CHAPTER – 6

Summary and Implications
Reproductive Health was a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive Health deals with the reproductive processes, functions and system at all stages of life.

The poor health condition of the Indian Tribals was reflected in the status of their Reproductive Health correlated with individual and household, social and economic conditions (Middleberg, 2003). Reproductive Health also represented the overall health condition of a population. The reproductive role of women all through the process of gestation, birth, breastfeeding, and child-rearing places her at the focal point of a population’s Reproductive Health (Shankar and Thamilarasan, 2003). Moreover, women were central to various social and economic activities in Tribal communities requiring reciprocal interactions with the contributing factors of Reproductive Health.

**Importance of Reproductive Health**

Reproductive Health was a crucial part of general health and a central feature of human development. It was a reflection of health during childhood, and crucial during adolescence and adulthood. It sets the stage for health beyond the reproductive years for both women and men, and affected the health of the next generation. The health of the newborn was largely a function of the mother's health and nutrition status and of her access to health care.

Reproductive Health was a universal concern, but was of special importance for women particularly during the reproductive years. Although most Reproductive Health problems arise during the reproductive years, in old age general health continues to reflect earlier reproductive life events. However, men have particular roles and responsibilities in terms of women's Reproductive Health because of their decision-making powers in Reproductive Health matters. At each stage of the reproductive life cycle, a woman's needs differ. However, there is a cumulative effect across the life course events at each phase having important implications for future well-being. Failure to deal with Reproductive Health problems at any stage in life will set the scene for later health and developmental problems.
Reproductive Health was an important component of general health and it was a prerequisite for social, economic and human development. The highest attainable level of health was not only a fundamental human right but it was also a social and economic imperative because human energy and creativity were the driving forces of development. Such energy and creativity cannot be generated by sick, tired people, and consequently a healthy and active population becomes a prerequisite of social and economic development. Women’s access to ‘power and resources’ emerged as the important contributing factor to their Reproductive Health at the fourth world conference on women in 1995 held in Beijing which emphasizes increasing women’s economic and educational status, and as a consequence, women’s reproductive rights (Pillai and Wang, 1999). Thus, Reproductive Health indicated the level of self-determination, women’s reproductive rights, and strength of Tribals’ socio-political power.

Need for the study

A comparative analysis of the various indicators (political organization, religion, ritual practices etc.) among the different tribes of India, showed that the status of Tribal women was comparatively lower than that of Tribal men. Moreover, the status of Tribal women has gone from bad to worse as a result of the impact of social change which has affected the social structure of Tribal society (Chauhan, 1990). The status of women in a society was a significant reflection of the level of social justice in that society. Women's status was often described in terms of their level of income, employment, education, health and fertility as well as the roles they played within the family, the community and society.

There have been a number of studies on the tribes, their culture and the impact of acculturation on the Tribal society. There were a number of studies on the status of women relating to their socio-cultural problems, their economic rights, their participation in management, their access to employment, food, health, etc. But these issues also need to be reviewed in the light of changing socio-economic conditions especially with focus on Tribal women. Thus the study of Tribal women becomes important because the problems of Tribal women differ from a particular area to another area owing to their geographical location, historical background and
the processes of social change (Chauhan, 1990). For this, there is a need for proper understanding of their problems specific to time and place so that relevant development programs can be made and implemented. There is a greater need for undertaking a region-specific studies of the status and role of Tribal women which alone can give data that will make planning for their welfare more meaningful and effective.

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.

Fig.No.6.1 Conceptual framework on Reproductive Health
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.

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. (MEASURE Evaluation Population and Reproductive Health (PRH) 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.

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

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 -- Visakhapatnam 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.

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.

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 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.

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.

Major findings of the study

- The data indicated that majority of the respondents belonged to the younger age group. 43% women in Warangal, 47% in Kadapa and 48% of women in Visakhapatnam were in the age group of 31 – 35 years. This was followed by the next highest distribution of respondents in the age group of 36 – 40 years. The respondents of the sample area were relatively young. There were more number of respondents in the younger age groups compared to older age groups.
Majority got married at an young age and after attaining puberty. 58% respondents in Warangal, 60% in Kadapa and 65% in Visakhapatnam were married in the age group of 10 – 15 years. A very small percentage – 9%, 5% and 4% respondents in Warangal, Kadapa, and Visakhapatnam – were married above the age of 21 years. The data suggested a low age at marriage.

