CHATER – 4

RESULTS AND DISCUSSIONS

This empirical research was aiming at investigating the effectiveness of 'Package Developed' covering all the aspects of Reproductive Health with implementation of IEC. Present investigation was an experimental study that piloted pre-test, implementation of intervention through (various methods and media such as electronic media, print media and educational games included in) IEC package followed by post-test. To strengthen in study, bivariate and multivariate analysis have been performed on post-rest findings to acquire precision. Reaction scale was administered to assess effectiveness of IEC package in terms of gain in knowledge and awareness created regarding various Reproductive Health aspects.

This section describes findings and discusses these findings in depth with existing literatures. The overview of descriptive findings immerged after applying statistical analyses has been categorized in four sections and further sub-sections. It has been illustrated in Figure 16 with various headings.

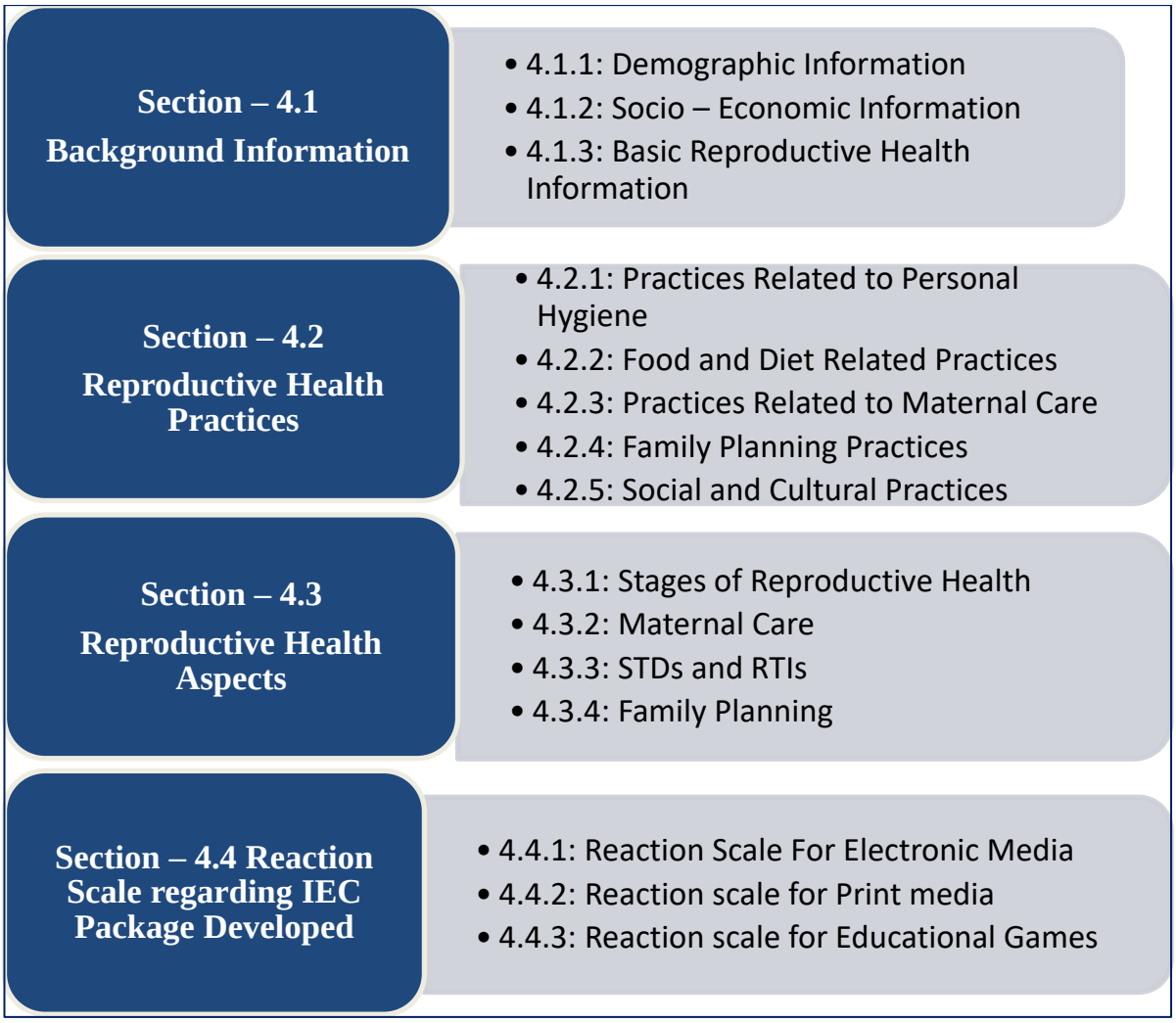

Figure 1: Categories of Findings of the Study

SECTION 4.1: Background Information

This section includes data related to demographic profile, socio – economic information and basic reproductive health information of the respondents.

4.1.1 – Demographic Information

4.1.1.1 Age

Table 1: Frequency and Percentage Distribution of the Respondents According to their Age (n=100)

S. No.	Age	*f*	%
1.	15 – 30 (Young age)	47	47
2.	31 – 45 (Middle age)	37	37
3.	Above 45 Years (Old age)	16	16

It was found that fourty seven percent of the respondents were from younger (15-30 years) age group, followed by 37 % were from middle age group (31-45 years)and only 16 % respondents were from old age group (45 and above) as depicted in Table 17.

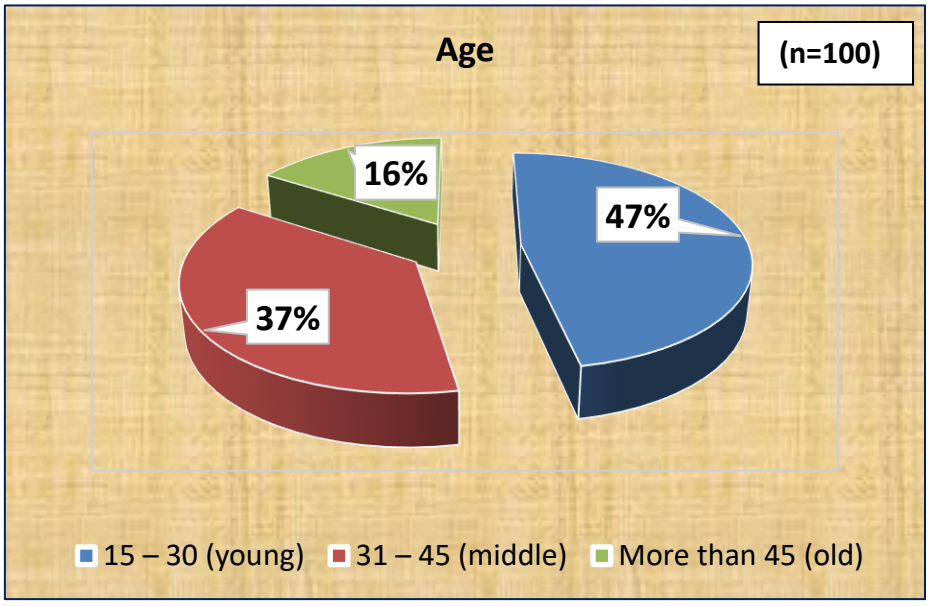

Figure 2: Percentage Distribution of the Respondents According to their Age

4.1.1.2. Education

Table 2: Frequency and Percentage Distribution of the Respondents According to their Educational Status (n=100)

S. No.	Educational Status	*f*	%
1.	Illiterate	58	58
2.	Up to 5th standard	6	6
3	6 – 8th standard	5	5
4.	9 – 10th standard	13	13
5.	11 – 12th standard	1	1
6.	Graduate and above	17	17

Table 18 shows a little more than half of the respondents (58%) were found to be illiterate. Very few respondents graduated i.e. 17% followed by 13% of the respondents studied till 10th standard.

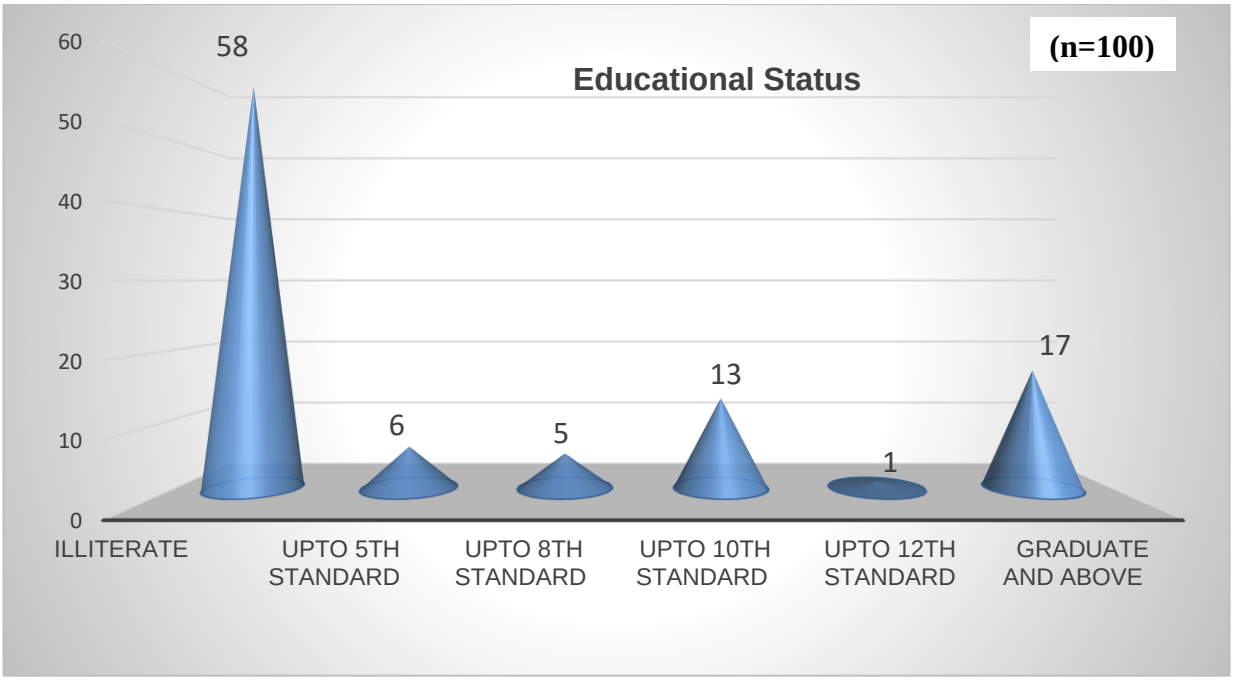

Figure 3: Percentage Distribution of the Respondents According to their Educational Status

4.1.1.3 Marital Status

Table 3: Frequency and Percentage Distribution of the Respondents According to their Marital Status (n=100)

S. No.	Marital Status	*f*	%
1.	Unmarried	22	22
2.	Married	74	74
3.	Divorced	0	0
4.	Widow	2	2
5.	Separated	1	1
6.	Kinship	1	1

Regarding marital status, it was found from Table 19 that a significant number of respondents (74%) were married. Twenty two percent of the respondents were unmarried. Negligible percent of the respondents were found either separated or having kinship. None of them were found divorced.

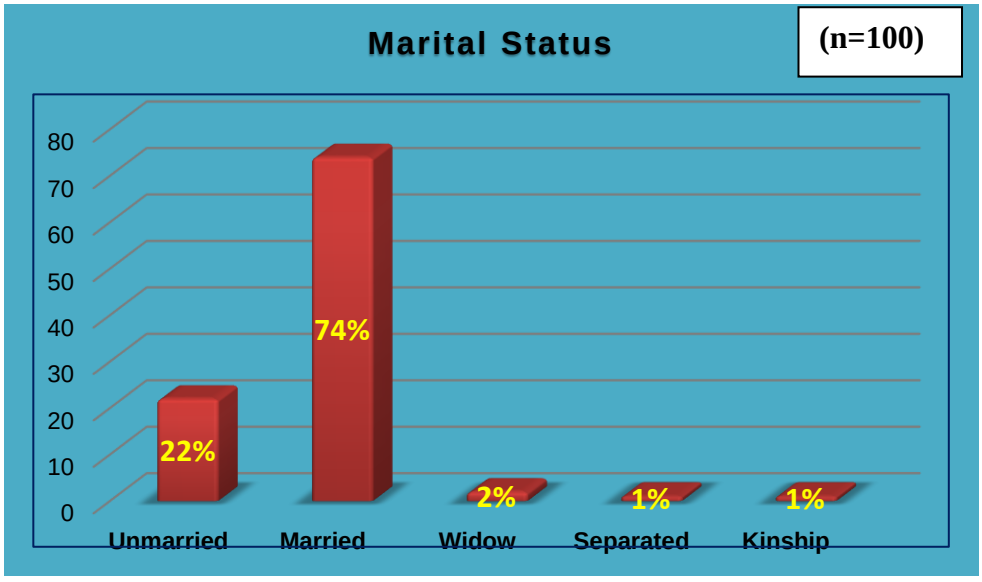

Figure 4: Percentage Distribution of the Respondents According to their Marital Status

4.1.1.4 Caste

Table 4: Frequency and Percentage Distribution of the Respondents According to their Caste (n=100)

S. No.	Caste	*f*	%
1.	Bhil	0	-
2.	Mina	100	100
3.	Garasia	0	-
4.	Gadia Lohar	0	-
5.	Any other	0	-

All of the respondents were found from Meena (a Fishy Clan) community from tribal population of Rajasthan. The whole village was found as tribal predominated village. None of the respondent belonged to any other caste or other tribal community. (Table 20)

4.1.1.5 Occupation of the Respondents

Table 5: Frequency and Percentage Distribution of Respondents According to their Occupation (n=100)

S. No.	Occupation	*f*	%
1.	Farming*	69	69
2.	Farm labor/ labor*	60	60
3.	Aanganwari worker	1	1
4.	Vegetable Vendor	1	1
5.	Grocery Shopkeeper	1	1
6.	Students*	29	29

**** Multiple Responses***

Table 21 depicted that majority of the respondents (69 percent) were doing farming, followed by the high percentage of the respondents who were also engaged as farm laborers. Data revealed that the respondents doing farming only at the time of availability of water as they were not having wells or other source of water. It was observed that no other water resource existing in "Kerwas" village to do farming and they had to depend on rainfall. Hence they were farm laborers on the daily wage basis. Apart from that it was also found that 29 percent respondents were students and they were found to be doing farming or labour work in others farm as and when they get free time or according to their financial needs.

A very small number of respondents having different occupations like they are ***aanganwari worker, shopkeeper*** or ***vegetable vendor.***

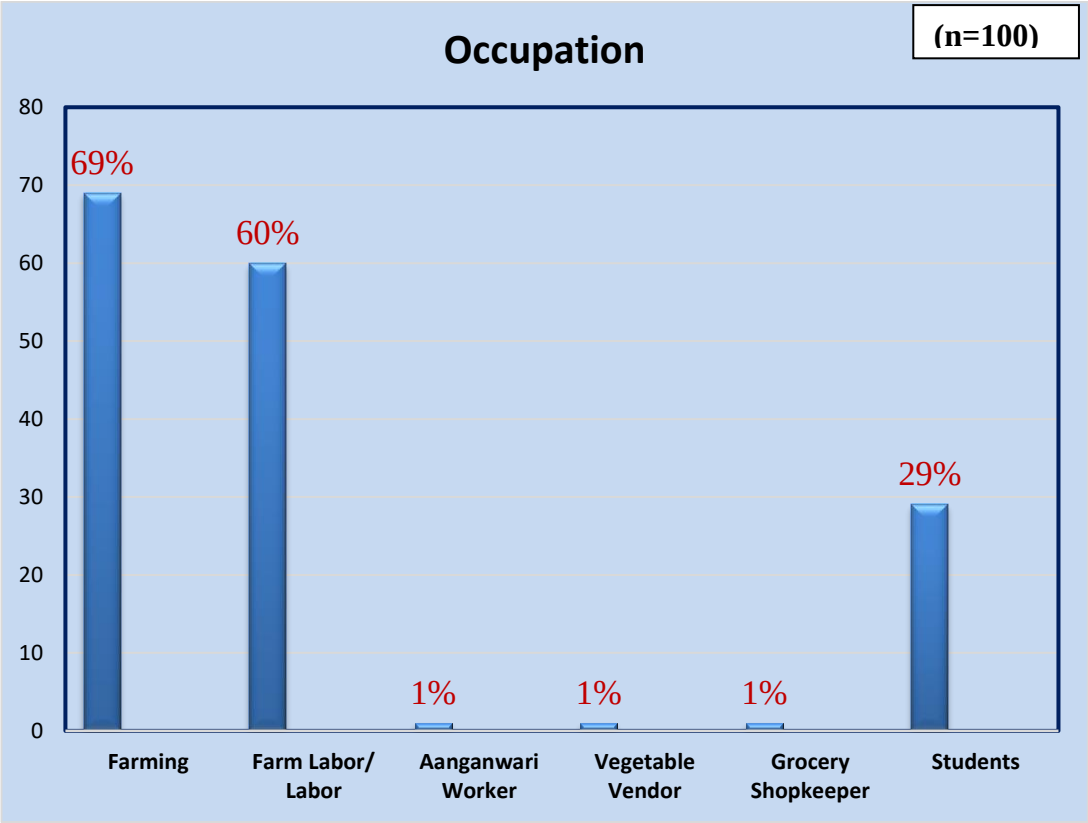

Figure 5: Percentage Distribution of the Respondents According to their Occupation

4.1.2 SOCIO – ECONOMIC INFORMATION

4.1.2.1 Family Type and Size of Family

Family Type

Table 6: Frequency and Percentage Distribution of the Respondents According their Family Type (n=100)

S. No.	Family Type	*f*	%
1.	Nuclear	57	57
2.	Joint	43	43

It is depicted in Table 22 that little above fifty percent of the respondents (57%) belonged to nuclear family and rest of them i.e. fourty three percent belonged to joint family.

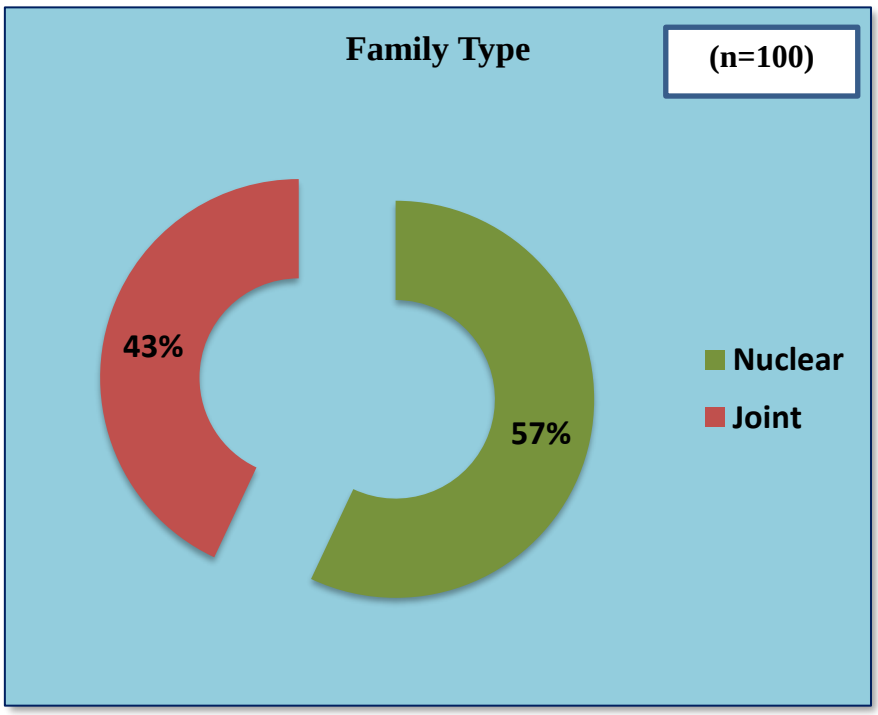

Figure 6: Percentage Distribution of the Respondents According to their Family Type

Family Size

Table 7 : Frequency and Percentage Distribution of the Respondents According to their Family Size (n=100)

S. No.	Family Size	*f*	%
1.	Small – (2 to 4 Members)	29	29
2.	Medium – (5 to 8 Members)	49	49
3.	Large – (Above 8 Members)	22	22

Almost half of the respondents (49%) were from medium size family having 5 to 8 family members in their family. While less than one fourth respondents (29% and 22%) belonged to small and large family size (respectively) as shown in Figure 22.

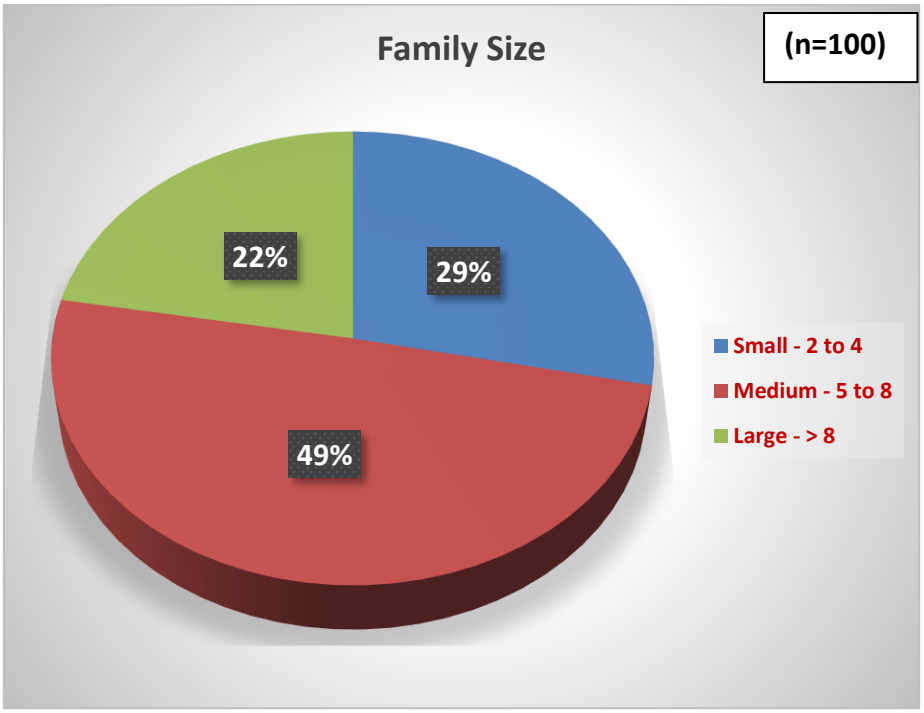

Figure 7: Percentage Distribution of the Respondents According to their Family Size

4.1.2.2 Type of House

Table 8: Frequency and Percentage Distribution of the Respondents According to their Type of House (n=100)

S. No.	Type of House	*f*	%
1.	Kachcha	59	59
2.	Mixed	8	8
3.	Pakka	33	33

More than half of the respondents (59 percent) owned ***Kachcha House***, whereas as more than one third respondents (33 percent) had ***Pakka Houses***. Table 24 further showed that very few of them i.e. eight percent possessed mix housing structure that is house having some portion of the house was ***pakka*** where rest of it was ***kachcha*** structure.

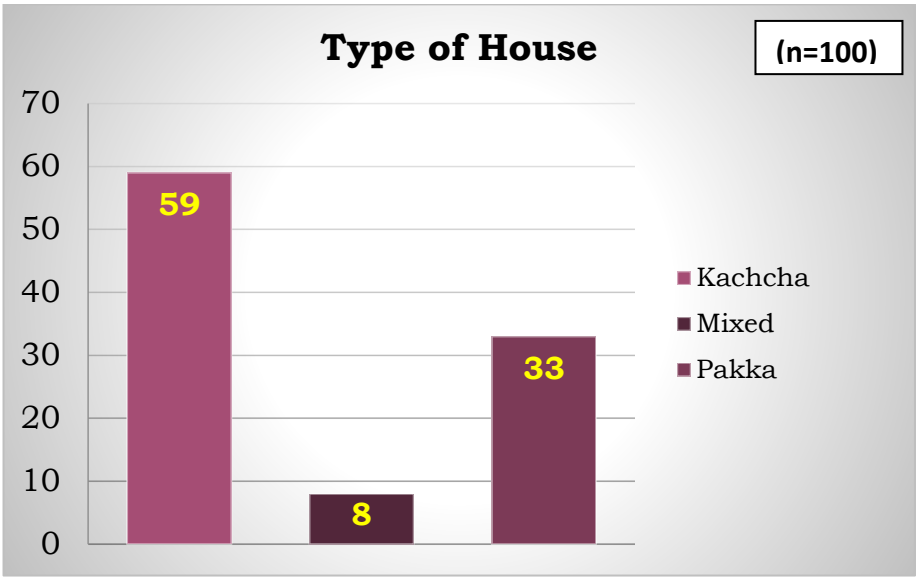

Figure 8: Percentage Distribution of the Respondents According to their Type of House

4.1.2.3 Monthly Family Income

Table 9: Frequency and Percentage Distribution of the Respondents According to their Monthly Family Income (n=100)

S. No	Monthly Family Income (in ₹)	*f*	%
1.	Up to 10,000 (Low Income Group)	63	63
2.	10,001 – 20,000 (Medium Income Group)	36	36
3.	More than 20,000 (High Income Group)	1	1

Regarding monthly income of family members of the respondents as shown in Table 25, it was found that majority of the respondents (63%) belonged to low income group, followed by 36 percent respondents belonged to medium income group. It was also observed that the respondents who belonged to high income group had more than one income source.

