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Study on Reproductive and Maternal Health Care Services among Tribes: Research for Tribe Development in Jharkhand

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Abstract

Maternal health is the urgent need of the India and state as it contributes to the overall progress of the country. Jharkhand state has strived hard to improve on the maternal health indicators but the progress is slow and steady. There are many causes hampering the smooth progress of maternal health status. The medical causes (direct & indirect) which include Severe Bleeding Hemorrhage, hypertensive diseases unsafe abortion, Obstructed Labor, Ectopic Pregnancy and infections are direct causes, whereas the indirect causes include Anemia, Malaria, Heart Disease and Tuberculosis and HIV. Whereas the social determinants of maternal mortality are poor educational levels, early age of marriage, early pregnancy, decreased spacing and large family size that contributes to the existing situation of maternal health status in Jharkhand. The health care delivery system should be designed effectively to cater to the specific needs of the tribal women during pregnancy and at childbirth by ensuring their personal involvement. Health interventions must focus on tribal culture, medical training of the tribal people, and a knowledgeable health care delivery system catering to the needs of tribal women and the child

Keywords: Gende, Tribes, Maternal Health, Reproductive Health, HIV/AIDS, Women Rights, Empowerment

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Introduction

Jharkhand is the home of largest tribes in India. According to the census 2011, the state accounts contributes 8.4 ST populations to the total ST population of the country. The major concentration of tribal population is in the six districts of Ranchi, Lohardaga, Gumla, West Singhbhum, Dumka and Pakur where more than 40 percent of tribal population of Jharkhand resides. With regard to the maternal health performance of the state is very poor. There is a common agreement that the reproductive health status of the tribal population in Jharkhand is very poor, deficient in sanitary conditions, personal hygiene, and health education (8Youth in India, Jharkhand state report, 2007). Tribal mothers have high rates of anemia, and girl children receive less than the desired nutritional intake. All told, the whole tribal community is deficient in adequate food intake. The level of knowledge and practice of family planning was also found to be low among the Scheduled Tribes (13Pandey Vipul; Singh S K ,2018). There is a need for proper understanding of the different health aspects of tribal women and their specific health needs so that relevant health measures can be prepared and implemented. More predominantly, there is a need for undertaking a region-specific study of the health of the tribal women, which will make arrangement for their welfare more flourishing. Every year, over half a million women die of pregnancy related causes worldwide and more than 99 percent of these incidences occur in the developing world (4Heisel 1999). Among the major objectives of National Rural Health Mission (10NRHM, 2005, 2012) are to reduce Infant and maternal mortality and also to improve it which is expected to be achieved with increased utilization of the maternal healthcare services and promoting Institutional Delivery in order to protect both mother and child. Maternal and Reproductive health as a concept is about Family planning, Preconception, Prenatal and Postnatal care. Various studies have shown that women who started prenatal care early in their pregnancies have better birth outcomes than women who do not receive any care or very little care. Reproductive health is not only about mortality/morbidity, it is about the recognition of women's rights to control their fertility and sexuality, and empowering women to avoid sexual violence. Maternal health is the urgent need of the state as they contribute to the overall

progress of the country. Jharkhand state has strived hard to improve on the maternal health indicators but the progress is slow and steady. There are many causes hampering the smooth progress of maternal health status. The medical causes (direct & indirect) which include Severe Bleeding Hemorrhage, hypertensive diseases unsafe abortion, Obstructed Labor, Ectopic Pregnancy and infections are direct causes, whereas the indirect causes include Anemia, Malaria, Heart Disease and Tuberculosis and HIV. Whereas the social determinants of maternal mortality are poor educational levels, early age of marriage, early pregnancy, decreased spacing and large family size that contributes to the existing situation of maternal health status in Jharkhand . Using data from National rural health Mission conducted during 2008-09 focus is on analyzing the utilization of the maternal health services such TT injection, place of delivery and Women receiving the Postnatal Care in Jharkhand, one of the EAG states of India. In addition, the paper has also tried to focus upon the awareness level of the women with regard to the JSY Scheme, Women knowing about the ASHA and her roles, Knowledge about the HIV/AIDS and Ideal age for a woman to become mother.

Literature review

"A healthy woman breeds a healthy race". This can only be significant where the woman knows the importance of health and its implications upon her life and other's. Specifically during pregnancy where due to unavailability of the quality services may lead to loss of life or disability, either or both of the women and child. Reducing maternal mortality and morbidity has a major focus for the developing world since the launch of the safe motherhood initiative in 2001 (16WHO, 2002). It has been said that with increase participation and utilization in the maternal health care services can bring significant changes in the maternal health of the women. With the introduction of NRHM in the year 2005, and it's one of the important goal is bring improvement in the Maternal and child health. In health care utilization there are two aspects implying the availability and quality of the health care system. This is also influencing the health seeking behavior of the clients. The prevalence of anemia among women in Jharkhand is higher than in almost all other Indian states (14Rani, S.,2007).

