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KEY WORDS:

# RECOGNIZING MENTAL HEALTH AND WELLBEING IN VICTIMS OF VIOLENCE AMONG SANTHAL TRIBE WOMEN IN JHARKHAND, INDIA

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## 1: Introduction

The World Health Organization has estimated that mental and behavioral disorders accounted for 12 percent of the global burden of disease in 2000 and it is projected to increase to 15 percent by 2020 (World Health Assembly, 2011). Around one-fourth of the people from a given geographical area, community, setting, socio-economic background and gender experienced the mental disorder at some point in time in their lives (WHO, 2001). Accordingly, WHO has developed an action plan to address this issue, known as Mental health Action Plan (2013-2020), with the following specific objectives and targets:

**Objective 1:** To strengthen effective leadership and governance for mental health

**Target 1.1:** 80 percent of countries will have to develop or update their policy/plan for mental health in line with international and regional human rights instruments (by the year 2020). Existence of a national policy and/or plan for mental health that is in line with international human rights instruments.

**Target 1.2:** 50 percent of countries will have to develop or update their law for mental health in line with international and regional human rights instruments (by the year 2020). Existence of a national law covering mental health that is in line with international human rights instruments.

**Objective 2:** To provide comprehensive, integrated and responsive mental health and social care services in community-based settings.

**Target 2.1:** Service coverage for severe mental disorders will be increased/ will have to increase by 20 percent (by the year 2020). Proportion of persons with a severe mental disorder (psychosis; bipolar affective disorder; moderate severe depression) who are using services.

**Objective 3:** To implement strategies for promotion and prevention in mental health.

**Target 3.1:** 80 percent of countries will have at least two functioning national, multi sectoral mental health promotion and prevention programs by the year 2020). Functioning programs of multi sectoral mental health promotion and prevention in existence.

**Target 3.2:** The rate of Suicide in countries will be reduced by 10% (by the year 2020). Number of Suicide deaths per year per 100000 population.

**Objective 4:** To strengthen information systems, evidence and research for mental health.

**Target 4.1:** 80 percent of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social Information systems (by the year 2020) Core set of identified and agreed mental health indicators will be routinely collected and reported every two years.

*Source: World Health Organization. Mental Health Action Plan 2013-2020. Available at http://www.who.int/mentalhealth/ publications/ action plan/ Accessed on 1st October 2016*

The above set objectives and specific targets indicate that gender is a critical determinant of health, including mental health. It influences the power and control, men and women have over the determinants of their mental health, including their socioeconomic position, roles, rank and social status, access to resources and treatment in society. As such, gender is important in defining susceptibility and exposure to a number of mental health risks. Gender has significant explanatory power regarding differential susceptibility and exposure to mental health. If it is accepted that both women and men have a fundamental right to mental health, it becomes impossible to examine the impact of gender on mental health without considering gender-based discrimination and gender-based violence. Consequently, a human rights framework is needed to interpret gender differences in mental health and to identify and redress the injustices that lead to poor mental health. Many of the negative experiences and exposures to mental health risk factors that lead to and maintain the psychological disorders, in which women predominate, involve serious violations of their rights as human beings including their sexual and reproductive rights. Addressing mental health in isolation has skewed the research agenda. The relationship of women's reproductive functioning, to their mental health has received protracted and intense scrutiny over many years while their vulnerability to sexual violence and its consequences on their mental health have been neglected. Recent research suggests that the impact of biological and reproductive factors on women's mental health is strongly mediated and, in many cases disappears, when psychosocial factors are taken into account. For example, research on menopause has revealed that emotional wellbeing in middle- aged women is positively associated with their current general health status, psychosocial and lifestyle variables, but not with their menopausal status nor their hormone levels (Dennerstein, Dudley and Burger, 1997). In contrast, the contribution of men's reproductive functioning to their mental health has been virtually ignored. The few studies that have been conducted reveal that men are emotionally responsive to many of the same events as women. For example, men as well as women experience depression following the birth of a child and there is a high level of correlation between parents regarding depressive symptoms (Soliday, McCluskey-Fawcett and O'Brien, 1999). Health programs directed towards women have typically had a narrow focus on reproductive health and fertility control, especially in developing countries. The preoccupations of health planners, aid agencies and researchers are not necessarily shared by the women towards whom these programs directed. In a study conducted in the Volta region of Ghana, nearly three quarters of the women, when asked to identify their most important health concerns, nominated psychosocial health problems such as 'thinking too much' and 'worrying too much', not reproductive health concerns (Avotri and Walters, 1999). The explanations women gave of their health problems stressed heavy workloads, the gendered division of labour, financial insecurity and unremitting responsibility for the care of children.

