Utilisation of Health Care Mechanism to improve the Maternal Health Services of Dalit Women in Odisha

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Abstract: *In order to provide the comprehensive health care services to pregnant and lactating women, the National Rural Health Mission Scheme of government of India has been implemented in Odisha. One of the features of NRHM is to ensure increased access and utilization of quality health services to minimize disparity on account of gender, poverty, caste, other forms of social exclusion and geographical barriers. Dalit women are most vulnerable group as they are exploited and discriminated for being women, being Dalit and being live in poverty. The study focuses on, how the Dalit women are receiving the maternal health care services through the mechanism of NHM scheme.*

The objective of the study is to examine the accessibility of maternal health care services to Dalit women through the mechanism of NRHM in Odisha. The second objective is to understand the extent of awareness of the Dalit women with regard to maternal health care services after delivery.

Dalit women those having below five years old children were selected for the study and used the purposive sampling method at the three Blocks of Odisha. Interview schedule and focused group discussions have been used for data collection. The Results of the study highlights the low level participation of lactating Dalit women in the VHND and Mamata Divas and not aware of Gaon Kalyana Samiti. In majority of the cases, the Janai express ambulance is not in reach at the time of emergency to remote villages which results severe inconveniences at the end of Dalit lactating women.

Key Words: *Dalit women, health care mechanism, participation and untouchable.*

1. INTRODUCTION:

The caste system affirms Dalit women to be intrinsically impure and 'untouchable; historically which endorsements social exclusion and exploitation in India. The vast majorities of Dalit women are poor; they have no land of their own and engaged on wage labourer. Therefore they are always lack of access to basic resources. They are dominated by patriarchal structures and exploited by both the general community and within their own family system. The lower caste people are lagging behind in terms of receiving maternal health care services like less antenatal care, postnatal care, and in most cases delivery take place at home. A greater availability and accessibility of healthcare for Dalit women required special attention.

Dalit women first and foremost suffer with tremendous exploitation, indignities and violence by the upper castes, classes and by the state. In addition to the above, gender- based discrimination, illiteracy and poverty or poor economic status becomes a triple fold burden for Dalit women. In India, around 66 million women are Dalits and comprise 48 percent of the total Dalit population. Of the 16.3 percent of Dalit women population in India, 81.4 percent live in rural areas. (Towards the National Health Assembly II, Booklet-3, 2006)

In India, due to early marriage and childbearing affect, women's health adversely deteriorates during pregnancy time. About 28 percent of the girls in India get married below the legal age and experience pregnancy. Reproductive Maternal mortality is very high in India. Only 16 per cent of the Dalit women in India received all the antenatal care are at least 3 antenatal check-ups, and at least one tetanus toxoid injection and supplementary iron in the form of iron, folic acid tablets/syrups daily for 100 days as recommended by the RCH Programme. (RCH-DLHS-3, 2002-04).

When comes to literacy rate among Dalit women , in 2001 only 41 percent Dalit women in rural areas were literate as compared to 58 percent non- Dalit women and across India 40.5 percent of the rural women were underweight, the incidence of under nutrition was eight per cent higher for Dalit women. Moreover, Dalit pregnant, lactating woman and their children had relatively poor access to public health services as compared to other social groups. (Borooah, et al,2010)

2. THE OBJECTIVE AND AIM OF THE STUDY:

The objective of the paper is to examine the accessibility of the maternal health care services for Dalit women through the mechanism of NRHM in Odisha. The second objective is to understand the extent of awareness of the

Dalit women with regard to maternal health care service after delivery. The Goan Kalyana Samit , Village Health Nutrition Day and Janani Express Yojana are the amenities provided through National Rural Health Mission scheme in Odisha, these mechanisms are aiming to facilitate inclusive and participatory health care services in Odisha. The present study focuses on these mechanisms, how Dalit women are obtaining maternal health care services. Child care is an important component of maternal health care, thus in this paper, it depicts when the mother started breastfeeding to the child after delivery and also measuring the weight of the child.

