CHAPTER 4

Methodology
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METHODOLOGY

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Methodology consists of obtaining information through empirical observation. It makes a study scientific and realistic by carrying methodological procedures. The present research study was systematically undertaken. The Objective of this study was to examine the Reproductive Health Issues and Concerns of Tribal women collecting data from primary and secondary sources. With a holistic perspective Reproductive Health was conceptualized as a comprehensive component consisting of social, economic and cultural inputs.

4.1. Statement of the Problem

“Reproductive Health Status-Issues and Concerns of Tribal Women”

4.2. Objectives of the Study

The general objective of the study was to assess and understand the Reproductive Health Status and concerns of Tribal Women. Specific objectives were:

- To assess the socio-economic, demographic and cultural conditions of Tribal Women.
- To assess the Knowledge of the Tribal Women regarding various Reproductive Health issues
- To study the actual Reproductive Health status and Reproductive Health problems of Tribal Women
- To assess the family planning preferences and contraceptive usage among the Tribal Women
- To know about the utilization of the health care services by the Tribal Women
- To study the food habits and dietary intake of the Tribal women
- To study the Reproductive Health status of the Tribal women and suggest remedial measures for improvement
4.3. Hypotheses

A hypothesis was a specific statement of prediction. It describes in concrete terms what one expects will happen between variables in the study. However, not all studies have hypotheses. Sometimes a study was designed to be exploratory. There may be no formal hypothesis, if the purpose of the study was to explore some area more thoroughly in order to develop some specific hypothesis or prediction that can be tested in future research i.e inductive approach. In inductive reasoning, the research begins with specific observations and measures, detect patterns and regularities, formulate some tentative hypotheses that can be fully explored, and finally end up developing some general conclusions or theories.

The present research study was exploratory in nature and examined the concerns of Tribal Women in three regions in depth. Hence no hypothesis was formulated as such.

4.4. Conceptual Framework

The conceptual framework adopted for this research study illustrates the pathways by which Reproductive Health (RH) programs achieve their objectives. This framework maps the pathways through which programs achieve results, and it constitutes a logical framework for developing an evaluation plan with appropriate indicators. The framework draws attention to the different aspects of programs (operational areas, access to services, quality of care) that must be working satisfactorily to achieve the desired end result.

The column on the far left defines the context in which the program operates: the social, cultural, economic, political, and legal systems in a given society, including that society's Reproductive Health programs. The top left-hand side of the figure no 6.1, outlines the role of demand in the effectiveness of a given program. Countries in which the population actively wants the services ("high demand") based on societal norms and preferences will have a far easier time achieving results than those in which the population is indifferent or outwardly negative toward the program.
Fig. No. 4.1 Conceptual framework on Reproductive Health
The lower left-hand side of the framework lists factors in the supply environment. Countries with strong social and economic development programs provide a more conducive environment in which to promote RH than those without systems to support such efforts. Strong political support ("political will") for a program also facilitates implementation, as they actively design interventions (e.g., advocacy) with the aim of shaping the policy environment.

The supply environment also comprises the functional areas that support service delivery and the service delivery environment itself. The functional or operational areas of a program provide the structure for carrying out interventions, including management, training, logistics, research/evaluation. These functional areas contribute directly to the services available to a prospective client in a given country. Measures of the service delivery environment focus on access to services and quality of care as well as sub-elements of quality: integration of services and gender equity/sensitivity.

These two sets of factors -- supply and demand -- jointly determine the level of service utilization in a given country. Although service utilization is not essential to the practice of certain behaviors (e.g., sexual abstinence, condom use, exclusive breastfeeding), it generally plays a key role in helping a client adopt healthy behaviors, through information and counseling (e.g., correct condom use, tips for adhering to exclusive breastfeeding), provision of supplies (e.g., contraceptive pills, condoms for pregnancy and sexually transmitted disease prevention), or clinical procedures (e.g., IUD insertion, surgical sterilization, male circumcision).

The box labeled "Health Behaviors" represents the objective of most RH programs: that is, the behaviors that members of the intended audience are encouraged to adopt. Examples include use of contraception for FP, use of condoms or decrease in number of sexual partners for HIV prevention, delivery with a skilled birth attendant, and exclusive breastfeeding. It is important to recognize that non-program factors may also play a role at this level in influencing both health behaviors and outcomes. For example, gender norms and gender inequalities may influence women's health behaviors. For instance, women's
limited control over decisions that affect their health and limited access to resources (e.g., transportation) makes it difficult for them to use services. Women are more susceptible to contracting HIV from an infected partner than men are. Fertility is determined not only by contraceptive use, but also age at marriage, extent of induced abortion, postpartum infecundability, and pathological sterility. The entire chain of causal events leading to specific health behaviors directly affects the ultimate objective of RH programs: improved health outcomes in terms of fertility, mortality, and morbidity. (This framework was developed by MEASURE Evaluation Population and Reproductive Health (PRH) which is funded by the U.S. Agency for International Development (USAID).) The framework was taken as a basis to study the Reproductive Health status of Tribal women which was a culmination of the effect of various socio-economic, cultural and demographic inputs.

