CHAPTER - 1

INTRODUCTION

Health is considered as a fundamental human right and a worldwide social goal, which leads to adequate energy, physical strength and harmony, allowing people to be productive and deal creatively with the development of society, family and themselves. In Indian scenario, various health indicators depict that during the last six decades and more, since the time of independence, considerable progress has been achieved in the promotion of health of the people. However, the health picture of country still constitutes cause for serious and urgent concern. While poverty is an important barrier to positive health outcomes for both men and women, poverty tends to yield a higher burden on women and girls' health, for example, feeding practices (malnutrition) and use of unsafe cooking fuels. Large masses of Indian poor continue to struggle for survival and health (International Conference on Population and Development, 1997).

Human Development as "the process of enlarging people's choices", said choices being allowing them "to lead a long and healthy life, to be educated, to enjoy a decent standard of living", as well as "political freedom, other guaranteed human rights and various ingredients of self-respect". (UNDP, 1997).

Human Development Report (2015) ranks India at number 130 among 188 countries in terms of overall human development. Women are very vulnerable part of our society and also play a very important role in human development. It proves direct relation with overall health of human too; moreover, women are the backbone of our society and many a times having threefold responsibility of farm, home and communities. This directly affects women's health specially "Reproductive Health" or "Reproductive Health" affects their responsibilities i.e. vice-versa.

The attainment and maintenance of health depends upon one's access to health goods and services too. One cannot remain healthy if the environment is unhealthy. According to World Health Organisation (2001)**,** being a man or a woman has a significant impact on health, as a result of both biological and gender-related differences. The health of women and girls is of particular concern because, in many societies, they are disadvantaged by discrimination rooted in socio-cultural factors,

and reasons which are deep rooted in Indian society and many other developing countries of the world.

Apart from the individual body differences and habits; the government policies, commercial interests, state of environment, quality of medical care, rural-urban differences and economic status are also crucial social determinants of health of an individual. There are some milestones phases/stages in a women's life, where in several medical or socio-cultural dimension act as causes of menacing effects on the women's health, lives or wellbeing. These stages, subsequent causes and their effects are shown in the following table.

Table 1: Stages of Women's Life, Determinants and the Consequences

S. No.	Stages in Women's Life	Determinants	Results
1.	Conception	Sex Determination Test	Death or Damage
2.	Birth	Female infanticide	Death
3.	Infancy	Inadequate breastfeeding and food or neglect of food	Death or Morbidity
4.	Childhood	No play Lack of education Insufficient or low attention	Death or Illness or Less Resistance
5.	Puberty	More restrictions Less mobility Inadequate food	Death, Anemia, Depression, Other Health Hazards
6.	a. Marriage b. Motherhood	Early pregnancy, Repeated Delivery, Abortion Sex determination test No control over sexuality STD, HIV, RTI, AIDS	Death, Severe Anemia, Psychological Problems Impaired Reproductive Health
7.	Old age	Lack of Medical care Menopause	Anemia and other Deficiencies

Source: Mathu and Pandya (Women and Health, 2002)

Some of the socio-cultural factors that prevent women and girls to benefit from quality health services and attaining the best possible level of health include:

- Unequal power relationships between men and women;
- Social norms that decrease education and paid employment opportunities;
- An exclusive focus on women's reproductive roles; and
- Potential or actual experience of physical, sexual and emotional violence. (WHO, 2017)

Any country's overall level of development affects the health status of its people. However, women are affected disproportionately more than, and in different ways from, men. There are several approaches followed to enhance the status of women and to improve their access to and control over resources. These include -

- The financial sustainability approach that concentrates on generation of additional income;
- The poverty alleviation approach that stresses improvement in the quality of life; and
- The empowerment approach that deals with gender inequalities and mainstreaming gender in the developmental processes.

The importance of good health and education to women's well-being and that of their families and society cannot be overstated. There are many organizations working for improving health status of women in India but there is still underutilization of health services by women which is mainly due to the following reasons -

- Lack of Awareness
- Ignorance of Women
- Poverty stricken families of these women
- Lack of importance of their own health
- Superstitions amongst low socio-economic families
- High illiteracy among women

Although improvement of health status of women in India has occurred in general since independence due to various public health initiatives and interventions, there is still scope for a lot of improvement. Agreed on the picture of women in India, Economic and Social Commission for Asia and Pacific placed on its agenda for Reproductive Health as the first and foremost health care need of women in Asia.

1.1 Women and Reproductive Health

"Reproductive Health" is a universal concern, but is of special importance for women particularly during their reproductive years. Although most reproductive health problems arise during the reproductive years, in old age general health continues to reflect earlier reproductive life events. Men too have reproductive health concerns and needs though their general health is affected by reproductive health to a lesser extent than is the case for women. However, men have particular roles and responsibilities in terms of women's reproductive health because of their decision-making powers in reproductive health matters.

Cairo Programme for International Conference on Population and Development (ICPD, 1997) stated that the Reproductive Health means "A state of complete, physical, mental and social well-being and not merely the absence of diseases or infirmity, in all matters relating to the reproductive system and to its functions and processes". Reproductive health therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth.

One of the major challenges of "Reproductive Health" in India is addressing the barriers in communication and thereby improving the dialogue between diverse stakeholders, particularly women in the community. Through a qualitative study conducted in one of the rural districts of India, it was attempted to understand the factors affecting women's decision-making process. In this study, knowledge, traditions, stigma and accessibility of services are identified as the key primary factors

affecting decision making of women in the community, particularly on their health-related issues (Saha and Somen, 2005).

Access to knowledge, safe and confidential, non-judgmental, and supportive clinical and counseling services are essential. However, due to existing social norms and gender biases these services are not currently freely and easily accessible to adolescent girls and young women in many populations. Further to our dismay, little is known about adolescent girls and young women living in isolated and neglected tribal areas in terms of their Reproductive and Sexual Health (RSH) needs, status and outcomes. The policies and guidelines around provision of RSH services to such adolescent and young women also remain largely ignorant and silent.

Among women of reproductive age which is normally 15-44 years, the burden of reproductive ill health is far greater than the disease burden from other like tuberculosis or heart disease, any infections, accidents and violence. Women run the risks of pregnancy, childbirth and unsafe abortion, take most of the responsibility for fertility regulation and are socially and biologically more vulnerable to reproductive tract infections and sexually transmitted diseases including HIV/AIDS. Men, too, suffer reproductive ill-health, particularly in the form of sexually transmitted diseases and HIV/AIDS, but to a less extent. Thus, while recognizing that the main burden falls on women, strategies to improve reproductive health must also consider the men's needs, concerns and roles.

The National Population Policy (2000) affirms the commitment of government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in providing family planning services. The Council's research activities are directed to address the issues related to reproductive health through basic and clinical research as well as operationalizing the existing knowledge and available technologies. The research was undertaken through Council's Institute for Research in Reproduction (IRR), Mumbai, the network of Human Reproduction Research Centers (HRRCs) located in different parts of the country and several non-ICMR institutes including NGOs.

Without reproductive health and freedom, women cannot fully exercise their fundamental human rights. Yet around the world, the right to health, and especially reproductive health, is far from a reality for many women. According to the World Bank, a full one-third of the illnesses among women aged 15-44 years in developing countries is related to pregnancy, childbirth, abortion, reproductive tract infections, and Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS). An approach for women with basic reproductive right is therefore changed, which highlights the rights of women to have children by her own choice, to receive quality reproductive health care and to have a safe and satisfying sexual life. Therefore, the recognition having such rights legally (especially for girls and women) forms the first step to ensure they become a reality.

