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Status of Reproductive Health: A Study on Santhal Women in Lakhimpur District, Assam

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Abstract

Health is a complete state of physical, social, mental wellbeing and not merely the absence of any disease or infirmity. Woman Reproductive health has gain greater recognition from the health practitioner and academician since 1970. In the mid of 1970, sociologists took interest in human reproduction. They began to question medical orthodoxy and with its existence and operation of health services and the role of medical profession within them. Some feminist group and sociologist felt that doctors were making the natural, normal physiological process or reproduction- conception, contraception, pregnancy and child birth in to medical events to be actively managed and controlled by medical experts who were alienating women in the process. The women reproductive health is a very sensitive issue in our society. Women workers from tea industry are one of the most vulnerable groups. They are engaged in tea industry at a very negligible amount of earning from time immemorial. Due to their low income, they are unable to get proper meal and hence they faced more anemia than the other people. As Assam records highest in India and around 69% comes from tea garden labouers. Though the special progrrames and schemes are introduced by the government in various time to mitigate this problem, those benefits are yet to be availed by deserving people. The santhal women are still not financially strong to take care of their nutritious food. Most of the santhal women are still deprived of the minimum health care facilities due to unavailability of health care services in their locality. This paper is an attempt to study the reproductive health among the Santal women in Lakhimpur District.

Keywords: Reproductive Health, Tribal Community, Santal Women, Hygiene.

Introduction

The women reproductive health is a very sensitive issue in our societies. Sociologist and feminist have given special attention on human reproduction. They began to question medical orthodoxy and with its existence and operation of health services and the role of medical profession within them. According to Malinowski there are some direct connections between culture and health. He says culture as 'the integral whole' encompassing 'human ideas' and crafts, beliefs and custom. A vast apparatus, partly material, partly human and partly spiritual, by which man is able to cope with the concrete, specific problems that face him. He saw those problems as human 'needs' that prompted 'cultural responses'. These needs were metabolism, reproduction, bodily comforts, safety, movement, growth, and health. Malinowski proposed hygiene as the 'cultural response' to health. Hygiene involves all 'sanitary arrangement' in a community, native beliefs as to health and magical danger (Malinowski: 1944:37). Some feminist group felt that doctors were making the natural, normal physiological

process or reproduction- conception, contraception, pregnancy and child birth in to medical events to be actively managed and controlled by medical experts who were alienating women in the process (Maureen:1990).

Maternal Health is an important aspect for the development of any country in terms of increasing equity & reducing poverty. The survival and well- being of mothers are not only important in their own right but are also central to solving large broader, economic, social and developmental challenges.

Today India faces a demographic and health situation that is radically different from the prevailing conditions when the national family planning program was launched in 1951. In the intervening period, mortality fell by nearly two-thirds, fertility declined by about two-fifths, and life expectancy at birth almost doubled. India's population has more than doubled since 1961. The decline of fertility and mortality ran roughly in parallel for many years. so that the population growth rate remained above 2 percent a year until 1991, by 1992, India had achieved 10 percent of its goal of replacement fertility(2.1 birth per woman) with fertility having declined from about 6.0 to 3.6 births per woman.(Anthony r.)

Maternal Mortality Ratio is one of the important indicators of the quality of health services in the country. India has made remarkable progress in reducing maternal deaths in the last two decades. In 1990, Maternal Mortality Ratio (MMR) in India was very high with 600 women dying during childbirth per hundred thousand live births, which meant approximately one and a half lakh women dying every year. Globally MMR at that time was 400, which translated into about 5.4 lakh women dying every year, India at that time contributing to 27 percent of the global maternal deaths. In the year 2010 global MMR was 210. Against this, MMR in India has declined to 178 per hundred thousand live births in 2011 as per SRS estimates. India now contributing to only 16 percent of global maternal deaths. Globally there has been a 47% decline between the years 1990 and 2010. Compared to this, India has registered a decline in India has shown an increasing trend from 4.1% annual rate of decline during 2001-03 to 5.5% in 2004-06, to 5.8% in 2007-09 and is maintained at almost the same level of 5.7% in 2010-12.