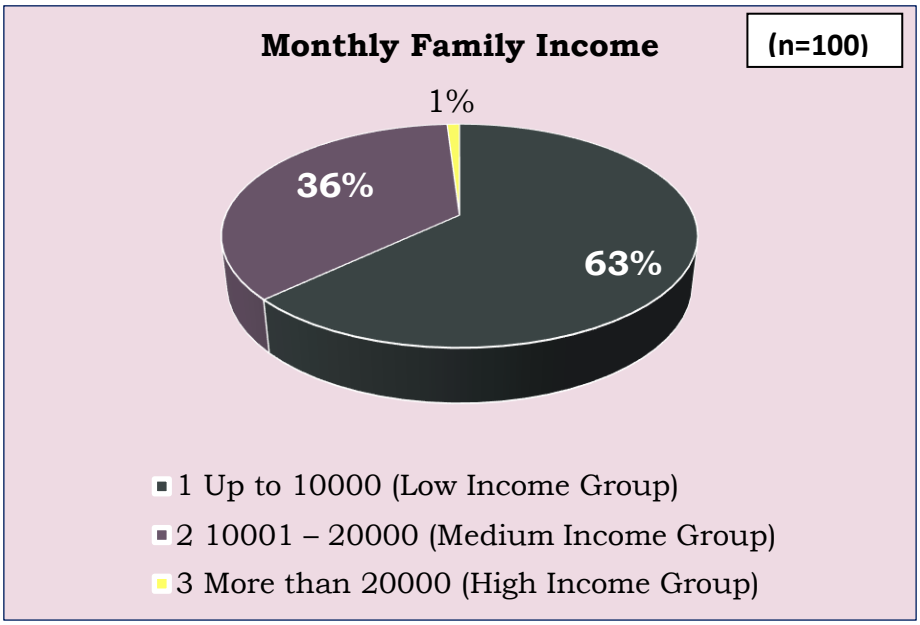

Figure 9: Percentage Distribution of the Respondents According to their Monthly Family Income

4.1.2.4 Landholding

Table 10: Frequency and Percentage Distribution of the Respondents According to their Landholding (n=100)

S. No	Landholding	*f*	%
1.	Landless	7	7
2.	Marginal (upto 5 *bigha*)	57	57
3.	Small Farmer (5.1 – 10 *bigha*)	27	27
4.	Medium Farmer (10.1 – 15 *bigha*)	7	7
5.	Large Farmer (above 15 *bigha*)	2	2

Table 26 depicted that more than half of the respondents i.e. 57 percent having farm land upto 5 *bigha*, followed by 27 percent who were having land 5.1 to 10 *bigha***.** Similar number of respondents was landless farmer with having no land in contrast to those medium farmers, who were having land 10 -15 *bigha.* Very few of them i.e. 2 percent were found to be larger farmer with land upto 15 *bigha* or more.

As it was also observed the respondents having farming land either doing farming or was working as farm labor in other's farm. The reason behind above findings could be that no crops were raised in their farm due to less rain fall in the area. As most of the farmers were depended on the rainfall and has no water well in their farm hence found to be not doing farming on their land.

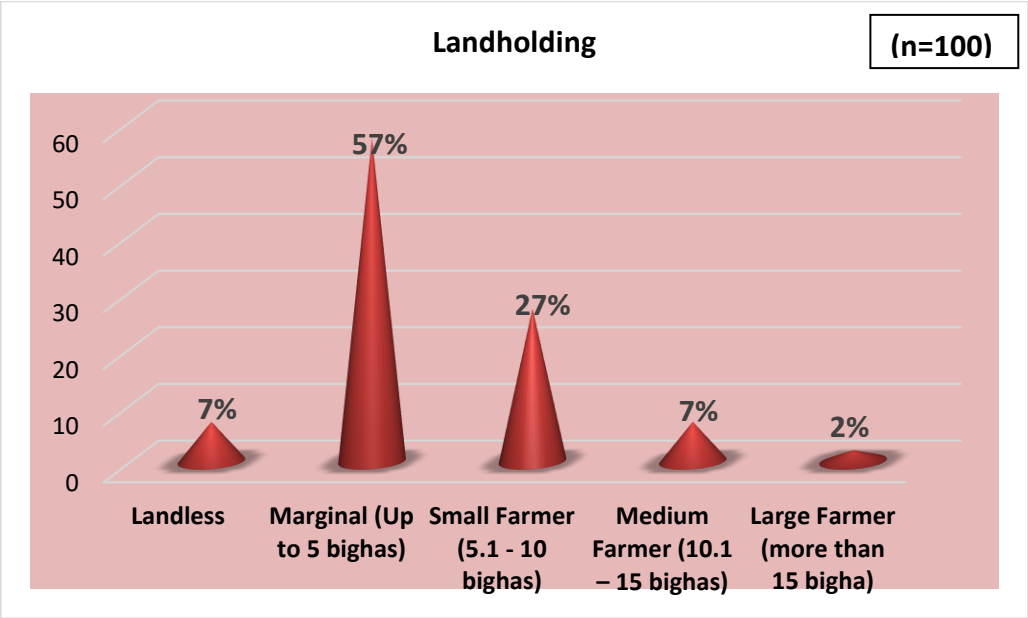

Figure 10: Percentage Distribution of the Respondents According to their Landholding

4.1.2.5 Media Accessibility

Table 11: Frequency and Percentage Distribution of the Respondents According to their Media Accessibility (n=100)

S. No.	Media Accessibility*	*f*	%
1.	No Media	37	37
2.	News Paper/ Magazines	1	1
3.	Radio / Transistor	6	6
4.	Television	22	22
5.	(Any Other) Cell phones	50	50

** Multiple Response*

Table 27 showed that fifty percent respondents having cell phone as media, whereas 37 percent respondent had accessibility to any media. Less than half of the respondents were having television as media i.e.22 percent. It was also observed that the respondents reported about the accessibility to cell phone, they were using either fall phones of family members, relatives or of their neighbors, very few of them possessed it as their own one.

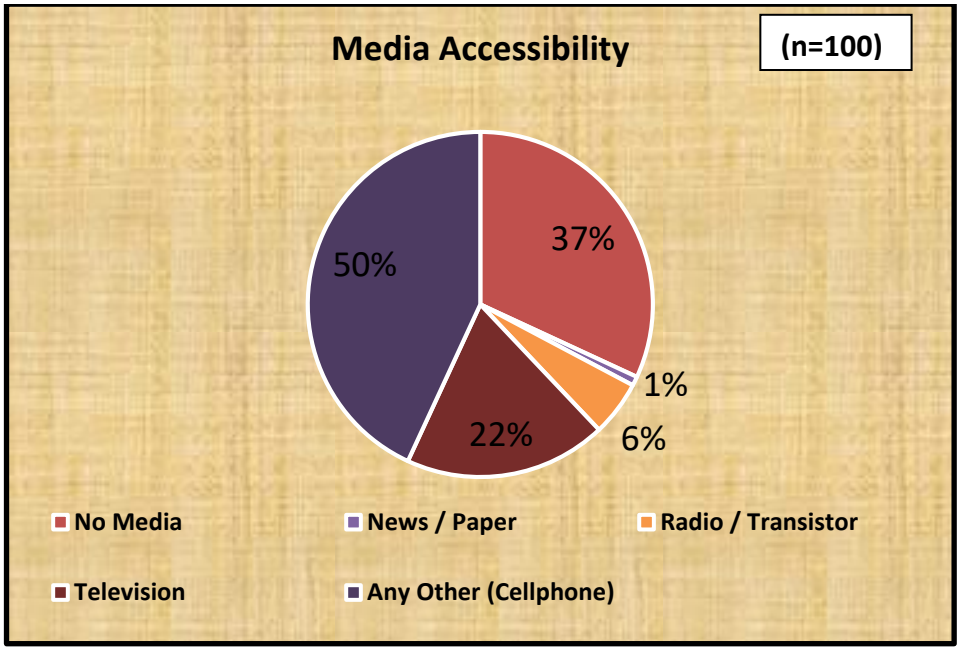

Figure 11: Percentage Distribution of the Respondents According to their Media Accessibility

4.1.2.6 Socio – Economic Status

Table 12: Frequency and Percentage Distribution of the Respondents According to their Socio - Economic Status (n=100)

S. No.	Socio – Economic Status	*f*	%
1.	Low Socio – Economic Status	88	88
2 .	Medium Socio – Economic Status	12	12
3 .	High Socio – Economic Status	0	0

Findings from Table 28 revealed that, a high majority of the respondents (88%) were belonged to low socio – economic status, whereas rest of the respondents belonged to medium socio – economic status. none of them were from to high socio – economic status.

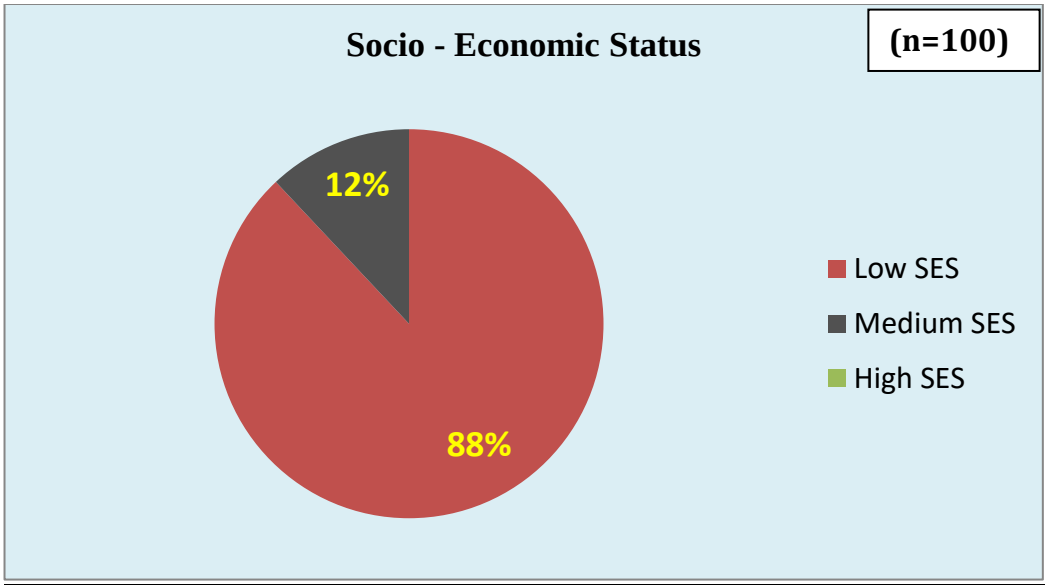

Figure 12: Percentage Distribution of the respondents According to their Socio - Economic Status

SECTION 4. 1.3 BASIC REPRODUCTIVE HEALTH INFORMATION

4.1.3.1 Information on Marriage and Pregnancy

Table 13: Frequency and Percentage Distribution of the Respondents According to their Age at the time of Menarche (n = 99)

S. No.	Statement	*f*	%
1.	Age at the time of menarche (in years)		
	• 11-14	59	59.59
	• 15-18	39	39.39
	• 18 and above	1	1.01

Menstruation plays a very important role in a women's life at this is the beginning of her reproductive years and she would be the mother of

tomorrow. Present study concludes (Table 29) that, almost sixty percent respondents got their menarche between the ages of 11 – 14 years, followed by 39 percent respondents who got their menarche between the ages of 15 – 18 years. Times of India (2014) reported that pediatrician in Goa are witnessing young girls reaching menarche at early ages of 8 and 9 years-as compared to 12 to 14 years a decade ago. While early menarche is now accepted the world over, whereas from the present investigation this age criterion had been changed and the standard age of menarche is declared as 12 – 14 years.

The reason behind the above findings may be the environmental changes, change in food practices, change in living standard of people and pattern of the livelihood. Moreover, the people living in the tribal area are more connected to the nature and their practices have remained unchanged to an extent. Hence this variation was found in the age of menarche of the respondents. Thakre et al. (2011) concluded that the mean age of menarche in the subjects of their study was 12.85 ± 0.867 years. The present study also revealed that the maximum respondents reported about beginning of menarche in the same age as per the other researchers.

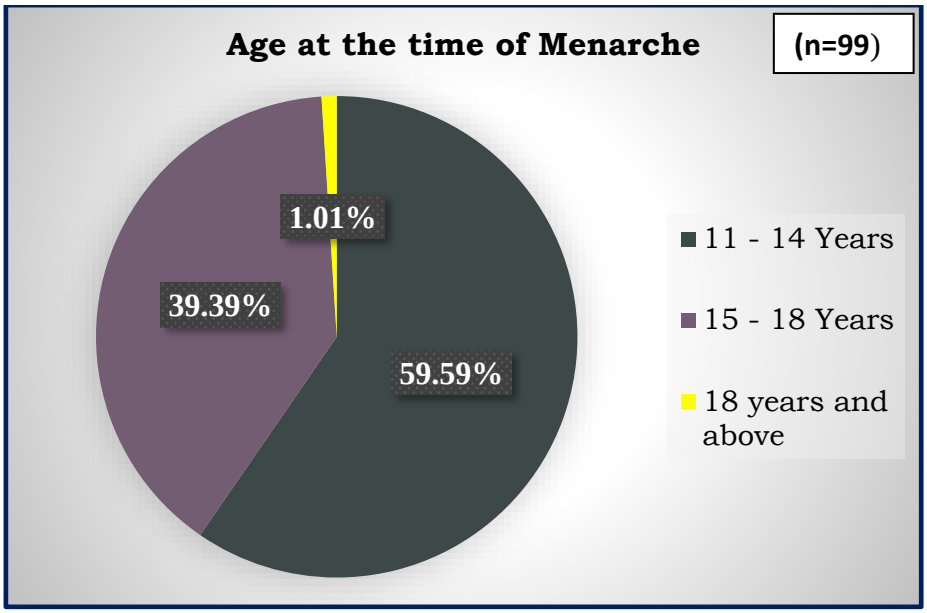

Figure 13: Percentage Distribution of the Respondents According to their Age at the time of Menarche

Table 14: Frequency and Percentage Distribution of Respondents According to their Age at the time of Marriage and Length of Marriage (n=78)

S. No.	Statements	*f*	%
1.	Age at the time of marriage (in years)		
	• 12-14	8	10.25
	• 15-17	31	39.74
	• 18 and above	39	50
2.	Length of marriage (in years)		
	• 0-10	23	29.49
	• 11-20	22	28.21
	• 20 and above	33	42.31

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Amongst married respondents Table 30 portray that 50 percent respondents were married by their legal age; in contrast to that 40 percent respondents got married before legal age.

It can be said on the basis of observation that the selected tribal women are living in the villages as they are not like tribal living in the forest areas

moreover they were more connected to the developed town since few decades. So, they may have avoided early marriages.

Another reason behind occurrence of few early marriages that, amongst married respondents' significant number of respondents were found as younger and most of them were illiterate yet they do believe in ANM and other local leaders. So, they avoided early marriages. On the other hand, they were also following their community rules and regulations hence some marriages took place before legal age was detected. However, no child marriages were found in the selected area.

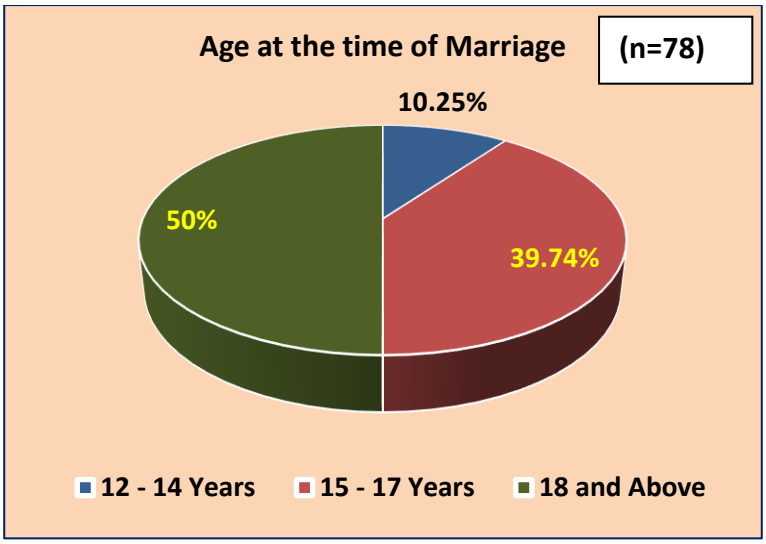

Figure 14: Percentage Distribution of the Respondents according to their Age at the time of Marriage

Regarding length of marriage, it was noted that less than half of the respondents i.e. 42 percent were married for more than 20 years. Almost similar numbers of respondents (29% and 28%) were found married for 0 to 10 years and 11 – 20 years respectively. It was already stated that more than half of the respondents were married and as per literature reviewed it can be said that in the rural and tribal India early marriages were highly prevalent. Thus, the majority of respondents (amongst married) were having long time span of their married life.

Table 15: Frequency and Percentage Distribution of Respondents According to Total Number of Conception (n=68)

S. No.	Statement	*f*	%
1.	Total number of conceptions		
	• 1-2	20	29.41
	• 3-4	33	48.52
	• 5 and above	15	22.06

Having frequent conception and frequent delivery may spoil or affect the Reproductive Health of a woman. But need of having more children or prevalence of a societal evil namely gender discrimination; force women to conceive again and again. In light of that, the present investigation revealed that 48 percent respondents conceived 3 – 4 times. 29 percent respondents conceived 1 – 2 times in contrast to that approximately 22 percent respondents conceived 5 times or more than that. Table 31, Figure 30

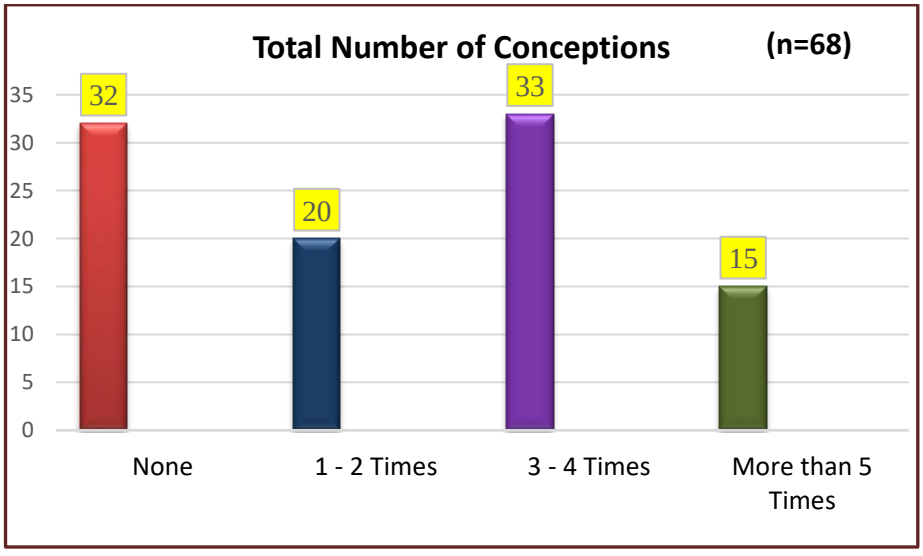

Figure 15: Percentage Distribution of the Respondents according to their total Number of Conception

Table 16: Frequency and Percentage Distribution of Respondents in Relation to Information about Pregnancy and Delivery (n=68)

S. No.	Statements	*f*	%
1.	Age at the time of first pregnancy (in years)		
	• 15-18	10	14.71
	• 18 and above	58	85.29
2.	Total number of deliveries		
	• None	1*	1.47
	• 1-3	35	51.47
	• 4-6	19	27.94
	• 6 and above	13	19.12
3.	Total number of still births		
	• 0-2	4	5.88
	• 2-4	-	
	• 4 and above	-	
4.	Total number of infants died		
	• 0-2	17	35
	• 2-4	2	2.94
	• 4 and above	1	1.47
	Reasons of infant death		
	• High fever	7	35
	• Pneumonia	4	20
	• Diarrhea and vomiting	3	15
	• Don't know	3	15
	• Tumor in backbone and ruptured hence died	1	5
	• Poisoning	1	5
	• Infection due to Injection	1	5

Pregnant women

It is revealed from table 32 that maximum respondents (85%) were found pregnant for the first time when they were 18 or above 18 years old. In contrast to that remaining 15 percent respondents had their first pregnancy at the age of 15 – 18 years. It was observed that some decades ago the concept of early marriages was prevalent. The present study revealed maximum marriages took place on or after the age of 18 years and more. According to the governmental norms the standard and matured age of marriage for female are 18 and their body becomes mature enough to conceive by this age or ready to bear a child (National Rural Health Mission, 2013).

Tribal Women have dual burden and responsibilities of farm and home in addition to that she has to take care and rare children in her life. As she carries babies in her womb with having bundle of difficulties and faces many prenatal dilemmas. Still some problems may occur due to some abnormal conditions which may later leads to the undesirable results. In the present investigation it was found that 35 percent respondents had death of their infants was about 0 – 2 in number. Only few of them viz. three percent and two percent respondents lost their infants 2 – 4 and more than 4 in number respectively.

Six percent respondents had still births. Accidents were the main causes of still birth of neonates (Table 32).

There were various reasons found behind infant death. More number of (35%) infants died due to raising body temperature (High Fever), whereas 20 percent infants died due to pneumonia. Diarrhea and vomiting led to the death of fifteen percent infants, followed by 5 percent infant's death, which occurred due to poisoning and infection due to injection. Later on, it was noted that the non-sterile injection was the reason for infant death. As disposable syringes were not in practice for injecting intravenous medicines. Five percent infant died due to the presence of tumor that led to children to death. Fifteen percent respondents were unaware of the reason behind death of the infants.

On the basis of observation, it can be said that they may not be getting the children immunized and not following correct immunization practices. Pneumonia was also one of the reported reasons for the death of the infant.

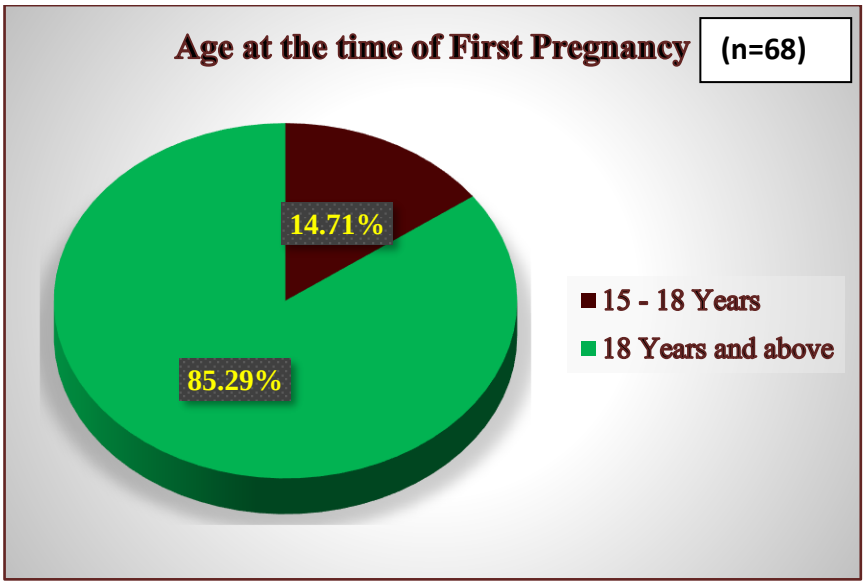

Figure 16: Percentage Distribution of the Respondents According to their Age at the time of First Pregnancy

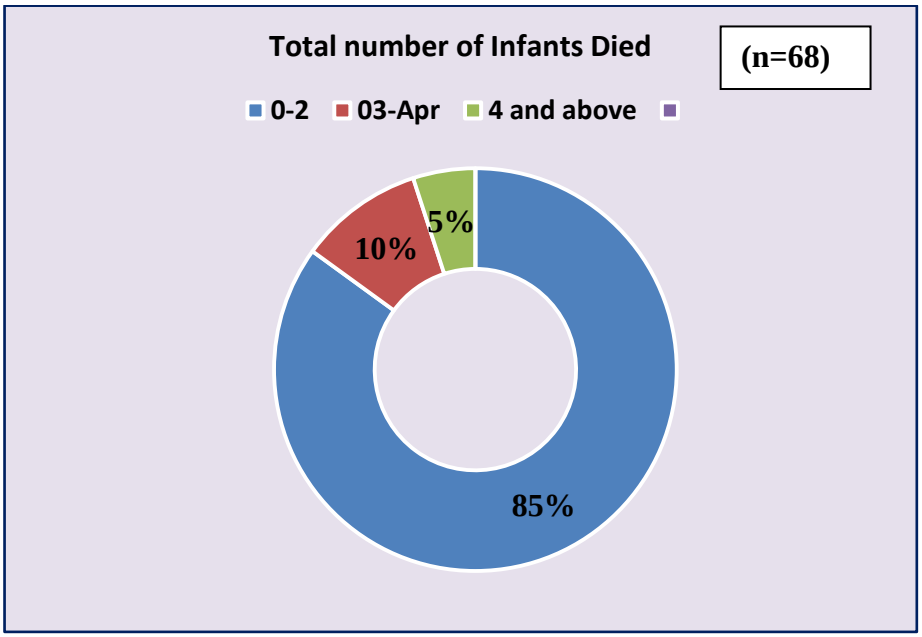

Figure 17: Percentage Distribution of the Respondents According to total Number of Infant died/Children Expired

4.1.3.2 Abortion Related Information

Table 17: Frequency and Percentage Distribution of the Respondents regarding information about Abortion and Miscarriages

(n=8)

S. No.	Statements	*f*	%
1.	Total number of abortions	2*	2.94
2.	Reason(s) for induced abortions • Ectopic pregnancy	 2*	 100
3.	Total number of miscarriages • 1 • 2	 7 1	 10.29 1.47
	Reason(s) of miscarriages • Natural miscarriage / reason doesn't know • Accident • UTI/RTI • Due to anemia • Internal heat	 2 2 1 2 1	 25 25 12.5 25 12.5

Data emerged from 8 respondents

Table 33 revealed that 3 percent respondents had gone through abortion process. The reason behind abortion was ectopic pregnancy. As this situation is found in very rare cases the reason behind ectopic pregnancy could be slow movement of ovum in fallopian tube or faulty movements of ovum.

