

**REPRODUCTIVE HEALTH STATUS- ISSUES AND CONCERNS OF TRIBAL WOMEN**

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**ABSTRACT**

Demographic profile of women in Reproductive age (15-49) and children (under 15 years) consisting 60% of the Indian population, in this population assumes that two thirds of our population are vulnerable to ill health and death while being in the Reproductive cycle of Natal- Antenatal and Post-natal care period of survival and development. This paper focuses on to assess and understand the Reproductive Health Status of Tribal Women. The study was carried out in the state of Andhra Pradesh one each from the three regions of Andhra Pradesh namely Andhra, Telangana and Rayalaseema were selected for the study. Adopting stratified random sampling technique 400 tribal women were selected from each region, totalling a sample of 1200. Data pertaining to the study was collected from both primary and secondary sources. Examination of reproductive health concerns of Tribal women is useful in assessing the extent to which populations enjoy the human rights to maximize their opportunity to enhance reproduction in a secured environment.

**KEYWORDS:** Reproductive Health of Tribal Women, Antenatal And Postnatal Care, Reproductive Health

**INTRODUCTION**

India is one of the countries having the largest concentration of tribal population in the world. According to 2011 census, the Scheduled Tribe Population in the country is 8.43 crores, constituting about 8.2 percent of the total population. Majority of the tribal population is concentrated in nine states of India, i.e. Andhra Pradesh, Madhya Pradesh, Bihar, Odessa, Gujarat, Rajasthan, Assam, Maharashtra and West Bengal.

Andhra Pradesh is the traditional home of (7% of total population) 59, 18,073 lakhs of tribal's (belonging to 33 different groups and 200 ethnic groups) found inhabiting the border areas of Andhra Pradesh. The Tribal women in India are undisputedly considered as the weakest sections of the population in view of common socio-economic and socio-demographic factors like poverty, illiteracy, lack of developmental facilities, and lack of adequate primary health facilities, guidance and direction..

Reproductive health also represents the overall health condition of a population. The reproductive role of women insight from the most attaining menstruation to the post menopausal period all through the process of gestation, birth, breastfeeding, and child-rearing places her at the focal point of a population's reproductive health (Shankar & Thamilarasan, 2003). Moreover, women are central to various social and economic activities in tribal communities requiring reciprocal interactions with the contributing factors of reproductive health. Women's access to 'power and resources' emerged as the important contributing factor to their reproductive health at the fourth world conference on women in 1995 held in Beijing which emphasizes increasing women's economic and educational status, and as a consequence, women's reproductive rights (Pillai & Wang, 1999). Thus, reproductive health indicates the level of self-determination, women's reproductive rights, and strength of tribal's socio-political power. Social justice is also linked to the status of reproductive health of Indian tribal population as the right to have basic needs and opportunities for reproductive well-being of women is linked to their empowerment.

The health status of the tribal population in India is very poor, deficient in sanitary conditions, personal hygiene, and health education. Tribal mothers have high rates of anemia, and girl children receive less than the desired nutritional intake. All told, the whole tribal community is deficient in adequate food intake. The extent of knowledge and practice of family planning was also found to be low among the Scheduled Tribes.

NFHS III(2005-06) data on reproductive health status of tribal women showed that the under-five mortality rate and the child Mortality rate are much higher for STs than any other social group/ castes at all childhood ages (95.7 and 35.8 respectively). As per the estimates of NFHS-3, the likelihood of having received care from a doctor was lowest for scheduled tribe mothers (only 32.8 percent compared to all India total of 50.2 percent.) The percentage of Scheduled Tribe women consuming Iron Folic Acid (IFA) for at least 90 days and who took a drug for intestinal parasites during their pregnancy was only 17.6 and 3.7, respectively. Among ST women who received antenatal care for their most recent birth, only 32.4 percent of ST mothers (lowest among all social groups) received advice about where to go if they experienced pregnancy complications. Only 17.7 percent of births to ST mothers were delivered in health facilities compared with 51% of births to mothers in category 'others'. Though Obstetric care from a trained provider during delivery is recognized as critical for the reduction of maternal and neonatal mortality, only 17.1 % of births to ST women were assisted by a doctor.

ST women were found to be highly anemic among all social groups. 68.5 percent of women whose hemoglobin level was tested were found to be anemic. 44.8 percent of ST women are mildly anemic, 21.3 percent moderately anemic and 2.4 percent severely anemic. The ST women were found to be mostly prevented from getting medical treatment from a health facility for themselves, due to distance to healthy facility (44 percent reporting it). 28.4 percent of ST women report concern that no female provider was available to 18.7 percent of total women.