Under the NRHM there is provision for Accredited Social Health Activists. The name itself suggests 'Ray of Hope' acts as a connecting link between the community and the public health system. One of the core strategies of National Rural Health Mission is to promote access to improved healthcare at household level through ASHA. Since the early days of independence, strengthening of maternal health care services has been an essential component of all development programmes and has received attention in all Five years plans with an objective to improve the availability, accessibility and quality of health care services in India.. The maternal health component of the maternal and child health after a long time in 1990's when government of India launched child survival and safe motherhood programme (3Government of India 2004). The major paradigm shift in the delivery of maternal and child health was with the introduction of the reproductive and child health approach in 1997 for the implementation of the National Family Welfare Programme following the recommendations of the World Bank and the consensus arrived at the International conference on Population and development at Cairo. Nearly of all maternal deaths is developing countries occur during labour or delivery, or in the immediate postpartum period. Key factors influencing programs aimed at reducing these deaths are who delivers the woman and where she delivers (1Campbell 2002).

Despite the fact that Maternal and child health services have been an essential component of all health care development plans and activities in India since independence, the current Maternal Health scenario cannot be termed as satisfactory (9Mohanthy, 1997.). Considering the situation in India where women lag far behind as compared to males, her health preferences and perception are difficult to understand. Many of the so called "female Conditions" are not considered health problems, either by the health professionals or by the women itself (14Shina R K , 2005,).

The social distance between the women and a health centre due to her religion, caste, class, level of autonomy is an even greater gulf than physical distance

Poorly educated women are more likely to get married and have children at an earlier age. Culturally too the women are taught to accept and mould themselves into the culture of silence. Regarding physical access to healthcare, travel time is also an important factor influencing in several ways the utilization of the maternal health services. The distance from the place of living or house is also highly influencing her utilization pattern and preferences for maternal health services.

Need for the study

Various demographic indicators of the state show the low health status of the women from various aspects. Since the NRHM has been launched several studies have been made to understand the utilization pattern among the women. In Jharkhand institutional deliveries is only 13.4 in the rural areas 6NFHS 3, 2005-06) and deliveries at home raises upto 86.2 (6NFHS 3, 2005-06). Along with this there are lot more variation among the EAG states too such as in Orissa institutional deliveries is around 40.4 and home deliveries is approximately 58.5. It is crucial to explore why the women still prefer home delivery when they can take benefit of the institutional deliveries and receive incentives at the same time. It is noticeable that among all the EAG states the poorest performance with regard to the Maternal Health is in the Jharkhand.

Therefore the specific objective of the study is to understand the utilization pattern of the maternal health services among the tribal women in Jharkhand.

Data Source

The present study used field work data collected from 247 Santhal women during PhD(2014-15) and National Rural Health Mission (2005-12) concurrent evaluation data to complete the study. The concurrent evaluation of the NRHM, conducted during May to December 2009. The concurrent evaluation was completed in 187 districts and covering 33 states and union territories. Of the total 2, 13,067 eligible women were interviewed.

Methodology

In order to analyze maternal health Utilization among the women in EAG states, three indicators

namely, Tetanus Toxoid (TT) Vaccine, Place of Delivery and Skilled Birth Assistance has been taken.

Tetanus Toxoid (TT) Vaccine:

Women were asked whether they were given the injection or not when they were pregnant in order to prevent them and their babies from getting tetanus. Along with this they were also asked about how many injections they received.

Place of Delivery:

The place of delivery is an important determinant for reducing the risk of Infant and Maternal death. Women were asked about the last three births that they were born at home or institute.

Assistance during Delivery:

In addition to the question asked about the place of delivery women were also asked about the Birth assistance provided if the delivery took

place at home. Assistance during delivery is an important component in the maternal health services. It can significantly reduce the risk of obstructed labour during delivery. Information was gathered about who assisted during home based delivery: Doctor/ANM/ Nurse or midwife, Trained Birth Attendant (Dai) or Non- Skilled Personnel (Friends/Relative etc.), in this study attempt is to show her relevance with regard to the birth assistance in case of home based deliveries.

Reproductive health

Reproductive tract infections/sexually transmitted infections (RTI/STI) among Santhal women (N=247)

The tribal women were asked if they ever heard of sexually transmitted infection (STI). Table 1 shows the differentials of awareness of STI. Around three-fifths of women reported to be aware of STI.

