CHAPTER – 3

Review of Literature
CHAPTER-III
REVIEW OF LITERATURE

3.1. Studies on Socio, Cultural and Economic Status of Tribal Women

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Review of literature is essential for the research to have a strong base and to support the study with the help of the literature in all dimensions. The main function of the review of literature was to determine the theoretical and empirical work done previously and assist in the delineation of the problem area. It provides insight into the methods and procedures and suggests operational definitions of major concepts. Review of literature provides a basis for interpretation of the findings.

Studies conducted by scholars from other disciplines such as, anthropology, medicine, and demography, on Tribal communities with respect to their health and Reproductive Health, mainly reported descriptive statistical information obtained from cross sectional surveys and field observations. These studies have focused on Reproductive Health of Tribals at micro and macro level. This chapter reviews the literatures on Tribal Reproductive Health and attempts to generalize the reported findings and observations. The literature review includes peer reviewed articles, relevant books and book chapters, and articles from recognized news sources.

This review has been categorized and presented under the following headings.

- Studies Related to Socio, cultural and Economic Status of Tribal women.
- Studies Related to Reproductive Health
- Studies Related to Nutritional Status and Morbidity
- Studies Related to Literature on Fertility Behavior and contraceptives
- Studies Related to RTI, STD’s and HIV/AIDS

3.1. Studies on Socio, Cultural and Economic Status of Tribal Women

Heggade (1984) with special reference to India has identified the socio-economic and politico-cultural obstacles for women participation in economic development and also identified different institutional mechanisms and policy measures to promote women empowerment in India. This is one of the early studies on women in economics development in India. It has analyzed the empowerment level, malnutrition, and absence of property rights, lack of access to bank credit, absence of skill formation programmes for women, low parental investment in women, HRD or capabilities as the factors responsible for women’s low participation.
Bhasin (1991) described and analysed the life of Gaddi women of Bharamour in Chamba district in Himachal Pradesh. It has been observed in traditional gaddi community; the women have an important role to play. Gender principles were central to the hill organisation of traditional communities. In Bharmour, role of women was not only of important in economic activities due to ecological and environmental factors, but her role in non-economic activities was equally important i.e. formation and continuity of family health and home were the domain of women. Women’s role as wives, mothers, organizers, and as basic foundation of other dimensions of social life was of utmost importance.

A study on socio-cultural aspects of health care in Kamar Tribe was conducted by NIN (1992) and they concluded that most of the Kamar population was superstitious, poor and ignorant. The status of women was high i.e. age at marriage was high. Widow remarriage was practiced and bride price was prevalent. The houses had no drainage or toilet facility. They considered a girl of marriageable age as soon as she attained menarche. The mean age at menarche was 13-18 years. People were aware of male and female sterilization methods for family planning and no other methods were known.

NIN (1992) assessed the economic factors in the context of health care of Kamar tribe. The study was based on the information collected from 317 Kamar households from randomly selected 25 villages in Raipur. It revealed that the annual income and expenditure per Kamar household was estimated to be Rs.4788/- and Rs.5171/- respectively. Majority (90%) of the Kamar households were economically below poverty line. Labour (40%) and basket making (31%) were the major occupations of the Kamar people.

Pandey et al., (1991) analysed and compared the characteristics of Tribal households (1297) of Kundan block area of Jabalpur district with the non-Tribal household (915) of the same area. It was evident from the study, that the Tribal households differed significantly from the non-Tribal households with respect to (i) type of household (higher percentage of agriculture) and (ii) level of education of the head of the household (higher percentage of the low level of education).
Chauhan (1993) analysed the position of Saharia Tribal women of Madhya Pradesh, amidst the process of continuity and change by focusing on the various aspects of their life – social, religious- economic and political. The study indicated that the position of women should be understood by examining their position in the traditional social structure and their place in the Tribal social institutions or in the division of labour. They still largely believed in spirits, ghosts and nature worship. Sahari women were marginalized in their occupational structure and were considered as dependent on men.

Deoghar (1993) assessed the “Work participation of female Tribals of South Chotanagpur”. It was found that the participation rates varied with the occupational status. The Tribal female participation rate was comparatively higher than non- Tribal females of the area. Families with high social status had less female participation, as also those with higher literacy. Increase in the income level discouraged women from working for money, and low wage rate in the rural labour market also discouraged women’s work participation. Lack of sufficient work in the region forced these women to migrate to other regions.

Oraon (1993) made an attempt to study the present state of education among the Tribals and attitudes and aspiration of Tribal women regarding the education of their children. It was found that many of the Tribals were still illiterates. The socio economic status was related to their educational achievements of their children. Reasons identified for irregular attendance and non-enrolment were lack of interest, and the necessity for girls to do the household work.

Palta et al., (1995) assessed the Socio- economic profile of the Kamars of Madhya Pradesh” The study revealed that the Kamar families had quite a low socio-economic status. Housing and sanitary conditions were not satisfactory. The level of illiteracy showed their poor educational status. The average family size of the Kamars was 4.73. The water supply to Kamar settlements was inadequate. Economically, most of them had no assets.

Sharma et al., (1993) conducted a study on “Deprivation of female farm laborers in Jharkhand region of Bihar” It has been observed that the agriculture of this region has remained more or less stagnant. This was primarily due to Madaiti
system of agricultural operation (Mutual exchange of farm labour) prevalent in this region and discrimination against and consequent deprivation of female farm labourers both inside and outside Madaiti system. The female workers were usually uneducated and had no training to undertake skilled Jobs. The Jharkhands Tribal economy was an embedded economy in which economic activities were based on the socio-cultural laws which were aimed at maintaining cohesion and harmony in the society.

“Status of Tribal Women” was examined by Borthakur (1994). The findings revealed that women were given fair treatment in the society. Dowry, child marriage, female infanticide and atrocities on women, were generally found among most of the Khmyang community. Opportunity to participate in political and religious spheres also were very limited among the Khamyang women. The Khamyang women were not involved in decision making process. As such they were not found holding any positions in political and economic institutions.

Oberoi et al., (1994) conducted a survey on “Environmental limitations, socio-economic status and constraints of Tribal economy on outer Himalayas” The study revealed that lack of transportation and lack of basic infrastructural facilities were the major constraints for their development.

Hanumantha Rao et al. ,(1994) made a comparative study between Mario Gonds of Bhamraged area of Maharashtra and Bastar of Madhya Pradesh to assess the “Levels of malnutrition and socio-economic conditions” The study revealed that the average monthly per capital income was Rs.50/- among Maria Gonds of Bastar. Labour (69.9%) was the major source of income in Bhamragad as against agriculture (66.9%) in case of Bastar. Both by extent and type of malnutrition Maria Gonds of Bhamragad were comparatively better than those of Bastar. The dependency of the Maria Gonds of Bastar on primitive forms of agriculture with low yields of food grains and lack of income generating activities resulted in low per capita income which ultimately reflected in their poor nutritional status.

Reproductive Health behavior of the women in Arunachal Pradesh was examined by Kar (1993) and he reported that the females were having an edge on the males (M.F. ratio 100: 101). Literacy level of the people was around 30 percent.
Marriage with mother’s, brother’s daughter was a preferred one. Polygamy was permitted but was very rare. The size of the family varied from 1 to sometimes around 15. The position of the women in the society was relatively low.

Khan (1995) studied on economic life among the Gadbas of Bastar. It was evident from the study, that about three-fourths of the heads of the households have own land up to 6 acres. The remaining owned land from 7 acres to more than 13 acres. But their proportion was less. The possession of land influenced the capacity to maintain caste as well. About 38 percent of the heads of households had income of less than 2000 rupees, 36 percent had Rs. 2000-3000, 11.3 percent had 3000-4000, 3 percent had income that exceeded Rs. 5000/- and above.

Saraswathi (1995) conducted a survey to study the changing status and role of women among Kurichians. This study was conducted in Waynad district of Kerala state in 2 villages where the Tribal concentration was more. She reported that the status of women was not uniform among all the different castes and communities. Women’s sphere of activity and control, expected behavioral norms, taboos, rights and duties were quite distinct from those of men, showing clear dichotomy between the roles of women and men.

Chandra Jyothi (1995) described and analysed the “Identity-Crisis and revivalism among the Sonowal Kacharis”. The findings indicated that the revivalist movement among the Snowal Kacharis has gained its pace and definite direction. Religious exploitation played an important role in socio-cultural disintegration amidst the colonial grasp and in the way of nation building were now becoming more and more interested in re-structuring and reliving their own culture in a new perspective. The older generations were interested in leaving the traditional religious practices and they have a sort of inferiority complex in terms of social status among their non-Tribal counterparts.

Tenuja et al., (1995) made an attempt on the status of Tribal women in Singbhum district of Bihar state. It was found that majority of them were Hindus (99.6%). Among the different tribes Santal (59.0%) was the largest group. They were followed by Bhoomiji (25.2%) and Mahalli (11.7%). Bihrhpor tribe was the smallest group (4.1%). Over 96.0% of the Tribal women were illiterates engaged in agricultural manual work (97.3%).
Study on “Structure and marriage patterns among Tribals in Karnataka” was attempted by Mutharayappa (1996). Findings revealed that Jenu Kuruba and Kadu Kuruba tribes were endogamous in character, having different social structures and marriage patterns. While Kadu Kurubas have divisions and clans among them, the Jenu Kurubas do not have any clans but they speak of god and groups. Among Kadu Kurubas, the parti-sibs help in regulating marital relations. The Jenu Kuruba children were free to marry any one they like among them but one should not marry blood relations. Very often, they separate and remarry in succession. Among these tribes, there was very little control for elders over the brides and grooms. They acquired a mate both arranged by parents and also by elopement. Consanguineous & non-consanguineous marriages were prevalent among these tribes.

NIN (1996) assessed the health and morbidity profile of the Gonds of Jabalpur. 2734 individuals have been examined. The study revealed that most of the households were nuclear type (63.1%). The average size of the household was 4.5 persons. Agriculture was main occupation (67.9%). Almost all the houses (98.2%) were of kuchha type without sanitary latrine (99.8%). Open pit was used in 78 percent households for refuse disposal and animals were kept inside the living room (86%). Most of the households (74.5%) used tube well water for drinking.

Naba Kumar (1997) conducted a study on “Role economy in education of development-A comparative study of the HO in different settings”. The study revealed the poor economic condition of the HO in Hoshanpur village than the Shikurshai village. He also found that the level of education at the individual level was very low as compared with the Shikurshai Village therefore, in both the village and in all the cases of males i.e., on the basis of sex, age and attendance of school, education rates were quite high than females. The school education rates were quite high than females and its corresponding figures also indicated that the HO of Hoshanpur possessed low literacy rate and low educational level than the Shikurshai. In this situation, it was an acceptable fact that the economy had a greater role in education development of the Tribal population of the county in general and the HO in particular.
Sengupta et al., (1997) made an attempt to describe the socio-cultural variations and selection intensity among the Oraons of Assam. The study was based on differential fertility and mortality computed for Oraons of Dibrugath district, Assam. Total index of selection was acting with relatively greater intensity among Christian Oraons compared to their Hindu counterparts. The index was much lower in extra Oraon Labourers than those who still work on tea plantation as labourers.

“Socio-economic condition and dietary habits of Reang tribe” was examined by Swapan Kumar et al., (1998). They concluded from the above study, that the average family size and sex ratio of, Reang families were more than the Bengalee families. Literacy rate of Reang was lower. 52per cent of Reang families still live in their special type of houses named “Tong Ghar” while Bengalees preferred kachha houses. 86 percent of Reangs were still habituated to defecate in open air, where as this type of defecation habit was rarely found among Bengalees. Average income of the Reang families (Rs.893.1±294.3) was significantly (P<0.001) lower than the Bengalee families (Rs.1494.1±380.4).

“A study of Nuptiality behavior of a primitive tribe- the Birhors of Raigarh” was conducted by Pandey (1998).the findings revealed that the age at marriage in the tribe was low. There has been an increase in age at marriage overtime for both males and females. The type of household, main occupation and consanguity were associated with the age at marriage.

An overview of the socio-economic and demographic transition among the Santals was studied by Kalyan et al., (1998) and they concluded that the field of educational have achieved a little over 12 per cent of literacy in Bihar and West Bengal and 14.91 per cent in Orissa. They were found to marry at adult age. Bihar was having the largest share of Santal population followed by West Bengal and Orissa and their growth rate was below national average In spite of the different developmental programmes, their socio-economic life was below the desired level. However, an all around transition has set in their life.