Despite all, a woman's health revolves around maximum portion of her reproductive health which includes satisfying but safe sexual life, her ability to reproduce the new human creature, successful marital life along with the survival of child and mother, access to reproductive health care services available and meant for her, knack to have minimum reproductive complications and freedom to take decisions to reproduce. When a woman lacking in all the above includes, her reproductive health may decline and leads to even death. There are some other factors responsible for her awful reproductive health which are explained below:

1.2 Factors Affecting Reproductive Health and Reproductive Rights of Women

Reproductive health problems are widely prevalent among women, especially among those living in rural and tribal areas. Vulnerability factors that have been flagged for concern include:

- Unmet educational needs of the women
- Inadequate health services
- Cultural norms and taboos
- Lack of knowledge and awareness
- Low status of women in all the aspects (i.e. social, emotional and economic, cultural).

- Lack of supportive environment in the family and in community context
- The absence of an enabling and supporting environment.

One of the reasons why women succumb to reproduction related complications is lack of timely transportation to the nearest hospital. Experts estimate that 70% of the maternal -related deaths are preventable. Tetanus and anemia claim a large number of women because mothers get very little or no care in the post-natal period (Azad Foundation of India, 2010)

Reproductive rights of women usually include the following concepts:

1. The right to health in general
2. The right to reproductive choice
3. The right to receive reproductive health services
4. The right of men and women to marry and found a family
5. The right of individuals to make reproductive decisions free of discrimination, coercion and violence
6. The right of the family to special protection
7. And sometimes, concepts of special rights in relation to motherhood and childhood (pre and post-natal care) (ICPD CAIRO, 1997)

Owing to all the above reproductive rights of women if she is educated enough in a right way, especially in regards to the reproductive health concern some contributory efforts can reduce all the adverse and ill effects of the reproductive health of all the women.

1.3 Concept of Tribe

According to Sociology Guide (2006) “Adivasis” (Tribes) means "original inhabitants” and these comprise a substantial indigenous minority of the population of India. The word 'Tribe' denotes a group of people living in primitive conditions. It is a social group with territorial affiliation, endogamous with no specialization of functions. They have a headman or a chief who controls the activities of that group. Tribals have several sub-groups and all of them together are known as 'Tribal Society'. It is really difficult to say whether they are indigenous or not, but they are earliest

settlers of India. They were living in forests since early times and even now some of the groups follow the same trends and live in forests. Tribal population constitutes around 8.08% of the total Indian population, and of the total tribal population, nearly 80% is found in central India since they are older settlers and are living in forests, they are known as *"Vanyajati", "Vanvasi", "Pahari", "Adivasi", "Anusuchit Jati", "Anusuchit Janjati"* and so on in Indian languages. The word implies the meaning itself i.e. old settlers "Adi" which denotes old and "Vasi" which denotes those who stay.

In the Indian context, tribal people engage in a variety of economic pursuits, like hunting and gathering *"Pulayas"* in the south, to professional agriculturalists like Ho and *"Orans"* of Chotangpur region, to bureaucrats and professional tribes from the north east in Rajasthan. Mehrotra (2006) mentioned contrary to the anthropological myth of relative isolation; tribal people exist as a part of mainstream. A common similarity however, is that a large chunk of their population still reels under poverty, social backwardness, and literacy.

Kamat (2006) opines in one of his articles that over hundred or so different tribes spread over India have suffered the indignity of caste discrimination for centuries. It was our freedom fighter Mahatma Gandhi who fought hard to recognize them as free citizens of India and called them the *"Girijans"* or the Children of the Forest God. Upon independence in 1947, the Government of India spent a lot of resources to improve the life of these native Indians or Scheduled Tribes, as they are known in India today. While much progress is made in reforming the tribal population, the forced change gave rise to numerous unforeseen problems in India, including social conflict, loss of identity, and coerced religious conversions. Tribal people like the Gond, Bhil, and Halbi almost live like Hindus do in the outside world.

1.3.1 Distribution of Tribal Population in India and Rajasthan

1.3.1.1 Distribution of Tribal Population in India

The tribal areas that are mostly isolated villages or hamlets constitute a significant part of under developed areas of the country. A smaller portion of their population has now settled in permanent villages as well as in towns and cities. As per rough estimates, the prominent tribal areas constitute about 15 percent of total geographical area of the country (Census, 2001).

According to the Ministry of Tribal Affairs Statistics Division (2013) Tribal communities live in various ecological and geo-climatic conditions ranging from plains and forests and to hills and inaccessible areas. Tribal groups are at different stages of social, economic and educational development. While some tribal communities have adopted a mainstream way of life, at the other end of the spectrum, there are certain Scheduled Tribes, 75 in number known as Particularly Vulnerable Tribal Groups (PVTGs), who are characterized by:-

- Pre-agriculture level of technology
- Stagnant or declining population
- Extremely low literacy; and
- Subsistence level of economy

