REVIEW OF RESEARCH
ISSN: 2249-894X
IMPACT FACTOR : 5.7631(UIF)
UGC APPROVED JOURNAL NO. 48514
VOLUME - 8 | ISSUE - 9 | JUNE - 2019

HEALTH CARE SERVICES AND DEVELOPMENT IN INDIA: A STUDY OF TRIBAL WOMEN REPRODUCTIVE HEALTH

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ABSTRACT:

A good health is a state of complete physical, mental and social well-being and not merely absence of any disease and it is fundamental to attain peace and security. Among the underprivileged groups, NFHS IV (2015-16) reports tribal population to have poor sexual and reproductive health indicators. A good reproductive health describes the right to access appropriate health care services that will enable women to go through safe pregnancy and child birth. The health of the women determines her child's health which implies reproductive health is extended lifelong. It is socially and culturally embedded and in India reproductive health is often ignored. Maharashtra being a developed state does not exhibit uniform development and Nandurbar is one of the backward districts which have the highest proportion of tribal population in Maharashtra. This study is an attempt to focus on the living conditions of the tribal married women of Nandurbar district in Maharashtra focusing on their sexual and reproductive health status. The paper is based on my M.Phil dissertation and data is collected by using both quantitative and qualitative methods. The data indicates that early marriages of tribal women are still prevalent and the educational status of the tribal women is poor with nearly one-third of the respondents not attended school. Among those who experienced pregnancy, majority of them reported their place of delivery at home. Nearly one-fifth of respondents reported that they did not receive ante natal care and more than half of respondents reported the unavailability of post-partum check-ups. The data reveals that the socio-economic indicators and the sexual and reproductive health of the respondents are poor. The relevance of this paper is to emphasize on the reproductive health status of the tribal women and recommendations emerged from the study can be used by policy makers to make appropriate policy to ameliorate their health conditions.

KEYWORDS: *good health , safe pregnancy and child birth.*

INTRODUCTION

WHO defines health as a state of complete physical, mental and social well-being and not merely absence of any disease. Good health is crucial part of human well-being and central to human happiness. The essence of health is interdependence with development. Health and development has a complex link where impact of better health has effect on development, and conversely, the impact of development policies have effect on the health. Unequal development in the promotion of good health is a threat. Health of all people is fundamental to attain peace and security. Among the under

privileged groups, the tribal have the poorest health indicators. In India tribal population has been a marginalized section and their health indicators have been significantly poor (Pandey et.al 2018). Various demographic indicators show the low health status of tribal women from various aspects. Maharashtra being a developed state does not exhibit uniform development and Nandurbar is one of the backward districts which have the highest proportion of tribal population in Maharashtra. In Nandurbar the institutional delivery is 80.4 per cent and delivery at home is 19.6 per cent. It is crucial to explore why women still prefer home delivery when they can take benefits of the institutional deliveries and receive incentives at the same time. Also only two- third of the population received ante natal care and less than one-fourth of the population have heard about RTI/STI (DLHS, 2012-13). Various studies have been launched to understand the health care utilization pattern among the women.

A good reproductive health describes the right to access appropriate health care services that will enable women to go through safe pregnancy and child birth. Reproductive health is not only the outcome of the biological or genetic factor alone; there are different other factors, such as social and demographic factors, economic factors, cultural factors, health care service factors, knowledge factor, etc has an important role in influencing the reproductive health status of the women. It is very crucial to focus on these social determinants of health (Babu, 2017). The reproductive health behavior of women which was traditionally considered as an individualistic process did not consider the human actions and decision making unit of a family. The reproductive health behavior is shaped by various social relations such as kinship groups, social informal groups, social institutional groups, religious and political leaders and healers and widely influenced by the socio-economic, cultural and historically processes. Studies report that more than half of the population of tribal women never attended school and the main reasons to dropout from school include long distance commute from home to school, household work and responsibility of looking after young siblings. The level of women's education is very closely associated with the health status of the women (Sandhya Rani, 2010).