Reddy, K.V., (2001) carried out a study on environmental impact on the economic life of Yerukula tribe (a case study of Rayalaseema region of A.P.). The study revealed that Yerukula was one of the principal tribes of the A.P., mostly
inhabiting in and around the forest areas of Nallamala forest region and range. They are, in general, semi-nomadic and gradually setting down. Yerukula tribe was a wandering tribe connected with occupations such as basket-making, stealing, begging and fortune telling. The Yerukala were good at basketry and most of them were employed in that art. Bamboo was the raw material available in Nallamala forest region and other areas of Rayalaseema region of Andhra Pradesh.

Rao (2002) has analyzed the determinants of social economic status of Tribal woman in Arunachal Pradesh. This study analyzed in education and economic empowerment of Tribal women of Arunachal Pradesh. Since 1985 some of the findings are A large majority of women in Arunachal Pradesh participate in wage employment activity. They are also involved in household chores. This on an average of women in Arunachal Pradesh work for over 12 hours a day and hence like elsewhere are confronted with double cay work problem. A good number of NGOs have been established for the emancipation of women and girl children of Arunachal Pradesh. These NGO’s are working towards educational empowerment, social empowerment and improving the women status.

Sathya sundaram (2004) this study has examined the difficulties and issues in empowerment of Tribal women. He observes that the wide spread illiteracy, poverty, early marriage and under nutrition are the major obstacles for development of Tribal women. Tribal women also suffer from atrocities caused by mainland people and the police. Therefore to reduce the exploitation and threats to life and decency, self-respect of Tribal women. They suggest improving the nutrition status of Tribal women and child.

Lal Suresh and Padma (2005) have analyzed the problem of empowerment of Tribal women of Andhra Pradesh this study makes use of census data on Tribal population, literacy rates in Andhra Pradesh, the Tribal women in Andhra Pradesh were found well at dry land agriculture. Tribal women are facing the following problems in health and nutrition such as malnutrition is common among the Tribal women, higher infant mortality rate in Tribal compared to national average, and the average protein calorie intake was found to be low among Tribal women.
Mohammad Awais Tosib Alam Mohd (2009). This study focuses on the status of tribal women in present society as a significant reflection of the level of social justice in that society. Women’s empowerment is often described in terms of their level of income, employment, education, health, and fertility, as well as their roles within the family, the community, and society. They are also taking considered in the primary sector. Over 80% of tribal women work in agriculture, compared to 53% of the general population. About 45% are cultivators against 32.5% of the general population. Tribal women in education play an extensive role in the economic development of tribal areas, contributing to the sustained growth of a developing society. And it is largely responsible for reducing the disgraceful trouble of tribal women mistreatment. Healthcare is a major problem in far-flung isolated tribal areas. Lack of food security, sanitation, and safe drinking water, poor nutrition, and high poverty levels aggravate their poor health status. Till recently, an abundance of fruits, tubers, roots, and leaves in forests on the one hand and indigenous health-care systems on the other, contributed positively to tribal health. Some health indicators of tribals, SCs, and others are given below to establish their poor state of health. Tribal women play a major role in the management of their natural, social, economic resources and agricultural development including crop production, livestock production, horticulture, and post-harvest operations but they remain backward due to traditional values, illiteracy, superstitions, and dominant roles in decision making, social evils, and many other cultural factors.

Puttaraja and Heggade (2012) Women in a tribal society play a vital role in their social, cultural, economic, and religious ways of life and are considered as an economic asset in their society. But they are still lagging far behind in various walks of life like education, employment, good health, and economic empowerment etc. Empowering may be understood as enabling weaker sections like poor women, especially tribal women to acquire and possess power and resources. The purpose of the present paper is exploring factors facilitating or discouraging economic empowerment of women, such studies are attempted by Banerji, Sen, Krishnaraj, Agarwal, Kelkar, and Heggade. These Indian scholars have explored the economic opportunities like employment, education, access to healthcare services, improvements in human resources development, property rights, and inclusive
growth process for women as important determinants of economic empowerment of women. Some other studies reveals the similar results, according to Lesmke (2003) study has analysed, how very high levels of domestic violence and rape have caused women disempowerment and thus has become a source of economic poverty. Budlender (2000: 133) state “poorer women are often rapped in abusive relationship due to their dependence on partner for food, shelter and money”.

Awais et al. (2009) Point out that Tribal women face problems and challenges in getting a sustainable livelihood and a decent life due to the environmental degradation and the interference of the outsiders. However, there are wide variations across regions and tribes in terms of work participation, sex ratio, economic productivity, and social life.

Awais et al. (2009: 2) further pointed out that without any healthy and productive Tribal women, the Tribal societies cannot have productive settled agriculture. That means Tribal women contribute immensely to the Tribal agriculture. However in modern India, the natural resources and natural habitat of the tribes are used for commercial purposes and thus their ecological sustainability is damaged. This has the potential to damage the life sustenance of goods from the forest and its water bodies. This study suffers from primary data about Tribal women participation by different State sponsored employment and welfare programmes in Tribal regions.

Kantidas (2012) has made out a strong case for the socio-economic empowerment of the Tribal women in India. This study identifies many social, political, economic, technological and physiological constraints in the way of Tribal women empowerment. Kantidas has attempted an analysis of constraints in women empowerment in the Tribal area of Assam State. This research has found that, the cognitive and infrastructural constraints are major hurdles for Tribal development as well as Tribal empowerment. In particular, Kantidas has pointed out that the main reason for the poor empowerment of Tribal women was noted as lack of knowledge about new technology and information.

D. Pulla Rao (2013) This paper addresses the socioeconomic status of the scheduled tribes in Visakhapatnam district of Andhra Pradesh State (India). In the
sample, the majority of the households is the tribe of Konda Dora. The majority of the sample households in the study area are Hindus and more than 70 percent of the sample population were illiterate. There is a need to put more attention on educational aspects of scheduled tribes, where this only can motivate them for future life.

3.2. Studies on Reproductive Health

Koen et al., (1992) analyzed “Prevalence of anemia among pregnant women in TamilNadu”. This community based survey was conducted by R.U.H.S.A department, Christian medical college, Vellore. It was found that 76 percent of women had a hemoglobin level of less than 11gidl. Severe anemia was observed in 11 percent of women. Stool specimens were collected from 130 subjects and observed microscopically. Another observation was that 62 percent of sample had hookworm infections. In brief the previous studies in India particularly done in South Indian states clearly showed that women were severely affected by many ill-health problems during pregnancy and delivery.

Health modernity scale was administered by Aruba et al., (1993) to measure scientifically correct information, on attitudes and behaviour in relation to physical and mental health, diet and nutrition, family planning, Breast-feeding, child care and health habits on a stratified random sample of 400 rural Tribal women of Chotanagpur and Santal Paragana. The extent of health modernity on these dimensions varied from 0 to 3 percent. The low health modernity was due to poverty, illiteracy and ruralness and it reflected in poor living conditions, faulty food habits, high prevalence of illness, disabilities and malnutrition in children under 5 years. He also identified areas of ignorance and misconceptions related to various dimensions of health modernity.

Chatterjee (1993) conducted a study on health of the Tribal women in three economic zones – forest based areas, denuded forest area and industrially polluted areas of West Bengal, Bihar and Orissa. The study revealed that the incidence of disease was found to be lowest in the forest areas and highest in the industrial areas. It was also pointed out that the health of the Tribal women was intricately related to their occupation.
Kar et al., (1993) studied the health culture and Tribal life among the noctes of Arunachal Pradesh. The authors reported that the basic diet of the noctes consists of cereals, millets, vegetables, meat and fish. Rice is the staple food. A large variety of wild leaf vegetables, roots, tubers and fruits as well as pumpkin, Brinjal, onion were also included in the diet. For expectant mothers they did not prescribe any special diet. There were, however, no food restrictions. Housing pattern showed that the people were not conscious about personal cleanliness and sanitation practices. Lack of cleanliness, sanitation, potable water, minimum light and ventilation in the house was responsible for the occurrence of a number of diseases. The habit of defecating in the open was an important factor responsible for hook worm infestation. There were a number of diseases that were caused by natural factors, e.g.; Malaria, Scabies, Worm Infestation, Jaundice, Diarrhea etc. For the cure of these diseases, they resorted to natural, herbal or sometimes modern medical treatment. They generally went for medical treatment at the last stage when all the sacrifices, rituals and other measures have not yielded any result. Pregnancy being considered as a natural phenomenon, they were not interested in having regular medical checkups, taking medicines during pregnancy and medical help during child birth.

A study of economic factor in relation to health care of Bharias was examined by NIN (1993). The findings highlighted that most of the Bharia (90.2%) lived below poverty line. Though agriculture was their main stay they depended on forest service, cattle rearing, poultry, etc. 7.6 percent Bharia households were land less, 16.6 percent population was reported to be engaged in service. The percentage population engaged in service was lower (11%) among the Bharias inside the valley as compared to others (16.6%).

Shireen Jejeebhoy (1995) in her study “Addressing Women's Reproductive Health Needs: Priorities for the Family Welfare Programme” found a growing recognition that population dynamics, quality of life and women's status were closely interrelated. She argued strongly for a fresh look at India's population programme, with a broad Reproductive Health and woman-centred orientation, especially in view of the fact that a national population policy is currently in the process of formulation. In theory, India has a model population programme which
aims to provide family planning within a broad framework of maternal and child health care, with emphasis on voluntarism and informed choice. In practice, however, the programme was characterized by a singular focus on sterilisation, by poor quality of services, and insensitivity to women and their broader Reproductive Health needs. Strategies to broaden the narrow focus of services, and more important, to put women's Reproductive Health services and information needs in the forefront were therefore urgently required; at the same time, men's information needs, especially in the area of STDs and AIDS cannot be ignored. In the long term, however, the pace at which improvements in quality of life in general and women's health in particular occurred was powerfully constrained by low levels of education and control over material resources among Indian women. The importance of programmes to promote universal primary education for girls and non-formal education, skill and employment generation for women cannot be sufficiently emphasised.

Sathiya Suman et al., (1997) presented a study on “Reproductive Health care of women in rural areas: an exploratory study in Nilagiris district in Tamil Nadu”. The Southern States of Tamil Naidu in India has been selected for the study. The Nilgiris District has a large concentration of hill Tribal population in Tamil Naidu. Reproductive Health care was an integrated health programme of women, which takes into consideration the antenatal care of women and post-natal care programme of the child. Socio-economic factors like educational, cultural and economic backgrounds of the Tribal and non-Tribal women help in mainstreaming good health during pregnancy and childbirth as well as for the survival of the child. Tribal women responded better to the programmes than non-Tribal women. Some socioeconomic factors such as income, better living conditions like houses with electricity, safe drinking water, and family planning practices were important factors for better Reproductive Health practices.

Deepak’s (2001) study on child mortality in three Tribal populations of Shillong focuses on early childhood mortality among the Khasi, Garo and Mizo tribe of Shillong especially causes of death, mortality rates and medical facilities. The study revealed that diarrhea, respiratory troubles, asphyxia and jaundice were the main factors causing child mortality in these three populations. Infant and under
five mortality was found to be very low among the Mizo than India’s urban rate, whereas among the Garo these rate were considerably lower in comparison with India’s urban population. When the medical facilities availed by the communities were taken into consideration, it was found that the Mizo’s availed considerably more facilities than the Khasi Garo, and in turn, the Khasi availed more medical facilities than the Garo.

Pandey (2001) in his study on “Socio-Cultural Reproductive Health Practices of Primitive Tribes of Madhya Pradesh: Some Observations” have attempted to describe the socio cultural beliefs and practices of three primitive tribes-Bharias, Hill Korwas and Kamaras of Madhya Pradesh. Some of their practices were good and can be utilized for strengthening Reproductive Health. For instance: They considered pregnancy a natural phenomenon and do their normal chores till the onset of labour pains. They avoided cohabitation during pregnancy. Pregnant women did not consume alcohol. Delivery was conducted in squatting position’ which according to the doctors was the less painful and more scientific position if carried out carefully. Colostrums was given to the child, which prevented the child from various infectious diseases. Prolonged Breast feeding was adopted as it was beneficial to both mother and child in several ways’ including birth spacing.