In rural areas community ideas have generally played an important role in improving, maintaining and shaping maternal and child health care service in many ways including through the lifestyles that individuals adopt, through provision of informal care at home, through the sharing information to neighbourhood and through participation either as individuals or as a community in decisions about healthcare provision.(Gerein, Green, Mirzoev, and Pearson,2009). In this regard, the different mechanisms has been constructed in commensurate with community needs and requirements, for instance, in India village Health Nutrition Committee has been constituted as the need for providing maternal health care to the community people.

3. HEALTH SERVICE DELIVERY:

The purpose of the healthcare system is to deliver health services in the most effective and efficient way to address priority health needs in the community. As such, the delivery of health services should become important part of the healthcare system providing intensive care to the people. Health service delivery is a complex and critical issue, requiring contemplation of several question like firstly, what types of health services are needed and at what level? The secondly, what relationships should exist between health care services? Thirdly, where would be health services is provided? Here place of service is important. Fourthly, ownership of health service institution is important, who should own the health service institutions? Lastly, what level of quality should health services maintain? (Gerein, Green, Mirzoev, and Pearson, 2009) As the mentioned in the health service delivery, this study attempt to show, how the Dalit lactating women in rural areas are receiving the maternal health care services in order to improve their health status?

4. GOVERNANCE AND HEALTH CARE SERVICE:

Governance emerged in the late 1990s in health sector as a key concept for improving health care systems. Governance with relation to health care services refers to how decisions are made and how the health sector is regulated in order to reach every citizen of the respective country. Key questions around governance include the following: What are the fundamental values of the healthcare system? Decision making is important in health care service, so who makes decisions and to whom are the decision makers accountable? How transparent and inclusive is the decision making process in order to facilitate health care service? How effective and efficient are the management and planning processes in identifying and responding to needs? Individual and institutional participation in health care service is very much essential to inclusive health care development. Therefore the question is how are different entities individuals or institutions associated with the health system brought together? (ibid). Here good governance provides the inclusive health care service to all social groups. Mechanism of heath care is part of the governance, it plans and designs approach to provide for improving health care service to the marginalised group.

5. REVIEW OF LITERATURE:

The study identify the factors are Socio and economic dependency, gender and social norm, limited decision-making authority and limited access to financial, material and knowledge resources are also associated with the lower likelihood of demanding, accessing and utilizing health services thus creating risks factor for reproductive health service to weaker section women. There is lack of knowledge among women and men in terms of information of the signs and symptoms of obstructed labor, hemorrhage, hypertensive disorders, infection, and other complications of pregnancy. They also don't know where they can access help. So it becomes important that proper awareness programs are undertaken.

Thorat and Gupta (2009) in the working paper series attempt to explore the achievement of Millennium Development Goal i.e. Goal 5 is to reduce maternal mortality rate and increase of birth attendant by skilled Health persons. Moreover caste, ethnicity, and religion affected in endemic and chronic poverty, illiteracy, ill health ,higher mortality rate among schedule caste and schedule tribe and Muslim. They are discriminated and being excluded to access health care and social provision. This paper articulate that schedule castes (Dalit) are facing social exclusion due to untouchability and discrimination. Although the Govt. of India effort to safeguard and welfare to them, untouchability and exclusion in variable measure. The study explores caste based discrimination is main cause for creating social exclusion of Dalit from socio economic political cultural spheres and the development spheres. So that addressing caste based discrimination is a critical step toward achieving the equality which is the cornerstone of the MDGs. The reduction of MMR is dependent upon a range of social, economic and health service determinant such as access to trained birth attendant ,facilities and access to emergency obstetric care and ante natal care ,post natal care and thus patriarchal society, low income and under nutrition maternal health status are social determinant influence

the accessible of maternal health care service. Due to low caste they had less use of maternal health care describes in the study.