Karear et al., (2006) conducted a prospective case-control study for the role of several risk factors in the occurrence of ectopic pregnancy in Turkey. A total of 225 cases and 375 controls were compared for sociodemographic characteristics, cigarette smoking, obstetric, gynecological, surgical histories, the presence or absence of assisted conception and contraceptive usage. The main risk factors for ectopic pregnancy were prior ectopic pregnancy (adjusted

odds ratio (AOR): 13.1) and a history of infectious reproductive system (AOR for pelvic inflammatory disease: 6.8). Other risk factors found to be associated with an increased risk for ectopic pregnancy were multi sexual partner (AOR: 3.5), history of infertility (AOR: 2.5), induced conception cycle (AOR: 3.4), current intrauterine device usage (AOR: 3.2), prior Caesarean section (AOR: 2.1) and cigarette smoking at the time of conception (AOR=1.7). On the contrary, barrier methods were protective from ectopic pregnancy (AOR: 0.4). The increased awareness and knowledge of risk factors have enabled an early and accurate diagnosis of ectopic pregnancy. This study has found prior pelvic infection to be a major etiological factor for ectopic pregnancy. Furthermore, other factors found to be associated with ectopic pregnancy, such as prior ectopic pregnancy, infertility history and induced conception cycle, may be the result of a previous pelvic infection that may cause tubal sequelae. These factors are potential targets for intervention and modification. On the contrary, barrier methods were protective than ectopic pregnancy. So, the awareness can be created in the concerned area to avoid ectopic pregnancy.

Ten percent respondents had miscarriage for one time whereas only one percent respondent had miscarriage for 2 times. No respondents were found with having miscarriages for more than two times.

Regarding reasons of miscarriages, two percent respondents reported that they don’t know the reason behind it, in similar to that respondents also reported that they had miscarriage due to accidents. Another reason found was anemia and internal body heat felt and reported by the respondents which was found responsible for the miscarriage. Table 33

4.1.3.3 Information on Family Planning

Table 18: Frequency and Percentage Distribution of Respondents According the use of Family Planning methods (n=78)

S. No.	Statements	*f*	*%*
1.	Using / used family planning methods		
	• Using / Used	20	25.64
	• Not using / Not used	58	74.36
	Specify		
	• Tubectomy	13	65
	• Copper – t	4	20
	• Withdrawal	2	10
	• Male condom	1	5

Use of family planning methods are such an important part of married or unmarried couple at the time of indulging sexual intercourse as it is always being helpful in protecting from various STDs / RTIs, protecting from unplanned and unwanted pregnancy and so on. Table 34 revealed uses of family planning methods by the respondents it was shown in the table that approximately one fourth respondents (26%) were using various family planning methods while majority of the respondents (74%) were not using any family planning method. It was also noted that the respondents who were using family planning methods a significant number of respondents (65%) had female sterilization while very few of them were using copper –t. Ten percent and five percent respondents were using withdrawal method and male condom respectively.

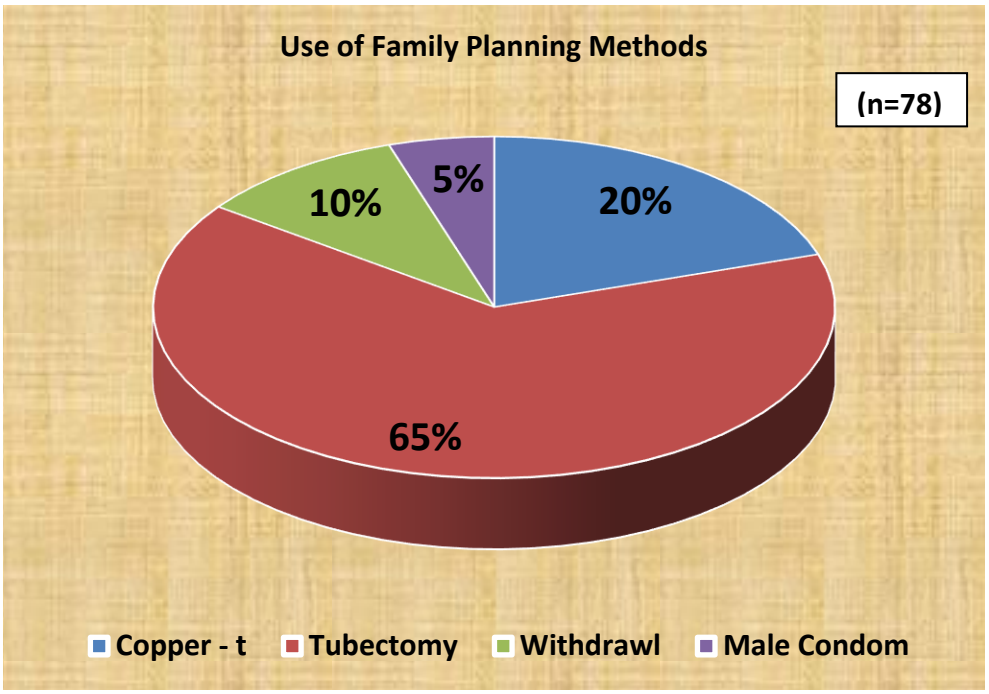

Figure 18: Percentage Distribution of the respondents According to the Use of Family Planning Methods

The reason behind not using family planning methods or avoid using contraceptives were non readiness of their marriage partner. It was also observed that use of contraceptives like condom does not give sexual satisfaction to their marriage partners. Moreover, some of them were using copper-t just because they want to prevent themselves from unwanted pregnancy. The respondents who were using tubectomy already completed their family and they didn't want more children. In contrast to that some of them were using withdrawal method as either their partner was not ready for any contraception or they have not started their family.

It is proved from various evidences that having unprotected sexual life may lead to various STDs and RTIs, therefore taking care / having safe and protected sexual life can be helpful for having health reproductive health by women and men both. *A single respondent who reported the use of male condom by her husband as she had frequency of getting more RTIs and it may responsible to transfer disease from one person to another person.*

A similar study conducted by Reddy R et al., (2003) on Rapid Appraisal of Practices to Family Planning Methods on fishermen of Pondicherry and concluded that the most popular amongst fisherman was tubectomy while condoms were used by only 54 percent respondents as on temporary basis.

Table 19: Frequency and Percentage Distribution of Respondents Regarding Information about Reproductive Health Ailment/Disease (n=100)

S. No.	Statements	*f*	*%*
1.	Suffering from any reproductive health disease/ailment(s) • Suffering • Not suffering If yes than name it • Don't know	 2 98 2**	 2 98

*****Diagnosed UTI and STD***

Table 35 shows data related to Reproductive Health disease/ailments, only 2 percent respondents reported positively that they were suffering from such ailments. Though respondents were not aware about the symptoms pertaining to any UTI or STD. the researcher took them to the doctor as they complaint about frequent and uncontrollable urination, burning while urination and other related symptoms. The other respondent reported that she had irregular menstrual cycle in addition to pain while sexual intercourse, sudden pain in lower abdominal area and so on. Later both the patients diagnosed with UTI and STD. The reason found was multiple sexual partners, as the people of the selected area were having several sexual partners.

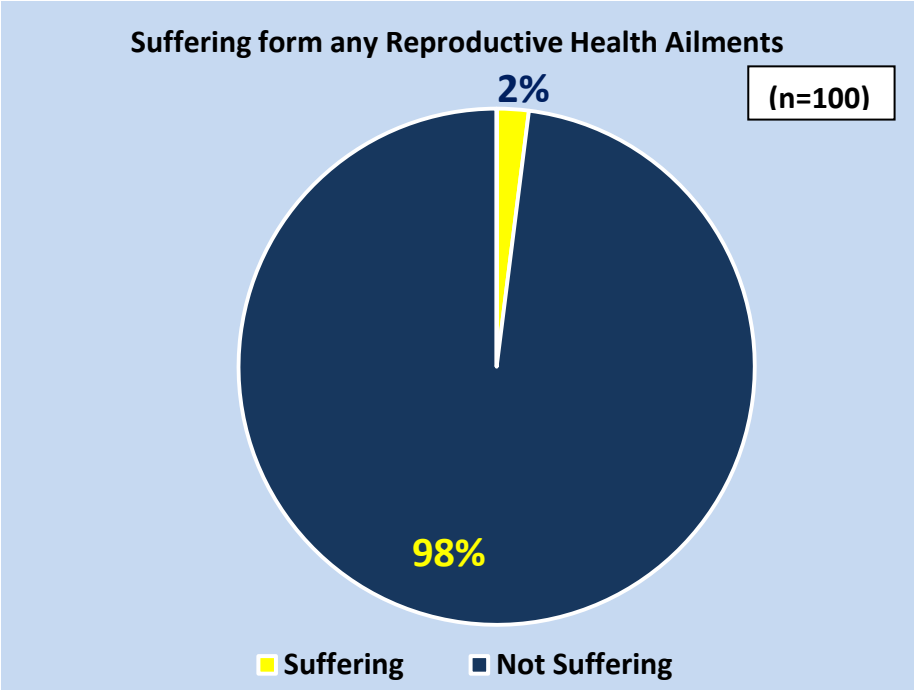

Figure 19: Percentage Distribution of Respondents Regarding Information about Reproductive Health Ailment/Disease

Table 20: Frequency and Percentage Distribution of Respondents According to their Age at the Time of Menopause (n=8)

S. No.	Statement	*f*	*%*
1.	Age (in years) at the time of menopause		
	• 35-45	1	12.5
	• More than 45	7	87.5

Table 36 revealed that majority of the respondents got menopause at the age after 45 years, while very few got between the ages of 35 – 45 years.

Getting menopause by the age of 45 or more is considered as good sign of being healthy. The reason could be that the fertility or reproduction capacity of women can be decided on the basis of their menstruation only. Women having menstruation for long years of life always consider as healthy.

According to the data depicted in the above Table, only one respondent had menopause between the age of 35-45 years, she quoted that having

menstruation and menopause is a natural process. As you get over with the process of having kids it doesn't matter at what age you are getting menopause.

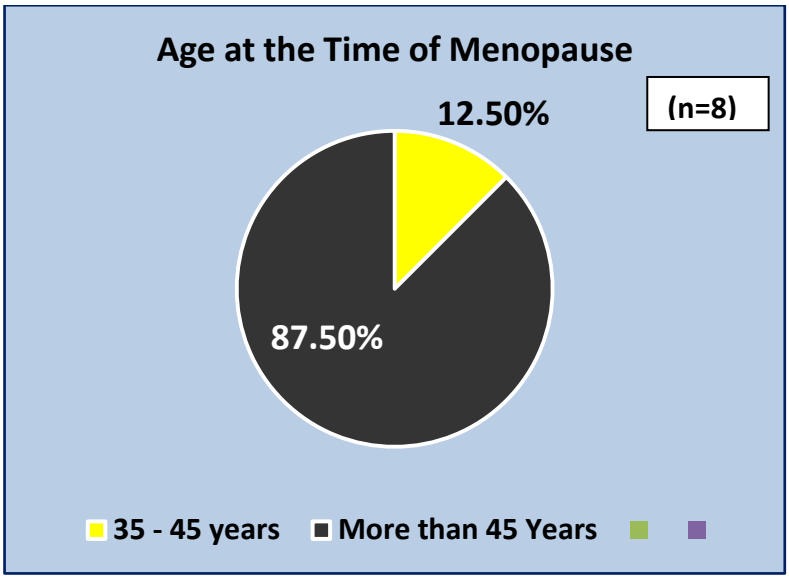

Figure 20: Percentage Distribution of the Respondents according to their Age at the time of Menopause

SECTION 4.2 REPRODUCTIVE HEALTH PRACTICES

4.2.1 Practices related to Personal Hygiene

Table 21: Frequency and Percentage Distribution of the Respondents According to the use of Cloth/Sanitary Napkin (n = 99)

S. No.	Statement	*f*	*%*
1.	Materials using/ used for protecting from menstrual bleeding		
	• Cloth	87	87.87
	• Sanitary napkin	12	12.12

Table 37 Depicts that maximum (88 %) number of respondents were using cloths while menstruating whereas very few of them (12%) were using sanitary napkins during their menstruation. It was also noted that the cloth they were using was a piece of old and used bed sheet or it was taken from old stole *(Dupatta)*. The data regarding the use of sanitary napkins, respondents reported that they use sanitary napkin maximum times. They used to purchase it from medical store or grocery store from the nearby villages. It was also reported by the respondents that if they have no access of sanitary pads by any reason they used cotton cloth. None of them were found to be using other than cotton cloths while menstrual bleeding.

The reason behind the less use of sanitary napkin may be either the respondents were unaware about its use or it was not accessible and expensive. The reason may be that financially it may overburden them to purchase it for every month. Using sanitary napkin is always considered as hygienic practice; in the same context Singh A (2006) stated that good hygienic practices such as the use of sanitary pads and adequate washing of the genital area are essential during menstruation. Women and girls of the reproductive age need access to clean and soft, absorbent sanitary products which can in the long run, protect their health. But to reach this stage it may take some more time.

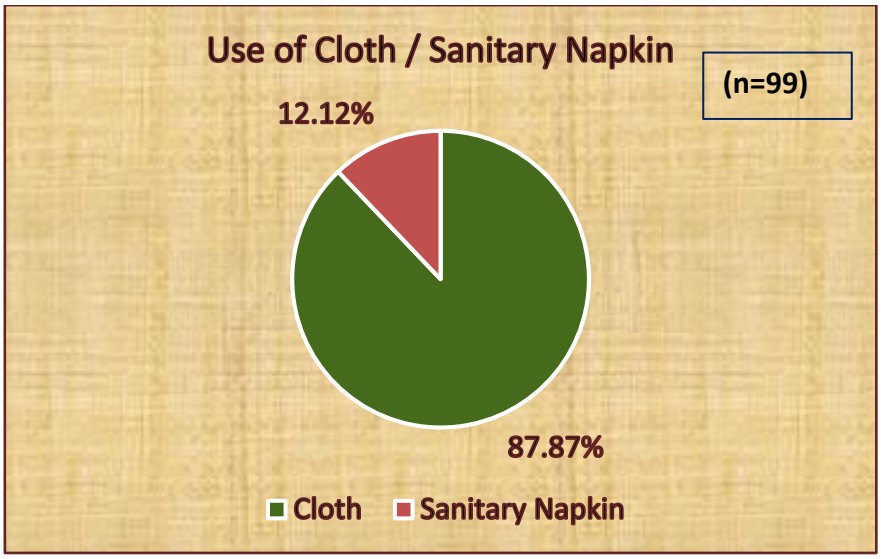

Figure 21: Percentage Distribution of the Respondents According to the Use of Cloth/ Sanitary Napkin

Table 22: Frequency and Percentage Distribution of the Respondents According to the Practices of Using Sanitary Napkin

(n=91)

S. No.	Statements	*f*	%
1.	Frequency of changing cloth/sanitary napkin in a day		
	• 1-2 times	10	10.98
	• 3-4 times	39	42.85
	• 4-5 times	17	18.68
	• As and when need	25	27.42
2.	Information about reuse of sanitary napkin		
	• Reusing	0	0
	• Not Reusing	12	13.1

Data from Table 38 revealed that less than half of the respondents (43%) used to change the menstrual cloth/sanitary napkin three to four times in a day followed by twenty seven percent respondents who used to change their menstrual cloths/sanitary napkin as and when they need to change it. Only some of them viz. nineteen percent and eleven percent used to change it four to five times and one to two times respectively. Regarding changing practice

of menstrual cloth or sanitary napkin in a day, respondents reported that they used to change it according to their need. Table 38 also revealed that the respondents who were using sanitary napkin none of them were found to be reusing it. As they know that reuse of sanitary napkin is harmful for their health and it should not be used at all.

Menstrual hygiene and management will directly contribute to Millennium Development Goals (MDG)-2 on universal education, MDG-3 on gender equality and women empowerment Ten (2007). Hygiene practices during menstruation are a contributory factor directly associated and affect the health of women. But in our country (India), especially among the remote areas where lack of facilities available and the source of information is also found to be less, women may not be aware about the correct practices to be followed to achieve the goal of good health.

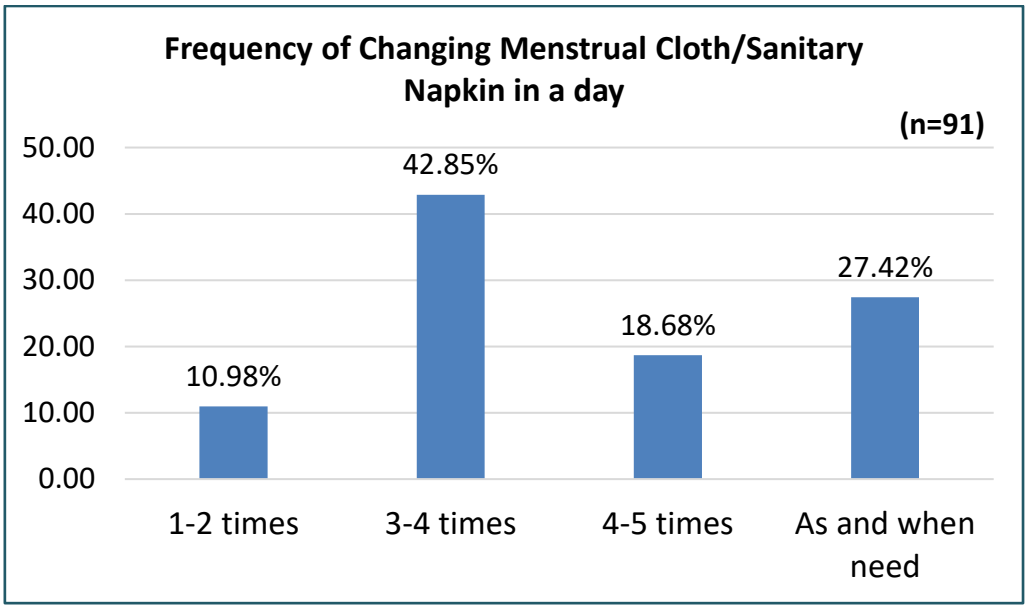

Figure 22: Percentage Distribution of the Respondents According to their Frequency of Changing Menstrual Cloth/ Sanitary Napkin in a day

Table 23: Frequency and Percentage Distribution of the Respondents According to the Practices of Using Cloth during Menstruation (n=87)

S. No.	Statements	*f*	%
1.	Duration of reuse of menstrual cloth		
	• 1-2 months	38	43.67
	• 3-5 months	41	47.12
	• more than 5 months	5	6.32
	• Never / use fresh every time	3	3.44
2.	Place of drying washed and used menstrual cloth		
	• Sundry	19	21.83
	• Dry in shade	68	78.16

It is revealed from Table 39 that less than half of the respondents (47 %) were found to be reusing menstrual cloth for 3 – 5 months followed by 44 percent respondents who were reusing it for 1 – 2 months. Very few of them i.e. six percent were reusing it for more than 5 months. Only few respondents reported that she was using fresh cloth during every menstruation.

Data also revealed that maximum respondents (78%) were drying their cloth in the shade and rests were drying under sunlight (22%). Drying normal cloth or menstrual cloth under sunlight always helps to kills bacteria and microorganisms developed due to moisture and dirt.

Drying cloths in shade may lead to bad odor or fungal or microbial infection in the cloths as well as after using such cloth while menstruation may be responsible for vaginal infection or RTIs. This problem rises especially in monsoon time when cloths retain some moisture. Increase in RTIs or other related infections may hazardous to a human being and can be responsible for occurrence of various diseases like cervical cancer, leucoria, infection in uterus, etcetera. On the other hand, respondents also stated that they feel shy while drying cloth under sunlight and in an open area. As they feel embarrassment while menstruating. They were felt that the blood passes

through vagina is impure in nature hence menstruating cloth should be kept separate from common place.

The present study was conducted with the tribal respondents in contrast to that Punitha (2010) conducted study to assess the practice and problem in using pad or cloth during menstruation among the blind children. Research design used for the study was comparative-correlation survey. Sample size for the study was 50 blind children who used pad during menstruation and 50 blind children who used cloth during menstruation. Structure interview questionnaire used for validating the responses. In that there was a significant negative correlation between practice and problem of using cloth during menstruation $r = -0.139$ ($p<0.05$) among blind school children. There was a high significant correlation between the practice and problem while using pad during menstruation in relation to prolonged menstrual flow $r = 0.874$ ($p = 0.043$) among blind school children. When the menstrual hygienic practice is less the problem will be more. Therefore, blind children need adequate education and suitable assistance to use sanitary materials to prevent problems among blind school children.

As a whole this can be concluded that menstrual hygiene practices should always be inculcated whether they are adolescent or women of adult hood, whether tribal, rural or urban.

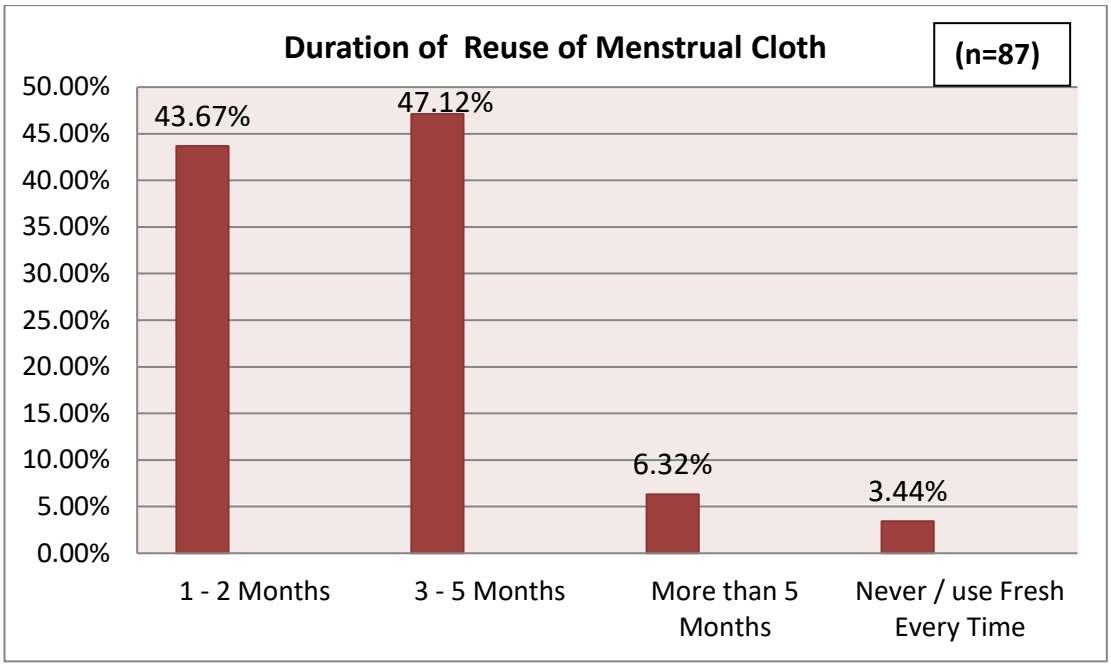

Figure 23: Percentage Distribution of the Respondents According to the Duration of Reuse of Menstrual Cloth

Table 24: Frequency and Percentage Distribution of the Respondents According to the Disposing Practices of Menstrual Cloth/ Sanitary Napkin (n=91)

S. No.	Statement	*f*	%
1.	Disposing practice of used Menstrual cloth/napkin		
	• Burn it	67	73.62
	• Dispose in dustbin	24	26.37

Table 40 depicted regarding disposing practices of used cloths / napkins, almost one third respondents i.e. 74 percent said that they burn it after using, washing and drying whereas twenty six percent respondents dispose it in the dustbin. No other option was discovered regarding this practice. “The general practice that people are comfortable with is to dispose of menstruation waste in toilets or rubbish bins. Some also prefer burning them. The rural women respondents usually rinse the blood first before disposing. The reason behind

this is the belief that blood is sacred and it should not be left around in the open."

"The disposal of menstruation protection seems to be influenced by location. Women dispose of this differently depending on where they are at the time". For instance, their behaviour when they are at home is different than when they are in public places. When in public places, the behaviour of rural people who are accustomed to throwing products in the pit, changes according to the toilet type used. For instance, when they are in a place using flush toilets, they flush the products in the toilet. When it does not flush, they take it out, wrap it with Newspaper and throw it in the dustbin inside the toilet. There are those who also say that they wrap it and carry it home with them and dispose it in their pit toilets. (Molefe and Appleton, 2001) the statement from the above authors from an international conference reveals the importance of menstrual hygiene and practices.