Among ST women age 20-49, the median age at first marriage was 16.5 yrs and among age 25-49 years, it was 16.3yrs. The increase in the median age at first marriage was proceeding at a very slow pace, and a considerable proportion of women still marry below the legal minimum age of 18. 61.8 percent of currently married ST women had demand for family planning, of which only 77.5 percent have a met need for contraception.

The percentage of ST women who have heard about AIDS was far below the general population. (38.6 percent of ST women compared to 60.9 percent women general population). Among STs, only 8 percent of women have comprehensive knowledge of HIV/AIDS.

The poor health condition of the Indian tribal women is reflected in the status of their reproductive health correlated with individual and household social and economic conditions. There is need for proper understanding of the different health aspects of tribal women and their specific health needs so that relevant health measures may be prepared and implemented.

### **Need for the study**

Examination of reproductive health concerns of Tribal women is useful in assessing the extent to which populations enjoy the human rights to maximize their opportunity to enhance reproduction in a secured environment. The tribal women fulfill multiple productive functions in addition to bearing children and performing household chores.

Ironically, despite the agricultural innovations, it has not benefited women, who still have to perform the conventional household work and at the same time be engaged in agricultural and construction works. Women are obliged to resume work even before they have fully recovered from the process of childbirth. Moreover, the peripheral position of tribal's community in the Indian society restricts tribal's access to socioeconomic institutions and resources related to their level of empowerment. In the backdrop against reproductive health,

social work perspective views 'empowerment' as the tribal's ability to participate in decision making in regards of reproductive decision and to utilize their own strength and resources to continue or sustain reproduction.

There have been a number of studies on the tribes, their culture and the impact of acculturation on the tribal society. There have also been studies on the status of women relating to their socio- cultural problems, their economic rights, their participation in management, their access to employment, food, health, etc. But these issues have not been properly focused in relation to the tribal women.

There are only a few studies on the status of tribal women in India (K. Mann, 1987; J.P. Singh, N.N. Vyas and R.S. Mann, 1988; A. Chauhan, 1990). Thus the study of tribal women cannot be ignored. It becomes important because the problems of tribal women differ from a particular area to another area owing to their geographical location, historical background and the processes of social change (A. Chauhan, 1990).

For this, there is a need for proper understanding of their problems specific to time and place so that relevant development programmes can be made and implemented.

There is a greater need for undertaking a region-specific study of the status and role of tribal women which alone can throw up data that will make planning for their welfare more meaningful and effective (K.S.Singh. 1988).

The status of women in a society is a significant reflection of the level of social justice in that society. Women's status is often described in terms of their level of income, employment, education, health and fertility as well as the roles they play within the family, the community and society (Gosh, 1987).

## **REPRODUCTIVE HEALTH STATUS-ISSUES AND CONCERNS**

In India, it is estimated that about 437 women out of every 1, 00,000 women die even year due to pregnancy and its related causes (NHFS: 1992-93). It is also estimated that about 4,00,000 maternal deaths occur every year in the world and out of these 1, 00,000 deaths occur in India. The major causes of maternal deaths are bleeding, severe anaemia of various origin, puerperal sepsis and obstructed labor and toxemia of pregnancy.

Early marriages, early pregnancies and short-spaced pregnancies are also some of the factors underlying such high rates of maternal deaths. Low literacy level of mothers, low knowledge of nutrition health education, and lack of adequate maternity services and under utilization of the existing services has aggravated the problem.

Therefore, the safety of the life of woman in her reproductive age depends on a number of factors, such as, number of pregnancies, number of miscarriage/ abortions, and stillbirths she has had; also antenatal, natal and post-natal care she receives during her pregnancy and child birth. In order to assess the existing status pertaining to the reproductive health of the Tribal women, the present study was undertaken.

### **Importance of Reproductive Health**

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

Reproductive health is a universal concern, but is of special importance for women particularly during the reproductive years.

Because reproductive health is such an important component of general health it is a prerequisite for social, economic and human development. The highest attainable level of health is not only a fundamental human right for all; it is also a social and economic imperative because human energy and creativity are the driving forces of development. Such energy and creativity cannot be generated by sick, tired people, and consequently a healthy and active population becomes a prerequisite of social and economic development.