Statement of the problem

The maternal mortality rate is highest in Assam across India. The main cause is the Anemia, the maternal mortality rate in India is 212 per lakh and in Northeast it is 291. In Assam 6.6 lakh babies are born annually, among them 30,000 babies being born with severe health complications such as low birth weight, premature birth, which lead to their death within a year. Nearly 20,000 die within four weeks of their birth, mostly due to respiratory and other infection related complication. The Health department tried to reduce the frequency of such deaths, still lot more to be done. The women among tea garden workers are the most facing the problem of maternal mortality, among all tea-garden workers, The Santhal women are also facing this problem since beginning. The tea-garden workers are almost illiterate and hence women in tea garden are less aware of health care. Their health is being exploited every day, also there is patriarchy dominant is existing among them, so in this pathetic condition, how the women manage their health and their physical environment is an important matter to study. This paper is an attempt to study the health and hygiene practices and its effect on fertility and mortality among the woman of Santhal in Hurmatty Tea-garden. The study also intends to understand the attitudes of the Santhal towards the medical, and the status of women within the household structure, how the women struggle during pregnancy period, and also try to focus

on the impact of the role of ASHA workers, Anganbadi workers and the responds of the women towards of the newly introduced medical health progrrames.

Though the special progrrames and schemes are introduced by the government and other non-government agencies, but it is not touching the ground level. Most of the communities are being deprived of the minimum health care facilities of newly adopted government schemes like NRHM, 108 Mrityunjoy Sewa, toilet and water pump with modern technique of filters etc. Due to the lack of these basic facilities many of the women practicing the ethnic medicines which are being prescribed by some village experts. Women in tea industries are most vulnerable groups. They have lack in education related to health and hygiene condition. Their awareness on health and healthy lifestyle was superficial, knowledge on common illness and their prevention pattern and treatment related education & awareness. Santhal in Assam have been leading a miserable life but real situation is yet to be investigated. Very few micro-level studies on women health in tea industries have been done so far. Therefore, this paper is an attempt to study on health and hygiene practice by santhal women in tea gardens.

Conceptual Framework

Patriarchy mode of production

The concept patriarchy is an essential tool in the analysis of gender relation; it refers to a system of government in which men ruled societies through their position as heads of households. The patriarchy mode of production is one of two patriarchy structures operating at the economic level. Women's labour is expropriated by their husbands within the marriage& household's relationship. The husband is able to expropriate by the wife's labour because he has possession of the labour power which she had produced. Also, sometimes the authority and management dominate the Santhal women in tea garden.

Fertility

It is the most important demographic variable. it refers to the annual number of births per thousands women of child bearing age 15-44. Fertility shows the actual number of children birth to women.

Mortality

The study of patterns of mortality and its indicators helps in understanding the health status of a population and the change of the demographic structure of population. crude birth Rate indicate the trends in human mortality. Mortality is of death in the population. Crude death rate is the number of deaths per thousands person in a society in a given year.

Study area:

The present study has selected three tea gardens of Lakhimpur District of Assam. The district has total number 11 tea garden, among them three Tea Garden such as- Harmutty tea garden, Bordoibum tea garden and Modhupur tea garden has been selected. In the Harmutty tea-garden total number of tea garden workers are 920. 709 are permanent worker 211 are temporary worker. Total 90 workers were found santhal, and 20 respondents from them taken for this proposed study.

Bordoibum Tea Garden is situated in Ghilamara town of north Lakhimpur District, this is a beautiful, peaceful place, Dhemaji is on the east, Gogamukh is on the north, Brahmaputra is on the south and Subansiri River is on the west of it. Total population is 700, among these 30% of population belongs to bastis. It has 108 are permanent and 108 are temporary workers.

This tea- garden is a unit of Ananda tea-estate, it has two catchment one is consisting of around 4sq km comes under Bordoibum tea-estate and another comes under Ananda tea-estate. The workers under Bordoibum tea garden are mixing of Adivasi, and mishing, mishings are the temporary workers. Almost 60% workers of Santhal tribes are living in 'Majhigaon'. Very nearest village of Bordoibum tea-estate. They are all now permanent residents of Majhigaon

Madhupur tea garden is situated at Machkhowa near the Arunachal Pradesh Hill s in North Lakhimpur District of Assam. The Garden was purchased on 4th January 1908 by Srimati Suchandi Devi wife of Srijut Someswar Sarnath of Bezgaon village of Sibsagar, Assam. Total population is 5000 including official staff, tea factory worker and tea garden labour. There are 377 permanent workers and 623 are temporary, among these, total Santhal population is 80, for the study total 20 respondents has been selected from this santhal community.

Techniques of Data Collection

Both Primary and secondary data were used for the study. primary data were collected from Santhal women and an unstructured interview schedule was used. From each tea garden 20 no of respondents selected from the santhal community. Conclusions of the study area are drawn on the basis of the results from the data analysis and personal experience gathered through the observations during field study.