Nagda examined a study on “Tribal Population and Reproductive Child Health in Rajasthan”. The information and data regarding Tribal population of Rajasthan state collected through ethno demographic literature, census, NFHS-2 and other survey’s conducted in the Tribal areas in Rajasthan on socio-cultural practices was collected through free listing, focus group discussion and in-depth interview techniques. Findings of the study reflected that Rajasthan has 12.44 percent Tribal population. The growth rate of Tribal population (34.46) was higher than the State (28.44). The sex ratio of Tribal population (929) was higher than the general population (909) of the state. The number of pregnancy related deaths in the Tribal areas was higher in the state. Malnutrition was widespread among the Tribal girls and women. More than half (58%) of Tribal women and 80 percent of children were suffering from anemia. Majority of the Tribal women suffered from domestic violence. About 62 percent of women were physically beaten by their husbands at least once a month and 83 percent of females reported verbal abuse by their
husbands, in laws and other family members at least once a week. The violence among Tribal women was higher among the labor. The wives of non-worker, alcoholic and smoker husband’s suffered 45 percent more form of domestic violence in comparison to the wives of working husbands. The position of literacy among tribes of Rajasthan was extremely poor, and more so in the case of female literacy. More than half of mothers had 3 and more live births. Tribal women produced average 4.31 children during her reproductive life but they want only 2.7 children. The traditional health care system and treatment were based on their deep observation and understanding of nature. About 86 percent deliveries performed at their home and three fourth of deliveries conducted by dais and other untrained persons. About 74 percent of the mothers squeezed first milk from breast. Female sterilization was more popular among tribes. About 29 percent of the women were using any method of birth control.

Richa Chandraker et al., (2009) A Study of “Reproductive and Child Health among the Dhur Gond Tribal Community of Mahasamund District, Chhattisgarh, India”. This cross-sectional study was conducted to understand the pregnancy related issues, women’s Reproductive Health, infant and child morality and also to assess the nutritional status of mother and under five children among Dhur Gond Tribal community of Mahasamund district of Chhattisgarh, India. 174 ever married women and 68 under five children were selected for the present study. Pre-structured schedule was used to collect socio-economic, demographic, Reproductive Health including ante-natal care, delivery practices etc. Weight of under five children and height and weight of mother were measured by standard techniques. Weight for age was calculated for assessing child nutritional status using NCHS standard, body mass index (BMI) was used to assess for mother nutritional status. Results revealed that high percentages of mother had not taken ante-natal checkup (51.72%), tetanus injection (41.38%) and iron and folic acid tablets (56.32%) during pregnancies. 94.83 percent deliveries performed at home and 57.47 percent births were done mainly by untrained dai (traditional birth attendant’s). Infant and child mortality rate was 5.92 and 4.28 per 100 live births respectively. 47.12 percent of mothers were undernourished (BMI <18.5 kg/m2) and all the children suffered from malnutrition. Grades II and III malnutrition were
higher among girls compared to boys. Poor health status during child bearing period, low ante-natal care, high deliveries at home along with high prevalence of under nutrition of under five children and mothers were mainly due to low socio-economic conditions, high illiteracy and lack of awareness among Dhur Gond Tribal community.

Narahari et al., (2009) in his study “The Porja: A Study on Pediatric Practices” recorded the Feeding Practices of 260 ever married women , who have at least a child in their reproductive span, belonging to the Porja, a Primitive Tribal Group of Visakhapatnam District, Andhra Pradesh. The sample hails from 18 villages of Munchangiputtu and Pedabayalu Mandalas. The results show that almost all the mothers started breast feeding to their new born immediately. About 71 percent of the respondents squeezed out the ‘colostrum’ (milk) ere to start the feeding the baby , thereby depriving of their babies from ‘colostrum’, a thick yellow liquid rich in factors that provide natural immunity. This may be due to illiteracy and lack of awareness about the nutritive and immunity value of the colostrum.. The duration of lactation was noticed mostly for 2years (42 percent) followed by 3years (38 percent) and 4years (17 percent). Very few mothers (3 percent) lactate their babies below the age of 1year due to conditions of ill health. The practice of supplementary feeding starts from 6 months onwards which is greater during 8-12 months (60 percent).The predominant type of supplementary feeding is ‘Ambali’ a liquid form of rice or chodi (87 percent) and a few of them are fed with rice in mashed solid form. The results are discussed in the light of available information on other local tribes besides focusing the relevance of illiteracy, status of awareness etc., on Pediatric health care practices.

Nalin Singh Negi et al., (2010) evaluated a study on “Antenatal Care among Tribals: A Study of Chhattisgarh and Jharkhand”. The study examines the influence of socio-economic and demographic variables influence (age, social class, religion, marital duration, surviving children etc.) on the utilization of Antenatal care (ANC) services from public or other health professionals among Tribals and non-Tribals. It also examines the effect of availability and accessibility of Reproductive and Child Health (RCH) services on utilization of ANC services. The data from District Level Household Survey under Reproductive and Child Health Project (DLHS-RCH-II)
has been used for analysis. This survey collected data from 8860 currently-married rural women of Chhattisgarh and 10,569 currently-married rural women of Jharkhand during 2002-04. The discussion clearly reveals that in each socio-economic and demographic parameter, the Tribal women are lagging behind others in both the states. Distance to the nearest public health facility is not a satisfactory predictor for utilization of public health services because distance to the nearest public health facility does not indicate the relative accessibility of that health facility when there are a number of alternative places to go for the same services. Accessibility is a matter not only of distance but also of the quality of services provided.

Stoop et al., (2010) evaluated a study on “A survey on the intentions and attitudes towards oocyte cry preservation for on-medical reasons among women of reproductive age”. The aim of the present study was to investigate attitudes concerning social oocyte freezing among women of reproductive age in Belgium. The electronic questionnaire was completed by 1049 women, giving a response rate of 55%, and 25 were excluded as they were incomplete/inconsistent. Our results demonstrate that 31.5% of respondents consider themselves as potential social oocyte freezers, of which 3.1% would definitely consider the procedure. Just over half of the women (51.8%) would not consider the procedure while 16.7% indicated they had no opinion. Potential oocyte freezers are characterized by a higher number of desired children and more openness to oocyte donation. The decision to actually embark on such treatment would primarily depend on conditions, such as the procedure not affecting their natural fertility and the health of future children. They conclude that a significant proportion of young women would consider safeguarding their reproductive potential or are at least open to the idea of social oocyte freezing.

Caserta et al., (2010) “Environment and women’s Reproductive Health” this study summarized and classified as fertility and fecundity, pregnancy outcomes, transgenerational exposure and effects. Epidemiological studies on EDCs are not always consistent, in part due to limitations imposed by practical constraints. In order to make progress in this field, we recommend taking advantage of biomonitoring and biobanks, including the development of appropriate biomarkers,
and taking into greater consideration modulating factors such as genetic polymorphisms and dietary habits. Further human studies are warranted with particular focus on impaired fertility/fecundity associated with currently widespread ED (e.g. bisphenol A, phthalates and polybrominated flame retardants). A detailed appraisal of compounds specifically related to adverse reproductive outcomes is very important for prevention and risk-communication strategies. Besides research needs, the current evidence is sufficient to prompt precautionary actions to protect women’s Reproductive Health.

Ndidi et al., (2010) A cross sectional questionnaire based survey conducted to determine the reasons for late booking among women presenting at the antenatal clinic of a major tertiary hospital in the Niger Delta, Nigeria. Findings revealed that the majority of respondents were aged 20-39 years (97.1%), quarters were primigravidae and 25% of the women belonged to the upper socioeconomic class. Seventy three point six percent booked in the second trimester and 26.4% in the third trimester. Of the women who had given birth before, 80% had booked late in at least one previous pregnancy. More than three-fifth of the women (65.6%) booked late due to ignorance or misconceptions of the purpose of, and right time to commence antenatal care. their study suggest that most women book late because of a belief that there are no advantages in booking for antenatal care in the first three months of pregnancy.

Susan Hally (2011) “Nutrition in Reproductive Health” This article reviews nutrition-related issues affecting women and their Reproductive Health. Health care providers must be able to perform a basic nutritional assessment to identify risk factors and develop a plan of care to reduce those risk factors and improve health. Guidelines are provided to assist in performing a nutritional status assessment. Nutritional assessment of women of reproductive age should identify factors that may affect fertility, periconceptional health, and pregnancy outcome. Recommendations are provided to assist the health care provider in counseling women regarding the relationship of food choices and exercise to health, fitness, and optimal bodily function. Controversies surrounding the effect of micro-nutrient deficits and excesses on reproduction and correction for these imbalances are
discussed. Women should be encouraged to initiate dietary and other lifestyle changes to allow for optimal reproductive outcomes.

Monali Goswami et al., (2011) conducted an intensive explorative study “Traditional Method of Reproductive Health Care Practices and Fertility Control among the Bhumija Tribe of Baleswar, Orissa”. To collect data in the Tribal (Bhumija) dominated villages of Baleswar District. Five villages of Remuna Block namely, Phulkiary, Jodabari, Ghatgharsahi, Jambani and Gudgudia and three villages of Nilagiri Block namely, Chaturkhunta, Chandipur and Makhapada of the district were covered. The study reveals that the Bhumijas have vast knowledge about ethno-medicinal uses of plants growing in their vicinity. It has been well revealed in this study that the Bhumija community has been changing at a certain pace along with their health seeking behaviour. The Tribals inherit a rich traditional knowledge about the flora investigated and apply this knowledge for making crude herbal medicines to cure different diseases. But it is observed that the traditional knowledge which formed the basis for the origin of alternative medicine also paved way to evolution of modern medicine. Now such indigenous knowledge is facing slow and natural decline. However, the study certainly points out that the traditional Reproductive Health care system still finds its meaning of survival in the Tribal domain. In this study, it is also found that though the Bhumijas are in favor of taking the modern medical facilities, the older generation still has inclination towards traditional medicine. Presently, very few elders in the Tribal community practice traditional medicine, while the young generation knows little or nothing about the traditional medicine. If this trend continues, a few years from now, there will not be a single elder member in the Tribal community who would speak on the traditional medicine. The growing disinterest in the use of traditional medicine for Reproductive Health problems among the younger generation will lead to disappearance of this practice. Therefore, greater efforts are required to document the rich traditional knowledge of the local people so as to prepare a comprehensive account of it. Wild plants and other natural resources used as traditional medicine unfortunately are being eroded due to the loss and degradation of their natural habitats or over harvesting for commercial purposes. Therefore, there is an immediate need to execute a revitalization strategy for protecting the indigenous knowledge from complete desertion.
Sathiya Susuman (2012) in his study “Correlates of Antenatal and Postnatal Care among Tribal Women in India” an attempt is made in this paper to relate the socio-economic and demographic characteristics of the currently married Schedule Tribes’ women in eight districts of Chhatisgarh with factors associated with antenatal and postnatal care. Data for this study were taken from District Level Household Survey on Reproductive and Child Health (DLHSRCH 2002), a representative sample of 1569 Scheduled Tribes’ currently married women aged 15-44, residing in eight districts of Chhatisgarh. Adjusted effects (odds ratios) analysis has been used to find out the effects of antenatal and post-natal care on institutional delivery in Chhatisgarh. It is observed that majority of the Scheduled Tribes’ women, about 84 percent, have a low standard of living. Also, 74 per cent of the Scheduled Tribes’ women are illiterate. The finding of the adjusted effects (odds ratio) shows that giving birth in the medical institution for the Scheduled Tribes’ women who received full antenatal check up is 2.5 times higher than those women who did not receive any antenatal check-up. It suggests that majority of the currently married Scheduled Tribe women have low standard of living there is a need to improve their economic standard so that they can fulfill their basic needs.

Krishna Kumari (2014) investigates the issues and challenges among the Tribal women in comparison to the non-Tribal women in the newly states by drawing upon data from the National family health in terms of standard of living, education and other socio-demographic indicators. There is a need for proper understanding of the different health aspects of Tribal women and their specific health needs so that relevant health measures can be prepared and implemented, More particularly, there is a need for undertaking a region-specific study of the health of the Tribal women, which will make planning for their welfare more successful. In this investigates the maternal health care practices, health condition, education and unemployment among the Tribal women in comparison to the Tribal women. Education as a means of advancement of capacity, well being and opportunity is uncontested and more so among communities on the periphery. Low literacy rates in Tribal communities continue to indicate a need for overarching support that tactless issues from health, education and unemployment of non-Tribal population.
3.3. Studies on Nutritional Status and Morbidity

Kasar et al., (1990) studies the consumption behavior of Tribals of Ambegoan Tahsil in Pune district. The study revealed that food was the major item of family expenditure which alone shared 67.74 per cent of the total family expenditure. Sugar and jaggery, milk etc the consumption of cereals alone provided 80.60 and 70.72 per cent total intake of calories and proteins respectively. There was no nutritional gap from the view point of the minimum intake of calories and proteins recommended for average work. This was mainly due to the inadequacies in consumption of pulses and protective food such as vegetables, fruits milk, fats and oils, egg, fish, meat etc. the consumption expenditure of Tribals was found to be significantly influenced by the annual gross family incomes and the family size in adult units.