Saroha, Altarac, and Sibley (2008) the study revealed that caste is important factor which is associated with maternal health care services in Maitha, Uttar Pradesh. Upper caste women were almost three times more likely to use antenatal care, tetanus toxoid and contraceptive and almost likely to have a train birth attendant compare to the lower caste women.

Kumar (2010) the study examine state specific analysis in Tamil Nadu , Orissa and Kerala of issue of quality care, problem of institutional delivery, quality and equity issues in maternal care. The study showed historical background policy of maternal health care in India. Maternal deaths are seen in poor and disadvantaged women in different countries of the world. The study clearly mentioned that caste and religion is important determinant of health care, due to that factor inequality persist in health provision. Jena , Mahajan and Bhatia, (2013) studied status of institutional delivery in the state of Odisha .This paper reviews the current status and factors associated with institutional delivery in the state of Odisha. In this study Data was taken from DLH-3 shows that district wise institutional delivery and Balangir district is 51.7 percent which is still to go ahead and it is far from satisfactory. Other district of Kalahandi, Balangir and Koraput (KBK) region are worst performance of institutional delivery like Kalahandi and Koraput are 27.5 percent and 18.9 percent respectively. The paper explore that the factors associated with institutional delivery are lowest female literacy, early age at marriage (girls),lack of Antenatal care, Low standard of living in Odisha.

Socio, economic and political status and its variations are mainly represented by caste in Indian context and played an important role when it comes to mapping the reproductive health of women amongst various caste groups. The study would spell out the ways in which the women are accessing maternal health programmes for them has been conceptualized in the Constitution of India as a matter of equality of opportunity. The analysis of paper covers in the village level structure where the maternal health services are provided through the mechanism of governance for inclusive development of all. For example, the MAMATA divas, gaon kalyana samiti which main aim to provide maternal healthcare to all pregnancy and lactating women with holistically manner.

6. NRHM (NATIONAL RURAL HEATH MISSION)

NRHM (2005-2012) was launched in April 2005 by the honourable Prime Minister Dr.Manmohan Singh and its detailed framework for implementation was approved in July 2006. It seeks to provide effective healthcare service to rural population throughout the country with special focus on 18 states including Odisha, which have comparatively weaker public health indicators or weak infrastructure. Furthermore, while considering significance of the urban health care, the 12th Plan document of the Planning Commission, the flagship programme of NRHM will be strengthened under the umbrella of National Health Mission. The focus on covering rural areas and rural population will continue along with up scaling of NRHM to include non-communicable diseases and expanding health coverage to urban areas. Accordingly, the Union Cabinet, in May 2013, has approved the launch of National Urban Health Mission (NUHM) as a sub-mission of an overarching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other sub-mission of the National Health Mission. Therefore in 2013, NRHM was renamed the national health mission.

The goals of NHM include the following:

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR).
- Universal access to public health services such as women's health, child health, water, sanitation & hygiene, immunization and nutrition.
- Prevention and control of communicable and non-communicable diseases including locally endemic diseases.
- Access to integrated comprehensive primary healthcare.
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstreaming of AYUSH.
- Promotion of healthy life styles.

There are some important features of NHM with relation to equity in health care facilities. In this context the first feature is to ensure increased access and utilization of quality health services to minimize disproportions on account of gender, poverty, caste, other forms of social exclusion and geographical barriers. The second feature for equity is to plan for differential financial investments and technical support to states, districts and cities, with higher proportions of vulnerable population groups, including urban poor and destitute, and with difficult geographical terrain that face special challenges to meeting health goals.Thirdly to empower the ASHA to serve as a facilitator, mobilizer of community level care.