Characteristics	Percent
Ever heard of an RTI/STI	27.1 (N=65)
How is RTI/STI transmitted	
Unsafe delivery	6.6
Unsafe abortion	4.5
Unsafe IUD insertion	2.1
Unsafe sex with homosexual	6.3
Unsafe sex with persons who have many partners	10.0
Unsafe sex with sex works	10.8
Others	0.8

Table-1: Percentage of women age 15-49 years who heard of STI, and awareness about transmission in Santhal, Jharkhand, India, 2014-15

The above table describes the respondent's knowledge regarding to the sexually transmitted diseases. The number of women who said they had knowledge were 65, which came to around 27 percent of the respondents. When asked about how RTI/STI is transmitted, to understand their knowledge on this matter, 6.6 percent said unsafe delivery, 4.5 percent said unsafe abortion, 2.1 percent responded said it's due to unsafe IUD insertion, while 6.3 percent said that it was due to unsafe sex with homosexuals, 10 percent of the respondents believed that it was due to having sex with persons who have multiple sex partners, while 11 percent said that it was due to unsafe sex with sex workers, and the other reasons comprised of 0.8 percent

Characteristics	RTI/STI	N
RTI		
Pain in lower abdomen not related to menses	38.6	83
Pain during urination or defecation	46.9	128
Low backache	61.4	132
Vaginal Discharge	63.8	141
STI		
Itching or irritation over vulva	60.8	130
Boils/ulcers/warts around vulva	58.8	165
Swelling in the groin	20.0	85
Painful blister like lesions in and around vagina	19.0	79
Pain during sexual intercourse	61.4	132
Spotting after sexual intercourse	15.2	79

Table 2: Prevalence of some specific problems of RTI and STI among women age 15-49 years in Santhal, Jharkhand, India, 2014-15

Table 2: The prevalence of some Reproductive tract infections (RTI) and Sexual tract infections (STI) are reported by women, pain in lower abdomen, pain during urination and defecation and vaginal discharge are considered as RTI and itching or irritation over vulva, Boils/ulcers/ warts around vulva, swelling in the groin, painful blister like lesions in and around vagina, pain during sexual intercourse and spotting after sexual intercourse are considered as STI. More than 60 percent of women reported experiencing vaginal discharge followed by 47 percent of women who reported pain during urination and defecation. Further, around 39 percent of women reported experiencing pain in lower abdomen which is not related to menses. When symptoms of STIs are concerned, around 61 percent of women reported experiencing pain during sexual intercourse and itching or irritation over vulva. A little less than 60 percent of women reported boils, ulcers, warts around the vulva followed by 20 percent of women who reported swelling in the groin. Some symptoms of STIs like painful blister like lesions in and around vagina and spotting after sexual intercourse are found reported by very less proportion (19% and 15%) of women

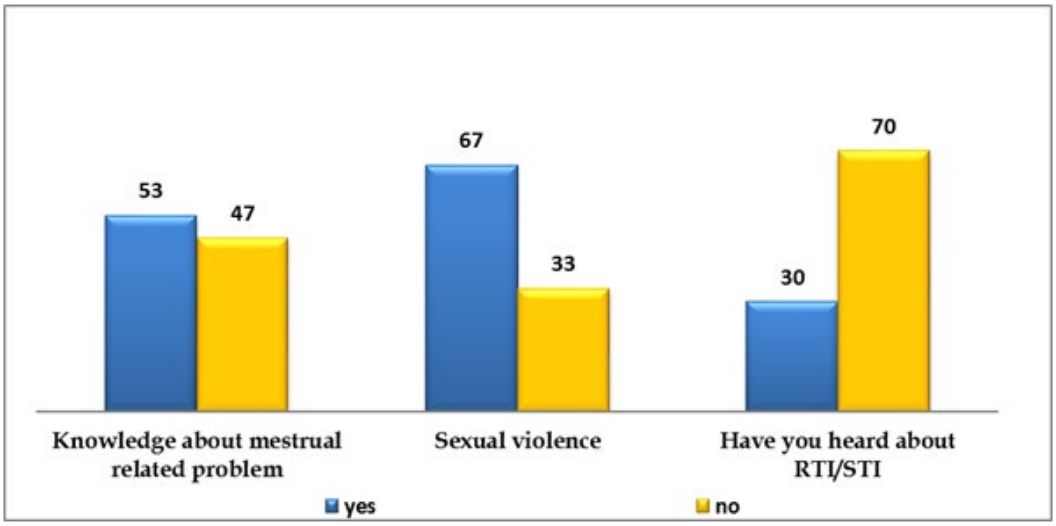


Figure 1: Percentage of women having RTI problem by Knowledge and Incidence of sexual violence among Santhal women

