MATERNAL AND CHILD HEALTH CARE PRACTICES AMONG SANTHAL TRIBES IN DUMKA DISTRICT, JHARKHAND

Dissertation Submitted to the Jawaharlal Nehru University in Partial Fulfillment of the Requirement for the Award of the Degree of

MASTER OF PHILOSOPHY

Divya Kisku

Centre of Social Medicine and Community Health
School Of Social Science
Jawaharlal Nehru University
New Delhi – 110067
India

2008

CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
New Delhi - 110 067

Date: 21/07/2008

CERTIFICATE

This dissertation entitled "***Maternal and Child Health Care Practices among Santhal Tribes in Dumka District, Jharkhand***", is submitted in partial fulfillment of six credits for the award of the degree of Master of Philosophy (M. Phil.) of this university. This dissertation has not been submitted for the award of any other degree of this university or any other university and is my original work.

Divya Kisku

We recommend that this dissertation to be placed before the examiners for evaluation.

Dr. Rama V. Baru
(Supervisor)
Dr. Rama V. Baru
Associate Professor
Centre of Social Medicine & Community Health, SSS
Jawaharlal Nehru University
New Delhi—110 067

Dr. K. R. Nayar
(Supervisor)
Prof K. R. Nayar
Centre of Social Medicine & Community Health SSS
Jawaharlal Nehru University
New Delhi 110067

Dr. Mohan Rao
(Chairperson)
Chairperson
Centre of Social Medicine & Community Health, SSS
Jawaharlal Nehru University
New Delhi-110067

Tel.: (011) 26704420, 26717676, 26717557 Gram: JAYENU Fax: 91(011) 26717586, 26704429

This Piece Of Work Is Dedicated

To

All Tribal Women...

Still have I borne it with a patient shrug,

For sufferance is the badge of all our tribe."

~ William Shakespeare

Acknowledgement

Writing this part of the dissertation gives a sense of relief, as it gives us the feeling of accomplishment and a pleasure to acknowledge all those who contributed in the completion of this work. There are no words to thank the ultimate being "The Almighty" but I entrust all my thanks and gratitude to the 'One' for guiding me all through my life, and for loving me in my best and in my worst. For being the ultimate source of happiness and for letting fight every odd situation in my life. Thank you Father Lord.

First of all I would like to thank Dr. Rama Baru, my supervisor, for her continuous support and guidance. It was her constant encouragements and timely scolding blended with her motherly care which helped me doing my work. I thank her for imbibing in me the confidence and giving me good teachings of life. Thank you ma'am.

I also would especially thank my supervisor Dr. K.R Nayar for his guidance and teachings. I thank him for sharpening my intellect time to time and giving me insights and helping me overcome my silly faults and doubts. I thank him for making a lazy girl like me work on her toe. Sir thanks a lot.

I also want to show my appreciation to all my faculty members – Dr. Mohan Rao, Dr. Ritu Priya, Dr. Sanghmitra, Dr. Rajibdas Gupta and Dr. Sunita Reddy for their constant remarks and insights to my work all through my course work.

My deep sense of gratitude and recognition goes to Stensila Masi and Mausa who provided me with an abode during my fieldwork, and for not letting me feel away from home, keeping me with so much of care. I want to thank Meenu, Choti, Chotu for accompanying me to various tolas and helping me interact with people. I also like to thank Dr. J. Kisku; the MS of Mohulpahari Hospital for letting me have a general idea of the hospital. Thank goes to Dr. Joel Kisku for providing me with informations appropriate for my study. Thanks to Utpal Tudu and Sarla Baski for being a friend and giving me true picture of the state of people in the villages. I want to thank all those women who shared with me their life and their hardship. I salute all of them.

I like to pay a lot of thanks to the inspirations of my life – my Moma and Dadu. Without their love, their support, their constant encouragement, their care I would not have been here. They are

there all through whatever I do; they have given me the freedom to be myself. Thank you mamma papa. I also want to thank my Masi for her all time concerns and care. I love all of you.

I am grateful to my brother Bread for giving me enormous support when I needed most. Without him things would not have been managed – giving me a home, making tea for me, for bearing my frustrations, for tolerating my mistakes. Thanks to his techi-knowledge, his presence made things easier for me. Thanks a lot brother, you are great. I also want to thank my little sis Kuhu for her love, moral support, and her prayers.

Most essential mention and thanks go to my best friend Bhrigu who has just been there all the time, witness to all the changes and saw me growing with my work. He has never consulted his calendar before helping me and has been a source of positive energy in my life. In times of distress he always lifted me and motivated me towards working more and more even scolded me wherever needed and for keeping a track record of all the work I did. Thank you my dear friend.

My close friends Shailendra and Rajshree have been a moral support all the time and encouraged me all through whenever I was disturbed or troubled, also for bearing with all kind of moods I carried. Thanks to both of you. Want to thanks a lot to Minakshi for giving intellectual insights to my works and for being there always like a true friend. Thank you Mini. The phrase friend in need is a friend indeed holds correct for my friend Arvind, who many a times went out of way to help me and for letting know that he is there 24*7. Thank you friend for your timely assistance. I want to especially thank Mohan for taking care of me, reminding of medicines and timely food and giving me moral support all through. Thank you so much dear.

I have been fortunate enough to have friends whom I call angels who pray for me selflessly and have been a source of encouragement all through my work. My angels are Sneha, David (Rahul), Abhi, Sudhakar, Arshi, Meghna, Dimpee. Thanks to all of you for praying for me unconditionally and being a great support. My other friends – Kumaran, Nisha, Shweta, Mou, Mrityunjay, Shrenya, Mayurish, Shubhakrity and Shubmay who have shown a positive attitude, and helped me in some or the other way, whether by simply letting know that they are there, or by their steady support, or by simply turning the stressed up mood in to a smiling and rejuvenating one. Thanks to all of you. Finally once again I want to thank The Supreme for being there.

Abbreviations

MCH - Maternal and Child Health

RCH – Reproductive and Child Health

IMR – Infant Mortality Rate

MMR – Maternal Mortality Rate

TFR – Total Fertility Rate

ANM – Auxiliary Nurse Midwife

AWW – Anganwadi Worker

PHC – Primary Health Centre

SLI – Standard Living Index

CBR – Crude Birth Rate

ICDS – Integrated Child Development Scheme

LBW – Low Birth Weight

IUGR – Intra Uterine Growth Retardation

ST – Scheduled Tribe

SC – Scheduled Caste

OBC – Other Backward Caste

BMI – Body Mass Index

ANC – Antenatal Care

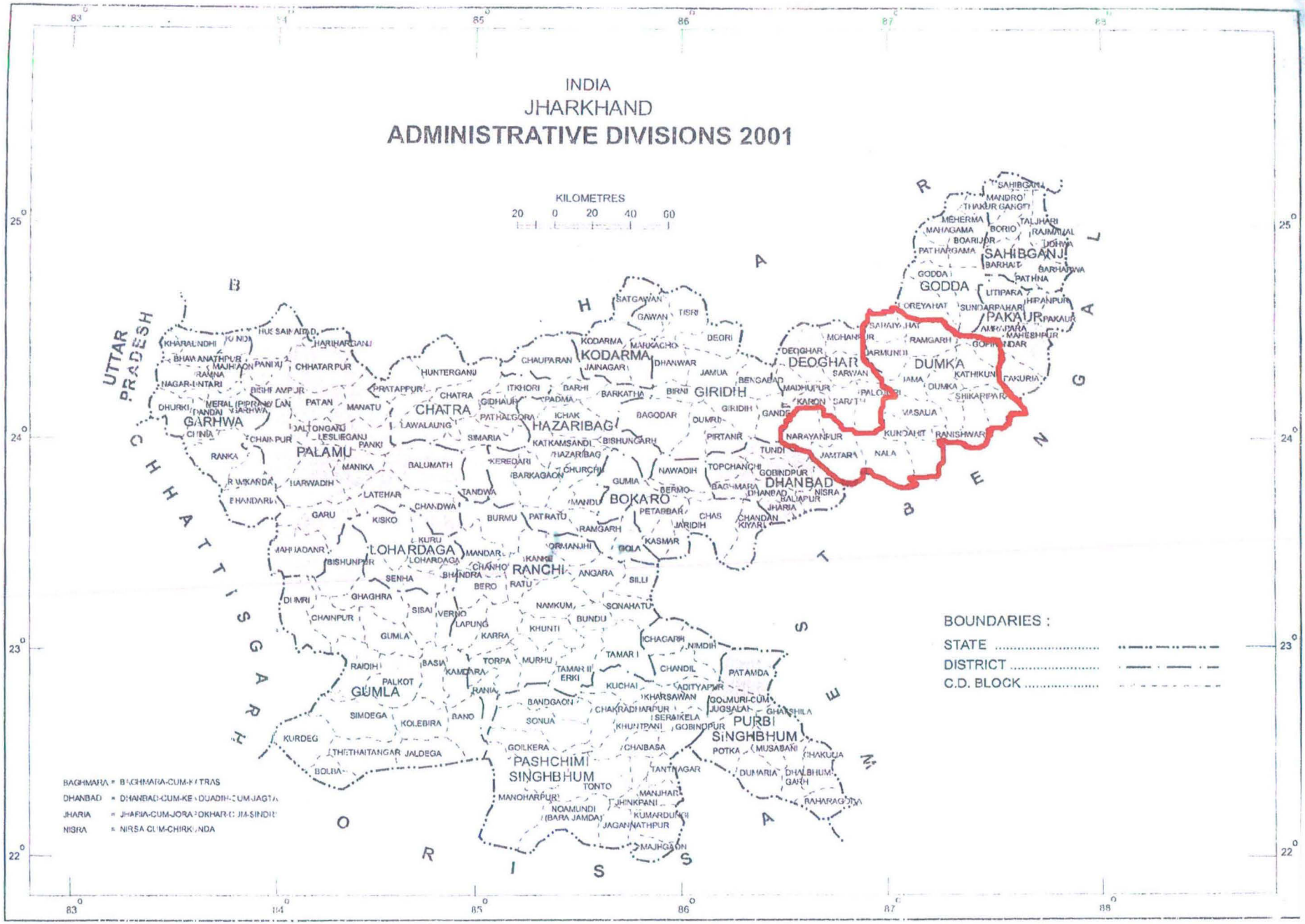
TBA – Traditional Birth Attendant

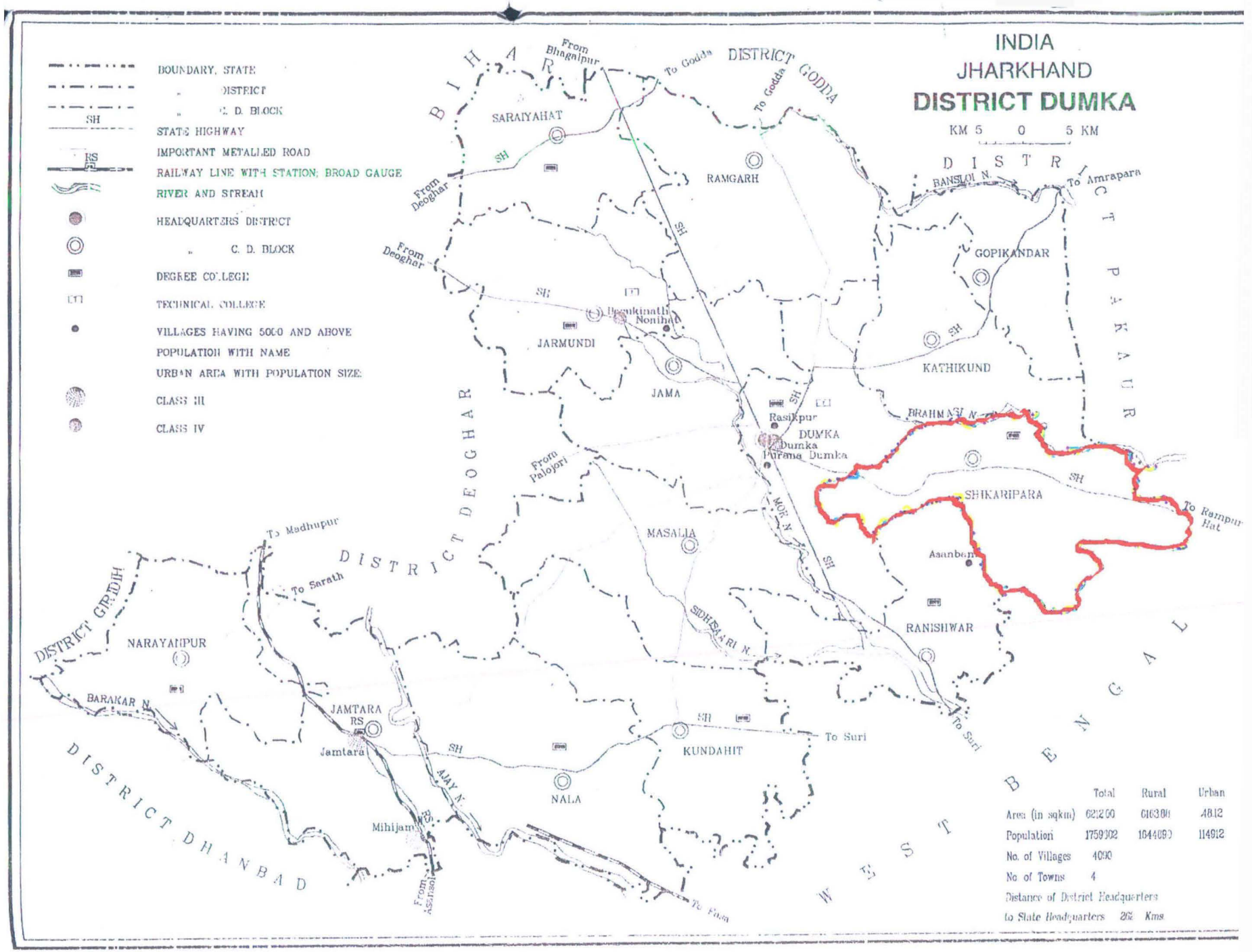
IUD – Intra Uterine Device

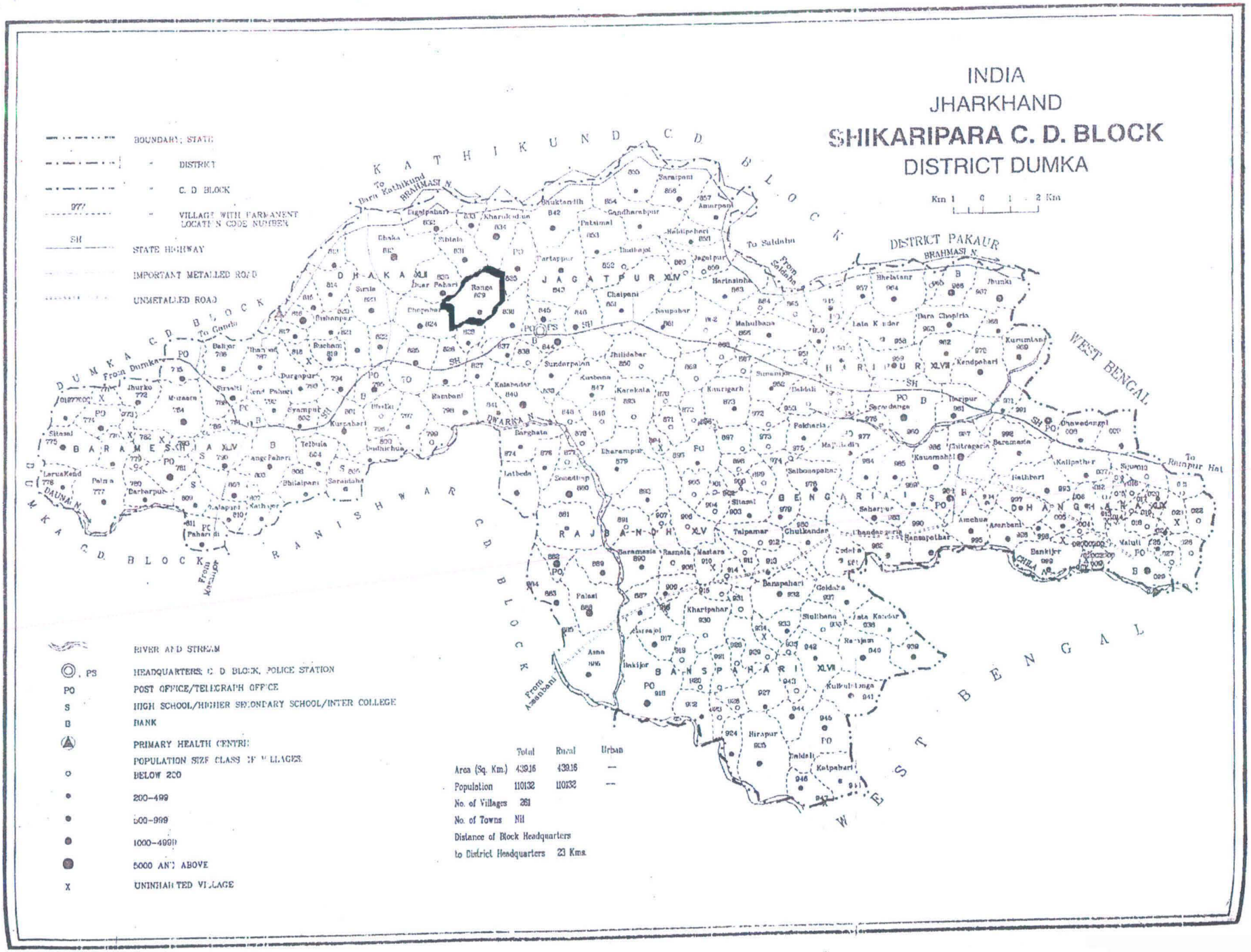
ASHA – Accredited Social Health Activist

MPH - Multipurpose health Supervisor

List of tables


INDIA
JHARKHAND
ADMINISTRATIVE DIVISIONS 2001
KILOMETRES
20 0 20 40 60
BOUNDARIES :
STATE
DISTRICT
C.D. BLOCK
BAGHMARA = BAGHMARA-CUM-KUTRAS
DHANBAD = DHANBAD-CUM-KENDUADIH-CUM-JAGTA
JHARIA = JHARIA-CUM-JORAPOKHAR-CUM-SINDRI
NISRA = NISRA-CUM-CHIRKUNDA
UTTAR PRADESH
BIHAR
WEST BENGAL
ORISSA
CHHATTISGARH
GARHWA
PALAMU
CHATRA
HAZARIBAG
KODARMA
GIRIDH
DEOGHAR
DUMKA
GODDA
SAHIBGANJ
PAKAUR
BOKARO
DHANBAD
LOHARDAGA
RANCHI
GUMLA
PASHCHIMI SINGHBHUM
PURBI SINGHBHUM
SERAIKELA
KHARSAWAN


INDIA
JHARKHAND
DISTRICT DUMKA
KM 5 0 5 KM
BOUNDARY, STATE
" DISTRICT
" C. D. BLOCK
SH STATE HIGHWAY
IMPORTANT METALLED ROAD
RS RAILWAY LINE WITH STATION; BROAD GAUGE
RIVER AND STREAM
HEADQUARTERS DISTRICT
" C. D. BLOCK
DEGREE COLLEGE
TECHNICAL COLLEGE
VILLAGES HAVING 5000 AND ABOVE POPULATION WITH NAME
URBAN AREA WITH POPULATION SIZE:
CLASS III
CLASS IV
BIHAR
DISTRICT GODDA
DISTRICT DEOGHAR
DISTRICT GIRIDH
DISTRICT DHANBAD
WEST BENGAL
From Bhagalpur
To Godda
From Deoghar
SARAIYAHAT
RAMGARH
BANSLOI N.
To Amrapara
GOPIKANDAR
KATHIKUND
JARMUNDI
Baidyanath Nonihat
JAMA
Rasikpur
DUMKA
Dumka
Purana Dumka
BRAHMANI N.
SHIKARIPARA
To Rampur Hat
From Paloyri
MASALIA
MOR N.
Asanbani
To Madhupur
To Sarath
SIDHSARI N.
RANISHWAR
NARAYANPUR
BARAKAR N.
JAMTARA RS
Jamtara
KUNDAHIT
To Suri
AJAY N.
NALA
Mihijam RS
From Asansol
To Pasa
Total Rural Urban
Area (in sqkm) 6212.00 6163.00 48.12
Population 1759302 1644090 114912
No. of Villages 4090
No. of Towns 4
Distance of District Headquarters to State Headquarters 265 Kms


INDIA
JHARKHAND
SHIKARIPARA C. D. BLOCK
DISTRICT DUMKA
Km 1 0 1 2 Km
BOUNDARY: STATE
DISTRICT
C. D BLOCK
VILLAGE WITH PERMANENT LOCATION CODE NUMBER
STATE HIGHWAY
IMPORTANT METALLED ROAD
UNMETALLED ROAD
RIVER AND STREAM
HEADQUARTERS: C. D. BLOCK, POLICE STATION
POST OFFICE/TELEGRAPH OFFICE
HIGH SCHOOL/HIGHER SECONDARY SCHOOL/INTER COLLEGE
BANK
PRIMARY HEALTH CENTRE
POPULATION SIZE CLASS OF VILLAGES
BELOW 200
200–499
500–999
1000–4999
5000 AND ABOVE
UNINHABITED VILLAGE
DISTRICT PAKAUR
WEST BENGAL
KATHIKUND C.D. BLOCK
DUMKA C.D. BLOCK
RANISHWAR C.D. BLOCK
BARMESIA JAGIR XLV
JAGATPUR XLIV
HARIPUR XLVII
RAJBANDH XLV
BANSPAHARI XLVI
BENGARIA
Total Rural Urban
Area (Sq. Km.) 439.16 439.16 —
Population 110132 110132 —
No. of Villages 261
No. of Towns Nil
Distance of Block Headquarters to District Headquarters 23 Kms.

Contents

Page Nos.

Introduction

India is a country of diversity. With a population of more than a billion, people differ in nearly all dimensions whether it is food patterns, occupation, education, health status, morbidities and mortalities associate with various disease, access to health care or traditional and age old practices associated with variety of things.

Jharkhand, being one of the newly formed states, with its predominant tribal and backward population is one among the most poorest and the backward among the states. Low per capita incomes, low literacy especially female literacy and high unemployment rates compounds the problem. With predominantly a tribal population, with a major proportions of schedule castes and backward classes, the problem of maternal and child health is more acute in the state.

The tribal population is by and large socially and economically backward. One issue which affects them in every sphere, and around which revolves many things is their poverty. Poverty is so pervasive among them that it doesn't require any profound study to discover it. There are certain health problems that are poverty related, and there are different perceptions and attitudes of people towards those health problems. Though tribal population is largely viewed as homogeneous group but there is stratification. Here again the poverty plays an immense role, because poor are always on disadvantageous position even if they largely belong to a socially and economically backward group. Not much improvement has occurred regarding health status of the tribal population. To a large extent they get socially excluded from the main stream. And many a times they are just left out stating that tribals are isolated homogeneous group, who have defined boundaries for everything, be it their dialect, area, or culture. Moreover, the prevailing and the dominant understanding say that they are unchanging and resistant towards newer innovations. They are mostly perceived as an inhibitor to the so called "modernizing process". The same view is applied regarding their attitude to western medicine as well.

The tribes differ considerably from one another in race, language, culture and beliefs. Notwithstanding so much diversity, there are certain broad similarities between the mutually divergent tribal groups. Striking similarities are noticed in their modes of living, each tribe lives in a definite area, has common dialect, cultural homogeneity and unifying social organization.

The tribes are at different stages of social, cultural and economic development. The cultural pattern varies from tribe to tribe and region to region. The economic life of the tribals is specific in nature, based on the manner in which the tribals primarily and distinctly make their living. The common beliefs, customers and practices connected with health and disease have been found to be intimately related to the treatment of disease. It is necessary to make a holistic view of all the cultural dimensions of the health of a community. In most of the tribal communities, there is a wealth of folklore related to health.

Cultural practices such as child bearing imposes additional health needs and problems on women – physically, psychologically and socially. The Maternal and child health practices are quiet different within various tribes and much dissimilar from what is practiced under 'Modern Medicine'. These practices, whether beneficial or harmful, are deeply rooted within their tradition and are practiced during pregnancy and child birth. At the same time, the variety of services provided by government under various programs and Institution based services are far out of reach of the tribal population due to variety of reasons.

I have tried to examine into the traditional practices relating to pregnancy and child birth and issues related to health seeking behavior in the largest tribal community in Jharkhand i.e. 'Santhals' of Ranga village in Dumka district during my one and a half month's field work. In addition, I have tried to locate the changes that had occurred across generations in the area of maternal and child health practices among Santhal tribals.

Chapterisation

The conceptualization of the study and the methodology applied in the present research study used qualitative methods and data collection. A description of the methodology is given in the first chapter. The second chapter builds the background for the study through reviewing various literatures. The third chapter gives an outline of the area of study and social composition, along with the status of women in the village. The fourth chapter gives an insight into the practices related to maternal and child health care and also provides a general idea about the national health programmes functioning, along with an indication of people's and provider's perspective towards traditional and modern system of medicine. The fifth chapter on discussion and conclusion brings out the issues that emerged from the study.

-Chapter 1-

Methodology and conceptualization

The Conceptualization

Culture is defined as a shared system of values, beliefs, and learned patterns of behaviors[1] and is not simply defined by ethnicity. Culture is also shaped by factors such as proximity, education, gender, age, and sexual preference.[2] The culture determines the response of the group both in terms of formation of institutions for dealing with different health problems and in determining the behavior of individuals when they encounter such problems. We know that ill health corresponds to the state of instability, loss of function and failure of self-regulation but the perception about health, disease and health seeking behavior are not the same across cultures.[3] It varies from culture to culture as an integral part of human ecology and cultural ways. Illnesses are constructs of beliefs and knowledge, which vary with time and space. Cultural processes play explicit part in sickness and health. Cultural and biological dimensions of human beings are interrelated.[4] Illness is shaped by cultural factors governing perception, labeling, explanation, and valuation of the discomforting experience, processes embedded in a complex family, social, and cultural nexus. Because illness experience is an intimate part of social systems of meaning and rules of behavior, it is strongly influenced by culture. Illness is culturally shaped in the sense that how we perceive, experience, and cope with disease is based on our explanation of sickness, explanations specific to the social positions we occupy and systems of meaning we employ.[5]These have been shown to influence our expectations and perception of symptoms, the way we attach particular sickness labels to them, and the valuations and responses that flow from those labels. How we communicate about our health problems, the manner in which we present our symptoms, when and to whom we go for care, how long we remain in care, and how we

[1] Low SM. The cultural basis of health, illness and disease. Social Work in Health Care 1984;9:13-23

[2] Carrilo Emilio, Green Alexander. Cross-Cultural Primary Care: A Patient-Based Approach. Annals of Internal Medicine 1999; 130: 829-834.

[3] Praharaj Purujit and Sonowal C.J. Tradition vs Transition: Acceptance of Health Care Systems among the Santhals of Orissa. Studies on Ethno-Medicine 2007; 1(2):135 – 1466.

[4] Bhasin Veena. Medical Anthropology: A Review. Studies on Ethno-Medicine 2007;1(1): 1-20

[5] Kleinman Arthur, Eisenberg Leon, and Good Byron. Culture, Illness, and Care: Clinical lessons from anthropologic and cross-cultural research. Annals of Internal Medicine 1978; 88:251–258.

evaluate that care are all effected by cultural beliefs. Illness behavior is a normative experience governed by cultural rules: we learn "approved" ways of being ill. It is not surprising then, that there can be marked cross-cultural and historical variations in how disorders are defined and coped with. The variation may be equally great across ethnic, class, and family boundaries in our own society. And doctor's explanations and activities, as those of their patients, are culture specific.

The term health has many meanings. It can mean the absence of illness. It can also mean equilibrium: thus sickness means imbalance or disequilibrium. Health is often seen to have both physical and mental components. Health is not only physical or mental health per se – health is also situated in a cultural context. The anthropological examination of health involves also norms, worldview, power structures, the role of beliefs, practices, etc. Health is a function, not only of medical care, but also of the overall integrated development of society – cultural, economic, educational, social and political. The health status of a society is intimately related to its value system, philosophical and cultural traditions, and social, economic and political organization. Each of these aspects has a deep influence on health, which in turn influences all these aspects. Hence, it is not possible to raise the health status and quality of life of people unless such efforts are integrated with the wider efforts to bring about overall transformation of a society.[6] Illness and distress are "not simply individual experiences, which arise, out of the contingency of life and threaten to disrupt a known world. These may also be experiences which are actively created and distributed by the social order itself". And the disease is a form of social suffering that is an outcome of the complex interplay of biological, socio-economic, political and institutional factors in a given society.[7] The culture of community determines the health behavior of the community in general and individual members in particular. The health behavior of the individual is closely linked to the way he or she perceives various health problems; what they actually mean to him or her, on the one hand, and on the other, his or her access to various relevant institutions. The holistic concept of health culture provides a valuable framework for analyzing the dynamics of maternal and child health practices. However, very few studies are available in this direction, especially among the tribal population.

---

[6] Basu S.K. Health and culture among the underprivileged groups in India. In: State of India's Health. Voluntary Health Association of India 1992: 175-186.

[7] Baru Rama. Disease and Suffering: Towards a Framework for Understanding Health Seeking Behavior. Indian Anthropologist 2005; 35:1& 2: 45-52.

It has been observed that among the tribal people the universal index of a threat to health is expressed through withdrawal from work. Mahapatra (1994)[8] sees health among tribal groups as a functional and not clinical concept. According to Sachchidananda (1994)[9] the field of tribal health is a cultural concept as well as a part of social structure and organization which is continuously changing and adapting itself to changes in the wider society. It is a faith prevailing among tribes that diseases are caused by supernatural agencies. Broadly, the tribal people believe in four types of super-natural powers. These are (1) protective spirits who always protect them; (2) benevolent spirits who are worshiped at the community and familial level regularly, otherwise they may bring diseases or death; (3) malevolent spirits - the evil spirits who control smallpox, fever, abortion, etc. and (4) Ancestral spirits, the spirits of their ancestors and always protect them. The causes of ill health perceived by the tribal communities can be divided into two categories, namely, known and supernatural. Thus Choudhury (1994)[10] and Lewis (1958)[11] believes that the study of tribal health should be with reference to their distinctive notions regarding different aspects of diseases, health, food, human anatomy and faiths as well as in the process of interaction with modern world. Singh (1994) indicates nine factors to examine and assess the tribal health situation in India. He highlights the effect of changing physical environment on tribal health, which is ultimately related to their economic pursuits, nutritional availability, medicines etc.

Concept of Health and Perception of Disease

In a tribal habitat, a person is usually considered to be afflicted with some diseases if he/she is incapable of doing the routine work which is usually being expected to be carried out by that individual in the society i.e. incapacitation from work is the universal index of poor health. Thus the concept of ill health becomes a functional one and not clinical. Symptoms such as pains, ache, weakness, scabies, prolonged cough, mild fever, wounds etc. are not taken seriously as symptoms of disease. A tribal in general hardly makes a distinction in the magnitude of fever.

---

[8] Mahapatra, L.K. Concept of health among the tribal population groups of india and its socioeconomic and socio-cultural correlates. *Tribal health in India.* Manak Publications Pvt. Ltd; 1994. p.1-12.

[9] Sachchidananda. Socio-cultural dimension of tribal health. *Tribal health in India.* Manak Publications Pvt. Ltd; 1994. p.57-69.

[10] Chaudhuri B. Social and environmental dimensions of tribal health. *Tribal Health in India.* Manak Publications Pvt. Ltd; 1994. p.70-83.

[11] Lewis Oscar. *Village Life in Northern India.* New York: Random House; 1958.

However, within the limits of their own respective worldview, most of the tribal societies have definite means for identifying and classifying various kinds of ailments and diseases.

Child Bearing and Maternal Mortality

Child bearing imposes additional health needs and problems on women – physically, psychologically and socially. Maternal mortality was reported to be high among various tribal groups. The chief causes of maternal mortality were found to be unhygienic and primitive practices for parturition. Expectant mothers to a large extent are not inoculated against tetanus. From the inception of pregnancy to its termination, no specific nutritious diet is consumed by women. On the other hand, some pregnant tribal women reduced their food intake because of simple fear of recurrent vomiting and also to ensure that the baby may remain small and the delivery may be easier. The consumption of iron, calcium and vitamins during pregnancy is poor. The habit of taking alcohol during pregnancy has been found to be usual in tribal women and almost all of them are observed to continue their regular activities including hard labour during advanced pregnancy. [12]

An extremely important component of women's health during pregnancy is the state of their general health before pregnancy. The overall health status as well as health during pregnancy is a part of the women's social existence. Thus while medical care undoubtedly play an important role in maternal health, it is only one of the actors on the stage. Women's social reality incorporates in addition to health care, the larger social structures in which they exist. These include not only their social environment but also their self image that owes a great deal to their socialization as well as to their roles as caretakers of the households and its members. These different components that contribute to women's health are interlinked and each strengthens the effect of the other. The thread of poverty runs through all these factors.

Health is complex of different factors; besides social factors the economic circumstances of women's lives also have an impact on their health. The general health status of economically disadvantaged women is affected to a large extent by their poverty. Poverty leads to lack of sufficient food and this leads to malnutrition. In addition women's heavy workload and low

[12] Basu Salil. Health and Socio-cultural Correlates in Tribal Communities. Tribes of India, Ongoing Challenges. M.D. Publications Pvt. Ltd; 1996.

status also contributes to their poor health. Even before they become pregnant these women have high degree of morbidity. This situation is worsened by pregnancy. The larger social structures are important for all women whether they are pregnant or not. It is these structures that decide how a woman must behave in patriarchal societies, what roles they will play in their lives, and what their social status will be. Additionally, it is these structures that also decide 'the sick roles for women' and whether they need care or not, especially during pregnancy. The state of women's health is therefore affected by the sum total of their existence and that include their socialization and devaluation, their economic status, their employment and their physical environment, as well as the larger social mores. This general health of women in turn affects their health during pregnancy. It is the interaction between all these determinants that finally lead to the creation of the kind of health status that influences the outcomes of their pregnancies. The quality is reflected not only through their morbidity during their pregnancy, but also in their babies' birth weight.

