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Intersecting Mental Health and Social Development: Perinatal Challenges among Sub-Tribal Communities in Manipur, Northeast India

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Abstract

This conceptual paper explores the intersections between mental health and social development by examining perinatal challenges among sub-tribal communities in Manipur, Northeast India. The paper situates perinatal mental health within the broader socio-cultural, economic, and political contexts of marginalised Indigenous populations, particularly focusing on sub-tribal groups who often remain underrepresented in policy and research discourse. It critically interrogates how structural inequalities, gendered expectations, poor health infrastructure, and intergenerational trauma shape the perinatal experiences of tribal women. The analysis draws from Indigenous knowledge systems, feminist frameworks, and public health paradigms to advocate for culturally responsive and community-rooted mental health interventions. By mapping the systemic neglect and community resilience mechanisms, the paper underscores the potential impact of integrated social development policies that address the psychological, social, and developmental well-being of women during and after pregnancy in marginalised tribal contexts.

Keywords: Perinatal mental health; Sub-tribal communities; Manipur; Indigenous health; Social development; Gender; Northeast India; Structural inequalities; Community resilience

JEL Codes: J130, J160, R5

Introduction:

Manipur is in northeast India, and to the east, it borders Myanmar. It is a state with ethnographic diversity born of its geographical and ethnic complexion. It lies west of Assam's Cachar district, south of Mizoram, and north of Nagaland. "Manipur's inhabitants are of Mongolian descent and have varied ethnic cultures, traditional practices, religions,

and languages. The ethnic group of the majority, known as 'Meitei', lives in the central low-lying valley. The hilly regions are occupied by two ethnic groups: the Nagas and the Kuki-Chin-Zomi/Mizo" (Mishra et al., 2021; Siamkhum, 2014).

Since Manipur, a conflict-affected state, is home to diverse populations with several sub-tribal groups in the "hilly regions where most places are remote, have poor resources, and face marginalization in terms of development, healthcare facilities, and accessibility, along with many other under-presentations of policies" (Pautunthang, 2024). Additionally, tribal women living in the hilly region often experience significant barriers to "accessing healthcare services due to a lack of specialized health and mental health services and professionals" (Yumnam, 2024). The area of perinatal mental health, which is a part of maternal and child well-being, has remained under-explored, irrespective of its cruciality. Thus, this paper aims to bring perinatal mental health concerns of sub-tribal women in Manipur to the forefront by critically exploring the socio-political determinants affecting health outcomes. It seeks to contribute to the growing discourse on Indigenous mental health by advocating for development and care approaches responsive to the culture and community.

Understanding Perinatal Mental Health:

"Mental health is a crucial and fundamental part of health. Globally, it has been progressively recognized as a critical component of overall well-being and prioritized within the public health framework" (Francis et al., 2012). It does not only mean the absence of mental disorders but also the presence of positive mental health "which includes emotional well-being and the ability to cope with life's challenges" (Feller et al., 2018; Orpana et al., 2016). Globally, mental health problems are among the top ten contributors to the global disease burden (Charlson et al., 2019; GBD, 2019). In India, studies have shown that "10.6% of the population is affected by mental health problems, with at least 20% of the overall population. Further research has also highlighted gender disparities, with women, especially during the perinatal period, living in rural areas being at a higher risk as compared to men" (Malhotra & Shah, 2015; Howard & Khalifeh, 2020; Ram et al., 2012). "Mental health problems during this period are often overlooked in the reproductive health domain" (Gelaye et al., 2016). The perinatal period is broadly defined

as extending from one year before birth to 18 to 24 months after delivery (Helfer, 1987). Meltzer-Brody and Jones (2015) defined this period as extending from preconception planning to the postpartum phase following childbirth, emphasizing the importance of addressing the entire trajectory of this critical time. This period represents a significant developmental transition that can be understood through a "biopsychosocial framework, involving substantial changes across biological, psychological, and social aspects contributing to the emergence of mental health problems" (Nagle & Farrelly, 2018; Diamond et al., 2020). Globally, an estimated "10-15% of women experience significant mental health disorders during the perinatal period, which is found to be higher in LMICs" (Fisher et al., 2012).

Various factors, such as cultural beliefs, customary practices, and access to healthcare, influence mental health among tribal and rural populations. Due to the varied biological, physical, psychological, emotional, and other social changes, the "perinatal period is considered vulnerable. Any disruptions during this vulnerable period impact maternal well-being and have a long-lasting impact on the child's overall development" (Rahman et al., 2013).

