

# REPRODUCTIVE HEALTH STATUS OF WOMEN IN SRIKAKULAM DISTRICT OF ANDHRA PRADESH

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**Abstract:** The main aim of the paper is to find out differential impact of National Rural Health Mission (NRHM) on reproductive health indicators of rural eligible women (15-49) in the Tribal and Non-Tribal. It is observed that women respondents in the age groups 15-24 accounted for 46.4 per cent and 45.8 per cent between the age group of 25-34. A major proportion of eligible women respondents have got married before the age of 18 years in Tribal (41.6%) and Non-Tribal (43.3%). Of the 360 women respondents, as many as 234 (65%) received the first ante-natal checkup within three months of pregnancy and 126 (35%) received the same after three months. The home deliveries are among Tribal women (23.3%) compared to Non-Tribal (10%) women very low among Non-Tribal women sample (10%). This analysis brings out that there exists wide disparity between Tribal and Non-Tribal women particularly on the reproductive health status of women in the study area. All this calls for a suitable policy intervention by the government both at the State and Centre.

## 1. Introduction

Health status of women has become a very important topic especially after the successive Government's policy in reducing the maternal and infant mortality. Women's health is a very complex area which includes availability of good and nutritious food to growing female children and expecting mothers, educating them with the female physiology and changes that takes place in their body along with the age, providing counseling and guidance in matters of personal hygiene, pregnancy and child birth. All along, the motive "prevention is better than cure" is kept at the centre of all these programmes.

Reproductive health is defined by World Health Organisation (WHO) as "a state of physical, mental, and social well-being in all matters relating to the reproductive system, at all stages of life. Good reproductive health implies that people are able to have a satisfying and safe sex life, the capability to reproduce

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And the freedom to decide if, when, and how often to do so". Both male and female members of a family should be informed about and have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health care services that enable women to safely go through pregnancy and childbirth.

Most of the studies revealed that there are improvements in the availability of infrastructure catering to the women's health, institutional births have doubled in the last five years, though they are nowhere near the 100 per cent as aimed by the Government, and in spite of the Maternal Benefit Act (MBA), most of the women are not benefitting from it because the MBA does not cover the women

working in the unorganized sector. Women employed in unorganized sector are far greater than those women working in the organized sector. Most of the recommendations suggested by different researchers from different surveys are based on the nature of the observed correlation and regression coefficients between the desired outcome variable such as fertility, ante-natal care, infant mortality, contraceptive use, and immunization status or growth and development of children and selected predictors.

It was found that there were very few studies conducted in Andhra Pradesh, especially after the state reorganization took place on June 2<sup>nd</sup>, 2014, on Reproductive and Women's Health. To fill this gap to the extent possible and also throw light on the dichotomy of Tribal and Non-Tribal women's health, mainly their reproductive health practices, a scientific and systematic effort has been made here. The present work aims to study Tribal and Non-Tribal women of Andhra Pradesh in general and Srikakulam district in particular to fill the void in the existing literature with reference to Andhra Pradesh.

## Review of Literature

Some of the reviews of studies on Health Care Services are:

Janmejaya Samal (2017) has reviewed various Government documents and his paper focus on the role of AYUSH with special reference to National Rural Health Mission (NRHM). Decades back AYUSH systems of medicine were limited to their own field with few exceptions in some states as health in India is a state issue. This took a reverse turn after the initiation of NRHM in 2005 which brought the concept of "Mainstreaming of AYUSH and Revitalization of Local Health Traditions" utilizing the untapped AYUSH workforces, therapeutics and principles for the management of community health problems. As on 31/03/2012 AYUSH facilities were co-located in 468 District Hospitals, 2483 Community Health Centers and 8520 Primary Health Centers in the country. In case of paramedical staffs, Andhra Pradesh is the state where a maximum of 1500 of AYUSH paramedical staffs have been appointed. The required number of AYUSH workforces has been articulated in the Indian Public Health Standards (IPHS) documents. The role and responsibilities of AYUSH doctors have been spelt out very carefully in their term of reference (TOR). AYUSH principles have also been utilized for the management of common community health problems.

