises how language, labels, and collective narratives can silence or pathologise women's experiences during the perinatal period.

"Feminist and Intersectionality Theories by Kimberlie Crenshaw (1989) draws upon a feminist concept that underscores how gender interacts with other identity markers such as geography, class, and ethnicity" (Carbado et al., 2013). This can be associated with how tribal women of Manipur face various forms of oppression, including being a woman in a patriarchal system, living in a dominant ethnic framework, and residing in a rural or tribal region that has not seen enough social and political development as it should. These combined vulnerabilities restrict them from accessing even basic quality maternal care, heightening their risk of mental

health problems. This theory also criticises the gendered expectations of women and motherhood, making it challenging to seek help, instead demanding emotional strength and silence.

"Another influential perspective is contributed by Arthur Kleinman's (1980) Medical Anthropology and Sociology of Care towards medical anthropology, which stresses how culture negotiates and defines health, illness, and care. "According to the theory, traditional healers and clergy hold an important role in the community" (Underman & Hirshfield, 2016). In times of distress, women mostly turn to them, as emotional distress is usually considered an indication of spiritual imbalance or divine testing. These systems, though, may help in achieving spiritual balance, but could also delay or prevent access to formal medical care, despite offering community-based care. So, this framework calls for a culturally competent approach that acknowledges the integration of biomedical knowledge while also respecting the indigenous epistemologies for mental health problems.

Thus, integrating these frameworks calls for a sociological analysis and argues for a comprehensive and culturally sensitive view of perinatal mental health in tribal communities, one that takes into account the interplay of societal roles, cultural meanings, intersectional oppressions, and indigenous care practices.

Understanding the Context: Churachandpur and its Sub-Tribes

The state of Manipur is geographically divided into the valley and hilly regions, where about 29 tribes make up the broad Naga and Kuki-Chin-Mizo groups, called the tribals, inhabiting the hilly regions, while the non-tribals live in the valley regions. As much as the state has diverse ethnic groups, it has also experienced protracted ethnic conflicts and displacements. Churachandpur, which is one of the districts inhabited mainly by the "Kuki-Chin-Mizo, has several major and minor tribes with distinct dialects, customs, and traditions. They are anthropologically analogous in general, though they are known by different names" (Haokip, 2013). The hilly regions are mostly undeveloped and devoid of essential services and infrastructure such as public transport, educational institutions, and other distribution networks. The hilly regions are often at a disadvantage due to socio-economic and health disparities. On the contrary, the valley region ranks among the most advanced in the Northeast.

In comparison to the urban areas, the tribal or hilly regions have fewer mental health resources and inadequate health infrastructure. There is a significant

"treatment gap" in mental illness, or any treatment, showing a marked disparity. "This is particularly noticeable among Indian tribal communities, which have virtually no capacity for healthcare delivery and extremely inadequate infrastructure and resources" (Marbaniang, 2023). The tribal communities living in the hilly region are socially organised around kinship and clan affiliations. Women are predominantly viewed as carers and procreators due to the deeply ingrained patriarchal norms and gendered expectations. Apart from the biological role, motherhood is a social identity that carries with it high standards for moral and emotional toughness. Many women often suppress or "spiritualize their psychological symptoms or emotional distress because they believe that experiencing all these is a sign of weakness or spiritual failure, and also due to fear of stigma" (Kumar & Singh, 2016).

Faith-based organizations and clergy have a significant influence in the tribal regions since Christianity plays a major role. Clergy frequently act as informal counsellors and moral authorities in times of emotional distress. Although these organizations support the community, timely intervention may be delayed due to the spiritual contextualization of mental health problems. Hence, women who are in their perinatal period mostly go through without seeking professional help.

In the realm of medical care, tribal mental health is a neglected and disregarded area. There is a dearth of information regarding the prevalence of mental illnesses in tribal communities and health research on tribal populations globally. Tribal regions have less access to medical facilities and worse health indicators, regardless of the data available. The prevalence of mental illnesses among tribal people is even less well understood.