Characteristics	Percent
Any problem (STI)	62.9
Any Problem of (RTI)	64.8
Problem discussed with	
Husband	28.7
Mother-In-law	54.9
Mother	8.9
Relatives/Friend	27.6
Others	3.4
Sought Treatment	39.3
Accompanied you to seek care	
Husband	48.8
Mother-In-law	40.8
Mother	0.0
Relatives/Friend	3.2
Alone	7.2
Other	0.0

Table 3: Percentage of women age 15-49 years who discussed any seek treatment for any RTI/STI problems in Santhal, Jharkhand, India, 2014-15

The above table 3 briefs on the various actions taken after understanding the prevalence of RTI/STI and about the family member who accompany with them while seeking care. To the question to whom they discussed this problem with, 29percent responded husband, around 55 percent discussed it with their mother in law. It was seen that only 8.9 percent of the respondents shared it with their mothers, while 28 percent of the share discussed it with their relatives or friends, and 3.4 percent discussed it with others. Further, to understand who companied with the respondents to seek care, it was seen that those in mothers category and others category never accompanied them. While a major share of around 49 percent of the respondents were accompanied by their husbands and the second most common response was found to be with mother in law which came around 41 percent, while 3.2 percent responded that they were accompanied by relatives/friends and 7.2 percent said that they went alone

Characteristics		OR			
	Prevalence	Model 1	CI (95%)	Model 2	CI (95%)
Age (years)					
15 to 24	62.5				
25-34	57.1	0.5	0.23-1.25	0.5	0.21-1.20
35 and Above	67.4	1.03	0.38-2.76	0.9	0.34-*2.59
Education					
No education	77.3				
Below primary	43.9	0.2***	0.08-0.56	0.2***	0.07-0.54
Middle school	63	0.7	0.29-1.65	0.7	0.29-1.668
High School and Above	38.5	0.3**	0.08-6.37	0.3*	0.08-1.10
Number of children					
No child	36.2				
1 Child	72.1	2.1	0.81-5.23	1.6	0.62-4.35
2 Child	64.3	1.2	0.44-3.29	1.0	0.36-2.86
3 or More	71.7	2.2	0.73-6.37	2.0	0.66-6.33
Exposure to Mass Media					
No exposure	66.1				
Partial exposure	98.3	46.7***	5.62-388.15	63.2***	7.05-566.8
Full exposure	44.4	0.7	0.32-1.57	0.7	0.29-1.58
Religion					
Hindu	61.2				
Christian	61.9			0.9	0.43-2.06
No religion/Sarna	67.2			1.8	0.78-3.95
Wealth Index					
Poor	56.8				
Middle	67.9			1.4	0.62-3.08
Non Poor	63.8			1.6	0.71-3.57
Sexual violence					
No	70.1				
Yes	61.3			1.5	0.70-3.38
Total	**62.9**				
- 2log likelihood		**236.694**		**227.623**	

Table 5.16: Prevalence and odds ratio of any STI symptoms in the last 12 months among Santhal Women according to selected background characteristics

Table 5.16 shows the prevalence and determinants of any STI symptoms in the past 12 months among the Santhal women by selected background characteristics. Overall 63 percent of women have reported any STI symptoms in the last 12 months. The result portrays that the prevalence of any STI in last 12 months is found to be low among the Santhal women of age group 25-34 years (57%) than other counterparts. The prevalence of any STI in last 12 months is found high among the Santhal women who have no education (77%) whereas it is very low among who have the high school and above education (39%). It is observed that there is a significant impact of full media exposure (44%). Religion was the next characteristic based on which the next category was created understand the status of STI, for which 61 percent of Hindus, around 62 percent of Christians and 67 percent of those who had No religion/ Sarna said that STI was prevalent in them. The next categorization is based on the clan of the respondent. The respondents belonged to 9 clans of which none of the respondents in Baske clan had any STI, while the only respondent from Besra clan had STI, as reported, which made it 100 percent followed by 73 percent of the Soren clan had STI the same response was given by 68 percent in the Murmu clan, 66 percent in the Hebrom clan, 63 percent in the Hansda clan, 62 percent in the Marndi clan, 56 percent in the Kisku clan and around 42 percent in the Tudu clan. When the prevalence of STI among women was studied based on the wealth index of the respondent it was understood that around 68 percent of the women in the middle category, around 64 percent in the non-poor category and 57 percent in the poor category accepted that they had STI's. This study seeks to see if there was any relation to the number of children with regard to the prevalence of STI. It was seen that only 36 percent of women who had no child had STI which was lesser when compared to 72 percent who had 1 child, 64 percent who had 2 children and 73 percent of respondents who had 3 or more children. The next category was based on the exposure of the respondents to media. It was learned that a whopping 98 percent of the respondents were affected by STI's among those who had partial exposure to media, while 66 percent and only around 44 percent gave the same answer among those who had no exposure and full exposure respectively. It was noticed that, 70 percent of women suffered from STI problems who have experienced sexual violence in the last 12 months.