7. METHODOLOGY:

The study was carried out at Balangir district in Odisha in 2014. The paper focuses on only Dalit women having below five year child, and these untouchable castes belong to Ganda, Ghasi and Chamar. The researcher

visited the Anganwadi workers for concerned village; she provided the register with the pregnant women list in the village. Researcher also choose purposively only Dalit women having below five-year child by adopting purposive sampling method. As the study is exploratory and quantitative it has been used the both primary and secondary data. The secondary data collected from different journals, books, many websites, report of state and central governments. The interview schedule and case study method has been introduced as the tools of the data collection . Here Cases are elaborated in order to get more insights about the actual situation, how the Dalit women coped with the situation when problem rose. The total 12 villages were selected for the study area. The three Blocks were selected namely Balangir Block, Partnagarh Block and Loisinga Block. From Balangir Block, four villagers were taken for the study namely Barapudugia ,Kermeli ,Bandhanghore, and Sialbahali. Furthermore, from Loisinga Block, the villagers were G.S.Dunguripali, Kaindapali, Bagdunguri and Tapalbanji for the study. Similarly, from Partnagarh Block, the selected villagers were Rengtasil, Khuntsamalei, Bhallupita, and Gandamel.

The total sample of 80 Dalit women were selected for the study in order to know the role Village Health and Sanitation Committee in their village and also to understand men's involvement during their pregnancy, the participation of Dalit women in VHND (village health nutrition day), and the facilities of the Janani Express during emergency time and experience of abortion, touchable and untouchable experience of Dalit women while the anganwadi worker and ASHA were dealing the maternal health care service.

8. RESULTS:

8.1 The Village Health and Nutrition Day (VHND) and participation

The National Rural Health Mission introduced a national program called Village Health and Nutrition Day (VHND) and it is the most significant platform for providing essential Reproductive and Child Health services at the village level. The service is at the village level, participation of pregnant women and lactating women in this programme is very much essential in order to get the maternal and child health service. This provides as the first point of contact for primary health care for pregnant women and it works as a common platform for convergence amongst the service providers of Health worker , ICDS, AMN and the community. In Odisha, this VHND is known as Mamata Diwas. It is conducted at Anganwadi Centre (AWC) level on a monthly basis covering Pregnant Women, Lactating Mothers, and Children below 5 years and Adolescent girls as the primary beneficiaries. It renders essential and comprehensive health and nutrition services at grass roots level and has been introduced in the State of Orissa by the Department of Health and Family Welfare

Table No -1 Participation of lactating women in VHND n=80

Participation	No.of Respondents	Percentage
Yes	40	50.00
No	30	37.5
Don't know	10	12.5
Total	80	100

Source – primary survey

The Table No.1 shows that the VHND (village health nutrition day) is to be organized once every month (preferable on Wednesday, and for those village that have left out, on any other day of the same month) at the AWC in the village. The AWC is identified as the hub for the service provision in the RCH-II, NRHM, and also as a platform for inter sectoral convergence. The researcher asked the question to the lactating women , have you attended in the VHND in your village? Regarding this question 50 percent of respondents were participate in VHND whereas 30 numbers (37.5 percent) of respondents were not participated in VHND due to caste based discrimination in the study areas. Moreover, 20 per cent of respondent they do not about what is the VHND. In my study 37.5 % of respondents were not attending VHND in this regards the respondents reported that they sat separately and they had to wait some time to receive the service during the programme time. Due to Dalit they were not informer properly about VHND. So caste discrimination in maternal health care service is rampant in Odisha.

8.2 Gaon Kalyana Samiti (Village welfare committee)

In Orissa, Gaon Kalyana Samiti was launched as a simple and effective management structure at the lowest level comprising of representatives from the village. Getting the GKS registered under the Society Registration Act which was compulsory, led to a slower formation of Samitis. NRHM, Orissa realised that this was proving to be a major impediment and hence revised the guidelines, simplify the language and presentation and redistributed it across the state with a timeline. The objectives of the programme is to involve the community in planning and implementing health and other activities, the second primary purpose is to create awareness on maternal and child health services, family planning, adolescent health, environmental sanitation and hygiene and lastly to initiate action for managing health related issues and problems, Plan and prioritise activities and implement them through available funds.

As far as financial provision is concerned, amount of Rs.10, 000 is to be provided every year to the GKS from the Health and Family Welfare Department as per the norm. In order to maintain account , a joint bank account of the

Ward Member and AWW would be opened in any scheduled bank/Grameen (village) Bank/post office and it is operated by the Ward member along with the AWW for joint signature.