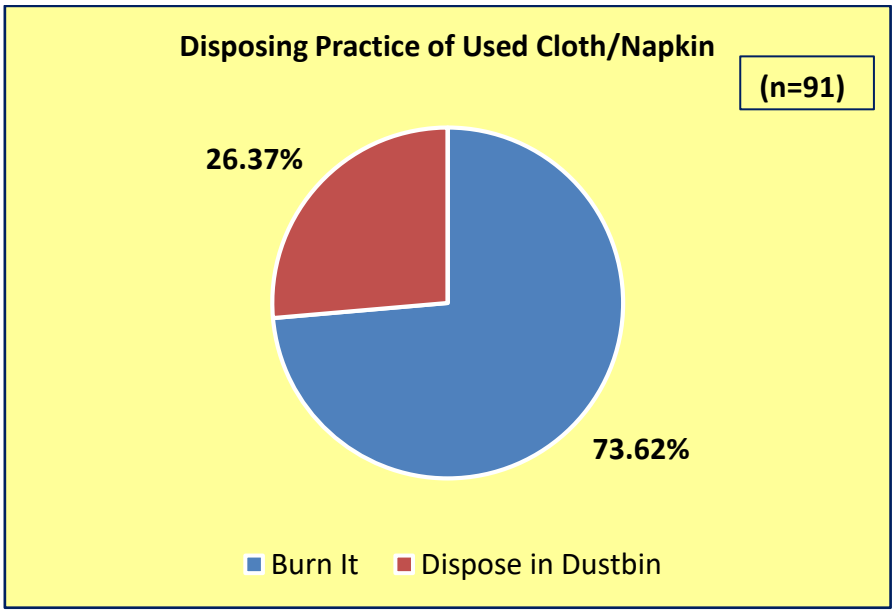

Figure 24: Percentage Distribution of the Respondents According to the Disposing Practices of Menstrual Cloth/ Sanitary Napkin

Table 25: Frequency and Percentage Distribution of the Respondents According to the Wrapping Practice of Menstrual Cloth / Sanitary Napkin (n=24)

S. No.	Statement	*f*	%
1.	Wrapping menstrual cloth /napkin before throwing in dustbin • Wrapping • Not Wrapping	 24 0	 100 0

It was found from the data depicted in Table 41 that, all the respondents were throwing napkin only after wrapping it in various things like in a polythene bag, in a piece of paper or in both the things. The reason behind wrapping in polythene and a piece of paper was the shame they feel at the time of throwing it.

Table 26: Frequency and Percentage Distribution of the Respondents According to their Personal Hygiene Practices (n=99)

S. No.	Statements	*f*	%
1.	Taking bath/ have Taken bath during menstruating • Regularly • Occasionally • Never take bath	 22 57 20	 22.22 57.57 20.20
2.	Frequency of cleaning genital areas during menstruation Not cleaning / only while bathing 1 – 2 times 3 – 5 times More than five times At the time of changing cloth / pads	 25 14 9 31 22	 25.25 14.14 09.09 31.31 22.22
3.	Taking/Taken any medicine in discomforts during menstruating • Taking / taken • Not taking / Have Not Taken	 29 70	 29.29 70.70
4.	Consulting while suffering from any reproductive health related problems No one Doctor / ANM Any other	 67 29 3	 67.67 29.29 3.03

Regular bathing is a basic fundamental personal hygiene practice, observed and expected in tropical country like India, provides cleanliness and facilitate to keep away from the infections and diseases. To add in that the results mentioned in Table 42 concludes that 57 percent respondents were occasionally bathing while menstruation whereas 22 percent were bathing regularly. Only 20 percent respondents reported about avoid bathing during menstruating. The reason behind never taking bath reported by the subjects was this need more water for bathing while menstruating and they were having less access to water as they have to bring water from various water sources like hand pumps and wells. Apart from that the respondents bathing occasionally at the time of menstruation, the reason they mentioned, that if they have any function during their menstruation than only they use to take bath.

Table 42 further depicts that medicinal use during menstrual discomforts most of the respondents (71%) denied and gave the reason that it is a natural process and it happens to almost all females hence they were avoiding taking medicines. In contrast to that more than one third respondents i.e. 29 percent acquire medicines during menstruation. Respondents also stated that they use to get medicines only when they feel intolerable pain or any other related discomforts while menstruating.

It is always better to have medicines in consultation with the help of health specialists in line of that, the respondents (29%) who were taking or taken medicines reported they take help go either doctors or ANM available at their place. Only 3 percent respondents described that they use to take help of others like older and experience people of their community, as they can explain home remedies for menstrual discomforts.

4.2.2 Food and Diet Related Practices

Table 27: Frequency and Percentage Distribution of the Respondents According to their Food and Diet Related Practices (n=100)

S. No.	Statements	*f*	*%*
1.	Kind of food preferred daily*		
	• Cereal based	100	100
	• Legumes and pulses	93	93
	• Fruits and vegetables	64	64
	• Milk and milk products	100	100
	• Sugar and jaggary based	100	100
	• Fats and oils	100	100
	• Conveniently available food	100	100
	• Any other	-	-
2.	Frequency of meals taken daily		
	• 1-2	21	21
	• 3-4	63	63
	• More than 4	16	16
3.	Taking/ Have Taken additional diet care during menstruation		
	• Taking / Have Taken	0	0
	• No t Taking / Have Not Taken	100	100

multiple responses

Having balanced food daily is the way for achieving good health. If this is practiced the physical disorders can be completely avoided. As it has been already said that women are the most vulnerable group in our society, and she has to go through many demanding phases of life like menstruation, motherhood and menopause. For this, her health has to be on the top form and this need regular balanced food. Data from table shows that all of the respondents having cereal based fats and oil based, sugar, milk and milk products and conveniently available food daily. Regarding legumes and pulses ninety three percent respondents described about their daily

consumption. More than half of the respondents (64%) were consuming fruits and vegetables daily.

The reason behind less eating of fruits and vegetables was either lack of accessibility or lack of money. Although they were consuming vegetables more than fruits, since they were able to get vegetables from their farm but they were getting it on rainy seasons. Alike this they were also having lesser amount of milk but they were having milk products daily in the form of *"Tea"*. Some of them possessed animal like cows, buffaloes and goats than they were found to be consuming milk in the form of *"Curd, Buttermilk and its recipes"*. Regarding sugar and jaggary their daily intake of only sugar was noted in the form of Indian Tea/Milk Tea.

More than half of the respondents stated that they eat 3 – 4 times in day instead of this approximately same number of respondents (21% and 16%) reported that they have the frequency of taking meals 1 – 2 times and more than 4 times in a day respectively. Table 43

None of them were taking extra dietary care during menstruation. And they were also not knowing about the concept of balance diet. Reason behind was they were less aware about the importance of taking additional dietary care during menstruation.

4.2.3 Practices related to Maternal Care (Antenatal and Postnatal)

Table 28: Frequency and Percentage Distribution of the Respondents According to their Practices related to Maternal Care (n=100)

S. No.	Statements	*f*	%
1.	Food usually prefers for pregnant women		
	• Cereal based	100	100
	• Legumes and pulses	100	100
	• Fruits and **vegetables**	75	75
	• Milk and **milk products**	100	100
	• **Sugar** and jaggary based	100	100
	• Fats and **oils**	100	100
	• Conveniently available food	100	100
2.	Food usually avoided for pregnant women		
	• ***Buttermilk***	87	87
	• ***Banana***	76	76
	• ***Papaya***	92	92
	• ***Ghee (clarified butter)***	55	55
3.	Taking / Already Taken / will take all the necessary vaccines during pregnancy		
	• Taking / Already Taken / Will Take	74	74
	• Not Taking / Not Taken / Will not Take	26	26
4.	Consuming/Consumed / will consume alcohol/tobacco during pregnancy and or lactation		
	• Consuming/Consumed/Will Consume	14	14
	• Not Consuming/Consumed/Will not Consume	86	86
	• Alcohol	3	3
	• Tobacco	11	11

Continued on next page

5.	**Preferred breastfeeding time after delivery**		
	• **After 1 hour**	**25**	**25**
	• **Next day**	**57**	**57**
	• **Any other**	**18**	**18**
6.	Full meal providing/provided to lactating women after delivery		
	• After few hour / same days	10	10
	• After two days	12	12
	• After 5 days	78	78
	• Any other	-	-
7.	Food usually Prefers for lactating women		
	Traditional food		
	For first 5-15 days		
	• *Rab (made from maize or wheat flour)*	76	76
	• *Methi and gud ka pani*	88	88
	• *Gond ka pani*	33	33
	• *Garam chai*	100	100
	• *Dalia (sweet and salty)*	59	59
	• *Laddoo (made of ghee, moondal flour and other ayurvedik supplements)*	57	57
	• *Simple roti and palak lauki moong dal*	56	56
8.	**Place Preference for Delivery**		
	• **Institutional delivery**	**81**	**81**
	• **Delivery at home**	**19**	**19**
9.	Preferring/preferred /will prefer use of contraceptives while having sexual activity after childbirth		
	• Preferring/preferred /will prefer	15	15
	• Not Preferring/ not preferred /will not prefer	85	85

Pregnancy is the most significant stage of a woman's life, as she expects a new life in her and very soon to be two. Table 44 revealed that all the respondents reported they were providing food to the pregnant women with all food groups, on the other hand contrasting results revealed that in the milk and milk product category they were providing / getting milk in the form of only *"Tea"* during pregnancy as well as in their normal days.

There is lot of faulty eating food habits usually found amongst less educated people. Because illiteracy mostly creates misunderstanding about any practices especially food practices, it mostly leads to nutrients deficiency in women as well as in their children too (Table 44).

In the same regards present investigation concluded that food that were usually avoided by the respondents during pregnancy were *"Buttermilk, Banana, Papaya and Ghee (Clarified Butter)"*. Respondents also told that these foods (except papaya) are sticky in nature and it gets stuck over the fetus in whatever position the fetus are it is always harmful to it. Regarding papaya, respondents told that it is hot in nature and miscarriage can happen to any pregnant women as well as a female can get their menstrual cycle early from the date after eating papaya. Unripe or even semi-ripen papaya has latex which may start uterine contractions. Papaya is usually advised to be eaten when women have irregular menstruation which means it is a powerful emmenagogue. If uterine contracts occur, then it encourages synthetic labor and this leads to miscarriage (Ind – Swift, 2015).

Another reason to consider papaya as unsafe during pregnancy is it contains pepsin and papain content can reduce growth and development of your fetus. In some cases, papain can wreck the possibility of the fetus's survival. Researchers have revealed that consuming papaya during pregnancy can cause anti-implantation, increased chances of post-implantation loss and embryo toxicity.

Regarding vaccines required to be taken during pregnancy, significantly a good number of respondents (74%) responded in a positive manner. Rests of them (26%) denied about the vaccines to be taken during pregnancy the reason

behind this found was they were less educated and unaware about the vaccines of pregnancy (Table 44).

In the present scenario alcohol consumption is day by day increasing in the rural and tribal people. Hence it always affects overall health of human beings. It's becoming a trend to consume alcohol in high economical societies in disparity of that in rural areas and tribal communities it is a found as routine of consuming alcohol. Present investigation also supported this statement but with only 14 percent of the respondents who were consuming either alcohol (3%) or found to be addicted to tobacco either in raw form or in the form of *"Bidi"* (tobacco filled on a dried leaf and rolled in shape of cigarette). In contrast to that maximum respondents (86%) were not addicted to any kind of drugs or alcohol.

The reason behind consuming alcohol and tobacco was they were having multiple partners and it is a need to have alcohol for fun sake or may be due to the force of the partners to consume alcohol.

Breastfeeding is a practice through which neonates get their complete food from their mother. As suggested by World Health Organization that mother's milk is the best milk for an infant till he/she becomes six months old. As this practice build strong immunity in the infants. Present study revealed the contradictory findings according that more than half of the respondents (57%) breastfeed their child on next day of the delivery. After one hour a women breastfeed their child, reported by one third (25%) respondents. Only few of them that is18 Percent reported about breastfeeding under any other point, like they use to breastfeed their child according to the situation of lactating women after delivery. The reason behind feeding newborn child on next day was until unless the mother won't take bath she cannot feed her child as she gets dirty during delivery process. Another reason was found that on the day of delivery women may not be able to secret breast milk and it may start from the next day of delivery of a child. Apart from that if mother has C-Section delivery process she may be able to breastfeed her child according to her situation.

There are numerous practices regarding food providing to the women after delivery. In the present study it was found that maximum women were getting complete or partial meal after five days of delivering baby. Whereas very few of them said that they were provided meal to the lactating women after two days (12%) and after few hours of the same day of delivery was reported by 10 percent. The reason given behind providing meal after five days was the traditional practice and, in this practice, it was reported that a women's body (after giving birth to a child) cannot digest heavy meal easily as it also affects the digestion of the newborn (as the newborn is being breastfed). Another reason was they were following tradition as their ancestors insisted to avoid complete meal to the newly lactating mother as they don't know the reason behind it. Respondents (12%) reported that the same day provision of meal was made as they were following instruction of doctors / ANM fully or partially (12%).

ICMR (Indian Council of Medical Research) recommended dietary guidelines on nutritional requirements for every age group including pregnant and lactating women. But due to faulty or wrong food habits and practices the everyday nutritional needs may not be fulfilled. Some of them were meant for lactating women too.

Table 44 revealed that none of them were providing complete balanced food to the lactating women in the selected target group. Though they were providing healthy and nutritious meal to the lactating women still the daily requirements were not fulfilling as per the recipes they stated. None of them were found to be providing fruits to any lactating women. For that they mentioned some reasons like banana leads to a mother to suffer from cough & cold, papaya may lead to diarrhea and so on. At the same time, they also reported that they were not financially strong to purchase fruits.

Hundred percent of the respondents reported that they provide tea with milk and sugar to lactating women daily. Followed by maximum respondents (88%) who were providing them *"methi and gud ka pani"* that was the fenugreek seeds infused hot water with jaggary added to clean the uterus and

it provide stamina to lactating mother and for good digestion. On the other hand, respondents (76%) stated about the conventional food i.e. *"Rab" made with maize flour or wheat flour either with buttermilk salt and powdered cumin seeds or with milk and sugar or with water and jaggary (A kind of Indian Porridge).* It was found as healthy recipe as it was fulfilling the protein, carbohydrate and energy need together. But exemption of fruits and vegetables from the diet may not fulfill the absorption of other nutrients like vitamin and minerals or they may not get it from any other sources like medicinal supplements. Almost identical number of respondents 59, 57 percent and 56 percent respondents reported about the food during lactation was *"Dalia (Broken Wheat made with milk either sweet or salt and water)", "Laddoo (Roasted round ball made of dehusked green gram flour clarified butter and other natural herbal supplements and dry fruits) to boost up energy and physical recovery of women after delivery" and "Roti, moong dal and sabji" (Indian Bread with dehusked splited grren gram pulse, spinach vegetable and bottle guard vegetable"* as it gives satiety to women and also helps fast digestion and helps in milk secretion.

Regarding child birth very few respondents (19 %) preferred home delivery. The reason behind was lack of facility available at the time of their delivery and lack of awareness about services and facilities available and meant for them as well as low access to money, transportation facilities. Data also reveals that maximum respondents (81%) quoted that they prefer institutional delivery. The reason found was they were getting free institutional delivery, money for institutional delivery, free health supplements and free contraceptive under *"Janani Suraksha Yojna"* regarding money they were getting it on the birth of a female child only.

Use of contraceptives while performing sexual activity after childbirth very few respondents (15%) reported positively in contrast to that utmost respondents (85%) were not using / used / will use contraceptives while performing sexual activity.

Table 29: Frequency and Percentage Distribution of the Respondents with Regards to Sexual Activity During Pregnancy (n=78)

S. No.	Statement	*f*	%
1.	Engaging/Engaged/will engage in sexual activity during pregnancy		
	• Engaging/Engaged/Will engage	-	-
	• Not Engaging/ Not Engaged/Will not engage	78	100

Table 45 revealed that none of the respondents performing /performed/will perform sexual activity during pregnancy. Reason reported was indulging in sexual activity can harm the fetal progress. Moreover, it can also be said performing sexual activity during pregnancy may be injurious to the fetus as this causes pressure on uterus and may also lead to miscarriage. The fact is well known that each individual has different health status as well as different pregnancy conditions, so one should always proceed in accordance to medical help and advices.

Table 30: Frequency and Percentage Distribution of the Respondents According to their Post Delivery Sexual Involvement (n=67)

S. No.	Statement	*f*	%
1.	Involving/Involved in sexual activity for first time after delivering baby		
	• After 1 month	3	4.47
	• After 6 months	2	2.98
	• Any other (depends on need of husband)	62	92.53

Table 46 revealed data related to the indulgence in sexual activity after delivering baby. Maximum respondents (93%) stated that they indulge themselves in sexual activity as per the need of their husband. While very few of them only four percent and three percent involved themselves either after 1 month of deliver or after six months of delivery. The reason reported was that if they deny husband's demand, then he may abuse them.

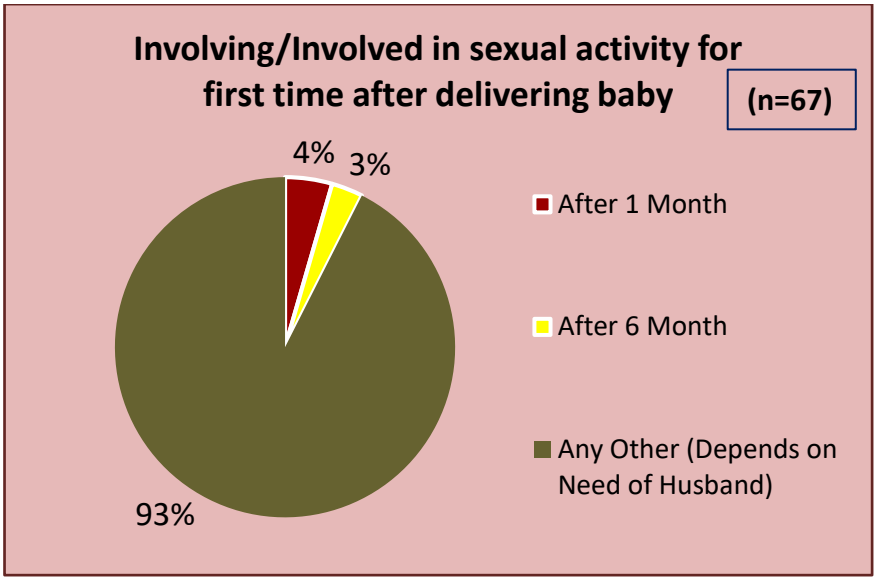

Figure 25: Percentage Distribution of the Respondents According to their Post Delivery Sexual Involvement

4.2.4 (Section D) Family Planning Practices

Table 31: Frequency and Percentage Distribution of the Respondents According to their Family Planning Practices (n=74)

S. No.	Statements	*f*	%
1.	Preferring / Preferred use of contraceptives during sexual intercourse		
	• Preferring / Preferred/ Will prefer	8	10.81
	• Not Preferring /Not Preferred/ Will not prefer	66	89.18
	Using/used contraceptives		
	• Male condom • Copper t • Tubectomy		
2.	Preferring/Preferred institutional abortion or any other way to do so		
	• Prefer	74	100
	• Do not Prefer	0	0

Table 47 described the use of contraceptives by the respondents while having sexual activity, maximum (89%) were not using/used any contraceptives either they were not aware about it or they don't want to use it. Only few of them using/used contraceptives like copper t, male condom and tubectomy.

Similar findings were reported by Bandhi et al. (2014) that, out of 711 women, 91.56 % women were aware of one or multiple methods of contraception and 53.02% used or are using contraception at the time of study. Among those 49.23% and 3.8% used permanent and temporary methods respectively. The proportion of current non-users was 32.9% in current study. The major reasons for their non-use are Anemia, weakness, lactational amenorrhea (47.01), fear of side effect (29.49%) and Compulsion of non-use by husband (13.67%). Author concluded that there is a wide gap between awareness and practice regarding contraception. Extended efforts are required to make them understand the importance and to follow the contraception

India was the first country in world to launch - The National Family Welfare Programme in 1951 but even today the couple protection rate (CPR) is still not achieved as desired by the government.

4.2.5 (Section E) Social and Cultural Practices During Menstruation

Table 32: Frequency and Percentage Distribution of the Respondents According to their Social and Cultural Practices During Menstruation (n=99)

S. No.	Statements	*f*	*%*
1.	Attending/Attended religious places/functions during menstruating		
	• Attending/Attended	-	-
	• Not Attending / Not Attended	99	100
2.	Attending/Attended social ceremonies/gathering during menstruation		
	• Attending/Attended	50	50
	• Not Attending/ Not Attended	49	49
3.	Performing/Performed household tasks during menstruation		
	• Performing / Performed	66	66.66
	• Not Performing / Not Performed	33	33.33
	Type of tasks		
	• Dusting / floor cleaning		
	• Washing clothes		
	• Washing utensils		
	• Any other		
4.	Cooking/Cooked food during menstruation		
	• Cooking / Cooked	73	73.73
	• Not Cooking/ Not Cooked	26	26.26
5.	Touching/Touched any person during menstruating		
	• Touching / Touched	99	100
	• Not Touching / Not Touched	-	
6.	Sleeping pattern during menstruation		
	• Sleep on routine bedding	19	19.19
	• Sleep on some other/special bedding	80	80.80
	• Sleep together with family members	99	100

Table 48 denotes regarding attending / attended religious places or functions at the time of menstruation. Almost all the respondents (99%) avoid/avoided going to religious place or functions because they consider women gets impure at the time of vaginal bleeding, as she is not considered pure while menstruating hence they do not attend any religious functions.

Regarding attending social gatherings, during menstruation almost equal number of respondents attending (50%) it and at the same time the other half of the respondents reported that they avoid attending any social gatherings. Again, the reason behind was the women becomes impure at the time of vagina bleeding. On the other hand, it was also reported by the women that she can attend social functions as it does not have any spiritual connection. None of them were reported about sleeping alone.

Similar findings were reported by Nemade et al., (2009) on impact of health education on knowledge and practices about menstruation among adolescent school girls of kalamboli, navi-mumbai and concluded that in the pre-test, menstrual perceptions amongst them were found to be poor and practices incorrect while in the post-test, there was a significant difference in the level of knowledge ($P<0.01$). There was no significant difference in pre-and post-test with regard to restrictions followed during menses ($P>0.05$).

In some places, it was believed that one should avoid performing household tasks while menstruating as they consider a woman impure while menstruating. Whereas in the present investigation a smaller number of respondents (33%) said no to perform household tasks, while more than half of the respondents (66%) was in favor of doing household tasks like dusting, washing clothes, washing kitchen utensils etcetera.

Patkar and Bhardwaj (2004) also expressed in an article that several Asian and African cultures, women were put in seclusion (isolation) in special menstrual huts. These are still in use today in some parts. A Hindu woman abstains from worship and cooking and stays away from her family as her touch is considered impure during this period. Jewish tradition regards a woman as ritually impure during menstruation and anyone or anything she touches becomes impure as well. As time went on, more items were added to include her breath, footprints, voice and nail clippings. Under Islamic law, a menstruating woman is not allowed to pray, fast or have sex. She is not allowed to touch the Koran unless it is a translation (as only the Arabic version is considered to be the holy book).

SECTION 4.3 REPRODUCTIVE HEALTH ASPECTS

This section of the results and discussion chapter consists of the findings related to the effectiveness in terms of gain in knowledge and awareness of the respondents regarding various aspects of Reproductive Health. This section is divided into two parts:

4.3.1. Quantitative Findings

4.3.1.1. Overall Effectivenesss of IEC Package Developed on "Reproductive Health Aspects".

4.3.1.2. Overall Effectivenesss of IEC Package Developed on "Reproductive Health Aspects" in realtion to selected variables.

4.3.1.3. Aspectwise Effectivenesss of IEC Package Developed on "Reproductive Health Aspects".

4.3.1.4. Aspectwise Effectivenesss of IEC Package Developed on "Reproductive Health Aspects" in relation to selected variables.

4.3.2. Qualitative Findings (Family Planning)

4.3.1. Quantitative Findings

Qualitative Research is primarily exploratory research. It is used to gain an understanding of underlying reasons, opinions, and motivations. It provides insights into the problem or helps to develop ideas or hypotheses for potential quantitative research. Qualitative Research is also used to uncover trends in thought and opinions, and dive deeper into the problem.

In the present study researcher prepared a structured Interview Schedule for assessing knowledge awareness and reactions of the respondents towards IEC Package developed. Further findings are discussed below.

4.3.1.1. Overall Effectiveness of IEC Package Developed on Reproductive Health Aspects

Table 33: Overall Mean Scores of Pre-test and Post-test of the Respondents on Reproductive Health Aspects (n=100)

S. No.	Statements	Mean
1.	Total Mean Score of Pre-Test of Selected Reproductive Health Aspects	**22.66**
2.	Total Mean Score of Post-Test of Selected Reproductive Health Aspects	**169.16**

Table 49 depicted that there was a remarkable difference found in terms of gain in knowledge and awareness of the respondents noted in total mean score of pre-test and total mean score of post-test of the respondents. Data also revealed that the mean score of the all the selected respondents was calculated 22.66 and it was significantly improved after implementation of Instruction Educational Package with having mean of 169.16.

The reason behind low awareness of the respondents and low mean score of the respondents regarding overall aspects of reproductive health was either their low educational status or low accessibility towards various sources of information like Radio, Television etcetera. Apart from that cultural and social

norms and issues may also be responsible for low awareness about reproductive health aspects.

Sharma U (2002) conducted a study with slum women and concluded that the knowledge of respondents about reproductive health was, in general very poor. The mean percentage reproductive health knowledge score was only 26.39. Of the six aspects of reproductive health i.e. family planning, mother and child health, adolescent health, safe abortion, STIs including AIDS and sexual behaviour, knowledge could be considered satisfactory only on sexual behaviour as the mean percentage score was about 70 per cent. It was least on STIs including AIDS.

When we talk about reproductive health of women it covers all the related aspects i.e. menstruation, menopause, STDs, RTIs and Family Planning etcetera, which affects more in terms of physically, mentally and socially. In the present study all these aspects were considered for imparting knowledge to the tribal women. Results of post-test revealed a considerable gain in knowledge of all these important aspects of Reproductive Health.