Moreover, researcher attention has focused upon status of mental health disorder, which is often unnoticed. In developing evidence based research, it is important to envisage the contemporary situation of the study population. Women in Jharkhand are deprived mentally and physically as compared to women

elsewhere in the country in terms of discrimination and disadvantages. There are a number of common characteristics, which the women of Jharkhand lack behind their male counterparts, mainly their level of literacy and education, doing unpaid work, low participation in the work force, very little property rights and even discrimination within the family which may lead to poor mental health outcomes. These patterns of mental disorder distributions are consistent with the distributions of major role-identities particularly in tribal society, at least among the married. Traditionally, married women have held fewer identities (e.g., spouse, parent) than married men (e.g., spouse, parent, employed worker). However, over the past two decades in tribal dominant regions where no defined role and responsibility are designated to women and a large number of women population have entered the labour force, increasing the number of role-identities held by women, these inconsistent findings suggest that further examination of the role-identities held by tribal women is required.

It is against these backgrounds; this paper examines the status of mental health disorder in Santhal women with the help of a widely acknowledged General Health Questionnaire using 12 pertinent questions as explanatory factors for the relative mental health advantage. The dependent variable, mental health problems, was assessed with the 12-item General Health Questionnaire inventory (GHQ-12), originally developed in the United Kingdom to screen for nonspecific psychiatric morbidity in the general population (Goldberg, 1992; Patel and Andrew, 2001). Santhal women were asked to indicate whether in the past three months they had experienced a range of positive and negative emotions including feeling constantly under strain, worthless as person, unhappy and depressed, capable of making decisions, and able to enjoy normal activities. For each item, a negative emotional state was coded 1 and 0 otherwise. The items were summed to produce a score for each individual, with mental health problems increasing as scores, ranging from 0 to 12, increase.

Although most studies impose a diagnostic cut-off, this study retained the dependent variable as a scale. Scales better reflect the full spectrum of variation in mental health whereas arbitrary cut-offs lose important information. The decision was warranted given that the GHQ-12 is widely accepted as a screening tool for mental health problems but performs poorly in clinical settings as a diagnostic instrument (Youth state Report, Jharkhand, 2006-07, Bansod, 2011). Importantly, prior research shows that diagnostic cut-offs for the GHQ-12 in the Indian population have low positive predictive value.

This paper is organized into three sections. The first section examines attributes of Mental Health using a widely acknowledged General Health Questionnaire based on 12 pertinent questions as explanatory factors for the relative mental health status of Santhal women in community. The second section explores the sources of psychological benefit more closely by comparing the distress levels of women who share the same number and combinations of role-identities. To elucidate the issue, this paper examines the effects of household variables and a predictor variable related to women's role identities and its relation with mental health among women. The last section of this paper summarizes the key findings emerging from the analysis presented in different sections of this paper and also its implications to address the mental health status of Santhal women by analyzing the adjusted effects of confounding variables on mental health status of women which is categorized under three segments "*Normal, Moderate* and *Severe*" .

**Need for the study**

For these reasons, this paper examines gender differences and gender by marital status differences in mental health using a widely acknowledged General Health Questionnaire using 12 pertinent questions as explanatory factors for the relative mental health advantage of married and unmarried men compared to similar women. The paper then explores the sources of psychological benefit more closely by com-paring the distress levels of men and women who share the same number and combinations of role-identities. To elucidate the issue, this paper examines current evidence regarding rates, risk factors, correlates and consequences of gender disparities in mental health.