Kristi Sidney (2012) argued that the majority of deliveries (76%) took place within the Janani Suraksha Yojana (JSY) programme; 81 per cent of all mothers below poverty line delivered in the programme. About 90 per cent of the women had prior knowledge of the programme. Most of the respondent mothers reported receiving the cash incentive within two weeks of delivery. The ASHA's influence on the mother's decision on where to deliver appeared limited. Women who were uneducated, multifarious or lacked prior knowledge of the JSY program were significantly more likely to deliver at home. Nevertheless, there is still a subset of mothers delivering at home, who do not or cannot access emergency obstetric care under the programme and remain at risk of maternal death.

Government of India (2011) envisages that under the umbrella of National Rural Health Mission launched in 2005, the Janani Suraksha Yojana (JSY) has resulted in a huge increase in institutional deliveries within four years. The number of beneficiaries was rising from 7.39 lakhs in 2005-06 to 1.13 crore in 2010-11. The backbone of the success of the NRHM, massive training of Anganwadi workers, ANMs and Nurses for safe delivery and management of sick children, establishment of special newborn care units, new born stabilization units have also helped in achieving improved maternal and child health care.

Rajesh Garg et. al. (2010) study shows that about 66 per cent of the deliveries were took place at home. The most common reasons cited for home delivery were traditional attitude (86.2%) and economic reasons (13.4%). They found that home and unsafe deliveries were still widely prevalent in the rural areas of Punjab.

Olufemi T. Oladapo, et. al. (2008) study found that at least two-thirds received information on aspects of ante-natal health needs. Frequency of ante-natal visits was "about the same as expected" for 93.6 per cent of the women. Approximately two-thirds of women were unhappy about their involvement

in decision-making with respect to birth planning and postpartum contraception. They also observed that about 81 per cent of the respondents expressed a high level of satisfaction with the care received. The survey indicates that ante-natal women may generally express satisfaction with the quality of services despite some inconsistencies between received care and their expectations of the facilities.

Chander Shekhar and K Srinivasan (2007) analysis reveals that the state-level effects of various RCH services are significantly higher than those at the district level. The pace of annual progress after 1998 in many RCH indicators is slower than before and a few indicators (e.g., child-immunisation) have worsened, despite the expenditure on the programme being doubled. Decentralisation and integration of basic healthcare services may not be effective unless monitored centrally and backed by full time health (medical/paramedical) professionals at the delivery level.

Krishnamurthy and Balasubramanian (2006) observed the UN projections in the 25 years period between 2000 and 2025, the number of women in reproductive ages 15-49 years is expected to increase from 250 million to 350 million and the number of married couples, from 200 million to 280 million. The demographic burden of growing number of women, married women and deliveries that are expected in the next 20 years will create heavy demand for provision of reproductive and child health services. Reproductive health problems including problems relating to menopause will pose serious challenges for the health care delivery system. Both efforts and resources have to be enhanced to increase the coverage and improve the quality of reproductive health services. Reproductive health clinics should be established at the primary health centre level to provide advice and services to growing number of women in rural areas.

Somayajulu, U.V (2004) analyses that the practice of having ante-natal care checkups is still moderate as one third of the women did not have even one such checkup. The rural - urban differentials get pronounced. Provision of ANC at home appears to be low as only 2 to 7 per cent of the women had ANC at home provided by the health workers indicating perhaps the low levels of provision of outreach services. Coverage of the pregnant women for TT (67%) and Iron and Folic Acid (IFA 58%) is moderately high, though not very high. Still majority of the deliveries are home deliveries 3/4<sup>th</sup> in rural areas and 1/3<sup>rd</sup> in urban areas, one-tenth of the women had postpartum complications while two fifth had RTI symptoms the study concluded that the necessity of ante-natal checkup and its role in enduring safety of mother as well as a child. Give emphasis to women in rural areas, SC/ST women and mothers going to have higher order births.

## Objectives

The Objectives of the Paper are:

- To find out the utility of ante-natal care services of women respondents selected for the study in Srikakulam District.
- To analyze women's health problems in relation to the place of delivery and treatment of health problems in the study area.
- To suggest more practical policy interventions for improving women's health, particularly RCH practices in rural areas.