"There is a considerable body of literature that discusses the disparity in the development between the valley and the hills, most of which has concentrated on political demands and ethnic conflict" (Singh & Singh, 2017). However, the gap in terms of maternal health care services or perinatal mental health services has not been studied extensively and is not well understood. Little attention has been paid to these areas.

Methodology

The methodology used in this study is qualitative, interpretive, and review-based. It uses secondary data sources such as PubMed, Google Scholar, Science Direct, Cochrane Library, and PsycInfo with a focus on sociological knowledge and

theoretical interpretations. The objective is to critically evaluate the existing body of literature currently available on perinatal mental health issues among tribal communities in the Churachandpur district of Manipur. The conceptual nature of the study and its emphasis on examining complex socio-cultural and health-related issues that interact with gender, ethnicity, and indigenous identities make this methodology suitable. The review specifically focused on cultural anthropology and socio- political context of Northeast India, perinatal or maternal mental health, tribal or indigenous populations especially with reference to Northeast India, sociology of health and illness, sociological theories ad frameworks that help in better understanding of institutional, structural and cultural influences on perinatal or maternal mental health. The literature review covers the period from 2000 to 2025 for proper historical depth and current relevance. In order to promote a multidisciplinary understanding, the study also included information and viewpoints from various disciplines like psychiatry, social work, gender studies and public where the literatures were analysed from a sociological perspective, emphasizing the ways in which historical marginalization, cultural beliefs and societal structures impact tribal women's mental health during the perinatal period.

Literature Review

The perinatal period, defined from the time of pregnancy and up to one year after postpartum, is particularly vulnerable for women to develop mental health problems. "Common mental illness (CMIs), especially anxiety disorder and depression, are found to be more prevalent than severe mental illness (SMIs) in the tribal communities, which calls for the urgent need for mental health intervention" (Sutar et al., 2021). Early bonding, cognitive and emotional development, and general well-being can all be negatively impacted by such problems, which can have significant and enduring effects on both the mother and the child (Stein et al., 2014; Surkan et al., 2011). When these problems go undiagnosed or untreated, the consequences can be particularly dire.

"Scheduled Tribes (ST), represent about 8.6% of the Indian population and are at risk of adverse perinatal outcomes such as preterm or still birth due to lack of access to maternal and child health services" (Singh & Kumar, 2024). Among the Indian STs, children under 5 years are found to have a high mortality, but maternal depression has been identified as a key overlooked cause that plays a role.

"The Northeastern regions of India, comprising mostly tribals with a varied socio-cultural landscape consisting of plains, hills, and forests, have been negatively impacted by insurgency, displacements, numerous disaster-prone areas, and lack of accessibility and availability" (Alee & Hassan, 2018). The states are vulnerable to several problems and should prioritise the mental health problems of the people.

"The National Mental Health Survey of India 2015-2016, Assam has an 8.1% lifetime mental morbidity rate while Manipur has a 19.9% lifetime mental morbidity rate" (Murphy, 2017). The socio-cultural factors are primarily connected to people's mental health. Mental illness is a combination of biological, psychological, social, and cultural factors, whereby social and cultural factors significantly contribute to mental illness. In Northeast India, there are several medicinal or herbal plants used by traditional healers for therapeutic or treatment purposes. Traditional birth attendants, herbalists, and diviners make up a portion of the majority. Using "Faith instead of medical methods to treat illness is known as faith healing" (Hassan & Alee, 2018). which is still practiced by some people. "In addition to this, charms and traditional or religious rites are carried out by the person or members of their family" (Hassan & Alee, 2018). This clearly shows that socio-cultural aspects and mental illness are closely interconnected due to their unique dialect and other necessary needs, including health facilities.

Each state has its own dialect, plant and animal resources to meet community needs, including health facilities, according to a study on North-east India's traditional healing practices. To stay healthy, they all adjust to using herbs, animal parts, and mantras. Additionally, it was noted that the "Traditional healers in this area fall into a variety of categories, including birth attendants, herbalists, and diviners" (Ramashankar & Sharma, 2015). A study conducted in Nagaland to understand the beliefs and approaches used by traditional healers to treat mental illness reported that "Psycho-spiritual therapy was used to treat mood disorders, epilepsy and psychosomatic issues" (Longkumer & Rao, 2021).