4.5. Research Design

Study area

The present study was carried out in the three regions of the state of Andhra Pradesh (59,18,073 lakhs of Tribal population ) before bifurcation of the State. One district from each region namely Andhra, Telangana and Rayalaseema were selected giving due representation and weightage to the inhabitation of Tribal population. The three districts purposively selected for the study were -- Vishakapatnam with a Tribal population of 6,18,500 lakhs i.e 14.42% of the total population from Andhra region, Warangal with a Tribal population of 5,30,656 lakhs i.e 15.11% of the total population from Telangana region and Kadapa with a Tribal population of 75,886 lakhs i.e 2.63% of the total population from Rayalaseema region.
As per 2011 in India, the population of tribes was 8.2%. In Andhra Pradesh 7% Tribal populations exists. In the state two types of Tribal group existed. One group was at present across the hilly tract of the Deccan Plateau and by the rivers Godavari and Krishna. The second group live along the extended areas between the river Krishna and Godavari. According to ST order Act 1976, there were 33 types of Tribes in 8 districts and 50 lakh other nomadic tribes. Overall in the State, there were 5.96 per cent Tribals in Coastal Andhra, 2.86 per cent in Rayalaseema and 8.87 per cent in Telangana. The prominent tribes were Khonds, Kholamis, Nayakpods, Koyas, Kondadoras, Valmikis, Bhagats, savaras, Jatayus, Godabas, Yanadis and Chenhus. 76% of Tribes consisted of Sugalis (4.4%), Koyas (11.3%), Yanadis (9.2%), Yerukulas (8.7%), Gondas (5%) and remaining 24% belonged to small tribes. Nomadic Tribals like Pichukaguntulu, Balasanta, Saradakandru, Veeramustivaru, Bhavaneelu, Birannalavaru, GollaSuddulu, Pasaralu, Gangamulu, Kommuvaru etc. habitat Andhra Pradesh. They don’t have scripts for their language. They follow their customs and traditions strictly. 92.5% population lived in rural areas. Their livelihood was based on occupations like making of toys, baskets, mats, cosmetics and collection of leaves, honey and other forest products. The life style of tribes has been changing gradually after initiation by government.
contribution. Reservations in education, employment and Legislative Assemblies and local bodies were gradually changing the life style of the Tribal’s.

**Warangal District profile**

Warangal was one of the oldest cities in Andhra Pradesh with a history of over 800 years. The city was ruled by Kakatiyas between 12th and 14th Centuries. In ancient days the city was called “Oruguallu” or Ontikonda (Single Rock) to indicate the entire city had come up on a huge junk of rocky land. The city was also called as “Ekashila Nagaram”. Warangal was well known for its granite quarries (notably the black and brown varieties) and as a market for rice, chilies, cotton, and tobacco. The city was also called as tri-city, as it includes Warangal, Hanamkonda and Kazipet cities. Warangal District has an area of 12,846 Sq. Kms, and constituted 4.46% of total area of Andhra Pradesh. The district was bounded by Karimnagar District to the north, Khammam District to the east and southeast, Nalgonda District to the southwest, and Medak District to the west. The population as per 2011 Census was 3522644 of which 28.33% was urban and 71.67% was rural population (SC Population 16.9%, ST Population 14.07%). Overall literacy rate was 60.01%. The district has 5 Revenue divisions, 51 Mandals and 1014 GramaPanchayas. The Tribal Population in the district was 457675, ITDA Eturnagaam looks after the overall welfare and development of Tribal Population.

The most important Tribal Festival was Medaram Jathara. Sammakka Saralamma Jathara celebrated once in two years on a very large scale for three days. The important historical and archaeological and Tourist attraction places are 1000 Pillor Temple, Badhrakali Temple, Ramappa Temple, Kolanpaka Museum, Laknavaram Lake, Pakal Lake, Eturnagaram forest sanctuary. The prominent Educational Institutes in Warangal were National Institute of Technology, Kakatiya University, Kakatiya Medical College and Law College.