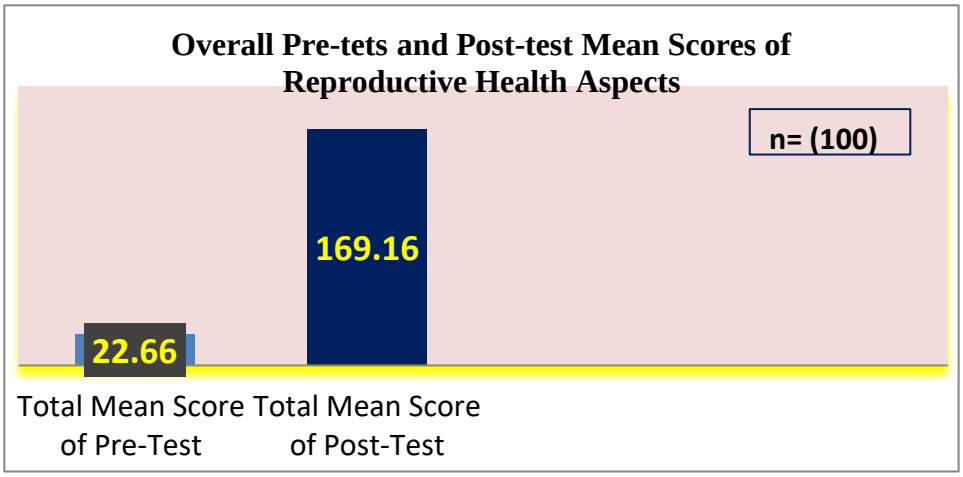

Figure 26: Overall Mean Scores of Pre-test and Post-test of the Respondents on Reproductive Health Aspects

In the present investigation, various important Reproductive Health related methods and materials were effectively developed and shown to the tribal women of the

selected area and a post-test was done to check the gain in knowledge of selected respondents regarding the different Reproductive Health aspects.

Table 34: Paired t-test for overall Effectiveness of the IEC Package on Reproductive Health Aspects (n=100)

S. No.	Criteria	Overall Mean Scores	n	SD	t-value	df	Sig. (2-tailed)
1.	Pre-test	22.66	**100**	8.55	119.29	99	0.01**
2.	Post-test	169.16	**100**	8.96			

***** Significant at 0.01 level***

Table 50 depicts that, the mean difference between pre-test and post-test was varying with t - value with -119.29. It reflects high significant difference between the mean score of pre-test and post-test of the respondents. The standard deviation in the mean scores of pre-tests was found 8.55, whereas it increased in the post-test to 8.96. The significant difference when checked at 0.01 level, it was found significant hence the overall gain in knowledge was increased after implementation of IEC Package on various Reproductive Health aspects.

After analyzing the pre – test data, it can be concluded that the media accessibility as well as the educational status was found quite low amongst the respondents. On the other hand, the medical facilities and educational facilities were found to be available and accessible in the selected area. Despite all, in most of the Indian communities' household and social restrictions are still prevalent. Moreover, health related decisions of the girls and women are still being taken by the elders of the family. In the present study it was found that females were mostly occupied with various tasks like farming, labors and household chores. It was also observed that, if it reaches to take decision for herself, she abandoned for the same. Either their maternal family takes that or the husband and in laws takes decision related to her. Sometimes they were even denying women to go alone to avail any health care facilities and to gain any information of related concern. This attitude doesn't help in making them aware about the necessary health related information.

Jeyashri G (2007) conducted a study to evaluate the effectiveness of planned teaching programme on selected aspects of reproductive health among the rural adolescent's girls. In the pre - test 69.77% of the subjects had poor knowledge, whereas post test scores showed that 96.5% of subjects had good knowledge. This result related to the post- test knowledge (mean 34.35) scores showed that the adolescent girls had a significantly higher score on Reproductive Health than the pre-test (mean 21.81). The significant value was found significant at 0.01 level of significance and the investigator concluded overall pre- test knowledge about Reproductive Health was poor, after the exposure to the planned teaching programme, post test result showed significant improvement in knowledge of reproductive health.

Similar findings were found in the present study where almost all the topics related to Reproductive Health care aspects, and statistically analyzed the significant gain in knowledge was found. Thus, the Null Hypothesis there will be no significant difference between mean achievements scores of pre – test and post – test the respondents on "**Reproductive Health Aspects"** was not accepted.

4.3.1.2. Overall Effectiveness of IEC Package on Reproductive Health Aspects in Relation to selected Variables

Table 35: ANOVA with Mean achievement Scores of Reproductive Health Aspects in relation to the Age of the Respondents (n=100)

S. No.	Age	n	Mean	SD	Df	F	Sig.
1.	15 - 30 Years (Young)	47	171.13	7.83	2, 97	2.20	0.11 NS
2.	31 - 45 Years (Middle)	37	167.30	10.48			
3.	Above 45 Years (Old)	16	167.69	7.49			

NS = Non-Significant at 0.01 and 0.05 level

The Table 51 depicts that the there was no significant difference found between overall mean achievement score of respondents in relation to their age. Thus, it can be concluded that the age of the respondents did not affect the knowledge level of the respondents. Almost similar mean achievement of scores were found among the respondents from middle age and old age i.e. 0.39. Whereas respondents from younger age group was having higher mean of achieved score of various Stages of Reproductive Health. It is found from the Table 51 that the F-value calculated was 2.20 with 99 degrees of freedom. The significant value calculated was 0.11 which was found non-significant at both 0.01 and 0.05 level.

As the person grow in age the understandings of their surroundings also increase but the general prevalent traditions and beliefs may force them also to follow all the customs and traditions religiously. The reason behind this finding may be that they belong to the same strata and are homogeneous in nature. They do believe in the opinions of their friends and relatives and neighbors. Another reason may be that they follow the same traditions whether they belong to young age group, middle age group or old age group.

The Reproductive Health covers all the aspects which begins with menstruation and ends with menopause. It forms a vicious cycle of all containing care about maternity, family planning, STDs and RTIs. The knowledge of women increases as their age increases through various Reproductive Health experiences. In the present

investigation researcher tried to get pre knowledge from the respondents regarding various stages of the reproductive health and post knowledge of women's Reproductive Health aspects. However, age wise significant difference was not found.

Hence the Null Hypothesis stated that there will be no significant difference in the mean achievement score of the respondents regarding selected **"Reproductive Health Aspects"** in relation to **Age** was accepted.

Table 36: ANOVA with Mean Achievement Score of Reproductive Health Aspects in relation to Educational Status of the Respondents (n=100)

S. No.	Education	n	Mean	SD	Df	F	Sig.
1.	Illiterate	58	167.53	9.01	5, 94	1.87	0.10 NS
2.	Up to 5th Standard	6	173.83	8.26			
3.	6 – 8th Standard	5	171.40	7.09			
4.	9 – 10th Standard	13	167.38	5.24			
5.	11 – 12th Standard	1	168.00	-			
6.	Graduate and Above	17	173.82	10.42			

NS = Non-Significant at 0.01 and 0.05 level

The Table 52 depicted that overall mean achievement score related to Reproductive Health Aspects of the respondents of the study with reference to their Educational Status. The above table showed that the mean score of the graduate respondents were found high with 10.418 significant difference, which concludes that the respondents who were graduate or more had high knowledge gain. The F – value calculated was 1.87. Whereas, data also revealed that the mean score of respondents who were educated up-to 8th standard were having high mean as compare to respondents who were illiterate. In contrast to that the standard deviation of illiterate respondents was found to be higher than other respondents. This reflected that there is very fluctuating trend amongst respondents related to their educational status and their awareness level.

As far as the educational level is concerned no significant difference was found when checked at 0.01 level or 0.05 level.

This is very strange, as the gain in knowledge related to any concept generally has its dependency on the educational level of the person with higher educational status comes the conceptual clarity, ability to understand synthesizing ability, comprehension skills, which collectively provide a supportive environment for easy gain in knowledge. Other than that as per the available literature it was found that tribal population who are living in a clan possess same characteristics and do not get affected by the other factors. As they strongly believe in their culture. If they are educated enough still they follow their culture religiously. The above Table (52) depicted that there was no significant difference found in the overall mean score in relation to their educational level.

Reproductive Health education sessions were carried over the period of one year among ninth standard school students of a slum area in Mumbai by Bobhate (2011)**,** Pre-test, immediate post-test, along with a follow up post-test at six months and one year after intervention were administered. Base line knowledge in all aspects of reproductive health was observed to be very low as compared to the post tests. Knowledge was retained over the period of one year in questions pertaining to physical changes in boys and girls, female anatomy and role of female in sex determination. However significant loss ($p<0.01$) of the acquired knowledge was observed in questions pertaining to hormones, night emissions and masturbation. Health education sessions were very effective in increasing knowledge. However, students tend to lose information regarding certain aspects as time progresses. In the present investigation almost, similar method was used but sample was not restricted to only school girls, the whole tribal community women were included in the present study, but the educational status of the respondents was not found to be intervening in their gain in knowledge.

Therefore, null hypothesis there will be no significance difference in the mean achievement score of the respondents regarding selected **"Reproductive Health Aspects"** in relation to their **Educational Status** was accepted.

Table 37: ANOVA with Mean Achievement Score of Reproductive Health Aspects in relation to Marital Status of the Respondents (n=100)

S. No.	Marital Status	n	Mean	SD	df	F	Sig.
1.	Unmarried	22	171.32	8.48	4, 96	1.630	0.17 NS
2.	Married	74	168.66	8.92			
3.	Widow	2	176.00	11.31			
4.	Separated	1	156.00	-			
5.	Kinship	1	158.00	-			

Non- Significant at 0.01 and 0.05 level

Data from Table 53 revealed, no significant difference in the mean achievement score of the respondents in relation to their marital status. Findings also revealed that majority of the respondents were married i.e. 74%. However, 22 % of the respondents were not married. Rests of them were widowed, separated or adopted kinship relationship. Likewise, the mean of unmarried respondents was quite high in comparison to the married women to 2.66. The F- value was found 1.630 and its significance difference was found 0.17 which denotes non significance in terms of marital status of the respondent. -

The reason behind it may be that the unmarried women had lot of restrictions in family life than the married women, or they may feel shy to share information openly. The cultural norm of marriage practice has robust direct as well as indirect effect on reproductive health of tribal women. For instance, in tribal marriage, spouse is selected according to traditional custom which may directly influence the reproductive practice by deciding the partners in a sexual union. On the other hand, marriage practice indirectly influences the reproductive health of women by determining several other factors such as, age at marriage, pattern of family organization, women's status in society, and, women's decision-making ability (Kshatriya, 2005). But their knowledge and awareness cannot be affected by all these above determinants. It is obvious that somewhere this can definitely affect the Reproductive Health of women.

However, several contradictory findings and various other reasons responsible for the difference of opinions and observations were found by the different researchers. As it is very meaningful to say that married women came with various exposures in comparison to unmarried ones, this always affect their perception level and the way of expressing things related to Reproductive Health. Involvement of male person in their life may also be responsible for such nature. Multiple factors are there which affect their lifestyle, hence they may not be able to express their feelings and emotions in a right manner.

Thus, the Null Hypothesis stating that there will be no significant difference in the mean achievement scores of the respondents of **"Reproductive Health Aspects"** in relation to **"Marital Status"** was accepted.

Table 38: ANOVA of Mean Achievement Scores of Reproductive Health Aspects in relation to Monthly Family Income of the Respondents

(n=100)

S. No.	Family Income (in ₹)	n	Mean	SD	df	F	Sig.
1.	1000/- to 10,000/- (Low)	63	169.73	8.89	2, 97	1.980	0.14 NS
2.	10001/- to 20,000 (Middle)	36	167.75	8.84			
3.	More than 20,000 (High)	1	184.00	-			

Non -Significant at 0.01 and 0.05 level

Women's income or their family income may affect their occupational status, educational achievement, and opportunity for accessing institutional support (in terms of medical service meant for them). These are the factors that can directly affect their reproductive health too. Findings revealed that majority of the respondents belonged to low income group i.e.63 percent, whereas 36 percent belonged to middle family income. But the mean difference among the two groups - low income and medium income, was statistically not varying from each other. The F- value for this variable calculated was 1.98 and it was found that significant value calculated was 0.14, which was found non -significant when checked at 0.01 and 0.05 level. Hence it can be said

that monthly family income was not affecting their gain in knowledge on Reproductive Health Aspects as a whole.

After implementation of package the mean score of post-test was increased which shows that there are certain things which are by enlarge has no association with the economic status. Therefore, investigator planned the present study to inculcate some very basic yet important health aspects of women's life.

Family income is always responsible for the economic condition as well as their other accessibility too. **Mehar (2007)** revealed that if employment, income and social security were improved, women would automatically become economically stronger which will lead them to become powerful forces in contributing to the social and economic development as they would achieve good health. This is obvious that if you have money you can easily access to all the facilities whether it is health related or any development related. In the present study it was also observed that there were facilities available related to their health care, but as a whole their knowledge before implementation of the package was not found to be good, however, it was found to be increased after the implementation of package. Although this increase in knowledge was not found significant.

Thus, it can be concluded that the Null Hypothesis, there will be no significance difference in the mean achievement score of the respondents regarding **"Reproductive Health Aspects"** in relation to **Monthly Family Income** of the respondents was accepted.

4.3.1.3. Aspect wise Effectiveness of IEC Package Developed on Reproductive Health Aspects

Table 39: Paired t-test for Aspect Wise Effectiveness of Developed IEC Package on Reproductive Health (n=100)

S. No.	Reproductive Health Aspects	Test	Mean	SD	df	t- value	Sig. (2-tailed)*
1.	Stages of Reproductive Health	Pre-test	8.88	3.76	99	82.39	**0.01** **
		Post-test	55.56	3.99			
2.	Maternal Care	Pre-test	8.88	3.77	99	82.39	**0.01** **
		Post-test	55.56	3.99			
3.	STDs and RTIs	Pre-test	2.55	1.03	99	90.89	**0.01** **
		Post-test	35.34	3.54			
4.	Family Planning	Pre-test	2.35	1.57	99	85.20	**0.01** **
		Post-test	22.70	2.05			

**** *Significant at 0.01 level***

Table 55 revealed that there was a significant difference found in total mean score of pre-test of the respondents and total mean score of the post test of the respondents regarding stages of reproductive health. In the above Table the mean score of pre-test of stages of reproductive health was 8.8 which increased after implementation of package with the mean score 55.56. The significant value calculated was -82.39 that indicated higher achievement trend. The significant value therefore found to be significant at 0.01 level which shows that there is significant gain in knowledge and awareness of the respondents regarding stages of reproductive health aspect. After exposure to the developed IEC Package covering above mentioned Reproductive Health aspects. Thus, the Null Hypothesis, there will be no significance difference between mean achievement score in pre-test and post-test regarding **"Stages of Reproductive Health"** was not accepted.

Regarding Maternal care of the respondents Table 55 showed that there was a significant difference found in total mean score of pre-test of the respondents and total

mean score of the post test of the respondents. The mean of pre-test of Maternal Care aspect was 8.88 which was then increased by 55.56. The significant value was calculated -82.39 it further shows marked improvement in gain in knowledge regarding selected aspect. Thus, the Null Hypothesis, there will no significance difference between mean achievement score in pre-test and post-test of the **Maternal Care** aspect was not accepted.

In line with that (Table 55 and Figure 42) also represents significant increase in knowledge and awareness of the respondents towards Sexually Transmitted Diseases and Reproductive Tract Infections. It can be concluded on the basis of findings that the total mean of pre-test of STDs and RTIs was quite low to 2.55 whereas it remarkably increased by the mean to 35.34. The t-value calculated was -90.89 with 99 degrees of freedom, it was found significant at 0.01 level. Hence the null hypothesis there will be no significant difference between the mean achievement score in pre-test and post-test regarding **STDs and RTIs** was not accepted.

Data from the Table 55 also reveals that the overall mean score of pre-test of the respondents regarding the Family Planning Aspect was quite low. But after implementation of the package it was calculated and found to be high to 22.70. The significant value for the same was also calculated and found to be high -85.20 and significant at 0.01 level. Thus, it can be stated that there was a significant difference found in total mean score of pre-test of the respondents and total mean score of the post test of the respondents regarding **Family Planning** hence the Null Hypothesis was not accepted.

Various programmes to improve awareness level of the target group and to combat the need to access to their good reproductive health Parwej et al., (2005) suggested that a study should be planned to impart education among the adolescent by developing an educational package containing package of various aspects of reproductive as a whole and planned a study to develop a reproductive health education package for adolescent girls for Chandigarh (India) and to evaluate its effectiveness in improving their knowledge and perceptions about reproductive health when delivered through different educational strategies like peer education and conventional education. The significance difference was noted in the score of pre-test and post-test of the

adolescent. High mean value while pre-test and post-test was noted as the sample for this study was adolescent and school going hence the mean score was found on a higher side as compared to the present study.

According to the findings of the present study it can be stated that a comprehensive Reproductive Health programme can effectively provide biomedical information through instructive education methods like lectures, expert talk, films, posters, etcetera which can influence the attitude and behaviour of the people worldwide through this participatory approach.

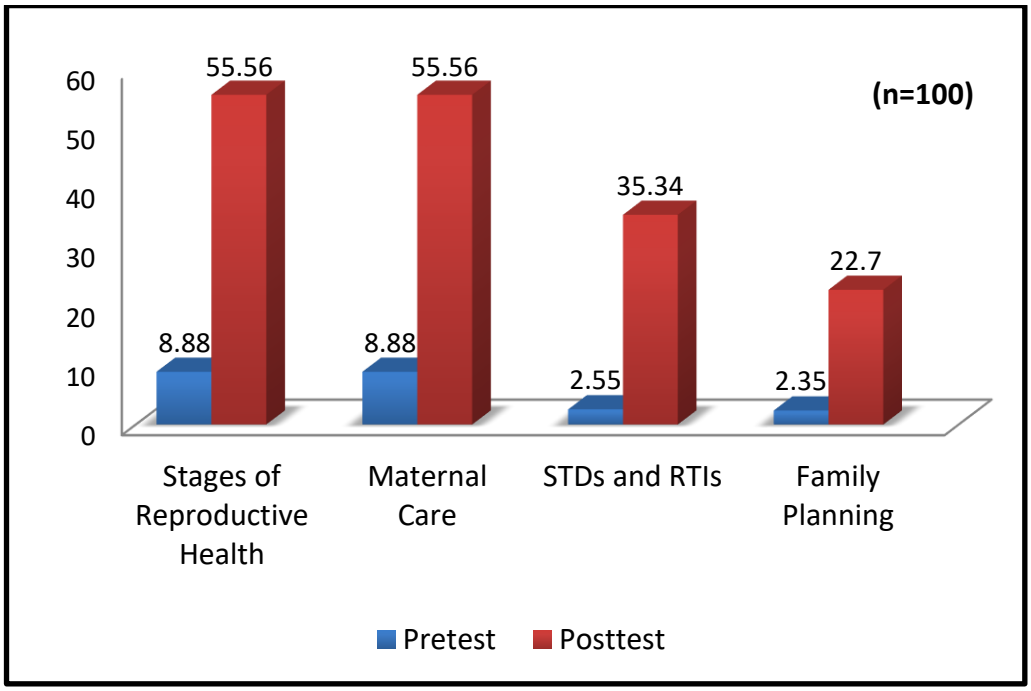

Figure 27: Aspect Wise Effectiveness of Developed Information Education and Communication Package on Selected Reproductive Health Aspects

4.3.1.4. Aspect wise Effectiveness of IEC Package Developed on Reproductive Health Aspects in Relation to the Selected Variables

4.3.1.4.1. ANOVA on Stages of Reproductive Health aspect in Relation to selected variables

Table 40: ANOVA with pre-test and post-test Mean Scores of Respondents regarding Stages of Reproductive Health in Relation to their Age (n=100)

Criteria	Age	n	Mean	SD	Df	F	Sig.
Pre-test	15 - 30 Years (Young)	47	9.62	3.17	2,97	0.17	0.85NS
	31 - 45 Years (Middle)	37	9.41	2.56			
	Above 45 Years (Old)	16	9.88	1.86			
Post test	15 - 30 Years (Young)	47	75.45	6.23	2,97	0.17	0.84NS
	31 - 45 Years (Middle)	37	75.84	6.31			
	Above 45 Years (Old)	16	76.50	6.42			

NS = Non – Significant at 0.01 and 0.5 level

Data from table 56 depicts that the mean score for pre-test of the respondents were found almost similar in all the three categories. Difference was found in standard deviation of the respondents with higher value in young category and lower value in old category of the respondents. The F – value calculated was 0.17 with 0.85 value of ANOVA with age category. Data was found non-significant when checked at 0.01 and 0.05 level.

The findings clearly reflect that respondents belonged to different age groups were not having much difference in their knowledge about various stages of reproductive health. The reason behind above findings can be that the maximum respondents were found illiterate and moreover they were following their generalised rules and regulations. “Change is the rule of life” but people usually do not change their attitude easily as they are abided to follow their early made rules, regulations, customs and traditions. Especially they believe more in their relatives, friends and society rather than development functionaries.

Another reason for getting low pre-test mean score on stages of reproductive health can be that, the respondents were belong to tribal group and always feel shy to share such sensitive issues even if they are aware about above such issues and concerns of their life.

While looking to the post – test scores, there were no significant differences found in the mean of post-tests of the respondents regarding the aspect namely "Stages of Reproductive Health" in relation to the age of the respondents. The mean value calculated for the old age group was found higher i.e. 76.50 which was quite strange. Data revealed that the mean score of respondents belongs to middle age group and young age group was almost similar i.e. 75.84 and 75.45 respectively (Table 56). A little variation can also be seen about standard deviation of the respondents of different age group as it was found higher in the post-test than in the pre-test.

This is well known that age may always be a bar for experiential learning. To support above findings, it can be said that with increase in age, a person passes from various lifelong experiences and also learn through the different experiences of life. According to the present findings it can also be said that, as the age increases people are able to understand various concepts of Reproductive Health easily. Though the literacy level of the respondents were quite low, but many of them were from younger age group hence increase in awareness was marked significantly.

This is quite obvious that people belong younger age group are quite easy to mould as they are fresh minded to learn new things and are easy to stimulate. The younger people in comparison to their older counterparts may also not be intensively affected by the age-old traditions and customs and rituals, which may not be scientifically correct. Thus, the IEC Package when exposed to younger age group people they may have understood it; completely, hence their understanding is reflected in their gain in knowledge as it can be seen from the mean scores they have achieved.

In a similar study reported by Kotwal N (2014) in a school-based intervention in Rural (Haseen F, 2004) Bangladesh, 3 booklets were developed with the help of parents, teachers and local decision makers and were distributed to students. The booklets were developed covering sexual and reproductive health aspects of reproductive health. A significant improvement in knowledge favouring students' attending the intervention schools were found.

Similarly, in the present investigation, under one Reproductive Health Aspect i.e. menstruation menopause one documentary cum video film was prepared. In the video film, the complete aspects related to menstruation like do's and don'ts while menstruating, nutrition during adolescence and menstruation etcetera were included. As it was a video film the respondents got directly influenced by its visuals, sound & music and dialects etcetera. Therefore, the above findings revealed that knowledge and mean score of the respondents were increased.

While comparing data generated from analysis of pre-test and post-test it can be seen and concluded that after implementation of IEC package the mean score of the respondents belongs to various categories has been increased. Although the data was again found non-significant at various level.

Table 41: ANOVA with pre-test and post-test Mean Scores of Respondents regarding Stages of Reproductive Health in Relation to their Educational Status (n=100)

Criteria	Educational Status	n	Mean	SD	df	F	Sig.
Pre – test	Illiterate	58	9.60	2.91	5, 94	0.60	0.70 NS
	Up to 5th Standard	6	11.17	2.23			
	6 – 8th Standard	5	8.40	2.07			
	9 – 10th Standard	13	9.38	2.90			
	11 – 12th Standard	1	10.00	-			
	Graduate and Above	17	9.41	2.55			
Post – test	Illiterate	58	76.10	6.42	5, 94	1.64	0.16 NS
	Up to 5th Standard	6	76.17	6.11			
	6 – 8th Standard	5	73.40	4.56			
	9 – 10th Standard	13	72.62	6.78			
	11 – 12th Standard	1	68.00	-			
	Graduate and Above	17	78.00	4.83			

NS = Non- Significant at 0.01 and 0.05 level

Data from Table 57 shows that the mean score of the respondents was quite low in pre – test as compared to the mean of post – test of the respondents. amongst all the category respondents who were educated upto 5th standard despite having high mean score than others. Followed by the respondents who were studied or studying till 12th standard. It has been also noted that the respondents belong to the other categories were having almost similar mean in their knowledge of pre-test. No major differenc was noted for standard deviation of the respondents as it was ranging from 2.07 to 2.91, The F value calculated was also found as low as 0.60 with non-significant value (0.70) when checked at 0.01 and 0.05 level of significance.

The trend emerged out from the above data clearly shows that education does matters in acquiring knowledge related to any issues like health and its care and so on. Overall it can be concluded that despite various health care programmes and schemes running in the selected area, respondents were less aware about the selected reproductive health aspect. It can be also stated that education at a time act as a supportive tool to gain insight into the selected issues which fulfils their required responsibilities.

Table 57 also reveals that there was no significant difference noted regarding the knowledge gained (pot-test score) by the respondents on stages of reproductive health with their educational statuses. The trend appeared from the above findings explains that the respondents who were educated upto 12th standard gained little low mean score i.e. 68.00 as compared to other respondents belongs low education. In other words, there was little gain in knowledge noted by the respondents with varying educational status. But the score of the illiterate respondents, graduate respondents and primary educated respondents were found almost similar as shown in table 57. Almost similar mean scores were noted in the respondents who were educated between 6th and 10th standard. Significant gain was also noted for standard deviation of the respondents and the range was 4.56 to 6.78. F-value for the post – test findings was calculated 1.64 and the significant value for difference noted was 0.16. It was again found non-significant when checked at 0.01 and 0.05 level.