**Methods**

Data for the present paper comes from my "Field Survey of PhD Work," on 247 Sample conducted in Jharkhand 2014-15. The dependent variable, mental health problems, was assessed with the 12-item General Health Questionnaire inventory (GHQ-12), originally developed in the United

Kingdom to screen for nonspecific psychiatric morbidity in the general population . Santhal women were asked to indicate whether in the past month they had experienced a range of positive and negative emotions including feeling constantly under strain, worthless as person, unhappy and depressed, capable of making decisions, and able to enjoy normal activities. For each item, a negative emotional state was coded 1 and 0 otherwise. The items were summed to produce a score for each individual, with mental health problems increasing as scores, ranging from 0 to 12, increase. The scale has strong psychometric properties with acceptable

internal consistency ($\alpha$= .76) and has been widely used throughout India and demonstrates validity in the Indian population . Although most studies impose a diagnostic cut-off, this study retained the dependent variable as a scale. Scales better reflect the full spectrum of variation in mental health whereas arbitrary cut-offs lose important information. The decision was warranted given that the GHQ-12 is widely accepted as a screening tool for mental health problems but performs poorly in clinical settings as a diagnostic instrument. Importantly, prior research shows that diagnostic cut-offs for the GHQ-12 in the Indian population have low positive predictive value.

**Results**

**1.2: Mental health status of Santhal women**

This section presents the existing scenario of mental health status of Santhal women using GHQ-12 Questionnaire. The General Health Questionnaire consists of 12 items, each item measuring the severity of mental disorders over three months preceding the study. Each item was assessed on a four-point scale (Not at all, no more than usual, rather more than usual, much more than usual) widely used by various mental health researchers (Singh and Kashyap., 2016). We have arranged the response of GHQ-12 items by keeping all the item in the same direction. GHQ – 12 is a dimensional indicator of common mental disorders from which a score is produced, and this score was divided into three equal measures. However, researchers have categorized mental health score into normal, moderate and severe groups by using the principal component analysis (PCA). where the major attributes are – *"Able to concentrate, Loss of sleep over worry, Paying useful part in life, Capable of making decisions, Felt constantly under strain, Could not come over difficulties, Able to enjoy day to day activities, Able to face problems, Feeling unhappy and depressed, Losing Confidence, Thinking of self as worthless, Feeling reasonability happy"*. Results are presented in Table 6.1.

**Table 1.1** Prevalence of self-reported mental health problems experienced by Santhal women in last three months preceding the survey using GHQ-12, Jharkhand ,India, 2014-15

| GHQ-12 scale items | Not at all | No more than usual | Rather more than usual | Much more than usual | N |
|---|---|---|---|---|---|
| Able to concentrate | 39.8 | 32.4 | 24.9 | 2.9 | 241 |
| Loss of sleep over worry | 49.4 | 35.3 | 15.4 | 0.0 | 241 |
| Playing a useful part | 22.8 | 36.5 | 32.8 | 7.9 | 241 |
| Capable of making decisions | 30.7 | 35.3 | 26.6 | 7.5 | 241 |

| | | | | | |
|---|---|---|---|---|---|
| Felt constantly under strain | 19.9 | 69.3 | 4.1 | 6.6 | 241 |
| Could not overcome difficulties | 3.0 | 72.1 | 24.9 | 0.0 | 233 |
| Not Able to enjoy day-to day activities | 20.0 | 43.8 | 36.3 | 0.0 | 240 |
| Able to face problems | 23.7 | 46.9 | 29.5 | 0.0 | 241 |
| Feeling unhappy and depressed | 19.5 | 69.7 | 7.9 | 2.9 | 241 |
| Losing confidence | 35.0 | 36.3 | 24.6 | 4.2 | 240 |
| Thinking of self as worthless | 14.9 | 51.5 | 29.5 | 4.1 | 241 |
| Feeling reasonability happy | 10.8 | 62.2 | 27.0 | 0.0 | 241 |