The results of logistic regression models is showing the association of any STI symptoms among the Santhal women by background characteristics in last 12 months; Model 1 includes age, education, number of children, and exposure to mass media. The results of logistic regression model 1 shows that the Santhal women having below the primary and the high school and above education are significantly 80 percent and 70 percent less likely to have any STI in last 12 months as compared to having no education respectively. It is also found that the Santhal women having partial media exposure are 46.7 times ($p<0.01$) more likely to have any STI in last 12 months as compared to having no media exposure. When we added some others factors like religion, wealth index and sexual violence in model 2, the results show that the Santhal women having below the primary and the high school and above education are significantly 80 percent and 70 percent less likely to have any STI in last 12 months as compared to the Santhal women having no education respectively. The Santhal women having partial media exposure are 63 times ($p<0.01$) more likely to have any STI in last 12 months as compared to having no media exposure.

The Binary Logistic analysis and cross tabulation is used in the study to understand the utilization of the maternal health services in the Jharkhand state according to their background characteristics. The independent variables used in the first objective are Women's current Age, Age at marriage, Educational Attainment, religion, Caste and total number of live birth of the women.

Background Characteristics	Percentage Distribution of the Women receiving Maternal Health Services		
		Institutional Delivery	Birth Assistance
15-19	88.5	26.7	78.8
20-29	85.7	21.8	80.6
30-49	73.2	18.3	83.9
Age at Marriage			
Less Than 18	82.3	20.9	81.3
More than 18	85.2	24.2	81.1
Educational Attainment			
No Education	77.5	18.4	80.2
Upto 5 Years	92.7	16.8	83.4
More than 5 Years	97.2	33.8	84.6
Religion			
Hindu	82.9	21.6	81.6
Non- Hindu	84.9	24.7	78.8
Caste			
SC	75.4	25.5	84.6
ST	74.8	14.3	71.9
Others	91.5	23.6	84.1
Live Birth of women			
One	82.9	22.7	81.5
Two	84.9	20.1	79.2

Utilization of the Maternal Health Services in the Jharkhand State

ANC Care among the Tribal Women

Antenatal care (ANC) refers to pregnancy related health care provided by a doctor or a health worker in a medical facility or at home. The Safe Motherhood Initiative proclaims that all pregnant women must receive basic professional antenatal care (Harrison, 1990). The Antenatal care is the systemic supervision of women during pregnancy to monitor the progress of fetal growth and to ascertain the well-being of the mother and the fetus. A proper antenatal check-up provides necessary care to the mother and helps identify any complications of pregnancy such as anemia, pre-eclampsia and hypertension etc. in the mother and slow/ inadequate growth of the fetus . Focusing upon any ANC taken by the women in the Jharkhand State it was found that the utilization of the TT vaccine taken by the women among the tribal women of the state is having lowest among those who have taken Two or Three & More TT vaccine. In the given figure it can be observed that the percentage of women who have taken TT Vaccine is very low among tribal women preferably among those who have taken two or three and more

	Only One	Two	Three & More
SC	12.90	54.40	32.70
ST	17.40	42.60	40.00
OBC	6.30	52.20	41.50
No Caste	6.30	58.30	35.40

Table 1: Percentage Distribution of the number of TT Vaccine taken by the women

Place of delivery among the tribal Women:

Delivery in a medical institution promotes child survival and reduces the risk of maternal mortality. Many initiatives under the National Rural Health Mission (NRHM) focus on increasing the institutional deliveries. The place of delivery is a crucial factor which affects the health and well-being of the mother and the newborn. Institutional deliveries provide easy access to skilled assistance, drugs, equipment, and referral transport. One of the socio-demographic goals mentioned in the National Population Policy 2000 of India is to achieve 80% institutional deliveries and 100% deliveries to be assisted by skilled health personnel by 2015 . These two interventions have also been identified as important initiatives to reduce the maternal mortality ratio the fifth Millennium Development Goal. According to the available data of NRHM it was found that the performance of the Jharkhand and specifically the tribal women is very poor when compared to all the other categories. It was found that out of total deliveries only 21 percent can be termed as institutional in nature

	SC	ST	OBC	None of the above
Institutional Delivery	28.4	21.9	46.9	2.9

As mentioned above it's very crucial to understand why the women prefer to deliver at home. With regard to this questions were asked under the evaluation of NRHM, which have been utilized in this paper to understand and explore the possible reasons. As per the information gathered from the ASHA several reasons can be drawn regarding why do women prefer to deliver at home. Since no exact and accurate time for the delivery can be decided majority of the ASHA (44.2) at national level considers No transport facility available when required as the major cause why women prefer to deliver at home. In the Jharkhand having no appropriate facility was the major reason mentioned for the women to deliver at home followed to which was the no availability of the transport facilities.