The reason may be that the respondents having low educational status may be married or came across the life experiences in comparison to the respondents who are studied till higher secondary. In contrast to this Neelam (2010) conducted a study to assess the

effectiveness of a planned teaching programme on knowledge regarding puberty among pre-adolescent girls in Vijaya English school at Hassan, the study shows percentage of knowledge in each aspect of puberty such as anatomy and physiology, characteristics of puberty, menstrual hygiene and sexually transmitted diseases, before Planned Teaching Programme (PAP). Preadolescent girls having below average knowledge on all aspects except menstrual hygiene. Over all knowledge score shows that the girls are having only 33.52% of knowledge before the administration of the Planned Teaching Programme. It means they were able to answer on an average 8 questions out of 25 total questions before Planned Teaching Programme pre-adolescent girls were having more than 70% knowledge on all the aspects of puberty, the overall percentage of post-test knowledge on different aspects of puberty after the planned teaching program, on an average the adolescent girl's knowledge was increased 80.71% after the planned teaching programme regarding puberty. The above study was carried out with school children with English medium of instruction; whereas the present investigation was done on the tribal women of the remote village of Rajasthan. The characteristics, homogeneity and language may be the responsible factor for having no significance difference between the aspects with the selected variable.

In the present study it is proved that the mean score of the respondents of various categories has remarkable difference in the pre-test and post-test. It is commonly known that the electronic media always create a remarkable and sustainable improvement of knowledge among the people (especially illiterate). In the present study various means of communication was used along with electronic media for imparting knowledge on various stages of Reproductive Health of women. From the findings it was found that media has no bar in learning by the people having different educational status. Impact of Package can be easily judged by the achieved mean score (post-test) of the respondents.

On the other hand, the electronic media used for imparting knowledge on various stages of Reproductive Health of women also proved that media has no bar in learning by the people having different educational status. Impact of Package can be easily judged by the achieved mean score of the respondents.

Table 42: ANOVA with pre-test and post-test Mean Scores of Respondents regarding Stages of Reproductive Health in Relation to their Marital Status (n=100)

Criteria	Marital Status	n	Mean	SD	df	F	Sig.
Pre – test	Unmarried	22	9.23	2.60	4,95	0.47	0.75NS
	Married	74	9.69	2.86			
	Widow	2	11.00	0.00			
	Separated	1	7.00				
	Kinship	1	9.00				
Post – test	Unmarried	22	57.00	3.95	4, 95	2.21	0.04*
	Married	74	55.24	3.86			
	Widow	2	57.50	4.95			
	Separated	1	50.00	-			
	Kinship	1	49.00	-			

NS = Non – significant at 0.01 and 0.05 level
**** Significant at 0.05 level***

Data shown in table 58, gives some glimpses about the knowledge level of the respondents towards various Stages of Reproductive Health with their various marital statuses. Very eccentric mean scores of pre – test was noted in concern to the respondents from widow category, whereas other respondents (unmarried, married, separated and kinship) were having quite low mean score of pre-test than widow respondents, which were also found almost similar i.e. 9.23, 9.69 and 9.00 respectively. Only the respondent who were separated possessing lowest mean score i.e. 7.00. regarding standard deviation unmarried and married categories were having almost similar value i.e. 2.60 and 2.86 respectively. The F value found was 0.47 and the significant value calculated was 0.75 which was found non-significant at 0.01 and 0.05 level of significance.

Possessing high mean score in the pre-test by widow respondents might be due to the life experiences felt after marriage. For rest of the respondents it can be concluded that either they were having exposure to the married life or they (unmarried) have gain the

knowledge from their relatives, friends and family members. Another possibility can be the community health workers working in the selected area.

Table 58 also shows that marital status of the respondents may affect gain in knowledge. It may increase in awareness level related to any topic as they came across with the life experiences along with multitasking. Above findings clearly indicates that significant difference was found amongst the marital status and stages of reproductive health. The stages of reproductive health included puberty, menstruation, male and female reproductive organ and menopause. The significance difference was found at 0.05 level with the significant value 0.04. with 4,95 df. Almost similar mean score was noted in the post – test with various marital status of the respondents.

It is clearly indicated that the married women have more experience of various reproductive health stages in comparison to the unmarried women. As the data in the above Table 58 shows that married, widow or separated women must have gone through the process of sexual relationships, pregnancies etcetera, whereas the unmarried may not have had the experiences. Thus, marital status adds more exposure towards various aspects of reproductive health.

Table 58 also indicated that imparting knowledge on sub aspects of stages of reproductive health was found helpful in gain in knowledge amongst the selected respondents. Various posters, pamphlets, charts and video film were designed under IEC package including reproductive developmental aspects of adolescents as well as women, nutrition during adolescence etcetera.

Table 43: ANOVA with pre-test and post-test Mean Scores of Respondents regarding Stages of Reproductive Health in Relation to their Monthly Family Income (n=100)

Criteria	Monthly Family Income (in ₹)	n	Mean	SD	Df	F	Sig.
Pre-test	1000/- to 10,000/- (Low)	63	9.46	2.781	2, 97	0.20	0.82 NS
	1001/- to 20,000 (Middle)	36	9.81	2.786			
	More than 20,000 (High)	1	9.00	-			
Post – test	1000/- to 10,000/- (Low)	63	55.54	3.96	2, 97	1.33	0.26 NS
	1001/- to 20,000 (Middle)	36	55.42	4.00			
	More than 20,000 (High)	1	62.00	-			

NS = Non-Significant at 0.01 and 0.05 level

Regarding Stages of Reproductive Health Knowledge, Data from table 59 for pre – test depicts that monthly family income was not found responsible. The mean scores of the respondents belongs to middle income category was quite high (9.81) than the respondents belong to low income category (9.46) and high-income category (9.00). There was no major difference calculated amongst all the three categories. The standard deviation was also found similar in low income group category and high-income group category. The F value calculated was low (0.2) and the significant value calculated was 0.82 which was non-significant at 0.01 and 0.05 level of significance.

Further, it can be stated that the respondents belong to same strata have equal participation in almost all the activities of routine life. No matters how much they are earning in their life the socio – economic condition was not responsible for their knowledge about the selected aspect. Selected respondents were equally facilitated for education, employment, social participation and such related services and facilities. No discrimination was found in the selected area with their economic status. So far it can be concluded that money factor was not creating any boundaries for their learning.

For post – test data no significant difference was found between the knowledge gained by the respondents about stages of reproductive health in relation to their monthly family income. Very minimal mean difference was observed between the category of low income and middle-income group i.e. 0.12. The standard deviation was also

showing the lesser amount of difference between the categories. The F value found was 1.33 and when the significant value was checked at 0.01 and 0.05 level it further showed no significant difference in relation to monthly family income of the respondents as shown in Table 59

The reason could be that no matter how much they are earning their culture, their values, customs and traditions remains same as a conservative tribal community. It was clearly indicated in some studies that tribal are always homogeneous in nature and they strongly believe in their beliefs they don't get affected by any other resources until unless they are motivated by some external reliable sources.

Sharma S (2002) reported in her study that the respondent who belonged to low income group families having more number of children, this way it can be predicted that they had set values in their mind that more the children in the family more the income will be added in the family, but it was observed and found out from the present investigation that children are the precious gift of God and we should not interfere with the reproductive process.

Similarly, it was reported by Mistry P (2012) that the adolescent from both high and middle income could gain knowledge, which means family income is not concerned with the knowledge of the respondents. This may be the reason that the respondents may have gained equally, familiarity and competence of learning irrespective to their family income level. The present study implies that the income cannot be a bar to access the facilities available and actually meant for them to utilize for their betterment of life as the gain in knowledge occurred irrespective of the income.

Likewise, other variable this was also found non-significant but their knowledge level was again increased which can be observed from comparing mean score of pre-test and post-test of the respondents. The major contributory factor for gaining knowledge is always the participation of the people in whatever programme is running or meant for them. But the fact still exists that women's participation in such programmes schemes and policies still depends on the familial decision making. The superlative part of this research was that the respondents were participated enthusiastically along with the concern of their family members. As it was meant for their health benefit.

Findings concluded that wealth cannot restrict learning any of the people in the universe, proved by the present study as the IEC material was prepared according to the need and status of the selected respondents. To add this, it can also be said that combining various interactive media like showing them self- learning cards, posters on menstruation or menopause or such aspects along with some discussion can always help respondents to increase in their knowledge.

Table 44: ANOVA with mean difference of pre and post – test scores of the respondents regarding Stages of Reproductive Health in Relation to selected variables (n=100)

Variables	Categories	n	Mean	SD	df	F	Sig.
Age	15-30 (Young)	47	65.04	5.76	2,97	0.18	0.83 NS
	31-45 (Middle)	37	65.00	6.28			
	45+ (Old)	16	64.00	7.20			
Education	Illiterate	58	64.64	6.23	5,94	1.64	0.16 NS
	up to 5th Standard	6	64.00	4.47			
	6-8th Standard	5	64.00	6.24			
	9-10th Standard	13	63.31	7.09			
	11-12th Standard	1	55.00	.-			
	Graduate & Above	17	67.94	4.79			
Marital Status	Unmarried	22	65.77	6.64	4,95	0.91	0.46 NS
	Married	74	64.74	6.03			
	Widow	2	62.50	4.95			
	Separated	1	68.00	-			
	Kinship	1	55.00	-			
Monthly Family Income (in ₹)	1000/- to 10,000/- (Low)	63	65.75	5.80	2,97	1.90	0.15 NS
	1001/- to 20,000 (Middle)	36	63.28	6.57			
	More than 20,000 (High)	1	66.00	-			

NS = Non -significant at 0.01 and 0.05 level

It is evident from table 60 that the mean differences of respondents belong to various age were found almost similar, it was ranging from 64 – 65.04, which shows considerable gain in knowledge about various stages of reproductive health. However, standard deviation was high of the respondents belongs to old age group

(7.20), followed by middle age group and young age group which was 6.28 and 5.76 respectively. The F value for age variable was calculated 0.18 and there was no significant difference found when the value (0.83) checked at 0.01 and 0.05 level of significance. As the data was found still non-significant even after delivering the related knowledge. Therefore, the null hypothesis stated **there will be no significant difference between mean achievement score of pre-test and post-test of the respondents regarding stages of reproductive health in relation to age of the respondent was accepted.**

The table 60 reveals that majority of the respondents having various educational qualifications, have gained ample amount of knowledge on maternal care aspect. Almost all the respondents achieved substantial mean score except the respondents belongs to 11 – 12^{th} standard, whose mean achieved score was little less than the respondents from other categories. The mean score range noted between 63.31 and 67.91 for various respondents possessing various level of education. However, respondents having educational qualification upto 11^{th} standard or 12^{th} standard has achieved quite low mean score i.e. 55. The standard deviation was also varying shown in table 60 with 5,95 degree of freedom within and between various categories of the respondents. The F value calculated for educational statuses of the respondents was 1.64, data was also found non-significant at 0.01 and 0.05 level of significance with the calculated value .156. Thus, it can be said the null hypothesis, **there will be no significant difference between mean achievement score pre-test and post-test of the respondents regarding stages of Reproductive Health in relation to their educational status of respondents was accepted**.

For marital status it can be easily seen from table 60 that lowest mean score (55) possessed by respondent belong to kinship category, whereas, other respondents had almost similar mean score ranging from 62.50 to 68. F value calculated was 0.91 and significant value was calculated 0.46. calculated which was found non significant at 0.01 and 0.05 level of significance. Thus, it can be concluded that the Null Hypothesis stated, **there will be no significance difference between mean achievement score of pre-test and post of the respondents regarding stages of reproductive health in relation to marital status of the respondents was not accepted.**

Analysis of variance was applied to find out the significant difference among all the selected variables, it was found that the respondents belongs to various income groups were possessing almost similar mean ranging from 63.28 to 66, which shows income was not responsible for their gain in knowledge. The standard deviation calculated for low family income group and middle income group was 5.80 and 6.57 respectively. Thus, it can be said that the null hypothesis stating **there will be no significant difference between mean achievement score of pre-test and post-test of the respondents regarding stages of reproductive health in relation to monthly family income was accepted.**

4.3.1.4.2 ANOVA on Maternal Care aspect in Relation to selected variables

Table 45: ANOVA with pre-test and post-test Mean Scores of Respondents regarding Maternal Care in Relation to their Age (n=100)

Criteria	Age	n	Mean	SD	df	F	Sig.
Pre – test	15 - 30 Years (Young)	47	8.26	3.39	2, 97	1.25	0.29 NS
	31 - 45 Years (Middle)	37	9.51	3.80			
	More Than 45 (Old)	16	9.25	4.61			
Post – test	15 - 30 Years (Young)	47	56.74	3.77	2, 97	4.12	0.01* *
	31 - 45 Years (Middle)	37	54.62	4.10			
	More Than 45 (Old)	16	54.25	3.55			

NS = Non-significant at 0.01 and 0.05 level, **Significant at 0.01 level

The mean score of pre – test of various age groups was not varying majorly regarding knowledge of the respondents about maternal care. It can be seen from table 61 that the respondents belong to young age group were having lowest mean score whereas the respondents belong to middle age group possessed little high mean score amongst all. The F value calculated was 1.25 and the significant value found was 0.29 and also found non-significant when checked at 0.01 and 0.05 level of significance.

This is very spontaneous and obvious that life experiences are always good for sustainable learning on any issue. Especially maternal care is such a sensitive and important issues in each women's life that can be learned more with their own experiences. The above findings represent that respondents who are educated more

(young age respondents) but they may not have such experiences, having comparatively less knowledge than other respondents.

Apart from all, spouse of women also plays an important role in having positive experiences and knowledge of issues related to maternal care. It is also well known that this kind of issues always need cautious discussion as the major health parameters of women's life is revolved around it. In India it is still consider as issues of either pregnant women or the women with motherhood experiences. The females who are unmarried or they are not pregnant, are not supposed to discuss about maternal acre aspects, since according to their relatives and family members it is not their concern.

Table 61 pointed out the significant difference between maternal care and age of the respondents. Data was found to significant at 0.01 level with F-value of 4.12. There was 2,97 degrees of freedom noted with the various age group of the respondents.

Improving the maternal and child health and their survival are central to the achievement of national health goals under the National Rural Health Mission (NRHM) as well as the Millennium Development Goals (MDG) 4 and 5. In relation to that the present study was planned with the purpose to increase in their knowledge and to create awareness about the maternal care among the tribal population of the Rajasthan. Social determinants for maternal and child mortality include marriage and childbirth at a very young age, less spacing between births and low literacy level among women, in particular those belonging to the urban poor and rural settings, and socially-disadvantaged groups (such as scheduled castes and tribes) Government of India (2013). Similarly, the present investigation was also planned in the same context and marked a remarkable improvement in their knowledge about maternal care after the exposure to the IEC Package on Maternal Care.

As per the District Level Household Survey conducted for Reproductive and Child Health in the year 2002 by Nagda At least three antenatal check-ups, two doses of tetanus toxoid vaccine and iron and folic acid supplementation during first three months of pregnancy are encouraged under the RCH programme. The institutional delivery or home deliveries attended by trained medical professionals, and three postpartum visits are also envisaged under the programme. As per the data of RCH survey of Rajasthan, only 32 percent of the pregnant women get three or more ANC

checkups, less than half (48 percent) women receive skilled attendance at birth, and 36 percent of women had pregnancy complication.

Antenatal Care

The information on antenatal care (ANC) services was collected from women who experienced either a live or stillbirth during the three years of the survey. Data concludes that more than two-third of women (69 %) received antenatal check-up during pregnancy. One third of pregnant women received three and more ANC and eleven percent women had got checked-up for antenatal services at home. Very little (3.7 %) number of pregnant women had received full ANC services. The women who had received any kind of ANC were the lowest in western region. The lowest number of pregnant women who received full ANC was reported in north eastern region (3.67 %) only.

It was found in the present study that, women who was pregnant, was getting timely antenatal check-up and those who have already having children also acquired their timely check-ups. The respondents who got their check-ups done were mostly from younger age group and middle age group. When it was discussed with the old age group it was found that no facilities of antenatal check-ups were available in the village at the time of their conception and delivery. Therefore, it can be said that women who is seeking or already taken the benefits of antenatal check-ups, were having more knowledge in comparison to the other group of respondents. Hence the various respondents from various groups were having different knowledge about maternal care. Moreover, mean score of all the respondents were found almost similar, which denotes almost equal knowledge gain by the respondents regarding “Maternal Care Aspect”.

It can be concluded well on the basis of calculated pre-test mean data and post-test mean data that a vast augmentation of knowledge can be easily inculcated with the help of either various approaches or communication strategies or by blending of both the measures. This is also very spontaneous that if the strategies are well planned as per the situation of the target audiences, a sustainable learning can definitely be placed.

Despite all in the Package "Maternal Care Aspect" was supported by various interactive IEC Materials like Power Point Presentations which is powerful media to impart knowledge among the respondents. As it contained colourful visuals, sounds animations etcetera, so to create interest among them and help to sustain knowledge.

Turkey's HSD = Post Hoc Analysis within the categories

Table 46: Post Hoc test for ANOVA within various age groups (n=100)

Aspect	Age Groups		Mean Difference	Sig.
Maternal Care	**15 - 30 Years (Young)**	**31-45 Years (Middle)**	**2.123***	**0.037**
	16 - 30 Years (Young)	More Than 45 (Old)	2.495	
	31 - 45 Years (Middle)	More Than 45 (Old)	.372	

**** The Mean Difference is significant at 0.05 level***

It was found from the post hoc analysis (Table 62) that again within the category the difference was noted. The lowest mean difference was noted between young age group and middle age group hence it can be said that the significant difference came out on the basis of the age group of the respondents.

This variable focused on how various age groups can affect the gain in knowledge and awareness of the respondents. It can be concluded that the experiential learning may contributory factor for the respondents to find the significant difference and the mean achievement score.

Table 47: ANOVA with pre-test and post-test Mean Scores of Respondents regarding Maternal Care in Relation to their Educational Status

(n=100)

S. No.	Education	N	Mean	SD	df	F	Sig.
Pre – test	Illiterate	58	9.40	3.96	5, 94	1.23	0.30 NS
	Up to 5th Standard	6	10.00	5.40			
	Up to 8th Standard	5	7.40	2.30			
	Up to 10th Standard	13	6.92	2.10			
	Up to 12th Standard	1	10.00	-			
	Graduate and Above	17	8.59	3.57			
Post – test	Illiterate	58	54.74	3.84	5, 94	1.69	0.14 NS
	Up to 5th Standard	6	56.33	4.03			
	Up to 8th Standard	5	57.20	2.77			
	Up to 10th Standard	13	56.08	3.04			
	Up to 12th Standard	1	52.00				
	Graduate and Above	17	57.41	4.89			

NS = Non -Significant at 0.01 and 0.05 level

Level of education and knowledge about any of the reproductive health is directly and indirectly associated with each other. In the present study the data from above table 63 for pre-test, reflects that the respondents who were primarily educated and educated upto 12th standard having common understanding on the maternal care aspect with the similar mean scores i.e. 10.0. Quite strange findings revealed from data analysis that the respondents who were illiterate having higher mean score i.e. 9.40 than the respondents who were graduate or above (8.59). the respondents who were educated upto 8th standard. Regarding standard deviation only primarily educated respondents possessing higher value. The significant value was found non-significant when checked at 0.01 and 0.05 level.

Safe motherhood is one of the most important and prime concern in women's life as it plays a major role in keeping women healthy in all another way. This is very general and commonly known fact that the women belong to any clan always have faith in the

people of their surroundings rather than believing in health functionaries or other outsiders. On the other hand, it can be stated that appropriate knowledge on maternal care aspect can be helpful to attain a good health of mother as well as children in all manner. If the knowledge is insufficient and improper the health can get affected. In the present study the mean score of maternal care aspect was found quite low among all the respondents. This aspect covers antenatal and postnatal care, a little technical guidance and short-term training programmes can be enough to aware them about maternal care.

Therefor IEC package included with the various materials and methods related to maternal care for women and imparted effectively to create awareness about maternal care aspect.

For data obtained from post – test score table 63 indicates that the significant value calculated was 0.14 showing no significant difference of maternal care with educational status of the respondents. The F- value calculated was 1.69 at 5,94 degrees of freedom. Almost equal mean values were analyzed with every educational group of the respondents. Though more than half of the respondents were illiterate but the value of education was no bar to significantly affect their knowledge level.
The much-generalized statement usually used everywhere is “human beings learns more with their experiences, than with their education”. This statement stood true for the present study too. Findings from the present research reflect that the educational status had no effect on the gain in knowledge regarding maternal care aspect of Reproductive Health of women.

The above findings can be supported by another study by Malleshappa (2011) which was conducted at Kuppammandal, Chittoor district of Andhra Pradesh state. The data from the study revealed that 656 girls who received Reproductive Health education had a significant increase in overall knowledge regarding menstrual cycle, ovulation, fertilization, pregnancy contraception, transmission and prevention of STDs.

Another study carried out by Parwej et al., in 2005 In Chandigarh (India), a reproductive health education package, developed in consultation with parents, teachers and adolescents, was delivered to randomly sampled classes of two senior secondary schools and one school was selected as control group. In one school, a nurse

conducted 15 sessions for 94 students in three batches using conventional education approach. In another school, she conducted sessions for a selected group of 20 adolescents who later disseminated the messages informally to their 84 classmates (peer education). The knowledge of adolescents was assessed before and one month after the last session. Teachers, parents and students overwhelmingly favoured reproductive health education program. Peer education and conventional education strategies were effective in improving the reproductive health knowledge of adolescent girls but peer strategy was less time consuming. Owing to the above studies it can be concluded that both the studies have been carried out having different sample size with different experimental designs yet resulted in an effective gain in knowledge.

Similarly, the present investigation also reveals the respondent's knowledge was quite low in the pretest conducted on the "Maternal Care" aspect and gain in knowledge was found in the respondents when the IEC package was imparted via using various combination media developed under IEC Package. Where the experiences, spontaneity and cohesiveness work education may not be barrier to expand in any health matters. It can be summed up that the adjoining various IEC materials to form a package and imparting them was found as an effective way even for highly educated people or less educated people. Findings shows that educational status was not hindered the learning of the respondents.

Table 48: ANOVA with pre-test and post-test Mean Scores of Respondents regarding Maternal Care in Relation to their Marital Status (n=100)

Criteria	Marital Status	n	Mean	SD	df	F	Sig.
Pre – test	Unmarried	22	7.59	2.28	4, 95	1.33	0.26 NS
	Married	74	9.27	4.08			
	Widow	2	8.00	2.83			
	Separated	1	13.00	-			
	Kinship	1	6.00	-			
Post – test	Unmarried	22	22.68	1.91	4, 95	0.10	0.04*
	Married	74	22.69	2.15			
	Widow	2	22.50	0.71			
	Separated	1	23.00	-			
	Kinship	1	24.00	-			

NS = Non- Significant at 0.01 and 0.05 level, * Significant at 0.05 level

Data from the Table 64 denoted that the mean score achieved by the respondents were found almost similar with respect to the various marital status. The values of standard deviation within the various categories showing higher difference in married respondents i.e. 2.15, followed by unmarried respondents with standard deviation value of 1.91. There was noticeable difference found in standard deviation of both the categories. i.e. unmarried and married. The F- value calculated was 0.10 and the significant value found was 0.98 which represent no significant difference in the mean achieved score of the respondents.

The combination of all the media together is an effective strategy to impart educational knowledge to the people (especially tribal and illiterate people). The above table revealed that no significance difference was found in the marital status of women with maternal care aspect.

It is very obvious that married women have more knowledge about maternal care in comparison to unmarried women. As they already passed through the pregnancy, lactation and delivery stages of reproductive life. In contrast to that, finding from the present study reveals that the marital status was not affecting their gain in knowledge of the respondents about maternal care. The reason can be that tribal as a whole shy in nature to share anything with people from outside the community. They are quite comfortable within the community to talk on any issue. Moreover, sex is not generally considered taboo in tribal societies, further tribal community are close knit communities, the happenings, events in the family are shared and observed by all the members. Thus, the present findings may have arrived.

Direct interventions with young married women/couples were given: In almost all studies/project reports, the direct intervention with young married women focused on individual counselling during home visits. The young married women in most of the studies/project reports were in the age group of 15–24 years, although two projects–PRACHAR and ACQUIRE (Denial et al 2008 and the Acquire Project 2008) targeted younger women in the age group of 10–24 years. In all studies/project reports (Khan et al. 2008, Santhya K 2008, Denial et al 2008, the Acquire Project 2008, CREHPA, 2004, Pande et al. 2006) apart from, the major strategy for direct intervention included formation of groups of young married women in the community to expand their social

support network and enhance their ability to act in their own interests; group counselling (information on reproductive and sexual health issues by peer educator/frontline functionary/change agent/project staff); and direct information provision to the young married women/couples through home visits.

Table 49: ANOVA of Mean Scores of Pre-test and Post – test of the Respondents regarding Maternal Care in Relation to their Monthly Family Income (n=100)

Criteria	Family Income (in ₹)	n	Mean	SD	df	F	Sig.
Pre-test	1000/- to 10,000/- (Low)	63	9.65	4.17	2, 97	4.03	0.02*
	1001/- to 20,000 (Middle)	36	7.64	2.51			
	More than 20,000 (High)	1	5.00	-			
Post-test	1000/- to 10,000/- (Low)	63	55.54	3.96	2, 97	1.33	0.26 NS
	1001/- to 20,000 (Middle)	36	55.42	4.00			
	More than 20,000 (High)	1	62.00				

= Significant at 0.05 level, NS = Non- Significant at 0.01 and 0.05 level

The evidences available proves that income of any family is supreme concern to fulfil any requirement. That can be spend on generating awareness or may be related to availing any necessary facility. According to table 65 with the findings of pre – test, it can be stated that the respondents who were having low monthly family income possessed high mean score (9.65), followed by 7.64 mean score possessed by respondents belongs to middle income group. Respondents who were falling under the category of high income group were having lowest mean score i.e. 5.00. The F value was found 4.03 and the data was found significant at 0.05 level of significance.

Table 65 portrays some odd findings like on majority basis the development of people always depends on the income of their family, on the same ground it is helpful to avail facilities. In this research, findings from table 64 depicts that though the respondents were not having high family income but that was not a bar to sharing information and their own related experiences with each other.

