

**Analysing The Reproductive Health Status of Santhal Tribal Women in India: A Field Based Study in Kharibari, Community Development Block of District Darjeeling**

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***Abstract***

*The reproductive health status of Santhal tribal women in India not only presents socioeconomic inequities but also addresses substantial obstacles towards healthcare accessibility. Members of one of India's largest indigenous populations, Santhal Tribal women, live primarily in rural and economically deprived areas. These limitations significantly limit their access to appropriate healthcare services, resulting in poor reproductive health outcomes. Maternal health for Santhal women is a major concern, with high rates of maternal mortality and morbidity. Insufficient nutrition, limited access towards prenatal and postnatal care and lack of knowledge about reproductive health rights and services all play a role. Traditional beliefs and cultural practices restrict their access to modern healthcare facilities and contraception options which frequently results in unintended pregnancies and unsafe abortions. The objective of the study is to analyse the quality of reproductive health care utilization among Santhal women during prenatal and postnatal pregnancy. The study will further investigate the socioeconomic and psychological status of Santhal women of reproductive age which is greatly influenced by their prevailing culture and value system as against their desired goals, expectation and standard in the select block of Kharibari Community Block Development of Darjeeling District. The present study examines the reproductive health care of women belonging to the Santhal tribal communities in the Kharibari Community Block Development of Darjeeling District. The findings also highlight the Santhal women's quality of life in these areas, emphasising the need for more effective mechanisms to strengthen tribal women's reproductive rights and provide the best possible maternal health care without jeopardising their community-based guidelines.*

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**Keywords:** Santhal Tribal Women, Maternal Health, Reproductive Rights, Kharibari Community Block Development.

## I. Introduction

Reproductive health care is regarded as a combination of methods, techniques, and attitudes that promote reproductive health and well-being by preventing and resolving reproductive health issues. It includes diseases and conditions affecting the female reproductive system, as well as symptoms, diagnosis, treatment, and prevention of women's reproductive health issues. Reproductive health is also an indicator of a population's overall health. Hence, the reproductive role of women all through the process of gestation, birth, breastfeeding, and child-rearing places her at the focal point of a nation's overall reproductive health. Women's health is influenced by a variety of biological, social, economic, and demographic factors, including their social status, economic affluence, age at marriage, and caste-based tradition. Tribal women in this case, being central to various social and economic activities within their community require reciprocal interactions, necessitating reciprocal interactions with reproductive health contributing factors.<sup>2</sup>

Women in tribal societies have a vital role to play, in their social, economic, cultural and religious lives and are often viewed as an economic benefit to their community. However, they continue to lag far behind in areas such as education, employment, good health, and economic empowerment, among others. In several tribal communities, maternal and child health care practises have been largely neglected.<sup>3</sup> Most Indian tribal women make their sexual debut as married adolescents. Large surveys have revealed that nearly half of all tribal women aged 20–24 in India marry at the age of 16. Ignorance and high-risk beliefs and practises, as well as a high level of poverty and insufficient and inaccessible health resources, have all contributed to this population's early marriage/pregnancy. Social and economic circumstances linked towards their

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<sup>2</sup> A.K. Ravishankar and S. Ramachandran, *Early pregnancy and its association with pregnancy-related health problems among tribal young women in India*, (2009), <https://iussp2009.edu.paper.90140>

<sup>3</sup> Nandini Ganguly, *Birhor Women and Their Health Care Utilization During Pregnancy: A Study On Particularly Vulnerable Tribal Group Inhabiting in West Bengal, India*, Vol 8, Issue 5 ,*JCRT* , (ISSN: 2320-2882), (2020).

household also play an important role in mirroring poor health in their reproductive health.

The Universal Declaration of Human Rights is founded on the principal of equality which says that all human beings are born free and that there shall be no discrimination of any kind with everyone entitled to rights and freedom.<sup>4</sup> The declaration also affirms that every individual have the right to share in scientific advancement and its benefits.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) contends that states must ensure to take all possible measures to discard discrimination against women basically in the field of health care. This should be done in order to enhance equal access towards health care services. This should also include services related to family planning for both men and women, and ensure to women a safe and healthy environment."

It also emphasises on the right to protection for all and ensures the right to health and safety in the sphere of work. Recognizing the vast reach of the notion of safety, the Working Group plans to concentrate its efforts on the impact of safety on women's physical and mental health. This could involve gender violence in public space concerning women, and their access to justice in order to protect their health and for safety in general.