The marital status of the respondents, on the whole showed that majority were married and living with spouse. 1.20% and .50% women in Warangal and Visakhapatnam respectively were separated. 9% women in Warangal, 17% in Kadapa and 7% in Visakhapatnam were widowed.

The data showed that 68%, 67%, and 59% of the women’s family size in Warangal, Kadapa and Visakhapatnam districts was less than four. 30 to 37% of the respondents family size was between 5-7. Respondents with a family size of 8 plus was very less in number.

A major proportion (90.50%) of the respondents from Kadapa, 87 percent from Warangal and 84 percent of Vishkhapatnam districts were having nuclear families. The data revealed that the effect of globalization process has increased the adaption of nuclear families in all major societies as also in the Tribal society.

90 percent of respondents from Kadapa district, 87 percent from Warangal and 86 percent of respondents from Vishakhapatnam lived in Kucha houses. A small percentage (11.70%) were living in pucca houses. 9 percent of Warangal District respondents were living in tiled houses followed by 11 percent in Vishakhapatnam and 7 percent in Kadapa.

More than two third (67%) of the respondents from Vishakhapatnam were living in single room houses followed by more than half of 59 percent Warangal and 51.50 percent of the respondents in Kadapa.

The data on the three districts showed that majority of the respondents were illiterates with Visakhapatnam having the highest number. Kadapa had 1 percent respondents with higher education while the other two districts did not have any 29, 38 and 27 percent respondents in Warangal, Kadapa and Visakha.
had primary education while 11, 9 and 4 percent had secondary school level of education in the three districts respectively. NFHS III report also stated that the lowest Literacy Rate among ST women was observed in Andhra Pradesh and Madhya Pradesh.

- The data was consistent with the general educational status of the respondents and families. The data from Warangal district revealed that 39.50% of the families members were illiterates. Only 1.25 percent of the families had 5plus educated members. In Kadapa too a similar situation prevailed. A large majority i.e 42 percent of families had no literate members. None of the respondents had more than 4 literate members in their families. According to data from Vishakhapatnam district, more than half of (51%) the families had no literates. Only 6 percent of the families had 3 to 4 literate members.

- Majority respondents in three districts were agricultural labourers with highest in Kadapa district (83%) and Visakhapatnam district (76%) followed by Warangal district (72%). Majority of the respondents were linked with agriculture as their main occupation.

- The data indicated that considerable number of respondents had poor economic background 12%, 14% and 9% of the respondents in Warangal, Kadapa and Visakhapatnam respectively belonged to the low income group of less than Rs. 10,000/- per annum. 27%, 28% and 15% of the respondents in Warangal, Kadapa, and Visakhapatnam respectively belonged to the Rs. 20,001/- income group per annum. Kadapa district had the highest number of low income as well as higher income level respondents. On the whole, a large proportion of the Tribals were living below the poverty line.

- The data showed that about 90% of the respondents had individual earnings and 69%, 73% and 57% in Warangal, Kadapa and Visakhapatnam districts respectively were given ornaments by their parents. 42%, 39 % and 27% of the respondents were given dowry at the time of their marriage with Visakhapatnam registering the lowest proportion. However, 63%, 76% and 71% of the respondents did not have individual savings. This is in line with the NFHS data. The women further informed that they handed over their earnings to their
spouse and major decisions were taken by him. About one third of the women stated that they were informed of the expenses to be made though their opinion made no difference.

- The data in Warangal district showed that about one third of the respondents attended various meetings. About three fifths (77%) of the respondents never attended Gramasevika meetings. The data from Kadapa district showed that about two thirds (69%) of the respondents never attended the Gramasevika meetings. The data from Vishakhapatnam district revealed that a higher percentage (77) of the respondents never attended the Gramasevika meetings. A small proportion of (7% in Warangal, 5% in Kadapa and 2% in Visakha) the respondents attended meetings of other developmental agencies and extension officers or demonstrations, Kisanmela etc. In general, the data showed that participation in community developmental activities was not as desired.

- More than three fourths (87%) of them in Vishakhapatnam districts and 85 percent in Kadapa, 83 percent in Warangal districts respondents were always performing religious rituals and ceremonies. A large proportion (91%) of the respondents in Vishakhapatnam were performing puja sometimes followed by 88 per cent of the respondents in Warangal District and 83 per cent in Kadapa District.