The concept of health culture

Health culture becomes an integral component of the overall health culture of a community. The culture of a community also directly influences its health culture because certain cultural practices such as child rearing, food and drinking habits, pregnancy and child birth practices are directly related to the generations of some community's health problem.

Gochman (1988) views the health culture as a macro level concept – concepts those that apply to health behavior and understood in terms of group or systems phenomena; micro level concepts are those that apply to health behavior understood in terms of individual actions or interactions. The macro level concept of culture may be defined as a society's repertoire of patterns for cognition, affect, and behavior. As such it provides the framework within which individuals in various positions in the status hierarchy and for positions of centrality or marginality in a social system learn specific ways of thinking, feeling and behaving. In this respect culture is a group concept.

Banerji's health culture observes that health culture is the sub-culture of the larger complex of culture. As a result, the changes in the overall culture influence changes in the health culture of a

community. He further argues that 'health culture' covers an equally wide range of consideration, which intimately interacts with one another to form a sub-cultural complex.

Cultural perception of health problems, cultural meanings and cultural response to these problems, both in terms of formation of various institutions to deal with various health problems and actual (health) behavior of individuals or groups, form this sub cultural complex.

The present study attempts to understand the cultural and the social realities among Santhal Tribes and their influence on the maternal and child health care practices. Secondly, it explores the gaps between perceptions and actual care practices of mothers and children. The study also tries to look at the perceptions of people towards the pluralistic medicine.

The research questions of this study are:

1. How has health practices (traditional and allopathic) changed overtime in a Santhal society?
2. What are the underlying reasons for the pluralistic use of health care in such societies?

Broad objective:

- To study the Maternal and Child health care practices among Santhal tribes of Dumka district, Jharkhand.

Specific objectives

1. To study the patterns of maternal and child health care practices (institutional or home deliveries).

2. To study the health care practices across generations.

METHODOLOGY

The Design

Since the focus of this study was to examine the patterns of the health care practices among the santhal tribes and also to study the health care practices across generations, an in-depth qualitative design was found to be appropriate. Qualitative methodology was used keeping in mind that I have to study the lives of women in their entirety, to closely look at their daily lives so as to know and observe their practices, and to explore different dimension of their lives. I wanted to acquire an in-depth understanding of their day to-day behavior and practices, and the reasons that governs those behaviors. This is an emic (native's point of view) perspective, which would be different from the outsider's perspective on their local living.

Given the above backdrop, some degree of familiarity with the local culture, knowledge of social customs and proficiency in local language and dialect could be an asset. I chose a village called 'Ranga' in Dumka district of Jharkhand, where the degree of communication and interaction with the people was easy and feasible. I stayed in the village for one and a half months, which was full of challenges. I got rich insights on the lives of the people during this period. I gained a close intimate familiarity with the people and their practices, especially with the women through an intensive involvement in their natural environment. Being a participant observer, I first build rapport with the women of the village, and the best of way was by being a good listener, and let them speak whatever they wanted to. To address my objectives I conducted in-depth interviews with the pregnant women or women who have delivered within the last 2 years, and located their patterns and practices. I further talked to the old women to draw a contrast or see the changes in the health care practices across generations. Apart from it, I looked into health status of children up to the age of one year and inquired about the morbidities suffered by them in past or present. Depending on the circumstances of the place, or the informant's or women's position within it, I conducted the interview in a private place, as far as possible. I also made sure that the respondents knew that the data are to be used for my research work.

Study Village and Its Population

The village where I carried my field work was "Ranga village" which had four hamlets or 'tolas' i.e. Baru tola, Rasi tola, Gajal tola and Jolha tola (Muslim tola). This village was under

Shikaripada block in Dumka district, Jharkhand. The village population is approximately 800-900. And the total population under Shikaripada block is 110132; it is predominantly a tribal area in which the total tribal population is 68718.

Nature of Data Required

As the objective is to study the health practices of women focusing on their maternal and child health, I wanted to look at the influence of socio-economic and cultural environment on women's health. For this, it was necessary to study the nature of economy and the production pattern in the village, and its social structure.. Within these intricacies, the effort was to establish linkages between health of women (pregnant) and children, in their social and physical environment. The following data was collected in this regard:

a) General Data

- An overview of the village – Location, communication, transport linkages, irrigation facilities, institutions - government and non government- PHCs, schools, private institutions etc.
- Economic aspects – Cropping patterns, land holdings, possessions of milch cattle, term and conditions of labor exchange, wages, hunger situation etc.
- Social aspects – Caste and religion groupings, education levels, family structure, decision making powers, cultural beliefs, social customs, ceremony etc.
- Health Services for the Village – Availability, interaction between health workers and people of different tolas or villages, at the PHC and in their day to day work in the field and accessibility to private hospitals.

b) Role of Women in Village Life

- Economic activity – share or amount of works in field, the decision-making power with regard to economic matters etc

- Social Status – Women's relationship with other family members, their experiences of pregnancy and diseases, their interaction with the medical personnel, the women's perception of all these as well as their coping techniques.

c) MCH Practices

- Qualitative Data – Regarding food patterns and work patterns during pregnancy and after delivery, interaction with health services, practices at the time of delivery, care of pregnant women, post partum mothers and small children, feeding and weaning practices, customs, ceremonies and superstitions regarding MCH etc.

d) Past obstetric history

- The number of still births and live births the women had delivered and causes of still births was enquired from the women. All this needed sitting and talking to the women at length so that they feel comfortable enough to cite any morbidity they had and what do they identify as morbidity or illness is again to be determined by women themselves.

Tools for data collection

Participant observation

The participant observation gains a close and intimate familiarity with a given group of individuals (such as a religious, occupational, or sub cultural group, or a particular community, here the Santhal community) and participated as much as possible in the local daily life (everything from important ceremonies and rituals to ordinary things like meal preparation and consumption) while also carefully observing everything I came across, over an extended period of time. Observation is more fruitful when one is at ease with the surrounding. The information on physical environment, cleanliness or hygiene, daily chores etc, are some of the data which I collected using participant observation. It included not only observation but also interaction, sharing and extraction of the data from the natural world.

Informal discussions

This goes throughout the day, as the researcher moves around to gather data people were queries want to know the purpose of the data collection, would often sit and give their views on the health conditions, the health system, poor sanitation, relationship between morbidity, poverty and unhealthy environment. This helps in building an understanding and also an unending source of information on awareness of many dwellers of the reasons behind poor health, as well as their feelings of powerlessness.

Focused group discussion

This was used to obtain information on women's perceptions on certain topics like gynaecological problems etc, issues which were being raised repeatedly by women during informal discussions, and during group discussion a better insight of the women health status came into picture which otherwise would have been missed

Case studies

Case studies were collected to illustrate the complexity of maternal health. The pregnant women's stories were put together in detail and every minute discussion was recorded. Information collected from them as well through observation at different points of time helped in understanding the situation and circumstances women face within the Santhal tribe.

In-depth interviews

In-depth interviews and probing was helpful in bringing out the intricate information such as family planning decisions etc. which otherwise were very difficult to seek. In-depth interviews provided a chance to learn how people reflect directly on behavior, circumstances, identity, events etc.

Informal interviews

This was required to get in rapport with the people initially, and to prepare a backdrop for the actual study so that people themselves become free to talk. Later, such interviews also helped in gathering information on the state of health services and the working patterns of the health

workers. This was also a way of knowing each other in order to make the study flow in a smoother way. This went on throughout the course of one and half months.

Interview schedule

An interview schedule was used to probe issues pertaining to all sphere of life, such as their social status, housing pattern, occupation, perception and knowledge about various problems, day today activities, maternal and child health care practices etc. It was an open ended interview schedule.

Limitations

An in-depth understanding of the tribal life requires a much more intensive fieldwork and more time. This fieldwork of one and half months only provides an exploration into the theme of maternal and child care practices. And as the study was carried in a single village, the analysis cannot be generalized for the entire tribal community, as variations both in practices and health seeking behavior is witnessed from place to place.

Other limitations have been in terms of my commute from one hamlet to another in the hilly terrain region. Also the study was very challenging required to interact with women during their time of work, and during pregnancy. It took a lot to make them speak free flow.

Ethical issues

Since our research took place in the real setting among human beings, there were a number of ethical concerns to be aware of. The researcher made the research goals clear to the members of the community where she undertook her research and gained the informed consent of her respondents to the research beforehand. It was also important to learn whether the group would prefer to be named in the written work of the research or given a pseudonym. Above all, researcher made it sure that the research does not harm or exploit those among whom the research is done.

-Chapter 2-

Overview of maternal and child health status and programs

Introduction

This chapter, through various studies and data sets, traces the situation of maternal and child health in the country, past and present. It then looks into the nutritional status of women and children in the country. Moving forward, this chapter traces the relation of socio-economic partitions created in the name of caste and class and SLI on the health of women and children in the country. Situation of Jharkhand and Bihar is then compared in context to National averages and other States of the country. As the study is focused on tribals of Jharkhand, this chapter looks into studies, although limited in number, conducted on them and discuss the patterns depicted by them. Further, the reflection of the data makes ground for our present study.

Population trends of women children along with fertility pattern in the country

The 2001 census highlights that, more than 2,82,238,162 women in the country belong to the age group of 15-59 years, making nearly 56.9% of the total female population in India. This age group represents more than 28% of Indian population and most of the women in this age group also belong to the reproductive age, making it one of the most vital group. Children below 14 years of age constitute more than 35% of the total Indian population with figures over 360,000,000. The combined population of these two age groups constitutes more than 63% of Indian population. These 63% also represent one of the most vulnerable section of our society for under nutrition, health related morbidity and mortality and many other factors.

With an infant mortality rate of 57 deaths per 1,000 live births (NFHS-3), more than one in 18 children die within the first year of life, and more than one in 13 die before reaching age five. Nationally, a girl child's disadvantage with regard to survival is most evident in the under-five

mortality rate: 79 girls per 1,000 births die before their fifth birthday, compared with 70 boys per 1,000 births.

The NFHS III suggests that 5.2% of women age 15- 49 are currently pregnant. The percentage of currently pregnant women is relatively higher in rural areas and women with no education, Muslims, Schedule tribes and women living in household in the lowest wealth quintile.

Although not very specific, Crude Birth Rate (CBR) is taken as of the basic indicators of trends in fertility within the country. CBR has declined from 28.7 in NFHS-I to 24.8 in NFHS-II. This steep fall between NFHS I and NFHS II was not observed during the period of NFHS II to NFHS III (CBR 23.1). Another indicator used in the estimation of fertility is the Total Fertility Rate (TFR) which shows a decline in the same pattern as CBR. The rate of fall of TFR (15 – 49 ages) from NFHS I to NFHS III is:

Total Fertility Rate			
	URBAN	**RURAL**	**TOTAL**
NFHS I	24.1%	30.4%	28.7%
NFHS II	20.9%	26.2%	24.8%
NFHS III	18.8%	25.0%	23.0%

According to NFHS III, the TFR is clearly affected by household wealth index which declined from 3.9 children for women living in household in the lowest wealth quintile to 1.8 children for women living in household in the highest wealth quintile.

When analyzing the TFR of the country according to Age specific fertility rate (ASFR) we find that between NFHS II and NFHS III, the decline in ASFR was very small at all the ages, with ASFR for women age 20- 24 showing very small increases in rural. The trends between NFHS II and NFHS III clearly suggest a slowdown in fertility decline as compared between NFHS I and NFHS II.

Nutritional status of women and children in the country: An overview

The nutrition and health status of women is important both for the quality of their lives and for the survival and healthy development of their children, yet relatively little attention has been given on this area; further women should not be considered solely with respect to their reproductive roles as mothers, adequate nutrition is a human right for all and the nutritional benefits to women's social and economic capabilities need to be viewed as goals (UNICEF 1997). In recent years, renewed emphasis through different governmental programmes (ICDS, RCH etc.) has been given to improve the nutritional status of mother.

Health of children is considered as one of the finest indicator to progress of a Nation, both economically as well as quality of living. Children of today represent the future generation and their health is of greatest concern.

While there has been secular improvement in most health indicators, India continues to perform inferiorly in terms of health. Infant mortality rates have fallen and life expectancy has been rising. Maternal and child health, on the other hand, remain areas of neglect and as a result maternal mortality rates remain high, there is pervasive under-nutrition among children and women, and conditions of safe child birth elude large proportions of pregnant women.[13]

Nutrition has a large role to play in determining the health outcome of an individual. Although Indian population has doubled during the period of 1960-1992, yet production of food grains has kept in pace with the population growth and therefore the per capita food availability did not decline[14] . While the estimate per capita food availability did not decline, surveys point out that 40% of Indian population consumes less than 80% of energy required and this has many fold reasons[15] . A review by Richard Lipton and Richard Longhurst (1989)[16] of the impact of modern seed varieties on the poor emphasizes that increased availability of food per se does not translate automatically into increased consumption by poor farm laborers. Nearly 1 in every 5 persons in the developing world is chronically undernourished (i.e., too hungry to lead a productive life); this is twice as many as a decade ago.

[13] Bajpai Nirupam. India: Towards the Millennium Development Goals. Background Paper Human Development Report; 2003.

[14] Nutrition in South-East Asia. World Health Organization. New Delhi: Regional office for South-East Asia; 2000

[15] Nutritional Trends in India. National Institute of Nutrition, Hyderabad, India; 1996

[16] Lipton M, Longhurst R. New Seeds and Poor People. Baltimore. The Johns Hopkins University Press; 1989.

Nutritional status of children

In case of children, the effect of under-nutrition is exponential. It affects not only the present physical and mental growth of the children but also has an effect on the healthy living in the coming years of life. Gopalan[17] in his 1994 study showed that poor fetal growth has been attributed to widespread maternal under nutrition. 1/3rd of babies born in India are of low birth weight and this contributes to a major public health problem. In addition to short term consequence such as high infant mortality and childhood growth failure among survivors LBW carries long term risk for adult coronary health disease and type II DM. Barker (1998)[18] states that, fetal under nutritional at critical periods of development and during infancy leads to permanent metabolic and structural changes that increase risk for adult disease. The Shobha Rao[19] study states that first 3 years of life of a child are critical and rural children may miss the "second opportunity" for catch-up growth during adolescence due to stunting in early life. It also states that supplementation beyond the age of 3 years may not be beneficial and existing program need to focus on coming children below 3 years of age. Rao (2001) study also point out that the range of systematic fluctuation was significantly smaller in case of under nourished children as compared to normal weight children suggesting homeostatic limits of under nourished children. It also suggests that under nourished people exhibiting lower capacity to interact with the environment due to lower range of homeostatic. Shanti Gosh's study following the Low Birth Weight (LBW) of infants for 18 years reveals that the growth performance of the LBW infants was poor when compared to other infants and children of the same socio-economic groups born with normal birth weight. Apparently, children suffering from IUGR are programmed to grow and develop in a substandard growth trajectory, thus swelling the numbers of stunted and underweight children with low learning capacity and adults with low BMI with low productivity.[20]

The NNMB survey on nutritional status of children found that severe form of Protein Energy Malnutrition (PEM) in Pre-School children was 8.7% during 1988-90. The prevalence of under-

[17] Gopalan C. Low birth weights: significance and implications. In: Sachdev, H.P.S. & Choudhury, P, Editor. Nutrition in Children. Developing Country Concerns. Delhi: Cambridge Press; 1994

[18] Barker DJP. Mothers, babies and health in later life. Edinburgh: Churchill Livingstone; 1998.

[19] Rao Shobha. Nutritional Status of the Indian Population; Journal of Biosciences 2001 November;26:4; 481-489.

[20] Nutrition – Hindu magazine ; The Hindu ; Online edition of India's National Newspaper Sunday, Mar 02, 2003

weight children below 5years of age was 52.5% in 1988-90. The NNMB survey in 1996 pointed that the prevalence of under-weight children is still at 50%. It was also pointed that moderate to severe malnutrition is more prevalent in children of 1-3 years of age rather than 3-5 year age group (NIN 1996), the vicious cycle of under nutrition starts in early ages of life. The NNMB study also highlights that around 63% percent of preschool children suffer from stunting, which of indicative of long term chronic malnutrition and 17% suffer from wasting which indicates acute or current malnutrition.

Carlson and Wardlaw in 1990[21] showed that 36% of children in the developing world, excluding China, are malnourished; about 34% are stunted, and 8% are wasted. In a study by Dutta (1998)[22], of all the children surveyed, only one fifth qualified as nutritionally normal, leaving roughly 80% in the malnourished category. It is also apparent from Dutta and Kumar 1997 [23] study that children suffer from higher levels of poor health than adults, with preadolescents, adolescents, and teenagers the worst off nutritionally. This indicates that certain specific factors may have adverse effects on health, as children grow older.

Bharati S[24] studied the determinant of nutritional status among pre-school children using NFHS-II data and showed that there are gender difference and spatial variance in nutritional status of children in India. Gender differences are not very prominent and almost disappear when the effects of age and socio-economic demographic variables are removed. The spatial differences specially the rural-urban difference was found to be very large and decreased substantially when effects of age and socio-economic variables are removed.

A recent study conducted by Bose K among children of age 1 -12 years belonging to low socio-economic status in West Bengal indicated that overall rate of underweight was 60.4% & 45. 3% while stunting was 51.7% & 48.4% in boys and girls respectively. It also indicated that

---

[21] Carlson B, Wardlaw T. A Global, Regional and Country Assessment of Child Malnutrition. UNICEF Staff Working Papers 7. New York: UNICEF; 1990.

[22] Dutta A. Victims of unsustainability, health status of Garhwali children. Mountain Ecosystems. A Scenario of Unsustainability. New Delhi, India: Indus Publishing Company; 1998. P. 154-159.

[23] Dutta Anuradha Pant Kiran. The Nutritional Status of Indigenous People in the Garhwal Himalayas. Mountain Research and Development 2003 (Aug); 23: 3:278-283

[24] Bharati S, Pal M, Bharati P. Determinants of nutritional status of pre-school children in India. Journal of Biosocial science 2008 Apr; 28:1-14.

prevalence of underweight and stunting was very high (greater than 30%) in both sexes (Rao 2001).

NFHS III data suggests that almost half of the children less than age of 5 years (48%) have stunted and 43% are underweight. The proportion of children who are severely undernourished is 24% according to height for age and 16% according to weight for age. 20% of Indian children showed wasting, the proportion of children who are stunted or underweight rapidly increases with child's age through 20- 23 months.

	Stunted	Wasted	Underweight
NFHS II	51	20	43
NFHS III	45	23	40

Source: NFHS II and NFHS III

Even during first six months of life, when most babies are breastfed, 20- 30% children are undernourished. At the age of 18- 23 months when many of the children are wean from breast milk, 30% of children are severely stunted and $1/5^{th}$ is severely underweight. Under nutrition is generally lower for first births, but then subsequently increases with every birth. Breastfeeding and supplementation- data from NFHS III suggested that most mothers (57%) gave their last born child something to drink other than breast milk in first 3 days after delivery. And the most common liquid given to the child was milk other than breast milk. Pre- lacteal feed is most common in Bihar (91%). NFHS III also indicated that only 69% of children of age less than two months are exclusively breast fed which drops down to 51% and 28% at the age of 2–3 months and 4- 5 months respectively.

In 1996, Govt. of India's micronutrient task force estimated that 88 million pre-school children are at risk for vitamin A deficient. A study done on vitamin A deficiency among children indicated 12% and 58% of severe & moderate vitamin A deficiency while NIN-1990 study showed that 50% of mother & 20% of children had low serum retinol at the time of delivery.

Nutritional status of women:

The nutritional status of women has a direct effect on her productive life as well as on the babies born by her. Neglect in women's health translates directly into worsened child survival as well as her poor reproductive health. Nutritional deprivation during pregnancy and lactation exacerbates the natural effect the maternal depletion from child being. Malnutrition in women can result in reduced productivity, slow recovery from infection increased susceptibility to infection and high level risk of adverse pregnancy outcome greater risk of obstructed labor, baby with low birth weight whose survival are far lower than those with normal birth weights, production of low quality breast milk, deaths due to postpartum hemorrhage and complications etc. A study by Gautam et al[25] in rural areas of northern India showed that the intake of calories, protein, iron, folic acid and vitamin was found to be less than the recommended dietary allowed in 100%,91.2%,98.2%,99.1% and 65.5% of pregnant women respectively.

Although malnutrition in India is prevalent among all segments of the population, poor nutrition among women begin in infancy and continues throughout their life time (Chatterjee 1990)[26]. Women and girls are typically the last to eat in a family, thus if there is not enough food available they are the ones to suffer most (Horowitz and Kishwar 1985)[27]. Several studies have found that one of the reasons for poor health of Indian women is the discriminatory treatment girls and women receive compared to boys and men (Desai 1994). Sen in 1985[28] argued that the low Indian sex ratio appears to be the result of differential mortality arising from the neglect of female children. Drawing upon his study of two West Bengal villages, he shows that girls were even more undernourished than boys in both villages, with malnutrition being most severe where landlessness was greatest. The study by Bhalla (1995)[29] and Jejeebhoy & Rao (1995)[30] showed

[25] Gautam V P, Taneja DK, Sharma N, Gupta VK, Ingle GK. Dietary aspects of pregnant women in rural areas of northern India. Maternal Child Nutrition 2008 Apr; 4(2):86-94.

[26] Chaterjee, Meera. Indian Women: Their Health and Economic Productivity. World Bank Discussion Papers 109, Washington DC; 1990.

[27] Horowitz, Berny, Madhu Kishwar. Family Life – The Unequal Deal. In: Madhu Kishwar and Ruth Vanita, Editor. In Search of Answers: Indian women's Voices for Manushi. London:The Pitman Press for Zed Books Ltd; 1985

[28] Sen A. Commodities and Capabilities. Amsterdam and New York: North-Holland; 1985.

[29] Bhalla AS. Uneven development in the third world: a study of china and India. United Kingdom: Basingstoke; 1995.

[30] Jejeebhoy, Shireen J, Rama rao Saumya. Unsafe Motherhood: A Review of Reproductive Health. IN: Monica Das Gupta, Lincoln C. Chen, Editor. Women's Health in India: Risk and Vulnerability. New Delhi, India: Oxford India Paperbacks; 1998. p. 122-52.

that boys who are ill are most likely to be taken to medical treatment than girls. On the contrary the 1987 study by Harriss and Watson[31] found "little evidence of discrimination against females in access to health facilities". Monica Das Gupta (1987)[32], however, found in her study of Ludhiana District, Punjab that families spent more than twice as much on health care for boys as for girls in the first two years of life. She found that excess mortality was not uniform for all girls; rather, it was concentrated among second and subsequent daughters. Das Gupta argues that this pattern reflects entrenched cultural patterns of preference for sons in Punjab. Anemia among women is one of the most indications for nutritional and health status of female. WHO-SERO 1997 National report stated that there is 87.5% prevalence of anemia among Indian pregnant women and 56% in under-5 children[33]. Although NFHS-2 reported reduction in prevalence of anemia, a study by Dr. Aggrawal[34] used the same district and villages studied by NFHS-2 highlighted that the prevalence as well as severity of anemia was significantly higher as compared with data with NFHS-2. It cites the reason for this difference in data due to different method of hemoglobin estimation used in previous studies and in NFHS-2. This study also showed that the inter-state differences particularly in fertility, women education, nutrition status, occupation, availability of ANC services and iron-folic acid tablets are possible factors responsible for difference in prevalence of anemia.

NFHS III data suggest that ANC service utilization has increased substantially from 65% (NFHSI), 66% (NFHS II) to 77% (NFHS III) and the increase is higher in rural areas.

Trends in Any Antenatal Care Utilization			
	Rural	**Urban**	**Total**
NFHS I	59	83	65
NFHS II	60	87	66
NFHS III	72	91	77

[31] Harriss B, Watson E. The sex ratio in South Asia. Geography of Gender in the Third World. Albany: State University of New York Press; 1987.
[32] Das Gupta M. Selective discrimination against female children in rural Punjab, India. Population and Development Review 1987; 13(1): 77-100.
[33] National Reports on the Third Evaluation of Implementation of HFA Strategies. SEA Region,WHO;1997.
[34] Agarwal KN. Prevalence of Anemia in pregnancy and lactating women in India. Indian Journal of Medical Research 2006 August; 124: 173-184

Role of caste and socio-economic living index in determining nutritional status of women and children

There has been seen a declining trend in the risk of dying during infancy and childhood and maternal mortality, which has come about with effective mortality control during the present time. However, the benefits of this reduction are not equally shared by all sub sections of population to an adequate degree. A wide variety of studies dealing with this general issue have consistently shown that the lower socio economic strata in our society have been and continue to be characterized by an extremely pronounced disadvantage when it comes to survival of infant and mother . Deprivation among people of a particular region, class or ethnic group within a country is likely to show up in the form of an increased IMR for the affected group.[35] Scheduled tribes and scheduled castes are the most socially disadvantaged groups and have traditionally been identified by the Indian government as needing affirmative action.[36]

S.V. Subramanian, Shailen Nandy et al, conducted a multilevel cross-sectional analysis of individual mortality, using the 1998–1999 NFHS Survey data for 529321 individuals from 26 states. Their objective was to investigate the contributions of gender, caste, and standard of living to inequalities in mortality across the life course in India. Among young children (aged 2–5 years), differences in mortality were apparent by gender, caste, and standard of living. Mortality risk was higher for girls than for boys. Although the mortality risks for children from scheduled castes and other backward classes were not different from those of children from other castes, children from scheduled tribes had a substantially greater mortality risk. The standard-of-living gradient was stronger for children than for infants, with children from the lowest quintile compared with those in the top quintile. Children's odds of mortality increased steadily as household standard of living declined.

Mortality differentials among children and adolescents (aged 6–18 years) were also patterned by social caste and standard of living. Children and adolescents belonging to scheduled tribes had the greatest risk of mortality, followed by those from scheduled castes and other backward classes, with "other castes" as the reference group.

---

[35] Syamala TS. Relationship between Socio Demographic Factors and Child Survival: Evidences from Goa, India. Journal of Human Ecology 2004; 16(2): 141-145.

[36] *National Family Health Survey 1998–99.* Mumbai, India: International Institute of Population Sciences; 2000.

Among young adults (aged 19–44 years), there were gender-based mortality differentials; women had a lower mortality risk. Caste differentials were observed mainly for scheduled tribes. Standard of living remained a strong predictor of mortality.

Caste too remains a salient social feature and people belonging to scheduled castes and tribes lag behind in terms of education and health. Caste differentials in mortality were substantial among children and adolescents (aged 6–18 years) and the elderly, with scheduled tribe members experiencing a greater mortality risk across the life course. Caste affiliation in India traditionally reflects a person's status within a hierarchical social structure. If status-based position within a social hierarchy influences mortality, then caste might be expected to show a strong association with mortality after control for living standards. Indeed, one might expect the association between standard of living and mortality to be attenuated on adjustment for caste. It is also clear that the public legitimacy of caste in India has been diminishing[37]and caste status is changing from being a marker of vertical relative rank to representing some sort of horizontal cultural distinctiveness.[38]

Looking at the health status of women and children as per various social and religious groups it becomes quite evident that the poor and socio-economically deprived class caries the maximum burden of ill health and under nutrition throughout the country. According to NFHS III, the fertility rates are higher for women in disadvantaged groups (3.1 children per women among ST, 2.9 among SC and 2.8 among other backward casts) compared with women who are not in any of these groups. This also has an evident effect of place of living with rural areas having 3 children per women fertility rate as compared to urban area with 2.1 children per women which is near to replacement level. As per NFHS III, 12% of ever married women are below the height of 154 cm (NFHS II 13%). This short height increases the risk of having a baby of low birth weight. By class/Tribes, SC women are the shortest followed by ST and then OBCs.

Women belonging to the Scheduled Castes and the Scheduled Tribes are more likely to suffer from moderate and severe anaemia. At the same time, considerable proportions of women of socio-economically advantaged backgrounds (that is, those belonging to high standard of living;

[37] Beteille A. Caste in contemporary India. Caste Today. New Delhi, India: Oxford University Press; 1996. p.150–177.

[38] Fuller C. Introduction. Caste Today. New Delhi, India: Oxford University Press; 1996. p. 1–31.

high education) are obese. Thus, the nutrition profile of the country is not only indicative of the deprivation that disadvantaged social groups suffer from but also provides a vivid picture of the double burden of nutritional disorders that differentially affect social groups in the country.[39]

Studies show MMR (per 100000 live births) among scheduled tribes (652) and scheduled castes (584) is higher than in women of other castes (516, according to one study). It is higher among illiterate women (574) than those having completed middle school (484). The key determinant seems to be access to healthcare. Less-developed villages had a significantly higher MMR (646) than moderately or well-developed villages (501 and 488 deaths, respectively).[40]

As per NFHS III, according to caste and tribe, the likelihood of having received any antenatal care and care from a doctor is lowest for schedule tribe mothers and highest for mothers belonging to other castes (non ST, SC or OBC). The proportion of mother receiving 2 or more tetanus toxoid injection during pregnancy for most recent births substantially low in mothers with no education, ST mothers and mothers with household of lowest wealth quintile

Although the percentage of births to ever married women who delivered in a health facility is on an increase from 26% to 34% to 41 % in NFHS I, II and III respectively. Yet according NFHS III, only 18% of births to ST mothers are delivered in health facilities as compared to others, to mothers who belong to non SC/ST or OBC castes. Only 17% of births to women who belong to ST were assessed by a doctor as compared with 47% of births to women who belongs to non ST, SC or OBC. Yet another observation among assistance during delivery is that more than 50% of births to ST mothers are assisted by a Dai (helping lady) or a trained birth attendant, while only 17% by doctor, 7% by ANM/Midwife. NFHS III suggest that post natal check- up is not received by majority of women (58%).Urban mothers have twice the chance of getting a post-natal check-up (66%), as birth to a rural mother (34%). For ST mother more than 68% did not receive any post natal check- up.

The peri-natal mortality rate were highest in Hindu (49), while lowest in Sikhs (31).The schedule tribe have a lower peri- natal mortality (41) as compared with schedule castes (55),

[39] Mishra M. Gendered vulnerabilities: women's health and access to healthcare in India. The Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai; *2006.*

[40] Arati Rao. Who cries when mothers die? India Together (online); Wed 19 Dec 2007.

other backward castes (49) and others (45). Children belonging to ST, SC and OBC have a higher level of under nutrition on all three measures (stunting, wasting and underweight), with children from ST having the poorest nutritional status.

Interpreting health inequalities in relation to the socioeconomic circumstances of individuals and populations provides a useful assessment of potentially avoidable inequalities.[41]In particular, socioeconomic inequalities in mortality suggest not only contemporaneous exposure to disadvantaged individual and ecological circumstances but also cumulative exposure to adverse circumstances.[42] A necessary prerequisite for reducing health disparities, consequently, is to ascertain the socioeconomic distribution of health and mortality.[43]

.In a study done by S V Subramanian, Ichiro Kawachi, George Davey Smith, where they examined the association between contextual income inequality and the double burden of under- and over nutrition in India. They found in their study an association between state income inequality and levels of nutritional status, as measured by BMI, even after adjusting for a range of individual and state level covariates in India. Found the adverse contextual effect of state income inequality that is observed for the possibility of being underweight as well as categories that characterize over nutrition (i.e. pre-overweight, overweight and obese). They emphasized that whatever they report is a contextual effect of income inequality, after adjusting for individual-level factors, including economic standard of living, which they know has a clear relationship to nutritional status (in that women of low socioeconomic status experience the greatest risk for underweight and those in high socioeconomic status experience the greatest risk for being pre-overweight, overweight and obese)[44], a pattern also observed in this study. Thus, the context of inequality seems to accentuate the income-based disparities in consumption (reflected in people's BMI).[45]

---

[41] Braveman P, Krieger N, Lynch J. Health inequalities and social inequalities in health. Bulletin of World Health Organization 2000; 78 :(2):232–234.

[42] Davey Smith G, Hart CL, Blane D, Gillis C, Hawthorne V. Lifetime socioeconomic position and mortality: prospective observational study. British Medical Journal 1997; 314:547–52.

[43] Whitehead M. The concepts and principles of equity and health. International Journal of Health Services 1992; 22:429–445.

[44] Reddy NR. Body mass index and its association with socioeconomic and behavioural variables among socioeconomically heterogeneous populations of Andhra Pradesh, India. Human Biology 1998; 5:901–17.

[45] Subramanian SV, Kawachi Ichiro, Smith G. Income inequality and the double burden of under- and over nutrition in India. Journal of Epidemiology Community Health 2007;61:802–809.

Radhakrishna et al in their paper conceptualize chronic poverty by using dimensions based on income and nutrition. A household is identified as chronically poor if its income is below the poverty line, and its family members are suffering from malnutrition. There are several reasons for considering malnutrition along with income in the identification of the chronically poor. First, poverty and malnutrition are mutually reinforcing and poor households suffering from malnutrition find it difficult to escape the poverty trap. Empirical studies demonstrate that productivity is low for workers suffering from chronic energy deficiency[46]. Hence, malnourished workers are at a disadvantage in procuring adequate food to fulfill nutritional needs.

The malnourished children of poor families not only fail to achieve their full genetic growth potential but also are exposed to greater risk of child mortality. As adults they will be less productive, suffering from chronic illness and disability.[47] The risk of malnutrition is higher among children whose mothers suffer from chronic energy deficiency, and the link between child-adult malnutrition leads to a lifecycle of poverty within the family. Since the present nutritional status of a mother depends on her childhood nutritional status, the vicious circle of malnutrition (mother-child-mother) leads to an intergenerational transmission of poverty. Clearly, the nutrition theory of poverty explains why some households/individuals remain trapped in poverty for a longer period even when the economy achieves higher growth.