A study explains five main structural determinants education, age, gender, economic status and social status. These five determinants are very closely interlinked. There is a need to give appropriate attention to how these social determinants interplay in generating and sustaining inequity when designing policies and programs to reach equitable progress towards improved maternal and reproductive health (Sanneving etal. 2013). Child marriage still remains a common practice in India, despite its illegality. Young age marriages of women have implications on their reproductive health. A study intended to find association between child marriage and reproductive health. Early marriage was consistently and positively associated with having had a pregnancy that ended in miscarriage, still birth or abortion (Doskock, 2013). Further, child marriage was positively associated with lower number of antenatal visits, lower number of delivery in a health care facility and having skilled delivery personnel (ibid.). Also, a study on Socio-demographic determinants of contraceptive usage in Pune, Maharashtra reported that early marriages and early childbearing below 18 years is still prevalent (Valekar etal.2017). A study on reproductive and maternal health care services among the tribes in Jharkhand reported that education of women has positive relationship with the utilization of the maternal health services (Pandey et.al 2018). Primary health care of women can be sustainable if embeded within the broader development of education sector as it is major factor to bring improvements in the health status of women (ibid.). A study on needs of tribal women and their experiences with maternity services in Odisha which explores the experiences with maternal health services of women from the tribal communities reports that proportion of home deliveries continues, they less likely to receive antenatal and postnatal care from skilled provider (Contractor etal. 2018). Another cross-sectional study in Maharashtra state reports that compared to women with primary education or less, women who had up to secondary level education had 41% lower odds of using a public facility (Thind etal. 2008).

This paper primarily focuses on health care services in the context of development. For this reproductive health status of tribal women has been taken to study.

METHODS/DATA

This study is a primary study and the data was collected by using both quantitative and qualitative methods. For quantitative, a survey approach was adapted. Nandurbar district was selected for the study as it has the highest tribal proportion in Maharashtra (DLHS, 2012-13). Taloda tehsil of Nandurbar district was selected for the study. Taloda tehsil is located in the middle of the Nandurbar district. It has 94 villages which are approximately 100 villages. One-fifth of the population which is 20 villages was selected by using probability population sampling (PPS) sampling method. The sample size for the study was 200 selected by using purposive sampling and the target population was 15-49 years of tribal married women. 10 respondents for each village where selected to meet the requirement of 200 sample size. Selection of the respondents was done by using systematic random sampling technique. The qualitative data was collected by using Focused group discussions, Key informant interviews and observation methods. Focus group discussion was conducted by using focus group disscussion guidelines. The key informants for the study were Auxilluary Mid Wife (ANM), Accredited Social Health Assistant (ASHA), Bhagat (Traditional Healer), Untrained Dai, Trained Dai, community leaders and resident who conducted delivery on her own.

STUDY AREA

Nandurbar is located in the North-west side of Maharashtra state. It has the highest proportion of tribal population and more than half belong to Below Poverty Line (BPL) families. Majority of the households live in the Kuccha houses and less than 10 per cent of the households live in pucca houses. Not more than 20 per cent of the houses have access to toilet facilities. Female literacy rate is 42 per cent which places Nandurbar the lowest female literate district in Maharashtra (DLHS, 2012-13).

RELIGION AND TRIBE

Majority of the respondents belong to Hindu religion (99.0%). Very few respondents belong to Christian religion (1.0%). The tribes found here predominantly are Bhil and Pawra. Bhil is the dominant tribe in this region (91.0%) and pawra tribe (8.5%) as shown in table 1. The most prominent difference between these tribes can be noticed in their Dressing, marriage practices and dialect. The women of the Pawra tribe drape one piece sari called *Nathi* while the women of the Bhil tribe drape a three piece sari. They wear heavy ornaments made of silver. These ornaments are given to the women after marriage as bride price. These also symbolizes that the women is married. *Bhili* is the most commonly used dialect among the tribal population. Marathi and Ahirani are next most commonly used languages among the people. The mean age of the respondents is 25.8 years and the mean age at marriage of the respondents is 17.9 years as shown in table 1.