- A high proportion (80%) of the respondents were always permitted to cook food on religious occasions in Warangal followed by 83 per cent in Vishakhapatnam and 78 per cent in Kadapa. A larger proportion of the women were involved in the many religious rituals that were performed by the Tribals.

- Majority (46%) of respondents in Warangal district consumed milk and milk products at least once in a day followed by more than one third (37%) in Kadapa and two fifths (40) of the Vishakhapatnam district respondents who also consumed milk and milk products daily.

- Two fifths (43%) from Kadapa, 39 per cent from Warangal and 37 percent of Visakhapatnam districts respondents consumed Rice cereal weekly. Apart from rice which was given in the fair price shops, many of them consumed other
cereals also like Jowar, Sajja, Ragi etc which they cultivated for their regular consumption.

- More than one third (34%) of the respondents in Warangal district consumed pulses weekly followed by 37 percent in Kadapa and 28 percent of the respondents in Vishakhatpatnam districts. Their diet mainly consisted of Rice / Ragi porridge or sangati with green chilly / green leaves curry / vegetable stew.

- In Warangal district, a larger proportion (77.25%) of the respondents consumed vegetables twice or thrice in a week followed by 71 per cent of Kadapa and 65 per cent of Vishakhatpatnam districts.

- Three fourths (72.75) of the Warangal respondents and more than three fifths (60) of the Kadapa district respondents had meat and meat foods once a month as also nearly two thirds (61) of the respondents in Vishakhatpatnam district. Women and men in households with a low standard of living were less likely than others to eat each type of food listed, and their diet was particularly deficient in fruits, milk or curd and meat and meat products. In general, the nutritional status of the Tribal women was poor.

- In this section find out the Majority (47.25%) of in Warangal district respondents age at menarche was 13 years followed by Kadapa district showed that nearly two-quarters and 44.75% Vishakhatpatnam district respondents also menarche at 13th year. The data is in line with the studies of Sharma (1995) and Pandey et al (1999) which also stated that the age at menarche in Tribal population varied between 12 to 15 years.

- About half of the respondents from Kadapa district 47.50%, Vishakhatpatnam district and 42.50% Warangal district showed that majority respondents stated after the onset of menstruation restrictions were imposed and were not permitted to go out with brothers or male members.

- Majority of the respondents in the three districts (98.75 Warangal, 100% in Kadapa and 96.75% Vishakhatpatnam) were restricted from entering the puja room at the time of menstruation. Highest proportion of Kadapa women followed by Warangal and Visakhapatnam reported that they were not permitted
to enter the puja room. As most households did not have a separate puja room the women stayed out side the house in all weather including winter and rainy season.

- Majority of the respondents from the three districts showed that 73 to 81 percent of women felt uncomfortable before menstruation with a higher proportion in Kadapa. 67%, 74% and 72% of respondents reported abdominal pain 55 to 67 percent complained of tiredness. About three fourths in all the three districts cited weakness. Another 64%, 57% and 67% of the respondents stated that they suffered from lower abdominal pain. The data, in general, suggested that majority of the Tribal women experienced physiological and psychological changes before menstruation which was affecting their general health, work efficiency and productivity.

- Majority of the respondents from Visakhapatnam district (39.50%) of did not receive antenatal care followed by 35 percent Kadapa district and Warangal district (31%). Majority respondents are received antenatal care in rest more than one fourth of respondents (29%) Kadapa and Warangal (26.75%), Vishakhapatnam (24.75) stated that they received care from a doctor. The present results confirm to the NFHS III data which also showed that STs received lowest antenatal care and care from a doctor.

- A higher proportion of the respondents from Warangal district showed that about three fifths (61.20%) have received three or more antenatal check-ups followed by Kadapa district showed that more than half of (59%) and Visakhapatnam district (56%). The data suggested that considerable number of respondents have not gone for any antenatal care. In all the three districts antenatal care was poor.

- Visakhapatnam district showed that more than half of the (52%) respondents received antenatal check-ups at their home only followed by 40 percent of the respondents whose source and place of antenatal check-ups was Government health facilities comparatively from Warangal district 46.40 percent and also 43 percent of respondents from Kadapa districts said Place of antenatal check-ups as Government health facility which includes PHCs, Sub Centers, CHCs
rural and referral hospitals, Urban health and family welfare centers. In this issue the present data strongly correlates to report of United Nations Summit (2010) explores that more women are receiving antenatal care and skilled assistance during delivery. In all regions, progress is being made in providing pregnant women with antenatal care.