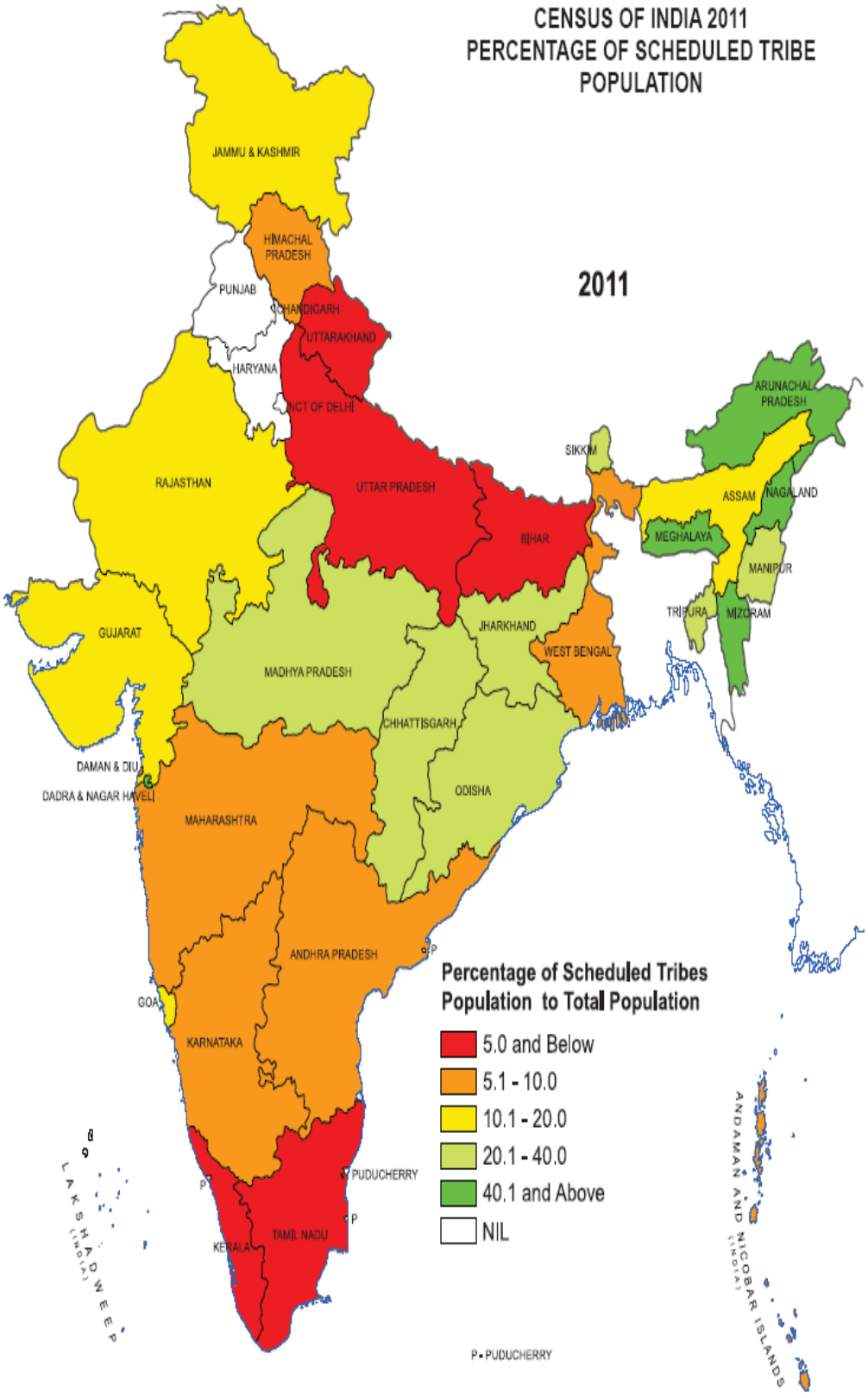

Figure 1: Tribal Population of India

Source: Census of India 2011

The tribal population of the country, as per 2011 census, is 10.43 crore, constituting 8.6% of the total population. 89.97% of them live in rural areas and 10.03% in urban areas. The decadal population growth of the tribal population from Census 2001 to 2011 has been 23.66% against the 17.69% of the entire population. Broadly the Schedule Tribes inhabit two distinct geographical areas – the Central India and the North- Eastern Area. More than half of the Scheduled Tribe population is concentrated in Central India, i.e., Madhya Pradesh (14.69%), Chhattisgarh (7.5%), Jharkhand (8.29%), Andhra Pradesh (5.7%), Maharashtra (10.08%), Orissa (9.2%), Gujarat (8.55%) and Rajasthan (8.86%). The other distinct area is the North East (Assam, Nagaland, Mizoram, Manipur, Meghalaya, Tripura, Sikkim and Arunachal Pradesh).

1.3.1.2 Distribution of Tribal Population in Rajasthan

According to Census Data of the year 2001, Rajasthan is the largest state in the country having geographical area of 3, 42,339 sq. kilometers or 10.41% of the total geographical area of the country.

The population of the state is 5, 64, 73,122 or 5.50% of the country as per the 2001 Census data. The population of Scheduled Tribes (according to Census 2011) is 13.5 % of the country; but the concentration of the ST population is greater in some parts of the state. Rajasthan's population includes many tribes, who today constitute 12% of the state population, nearly double of the national average. The main tribes of Rajasthan are the *"Bhils"* and the *"Minas"*. These were the original inhabitants of the area now called Rajasthan. Historically, they were forced into the Aravalli Range by the Aryan invasion. Smaller tribes include the *"Sahariyas"*, *"Garasias"* and the *"Gaduliya lohars"*.

Regionally, the scheduled tribal areas of Rajasthan include Dungarpur, Banswara and Pratapgarh districts. Kherwara, Kotra, Gogunda, and the Phalasia tehsils of Udaipur district, the Abu road tehsil of Sirohi district and the Achnera and Arnod Panchayat samities of Pratapgarh district are exceptionally heavily concentrated tribal areas. The Scheduled Caste and Scheduled Tribe (ST) population in Pratapgarh district is 7.0 percent and 63.4 percent respectively whereas the state percent of Scheduled

Caste and Scheduled Tribe population is 17.8 and 13.5 respectively. http://www.censusindia.gov.in/2011census/dchb/0833_PART_B_DCHB%20_0833_PRATAPGHARH.pdf

State Wise Tribal Population in Rajasthan

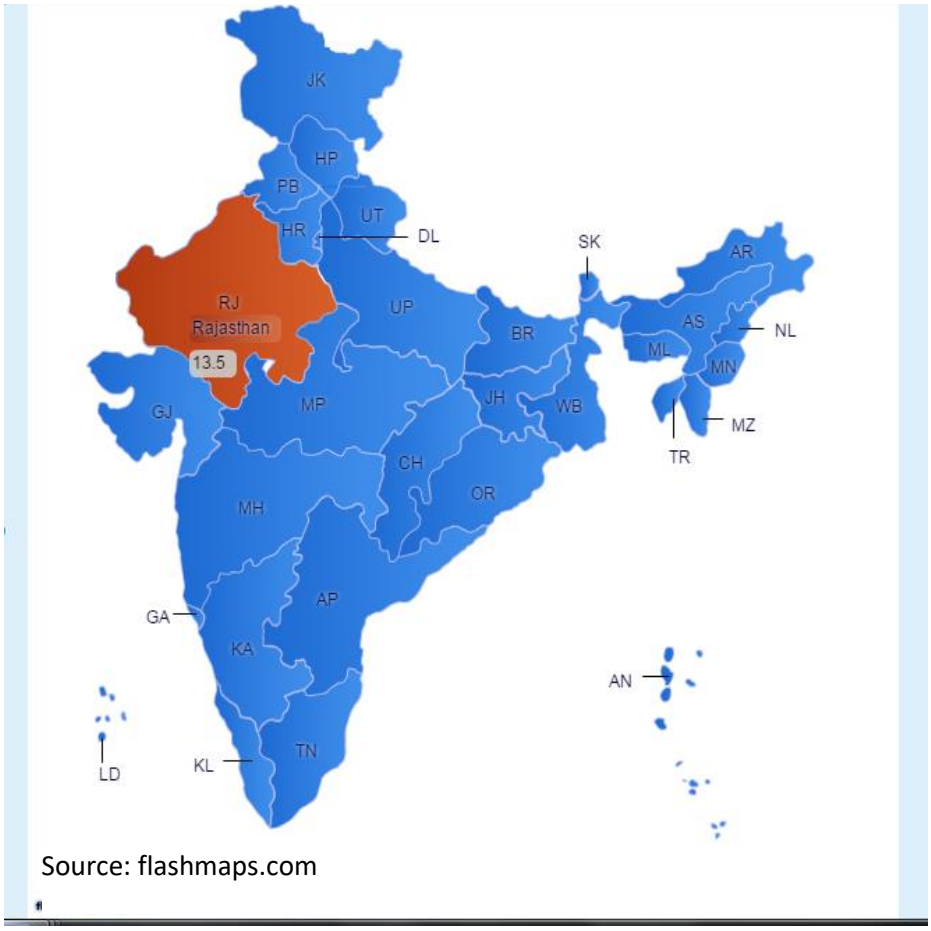

Figure 2: Tribal population of Rajasthan

It is evident from the information available from Census data 2011, that average population of scheduled tribe in the state is 13.5 percent. Districts having higher population than the state average are- Banswara- 72.27 percent, Dungarpur- 65.14 percent, Udaipur- 47.86 percent, Dausa- 26.81 percent, Sirohi- 24.76 percent, Karauli- 22.37 percent, Sawai Madhopur- 21.58 percent, Chittorgarh- 21.53 percent, Bundi- 20.24 percent and Rajsamand- 13.09 percent. Districts of Banswara and Dungarpur have more than 50 percent tribal population, whereas districts of Udaipur, Chittorgarh and Sirohi have certain blocks having more than 50 percent population of scheduled tribes. Girwa block of Udaipur district has a concentration of scheduled tribe in one of

the specific part of about 1/3 of the block and accordingly 81 villages of the block are included in the Tribal Sub-Plan Area.