NIN (1990) studied the nutritional status of primitive tribes in Andaman-Nicobar islands. Glosstis was observed in one adult woman. The daily intake of foods like cereals, oils and coconut did not very much. But the consumption of fresh foods like pork, tortoise, crab and fish showed wide variation from day to day. Protein intake varied between 45- 90 gms and that of calcium between 150- 670 mg per CU per day. Intakes of all nutrients except for protein and thiamine were lower than the RDA. Among the Andaman’s, the adult women were very short with a mean height of 2140 cm and heavier by about 7 kgs to rural women. Some of them showed signs of vitamin A deficiency and pallor suggestive of anemia.

NIN (1990-91) reported the nutritional status of certain Tribal groups of the north- eastern hill states. Their consumption level, in general, tended to be more than what has been recommended in the “Balanced diets” by ICMR. The daily average intake levels (per CU) of nutrients such as protein, calcium, iron, riboflavin and thiamine were more than RDA in all the Tribal groups.

Pande et al., (1990) studied the nutrient intake of selected Tribal population in Kinwat area of Maharastra. Forty five families were selected from Gond (12), Andh (12), and Kolum (10) communities. The differences in intake of calories and protein among the four tribes average did not reveal any statistically significant variation. It was observed that the intake of protein by adult male and adult female
(90.01 and 68.5 gm respectively) was more than recommended daily female (90.01 and 68.5 gm respectively) allowances (55 and 45 gms respectively). Whereas the intake of energy was (3000 and 2184 Kcal respectively) less than the recommended allowances.

Mohanty et al., (1991) made an attempt to study the food habits, childhood mortality, growth and nutritional status of the rural Kisans of Sambalpur, Orissa. It was observed that their average diet was much inferior to the standard balanced diet required for normal growth and well-being. Nutritional status as studied by weight/height index shows the presence of malnutrition among 46% adults. The observed childhood mortality was 18.75% and the rate of pregnancy wastage among the Kisan mothers was 8.1%.

Hanumantha Rao et al., (1992) conducted a study on “Nutritional status of Maria Gonds- A primitive tribe of Maharashtra”. The study revealed that Maria Gonds were better off as compared to their rural counterparts in Maharashtra as revealed by their better food and nutrient intake and anthropometry. They were also found to be better off than the Gonds of Bastar who mainly depended on agriculture. Thus the Tribal population in habitating isolated regions with little exploitation by outside people and with sufficient employment potential was found to be nutritionally better.

Sar et al., (1992) studied the consumption pattern of Tribals in Thane district. The study was based on a diet survey in 120 rural households in Thane district, out of which, 42 Tribal households were selected randomly and surveyed, they reported that the intake of almost all the foodstuffs, except pulses, vegetables, roots and tubers, was inadequate among the Tribals. At overall level, the calorie intake was inadequate while protein intake was just adequate among the Tribal of Thane district per day per capita cost of the Tribals was Rs.6.81 which was less than the cost of balanced diet (Rs.7.04). The diet of Tribals with respect of 69 and 52/4 per cent households was deficit in calories and proteins, respectively. Among the various influence on calories and protein intake of the Tribals.

Tandon et al., (1992) studied the impact of ICDS on immunization coverage of children and mothers in nineteen rural, eight Tribal and nine urban ICDS projects
DPT, BCG and polio vaccine was recorded for 65.00% 63% and 64% of children respectively in ICDS population. By comparing the coverage in non ICDS group was only 22% for BCG, 28% for DPT and 27% for polio Myelitis. Complete immunization with tetanus toxoid was recorded for 68% of the mothers in the ICDS group and for 40.00% in the non ICDS group.

Kulakarni (1993) conducted a study to assess the malnutrition in Junnar and Dhule Tribal of Maharastra state. The study revealed that although these Tribal of basic potentialities to grow normally, the overall malnutrition due to several factors have affected the growth, indicated specially through body weight and mid upper arm-circumference. An intermittent intervention programmmes of environmental ecological balance and various health’s on nutritional practices to some extent might help improving their nutritional status. This could possibly be done by alternated intervention and assessment activities.

Rajya lakshmi et al., (1995) made an attempt to study the traditional food and agricultural practices of Tribals in tow agency in two agency blocks namely, Bhadragiri and Pachipenta in Vizayanagaram district in Andhra Pradesh which has a Tribal population of 1.53 lakhs. The major tribes in the area were Jatapu, Savara, Gadaba and Konda Dora. Agricultural and allied labor, apart from collection of forest produce from the major economy also cultivates diverse food crops. The main storage structures of the Tribals are earth wares and majority of the Tribals stored staple wild foods grains for a period of six months or less. Tribals also store some wild foods like mushrooms, tender bamboo shoots, caryoto palm pith, mahuva seeds. Sun drying was the common practice followed prior to storing of foods. Millets were the staple food of the Tribals. They followed traditional parboiling of millets were the staple food of the Tribals. They follow traditional parboiling of millets and paddy. Elaborate processing is practiced in case of wild foods like dukka chikkudu (Mucuna Pruriens), while tuber (Disosocea hispida) storage and preservation of fruits and vegetable were uncommon with the tribes. Tribes follow primitive techniques like parboiling, storing and cooking of foods.

Sharma et al., (1995) made an attempt to assess nutritional status of Hill Korwa Tribal population of Madhya Pradesh. The study based on 239 unrelated
individuals (136 adult males 103 adult females) from predominated inhabited villages namely Ghatgaon and Sewari (Rajpur blocks), jori and Raghupur and Khala (Ambikapur blocks) of the Suguja district, M.P. The pelidisi index indicated that all males and females have low nutritional status, whereas the Pignet index (Body Build Index) showed that 0.82%, 1.64%, 18.03%, 27.87%, 13.11% and 9.84% males belonging to very sturdy, good, weak, and poor nutritional status groups, respectively.

Thanuja et al., (1995) carried out a study to measure the extent of malnutrition among the Tribal women of Singhbhum district of Bihar state. Completed data were available for 222 Tribal women. Tribal women in this study did not have the habit of wearing slippers when they go out. This may increase the chances of getting hookworm infestation there by causing anemia thus majority of women were at a risk of delivering low birth weight babies and have pregnancy complications. Some of the reasons for under nutrition among Tribal women could be poor diet intake, ignorance, early marriage, and high morbidity due to unhygienic practices and surroundings. Under nutrition of mothers may be carried over to their children. Hence, there was a need to provide special attention to this group in improving their nutritional status by intervening appropriate health and nutritional programmes like nutrition education, iron supplementation and deworming both during adolescence and during adulthood.

Vaishnav (1995) made an attempt to study bio-cultural analysis of “Diet and Nutrition on Gamit tribe of Gujarat”. Altogether 45 families from the Gamits were brought under diet survey; principal food crop was “Jowar”. The next important food crops were “Bhat” (rice), “Tuver” (pegion pea), ‘Arad’ (phascalcus mango), ‘val’ field bean ‘Mag’ (kidney bean) and some seasonal vegetables. These people entirely depend on locally produced food grains. The tribes do not take new food grains before Diwali festival. They believe that if they have new food grains before Diwali, ‘Kansari mata’ (local goddess) will get angry and will cause bodily pain and illness to them. In the tribe, during pregnancy, lactation period, at the time of pooja and in some feasts meat, egg, fish and chicken were not allowed. Similarly they do not take milk and non-vegetarian food on some days. During illness chilies, oil and heavy foods were not eaten and only light foods were preferred. Milk, fruits,
honey, meat, eggs and fish are recommended for weak persons. They consumed very small amounts of oil, milk and milk products, flesh foods, leafy vegetable, fruits and flower vegetables, sugar and jaggery roots and tuber vegetables were consumed. Nearly sufficient quantity of cereals and pulses were used. The consumption of calories, protein, niacin, thiamine, phosphorous and iron were satisfactory. Consumption of fat, Riboflavin were low. Vitamin ‘A’, Vitamin ‘C’ and calcium were very low compared to recommended allowance.

Guru et al., (1997) conducted a study on maternal nutrition, antenatal care and infant mortality in the Rayagada district of Orissa state. The nutritional status of the Paraja Mothers was more or less the same as that during their last pregnancy and lactation periods. Paraja population lived under acute poverty and their nutritional standards were likely to be low. It was observed that slightly above one fifth (22.75%) of the Paraja mothers possessed good weight for height status. Moderate weight for height status constituted 45.10 percent and almost one third (32.16%) belonged to the category of poor weight and height status. 46.27% of Paraja mothers were severely anemic. Only 16.85% were normal. Rice during summer and winter and maize during the rainy seasons constituted staple food among the Parajas. Even regular consumption of pulses, meat or fish was not possible. Regarding the distribution of food, there was no gender discrimination among the Parajas. Majority (63.13%) of the mothers in the sample did not receive any antenatal care during pregnancy of the index child. Only a small proportion of mothers (13.72%) received complete antenatal care. A very low proportion (18.04%) of deliveries took place in a hospital in the population under study. An overwhelming proportion (8.96%) of deliveries were carried out at home which were attended by indigenous untrained dais or elderly female members of the family.

ICMR (1996-97) conducted studies on “Health and nutritional status of Great Andamanese-a primitive tribe of Andaman and Nicobar Islands”. Andamanese diet was found to be grossly deficient in green leafy vegetables and other vegetables. At the same time, their meat intake was eight times the recommended daily allowance. All the families had deficient intake of iron, vitamin A and riboflavin. Andamanese adults as whole had better nutritional status with
only 23.5% of them having BMI less than 18.5. Hemoglobin estimates showed that 94.3% of them were anemic. Moderate to severe degree of anemia was common among them. Drinking water sources in the Andamanese settlement were found to be contaminated and unsuitable for human consumption.

Raja Rathnam et al., (1997) studied the maternal and child health practices and nutritional status of Malto Tribals in Bihar. Anthropometric measurement of mother and their children were taken using standard procedures. Mother’s antenatal practices and child feeding practices were ascertained to understand the reason for poor nutritional status. During the last antenatal period, 87% did not have TT injection, 83.3% did not consume iron and folic acid tablets and 74% did not have any restriction over the food. Almost all had home deliveries except one. Over 80.9% had given colostrum to their last child. The nutritional status of mothers of Malto tribe was poor when compared to general population. Around 50.0% of mothers were stunted and 52.9% of the mothers were underweight.

Shukla et al., (1997) conducted a study on diet and nutritional status of Muria of Baster. 50 adult males and 50 females were measured for the nutritional anthropometry. This study revealed that most of the Murias were undernourished as ascertained by dietary intake as well as different anthropometric indices. Their diet mainly lacked in calories. Vitamin B2, niacin. It is evident that most were having weak physique and were in chronic energy deficiency state.

“A note of dietary habits and malnutrition among Tribal of Bastar, Madhya Pradesh” was attempted by Choubey (1998). The study revealed that due to lack of various nutrients in the diet of Tribals of the region, they were likely to be more susceptible to diseases or to have weak resistance power. Faulty dietary habits, selection of food stuffs, poverty ignorance, and tradition were some of the other factors which were likely to affect their nutritional status. Personal bad habits like smoking, chewing tobacco and drinking country liquor, rice beer in large quantity were additional factors which made them susceptible for various health hazards.

Khongsdier et al., (1998) described the food and nutrient intakes among the Dimasana of North Cochar hills in Assam. The findings indicated that the overall dietary intake among the Dimasana was more or less according to the recommended
allowances given by the Indian council of Medical Research, though the consumption of nutrients like iron, carotene and vitamin B12 was far below the recommended requirement. The problems concerning the practical method for measuring under nutrition in a population were pointed out taking into consideration the use of recommended allowance for any given nutrient as a cut-off point and the hypothesis of homeostatic variation in dietary requirements.

Lim Hwei Mian (1998) conducted a study “Nutritional status and Reproductive Health of Orang Asli women in two villages in Kuantan, Pahang”. The study was conducted to determine the nutritional status and Reproductive Health of 34 Orang Asli women, aged 16-45 years, from two Orang Asli villages in Kuantan, Pahang Darul Makmur. The results of the study indicated that on the whole, the women’s nutritional status was generally not satisfactory. Their mean iron intakes for example, were very low, about one-quarter to one-third of the required level. All their other mean nutrient intake levels were below the required level. Only their mean intake of vitamin C exceeded the required level due to their frequent intake of raw vegetables. Their main source of carbohydrate was rice, while their main source of protein was fish, and their main source of minerals and vitamins were Chinese mustard and cabbage. From BMI measurements, it was found that less than half of the women (42.9%) have normal weight, 35.7% suffered from chronic energy deficiency (CED), 7.1% (one) were overweight, and 14.3% (two) were obese. The accessibility and availability of food were a problem for the women, limiting their choice of varieties of food sources. For their Reproductive Health needs, the pregnant women relied on the government hospital and clinics for their antenatal check-ups and birth deliveries. Of all the women, nine suffered from menstrual pain and five from vaginal discharge. Food taboos and cultural practices were practiced by the pregnant women during their confinement. It was concluded that the nutritional status of the women needed to be improved since most of them had insufficient nutrient intake.