Alexander Moradi's study[48] on how the height distribution responds to increasing inequality, talks of the relationship between social status and human stature. While height differences reflect inequality between social groups, comparing mean heights neglects inequality within those groups and may even result in misleading conclusions of total inequality. Heights are a measure of net nutritional status, because they reflect nutritional intake net of claims due to diseases and physical exertion. In being very sensitive to poverty and its effects, such as hunger, low-nutrient diets, poor housing and sanitary conditions, contaminated food and water, no or limited access to medical care, child labour, etc., heights put the emphasis on the consumption of basic necessities,

[46] Deolalikar A.B. Nutrition and labour productivity in agriculture: estimates for rural south India. Review of Economics and Statistics 1988; 70: 406-413.

[47] Smith LC, Haddad L. Overcoming child malnutrition in developing countries: past achievements and future choices 2020 Vision. International Food Policy Research Institute. Washington DC: Food, Agriculture and the Environment Discussion Paper 30; 2000.

[48] Alexander M. On inequality in net nutritional status. Centre for the Study of African Economies, Department of Economics, University of Oxford; 2006.Available at: http://www.csae.ox.ac.uk/ conferences/2006-EOI-RPI/papers

i.e. they are consistent with the basic needs approach of measuring welfare.[49] Thus, social differences in net nutritional status, proxied by differences in height, reflect basic differences in welfare of whatever group has been measured – more fundamental and more comprehensive than those proxied by income or wealth.

The table below from NFHS II shows the proportion of stunted and wasted children, by gender, as a function of a "Standard of Living Index" (SLI). The NFHS does not include data on income or consumption, but it records information on ownership of a large number of assets and other wealth indicators. The Standard of Living Index, which is included in the database, is constructed by summing up scores assigned to each indicator, and then categorizing each household as having either a "low", a "medium" or a "high" index. Not surprisingly, there is a monotone relation between the SLI and growth performance. However, the figures in the last row of the table below show that even in households with a high index, approximately one third of children are stunted, and about 15 percent are wasted.[50]

Thus there are wide variations among members of different tribes in health status and in their willingness to access and utilize health services, depending on their culture, level of contact with other cultures and degree of adaptability. Some health indicators of STs, SCs and others (per thousand persons) are given below to establish the poor state of health amongst STs-

	Infant mortality rate	**Under-5 mortality rate**	**Under-nutrition**
SC	83.0	119.3	535
ST	84.2	126.6	559
ALL	70.0	94.9	470

Source: Bulletin on Rural Health statistics in India, 2005, Ministry of Health and Family Welfare

[49] Steckel RH. Stature and the Standard of Living. Journal of Economic Literature *1995;*33(4): 1903-1940.

[50] Alessandro T. Growth Reference Charts and the Nutritional Status of Indian Children. Dept of Economics, Duke University; Durham, NC; 2007. Available at: http://www.econ.duke.edu

Jharkhand and Bihar: Lagging far behind

India with its vast geographical variation has got enormous differences in nearly all indicators. Comparing a few States on TFR we can clearly see that Bihar, Jharkhand Uttar Pradesh have high TFR as compared to other States like Kerala, Tamil Nadu, Punjab throughout the period from NFHS I to NFHS III. The same variation can be depicted in CBR across various States.

		TOTAL FERTILITY RATE			CBR
State		**NFHS III**	**NFHS II**	**NFHS I**	**NFHS III**
BIHAR	*Rural*	4.22	3.82	N/A	34.0
	Urban	2.87	2.61	N/A	23.5
	Total	4.00	3.70	N/A	32.4
JHARKHAND	*Rural*	3.69	2.72	N/A	28.2
	Urban	2.32	2.95	N/A	21.00
	Total	3.31	2.76	N/A	26.8
KERALA	*Rural*	2.03	2.07	2.09	16.9
	Urban	1.73	1.51	1.78	15.4
	Total	1.93	1.96	2.00	16.4
TAMIL- NADU	*Rural*	1.90	2.23	2.54	16.8
	Urban	1.70	2.11	2.36	16.00
	Total	1.80	2.19	2.48	16.4
WEST BENGAL	*Rural*	2.54	2.49	3.25	24.2
	Urban	1.59	1.69	2.14	14.3
	Total	2.27	2.29	2.92	21.2
UTTAR PRADESH	*Rural*	4.13	4.39	N/A	30.9
	Urban	2.95	2.91	N/A	23.5
	Total	3.82	4.06	N/A	29.1
MADHYA PRADESH	*Rural*	3.34	3.73	N/A	26.00
	Urban	2.58	2.68	N/A	22.1
	Total	3.12	3.43	N/A	24.9
PUNJAB	*Rural*	2.06	2.42	3.09	19.2
	Urban	1.88	1.79	2.48	17.7
	Total	1.99	2.21	2.92	18.6
DELHI	*Rural*	2.98	3.07	3.67	25.00
	Urban	2.06	2.27	2.70	18.8
	Total	2.68	2.85	3.39	23.1

Within the country infant and child mortality has vast variation among the states; with Uttar Pradesh being highest at infant mortality rate of 73/1000 live births to lowest of Goa and Kerala being lowest 15 deaths/1000 live births.

	Neo- Natal Mortality	Post Neo-Natal Mortality	Infant Mortality	Child Mortality	Under 5 Mortality
India	39.0	18.0	57.0	18.4	74.3
Punjab	28.0	13.7	41.7	10.8	52.0
Madhya Pradesh	44.9	24.7	69.5	26.5	94.2
Uttar Pradesh	47.6	25.0	72.7	25.6	96.4
Bihar	39.8	21.9	61.7	24.7	84.4
Jharkhand	48.9	20.2	58.7	26.1	93.0
West Bengal	37.6	10.4	48.0	12.2	59.6
Kerala	11.5	03.8	15.3	01.0	16.3
Tamil Nadu	19.8	11.2	30.4	05.3	35.5

As per table it is quite evident that Bihar and Jharkhand have high early childhood mortality rate under all sub headings as compared to national average and other states. In addition NFHS III also highlights that Bihar and Jharkhand continue to have high Peri- natal mortality rate as compared with national averages.

Earlier to NFHS III, National level estimates from the NFHS-2 also show that girls are more likely to be undernourished or even severely undernourished for the indicators of weight for age and height. The NFHS-2 estimates that 35.8% of women in the country suffer from chronic energy deficiency, with a body mass index (BMI) of less than 18.5 kg/m2. The proportion of such women is highest in Orissa (48.0 %), followed by West Bengal (43.7%). Women's physiological makeup calls for special nutritional supplements. Menstruation and childbirth are iron depleting physiological processes. Calcium needs to be continually supplemented during a woman's life cycle as a bulwark against osteoporosis in later life. The NFHS-2 estimates that 35.8% of women in the country suffer from chronic energy deficiency, with a body mass index

(BMI) of less than 18.5 kg/m2. The proportion of such women is highest in Orissa (48.0 %), followed by West Bengal (43.7%). However barring a few small states, in the rest, a quarter or more of the women have a body mass index below 18.5 kg/m2 (Table 2). The NFHS-2 also shows that, at the national level, more than half (51.8%) of the women in the reproductive age group suffer from some form of anaemia. With the exception of Kerala (22.7%) and Manipur (28.9%), levels of anaemia are consistently high for the other states, the proportion of women suffering from some form of anaemia often being more than 40.0%. Assam leads with 69.7% of its women anemic. Bihar (63.4%), Meghalaya (63.3%) and Orissa (63.0%) follow (39).

The nutritional status of people in general and women and children in particular is very low in Jharkhand. According to National Family Health Survey (NFHS-II), during 1998-99, amongst the under-3 age group children, 54.3 % were under-weight, 49 per cent were stunted and 25% were wasted. The under-nutrition was higher in rural areas, particularly among SCs and STs. Infant and child mortality rates in Jharkhand were lower than both the national average and that of Bihar. While infant mortality level in India has been estimated to be 67.6 and that of Bihar to be 72.9, the same has been estimated as 54 for Jharkhand (1998-99). The same trend can be observed in regard to child mortality. The incidence of anemia in adolescent girls was 72.5%, amongst pregnant women was 63.9% and among the lactating women it was almost 76 %.

NFHS-2 indicates that nationally about two-thirds (66.8%) of the births in the three years preceding the survey had received two or more tetanus toxoid injections during the pregnancies (IIPS and ORC Macro, 2000). In no state is there universal coverage of such a service, though the southern states and some others in the rest of the country may have more than 75% coverage. In 10 out of the 25 states of the country (for which the NFHS provides the figures), less than 60% of the births have received two or more tetanus toxoid injections. Meghalaya (30.8%), Mizoram (37.8%) and Arunachal Pradesh (45.6%) bring up the rear .Other indicators of antenatal care services are as discouraging. Only 43.8 percent of the births in the preceding three years of the survey had received three or more antenatal checkups, there being large interstate variations in this regard, too. While states like Kerala (98.3%) and Goa (95.7%) are the leaders, Uttar Pradesh (14.9%) and Bihar (17.8%) are the tail enders. Similarly, less than half (47.5%) of the births received the supply of iron or folic acid tablets or syrup for three months and more. Further, women of certain backgrounds (tribals, illiterates, poor) are less likely to receive

antenatal care during their pregnancy. For example, almost half of the births among illiterate women (48.4%) and poor women (45.1%) are not preceded by any antenatal checkups (39).

- About two-thirds of maternal deaths occur in a handful of the states - Bihar and Jharkhand, Orissa, Madhya Pradesh and Chhattisgarh, Rajasthan, Uttar Pradesh and Uttaranchal (the Empowered Action Group or EAG states) and in Assam.

- The maternal mortality ratio (MMR) - the number of maternal deaths per 100,000 live births has declined from 398 (95%CI 378-417) in 1997-1998 to 301 (95%CI 285-317) in 2001-2003.

- The overall relative decline of nearly 24 per cent during 1997-2001 includes a 16 per cent relative decline in the EAG states and in Assam. In contrast MMR has fallen by 7 per cent in the southern states of Andhra Pradesh, Karnataka, Kerala and Tamil Nadu.

- In 2001-03, the lifetime risk of a women dying of in childbirth is 1.8 per cent in the EAG states and in Assam, 0.4 per cent in southern states and 0.6 per cent in other states.[51]

NFHS III data suggest that almost one out of every 5 Indian women did not receive any ANC care for their last birth. The regional variation can also be observed on grounds of availability and utilization of services where utilization of ANC is almost universal in Kerala, Tamil Nadu and Goa while it is lowest in Bihar 34% followed by Himachal Pradesh, Nagaland, Jharkhand (57 -59%). Bihar rank the lowest on many ANC indicators, and jharkhand also followed nearly the same pattern. For India as a whole NFHS III suggest that only 15% mothers received all the required components of ANC. It was as high as 64% for Kerala and as low as Bihar and Jharkhand ranged from 6- 9%. Teenage Pregnancy is also high in Jharkhand; WB and Bihar with 1 out of 4 teenage women has begun children bearing.

Distribution of malnutrition is also highly skewed within the country with most pronounced under nutrition being reported from M.P, Bihar and Jharkhand (NFHS III). Indian women suffer from a dual burden of malnutrition, with nearly half (48%) being either too thin or overweight. The proportion of women who are too thin is particularly high in Bihar (45%), Chhattisgarh and

[51] Sample Registration System. Maternal Mortality in India: 1997-2003 Trends, Causes and Risk Factors. Registrar General, India, New Delhi and Centre for Global Health Research University Of Toronto, Canada.

jharkhand (43% each), the lowest in Delhi and Punjab (NFHS III). Prevalence of anemia for both women and men is very high in Jharkhand and Bihar where more than 2/3rd of women and 1/3rd of men are anemic.

Maternal and child mortality patterns in the country: figures speak themselves

Maternal morbidity and mortality are major public health problems in almost the entire south-east Asian region, signifying not only the poor status of women in the region but also the often appalling standards in basic healthcare.

Though there have been near universal reduction in infant mortality and child mortality rates, they remain at very high levels for large sections of the population. Child health remains precarious with very high levels of anemia found among children indicating pervasive under-nourishment. (13)

About 40 percent of all maternal deaths in the world occur in the south-east Asia region (WHO, 1998)[52] with India alone accounting for half of all such deaths. The number of maternal deaths in the country is estimated at 1, 12,000 per year (UNFPA, 2000)[53]. It is estimated that maternal deaths account for a tenth of all female deaths in the reproductive age group in the country.[54] The survey of causes of death estimates bleeding during pregnancy and childbirth, and anaemia to be the leading specific causes of maternal mortality (reported in CBHI, 2003). It has also been commented Shiva in 1992[55] in this context that widespread anaemia in pregnant women, low height of many Indian women that puts them at risk of obstructed labour, poor weight gain during pregnancy among women of the low socioeconomic groups and dietary deficiency during pregnancy are 'major causes of maternal deaths' in the country. Further, unsafe abortions are a 'leading cause of maternal mortality and contribute significantly to the maternal morbidity' in the country (UNFPA, 2000).

---

[52] World Health Organization. Reproductive health in the south-east Asia region (50 years: Commemorative series-5).New Delhi: Regional Office for South-East Asia, World Health Organization.

[53] UNFPA. Population and reproductive health facts on India: Briefing kit. New Delhi: UNFPA;2000.

[54] Central Bureau of Health Intelligence. Health Information of India, *2000 & 2001*. New Delhi: Central Bureau of Health Intelligence; 2003.

[55] Shiva, M. Women and health. *State of India's Health*. New Delhi: Voluntary Health Association of India (VHAI),1992 .p. 265-301.

The NFHS-2 estimates the maternal mortality ratio in the country to be 540 per 1, 00,000 live births for the two year period before the survey. The ratio is more severe for rural India, being 619, in comparison to urban India which records 267 during the same period (IIPS and ORC Macro, 2000). Maternal mortality ratio in the country has been 'steadily falling' during the past decades. In the late 1950s, it stood at around 1,300, but was between 800-900 deaths in the 1970s, 500-600 deaths in the 1980s and 400-500 deaths in the 1990s.[56] Using the sisterhood method to estimate levels of maternal mortality indirectly in rural India, the ratio was found to be comparatively higher for certain social groups (for example, Scheduled Tribes, Scheduled Castes, less developed villages and illiterate women and Hindus). State level estimates of maternal mortality ratio have also been indirectly estimated from sex differentials in adult mortality (Bhat, 2002). Female autonomy, as measured by a woman's own assessment of her role in household decision making, also correlates with child survival. An analysis of the determinants of child mortality Das Gupta 1990[57] showed that the mother's autonomy was significantly negatively related to the probability of her children dying: the children of women who had greater decision-making authority in the household were less likely to die.

Female children suffer an additional burden because of the strong preference for male children in this society and discrimination against daughters. Girls suffer from substantially higher levels of mortality during childhood, except for the first month of life.

The crossover between the male-female ratio in neonatal and post neonatal mortality is clearly indicative of differential care of boys and girls. During the neonatal period biological factors are the primary cause of death, and the higher male mortality is consonant with their being biologically weaker than females. After the first month of life, environmental and care-related factors become more important determinants of survival; the substantial gender gap in survival indicates that girls receive much less care than boys.[58]

While antenatal care is paramount in the prevention of pregnancy-related deaths, septic abortions are more insidious. What is worse, the latter tends to go unreported due to the nature and

---

[56] Bhat, Mari PN. Maternal mortality in India: An update. *Studies in Family Planning 2002;* 33(3): 227-236.
Das Gupta Monica. Death Clustering, Mothers' Education and the Determinants of Child Mortality in Rural Punjab, India. Population Studies 1990 Nov; 44:3: 489-505.

[58] Das Gupta M. Life Course Perspectives on Women's Autonomy and Health Outcomes. American Anthropologist 1995 Sep; 97: 3: 481-491

circumstances surrounding it. In many rural areas couples do not use any spacing methods and women conceive within 7 months of having given birth.

Anemia during pregnancy leads to 20% of all maternal deaths, 3 times greater risk of premature delivery and low birth weight babies, 9 times higher risk of prenatal mortality and higher risk of irreversible brain damage in infants born to severely anemic mothers.

Lack of interest among other members of the household, and among health personnel, creates a situation in which a woman feels that her reproductive health problems must be borne silently as "women's problems." That a high proportion of births are still attended by poorly trained women leads to widespread reproductive health problems, including prolapsed uterus and pelvic inflammation. This in turn increases the potential complications of subsequent deliveries and raises infant mortality. The combination of poor delivery conditions and nutritional deprivation during childbearing must go a long way toward accounting for the extraordinarily high proportion of infant deaths in India that occur in the first month of life. Of course, in much of India, poverty and chronic undernutrition make for increased reproductive stress. (58)

Age Distribution of Maternal Deaths (2001-03, Special Survey of Deaths)				
	Maternal Deaths		Non-maternal Deaths	
Age Groups	Proportion	95 % CI	Proportion	95 % CI
15-19	12%	(9-14)	14%	(12-17)
20-24	29%	(26-32)	15%	(12-18)
25-29	21%	(18-24)	13%	(11-16)
30-34	20%	(17-23)	12%	(10-15)
35-39	12%	(10-15)	14%	(11-16)
40-44	4%	(3-6)	14%	(12-17)
45-49	1%	(0-2)	17%	(14-20)
15-49	100%		100%	

The age-distribution of maternal and non-maternal deaths from the 2001-2003 Special Survey of Deaths suggests that more than two-third of the maternal deaths is of women in the age group 20-34. In contrast, non-maternal deaths are more evenly distributed over the reproductive age span of 15-49.

It is estimated that out of half a million maternal deaths in the world each year about 20% are in India. Maternal deaths are caused either by direct causes arising from complications of pregnancy, delivery or their management; or indirect causes due to aggravation, by pregnancy or child birth, of an existing abnormal condition.

The leading causes of maternal death have been, haemorrhage (38%), sepsis (11%), and abortion (8%). (51)

Causes of Maternal Deaths (2001-03)

Maternal Causes	India		EAG and Assam		South		Other	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Haemorrhage	38%	(34-41)	37%	(33-42)	30%	(17-44)	40%	(33-47)
Sepsis	11%	(9-14)	11%	(8-14)	17%	(6-28)	10%	(6-15)
Hypertensive Disorders	5%	(3-6)	4%	(2-6)	13%	(3-23)	6%	(2-9)
Obstructed Labour	5%	(3-6)	5%	(3-7)	9%	(1-17)	4%	(1-7)
Abortion	8%	(6-10)	10%	(7-12)	4%	(-2-10)	3%	(1-6)
Other Conditions	34%	(30-37)	33%	(29-37)	26%	(13-39)	37%	(30-44)
Total	100%		100%		100%		100%	

India's maternal mortality rate, estimated at 3.4 per 1000 live births, on average between 1980 - 87(UNDP 1990) compares with an average of 2.9 for 'all developing countries' and 0.24 for industrialized countries. There is no figure for the maternal mortality rate of the country which can be considered as reasonably conclusive, more so because levels as high as 13 have been noted in certain rural areas. The actual life-time risk of an Indian woman dying from a maternity-related cause is far greater than comparative rates between India and the industrialized countries would suggest owing to the higher total fertility rate (4.0 in 1990 according to the World Bank 1992). Maternal age and number of births have a strong effect on maternal mortality. A woman giving birth to children at 20-35 years of age faces a much lower risk than women below 20 and over 35 years. An estimated 8% of the 26-27 million annual births in India are to mothers below 19 years, whose growth and maturation may be retarded. Maternal illness and death rose significantly with the fourth pregnancy and reached a high level after the fifth. Some 35% of live births in rural areas and around 29% of live births in urban areas are of the fourth birth order and above (Registrar General of India 1984). In India, as in many developing countries, maternal mortality accounts for the-largest, or near-largest, proportion of deaths among women in their prime years (UNICEF 1990).

In 1987, deaths related to pregnancy and child birth accounted for 13.2% of deaths among rural women aged 15-45 years; and 14.0% of those in the 15-24 years age group. Most of maternal deaths are associated with malnutrition, particularly anaemia. Other major causes such as toxaemia and septicemia reflect the inadequate health care available to women during ante-natal, intra-natal and post-natal periods. The share of deaths from toxaemia and puerperal sepsis is higher in the 15-24 year age group which also faces a considerable threat from abortion, anaemia and bleeding (the latter two are inter-related). These young women are thus particularly at-risk, in addition to their greater propensity for delivering low-weight babies and to infant loss (Registrar General of India 1987).

The infant mortality rate (IMR) is a valuable indicator of health and development. It has shown a decline from 129 per 1,000 live births in 1971 to 91 in 1989. The data from office of Registrar General of India shows that maternal age, education, age at marriage, religion, social status and annual income of the household are the factors associated with infant deaths. Prenatal deaths (still births and deaths within 7 days of birth) contribute to over 80% of neo natal death in India.

The reason for this are complicated but primarily point to neglect of female health and nutrition, lack of still assistance during delivery and poor neo natal care. A survey conducted by Baniji et al[59] in rural Andhra Pradesh showed that even after good compliance with ANC checkup, over 50% of deliveries in rural India are conducted at home, mainly for the reason of affordability (Banji 2008). The high level of maternal mortality is combined with the fact that majority of these deaths could be prevented if women had appropriate access to health services (Jejeebhoy & Rao). According to NFHS III infant mortality has declined from 77 deaths per thousand live births in 1991 -95 to 50 deaths per thousand live births in 2001 -05.Implying an average rate of decline of 2 infant deaths per thousand live births per year.

	Neonatal Mortality	Post- Neonatal Mortality	Infant Mortality	Child Mortality	Under 5 Mortality
NFHS I	49	30	79	33	109
NFHS II	43	24	68	29	95
NFHS III	39	18	57	18	74

Source: NFHS I, II and III.

During the period between NFHS I and NFHS III, neonatal mortality has decreased by 12 deaths/1000 live births while post- neonatal mortality has decreased by 7 deaths/1000 live births. The child mortality has decreased by 14 deaths/1000 children of age 1. Although these rates have declined still 39 neonatal/1000 live births cannot survive for even 1 month of life. While 57 infants/1000 children do not complete their first year. This is of very serious concern as one out of every 14 children born dies before reaching the age 5. Infant and child mortality rates are considerably higher in rural areas than urban area. NFHS III indicates that in the period 2001- 05 IMR was 50% higher in rural area (62) than in urban areas (42).The rural urban difference especially higher for children in the age interval of 1- 4 years. Yet another point to be focused is the fact that infant and child mortality rates have declined significantly faster in rural areas than urban areas, with IMR declining 27% in rural areas as compared to 21% in urban areas.

[59] Banji et al. Maternal nutritional status and practices and perinatal, neonatal mortality in rural Andhra Pradesh, India. Indian Journal of Medical research 2008; 127: 44-51.

As per NFHS III data it has been observed that infant and child mortality rate decreased steadily with increase in mother's schooling. Among religious groups Hindu have the highest IMR (59) while Christians have the lowest (42). The same is observed for mortality rates at all ages under 5 years. Although schedule tribes have low infant mortality rate (62) than schedule casts (66), the under 5 mortality rate is higher among schedule tribes (96) than schedule casts (88).Other backward cats have lower mortality rates than schedule cats and schedule tribes but have higher mortality rates than other castes at all childhood ages. Overall, the under 5 mortality rates is 23% higher among OBCs than among the population in general category. Household wealth index also has a direct effect on infant mortality rate which is as high 70 among children in household in lowest wealth quintile to only 29 in the highest wealth quintile household. The ratio between highest and lowest neo- natal phase (1:2) and highest in age interval 1- 4 years (1:7).More or less similar picture is seen in rural and urban areas. According to NFHS III, in neo- natal period mortality is lower for females (37) than for males (41).But as the child grows older females are exposed to higher mortality than males. Females have 36% higher mortality than males in post neo- natal period but 61% higher mortality than males at age 1- 4 years. The interval between previous birth and current birth shows a strong negative effect on input and child mortality rates with births occurring at an interval of less than 2 years has an infant mortality rate of 86.When the interval is 24-35 months and 36- 48 months, the infant mortality rate decreases to 50 and 30 respectively.

Women and children morbidity picture

From time to time, different rounds of the National Sample Survey Organisation (NSSO) have collected information on the morbidity and health seeking behaviour of people in India. In the survey, pregnancy and child birth related events are not considered as morbidities though complications arising out of pregnancy and childbirth are. The 52nd round of the NSSO (conducted in the mid 1990s) reports that in rural and urban areas of India, for the 15 day reference period, greater proportions of women than men report acute as well as chronic ailments (NSSO,1998). The gender differences in reported morbidities for both acute and chronic ailments are slightly higher in urban areas. Roughly speaking then, the data from various rounds of the NSSO show that morbidity rates have increased for the people of India since the 1970s. The

early sixties, when the NSSO 17th round was carried out, show very high rates of proportions of people reporting ailments, across both the genders in rural and urban areas of the country. The morbidity rates declined in the 1970s (28th round), after which they showed an increase. This is true for both males and females in rural as well as in urban areas of the country. In fact, the increase in morbidity rates is higher for women in comparison to that of men in both the settings.

The path breaking study by Bang, et.al (1989)[60] which highlighted the high prevalence of gynaecological or sexual diseases among rural Indian women opened the proverbial Pandora's Box. The study carried out among 650 women in two villages of the backward Gadchiroli district of Maharashtra found an astonishing 92.2 percent of all women having one or more gynaecological or sexual diseases, with an average of 3.6 diseases per woman (Bang, et.al., 1989). The incidence of maternal morbidity was found to be 52.6 percent. It was observed that labour complications (17.7%) were more serious in nature while post partum morbidities were more frequent (42.9%). Prolonged labour and prolonged rupture of membranes were the most common intrapartum morbidities while breast problems and secondary postpartum haemorrhage formed the two most common post partum morbidities. The study estimated that almost 15 percent of the women who deliver at rural homes potentially need emergency obstetric care and 34.7 percent are in need of medical attention (emergency or non emergency).. The surreptitious nature of such diseases can be gauged by the fact that only 55.38% of the women had one or more gynaecological or sexual complaints (apart from complaints of 'non-specific but related symptoms' of low backache and lower abdominal pain) and that even women without any symptoms were 'very likely' to have diseases of the reproductive tract. Such diseases were also more frequent among women who had used contraception (especially tubectomy). Quite notably also, only 7.8% of the women had sought gynaecological care in the past for their problems. Thus maternal mortality is, of course, a small part of the totality of women's reproductive health problems.

[60] Bang et al. Gynecologic Disorders Are Common in Rural Areas of India and Bangladesh, but Treatment Is Lacking. International Family Planning Perspectives1989 Dec; 15: 4: 152-153.

Bhatia and Cleland(1996)[61] report from their study of 3600 women near Bangalore in Karnataka that about 40 percent of all women suffered from at least one morbid condition during their antenatal, delivery or post natal period. About 18 percent of the women reported one morbid condition during their antenatal period, 8 percent experienced a problem (especially prolonged labour) during delivery and (quite notably), 23 percent had a problem during their post natal period. An average of 1.6 episodes per person was estimated for those reporting at least one morbid condition (Bhatia and Cleland, 1996). At the national level, possible post natal complications are indicated by the NFHS- 2 which reports that 11 percent of the women giving birth in the preceding three years reported massive vaginal bleeding and 12.6 percent reported very high fever within two months of the birth – both complications registering higher proportions in rural India (IIPS and ORC Macro,2000).

Women of child bearing age constitute the vulnerable segment of the population because of their special reproductive needs. According to the 1981 census there were 143.5 million women of child bearing age, constituting about 21% of the total population. An average Indian woman has 6-7 pregnancies resulting in 5-6 live births, of which 4-5 survive. She is estimated to spend a greater part of her reproductive years in pregnancy and lactation. Chronic maternal undernutrition and overwork among the low income group pose a serious threat to the welfare of the mother and the infant.

In the Nasik study by Madhiwalla, et.al,[62] 45% of the episodes of ill health in women went untreated. In most cases it was financial incapacity that precluded women from seeking treatment. But, quite notably, in almost a quarter of the cases, women thought that the illness did not require medical attention. Treatment was also not sought for reasons like inaccessibility /inadequacy of the health facilities.[63]

Though nutritional anemia affects all age and sex groups in India, it is particularly severe among pregnant women, lactating mothers and adolescent girls. More than half of the pregnant women

[61] Bhatia JC, Cleland J. Obstetric morbidity in south India: Results from a community survey. Social Science and Medicine 1996; 43(10):1507-1516.

[62] Madhiwalla N, Nandraj S, Sinha R. Health, households and women's lives: A study of illness and childbearing among women in Nashik district, Maharashtra. Mumbai: Centre for Enquiry into Health and Allied Themes (CEHAT); 2000.

suffer from Anemia. 13% are severely anemic (hemoglobin levels below 7gm./dl.). One in five of all the maternal deaths are attributed to anemia during pregnancy. More than half of the adolescent girls (50-60%) are anemic.

Acute respiratory infection (ARI) is one of the leading causes of childhood morbidity and mortality throughout the world. NFHS III data suggest that 6% of children under age 5 years in India showed symptoms of ARIs at some point of time in the two weeks proceeding to the survey. Children who were taken to a health facility or provider were relatively low in ST children, children to household belonging low wealth quintile and Christian children. The percentage of female children being taken to a health facility was lower as compared to male.

Fever- NFHS III suggest that 15% of children suffered from fever during the 2 weeks before survey. The prevalence of fever was higher among children in age group 6- 11 months and 12-23(19%) and among Muslim children (20%).

Diarrhea- one of the single most common cause of death among less than 5 years children following ARI is diarrhea. NFHS III suggest that in the preceding 2 weeks of the survey 9% of all children under the age 5 years had diarrhea with 1% having diarrhea with bloods. Only 1 in 10 children in India who had recently suffered diarrhea were given more than the usual amount of fluid to drink.

Under nutrition levels continue to increase during the first two years of life, largely due to poor breastfeeding and faulty weaning. About half of all children below 3 are undernourished, more than half are deprived of full immunization, and a large majority suffers from anaemia. Illness is also widespread, with a fifth of all children suffering from diarrhea and almost a third suffering from fever. A substantial proportion of Indian children (about one-tenth) never reach the age of 5.

Tribals in Jharkhand and issues related to Maternal and Child health

The state Jharkhand has 30 scheduled tribes and the population of these tribes constitutes 36.3% of the total population of Jharkhand, reaching to figures of more than 7 million according to 2001 census. The growth rate of tribal population has been 17.3% which is lower by 6% as compared to state growth rate. Most of the tribal population resides in rural area. The most common tribe among Jharkhand tribal is 'Santhal' constituting around 34% of Jharkhand's tribal

population. The second most common tribe is 'Oraon'[64]. District wise Santhal are highest in population in Dumka District. With a sex ratio of 987 females per 1000 males, it is even higher than the national average of 978 for ST population. Santhal have an overall sex ratio of 985 and a 0-6 Years sex ratio of 980 females per 1000 males. The overall literacy rates are quiet low with average of 40.7% (Santhals-33.4%) for all tribes. The female literacy is even lower to 27.2% (Santhal-19.5%)[65].

Although forming the core population of Jharkhand, study of their health needs, the practices related to health, especially in the field of maternal and child health is limited (Barnes 2007). Jejeebhoy (2007) states that 'despite the fact that many girls in Jharkhand experience there first pregnancy during adolescence, little is known about their pattern of maternal health care seeking and evidence is more lacking in case of disadvantaged groups as tribal adolescent group'. Health care seeking in tribal setting is limited and suggests a clear link between young women's level of education and their pregnancy related practices and experiences. Household income and autonomy in terms of household decision making are factors influencing pregnancy related care. Other key factors playing a major role are peer and social support and spousal communication (Jejeebhoy 2007)[66]. Barnes study suggested that there are multiple socio-cultural and systematic obstacles that deny tribal women to access quality care during pregnancy and delivery.

As stated earlier, studies among tribal of Jharkhand relating to maternal child health are very scarce. Yet an important study conducted by Lindsay Barnes[67] on maternal child health practices in rural Jharkhand provides an in-depth of various practices and traditions associated during pregnancy and child birth. This study highlights that home is the most preferred place for delivery and institutional delivery was nowhere in their choice. As per Barnes, fear for unacceptable cost associated with institutional delivery and perceiving institutional delivery as threat are few reasons for not accepting it. The study also states that most of the births are assisted by Dias or local birth attendants of the village. Dais follow many traditional practices like palpating the abdomen to assess the position of fetus, poring oil on navel to monitor

[64] Mittal PC, Shrivastava S. Diet, nutritional status and food related traditions of Oraon tribes of New Mal (WB), India. Rural and Remote health (online) 2006;6:385
[65] Census of India 2001, Office of Registrar General, India
[66] Jejeebhoy SJ. Sexual and reproductive Health among youth in Bihar and jharkhand: An overview. Economic and Political Weekly 2007 Dec; 34-39
[67] Barnes L. Women's Experience of Childbirth in Rural Jharkhand. Economic and Political Weekly 2007 Dec.; 62-70

direction of flow, ensuring that the pregnant mother keeps drinking hot and sweet drinks or eating rice –gruel, cleaning the baby with oil, burring the placenta at the place of birth, pressing her head in mothers belly while she is in standing position so as to expel blood clots post delivery, fomenting the baby's cord with heat from wick lamp etc. Under circumstances of complications like birth asphyxia, sprinkling of water on the infant, chewing black pepper and blowing into infant's ear, mouth and nose and more is done by the birth attendants. Barnes also points out some harmful and potentially dangerous practices like considering heavy bleeding as a part of normal delivery and do not seeking any health care in this regard, post partum fasting and keeping the mother who has just delivered on fasting and sometime not even giving her water to drink etc. Jejeebhoy (2007) suggested that traditional practices adopted by tribes were not harmful but in some circumstances they are faulty and harmful like not seeking care for heavy bleeding following child birth was considered normal, massaging the abdomen following delivery and using oxytocin injection to speed up delivery by untrained RMPs leading to potential life threatening complications.