GKS is envisaged as a community level platform designed to facilitate public health related activities. The Village Health and Sanitation Committee (VHSC) is one of the nine institutional mechanisms under NRHM, a body facilitating all village level development programmes. The VHSC has been renamed as the GaonKalyanSamiti (GKS) to broaden its scope to include all welfare and development programmes of the village. One of the objectives was create awareness on maternal and child health services, family planning, adolescent health, environmental sanitation and hygiene. In this present study 100 percent of respondents (80 numbers) did not knowledge of GKS. They were totally unaware its function and activities. On this background, Government intervention with regard to maternal health among Dalit women was not impacting to their maternal health service that reveals in this study.

The NRHM scheme of Janani Suraksha yojana is implementing effectively but there is still shortcoming to achieve target of programme. Among 80 respondents 31 numbers (38.8 percent) were agree that they had problem of reaching to Hospital during emergency time of delivery. Similarly 61 .3 percent respondents were not had problem to reaching to Hospital. The means of communication to reach health care center are rented vehicle and Janani express ambulance. The janani express is part of NHM scheme which provides the free ambulance service to the pregnant women. Of 61.3 percent respondent 60 per cent used the janani express and 40 percent had been reached hospital by rented vehicle like car and Bolero. The Janani Express is functioning in this area but some proportion of area yet to coverage in rural areas in Odisha . The cost of travel can also be substantial and pose a significant barrier in this place. These 38 percent of pregnant Dalit women were facing problem to reach hospital which is not only risky for individual but also difficult and painful. What type of problem they were facing during emergency time. These problem are lack of money and not reaching Janani Express ambulance in time.

8.3 Social exclusion Practice of anganwadi worker and ASHA

The following table shows that ASHA and Anganwadi worker are discriminating and not touching to the Dalit lactating women when they are providing the maternal health care service in rural village.

Table No. 2 Practice of Untouchable by ASHA and Anganwadi worker

Health Worker	No. of Respondent	Percent
Aganwadi worker		
Yes	20	25.0
No	56	70.0
Don't know	4	5.0
Total	80	100
ASHA	No. of Respondents	Percent
Yes	22	27.5
No	53	66.3
Don't know	5	6.5
Total	80	100

Source – primary survey

In the table No. 2 shows that Dalit women are routinely denied health services that of the higher caste women take for granted. There are many factors like caste-based factors, including lack of access to contraception, differences in education or economic status, and physiological factors all put Dalit women at risk for experiencing maternal health problems even before complications begin. Anganwadi worker played major role in providing health service to Dalit women. But in this study Anganwadi worker were not willing to touch to Dalit women due to untouchability and lower caste in Hindu society. In these present study 56 numbers (70 per cent) of respondents reported that they were not touched by Anganwadi worker while providing health service to the women. Regarding discrimination 20 numbers (25 per cent) of women were touched by Anganwadi Worker without any discrimination of Dalit caste. During interview time some respondents revealed that while they attended Village Health Nutritional Day with general caste women they were forced to sit separately and keep distance to general, OBC category women.

The role of ASHA in NRHM pragramme is crucial to implement health care service. The Accredited Social Health Activist (ASHA) is the key facilitator under the National Rural Health Mission. ASHA was introduced as a link between the community and the health system to motivate and help vulnerable sections to improve their accessibility to basic health services. While during providing service to women, the study shown 53 number (66.3 percent) respondents were not touched by ASHA, while 22 numbers (27.5%) of lactating were touched by ASHA in the present study. As regards of don' know of respondents, 6.3 percent of respondents revealed they were unaware regarding touching and not touching . ASHA were belonging to higher Hindu caste society, so as Dalit women demanded that ASHA would have their own community due to caste based discrimination prevalent in present study area.