**Kadapa District profile**

The Kadapa District was surrounded by Kurnool and Prakasam Districts on the north, Chittoor District on the South, Nellore on the East and Ananthapur on the West. Total Geographical area of the District was 15,379 Sq. Kms with 3 Revenue
Divisions, 51 Mandals, 804 Gram Panchayats, 965 Revenue Villages and 4533 Habitations. Kadapa lies between the 13043’ and 15014’ Northern Latitudes and 77055’ and 79029’ of the Eastern Longitude. As per the 2011 Census (Provisional) the population of the District was 2884524 of which the Rural Population was 1846095 and the Urban Population was 1038429. The density of population in the District was 169/Sq. K.M. The Scheduled Tribe Population was 67498 in the District.

**Visakhapatnam District profile**

Visakhapatnam District was one of the North Eastern Coastal districts of Andhra Pradesh. It was bounded on the North partly by the Orissa State and partly by Vizianagaram District, on the South by East Godavari District, on the West by Orissa State and on the East by Bay of Bengal. The district consists of 43 mandals covering 3 divisions (Visakhapatnam, Paderu and Narsipatnam) The population of the district was 42.88 lakhs as per census 2011 and this constituted 5.0% of the population of the state while the Geographical area of the District was 11161 Sq. KM. which was only 4.1% of the area of the State. Out of the total population, 21.41 lakhs were Males and 21.47 lakhs were Females. The Sex Ratio was 1003 Females per 1000 Males. Scheduled Castes constituted 7.60% of the population while Scheduled Tribes accounted for 14.55% of the population of the district. Visakhapatnam district had 11 Tribal mandals with hill top areas, inaccessible, interior areas and 1 Greater Visakhapatnam Municipal Corporation and 2 Municipalities (Anakapalli and Bheemunipatnam) in urban areas.

**Sample Unit**

The sampling unit of the study was a married Tribal woman with at least one living child. A list of married women in the age group of 25-45 years was prepared and adopting purpose stratified random sampling technique, 400 Tribal women were selected from one district from each region, totaling a sample of 1200.
4.6. Methods and Tools of data collection

The study was initiated in the month of August 2011 and data collection was completed by February 2012. The data pertaining to the study was collected from both primary and secondary sources. In the present research study ‘Interview Schedule’ was used to collect primary data.

Primary data

An exclusive Interview Schedule was prepared for the purpose of data collection on the field. The NFHS III Survey questionnaire was adopted for the present research. The interview schedule explored the following sections. They were:

Section – 1 Socio-economic, demographic and cultural conditions of the Tribal Women

This section covered the socio-economic, demographic and cultural conditions of the Tribal Women viz. Age, Age at Marriage, Marital Status, Household Size, Family Type, Type of House, Number of rooms in the dwellings, Educational status, Highest education in the family, Occupational Status, Economic
Status, Status of earnings and Savings, Participation in Community Development activities, rituals and religious practices of the respondents

Section-2 Covered the food habits and dietary patterns of the Tribal women

Section -3 Covered various aspects of Reproductive Health, status, issues and utilization of the health care services. In this section information relating to age at menarche, restrictions imposed during menstruation, antenatal Care, antenatal checkups, place of antenatal check-ups, reasons for not receiving antenatal care, Number of tetanus toxoid injections received, consumption of Iron and Folic Acid (IFA) tablets/syrup, utilization of selected services during antenatal care, pregnancy complications, place of delivery, assistance during home delivery, reasons for not delivering in a health facility, postnatal Care, first feed to new born, postpartum complications.

Section-4 Covered Family Planning and Usage of Contraceptives

This section explored the adoption of family planning methods, reasons for adoption of Family Planning and reasons for non-adoption of family planning.

Section-5 Covered Aspects about RTI/STI and HIV/AIDS

This section examined information about source Knowledge of RTI/STI, sources of information about RTI/STI’s, knowledge of mode of transmission of RTI/STI, awareness about HIV/AIDS, source of Knowledge of HIV/AIDS

Secondary data

Related reviews, Reproductive Health status reports, findings in various books, printed journals, online journals, Govt. documents and reports etc were gone through to collect secondary information on Tribal women.

4.7. Analysis of the data

The data thus collected was subjected to statistical tests to enable interpretations. Numbers and percentages were used to find out the variations and differences among the three districts. After the data was collected from the field, it was processed through the use of Statistical Package for Social Science (SPSS),
excel and other software packages. These packages were used in order to make the analysis easy and clear.

**Statistical tests and procedures**

The schedules were numerically coded for computer applicability and analysis. Suitable statistical techniques viz., frequencies, percentages, one way ANOVA test were applied to identify the variations of differences between three districts in the type of maternal health care, Reproductive Health Status, Family Planning, food intake, infections like STDs, HIV/AIDS.