"Studies have shown that common mental health disorders (CMDs) are the most common issue experienced by women during the perinatal period, including anxiety and depression, with a 15%-20 % prevalence in low middle-income countries, which can lead to suicidality in severe cases" (Fisher et al., 2012; Supraja et al., 2016). Chandra et al. (2021) in their study found that perinatal mental health problems of mothers were negatively associated with the development of the foetus, mother-baby attachment, and higher obstetrical complications. Factors such as early maternal age, perceived inadequate social support, history of intimate partner violence, history of mental health issues, and suicidal risk. Furthermore, women in LMICs face heightened "vulnerability due to many other social challenges, such as economic hardships, unmarried status, childhood trauma, and other psychosocial stressors" (Kishore et al., 2018; Woody et al., 2017; Chmielowska & Fuhr, 2017).

Objectives:

1) To investigate the socio-cultural, economic, and structural factors affecting perinatal mental health among sub-tribal women in Manipur within the broader context of social development.
2) To assess how traditional beliefs, gender norms, and community practices shape maternal mental health experiences.
3) To identify service delivery gaps and promote culturally responsive, community-based, gender-sensitive mental health policies.

Methodology:

This paper adopts a conceptual and interdisciplinary approach by integrating Indigenous knowledge systems, Feminist frameworks, and public health paradigms. It employs a narrative literature review of academic journals, reports (such as those from NMHS and WHO), and policy documents, alongside a critical analysis of secondary data, to explore the socio-political and cultural determinants of perinatal mental health. The methodology involves thematic synthesis and contextual grounding in the lived realities of Manipur's sub-tribal communities without primary data collection.

Sub-Tribal Communities in Manipur: Social and Cultural Context:

Manipur is ethnically diverse, with many sub-tribal communities predominantly residing in the hilly regions and having their customs and traditions. Ethnographically, these tribal communities possess a robust cultural identity characterized by distinct dialects and languages, clan descent, and customary laws. These tribal communities are "predominantly patriarchal, composed of different clan-based affiliations that form social norms, kinship or group identities, and decision-making systems" (Huirem, 2024). Social structures are given importance as they are closely associated with their indigenous belief systems. "Christianity, which was brought in during the colonial era, plays a crucial role in shaping their moral and spiritual life" (Haokip, 2013).

Additionally, cultural knowledge systems and traditional beliefs play a vital role in shaping maternal health practices among tribal communities. During the perinatal period, some are still bound by "cultural rules and taboos surrounding the behaviour and diet of women. For instance, some restrictions on foods, such as avoiding banana flowers or some

fermented foods, are believed to cause miscarriage" (Nijhawan & Mihu, 2020). With advancements in education and knowledge, many others still practice "non-institutional deliveries with older women or midwives" (Humtso & Soundari, 2019). The post-delivery period, usually "7 to 30 days, is crucial when the mother is given healthy foods for recuperation care. These are not only for the safety and health of the mothers but also to position them within a system of familial and communal support. Since the initiatives taken by health missions such as Janani Suraksha Yojana (JSY), institutional deliveries have been practised more" (Shimray & Devi, 2014).

While the roles of women are important in the family and society in aspects like agriculture, domestic economies, and preservation of cultures, gender roles are determined by patriarchal values. The kinship system is patrilineal, with clan membership passing through males and inheritance mostly to the sons. "Women usually relocate to their husbands' homes, restricting their direct support from their biological kinship and access to land ownership" (Shimray, 2004). Despite these structural limitations, women's roles in informal and religious settings are found to be prominent. "Their roles in churches, community welfare programs, and advocacy for maternal health are being more acknowledged" (Mondal, 2023). Irrespective of all these, their reproductive autonomy is restricted by cultural expectations and limited access to mental health care, particularly in rural or tribal areas. Researchers have argued that the intersection of gender, tribal identity, and socio-economic marginalization increases women's vulnerability during the perinatal period "Stressors such as domestic burden during the perinatal period, poor awareness of mental health, poor transportation, lack of support from family, and limited accessibility of health care exacerbate maternal mental health concerns in Northeast India" (Gupta et al., 2025) points out that interventions are often top-down and culturally misaligned, leading to underutilization of services.

Perinatal Challenges: Mental Health Dimensions:

In India, the tribal population varies from region to region. Based on the 2011 census, there were 705 Indigenous Scheduled Tribes in India, accounting for 8.6% of the country's population. Each tribal community exhibits a wide diversity, even within a single state. Despite the existing diversity, they share a commonality in their experiences of social

discrimination, marginalization, and poverty. They also bear the brunt of many health problems, including malnourishment, mental health issues, addictions, mortality, and morbidity issues, along with limited access to healthcare facilities intricated by poor help-seeking behaviour. "The tribal community goes far behind the country's average on numerous health metrics, making women and children one of the most vulnerable groups" (Sharma et al., 2015). An estimated one in every ten people in India suffers from mental health issues, according to the "National Mental Health Survey 2016" (Gautham et al., 2020). Women are found to have a higher risk of having mental health problems than men, especially those in the perinatal period. Mental health issues, such as depression and anxiety, ranging from mild to moderate distress, are reported to be one of the most typical issues.