"*Bhils*" - The Skilled Archers

The *"Bhils"* are one of the eminent tribal groups, traditionally inhabited in the south-eastern pockets of Rajasthan, although they are mostly concentrated in the neighboring state of Madhya Pradesh. Annexed from the Tamil word for bow, vil, the "*Bhil"* bowmen are corroborated as dexterous archers in the history. The legend of *"Eklavya"*, a *"Bhil"* who outshined the skill of "Arjuna" – a legend from Hindi Mythological Cereal "*Mahabharat"* only to be restrained by the command of his guru, *"Dronacharya"*, is mentioned in the Mahabharata epic. The *"Ramayana"* talks of *"Ratnakara"*, the *"Bhil"* bandit who ameliorated with the blessings of Lord *"Narad"*, to become *"Valmiki"*, the renowned poet sage. The women of bhil tribes used to wear the bangles on overall their hands and also wear the jewelry. (Nagda, 2004)

"*Minas*" - The Fishy Clan

The *"Mina's"* tribes are not only the second largest tribal community in Rajasthan, but are also the most widely spread, from the eastern terrain to the northern regions of "*Shekhawati"*. This comprises of about 39% of total population of tribal of Rajasthan. A special and unique type of attire worn by women of *Mina* tribes makes them look very different from the women of other tribes. The name Mina is derived from the Sanskrit word "*Mina*" (fish) and claim to descent from the first incarnation of Lord Vishnu as a fish. The Vedas condemn them as the enemies of the "***Aryans"*** and the "***Mahabharata***" traces their glory in the kingdom of *"Matsyaraja"*, where the mighty *"Pandavas"* took shelter during their one year of concealment. It was the Kachhawaha clan of Rajputs who finally diluted their power, banishing them to forest and hill hide outs in the Aravalis. After independence, their ignominious status as a criminal tribe was dispersed and they took to agriculture. "Mina" tribe is believed to be a mixture of more than one tribe. It seems the fisher men community called *"Meenavar"* eventually became *"Mina"*, who are notoriously known as thieves and robbers. They do not intermarry with other tribes. The younger brother of a deceased can marry his widow. It is told that a married man have freedom and access on his

older brother's wife and wife's younger sister. Drums and dances are usual in marriages and other festivals. It is said that in such occasions as the drum beats tightens, dresses loosen and the dance becoming indecent is not uncommon. According to 2001 census data, there are 3.8 million *"Minas"* and most of them are in Rajasthan. They are known by the language they speak – "*Mina"*. There are not many serving among the *"Mina"* people to uplift from the superstitious beliefs and evil practices.

Bhil Women of Rajasthan

Mina Women of Rajasthan

"*Gaduliya Lohars*" -The Nomadic Black Smiths

The *"Gaduliya Lohars"* derive their beautiful bullock carts, or gadis that have taken them wandering from their original land, Mewar, to different parts of India. Legend has it that they were committed to fight on behalf of Rana Pratap who battled bravely against the Mugul Emperor, Akbar when Maharana Pratap was ousted from Chittaur and he fought the historic battle of Haldighati, the Gaduliya Lohars were a clan of warring Rajputs who swore to enter the Mewar stronghold of Chittaur only after the victory of their Maharana.

***"Garasias"* -The 'fallen' Rajputs.**

According to the legend, the "*Garasia"* tribals are descended from the Chauhan Rajputs of Jalore in south-west Rajasthan. Some six centuries ago, after defeat in a battle, they fled to the hills, where they mingled their blood, their myths and rituals with the local *"Bhil"* tribals, to become a distinct group. The *"Garasias"* have an interesting custom of marriage through elopement, which usually takes place on the occasion of the annual gaur fair held during the full moon of March-April month. The Garasis celebrate 'nyat', a feast of honour, for their dead people which is performed only on Mondays and a stone memorial called 'sura' is erected after the cremation.

Saharai and Gadoliya Luhar Women of Rajasthan

***"Sahariyas"*- The jungle dwellers**

The *"Sahariyas"* possibly derive their name from 'Jungle' in Persian. Although they are believed to be an offshoot of the *"Bhils"*, they supposedly earned this name from the Muslim ruler of Shahbad, as they had chosen to make their home in the jungle hideouts of the Shahbad district of Kota, and in the neighboring regions of Jhalawar, Sawai, Madhopur, Durgarpur and Udaipur.

"*Damors*" - The migrated tribe

The small community of *"Damors"* seems to have moved northwards from their original home in Gujarat to settle in Dungarpur and Udaipur districts. The scantily available information and facts about the tribal women inhabiting these regions and their reproductive health are presented underneath for our understanding and knowledge. (Rajasthan Travel and Tourism Department, 2006 – 07)

1.4 Tribal Women and their Health

Women have always been figured in monographs on tribal societies. Interest in them translated in describing them as important social actors (wives, daughters, sisters and mothers). Tribal women themselves have been increasingly subjected to the stress associated with the developmental activities.

Compared to modern women, tribal women have very little wealth of their own or of their families. They have just a piece of coarse cloth to cover their womanhood. They are very fond of ornaments, yet have just one or two strings of red, blue or white beads. In addition, they may have some bangles, earrings and necklaces made of cheap metal. That materialistic comforts and riches are not the indices of happiness is well illustrated by the tribal women.

They are always very cheerful and light-hearted, often laughing and joking with members of their family or with the neighbors. They are truthful and honest. They never deny any offense they might have committed and willingly face the consequences. These are some of the sterling qualities, the modern women and men have to learn from the tribal sisters. It is true that the tribal women avoid outsiders, but once they get over their natural shyness, they are extremely frank and communicative.

Considering their utter poverty, and their constant struggle to maintain the barest minimum standard of life, their light-heartedness is amazing.

But some of the evidences said that the condition of tribal women somewhere is not up to the mark as tribal people living in remote areas (especially women) still not getting enough access to the health care services. Some data released on women stated that 'Maternal Mortality' has been an area of concern for all countries across the globe. Chantia and Mishra (2015) stated in their article that, India tops the rate of maternal deaths worldwide. The Maternal Mortality Rate (MMR) of India is 212 per one lakh live births, whereas the country's target was to achieve 200 maternal deaths per lakh of live births by 2007 and to reduce it to 109 per lakh of live births by 2015 (as set by the Millennium Development Goals (MDG) of the United Nations in 2000). The reason behind this data was (NFHS-3), the likelihood of having received antenatal care from a doctor is lowest for scheduled tribe mothers (only 32.8 percent compared to all India total of 50.2 percent and 42 percent for Schedule Caste). 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.

One of the main reasons behind such data was found to be that only 17.7 percent of births to ST mothers are delivered in health facilities compared with 51% of births to mothers in category 'others.

Such data is always apparently providing a glimpse towards the reproductive health status of tribal women in India. Similarly, the related issue of family planning attitude is so responsible for their reproductive health concern like STDs and RTIs. To support this quote NFHS has taken the initiative and concluded that currently married women who are not using any method of contraception but who do not want any more children are defined as having an unmet need for limiting and those who are not using contraception but want to wait two or more years before having another child are defined as having an unmet need for spacing. The sum of the unmet need for limiting and the unmet need for spacing is the unmet need for family planning.

With regards to that 61.8 percent currently married ST women have a demand for family planning of which only 77.5 percent have met need for contraception.

Much of the information, awareness and services pertaining to reproductive and sexual health provided by the stakeholders, do not reach to these isolated and poor women of tribal areas. The main constraining factors that have been identified are as follows:

- The health of women, especially reproductive women remains neglected in rural India.
- Facility is not available all the time i.e. for 24 hours.
- Tribal women are not aware about the importance of reproductive health.
- The cultural taboos and myths are still prevalent among them.
- Less care during reproductive or for any health problems.
- Prevalence of unhealthy health care practices.

There is a serious dearth of studies conducted on tribal women's reproductive health. Although, there are some studies that have been conducted on tribal women and their reproductive health, the main limitations of these studies is the approach used. Further many such studies are conducted on very small sample sizes, and therefore, largely insufficient to make any valid inferences.