8.4 Discrimination by health care practitioner

The humiliated treatment by health providers are still occurring in Government Hospital. In this study 60 percent respondents were not experience humiliated treatment by health provider whereas 20 percent respondents were experience of humiliated treatment due to low caste or untouchable caste. Caste based discrimination is existing in the study area among Dalit women.

The Dalits women were discriminated by health worker at the time of home visit- the workers were hesitated to enter into the house, standing only at the main entrance, not in the living quarters, not sitting in the house if entered, not consuming anything to eat when offered by the resident. These were form of discrimination by health care provider.

Table No 3 Number of Post Natal Care Dose taken by the women

Number of time	No. of Respondents	Percent
One time	6	7.5
Two time	10	12.5
Three time	46	57.5
Do not have received	18	22.5
Total	80	100

Source – field survey

The Ministry of Health and Family Welfare recommends at least three time three PNC visits. Phase II of Reproductive and Child Health Programme had also planned increasing coverage of PNC. Moreover, Indian Public Health Standards (IPHS) emphasize a minimum of two PNC visits within a week after delivery, one within 48 hours. (Padhye ,Sardeshpande and Shukla ,2013) In this table No 3 shows number of post natal care received by respondents shown that most of the respondents among Dalit family which is 46 respondents (57.5 percent) received three times PNC. With regard to two times PNC received among Dalit women were 10 numbers (12.5 percent) of respondents. One negative factor of PNC in this study respondents don't have received PNC among Dalit women that was 22.5 percent of respondents .Among 80 number of respondents only 6(7.5 percent) were received one time PNC.

The post natal visits helps to address both the physical and mental wellbeing of the mother and general concerns about the baby and of course feeding issues in future health care. When the post natal care access they can benefits the physical and mental wellbeing of the mother, breast feeding and artificial feeding, bathing, safe infant sleeping and other cleanness. So here 22.5 percent do not visit for the PNC after deliveries that make them unaware to take care of breast feeding, cleanness and nutrition.

The study attempts to understand the awareness of the Dalit women with regard to maternal health care service after delivery. In this regard, how the lactating women are taken care of their health and their child after their delivery. How the Dalit women are taking care of their new born child after delivery? Did they measure of their baby's weight after delivery? In the present study 70 numbers (87.5 per cent) of respondents revealed that their child weight was measured soon after the baby birth and 12.5 percent (10 numbers) of respondents were not weighted to their child after their delivery. It was observed that the maternal age, education, and socio-economic status were significantly associated with low birth weight.The weight of child and size of the child is part of postnatal care (PNC).

Table No -4 Size of children in post-delivery period

Child size	No. of Respondents	Percentage
Average size	36	45
Smaller than average	27	33.75
Very small	5	6.25
Large than average	9	11.25
Very large size	3	3.75
Total	80	100

Source- Field Work Survey

It is measure and record weight of child, essential part of PNC. Weights of child have been measured in this study area. ? In the websites of www. Indianparenting, com, it has mentioned that an average Indian baby weighs approximately 2.8 kg. At full term, an average baby is 51 cm long and will weigh anywhere between 2.7 to 4 kg. Because a baby born either heavier or lighter than the average weight may be likely to health problems, it needs of doctors may keep the newborn under observation for a little while as a precaution. Low birth weight (LBW) is the important problem, defined by the World Health Organization (WHO) as weight at birth less than 2500 g (5.5 lb).

WHO reports talks that Low birth weight continues to be a significant public health problem globally and locally, is associated with a range of both short- and long-term consequences. (WHO,2014) How can we the Weight of a New-born Classified? In the websites of www. Indianparenting, com, it has described that Babies are classified on the basis of their weight at birth High Birth Weight (HBW) means Birth Weight more than 4 kg, Normal Birth Weight indicates Birth Weight around 3.2 kg, Low Birth Weight (LBW) refers to Birth Weight less than 2.5 kg, Very Low Birth Weight (VLBW) denotes Birth Weight less than 1.5 kg. Extremely Low Birth Weight (ELBW) is Birth Weight less than 1 kg. ELBW is very small and High birth weight is very large size, Low Birth Weight is Smaller than average, which notifies in this study.