A similar study conducted among one of the tribal communities in Nagaland also found that mental health issues were considered as a consequence of psycho-social factors by about 74% of the population, where a substantial number of them sought treatment from either a psychiatrist or a psychologist. Nevertheless, 15.4% believed it to be from evil spirits, 25% preferred spiritual prayer, 4.4% preferred traditional healers, and nearly 10.6% preferred both psychiatric assistance and a

spiritual prayer group. Consistent with the study conducted in the same state among both the rural and urban communities, it was also found that traditional healing methods were preferable for treating mental illness. "However, with the rise in substance use disorder and other mental health-related issues, traditional healing demand has declined" (Ningsangrenla & PSS, 2019).

"A recent study conducted in 2023 among the tribal indigenous populations showed that there were 29.8% anxiety and 35% depression prevalent among the tribal perinatal women" (Ansari et al., 2023). A study conducted in Karnataka found that 34% women suffered from depression during the perinatal period. "Psycho-social factors such as lower educational level, unemployment, lower socio-economic status, preference for a male child over a female, and interpersonal relationship issues were some factors associated with it" (Begum, 2024).

Postpartum psychosis is the most severe type of perinatal mental illness. If left untreated, it can have significant repercussions for both the mother and the child. Early treatment in a specialised setting is necessary for "mothers who have postpartum psychosis to protect both the mother and the child, as well as to avoid needless separation of the mother and child. According to reports, postpartum psychosis in India frequently manifests as catatonia" (Nahar et al., 2017). "In India, an estimation of one in five women encounters mental health struggles during the perinatal period, with 7.6% of women reporting self-harm" (Supraja et al., 2016).

According to studies, some common mental health problems that occur during the perinatal period can be "manifested in the form of fluctuations in mood and anxiety and depressive symptoms affecting one's functionality, family system, prenatal care, or impaired mother-baby bonding" (Brockington et al., 2011; Kundakovic et al., 2015). Negative emotions or experiences during the perinatal period, such as fear of childbirth, apprehension about delivery, or childcare, have been associated with perinatal anxiety and depressive symptoms.

Intimate partner violence (IPV) has become a concern for maternal and child outcomes. There are studies that have indicated the "perinatal period as a protective factor as well as a factor that worsens women's ongoing situation, especially for partners who are alcohol dependent" (Chisholm et al., 2017).

"Untreated maternal mental health problems are found to have a lasting repercussion, negatively affecting the psycho-social well-being of not only mothers but also the overall development of the child" (Surkan et al., 2011; Stein et al.,

2014). Neonatal outcomes, including weight and overall health, are affected by the mental health of mothers, leading to maternal and neonatal morbidity or mortality. "Preterm deliveries and low birth weight of babies are quite common among women with perinatal mental health problems in LMICs" (Fekadu et al., 2020).

Family plays a crucial role in improving women's mental health during this period. However, family-related "issues that heighten the risk of perinatal mental health issues include: intimate partner violence, substance use disorder, unintended pregnancy, gender-related roles and responsibilities, poor social support, and most importantly, poor mental health literacy among the perinatal women themselves and their spouses" (Johnson et al., 2012). While social support is essential for women, professionals find it challenging to draw an equilibrium between protecting the privacy of women and involving their families. Family plays a crucial role in promoting the mental health of women during pregnancy and after childbirth.

"However, medical professionals often overlook spouses and family members, leaving women and families uncertain about the responsibilities during and after pregnancy. Thus, families often experience a number of socio-cultural obstacles in providing support" (Taylor et al., 2019).