➢ A large percent of Kadapa district (25.70%) respondents stated reason for not receive antenatal care is treatment of antenatal care was too costly as followed by 25 percent Vishakhapatnam and Warangal (23.50%) while another 21% in Warangal, 13% in Kadapa and 18% in Visakhapatnam district cited lack of transport/health facility too far from Living place.

➢ A higher proportion of respondents in Warangal district (57 %) had taken 2 +TT injections followed by respondents in Kadapa (49%) and Visakhapatnam (41%).

➢ Majority of the respondents said that they have received iron and folic acid (IFA) tablets/syrup but did not consume them during their last pregnancy in all three districts (Warangal 41.75 percent, Kadapa 44 percent and Vishakhapatnam 39 percent). More than a quarter of the women in all the three districts had received 100+ IFA tablets/ syrup and consumed them for at least three months. In general the consumption of IFA tablets was low.

➢ Majority of the respondents in the three districts had regular abdominal checkups (Warangal 260 respondents, Kadapa 239 and Vishakhapatnam 237 respondents) and had their weight checked. 110, 170 and 210 respondents had their blood pressure checked regularly. These examinations and tests were essential for detecting any health problems which the pregnant women may have and which would be further aggravated during pregnancy endangering both the mother and the fetus.

➢ A large percentage of the respondents reported swelling of hands and feet/edema at the time of pregnancy - Vishakhapatnam (80%), Kadapa (78%) and Warangal (71%) respectively. Weak or no movement in the fetus was also cited by 11, 7 and 9 percent of the respondents. About 7, 8 and 3.50 percent of the
respondents in the three districts respectively cited that they had other complications like visual disturbances, convulsions etc. Many of the complications were related to poor dietary habits and low nutritional status.

- Majority respondents from Kadapa (59%), 56% Warangal and 54 percent of the respondents from Vishakhapatnam cited Public health facilities like Government hospitals as their place of delivery. 22, 20, and 29 percent of the women in three districts reported home deliveries. Of the total home deliveries, a large percentage of deliveries were at their parents’ home. It showed that majority followed the traditional values prevalent in Tribal system and customs.

- More than half of the (53.80%) home deliveries in Kadapa were assisted by health personnel followed by Warangal district (47.70%) and Visakhapatnam district (47.80%). 14, 10 and 19 percent women in Warangal, Kadapa and Visakha respectively had deliveries at home without trained personnel. Considerable proportion of women were yet to opt for safe deliveries in the sample area.

- A higher proportion of the respondents of Vishakhapatnam district (57.50%) stated that health care cost was too much in a health facility followed by Kadapa (49.10%) and Warangal (37%) districts. 27, 32 and 26 percent of the women reported that the health facility was too far a distance to travel and or Transportation was poor. The data reflects the poor economic and infrastructural conditions of the Schedule Tribes where majority of the households lived below the poverty line. Communications and transport facilities were also not fully developed/accessible.

- Majority respondents in Vishakhapatnam district (41%) of the respondents received health check up within the critical first two days after their last delivery followed by 37 from Warangal and 29 percent from Kadapa districts and this situation we are analyzed the delay of postnatal care due to the cause of lack of transport/ convenient transport facilities. Another 19, 31 and 21 percent respondents reported that they also had post natal check up with in 4 to 24 hours. About 24, 26 and 12 percent of the women in Warangal, Kadapa and Visakhapatnam respectively had their post natal check up with in the first four
hours of their delivery. The proportion of respondents who did not have postnatal check up after delivery was quite large leaving much to be desired in the realm of health care.

- Majority of the respondents in the three districts (69% Warangal 73% Kadapa district, 59.25% Visakhapatnam district) fed colostrum as the first feed to the new born child. A higher proportion did so in Kadapa with lowest in Visakhapatnam. Surprisingly, a higher proportion of women in the sample area fed colostrum to the babies as first feed though there were misconceptions -- sugar water/ honey was better – were prevalent.