Women are perceived to be the key to providing health care to both the family and the society. She is the central figure who teaches children about child care, nutrition, hygiene, and even basic health care. If she is not mentally and physically fit, she will be unable to sustain the health and development of the child, her family, and society as a whole.<sup>5</sup> Despite this, she continues to be ignored and exploited when it comes to health-care issues. Among women, the tribal women bear the status of lowest of the low. As a result, it is vital to provide them with the required socioeconomic features in order to ensure their dignity as individuals and to integrate them into the mainstream of national life.<sup>6</sup>

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<sup>4</sup> Subhram Rajkhowa and Manik Chakraborty, *INDIGENOUS PEOPLES AND HUMAN RIGHTS*, 3 (R. Cambray & Co. Pvt. Ltd., 1st ed., 2009).

<sup>5</sup> A.K. Kalla and P.C. Joshi, *TRIBAL HEALTH AND MEDICINES*, 168-173 (Concept Publishing House, New Delhi) 1<sup>st</sup> 2004.

<sup>6</sup> Supreme Court on Human Rights and Civil Rights, Volume 2 page no: Surendra Malik and Sudeep Malik,

Early childbirth rates are chronically high in India, particularly among ethnic and caste minorities and women from low-income families. According to the National Family and Health Survey (NFHS-3) data, rural women, especially those from Scheduled Tribes (ST) and those from low-income families, are more likely to have given birth before the age of 18.<sup>7</sup>

The importance of women's health and reproductive health in particular, for general development was emphasized at the 1994 International Conference on Population and Development (ICPD). As per the conference, Reproductive health is "A state of complete physical, mental and social wellbeing and not merely an absence in all matters relating to reproductive system and to its functions and processes".<sup>8</sup>

### **1. Tribal Women and Their Reproductive Rights: Indian Scenario**

Reproductive rights of women have been recognized as a core human right by different legal systems and statutory provisions both globally and regionally. However, the legal regime has done very little effort on the tribal communities especially the reproductive and health care rights. It is important that tribal women should also be acknowledged within a legal framework. In order to avail reproductive health care utilization to tribal women there should be more facilities available.

Indian legal regime acknowledges the rights of women including their reproductive rights as well. There are several international instruments and national provisions that acknowledge the rights of women. It is, inter alia, assumed that the expression women include women belonging to tribal communities. However, in both social and legal disorders it has been felt that tribal women are placed in a disadvantages position when it comes to their basic rights. Community-driven traditional and cultural factors and ineffective and inadequacy of health providers doubly victimises a Tribal woman because she is required to fit the mould of a tribal women within her community and in the other

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<sup>7</sup> Daniel EE, Masilamani R, Rahman M. The effect of community-based reproductive health communication interventions on contraceptive use among young married couples in Bihar, India. *Int Fam Plan Perspect*. 2008; 34(4):189–97.

<sup>8</sup> Asha C M, *Reproductive Health of Tribal Women in Kerala*, 10 IJCRT. e364,365-365 (2022).

hand disregarded from the basic women's right. Appropriate mechanisms, special policies and effective programmes and consultations with emphasis to tribal women to enhance their reproductive health is hence yet to be streamlined.

In Indian Context, there is a broad consensus that the health of India's tribal population is deplorable, with inadequate sanitary conditions, personal hygiene, and health education. The health status of primitive tribal population is rather poor, due to reasons like isolation, remoteness and lack of knowledge regarding the nation's development provisions.<sup>9</sup> It is generally agreed that tribal women's health was given less priority in India owing to superstitious beliefs, conservative traditions, illiteracy, poverty, and stereotypes. The information available on the reproductive health status of tribal women in India is also rather scanty.

## **2. An Over View on Santhal Tribal Community:**

The Santhals are India's third largest tribe. West Bengal, Bihar, Orissa, Jharkhand, and Assam are the most common locations. Santhals are from the pre-Aryan period.<sup>10</sup> They speak Santhali language that belongs to the Austro-Asian language family. The word 'Santal' is made up of two words: Santa, which means calm and tranquil, and ala, which means man. Santhals use the Olchiki script, which was created by Dr Raghunath Murmu in 1925. Their population, according to the census, is roughly 49,000. They are, on the whole, bilingual. They also speak Bengali, Oriya, and Hindi and Nepali in addition to Santhali language. The Santhals' livelihood is dependent on the forests in which they reside. They get their basic needs from the forest's trees and vegetation.