1.5 Justification of the Study

1.5.1 Need and Significance of the study on Reproductive Health

Reproductive Health is a crucial part of general health and an essential feature of human development. The need for Reproductive Health care, including family planning, does not diminish during or after crises; rather, the need grows, while supply diminishes. Yet the health delivery system, including health care providers, donors and NGOs, often relegates family planning to a second- or third-tier intervention after the more "urgent" needs of a population are met. It is because of this attitude that the "Reproductive Health" of women is either neglected grossly or it suffers to a great extent, especially amongst rural women and tribal women who are even for or distantly located physically.

Reproductive Health Surveys (2002-04) reveal that half of the girls between 15-19 years of age have experienced childbirth or pregnancy; 80% of all deliveries are done at home; 8% of the women are suffering from Reproductive Tract Infections and 44% of the women in the reproductive age group are anemic. This is a grave situation and need attention from all concerned, the policy makers, the stakeholders, social activists, social scientists and the health care providers count as the vote banks or decision makers in policy decisions.

Central Bureau of Health and Intelligence reported that, the State of Rajasthan has one of the highest recorded maternal mortality rates (670 per 100,000 births) in India. The situation is due to poor socio-economic conditions, non-availability of trained health personnel in tribal areas and traditions surrounding marriage and childbirth. Eighty-five percent of deliveries in rural areas take place at home and most of the communities rely on a *"dai"* (traditional birth attendant) or relatives for delivery care (National Family Health Survey-2, 1998-99). There are approximately 56,225,000 women aged 15–19 years living in India, as of 2014. (UNDP 2012)

In tribal communities, illness and the consequent treatment is not always an individual and familiar affair, but the decision about the nature of treatment may be taken at the community level. In case of some specific diseases, not only the diseased person but also the total village community is affected. Health and treatment are very much connected with the environment. The traditional health care system and treatment are based on their deep observation and understanding of nature. The Tribal healer used different part of plants not only for treatment, but also even for population control. This knowledge can be fruitfully utilized in a wider context. (Nagda, 2004)

Table 2: Indicators of Maternal Care in Rajasthan

Delivery Care (for births in the 5 years before the survey): Indicators for Rajasthan (Urban and Rural 2015-16)		
Institutional births (%)	90.3	82.3
Institutional births in public facility (%)	7.6	65.1
Home delivery conducted by skilled health personnel (out of total deliveries %)	2.9	3.3
Births assisted by doctor/nurse/LHV/ANM/other health personnel (%)	92.8	84.9
Births delivered by caesarean section (%)	16.4	6.5
Births in a private health facility delivered by caesarean section (%)	28.8	20.4
Births in a public health facility delivered by caesarean section (%)	12.2	4.6
Delivery Care (for births in the 5 years before the survey): Indicators for Pratapgarh (Urban and Rural 2015-16)		
Institutional births (%)	89.3	89.5
Institutional births in public facility (%)	85.2	84.3
Home delivery conducted by skilled health personnel (out of total deliveries) (%)	1.4	1.5
Births assisted by a doctor/nurse/LHV/ANM/other health personnel (%)	90.4	90.8
Births delivered by caesarean section (%)	2.5	2.7
Births in a private health facility delivered by caesarean section (%)	*	35.6
Births in a public health facility delivered by caesarean section (%)	1.1	1.0

Source NFHS 4 Data (2015-2016)

It can be easily said that despite the above data, the woefully miserable health conditions and the quality of health care services available to the pregnant women and the new born infants in most of the states in India, call for urgent action from a number of fronts. These include strengthening of the primary health care system in the country, especially in the rural and tribal areas, improving the efficiency and acceptability of the system and when the system falls short of the stipulated norms to take appropriate and timely action to remedy the system. The future of the country will be permanently and irreparably compromised if urgent measures are not taken in these dimensions in order to improve the health conditions of the pregnant women and the new born. Statistics to prove these points are available a plenty but for some reason or the other

the needed actions are not forthcoming. It may be because they are a real minority when it comes to their ratio compared to the overall population of the state or region they belong to and thus for the government have already set some policies and scheme for their health betterment, which is unfortunately remain negligible.

While teachers and facilitators may have the necessary information on reproductive anatomy and Reproductive and Sexual Health (RSH) issues, they often face personal and situational hurdles in being able to start a discussion on these sensitive issues that are evidently seen as taboo in villages and tribal areas. Since many villages are remote and hard to reach, RDI has been working simultaneously on increasing access to health services and mobilizing the communities. Trained women volunteers at village level go from house to house providing information about health, making referrals and delivering contraceptives in their communities. Despite 35 percent of the population being in the 10-24 age groups, the health needs of adolescents have neither been researched nor addressed adequately. Particularly their reproductive health needs are often misunderstood, unrecognized or underestimated. Limited research in that area shows that the incidences of unplanned and forced pregnancies among them is rising and most of them face the risk of induced abortions under unsafe conditions, and contracting sexually transmitted infections including HIV (UNDP,1999).

This can be real serious issues as mostly the women in the world constitute about fifty percent of the total population and an unhealthy women population.

Some studies have been conducted on reproductive health but a comprehensive study is needed to find out the existing knowledge of the women, the prevalent practices and their attitudes about reproductive health and to assess their existing health conditions. According to a report by United Nations Fund for Population, “In India adolescents (10-19 years of age) account for one fifth of the population and are in great need of information and services on sexual and reproductive health”. This is very crucial and needs lot of attention on the part of all women’s health improvement with the help of academicians, social activists’ health care personal, government and non – government functionaries.

The precise configuration of Reproductive Health needs and concerns, and programmes and policies to address them, will vary from country to country and will depend on an assessment of each country's situation and the availability of appropriate interventions. Globally, however, both the epidemiological data and the expressed wishes of diverse constituencies indicate that reproductive health interventions are most likely to include attention to the issues of family planning, STDs prevention and management and prevention of maternal and perinatal mortality and morbidity. Reproductive Health education and awareness should also address issues such as harmful practices, unwanted pregnancies, unsafe abortions, reproductive tract infections including sexually transmitted diseases and HIV/AIDS, gender-based violence, infertility, malnutrition and anemia, and reproductive tract cancers. Appropriate services must be accessible and include information, education, counseling, prevention, detection and management of health problems, care and rehabilitation. This should be taken care of during the adolescent years to protect further damage.

According to the data available (State Institute of Health and Family Welfare, 2008-09) the total health expenditure done by the Government of India was 4.2 percent of total GDP and it was also noted that amongst above expenditure per capita health expenditure was ₹503 for India wherein ₹287 allocated to Rajasthan. Apart from that the reformation of various sectors has also been initiated with various projects and schemes, listed below:

1. Deshi Ghee Scheme on First Delivery to Below Poverty Line women

It 100% State Govt. sponsored scheme, which was implemented in all the districts from 01.03.2009. In this scheme provision of 5 liter Saras Deshi ghee as a token of gift. The beneficiaries of this scheme were BPL Families and women for their first delivery. Provisions were made through medical officer in urban and ANMs in rural areas. In this scheme a desi ghee coupon was provided at the time of discharge from hospital indicating dairy booth number.

2. Sanjivani scheme - specialist services in tribal and desert areas through health camps

3. Swasthya Chetna Yatra
4. Rajasthan Janani-Shishu Suraksha Yojana (RJSSY) assures NIL out of pocket expenses in all Health for Women & Newborns

(State Institute of Health and Family Welfare, 2011) www.sihfwrajasthan.com

These schemes were introduced to benefit rural as well as tribal people, below poverty line. Unfortunately, due to some malpractices and poor provision to all the beneficiaries the loophole was found from the various evidences in all related health matters. The present study is an effort in the direction of presenting the Reproduction Health woes related knowledge of the tribal women from their own perspective and an initiative to provide a grass-root, practical and planned solution. Through its well-researched and methodical approach, this study earnestly yearns to create a supportive environment that would positively influence knowledge and perceptions, of adolescent girls and young tribal women and may also help in increasing access and use of sexual and reproductive health services.