Table 1. Demographic Statistics of the respondents

Indicators	Percentages
Mean age of respondents	25.8 years
Mean age at first marriage	17.9 years
Religion	
Hindu	99%
Christian	1.0%
Tribe	
Bhil	91.0%
Pawra	9.0%

HOUSING CONDITION

Table 2 shows the housing type which indicates the overall living condition of the household. More than two-third of the respondents stay in Kaccha house structures (64.0%). Nearly one-fourth respondents stay in Pucca houses (22.5%) and a very few stay in semi-pucca houses (13.5%). The

highest percentage of the respondents recorded that toilet facilities were not available at their house (89.0%). A very few of the respondents have toilet facilities in their house (11.0%). Absence of toilet facilities has an important influence on the health of woman. Majority of them go for open defecation to the nearby fields and open grounds. There are no common toilets built in the villages. Women and young girls' would go before dawn while men have the leisure of time. Pregnant women and lactating mothers also have to travel distances before dawn to perform in the open fields. To avoid the frequency of the toileting pregnant and lactating mothers are on exclusive diet of "Lapsi" which is a mixture of wheat flour and water which is insufficient to meet the nutritional requirement of the pregnant and lactating mothers.

Majority of the respondents reported that their source of water is hand pump (47.0%) and major source of light in this area is electricity (94.0%). The major source of water in this region is ground water. Every village has installed hand pumps to draw water which is used for various purposes including drinking water. Some households have installed hand pumps within their premise, while many other households depend upon the common hand pumps in the village. Standard of living index (SLI) was calculated, the data shows that majority of the women belong to medium standard of living index (45.0%), about one-third of the women come under low standard of living index (36.5%) and few of the women come under high standard of living index (18.5%).

Table2. Housing conditions of the respondents

Housing conditions	Percentages
Type of house	
Kaccha	64%
Pucca	22.5%
Semi-Pucca	13.5%
Toilet facility	
No	89%
Yes	11%
Source of water	
Handpump	47.0%
Public tap	32.0%
Tap inside the house	16.0%
Common well outside the village	2.5%
Common well outside the house but inside the village	2.5%
Source of light	
Electricity	94.5%
SLI	
Low SLI	36.5%
Medium SLI	45.0%
High SLI	18.5%

Education

The educational status of the women affects the reproductive behavior, contraceptive use, the health of the children and hygienic practices. The table 3 shows the percentage distribution of educational attainment by the respondents and the reasons for not attending school. Nearly one-third of the respondents informed that they have never attended school (31.0%) mainly because the number of government schools are very few. The student teacher ratio is very less and girls' enrolment rate is

very low. Only one-third women who have attended school till primary education (33.0%), while very few attended till secondary education (9.0%), and above secondary (27.0%).

Majority of the respondents reported the reason for not attending school as they were needed for family farm/ businesses (44.0%) followed by respondents who reported that they were needed for household work (16.5%), engaged/married(11.5%) and parents disproved schooling for girls' (6.5%) as shown in table 3.

Table 3. Educational attainment of the respondents

Education attainment	Percentages
No Schooling	31.0%
Primary education	33.0%
Secondary education	9.0%
Above secondary	27.0%
Reasons for dropout	
School too far away	3.5%
Cost too much	2.0%
Not interested	4.0%
Needed for household work	16.5%
Needed for family farm/business	44.0%
Parents disproved schooling for girls	6.5%
Got engaged/married	11.5%
Failed	1.0%
Wanted to leave	5.0%
Teacher beating	6.0%

Reproductive Health

Majority of the respondents reported that the place of delivery was home (46.0%) followed by respondents who reported that place of delivery was government hospital (32.0%) and very few of the respondents reported that place of delivery was private hospital (8.5%) as shown in table 4. Deliveries are conducted in both places, hospitals as well as home. Some villages do not have PHC and are located at far distances from the PHC. The pregnant woman is then taken to the nearest PHC for the delivery. A private rickshaw is hired for this purpose or the ambulance is called for assistance. However, it does not give prompt services. The ambulance takes one hour to respond to the call. PHC has only one ambulance and it takes time to reach the location. The rickshaw services are also not very well rooted. Very few rickshaws are available in the village on time. If the pregnant woman fails to reach the hospital, the *dai* of the village is called to conduct the delivery at home.