% of tribal and non-tribal women with health problems during pregnancy, Jharkhand, 1998-99[68]

Health problems during pregnancy	Tribal Women	Non-tribal women	Total
Night Blindness	20.4	14.1	15.9
Blurred vision	33.6	36.0	35.3
Convulsions	38.4	34.1	35.3
Swelling in legs , body of face	49.0	31.1	36.1
Excessive fatigue	49.3	55.7	53.9
Anemia	28.9	29.2	29.1
Vaginal Bleeding	2.1	3.3	2.8

[68] National Family Health Survey 2: India, 1998-1999, International Insitute for Population Sciences, Mumbai.

As per data from NFHS II , tribal women share a larger load of night blindness , convulsions swelling in legs , body or face during pregnancy as compared to non-tribal women in Jharkhand[69].

% of tribal and non-tribal women receiving ANC care during pregnancy, Jharkhand, 1998-99			
Components of ANC checkup	Tribal Women	Non-Tribal women	Total
Antenatal Measurements/Check-ups			
General Checkup	49.7	56.7	55.3
Blood Pressure checked	37.0	60.0	55.3
Blood test	41.3	59.8	56.0
Urine test	28.3	53.3	48.2
Abdominal examination	53.2	70.0	66.5
Internal examination	14.9	26.1	23.8
X-Ray	0.0	2.2	1.9
Sonography	0.0	6.7	5.3
Antenatal advice			
Diet	63.0	69.4	68.1
Danger signs of pregnancy	34.9	40.2	39.1
Delivery care	39.1	45.6	44.2
Newborn care	42.6	42.2	42.3
Family planning	6.5	19.4	16.8

[69] Maiti S, Unisa S et al. Health care and health among tribal women in Jharkhand: A situational Analysis. Studies of Tribes and Tribals 2005;3(1):37-46

NFHS II clearly depicts the lack of ANC practices among tribes of Jharkhand, the reasons being, as suggested by Barnes, mainly due unavailability of services and as the fear associated with institutional delivery.

National health programs on Maternal and child health: An insight

This section traces the evolution of national programmes for Maternal and Child Health. Largest among these is the Family Welfare Programme.

Family Welfare – including Fertility Reduction

In 1951, The National Family Welfare Programme was launched where India became the first country in the world to launch a family planning program. The clinic based approach of the 1950s gave way to a more proactive extension approach, following target oriented, time-bound, incentive based and sterilization focused approach. The Indian government adopted a policy of reducing the birth rate as its way of dealing with the economic crisis of 1966, which was not an adequate solution. What it did, however, to transform the problem of high fertility – of which women and children were the victims – into the problem of 'women who are having too many children' – of which women were perpetrators.[70]

In order to hasten the pace of fertility reduction, the existing family planning programme was transformed in 1966 from one that provided services to those who requested them, into a population reduction programme with specific demographic goals. Although India had a Family Planning Programme since 1951, more than fifteen years after the programme was initiated, in 1966, the percentage of couples effectively using contraception was only 4.5 per cent. [71]

The target of reducing the crude birth rate from 39 to 32 per 1000 by 1974 was set. This was translated into numbers of family planning 'acceptors' to be recruited by the programme. Family planning services were integrated with maternal and child health (MCH) services as part of

[70] Ravindran TKS. Women and the Politics of Population and Development in India; reproductive Health Matters, Vol. 1, No. 1, Population and Family Planning Policies: Women-Centered Perspectives 1993May;1:1: 26-38

[71] Department of Family Welfare. Family Welfare Programme in India Year Book 1989-90. Government of India, Ministry of Health and Family Welfare, New Delhi; 1991.

Primary Health Care strategy, and services were offered free of cost at government health facilities. MCH services providers at the community level were required to fulfill a specific quota of family planning 'acceptors'. Quotas were accompanied by an elaborate system of financial incentive for acceptors and service providers at all levels, and institutions delivering family planning services.

During 1969-74, family planning was declared as a programme of the highest priority and unrealistically high targets were set. There was supposed to be a decline in crude birth rates from 39 to 25 per 1000 over the next ten years. To achieve this, mass sterilization 'camps' were set up in make-shift facilities. Medical personnel from referral hospital contributed their services for a few days at a time, and hundreds of sterilizations per 'camp' were carried out each day. (72)

During this period, and particularly after 1975, service providers were threatened with punitive measures for non-fulfillment of targets. Teachers, local leaders and government employees working at the grassroots were all required to recruit women and men for sterilization. Not surprisingly, programme implementation included measures that blatantly violated individual rights and well being. Not only women, but a large number of men were the victims of compulsory sterilization during the period of political emergency in 1975-77. Little wonder that from only 4.5 per cent of all couples in the reproductive age groups in 1966, contraceptive prevalence rates increased to 17 per cent in 1975 and 24 per cent during 1975-77. The ensuing male protest against coercive mass vasectomies is believed to have brought down the ruling party in the 1977 elections. The excess of these campaigns lead to a backlash from which it took years to recover. This programme almost collapsed in 1977-78, and when it recovered, its focus shifted exclusively to women. The 1980s saw the rebuilding of the program with an emphasis on female sterilization.

Figures on sterilization reflect the rapid change in gender focus. Female sterilization which accounted for 46 per cent of all sterilizations in 1975-76, and fell to only 25 per cent in 1976-77, rose to 80 per cent in 1977-78. Throughout the 1980s they accounted for about 85 per cent of all sterilizations, and in 1989-90, it reached 91.8 per cent.

Family planning programme and its limitations

One serious limitation of this programme is that it introduced family planning services in a context of high reproductive morbidity, without the support of comprehensive reproductive health care. This operates against the programme's interests by discouraging women from seeking contraceptive services. A study conducted by T.K Sundari Ravindran mainly based on research carried out by her with women from two poor communities, one rural and one peri-urban, in two villages in Tamil Nadu in 1989-90. In her study one in three women in the Tamil Nadu had an infection of the genital tract. Similarly Bang et al found in rural Maharashtra that more than 46 per cent of women examined were suffering from an infection of the genital tract. She has seen firsthand that IUD insertions or sterilization performed without treating these problems, aggravates them and causes women further suffering.

Since 1966, the 'integration' of family planning with maternal and child health (MCH) services has diverted scarce resources and personnel away from women's maternal health needs, and has also encouraged the shift of responsibility for family planning exclusively onto women. It can be again sufficed by T.K Sundari Ravindran's study where driven by the need to fulfill specific quotas of family planning acceptors and threatened with punitive action for failing to do so, MCH service providers at the community level give top priority to recruiting 'cases' for family planning. Antenatal care is reduced to tetanus toxoid immunization in the best of circumstances, and post-partum care is unheard.

Further, since family planning services are made available only through MCH services, unmarried adolescents and other single women are denied access to contraceptive services.

The limited choice of methods available acts as a negative feature in the service provision, women remain to be mute recipients of whatever the programme makes available to them. The availability is decided on the basis of programme efficacy and not on the women's needs or preferences. In operation, the family planning programme is largely a sterilization programme, which the incentive system is partly responsible for. Under the incentive system, performance is evaluated according to the number of 'sterilization equivalents' achieved. Sterilizations have the highest weight, IUDs a distant second and oral pill and condoms the least. Targets can therefore be met and incentives availed more easily by concentrating on sterilization.

Limiting 'choice' to sterilization also leaves out women for whom time constraints and lack of social support are major problems. Since sterilization involves hospitalization, women have to arrange the farm work, child care and household tasks, including fetching of fuel and water, to be attended at her absence. There should be no rest on their return, and a companion is needed to accompany a woman to hospital and attend to her needs there.

Family Welfare Programmes enhancing Maternal and Child Health

Till 1977 the major health activity was family planning which was changed into Family welfare programme with Maternal and Child Health becoming an integral part of family planning programme with the vision that reduction in birth rate has a direct relationship with reduction in infant and child mortality.

Furthermore, the Ministry of Health and Family Welfare proclaimed in a policy statement that 'compulsion in the area of family welfare must be ruled out for all times to come. Our approach is educational and wholly voluntary'[72] even the name of the programme was changed from that of 'family planning' to 'family welfare'.

Maternal Health Care was a part of Family Welfare Programme from its inception. Interventions were identified and vertical schemes namely the National Nutritional Anaemia Control Programme, TT immunization of pregnant mother (part of immunization programme) and Dais training programme were introduced over the years. Family Planning remained a separate intervention.

The Family Welfare Programme suffered a setback during the coercive approach of 1976-77, but in subsequent recovery phase, the scope of programme broadened significantly by integrating family planning with maternal and child services. Since 1977, family planning has delivery, and

[72] Bharat S. Social assessment of Reproductive and Child Health Programme-A Study in 5 Indian States; Assam, Haryana, Maharashtra, Orissa and Uttranchal (Part - 1). Ministry of Health and Family Welfare and DFID, New Delhi; 2003.

post natal care, immunization of children against various vaccine-preventable diseases, and counseling on maternal and child health problems and nutrition. [73]

Immunization Programme in India was introduced in 1978 as Expanded Programme on Immunization with limited reach mostly in urban area. The programme was universalized in 1985-86 to cover six vaccine preventable diseases under Universal Immunization Programme in phased manner and covered all districts in the country by 1989-90. In 1986, the programme became part of the Technology Mission and monitored under 20 point programmes by Prime Minister's Office. Since 1992, the programme formed a part of the CSSM programme and subsequently under RCH programme from 1997.[74]

National Health Policy 1983 envisioned significant reduction in IMR, NMR & CMR by 2000. All the child health programmes are directed towards achieving these goals. Universal immunization against 6 vaccine preventable diseases (VPD) by 2000 was one of the goals set in the National Health Policy (1983).

In 1992, the government launched the Child Survival and Safe Motherhood (CSSM) Programme as a part of the Family Welfare Programme. The aim was to have an integrated package of interventions for the betterment of the health status of mothers and children. The additional components of this programme were treatment of diarrhea and acute respiratory infections, essential newborn care, and strengthening of emergency obstetric care services.

The Child Survival and Safe Motherhood Programme jointly funded by World Bank and UNICEF was started in 1992-93 for implementation up to 1997-98. The Child Survival and Safe Motherhood Programme was implemented in a phased manner covering all the districts of the country by the year 1996-97. The objectives of the programmes were to improve the health status of infants, child and maternal morbidity and mortality. The programmes seek to sustain high coverage levels achieved under the Universal Immunization Programme (UIP) in good performance areas and strengthen the immunization services of poor performing areas. The

[73] National Family Health Survey 3: India, 2005-06, International Insitute for Population Sciences, Mumbai

[74] Report Of The Working Group On Health Of Women And Children For The Eleventh Five Year Plan (2007-2012) Government Of India Planning Commission, New Delhi.

programme also provides for augmenting various activities under the Oral Rehydration Therapy (ORT) Programme, universalizing prophylaxis schemes for control of anemia in pregnant women and control of blindness in children and initiating a programme for control of acute respiratory infection (ARI) in children. Under the safe motherhood component, training of traditional birth attendants (TBA), provision of aseptic delivery kits and strengthening of first referral units to deal with high risk and obstetric emergencies were taken. The approved outlay for the CSSM Programme was Rs. 1125.58 crores for the entire IDA credit facility of SDR period. The Programme yielded notable success in improving the health status of pregnant women, infants and children & also making a dent in IMR, MMR and incidence of vaccine preventable diseases.

In the consequences of United Nation's 10^{th} International Conference on Population and Development (ICPD), the Government of India launched the Reproductive and Child Health (RCH) programme in 1997. Following the Cairo Conference, the Government of India sets in motion a process to translate the ICPD programme of action within the national context. In order to effectively improve the health status of women and children and to fulfill the unmet need for Family Welfare services in the country, especially the poor and under served by reducing infant child and maternal mortality and morbidity, Government of India launched the RCH Programme for implementation during the 9th plan period by integrating Child Survival and Safe Motherhood (CSSM) Programme with other reproductive and child health (RCH) services.

In the first phase (1997-2002) the objective of the RCH programme was to benefit poor rural women between the ages 15-49 and children under 5 years by improving their health condition and accessibility to services. The program also aimed to provide user friendly services for couples to enable them to space or limit births according to their needs. In more specific terms the programme was redesigned to include district level planning and monitoring to enhance responsiveness to local needs, increased client focus and improved quality care, decentralization and local ownership and improved referral system for health care seekers. At the level of service delivery the programme aimed to revitalize the existing network of rural health functionaries through better supplies of drugs and equipments, training and better IEC. (74)

The Reproductive and Child Health Programme, lays emphasis on comprehensive approach which includes a 'package' of services for the prevention and management of unwanted

pregnancies; promotion of safe motherhood and child survival; nutritional services for vulnerable groups; services for the prevention and management of reproductive tract infections; and reproductive health services for adolescents. [75]

The first phase of Reproductive and Child Health (RCH) Programme was launched by integrating all on-going fertility regulation and maternal and child health schemes of the Ministry under a single umbrella, adopting a holistic target free approach.

The specific objectives for the RCH I project were set for assisting the National Family Welfare Programme (NFWP) to:-

(a) Improve management performance by nationwide implementation of policy change referred to as the "participatory planning approach,"' and institutional strengthening for timely, coordinated utilization of project resources;

(b) Improve quality, coverage and effectiveness of existing FW services;

(c) Progressively expand the scope and content of existing FW services to include more elements of a defined package of essential reproductive and child health (RCH) services; and

(d) In selected disadvantaged districts and cities, increase access by strengthening FW infrastructure while improving its quality. (76)

Under the RCH approach, Community Needs Assessment was introduced and treatment of reproductive tract infections (RTIs) and sexually transmitted diseases (STDs) was added to existing services provided under the family welfare and CSSM programmes.

The second phase of RCH program i.e. RCH – II has been commenced from 1st April, 2005 the five year file 2010. The main objective of the program is to bring about a change in mainly three critical health indicators i.e. reducing total fertility rate, infant mortality rate and maternal mortality rate with a view to realizing the outcomes envisioned in the Millennium Development

[75] Sama. Reproductive Health services – The Transition From Policy Discourse to Implementation. In: Leena V. Gangolli, Ravi Duggal and Abhya Shukla, Editor. Review of Health Care in India. Centre for Enquiry into Health and Allied Themes;2005.

Goals, the National Population Policy 2000, and the Tenth Plan Document, the National Health Policy 2002 and Vision 2020 India.

The principles underlying the design of RCH-II are as follows:

a) Improving health outcomes is a shared responsibility of providers, local governments, households and communities.

b) There should be no discrimination in access to essential quality health services.

c) The poorest have the right to get value for money being spent by government or out of pocket.

d) Service providers should be responsible for outputs and outcomes, suitably empowered, and made accountable within the principle of subsidiary.

e) Female children have an equal right to health, emergency medical aid, and to live with human dignity.

f) The program would include voluntary and informed choice in administering family planning services. Responsibilities of service providers would be clearly outlined with careful regard for human resources. Clear tasks would be laid out for service providers to provide quality services to meet unmet needs of family planning and spacing methods in desirable quantities.

g) The strengths of public and private sectors should be harnessed to achieve the RCH program goals.

h) The RCH program will protect people in accordance with the statutes.

i) The RCH program efforts will consistently focus on the most vulnerable.

Another major intervention done in the field of enhancing the maternal and child health, and especially in the field of child development, the Government of India launched Integrated Child Development Services Scheme (ICDS) which was initiated in India in 1975, and has been operational for over 33 years. It happens to be the largest single programme in the area of child development anywhere in the world. It includes services not only to children, but also to pregnant and lactating women. It is the most extensive nutrition programme which has expanded to become the largest nutrition programme in the world, with 3,381 projects covering 16.2

million children in the age group of 0-6 years as well-as five million pregnant and nursing women. The programme provides a package of services comprising supplementary nutrition, immunization, pre-school education for children below six years of age, health check up and referral, immunization for pregnant women, nutrition and health education for all women in the reproductive age group. Simultaneously maternal and child health services in the rural areas have been strengthened.

A number of evaluation studies have indicated faster decline in infant and child mortality in ICDS project areas. Also, the proportion of children in severe grades of malnutrition has declined and shifted in favor of less severe grades. Efforts are on to universalize the programme. The ICDS has however not met all its objectives due to its poor delivery system. Growth monitoring, a pillar of ICDS malnutrition prevention strategy, is conducted in a routine manner which does not facilitate growth promotion. Finally, failing to foster community participation and build capacity of mothers has not been achieved to the desired level. Various initiatives have been taken up to strengthen the delivery system of ICDS with a view to improve the outreach of the programme as well as quality of services provided to children and mothers. However with many well-conceptualized schemes, this one also fell far short of its objectives due to gross inattention to setting up implementation capacities within the scheme. Though there was a good intention behind its articulation but there was no real will to have it translated into action. The entire task of looking after the young children of a population of 1000 both at the centre and within homes in the community was to be undertaken by a single poor, poorly trained and very poorly remunerated 'honorary' worker aided by an even worse off 'helper'. (It may be noted that with affect from April 2002 the honoraria of workers and helpers has been increased from rupees 500 to 1000 and 250 to 480 rupees and they have also been authorized maternity leave for 135 days)

The ICDS scheme which has a great potential for improving the health of a vast number of children under the age of six years, needs universalisation, regularization, better support in terms of funds and personnel, better convergence with other systems of health and education, decentralization of programme and greater value and demand from the community.

The other nutrition intervention programmes of the Department of Women and Child Development are Special Nutrition Programme, Balwadi Nutrition Programme, Wheat Based Supplementary Nutrition Programme, Tamil Nadu Integrated Nutriton Programme and Mid Day

Meal Programme for School Children. The intervention programmes of the Department of Family Welfare for combating specific nutrition deficiency diseases are National Goitre Control Programme, National Iodine Deficiency Disorders Control Programme, Anaemia Prevention and Control among Pregnant Women, and Prevention and Control of Vitamin A Deficiency among Children.

-Chapter-3-

Social-economic fabrication of the Village and Status of tribal women

Introduction

This chapter contextualizes the present study. It is basically divided into two sections. The first section provides the background of the place i.e. the village and the district with the current amenities. It further gives a broad preface of the people being studied; under social and cultural aspects we offer their social and ethnic configuration, their housing pattern, traditional panchayat, their religious and supernatural beliefs, marriages and festivals. Under the economic aspects, we discuss the agricultural pattern and the problem of migration. The second section gives full-fledged description of the prevailing condition of the women in the village. Here we discuss about women's participation in agriculture, and their involvement in household works. Under women's social status we look at the decision making power of women, including their family planning decisions. Discuss their practice of early marriages and remarriages and components of domestic violence. We further focus at the health status of women dealing with their gynecological problems, perceptions that women have towards their ill-health, the pregnancy waste and their complications during pregnancy. We then look at the health conditions of older women citing their lived experiences.

Section 1: An overview of the village

Dumka district

The district of Dumka was basically formed into an administrative district by the British to contain the warring Pahadiyas and the local Ghatwal kings. In this process the Santhal Tribes were allowed to infiltrate and settle in large number. After the partition of Bengal, it also played a major role in the settlement of Bengali population and thus a good number of Bengali speaking populations soon dominated the social and educational life.

In the next phase with the beginning of transport services and a bit of business and educational institutions, a good number of Bhojpuri speaking people made their way to Dumka. Thus the urban population basically constituted of Bhojpuri and Bengali speaking people. However, the interiors remained dominated by the santhals and the other backward caste communities. Similarly, people residing on the hills known as Pahadiyas preferred to remain outside the domain of main stream population.

From the administrative point of view, Dumka become a district way back in 1965 and later on the divisional head quarter of Santhal Pargana in 1982. It consisted of Deoghar, Godda, Sahebgunj, Pakur and Jamtara sub divisions. It was also a hub of all administrative and Judicial activities and thus allowing a good number of floating populations.

The present Dumka district has an area of 3716.02 Sq. KM. and consists of only one sub division namely Dumka. Under Dumka sub division, there are ten blocks namely Dumka, Gopikander, Jama, Jarmundi, Kathikund, Maslia, Ramgarh, Raneshwar, Shikaripara and Saraiyahat.

Dumka has predominantly undulating terrain with hard rocks in the underground. The entire district has topography with high ridges and valleys bounded by mountains and rivers. The fertility of soil is poor due to extensive erosion, acidic character and low retaining capacity.

The climate of the district is characterized by hot summer and cool winter. The district experiences a prolonged dry period from January to May which keeps the soil dry for more than 90 days in a year. As such the area, in general, qualified for typical soil moisture regime. The length of cropping season varies from 150 to 180 days.

The landscape of the district is characterized by gentle to very gentle slopes. Soils are sandy loam to clay loams, non-calcareous, slightly to moderately acidic and have location exchange capacity. The soils are generally shallow on the ridges and plateaus and deep in the valleys. Total geographical area of the district is 5.58 lakh hectare out of which nearly 40% area comes under net cultivated area, 11%covered forests and the rest 49%area falls under barren, cultivable waste, pasture and other agricultural use.

Shikaripada block

The Shikaripada block comes under the Dumka district and is about 30 kilometers away from the main Dumka town. There are 261 total villages in the Shikaripada block. According to the 2001 census this block has a population 110132, with the male population of 55546 and female population of 54586, with a sex ratio of 983. Among the total population the number of SC population is 3976, and the number of ST population 68718 and the population of others remaining to be 37438. Thus this area is predominantly a tribal populated area. The total sex ratio of this block is 983 according to 2001 census, the Jharkhand sex ratio being 941 and India sex ratio which was 933 at the time of 2001 census.

The entire area of the Shikaripada block is 43918.48 hectare. Under which the total agricultural land is 14635 hectare. The barren land sums to 14635 hectare, and the forest land of this area is 3407.77 hectare.

The village Ranga

The village is dominated by Santhal Tribe. There are four hamlets in this village – Baru *tola*, Rasi *tola,* Gajal *tola*, Jolha *tola*. Among the four hamlets, three of the hamlets are dwelled by santhals and one of them i.e. jolha *tola* is dwelled predominantly by Muslim community. The Rasi tola is the biggest tola in terms of both population and number of households and Gajal tola has the smallest population.

The entire region is a hilly terrain, with red laterite soil, and rocks, with small hills surrounding the entire region. The landscape of the district is characterized by gentle to very gentle slopes. Soils are sandy loam to clay loams, non-calcareous, slightly to moderately acidic and have location exchange capacity. The soils are generally shallow on the ridges and plateaus and deep in the valleys.

1) *Amenities*

Education and Health facilities in the Village

Kind of Facility and distance in Kilometers	Baru Tola	Rasi Tola	Gajal Tola	Jolha Tola
Primary School	-	Yes	-	yes
Aanganvadi	-	Yes	-	Yes
Sub centre (12 kilometeres)	-	-	-	-
PHC (5 kilometers)	-	-	-	-
Mission Hospital (10 kilometers)	-	-	-	-

One can clearly see from the above table that all the amenities are centered in Rasi tola and Jolha tola (Muslim dominated).

a) Education

The village has two primary schools. The children from Baru and Gajal tola (tribal tolas) prefer going to the school in Rasi tola.

For secondary education, there is a government high school in Shikaripada. It is 5 – 8 kilometers away from all these tolas. Apart from this, there are missionary schools in Shikaripada.

The educational levels of this village are low and majority of them were illiterates, and only a few have passed the primary school. There are very few families who think of sending their children to school, and it was mainly the Christian families who encouraged their children. Some families also get assistance from the missionaries. The missionaries are far better in rendering the service of education than government schools.

b) Health Facilities

Anganwadi

There are two Anganwadi centers in the village. But the Anganwadi center in Muslim dominated tola is not used by children from tribal communities.

Sub – Centre and PHC

There no Sub-centre or PHC in the village. The nearest PHC is almost 5 kilometers away from the village. While the sub-centre is almost 12 kilometers away from the village.

Mission hospital

There is a mission hospital in Mohulpahari which is 8 – 10 km away from the three tolas. Where people generally go if they can afford. But it is usually a referral hospital of PHC.

c) Lamps / Banks

There is 1 lamps i.e. cooperative bank in Shikaripada block. It gives loans to the villagers for seeds, and other agricultural inputs. There is also a commercial bank i.e. State Bank of India in Baramasia which is around 12 – 14 km away from this village.

d) Water source

The open wells are the main source of drinking water. Baru tola has 1 privately owned *chapakal* (hand pump). In Rasi tola there is one hand pump in the primary school. There are also ponds owned by some families and they pursue fisheries.

e) Electricity

There is no electricity supply in the entire village.

f) Roads

The roads leading to this village from the Shikaripada main road is all Kutcha. One has to cross '*khet*' (field) and come all the way crossing huge stones and pebbles in order to reach this tola. There is no straight path; there are huge rocks on its way which always makes the walk or the

journey a difficult one. Here no vehicle can go, only one's foot and bicycle can move or commute.

g) Transport

The only mode of transport in all these three tolas is either by walks or by a bicycle. There is no other option left for the villagers. In case of emergency a jeep is called which is parked far from the village, and the concerned person is lifted on a cot and taken till the jeep. And rest of the people walk till there. The amount charged by the jeep drivers is also fairly high, which villagers feel hard to pay.

2) Social and Cultural Aspects

This part will largely examine the social and cultural aspects of the village i.e. the ethnic composition, marriage pattern, festivals and other cultural practices.

Ethnic Composition in Ranga and characteristics of santhal tribes

The village 'Ranga' is a tribal dominated village, comprising mainly of Santhal tribe. But among the four tolas there is one Muslim dominated tola called Jolha tola. They are migrants from Bangladesh. They do not own much land but are good at business like tailoring and small trade. So they are doing much better than the Santhal tribe, who are solely dependent on agriculture.

The santhals have been one of the major tribes of India constituting a large percent of the total tribal population. This tribe has been in contact with mainstream society and has a rich historical and a cultural background. The santhals call themselves as *'hor'* in their own language, and generally the non –tribals as *'dikus'*. Santhals have their unique religion and culture. And they are very much attached to their culture, they are very conscious about their identity and heritage. And this is the reason why they have, most probably consciously, built up a sense of solidarity amongst themselves and are very much conscious about their own identity. The santhal tribe, and especially the tribe of 'Ranga' village, or for that matter any tribe, are very submissive and quiet. The tribes with whom I interacted were all of them very good natured, simple and hesitant but at the same time very laborious hard working. Their internal solidarity is often based on their principle of likeness, which is a shared cultural characteristic, which binds them together. The Santhals live in peace and harmony among themselves. All of them are nature lovers, their

culture is very rich, and not to forget they are incomplete without music, songs and dance. If they were made not to think of their living and livelihood, for which they toil hard day and night, then they would have been the happiest people on earth. As it is in their nature not to complain about things, they are happy with whatever little they get, even they're happy if nothing at all is given. But on contrary they are among those people who suffer because of various factors, be it social economic or political factors, but ultimately the brunt of all this falls on them.

Housing Pattern

This village has mud thatched (*kaccha*) houses. There are parallel houses with a path running right in the middle. These houses are airy with verandah both at the front and on the back side. The walls of the houses are usually adorned with a variety of artistic paintings in diverse colors.

Traditional Panchayat

The village has an organized judicial system. The head of the community is called *'Manjhi Hadam'*. He is the chief of the executive, judiciary and performs all the other functions within the village. He is assisted by other office bearers like *Paranik, 'Jogmanjhi', 'Jogparanik', 'Naike', and 'Gudit'*. They have a specific role to play in the community. During the birth and the death ceremonies the *Jogmanjhi* and the *Gudit* have a major role to play. While *'Manjhi Hadam'* looks into the judicial cases.

Statutory Panchayat

There is also a parallel running statutory Panchayat which looks after the developmental work of the villages and every 7-8 villages come under one village Panchayat.

Marriage

The cultural sphere of santhal tribes is quite wide, and it encompasses many things. To start with the institution of marriage, the santhals have different types of marriage. They follow clan exogamy and tribe endogamy. If marriages are undertaken within the same clan, such couples are ostracized and chased away from society. These marriages are of seven types namely **1) *Sindradhan*** – It is the most respectable form of marriage, and is given a lot of importance. It is an arranged marriage and is most approved by the society. Marriage ceremony goes on till 5-6

days **2)** ***Tunki Dipil*** – It is also an arrange marriage but is conducted in one day. Only 5-6 members of both bride and groom side come together in front of the village head and other respectable members of the society and conduct the marriage. People who are poor or cannot afford more usually do such marriages. **3)** ***Kundal Yapam*** – The girl and the boy with mutual likeness or love accepts each other. The boy keeps the girl in his home, and then gradually it is accepted by the society. There are no expenses attached to this marriage, and also not regarded as bad. **4)** ***Itut*** – The boy if likes any girl, he would forcefully put *sindur* in girl's forehead in some public place or some public ceremony. Girl if not agreed can take the case to the village head resulting in boy's punishment (*Dandom*) but if she also likes the boy, the marriage is accepted. **5)** ***Angeer*** – the boy and the girl who are in love, if not accepted by their parents they elope and get married. It is generally not considered good in the society. **6)** ***Sangha*** – it is the widow remarriage or the marriage of divorcees. **7)** ***Kirin*** – If found some demerits in girls, for ex – pregnant or older in age, then in that case boy by giving some heavy amount is in a way purchased for girl to marry.

Divorce can be obtained easily; however, some alimony has to be given to the women. There is also the practice of the son-in-law staying in his in-laws` house (*ghar - jamai*). There are also customary laws which are not much in favor of women, but with the changing time they are also undergoing changes. As such tribal women have no right to property. According to santhal customary laws only males can inherit land. Except in a few circumstances, women have no right to inheritance. If brothers are co-shares in holdings and one brother dies, the surviving brother and the son of the deceased inherit his share. While an unmarried santhal daughter has no rights to the immovable property of her family, any property that a santhal woman acquires out of her own wage is her own. [76]

Religious Beliefs

They believe in four types of super-natural powers. These are (1) protective spirits who always protect them; (2) benevolent spirits who are worshiped at the community and familial level regularly, otherwise they may bring diseases or death; (3) malevolent spirits - the evil spirits who

[76] Bagchi J, Dutta Gupta S. The Changing Status of Women in West Bengal, 1970-2000: The Challenge Ahead. Sage publication; 2005

control smallpox, fever, abortion, etc. and (4) Ancestral spirits, the spirits of their ancestors and always protect them.

Their life is dominated by rituals and customs that they practice time to time. They follow their traditional religion and have their gods represented in nature. *Thakur Jiu* is their god and M*aran Buru* is their guiding spirit. In addition to these, they have clan and family deities or spirits called *bonga*. The dead ancestors are also considered to belong to the realm of *bonga*. They do not practice idol worship; instead they paint on the sacred groves.

The basis of Santhal religion is the belief that they are totally surrounded by *bongas* or spirits and frequently are visited by deceased ancestors. Their day today life is shrouded with various customs and rituals. They believe that its evil spirits and ghosts that cause certain diseases, and it can be only cured by some specialists who can take off the bad spirit, they are *Ojhas*. They also believe that by worshipping or giving sacrificing of animals to the spirits they believe the disease can be cured or overcome. But the Christian santhals gradually deserted many of their functional rites and rituals. Otherwise santhals have elaborate rituals and these are interrelated with their daily life activities.

Evil eye, witch craft and supernatural beliefs

Every culture has its particular explanation for ill health; likewise santhal culture also has one. Culture provide people with ways of thinking, that are "simultaneously models of and models for reality" Geertz (1973).[77] It is a faith, prevailing among tribes that diseases are caused by supernatural agencies.

During my exposure to the field, I got a firsthand experience of listening to the people about various beliefs, dealing with evil eye, and witch craft, spirit intervention, human intervention etc. Villagers told me that evil eye or '*Aha*' (in santhali) causes a lot of sickness. In the same context they told me about a woman in the neighborhood, who hex on others just by looking at them. So nobody stands for too long in front of her, talks to her or goes near her. Even her own daughter who came to visit her mother did not have nice things to say about her. I encountered her many times near the well, she use to give a weird look, simply stare at me. People say she can cast

[77] Geertz C. The Interpretation of Cultures. New York: Basic Books; 1973.

'*Aha*' (evil eye) on anybody whom she is jealous of or whom she does not like. This women also knows to make some herbal paste which when taken by any man, can make that man get attracted towards the women who gave it to him. Several persons believe that she had enticed her husband by enticing him through witchcraft and then married him.

The use of witchcraft and evil spirits was exemplified in one of the case studies given in annexure (case 1).

Apart from it, social and religious life of santhal is very rigid. Among their community the notion '*DUN JUGIN*' (dayan) is very popular. And these *duns* are famous for inflicting illnesses and diseases; it is what the people believe.

The santhals have this strange habit of witch killing. If they suspect any woman being possessed by *dun* or witch, all the villagers come together and take the decision of killing the woman whom they perceive to be possessed. They literally assault her, beat her up, persecute her, and make her drink mixture of crushed glasses and urine. And keep torturing her till she dies. One thing is very evident here that those woman are only suspected to be a witch who is either a widow or an old lady, who do not have many to support them, and are vulnerable to be attacked by the society. If anybody is ill in the neighborhood or diseased, then the old women or widows in most of the cases are blamed for having afflicted the problem. So the society takes a decision to get rid of her.

The superstition is there in this society to the extent that many times they take away innocent lives, and mostly its women who fall in prey to this entire thing. Because it is quite ironical that if the witches are women, and when they are suspected and killed, why not men are suspected, not to forget the *Guru* (teacher) of the witches is men only. But it is a patriarchal society and this notion gets reflected through these practices only.

Festivals

The common festivals in the santhals annual calendar include Dussehera, Hariar, Irigundali, Janthar, Soharai, Sokarat, Baha, Magh, Mak-more, Erok and Baijayantri. Most of the festivals have their peculiar songs. The most important festival is Soharai, which is celebrated in the month of December & January with great zeal & joy.