After reviewing the available literature, the following components of Reproductive Health Education were found crucial about which it was felt that knowledge and awareness should be created among tribal women under study mean achievement score in pre-test and post-test regarding:

- Qualitative reproductive health care
- Safe nurturing environment during pregnancy and lactation
- Safe sex and motherhood
- Unwanted pregnancy and abortion or Medically terminated pregnancies
- Sexually Transmitted Diseases
- Reproductive Tract Infections
- Taking advantage of services available for them related to reproductive health.
- Family planning and care

Though in the last few decades the efforts were being made and attention has been drawn to Reproductive Health of women still there is a need to reach out to the grass –root level reproductive health concerns of women. For combating the above problems, it is necessary to empower women physically, socially and emotionally with

regards to reproductive health concerns. The present study aims to fulfill this important requisite also in a simple yet systematic way.

The importance of education as one of the most powerful means of bringing about socio-economic development of the Scheduled Tribes cannot be over-emphasized. As educational development is a stepping-stone to economic and social development, and the most effective instrument for empowering the tribals (Ministry of Tribal Affairs 2017).

1.5.2 Justification for the Sample (Tribal Women)

Women have the right to the enjoyment of the highest attainable standard of physical and mental health. Good health is essential to leading a productive and fulfilling life, and the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment. However, health and well-being elude the majority of women.

--From the Beijing Platform--1995

The role of women in society is influenced by a complex set of traditions, customs, and values. Since they hardly wield any power, women face disadvantages relative to men in all spheres of life. In addition, they are often victims of gender-based violence that directly affects their reproductive health, and they suffer silently by adjusting to the situations as dictated by cultural norms.

Sant (2006) stated that a woman who fulfill multifarious responsibilities daily without any hue and cry, is mother, wife, and sister providing food for her family's wellbeing as well as an in-charge of natural human resources management which ensures future food security for her family. She does not hold apparent and any discrete identity of her own on world platform but undoubtedly perform the most arduous and time-consuming work behind the behind the curtain without much resources and newer innovations.

Although, they are the kingpins of their families in the sense she does all the multiple productive functions from bearing the children to performing household

chores, their role has often been underestimated or worse ignored. In the rural or tribal villages, they are still confronted with real difficulties of overburdening.

The crucial part of Indian women's life is to get married with a person and give birth to children. Moreover, they have the right to have a healthy and safe sexual life as well as a healthy reproductive health. Because of their ignorance in the society, they are suffering from the problems of their reproductive health matters, like abortion, unsafe motherhood, unsafe sex and reproductive tract infections and there is a strong need to make them aware about their reproductive health care so that they can improve their reproductive health and can have a safe and enjoyable life. Therefore, the study was planned with the tribal women of Pratapgarh District of Rajasthan.

The Reproductive Health of tribal women has acquired permanent significance as an issue in India. Where, the tribals occupy sizeable proportion of the national as well as regional proportion. The irony of reproductive health development of women's outcome is that, the most of the tribals are getting worse off with their health conditions due to the lack of use of health care services by them, even in the regions which have witnessed monumental urban and industrial development. Regional development projects have inevitably led to encroachment into tribal areas which were once considered remote and inaccessible. Yet they are not paid due attention when it comes to Reproductive Health Education or Awareness regarding the various pertinent Aspects of Reproductive Health Education viz: menstruation, and care, pregnancy and care, STDs and RTIs and Family planning matters.

The selected six tribal dominated areas have fairly large amount of tribal population in Rajasthan. Women in Rajasthan, tribal areas still consider home to be the safest place for deliveries, are afraid of using contraceptives and don't get their children immunized. This leads to the poor level of health care among women in the region.

Amongst the tribal woman delivery is usually carried out without the assistance of a midwife and the mother herself cuts her umbilical cord. This is a tradition and they have their own general beliefs. Tribal women do not have modern health care facilities, as compared to the rest of the population. Their own belief, illiteracy,

poverty, non-access to scientific information leads to this low health modernity status. Obviously, it might lead to maternal as well as child mortality and high mortality rate amongst the tribal population in India. Similar crude births practices are normally found to exist in other tribal groups in India.

Hence with this background all the above problems it is really necessary to use a participatory approach to make tribal women aware regarding their reproductive health matters. Therefore, the tribal women would be selected as respondents and beneficiaries for action research issues and concern for the present study.

1.5.3 Justification of the Instruction Education and Communication (IEC) Package

A reproductive health educational package can provide a supportive environment that enables all the selected women to enrich and enhance their sexual and reproductive health. The sexually healthy women can develop a healthy home, society at large and community. The level of sexual health is reflected in the general health of women. Reproductive health is interconnected with who we are and how we live. The good reproductive health of women, whether they are normally active or not, is a common characteristic they share as humans, which is a common thread weaving through the fabric of life, and for health pregnancy.

This effort of developing a package addresses the relationships between reproductive health and communities by examining two sub-points: factors that determine reproductive health and why reproductive health is important to a woman. There are some factors that determine the reproductive health of women.

After reviewing all the studies and available literature, and keeping in mind all the factors that determine the need of awareness about reproductive health to the women. Sexually transmitted infections, unintended pregnancies, a greater number of low-birth weight babies and sexual violence, are some of the symptoms of poor sexual health for which we pay a price—as individuals and as a community.

With this background, it can be pointed out that awareness on overall aspects of Reproductive Health altogether only fulfills the need of overall development of women

with regards to reproductive health. An IEC package (which will include almost all the aspects of reproductive health of women) will definitely provide proper environment and an authentic source to improve the quality of Reproductive Health of women. Hence the present study has been planned to develop an educational package for reproductive health of tribal women to create awareness of Reproductive Health care aspects. This complete Information Education and Communication package can be an effective source to impart "Reproductive Health Education" in such a way to improve their knowledge as it may be work and be able to fulfill as to:

1. Give accurate, clear, simple information related to various reproductive health concerns.
2. Delivering information through illustrative talk, group discussions and so on with the greeting, comprehension and acceptance of that information.
3. Listening and learning from researcher as it imparts information to understand their values, attitudes, beliefs, practices and personal/family as well as community situations on part of Reproductive Health.
4. Motivating people to adapt and correct practices and follow appropriately within the context of their personal and social life.

1.5.4 Justification of Variables

Variables included in the study were selected on the basis of extensive review of literature and discussion with experts in the field. This part deals with the measurement procedures followed in the study of various variables involved in the present investigation. The Table describes the variables under study and the instruments (either adopted or developed) used for the purpose. A list of variables studied along with tools used for their measurement is given below. The selected variables were put into a conceptual framework in following table:

Table 3: Variables Selected for the Study and Their Measurements

Variables	Measurement
1.5.4.1 Independent Variables (Socio-Personal Variables)	
i. Age	Chronological Age of the respondent
ii. Education	Interview Schedule developed
iii. Marital Status	Interview Schedule developed
iv. Monthly Family Income	Schedule developed
1.5.4.2 Dependent Variables	
i. Knowledge of the Respondents	Interview Schedule developed
ii. Information Gain	Interview Schedule developed

Operationalization of Variables

1.5.4.1 Independent Variables

They are as follows:

i. **Age of the respondent –** Age is the most important variable which affects overall knowledge of the respondents directly. A girl of the age group of 15-20 years can have lack of awareness about reproductive health concerns. This may be because she may not have experienced the life events, whereas the women or girls from the age group of 21 years and more may have more or less knowledge regarding reproductive health concerns. This is so because; they may have experienced various phases of reproductive lifecycle in the past years as compared to the women belonging to the younger group.