Table 65 also represents from post – test data that, there was not much difference found in the mean of various categories viz; low income group and medium income group. However, low-income group consisted a greater number of respondents than in middle income group, but their knowledge level regarding maternal care aspects found was almost same as low income group. Findings were varied according to standard deviation, which was showing very little difference (0.04) between medium and high-income group, whereas, the value of standard deviation was found high in middle income group. The F-value calculated was 1.33 and significant value was found 0.26, also found non-significant at 0.01 and 0.05 level.

The maternal care is an essential component and a serious concern on which the future of the newborn baby and the Reproductive Health is dependent upon. Improving the maternal health of targeted women is an immense challenge, no matters if one is earning more or less, they always take care of the health according to the lifestyle and planned balanced money. Evidences proved that taking maternal care in a right manner will always be helpful for the future mother and baby both. In our country like India people believe and have faith to follow any care related practices from sources like relatives, family members and friends. Talking about women, she is ready to know all the related queries, questions and its remedies from the mentioned sources and religiously follow that, as it is a very pleasing part of their life. It was observed from the data revealed from the present investigation that the knowledge was found to be high regarding maternal care of reproductive health aspect, but again the economic status was not influential so far. On the basis of observation, it can also say that the younger generation was availing maternal health care facilities while older women did not feel to avail the same, because of their beliefs or they may not need to avail, this is also one of the important characteristics of tribal people.

In contrast to that study conducted by Bhasin V (2007) and stated the fact that even the poor tribal population uses private health facilities in preference to Government Primary Health Centre is an indication of the failure of the Public Health Delivery System However, until health awareness at the household and community level improves, success in upgrading health services, though necessary will be of little service. Cultural and social factors erect will remain as the barriers to the utilization of health care.

If private health facilities are not available, they do believe in using governmental health care facilities available and meant for them. In the present study while discussing with ANM working in the area, where PHC is available people were using governmental schemes meant to save the girl child, and to reduce maternal mortality, the providence of some financial help on delivery of girl child, free delivery, free hospitalization along with free vaccination and initial medicines were arranged for the beneficiary, who registered herself in the Government PHC. It was also found that rural tribal women taking advantages of the schemes offered, therefore they were having adequate post-test knowledge regarding maternal care.

While comparing pre-test and post-test data a significant increase can be marked in the respondents belong to middle and high-income group, where as it was decreased in the respondents belong to low income group after implementation of package. Therefore, in overall context it can be said that the knowledge was found high after implementation of IEC Package and no economic factor affected that.

Table 50: ANOVA with mean difference of pre and post – test scores of the respondents regarding Maternal Care in Relation to selected variables (n=100)

Variables	Categories	N	Mean	SD	Df	F	Sig.
Age	15-30 (Young)	47	48.49	5.540	2,97	4.88	0.010**
	31-45 (Middle)	37	45.11	5.441			
	45+ (Old)	16	45.00	5.228			
Education	Illiterate	58	45.34	5.385	5,94	2.20	0.061*
	up to 5th Standard	6	46.33	5.989			
	6-8th Standard	5	49.80	4.764			
	9-10th Standard	13	49.15	3.805			
	11-12th Standard	1	42.00	.			
	Graduate & Above	17	48.82	6.840			
Marital Status	Unmarried	22	49.41	4.717	4,95	2.70	0.035*
	Married	74	45.97	5.712			
	Widow	2	49.50	2.121			
	Separated	1	37.00	-			
	Kinship	1	43.00	-			
Monthly Family Income (in ₹)	1000/- to 10,000/- (Low)	63	45.89	5.75	2,97	3.07	0.051*
	1001/- to 20,000 (Middle)	36	47.78	5.18			
	More than 20,000 (High)	1	57.00	-			

***** = Significant at 0.01 level, * = Significant at 0.05 level***

Age group wise mean score was calculated to find out the significant difference on maternal care aspect in relation age and revealed that young respondents attained a little high score viz; 48.49, followed by old and middle age respondents who pertained mean score i.e. 45.00 and 45.11 respectively. Whereas, almost similar standard deviation was noted for all the respondents as shown in table 66. The F value for various ages calculated was 4.88 and the significant value (0.010) was found highly significant at 0.01 level of significance.

Turkey's HSD = Post Hoc Analysis within the categories

Table 51: Post Hoc test for ANOVA within various age groups (n=100)

Aspect	Age groups		Mean Difference	Sig.
Maternal Care	15-30 (Young)	31-45 (Middle)	**3.381****	.016
	45 and above (Old)	15-30 (Young)	-3.489	.075

***** Significant at 0.01 level***

Turkey's post hoc analysis was done for computing multiple comparison between various categories of the respondents and there was association found between young and middle age group people table 67.

This aspect is such an important aspect of every women's life and they usually have conversation about it. There were some interesting interactive media and methods used to impart information on related topic they percept it in a better way. Hence the null hypothesis stated, **there will be no significant difference in the mean score of pre-test and post-test of the respondents of maternal care in relation to age was not accepted.**

The very obvious findings were derived for mean score of the respondents regarding maternal care aspect in relation their educational status. In contrary the respondents who is educated either 9th standard or 10th standard calculated with less standard (3.80) deviation as compared to other respondents. 4.76 was the standard deviation for the respondents having education from 6 to 8th standard. The F value calculated was 2.20 whereas the significant value was found near to significant 0.05 level which shows the education was responsible to increase in mean score of the respondents. **Therefore, it can be said that the null hypothesis, stating there will be no significant difference in the mean score of pre-test and post-test of the respondents regarding Maternal Care in relation to Educational Status of the respondents was accepted.**

One way ANOVA was applied to see and check the significance among the mean score of respondents about maternal care aspect in relation to their marital statuses. It was found that unmarried and widow sharing almost similar mean score i.e. 49.41 and 49.50, which was highest among all the respondents, followed by 45.97 and 43.00

mean score possessed by married respondent and respondents having kinship respectively. Only separated respondent had comparatively low mean score i.e. 37. Married women found with high standard deviation (5.71) followed by unmarried (4.72) and widow (2.12) respondents. The F value was 2.70 and the significant value was found 0.035 which denotes that marriages does affects the knowledge of the people. From all the above findings, it can be concluded that direct intervention on any of the related issue or theme can always be helpful to bring desirable changes among them. Likewise, it helps in maintain uniformity in learning too. Findings of the present study proved that being married or unmarried did not act as an obstacle in learning by human being. Therefore, the null hypothesis, **there will be no significance difference in the mean score of pre-test and post-test of the respondents about Maternal care aspect in relation to Marital Status of the respondents was accepted.**

With reference to monthly family income it can be seen from table 66 that no major difference had been noted in the mean score of the respondents belong to low (45.89) and middle-income families (47.78), whereas, the respondent belong to high family income possessed comparatively high mean score (57). The standard deviation was also found similar among low and middle income group i.e. 5.75 and 5.18 respectively. The degree of freedom was found 2,97 and F value was 3.072. The significant value was found with relevancy when checked at 0.05 level which indicates that income was responsible for gain in knowledge. Even after conducting some participative activity respondents from every income group were unable to possess concrete knowledge about this aspect. Thus, the Null Hypothesis, framed **that there will be no significance difference in the mean score of pre-test and post-test of the respondents regarding Maternal Care in relation to the Monthly Family Income of the respondents was accepted.**

4.3.1.4.3 ANOVA on STDs and RTIs aspect in Relation to selected variables

Table 52: ANOVA of Mean Scores of Pre-test and Post – test of the Respondents regarding STDs and RTIs in Relation to their Age (n=100)

Criteria	Age (In Years)	n	Mean	SD	Df	F	Sig.
Pre – test	15 - 30 (Young)	47	2.32	0.81	2, 97	8.55	0.01**
	31 - 45 (Middle)	37	3.05	1.13			
	More Than 45 (Old)	16	2.06	0.93			
Post – test	15 - 30 (Young)	47	35.15	2.96	2, 97	0.13	0.88NS
	31 - 45 Years (Middle)	37	35.51	4.41			
	More Than 45 (Old)	16	35.50	2.99			

***** = Significant at 0.01 level, NS = Non-Significant at 0.01 and 0.05 level***

The pre-test data shows almost similar mean score among the respondents belong to young age group (2.32) and old ag group (2.06), whereas little high mean (3.05) was noted for middle age group. Similarly, the standard deviation was also noted in line with the mean score (Table 68). The F value calculated was 8.55 and the significant value was found significant at 0.01 level. Overall scenario depicts the low knowledge among the respondents for STDs and RTIs but the age was significantly affecting the awareness of the respondents.

For post-test thee data from Table number 68 revealed that the gain in knowledge regarding STDs and RTIs was noted significantly high than the pre-test scores. The mean difference between young age group and old age was not much higher, but a little bit difference was found with respondents from young age group in comparison to other age groups. Data also shows that standard deviation was found high in middle age group in comparison to young and old age group. The F-value calculated for the same was 0.12 and the significant value was noted 0.88 with no significant difference with the selected variables. Data was varied with little bit ups and downs within the categories, but age wise no significant difference was found at 0.01 and 0.05 level.

A contradictory findings indicated in table 68 indicates that, this is such a sensitive issue to handle by the people, especially in Indian Tribal context. The reason behind such findings might be that the STDs and RTIs starts from the infections and afterwards it converts into major disease. Now days lot of health care services and facilities had been provided by the stakeholders, but the prevalence of illiteracy put their step behind to talk about such things. Though the wrong practices are still prevalent among the tribal and rural women which is affecting reproductive health badly. Therefore, it becomes necessity to point out this aspect widely to prevent people from such deadly happenings in the form of sexual diseases.

Meitei M (2005) reported that reproductive tract infection is a generic term used to cover three types of infections viz. sexually transmitted disease (and infection), endogenous vaginal infections and infections related to reproductive tract. Further it was reported that the level of awareness of males and females about RTI in different districts of North-Eastern States of India. The knowledge of both males and females about RTI was observed to be relatively poor. The level of knowledge of females about RTI was 3.8 per cent in Arunachal Pradesh and 37.5 per cent in Manipur compared to the all India average of 45.4 per cent. However, females had better knowledge about; RTI than males in nine out of 34 districts. The nine districts are Sibsagar and Sonitpur in Assam; Ukhrul, Senapati, Imphal and Bishnupur in Manipur; Jaintia Hills'in Meghalaya; and Phek and Makokchung in Nagaland. The knowledge of females about RTI was reported to be the highest (82.4%) in Makokchung district of Nagaland, whereas it was the lowest (0.1%) in West Khashi district of Meghalaya followed by Changlang (0.5%) and Tirap (0.7%).

Another study by Desai and Patel (2008) highlighted that although prevention and control of RTIs and sexually transmitted infections (STIs), including HIV have been accorded to a national priority in India, the fact remains that many men and women suffer from various types of RTIs and STIs. Researchers have emphasized that the knowledge and awareness regarding such parameters is a must amongst any group of women, whether rural, urban and tribal.

Turkey's HSD = Post Hoc Analysis within the categories

Table 53: Post Hoc test for ANOVA within various age groups

Aspect	Age Groups		Mean Difference	Sig.
STD and RTIs	15 - 30 Years (Young)	31 - 45 Years (Middle)	**-.735***	.002
	31 - 45 Years (Middle)	More Than 45 (Old)	**.992***	.002

**** = Significant at 0.05 level***

Table 69 shows multiple comparison among the various age group categories. The major difference we found among middle and old age groups with mean difference of .992. further the difference was also noted among young and middle age groups.

In the present study researcher tried to impart knowledge about commonly prevalent STDs and RTIs amongst the selected tribal women, through Power Point Presentation and Flip Book. Higher gain in knowledge was reported by the respondents. Statistically age group was again not found as a difficult factor to learn about STDs and RTIs. Therefor it can be stated that present investigation was able to felicitate the basic knowledge of STDs and RTIs amongst the selected respondents.

Table 54: ANOVA with Mean Scores of Pre-test and Post-test the Respondents Regarding STDs and RTIs in Relation to their Educational Status

(n=100)

Criteria	Educational Status	n	Mean	SD	df	F	Sig.
Pre-test	Illiterate	58	2.67	1.13	5, 94	1.04	0.41NS
	Up to 5th Standard	6	2.50	1.05			
	6 – 8th Standard	5	1.80	0.84			
	9 – 10th Standard	13	2.23	0.60			
	11 – 12th Standard	1	2.00	-			
	Graduate and Above	17	2.65	0.93			
Post-test	Illiterate	58	35.24	3.886	5, 94	2.16	0.05 *
	Up to 5th Standard	6	37.67	1.033			
	6 – 8th Standard	5	35.80	3.033			
	9 – 10th Standard	13	33.15	2.304			
	11 – 12th Standard	1	40.00	-			
	Graduate and Above	17	36.12	3.018			

NS = Non – significant at 0.01 and 0.05 level, *Significant at 0.05 level

The pre – test data from 70 gives clear vision that all the respondents were having almost similar means, the level of education was not affecting their awareness towards STDs and RTIs. This is quite possible that this issue is somewhat technical and also contain some medical terminologies. But the symptomatic condition of occurring such diseases are quite similar to others. When pre – test was done with respondents, the mean score for the same was again found almost similar for each of the category, except the respondents who were having education upto 8^{th} standard. The F value calculated was 1.04 and the significant value was found 0.41 at 0.01 and 0.05 level of significance which shows non relevancy with their knowledge as per their age.

Educating one woman can be equalized to educating a whole family. In this context the post - test data given in Table 70 indicated very contradictory findings at various level of education of the respondents. Almost similar mean was noted among illiterate respondents 35.24 and respondents having education from 6th - 8th standard with the mean 35.80. Slightly increased mean (36.12) of graduate respondents and respondent's having education up-to 5th standard (37.67). Low mean was noted amongst respondents having education up-to 10th standard. The F-value calculated was 2.16 which denote high awareness level of the respondents. The calculated significant value was then checked at 0.01 level and 0.05 level and was found with significant at 0.05 level in relation to educational status of the respondents.

The findings clearly reflect that STDs and RTIs have terminologies and the various names of diseases which are difficult to pronounce. However, educated respondents always found clear in pronouncing various terminology as well as difficult words to speak. The other information pertaining to STDs and RTIs was the signs and symptoms related these disease and infections, which was quite easy to perceive. As these can be easily perceived by the respondents so sustainable learning can take place by the respondents.

Desai and Patel (2008) conducted similar study and reported that the awareness and treatment seeking increased with the education level of women as also with the education of their spouses, being 18 percent more among higher secondary and above level of educated women as against illiterate ones and 17 percent more among these whose husbands had studied up to higher secondary and above compared those whose husband, were illiterate. The young women's (age 25-34) chance of seeking health care is 12 percent higher than the adolescents (age 15-24) whereas the older (35 and above year) women have 8 percent lesser chance of going to seek treatment of their problem. This could be because women aged 35 years and above would have possibly completed their family size and may now neglect their health problems. Similarly, in comparison with

the women whose last pregnancy terminated in a live birth, women who have had a still birth in their last pregnancy have 30 percent higher chances to seek treatment. The anxiety of these groups of women is understandable as they would want to avoid a similar outcome of pregnancy in future and cure the problem, if any and hence seek treatment. The alertness to seek treatment also increases among women as the number of live births increases and is the highest (50 percent) among women with 5 and more births. Although prevention and control of RTIs and STIs, including HIV, have been accorded a national priority in India, many men and women continue to suffer from various types of RTIs and STIs.

This shows that the awareness concerning to STDs and RTIs is helpful to get rid of such diseases and ailments to combat the need of accessing health care. It is also well known that these are sensitive issues to talk and handle, mostly in our country like India people feel shy to discuss about, therefore imparting knowledge to create awareness becomes mandatory especially in rural, tribal and illiterate people. It is important that the gain in knowledge regarding various STD and RTIs will always be contributory to keep men and women both healthy and to live a healthy and happy life. Various training programmes and camps will always fulfil the needs to bridge the gap amongst the people having low knowledge and those having knowledge. In the present study education wise difference was found in both pre-test and post-test of the respondents but according to statistical data it the education has no correlation with their gain in knowledge.

Table 55: ANOVA with Mean Scores of pre-test and post-test of the Respondents Regarding STDs and RTIs in Relation to their Marital Status

(n=100)

Criteria	Marital Status	n	Mean	SD	df	F	Sig.
Pre-test	Unmarried	22	2.27	0.70	5, 94	2.32	0.061NS
	Married	74	2.66	1.08			
	Widow	2	1.50	0.71			
	Separated	1	4.00	-			
	Kinship	1	1.00	-			
Post-test	Unmarried	22	34.64	3.21	4, 95	0.75	0.55 NS
	Married	74	35.49	3.67			
	Widow	2	38.50	0.71			
	Separated	1	33.00	-			
	Kinship	1	36.00	-			

NS = Non-Significant at 0.01 and 0.05 level

Pre – test mean score from table reveals that the respondent who was living separately were having comparatively high (4.00) in comparison to other respondents. This was again noted strangely that unmarried and married respondents were possessing almost similar mean score i.e. 2.27 and 2.66 respectively. Rests of the respondents were having very low awareness according to their marital statuses. The F value for pre- test of the respondents were come was 2.32. the significant value for pre – test was near to 0.05 level of significance nut was found quite higher 0.061, hence concluded non – significant at both levels.

Table 71 shows almost similar mean difference emerged out from score of post – test of the respondents that, amongst various categories of the respondents

regarding knowledge and awareness of STDs and RTIs. The standard deviation was also found almost similar amongst unmarried and married respondents, followed by widow category showing less standard deviation. The F-value calculated was 0.75 which denotes less gain in knowledge. The significant value when checked was showing no significant difference at both 0.01 and 0.05 level.

There are some data released by District Level Household Survey which indicates the awareness level of women of Rajasthan regarding STDs and RTIs shown below. There are indicators which denotes the percentage of unmarried women's knowledge and awareness about mentioned aspects.

The key indicators below form **District Level Household Survey** 2 and 3 showing the awareness level of unmarried women from India regarding STDs and RTIs

Indicators	**DLHS-3 (2007-08)**			**DLHS-2 (2002-04)**		
	Total	**Rural**	**Urban**	**Total1**	**Rural**	**Urban**
Unmarried women who have heard of RTI/STI (%)	33.3	28.6	43.6	43.9	41.5	50.1
Unmarried women who have heard of HIV/AIDS (%)	59.6	50.1	80.2	52.2	42.1	78.1
Unmarried women who know the place for testing of HIV/AIDS (%)	18.2	19.6	15.0	32.5	33.7	29.3
Unmarried women underwent test for detecting HIV/AIDS14 (%)	61.7	56.5	68.9	NA	NA	NA

These data depict the complete picture of awareness level of unmarried respondents towards STDs and HIV AIDS, which was as a whole found low in comparison to the DLHS 2. Regarding HIV/AIDS it was found that unmarried women increase their knowledge in DLHS 3. In contrast to that data from the present investigation concludes that the level was found low regarding STDs and RTIs in the pre-test mean which was remarkably increased in the pre-test.

But if we compare the mean of all the selected aspects of reproductive health low achievement was found in the context to STDs and RTIs among all the respondents. Although they were able to recognize the symptoms and prevention and treatments but were unable to speak the name of some disease. So, it can be said that the longitudinal researches should be carried out frequently to acquaint them with the knowledge.

In an article published in "women's link (2007)" stated that the HIV/AIDS epidemic in India and spreading rapidly and increasingly which is affecting women's health in recent years. Out of total infected 38.45 were females, 57 percent in rural area. Similarly, in the present investigation some of the women diagnosed with the STDs as well as RTIs. But they were not aware about it as they were having low or less knowledge and awareness regarding signs and symptoms of STDs and RTIs. The reason behind having such health problem observed may be the extra marital sexual relationships, having multiple sex partners and less use of protective contraceptives. More or less another reason may be less education, lack of knowledge and awareness about contraceptives of STDs and RTIs. For achieving the goal to eliminate such health ailments from the tribal or poor communities, present investigation was an effort to create awareness among the selected respondents. Data shows significant achievement in the gain in knowledge and awareness by the respondents but not marital status was affecting the learning of tribal women.

Table 56: ANOVA of Mean Scores of Pre-test and Post-test of the Respondents regarding STDs and RTIs in Relation to their Monthly Family Income

(n=100)

Criteria	Family Income (in ₹)	n	Mean	SD	df	F	Sig.
Pre-test	1000/- to 10,000/- (Low)	63	2.68	1.09	2, 97	1.47	0.23 NS
	1001/- to 20,000 (Middle)	36	2.33	0.89			
	More than 20,000 (High)	1	2.00	-			
Post-test	1000/- to 10,000/- (Low)	63	35.73	3.54	2, 97	1.1	0.33 NS
	1001/- to 20,000 (Middle)	36	34.64	3.52			
	More than 20,000 (High)	1	36.00	-			

NS=Non-significant at 0.01 and 0.05 level

According to table 72 it can be said that all the respondents had almost similar range of mean score from 2.00 to 2.68. There was not much variation found in the standard deviation of the respondents of both the income group i.e. low and middle. 1.47 was the F value and significant value found was 0.23. both the value was found non-significant at 0.01 and 0.05 level of significance. Getting low mean score depicts low level of conceptual clarity about STDs and RTIs but income level was not the factor which affects their awareness about this aspect.

Table 72 revealed that sequential improvement in the mean of the respondents which was (34.64) in the middle income group, (35.73) in the low income group and (36.00) in the high income group. But standard deviation was almost found similar in the low income group and middle income group. The F-value was calculated to 1.1 and significant value calculated 0.33 which is showing significant improvement in gain in knowledge but was not associated with the income of the family members. Both pre-test and post-test significantly shows the difference between their mean before and after implementing the package. Moreover, this aspect included some medical terminologies hence found a little difficult to learn about the same.

There may be various reasons behind it, it is well known fact and observed by different researchers that the trend in tribal area are quite different from the people living in

urban area, as they are living in villages though they are tribal. They do believe in kinship and other likely issues like if one is not having kids he/she is allowed to have sexual intercourse with other than the marital partner, which directly leads them to infectious diseases like STDs and RTIs. There is prevalence of some of the disease like syphilus (Diagnosed to a women) who had multiple sexual partner, though she is found to be living with her family only. There are the medical facilities available to seek treatment to cure STDs and RTIs. But they are denying accessing the medical services as they feel shy to go for treatment and do not share about their personal Reproductive Health problem.

In regards to this some schemes and survey have already been carried out to diagnose and some of them were undergoing treatment and some of them were not, they even didn't share their problems or symptoms. Some awareness programmes may create an open environment to such beneficiaries to share their feelings problems and so forth their needs can be addressed.

Through present study researcher tried to create awareness about pros and consequences of the STDs and RTIS with the help of various IEC Materials viz; Power Point Presentations, Pamphlets and Flip Book. The result was found significantly high with having high achievement score by the maximum respondents. As the topic was quite sensitive and new for the respondents but their monthly family income had no association to affect their learning.

Table 57: ANOVA with mean difference of pre and post – test scores of the respondents regarding STDs and RTIs in Relation to selected variables (n=100)

Variables	Categories	n	Mean	SD	Df	F	Sig.
Age	15-30 (Young)	47	35.62	2.98	2,97	.49	0.61NS
	31-45 (Middle)	37	35.27	5.04			
	45+ (Old)	16	36.44	3.44			
Education	Illiterate	58	35.38	4.45	5,94	1.63	0.16NS
	up to 5th Standard	6	38.00	1.55			
	6-8th Standard	5	36.60	3.36			
	9-10th Standard	13	33.85	2.94			
	11-12th Standard	1	41.00	.			
	Graduate & Above	17	36.35	2.57			
Marital Status	Unmarried	22	35.45	2.96	4,95	1.0	0.39NS
	Married	74	35.55	4.16			
	Widow	2	40.00	1.41			
	Separated	1	32.00	-			
	Kinship	1	39.00	-			
Monthly Family Income (in ₹)	1000/- to 10,000/- (Low)	63	35.92	3.83	2,97	0.62	0.54NS
	1001/- to 20,000 (Middle)	36	35.06	4.09			
	More than 20,000 (High)	1	37.00	-			

NS = Non - Significant at 0.01 and 0.05 level

Table 73 Clearly indicates that no major differences were found among the mean score of respondents of various age groups which was ranging from 35.27 to 36.44. in contrast to that a little large variation was calculated for standard deviation of the respondents as it was noted quite low for young age group (2.98), a little high for middle age group (5.04) and moderate (3.44) for old age group. The F value calculated was 0.49 and the significant value was found 0.61 which shows no correlation of the age on their gain in knowledge about STDs and RTIs.