3) Economic Aspects

The Santhals are not bound to follow a fixed occupation by any caste rule. In fact their social life, philosophy or thinking, their rites and rituals are practically centered on different agricultural activities. They cling to their land as their principal occupation and means of subsistence. Agriculture, cultivation of fruits and vegetables and at times hunting, fishing and food gathering are still considered important sources of subsistence. Evidently, the seed and womb constitute the center points of cosmology and imagery of beliefs and rituals that go a long way in developing their social organization and life functions.[78]

The life of santhal tribes mainly thrives on the agriculture, to which they depend most. But apart from it few have their own ponds so they have side business of fisheries. People do have milch cattle here, but they are not any source of income for the tribals. They don't have enough to feed rich fodders to the cattle so that they may give milk. The cattle are mainly and only for the agricultural purpose. There are practice of rearing pigs because it is a source of income, in the same manner that of goat.

People in a tribal village are to a large extent very cooperative, they lend a helping hand to each other for everything. And this is probably they belong to the same community and broadly belongs to the same strata, and that they are 'poor'.

The socio – economic dynamics of the village is mainly determined by the pattern of agriculture of that particular village and the pattern of out-migration.

Agricultural pattern

They practice settled agriculture. They start the process of sowing operations after the *'Ruhni'* festival which is celebrated for a week. This is somewhere around the last week of May. *'Ruhni'* is celebrated for many reasons. It is believed that if the sowing is completed on time then the cultivation is guaranteed. It will not get inflicted by insects and the cultivation will be of good

[78] Mathur N (Ed.). Santhal Worldview. New Delhi: Indira Gandhi National Center for the Arts; 2001.

quality. This also is celebrated because it is the initiation of the agricultural year. The agriculture is dependent on rains. If it does not rain in a particular year then no cultivation takes place.

Mostly all santhal women are equal partners with their husband in agricultural operations. They carry out at times more work in the field than their husbands.

Migration

It is only for five months that the Santhals are engaged in agriculture, rest of the year they really have to struggle every bit to earn something. Most of the villagers whatever they cultivate are not enough round the year, and in order to survive they need to out migrate. And this is the time when most of the villagers out migrate to earn some money by working on the agricultural fields of other caste groups. They mostly go to West Bengal and Assam. Historically, tribals, when faced with an onslaught of adversities, seem to have resorted more readily to migration and mobility as a survival response than their non-tribal counterparts would do under a similar predicament.[79] Breman (1985), on the basis of his intensive study of Surat district of Gujarat remarks: 'seasonal migration is a matter of survival or, at best consolidation, and hardly ever results in an accumulation or re-investment in the home area.'[80]

Not all the villagers go out to work as laborers on daily wage basis. There is an outmigration of the people of the village where in they go out, work, and come back home with some earning to feed their family. Many families go in groups with all its members to Bengal and other neighboring states to work on others field. A middle man comes there and fixes a rate on daily basis and takes them along. People carry all their belongings which they need for next few months, wrap it in a large *Bora* (bag made of jute), keep it on their head, take along their kids and walk towards their destination.

All they get after working hard is 50 rupees a day, 1 kg raw rice and a shelter to sleep. They generally migrate seasonally mostly during transplanting and harvesting seasons. This seasonal migration entails travel, temporary settlement away from home, interactions with farmers to the

[79] Maharatna A. On the 'Brighter side' of tribal mobility: a case study of Santhals in rural West Bengal. Demographic Perspectives on India's Tribes. New Delhi, Oxford University Press; 2005.

[80] Jan B. Of Peasants, Migrants and Paupers: Rural Labour Circulation and Capitalist Production in West India. Delhi, Oxford University press; 1985.

place where they migrate. This migration has serious negative consequences especially in matters of labour relations, children's schooling and health care, living conditions and women's safety from sexual abuse.

During temporary migration, the tribals go with their whole family leaving behind the elderly members and little children. So the families worry a lot for those who are left behind, but they know they have to earn in order to feed their families.

Section 2: Condition of women in the village

Women's participation in agriculture

Women play a significant and crucial role not only in agricultural development but allied fields including crop production, livestock production, post – harvest operations etc. and also in non-farm operations and other households activities.

Agricultural labour

Women in the village work as cultivators, agricultural laborers, artisan and housewives; they constitute a substantial section of workforce. Their contribution in agriculture is roughly around fifty per cent. They participate as cultivators and are engaged in a number of field operations with men (husbands) or independently. This participation of women varies from carrying out actual farm operations in the field to supervision, management and decision making in different agricultural work. In many places the contribution of these tribal women towards agriculture is more than that of men. They are responsible for the entire management of livestock, starting from the cutting, harvesting, carrying and chaffing the fodder.

The association of women in agriculture is an age-old practice. The 1991 census data indicate that 43.6 percent of women are working, as agricultural laborers 34.5 percent are cultivators (Census of India 1991). Though rural farm laborers work under severe limitations, their contribution towards agricultural production and development is noteworthy. Apart from the job they do outside the household, the unpaid activities in the domestic sphere go unnoticed and unrewarded. Women workforce outside the four walls is larger in rural areas than in urban India.

Women in rural areas help to grow least about 50 per cent of the world's food. They work in all aspects of cultivation including planting, weeding, harvesting, sowing, threshing, etc.[81]

The double burden

These tribal women who work in the field participate in a wide range of agricultural activities by slogging alongside with men in the field as well as taking care of the home and children, thereby performing a dual role that of a homemaker and of a partner in the farming activities outside the home. A large section of the santhal women depend on agriculture by working as laborers, who possess no land of their own in the family. A few women, who are marginal farmers work in their own field and also work as laborers for wages on other's farms, thereby adding to the family's income. But one thing was very evident that all women worked in their own field. Agricultural lands are often far away from homes, and men and women leave for work early in the morning, usually without having any food. The first peak period of work in agriculture is June or July through August, from morning till night, these women engage in breaking up surface layer of ground containing a mat of grass and grass roots of earth, sowing and weeding. The second peak period is October through November, when women are involved in harvesting, drying, pounding and husking paddy.

In this area mainly paddy, corn, pulses and inferior varieties of paddy which are called *'gundli'*, *'ghangra'* and *'janhe'* in santhali are grown here. Rice is the staple food and is grown extensively in this area where our study was conducted. Activities such as sowing of rice in the seed-bed and preparing the seed-bed by cleaning and removing stones, thorns and leveling the ground with hands and feet are performed by the women. Transplanting is a woman's job and is the most labor-intensive process because saplings are planted in the knee-deep muddy water for the whole day under the scorching sun and pouring rain. Weeding, that is plucking out the weeds is done after transplanting. Generally women and children are employed for this. Harvesting is a major agricultural activity, which is strenuous, where both men and women take part in paddy fields, again largely done by women.

[81] Reddi P, Reddy M. Women in Agriculture: A Sociological Study in Southern India. Presented at "Women Working to Make a Difference," IWPR's Seventh International Women's Policy Research Conference, June 2003

In a few families women are solely headed for agricultural activities, where men are passive. And most families it is both men and women working together, but the brunt of work more falls on the shoulders of women.

Women's work in general

There are many other different tasks that a santhal woman performs apart from agricultural work. Women generally go to the forest as a group to collect the forest products. The peak season for this is April to June. Tribal people depend on the forest for their livelihoods, including for the non-timber or "minor" forest products. From these they obtain foods such as fruit and oil, and items for the home such as '*bidi*', brooms '*jono*``, baskets, mats, rope, home-made toothbrushes called '*datani*', leaf plates '*patra*' and medicines. Some forest products are also sold for small cash. This work is hard, and is made more difficult by the fact that women often walk a long way to get to the forest, suffer scratches from thorny bushes and work in the heat without water.

Household work

Women perform multiple roles in the household and this holds true for tribal women as well.

Range of work

In the life of santhal women, there is a whole range of works that she carries on throughout her day. And each day is a very long day for her even though she feels tired; there is little time to take a break and rest. Domestic work includes sweeping, mopping the floor with cow dung paste, fetching water from the well which is not necessarily near the house (on an average it is half a kms from the house), cleaning the house, washing utensils, clothes, cooking, feeding and bathing children, collecting crop residues or dry leaves for cooking purpose, carrying food to fields, stitching, supervising children's education etc., and all this is done with little help from others. Cooking is regarded as the most important work for women along with the reproductive and nurturing roles that they have to perform.

Apart from it she looks after the cattle, sometimes send her children or herself go with the cattle while grazing. Looking after the elderly members like mother in law and father in law in case they have grown very old, look after them in time of ill health, where even the son doesn't look after them. Also have to go to '*hatia*' – the local market for the week's ration and do all the

buying and selling herself. There were men also in the local market but maximum it was women who came with loads of cultivated grain carrying on their head to further sell them.

A normal day in a santhal woman's life

Every single day of a santhal tribal woman is very challenging and a rigorous one. I would just narrate a day of my aunt at whose house I stayed in the village, though it was her daily routine I closely watched her than those of the other neighborhood women. Though I talked to many women, it would be easier for me to narrate this one:

> The day for Stensila starts in the very early hours of the morning at around 4 o'clock. Soon after she wakes up, she simply splashes water on her face, and then sweeps the floor of the house with a home-made broom, open space inside her house and space outside her house where people pass by. The time she wakes up is still dark, so she waits till the light comes and then she releases her cattle like goats, pig and two of her cows so that they graze on their own.. Her mother in law who is an old lady remains very ill. She suffers from diabetes and blood pressure, she has almost lost her sight, she cannot even locate things, she has grown very thin, and so all the time someone or the other needs to be with her. Much of the responsibility for her care falls on Stensila. Soon after sweeping she goes to her mother in-law and gives her an oil massage, as most of the time she is lying and her body aches. She then prepares black tea for all the family members, and wakes them up. And this tea preparation was only because I was there. Otherwise they don't take tea, instead have food. She calls her younger daughter to assist her in cleaning the utensils and in drawing water from the well which is nearby. After this she starts preparing food, initially for her in-law which is a different preparation, and then for the rest of the family members. For a few days she has been getting milk for her mother in law. Since their cows don't give milk, she had to go to another tola that is Jolha (Muslim) tola which is about one kilometer away. After coming back from there she makes a paste of cow dung, and mops the whole house including the outer verandah. After that she again collects the fresh cow dung from nearby places and keeps it in a separate place. It almost resembles a small mountain of cow dung (*gurik'*), as they also

use it as manure. She then serves food to everybody at home, following which she takes bath. Till this time its afternoon and she hasn't had anything. It is after serving everybody, taking bath, washing clothes that she also has her food. After having food she goes to the field, where generally the drying, pounding and husking of paddy are done. That field is called *'Kharai'*; it is not too far from their house so every day soon after having food Stensila goes to the field. Though the major grains were been sold out but there were left over paddies which were still to be husked. So later in the second half of the day she worked in the *'Kharai'*, and also guarded the grains which were being dried on the floor by the cattle around. It really needed a lot of vigilance to guard it as every now and then the cattle would come from all around. And if on some day it suddenly rains then Stensila runs to gather all the grains and get it back home, also the un-husked paddies. Then she goes around looking for her cattle, and brings them back home. It is during rain that the young cattle tend to get lost, so Stensila hurries to find them. In the days it doesn't rain, she carries with work in field. During the evening time she goes in the nearby mountain to get dry leaves *'palha'* and wood for cooking purpose. After getting back, she ties her cows in the cattle room, bring back pigs and goats. And start preparing for the meal. She separately prepares for mother in law and rest of the members again, which takes a long time of preparation. After serving everybody including her mother in law, she has her meal. After that she keeps various things which are all scattered in home in its respective place, prepares the bed for everyone at home. Goes to mother in law, give her massage before sleep. So she works for 18 hours or more from morning until night before she retires to bed. And many nights, almost every night I saw her waking up in between for her mother in law, sometimes to give her water, sometimes to give her warm blows prepared by residues of burning wood, and sometimes to simply sit beside her when the old mother in law couldn't sleep.

What came apparent from the above case study is that the women in the village were very hard working and diligent. They have a lot of stamina though looked very thin and weak but because they feel it is their duty so they try to complete every task till the point of perfection.

Social status of women

The status of women is determined by many factors such as:

In the area of decision making power

Once a santhal woman is tied in the nuptial bond, and comes to her new home she does not have much say in the decision making. Here, her role is that of a cook, a washerwoman, a custodian, to sum up, that of a domestic help to say. Nobody recognizes the hard work that she puts into making the 'house' a 'home', not even her. Lots of hard work goes into looking after the home, rearing the children, running errands for the house. And when asked what she does, the answer is 'nothing, a house-wife'. The women do not recognize their role or position, and even the society does not and therefore in most of the cases the decision making power is not shared by the women. In my study I found by talking and taking in-depth cases of women that mostly in a family, it is the husband who does most of the decision making and if not husband it is the mother and father in-law who does it. Although woman put in equal or sometimes more effort in the cultivation, during the selling of the grain or determining distribution/sell of wages/produce, the suggestion of the woman is not taken. It is the husband and his mother and father who take decisions. Only in a nuclear family the decision-making power is shared by both husband and wife.

Family planning decisions

The decision making in the area of family planning is least among the santhal women of this village. They hardly have any decision making power, most of the choices in regard to this are largely made by husbands and second choice is that of the mother and father in-law but not that of the woman herself who has to give birth to the child. The husbands compel their wives to have more children and give birth to male child. Though not every family that I visited wanted a male child but definitely they would be happy to have a son.

Most of the family knew about family planning method and that too about sterilization and indigenous medicine. The herbal medicine *'rehe raan'* is most popular among the tribes of this area. Nearly all the families and all the women whom I interviewed told that they would

consume *'rehe raan'* in order to discontinue having children rather than going for sterilization. None of the males adopt any contraception such as herbal medicine or the vasectomy.

The following case studies highlight the issues concerning the family planning decisions of a woman.

Case 1 – In one of the case studies where the woman had a five month old daughter, I asked her whether after how many children she and her husband would go for family planning. She told me that she intended to have 5 children – 2 girls and 3 boys. It was not purely her intention but her husband is the one who demands more children. This time when she delivered a baby girl, her husband told her *'lajao bam ayikau lidam kudi gidra em janam kidi'*, which means *'didn't you feel ashamed of delivering a baby girl'*. Another statement was *'if you would have delivered a boy, I would have received assistance for cultivating my field'*. So it is solely her husband's choice to have so any children. In case of any means of family planning, the woman would take the initiative. She says it is better for her to go for it because by the time she will have 5 children, she would be weak, and so therefore it is a noble decision that not husband but wife go for it. She prefers at first the *'jaddi buti' (rehe raan)*, later if it does not work, then she might go for tubectomy.

Case 2 – In another case study where I visited the house of a *'sahiya'* (ASHA) and I talked to her daughter in-law, who had a baby girl of two months. When I asked her how many children she plans to have, the woman said she intends to have two children altogether as she has to look after children's education and their living. They have few acres of land, so if they have more children, they'll have more expense and said she will go for tubectomy. When I asked her why not her husband goes for vasectomy then she said "that men are more powerful, can work more, they are more able. So it is woman who should take up the problems." As she is already weak so in case one has to stay back at home because of weakness, the woman can stay but a man has to work, so they can't afford to get weak, she said. And this decision of her for tubectomy was in consent of the entire family.

So it is quite visible the frame of mind that women have towards why one should get sterilized. This thinking is deep entrenched in their mind due to roots of patriarchy. They are made to feel weak and inferior by the society and family members. Coming down to the decision making woman has minimal role in deciding the family planning issues. Be it in the number of children she wants to have or whether really she wants to take the initiative of tubectomy, the choice or the preference is never hers. From the above description, it is apparent that it is only women who are forced to take any kind of contraception, be it herbal or sterilization.

Early marriage and remarriages

Most of the women with whom in-depth interviews were carried out were married at an early age. Even those who were not formally married but cohabited together, the woman were all of very young age, ranging from 14 – 18 years. Early marriage is extremely common among this society; as soon a girl reaches her puberty it is thought of giving her off marriage. She is seen as a liability and so given off soon. Though many girls choose their own partners but the constraint of society is so much that they make a choice at a very early age itself.

The santhal society is liberal towards women remarriage unlike other sections that tend to take a conservative view of it. In both the case whether a woman is earlier widowed and then gets married, and in the other case where she walks out of a marriage because she is not compatible with her partner, society is accepting with no apprehensions. Even the society is flexible towards the type of marriage; one is free to choose one's partner but strictly according to tribal norms (tribe endogamous and clan exogamous). The Santhals have different types of marriages known as `***Bapla***`, there are of seven types mentioned above.

Domestic violence

The issue of domestic violence was not very outspoken in the village, it was there in most of the houses but nobody talked about it. Until I probed to ask a few women, whether they confront any kind of domestic violence and their answer was 'yes'. In most of the families I found that the men usually comes home drunk and beat up their wife indiscriminately. And women never act against their husbands. In cases where they do, they normally quit their marriage life.

Health status of women

The health status of women can be studied by looking at the overall health of women, and looking at it in context of ill health. It can also be studied by looking at women's own perception of their ill health etc. So below we will be studying the self-reported gynaecological problems of the women. We will also look at the health conditions of older women as to how they cope with their old age problems and illnesses.

Women's perception about their ill health and their Gynaecological problems

The perceptions of the women were studied by using focus group discussions with the women. During discussions, their response was cold and they said they are fine. But when I made them think deeper, they came up telling about their individual complications problems of ill health. After that each one of them spoke something about themselves.

One of them said, whether she is well or unwell, she continuously suffers from back ache. And many times she feels weak and has blackouts. She didn't know the reasons, but says probably because of weakness that make her head spins and her eyes rotates, and feels that something is coming out of her eyes . Also tends to see many colors in front of her eyes. Because of weakness only she says her legs and hands 'die' (become limp) and does not move instantly. Even during menstrual periods she has a lot of pain.

Another woman sitting in the group said that after having her baby, she started having lower back pain. Before delivery or before conception she never had this pain. One thing she complained of that they didn't call the *'dom budhi'* (Dai) who could have massaged her body till a few days after birth. She thinks that due to the lack of massage probably her body remained loose after giving birth, resulting in lower back aches.

Another woman said that she also suffers from back pain. And one by one gradually every woman complained of having lower back pain, each one of them complained the same. One among them said she always suffers severe headaches and these days one disease that is very much prevalent in this area and adjoining areas is Brain Malaria. Earlier she had suffered brain malaria, and she said that if not treated it can lead to death. For this disease she got treatment from a local quack.

One woman said, she was having severe dysentery following which she had bleeding. The bleeding was with the stool but lately without it, and continued bleeding for many days. She was then put on saline water (8 bottles); only then she was able to recover. People told her not to seek treatment here in Shikaripada as many people are dying. So she told her family members to take her to Saldoha hospital, which is about 20 km away. She was taken there and had recovered.

With one woman, things were even worse. She frequently had malaria. And it has been 8 or 9 times that she suffered from malaria. And each time she went to the indigenous healer and got herself *'rehe raan' ((jaddi buti).* And most of the time her hands and legs become weak, often she has headache, backache, her finger and legs get stiff, as usually one gets during fits. While telling the group she stressed to the point that many times her hands and legs get stiff, also her face turn to one side and gets stiff. Even though one tries to move her face at that time, one cannot. Her menstrual periods are also very irregular; it is just for one day in the whole month.

The other woman sitting next to her complained of having continuous headaches. She does not feel good or comfortable while bending, her head spins a lot, joint pains and back aches. She is very uncomfortable with her stomach, it pains often. She feels very weak; she says it is all probably because of pain in abdomen, head ache, and backache. One more woman sitting in the group said she has chest pain, and pain exact in the middle of the head. She too complained back ache, weakness, but she did not had any chronic illness. At times her leg shivers, despite of regular massage, it does not cure. Many other women complained of backache and weakness, and it was very common among the tribal women of that village.

During my in-depth case studies many women complained of having white discharge, which they call it *'pordhol'*, and if the discharge is with a burning sensation, they call it *'jala pordhol'*. They believe that by having a lot of white discharge complicates conception. And so they usually go to herbalist, and take 'rehe *raan'* for this problem. The complication or the irregularity in menstruation is called *'fool silka'*. But there were also a number of women who simply did not take any medicine or treatment for white discharge or irregular menses. They just feel it is normal to have it, and cannot take off time from their day to day routine to go for any form of medicine. And it was quite evident from my study that every woman had some form of gynaecological problem but their general weakness and body and joint pains was a shared reality in their lives. They did not take action for these problems for a number of reasons.

Pregnancy wastage

In my study there were few cases of still births also. I would give two instances from my study below in this regard which would make things more clear.

Case 1 –

Suhagni who is 26 years old, was married 10 years back, and has four kids. The elder one being 9yrs, followed by 7yrs, 4 yrs and the last one is of one and a half months. In the last nine years she has delivered four babies. When I enquired about her past obstetric history, I came to know that that she also has a still birth. While her second pregnancy she had a miscarriage. She then explained what happened; Suhagni recalled that when she was pregnant for the second time, she got a severe head ache. So much so that she could not bear it, so they call upon the local quack. And he gave her some medicine for head ache. Following this after a few hours she had intense pain and suddenly felt hollowness within her. Again the quack was called and he declared that it was a miscarriage and baby was no more. But after that she did not take any medicine during her pregnancies, even during severe headaches.

Case 2 –

Susila Hansda (24 – 25 yrs old), has a tired, sun burnt face. Her face reflects all her uncertainties, looks extremely worn-out, and shows all her doubts and worries. They have a family of four, her husband, two children and herself. Both Susila and Hopna (her husband) before getting married were married earlier. Things did not work for both the couple. Susila and Hopna were both alone, so they decided to marry each other. Both of them had a child each from their earlier marriage, Susila had a eight year old son,Ashish,and Hopna a ten year old daughter, Elizabeth. Five years back when they married children their children were 3 and 5yrs old respectively and now they are 8 and 10yrs.

Presently Susila is pregnant and it is her 9^{th} month of conception. Before pregnancy she carried out all her household works and looked after the two kids, apart from that she

worked in the crusher, where large huge rocks are turned into stone chips. She lifted heavy stones or stone chips from one place to another, and all this under the scorching heat and sun. When they carry these to and fro 400 times, they get 50 rupees for that. Though the task being very tough, Susila continued going to the crusher and work there till her 7th and 8th month of pregnancy. Presently she continues doing work at home but has stopped going to crusher.

Since last five years, she conceived five times, among which in the last four pregnancies, the babies died in the womb in the seventh month, and it has happened for four consecutive years. During her first pregnancy i.e. five years back, she used to work in the same manner as she worked now. But she used to feel extremely weak. She had a spontaneous abortion. This was happening to her for the first time. She rushed to an indigenous herbalist. He gave her medicine; it made her fine in few days. As soon she felt a bit better she again conceived. She used to feel weak in the same manner but she continued doing her usual work. Again in the seventh month with her second pregnancy, she had the same experience. This time she went to a private doctor in Dumka. There they detected that the baby has died in the womb. So then they got the baby out by giving her some medicine. The third time when she conceived the baby, she experienced the same thing and this time she went to Sadar (District) hospital, Dumka, where she received a very cold response from the doctors and attendants. The doctors said "we can't handle you here, we are short of beds, and you go and get it cleaned out in some clinic outside". So with a hard heart in such a painful situation she had to again move from there. She went from there to the District hospital so that she does not have to pay much like last time in a private clinic.. Here she was really disappointed by the response of the doctors in district hospital. When she walked out towards the gate, there was a private clinic of a lady doctor. So they went there, the lady doctor told Susila not to conceive for another 2 -3 years. But Susila again conceived for the fourth time and the same happened to her, she again had a painful miscarriage.

In each case except the first one, she had to spend around four –five thousand rupees. They have been borrowing money since five years which they have not returned till now; they are still in debt. They are very poor, and have meager land holdings. So even

though both of them are working out as laborers, they are unable to pay back the debt. The debt has really accumulated in these five years. But because of their poverty they are not able to come out of this vicious circle of indebtedness.

From the above case study it is evident that how a woman has been taking actions to bear a child and how she is coping with all the hurdles coming in her way, and in spite of being supportive, on contrary how the system treats her.

Complications during pregnancy

Every other woman in the village has some kind of complications during pregnancy, though many times they suppress or avoid the complications. The most common among them is the relapsing intense pain during pregnancy. From our study, a list of complications was marked. Pregnant women suffer from weaknesses mostly all the time but it increases during 7^{th} to 9^{th} month. Their feet and hands swelled mostly. Women have extended days of labour pain. And during this time usually the *'dom budhis'* are called who gives them a rough massage further increasing their pain, and bringing in new complications like ruptured uterus.

Health condition of older women

The health conditions of older women are even more deplorable, and especially for those women who have nobody to care for them. Women who are still strong, physically can have still a better position in the family but those who grow feeble and weak, for them life becomes more tough. When asked the young ones as what problems do the old women have, they said "among old women usually the blood dries up and only the bones are visible". Leaving a few women of the village who were assertive, rest of the women were timid and hesitant. I would put down a case study of an old woman showing her plight.

Case 1 –

Kaldhi hansda, her age was 65 years old, she looked very old. She has some skin disease in her entire body. It looked like big boils in her whole body including face, neck, hands and legs. It has been many years since she had this disease, and she is living with it. Her husband died way back when her kids were very small. She has two children – a son and a daughter.

Since their childhood Kaldhi has brought them up all alone, in an extremely deprived and poor condition. She has taken a lot of pain in rearing them. She often went out to other states to work as a laborer. She took her children along with her to wherever she worked and she just received 5 – 6 rupees a day and with such minimal amount she managed to sustain them. Many a times there was a question to their survival. She worked in the same manner during both her pregnancies as she had no option but to work throughout. She carried on with all type of work, be it heavy or light works, she never thought of taking rest. Her son was delivered by a *'dom budhi'*, and her daughter was born while she was back from work, Kaldhi delivered her in the verandah.

Her son 'Sushil Hembrom' is now 47 years has deformities in both the legs and hip. He was not born like that but gradually as he grew up, his lower half of the body got deformed, and now he cannot move on his own. And it has been thirty years or more since he can't move, so he has got a wheel chair from the government. He does not even work, so he is being looked after by his mother Kaldhi.

Her daughter 'Panuni' who is now 47 years old was married earlier. She gave birth to two daughters, the elder one is of 20-22 years and younger one is of 16-17 years old. Panuni was deserted by her husband so she came back to live with her mother. But when she came back she started having some health problems. She started having a lot of pain in her hip bone and soon her condition started deteriorating. Now she can't even bring her own food or anything. Her mother Kaldhi does all the work for her, who herself has grown old. They don't have money, so she is unable to take her to the doctor. Mainly she gave her daughter *'rehe raan'* (jaddi buti) in the early days, which gave her some relief initially but never cured her permanently. Panuni suffers from burning sensation in her vagina, she bleeds often, and has a lot of white discharge now a days. For all these complications she takes herbal medicine (*rehe raan*) only.

When I saw Panuni I could not imagine that she was Kaldhi's daughter, she looked as old as her mother. This is probably because of the deteriorating condition of her body. She could not even move, she keeps sitting at one place.

> Kaldhi who is growing older day by day, was complaining that she has to work a lot and that she cannot work like she did before since she has become weak. She was worried about who would look after her son and daughter when she was gone. The other source of worry was their poverty as a result of which there was no money and they could not afford to get food round the year.

To sustain her family life, the only means of livelihood for Kaldhi was to weave plates. She gets leaves from the mountain, stitches plates and sells them in the market. Though she earns very little, but there are no options for her and she can't do anything about it.. She says now she can't go out and work as laborer so there is little choice of work left for her.

We witness how challenging could be the life of an older women. And the biggest factor contributing towards their impoverishment is Poverty. The state of women including older women and their health is an area of grave concern.

Summary

This chapter brings in various ideas and trends in areas of condition of a tribal woman. She pays to be a woman by leading a life full of hardships. Being born in a patriarchal society she simply becomes a pawn of the social order and she is bound to accept every challenge which comes her way. We saw from the above section the way women fall into the triple burden – doing household labor, labor outside home (agricultural chores) and the burden of child bearing and child care. The section discussed the oppression suffered by women in the name of witch killing. It encountered the plight of families who were in great mental and psychological loss, with no material gain. For them it is just hand –to-mouth existence, and no savings. Women in the village are heavily occupied with work, whether household or outside home which takes a toll with their poor health conditions. Her social position is not much recognized; she fails to make any decision in any area- financial or household affairs. Especially in the area of family planning she has no decision making power. Neither is she given the choice of selection of the contraception, nor the option of denying it. In addition the fear associated with permanent sterilization, especially the loss of power, is so intense that women do not prefer their husbands to get sterilized. They rather believe in sacrificing themselves. Women never doubt their health until it

obstructs their regular work. They feel they are fine till the time disease or illness becomes a hurdle in their everyday work. Normally the complications during pregnancy in the village were prolonged labor pain, swelling of feet and hands, excess of bleeding after birth and ruptured uterus. The health situations of older women are very deplorable in the village. They mostly take care of themselves as everybody is so occupied with their own life and have so much to do that they are unable to pay attention to the elderly. On the whole, the scenario in the tribal village is grim; abject poverty, lack of employment opportunities, inaccessibility to services when they need most especially during pregnancy. Some of them thus will be highlighted in the following chapters.

-Chapter 4-

Health seeking behavior and practices associated with Maternal and Child health care among Santhal tribals

Introduction

This chapter is again divided into two sections. The first section combines the health seeking behavior and study their accessibility and utilization among the villagers. Also it looks at the providers and people's perspective. Moreover it examines the status of various programs in terms of their accessibility and availability. Further in the second section, we studied the maternal and child health care practices under which we probed the practices relating pregnancy, the perception about pregnancy, the concept of rest during that period, care for pregnant women, their work pattern and food patterns, their antenatal care, their superstitions followed during pregnancy and the changes across generation in these spheres. We especially focused on the practices at the time of delivery and post partum period. We also studied the place of delivery, the preference of birth attendants and expense involving the delivery. We inquired the process involved in conducting the home deliveries.

Section 1 – Seeking health care – accessibility and utilization

PHC Shikaripada

The Shikaripada PHC is located in the centre of the area, alongside the main road; it is near the Shikaripada block and ICDS.

Some observation and its function

The Shikaripada PHC was about 4 km away from the Ranga village where I stayed.
There total numbers of OPD patients are 1298 (new patients), total OPD patients (old) are 191. Indoor patient – 176, Communicable patient – 62, Non – communicable patient – 1236, ANC – 68, Leucorrhea – 16, Delivery – 1, Irregular periods – 3

The Shikaripada PHC caters to a population of 1 lakh 26 thousand. And the list of medicals and para - medicals is below:

Two doctors (2), Two ANMs (2) – one looks After ANC and the other work as pharmacist, One (1) female ward attendant , One (1) laboratory technician; and Three (3) fourth grade staffs.

It was found that largely the functioning of health services was inadequate. A normal PHC caters to a population of 30000, and if it is a hilly region the population that it caters is reduced to 20000.

But in Shikaripada PHC things are quite ironical. The normal hilly terrain PHC caters to around 20000 populations, but this PHC caters to 1, 26,000 populations. With only two doctors, two ANMs, 1 female ward attendant, 1 lab technician, and 3 fourth grade staff in which manner this PHC must be catering to such a huge population, and how it would be rendering services to people now becomes easier to understand. Even normally a PHC has 5 – 6 sub centers, but this PHC has 29 sub – centers within it. And generally under a PHC there are 25 – 30 anganwadi but this PHC has 145 Anganwadi under it.

Provider's behavior

The following observation illustrates the quality of responsiveness that patients receive in a PHC based on the observation of the interactions:

A lady came and she wanted to show to a particular doctor, she tried approaching that doctor, but each time she was sent back making some excuse. Probably some other dynamics must be attached to it, but at that particular time a patient was in front of the doctor, and the doctor should have done her duty. The patient who was a woman, later went outside and told her husband following which her husband started abusing the doctor, not literally but said many things which were embarrassing and humiliating. And the doctor did not even bother to know what that lady's problem was. The environment of the PHC was that of a very casual one, everything was laid back upon, unplanned, Unsystematic. And this was the reason why the PHC records were not managed appropriately. Along with ANM there were three more women sitting and chatting while on duty.

This clearly reveals the attitude of the doctors and staffs as how they perform their duties. And with such few resources in hand, they too become more indolent, leading them to be typically non-functional.

Perception of people

The village people did not really go to the PHC for any ill health problem. And it was the case with all the adjoining villages too. With most of them they said that doctors do not treat them well, do not diagnose them properly. One point that clearly comes out of my study is that people have lost their faith in the services provided by the PHC, and this process has been a gradual one. Villagers said "they give the same medicine for any problem that we approach for, and many times they give us expired medicine". This I heard from many villagers I interacted with. Few villagers do not even know that medicines are provided free of cost in PHC. There were countable families who went to PHC, those who got some affirmative response. But if I go by majority, people were not satisfied with the services provided by PHC.

Mohulpahari Mission Hospital

This hospital is around 8 – 10 km away from the village. This hospital is sixty years old, and has a nursing school of its own since more than fifty years. The hospital's main objective is to serve the people, especially the deprived section.

Some observation and its function

For the village of Ranga and for this entire region, the 'Mohulpahari Christian Hospital' is seen as a big support. This is what researcher gathered from the most of the in-depth case studies, or by simply talking to people. Researcher really wanted to know the functioning of this hospital, and know to which all level does this hospital caters to the needs of the people around.