Priti et al., (1998) studied the nutritional status by anthropometry of Tribal women of Jhadua district of Madhya Pradesh. Households with women in the reproductive age group i.e., 18 to 45 years were studied. They were categorized as pregnant and lactating status. The findings revealed that the Bhill Tribal women
were living in a state of great deprivation due to poor socio-economic status. Anthropometric measurements showed that the weight deficit was maximum compared to height, BHI values indicated higher prevalence of moderate forms of malnutrition. Almost three-fourths Bhil women in all psychological groups belonging to lower socio-economic status were in moderate grade of malnutrition. This was likely to have an adverse long term impact on their own health as well as on the welfare of the entire family.

Roy et al., (1998) examined the present state of socio-economic conditions and dietary habits of Reang Tribal community of Amarpur sub-division of South Tripur. A total number of 181 Reang tribes were going through a transition phase in most respects, even though they still retained some of their primitive forms of socio-cultural and economic entities viz., large family size, tong ghar (water estate), defecation habit, infant feeding practices, primitive form of cultivation and free collection from nearby forests. However, the traditional economy of gathering, hunting and farming has much lost importance due to scarcity of forests and tillable land. They were more dependent on plough cultivation and salaried jobs. Along with these socio-economic changes, dietary habits of Reang communities also changed, though not very vividly. Dietary habits of Reanges were different from the dietary habits of Bengaliees, specially in their cooking procedures and variations in intake of dietary foods. The intake of vegetables was high. Low fats and oils, pulses, milk etc., either might be due to their primitive pattern of dietary habits, related to their socio-cultural background or due to their poor economic condition or due to the combination of both.

Ramakrishna et al., (2000) conducted a prospective study in rural Karnataka to establish the type and extent of obstetric morbidities, explore health seeking behaviors and factors affecting service uptake during the study period. 535 women registered at the ages of 18-24 years. The information was collected through questionnaires during pregnancy and immediately after pregnancy and three months postpartum. The socio-economic characteristics and symptoms of post-delivery illness were also collected. Qualitative data containing perceptions of morbidities found that antenatal care was very high. Around 97 percent of women reported that they had routine antenatal care check ups and the most common person consulted
was the auxiliary nurse midwife (ANM). More than half of the women had their first contact in the first trimester. The delayed contact was more common among women who were poorly educated of higher gravidity and had fewer possessions.

Prevalence of anemia among pregnant women in Tamil Nadu was analyzed by Koen et al., 1992. This community-based survey was conducted by R.U.H.S.A department, Christian medical college, Vellore. It has been found that 76 percent of women had a hemoglobin level of less than 11g idl. Severe anemia was observed in 11 percent of women. Stool specimens were collected from 130 subjects and observed microscopically. Another observation was that 62 percent of sample had hookworm infections. In brief, the previous studies in India particularly done in South Indian states clearly showed that women were severely affected by many ill-health problems during pregnancy and delivery the most important.

Suneela Garg et al., (2001) presented a paper on “Perceived Reproductive Morbidity and Health Care Seeking Behavior among Women in an Urban Slum”. This paper estimated the prevalence of various Reproductive Tract Infections in females in a slum of Delhi. All ever married women in the reproductive age group were interviewed by a pre-designed and pre-tested interview schedule. As many as 62.3 per cent reported one or more problems in the past six months. The risk factors like genital hygiene and abortions were significantly associated with reproductive morbidity. Out of the women who experienced a Reproductive Health problem, only 27.8 per cent consulted a health facility for management. The authors recommend effective services for RTIs/STIs coupled with an awareness generation for the better utilisation of these services in the urban slums.

Zoe Matthews et al., (2001) conducted a study on “Antenatal Care, Care-seeking and Morbidity in Rural Karnataka, India: Results of a Prospective Study” to identify the socioeconomic determinants of antenatal care-seeking among rural women in a South Indian setting. The extent and nature of the antenatal morbidities suffered by these women were also described. The results give their responses to sequential questionnaires administered during pregnancy and beyond. All those who became pregnant in 11 South Indian villages within a 25-month period from August 1996 to September 1998 were followed as part of the study. Responses were
collected during pregnancy itself, thereby reducing the recall error inherent in many cross-sectional studies. This article presented survey results for 282 women interviewed two or more times during pregnancy, with the second interview taking place during the latter part of the third trimester. Occasional supporting qualitative information was also given based on in-depth interviews with pregnant women and their families, as well as with health-care providers and other key informants. The study took place in the state of Karnataka, which has a rural profile typical of South India. Early marriage and consanguineous marriages, especially between first cousins, were very common in this part of the country. Recent rapid fertility declines at all ages have brought the total fertility rate to 3.09 children per woman for rural residents, but short birth intervals still predominated - almost half were less than two years in duration. Literacy levels in the state were just a little higher than the national average of 52 per cent, with levels for men exceeding those for women by over 30 per cent (IIPS, 1993). This was a progressive rural setting for a developing country in South Asia; the fertility transition was well advanced in this part of India but maternal health was still very poor. Within India, which showed a considerable diversity of maternal health care provision, Karnataka falls between the extremes of good and poor health infrastructure. It was therefore a state with the potential for substantial improvement in maternal health.

The Report (2002) Macro Determinants of Nutritional Status of Women and Children in Ethiopia based on data from the 2000 Demographic and Health Survey with reference to 13,447 women age 15-49 years and 9,768 children under five of interviewed mothers with complete and plausible anthropometric data. This study showed a significant association between nutritional status of women and each of the explanatory variables under study. The proportion of women suffering from chronic energy deficiency (CED) malnutrition was significantly higher in rural areas than in urban areas. The highest prevalence of chronic energy deficiency in women was observed in Somali (48%), followed by Affar (42%), Gambella (39%), and Benishangul-Gumuz (38%); it was lowest in Addis Ababa (18%) and Harari (25%), the two most urban areas of the country. Women’s educational level was also found to be negatively associated with malnutrition in women. The prevalence of CED was higher among very poor women than among poor women, who in turn
have higher rates of CED than women of medium/higher economic status. The prevalence of malnutrition in women was also higher among the unemployed than women who were employed (cash or not). Women who have no say or joint say in how their cash earnings were to be used were more likely to suffer from malnutrition compared with women who have a full say. Demographic variables such as age, parity and marital status of the women were also found to be significantly associated with women’s nutritional status. The highest proportion of malnourished women was observed in the youngest age group of 15-19 years (38%), followed by the oldest age group of 35-49 (33%). The lowest rate was found in the age group 20-24 years (23%). The highest rate of malnutrition was also observed among nulliparous (34%) women, followed by higher parity (6+) women (30%); the level decreased as the parity group decreases. A significant association between malnutrition in women and their marital status was also observed; the prevalence of malnutrition was highest among never married women (36%), followed by widowed (32%) and divorced women (29%).

Parul Christian (2003) in his study on “Micronutrients and Reproductive Health Issues: An International Perspective” stated that Micronutrients may have a role in enhancing Reproductive Health of women living in the developing world. Two illustrative micronutrients zinc and vitamin A, have received some attention in this regard. Numerous animal experiments and observational studies suggested the potential role of zinc deficiency in labor and delivery-related complications such as premature rupture of membrane, placental abruption, preterm labor and inefficient uterine contraction. These associations have not been confirmed in supplementation studies. Zinc does not appear to be a limiting factor in intrauterine growth in the developing world, contrary to some evidence of its suggested benefit among women residing in industrialized countries. One study in Nepal found that maternal vitamin α or β-carotene supplementation reduced pregnancy-related mortality but not infant mortality. These findings were corroborated by observations of the significantly higher risk of mortality among night-blind women compared to non-night-blind women long after the termination of pregnancy and the resolution of night blindness. Maternal multiple micronutrient supplementation needed more careful evaluation before its use in large-scale programs. Two recent trials indicated that a
prenatal multiple micronutrient supplements provided no added advantage over iron and folic acid in reducing outcomes such as low birth weight and probably no survival benefit. Data were also suggestive that adding zinc may negate the beneficial effect of iron and folic acid on birth weight. Research was needed to further understanding of nutrient–nutrient interactions.

Uppal et al.,(2006) conducted a study on “Health Care Seeking Behavior among Men in an Urban Slum for Reproductive Morbidity”. A total of 268 males residing in an urban slum of Delhi were interviewed to study their socio–demographic characteristics, perceived reproductive morbidity and sources of health care facilities utilised by them for reproductive morbidity during the last 6 months preceding the study. The study revealed that majority of the sample respondents were in the age-group of 20-29 years and 154 were married. Out of 268 males, 64 (23.9%) had some kind of perceived reproductive morbidity, of which, 25 (39.1 %) did not seek any treatment from any health care facility. Of those who sought any treatment, more than half (56.5%) preferred informal sources, the study revealed. So, the authors feel the necessity for making people aware of the availability of formal health care services for male reproductive morbidity.

Kiran Vani (2007) in the study on knowledge and adoption of selected health and nutritional practices by rural women in Belgaum district, Karnataka with a total of one hundred and fifty (150) respondents found that while studying nutritional practices of children, majority reported that colostrum should be given to new born baby (53%), breast feeding for infants was must (100%), introducing solid foods like kichri/ rice/ dal/ soaked chapattis has to be given to seven month old child (63%), daily consumption of combination of rice, dal and vegetables was beneficial for growing children (55%), introducing small quantities of soups, juices, kheer etc. to baby’s diet at 3 month stage was good for child health (42%), introducing milk , milk products, egg and its products was good for growing child (87%). And the knowledge about the nutritional practices of adults revealed that green leafy vegetables must be included in the diet( 58%), sprouted pulses were more nutritious (46%), including cereal-pulse combination(dal chapatti, dal-rice) in regular diet was nutritious for the body (63%), consumption of milk and curd strengthen bones (56%), using the jaggery often in the diet reduces iron deficiency.
(38%), fruits provide vitamins and mineral(78%), drinking of 2 liters of water would makes the person hygiene(42%), mixing Soya bean with jowar and wheat during grinding makes food more nutritious (60%). The remaining percent of each statement showed that the respondents did not have the knowledge about nutritional practices.

Krishna Ray et al., (2008) conducted a cross-sectional study carried out on women attending the peripheral government clinics of Delhi. The study was conducted over 26 months in 4090 women attending peripheral government healthcare centers, both rural and urban, in four zones of Delhi. Data were analyzed by applying statistical methods. Overall, self-reporting of morbidity was 65.0%. This study highlighted the wide variation between self-reporting of morbidity and syndromic- and etiology-based diagnosis in women from both rural and urban settings.

Shin et al., (2008) conducted a study on “Evaluating Completeness of Maternal Mortality Reporting in a Rural Health and Social Affairs Unit in Vellore, India”, 2004. This study identified under-reported and misclassified maternal deaths among women of reproductive age between 1999 and 2004 in a rural service unit in Vellore, India. In-depth interviews, semi-structured interviews and structured questionnaires were used to identify maternal deaths known to health care providers and community leaders who regularly come in contact with pregnant women. Eighteen under-reported and misclassified cases – or 50% of maternal deaths – were reported. These included 29% of abortion-related and 7% of domestic violence-related deaths. Based on this study’s fieldwork, the existing death surveillance system detected 100% of the maternal deaths reported by hospital staff; however, it missed most maternal deaths reported by community workers. The latter were more likely than deaths reported by hospital workers to result from abortion and family violence. The existing surveillance system should be augmented with a community-based death surveillance system. This comprehensive approach identified twice as many maternal deaths than previously recorded and could be applied in other settings. Appropriate public health interventions should be initiated to prevent maternal deaths in this community.
Miguel Angel et al., (2009) conducted a cross-sectional study “Differences in the reproductive pattern and low birth weight by maternal country of origin in Spain, 1996–2006”. Designated study objectives: maternal age on the date of giving birth, birth multiplicity, birth weight and the mothers’ country of origin. The maternal country of origin variable comprised of 21 categories. LBW was associated with a combination of older maternal age and multiple pregnancies in the case of women who had been born in Europe (EU15). However, this association was not found in women who originated from outside the EU15, mostly from countries who have shown significant emigration to Spain during the last decade. LBW was present among all age groups, in both singleton and multiple births, and in particular Romanian mothers showed the highest OR 2.34 (95% CI 1.20–4.80). This study confirms differences in the reproductive pattern and LBW depending on maternal country of origin. These results allow a better understanding of the reproductive pattern and the implications of mothers’ country of origin in LBW. Thus, helping health decisions makers to plan future health interventions aimed at reducing the LBW prevalence in Spain.