Apart from this when a girl belongs to the younger group or between the age group of 15-20 years sometimes has less or no family responsibilities, they spend most of the time in playing or spend time with peer group and engage in some recreational activities and is free from the other responsibilities like child bearing etcetera, so they may have less or low knowledge and awareness regarding their Reproductive Health matters. Whereas, women who are at the age of 22 years and above and also married have their sexual life as well as they have to fulfill the

responsibilities like child bearing etcetera. Moreover, at this age generally women get mature enough; hence they may have more knowledge about reproductive health matters.

In spite of that the women of older age group may have practical experiences towards reproductive health matters, whereas the younger women do not have the practical experience of life especially related to their reproductive matters, this can be other reason to have less knowledge about their reproductive health concerns.

On the basis of all the above statements, it can be said very clearly that the age of the respondents affects the knowledge level of the respondent.

ii. **Education of The Respondent –** Whether the respondents are more educated or less educated, this has remarkable impact on the knowledge level of the respondents. If respondents have education level up to primary and / middle level they have lack of exposure with books of courses (containing knowledge about basic reproductive health care), as compared to the knowledge level of the respondents having education level up to or more than secondary, higher secondary or graduation level.

Higher education means greater exposure, orientation and interacting of women with the world and thereby increasing the awareness regarding reproductive health. Thus, they may adapt more easily to the change, resulting in the advancement for a better quality of life, whereas, the awareness level of the uneducated or less educated women mostly remain confined to whatever they uptake or understand from their surroundings resulting in limited and poor awareness regarding reproductive health. Because at the higher education level the course content itself contains some very basics about the reproductive health care so the women or girls who are taking advantages of this will be more aware about reproductive health matters as compared to the women or girls who are having less education or no education. Because if they far from the books or other literature they will not come across information which has been given in the literature. Hence, the education level can also affect the knowledge of the respondents regarding reproductive health concerns.

iii. **Marital Status of the Respondents –** Marital Status may affect determined by the knowledge level of women. The married women may have practical experience of life towards their sexual health or reproductive health, but the females, who are not

married and do not have any sexual relationship, they may have less knowledge or less awareness about the problems. Either the unmarried have more knowledge due to the higher education or more exposure as compare to married women or the peer group may also be the source of information. In other words, the married women sometimes have gone through all the necessary information like gap between two children, family planning methods, Sexually Transmitted Diseases, whereas the unmarried women may not pass through all this information, especially of rural and tribal areas, this could be the other reason among many. Marital status of the respondents affects the knowledge about Reproductive Health concerns. Because, if women are unmarried then they have less knowledge about sexuality, care during pregnancy, lactation and so on, as compared to women who are married or have one or more number of children. Therefore, it is important variable of the study.

iv. **Monthly Family Income of the Respondents:** Family income was operationalized as the total earnings of the family in terms of money including farm and off-farm income per month which provides them with the main source of livelihood and income for their families. Family income of respondents may have direct impact on accessibility to any of the services for the daily life. With high income, accessibility to almost every requirement can be fulfilled, whether it is related to the health care sector or any essential such services. On the other hand, approaches to the necessities may not take place in the state of low family income. Family income may also be responsible to affect the Reproductive Health of women, especially at the time of care during maternity, post-natal care, eating pattern, standard of living etcetera. Hence this variable was also included in the present study.

1.5.4.2 Dependent Variables

I. Knowledge of Tribal Women on Reproductive Health Aspects

Learning is defined as the process by which an organism, as a result of its interaction with the environment in a situation, acquires a new mode of behaviour, which tends to persist and affect the general behaviour pattern of the organism to some degree. Learning may involve positive changes in awareness and knowledge, skill and attitude of the people. The present study aims to find out the information gain from Information

Education and Communication Package on the objective of overall effectiveness of Developed Information Education and Communication Package on Reproductive Health Aspects viz; Stages of Reproductive Health, Maternal Care, STDs and RTIs and Family Planning.

An interview schedule to test the knowledge was prepared based on the 'standardized test' procedure to test the level of knowledge of tribal women regarding the four key areas of women's Reproductive Health. The items of the schedule were pre-tested and necessary changes was being made. Statements, which are clear, specific and scalable and could, discriminate between high and low level knowledge groups, will be retained. Equal weightage was given to all items assuming that all the items included will be equal in difficulty to understand, apply and recall.

Four specific aspects of woman's Reproductive Health have been identified for studying the level of knowledge of tribal women. The details of these aspects are given in the methodology chapter.

i. **Stages of Reproductive Health:** This is given an important place in package of health care system. Tribal women need to give special attention to their diet and personal hygiene during menstruation, menopause as well puberty and adolescence, as the reproductive period is the most crucial period of foundation for their reproductive lives. Creating awareness among tribal women about menstruation process, menopause, personal hygiene and consulting doctors in case of medical emergencies are again is an important aspects of tribal women's health care.
ii. **Maternal Care:** Antenatal care is the care of women during pregnancy. It includes taking care of the pregnant women soon after conception, providing antenatal medical check-ups throughout the pregnancy and preparing the women for safe motherhood. It includes promotion, protection and maintaining the health of the mothers during pregnancy in order to achieve at the end of the pregnancy a healthy mother and a healthy baby. It also includes detection and foreseeing of complications and preventing them, in addition to administering iron folic acid tablets and calcium tablets for the pregnant women to take care of anemia, and immunization against tetanus. The intra-natal care includes adoption of 'five-

cleans' during the delivery of the child, taking care of the health of the newborn and the new mother.

iii. **Sexually Transmitted Diseases / Reproductive Tract Infections:** Mostly women were not at all aware of the sexually transmitted diseases (STDs) and Reproductive Tract Infections (RTIs) and their control. So, awareness of STDs / RTIs problem is necessary, especially: awareness about Sexually Transmitted Diseases and Reproductive Tract Infections, awareness of symptoms of STDs/RTIs, seeking medical advice for STDs/ RTIs, sex education during adolescence, and awareness about dangers of STDs/ RTIs. Anyone who is sexually active can get STDs/ RTIs unless if she or he does not take adequate care of personal hygiene and healthy sexual practices. Ignorance about sexual hygiene may be some of the reasons for problems to arise in sexual relations between couples. Reproductive Health education needs to be given in schools to increase awareness about sexually transmitted disease, only to help our youth escape the dangers of falling as victims due to ignorance.

iv. **Family Planning Methods and Contraceptives:** This aspect is defined as the covert behaviour of collecting information, and thereby enhancing knowledge on various family planning methods and contraceptives from different mass media and interpersonal communication channels and overt behaviour of adopting these family planning methods and contraceptives. In addition, it also includes all the practices and knowledge regarding the advantages of family planning, ideal family size, and ideal age at marriage, ideal age at first pregnancy. This also includes awareness of the dangers of pregnancy after 35 years of age. This also includes the knowledge of and practice of maintaining ideal space between two pregnancies in order that both the mother and child are hale and healthy. This helps the new mother to recuperate her health in the ensuing period and also enables the mother to provide proper care and nourishment to the newborn. The ideal spacing between two births is two and a half-year to three years.

II INFORMATION GAIN: is operationally defined in this research as gain in knowledge by the respondents after the exposure to the developed Reproductive Health Package and its various aspects. A standardized interview schedule was developed which included of various Reproductive Health aspects viz; Stages of

Reproductive Health, Maternal Care, RTIs and STDs and Family Planning. With the help of this interview schedule gain in knowledge was assessed on various mentioned aspects

On the basis of above discussions some research questions arise which are as follows:

- Do women (especially, tribal women) be able to know more about their Reproductive Issues?
- Can an Instructional Educational Package covering almost all the necessary facets of Women's Reproductive Health, be able to contribute to their knowledge?
- Do the electronic media and print media produce remarkable impact on tribal women?
- Are the Reproductive Health practices followed by tribal women affects adversely their health?