Table 6.1 shows the prevalence of self- reported symptoms of mental health problems experienced by Santhal women in last three months preceding the survey for each of the 12 items in the GHQ-12 scale. The results portray the experience of symptoms of mental health problems from the following statements. Nearly two-fifths of the women reported that they are not at all "able to concentrate", 15 percent reported that they lose sleep over worry much more than usual, 37 percent women reported that they are playing a useful part not more than usual, 31 percent of women reported are not at all capable of making decisions, 7 percent of women fell constantly under strain and 3 percent of women reported feeling unhappy and depressed much more than usual, 25 percent women reported they could not overcome difficulties and they feel losing confidence more than usual times, and 30 percent of women reported that they think themselves as worthless more than usual times.

**Table 1.2: Percentage of women with mental health disorder by background characteristics in Santhal, Jharkhand, India, 2014-15**

| Background Characteristics | Normal | Moderate | Severe | Number (N) | Chi-squire |
|---|---|---|---|---|---|
| **Age** | | | | | |
| 15 to 24 | 54.6 | 22.7 | 22.7 | 66 | |
| 25-34 | 43.2 | 38.3 | 18.5 | 81 | 4.10, p<0.392 |
| 35 and Above | 48.8 | 31.7 | 19.5 | 82 | |
| **Education** | | | | | |
| No education | 64.8 | 9.1 | 26.1 | 88 | |
| Below primary | 40.0 | 35.0 | 25.0 | 40 | |
| Middle school | 36.3 | 48.8 | 15.0 | 80 | 37.6, p<0.000 |
| High School and Above | 50.0 | 45.8 | 4.2 | 24 | |
| **Religion** | | | | | |
| Hindu | 50.9 | 28.1 | 21.1 | 114 | |
| Christian | 46.8 | 35.5 | 17.7 | 62 | 1.11,p<0.892 |
| No religion/Sarna | 48.2 | 32.1 | 19.6 | 56 | |
| **Wealth Index** | | | | | |
| Poor | 44.2 | 41.6 | 14.3 | 77 | |
| Middle | 44.3 | 30.4 | 25.3 | 79 | 9.92,p<0.042 |
| Non Poor | 59.2 | 21.1 | 19.7 | 76 | |
| **Number of children** | | | | | |
| No child | 35.6 | 46.7 | 17.8 | 45 | |
| 1 Child | 59.4 | 23.4 | 17.2 | 64 | 11.05,p<0.87 |
| 2 Child | 45.5 | 27.3 | 27.3 | 66 | |
| 3 or More | 52.6 | 31.6 | 15.8 | 57 | |
| **Exposure to Mass Media** | | | | | |
| No exposure | 48.3 | 10.0 | 41.7 | 60 | |
| Partial exposure | 87.7 | 5.3 | 7.0 | 57 | 87.74,p<0.000 |
| Full exposure | 30.4 | 54.8 | 14.8 | 115 | |
| **Husband Education** | | | | | |
| No education | 22.81 | 2.78 | 45.65 | 49 | |
| Below primary | 5.26 | 18.06 | 4.35 | 21 | 42.87,p<0.000 |
| Middle school | 37.72 | 31.94 | 34.78 | 82 | |
| High School and Above | 34.2 | 47.2 | 15.2 | 80 | |
| **Total** | **49.1** | **31.0** | **19.8** | **232** | |

Prevalence of mental health disorder among women by some selected background and individual characteristics are presented in Table 6.2. Mental health variables were categorized into three groups – normal, moderate and severe. The younger age group (23%) women reported severe mental health problems as compared to higher age group women. About 26 percent of women having no education reported to have severe mental health disorder, followed by 25 percent women whose education was below primary; only 4 percent women whose education level was high reported severe mental health disorder. When religion was considered, it is found that more than 20 percent of women of Hindu religion followed by a little less than 20 percent of the women belonging to no religion reported severe mental health disorder. The non-poor women were more in proportion to report mental health disorder as compared to poor women in all the three categories. Around 27 percent of women who had 2 child reported severe mental health disorder followed by 18 percent women who had either no child or at least one child. More than 40 percent of women who had no exposure to mass media reported severe mental health disorder followed by 15 percent women who had full exposure to mass media. When the association was checked between the response and the predictor variables then it was found that all the variables had a significant relationship with mental health disorder.