A key component of Santal civilization is the customs and ethnicities practised. However, urbanization, industrialization, and regular encounters with various religious converts, have significantly altered their way of life. Many Santal teenagers are now relocating to towns and urban areas for education and work opportunities. Occupational mobility has also resulted in a significant shift in their lifestyle.<sup>11</sup> In a conventional style, the judicial system is well organised. It

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<sup>9</sup> Health of Tribal Population in India; Results of Some ICMR Studies. Indian Council of Medical Research, New Delhi, p.1, 1998.

<sup>10</sup> Eco India, Santhals Tribe (13 Sep 2021 05:04 pm), <http://www.ecoindia.com/eco-tourism-in-india.html>.

<sup>11</sup> Somrita Sinha, Tribes of India: Santal/Santhal, Human and Social-Cultural Geography (Theory).

is in charge of managing and resolving problems within the community. They make every attempt within society to fix the problem within themselves. Manjhi Hadam is the Santhal Tribe's leader. He is regarded as the head of society's judicial, executive, and other functions. Manjhi is assisted by a number of others, including Jagmanghi, Jagparanik, Naike, and Gudit, who operate in a variety of professions.

### **3. Tribal Population in Kharibari Community Development Block, District Darjeeling**

According to the 2011 census, India's tribal population is 10.43 crore, or 8.6% of the overall population, living on 15% of the country's land. Having a sex ratio of 990 females per thousand men.<sup>12</sup> As per India's 2011 census, the Kharabari CD block has a total population of 109,251, with 97,399 people living in rural areas and 11,852 in urban areas. Males made up 55,671 (51%) and females made up 53,580 (49%) of the total. There were 14,931 children between the ages of 0 and 6. The Scheduled Castes accounted for 58,570 people (53.61%), while the Scheduled Tribes accounted for 21,262. (19.46 percent).<sup>13</sup>

### **4. Reproductive Rights and Maternal Health Care in India**

One of the primary objectives of India's Family Welfare Programme has been to improve the maternal and child health. The basic initiatives to strengthen these health services were launched as early as the First and Second Five-Year Plans (1951-56 and 1956-58). During the Fifth Five-Year Plan (1974-79) the maternity, child and nutrition care were incorporated with family planning services as part of the Minimum Needs Programme. The main goal was to ensure that pregnant women, breastfeeding moms, and preschool children received at least basic public health services in India.

Rural areas in India, receive healthcare through a network of Primary Health Centres (PHCs), sub-centres, and other government health facilities that provide reproductive and other health services.<sup>14</sup> In addition, pregnant women and children also receive assistance from private maternity homes, hospitals, private

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<sup>12</sup> Simon V. S, *Land Laws, Livelihood and Human Security of Tribes in India*, *Journal of Politics & Governance*, Vol. 5 (3), 5-16 (ISSN: 2278473X), 2016.

<sup>13</sup> 2011 census: West Bengal – District-wise CD blocks. Registrar General and Census Commissioner, India. Retrieved 12 February 2020.

practitioners, and on occasion, non-governmental organisations (NGOs). In urban areas, reproductive health services are mostly provided by government or municipal hospitals, urban health posts, NGO-operated hospitals and nursing homes, and private nursing and maternity facilities. In each sub-centre there is an Auxiliary Nurse Midwife (ANM) also regarded as a female paramedical worker who provides basic maternity health, child health, and family welfare services to women and children in their homes or at the clinic.

The Reproductive and Child Health Programme recommends that pregnant women receive two doses of the tetanus toxoid vaccine and proper iron levels as part of their prenatal care.

As per the Safe Motherhood Initiative, all pregnant women should get necessary, competent antenatal care (ANC) which refers to prenatal health services offered by a doctor or healthcare worker in a hospital or at home. This care is facilitated to monitor pregnancy for indicators of difficulties and to diagnose and treat pre-existing and concurrent pregnancy illnesses. It also provides information on preventative care, nutrition throughout pregnancy, delivery care, postnatal care, and other related issues.<sup>15</sup>

According to the Reproductive and Child Health Programme in India, pregnant women should attend at least three antenatal care visits. The program's standards also states that each pregnancy should be recorded between the first 12-16 weeks. Hence, as a result, the first antenatal check-up should preferably take place during the second trimester. In the NFHS-2 survey, women who had antenatal check-ups for births during the previous three years were asked about the total number of check-ups they received and the date of their first visit.