### **Factors affecting reproductive health**

Sexual and reproductive behaviors are governed by complex biological, cultural and psychosocial factors. Reproductive health affects, and is affected by, the broader context of people's lives, including their economic circumstances, education, employment, living conditions and family environment, social and gender relationships, and the traditional and legal structures in the community. Therefore, the attainment of reproductive health is not limited to interventions by the health sector alone.

Nonetheless, most reproductive health problems cannot be significantly addressed in the absence of health services and medical knowledge and skills.

The status of girls and women in society, and how they are treated or mistreated, is a crucial determinant of their reproductive health.

Educational opportunities for girls and women powerfully affect their status and the control they have over their own lives and their health and fertility. The empowerment of women is therefore an essential element for health.

### **Reproductive health problems**

Women bear by far the greatest burden of reproductive health problems. Women are at risk of complications from pregnancy and childbirth; they also face risks in preventing unwanted pregnancy, suffer the complications of unsafe abortion, bear most of the burdened with nutritional disorder due to lack of food security and contraception are more exposed to contracting, and suffering the complications of reproductive tract infections, particularly sexually transmitted diseases (STDs).

Among women of reproductive age, 36% of all healthy years of life lost are due to reproductive health problems such as unregulated fertility, maternal mortality and morbidity and sexually transmitted diseases including HIV/AIDS.

### **Review of literature**

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. Review of literature on reproductive health of tribal women in India was undertaken.

“Status of Tribal Women” was examined by Borthakur (1994). He stated 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 tribal community.

Sri Devi et al., (2007) presented a study on “Prevalence of RTI/STI among Reproductive Age Women (15-49) 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.

Vinitha et al., (2007) evaluated a study on “Level of reproductive health awareness and factors affecting it in a rural community of south India”. This study found that Enhancing health awareness among women in India was a challenging task. Educational status, which was significantly associated with awareness on all the four reproductive health issues.

Results of Chandraker et al., (2009) A cross-sectional study was conducted to understand “Reproductive and Child Health among the Dhur Gond Tribal Community of Mahasamund District, Chhattisgarh, India” -- revealed that high percentages of mother had not taken ante-

natal check-up (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 birth 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/m<sup>2</sup>) and all the children were suffered from malnutrition.

Caserta et al., (2010) study on "Environment and women's reproductive health" summarized that 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.

Nalin Singh Negi et al., (2010) evaluated a study on "Antenatal Care among Tribals: A Study of Chhattisgarh and Jharkhand". The results showed 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.

De M et al., (2011) analysed a study on Incidence of anemia and effect of nutritional supplementation on women in rural and tribal populations of eastern and north-eastern India. The study identifies Screening of women of child bearing age among the tribal and rural population of different north eastern and eastern states of India was performed.

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" which points out that the traditional reproductive health care system still finds its meaning of survival in the tribal domain.

Susuman A. (2012), In his study "Correlates of Antenatal and Postnatal Care among Tribal Women in India 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 were 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 was 2.5 times higher than those women who did not receive any antenatal check-up.

The review showed that most studies focused on only some components of reproductive health and that there was need for comprehensive studies. As such the present research study was undertaken.

### **Objective of the study**

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

1. To assess the socio-economic, demographic and cultural conditions of Tribal Women.
2. To assess the Knowledge of the Tribal Women regarding various reproductive health issues
3. To study the actual reproductive health status and reproductive health problems of Tribal Women
4. To assess the fertility preferences and contraceptive usage among the Tribal Women
5. To know about the utilization of the health care services among Tribal Women
6. To study the nutritional status and morbidity diseases among tribal women
7. To study the reproductive health status of the tribal women and suggest remedial measures for improvement

### **Hypotheses**

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

## **Methodology**

### **Study area**

The present study was carried out in the state of Andhra Pradesh (59, 180, 73 lakhs of tribal population). Three districts i.s Vishakapatnam (6, 18,500 lakhs of tribal population), Warangal (5, 30,656 lakhs of tribal population), Kadapa (75,886 thousands of tribal population) one each from the three regions of Andhra Pradesh namely Andhra, Telangana and Rayalaseema were selected for the study, giving due representation and weightage to the inhabitation of Tribal population.