Ragini Kulkarni et al., (2009) was evaluated a study on Maharashtra component of a large multicentric task force study on the cause of death by verbal autopsy conducted in five States of India. The data pertaining to deaths among reproductive age group women were presented along with the factors contributing to these deaths. House-to-house surveys of a representative population from rural and urban areas in six districts of Maharashtra were undertaken by probability of proportion to size (PPS) sampling. Their study found Communicable diseases, injury and poisoning and cancers were the major killers among reproductive age group women. Several factors responsible for accidents and suicides also contributed substantially to the mortality load among these women. Majority of the maternal deaths were seen in rural areas indicating the need to strengthen the maternal health care.

Miteshkumar et al., (2010) “Untreated Reproductive Morbidities among Ever Married Women of Slums of Rajkot City, Gujarat: The Role of Class, Distance, Provider Attitudes, and Perceived Quality of Care”. This paper was an attempt to assess untreated reproductive morbidities and to study factors affecting
treatment seeking behavior among ever married women of urban slums. They selected 1,046 women of the reproductive age group (15–49 years) using two-stage cluster sampling for a community-based, cross-sectional study. From this sample, 593 responses reporting reproductive morbidity were analyzed for treatment-seeking behavior and its correlates. Information was collected on demographics, socioeconomic status; self reported reproductive morbidity, and treatment-seeking patterns, along with reasons for not utilizing available health services, all using a pre tested, structured interview schedule. Univariate and multivariate analyses were done in SPSS 15.0. In there sample, 57% of women had at least one reproductive morbidity; of these, only one third sought health care. Women belonging to the Scheduled Castes/Scheduled Tribes caste group (OR=3.92, 95% CI 1.44–10.64), at a distance of more than 2 km from a health facility (OR=2.67, 95% CI 1.28–5.58), and whose duration of illness was more than 1 year (OR=14.44, 95% CI 3.66–56.87) accessed fewer Reproductive Health services compared to their counterparts. The present study found that a lower sense of need, the cost of care, and societal barriers were the reasons for not seeking care. Providers’ poor attitudes, poor quality of services, and long waiting times were found to be the reasons for not utilizing health facilities. The determinants for accessing Reproductive Health care were resources available at the household level, social factors, the availability of services, and behaviors related to health. Government facilities remained underutilized.

Prabha Chauhanet al., (2012) in his study on Maternal Mortality as per Gravidity among Tribal women at a tertiary level of care in Bastar, Chhattisgarh, India. Materials and Methods: This was a hospital based retrospective, reproductive-age mortality study (RAMOS) of Tribal women of Bastar region, Chhattisgarh, that were admitted and managed in Obstetrics and Gynecology Department Govt. Medical College, Jagdalpur, Bastar, Chhattisgarh, between July 2007 and October 2011. There were total 120 cases. Result: Results of the present study showed that among 120 deceased Tribal women, highest maternal mortality 65 cases (54.166%) was noted in Primigravida (Nullipara G1P0), second highest maternal mortality 44 cases (38.333%) was noted in 2nd to 4th Gravida (Multipara), 10 cases (8.333%) were in 6th and 7th Grand Multigravida (Grand Multipara), and
01 case (0.833%) was in 8th Great Grand Multigravida. Direct causes of maternal mortality were highest 46 cases (38.333%) due to hypertensive disorders of pregnancy. Among direct causes second highest 18 cases (14.999%) maternal mortality were due to Rupture Uterus, third highest 12 cases (09.999%) of Septicemia, 06 cases (04.999%) of obstructed labor, 06 (04.999%) of Hemorrhage, 02 cases (01.666%) of unsafe Abortion, 02 cases (01.666%) of Pulmonary Embolism and 01 case (0.833%) due to Aspiration. Indirect causes of maternal mortality maximum 15 cases (12.5%) of Malaria and 10 cases (08.333%) were due to Anemia and 02 cases (01.666%) were of Sickle cell Anemia. The result of the present study showed that in Tertiary level of care of Bastar in the year 2008 - 2009, 2009 – 2010 and 2010 - 2011 the total maternal deaths were 35, (n=35), 27 (n=27) and 26 (n=26) respectively. The Maternal Mortality Ratio was 1615.881, 1168.325 and 1000.769 Per 1, 00,000 live births in the year 2008 - 2009, 2009 – 2010 and 2010 – 2011 respectively. In the year 2008 - 2009, maternal mortality percentage among Tribal women was 85.714% and was 100% in the year 2009 – 2010 and 2010 – 2011.

3.4. Studies on Fertility Behavior and Contraception

Ramachandra Reddy et al., (1986) studied “Fertility Behavior In The Sugalis of Chittoor District, Andhra Pradesh”. The fertility behavior studied on 353 couples of the Sugalis, a Tribal population, showed that it was at its biological maximum. The crude birth rate, the general and total fertility rates were comparable to the highest levels observed for any population. The child-woman ratio also confirmed potential growth trend of the Sugalis. The cumulative fertility measures were also high in this population. The influence of age at marriage on fertility was inverse and the occupational variability in the Sugalis also had an influence on fertility behavior. The fertility behavior of the Sugalis of the Chittoor district was studied on 353 couples. The fertility data was analyzed in two ways first one was Fertility performance of women in one year; and second one was Cumulative fertility of woman over a long period. The crude birth rate, the general fertility and total fertility rates of the Sugalis are relatively higher. The child-woman ratio was also high indicating the potential growth trend of the Sugalis. The cumulative fertility and mortality measures were moderately high in the mothers of all ages.
These were still higher in the mothers who have completed their reproductive stage. So these again confirmed high potential growth trend of the Sugalis. The influence of age at marriage on fertility and mortality was inverse, i.e. the lower the age at marriage, the higher the fertility and mortality. The fertility and mortality behaviour differed in relation to the occupation of the Sugalis.

Sundar (1990) in his study on “The status of women and family planning acceptance: some field results” examined the effect of education and occupation on contraceptive behavior. The survey used for this report was conducted by the National Council of Applied Economic Research in a large resettlement colony in East Delhi. The residents who lived in this area were of a low socio-economic class. The sample included 578 ever married women who migrated from Tamil Nadu during the 1960s. This survey showed an increase in contraceptive use from 27.8 for women who were illiterate, 46.4 for women with a primary education, 53.0 for women who had reached the secondary level, and 64.4 for college educated women. The only significant relationship found between employed and family planning was in the case of women who work as domestic servants. Domestic servants were found to be more motivated to use birth control because of a greater incompatibility between job and childbearing and greater exposure to the benefits of a small family.

Pandey (1990) conducted a study on fertility in the kol Tribals of Madhya Pradesh. This study was based in retrospective date on the fertility performance of a sample of 919 eligible Tribal couples consisting of 443 kol couples and 477 couples belonging to other tribes such as the Gonds. Mawasis Khairwars etc. the results indicated that Kol women take longer to conceive after marriage as compared to women of other tribes. The age at marriage for women belonging to these two tribes does not differ considerably. Therefore, it appears that fecundability may be lower among the Kol women. It was worth noting that on an average, a Kol women takes 3.5 years to have her first delivery after marriage at the age of 18 years, while it takes 3.4 years for non- Kol women, 2.06 years for Gond women and 2.3 years for rural women. The reasons for lower fecundability of Kol women need to be investigated.
Sharma et al., (1990) described the fertility and mortality trends of the Khairwar Tribal women of Madhya Pradesh. The study was based on data of 121 households from Pandri, Anjni, Harra, Chapoda and Chumadand village. It was found that Khairwar mothers exhibited 85 live births per mother and 145 infant deaths per thousand live births. The average rate of fertility per mother was 4.85 in the sample.

Jesurathnam Devarapalli (1992) observed the maternal care and obstetric practices among the Konda Dora tribe in the agency areas of Visakhapatnam district in Andhra Pradesh. The various pregnancies related tabos and cultural practices observed by the Konda Dora women have a significant effect upon the health of the mother and child. Prenatal practices encouraged include giving the pregnant women light work in good practice. The practices of barring the placental contents and hot water immediately after delivery as also the application of kang oil were other obstetric practices. The Konda Dora women preferred her own house to a hospital for delivering her baby. Feeding the new mother with chilli powder as an important constituent of her food for a few days after delivery was a harmful practice. The Konda Dora women preferred her own house to a hospital for delivering her baby. Feeding the new mother with chilli powder as an important constituent of her food for a few days after delivery was a harmful practice. The observance of post partum conjugal taboos for a period of two years was another good practice which helped to maintain adequate spacing between successive pregnancies, ensured a longer period of lactation as well as the health of the mother and child.

Puri (1992) conducted a study on breast feeding among Tribals as an aid to fertility control in Udaipur district of Rajasthan. Data was collected from about 200 randomly selected Tribal females. The Tribal females were found to experience at least one- and a half years of lactation amenorrhea. Both socio cultural practices and economic compulsions tend to promote and prolonged breast feeding among the Tribals. Thus, breast feeding was a major role to play in being effective natural contraceptive techniques available today. Keeping in view its practical relevance, there was a need for family planning programme managers to intensity their educational efforts to further support and reinforce breast feeding practices. The
mean birth interval following and infant loss was 1.6 years. The birth interval between two live births was found to be the longest (2.5 years).

Vineeth Sharma et al., (1993) studied the status of women, fertility and family planning among Tribals in the Udaipur district of Southern Rajasthan. It was observed that almost all (95.4 per cent) the respondents were illiterates. More than 92 percent of them showed evidence of varying degrees of vitamin a deficiency. None of the interviewed were women had ever availed antenatal care and most of the deliveries were conducted by untrained traditional birth attendants at home. Most of the respondents felt that they had no say, what so ever, in decision making with in the family. Similarly, almost all of them said that they had nod inherited anything (and were not likely to get anything) from the ancestral property of their parents. Both these factors point to a degradingly low status of women in this society of women in this society and it was surprising to note that even in matters like family planning. The method of contraception to be adopted by the couple, utilization of antenatal care services etc. Which were all know to have a direct effect on the health and well being of women. The women had to depend on the decisions of their husband or even their mothers in-law.

Sengupta et al., (1996) described and analysed “Menarche and menopause among the Ahom women Dibrigar”. This study found that the onset of menarche and mean menopausal age of Ahom (46.32±0.27 years) and other population of Assam indicated comparatively higher mean menopausal age in the former population. The present Ahom sample was not only akin to other Monogoloid groups but also showed close (statistical) affinity with several Caucasoid (castes) group of high status.

Mutharayappa (1998) conducted a comparative study between Jenu Kuruba and Kadu Kuruba Tribes of Karnataka to assess the “fertility and family planning methods”. The study revealed that fertility was higher among Kadu Kuruba tribe than Jenu Kuruba tribe. Women who married at the age of 16 years. The differences between two tribes in terms of fertility levels in each age group were large. The practice of induced abortions were common among them. Most of the women who terminate pregnancy either before or after marriage, use only indigenous medicines.
Among Jenu Kuruba tribe more number of women were using modern method of contraceptives. The women who were using indigenous medicines to prevent pregnancies had lower fertility.

Sengupta et al., (1998) studied the effect of place residence, on fertility and mortality among the Ahom of Assam. The study revealed a close relations between place of residence and both fertility and mortality. In rural areas mean age at menarche was comparatively higher than in the urban area. The mean age at marriage of the rural Ahom women was fairly early (18.58±0.34 years) in comparison to that of the urban Ahom women (20.06 ± 0.39 years) and the difference between the two values was statistically significant (t value +2.86).

Sikdar (1998) made an attempt to study the impact of education on awareness of family planning programmers among the santal women in the Kalyani block under district of Nadia, West Bengal. The study reveals that the santal women used to prefer Oral pill only as a method of family planning. Main reasons behind such liking are their unfamiliarity about different family planning methods and lack of proper education. But basic education as well as health and sex education can change this picture. Therefore, information, education and motivation (IEM) package is the integration of Reproductive Health with the family welfare programme which has now come to acquire a new dimension. By this IEM programme santal women can understand that there is minimum risk factor in case of other family planning method and all the process are as same as natural.