Good care during pregnancy is important not only for the development of the baby but also for the health of the mother. Pregnancy is the crucial time to promote healthy behavior. Antenatal care (ANC) during pregnancy increases the chances to monitor the health of the women. Majority of the respondents reported that they have received antenatal care in the first trimester (69.0%). While on the other hand less than one-fifth of respondents reported that they did not receive antenatal care (17.5%). Majority of the respondents reported on the consumption of IFA tablets during pregnancy that they took IFA tablets during pregnancy (67.0%) while about one-fifth of the respondents did not take IFA tablets (19.5%). Majority of the respondents reported that they took the TT injections (69.0%) while on the other hand less than one-fifth of the respondents reported that they did not take TT injections (17.5%). The data explains that less than one-fifth of the respondents are aware about STI (16.5%). While majority of the respondents have never heard of STI (83.5%). Nearly one-fifth of the respondents have only heard of HIV (19.0%) while the majority have not heard about HIV/AIDS (81.0%). The data explains that the respondents are not aware about HIV/AIDS More than half of the respondents

informed that they did not receive postpartum check-ups (55.5%). Nearly one-third of the respondents informed that they received postpartum check-ups (31.0%). Among those who received postpartum check-ups nearly one-third of the respondents informed the place for check-up as government hospital (31.0%).

Table4. Reproductive health indicators of the respondents

Reproductive health Indicators	Percentages
Place of delivery	
Home	46.0%
Clinic/Health centre	8.5%
Government hospital	32.0%
Not Applicable	13.5%
ANC in the first trimester	
No	17.5%
Yes	69.0%
Not Applicable	13.5%
IFA tablets	
No	19.5%
Yes	67.0%
TT Injections	
No	17.5%
Yes	69.%
Heard of STI	
No	83.5%
Yes	16.5%
Heard of HIV/AIDS	
No	81.0%
Yes	19.0%
Postpartum Check-ups	
No	55.5
Yes	31.0

Result

Child marriage still remains a common practice in India, despite its illegality. Young age marriages of women have implications on their reproductive health. In this paper we will establish relation between both the indicators and derive explanations with cultural practices of the study population. To understand the relation two variables are selected; level of education of the respondents and the age at marriage of the respondent.

For the analysis, the age at marriage of the respondents was categorized into three categories; <18 years, 18-24 years and 25-34 years. The level of education was categorized into four categories; No schooling, primary education, secondary education and higher secondary education. Reproductive health indicators; place of delivery, ANC, Consumption of IFA tablets, TT injections and the Postpartum check-ups were selected to draw relation. To understand the relation between the two variables a cross tabulation with chi-square test was performed. The variable place of delivery of the respondent is studied across level of education and age at marriage.

For respondents married at the age less than 18 years it was observed that percentage of home delivery is more in respondents who never attended school compared to respondents who have attended school. Also, it can be observed that when there is increase in the level of education there is decrease in the percentages of home delivery. This value when tested with chi-square is found to be

significant (p=0.019). Similarly, it was found that percentages of respondents who never attended school and did not get ante-natal care are the highest. However, there is no significant relation between the level of education and the ante-natal care received. Consumption of Iron and Folic acid tablets were found least in the respondents who never attended school. However, there is increase in the percentages of respondents who consumed IFA tablets when the level of education increases. This value when tested with chi-square was found to be significant (p=0.030). Least consumption of TT injections was found to be least in respondents who have never attended school. There is increase in the percentages of respondents who consumed TT injections when the level of education increases. This value when tested with chi-square was found to be significant (p=0.015). Also percentage of respondents who never attended schooling and did not get postpartum check-ups is high. However when this value was tested it was not found to be significant (Table 6).

Table 6. Distribution of age at marriage and educational status of respondents in relation to reproductive behavior