**Table 1.3: Percentage of women with mental health disorder by women's autonomy and Violence among Santhal, Jharkhand, India, 2014-15**

| Characteristics | Normal | Moderate | Severe | Number (N) | Chi-squire |
|---|---|---|---|---|---|
| **Women Empowerment** | | | | | |
| Yes | 29.6 | 70.4 | 0.0 | 71 | |

| | | | | | |
|---|---|---|---|---|---|
| No | 63.7 | 15.1 | 21.2 | 146 | 69.78,p<0.000 |
| **Mobility** | | | | | |
| Yes | 2.6 | 97.4 | 0.0 | 38 | |
| No | 58.3 | 18.0 | 23.7 | 194 | 93.45,p<0.000 |
| **Financial Autonomy** | | | | | |
| Yes | 32.3 | 67.7 | 0.0 | 62 | |
| No | 61.0 | 18.8 | 20.1 | 154 | 51.59,p<0.000 |
| **Decision Making** | | | | | |
| Yes | 51.8 | 27.3 | 20.9 | 12 | |
| No | 100.0 | 83.3 | 100.0 | 220 | 28.12,p<0.000 |
| **Husband Alcohol Use** | | | | | |
| Yes | 49.8 | 27.4 | 22.9 | 201 | |
| No | 43.3 | 56.7 | 0.0 | 30 | 14.277,p<0.001 |
| **Violence characteristics** | | | | | |
| **Violence against Women** | | | | | |
| Yes | 64.6 | 3.5 | 31.9 | 144 | |
| No | 22.9 | 77.1 | 0.0 | 83 | 138.99,p<0.000 |
| **Justification for violence** | | | | | |
| Yes | 69.1 | 3.0 | 27.9 | 165 | |
| No | 0.0 | 100.0 | 0.0 | 65 | 207.09,p<0.000 |
| **Femininity index** | | | | | |
| Low femininity | 90.9 | 5.2 | 3.9 | 77 | |
| Moderate femininity | 58.5 | 28.3 | 13.2 | 53 | 85.08,p<0.000 |
| High femininity | 16.7 | 83.3 | 0.0 | 42 | |

Table 1.3 gives percentage of women with mental disorder in terms of women's autonomy and violence. More than 20 percent of women who were not empowered, who did not have freedom of mobility, who neither had financial autonomy reported severe mental health disorder as compared to women who were empowered. On the other hand, a little more than 20 percent of women who had autonomy in decision making had severe mental health disorder. Those women whose husbands use alcohol, 23 percent of them reported having severe mental health disorder. In context of violence experienced by women it is found that, those women who had experienced violence, 32 percent reported severe mental health disorder. Similarly, 28 percent of women who perceive that violence are justified; they reported severe mental health disorder as compared to women who did not perceive that violence is justified. All variables such as women empowerment, freedom of mobility, financial autonomy, autonomy of decision making, husband's alcohol use, violence against women and justification for violence are significantly associated with women's mental health disorder.

### 1.3: Socio-economic and cultural correlated correlation of mental health

Santhal community is clearly distinguished with high poverty, less education among women and having low sectoral employment opportunity in the organized sectors. Poverty, low levels of education and working status are closely interlinked to mental disorders which in turn contribute to impoverishment. Data from the study reveals that mental disorders were significantly higher in households with lesser income, poor education and limited employment. It is evident that these tribal women have a greater vulnerability to mental disorders moderated by adverse social and economic determinants widely prevailed prevalant in the Santhal community. These factors also limit their access to and their utilization of mental health services. Our study showed that the husband husband's education and Alcohol use is one of the important determinants of women's mental health.