To seek the answer of above emerged questions some developmental means should be arranged in such a way, so the overall health development (especially of tribal women: who is somehow neglected part of the society) can be taken place. The present study has been planned to understand and study the Reproductive Health status, needs and concerns of tribal women in a structured and planned manner to bring out important revelations. The results of the study can inform existing policies and programmes besides filling up the void in essential knowledge and information about the reproductive health of these women. Despite all, another motto of the study is to impart them with essential knowledge about various facets of reproductive health of women like how a woman have periods (the complete process), what should be followed during periods, how a woman conceives, process of childbirth, nutrition during and after pregnancy, various contraceptive methods etcetera.

As to work with tribal women knowing the majority of respondents are illiterate, it is important that they must be educated with some responsive way so that they gain effectively. Many of the researches conducted either by some researchers or by some developmental agencies, it is already proved that such people should be educated with the help of various IEC materials. In the present investigation, researcher tried to develop a complete package covering important Reproductive Health aspects. Once it

is being developed its effectiveness also being checked with the help of structured interview schedule and various statistical analyses. Before this it is mandatory to illustrate an active plan of work so that it can be effectively implemented with its action plan. Keeping in mind present investigation has been planned with following topic and objectives viz;

1.6 Statement of Problem

"Effectiveness of Developed Reproductive Health Package for Tribal Women of "Kerwas" Village of Pratapgarh District" (Rajasthan, India) and Identification of Their Reproductive Health Practices".

1.7 Objectives of the Study

1.7.1 Broad Objective

To Develop Information, Education and Communication Package on various selected "Reproductive Health" aspects for Tribal Women and to check its effectiveness in terms of gain in knowledge.

1.7.2 Specific Objectives

1. To prepare Profile of the selected Respondents.
2. To identify Reproductive Health Practices prevalent amongst selected respondents.
3. To develop an Information, Education and Communication package on following selected "Reproductive Health" aspects:
    A. Stages of Reproductive Health
    B. Maternal care
    C. Sexually Transmitted Diseases/Reproductive Tract Infections
    D. Family planning
4. To study the overall effectiveness of developed Information Education and Communication Package on following selected "Reproductive Health" aspects:
    A. Stages of Reproductive Health
    B. Maternal Care
    C. Sexually Transmitted Diseases/Reproductive Tract Infections
    D. Family Planning

5. To study the overall effectiveness of developed Information Education and Communication Package on selected “Reproductive Health” aspects in relation to following selected variables:
    A. Age
    B. Educational Status
    C. Marital Status
    D. Monthly Family Income

6. To study the effectiveness of developed Information Education and Communication package on “Stages of Reproductive Health” in relation to following selected variables:
    A. Age
    B. Educational Status
    C. Marital Status
    D. Monthly Family Income

7. To study the effectiveness of developed Information Education and Communication package on “Maternal Care” in relation to following selected variables:
    A. Age
    B. Education
    C. Marital Status
    D. Monthly Family Income

8. To study the effectiveness of developed Information Education and Communication package on “Sexually Transmitted Diseases and Reproductive Tract Infections” in relation to following selected variables:
    A. Age
    B. Education
    C. Marital Status
    D. Monthly Family Income

9. To study the effectiveness of developed Information Education and Communication package on “Family Planning” in relation to following selected variables:
    A. Age
    B. Education
    C. Marital Status
    D. Monthly Family Income

10. To study the reactions of selected respondents on various media developed on various selected “Reproductive Health” aspects.

1.8 Assumptions of the study

1. An Information Education and Communication package covering all the selected “Reproductive Health” aspects can be developed to impart knowledge among the selected tribal women.
2. Tribal women can be able to gain knowledge on various “Stages of Reproductive Health”.
3. Tribal women can be able to gain knowledge on “Maternal Care”.
4. Tribal women can be able to gain knowledge on “Sexually Transmitted Diseases and Reproductive Tract Infections”.
5. Tribal women can be able to gain knowledge on “Family Planning”.

1.9 Null Hypotheses (H_0)

There will be no significant difference in the mean achievements score of the respondents in pre-test and post-test. Since an Instructional Educational and Communication Package consists of four components in order to test their effectiveness the following null hypotheses was formulated for each “Reproductive Health Aspects”.

1. There will be no significant difference between the mean achievement scores of pre-test and post-test of the respondents of selected “Reproductive Health Aspects”.

2. There will be no significant difference between mean achievement scores of the respondents regarding selected "Reproductive Health Aspects" in relation to following selected variables:

A. Age

B. Education

C. Marital Status

D. Monthly Family Income

3. There will be no significant difference between the mean achievement scores of pre-test and post-test of the respondents of the selected "Reproductive Health Aspects" viz:

A. Stages of Reproductive Health

B. Maternal Care

C. Sexually Transmitted Diseases and Reproductive Tract Infections.

D. Family Planning

4. There will be no significant difference between mean achievement scores of pre-test and post-test of the respondents regarding "Stages of Reproductive Health" in relation to following selected variables:

A. Age

B. Education

C. Marital Status

D. Monthly Family Income

5. There will be no significant difference between the mean achievement scores of pre-test and post-test of the respondents regarding "Maternal Care" in relation to following selected variables:

A. Age

B. Education

C. Marital Status

D. Monthly Family Income

6. There will be no significant difference between mean achievement scores of pre-test and post-test of the respondents regarding "Sexually Transmitted Diseases and Reproductive Tract Infections" in relation to following selected variables:
    A. Age
    B. Education
    C. Marital Status
    D. Monthly Family Income

7. There will be no significant difference between mean achievement scores of pre-test and post-test of the respondents regarding "Family Planning" in relation to following selected variables:
    A. Age
    B. Education
    C. Marital status
    D. Monthly Family Income

1.10 Delimitations of the Study

1. The study is delimited to the tribal women only.
2. The study is delimited to the selected Reproductive Health aspects only.
3. The study is delimited to the "Kerwas" village of Pratapgarh district of Rajasthan only.

1.11 Operational Definitions

1.11.1 Reproductive Health Package

In the present investigation Reproductive Health Package implies with the combination of different Information, Education and Communication (IEC) materials with regards to different facets of women Reproductive Health viz; "Stages of Reproductive Health (Adolescence, Menstruation, Menopause etcetera), Maternal Care, Sexually Transmitted Diseases/ Reproductive Tract Infections and Family Planning (Methods and Contraceptives), to promote "increased availability of information and enhanced awareness of tribal women about Sexual and reproductive

Health" meet the unmet need of women lacking in proper "Reproductive Health" care, knowledge and practices.

The Information Education and Communication material comprises various educational Audio – Visual materials developed and combine all together according to the need and level of selected target group. Imparting knowledge among the selected target group is than taught with the help of this Instructional Educational Material such as Picture Cards, Posters, Booklet, Self-Learning Cards and various Electronic Media etcetera to compare the knowledge of target group before and after implementation of package. **(For Detail Refer Appendix 6)**

1.11.2 Standard Operational Definitions

1. **Reproductive Health:** Reproductive health is a state of complete physical, mental and social well – being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and process.
2. **Maternal Care:** the care of women taken before the delivery and after delivering the baby in concern with nutritional needs and health needs etcetera.
3. **Sexually Transmitted Diseases** – Sexually transmitted diseases (STDs) are diseases that are mainly passed from one person to another (that is transmitted) during sex. There are at least 25 different sexually transmitted diseases with a range of different symptoms. These diseases may be spread through vaginal, anal and oral sex.
4. **Reproductive Tract Infections** – Reproductive tract infections (RTIs) that includes all infections of the reproductive tract, including those not caused by sexual contact.
5. **Family Planning** – A programme to regulate the number and spacing of children in a family through the practice of contraception or other methods of birth control.