## Methodology

Srikakulam is one of the most backward districts in Andhra Pradesh. The rationale for selecting this particular District is to know the health status of women, specifically to find out the variations in the Tribal and Non-Tribal women of the Srikakulam District in Andhra Pradesh. It is also aimed at finding if the implementation of NRHM since 2006 in this district has made any difference. Politicians, administrators, health staff in rural areas have put in hard work and concerted effort in improving the health status of rural women under NRHM. As such it is felt appropriate to undertake the study in this backward district to find out the impact of various policy measures on the reproductive health of women and children. The reference period of the study is 2013-2016. The study proposes to

analyze the impact of NRHM on reproductive health indicators of rural eligible women (15-49) in the two sample divisions, one Tribal and another non-Tribal, in the District.

Srikakulam District has been divided into three revenue divisions viz., Srikakulam, Tekkali and Palakonda. Primary Health Centre (PHC) is a very important link in the health services delivery mechanism especially for the implementation of reproductive and child health programme. A total of two(2) PHCs were chosen; one from each sample division, namely Palakonda for Tribal women sample and Srikakulam, for Non-Tribal women sample, randomly. From each PHC, three(3) Sub-centres were selected and from each Sub-centre 60 eligible women respondents were covered under study. In Tribal division, Goidi, Kusumi and Chinakamba Sub-Centres under Kusumi PHC in Seethampeta mandal of Palakonda division and in the Non-Tribal areas the other three Sub-centres are K.S.Palem, Murapaka and Budumuru come under Murapaka PHC in Laveru mandal from Srikakulam division. The structured schedule has been canvassed among the eligible women respondents in all the selected 6 Sub-Centres.

The study covered 180 eligible women respondents, selecting 60 each from the three Sub-Centres from each division with the help of the stratified random sampling technique to give due representation to different strata of the society. Thus 360 eligible women respondents have been covered for intensive Study.

### Findings of the Study

The characteristics of the eligible women including age, age at marriage, ante natal care, place of delivery and treatment of health problems of women in the study area.

### Age of Women Respondents

Table 1 shows the data on distribution of the eligible women in the two selected revenue divisions of Srikakulam District. The median age of the eligible women was 28 years in the study area (not showed in the table).

Across the two sample areas, with respect to age distribution of eligible women reveals that it is different from each other. In the Tribal sample, largest number of women respondents 88 (49%) are found in the age group 25-34. While in the largest group of respondents 98 (54.4%) are found in the age group 15-24. Smallest number of respondents is found in the age group 35-49 in both the sample locations i.e., 12.7 per cent in Tribal areas and 2.8 per cent in the Non-Tribal areas. When combined, distribution of women respondents in the age groups 15-24 and 25-34 is 46.4 per cent and 45.8 per cent respectively, is not much different from each other. The women respondents are still in their prime age to bear children and assessing and analyzing their behaviour will certainly throw light on the ground level realities. It will also help in finding ways to mitigate the problems they face.

**Table 1**  
**Distribution of Women Respondents by Age Group**

Age Group	Tribal		Non-Tribal		Total	
	No.	%	No.	%	No.	%
15-24	69	38.3	98	54.4	167	46.4
25-34	88	49.0	77	42.8	165	45.8
35-49	23	12.7	5	2.8	28	7.8
<b>Total</b>	<b>180</b>	<b>100.0</b>	<b>180</b>	<b>100.0</b>	<b>360</b>	<b>100.0</b>

Source: Field Survey

### Last Delivery During 2013-2016

Information was gathered from the eligible women about their pregnancy related matters for the period during April, 2013 – March, 2016 in the study area and these details are shown in Table 2. A higher percentage of eligible women got last delivery accounted for 30.6 in 2014 followed by 29.4 in 2015, 23.3 in 2016 and 16.7 in the year 2013 in Tribal sample. In case of Non-Tribal sample the last

delivery constitutes 42.2, 27.2, 20.0, and 10.6 per cent respectively during 2015, 2014, 2016 and in 2013. Majority of the eligible women respondents have occurred last delivery during 2015 among Non-Tribal (42.2%) and in case of Tribal sample (30.6%) in 2014.