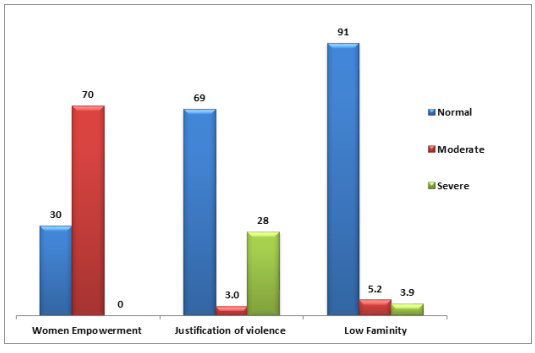
**Table 1.4: Odds ratio for the women having Mental Health disorder by background characteristics of respondents among Santhal, Jharkhand, India, 2014-15**

| **Background Characteristics** | **Odds ratio (95% CI)** | | |
|---|---|---|---|
| **Age** | **Model 1** | **Model 2** | **Model3** |
| 15 to 24 | | | |
| 25-34 | 1.7(0.76-3.99) | 1.7(0.99-3.96) | 0.9(0.19-4.07) |
| 35 and Above | 1.2(0.45-3.10) | 0.9(0.35-2.81) | 1.1(0.17-6.43) |
| **Education** | | | |
| No education | | | |
| Below primary | 2.9**(1.11-7.64) | 3.1**(1.11-8.71) | 4.8*(0.94-24.41) |
| Middle school | 3.4***( 1.40-8.31) | 3.4**(1.27-8.95) | 5.1**(1.02-24.84) |
| High School and Above | 1.4(0.38-4.83) | 1.4(0.33-5.92) | 2.6(0.22-30.80) |
| **Number of children** | | | |
| No child | | | |
| 1 Child | 0.7(0.28- 1.87) | 0.7(.26-1.96) | 1.7(0.33-9.34) |
| 2 Child | 1.4(0.49-3.94) | 1.2(0.42-3.67) | 1.9(0.28-12.76) |
| 3 or More | 0.7(0.23-2.08) | 0.5(0.17-1.68) | 1.3(0.19-8.30) |
| **Exposure to Mass Media** | | | |
| No exposure | | | |
| Partial exposure | 0.08***(0.03-0.23) | 0.08***(0.026-0.25) | 0.2*(0.02-1.19) |
| Full exposure | 1.2(0.49-2.76) | 0.5(0.72-4.98) | 0.9(0.13-6.04) |
| **Religion** | | | |
| Hindu | | | |
| Christian | | 1.3(0.59-2.88) | 1.9(0.55-6.66) |
| No religion/Sarna | | 0.8(0.35-1.80) | 1.2(0.32-4.19)) |
| **Wealth Index** | | | |

| | | | |
|---|---|---|---|
| Poor | | | |
| Middle | | 1.5(0.65-3.44) | 4.1**(1.01-16.94) |
| Non Poor | | 0.6(0.25-1.23) | 0.8(0.19-3.42) |
| Husband Education | | | |
| No education | | | |
| Below primary | | 1.1(0.26-4.67) | 1.9(0.21-17.26) |
| Middle school | | 0.3**(0.10-0.79) | 0.3(0.04-1.77) |
| High School and Above | | 0.3**(0.10-1.01) | 0.5(0.07-3.85) |
| **Women Empowerment** | | | |
| No | | | |
| Yes | | | 4.5*(0.81-24.41) |
| **Husband Alcohol Use** | | | |
| No | | | |
| Yes | | | 0.2(0.03-1.37) |
| **Violence against Women** | | | |
| No | | | |
| Yes | | | 1.7(0.13-21.23) |
| **Femininity index** | | | |
| Low femininity | | | |
| Moderate faminity | | | 3.0(0.50-18.26) |
| High faminity | | | 16.9*(0.83-347.71) |
| **2log likelihood** | **124.614** | **116.957** | **54.283** |

Logistic regression of women having mental health disorder on the basis of background characteristics is done in three models. In model one only individual characteristic are taken into considerations. The result portrays that women who had completed middle school are 3.4 (1.40-8.31) times more likely to have mental health disorder in reference to women who are not educated. Further, women who had partial exposure to mass media are 0.08 (0.03-0.23) times less likely to have mental health disorder in reference to women who had no exposure to mass media. In model two, even household characteristics are taken into considerations of which the result is as same as model one for education and exposure to mass media. Further, even the women whose husband's education is up to middle school, they are 0.3 (0.10-1.01) times less likely to have mental health disorder in reference to women whose husbands were not educated. The third model consists of attributes of women's autonomy along with individual and household characteristics. In model three also, the education level of women and exposure to mass media showed the same significance on mental health disorder of women as model one.