Untreated perinatal mental health problems were also correlated to a higher risk of "suicide and other adverse outcomes such as miscarriages, preeclampsia, preterm delivery, low birth weight, developmental delays, impaired mother-baby bonding, and poor mental health outcomes in the child" (Rahman et al., 2003; Vesga Lopez et al., 2008). Further, children of "highly anxious mothers have twice the risk for ADHD and other behavioural symptoms" (O'Connor et al., 2003; Rogers et al., 2020). Similarly, mothers with postpartum depression were more likely to be negligent in "child-rearing and breastfeeding" (Britton, 2007; Choi et al., 2019). Contrary to this, a systematic review of "14 articles revealed that the impact of perinatal anxiety on a child's emotional problems was low" (Rees et al., 2019).

Stigma and cultural issues may have a significant impact on the mental health of perinatal women among the tribal population. Factors such as the traditional belief system and other psychosocial issues- intimate partner violence, substance use, and poor interpersonal relationships with in-laws may heighten the vulnerability. "Family and societal roles contribute to shaping the perceptions and help-seeking towards mental health problems. In many tribal communities, mental health problems are still viewed in the context of superstition, black magic, weak religious beliefs, or moral weakness or shame, thereby stigmatizing and socially alienating the victim" (Kumar et al., 2017). Concurrent factors like religion and traditional beliefs add another layer of complexity to women's mental

health experiences. Although family takes the prime "responsibility in caregiving, the lack of awareness and resources towards mental health is often overlooked and goes unnoticed; particularly, women with mental health issues face stigmatization as they are often linked to the notions of impurity, weakness or unfit for motherhood" (Reji, 2025). Family and Societal Attitudes toward Women with Mental Illness in India: A Systematic Review of Barriers and Support. Thus, these misconceptions often lead to preliminary consultations with faith healers rather than mental health professionals. Existing literature has highlighted the poor mental health literacy and stigma attached to mental health problems among the "tribal communities and health care providers, hampering impeding time interventions" (Goyal et al., 2020; Insanet al., 2022).

Kumar et al. (2017) have highlighted that "most tribal inhabited populations are detached from the national socio-economic mainstream, where the mental health literacy rate is minimal, and public health services are limited due to geographical remoteness". It has been pointed out that socio-cultural beliefs, systems, and practices strongly affect their health status and help-seeking behaviour. Concerning Manipur, which has a history of "protracted armed conflict, women suffer indirectly or directly due to this, where the burden of mental health becomes higher" (Kesharvani & Sarathy, 2020). The protracted conflict has propagated psychological distress, including anxiety, fear of uncertainty, and other social and economic challenges. However, these issues are rarely acknowledged as legitimate illnesses due to a lack of awareness and stigma. Parallel to this, healthcare systems, in most cases, fail to address perinatal mental health, and women suffer in silence, fearing discrimination, ostracisation, or poor understanding of mental health.

Health Systems and Developmental Gaps:

"Mathur et al. (2014) showed that a substantial population in India is not aware of mental illness and the availability of mental health care". The National Mental Health Programme has prioritized and addressed the issue of stigma towards mental illness through the dissemination of IECs; however, it has not been fully effective. From the "National Mental Health Survey 2015-2016 data, all states had at least one mental health hospital, except Manipur". All states also had medical colleges with psychiatric departments and general hospitals with psychiatric units. Despite the few existing infrastructures, there is a

shortage of skilled professionals and inconsistent service delivery. For the year 2021-2022, India's Ministry of Finance allotted Rs. 712,690 million to the Ministry of Health and Family Welfare, out of which Rs. 5970 million was given to mental health care and only Rs. 400 million to the National Mental Health Programme (NMHP). Although these national programs have been implemented to address the existing burden of perinatal mental health, their execution in the tribal areas is poor due to logistical, political, and bureaucratic barriers.

While mainly in the tribal regions, traditional healers or faith leaders are usually one of the first points of contact for individuals experiencing any mental health or health problems. They are well-trusted and respected by the community as they hold substantial cultural legitimacy, making them the key actors in the local health-seeking process.

Their understanding of mental health problems and healing methods aligns with the community's beliefs. "Often, mental health problems are attributed to spiritual imbalance or caused by black magic, which is more acceptable and relevant for the local community than biomedical diagnoses like postpartum anxiety and depression" (Kleinman, 1980).