**Table 2**  
**Distribution of Women Respondents by Last Delivery**  
**during 2013-2016**

Years	Tribal		Non-Tribal		Total	
	No.	%	No.	%	No.	%
2013	30	16.7	19	10.6	49	13.6
2014	55	30.6	49	27.2	104	28.9
2015	53	29.4	76	42.2	129	35.8
2016	42	23.3	36	20.0	78	21.7
<b>Total</b>	<b>180</b>	<b>100.0</b>	<b>180</b>	<b>100.0</b>	<b>360</b>	<b>100.0</b>

Source: As ex ante

Across the study area, 35.8 per cent of eligible women respondents have got last delivery during 2015 followed by 2014 (28.9%), 2016 (21.7) and 13.6 per cent of them during 2013.

### Age at Marriage

The National Surveys shows that early marriage seems to be common in the state as nearly 70 per cent of the eligible women were married before the age of 18. Information was extracted from the eligible women respondents on the age at marriage in the study area and these details are presented in the Table 3. It is evident from the table that a major proportion of eligible women respondents have got married before the age of 18 years in both the sample areas i.e., 41.6 per cent and 43.3 per cent respectively in Tribal and Non-Tribal sample. At the age of 18, the highest percentage of them has got married in Tribal sample (30.6) and it is only 8.3 among Non-Tribal sample. The eligible women respondents have got married at age of 19 and above accounted for 27.8 per cent in Tribal sample and it is 48.4 per cent in Non-Tribal sample. The analysis reveals that there is no uniform pattern of age at marriage in both the sample areas. It is surprising that among Tribal sample who have got married before the age of 18 years is slightly lower than their counterparts in the Non-Tribal sample. Non-Tribal sample that have married at age of 19 years and above is significantly higher than those in the Tribal sample, while those who got married at age of 18 years is higher among Tribal sample.

**Table 3**  
**Distribution of Women Respondents by Age at Marriage**

Age in years	Tribal		Non-Tribal		Total	
	No.	%	No.	%	No.	%
Before 18	75	41.6	78	43.3	153	42.5
At 18 years	55	30.6	15	8.3	70	19.4
19 & above	50	27.8	87	48.4	137	38.1
<b>Total</b>	<b>180</b>	<b>100.0</b>	<b>180</b>	<b>100.0</b>	<b>360</b>	<b>100.0</b>

Source: As ex ante

In the study data reveals that 61.9 per cent of the marriages took place either at 18 years, the legal age or before. In fact the number of marriages that take place before is greater in proportion that those who got married at the legal age. This clearly suggests that to create awareness levels about the legal age at marriage and also tell them the negative effects on the health of the women and children in rural areas.

### Ante-natal Checkups

The ante-natal checkup is one of the most important precautions taken during the pregnancy period. Information was gathered from the women respondents about ante-natal checkups in both the sample areas. These details are presented in Table 4. A majority of the eligible women respondents have received first ante-natal checkup within three months of pregnancy accounted for 91 per cent in Non-Tribal sample and it is only 39 per cent in Tribal sample. After three months of pregnancy in both the

sample areas, it is the Tribal women respondents who went checkup more (about 61%) than their counterparts in the Non-Tribal areas (only 9%). The data on ante-natal checkups indicates that such checkups within three months of their pregnancy are far higher among the Non-Tribal sample compared with Tribal sample. It is also observed that 51 per cent of the eligible women respondents have received 1-5 times ante-natal checkups and 49 per cent received 6-10 times among Tribal whereas it is 23 and 67 per cent respectively in Non-Tribal sample.

In case of receiving ante-natal care women have approached different health institutions like Government hospital, dispensary, CHC, PHC, Sub-Centre or private hospitals. As many as 88 (49%) of the eligible women who received ante-natal care in Government hospital in Tribal sample compared with 27 (15%) in Non-Tribal sample. Three-fourth of the eligible women in Non-Tribal received ante-natal care in private hospital and it is only three per cent in Tribal sample.