**Figure 1.1: Percentage of women experiencing mental health disorder by their empowerment status, f femininity and Justification of Violence in Santhal, Jharkhand, India,2014-15**




### 1.4: Summary of Findings and Conclusions

Previous theoretical and empirical work has suggested that psychological benefit accrues from identity accumulation. This study represents an attempt to apply this general finding to the phenomenon of women empowerment and effect of domestic violence in mental health disorder. As a straightforward extension, it seemed reasonable to propose that the higher prevalence (19%) of severe mental health problems among Santhal tribe women in Dumka, Jharkhand, especially among women with low mobility, decision making and financial autonomy, might be explained at least in part by a relative lack of women position in community. This research documented clear relationship of violence, women autonomy in mental distress and in identity accumulation, reconfirmed the anxiety- and mental health disorder among this section sub population.

Conceiving thus to address mental health status of Santhal women by understanding its relationship with a series of variables which has direct and indirect relationship with the psychological wellbeing of women. The women, the overall finding illustrates that the mental health status of women in Santhal tribe is 19 percent whereas, the Youth in India,(2006-2007) study findings shows that 17 percent of women exhibit symptoms of mental health disorder. It is found that those Santhal women who have low mobility, also exhibit sever mental health disorder.

Establishing research that address Santhal women mental health condition findings reveals that one in five Santhal women reported symptoms or behaviors suggestive of mental health disorders. This suggest that there is a need to establish systems that address mental health of sub section of a population which is often hidden. It is important that the state must take note of these findings and incorporate a special focus on identifying and treating women in need by empowering them with creating more local employment opportunities, creating Self Help Groups(SHGs), promoting women in developing poultry and animal husbandry, local food selling enterprises, vegetables and fruits growing and selling. Programs should priorities prioritize need of tribal young women who often become victims of domestic violence—particularly those women who justify the violence and believe Santhal men as custodian of the community. Santhal women among whom symptoms were more likely to be reported—for possible mental health disorders where there is lack of primary health services, including, for example, sexual and reproductive health services, and to refer women with such symptoms to appropriate health facilities and providers. Findings that young Santhal women having No education in Dumka Jharkhand were more likely than others, reporting symptoms suggestive of mental health disorders highlight the need for such efforts on a priority basis in these tribal communities.

Another important finding of this study is that women whose husbands consume alcohol are more susceptible to severe mental health disorder. It is clearly found in this study that Santhal men are more affiliated to consuming of alcohol or any substance abuse. The wives of these men are hence with more prone to the domestic violence and clearly displays symptoms of severe mental health problem. Data on husband's alcohol use indicates that substantial proportions of married men reported the consumption of alcohol. Efforts are needed to sensitize tribal men about the adverse effects

of substance abuse. Directions for future research findings presented in this report provide a broad picture of Santhal tribe in Jharkhand. At the same time, findings have raised a number of issues that require further investigation, particularly with regard to the determinants and consequences of domestic violence and practices of alcohol use which is believed to be an integrated part and parcel of theses tribal communities.

Theses illustrated problems requires action at many levels. In particular, decisive mental health policies must be developed that are based on an explicit analysis of violence against women in risk and outcome. Consequently, a rights framework needs to be adopted to improve the interpretative dimensions of research. The SHGs in Santhal villages can contribute to changes in financial conditions, social status, decision-making and include women in outdoor activities. The small saving approach through "gramin banks" (Micro finance) could serve as valuable instrument to improve the living conditions of the women and contribute to local economic development.

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