Therefore, many social determinants, such as economic hardship, a lack of social support, a personal or family history of "mental illness, intimate partner violence experiences, being single, childhood trauma, and other psycho-social stressors, have been shown to increase the vulnerability of women in low- and middle-income countries (LMICs) to mental health issues" (Kishore et al., 2018; Woody et al., 2017). Access to proper mental health care is still severely hampered, even in light of the high prevalence of perinatal mental health issues. These include widespread social stigma, low awareness, especially in rural areas, a lack of mental health professionals with the necessary training, poor transportation, and a lack of basic resources. Further discouraging women from seeking help are societal expectations that women put the needs of their families before their own, worries about confidentiality, and fears of being seen as weak or incompetent. "All of these obstacles work together to cause perinatal mental health disorders to be widely underreported and underdiagnosed" (Fellmeth et al., 2021).

The World Health Organization defined maternal health as "the health of women during pregnancy, childbirth, and the postpartum period." In order to lower the maternal mortality and morbidity and improve women's reproductive health,

women's autonomy in making decisions about their health is essential. "Mother's access to healthcare services such as prenatal care, delivery preferences, etc., is influenced by her financial independence" (Sarmah et al., 2025).

Emerging literature from Northeast India, especially Manipur, emphasises how traditional healing methods and cultural beliefs influence maternal health practices. According to Singh and Devi (2020), many tribal communities avoid formal healthcare in favour of faith-based healing and elders for emotional or spiritual issues. Access to institutional services is restricted because mental distress is framed within communal and spiritual contexts, which is consistent with broader anthropological insights (Haokip, 2018). Given their associations with obstetric complications, developmental delays, and unfavourable parenting outcomes, treating depression and anxiety during pregnancy is essential. Integrated prenatal care, community-based education, and safe interventions are examples of proactive mental health support that can improve maternal and child health outcomes, especially in marginalised populations. This can break the cycle of poor health and promote stronger, healthier families. Despite this, there is still a dearth of research specifically addressing tribal women's perinatal mental health. The majority of research focuses on institutional deliveries and physical health, with little attention paid to postpartum psychological disorders or emotional well-being.

Underdiagnosis is further exacerbated by the lack of culturally relevant assessment instruments. The absence of information on tribal perinatal mental health, the lack of cultural integration in interventions, the under-representation in national surveys, and the restricted use of interdisciplinary approaches are some of the significant gaps. These demand participatory, culturally grounded research that is adapted to the lived realities of Indian tribal women.

Sociological Analysis of Perinatal Mental Health Challenges

It is impractical to comprehend the perinatal mental health of tribal women in Manipur without taking into account the broader perspective of the socio-cultural and structural framework in which they live. Various sociological factors such as the culture, gender roles, access to care, and intersectant identities influence the communities' perceptions and responses towards mental health problems. Cultural beliefs further play a significant role in how mental health is understood. In the context of a tribal community, experiencing mental health problems during the

perinatal period, during and after pregnancy, is viewed not as a sign of a medical condition, but as a sign of spiritual imbalance, weakness, or moral failure. This view perpetuates the stigma associated with disorders such as anxiety, perinatal depression, somatoform, etc. "Keeping in mind the stigma and discrimination attached to mental health, most women tend to suffer in silence without seeking help" (Rathod et al., 2018).

The patriarchal kinship system can be another barrier for women's autonomy in seeking mental health care. "In tribal communities, women are seen mainly as carers and expected to bear adversities without complaining. The head of the family, i.e., the male or the elders, mostly makes decisions. This hinders prompt assistance for maternal mental health issues and perpetuates power disparities based on gender" (Choudhury & Kumar, 2022). Another complexity in the tribal or hilly region is the accessibility of healthcare services, not only due to the geographical location and cultural remoteness. Several medical facilities also lack adequate equipment and trained professionals. "As a result, many women were deterred from using these services due to long-standing mistrust towards formal institutions" (Khamo, 2024). The challenges are augmented by intersectionality- a theory that explains how multiple forms of discrimination overlap with each other. Tribal women are not just marginalized by gender but also by ethnicity, socio-economic status, and rural location. Experiencing ethnic clashes or political unrest and displacement is common to many women, which may add another layer to their trauma or emotional distress. "These overlapping factors enhance their vulnerabilities and reduce accessibility to proper mental health services" (Haokip, 2018). Therefore, understanding these issues through the sociological framework reveals the cultural and structural complications that tribal women encounter and emphasizes the critical need for community-driven, gender responsive, and culturally sensitive mental health interventions.