Noticing this, global health agencies such as the "World Health Organisation" (WHO,2002; WHO, 2022) have advocated mainly for collaborative efforts between traditional faith healers and formal health sectors. Enhancing treatment adherence also "encourages health professionals to acknowledge cultural practices and indigenous healing metaphors for better outcomes" (Patel & Prince, 2010). These approaches are expected to fill the treatment gaps, reducing stigma and enhancing treatment plans and help-seeking behaviour rather than completely replacing traditional beliefs and practices.

Intersecting Social Development and Mental Health:

Among the tribal communities of Manipur, poor mental health remains a barrier to social development. "Structural injustices such as ethnic conflict, political instability, economic marginalization, poor healthcare facilities, and other issues result in poor mental health outcomes. These systemic concerns heighten the vulnerability of mental health during the perinatal period" (Kaur et al., 2021). Additionally, the absence of culturally sensitive

screening tools and therapeutic interventions results "in underreporting and under-recognition of mental health needs in the communities" (Barua et al., 2024). In such situations, approaches that are community-oriented, like the Self-Help Group (SHGs), "tribal women organizations, and other local tribal governance, have the potential mechanism for mental health resilience and recovery if strengthened with psychoeducation and psychosocial interventions" (Saggurti et al., 2018).

Recent studies have indicated that "incorporating mental health awareness into community development programs enhances emotional well-being and social participation" (Tripathy et al., 2016). Among the Christian tribals, churches and women's fellowships serve as a culturally strong support system, providing a platform for psychosocial care. Integrating mental health discussions during this fellowship and within the SHGs can provide a safe space for healing and empowerment among women. Along with this, "gender-sensitive and culturally grounded approaches, recognizing the problems and psychosocial issues, are essential" (Rao et al., 2023).

Findings:

Perinatal mental health remains significantly under-recognized among tribal communities in Manipur due to cultural stigma, low mental health literacy, and limited access to services. Structural challenges such as geographic remoteness, poverty, and inadequate healthcare infrastructure exacerbate these vulnerabilities. Patriarchal kinship systems and traditional gender roles further limit women's autonomy and access to care during pregnancy and the postpartum period, restricting their ability to seek timely and appropriate support.

Traditional beliefs and faith-based healing practices often shape help-seeking behaviour more strongly than biomedical approaches, especially in the absence of culturally responsive care. While community-based mechanisms like women's fellowships, SHGs, and religious networks offer informal support, they lack integration with formal mental health services. Government programs, including the NMHP and JSY, have limited effectiveness due to poor implementation, while armed conflict further compounds maternal stress and trauma.

Conclusion:

A complex interplay of socio-cultural norms, structural barriers, and entrenched gender expectations shape perinatal mental health among sub-tribal populations in Manipur. This paper has underscored that maternal mental health cannot be treated as a standalone health issue but must be integrated into broader frameworks of social justice and development. When left unaddressed, poor perinatal mental health outcomes affect not only the mother and child but the community at large. Justice in this context demands bridging the gap between formal mental health services and Indigenous belief systems through inclusive and respectful strategies. Tribal women's experiences must be brought to the forefront of policy, ensuring that their voices shape programmatic responses. Only with intersectional, community-embedded approaches can we ensure a future that is healthier and fairer for the tribal women of Northeast India.

Recommendations:

Perinatal mental health should be integrated into existing maternal health services under the National Health Mission, with a specific focus on tribal and rural areas. Culturally relevant screening tools and awareness materials must be developed, taking into account Indigenous worldviews and local languages. Frontline workers such as ASHAs, ANMs, midwives, and SHGs must receive training in basic identification, counselling, and referral procedures. Community-based initiatives, such as psychoeducation through women's fellowships and tribal organizations, can play a significant role in reducing stigma and fostering resilience. Collaboration with traditional healers and faith leaders is essential to enhance cultural alignment and acceptance. Mobile mental health clinics and dedicated budgets are critical to reach remote tribal areas. Additionally, participatory research that documents the lived experiences of tribal women will help formulate more grounded and responsive policy interventions while strengthening local tribal governance will ensure sustainability and community ownership.

At a broader level, the recommendations call for systemic changes that reflect both national and international best practices. Drawing on the World Health Organisation's Nurturing Care Framework (2018), there is a need to ensure that maternal mental health

is integrated into the standard package of care. While high-income countries routinely incorporate mental health screening and treatment into maternal services, low- and middle-income settings like India lag (Rahman et al., 2013). It is crucial to allocate resources, deploy trained mental health professionals in tribal regions, and establish accountability mechanisms within health programs (WHO, 2022; Patel & Prince, 2010). The development of culturally appropriate screening tools (Barua et al., 2022) and capacity building among community actors can ensure early intervention. Above all, focused research and authentic engagement with tribal women's experiences are essential to drive inclusive, rights-based, and locally relevant mental health responses.

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