Susmitha et al., (1998) studied about Antropo- Demographic characteristics among the caste and Tribal groups of central Himalayas – Fertility, child mortality and family planning. Statistical tools mainly multiple regression have been utilized to study the impact of various variables on fertility, infant and child mortality and usage of family planning methods among the caste groups of Kumaun and the Bhotia Tribal groups. Child mortality, age at marriage (wife), usage of family planning methods and educational level of wife were the variables were fertility, occupation of wife income and present age of wife. The determinants of usage of family planning methods were educational level of husbands, number of surviving children and income.
Reddy (2001) made a study on consanguinity and Reproductive Health among Kurchias, a Tribal population of Kerala. The study revealed that the age of marriage was less among the women of consanguineous marriages than the non-consanguineous marriages and the non-consanguineous marriages. Low fertility, live births and fertility, high prenatal mortality rate and hereditary diseases were observed among consanguineous couples. The congenital malformations were observed only in consanguineous marriages. Among consanguineous marriages, the disease prevalence, prenatal, postnatal mortality and morbidity were very high due to the increase in homozygosis and enhanced risk of hereditary disease.

Kulkarni (2003) was examine a study on “Exposure to Mass Media And Its Impact On The Use Of Family Planning Methods By Women In Goa” The impact of women's exposure to television, radio and newspapers and its influence on their use of family planning methods was analysed from the data collected from 250 married women in the age group 15-45 years in a northern Goa district. The study revealed that the current use of family planning practice by women was 48.4 percent. The use of family planning methods was found to be positively correlated with women's exposure to information on family planning methods in television, radio or newspapers. The multivariate logistic regression analysis subsequently established that this association was independent of women's education, place of residence and number of living children.

Patro et al., (2005) conducted A cross-sectional community based study was conducted in a resettlement colony of Delhi to find out the contraceptive usage among currently married women aged 15-49 years, and the factors influencing the use of such contraceptive practices. Out of 520 women interviewed, complete information could not be obtained from 60 and therefore data for 460 women were included in the final analysis. The findings revealed that about two-third (63.3%) of the eligible couples were using a contraceptive method, and the effective couple protection rate (CPR) was 56.1 per cent. Majority (37%) of these women had undergone tubectomy. Among the users of temporary methods of contraception, condom (56%) was the most preferred method. Permanent methods of contraception were mainly availed from public sector hospitals. Decision regarding contraceptive use in the family was mostly taken jointly by the husband and wife.
Number of living children at the time of first contraceptive use was found to be more than two in 74.4 per cent of the cases. Socio-economic status (SES) of the family was seen significantly associated with the use of contraceptive method. The reasons for non-acceptance were either for an expectation of a male child (44%) or fear of side effects (29%). Despite their knowledge on different methods, one-third of the women was found not using any contraception because it was not available free of cost. The above findings indicated married women in the study population seemed to possess a reasonable knowledge about contraceptives as five per cent only expressed having not heard of any contraceptive method at all.

Jagdish Prasad et al., (2007) examine a study on “Trends and Forecasting the Estimation of Different Contraceptive Needs in the Districts of Rajasthan”. This research paper made an attempt to find out the trends and forecasting the estimation of different contraceptive needs in the districts of Rajasthan. Secondary data were used for the study. The result showed that some districts of Rajasthan have a significant increment in accepting the family planning methods. Three methods of spacing, i.e., Intrauterine Devices (IUDs), Condom Contraceptives (CCs) and Oral Pills (OPs) performance are forecasted up to the year 2010-11 by using the method of least square. Forecasted values for different methods of family planning may be useful for government and social workers while formulating family planning policies. This also helps in finding users trend of different family planning methods and actions can be taken accordingly. It is also useful for manufacturers for inventory purpose of all family planning accessories in advance.

Saini et al., (2007) evaluated a study on “Study of Unmet Need for Family Planning in a Resettlement Colony of East Delhi”. The prevalence of unmet need for family planning in an urban resettlement colony of East Delhi and the factors associated with it are investigated in this study, using a sample size of 1051 married females aged 15-49 years who were fecund and sexually active. The findings reveal that (i) Among the subjects, 562 (53.5%) were currently using contraceptives, 130 (12.4%) were pregnant and 359 (34.1%) were not using any contraception; (ii) The overall unmet need for family planning was 25.4 per cent, of which 6.7 per cent had need for spacing and 18.7 per cent had need for limiting the family; (iii) Unmet need was the highest among the illiterate group, followed by women with per capita
income of less than Rs.500 per month and women having three or more children; and (iv) It was lower in women who discussed family planning with their husbands as compared to those who did not.

Harihar Sahoo (2007) was studied “Determinants of Contraceptive Use in Orissa: An Analysis from National Family Health Survey Iii”. This paper attempts to study the differentials of contraceptive use by women’s background characteristics and determinants by using data from National Family Health Survey III, conducted during 2005-06 for Orissa. Also, data have been drawn from Family Welfare Year Book 2001. Both bi-variate and multivariate analysis have been used in the present study. The various predictor variables used in the analysis were caste, religion, women’s educational level, place of residence, wealth index of the household, work status of women, number of living sons, age at marriage, marital duration, whether experienced infant death and exposure to mass media. The findings revealed that, only one-third of the women with one child use contraception in Orissa. Such proportion goes to 60 per cent, 73 per cent and 60 per cent for women with two, three and more than three living children respectively. The analysis indicate that spacing is not very common but most of the contraceptive’s uses are for limiting family size. Educational levels of women, sex preference, marital duration, infant death and exposure to mass media have a significant effect on the use of contraception. Therefore, these aspects may be given due attention while framing family planning program and efforts should be made to make people aware of the benefit of small family norm.

Hong He et al., (2009) found in their study “Reproductive and family planning history, knowledge, and needs: A community survey of low-income women in Beijing, China”. The purpose of this study is to broadly assess reproductive and family planning history, knowledge and health needs among low income urban women with an aim to informing health services interventions. Subjects of the study 1642 low-income women age 18–49 from Haidian district, Beijing were selected. All were interviewed via a standardized questionnaire in 2006. Most women reported at least one pregnancy and delivery (97.7%, 98.3%). Deliveries in hospitals (97.3%) by medical personnel (98.5%) were commonplace, as was receipt of antenatal care (86.0%). Nearly half had at least one abortion, with
most (56.0%) performed in district hospitals, by physicians (95.6%), and paid for out-of-pocket (64.4%). Almost all (97.4%) used contraception, typically IUDs or condoms. Reproductive knowledge was limited. Health needs emphasized by the participants included popularizing Reproductive Health information, being able to discuss their Reproductive Health concerns, free Reproductive Health insurance, examination and treatment. Among poor urban women in Beijing, antenatal care and contraceptive use were common. However, abortions were also common. Knowledge about Reproductive Health was limited. There is a need for better Reproductive Health education, free medical care and social support.

Ebru Gabalci et al., (2010) Descriptive study was carried out to determine the effects of contraceptive methods on the sex lives of women. The study was conducted at the Family Planning Center and Gynecology Clinics of Obstetrics and Gynecology and Children’s Hospital. The sampling comprised of 366 women who had applied to these centers. Data collection forms generated based on the literature and the Arizona Sexual Experience Scale (ASEX) was used as data collection tools. The average ASEX scores were similar for women using the withdrawal method as a traditional method (:13.75), RIA as a modern method (:13.93), condoms (:13.30), and oral contraceptives (:13.37), were found to be similar (p [0.05). Since the average scores of ASEX were higher than 11, problems in sexual life were determined at high levels. The difference between ASEX average scores and duration of family planning, problems due to the method, duration of marriage, number of pregnancies and living infants, frequency of sexual intercourse, communication between partners, and self-declared sexual perception; was statistically significant (p0.05). The study found higher than normal average ASEX scores and we therefore suggest counseling services, provided by healthcare staff, on sexual health and family planning that include information on FP methods and their effects on sex life.

Emily M Godfrey et al., (2011) conducted a study “Contraceptive methods and use by women aged 35 and over: A qualitative study of perspectives”. Semi-structured, in-depth interviews were conducted with 17 women. They were all 35 to 49 years old, regularly menstruating, sexually active, not sterilized, not desiring a pregnancy in the near future, and at least 3 months postpartum. The study purposely
sampled for women who had had at least one unintended pregnancy after age 35 (n = 9) and women who did not (n = 8). They assessed partnership, views of pregnancy and motherhood, desired lifestyle, perceived advantages and disadvantages of using and obtaining currently available well-known reversible contraceptives in the U.S. “They also assessed contraceptive methods used at any time during their reproductive years, including current method use and, if appropriate, circumstances surrounding an unintended pregnancy after age 35.” Each interview was taped and transcribed verbatim. Data were analyzed using Grounded Theory. Analysis focused on partnership, views of pregnancy, motherhood, desired lifestyle and perceived advantages and disadvantages of various reversible contraceptive methods. The women without an unintended pregnancy after age 35 were more likely to (1) use contraceptive methods that helped treat a medical condition, (2) consider pregnancy as dangerous, or (3) express concerns about the responsibilities of motherhood. The women who experienced an unintended pregnancy after age 35 were more likely to (1) report unstable partnerships, (2) perceive themselves at lower risk of pregnancy, or (3) report past experiences with unwanted contraceptive side effects. There was a greater likelihood a woman would choose a contraceptive method if it was perceived as easy to use, accessible, affordable and had minimal side effects. Women’s perspective on contraceptive use after age 35 varies. Public health messages and health providers’ care can help women in this age group by reviewing their fertility risks, as well as all contraceptive methods and their associated side effects. The impact of such interventions on unintended pregnancy rates in this age group should be tested in other areas of evidence-based medicine.

3.5. Studies on RTI, STD’s and HIV/AIDS

King et al., (1992) Reproductive Tract Infections/Sexually Transmitted Infections Including HIV/AIDS. This study shows about reproductive tract infections and sexually transmitted infections including AIDS. The diseases have been described according to major symptoms that can produce simplified guidelines for syndromic management that have been prepared by the National AIDS Control Organisation; the advantages and disadvantages of syndromes management have been detailed. The current case definitions of AIDS, the diagnosis of HIV infection,
prevention of mother to child transmission and voluntary counseling and testing have been discussed.

Pamina et al., (1998) “Reproduction, Risk and Reality: Family Planning and Reproductive Health in Northern Vietnam”. In collaboration with the National Committee for Population and Family Planning, a study was conducted in 1994 in two Vietnamese communes to provide community level information on women’s Reproductive Health and behaviours. A survey of 504 rural and 523 urban women collected five-year histories of reproduction, contraception, abortion and symptoms of Reproductive Tract Infections (RTI). This analysis focuses on the relationships between women’s individual characteristics, use of family planning and abortion, and reported RTI symptoms. The findings reveal that IUDs do not raise women’s likelihood of experiencing RTI symptoms in either commune. A recent abortion, however, strongly increases women’s likelihood of having RTI symptoms in the rural commune, while low socio-economic status is associated with RTI symptoms in the urban commune.

Janet Grimes et al., (2000) conducted their study on “Voluntary counseling and testing among post-partum women in Botswana” Women attending maternal and child health clinics for their first post-partum or well baby visit in 3 sites in Botswana were offered VCT after a written informed consent. A standardized questionnaire was used to collect socio-demographic characteristics and reasons for declining VCT. They approached 1735 post-partum women. Only 937 (54%) of those approached accepted VCT. In multiple logistic regression analysis, younger maternal age, not being married, and less formal education were significant predictors of acceptance of VCT. Thirty percent of women who accepted VCT were HIV-positive results indicated that in Botswana prior to the initiation of the government MTCT prevention program, routine HIV testing and antiretroviral treatment, younger, unmarried, and less educated post-partum women were more likely to undergo VCT and that HIV prevalence was high among women of childbearing age.

Kuhu maitra et al., (2001) conducted a study on “Prevalence of self-reported symptoms of reproductive tract Infections among recently pregnant women in Uttar
Pradesh, India”. This study examines the prevalence of self-reported reproductive tract infections (RTIs) and treatment seeking among married, recently pregnant women in Uttar Pradesh state, India. Associations between RTI symptom reporting and background characteristics are examined in a population-based sample of 18,506 married women with a pregnancy in the 3 years prior to a 1995 statewide survey. Logistic regression analyses are used to assess the effects of socio demographic covariates on the probability of reporting an RTI symptom. Nearly one out of four women reports experiencing at least one RTI symptom, with the most common symptoms being abnormal vaginal discharge and pain during urination. Reporting of RTI symptoms significantly increases if the woman’s last pregnancy did not end in a live birth or if she has low economic status. Symptom reports also increase with age and decrease with parity. Only one-third of women reporting an RTI symptom sought treatment. The results indicate that survey interviews can be a cost-effective option for measuring the magnitude of RTI symptoms experienced and identifying socio demographic influences. The findings suggest the need for improved RTI screening procedures and treatment at health facilities in this populous state of northern India.