Overall, of the 360 women respondents, as many as 234 (65%) received the first ante-natal checkup within three months of pregnancy and 126 (35%) received the same after three months. The women respondents who have received ante-natal checkups between 1-5 times is significantly higher among Tribal Sample (51%) and the percentage of women are considerably more between 6-10 times in Non-Tribal (67%). This suggests that ante-natal checkups need to be increased in the study area. It can be observed that 3/4<sup>th</sup> of the women respondents in Non-Tribal received ante-natal care in private hospitals and nearly 50 per cent of them received from Government hospital. The analysis clearly shows the existing infrastructure plays a major role as to where the respondents use the ante-natal services. In the Tribal areas there are no private medical hospitals or practitioners so they go to the government hospitals or PHCs whichever is available for their need. At the same time, in the Non-Tribal areas, private medical hospitals and practitioners are more and the general feeling of the public that infrastructure facilities in the government hospitals is not proper in working condition or the

**Table 4**  
**Distribution of Women Respondents by Number of**  
**Ante-natal Checkups**

Ante-natal Checkup	Tribal		Non-Tribal		Total	
	No.	%	No.	%	No.	%
<b>Received first ante-natal checkup</b>						
Within Three Months of Pregnancy	71	39.4	163	90.6	234	65.0
After Three Months of Pregnancy	109	60.6	17	9.4	126	35.0
<b>No. of times of ante-natal care received</b>						
1-5	92	51.1	51	28.3	143	39.7
6-10	88	48.9	120	66.7	208	57.8
10 above	0	0.0	9	5.0	9	2.5
<b>Received ante-natal care</b>						
Government Hospital	88	48.9	27	15.0	115	31.9
Private Hospital	6	3.3	135	75.0	141	39.1
Government Dispensary	19	10.6	0	0.0	19	5.3
CHC	11	6.1	3	1.7	14	3.9
PHC	29	16.1	9	5.0	38	10.6
Sub Centre	27	15.0	6	3.3	33	9.2
<b>Total</b>	<b>180</b>	<b>100.0</b>	<b>180</b>	<b>100.0</b>	<b>360</b>	<b>100.0</b>

Source: As ex ante

Hygiene conditions are not upto the mark, prompts them to opt for the private services rather than the Government hospitals. The interaction with the respondents clearly brings out that there is dire need to provide health infrastructure and facilities in almost all the Government hospitals in rural areas particularly in interior Tribal areas to reach the goal of 100 per cent coverage of ante-natal care.

## Ante-natal Care Services

As part of ante-natal care services of the pregnant women the hospital/ PHC conduct different kinds of checkups like weight, height, blood pressure, blood, urine, abdomen, breast examinations, sonogram or ultrasound scans to ascertain the health of the baby in the womb, delivery date, delivery advice, nutrition advice etc. all these details are gathered from the sample respondents in the study and shown in Table 5. It is observed from the table that of the ten aspects of ante-natal care on an average 98 of the pregnant women in the Non-Tribal areas received services in all but three examinations. They are examination like, abdomen (79.4%), breast examined (68.3%) and sonogram or ultrasound (67.5%). Among the Tribal pregnant women, the ante-natal services they received were not up to the mark or comparison to those in the Non-Tribal areas. Services like blood pressure (53.9%), blood testing (54.4%), urine (45.6%) scans like ultrasound / sonogram (6.7%) abdomen and breast examinations (35.4 % & 19.6% respectively) were not provided to the majority of the pregnant women in the Tribal area. One can simply observe that these services are mostly linked to the infrastructure facilities in the health centers. Services like delivery date, delivery advice and nutritional advice are linked to the availability of staff and their qualifications and experiences.

Across the study area, more than 70 to 90 per cent of the eligible women were taken care for seven services, like, delivery date (70.6%), blood pressure (76.1), blood (76.4%), delivery advice (79.7%), nutrition advice (87.2%), weight (90.3%) and height (90.3%). However, these figures are more influenced by the Non-Tribal samples. To make these services universal, Government needs to invest in improving the infrastructure and also need to recruit doctors to work compulsorily for a stipulated period in the rural/tribal areas. The study found that the health personnel should be more focused and give their services properly to the Tribal areas.