### **Sample Design**

The sampling unit of the study is a married tribal woman with at least one living child. A list of married women in the age group of 25-45 years was selected from each district. Adopting stratified random sampling technique 400 tribal women were selected from each region, totaling a sample of 1200. The information pertaining to number of pregnancies, ante-natal, natal and post-natal check -ups, etc., was gathered from 1200 tribal women in the reproductive age group.

### **Methods and Tools of data collection**

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

**Primary data:** An exclusive interview schedule was prepared for the purpose of data collection on field. Interview schedule was prepared based on the NFHS III Survey questionnaire. The interview schedule explored Socio cultural and economic status of the respondents, Reproductive health and Maternity care, Family Planning, Morbidity and nutritional deficiency diseases, infections like STDs, HIV/Aids.

**Secondary data:** Related reviews, Reproductive health status reports, findings in various books, printed journals, online journals, Govt. documents etc were gone through to collect secondary information on Tribal women.

### **Analysis of the data: -**

The data thus collected was subjected to statistical tests to enable easy interpretation.

**MAJOR FINDINGS OF THE STUDY:**

- Majority (48.25%) in Visakhapatnam followed by Kadapa (47.25%) and 43 percent in Warangal districts belonged to the age group of 31 to 35 years.
- 65 percent women in Visakhapatnam followed by 60.5 percent in Kadapa and 58.7 percent in the Warangal Districts were 10-15 years. It is evident that higher proportion of Visakhapatnam District respondents married at an early age.
- 92.5 percent of the respondents in Visakhapatnam were living with spouses followed by Warangal District (89.80%) and 83 percent in Kadapa District.
- 68 percent in Warangal District followed by 67.25 percent in Kadapa and 59 percent of Visakhapatnam Districts were having less than four members in their families.
- A large proportion i.e., 90.50 percent in Kadapa and 87 percent in Warangal and 84 percent in Visakhapatnam Districts were living in nuclear family system.
- Housing status of the respondent's revealed that majority (90%) of the respondents in Kadapa District were living in pucca houses, followed by 87 percent in Warangal and 86.30 percent in Visakhapatnam Districts.
- Majority of the respondents were illiterate as followed 69 percent of the respondents in Visakhapatnam, 51.70 percent in Kadapa and 49.50 percent in Warangal Districts.
- Annual income of the respondents showed that 75.50 percent earned Rs.10, 000 to Rs.20, 000 annually in Visakhapatnam followed by 61 percent in Warangal and 57 percent in Kadapa Districts respectively.
- 31 percent of the respondents were participating in developmental activities like meetings of developmental agencies and extension officers, Kisan melas etc in Kadapa followed by 23 percent each in Visakhapatnam and Warangal Districts.
- Majority (46%) of the respondents in Warangal and (40%) Visakhapatnam districts and 37 percent in Kadapa district bought milk and milk products once in a day.
- 43 percent respondents in Kadapa, 39 percent from Warangal and 37 percent from Visakhapatnam districts bought cereals once in a week.
- 39 percent of the respondents in Visakhapatnam district purchased pulses fortnightly followed by 34 percent of respondents in Warangal district who purchased weekly and 33 percent of Kadapa district respondents who bought pulses monthly.
- Most (77.25%) of the respondents in Warangal district and 71 percent in Kadapa followed by 65 percent in Visakhapatnam district purchased vegetables twice or thrice in a week.

- A large proportion (72.75%) of the respondents in Warangal district, 60 percent in Visakhapatnam and 61 percent in Kadapa districts purchased meat and meat products monthly once.
- A large proportion i.e., 69 percent of the respondent's in Warangal received antenatal care followed by 65 percent in Kadapa and 60 percent in Visakhapatnam respectively.
- 61.20 percent of the respondents in Warangal district received antenatal checkups followed by 59 percent in Kadapa and 56 percent in Visakhapatnam Districts.
- 52 percent respondents in Visakhapatnam, 46.40 percent in Warangal and 43 percent in Kadapa Districts received ante-natal checkups in government health facilities like P.H.Cs, C.H.C s, and Sub centers.
- A little more than half of the respondents (57.25%) in Warangal, 49.50 percent in Kadapa and 41.75 percent in Visakhapatnam districts have taken Tetanus Toxide injections during their last pregnancy.
- 44 percent in Kadapa followed by 41.25 percent in Warangal and 39 percent in Visakhapatnam districts received Iron & Folic Acid tablets during their last pregnancy.
- 59 percent of the respondents in Kadapa District said that their last delivery was conducted in a health institution as also 56 percent respondents in Warangal district and 54 percent in Kadapa.
- A high percentage of respondents had swelling of hands and feet at the time of pregnancy.80 percent respondents in Visakhapatnam, 78 percent in Kadapa and 71 percent in Warangal reported this problem. A large proportion of respondents in the three districts faced complications during their pregnancy due to nutritional deficiency.
- A higher proportion of the respondents – 75 percent in Kadapa, 68.75 percent in Warangal and 66 percent in Visakhapatnam districts had adopted permanent family planning methods.
- 60 percent respondents in Warangal, 68 per cent in Kadapa and 72 per cent in Visakhapatnam Districts said that they have adopted permanent family planning method due to their inability to support large families economically.
- Half of (50.50%) the respondents in Kadapa district have heard of reproductive tract infections and sexually transmitted infections followed by 47 percent in Warangal district and 43 percent in Visakhapatnam district.