However, the development initiatives of such planning have hardly been effective and continue to marginally hamper the reproductive rights of tribal women in particular. The situation of the tribal women has remained more or less the same. Here, it would be relevant to mention that the lack of financial support from the Government's end is also a reason for the poor socio-economic conditions of the tribal women. Fund shortage, lack of employment opportunities, proper wage and bonus provisions, ineffective educational policies

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<sup>15</sup> *Ibid.*

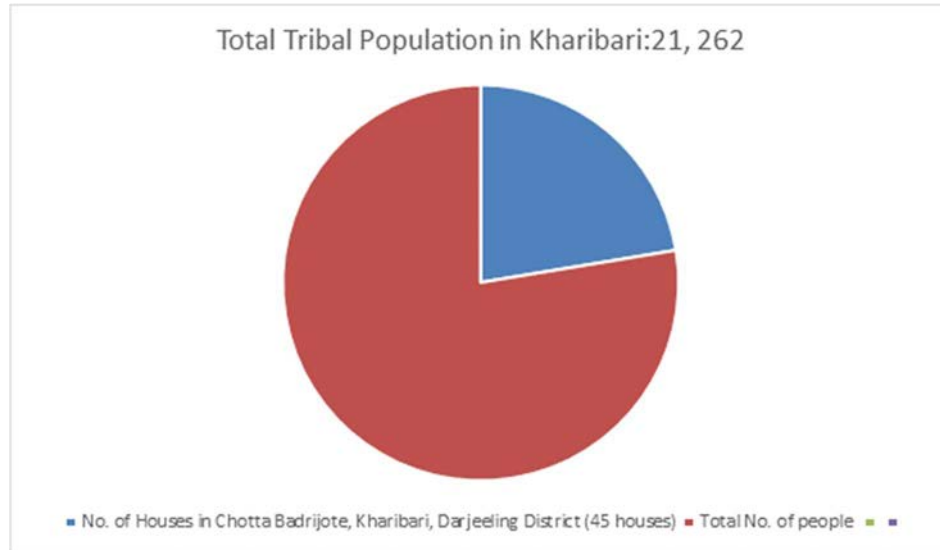
are also but few factors that constitutes a severe impact on the overall lifestyle and health status including maternal health of the tribal women.

The purpose of this study is to raise awareness about tribal women's reproductive health care, with a specific focus on Santhal tribal women. The study also emphasises the issues that women experience during pre- and post-natal pregnancy, child care, and obtaining health treatment. The document also contains recommendations for improving health and the health-care system. The research is based on a survey of 25 tribal women respondents who I spoke with during my fieldwork.

### **III. Detailed Methodology And Data Analysis**

#### ***1. Study area***

The study was conducted in the village of Chotta Badrajote, Khoribari block of District Darjeeling. The Scheduled Tribes accounted for 143 people residing in 45 households. The area is categorized as a tribal belt zone. Kharibari CD block is part of Western Dooars, a physiographic region spread over the Himalayan foothills. It is bounded by the Phansidewa CD block on the east and the list of scheduled tribes' population in this block makes up 21,262 (19.46 percent) of the total population of 109,251. In 2013, the Community Development block of Kharibari contained one rural hospital, two basic health centres, and one private nursing home with a total of 40 beds and 14 doctors (excluding private bodies). It included 11 subcentres for family welfare. 7,044 people were admitted to the CD block's hospitals, health centres, and subcentres, while 95,802 were treated as outpatients. In Darjeeling district, 24.40% of families were classed as below the poverty line (BPL). According to a World Bank report from 2012, 4-9% of the people in Darjeeling, North 24 Parganas, and South 24 Parganas districts lived below the poverty line, the lowest incidence among West Bengal districts, where the average was 20%.



## 2. *Detailed Methodology:*

A self-structured interview schedule was administered through a pilot study. Based on the population size, 25 Santhali married women respondents of reproductive age 15-45 years were recruited for the current study from two villages from Kharibari block of Darjeeling District. The research was conducted in a cross-sectional manner and the sample was gathered through a house-to-house survey. To evoke primary information, a semi structured validated questionnaire consisting of the socio-economic profile, reproductive health status, and pre- and post-natal health care, maternity services, place of delivery and the overall quality of life has been administered to randomly selected respondents.

Key informant interviews (KIIs) with health-care practitioners were also undertaken because they are the village's initial point of contact for health care counselling and maternal services by the tribal women residing in that particular area. The Indian Government has employed community health workers known as Accredited Social Health Activists (ASHA), Community Health Assistant (R) and Auxiliary nurse midwife (ANM) as part of the National Rural Health Mission. They provide the community in gaining access to public health services and also provide maternal health care benefits to women. Apart from these they also coach married couples on the use of family planning methods. Information

was also extracted from the local community leader (Maji Haram) and local NGOs. Furthermore, few respondents have also been personally interviewed, as a part of important qualitative tools to elicit information.