**Table 5**  
**Distribution of Women Respondents by Ante-natal Care**

Ante-natal Care	Tribal		Non-Tribal		Total	
	No.	%	No.	%	No.	%
Weight	148	82.2	177	98.3	325	90.3
Height	148	82.2	177	98.3	325	90.3
Blood Pressure	97	53.9	177	98.3	274	76.1
Blood	98	54.4	177	98.3	275	76.4
Urine	82	45.6	177	98.3	159	44.2
Abdomen	64	35.6	145	79.4	209	58.1
Breast Examined	35	19.4	123	68.3	158	43.9
Sonogram or Ultrasound	12	6.7	54	67.5	66	18.3
Delivery Date	77	42.8	177	98.3	254	70.6
Delivery Advice	110	61.1	177	98.3	287	79.7
Nutrition Advice	137	76.1	177	98.3	314	87.2

Source: As ex ante

## Treatment of Health Problems

Information was elicited from the women respondents on treatment of health problems whether they consult Government hospital or private hospital and the also if they get any supplementary food from Anganwadi Centres. These details are presented in Table 6. As many as 29 (16.1%) of women in Tribal women respondents went for treatment and almost all of them visited Government hospital, while of 26 (14.4) among Non-Tribal women, only 5.0 per cent (9 in number) visited Government hospital and 9.4 per cent visited private medical practitioners for treatment. The eligible women who received supplementary nutrition food from the Anganwadi Centres is accounted for 96 per cent and 97 per cent respectively in Tribal and Non-Tribal samples. This is a positive sign from point of view of the pregnant women in the study area.

**Table 6**  
**Distribution of Women Respondents by Treatment of Health Problems During Pregnancy**

Treatment	Tribal		Non-Tribal		Total	
	No.	%	No.	%	No.	%
Treatment of health problems	29	16.1	26	14.4	55	15.3
<b>Consultation</b>						
Government Hospital	29	16.1	9	5.0	38	10.6
Private Hospital	0	0.0	17	9.4	17	4.7
<b>Receipt of supplementary nutrition from Anganwadi Centre</b>						
Yes	172	95.6	175	97.3	347	96.4
No	8	4.4	5	2.7	13	3.6
<b>Receipt of IFA Tablets</b>						
None	3	1.7	5	2.7	8	2.2
1-30	10	5.6	10	5.6	20	5.6
31-60	48	26.7	19	10.6	67	18.6
61-100	119	66.1	146	81.1	265	73.6
<b>IFA Syrup</b>						
None	168	93.3	102	56.7	270	75.0
1-5 bottles	12	6.7	78	43.3	90	25.0
Tetanus Injections	180	100.0	180	100.0	360	100.0

Source: As ex ante

Safe guarding the pregnant women's health is intrinsically linked with the supply of iron and folic acid to the woman. This aspect was studied and the results show that there are very few people who did not receive any folic acid tablets 1.7 per cent and 2.7 per cent respectively in Tribal and Non-Tribal areas. Majority of the pregnant women, i.e, 66 per cent and 81 per cent have received 61-100 tablets during their pregnancy period. However, good it may be at present, still 100 per cent coverage of these women is still far and government should take the necessary steps to reach these goals. The pregnant women should be educated about the necessity of these tablets and who the new born baby would be more healthy. Then only with personal motivation of begetting a healthy baby these women will make use of this important service.

### **Place of Last Delivery, Attendant and Reasons for not going to Hospitals**

The major problem faced by the rural folk is that there are no proper health facilities. Whenever they fall sick, the rural masses faced this problem. Similarly, at the time of delivery rural women faced severe problems and sometimes they may not be able to go to hospitals or consult Doctors due to non-availability these facilities for them. This seriously affects both the new mothers and/or infants. Information was elicited from the eligible women respondents on the place of last delivery, attendant and reasons for not going to hospital and these details are shown in Table 7. It is evident from the data that 68.3, 23.3, 6.7 and 1.7 per cent of deliveries respectively took place at Government hospital, home, PHC and private hospital among Tribal sample and the corresponding figures are 37.2, 10.0, 0, and 52.8 per cent respectively in Non-Tribal sample.