In this table No. 4 display that a maximum number of sizes of the child were an average size 45 percent (36 numbers) of child of respondents was the average size of the child. Similarly, 33.75 per cent (27 numbers) of respondents' child was smaller than average due to irregular received of ANC and PNC. Moreover, 6.25 percent (5 numbers) of respondent's child were very small due to the parents early age of marriage. In this study, 11.25 percent of child was large than average that above 3 kg during delivery time. Very large sizes of the child were 3.75 percent (3 in number child of respondent). It is found during field work that, low birth weight (LBW) babies were more to the mothers who received less than three ante-natal visits in comparison to who received three or more ante natal visits.

Table no-5 Practice of Breastfeeding after Delivery n=80

Hour	No. of Respondents	Percent
Immediately	48	60
After 12 Hour	15	18.8
After one day	10	12.5
After two day	5	6.3
No response	2	2.5
Total	80	100

Source: Primary survey

The table No. 5 display that 60 percent of the respondents 48 numbers were put breastfeeding immediately. Apart from that 15 numbers (18.8 per cent) of respondents reported that were put breastfeeding after 12 hour of delivery. Similarly 10 numbers (12.5 percent) of respondents were put breastfeeding after one day. Moreover 5 numbers (6.3 %) of respondents revealed they were put breastfeeding after two days. Out of 80 number of the respondents 2 (2.5 %) of the respondents gave no response regarding breastfeeding. The study observed that taking folic acid tablet and more number of times received ANC among respondents put immediately breastfeeding to child. The researcher asked why you are not put immediately for breastfeeding the respondents were replied that their mother in law or traditional women refused to put because it will be harmful to the baby as old notion conceived by old women. Those who were delivered baby at home were not putting immediately and put to breastfeeding after one day and two days

Early initiation and exclusive breastfeeding for the first six months of life –lay down the best possible foundation for start of life. The WHO also urges member states to support exclusive breastfeeding for first six months (WHO Report, 2001).Breastfeeding not only nourishes the child but also help in development of a strong bond between mother and child. Special fatty acids in the breast milk help in increasing intelligence quotients (IQs) and better visual acuity (Dept. of women and child, Government of India 2004).

The present study 70 number of respondents (87.5 percent)reported practice of breastfeeding and 10 number (12.5 percent) of respondents were not practice of breastfeeding because of insufficient mother milk due to disease like anemia and sickle cell, lack of proper information, belief by traditional mother in law's wrong notion.

9. DISCUSSION:

The basic components of VHND and it became renamed the MAMAT Divas. Here, anganwadi worker , ASHA and ANM, are the health personnels provided the service of maternal health care service. These primary healthcare services, including early registration, deworming, counseling on early breastfeeding, identification and referral of high risk cases of children and pregnant women. Moreover, the other service are basic ANC and PNC care will be provided at community level in order to address the essential requirements of pregnancy, delivery, referral, childhood illnesses and adolescent health. In present study, 37.5 percent of Dalit lactating mother were not attending VHND. In this regards the respondents reported that they sat separately and they had to wait some time to receive the service during the programme time. Being Dalits they were not informed properly about VHND.

The issue of participation of the vulnerable groups is essential for securing the public health goals which is determine of the National Health Mission in Odisha. The inclusion of vulnerable social group is necessary in the mechanism of health care system so that the Dalit women can receive comprehensive health care with relation to maternal health care service.

Anganwadi centre is a vital place where the mental and physical development of children develops and the mothers from all communities residing in the respective village coming to gather and make their participation. In the study 70 per cent of lactating Dalit reported that they were experienced caste discrimination by anganwadi worker while providing health service to the women. Regarding no discrimination 25 percent of women were not facing any direct humiliation or discrimination by anganwadi Worker as they have some good connections with them even before. So there is need capacity building and training programme , caste discrimination and social inclusion should be a part of the training programme.