The variables taken into account for the study were education, occupation position, and age of the husband, as well as self-rated health of the women respondents,

As part of secondary sources, books, journals, periodicals, Govt. information reports have been widely consulted.

**Table 1: Distribution of Women respondents according to age**

AGE GROUP	FREQUENCY	PERCENTAGE
15-20 YEARS	13	52%
21-30 YEARS	8	32%
31-40 YEARS	4	16%

**Table 2: Socio demographic and family planning characteristics of tribal women**

FAMILY PLANNING MECHANISMS	PARTICIPANTS (N=25)	PERCENTAGE (%)
<b>Educational status:</b>		
<i>Primary:</i>	10	40%
<i>Higher Secondary:</i>	2	8%
<i>No education:</i>	13	52%
<b>Occupational status:</b>		
<i>Working:</i>	8	40%
<i>Housewife:</i>	17	68%
<b>Husband's Occupational status:</b>		
<i>Tea Garden Labourer:</i>	5	20%
<i>Manual Labourer:</i>	4	16%
<i>Driver:</i>	3	12%
<i>Farmer:</i>	2	8%
	5	20%

<i>Herdsmen:</i>	3	12%
<i>Businessman:</i>	3	12%
<i>Others:</i>		
<b>Do you take part in family planning with your husband?</b>	17	68%
<i>Yes</i>	8	32%
<i>No</i>		
<b>Are you avail the contraceptives disbursement at health centres?</b>	7	28%
<i>Yes</i>	10	40%
<i>No</i>	8	32%
<i>Don't know about the facility:</i>		
<b>What precautions do you take as for space births?</b>	16	64%
<i>Contraceptive Pills</i>	2	8%
<i>Condoms</i>	5	20%
<i>Sterilization</i>	2	8%
<i>Copper T</i>	0	0%
<i>Tubal Ligation</i>	0	0%
<i>Vasectomy</i>		
<b>Do you know the name of the Contraceptive pills you are taking?</b>		
<i>Yes</i>	6	24%
<i>No</i>	19	76%

**Table 3. Utilization of maternal health care during pregnancy among the participants**

<b>Utilization of maternal health care</b>	<b>Participants (N=25)</b>
<b>Which places did you visit for your prenatal care?</b> <ul style="list-style-type: none"> <li>• <i>Hospital clinic</i></li> <li>• <i>Health department clinic</i></li> <li>• <i>Private doctor's office</i></li> <li>• <i>Community health center</i></li> <li>• <i>Dint go anywhere</i></li> </ul>	6 (24%) 4 (16%) 2 (8%) 10 (40%) 3 (12%)
<b>Women who received antenatal check-ups</b> <i>Yes</i> <i>No</i>	17 (68%) 8 (32%)
<b>Were you supplied with enough multivitamin tablets during pre- and post-natal pregnancy?</b> <i>Yes</i> <i>No</i>	15 (60%) 10 (40%)
<b>Did you Use IFA tablet?</b> <i>Yes</i> <i>No</i>	13 (52%) 12 (48%)
<b>Did you Receive Tetanus Injection during antenatal care?</b> <b>Yes</b> <b>No</b>	22 (88%) 3 (7%)
<b>Place of delivery:</b> <i>Home:</i> <i>Government Hospital:</i> <i>Private Nursing Homes:</i>	3 (7%) 16 (64%) 2 (8%)
<b>Did ASHA workers visit your home for pre- and post-natal check-ups?</b> <i>Yes</i> <i>No</i>	20 (80%) 5 (20%)

<b>Received maternal health care knowledge from ASHA and ANM</b>	19 (76%)
Yes	6 (24%)
No	
<b>Attended any programmes and workshops organised by the Government with regard to Reproductive rights and maternal health care of women?</b>	0
Yes	25 (100%)
No	
<b>Complications pre delivery</b>	5 (20%)
<b>Complications post delivery</b>	8 (32%)
<b>Availed money from Janani Suraksha Yojona scheme</b>	2 (8%)
Yes	9 (36%)
No	14 (56%)
Unknown to the scheme	

### 3. *Data Analysis:*

#### **Educational and Occupational Status:**

Based on the basis of data majority of women having education below 5th standard (40%) whereas only 8% women have availed higher secondary education and about 52% tribal women are illiterate. The table reveals that tribal women are economically independent to the great extend as we find about 68% of the women are house wives. Tribal community as a live-in forest area, so they mainly depend on forest and forest food livelihood so women along with household chores carries out work like, making of cow dungs, gathering woods from nearby forest areas. Also, the occupational status of the women reveals that 16 to 25% of the men are engaged with manual labour. These are also some of the important factors for the overall socio-economic status and health status of the tribal women.