In case of home deliveries, 23.3 per cent women in Tribal sample prefer delivery at their homes with the help of friends and relatives, ANMs and health workers who are available at the nearest places. The home deliveries are very low among Non-Tribal women sample (10%). About 38 per cent of the women in Tribal sample felt that it was not necessary to visit hospitals while it is 50 per cent per cent of women in Non-Tribal sample. Some of the women prefer delivery at home due to lack of time and customary. The actual reasons for delivering a baby at home needs to be further investigated. Only on the basis of those factors can practical recommendations be made about the hospital services.



Table 7

Distribution of Women Respondents by Deliveries according to Place, Medical Attendant and Reasons for not going to Hospitals

Item	Tribal		Non-Tribal		Total	
	No.	%	No.	%	No.	%
<b>Place of Last Delivery</b>						
Government Hospital	123	68.3	67	37.2	190	52.8
Private Hospital	3	1.7	95	52.8	98	27.2
PHC	12	6.7	0	0.0	12	3.3
Home	42	23.3	18	10.0	60	16.7
Total	180	100.0	180	100.0	360	100.0
<b>Type of Delivery</b>						
Normal delivery	175	97.2	136	75.6	311	86.4
Caesarean	5	2.8	44	24.4	49	13.6
Total	180	100.0	180	100.0	360	100.0
<b>Medical Attendant (if delivered in Hospital)</b>						
Doctor	0	0.0	0	0.0	0	0.0
ANM	9	6.5	19	11.7	28	9.3
Other health personnel	6	4.3	22	13.6	28	9.3
Dai	0	0.0	0	0.0	0	0.0
Relatives/ friends	123	89.2	121	74.7	244	81.4
Total	138	100.0	162	100.0	300	100.0
<b>Reasons for not going to Hospital for delivery</b>						
No time to go	19	45.2	7	38.9	26	43.3
Not necessary	16	38.1	9	50.0	25	41.7
Not customary	7	16.7	2	11.1	9	15.0
Total	42	100.0	18	100.0	60	100.0

Source: As ex ante

In the study area on the whole, both Government and private hospital deliveries together account for about 83.3 per cent and 16.7 per cent and the remaining deliveries took place at homes. Women whose deliveries took place at their homes reported that not necessary to visit hospital (41.7%), no time to go (43.3%) and not customary to go the hospital (15%).

## Conclusion

To sum up, the largest number of women respondents 88 (49%) are found in the age group 25-34 in Tribal areas where as 98 (54.4%) in the age group 15-24 among Non-Tribal women. About 43 per cent of the total eligible women respondents got married before 18 years. More than 90 cent of women goes for confirmation test within three months of their pregnancy and about 36 and 33 per cent of them visit to the Government and private hospitals respectively. About 65 per cent of the women received their first ante-natal checkup within three months of pregnancy and 35 per cent of them received the same after three months of their pregnancy. It can be observed that ante-natal checkups need to be increased in both the sample areas. About 74 and 19 per cent of eligible women have received 61-100 and 31-60 IFA tablets during their pregnancy period. The data on IFA tablets and syrup shows that to create awareness levels in the use of IFA tablets and syrup during pregnancy period among women in the ruralites. It is observed that the ASHA and ANM workers play a major role in both advising and facilitating the pregnant women to use government provided services especially in the rural and tribal areas. About 53 per cent of women approached Government hospital for delivery and 27 per cent of them to go to private hospitals.

This analysis brings out that there exists wide disparity between Tribal and Non-Tribal women particularly on the reproductive health status of women in the study area. It is also observed that these differences in health status of women is caused mostly by lack of safe drinking water, inaccessible hospital facilities and a general awareness about personal hygiene. All this calls for a suitable policy intervention by the government both at the State and Centre and especially, Ministry of Health and Family Welfare Department. Working together with the other departments like Roads and Buildings for

providing motor able roads and building all weather building for housing hospitals and PHCs and providing safe drinking water in the rural and Tribal areas will help improving the reproductive health status of women and child health in particular.

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