Factors affecting the Utilization pattern of the women receiving Maternal Health Services

Education

According to the census 2011(Census 2011), the literacy of the state is approximately around 67.63 percent which almost comes near the bottom when compared all the 35 states and union territory. Followed to the considering the literacy of the women is further poor approximately around 56 percent. The average literacy rate amongst tribal's it is as low as 40.7 and 10 amongst women. This is particularly evident amongst the Santhal, Bhumij, Ho, Lohra and Kharwa which are numerically the larger tribes. It is also noticeable that "The Millennium Development Goals, 2000" cannot be met without getting tribal children especially girls educated. The table given below explains the years of schooling among the tribal's and non-tribal's women in the state

Caste	0	Between 1 to 5	Between 6-10	Between 11 -15	More than 15
SC	79.40	10.20	9.70	0.70	
ST	77.00	11.30	10.20	1.40	0.10
OBC	62.80	14.40	18.80	3.90	0.10
No Caste	37.20	19.30	33.80	9.70	

Table 2: Percentage Distribution of Women Reporting their Years of Schooling

In the given table we can observe that the years of schooling as reported by the women is comparatively low than those coming in the 'Other Backward Caste' and 'No Caste'. Education can be referred as a major factor to bring improvements in the health status of the women. Another figure explains that with the increase in literacy or years of schooling there has also been increase in the health seeking behavior of the women too

	Only One	Two	Three & More
Never Attended School	12.5	49.8	37.7
Less Than five Years	6.6	53.1	40.4
Between 5-10 Years	6.3	52.7	41.0
More than 10 Years	5.0	57.4	37.6

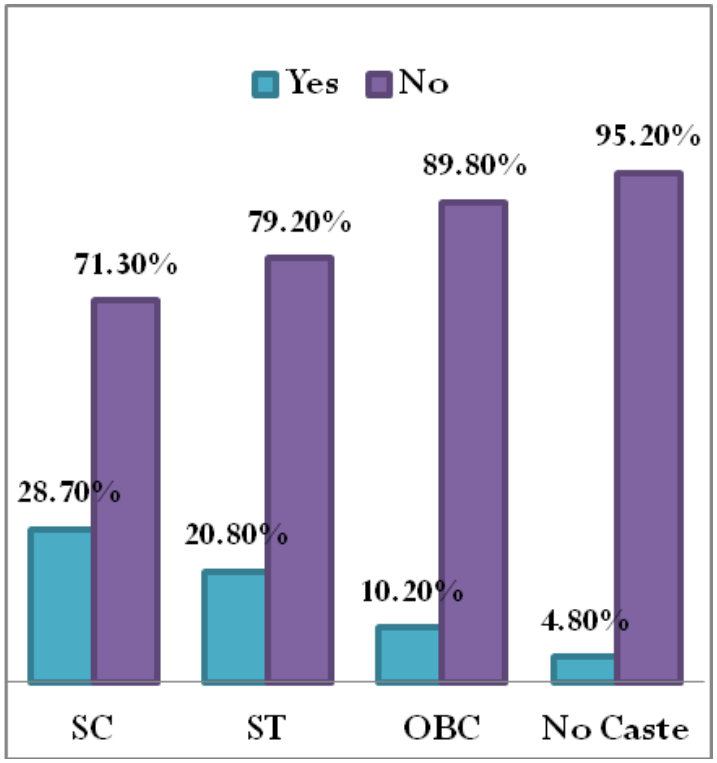
Percentage distribution of the women reporting the utilization of TT Vaccine according to their years of schooling

It is evident from the given table that as there has been increase in the years of schooling the women have been found of taking benefit of the health care services. Here the instance has been taken about the TT Vaccine. The highest percentage of the women who have reported that they have taken only one TT vaccine have never attended school. Those women who have been to school have reported that on an average they have taken at least two TT vaccine

Dimension of the livelihood

A large number of women and girls from tribal areas migrate to cities and towns all over India. Most of these women and girls are illiterate and unskilled. They work in inhuman conditions in cities as their living standard is extremely poor. A great number of these migrants are being exploited by middle men, contractors, construction companies and other types of employers. A large number of tribal women and girls become victims of sexual and financial exploitation. Their children rarely get an opportunity to go to school and learn a productive skill.