The untouchable are taking place among Dalit hamlet, so in the context of role of ASHA 66.3 percent Dalit lactating women were not touched by ASHA, while 27.5 per cent of lactating was not discrimination practice by ASHA. The lactating Dalit women were deprived the service of ASHA simply because of caste discrimination.Goan Kalyan Samiti is not actively working; it is in form of mundane. Here It is mechanism of the National Health Scheme completely which is completely failed to achieve its goals.

The two case study are given in the following that two new born baby died after delivery. The respondent reveals their experience and pain of their infant death. There are two case study are following.

Case study-1

A respondent, age 23, lives at Kaindapali, Dunguripali panchayat ,Loisinga block of Balangir district. During pregnancy, she was 20 years old and she gave birth to a pre- matured girl child after 7 months. The child could survive only for two hours before she died .Seventh month was not a mature time to deliver a baby. Her husband‘s income was less than Rs. 3000 per month. So they were unable to bear expenditure for health care and delivery arrangements to bring her to the Hospital at right time. They are belonging to BPL category family. The researcher noticed that illiteracy, home delivery, not receiving ANC properly are factors leading to the death of neo infant. Taking into consideration of caste based discrimination, ASHA and Aganwadi worker did not disseminate proper information regarding complexity of problem with relation to pregnancy. As a result infant death occurred in a poor family.

Case study- 2

The second respondent, age 23 year lives at Dunguripali village /GP , under Loisinga block . Her husband is working as a daily wage labor. She explained that during pregnancy time, she never went to Government hospital/ private hospital. Further she added she never received any kind of advice from ASHA and Anganwadi workers regarding ante natal care and taking nutritional food. Apart from that she was suffering anemia and weakness. After 8 months she delivered a male child at home without assistance of any skilled personnel leading to death of child due to various factors. The respondents told that the baby was not breast fed due to insufficiency of mother’s milk. These were other factors such as lack of decision in time by husband and other family members, remoteness of village to reach to hospital and unhelpful neighborhood due to caste discrimination.

10. SUGGESTIONS:

- This study shows that the cost of maternal health care is a significant burden on households among Dalit women. Interventions targeting the cost of transportation and loss of income are needed, as well as intervention reducing the burden of out-of-pocket payment for care by government effort.
- Untouchability is prevalent in the study area; so government policy should strengthen to eradicate caste based discrimination. It is very harmful social norm that prevents accessing maternal health care among Dalit women.
- Guarantee access to primary and secondary education for Dalit women. Ensuring basic education for girls is one of the principal factors of achieving women’s and girls’ empowerment and their ability to exercise their basic rights. The higher education allows to more access to maternal health care.
- The concerned authorities and services such as ICDS should formulate appropriate health awareness and health promotion programmes to encourage above 18 years old motherhood and discourage teenage pregnancy.

11. CONCLUSION:

Conclusion draws that attendance of VHND of respondents was observed that caste based discrimination still prevailing on the study area of Odisha .As a result it adversely affects the maternal health care among the Dalit community. To promote institutional delivery and reduce out of pocket expenditure by providing nonstop free transport facility and contributing to reduction of infant and maternal mortality was main purpose of Janani Express yojana. But it is vain as most of the Dalit families were facing financial problem of reaching to the hospital. The discrimination and exclusion faced by the Dalit communities still prevailing in Odisha. The practice of untouchability still is prevailing in Dalit hamlets. It depicts in the study that 66.3 percent Dalit lactating women revealed that they were not touched by ASHA workers and faced direct discrimination, whereas 27.5 per cent of lactating were not

observed direct discrimination practiced by ASHA workers. However, the lactating Dalit women were deprived the service of ASHA simply because of caste discrimination. Similarly the Anganwadi workers also under the clutch of caste system, they have prejudice that they get polluted while dealing with Dalit pregnant and lactating women in maternal health care service. It needs the capacity building training for ASHA and Anganwadi workers to enhance the holistic view, understanding and cooperation for the extension of maternal and child care services in rural Dalit hamlets.

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