Objectives of the study:

1. To study the socio- economic profile of Santhal women.
2. To understand the health & Hygiene practices among the santhal women.
3. To understand the attitudes of santhal women towards medical and ASHA workers and awareness of contraception.

Results and findings

Socio-economic profile of Santhal women in Lakhimpur District:

Table 1 represent the personal attributes of Santhal women in the field such as- age group, educational background, age at the time of marriage, religion they followed, and their marital status. Among the 60 total respondents, 28 % were between the age group of 20-30 years old. 38% were from 31-40 Years, 18% from 41-50 years older, other 10% &5% were belongs to 51-60 and 60 years respectively. Among these respondents, 63% women were married, 16% found unmarried, 15% were found widowed and rest 5% were divorcee. Since the study is about the reproductive health therefore the age of women at the time marriage was found to be very important, therefore one separate column has been made for this variable. 45% respondents were married before the age of 15 years, 46% were found between the age group of 16-20 years. Only 8% married at the age of 21-26 years. 55% santhal women follow Hindu Religion and 45% are Christian. The santhal women are educationally found very backward, almost 48% respondents were illiterate, 18% were studied upto class IV and capable of sign their name, 33% were studied till class VIII.

Table 2 represented the data about the distribution of income by the Santhal women in the Lakhimpur District. This table has been categorized into five groups of income, among 60 sample,21% of total respondents found in the earning group below Rs1500 per month, 18% earned between Rs1600-2500, 35% were earning between Rs2600-3500, 11% income between Rs 3600-4500 and ret 13% earning above Rs4500. The income of Santhal are found very low, most of them are temporary worker in the tea gardens, they earned Rs232 per day, the salary is distributed among them in every 15 days. If they take maternity leave their wages will become half.

Table 1: *Distribution of sampled women respondents by personal characteristics*

Variable	frequency	percentage	Mean age
Age group of respondent			
20-30	17	28%	
31-40	23	38%	
41-50	11	18%	25
51-60	6	10%	
>60	3	5%	
Marital status			
Unmarried	10	16.66	
Married	38	63.33%	
Divorced	3	5%	
Widowed	9	15%	
Age at the time of marriage	frequency	percentage	mean age
<15	27	45%	
16-20	28	46.66%	
21-26	5	8.33%	
Religion of the Respondent			
Hindu	33	55%	
Christian	27	45%	
Educational profile			
Illiterate	29	48.33%	
Studied upto iv	11	18.33%	
Class viii	20	33.33%	

Table 2: *Distribution of income among the Santhal women*

Income class	frequency	percentage
>1500Rs	13	21.66%
1600Rs-2500Rs	11	18.33%
2600Rs-3500Rs	21	35%
3600Rs-4500Rs	7	11.66%
Above 4500Rs	8	13%

Table: 2 This table represented the data about the distribution of income among the Santhal women in the field.

Health and Hygiene practices by the Santhal women in the Lakhimpur District:

Considering the economic importance of the people of India, the use of traditional medicines gains its importance. Although modern medicines are widespread but traditional medicines still popular in tribal societies. They are the actual custodian of traditional medicines. They are very shy and have a traditionally strong belief of their religious rituals and own medicinal practices. Santhals have also their own traditional medicines and are using those since time inception. They still first prefer to their traditional medicines only. Use of various herbs available in forest, they make ethnomedicines for various health situations. The reproductive health among Santhal found to be very poor and unhygienic. They still believe in black magic, they still rely on manjhi's(community head) advice regarding any affairs such as- health, social, cultural etc. Except few, most of them did not have any understanding about the

necessity of nutrition food and balanced diet in their daily life. Even they are unaware about child and pregnant women's food supplement. They viewed food as the survival elements only. On the othrhand, multiple factors are influential in determining one's personal hygiene behaviour including culture, economic condition opportunity etc. it is needed to be investigated that which one is more influential here. But these two factors have wide range of influence over their personal hygiene behavior. It is seemed to the researcher that they have traditional mood of learning which is unscientific and at the same time they have little or no opportunity to learn modern hygienic behavior. Even their working environment and living arrangement influence them negatively. (majumdar&Roy2012). Most of them still rely on used of ashes powder in cleaning their teeth, after toilet instead of toothpaste and hand wash. Also, they express their view on using sanitary napkin during menstrual period as misfortune. They use clothes; they express it as their misfortune that they cannot even effort for sanitary pads. Santhali women have less knowledge of personal hygiene. They are less aware of maintain personal hygiene, especially during childbirth period. In the field it is found that only 34% of Santhali women drink their own tap water. The rest are from various sources like garden taps, public health taps and ponds etc. it can be seen that due to Lack of healthy diet intake by lactating mothers which may leads many problems in newborns such as- low weight in infants, malnutrition, aneamia, vitamin deficiency etc.