Apart from providing outpatient and inpatient care, the hospital also runs CBPHCP (Congregational Based Primary Health Care Programme) that operates, one of the programmes run by the hospital to get the various developments and works going around. This program is a unit of the hospital and a program run under the community health department of Mohulpahari Christian Hospital since 2000. It is operated in around 110 villages of Shikaripada and

Raneshwar blocks of Dumka district in the state of Jharkhand. The program is run through laity and clergies (members of the church) of 11 congregations of Mohulpahari circle. The programme is being run by the hospital, with an idea that members of the church have potential that can be utilized for bringing 'Health for All' in the surrounding area of the hospital. With a view to operate effectively at congregational level, the program has local committee in each congregation with an administrative capacity at the local level. The committee members are responsible for motivation of congregational members to involve in community health work. They are also responsible for guiding and monitoring the activities of field level staffs of the programme i.e. Community Health Volunteers, which are presently 70 in numbers, and are at the congregational level. To implement the plans of programme at the grass root level, there are health guides and community health volunteers who are periodically trained at the hospital on different health and development issues. With a view to organize the people against health problems and poor economic and social condition, CBPHCP efforts to build awareness on health issues like – Immunization of pregnant mothers (TT); Antenatal care of pregnant women; Post natal care; Immunization of children under 5 years of age (BCG, DPT, OPV, Measles etc); Diarrhea; TB; HIV/AIDS; Malaria; Kalazar. Apart from these health issues the programme also focuses on diseases that are not commonly found in the area but has possibility to occur in the region.

Socio – Economic development by CBPHC – while working on the vital issues like health, the committee members found that major population of projected area is economically poor. A major portion of the population is living below the poverty line. The poverty has not only deteriorated their health conditions but has also prevented them from availing health care facilities. Death rate is high especially in Malaria, kalazar epidemic seasons because of people's inability to get proper treatment at the right time. Again the main cause found is the poor financial condition of people. Though efforts are made to aware people especially women, many of women are unable to receive care like antenatal care, immunization, proper food during pregnancy because of poor economic status and remained in the same status as they have been. A large number of villagers especially santhals remain untreated when they are suffering from disease like Malaria, Kalazar, TB, Diarrhea etc. The poor economic status leading to poor health condition of people has actually given birth to the concept of socio-economic development of people in this area.

The organizational structure of the Hospital is given in the annexure 4.

Perception of people

There was a major consensus among the people in regard to this hospital, that it is a very good hospital. And majority the bulk of them said that they have more faith on this hospital than any other form of treatment or medical system, be it indigenous medicine or visiting PHC. They believe that once they reach hospital, they can cure anything. And they are fairly satisfied with the response and behavior of doctors and staffs. One thing they all complained was that the hospital charges some amount, patient fee which is not possible for them to pay often. Though it seems nominal to the hospital, but for the people in the village that little amount is a large sum.

Indigenous healers

Just like any other tribal society have indigenous healers and informal practitioners in the same manner this community has them in large numbers.

Presence and functions of traditional healers

The Santhals believe in folk medicine. They have their traditional healers upon whom they have considerable faith and confidence. The Santhals have few common characteristics regarding perception of health and disease. Like many other tribal societies they also attribute the causation of diseases to the wrath of god, mischief of evil spirits and magic of human being. Treatment is based upon the removal of causative factor by appeasing the gods; controlling evil spirits through counter magic, use of sorcery and of course some herbal preparation. Thus religious practices of the Santhals are closely related to their health care system also. Apart from a host of spirits, the pantheon consists of the following deities or *Bongas,* namely, *Sing bonga*: the sun god, the supreme deity, and worshipped after harvesting and before sowing seeds. *2. Marang buru*: the mountain god is a community as well as a family deity and a guardian god. *3. Jahera bonga:* the widely celebrated goddess for protection from diseases, She is village deity and while displeased can punish with diseases. *4. Gossain era*: the associate of *Jahera bonga. 5. Moreiko and Turuiko:* the deity of fire and are placed in *Jahera,* a place of worship in forest outside village. *6. Majhi haram* and *Majhi burhi* are protective deities that stop *bongas* and sprits from doing harm

to their people. Besides these deities listed above they have their family deities like *"Ora bongas"* and the *"Abge bonga"*. There are 178 different bongas, which the santhals propitiate by magico religious performances.

Santhals continue to have faith in traditional medical systems. The traditional healers collect medicinal plants from the forests and mountains. And they have medicine for every ailment that people suffer from. They generally sit in weekly *'Hatias'* (local market). Many have their medical practice at their residence, where people themselves come for treatment.

There are many practitioners without any formal training who dispense allopathic medicines and all over Jharkhand the villagers call them *'dector'*. They come to the village very two or three days in a week by the bicycle, and ask if anybody is ill in the village. He keeps medicine and injections with him, but nobody knows whether the medicines he gives are genuine or not, because people have hardly any idea about it.

Perception of the people regarding traditional healers

What I gathered most in the area of traditional healers in my study, is that though people have more faith on the Mohulpahari hospital as they say, but it is the traditional healers to whom they come most for any sickness, disease or illness. But there are many also whose faith still lies with the traditional healers. When asked about it they said it is tried and practiced since many generations and they do not rule out the effectiveness that lies with it. People in a good number also approached the traditional healers was for contraception, some gynecological cases, post-natal cases, and for various diseases like jaundice, malaria and T.B, kalazar etc. When I asked most of them as why despite having more faith on the Mohulpahari mission hospital, they go for the traditional healers. The response was common, that they are poor enough so they cannot afford the treatment. And many emphasized that being poor they can only go to traditional healers, where medicines are much cheaper.

Opinion of villagers regarding RMPs was that they can approach them when somebody is ill, some small ailments like fever. Some may go to them also in case of some disease, but his idea is not to serve the people but to earn money. Quacks also keep a note of who is pregnant, so he himself goes to give the injection at time of pregnancy. His job is to gain the trust of people. Though many villagers do not like him, but they do not have option.

Section II-Health Institutions and Programmes in Shikaripada block

Integrated Child Development Scheme (ICDS)

ICDS is functioning in Shikaripada block, under which there are 215 Anganwadi centers. There are 213 ANMs and 211 *'Sahiya'*. And from the month of November 2007 to January 2008, the number of male children born alive is 89. The number of female born alive is 75. And only one still birth of a male child was recorded during this period. The fertility rate is 5.

The Anganwadi center operates from the house of the Anganwadi worker. I talked to the Anganwadi worker (AWW), and the excerpts of the interview are reproduced below:

> Children from the 3 -6 comes here to Anganwadi, mainly the pre-school children. The children of 7 months to 3 years get un-cooked food material. Also the pregnant women and mothers of less than 7 months also get the same material. She gets the food from the Shikaripada block, through *'Thela gadi'*, bicycle, and rent vehicles. So they really find difficult to carry the food materials. The ANM visits the Anganwadi every first Friday of the month. The DPT, BCG, Polio – 1st, 2nd, 3rd is given to the children between births to one year. She told the kind of mentality people have by citing an instance, where a jolha (Muslim) child died after pulse polio, so the community in that area made a consensus that pulse polio is causing death and so their children should not take the drops. She told that few people do not believe in government hospital medicine, they have more faith on the quacks and traditional healers. That particular day only 20 children were present. She added that number of children increases hugely at the time of food distribution. Food is the time when everybody comes. The cook of the Anganwadi Manobi Hembrom, is very reluctant towards her work. Many times she does not turn up, forcing worker to prepare food for the children. The teacher told that in this village, mainly the untrained dais deliver the child.
>
> She says she really finds difficult to manage the Anganwadi. She has to be behind children, call them each time, each day. For vaccines also, the villagers don't understand why it is important or necessary to get the vaccines, they have to be understood a lot. They don't understand much, in BCG vaccine children generally tend to fall ill, so people complain about it, and find it very difficult to get the vaccine done.

> The cook Manobi keeps telling people that due to polio children die. So she does not let people take vaccine. The teacher and the ANM find it very hard and very tough to get the people convinced.

Although, the AWW and the cook have a different perception regarding people's health behavior, in-depth interviews with a few mothers revealed entirely a different picture. The perception of the women was at variance from the Anganwadi worker and ANM. They said the ANM never visits the other tolas except the tola where the Anganwadi center is located. And therefore many women are deprived from getting the medicines and tablets. A few women to whom the ANM visits are not satisfied, and when asked, either some are only given tablets and not injection, or some only given injection and no tablets. Some pregnant women said they haven't been given the pregnancy kit, nor the ANM comes for visit. Hence, there was an air of dissatisfaction among people with the services given by the Anganwadi.

Revised National Tuberculosis Control Program (RNTCP)

The following is the status of RNTCP from the peripheral health institution:

Drugs (DOTS)

The stocks were not adequately available at PHC at the end of the month. Some categories had only 2-3 boxes of DOTS treatment. The remaining supply was provided during the month. During October, there was no stock available on the 1st day of month in Category 1 and 2, which was replenished in the coming days.

Staff in Position and Trainings

Although the post of four medical officers was sanctioned for this health institution, only two were in place. Similar was the situation for lab technician where only one was presently working as against the sanctioned post of two. In case of MPH (Multipurpose health Supervisor) and MPW all sanctioned post were filled. A positive factor about this institution is the fact that from medical officer to the MPWs, all were trained in RNTCP.

Case Load

The total numbers of new patients attending this peripheral health institution were around 1500 per month on an average. Around 6 - 8 per cent of the new adult patients who visited the OPD were sent for examination on the basis of chest symptoms. Around 13 – 20 % approximately of the patients referred or sputum examination is diagnosed sputum positive. Unique feature observed within the report was the fact that not all the patients diagnosed sputum positive were initiated DOTS treatment, due to unknown reasons. Although most of the columns in the reporting format were completely filled yet this data was not entered carefully and some common mistakes in calculation were observed. But of the new and old cases in total 75 – 90 % were males while females making only 5 – 25 %. Males belonging to 35 – 44 year age group most commonly smear positive new cases. There were no relapse and failure cases.

Equipment and Consumable

Although, the health care facility is provided with 3 binocular microscopes and 1 monocular microscope, only two are functional. Most of the other consumables like sputum container, slides, chemicals, were available in adequate amount.

Malaria (National Vector Borne Disease Control Program)

Under the National Vector Borne Disease Control Program, I was provided with three months of Malaria reports from PHC Shikaripada. As mentioned earlier this PHC has 36 sub-centres covering a population 120137.

Active and Passive Malaria Surveillance

The total number of slides examined under active surveillance during Oct-Nov 07, Nov-Dec 07, and Dec 07-Jan08 were 801, 1547, 832 respectively. From the total catchment population of 120137 averages of 1026 slides per month i.e. less than 1 % of total population is tested for malarial parasite through blood slides. Out of the total blood slides examined during Oct-Nov 07, Nov-Dec 07, and Dec 07-Jan08i.e. 801, 1547, 832, there were 61, 250 and 63 slides positive for malarial parasite respectively. This gives an average of 7 – 15 % slide positive rate. Under

passive malaria surveillance, 565 slides were examined during the month of Oct-Nov out of which 60 were tested positive. There was no passive surveillance conducted during the month of Nov-Dec. during the month of Dec-Jan, 288 slides were examined out of 65 slides were found positive.

On an average around 1200 – 1500 blood slides are examined for malarial parasite every month, and the positive slide rate ranges from 10 – 15 %. The most common age group among slide positive was above 15 yrs (70 – 80 % of total positive). Positive rates among 1 -4 yrs, and 5 – 15 yrs were nearly equally and each constitute 10 – 20 % of the total slide positive. Age group 0 -1 yr constitute 1 – 2 % of total slide positive. The distribution of patients according to sex was observed to be equal. The number of blood slides showing plasmodium vivax was 91 out of 121, during Oct-Nov, 103 out of 250 in Nov-Dec, and 84 out of 128 in Dec-Jan. while Plasmodium falciparum was found in 30 / 121 slides, 147 / 250 slides and 44 / 128 slides during Oct-Nov, Nov-Dec, and Dec-Jan respectively. Although during the month of Nov-Dec, cases of falciparum increased tremendously overshooting the number of plasmodium vivax cases, while in other two months 1 / 3^{rd} – 1 / 4^{th} cases of the total slide positive were reported to be plasmodium falciparum.

Leprosy

I met the leprosy monitoring officer of PHC Shikaripada and after talking to him I gathered that leprosy is more prevalent among STs more than SCs. Most cases come from the interior hilly regions or areas. The reasons are the contaminated water and the unhygienic environment that they live in.

Prevalence rate per 10,000	1.12
New case detection rate (NCDR)	21.6 / 100
Multibacillary %	37.03%
Multibacillary child %	14.8%
Multibacillary adult %	33.33%

Section III – Maternal and Child health care practices among Santhal Tribes

Practices relating to pregnancy and delivery

Usually during pregnancy many practices depend upon the perception of women regarding their pregnancies, concept of rest during pregnancy, care for pregnant women, work patterns, food patterns/food taboos and maternity care.

Perception about pregnancy

According to the santhal tribal women of the village, getting pregnant is just like any other task for them, and any other usual work. Their idea is to give birth to one more contributor to the family.

Concept of rest during pregnancy

The word 'rest' does not exist in the life of the women here in this village. They have so much work that they just can't think of taking rest, and 'works' in village never finish. They (women) have to look after practically everything under the sun and the work never decreases with the pregnancy. Their society doesn't differentiate between those who are pregnant and those who are not; they expect the same amount of work from the pregnant women too.
Even after pregnancy, just after the delivery, women do not take much rest. In my study, I found that only one woman had rest for a month. Rest of the women had taken rest either for 4-5 days or one week, two week etc. And soon after that they are expected to do every work on their own and start continuing with the same chores that she did earlier.

Care for pregnant women

Care for pregnant women is highly neglected in the santhal society and the same was seen in this village also. Pregnancy remains a very casual phenomenon for them. The only care they follow, that too not all of them, is doing light works by the end of seventh month. And a few families cared to give their daughters rest for about a month after their delivery.

Work patterns

The work pattern of santhal woman is hectic. Though men contribute to the work it is limited to agriculture and working outside as a wage laborer.

The following is a case study to highlight the plight of a pregnant woman:

> 'Chundki Murmu' is around 22 years and lives with her husband, mother in law and three children. The eldest child is 4 yrs, then next one 3 yrs and the youngest one, 1.5 years old. Presently she is eight months pregnant and looks underweight and unwell. They are very poor, she said "money is so less that basic needs cannot be fulfilled, whatever comes go away, even it is difficult to feed one at times". Chundki has been working rigorously all throughout. Apart from rearing up her children, she carries out all her household chores- cooking, sweeping, mopping, pouring water from the well, getting woods and leaves from nearby mountain to cook. Apart from the work at the household, she also works as wage labour. Working in other's field is locally known as *'Manjuri'* where she manages to earn Rs.35/- after toiling hard throughout the day.
>
> Presently while she is pregnant, she continues to do all the work which she habitually carries out every other day. She does not take rest. She said, rest is alien to them and do not relate to their life. Even her mother in-law intruded and said "why will she rest, we can't hire workers, we are poor, so it is only we who have to work, we can't rest". One woman who was neighbor, listening to our conversation, interrupted that "I tell you, Chundki never rests, even during her delivery. Soon after delivering the baby, within a week she started working".
>
> In between the conversation, the clouds were gathering and the rains were coming. So Chundki said she would continue this talk next day, and she rushed to the field almost running.

From the life of Chundki, we normally could visualize the state of the pregnant women, whose pattern of work never changes.

Food patterns / food taboos

The general food pattern reflects a subsistence economy. In most cases families do not get to eat round the year. If there is less to eat in a family, how can we expect that a pregnant mother

would be fortunate enough to get a lot of food? From the in-depth interviews, it was evident that leaving one or two cases, most women eats very less, but that did not mean that if they eat less they work less. The amount of work always remains the same. But certainly there were variation in the opinion of pregnant women, as to what one should eat and how much to eat. Through my study I was able to bring out some of these differences as evident from the following case studies:

Case 1 –

Chundki (22 yrs) whom I talked of in the earlier part is a mother of three, and is presently eight months pregnant. When I asked her about the food which she is taking presently, she said "one should eat less food, so that one feels lighter and can do much of work. I don't feel good when I eat more". Presently she just eats rice and dal, or sometimes rice with *'alu chokha'* or rice with 'tomato chutney'. They mostly eat twice in 24 hrs, one at around 11 am and the other at around 8 pm.

When asked whether they get insufficient food to eat, which I thought may be the reason for having less of food during pregnancy. Then Chundki said *"jasti jom khaye gidra ku kati ku janamo aa"* which means "if I eat a lot of food then the baby born will be small in stature". Regarding any restrictions or suggestion of food to be taken, she said "as such there are no restrictions of food, restrictions are for sick women. I would have taken good food like *'hariyar sakam'* (green vegetables) and *'so bili'* (fruits) but we can't afford".

Case 2 –

Kumisila Marandi (20 yrs) has 5 members in her family that includes the father in-law, her husband, and her elder son who is one and a half years. She gave birth to a son five and a half months earlier. Her family is not able to feed themselves round the year just depending on the cultivation so they have to borrow money from people and then gradually pays them back with some amount of interest.

During her pregnancy she did not eat much. Kumisila and her family usually eat the normal food i.e. rice and dal, and occasionally if affordable they have vegetable, or sometimes the local vegetable that they grow. She knows that one should eat more

during pregnancy, but cannot afford. People suggest that one should eat green leafy vegetables during pregnancy.

Case 3 –

Suhagini Hembrom (26 yrs) has four children, and her youngest child is one and a half months old. Her family has 8 members. They are not so poor, as she doesn't have to go out to work as '*manjuri*' or as wage laborer. Her husband and father in-law manages the house through agriculture and by working as wage laborers, but she works on her own field.

When asked about food, she said *"hisab te jom jur ra, bang do adi jasti, bang do adi kom"*, which meant *"one should eat in a balance, neither too much nor too less"*. She eats less food and when asked why she eats less, she said *"by eating more the belly becomes big, which gives a feeling of heaviness"*. And for them the feeling of heaviness means feeling inactive and lazy.

Case 4 –

Heleni Marandi (20 yrs) has a 5 month old daughter. While she was pregnant she used to eat a lot of food. Her baby was much healthier than many other children whom I saw. She told that while the baby was in the womb, one should eat *'hore dal'* (kurthi), as it cleanses the body. Among fruits one should not eat apple as people says it is a cold fruit, therefore the baby can also get cold if mother eats apple.

Case 5 –

Bale Murmu's (26 yrs) family has seven members- her mother in-law, her husband and her four children. The youngest one is a baby boy of 6 months old. While she was pregnant she wanted to eat a lot, but she said it all depends on affordability. She ate the usual food – *'daka utu'* (rice-dal). She did not have milk or fruits which she wanted to eat and drink. The only restriction during pregnancy, was not to have *'tadi'* i.e. 'todi', because it is raw, and can catch cold and pneumonia. She was suggested to have green vegetables but that again was a question of affordability.

The case studies show that affordability is the important factor determining the food pattern. Many household are not able to afford wholesome food even during pregnancy. When food is limited, the distribution is also influenced by the patriarchal structures in which the women including the pregnant become the last priority. Few of them simply did not eat because they felt vomiting and nausea. And were suggested to eat more of fruits and sprouts, and were told not to eat *'mirich'* (chilly) and *'khatta'*, like *'amla'* and *'jojo'* as it lightens the blood. So we got to see the kind of differences in the food pattern among the women of the village.

Ante natal care

The status of ante natal care given to the pregnant women in that area is very poor. And it is also determined by many variables. Antenatal care (ANC) refers to pregnancy-related health care, which is usually provided by a doctor, an ANM, or another health professional. ANC should monitor a pregnancy signs of complications, detect and treat pre-existing and concurrent problems of pregnancy, and provide and advice and counseling on preventive care, diet during pregnancy, delivery care, postnatal care, and related issues (NFHS 3). In India, the RCH programme aims at providing at least three antenatal cheek-ups which should include a weight and blood pressure check, abdominal examination, immunization against tetanus and folic acid prophylaxis, as well as anaemia management (Ministry of Health and Family Welfare 2005)

Among the above mentioned activities, the women in this area receive the minimal care. Under the ICDS, the ANM of an Anganwadi is suppose to keep a record of women who are pregnant and visit them time to time, give them iron, calcium and vitamin tablets. But here in the village with most of the women I talked to, had not been given the iron tablets. Only the privileged one received the tablets. Although they received tablets they were not told about the tablets. They did not know whether it is a calcium or iron or vitamins tablet. They just know that they are being given some tablets. And it is only once that they receive tablets. Only one or two among the women I talked had received the injection of tetanus toxoid. A few women who were regularly being visited by quacks received injection by quack itself.

Apart from this, the services rendered by the PHC are very poor in this regard. Even the ANC records are not kept well, but I saw a contrast in the service rendered at the PHC and that of the Mohulpahari Christian Hospital. The ANC check-ups are up to date there with each register

maintained for the different visits made. However, the services are not affordable to all the people in the area.

Superstitions followed during pregnancy

We also noted a few superstitions regarding pregnancy. A few among those are that while a woman is pregnant, she should not go to places which is said to be haunted places in the village. They believe that if she goes there her child would die in the womb itself. It is also believed that a pregnant woman should not sleep outside; she should always have a roof over her head. The bad spirits also roam around, which can bring major complications in the pregnancy. It is also said that if the shadow of *'puni'* bird falls on the pregnant woman then the child may be born or later become *'puni'*. *'Puni'* is rickets in santhali.

Changes in the above across generation

We observed that the practices during pregnancy among the Santhali women have not changed much. There has not been much change in the amount of rest that the pregnant women take, generations earlier also they use to hardly have any rest, and do the same amount of work, toil hard day and night. And even today they have the same condition, work so much so that one gets hardly any time to rest. 'Care' wasn't really taken of the conceiving mothers in older times because they themselves were supposed to be the custodian. They were expected to take care rather than them being taken care of.

There has been seen a few changes in the work pattern; the resources were scarce in the earlier period and in that situation it was the women who suffered more because they had to manage the households. The situation regarding materials needed for the household is better although the affordability is an important issue here as well.

But the natural raw materials, which they usually obtained from the forest, have really become limited and scarce. These forests which were a source of so many things for them, ranging from the fire wood to fruits, medicinal plants, plants and trees useful to make certain equipments etc.

have become depleted. The forests and the trees seemed to be their best friend, the benefactor and the giver. And this friend of theirs is being taken away by de-forestation.

The food pattern almost remains the same over generations. The patterns which the women now follow are those taught by either their mother in-laws and or mothers. The suggestions and restrictions given or made by women are those of the older generations only. Now they eat normal food consisting of rice and dal. As during earlier times, they use to have inferior paddies, they did not have rice. And not everyone could cultivate rice, as it was more expensive to nurture it. They mainly cultivated *'kode', 'janhe', and 'gundli'* what they call in santhali, in order to eat.

Talking of the ANC and Maternity care we see that less of care was taken from the ANM, less of visits and irregularity in distributing the medicine was basically found.

Practices at the time of delivery and post partum period

Various practices are reflected regarding the decision of the place of delivery, preferences and actual use of birth attendants, expenses involved in deliveries, home deliveries, and food restrictions during lactation, resuming work after delivery, family planning practices etc.

Place of delivery

One of the important thrust of Reproductive Child Health Programme is to encourage deliveries in proper hygienic conditions under the supervision of trained health professionals. Most of the deliveries in the village were home deliveries. Among the 17 in depth case studies that I took only two had institutional delivery. Otherwise rest of the 15 births that took place or which the family plans to have is home delivery.

Preferences and actual use of birth attendants

The preference of almost all people in the village except for one or two families was that of the conventional one, to call the *'dom budhis'* i.e. Dais, who are untrained. They have been in their profession for generations. They prefer the *'dom budhis'* as it has been followed since many years, and they find this the most simplest way to get a baby born, with not much complication involved. The other reason which apparently comes out from my study is that among the santhal

community, the pregnancy and the birth of a child is not glorified, it's just a normal phenomenon for them. Many women in the village give birth to the child in the field during work, or during some other unexpected time, and soon after they also continue working. So they have an attitude of taking pregnancy as a normal phenomenon and so they find it best to call a *dai*. One more reason for preferring a *dai* is that other form of deliveries costs them more than they could afford.

Expense involving deliveries

Even for 'dom *budhi'* , there involves a certain fixed cost.. But each *'dom budhi'* or *'dom ayu'* has their own fixed cost which may differ. And this cost is not in the form of money but in the form of 'dhan' grain. Generally dais in the village demand 8 *suli* for delivering a baby boy, and 6 *suli* for delivering a baby girl. There is a gender difference in the amount of grain demanded, as the birth of boy child is comparatively overvalued. I found that *'dom budhi'* took 3 *suli 'hudu'* (dhan) for girl child and 6 *suli 'hudu'* for the male child. In yet another case *'dom ayu'* took 5 *suli 'hudu'*.

Before or after pregnancy, if the woman gets a stomach ache, for which a *'dom ayu'* is called for massage so that it causes relief to the pregnant mother or the woman. In that case she demands 3-4 *pai 'chawli'* (rice). And every time she comes to massage her; she will take that amount of *'chawli'*. Here the measurement goes like this –

$$20\ pai = 1\ suli$$

'Pai' is a small round instrument made of bronze to hold some amount of grain.

The process of home deliveries

The processes of deliveries conducted at home were widely found to be similar in the village. The technique remains the same everywhere. As mentioned earlier, even when a woman is pregnant, she has to work till the last moment. At times when the labour pain is very intense the *'dom budhi'* is called to rubdown the pain. In most cases *'dom ayus'* are called during the last minute. Sometimes they give a massage, setting the angle of the baby in the womb, so that he/she is born in a right manner. After that when the baby is born, the umbilical cord is cut with a blade normally kept in the home. In one or two cases only, the blade was boiled before cutting; otherwise mostly the blade was used without sterilizing it. And before cutting, the cord is tied at

one place with any normal thread which is kept at home. Soon after baby is born, in few cases he/she is bathed with warm water, and a few other cases the baby is wiped and rolled in a cloth. A few other women also took care to get the blade boiled before cutting the cord. Following it, a cloth is tied to the waist of the mother, who just delivered the baby. Then she is made to lie down on the cot and just down the jute cot is kept *'bursi'* (angara made of left over burnt wood), which warms her back. This is done so that her body becomes firm, which they believe becomes loose after delivery. When the cord is cut, the oil is applied on the stomach and rubbed and massaged for a while.

Food restriction during lactation

There was the same kind of restriction on food the way it was during the pregnancy. The woman is not permitted to have chilies, nor any sour (khatta) food like *'amla'*. They do not take liquor, as it can catch cold both to the mother and the child. Otherwise t women are found to be eating normal food during lactation i.e. *'daka-utu'* (rice-dal). A few said that one should eat *'masoor dal' (hore dal)* and *'papita'*, by eating these, the milk secretes faster.

Working pattern after delivery

In the village, there were just a few women who did not work for at least one month after delivery. Otherwise in most of the cases mothers soon after delivery resume their work usually within a time span of five days, a few women after two weeks, and in very few cases after three-four weeks. But initially they avoid heavier works like pouring water from the well, or road work, which most women do in village. They also avoid heavy work in the fields.

Family planning practices repetition

Talking of the family planning practices, it seems from the fertility rate of the women of the village that people do not really follow any family planning practices. Given a life which they lead, they want more helpful hands, so they continue having children, and have at least four and five children. And when they finally decide not to have children, due to the reasons of poverty then the family goes to traditional healer and get herbal medicine *'rehe raan'* in order to stop

having children, that too women would only have to take the medicine. People do know about the sterilizations, but they fear having got it done, and their sole faith in the method of family planning is that on the herbal medicine. In my study there were two families who said they would go for sterilization, but again it would be tubectomy done by women. In case of family planning, there again shows biasness towards men, who are said to be strong and more working. And so if they go for vasectomy then they will grow weak, and hence further won't be able to work, and not earn for the family.

Beliefs and superstitions during post partum period for women and child

Among the main practices being followed after delivery was tying of the cloth round the waist, which was done so that the *'gidra oda'* that is the uterus doesn't move or come out. And so it is kept tied for a week or so, till the women feels a bit stronger. And in a supplement to this there are done massages in the stomach of the women so to settle the *'gidra oda'* i.e. uterus. After that, the idea of giving a *'bursi'* (angara made of left over burnt wood) under her cot is also their belief that it would soon make the women stronger. There is a belief of burying the placenta right near the entrance of the house. That too right under the entrance of the house, they believe that if it is buried deeper then the next child will be born a bit late, and if it's buried nearer to the surface, then the next child would be born faster. One family said that it should be buried outside house, or in the *'gali'* towards the left side of the house. The other belief is that one should bury the umbilical cord also in the house. Some believed that it should be buried near *'jarhi'* (it is a place where all the time water flows, or water passes). It is their belief that by doing this the child would not feel thirsty when he/she goes out. Santhals feel that their life is mostly spend out working, searching for food, hunting, in field, and so they naturally feel thirsty, so by having that practice done of burying the placenta the person would not feel thirsty be it woman or a man.

Changes in the post-partum practices across generations

As found out by talking to older women and the younger ones, the changes in the practices of the post partum and at the time of delivery have been seen in one or two generations, but the changes have not been sharp, and at a few places these changes are negligible. As far as the place of

delivery is concerned it, evident from the study that it has not changed by and large, but there has been seen a slight change place of delivery. Few families have started going for institutional deliveries, though it costs them and pays a lot. The preference of the birth attendant has also not changed, with maximum deliveries taking place in the village. Presently there are only a few families who decide to have the deliveries at hospital or at the private clinics.

The expenses of deliveries have changed. Earlier the *'dom budhi'* used to demand less of *'pais' of 'hudu'* (dhan), which has now increased with the time. While the process of delivery primarily remained the same, just the instrument to cut the cord changed, a few old women told that earlier they used to cut the cord with *'zhinuk'* (flat shells - Hard outer covering or case of certain organisms such as snails). Some other women reported of having cut the cord with *'holok'* (an instrument made of iron and wood especially made to cut the cord). After cutting the cord no dressing was done then, and much is not done even now. And the restriction during lactation also remains the same, because it is a simple society which has not much changed at least in terms of their beliefs and rituals. The work capacity and even the time of resuming work after delivery more or less remain same. Most of the older women said that they came back to work within 5-7 days. The other difference found between the generations is that earlier women exclusively went for herbal medicine *'reha raan'* for family planning. But now at least a few people have gone for sterilization, or even thought of getting it done. There is a slight difference in the willingness to even stop having children. Otherwise the attitude earlier was that *'hui na tobe hui na'*, which in hindi is *'ho gaya to gaya'* (whatever has happened has happened).
In areas of superstitions and beliefs similarly nothing has changed, and it is the beliefs and superstitions that are being carried on from the older times and are practiced with the same faith.

Child care practices

There are various child health care practices which are followed among the santhal society.

First feed

Though most mothers now feed their baby their own milk but still there are such mothers who waste their first milk and feed the milk of goat. Or they feed them the honey or sometimes they get some medicinal plant from mountain, and feed the juice extracted from it to the baby. They

believe that by feeding them all these the baby would grow stronger, and feeding them these before anything else or even before the mother's milk would increase their immunity towards various health ailments which they call it as *'karon'*.

Feeding colostrums

There were many women who fed their child the colostrums.. When I asked them why did they feed it to baby, they said they have heard that it contains something that would help the baby in future as the baby grows. So when asked why they feed the colostrums, they said that the first milk contains all the medicines and tonics and vaccines that they have taken during their pregnancy. And so they feel it's important to feed it to their children. A few women were also given iron tablets, calcium tablets.

Breast feeding

The women of this village are not quite regular in breast feeding their children, and it's all because of their work loads. They are so over pressured by the labour they have to do that they do not get the time to feed their babies. The time span till which they exclusively breast feed their baby is 6 months. Many women would just breast feed their child till 3-4 months. And mostly the weaning starts when the baby is 7-8 months.

Vaccination

Most of the children in this village have not taken the required vaccines. It is only those families who have been visited by the ANM s or *Sahiya* only those children are vaccinated. Majority did not give vaccinations simply because they thought they are fine without it. Some thought that vaccines can bring some ailment to their children and it is alien to them. They would rather go to herbal medicine than taking any vaccines.

Looking after children when mother is out for work

When the mothers are out for work sometimes when the baby is still an infant, in that case the mother in-maw looks after the baby and feed some 'pulse's water' which they call *'dal raasi'*. And many times the older kin takes care of the little babies but they are not able to feed them anything. In cases where the family is nuclear and then in that case mother carries the baby to work. She either keeps the baby nearby, or simply ties the baby with her waist.

Infant morbidities

In this village and mostly among santhals infant morbidity is very high. There are various morbidities which I could find the names from my interactions with the villagers.

'Kala Dhaba' – if a baby is suffering from this disease then in that the brain gets separated, this is what the mothers said. The baby doesn't feed the mother and continuously cries. The child shivers and cannot inhale or breathe properly. Also the size of the brain expands.

'Chura Dant' – when a baby suffers from *'chura dant'* then the baby is caught with dysentery and fever, the fingers and toes get hardened becomes white.

'Puni' – if a baby is suffering from *'puni'*, then the child's hands and legs get thin, weak, and small.

These were the main diseases found among the children of the village. But apart from these, they also suffered from malaria and jaundice (*'hamus'*). *'Rabang rua'* i.e. pneumonia was very common among babies.

Superstitions in child care

The birth of the child brings along some level of superstition, and one commonest superstition in child care is the ritual of *'Lai Tuba'* i.e. the branding of the stomach. In this the stomach of the child is branded with red hot iron sickle. The sickle is called *'datrom'*, most commonly used for branding the stomach. The juice of a medicinal plant which they call *'Dhelwa'* is extracted which is put in the edge of sickle used for branding the stomach. And this is done within two three weeks of birth of a child. And this process is repeated 3-4 times every week and goes on to three-four weeks, which causes utter pain and suffering for the child. By doing this they believe that

the child would not suffer from any stomach related problem in future. And it is dutifully done in every house where a baby is born. In case if a *'dom budhi'* is called to do the branding, then she demands 3-4 *'pais' 'chawli'* i.e. rice each time that she comes to brand. Otherwise in most of the cases the father in-law or mother in-law does the branding.