- Majority respondents from Waranga and Visakhapatnam and one quarter from Kadapa reported heavy vaginal bleeding. A higher proportion of women in Kadapa (31%) followed by a quarter in Visakhapatnam and 15 percent in Warangal stated that they had high temperatures. About one fifth in Warangal, one quarter in Kadapa and 19 percent in Visakhapatnam cited both postpartum complications.

- A higher proportion (75%) of the respondents from Kadapa and 68 percent of the respondents in Warangal, and Visakhapatnam (66%) reported that they have adopted permanent family planning methods. A large proportion in the women had faith in family planning and most of the respondents stated that female sterilization was the acceptable method of family planning. However they did not opt for vasectomy and all cent percent believed that it would affect the fertility of the male member. Spacing methods were also not adopted.

- Majority of the couples accepted family planning (60%) in Warangal, 68 % in Kadapa and 72 % in Vishakhapatnam due to their inability to support big families economically. Desire to provide better living conditions to family and children was also cited by 16, 12 and 3percent of the respondents in the three districts respectively.

- A high percentage (72 %) in Warangal, 69 % in Kadapa and 55 percent in Visakhapatnam district respondents cited other reasons like non availability of family planning services, desire for another child, desire for a son etc as reasons
for non-adoption of family planning method. Another important reason cited by one fifth respondents in Warangal, 23 percent in Kadapa and 28 percent Visakhapatnam was fear of adverse effect on health.

- More than half of the respondents in Warangal, Kadapa and 57 percent in Vishakhapatnam stated that they were not aware of what RTI/STIs meant. They did not know of any endemic diseases like STD and RTIs.

- A largest percentage of respondents from Vishakhapatnam district (66.9%) said that ICT was the major source of information followed by Warangal (61.25%) and Kadapa (55.45%). However, ICT sources like TV, cinema and Radio and Information from Health Personnel were the major sources of information cited in all the three districts

- Majority of respondents in Warangal, Kadapa and Vishakhapatnam districts showed that the main cause of transmission of RTI/STIs as reported by Unsafe sex with sex workers as the main cause of Transmission of RTI/STI’s and one third (34%), 27 and 20 percent of respondents respectively was unsafe sex with many partners.

- Majority (73.50%) of the respondents in Visakhapatnam district reported they do not discuss RTI/STI problems with husband/ partner followed by Warangal district (60%) and Kadapa district (51.50%). In Warangal district respondents more than half of (52%) of them reported that they sought treatment for RTI/STI problems followed by 31.50 percent Kadapa and 27.50 Vishakhapatnam districts also.

- A higher proportion of respondents from Kadapa district (78.75%) have heard about HIV/AIDS followed by 77.25 per cent of the Warangal district respondents and 66 percent of the Visakhapatnam District respondents.

- A larger proportion of respondents source of information on HIV/ AIDS was TV. (33.0, 25 and 31 percent in Warangal, Kadapa and Vishakhapatnam) Followed by 19.0, 16 and 15 percent of the respondents who cited cinema as their source of information. About 17 percent respondents in the three districts cited their source of knowledge as print media like newspapers charts, posters, pamphlets etc.
IMPLICATIONS OF THE STUDY

The findings of the study showed that large numbers of Tribal women were still plagued with various concern and uncertainties. Their needs and aspirations were hampered by various socio-economic and cultural constraints.

The basic needs of health care of Tribal women mainly relate to nutritional deficiency, child bearings, Reproductive Health and hygiene, unwanted pregnancies, abortions, RTIs and HIV. Pregnancy related risks and complications among Tribal women in general were high. The Tribal women in India suffer from high levels of female morbidity and mortality, but do not seek general medical facilities from health centers. Many of them neglected serious health problems like nutritional disorders, RTIs/STDs, menstrual disorders primarily due to lack of awareness and generally due to lack of accessibility to health facilities, proper information and guidance.

Based on the information observed, the following programmes may be undertaken for attaining quality Reproductive Health.

- The differences between states, places of residence, age groups, social status and economic background are simply too great in India to allow generalizations. A very focused campaign of action delivery services to the most disadvantaged, to reduce inequities in health, particularly in maternal and Reproductive Health, will be necessary at the national, state, and district levels to have a significant impact on the most disadvantaged populations.

- In addition, due to the wide disparities between and within states, which are often caused by varying policies and programs, health infrastructural shortcomings and governance challenges, analysis of inequities in maternal health care need to be undertaken at the state and district level. This also calls for additional research focusing on specific geographical areas or a specific group within the population.