In rural areas, livelihood system is primarily dependent on combinations of agriculture, forestry and laboring. Due to very small holding and very low productivity of land, most households eke out a living by maintaining a diversified pattern of occupations. There is however small artisan communities of tribal are who lend out their services or engage in small scale processing and marketing. Women's work is critical for tribal households both in terms of provisioning food and income as well as management of resources . In the figure one it has been shown that almost 80 percent of the total women reported of not being engaged in any work in the past one year. The tribal woman does not have property rights except in a matrilineal society which is a small proportion of the tribal population. She is paid fewer wages than her male counterpart for the same work. Besides this, the women work for more time than men, they receive wages which are enchased by males



The women do not have the decision making power. Tribal women in India contribute positively towards economic pursuits by participating equally with men folk. They participate in all agricultural operations like sowing seeds, weeding and harvesting, felling and burning trees. In plough based cultivation, transplantation, weeding, winnowing and de-husking is done entirely by women. They work in all sectors of indigenous cottage industries, tribal arts and production of artifacts. Generally, the ploughing is done by men but in some tribal societies, women do the ploughing too. The division of work is heavily loaded against the tribal woman because in addition to an equal share in the economic production process she has to take the sole responsibility of household chores. These entire situations heavily affect the reproductive health of the women

Knowledge pattern of the tribal women

	Yes	No
SC	54.90	45.10
ST	50.80	49.20
OBC	62.70	37.30
No Caste	58.50	41.50

Table 3: Percentage Distribution of Women Who Have Heard about ASHA

The lowest percentage was reported among the Scheduled tribe women in the state which is around only 50.8 percent of the women said that they have heard about ASHA. This low percentage also clearly indicates the health seeking behavior of the women towards her.

Women who have received any Maternal Health advice

Family planning

Family planning can be understood as the planning for the when to have children and along with that various methods of birth control. It is sometimes also used as the synonym of the birth control. According to the NRHM data it was also found that the though the situation of entire state is very poor with regard to the women receiving the family planning advice, the situation of the tribal women is further worse

	Yes	No
SC	12.10	87.90
ST	5.70	94.30
OBC	16.80	83.20
No Caste	31.00	69.00

Percentage Distribution of women who received any Family Planning Advice

On asking the women, it was reported that only 5 percent of the women received any family planning advice. On the other hand it is also noticeable that though the other categories are also having lesser percentages, are almost two or three times better than the tribal women. Similar to that on asking women with regard to the Post Natal advice the scheduled caste women is still in the bottom. On asking the women with regard to having any post natal advice, only 11 percent among the Scheduled tribe reported about it

Results of the Logistic Regression:

Background Characteristics	Institutional Delivery	TT Vaccine	Birth Assistance by Skilled &Trained Birth Attendant	Birth Assistance by Skilled personnel
<20				
20-29	.680***	0.882	1.325***	1.054
30-49	.502***	.598***	1.596***	0.951
Age at Marriage				
Less Than 18®				
More than 18	1.362***	1.443***	.981***	1.104
Educational Attainment				
No Education ®				
Upto 5 Years	1.492***	2.062***	.876***	1.316***
More than 5 Years	2.472***	3.805***	.639***	1.131***
Religion				
Hindu ®				
Non- Hindu	.806***	.320***	1.285***	
Caste				
SC®				
ST	.565***	.528***	.830***	.643***
Others	1.156***	1.223***	.876***	1.022
Number Of Live birth				
Only One®				
Two & More	1.215***	1.104***	.886***	.879***

Odds ratio for the women receiving Maternal Health services with regard to the background characteristics

Note: ® -Reference Category
***p<0.01, **p<0.05, *p<010.

The table explains the logistic regression analysis of the background factor affecting the women to receive the maternal health services. Birth Assistance give the result unlike of the institutional delivery and any ANC (TT Vaccine). According to the age we find as the age is increasing the likelihood of the utilization pattern is also increasing. Those women who are in the age group 20-29 are 1.325 times more likely to receive Birth assistance than those who are less than 20 years of age. Similar to that those women in the age group 30-49 are around one and a half times more likely to receive birth assistance. Marriage ages of the women who are more than 18 years of age are less likely (odds ratio .981) times to receive any birth assistance.

Opposite to the Institutional delivery and TT vaccine the women with increase in age are less likely to take birth assistance. Similarly those women with education are less likely to receive birth assistance than the illiterate women or women with no education. According to the results women upto five years of education are 87 percent and those having more than five years of education are 63 percent less likely to receive birth assistance than the women who is with no education.

Non-Hindu women when compared to the Hindu women are 1.285 times more likely to receive birth assistance compared to the Hindu women. In context of the caste both the categories i.e. ST and others are less likely to receive any birth assistance which was not the case with the other category in terms of Institutional delivery and receiving any ANC (TT Vaccine). In the given table it is clear that the Scheduled tribe women when compare to the Scheduled caste women the former always lags behind the latter. With regard to the institutional delivery scheduled tribe women are almost half times less likely to give birth at any health institution. Followed to this it was also found that similar is the pattern with the women receiving the TT vaccine. A scheduled tribe woman is reported of having .538 times less likely to take the TT vaccine when compared to the Scheduled caste women and others.