**Health care Utilization:**

As per the study, 68% of the women have had their check-ups done in the village Health Care Centres. Most of them have had their ANC check-ups done through health care workers working under the name of ASHA,<sup>16</sup> ANM.<sup>17</sup> About 60% of the women have taken multivitamins, and 52% of IFA tablets were given by the health care workers. 65% of the women have received a tetanus injection during pregnancy.

**Janani Suraksha Yojana (JSY)**

As per the maternity services available, around 36% of the women who have the knowledge about the scheme and have filled up the form as well still have not received any financial support under the JSY scheme. A few ladies even claimed that the JSY facilities were a fantasy for them because their child is already three years old and yet not received any financial assistance. According to the report, 56% of the ladies had no awareness of the concept or what it was all about.

**Place of Delivery**

According to statistical analysis, 64% of women give birth in government hospitals, 8% in private institutions, and 7% at home. Financial stability of the respondent's family is a basic factor in choosing the place of birth of women in the tribal community. Their transportation facilities are primarily public transport because they do not get any from the health care centres.

**Family planning:**

When it comes to family planning the study reports that 68% of the women have access to take part in family planning. They also follow space births. However, reports on precautions undertaken indicate that 64% of the women who have knowledge in space births consume contraceptive pills. The study emphasized that the husbands doesn't use precautions from their end like use of condoms

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<sup>16</sup> Accredited Social Health Activist (ASHA) is a government driven community health worker appointed by the Government of India's Ministry of Health and Family Welfare (MoHFW) as a part of the National Rural Health Mission (NRHM). The mission began in 2005.

<sup>17</sup> Auxiliary nurse midwife (ANM) is a village-level female health worker who works for the people in need of health care services. Their service is to provide safe and effective care to village communities.

(8%). The women participants disclosed that they took precautions in the name of contraceptive pills but when asked, they themselves did not know the name of the pills (76%). They just rely on their husband's choice upon such matters. Also, few women have undergone sterilization (20%) because they are afraid that their husband might want a baby later. Copper T birth control mechanisms is just availed by (8%) of the women respondents. Other space birthing mechanisms like tubal ligation and vasectomy is generally not used by any of the respondents. As they do not have the knowledge of what these tools are.

#### ***4. Case Study of 5 Tribal women Respondents***

##### **CASE STUDY I**

Name: Maino Hansta

Age: 17 years

Husband's age: 20 years

Occupation: Housewife

Husband's occupation: Tractor Driver

A young woman, married at the age of 17 years, she has done her schooling till class 9. Her Household chores is divided in between her in laws. During her education she recalls that she had not attended any sex and health education classes or programmes. She is not pregnant as for now but basically, she is planning to bear a child. As per her opinion, her age is not a barrier for marriage or bearing a child.

##### **CASE STUDY II**

Sunita Mardi

Age: 24 years

Husband's age: 32 years

Occupation: Housewife

Husband's occupation: Business Man

She was a gentle and calm woman with a four years old son. She got married in the age of 20 years and got pregnant that year itself. She had gone to the clinic to do the test and this is how she knew about her pregnancy. During her prenatal tests she visited the Clinic on rare occasions. She also visited the Kharibari Government Hospital. She did not recognise any health issues except chest pains. Her husband used to assist her during these visits. During her delivery she faced difficulty in giving birth to the child in the hospital. She complaint of unhygienic medical conditions and ineffective facilities. Situations were so bad that she was made to share her bed with other pregnant women, who were also there for the same cause. Sunita does family planning with her husband and is into contraceptive pills named Choice; however her husband does not take any precautions from his end. When asked about her access to such pills, she purchases it herself and does not rely on the pills disbursed by the Health Care Centres. She lacks knowledge about what is known as labour pain, Nation driven reproductive rights and schemes, baby's weight, his health.

### **CASE STUDY III:**

Anjali Tudu

Age: 18 years

Husband's age: 45 Years

Occupation: Housewife

Husband's occupation: Labourer

She was a woman who was facing health issues both physically and mentally. After being pregnant for 3 months she had just had a miscarriage. Keeping this in mind, she was interviewed within a brief timeline. There seemed to be a great age difference between she and her husband nevertheless she was his first wife. As per her the miscarriage was due to her taking certain pills during her pregnancy. She said that her pregnancy was unknown to her husband and he only came to witnesses about it after her miscarriage because he had gone to work out of town. She also did not go to any doctor or clinics. She was undergoing some health issues but that did not stop her from doing her household chores. She said that her husband also did not know about any reproductive health schemes and is unaware of any male training programmes related to maternal healthcare.