The villagers also believe that a child can be cursed by 'aha' (evil eye), due to which he/she can suffer any unknown disease and so they make the child wear amulet which is thought have a magical protection against evil or diseases, and which could breach the 'aha'. Also they are put *'aynom'* in their forehead which is thought to break the 'aha'.

Ceremonies and rituals during pregnancy and after child birth

When a child is born in a santhal family, they also have a big ceremony for the child. After five days of birth, they organize a big ceremony for the new born child called *'Nim Da Mandi'*. This is a name-giving ceremony, and almost the entire village is invited in this event. This ceremony of *'nim da mandi'* gives a social permission to the mothers and child to go out and interact with other villagers, or to access the well for water, where generally woman comes together. It is also done to defy the 'Aha' (evil eye) of the people. One of the women said during the interview, *"nim da mandi te chuth huyu aa, bakhaye do hor ku baku galmarawa abu songe"*, which meant that "*nim da mandi* gives us the sanction to interact; otherwise people won't even talk to us". So it is a mandatory ritual for santhals and an integral part of their social life.

Changes in the above across generations

We see a few changes across generation in the above. Most of the women feed their own milk as the first feed, though there are women who feed something else but not their milk to the baby. But earlier most mothers used to feed goat's milk, honey, or some medicinal plant juice.

Presently women in large number feed the colostrums to baby. Regarding vaccination, still today mothers do not have access to various vaccines that her child has to take. And they are accessible to only those whom the health workers visit regularly.

Many children grew up without undergoing vaccination. Earlier women carried their children to work, as most of the time they would go to neighboring states as migrant labor. But now even when mother is out for work she is not able to carry her child, and instead left to be looked after

by the older kin or the mother in-law. Among infant morbidities, children continue to get the same diseases which they used to get in older times.

Even the superstitions continued to be the same as it was generations before. Be it the branding of stomach or wearing of the amulets. If we talk of the ceremonies, one major occasion is that of *'nim da mandi'*. But when I talked to an older woman, I found that more rituals were followed during those times. One interesting aspect according to Munni (65 yrs) is that every time there was a delivery to be done, apart from the *'dom budhi'* an *'Ojha'* was also called. He would chant some prayers and apply oil on the belly. He himself would pour the oil and they believed that it will cure and heal any complication. Also, they believed that when the *'dom ayu'* apply oil thoroughly, the baby acquires an angel which would help the delivery.

There is another ritual practiced during a generation before as told to me by Dhina Marandi (56 yrs). After three days of the birth, the hair from the head was shaved-off in a small area. Dhina did not know why this was done. .She continued to practice it. After this the *'dom budhi'* comes, she makes the baby sit on her lap, and she sits on the entrance of the house. Then she takes a long leaf, *('kahuk sakam')* and gives it to the mother to drink water from that leaf. The *'dom budhi'* again takes *'kansa bati'* – a brass utensil and pours water and the mother has to drink water from it. When she wipes her face, head and neck then the baby is given back to mother.

Summary

The villagers go to three places for treatment as observed from the study. The herbal medicine was the most common of all to which people went for treatment. Though it was a resort for most of the ailments in the village but the area of family planning was such where people have more faith than in any kind of contraception method. There were a few others who went to Ojhas for treatment. On people's side the expense of treatment was a major reason for getting the cure done by the indigenous healer through herbal medicine. They also stick to the herbal cure as their conventional mode of treatment. PHC was another place where only some people had the experience of going, and the experience they received in terms of Provider's attitude and behavior, made a consensus by most of the villagers not to visit the PHC. One interesting trend that was seen among people was easiness in accepting the western or the allopathic medicine,

provided it is accessible to them and within their affordability. The people in village use pluralistic form of medicine, they accept all kind of medical system, provided the system builds the trust among peoples which is very important for a community where the kinship ties are very strong. Here in the village people trust each other's experience and words so that becomes very essential for the providers to keep things in mind and work for the section in a proper manner. When we reviewed the few national programs in the Shikaripada we found that catering staffs and para medicals were less enough than required for large population which suffered from various diseases like malaria, tuberculosis and leprosy.

The women do not take up their ill-health seriously until their illness becomes hurdle in their work. This also because their top priority is their everyday work which they cannot miss and their work pattern is so rigorous that it takes a price out of their life. They never rest during their pregnancy and even after the pregnancy as they have no one to assist them at work. They have few taboos associated with food pattern, but they lack high nutrients in their food. The antenatal care provided to pregnant are very poor in the village, even the superstitions which followed earlier is carried on till date. Other practices relating to pregnancy has not changed across generations. Even the place of delivery and the preference of birth have been the conventional one i.e. home delivery and the TBAs. The process of delivery conducted at home also remains the same; the superstitions related post partum has not even changed. A few families still gives their baby the first feed something other than milk. Many women in the village fail to breast feed their baby for longer period as they are so burdened with work and are out in field that are not available to feed their child. The little children mostly due to the negligence of ANM fails to receive the vaccinations on time; also the vaccines taken is irregular. Children suffer from much morbidity because of acute malnutrition combined with poverty.

-Chapter 5-

Discussion and Conclusion

Every human being's health is of utmost concern whether it is a man, women or a child. Women and children comprise of 2/3 of world population and together share a relationship in which health of one depends upon another. This unique relation shared between a mother and a child as single entity is an important field to be studied in detail. Overall the health of a woman is of great concern, and when we come down to reproductive, maternal health and child health the conditions are the condition is all the more deteriorating. Even amidst this worsening condition the section or the group which calls for concern is that of the tribal community or group, which performs the least in all health indicators, including the area of maternal and child health.

In this backdrop, the broad objective of my present research is to study the Maternal and Child health care practices among Santhal tribes of Dumka district, Jharkhand. The specific objectives are 1) To study the patterns of maternal and child health care practices (institutional or home deliveries), 2) To study the health care practices across generations. As we focus on the tribal community in Jharkhand, we have explored available studies that have examined their present conditions. In order to assess their situation we studied the All India picture and compared it with Jharkhand and Bihar. We also evaluated variation across social groups and located the status of Scheduled tribes. These studies further paved the need to carry out the present study i.e. Maternal and Child Health Care Practices among santhal Tribes of Jharkhand.

The literature review points to the need and importance of research on this most vulnerable section of the society. Though their overall health is of great concern, the health and nutritional status of two most important section of any society i.e. woman and children who constitute 63 percent of the population needs greater focus. The nutritional status of woman has a direct effect on her reproductive life and on the babies born by her. Neglect of women's health directly gets transformed into worsened child survival and has important consequences for health outcomes in terms of morbidity and mortality. A review of available studies shows that women and children is imperative both for quality of their lives and for the survival and healthy development. To have an adequate nutrition is a human right, therefore the nutritional benefits should be evenly dispensed in, and it needs to be viewed as an important objective. Studies show that though

internationally there has been a secular enhancement in most of the health indicators, India still lags behind in many domains. Though IMR has fallen and life expectancy has increased but the area maternal and child health continues to perform poorly. This is demonstrated in the prevalence resulting high MMR, malnutrition and undernutrition among both women and children. Low birth weight (LBW) is one of the major public health problems since one third of the babies born in India suffer from it. Several studies show that poor foetal growth is attributed to widespread maternal undernutrition. Other studies show that the first 3 years of a child are critical and a significant percentage of rural children are below the average physical growth. The study conducted by the NNMB, highlighted that around 63% of preschool children suffer from stunting, which is indicative of long term chronic malnutrition and 17% suffer from wasting which indicates acute or current malnutrition. NFHS III data suggested that almost half the children who are less than the age of 5 years are stunted and 43% are underweight. Studies also show that although malnutrition in India is prevalent across all segments of the population, in the case of women poor nutrition begins during infancy and continues throughout their entire life. These studies clearly point to the variation in undernutrition across gender, class and caste.

Prevalence of anaemia among women is a sensitive indicator for the nutritional and health status of women and children. According to WHO reports, the prevalence of anemia among pregnant women in India is 87.5% and 56% in under-5 children. We have witnessed a declining trend in the risk of dying during infancy and childhood and maternal mortality but the situation is still not very satisfactory. When the health indicators are disaggregated across socio economic strata, we find that the lower strata suffer from undue disadvantage when it comes to maternal and infant survival. Going by the health status of woman and children as per various social groups, it was evident that the poor and socioeconomically deprived class carries the maximum burden of ill health and under nutrition throughout the country. Fertility rates are very high for woman in deprived groups (3.1 children per women among ST, 2.9 among SC, and 2.8 among OBCs) compared with women who are not in any of these groups. Women belonging to the STs are more prone to suffer from moderate and severe anemia and children belonging to ST have a higher level of under nutrition on all three measures (stunting, wasting and underweight). Studies illustrate that the MMR among STs (652) and SCs (584) is higher than in women of other castes (516), the key determinant seems to be access to healthcare as rural villages have significantly higher MMR (646) than moderately or well-developed villages (501 and 488 deaths,

respectively). The probability of having received any ANC care from a doctor is lowest for ST mothers and highest for mothers belonging to other castes (non ST, SC or OBC).In addition more than 68% of ST mothers did not receive any post natal check-up. The proportion of mothers receiving 2 or more tetanus toxoid injections during pregnancy was found to be lowest in mothers with no education, ST mothers and mothers of household of lowest quintile. It is also seen that only 18% of births to ST mothers are delivered in health facilities as compared to mothers non ST, SC or OBC. Another observation says that more than 50% of births to ST mothers are assisted by traditional birth attendants, while only 17% by doctor and 7% by ANM. Subramanian et al study showed that when mortality differentials were patterned by social groups, it was found that children and adolescents belonging to scheduled tribes had the greatest risk of mortality; their standard of living remained a strong predictor of mortality. The standard of living has a clear relationship to nutritional status and this is seen in the case of women of low socio-economic status who experience the greatest risk for being underweight as compared to those in the high socio-economic status who experience the risk for being overweight. Undernutrition is to a great extent related to being chronically poor when the income is below the poverty line. We see that undernutrition and poverty strengthen each other, and therefore the poor household suffering from malnutrition find it very difficult to break this vicious cycle of poverty. Studies demonstrate that productivity is low for workers suffering from chronic energy deficiency. This malnourished worker is at a disadvantage of acquiring adequate food to fulfill nutritional needs of himself and his family. Therefore his children not only fail to achieve their full growth but are also exposed to greater risk of child morbidity and mortality. The risk of malnutrition is higher among children whose mothers suffer from chronic energy malnutrition, since the nutritional status of the mother depends a lot on her childhood nutritional status, this vicious cycle of malnutrition from mother-child-mother leads to an intergenerational diffusion of poverty. Income poverty is an important component of economic and social deprivation, which is more concentrated in areas with a greater presence of backward castes and tribes. We also see that there is a wide variation among tribal and non-tribal in terms of accessibility and thus seeking health care.

Comparison of maternal and Child Health Status and Services in Jharkhand and Other States

Looking at Jharkhand through various indicators, we find that throughout the period of NFHS I to NFHS III, the TFR of Jharkhand is much higher than other states like Kerela, Tamil Nadu and Punjab. Bihar and Jharkhand have high early childhood mortality rates as compared to national average and other states. In addition, NFHS III highlights that Bihar and Jharkhand have high peri-natal mortality compared with national averages. The nutritional status of people in general and women and children in particular is very low in Jharkhand. According to NFHS II, among the under-3 age group children, 54.3% were underweight, 49% were stunted and 25% were wasted. The under nutrition was higher in rural areas, particularly among SCs and STs. Infant and child mortality rates in Jharkhand were lower than the national average and that of Bihar. The infant mortality rate in India has been estimated to be 67.6 and that of Bihar to be 72.9, the same is estimated for Jharkhand, it is 54 (NFHS II). The same trend can be observed in regard to child mortality. The ANC is almost universal in Kerela, Tamil Nadu and Goa while it is lowest in Bihar 34% followed by Himachal Pradesh, Nagaland, Jharkhand (57-59). Bihar ranks the lowest on many ANC indicators and Jharkhand follows nearly the same pattern. Nationally only 15% mothers received all the required components of ANC, it was as high as 64% for Kerela and as low as Bihar and Jharkhand ranged from 6-9%. In addition the number of teenage pregnancy is very high in Jharkhand. Overall country's most pronounced under nutrition is being reported from M.P, Bihar and Jharkhand. The proportion of women who are too thin is particularly high in Bihar (45%), Chhattisgarh and Jharkhand (43%). Prevalence of anemia for both women and men is very high in Jharkhand and Bihar where more than $2/3^{rd}$ of women and $1/3^{rd}$ of men are anemic. As per NFHS III scheduled tribes have low infant mortality rate (62) than scheduled castes (66), but under 5 mortality rate is higher among STs (96) than SCs (88). Reviews reflect that chronic maternal under-nutrition and severe poverty among the low income group pose a serious threat to the wellbeing of mother and the infant. While there has been some improvement in national figure of various indicators, Jharkhand and Bihar per se lag far behind.

Tribals constitute 36.3% of the Jharkhand population and reside mostly in rural areas. Santhals being the most common tribal in Jharkhand (34% of total tribals) are highest in Dumka district. With the sex ratio of 987 females per 1000 males, tribals of Jharkhand are even above the national average for ST population. Although there are limited studies available on tribals of

Jharkhand yet few studies provide an in-depth view of traditions and practices followed by tribals in relation to pregnancy and child birth. These practices for e.g. palpating abdomen for fetus location, cleaning the baby with oil, pressing the belly of mother to expel blood clots post delivery etc. are deep rooted within their traditions although some of them are harmful and potentially dangerous. Seeking institution based health service for pregnancy and delivery related issues are nowhere a choice among tribal mothers. The reasons include un-affordability, uneasiness, and a sense of fear associated with these institutions. As per NFHS II very few tribal women receive all the component of ANC as compared to non-tribal women of Jharkhand.

The national programmes has also addressed the issue of maternal and child health and have been formulating policies since after the time of independence. Broadly the programmes came under the umbrella of family welfare programme and ICDS programmes. In the early 1950s the family welfare programme was initiated which was primarily focused on fertility reduction through its family planning programme. Later the family planning services were integrated with maternal and child health (MCH) services as a part of Primary Health Care strategy, and services were offered free of cost at government health facilities. The integration of family planning with maternal and child health (MCH) services has diverted even the scarce resources and personnel which were functioning for women's health needs to family planning and has promoted the transfer of responsibilities of family planning solely to women. Since family planning services are made available only through MCH services, unmarried adolescents and other single women are denied access to contraceptive services. Various interventions were carried on under the purview of Family welfare programme, maternal and child care being a part of it. Schemes like National Nutritional Anemia Control Programme, TT immunization of pregnant mother and Dais training programme were introduced over the year but family planning remained a separate intervention. National Health Policy 1983 visualized significant reduction in IMR, MMR and CMR by 2000. All child health programmes were directed towards achieving these goals. Universal immunization against 6 vaccine preventable diseases (VPD) was targeted to be achieved by the year 2000. The government also launched the Child survival and safe Motherhood in the year 1992 as a part of Family Welfare Programme. The plan was to have an integrated package of interventions for improvement of the health status of mothers and children. The additional components to this programme were services like treatment of diarrhea and acute respiratory infections, essentials newborn care, and strengthening of emergency obstetric care

services. Then in the late nineties government of India launched the Reproductive and Child Health programme. The objective of the first phase was to benefit poor rural women between 15-49 and children below 5 years by improving their health condition and accessibility to health services. Another landmark in the in the interventions towards child development was that of ICDS program which was launched way back in 1975, and provides an integrated approach for converging basic services through community-based workers and helpers. The services are provided at a centre called the 'Anganwadi'. The Anganwadi, literally a courtyard play centre, is a childcare centre, located within the village itself. A package of following six services is provided under the ICDS Scheme: Supplementary nutrition, Non-formal pre-school education, Immunization, Health Check-up, Referral services, Nutrition and Health Education. But despite all these initiatives it fails to foster community participation and in building capacity of mothers which has not been achieved to the desired level.

After a thorough appraisal of resources and literatures, there evolved a need to go deep into the issue of maternal and child health among tribals, and try to get an insight into the overall health seeking behavior and the maternal and child health care practices. Dumka district, being heavily populated by tribals is blend of rural population as well as populace who are newly exposed to transformation and modern ways.

Qualitative insights

The research area i.e. 'Ranga Village' in the Shikaripada block (Dumka district) was traditionally an isolated and highly underdeveloped, in terms of modern means. Recent developmental intercessions have disturbed their normal living, taken away their support on which they are mostly contingent i.e. the forest. The tribal health has been an issue of great concern since decades; their health status has been lagging behind in almost all health indicators and especially those associated with maternal and child health.

From all the evidences it is clear that Jharkhand performs extremely poorly in compares to the national average and other states. In order to explain we have undertaken qualitative exploration to the nature of work and tiring condition among santhal tribes. Our explanation shows the status of basic needs which is minimal for them –

Food – The santhal tribes of this village struggle even for the basic requirement i.e. food. The agriculture can just suffice them for five months and rest they have to struggle for their living. This lack in subsistence leads to one crucial marker in their life i.e. the phenomena of migration. It is the part of life for many of those who cannot afford to support themselves throughout the year. Agriculture, which is practiced only for a few months, is inadequate to sustain people throughout the year. Under such circumstances, villagers have no alternatives but to leave their homes for months and migrate to neighboring states. They take children who can help them along and leave behind the elderly and infants. The seasonal migration leads to a temporary disintegration of the family, which is a major loss in both psychological and social support. The outcome of migration never turns to be an accumulation for villagers; rather it is just a matter of their continued existence. They get a meager amount of fifty rupees a day and 1 kg raw rice with a roof upon their head. Their work is extremely arduous.

Food for them only means survival. The question of nutritional food remains far behind. One fact which is evident in this village is the extreme poverty. And this lack of basic food was a big evidence of poverty. It is all pervasive and is reflected in all their aspects of life. Most of their ill health was a resultant of their poor socio-economic status. The issue of poverty which normally is omnipresent in this village was likely to affect the family also. The reason which woman gave for not getting delivered in the hospital or in the private clinic was all an outcome of poverty and lack of money. Poverty has a lot to do with peoples falling health condition. Apart from this, most of the earning is spent on medical treatment and in cases of chronic conditions, the economic condition becomes worse. It becomes clear that the families are incapacitated in terms of most of the things; they are so poor that they cannot manage to have food round the year.

Their only complain for all crises they had in life was that they are poor. Even the absolute prerequisite of health i.e. access to adequate food remains denied to the people. Indebting poverty is the major hurdle in their life course. It is the poverty and the economic structures of these villagers which sometimes in a way keep them away or beyond the functions of the health services systems. The tribal population of this village is a live example of those hit by hunger, powerlessness and ill-health. This reason (poverty) behind all infirmities calls for larger structural changes in the society, and government institutions including health services institutions should take proper steps and interventions in going about people needs in these areas.

Education – The basic right towards education is also not available for the people of this village. There are two primary schools up to class V, and only one accessible to the tribal population, which further becomes difficult for them. There is absence of any secondary school further impeding their learning. Moreover education is accessible to few who can afford it. The government's incompetence to provide better schools has led little children being deprived of their basic right to education and thus fails in building a better future for them.

Water - The area was deprived of basic amenities like electricity and pipe water supply and toilets which all had an indirect effect on people's life, making each of their days a toiling one.

Health – Right to health is basic to all human beings, which equally holds true for tribal population. The tribes of this village suffer on many grounds of health. Both men and women suffer, but it is women who experience more burden of ill-health.

Women's Health - The study was able to highlight the following issues related to women's health. Most women in the village do not consider themselves ill. They always feel they are well and fine until their illness interferes with their daily chores. The moment their ill health hinders their work, they realize that something is wrong in their bodily mechanisms. Almost all women interviewed and studied have gynecological problems, although initially none of them accepted but after deep probing each of them came out with various problems i.e. weakness, white discharge, back ache, pain in lower abdomen, joint pains etc.

Access to ANC – the status of ANC is very poor in this area. Women hardly receive any antenatal care. The pregnant women are never visited by any ANM so there is no question of ANC care. The women in this area receive the minimal care. The ANM was all through criticized for not performing her duty well. Under the ICDS, the ANM of an Anganwadi is suppose to keep a record of women who are pregnant and visit them time to time, give them iron, calcium and vitamin tablets. But here in the village with most of the women had not been given the iron tablets. Only the privileged one received the tablets. Although they received tablets they were not told about the tablets. They did not know whether it is a calcium or iron or vitamins tablet. They just knew that they are being given some tablets. And it is only once that they receive tablets. Only one or two among the women had received the injection of tetanus toxoid. A few women who were regularly being visited by RMPs had received injection by them.

Apart from this, the services rendered by the PHC are very poor in this regard. Even the ANC records are not kept well, but there was seen a contrast in the service rendered at the PHC and that of the Mohulpahari Christian Hospital. The ANC check-ups are up to date there with each register maintained for the different visits made. However, the services are not affordable to all the people in the area. Above all this, their health is given a blow when ANM fails to inform the mothers about different vaccination leading the children to go without having any vaccines.

Lack of accessibility of health care and Attitude of health service providers – people in the village had major problem in accessing the health services. Women from one tola found it very difficult to go in other tola for vaccination during their pregnancy. When preoccupied with innumerous task women feel burdensome to commute in the hilly terrain go to PHC. What comes out is the lack of primary health care to the people when they need them the most which the health workers such as the ANM fail to deliver. How can one expect a pregnant woman to leave her work and walk down around 2 kilometers in such a hilly terrain to get the vaccines done? The Anganwadi do not function properly in the village. Villagers complained that they are not seeking proper services from it. Cost of medical treatment was a major reason for them not to resort to modern treatment. The herbal medicines were much cheaper and affordable for them so it came as an easy option of treatment. In most of the in-depth case studies conducted, it was informed by the people that cost of treatment to a considerable extent decide their preference of types of treatments (traditional or western).

Through our study it came out clearly that health service institutions did not function properly and were not up to the mark. It failed in gaining people's confidence to a large extent. Even the provider's attitude was ineffective in these health institutions and people were never satisfied as they often failed in diagnosing the disease and repeated the same medicine for any sickness the people suffered. Study shows people's faith towards Mission hospital and also demonstrates that they are not in particular against the of western medicine but it is the kind of services provided by public health services, or way of rendering service, which are not sensitive towards people. They do not trust the health services provided by the PHC. According to them, PHC or the government hospital is a total failure and people fear to go there. In addition, the services rendered are also irregular, reflecting the lopsidedness of the larger program implementation.

Women's burden of work – Santhal are a patriarchal society and they practice the terms of patriarchy in their day to day life. Women in this male dominated society have the maximum load of work in the family at the household level and in the fields. She has to perform all tasks irrespective of her own health status, whether pregnant or not, by virtue of being a woman. The tough life of santhal women in this village is preoccupied with whole range of works. It is this range of work that starts in the early morning and goes on till the middle of the night, affecting the women's health in a negative manner. They do not realize but they enter into such vicious cycle of work which continues all through day, and a women keeps working day and night. Among men and women the work is not equally shared, and it is the women who carry most of the burden. They have been an equal partner in the entire agricultural work. Apart from this she takes up all the allied work such as looking after the livestock, getting the ration for home etc. The entire tasks for which woman is most associated with and is largely considered to be the domain of a woman is her household works which further has its own diversities. Though cumulatively this range of effort including household and agricultural works consumes their energy, they still keep doing the strenuous job with ease. As the society in which they are prepared to trains them that it is a 'women's job', a woman cannot think beyond. It is the load of work that often leads a mother in failing to feed her baby till required time, or feed irregularly.

Work leading to no rest - While studying the traditions and care practices related to pregnancy and child birth, one facet was obvious that people carried on with their own traditional practices. It was believed that occurrence of pregnancy is a normal phenomenon for women, so they should keep their routine as usual during pregnancy as they have it in normal days. Absolutely no rest is taken during those nine months and the word 'rest' seems alien to them. The women are preoccupied with so many works that they do not have an option other than working themselves, as they barely have any helping hand. The study reflected the range of work a woman does in her normal day clearly depicting that rest is not meant for them. The society has not made things simple for these tribal women. In addition, on entirety the impoverishment of the whole community in terms of intake of nutrients and supplements has been directly affecting the health of the pregnant women. On the one hand deep rooted poverty has crushed their health; on the other hand the institutions have not been fair with them. Study reflects the incapability of the health care providers and health workers in rendering services to the tribal women. Study reflects the incapability of the health care providers and health workers in rendering services to the tribal

women. Women failed to get any kind of help or support from the ANMs, not even the basic ANC services. On the contrary the mission Hospital had a better image and villagers were fairly satisfied with its services although most of the villagers could not afford the services.

Patterns of delivery – As evident from the study, most villagers preferred home deliveries than institutional deliveries. People have strong grounds not to go for institutional deliveries; most importantly they have less access, cannot afford going to health institution and they find it safer at home only. Even their preference for the birth attendant is guided by such factors, they feel pregnancy is a normal thing and it should be dealt normally, and so they call up traditional birth attendants. Calling a traditional birth attendant is conventional; this is also why they go for it, but most importantly as they cannot afford an institutional delivery, they prefer calling TBAs. The expense involving a home delivery is much cheaper which villagers can easily afford, and those who cannot, are helped by some relative to get the delivery done.

Women's failure in Decision Making – Our in-depth interviews with women revealed that decisions were mostly made by men. In most of the family affairs, whether concerning financial or social, women have almost negligible say in it. This is especially evident in the area of family planning where women do not share any role either in decision of accepting it or denying it. In addition, decision regarding the mode of family planning is also taken solely by the husband. The fear associated with permanent sterilization, especially the loss of power, is so intense that women do not prefer their husbands to be sterilized. They rather believe in sacrificing themselves, if in case there is any mishap associated with the family planning operation. But Santhal society has a liberal view in the matter of re-marriage. Matters of domestic violence are also prevalent in the village, but is kept in a secret manner and not talked about much.

Women's social status – The woman's status all through has shared a second place in the society. Likely the tribal women of this village shares an inferior place to that of men and often not acknowledged for their work. Even the customary laws are not in favor of the women, all the properties are passed on to the son, and the unmarried daughter is even deprived of immovable properties. The practice of witch killing was also very common till few years back but now it is surreptitious, people fear doing any such act in public.

Dependence on herbal medicine – For any illness is it minor, or major ailments villagers went up to the herbalists and took *'rehe raan'* and especially for contraception people have full trust on herbal medicine. Even for gynecological complications women take herbal medicines. Even for the problems such as non secretion of milk, which majority of women suffered, it is the herbal medicine which the husband gets for his wife after birth of a child.

For most of their ailments the people commonly resort to this particular mode of treatment. It was evident from the study that people seldom went for other remedies except for herbal medicines. For minor ailments like fever they have the local doctors or the RMPs and for any major problems they would go to hospitals. However, for most people hospitals are unaffordable. People have major inclination towards the traditional medical systems and especially have faith on herbal medicine. It is mainly because the herbal medicines have managed to build in people's trust since ages and the government institutions fail in doing the same.

Belief in plural medical system – The village 'Ranga' was exposed to both types of medical system i.e. traditional and modern or western. Apart from it they have homeopathic medicine at their reach. Among the traditional medical system they have two kinds of treatment – one through herbal medicine and the other where they believe in the supernatural causation of diseases and seek treatment through *ojhas*. It came apparent that villagers do believe in the allopathic medicine; they do go for the western medicine but also carry their traditional practices. One of the respondent went to hospital for the delivery, and took almost all the medicine and vaccines, but she also got her child branded which again is a traditional practice, which means people do go for western allopathic medicine if it is accessible, and if they have faith in it. It also shows the varied choices of people where they are not totally against the western medicine as they are always thought to be, because of their illiteracy or their 'culture of poverty', which does not hold true. Here we see that when accessible and when affordable people do go for allopathic treatment, but they need to have that extent of faith in that particular treatment, which again do not come in a day or two. This faith has to be built gradually, as with the tribal people of the village, these ways of treatment sinks into their life and such failure which comes about with the health services can impossibly make place between tribal people.

Changes in the practices across Generation – There were various child care practices after birth followed by the villagers. Many believed in giving something other than milk as the first feed thinking that it will make the child fight against different diseases in future. They also go for branding of stomach seeking a future relief for the baby for any abdominal problem. Half of the women being studied did not feed colostrums, and were irregular in breast feeding their baby, due to workload and conceiving within 3-6 months after birth. But in many families women have started feeding colostrums, and mother's milk as the first feed, this change in the practice has occurred. Locating all the present practices what came out clearly was largely unchanging practices across generations, apart from a few changes in the work pattern. Except for minor changes like fee charged by TBAs, not many changes have occurred in the child care practices and practices during pregnancy.

There has not been much change in the amount of rest that the pregnant women take nor in the work pattern. Slight better change has been seen in terms of the food undertaken and grown, earlier they use to have inferior paddies such as *'kode', 'janhe', and 'gundli'* what they call in santhali, but now mostly they grow rice.

As far as the place of delivery is concerned it, evident from the study that it has not changed by and large going for home deliveries, but there has been seen a slight change in place of delivery. Few families have started going for institutional deliveries, though it costs them and pays a lot. 20 percent of houses visited had the institutional delivery, they are ready to go for the change until they can afford it, and can access it. The preference of the birth attendant has also not changed, with maximum deliveries taking place in the village. The expenses of deliveries have changed. Earlier the *'dom budhi'* used to demand less of *'pais' of 'hudu'* (dhan), which has now increased with the time. But the process of conducting deliveries has largely remained the same.

Earlier women carried their children to work, as most of the time they would go to neighboring states as migrant labor. But now even when mother is out for work she is not able to carry her child, and instead left to be looked after by the older kin or the mother in-law. Another interesting change which occurred is that compared to earlier days now few rituals are being carried on regarding pregnancy and child birth practices.

Changes told by the older women are that now a day's 'Manjuri' has increased due to which people's livelihood is going. 'Manjuri' is working in construction sites or in crusher. The government scheme of making roads, well, dams, and ponds has given temporary employment to the people. they repeated that now a day's people cannot get much out of agriculture, one who has acres and acres of land can only depend all through agriculture.

On the whole, it is seen that although the practices have not changed, one cannot blame them for this. It is sheer lack of resources and extreme poverty combined with non-availability of services, the non-functioning of the health workers which result in this scenario conducive to ill-health.

Importance of kinship and people's shared experience – the study finds out that any decision taken in regard to health services utilization, ANC check-up, etc., people's share experience which then are used for deciding any future responses towards it. The message passes on very effectively, as people trust each other, and any experience with one would mean experience with the whole tribe or village. The way people are treated at the health centre or negative experiences towards family planning etc are all analyzed by the village collectively. These shared experiences of people are a decisive factor for the formation of their opinion or judging a particular health system, whether it is a failure or a success to them. And when such experiences get reiterated then they finally pass judgments that health service system is bad. From various case studies we encounter the malfunction of the Anganwadi and health services.

Conclusion – Through our insights it is clear that the basic minimum need of people are not available to them, even if available either they are scarce or not accessible to them. This study creates a need to look and think deeper in to this matter. And find ways to intervene properly into the matter. There are so many aspects which revolve around the basic need to health and food, if the policies cater to it properly, the situations can turn out better. But this policy has to be kept sustained in order to have a good result. As from our study one mode of treatment which came out to be most influential in that area i.e. herbal medicine should be made a bridge between the public health services and the villagers or tribes. Study shows that people are not particularly against the western medicine but they are against the kind of services provided by public health services. The programs should be such that it should be able to make inroads in to the village with sentiments and beliefs and practices of people by integrating with the herbal medicine. This

strong belief and evidence in herbal medicine needs to be studied in details and further opportunities for its growth should be looked into.

The present study highlights the contemporary maternal and child health care practices among Santhal tribes of Dumka district and finds relatively few changes across generation. It also provides actual reasons as to why people do not use health services. The study shows that the problem lies in the delivery and organization. Accessibility is not only physical or geographical, but it is also economic, administrative, cognitive and physiological accessibility. It refers to dimensions of social access. The health services should be made available keeping all these determinants in mind. Our study contest many other earlier studies like that of Marriot and Carstairs, Hasan and Gould and Khare, who all had the tendency to blame people and their culture for not performing well in their health. They always regarded the technology and western medicine to be the panacea resort for people's illness. This dissertation holds that people still prefer traditional mode and practices for better health and treatment over newer institutions, not due to their illiteracy or superstitions but due to socio-economic factors and structural constraints.