The woman who is having more than one live birth is less likely to receive any birth assistance than those who have only one live birth. It clearly shows that the women who have given birth previously are less likely to receive any birth assistance than those who are having one live birth or no previous birth experience.

Analysis and Conclusion

The above discussion clearly brings out the differential in the health care and health condition among the tribal women and non-tribal women in Jharkhand. The findings reveal that in each and every

socio-economic, demographic as well as health parameters, the tribal women a very much poor than the non-tribal women. Malnutrition is pervasive among tribal women. There is also a high prevalence of anemia among the tribal women in Jharkhand. The utilization of maternal health care is also very less among the tribal women than non-tribal women in Jharkhand. Use of modern methods of contraception is also significantly less among the tribal women than the non-tribal women. All these will likely to have not only an adverse long-term impact on their own health and well being but also on their children. In India, the National Health Services have often neglected the tribal people in general and tribal women in particular. In addition to the social and economic factors contributing to the low health status of this underprivileged group, cultural factors might also play a role. People must understand that good health is an important asset of livelihood and illness a major cause of impoverishment. After analyzing all the data and interpreting it the discussion starts with the status of Jharkhand which is at the bottom of all the EAG states. There are several reasons for the poor performance of the Jharkhand such as the poor infrastructure of the Health system. In the whole state required sub centre are 5057 but in position there are only 1099, which is almost one fifth of the total requirement. Similarly there are only 330 primary health centre and falls short of 476 in total.

The condition of the CHC is not good but compared to SC and PHC its condition is at better place i.e. on the requirement of 201 CHC, 194 are functioning. Along with this, Health assistant (Female)/LHV at PHC's, Physicians at CHC and pediatricians at CHC are completely missing. In the state, Nurse/ Midwife are around 429 which is almost three times less than the requirement. Not avoiding the positive sides, requirement of male Health Assistant (PHC) is 330, contrary to that 660 are in position and of 330 required doctors at PHC 330 are in position. Similarly total required MPW worker (Female)/ ANM at sub centres & PHC is 4288 and in position are 5011. (RCS Bulletin, March 2008, M/O Health & Family Welfare, GOI).

However, the 60% of Sub Health Centres, 50% of PHCs don't have their own building. Women's autonomy, as measured by the extent of a woman's freedom of movement, appears to be a major determinant of maternal health care utilization. In other words we can see how the education has a positive relationship with the utilization of the maternal health services. The similar kind of achievement can be also obtained with the advancement in the social status of the women. Seven years of NRHM have made impact on the health system; apart from rise in institutional deliveries. The Asha is a positive feature of NRHM but it remains weak in training, accreditation, drug kit/refill, payment. This reduces the activist (envisaged to be a committed worker) into a minion of the system; NRHM is using the system of providing incentives for institutional births (and family planning). This is neither sustainable nor wholesome. Home births will still be around for some time, and not supporting dais is bound to hurt those home births seriously. Primary health care can be sustainable, if embedded within broader development such as education, water and sanitation, roads and transport as all these factors are inter-related and affect each other at several points. In order to improve the health status of the tribal women in Jharkhand, the health care delivery system should be designed effectively to cater to the specific needs of the tribal women during pregnancy and at childbirth by ensuring their personal involvement. Health interventions must focus on tribal culture, medical training of the tribal people, and a knowledgeable health care delivery system catering to the needs of tribal women and the child.

Recommendations

This study has identified six underlying causes of VAW among Santhal Tribes in Dumka district of Jharkhand.

Traditional unequal power relations: The local political, economic and social processes that have evolved over generations have kept Santhal men in a position of power over women.

Control of women's sexuality: Many societies use violence as a way to control a woman's sexuality, and likewise in many societies violence is used to punish women who exhibit sexual behavior, preferences, and attitudes that violate cultural practices.

Cultural ideology: Culture defines gender roles and some tribal customs, traditions, and religions are used to justify VAW when the women transgress these culturally assigned roles.

Dogmas of privacy: The persistent belief in many tribal societies is that, VAW is a private issue veil in secrecy should be resolved within family premises.

Patterns of conflict resolution: Links have been identified between VAW in the home and the community in areas that are in conflict or that are militarized. The heightened insecurity means that tensions within the home are more pronounced and can contribute to the perpetuation of VAW in the family. Equally, because eyes tend to be on the dispute, women's suffering is often overshadowed. The gender based violence is also frequently used as a formal conflict among clans.

Administration inaction: Administration negligence in preventing and ending VAW establishes a tolerance of VAW throughout the community.

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