**CASE STUDY IV:**

Name: Uditā Mardi Soren

Age: 24 years

Husband's age: 25 years

Occupation: Housewife

Husband's occupation: Tea labourer

She got married at the age of 21 years and is now a mother of a 3 years old son. Her prenatal visits used to be health care centres and for her delivery she opted for private nursing home, unlike her counterparts who usually give birth at home pertaining to the unavailability of basic health care facilities in the Government Hospitals. She had been promised in the health care centres that she would be given *JSY Scheme* of 800 Rs if she gave birth to a son and 1000 Rs in case of a girl child but however, it just remained a paper work only. She said that ASHA does come to their doorsteps to check on the women's maternal health and also the health of the child but they say nothing about family planning schemes and their health benefits in general.

In fact, the health care workers prohibit them from disclosing the age of the women to other people as this might cause some police case, instead of educating and forbidding them from bearing the child or marrying at such a tender age.

**CASE STUDY V**

Name: Lalita Hazola

Age: 21 years

Husband's age: 25 years

Occupation: housewife

Husband's occupation: Laboure

She is a mother of three children and regularly visited health centres for both prenatal and postnatal care. During her pregnancies, she was provided with vitamin tablets and injections and did not experience any major complications. For family planning, ASHA workers advised her to use a Copper T, but she faced

several health issues as side effects. Eventually, the ASHA workers recommended that she undergo a surgical procedure.

#### **IV. Conclusion and Findings**

To summarise, the study's findings highlight a lack of effective pre and postnatal care for tribal women in the study area, which has a direct impact on their quality of life. According to the study findings, tribal mothers who had regular prenatal visits reported a pretty good quality of life. The study results also clearly show that the quality of life among tribal women is also dependent on their education and family's financial situation. More than half of the women respondents, as well as their husbands, have no formal education. The majority of the responders were housewives or tea garden labourers. Their spouses' principal occupation was collecting wood from the forest. Aside from these jobs, a few respondents' husbands worked as drivers, tea estate labourers, and business owners. Within each village, the physical quality of the roads and the availability of transportation were both satisfactory. The findings based on the respondent's husband's occupation and age is the tribal santhali women's economic and financial backgrounds.

During the survey, it was revealed that girls in the village often marry at a very young age, typically between 14 and 17 years. In an interview, the community leader of the Santhal tribe, known as the Manjhi Hamad, mentioned that their community does not have a specific age for marriage, but he observed that most marriages occur within this age range. He also shared that many of the disputes he handles involve the elopement of young girls.

Another conclusion is that a woman's financial position significantly influences her maternal health. Women who had excellent reproductive outcomes and received high-quality maternity care were more likely to be financially stable. In contrast, many other women in less secure financial situations faced greater obstacles. Education also plays an important part in native women's maternal health care.

Based on the occupational status and age of the respondent's husband the only findings that could be drawn is the economic and financial background of the tribal santhali women. The study's findings suggest that the financial background of the women's household has a significant impact on the women's maternal health. The women who had a good experience of her reproductive stages and