Andrew et al., (2002); “HIV Infection and Pregnancy Status Among Adults Attending Voluntary Counseling and Testing in 2 Developing Countries”. This study investigated the impact of HIV voluntary counseling and testing (VCT) on reproduction planning among 1634 adults in 2 sub-Saharan countries. Data were obtained from a multisite randomized controlled trial. At 6 months post-VCT, the women more likely to be pregnant were younger (odds ratio [OR] = 2.5; 95% confidence interval[CI] = 1.0, 6.5), not using contraceptives (OR = 0.1; 95% CI= 0.1, 0.3), and HIV infected (OR = 3.0; 95% CI = 1.3, 7.0). An interaction emerged linking pregnancy intention at baseline and HIV sero status with pregnancy at follow-up (OR = 0.1; 95%CI =0.0, 0.4) Partner pregnancy rates did not differ by HIV sero status among men. HIV diagnosis may influence reproduction planning for women but not for men.

The NFHS-2 collected information from women on some common symptoms of RTIs. 38% of ever-married women report at least one type of problem related to vaginal discharge, and 19% report symptoms of a urinary tract infection.
Overall, 43% of women report either problems with vaginal discharge or symptoms of a urinary tract infection.

Kalavathi (2003) was presented a study on “RTI Control Programme by Pap smear screening among Tribal Women in Palakkad District. The study altogether shows the importance of social, cultural and educational developments which play an important role in the development of Reproductive Health of Tribal women especially in the area of controlling reproductive tract infection. These programmes should be integrated with pap smear screening programme which help in identifying not only precancer and cancer but also a variety of infections like TV infection, fungal infection and viral infections”.

Gaash et al., (2005) their study conducted on “Reproductive Tract Infections In Kargil: A Community Based Study” Reproductive tract infections (RTIs) are widely prevalent among married women. As a part of a comprehensive health survey, the Regional Institute of Health and Family Welfare (RIHFW), Dhobiwan, Kashmir, surveyed 1,835 women in the reproductive age from 955 households in Kargil, considered as the most backward district of J&K state, to find out the prevalence of RTIs through self-reporting. The study revealed that, when specifically asked, more than 38 per cent of women have reportedly admitted to suffer from at least one sign or symptom of RTIs. Further, a 26 per cent of the respondents showed positive signs or symptoms for the presence of pelvic inflammatory disease (PID). Women suffering from any kind of RTI or PID preferred to consult only the government doctor for treatment, while the nurse, multi-purpose worker (MPW) or lady health volunteer (LHV) were not at all approached. Dissatisfaction was widespread (67%) over the advice/treatment received, which probably indicates the unmet need for more female doctors in order to ensure increased consultation. In the lines of the WHO-recommended syndromic approach, the study recommends convergence of activities by all categories of health workers to such a common yet grossly ignored women’s health issue for a fast and appropriate redressal.

Meitei et al., (2005) presented a study on “Awareness and Prevalence of Reproductive Tract Infections in North-East Districts of India”. Reproductive tract
infection is a generic term used to cover three types of infections viz. sexually transmitted disease (and infection), endogenous vaginal infections and infections related to reproductive tract. The current study revealed that (i) the awareness level among both males and females regarding RTI is relatively low in majority of the districts in north-eastern part of India; (ii) electronic media and newspapers were the main sources of information regarding RTIs for both males and females in the districts of Arunachal Pradesh, Assam and Sikkim; (iii) sexual intercourse was reported to be the main mode of transmission of RTIs by more number of males than females in most of the districts; (iv) a higher proportion of male respondents from Cachar, Jorhat and Nalbari in Assam, Imphal and Senapati in Manipur, and Jaintia Hills and West Khasi in Meghalaya, Makokchung and Wokha in Nagaland and East Siang in Arunachal Pradesh reported lack of personal hygiene as one of the means of RTIs transmission; and (v) a wide gap between knowledge and prevalence of RTI in both males and females was observed which was higher among females.

Mathiyazhagan et al., (2005) conducted a study on “Knowledge, Perceptions and Sources of Information for Tribals about Common Diseases Prevailing in Mandla District of M. P.”. The study was conducted in Mandla, one of the Tribal dominated districts of Madhya Pradesh, in 2005. In this study an attempt was made to (i) study the knowledge of Tribals about various common diseases prevailing in Mandla district; (ii) identify the sources of information for Tribals about various common diseases; and (iii) understand the beliefs and perceptions of Tribals about the health care delivery system operating in the district. The findings reveal that, (i) the Tribals have knowledge about malaria and diarrhea as compared to other diseases viz.; STD/RTI, anemia, worm infestation, tuberculosis and leprosy; (ii) the major sources of information for Tribals in the study area have been the health functionaries followed by the relatives; and (iii) the Tribals tend to believe in traditional healers as compared to allopathic doctors.

Naik et al., (2005) were analyzed a study on “Rural Indian Tribal communities: an emerging high-risk group for HIV/AIDS” A nested cross sectional study was undertaken as part of the ongoing Reproductive and Child Health Survey. A total of 5,690 participants age 18–44 were recruited for this study. Data were
obtained through home interviews, and focused on socio-demographics, knowledge, attitudes and behaviors regarding sexuality, HIV/AIDS and other STDs. The study revealed that only 22% of adults had even heard of AIDS, and 18% knew how it is transmitted. In addition, only 5% knew that STDs and AIDS were related to each other. AIDS awareness among women was lower compared to men (14% vs. 30%). Regarding sexual practices, 35% of the respondents reported having. Lack of awareness, permissiveness of Tribal societies for premarital or extra-marital sexual relationships, and sexual mixing patterns predispose these communities to HIV/AIDS and STD infections. There is a dire need for targeted interventions in order to curtail the increasing threat of HIV and other STDs among these vulnerable populations.

Saseendran Pallikadavath et al., (2005) conducted a study on Women’s Reproductive Health, Sociocultural Context and AIDS Knowledge in Northern India. This paper identifies socio-cultural and Reproductive Health correlates of knowledge about HIV among ever-married women using 1998–99 National Family Health Survey data from two low HIV prevalence Indian states, Madhya Pradesh (MP) and Uttar Pradesh (UP). Logistic regressions were undertaken modeling women’s awareness of HIV, of whether the disease can be avoided and of effective means of protection. In MP 22.7 per cent women were aware of HIV; 56.4 per cent (of 22.7 per cent) knew that the disease can be avoided; and 47.5 per cent (of 56.4 per cent) possessed correct knowledge about effective means of protection. In UP 20.7 per cent women had awareness of HIV; 59.2 per cent (of 20.7 per cent) knew that the disease can be avoided; and 45.7 per cent (of 59.2 per cent) were informed about effective means of protection. In both states older, uneducated, rural, poor, those not exposed to television, and those who had never used a modern family planning method were less likely to possess HIV awareness. However, for women who were aware of HIV, acquisition of further knowledge about it had fewer socioeconomic barriers. These barriers were state specific so interventions to overcome them need to be highly focused.

Olanrewaju et al., (2007) evaluates a study on “HIV Voluntary Counseling And Testing Of Pregnant Women In Primary Health Care Centres In Ilesa, Nigeria”. This study was carried to determine the prevalence of HIV and the
acceptability of HIV voluntary counseling and testing (VCT) in pregnancy as a strategy for the prevention of mother to child transmission (PMTCT). Methods: Group and individual pre and post-test counseling were performed by trained field workers. Screening for HIV infection was based on two sequential rapid HIV tests. Focus group discussion was also held among HIV positive pregnant women. Results: 587 (80.6%) pregnant women underwent the test after pre-test counseling. Sixty-nine women (9.5%) had a positive result. The women were counseled on the need for prevention of mother to child transmission of HIV infection. Thirteen (18.8%) of the women accepted to utilize PMTCT facilities. Reasons cited for non-utilization of PMTCT facilities mainly bordered on the belief that they could not transmit HIV to their unborn children. Significant associations were found between HIV positivity and marital status, low educational status, low social class and high parity of the study subjects. Conclusion: The study suggests that a successful integration of VCT into the existing primary health care services is feasible in developing countries like Nigeria, though; there is a need to create more awareness on the effectiveness of PMTCT.

Sri Devi et al., (2007) presented a study on “Prevalence of RTI/STI among Reproductive Age Women (15-49) Years in Urban Slums of Tirupati Town, Andhra Pradesh”. Prevalence of RTI/STI in the present study was 35.6 per cent based on the symptoms and 26.9 per cent based on per-speculum examination. Prevalence of RTI was maximum in 15-29 years age group. The most commonly observed symptoms were vaginal discharge (21.3 per cent) and lower abdominal pain (4.9 per cent). Prevalence of vaginal discharge decreased with an increase in age, education and per capita monthly income. Prevalence was observed higher in scheduled castes and tribes, married women, unskilled worker, IUCD acceptors and those with unhygienic menstrual practices, history of abortions and non-institutional deliveries. Based on laboratory findings, highest positive results were seen in candidacies (88.9 per cent) followed by trichomoniasis (50.0 per cent). 80.0 per cent of women completed the course of treatment and 57.2 per cent of women got complete relief.

Krishna Ray et al., (2008) conducted a cross sectional study “Comparative study of syndromic and etiological diagnosis of reproductive tract infections/sexually transmitted infections in women in Delhi” A cross-sectional
study was carried out in women attending the peripheral government clinics of Delhi. The study was conducted over 26 months in 4090 women attending peripheral government healthcare centers, both rural and urban, in four zones of Delhi. Data were analyzed by applying statistical methods. However, the percentage of women with some STD-related syndrome was 71.4%. The rural women were observed to have significantly more STD syndromes than their urban counterparts. The etiological diagnosis could be established in only 32.2% of cases. This has implications for the syndromic approach to STI case management. These observations call for a review of the diagnostic policy for RTIs/STIs by national authorities in order to avoid the overuse of antimicrobials. The study also highlights the need for the introduction and/or strengthening of facilities for simple diagnostic tests for RTIs/STIs, especially at the peripheral healthcare level.

Lalima Srivastava (2010) is an important study “Reproductive Tract Infections among Women of Rural Community in Mewat, India”. Mewat is a backward area of north India, dominated by Meo community, a Muslim Rajput community following a mixture of Hindu and Islamic customs, practices and beliefs. A community based cross-sectional study was undertaken among married women (between 15 and 49 yrs) in Mewat. The objective of the study was to understand the socio-demographic and socio-cultural factors that increase vulnerability to RTI among women. Both qualitative and quantitative data were collected. This article presents the findings of the study. 72.6 per cent of the respondents reported one or more symptoms of RTI. Only 31 per cent of the respondents were aware about RTI and 21 per cent about HIV/AIDS. Bivariate analysis indicated statistically significant association between educational level, age at marriage, place of delivery and awareness about RTI with presence of self-reported symptoms of RTI among the study population. Improving literacy and increasing awareness level among women about Reproductive Health is needed to reduce incidence of RTI in the study area.

Paul Sebo et al., (2011) examined an in-depth study of the “Sexual and Reproductive Health Behaviors of Undocumented Migrants in Geneva: A Cross Sectional Study”. The aim of the present study was to describe sexual and Reproductive Health behaviors of undocumented migrants in Geneva. This
descriptive cross sectional study included consecutive undocumented migrants presenting from November 2007 to February 2008 to a health facility offering free access to health care to this population. Following informed consent, they completed a self administered questionnaire about their socio-demographic profile and sexual and Reproductive Health behaviors. A total of 384 patients were eligible for the study. 313 (82%) agreed to participate of which 77% (241 patients) completed the survey. Participants were mainly young, Latino-American, single, well-educated and currently working women. They had multiple partners and reported frequently engaging in sexual intercourse. Use of contraceptive methods and strategies of prevention against sexually transmitted infections (STI) were rare. Nearly half of the women had had at least one induced abortion and 40% had had an unplanned pregnancy. One in four participants reported a current or past STI or other genital infection. The results of our study suggest that undocumented migrants engage in frequent and high risk sexual intercourse with insufficient use of contraceptive methods and suboptimal strategies of prevention against STI.

Conclusion

The review of literature on various life aspects of the Tribals shows that there is further need for in depth research on the reasons for the existing inequities in the status of the Scheduled Tribe women. Very few comprehensive studies examining and assessing the socio- economic, cultural, reproductive and general health status have been undertaken. The review underlines the real need for specific sexual and reproductive educational programs targeting this hard to reach population. But region specific data base is needed to formulate and implement policies and programmes to bring the marginalized population groups like ST women out of the groove of miserable situation.