- Especially qualitative research is needed to answer questions on how social determinants influence access to and use of maternal and Reproductive Health in a specific setting or among a specific community. Disparities between
regions and subpopulations also emphasize the need for context sensitive policies and programs. It is clear that one-size will not fit all and especially the poor and vulnerable will be left out. How social determinants interplay in a specific context influencing access to and use of maternal and Reproductive Health needs to be carefully considered when designing and implementing policy and interventions.

➢ The study shows that the cost for maternal health care is a significant burden on households among the poor and socially backwards castes. Interventions targeting the cost for transportation and loss of income are needed, as well as intervention reducing the burden of out-of-pocket payment for care. The mechanisms through which economic status causes barriers to care may differ between geographical areas and it is likely that different strategies are needed to address inequity due to poverty depending on residency. There is also a need for strengthening the health system capacity to provide care to this fragment of the population, both in terms of referral systems and the quality of care.

➢ The government of India and state governments should consider following specific steps to reduce the service gap. There has to be substantial improvement of services in terms of capacity and quality in the public system where the poor and vulnerable live. Maternal and health care needs to be provided close to their homes, thus reducing the distance barrier. Maternal literacy and use of ANC services were important predictors of birth preparedness. The Indian Government should develop and annually publish special rates of infant mortality rate, maternal mortality rate, and still birth rate for marginalized groups, such as the poor and Tribals, through an expansion of the Sample Registration System already implemented. One of the reasons that services are poor in remote rural and Tribal areas is difficulties in recruiting doctor or health workers to these areas, thus creating barriers to service delivery or health education. This can be reduced by creating a special cadre or force of doctors, nurses, and health staff to run the health centers in remote and poor areas. The staff recruited will have to be specially selected based on commitment and attitude for serving the poor and marginalized. Furthermore, incentives, in the form of high salaries and other benefits such as better housing,
need to be provided to recruited staff. A special strategy in regards to services during delivery will be needed to reach out the most vulnerable and marginalized.

- Girls should be given equal opportunities of growth and development, education and share in family property. They should be taught dignity of labour and freedom. Women voluntary groups should be organized with honest, dedicated workers to fight against the problems of women and to assist and monitor the work of police dowry cells. To sensitize the Scheduled Tribe members of the community towards their health needs and to empower them to initiate, manage and sustain health action. Culturally appropriate learning materials prepared for the Tribal students may help to achieve minimum level of learning.

- For income generation the indigenous skills such as cloth embroidery, mat making, agarbathi making etc., of the women and of the elder siblings can be exploited. The women can be organized to harness these skills towards a small home industry. Initially such a programme may be subsidized by loans through DWCRA, TRYSEM for the purchase of raw materials. The strategy is to begin with their own indigenous skills and later expand the programme by beginning or developing other skills among the women such as tailoring and plastic basket making. A variety of home industries can be developed among the poor families in the long run. These would help to generate income.

- Poultry keeping can also be encouraged as a group occupation by initial loan. Subsidising such an occupation would not only raise income but also supplement the diet of the family in the long run with a change in nutritional practices.

- Loan for maintaining Milch cattle, sheep and goat rearing can be thought of provided some wasteland is available for the cultivation of feed for the animals. Cultivation of elephant grass etc may be encouraged.

- Mass consciousness about improving the status of women should be created. Gender sensitivity and equality of genders should be created.

- Restoring legal status and rights of women through implementation of various laws concerning them.
- Special measures for school enrolment of girls and organizing female literacy programmes.

- For encouraging women’s participation in development, there is a need for provision of social sciences, removal of gender bias, protecting women’s rights, opportunities for political participation, forums or women’s organizations, raising of awareness and creation of self-reliance.

- There is need that more and more women should have access to mass media and change agents. And also there is need to propagate the feeling of gender equality and dispelling the traditional feelings.

- For increasing their say in decision making, there is a need to increase women’s access to knowledge regarding new varieties of crops, credit, fertilizers, agro-chemicals and marketing.

- Creating social awareness among women, their superstitions and religious rituals.

- One of the important pre requisites for women’s development is fresh awareness and motivation among women about their religion and religious beliefs which will lead to the realization and improvement in the quality of life which can be brought about only through education.