Age at Marriage		Place of Delivery			ANC		IFA Tablets		TT Injections		Postpartum check-ups	
		Home	Private health centre	Government hospitals	Yes	No	Yes	No	Yes	No	Yes	NO
<18	No Schooling	45.0%	11.1%	32.6%	37.1%	39.1%	34.5%	46.4%	35.6%	44.0%	43.8%	35.0%
	Primary education	21.7%	22.2%	32.6%	24.7%	30.4%	23.8%	32.1%	23.0%	36.0%	21.9%	27.5%
	Secondary education	30.0%	66.7%	30.2%	33.7%	30.4%	36.9%	21.4%	36.8%	20.0%	31.2%	33.8%
	Higher secondary education	3.3%	0.0%	4.7%	4.5%	0.0%	4.8%	0.0%	4.6%	0.0%	3.1%	3.8%
18-24	No Schooling	53.3%	25.0%	0.0%	24.4%	58.3%	28.6%	45.5%	27.9%	50.0%	20.8%	41.1%
	Primary education	20.0%	25.0%	31.6%	26.8%	16.7%	21.4%	36.4%	20.9%	40.0%	29.2%	20.7%
	Secondary education	23.3%	50.0%	52.2%	39.0%	25.0%	40.5%	18.2%	41.9%	10.0%	37.5%	34.5%
	Higher secondary education	3.3%	0.0%	15.8%	9.8%	0.0%	9.5%	0.0%	9.3%	0.0%	12.5%	3.4%
25-34	No Schooling	0.0%	0.0%	50.0%	20.0%	0.0%	20.0%	0.0%	20.0%	0.0%	0.0%	50.0%
	Primary education	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Secondary education	0.0%	50.0%	50.0%	40.0%	0.0%	40.0%	0.0%	40.0%	0.0%	33.3%	50.0%
	Higher secondary education	100.0%	50.0%	0.0%	40.0%	0.0%	40.0%	0.0%	0.0%	0.0%	66.7%	0.0%
Total		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
P value significance		.019*			.225		.030*		.015*		.376	

DISCUSSION AND CONCLUSION

Government agenda's for bringing about comprehensive and inclusive socio-economic development for the tribal population can be achieved by focusing on proper education, health care and economic security. Various inclusive schemes have been established to enhance the educational status of the tribal population. These schemes mainly focus on bringing 100 per cent enrolment rate and to decrease the dropout rates of tribal girls' with affordable and quality education. Action plans to attain these goals are superficially made from numerical understanding of secondary data. These action plans mainly focus on incentives/scholarship schemes/ free distribution of study materials, uniform and mid day meals trying to pull attention of the tribal population does not solve the core problem. The problem lies in understanding the reason for the dropout rates and further creating solutions of the same. From our analysis it is clear that around one third of the population has never attended school and another one third of the population has only studied till primary level. On further asking the reason for not attending or dropping out of school almost half of the population responded that they were needed for family farm/business and one sixth of the population responded that they were needed for household

work and 11.5 per cent of the population responded that they got married. The core problem is embedded in the nexus of societal functioning. So the above plan of actions recommended by the program holders does not attend to the problem. Therefore there is need to implement plans that penetrate into the society to bring a positive change.

RECOMMENDATIONS

There is need to implement vocational training programs, educational programs i.e formal or non-formal and provide opportunities for small scale businesses primarily for the women in the study area. Ensuring the implementation of the above recommendation will not only help in making alternative income but also empower the tribal women and help them understand the ill effects of early marriage. Participatory Rural Appraisal (PRA) activities can be implemented by either government or non-government organizations and explain their recommendations to the key important persons of the community to create awareness about both importance of education and issues related to reproductive health. Given that the study area is located in difficult terrain teachers from the mainstream India shows least interest in teaching in this tribal area. There is a need to recruit educated tribal youth as teachers and provide them with residential and all amenities. Residential schools (Ashram Schools) should be focused on developing infrastructure and they should be extended up to post graduate level. Higher level officials should be appointed to be keeping a check on the functioning of these schools. Women have skills in making bamboo basket and jute hanging baskets (*Shika)*; these skills need to be promoted in the market to improve their financial conditions.

The analysis explains there is relation between the reproductive health indicators, age at marriage and educational status of the respondents. However there are more factors that need to be focused to enhance the reproductive health indicators. Table 4 shows that 46 per cent of women have delivered at home. This is mainly because primary health care is not in the village and women have to travel long distances to different village to receive health care. There is a need for establishing more number of health centers in the villages to increase the reach for acquiring health care for the tribal population. And the functioning of the health centre has to be monitored by regular visits and supervision by the concerned authorities. Awareness regarding safe deliveries, institutional deliveries and their importance to the women is to be promoted by the key important persons of the community and sexuality education should be provided at Ashram schools for the students. Knowledge on STI, HIV/AIDS and contraceptive methods is very poor and hence awareness and prevention methods should be essential part in these educational programs. It is clear from the field evidences that there is need to improve basic facilities like transportation, communication and amenities like safe drinking water and electricity. More over the need for understanding the ground realities of the community to make schemes/developmental programs is imperative to make larger and positive changes in better health care services as it has greater association with development.

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