Bibliography

- Low SM. The cultural basis of health, illness and disease. Social Work in Health Care 1984;9:13-23
- Carrilo Emilio, Green Alexander. Cross-Cultural Primary Care: A Patient-Based Approach. Annals of Internal Medicine 1999; 130: 829-834.
- Praharaj Purujit, Sonowal C.J. Tradition vs. Transition: Acceptance of Health Care Systems among the Santhals of Orissa. Studies on Ethno-Medicine 2007; 1(2):135 – 146.
- Bhasin Veena. Medical Anthropology: A Review. Studies on Ethno-Medicine 2007;1(1): 1-20
- Kleinman Arthur, Eisenberg Leon, and Good Byron. Culture, Illness, and Care: Clinical lessons from anthropologic and cross-cultural research. Annals of Internal Medicine 1978; 88:251–258.
- Basu S.K. Health and culture among the underprivileged groups in India In: State of India's Health. Voluntary Health Association of India 1992.p.175-186.
- Baru Rama. Disease and Suffering: Towards a Framework for Understanding Health Seeking Behavior. Indian Anthropologist 2005; 35:1& 2: 45-52.
- Mahapatra, L.K. Concept of health among the tribal population groups of india and its socioeconomic and socio-cultural correlates. Tribal health in India. Manak Publications Pvt. Ltd; 1994. p.1-12.
- Sachchidananda. Socio-cultural dimension of tribal health. Tribal health in India. Manak Publications Pvt. Ltd; 1994. P.57-69.
- Chaudhuri B. Social and environmental dimensions of tribal health. Tribal Health in India. Manak Publications Pvt. Ltd; 1994. P.70-83.
- Lewis Oscar. Village Life in Northern India. New York: Random House; 1958.
- Basu Salil. Health and Socio-cultural Correlates in Tribal Communities. Tribes of India, Ongoing Challenges. M.D. Publications Pvt. Ltd; 1996.
- Bajpai Nirupam. India: Towards the Millennium Development Goals. Background Paper Human Development Report; 2003.
- Nutrition in South-East Asia. World Health Organization. New Delhi: Regional office for South-East Asia; 2000
- Nutritional Trends in India. National Institute of Nutrition, Hyderabad, India; 1996

- Lipton M, Longhurst R. New Seeds and Poor People. Baltimore. The Johns Hopkins University Press; 1989.
- Gopalan C. Low birth weights: significance and implications. In: Sachdev, H.P.S. & Choudhury, P, Editor. Nutrition in Children. Developing Country Concerns. Delhi: Cambridge Press; 1994.
- Barker DJP. Mothers, babies and health in Later life. Edinburgh: Churchill Livingstone; 1998.
- Rao Shobha. Nutritional Status of the Indian Population; Journal of Biosciences 2001 November; 26:4; 481-489.
- Carlson B, Wardlaw T. A Global, Regional and Country Assessment of Child Malnutrition. UNICEF Staff Working Papers 7. New York: UNICEF; 1990.
- Dutta A. Victims of unsustainability, health status of Garhwali children. Mountain Ecosystems. A Scenario of Unsustainability. New Delhi, India: Indus Publishing Company; 1998. P. 154-159.
- Dutta Anuradha Pant Kiran. The Nutritional Status of Indigenous People in the Garhwal Himalayas. Mountain Research and Development 2003 (Aug); 23: 3:278-283
- Bharati S, Pal M, Bharati P. Determinants of nutritional status of pre-school children in india. Journal of Biosocial science 2008 Apr; 28:1-14.
- Gautam V P, Taneja DK, Sharma N, Gupta VK, Ingle GK. Dietary aspects of pregnant women in rural areas of northern India. Maternal Child Nutrition 2008 Apr; 4(2):86-94.
- Chaterjee, Meera. Indian Women: Their Health and Economic Productivity. World Bank Discussion Papers 109, Washington DC; 1990.
- Horowitz, Berny, Madhu Kishwar. Family Life – The Unequal Deal. In: Madhu Kishwar and Ruth Vanita, Editor. In Search of Answers: Indian women's Voices for Manushi. London:The Pitman Press for Zed Books Ltd; 1985
- Sen A. Commodities and Capabilities. Amsterdam and New York: North-Holland; 1985.
- Bhalla AS. Uneven development in the third world: a study of china and India. United Kingdom: Basingstoke; 1995.
- Jejeebhoy, Shireen J, Rama rao Saumya. Unsafe Motherhood: A Review of Reproductive Health. IN: Monica Das Gupta, Lincoln C. Chen, Editor. Women's Health in India: Risk and Vulnerability. New Delhi, India: Oxford India Paperbacks; 1998. p. 122-52.

- Harriss B, Watson E. The sex ratio in South Asia. Geography of Gender in the Third World. Albany: State University of New York Press; 1987.
- Das Gupta M. Selective discrimination against female children in rural Punjab, India. Population and Development Review 1987; 13(1): 77-100.
- National Reports on the Third Evaluation of Implementation of HFA Strategies. SEA Region, WHO; 1997.
- Agarwal KN. Prevalence of Anemia in pregnancy and lactating women in India. Indian Journal of Medical Research 2006 August; 124: 173-184
- Syamala TS. Relationship between Socio Demographic Factors and Child Survival: Evidences from Goa, India. Journal of Human Ecology 2004; 16(2): 141-145.
- National Family Health Survey 1998–99. Mumbai, India: International Institute of Population Sciences; 2000.
- Beteille A. Caste in contemporary India. Caste Today. New Delhi, India: Oxford University Press; 1996. P.150–177.
- Fuller C. Introduction. Caste Today. New Delhi, India: Oxford University Press; 1996. p. 1–31.
- Mishra M. Gendered vulnerabilities: women's health and access to healthcare in India. The Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai; 2006.
- Arati Rao. Who cries when mothers die? India Together (online); Wed 19 Dec 2007.
- Braveman P, Krieger N, Lynch J. Health inequalities and social inequalities in health. Bulletin of World Health Organization 2000; 78(2):232–234.
- Davey Smith G, Hart CL, Blane D, Gillis C, Hawthorne V. Lifetime socioeconomic position and mortality: prospective observational study. British Medical Journal 1997; 314:547–52.
- Whitehead M. The concepts and principles of equity and health. International Journal of Health Services 1992; 22:429–445.
- Reddy NR. Body mass index and its association with socioeconomic and behavioural variables among socioeconomically heterogeneous populations of Andhra Pradesh, India. Human Biology 1998; 5:901–17.
- Subramanian SV, Kawachi Ichiro, Smith G. Income inequality and the double burden of under- and over nutrition in India. Journal of Epidemiology Community Health 2007; 61:802–809.

- Deolalikar A.B. Nutrition and labour productivity in agriculture: estimates for rural south India. Review of Economics and Statistics 1988; 70: 406-413.
- Smith LC, Haddad L. Overcoming child malnutrition in developing countries: past achievements and future choices 2020 Vision. International Food Policy Research Institute. Washington DC: Food, Agriculture and the Environment Discussion Paper 30;2000.
- Alexander M. On inequality in net nutritional status. Centre for the Study of African Economies, Department of Economics, University of Oxford; 2006.Available at: http://www.csae.ox.ac.uk/ conferences/2006-EOI-RPI/papers
- Steckel RH. Stature and the Standard of Living. Journal of Economic Literature 1995; 33(4): 1903-1940.
- Alessandro T. Growth Reference Charts and the Nutritional Status of Indian Children. Dept of Economics, Duke University; Durham, NC; 2007. Available at: http://www.econ.duke.edu
- Sample Registration System. Maternal Mortality in India: 1997-2003 Trends, Causes and Risk Factors. Registrar General, India, New Delhi and Centre for Global Health Research University Of Toronto, Canada.
- World Health Organization. Reproductive health in the south-east Asia region (50 years: Commemorative series-5).New Delhi: Regional Office for South-East Asia, World Health Organization.
- UNFPA. Population and reproductive health facts on India: Briefing kit. New Delhi: UNFPA; 2000.
- Central Bureau of Health Intelligence. Health Information of India, 2000 & 2001. New Delhi: Central Bureau of Health Intelligence; 2003.
- Shiva, M. Women and health. State of India's Health. New Delhi: Voluntary Health Association of India (VHAI), 1992 .p. 265-301.
- Bhat, Mari PN. Maternal mortality in India: An update. Studies in Family Planning 2002; 33(3): 227-236.
- Das Gupta Monica. Death Clustering, Mothers' Education and the Determinants of Child Mortality in Rural Punjab, India. Population Studies 1990 Nov; 44:3: 489-505.
- Das Gupta M. Life Course Perspectives on Women's Autonomy and Health Outcomes.
- American Anthropologist 1995 Sep; 97: 3: 481-491

- Banji et al. Maternal nutritional status and practices and perinatal, neonatal mortality in rural Andhra Pradesh, India. Indian Journal of Medical research 2008; 127: 44-51.
- Bang et al. Gynecologic Disorders Are Common in Rural Areas of India and Bangladesh, but Treatment Is Lacking. International Family Planning Perspectives1989 Dec; 15: 4: 152-153.
- Bhatia JC, Cleland J. Obstetric morbidity in south India: Results from a community survey. Social Science and Medicine 1996; 43(10):1507-1516.
- Madhiwalla N, Nandraj S, Sinha R. Health, households and women's lives: A study of illness and childbearing among women in Nashik district, Maharashtra. Mumbai: Centre for Enquiry into Health and Allied Themes (CEHAT); 2000.
- Mittal PC, Shrivastava S. Diet, nutritional status and food related traditions of Oraon tribes of New Mal (WB), India. Rural and Remote health (online) 2006;6:385
- Census of India 2001, Office of Registrar General, India
- Jejeebhoy SJ. Sexual and reproductive Health among youth in Bihar and jharkhand: An overview. Economic and Political Weekly 2007 Dec; 34-39
- Barnes L. Women's Experience of Childbirth in Rural Jharkhand. Economic and Political Weekly 2007 Dec.; 62-70
- National Family Health Survey 2: India, 1998-1999, International Insitute for Population Sciences, Mumbai.
- Maiti S, Unisa S et al. Health care and health among tribal women in Jharkhand: A situational Analysis. Studies of Tribes and Tribals 2005;3(1):37-46
- Ravindran TKS. Women and the Politics of Population and Development in India; reproductive Health Matters, Vol. 1, No. 1, Population and Family Planning Policies: Women-Centered Perspectives 1993May;1:1: 26-38
- Department of Family Welfare. Family Welfare Programme in India Year Book 1989-90. Government of India, Ministry of Health and Family Welfare, New Delhi; 1991.
- Bharat S. Social assessment of Reproductive and Child Health Programme-A Study in 5 Indian States; Assam, Haryana, Maharashtra, Orissa and Uttranchal (Part - 1). Ministry of Health and Family Welfare and DFID, New Delhi; 2003.
- National Family Health Survey 3: India, 2005-06, International Insitute for Population Sciences, Mumbai

- Report Of The Working Group On Health Of Women And Children For The Eleventh Five Year Plan (2007-2012) Government Of India Planning Commission, New Delhi.

- Sama. Reproductive Health services – The Transition From Policy Discourse to Implementation. In: Leena V. Gangolli, Ravi Duggal and Abhya Shukla, Editor. Review of Health Care in India. Centre for Enquiry into Health and Allied Themes; 2005.

- Bagchi J, Dutta Gupta S. The Changing Status of Women in West Bengal, 1970-2000: The Challenge Ahead. Sage publication; 2005

- Geertz C. The Interpretation of Cultures. New York: Basic Books; 1973.

- Mathur N (Ed.). Santhal Worldview. New Delhi: Indira Gandhi National Center for the Arts; 2001.

- Maharatna A. On the 'Brighter side' of tribal mobility: a case study of Santhals in rural West Bengal. Demographic Perspectives on India's Tribes. New Delhi, Oxford University Press; 2005.

- Jan B. Of Peasants, Migrants and Paupers: Rural Labour Circulation and Capitalist Production in West India. Delhi, Oxford University press; 1985.

- Reddi P, Reddy M. Women in Agriculture: A Sociological Study in Southern India. Presented at "Women Working to Make a Difference," IWPR's Seventh International Women's Policy Research Conference, June 2003

- Health status of primitive Tribes of Orissa. ICMR Bulletin 2003 (Oct); 33:10.

- Srinivasan K, Shekhar C, Arokiasamy P. Reviewing Reproductive and Child Health Programmes in India. Economic and Political Weekly 2007; XLII: 27/28: 2931-2939.

- Sinha S. Tribal cultures of Peninsular India as a Dimension of Little Tradition in the Study of Indian Civilization: A Peninsular Statement. The Journal of American Folklore 1958 (Jul-Sep); 71:281: 504-518.

- Zurbrigg S. Rakku's Story: Structures of Ill-Health and The Source of Change. 3rd ed. Banglore, India: St. Paul Press Training School; 1991.

- Barua A, Hemant A. Quality of Abortion Care: Perspectives of Clients and Providers in Jharkhand. Economic and Political Weekly 2007; XLII: 4/48: 71-80.

- Rani S, Ghosh S, Sharan M. Maternal Healthcare Seeking Among Tribal Adolescent Girls in Jharkhand. Economic and Political Weekly 2007; XLII: 56-61.

- Banerji D. Poverty, Class and Health Culture in India. 1st ed. New Delhi, India: Prachi Prakashan; 1982.

- Basu S, Kapoor A K, Basu S K. Knowledge, Attitude and Practice of Family Planning Among Tribals. The Journal of Family Welfare 2004; 50:1:24-30.

- Rao V.L.N, Rao B.D et al. Illness and Treatment among Khonds of Vishakhapatnam District, Andhra Pradesh. Journal of Human Ecology 2006; 20: 2:83-86.

- Maharatna A. On Tribal Fertility in Late Nineteenth and early Twentieth Century India. Working Papers Series 1998 (January); 98:01: 1-20.

ANNEXURES

Glossary of terms

chapakal – hand pumpd

dikus – non-tribal

hor – tribal

dun – witch

gundli, ghangra and janhe – inferior qualities of crop

bidi – home made cigarettes

jono – broom

datani – traditional toothbrushes

patra – plates made of leaves

hatia – local market

gurik' – cow dung

kharai – field where threshing and winnowing is done

palha – dry leaves for the purpose of cooking

rehe raan – herbal medicine

sahiya – local name for ASHA

bapla – marriage

dom budhi or dom ayu – traditional birth attendant

pordhol – white discharge

jala pordhol – white discharge with burning sensation

fool silka – irregularity in menstruation

thela gadi – bullock cart

hariyar sakam – green vegetables

so bili – fruits

daka utu – normal food – rice and pulses

tadi – todi

mirich – spice

jojo – sour

puni – ricket

hudu – cultivated grain

chawli – raw rice

pai – small round instrument made of bronze to hold some amount of grain.

suli – 20 *pais* makes one *suli*

bursi – left over of burning coal or wood which still has heat

gidra oda – uterus

karon – ailments or illnesses

dal rasi – pulse's water

datrom – iron sickle

jarhi – place where water flows all the time

zhinuk – flat shells used for cutting the umbilical cord and placenta

aynom – kajal or black soot

Annexure 1

Case 1 -

In Gajal Tola, a woman from the neighborhood was listening to our conversation. In between she just popped in and said that she also is/was suffering from a problem. When I further probed into what it is, she said it is 'Bang Vish' – it is like a poison moving inside one's body. And it was visible from outside that something is moving. She believes it came in her because of Satan. This women named Mary Murmu, says she was Christian earlier but Satan pulled her down out of that faith. Because of that 'Vish' in her body she suffered from problems of breathing and had continuous vomiting. She went around seeing many doctors, but did not get cured. Then one of her relative suggested her to see an 'Ojha'. She went to see an Ojha who was blind. He conducted some rituals of his own (jhar phuk). Then the Ojha bite her and squeezed out blood from different parts of the body. Before seeing the Ojha she was unable to have food but after the treatment it worked out. The Ojha pulled out hairs and stones from her body from her back, or from the feet. Earlier she complained of many things but after treatment she got better. And now the kind of faith she has in Ojha, she visits him for any problems. The people around said he takes a lot of money from that lady, but it is her faith on him that she ignores the expense.

Annexure 2

My personal observation of PHC Shikaripada:

One morning around 10 o' clock I went to the PHC, first I visited the office which was an extension of the PHC that was located behind it..The official work of the PHC is carried on there. At that time the Prabhari of the PHC – Mrs. Tudu was sitting there. I gave my introduction and my reason to visit the PHC. She then sent me to other officials to gather whichever data or information I required. Those officials told me to come the next day for the records or data that I needed. Then the official sent me back to the PHC Prabhari, who sent me to the ANM who was then working as a Pharmacist. I went to the PHC main building to see the ANM. In the main building doctors were sitting in one room and in the adjacent room the ANM/ pharmacist were sitting. So I went to her letting know my need to visit there and my requirements. She was also being reluctant and gave me a cold response. She made me sit, and I kept waiting. Meanwhile she was talking to a patient in 'Santhali' language. Once more I asked her to give me or show me records of ANC visits, and data on patients coming for various diseases, and especially if I could get it for tribal population. But this time I asked her in my own language i.e. 'Santhali'. And the moment I spoke she stood up straight and she looked at me with bewilderment. She then got excited to know that both of us share the same language and belong to the same tribe. After a bit of informal information, she actually gave ear to what I needed. Then she went and told the Prabhari of PHC. She came to me and then again we had a bit of informal talk, following which she told the ANM to give me the required information. The ANM was busy distributing medicine as she also looked after the Pharmacist job. She told me to wait, and I kept waiting for

about an hour. The ANM was confused, as to where the records are kept. She asked the Prabhari, who herself was confused. It seemed they do not maintain it properly, and if at all they do, they haven't kept it at place. Then she brought the common register which was being used then, where there were general entries pertaining to all health problems including various diseases/ ANC visits/ leprosy case/ TB etc. So the Prabhari, ANM and I sat down to list the number of ANC visits, and it took us hours to do. Then the Prabhari told me to come the next day. She said they would be prepared with the records that I need. It was already late and I was supposed to go back to the village so I decided to come the next day.

Annexure 3

My visit to Mohulpahari Mission Hospital:

Then one fine day I went along with my uncle, and before going out to see different departments, I thought of first seeking permission of the Medical Superintendent Mr.J. Kisku, of the hospital before going inside and enquiring. So I had to really wait for around two hours before I met him, as the doctor was on rounds of patients in the morning. When I met him after introducing myself, and told him about the study I am carrying on in the village. He then told me to meet the coordinator of the CBPHCP (Congregational Based Primary Health Care Programme), one of the programmes run by the hospital to get the various developments and works going on in the hospital. I got to meet the program officer Mr. Utpal Tudu of CBPHCP with whom I talked. He told me that this program is a unit of the hospital and a program under the community health department of Mohulpahari Christian Hospital since 2000.

For the development work CBPHCP tried to build women's group consisting 10 – 15 members in each group (Mahila Mandal) in villages and promote them for development activities. The group members are trained on health and development issues at MCH and other institutions. There are CHVs (Community Health Volunteers) works as field staffs in the villages. Under the leadership of CHVs, the Mahila Mandals are responsible for developing strong groups in villages that make efforts to analyze and solve their health, socio-economic problems. They have their group meetings twice or thrice in a month, where they discuss their problems of different nature including health, social, economic etc., and find mutual solutions to solve them. The members are encouraged for building awareness among such women who are not the members of the Mahila Mandals so that the entire villagers can know about the health related information. The office staffs of the programme visit villages periodically and conduct training at the village level through lectures and other methods. The CHVs have register for keeping health and development records for every village and Mahila Mandals. With a view to strengthen and develop economic self reliance among the members of Mahila Mandals, CBPHCP motivates members women to form a group fund through their small contributions. The members contribute a small amount of money towards a group fund and use the fund for internal loans and development work of group. The fund is useful when any member of the group is in an urgent need of money (i.e. in case of sickness). Any regular member of the group can take a loan from the group fund and has to repay

it at a nominal rate of interest within a specified time limit as decided by the group members. The members of the group also use the fund for initiating small business like piggery, poultry, agriculture etc through the group or individually.
In order to foster a habit of saving money in the bank, the members of Mahila Mandals are encouraged to deposit money in the bank collectively. The SHGs contribute some money every 15 days. They have been given training on banking and saving activities so that they can get loans from the banks and blocks for income generation through development activities. CBPHCP has so far developed 68 womens' groups in villages coming under 11 congregations and out of 68 groups 45 groups have their bank accounts.
Based on an indepth interview with Dr Joel Kisku, a paediatrician in the hospital I was able to get some insight into the morbidities, both acute and chronic, antenatal and perinatal cases and causes of mortality in the area.
Dr. Joel said that they receive several cases of 'ruptured uterus' from the close by villages due to irregular massage by *Dom Budhis* (dais) at the village as a result of which they even have to operate and take out the ruptured uterus. Similarly large number of complicated delivery cases comes to the hospital after being mishandled by the village untrained dais. He pointed out that the causes of these seem to be the lack of awareness among people living in the villages as well as their poverty. There were cases of hypertension, pre-eclempsia, and post-eclempsia. He recalled a case which he handled earlier when a woman was brought in a precarious condition, with her child stuck half inside where the body was out and the head was inside. They managed to handle the case and both mother and child survived.

The diseases faced by children are mainly due to malnutrition. According to him all they need is nourished food, but this is all they never get, and is far from their reach. He says if a baby is simply having a viral fever, and is shown to the local quack, he gives the baby high anti-biotic which further aggravates the problem. For the disease which the villagers call *'Kala Dhaba'*, medically is known as Bronco-Pneumonia is treated largely by the indigenous healers. The healer gives the patient a string made of beads of thread in order to wear in the neck. The healer says that as the thread expands or lengthens the *'Kala Dhaba'* eventually gets cured. And people believe in them even if they don't get cured.

He then told me about the different cases that comes to this hospital are from nearby villages or region. In medical department, generally there are cases of Malaria both P.vivax and *P.falciparum* but more of the latter than the former. The people around this area are majorly affected by brain malaria. Its medically known as cerebral malaria which is a grave complication that happens at times with the *P. falciparum* infection. It occurs when the malaria infects of the very small capillaries that flow through the tissues of the brain. This complication has a fatality rate of 15% or more, even when treated and is extremely serious. Cerebral malaria can cause death within days.

Pneumonia among adults and bronco-pneumonia among children is also very common. Apart from this there are patients for cerebral vascular accident (stroke), meningitis, encephalitis, Kala-Azar, Typhoid, TB (pulmonary), hepatitis, plural effusion (where water fills in the chest mainly due to TB), plural abscess in lungs. There are also a few cases of renal failure due to delays in treatment and resort to local herbal medicine.

Gynecological surgery includes hysterectomies, fibroid removal, cervical cancer and ruptured uterus. Other operations like appendicitis, hydrosol, liver abscess, caesarians, D and C; abortions are carried out. Except for brain and heart surgery rests of the surgeries are done. He says in this region tropical diseases are more common – kala-azar, malaria, TB, hepatitis (alcoholic) are the few to be named which are most common.
Interview with nurse revealed that women come up with fibroid uterus, if there is some fibroid in the breast, there will be fibroid in the uterus also, she adds. Women suffer prolapsed uterus which is due to having more children and doing a heavy work throughout their pregnancy. Women with incomplete abortion also visit, which is mainly due to having intercourse after 3 months of conception. Women with septic abortion who uses too much herbal medicine '*rehe raan*' (jaddi buti) comes to hospital. And delivery cases of eclempsia and pre-eclempsia are very common.

Annexure 4

Organizational Structure and Functions of the Hospital

Work of hospital – this is a general hospital, with a bed capacity of 130. Treatments of all types of patients are being done except Brain and Heart surgery, different types of wards and beds are available.

These are Private wards – 10 cabins, 10 cottages;
General wards – Male surgical...15
Female surgical...15
OB...16
Gynecology...14
Male medical...16
Female medical...12
Children ward...6
Septic + TB + isolation ...13

Apart from it there is clinical laboratory, x-ray department, pharmacy service, operation theatre, maternity department (obstetrics), eye and dental work, sterile supply, OPD work.

Case 2 –

Dhonmuni Marandi (25 years), a mother of four, married since 10 years is a hardworking woman. Her life is no different from any other woman of the village, full of challenges and work. She got all the baby delivered at home itself. Even her baby did not receive any vaccine, the Anganvadi being in the same tola. For any minor illnesses they go to the local doctors, also to the herbalists. Even for family planning they plan to take 'rehe raan' i.e. herbal medicine. Last year she suffered jaundice and went for herbal medicine which cured her steadily. But in case of any major health problem they have faith on Mohulpahari mission hospital.

Case 3 –

In the present pregnancy of eight months Chundki (22 yrs) was visited by ANM but while her last three of her pregnancy, she was never seen by an ANM. This time she has been given the pregnancy kit. She has been given two injections but the ANM has not told her what those vaccines are. All she knew that it is taken so that no complication occurs during pregnancy. In her family it is her mother in law who has been doing the delivery of all her grand children. And this time also she plans to do; they find it safe doing it at home. They do not call 'dom budhi' as they cannot even fulfill the demand of the 'dom budhi'. Chundki's mother in law said "getting the delivery done is not a big task at all; I have been doing it for all my grand children." She used an old blade kept at home, did not boil it and a coin was kept under the cord as a support in order to cut the placenta. The thread was tied at one place, and soon after the birth the baby was given a bath with lukewarm water.

She always had some complication with regard to lactation and that was the reason she never was able to feed colostrums to her children. And it was later after weeks that her husband got her some herbal medicine that she started secreting milk. Her babies initially had powder milk, her milk was not thick, and it was quite thin.

For any major disease or ailment the first option they think of is going to the mission hospital but the hurdle is their capacity to pay, which they admitted they cannot. So in that case generally they go to quacks. Concerning family planning she told that soon after she delivered her 3rd baby, a quack came in order to take her for sterilization. But then she did not go. She says she will take 'rehe raan' that is herbal medicine to stop having children. And if at all anyone among her husband and herself has to be sterilized, it would be always Chundki will go for it. She said that after taking the 'rehe raan' there is no scope of having children again – they get it from Jangla village which is about 12 km away from their village and the one who gives medicine is also a santhal. She reiterated that with sterilization there can be doubt but with 'rehe raan' there is no doubt of having children again.

This family is badly stricken by poverty and this is reflected in their way of telling and talking. They have very few land holding, and no milch cattle, no source of livelihood except for 'manjuri' (working on others field) with which they cannot manage to eat round the year.

Case 4 –

Kumisila Marandi(20 yrs), like many of the other families in the village is very poor. Her last delivery took place 5 ½ months back. During the pregnancy of her elder son who is now of 1 ½ yrs, she use to work thoroughly, go to the field, was sowing the half grown paddy into seed bed prepared. She felt some pain and so she returned back home. As she reached she got an intense labour pain, she was then rushed to the hospital. The elder son was delivered at hospital. It cost them a lot. The hospital charges, the medicines etc. cost them around 2000/- which Kumisila's father in law had to lend it from one of the villager, with some amount of interest as they were incapable of bearing the expense on their own. So it took a lot for their family to return back the amount borrowed, even they had to sell some of their precious belongings. Kumisila's elder son has been from some or the other ailments since he was of few months. He was identified with worms in the stomach so he became very weak; he also suffered from 'hamus' (jaundice) that to 3 times within a gap of 1 month. According to Kumisila's knowledge the body swells during 'hamus', and the blood becomes thin and watery, one feels extremely weak and does not eat anything. He was shown to an indigenous healer who gave them 'rehe raan'. They said they have faith on the herbal medicine and they believed that they will get cured. Though he got better but still he do not keeps fine with his health. Kumisila also suffered jaundice and she too got treated by indigenous herbal medicine. For any major ailment they would prefer some private clinic. When asked why by chance they do not visit PHC, they said that PHC mostly keep expired medicine so they do not go there. And once she was very ill, and visited the PHC, there the doctors could not diagnose her problem, and could not identify her illness. Later when she visited a local doctor, then it got identified that she was suffering from brain malaria, which she gradually got treated from the local doctor itself.
Though visiting the doctor for 5 times during her pregnancy for usual check-up, Kumisila preferred delivering the baby at home because she felt that it is much safer delivering the baby at home., second bigger reason was that at home one do not have any expense, it was much cheaper, as they already lack money.

Case 5 –

Nilmuni Hansda (22 years) looked much older than her age; she had very less hair in her scalp, no hair in the eyebrow or eyelid. Their family is of three members, her husband, her 7 month old daughter and herself. Their family is very poor, they have few land holdings, and especially their part of land is not fertile enough. Apart from the household work, assisting her husband in agriculture, Nilmuni weaves plates out of dry leaves 'sarjom sakam', which can be fetched only from the mountains. As her husband does not go out to work apart from cultivation, she has to really work hard in order to raise the family. She suffered from malaria during her pregnancy and throughout the year she underwent constant headache. This pain hindered her every work, every facet of her life, it was simply unbearable for her, and this headache lead her in loss of hair, both of scalp and eyebrows and eyelids. She went to Dumka for her treatment and

wanted to know why her head is aching so much. But there the doctors were not able to diagnose why her condition was deteriorating. They gave her medicine but there was no effect of the medicine, instead adverse effect was seen that her headache increased day by day. So she decided to go for 'rehe raan' (herbal medicine) and got it from 'Zoborda' a village quite far from there. It took one year for her to improve but still she suffers from headache and fever, and there is no permanent cure until now. While baby was of 3 months, she was suffering headaches her husband was caught with jaundice, he also took 'rehe raan' and slowly his health got enhanced. Her child was also in frequent attack of various child diseases like 'Chura dant' and 'Kala Dhaba'. For that they took homeopathic medicine form Shikaripada. Initially the doctors again were not able to diagnose the illness, but later when they did it took around 3 months for her baby to get well again. Her baby has still not fed her mother's milk, because both mother and daughter have been simultaneously falling ill. Initially the baby was fed powder milk so gradually she got habituated with the powder milk. Whatever few they earn goes in for Nilmuni's treatment or baby's upbringing.

Case 6 –

Heleni Marandi (20 years) was a tender looking girl, who came 4 years back to this house with the man who is now her husband. She got married last year. Like any other woman she also slogs hard throughout day including her days of pregnancy. The head of her family is her mother in law, and no such decision making rests in Heleni's hand. Presently she has a daughter of 5 months. When inquired about whether she went for any ANC check-ups, she told us that till seventh month of her pregnancy she did not go for any checkup. It was after that when her relatives told her to visit the hospital, listening to them she went to Mission hospital. Had usual checkup, had a blood test and got an injection, she was again called for the next ANC checkup in the 8^{th} month. But this time woman from her neighborhood suggested her not to go to the hospital and take medicine. Or else the baby would become fat and healthy in the womb by eating the medicine, and that later she it would find her in pain during delivery. So she got scared and did not visit the hospital again. Heleni had a labor pain of 8 whole days, and she was finding difficulty in delivering the baby. The 'dom budhi' was called 3-4 times as each time they thought the child might get delivered. But the 'dom ayu' said she will not be able to help in getting delivered the child. So, therefore Heleni was taken to a private clinic in Shikaripada, there the nurse delivered the child. Getting delivered in the clinic cost them 2300/-. They did not have enough money at that time, so they had to lend money from person who was well off in the village. The complication during her pregnancy put them in great debt she said. But it was all paid off in several installments. There is an Anganvadi in the Jolha tola where Heleni resides. Till now her daughter has grown 5 months older, she has only received polio drops, and no other vaccines of BCG and DPT. Heleni criticized the ANM for not having her inform about the vaccines. The ANM did not even visit Heleni during her pregnancy For any small ailment she sometimes went to PHC and sometimes sought treatment from the indigenous healer. And though she has rarely visited the Mission hospital, because they cannot afford but still she has more

faith on it than the government hospital or local doctors. In family planning case she would first prefer 'rehe raan', if not that then she will go for tubectomy. Financially they are in constraint as now they are left with very few land holdings, as half of their earlier land has been given to the money lender (Jolha). He has taken the land for two years, and whatever cultivation comes out of it, the Jolha money lender keeps all the output with him.

Annexure 6

INTERVIEW SCHEDULE

Name/ Age- **Husband's Name-**

Occupation-

Family Members-

Village- **Nearest PHC/ Health Center-**

Block/ District-

1. Does a woman have say in determining distribution/sell of wages/produce?
2. What was the result of last pregnancy – alive or dead – cause of death?
3. What kind of work did before pregnancy?
4. How many days took rest before pregnancy?
5. How many days took rest after pregnancy?
6. How long were you in confinement after delivery?
7. Do you think pregnant women should have - more food/less/usual food?
8. How much you took when you were pregnant with this particular child?
9. What were the problem/ reasons behind taking less food?
10. Are there any food restrictions – foods shall be taken/ food shall not be taken?
11. Have you taken any medical advice during pregnancy?
12. From whom taken and is the advice regular?
13. Have you taken-
    a) Tetanus toxoid injection Yes/ No
    b) Calcium Yes/ No

c) Iron and folic acid Yes/ No

14. Place of delivery

Home/ PHC/ Private Hospital/ Other

15. Type of birth attendant

Dai/ Trained dai/ ANM/ Private doctor/ Government doctor/ Nurse

16. If the delivery was at home-

i. Which instrument was used to cut the cord?

ii. Was it boiled before using?

iii. If it was put on fire then why?

iv. After cutting, how was it dressed?

17. What and how much was given to the birth attendant?

18. Do you think that a woman can take any food and water immediately after delivery?

19. Do you tie cloth around the waist? If yes, how long?

20. Did you wear muffler and put cotton in ears?

21. Who paid the expenses of delivery?

22. What would have you done in case of any complication?

23. Was the colostrums fed to the baby? Yes/ No

Explain in either situation?

24. When was the baby put to breast feeding for the first time?

25. What was the first feed and on whose advice?

26. How long your baby was on breastfeeding?

27. If any of your baby was not breast fed then what was the reason?

28. What food was given?

29. How you feed the baby while away on work?

30. Who looks after the baby?

31. What important food items a woman must eat or not eat during lactation?

32. Do you think that breast feeding influence the onset of mensuration?

33. Were the children vaccinated?

    BCG Polio DPT

34. In your opinion at what age one should regularly introduce solid food to the child?

35. What food should be given for small children?

36. Have you burnt the skin of the stomach of your babies? Yes/ no

37. Do you know what disease can be prevented?

38. How many children have you ever given birth to? Male- Female-

39. Do you visit the PHC or doctor

    For every small problem/ Ailments like fever/ Major diseases

40. Do you have any serious or chronic illness in the past (like TB, Ashtama etc)? yes/ no

41. Do you have any complication during pregnancy?

42. Do you have any gynecologic problem?

43. Have you undergone tubectomy or your husband underwent vasectomy? Yes/ no

44. After how many children?

45. Who decides about sterilization?

    Husband/ Self/ Both /In laws/ Parents

46. Why did or do you want to be sterilized?

47. Have you ever used family planning techniques?

48. When did you start feeling fatigue? During which month of the present pregnancy?

49. During this pregnancy, when did you started getting help?

50. Who helped you most during pregnancy?

51. When pregnant at which time/ stage to feel the need to go to a doctor or require his/her help?

52. What were the reasons for your weakness during this pregnancy?

53. If delivery at home then what kind of medicine you will use-

    Allopathic/ Homeopathic/ Ayurvedic/ Indigenous