- Examining occupational mobility among Tribal women as a result of modernisation, education and social change.

- Age at marriage of women is also found to play a positive role in improving the status and it is impacted on Reproductive Health also. Government should undertake practical measures to implement the legislation on increasing the age at marriage and the legally prescribed age of 18 years for skills also be raised to 20 years at least. They should create awareness to the Reproductive Health problems arise at the early age marriages for women.

- Promotion of small family norm through family welfare and population education programmes through increase the using of contraceptive methods.
Improve the dietary pattern by promoting the production and increasing the per capita availability of nutritionally rich foods. The production of pulses, oil seeds and other protective food crops such as vegetables and fruits and other food items like milk, meat, fish and poultry will be augmented. Certain imbalances and anomalies in our agricultural policy will be redressed to introduce appropriate incentives, pricing and taxation policies.

Take action to reduce malnutrition through nutrition counseling and networking with ICDS. Nutrition education is to be given to mother for better weaning, practices and for better nutritional practices during pregnancy and lactation. Since mothers are the decision makers at home with regard to food and child care, their education should cover an awareness of childhood diseases and nutritional disorders to proper choice and methods of preparing foods and to better nutritional and health practices in order to improve the quality of the life of the families. In such educational programmes the women are to participate and play an active role. Nutrition demonstrations with adequate audio-visual equipment should be planned as also role play activities, choosing relevant themes for education.

Strengthen nutrition surveillance system, periodical monitoring of the nutritional status of children, adolescent girls and pregnant/lactating women living below the poverty line must be prioritized.

Basic health and nutrition knowledge with special focus on infant feeding practices should be imparted to the people extensively and effectively.

Supplementary feeding programme are to be established for the pre-school children, pregnant and lactating mothers in order to control the chronic under nutrition prevalent among the children and women. Iron supplementation and fortified iodine salt can be distributed to the community especially young girls and women. Deworming is to be done to alleviate anaemia among children.

Healthy nutrition should be encouraged through local produce and local recipes. Nutritional needs should be solved by the Tribal women themselves through a better utilization of their locally available cheap but nutritious food.
➢ To improve access and utilization of health services by Scheduled Tribe people, especially women. Safe and effective maternal and child care programmes along with strong population, education and family welfare measures should be provided.

➢ The health officials can select and train interested volunteers from the local ST community members for conducting home deliveries, in provision of basic health services, immunization and safe delivery. Effective implementation of this concept would increase effective antenatal care and safe deliveries in Tribal areas.

➢ Regular visits of health workers need to be facilitated with regard to prenatal and postnatal care and immunization programmes for children. By training the indigenous persons and attending deliveries the incidence of infant deaths and morbidities can be reduced.

➢ Immunisation is to be systematized to cover all the Women and children and to protect them from reproductive outcomes and childhood diseases.

➢ Motivational programmes for Tribals to take greater advantage of community credit organisations and for greater political participation should be undertaken to access the health infrastructure facilities to Tribal areas.

➢ Implementation of various welfare programmes with a human resource development approach would improve the quality of life of the Tribals.

➢ Evaluating ongoing integrated Tribal development programme in Tribal areas under the Tribal sub-plans through performance appraisal with reference to:

i) Improvement in social and economic status of the people.

ii) Health modernity.

iii) Use of science and technology in agricultural horticulture production

iv) Environmental conservation and

v) The role of mass media in educational development of Tribals needs to be reassessed.
The programmes formulated for their benefit should have an integrated multi-dimensional approach aiming at building up of awareness of health care. The programmes should facilitate for a holistic development of Tribal women.

Policies and programmes based on micro-level community data can contribute to eradicating harmful practices against women and girls, removing barriers to women’s rights, sexual exploitation and violence.

Research in this direction would help to promote responsible sexual behavior. Respect for women is fundamental for ensuring equal opportunity and status. Quality Reproductive Health care will improve the situation of women and thus, the family and community.

The following programmes may be undertaken for attaining quality Reproductive Health.

- **Population Information, Education and Communication Strategies for Good Reproductive Health**

  Effective advocacy is essential in creating awareness of reproductive rights and Reproductive Health and can be facilitated by the use of effective information, education and communication strategies.