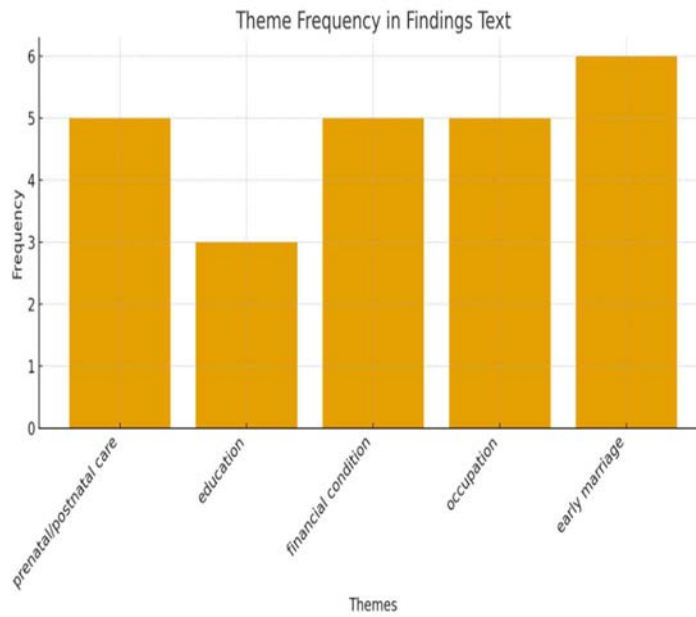
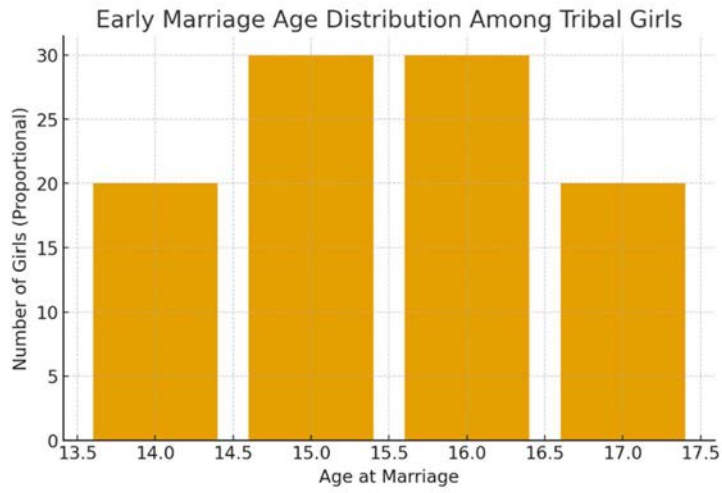
could avail the best available maternal care facilities were basically the ones whose financial condition was stable, then many other women respondents whose financial condition is not very stable. Education also plays a vital role upon the maternal health care status of tribal women. As with the study, the majority of the women who obtained reproductive health care services were educated. However, inadequate prenatal and postnatal health care facilities in the research area have been associated to a lower quality of life for indigenous women, as well as an impact on their overall maternal health.

ANM and ASHA workers do support each of the villages. As per the key structured interview, the ASHA workers and ANM, (Mrs Sabita Rani Biswas) revealed various provisions and schemes initiated by the Government to render maternal health services to the tribal women. They said that women were given Tetanus injections, Haemoglobin tests were done, 4 to 5 times check-ups were also carried out. Post-natal check-ups are also carried out by them frequently, including child birth weight, injections and complete immunization. Contraceptive pills like *Chaya*, and Condoms are also disbursed at the Centre.

Ms. Shila Roy, CHA(R), also said that programmes on Ligation are held on 11<sup>th</sup> of July every year. But as per my analysis, the women participants revealed that majority of them had not attended any programmes or consultations. The ASHA and ANM also faced issues like unavailability of medicines and Iron tablets in advance from the Government's end. They also face problems from the pregnant women because community driven tribal women are also pretty hard to be tackled with. Furthermore, women seeking reproductive health advice or treatment are unlikely to seek it from government health professionals.

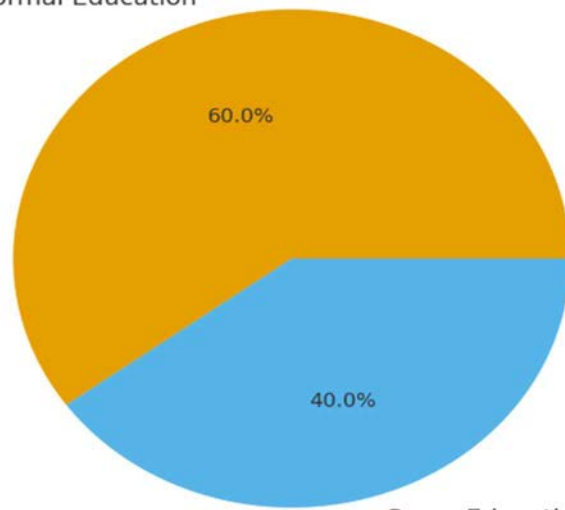
The study's findings underscore the crucial role of educating women about the signs and symptoms of various reproductive health issues. This kind of education is essential for enabling women to recognize and address potential health problems early, thereby improving their overall health outcomes. Additionally, the study also highlights the pressing need to expand multiple counselling and reproductive health services in rural areas, with particular focus towards tribal women. Many rural and tribal communities face barriers to accessing adequate health care, and increasing the availability and quality of these services can significantly enhance maternal and reproductive health. Expanding these services will help ensure that women in these underserved areas receive the support and

care they need, ultimately leading to better health outcomes and a higher quality of life.



### Education Level of Women Respondents

No Formal Education



Some Education