Attitudes towards medical and ASHA workers and Awareness of Contraception

Accredited Social Health Activists (ASHAs) are working as an effective link between the government and poor pregnant women who get financial incentive to promote institutional delivery. In the past, records reveal the number of deliveries in health centers was very low. There has been a little awareness grew since the government introduced the new schemes. ASHAs have a special role in rural areas; ASHAs are responsible for going from house to house, identifying maternity and newly pregnant women and registering them at government health centers. The Government Health Center provides all the facilities according to that registration. The community health officer said, "I used to find it very difficult to work in garden areas and slum areas. It was very difficult to convince them to bring them into the physical health centers. There is a little interest in registering people for the Rs. 5,000 currently paid under the government's maternal protection. Otherwise, it was difficult to make them understand about such things. In earlier time, the concept of medical birth was not common to them, but from last five years it is increasing. ASHA's playing an active role; ASHA workers help the pregnant women in every possible way. If sometimes ASHA worker fails to come then the elderly women help them in delivery.

WHO defines Contraception is the act of preventing pregnancy. This can be a device, a medication, a procedure or a behavior. Contraception allows a woman control of her reproductive health and affords the woman the ability to be an active participant in her family planning. (oshin M. Bansode; ManbeerS Sarao;Danielle B.Cooper 26th july,2021) Respondent view that- (community health officer), in earlier times, the Tea-Garden women were un aware of contraception measures; they hesitate to discuss about the contraceptive pills or any other measures of contraception. The fear of being insulted by the elders they don't prefer any abortion and contraception measure. If they once conceive, they will go for conceive the baby. Santhali women also usually do not use any contraceptive methods. As a result, there is no age gap between the two children. Therefore, the growth of children's health is hampered. They often use herbal medicines, especially those made by their Elders, and do not contact the ASHAs on sensitive issues like abortion. They are also reluctant to seek contraceptive pills after intercourse. Most men have been seen to be neglectful in this regard.

Conclusion

India is the second largest producer of tea in world and Assam ranks first which occupies a significant portion of GDP of this country. Tea workers and their contributions are not negligible. Women labourers especially have much more contributions in the tea production of India. Unfortunately, they are the most deprived sector in tea industry as well as in Indian society. From the present study it is seen obvious that this socio- economic condition is convincingly vulnerable. Santhal women are mostly deprived of their rights in almost every sector I;e- socially, economically, politically. Health and hygiene are one of the most significant factors for improving the living standard of female tea workers. The present study revealed that most of the santhal women suffer from aneamia, low blood pressure, skin disease and diarrheal diseases. Proper nutritional facilities are almost nil among santhal women. Most of them get health advice from the community elders only. Due to poor economic conditions of the family, they are unable to manage their daily expenses with the daily wages, the dominance of male person in the family is found to be as prominent among Santhal, researcher found that the decisions were taking only by the husbands and in-laws about the child birth.The preference of male child is a common phenomenon within the community because they believe that boy child will help the father in his work and can earn money for them, and attention of education was giving more on boy child than the girl child.

Education initiates attitudinal change and replaces traditional outlook towards health care and changes the habits concerning personal health and hygiene. Apart from that, the pattern of dietary intake, inadequate quality and quantity of food, socialization process, early age of marriage, unavailability of health facilities, coupled with poverty and believes, value system. All together degenerate the health of women. They have less social networking, and less communication with other non-santhal people. It can be said that this pathetic condition of health and hygiene have more or less effect on fertility and mortality which are considered as the two important variable of population growth.

The governments introduced progrrames must be run through the plans accordingly. Involvement of middleman in the process is a major problem. The government should initiate such steps to enquire those schemes of process. Government should produce some schemes related to awareness programs of woman reproductive health. The various government and other non-governments should take initiatives regarding knowledge improvement of mother's health. Electronic Media can take initiation regarding increasing of awareness of taking measures during intercourse. This media may create many short movies and stories in regional language related to replacing the traditional practices and to accept the modern measures of child birth.

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