- 66.90 percent of the respondents in Visakhapatnam district had information about of RTI/STIs through Radio, T.V, Print media as also 61.25 percent in Warangal district and 55.45 percent in Kadapa district respectively.
- Majority (74.20%) of the respondents in Kadapa district, 72 percent in Warangal and 66 percent in Visakhapatnam districts knew that the causes of transmission of RTI/STIs was unsafe sex, sex with many partners and sex workers.
- More than three fourths (78.75%) of the respondents in Kadapa and 77.25 percent in Warangal and 66 percent of the respondents in Visakhapatnam districts have heard of HIV/AIDS.
- ICT (Information communication and technology) sources like radio, T.V, Cinema, print media were cited as the major source of knowledge regarding HIV/AIDS, causes and prevention. 78.90 percent respondents in Warangal, 76.05 percent in Visakhapatnam and 69.80 percent of the respondents in Kadapa districts respectively reported this.

#### **IMPLICATIONS OF THE STUDY**

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

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

Hence many programmes formulated for their benefit should have an integrated multi-dimensional approach aiming at building up of awareness of health care. The programmes should facilitate for a holistic development of tribal women.

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

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

The following programmes may be undertaken for attaining quality reproductive health.

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

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

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

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

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

- **Gender equality and equity**

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

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

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

- **Participation of programme users**

The participation of programme users in the design, implementation and evaluation of information, education and communication programme interventions increase the likelihood of success.

Different population groups have their own perspectives, ideas and opinions in many areas, particularly about sexual and reproductive health. Communicating effectively with them requires their direct participation.

- **Training of personnel**

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

- Strict monitoring and enforcement of health personnel in Govt health facilities P.H.Cs and C.H.Cs, Sub-centres to see that they are present for duty regularly.
- Differential area-specific need assessment would provide data for strategies and programmes to improve access and utilisation of nutrition services for each of the tribal areas.

### **References**

1. Dr. P. Subramanyachary , 2013, Status of schedule tribes in Andhra Pradesh, DJ The Dawn Journal Vol. 2, No. 1, January - June 2013
2. Mashooq Azad Salehin, May 2012, Reproductive Health Of Tribal Populations In India: A Sustainability Approach, Ph.D thesis, University of Texas at Arlington
3. Sathiya Susuman.A, 2012,Correlates of Antenatal and Postnatal Care among Tribal Women in India, Kamla-Raj Ethno Med, 6(1): 55-62,2012
4. Shaila Bhardwaj and Mary Grace Tungdim, 2010, Reproductive Health Profile of the Scheduled Caste and Scheduled TribeWomen of Rajasthan, India, The Open Anthropology Journal, 3, 181-187
5. Richa Chandraker, 2009, Reproductive and Child Health among the Dhur Gond Tribal Community of Mahasamund District, Chhattisgarh, India
6. B. Sri Devi\* and N. Swarnalatha, 2007, Prevalence of RTI/STI among Reproductive age Women (15-49 Years) in Urban Slums of Tirupati Town, Andhra Pradesh Health and Population-Perspectives and Issues 30 (1): 56-70
7. Pillai, V. K., & Wang, G. Z. ,1999, Women's reproductive health in developing countries. Surrey, United Kingdom: Ashgate Publishing Ltd.

### **Reports & websites**

1. Indian Ministry of Tribal Affairs (2010)
2. International Institute for Population Sciences (IIPS). (2007). National family health survey
3. Indian National Family Health Survey-3 (NFHS, 2005-06)
4. [www.tribal.nic.in](http://www.tribal.nic.in)