Policy Gaps and Recommendations

Despite the country's growing attention on maternal and child health, mental health during the perinatal period is still largely ignored in India, especially in the tribal areas. While numerous programs such as the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) framework and the National "Mental Health (NMHP), much attention is not provided to mental health during pregnancy

and the postpartum phase. Moreover, culturally sensitive strategies on the particular requirements of tribal communities are not taken into account" (Gupta & Sagar, 2022).

This negligence creates a gap in several important policies. "First, planning focused interventions is challenging due to the lack of disaggregated data specifically related to the mental health of tribal women" (Khamo, 2024). Second, there are low detection rates because mental health evaluations frequently employ generic instruments that have not been validated for tribal contexts or languages. "Third, there is little to no training provided to frontline health workers, like ASHAs, on how to recognise or treat common perinatal mental health disorders" (Rathod et al., 2017). Lastly, women are denied the chance to receive "comprehensive care at a single point of contact because mental health and maternal healthcare are still separated" (Kumar et al., 2020). A multi-level, culturally sensitive approach is necessary to close these gaps. The following suggestions are put forth:

1. **Interventions Based in the Community:** Encourage local organisations to raise awareness, lessen stigma, and offer basic emotional support, such as churches, women's self-help groups, and traditional tribal councils. "Faith-based and community-led models can be a culturally acceptable starting point for mental health education and have demonstrated efficacy in other marginalised contexts" (Haokip, 2021).
2. **Health Worker Training:** Include mental health education in the training of primary care physicians, auxiliary nurse midwives (ANMs), and ASHAs. "Research has demonstrated that basic training, especially when tailored to local cultural idioms of distress, can significantly increase early detection and referral rates for perinatal anxiety and depression" (Upadhyay et al., 2020).
3. **Integrated Health Services:** Make primary health facilities stronger so they can provide both mental and physical health services. Psychological well-being is addressed as a component of "comprehensive maternal care rather than as a stand-alone concern when mental health screening is integrated into regular prenatal and postnatal checkups" (Khamo, 2024).
4. **Culturally Grounded Research:** Encourage the development of culturally sensitive assessment instruments through participatory research involving

local healers and tribal women. "The accuracy and community acceptance of screening tools are improved by this method, which guarantees that they represent indigenous conceptions of distress" (Kleinman, 1980).

5. **Policy Inclusion:** Push for the explicit inclusion of tribal perinatal mental health in state and federal health policies. In order to establish inclusive and "equitable mental health services, policymakers must acknowledge the intersectional vulnerabilities of tribal women and allocate funds appropriately" (Mahapatro et al., 2021). Public health officials, mental health specialists, sociologists, and the tribal communities themselves will need to work together to address these problems. Tribal perinatal mental health can only be improved in a significant and long-lasting way by taking a structurally integrated, culturally grounded approach.

Conclusion

This study investigated the structural and socio-cultural elements affecting tribal women's perinatal mental health in Churachandpur, Manipur. Through the use of a review-based methodology and sociological frameworks like intersectionality, structural functionalism, symbolic interactionism, and medical anthropology, it brought to light how gender norms, cultural stigma, and limited access to healthcare lead to the under-recognition and inadequate treatment of perinatal mental distress. Due to systemic marginalisation, patriarchal decision-making, and spiritual interpretations of distress, tribal women frequently endure emotional suffering in silence.

The results highlight important gaps in policy, service delivery, and research, especially the absence of integrated care models, culturally appropriate tools, and disaggregated data. A community-led, participatory strategy that takes into account customs and strengthens local stakeholders is needed to address these problems.

In order to create inclusive, equitable, and culturally sensitive mental health services for Indian tribal women, immediate action is required. Perinatal mental health must be viewed as a social justice and public health issue.

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