  The importance of information, education and communication in the area of reproductive rights and Reproductive Health derives from the stimulate attitudinal and behavioural change. In the area of human reproduction and health, various strategies have been used in attempts to develop positive attitudes and encourage responsible and health behaviour, help increase community participation in population activities and facilitate acceptance of population programmes in diverse cultural settings.

  Population policies and legislation have a major role to play in the creation of a supportive environment for Reproductive Health and family planning. Information, education and communication activities are facilitated when they are supported by population policies and appropriate legislation. It is also recognized that information, education and communication activities are valuable instruments
for facilitating the understanding and acceptance of the goals and objectives of population policies.

Population education is another common strategy adopted by Governments as part of their population policies. It usually covers such topics as population dynamics, pregnancy and family planning, family life, sex education and, more recently, new ways of looking at gender issues, HIV/AIDS and sexually transmitted diseases. There is increasing evidence that sex and HIV/AIDS education programmes may reduce unsafe practices among sexually active adolescents and reduce early pregnancies.

- **Gender Equality and Equity**

  The ICPD programme of action affirms that the full participation and partnership of both women and men is required in reproductive life.

  Education and information that promote such aims are fundamental to improving the status and role of women in society. Effective implementation of compulsory education to girls and women will contribute to their empowerment and to improved family health.

  Expanding women’s knowledge of Reproductive Health and expanding their choices enables them to meet their reproductive goals. Information, education and communication activities can contribute to eradicating harmful practices against women and girls, such as female genital mutilation drawing attention to the health needs of the girl child, eliminating nutrition practices that discriminate against girls, involving men in Reproductive Health and family planning programmes, removing barriers to women’s rights and enforcing legislation against early marriage, sexual exploitation and violence, and ensuring that women have equal access to education, guaranteed equal opportunity to work and receive equal pay for equal work;

- **Participation of programme users**

  The participation of programme users in the design, implementation and evaluation of information, education and communication programme interventions increase the likelihood of success.
Different population groups have their own perspectives, ideas, and opinions in many areas, particularly about sexual and reproductive health. Communicating effectively with them requires their direct participation.

- **Training of personnel**

  Health professionals should be trained to cater to the special needs of the population they serve, in such areas as interpersonal communication, sexuality, counseling, and team building, in ways that will promote work with social welfare workers, teachers, parents, and community leaders. The training of educators and student peers in education and counseling activities should focus on techniques dealing with problem-solving, listening, non-judgmental counseling, and basic education, as well as on sexual and reproductive health needs.

- **Strict monitoring and enforcement of health personnel in Govt. health facilities**

  P.H.Cs and C.H.Cs, Sub-centres to see that they are present for duty regularly.

- **Differential area-specific need assessment**

  Would provide data for strategies and programmes to improve access and utilization of nutrition services for each of the Tribal areas.

**Conclusion**

India is making progress toward reduced maternal mortality and improved access to Reproductive Health care. However, evidence shows that the progress made is uneven and inequitable. The picture that is presented in this study is that a number of determinants prevent reduced maternal mortality and increased access to Reproductive Health for women belonging to disadvantaged populations.

The study has attempted to estimate the facts and exact situations in association between social, economic, and cultural factors of Reproductive Health issues and concerns mediated by Tribal women. The findings of the study have identified uncertainties of the health care system in Tribal areas. At the same time, low literacy and economic status of women among the ST’s, poor basic infrastructure facilities were also closely associated with the low levels of Reproductive Health status of the Tribal women. Myths and misconceptions about various Reproductive Health issues like nutritional deficiency, child bearing,
Reproductive Health and hygiene, unwanted pregnancies, abortions, delivery assistance, care during pregnancy and lactation, contraception and fertility behavior, RTIs and HIV were all associated with inadequate and insufficient reach and poor quality Reproductive Health care services to the Tribal women. Scheduled Tribe women have low standard of living and there is a need to improve their economic standard so that they can fulfill their basic needs and improve their health status also. Interventions that target maternal mortality and increased access to Reproductive Health care need to take into account how these determinants operate in the Indian society and how this may influence access to health care for certain groups of women.

**Suggestions for Further Study**

a. A comparative study can be undertaken on samples of women belonging to different sub-tribes in the various regions.

b. Larger samples could be covered so that accurate generalization could be drawn for the population.

c. A comparative investigation can be planned to study the situation of literate and illiterate Tribal women.

d. A study can be undertaken to assess the Reproductive Health status of Employed women in Schedule Tribes.