STDs and RTIs are the topics where frequent discussion sometime becomes mandatory or relevant topics has to be taken care to aware people about its advantages along with preventive measures. Despite using multimedia for creating awareness about this aspect people respondents were only able to gain the basic things, which are also important. However, the Null Hypothesis framed, **there will be no significance difference between mean achievement score of the respondents regarding "STDs and RTIs" in relation to Age was accepted.**

One way ANOVA applied with mean score of pre-test and post-test of the respondents and found out that the respondents who was having education between 9^{th} and 10 standard possessed lowest means score (33.85) about STDS and RTIs, followed by other respondents who were either illiterate or having education upto 8^{th} standard or graduate and above obtained mean score ranging 35.38 to 38.00. The only respondents who were studying in 11^{th} or 12^{th} standard attained reasonably high mean score i.e. 41.00. There was much variation was noted regarding standard deviation, as it is evident from table 73 Primary educated respondents had 1.55 standard deviation, a little high standard deviation was computed for the respondents having education graduate and above i.e. 2.57 and 9-10 standard i.e. 2.94. rest of them had standard deviation from 3.36 to 4.45. the significant value had no relation about their learning towards STDs and RTIS aspect. Thus, this can be concluded that the Null Hypothesis stating that **there will be no significance difference between mean achievement scores of the respondents of "STDs and RTIs" in relation to Educational Status of the respondents was not accepted.**

For marital status it can be seen from table 72 that separated, unmarried and married women respondents had nearly equal mean score i.e. 32.00, 35.45 and 35.55 respectively, whereas, having kinship and widow women possessed relatively high mean score for STDs and RTIs i.e. 39.00 and 40.00 respectively. Widow and unmarried women respondents had little less standard deviation (1.41 and 2.96), while married respondents had comparatively high standard deviation 4.16. The F value found out was 1.0 and the significant value computed was 0.39 which was found insignificant at 0.01 and 0.05 level of significance. Marital status somewhere down the line does affect their knowledge as well as awareness, as they pass out with sexual

activities hence they may know about the symptoms of STDs and RTIs. findings also revealed that they had extra marital sexual activity which caused them suffering from STDs. But the subtle nature of such topic had hindered their response towards the STDs and RTIs. evidences from present study also showed no relevance with their marital positions, therefore, it can be said that the Null Hypothesis, **there will be no significant difference between mean achievement score of the respondents regarding "STDs and RTIs" in relation to Marital Status of the respondents was accepted.**

Table 73 denotes that no major difference in the mean of the respondents belong to varied family income group although it was found quite high from pre-test and post-test. The middle income group had mean 35.06, the low income group possess mean 35.92 and high income group achieved mean 37.00. the standard deviation for low income group Calculated was 3.83 and the middle income group was 4.09. the F value was found 0.39 and the significant value was computed 0.54 which has no relevance with their knowledge.it can be clearly said that the significant value was found irrelevant at 0.1 and 0.5 level of significance. Therefore, the null hypothesis stated there will be no **significant difference between mean achievement score of the respondents regarding "STDs and RTIs" in relation to their Monthly Family Income was accepted.**

4.3.1.4.4 ANOVA with Family Planning Aspect in Relation to Selected Variables

Table 58: ANOVA with pre-test and post-test Mean Scores of the Respondents Regarding Family Planning in Relation to their Age

(n=100)

Criteria	Age	n	Mean	SD	df	F	Sig.
Pre-test	15 - 30 Years (Young)	47	1.91	1.32	2,97	3.64	0.03*
	31 - 45 Years (Middle)	37	2.78	1.58			
	Above 45 Years (Old)	16	2.63	1.96			
Post-test	15 - 30 Years (Young)	47	35.15	2.96	2, 97	0.12	0.88 NS
	31 - 45 Years (Middle)	37	35.51	4.41			
	Above 45 Years (Old)	16	35.50	2.99			

**** = Significant at 0.05 level, NS= Non- Significant at 0.01 and 0.05 level***

Family planning becomes prime concern when it comes for the effective nurturing of the family, whether it is related to health or wealth. In the same context table 74 shows very, low mean score related to awareness regarding family planning issues. Young respondents possessed 1.91 mean score, whereas, slight high was noted with old (2.63) and middle age (2.78) respondents. While the standard deviation computed almost same in case of almost all the respondents. the F value was calculated little high viz; 3.64 and the significant value was found 0.03 which was found significant at 0.05 level. This shows that family planning concern does rely on age of the respondents.

While in post-test data table 74 showed similar trend in mean score of the respondents ranging 35.15 to 35.51 among all the age groups i.e. young, middle and old. Regarding standard deviation respondents from middle age group were showing higher gain in knowledge. The F-value calculated was 0.12 while significant value was found with high gain in knowledge i.e. 0.88. When it was checked on 0.01 and 0.05 level it was found to be non-significant with the categories mentioned. Overall it can be said that high gain in knowledge were there. Family planning now a day becomes a serious

concern to address the need to resolve the problems of STDs and RTIs in India. On the other hand, a remarkable rise in mean of post-test had also been noted.

Regarding concept of family planning and contraception, there are many schemes and programmes running since several decades. Researcher also observed and discussed with the ANM of the area about provisions of contraceptives absolutely free of cost at their health centre for the local people. The government hospitals and health centres of urban area are also providing contraceptives at free of cost to the people living in the urban area community. But attitude to adopt contraceptives always play an important role towards the services and contraceptives available to them.

Reddy et al. (2003) revealed that all the respondents were aware of the permanent methods of sterilization (both vasectomy and tubectomy). Among the temporary methods, 86% of the subjects were aware of condoms, 50% Oral Contraceptive Pills, 32% abstinence and 6% Intra-Uterine Contraceptive Devices. The subjects had a positive attitude towards Family Planning measures and were keen on restricting the size of their family to 'two'. 74% of men felt that couple must take a joint decision on the practice of family planning method(s) and the family size. They also expressed the need for their involvement in reproductive health. Practice of family planning method(s) and the family size. They also expressed the need for their involvement in reproductive health. Author also suggested the 'Need for involvement of Men in Reproductive Health'.

This study throws light that male can also perform the important role to take decision or to have positive attitude towards family planning matters. There is no age bar to have knowledge towards complete family planning issues. In the study married men with five-year experience were included and concluded that men equally contribute towards help in getting good health or spoiling the health of a women of any age in regards to family planning. To support this age is not bar to have knowledge regarding family planning and thus the similar data in the present was drawn after analyzing it statistically.

Turkey's HSD = Post Hoc Analysis within the categories

Table 59: Table Post Hoc test for ANOVA within various age groups (n=100)

Aspect	Age Groups		Mean Difference	Sig.
STDs and RTIs	15 - 30 Years (Young)	31 - 45 Years (Middle)	735*	.002
	31 - 45 Years (Middle)	More Than 45 (Old)	992*	.002

**** The mean difference is significant at the 0.05 level***

Table 75 denotes the significant association among the various age categories. There was a relation found among the young and middle and middle age group of the respondents. the knowledge about STDs and RTIs can be sustained when it better discussed with the people with awareness.

Table 60: ANOVA with the Mean Scores of pre-test and post-test of the Respondents Regarding Family Planning in Relation to their Educational Status (n=100)

Criteria	Educational Status	n	Mean	SD	df	F	Sig.
Pre-test	Illiterate	58	2.41	1.68	5, 94	0.80	0.55 NS
	Up to 5th Standard	6	3.33	1.86			
	6 – 8th Standard	5	1.60	1.67			
	9 – 10th Standard	13	2.15	1.28			
	11 – 12th Standard	1	2.00				
	Graduate and Above	17	2.18	1.29			
Post-test	Illiterate	58	22.81	2.14	5, 94	1.10	0.36 NS
	Up to 5th Standard	6	23.50	2.88			
	6 – 8th Standard	5	21.20	0.45			
	9 – 10th Standard	13	22.08	1.80			
	11 – 12th Standard	1	24.00				
	Graduate and Above	17	22.88	1.80			

NS = Non -Significant at 0.01 and 0.05 level

It can be easily seen from data given in table 76 the respondents who had education between 6-8th standard attained lowest mean pre-test score, whereas, the other respondents computed with a little high mean score ranging from 2.00 to 2.41 for illiterate, secondary, higher secondary and graduate and more educated respondents. It was found little strange that the respondents who had primary education possessed the score viz; 2.33. Not much variation was noted in terms of standard deviation of the respondents of various educational statuses. The F value calculated was 0.80 and Significant value was 0.55 which showed negative relevancy at 0.01 and 0.05 level of significance.

Regarding post-test., data from Table 76 reflected similar trends in mean of various categories were found. Regarding standard deviation, the value was found less among the respondents who were having education form 6 – 8th standard in comparison to respondents from other categories. Almost similar value of standard deviation was found among the respondents having education 9 – 10th standard and graduate respondents i.e. 1.80 and 1.80 respectively. Regarding illiterate respondents and respondents having primary education the value of standard deviation was found 2.14 and 2.88 respectively. Data reflecting fluctuating trend with various educational level of the respondents. The F-value calculated was 1.1 and significant value was found 0.36. When significant value checked at 0.01 level and 0.05 level, it was found non-significant with the various categories of educational level of the respondents.

More or less family planning matter is related to the married couple in our country like India, as it is associated with the marriage and sexual life of a couple. But now a day this trend is going beyond the Indian traditions and customs. People (specially living in urban) is diverting towards live – in relationship. In contrast to that, tribal respondents still believe and remain with multiple sexual partners and / or extra marital relationships. Such relationships many times results in various STDs and RTIs amongst involved people. To avoid occurrence of such health problems prevalence's, people should always encourage each and every individual to pertain knowledge and awareness in the family planning aspect.

Similar findings were reported by Dhingra et al. (2010) reported a high prevalence of illiteracy and associated ignorance among rural masses (35%) especially regarding the

concepts and measures of family planning ($\chi 2$= 14.24, Sig. 1%). Majority of rural respondents especially women folk (51%) were unaware of concepts related to family planning. Condoms were by far the most favorable contraceptive measures across both settings (81% males and 77.5% females) followed by birth spacing pills (39%). The appropriate knowledge regarding other measures e.g. Copper-t (13.5%) and male sterilization was lacking. Further, urban respondent entrusted the contraceptive responsibility on their respective partners (43% males, 44% females), while rural couples (74% females and 64% males) followed the same age-old traditional concept of male dominance and superiority. Television and magazines were found to be the major accessible sources of information. Results from rating scale revealed a major difference ($\chi 2$= 54.66, Sig. 1%) in the attitude of respondents. Education was found to be significantly associated with the respective attitude of respondents towards family planning. In the present investigation, almost similar findings were drawn. Therefore, it can be concluded that the knowledge and use of family planning methods and contraceptive can contribute significantly towards combating many Reproductive Health related diseases amongst both males and females.

Efforts were made in the same context to make tribal people aware about various Family Planning methods and contraceptives by using various IEC materials developed like, pamphlets, and booklet. One video film on the advantages of Family Planning were also shown to the respondents to create awareness among them. Data revealed high gain in knowledge in post-test as compared to pre-test, but was not found statistically significant with their educational statuses. This directly shows that no matter how much the people are educated belong to any homogeneous group learning can be effectively taken place if provided effectively.

Table 61: ANOVA with pre-test and post-test Mean Scores of the Respondents Regarding Family Planning in Relation to their Marital Status

(n=100)

Criteria	Marital Status	n	Mean	SD	Df	F	Sig.
Pre-test	Unmarried	22	1.82	1.33	4, 95	1.71	0.15 NS
	Married	74	2.51	1.62			
	Widow	2	2.50	0.71			
	Separated	1	4.00	-			
	Kinship	1	0.00	-			
Post-test	Unmarried	22	22.68	1.91	4, 95	0.10	0.98 NS
	Married	74	22.69	2.15			
	Widow	2	22.50	0.71			
	Separated	1	23.00	-			
	Kinship	1	24.00	-			

NS = Non -Significant at 0.01 and 0.05 level

A very fluctuating mean score was noted for pre-test for family planning aspect as per marital statuses of the respondents. the respondent belongs to kinship category had no knowledge about family planning aspect and in line with that unmarried respondents had very little mean score i.e. 1.82. married and widow respondents had almost similar mean as shown in table 77. The separated women respondents had comparatively high mean score i.e. 4.00. The standard deviation ranged from 0.71 to 1.62 in account of unmarried, married and widow women respondents. the F value was calculated 1.71 and the significant value was found 0.15 which was found insignificant at 0.01 and 0.05 level of significance.

Data observed in Table 77 reflects that similar mean was observed among unmarried, married and widow women respondent from the present study for the post treatment data. The standard deviation was found low among widow women respondents was 0.71. The F value was found 0.10 and the significant value was found 0.98 which was

showing the significantly higher side of gain in knowledge. When the t value was checked at 0.01 and 0.05 level it was not showing any significance in relation the various marital status of the respondents.

Again, a variation among the mean score of pre-test and post-test was noted in concern to family planning aspect. The reason behind this data emerged from the analysis from the present investigation was that family planning itself is not that difficult to sustain in terms of gain in knowledge. As it includes the methods and contraceptive, which one can easily sustain in terms of awareness regarding various methods of family planning and contraceptives.

The Reproductive and Child Health Programme (2004) has been implemented with a philosophy and direction to meet the health care needs of women and children. It was envisaged the provision of couples to control their fertility and have sexual relations free from the fear of pregnancy. Provision of free contraceptive services to all the needy couples was one of the components of the RCH programme. The information on knowledge of contraceptive was obtained by asking a question "which are the family planning method you know?" Knowledge of contraception has almost become universal in Rajasthan. Almost all the women (aged 15-44) know at least one modern method of contraception. About ninety percent of women have knowledge of any modern spacing method. The knowledge of any modern spacing method has been found to be lowest in southern region (71.68 percent). The knowledge of all the modern family planning methods is reported only by about half of the women (52.6 percent). Again, lowest knowledge of all the modern family planning methods is reported Southern region (34.83 percent) followed by Western region (45.38 percent). The Knowledge of any traditional method is 14.6 percent of women in the state. The highest knowledge of traditional methods is reported in southern regions (21.88 percent). It is the tribal dominate areas and still women practice traditional methods of birth control. To overcome and control this practice it is an essential part that the tribal people should convinced to change their attitude towards various family planning methods. For that knowledge and awareness regarding the same is an important factor considered.

Family Planning is as important in life as the food is, henceforth in the present research, investigator tried to make tribal women aware about the issues and concern of Family Planning. It was observed from the present findings that women of any age, whether married or unmarried and belongs to any family, gain knowledge effectively.

Table 62: ANOVA with pre-test and post-test Mean Scores of the Respondents Regarding Family Planning in Relation to their Monthly Family Income (n=100)

S. No.	Family Income (in ₹)	n	Mean	SD	Df	F	Sig.
Pre-test	1000/- to 10,000/- (Low)	63	2.38	1.58	2, 97	0.13	0.87 NS
	1001/- to 20,000 (Middle)	36	2.28	1.60			
	More than 20,000 (High)	1	3.00	-			
Post-test	1000/- to 10,000/- (Low)	63	22.92	2.07	2, 97	1.33	0.26 NS
	1001/- to 20,000 (Middle)	36	22.28	2.01			
	More than 20,000 (High)	1	24.00	-			

NS = Non- Significant at 0.01 and 0.05 level

For pre-test data low income group and middle group had very low difference of mean score viz; 2.38 and 2.28 respectively, whereas, the high income group respondents had mean score 3.00. The similar standard deviation was also noted for low and middle income respondents i.e. 1.58 and 1.60. the F value was found 0.13 with 0.87 significant value which was stated insignificant when checked at 0.1 and 0.05 level of significance.

Whereas, for post-test data derived statistically and quoted in table 78 revealed that, the mean difference was again found high as compare to pre-test data, but almost similar in the respondents from low income group and middle income group. The standard deviation was also not varied amongst low and high income group i.e. 2.07 and 2.01 respectively. The F-value was calculated 1.33 and the significant value noted was 0.26, which was when checked at 0.01 level and 0.5 level showed no significant difference with the respondents from various income categories.

The reason behind above findings might be that the tribal of the selected area were homogeneous in nature and having similar characteristics, also believe in the group cohesiveness. They trust their relatives, friends and family members more. It was also observed that income cannot be the barrier to gain in knowledge. On the other hand, the accessibility to information was also there in the form of medical facilities, but they believe that if they do not involve in the sexual activity there is no need to know about the Family Planning methods and contraceptives.

To find out awareness and knowledge regarding contraceptives **Serena et al. (2000)** conducted a study and found that almost all the interviewed women while being challenged of their active memory of knowledge of contraceptive methods, 72 per cent of women mentioned IUDs, 59 per cent sterilization, 44 per cent the pill, 20 per cent the condom, 15 per cent withdrawal, 12 per cent breast feeding, 11 per cent natural methods and 1 per cent injections. Among contraceptive methods ever used and actually in use: IUDs, female sterilization, oral pill and withdrawal were the most frequently reported methods. The prevalence of the use of high efficacy methods among the currently married women was 50 per cent. In the present study it was also found that women were more aware about the copper – t, condom and male and female sterilization etcetera.

It was observed and can be concluded from pre-test and post-test findings, that giving knowledge about Family Planning and contraceptives becomes an ethical issue, as the respondents were belonging to the traditional area and still following traditional culture. The efforts still have been made by the researcher to make them aware about their reproductive rights and Family Planning aspect. The study also concluded the amount of gain in knowledge was high after implementing the package. Once they are being able to understand they participated effectively and proved that no income can affect learning of the human being.

Table 63: ANOVA with Mean Difference of Pre-test and Post-test Scores of the Respondents Regarding Family Planning in Relation to Selected Variables (n=100)

Variables	Categories	n	Mean	Sd	df	F	Sig.
Age	15-30 (Young)	47	20.57	2.23	2,97	2.11	0.13NS
	31-45 (Middle)	37	19.76	2.45			
	45+ (Old)	16	21.06	2.52			
Education	Illiterate	58	20.40	2.52	5,94	0.35	0.88NS
	up to 5th Standard	6	20.17	2.86			
	6-8th Standard	5	19.60	1.34			
	9-10th Standard	13	19.92	1.77			
	11-12th Standard	1	22.00	-			
	Graduate & Above	17	20.71	2.62			
Marital Status	Unmarried	22	20.86	2.17	4,95	1.03	0.40NS
	Married	74	20.18	2.46			
	Widow	2	20.00	1.41			
	Separated	1	19.00	-			
	Kinship	1	24.00	-			
Monthly Family Income (in ₹)	1000/- to 10,000/- (Low)	63	20.54	2.32	2,97	0.62	0.54NS
	1001/- to 20,000 (Middle)	36	20.00	2.53			
	More than 20,000 (High)	1	21.00	-			

NS = Non - Significant at 0.01 and 0.05 level

The mean for various age group does not consists much difference as it was calculated 20.57 and 21.06 for young and middle age group respectively, a little less mean was reported for middle age group was 19.76 (Table 79). The standard deviation for all the age group was found almost similar as shown in table 79. 2.11 was the F value and 0.13 was the significant value which was found insignificant at 0.01 and 0.05 level of significance. Therefore, the null hypothesis stating, that there will be no significant difference between mean achievement score of the respondents regarding **"Family Planning"** in relation the **Age** of the respondents was accepted.

19.60 and 19.92 was the mean score found out for the respondent belong to 6^{th} to 8^{th} standard and 9^{th} to 10^{th} standard respectively. Rest of the respondents possessing little high mean score ranging from 20.17 to 22.00. The standard deviation for 6^{th} to 8^{th} standard and 9^{th} to 10^{th} standard was also found little low 1.34 and 1.77 respectively, 2.52 was computed for illiterate and 2.86 was computed for primary educated respondents. after further analysis 0.35 was the F value and 0.88 was the significant value which shows no correlation with educational statues of the respondents with regards to their knowledge gain. Therefore, the Null Hypothesis framed, **there will be no significant difference in the mean achievement score of the respondents regarding "Family Planning" in relation to Educational Status of the respondents was accepted.**

Table 79 further portray the about similar means of unmarried, married, widow and separated respondents i.e. 19 to 20.86, while respondent who was living in kinship had attained quite high score viz; 24.00. regarding standard deviation widow respondents had 1.41 standard deviation, whereas, unmarried and married had 2.17 and 2.46 standard. The 1.03 F value was calculated and 0.40 was the significant value was not showing association at 0.01 and 0.05 level of significance. Thus, the Null Hypothesis framed, **there will be no significant difference in the mean achievement score of the respondents regarding "Family Planning" in relation to the Marital Status of women was accepted.**

Almost similar means score was noted in case of all the respondents belong to various monthly family income groups, and the standard deviation was also found nearly as shown in table 79. The calculated F value was 0.62 and 0.54 was the significant value which has negative significance at 0.01 and 0.05 level of significance. Thus, the Null Hypothesis **there will be no significant difference in the mean achievement score of the respondents regarding Family Planning in relation the Monthly Family Income of the respondents was accepted.**

4.3.2. Qualitative Findings (Family Planning)

Qualitative data is typically descriptive data and as such is harder to analyze than quantitative data. Qualitative research is useful for studies at the individual level, and to find out, in depth, the ways in which people think or feel (e.g. case studies).

It is a fact that qualitative data always provide details about the target group, so as useful to conclude almost complete scenario of the selected target group. In the present investigation researcher tried to get some qualitative data related to Family Planning aspects with the help of developed interview schedule and group discussion.

Case 1: Response of the Respondents towards Advantages of Family Planning

Q 3: Advantages of the Family Planning with references to size of the family

परिवार नियोजन के एक परिवार को नियोजित रखने के लाभ

Answers given by the respondents are stated below (in Hindi and English):

- यह हमें बार बार गर्भधारण करने से रोकता है
- परिवार नियोजन से हम बच्चों में अंतर रख सकते है
- कम बच्चा वेगा तो कम पैसा में भी काम अच्छो चालेगा
- छोटो परिवार रे तो ज्यादा खर्चा भी नि छावे
- परिवार नियोजन से कम बच्चा वे तो ध्यान ज्यादा रखावे"
- Family Planning prevents from frequent pregnancies
- It helps in maintaining a gap between children
- Smaller the family, lesser the economic expenditure
- Small home can be fulfilling the need of small family
- Due to family planning we have less kids, so we can take care of them effectively

World Health Organization (2016) posted in an online article that Promotion of family planning – and ensuring access to preferred contraceptive methods for women and

couples – is essential to securing the well-being and autonomy of women, while supporting the health and development of communities**.** Various advantages of Family Planning include preventing pregnancy related health risks, helping to prevent HIV/ AIDS, slowing population growth etcetera. In the present study, various responses have been emerged from the discussion with the tribal women on advantages of various Family Planning Methods.

The above findings (Case number 1) interpret that the knowledge regarding the advantages of the Family Planning was correct and complete amongst women respondents. This reflects that the respondents (tribal women) selected had authentic information related to the Family Planning concept. However, when the background information related to the respondents was gathered, then it was found that almost 50 % of the respondents had family of (5-8 members) and 22 %o respondents had large families (above 8 members). This is quite contradictory to the responses sleeked through interviews related to advantages of Family Planning. These findings show synchronization among the knowledge gained by them and their perfect practices. Overall it is proved as respondents gained knowledge, post implementation of IEC Package on Family aspect.

Family Planning covers broad range of Reproductive Health care services and this also helps in many ways to attain better health by the women and even men. This basically helps people to control when and how often to conceive to have a family which directly or indirectly affect health. In the present investigation effectively gained knowledge about Family Planning concern as the specimens were used to show them along with its benefits to them.

Case 2: Responses of the respondents towards ways of using contraceptives

Q 6: Ways of using contraceptives

गर्भनिरोधकों के उपयोग की विधि

Answers given by the respondents stated below:

- कॉपर – टी ऐ एन एम / डॉक्टर लगावे ने बच्चेदानी में लगावे है
- कंडोम वे जो आदमी रे लगावे है
- इंजेक्शन बच्चा नि वेवा वास्ते लागे है
- औरता रे वास्ते भी निरोध आवे है जो योनी के रास्ते पे लागे है
- औरता रे ऑपरेशन में दोई नली या तो काटे हे या या फेर धागे से बांध देवे है, जो बच्चा छावे तो खोली सके
- आदमी रे वृषण के नीचे शुक्राणु की नली को थोडा सा काट देवे है, जिनसे औरत रे बच्चा नी रेवे
- ऐ एन एम / डॉक्टर के बतावे के हिसाब से गोली लेते हैं , जो औरत रे बच्चा नी रेवे है
- पैच चमड़ी पे लगावे जिसकी वजह से बच्चे भी नि रेवे है"
- रबड़ की टोपी के उपयोग से भी गर्भावस्था को रोक सकते हैं

- ANM or Doctors places copper t in the vagina
- Male Uses the condom
- Injections are also there for prevent pregnancy
- Female condoms are also there to put in the vaginal route
- Fallopian tubes in women can cut or tied to prevent pregnancy, if tied a knot it can be open while in need to be pregnant
- Seminal Vassals can be cut for male sterilization.
- Contraceptive tablets can be taken according to the instructions given by Doctors or ANMs.
- Patches are used in under the skin to prevent pregnancy
- Diaphragm is also useful to prevent pregnancy.

The above-mentioned answers were drawn by asking them related questions "Ways of using contraceptives". Findings revealed that the respondents have correct and authentic knowledge regarding the usage of contraception. This part of Reproductive Health was covered through "Demonstration method" in the IEC Package developed

along with the video film. The content of video film consisted of various advantages and disadvantages of Family Planning and use of contraceptives. Though it was in a story form and was picturized with ample amount of clear and colorful visuals along with the appropriate sound and dialects. The impact of showing the video film was therefore helpful to change in attitude of the respondents.

It was also observed that the videos shown them on the use of other contraceptives like male and female condom and diaphragm was good enough to make women aware about ways of using various contraceptives effectively. They were also told that the proper use of contraceptives will always help them to reduce various infections and communicable diseases. Therefore, the results of the package are found to be effective in terms of increase in their knowledge.

Case 3: Responses of the respondents towards ways of using contraceptives

Q 9: Advantages of contraceptives in family planning

गर्भ निरोधक के परिवार को नियोजन में लाभ ?

Answers given by the respondents stated below:

- *जो बच्चा नी छाई रा वे तो रोकी सके*
- *एक तो फ्री में मिले है जिससे जब भी छावे काम में ले सके*
- *बच्चा रे बिच में अंतर भी राखी सके*
- *बूँद और अंडा मिले ही नै तो बच्चा पनपे ही कोनी*
- *इससे फैलने (जननांगों की) वाली बीमारी भी नहीं होती*
- It in prevent unwanted pregnancies
- Contraceptives can be obtained free of cost from local health centers
- It Helps create gap between two children
- If there no connection between sperm and ovum, there will be no pregnancy
- It is also helpful in preventing STDs

New Zealand Family Planning (2013) an e-Newsletter reported the benefits of using various contraceptives. Among all the most important were Reducing pregnancy-related risk, reducing teenage pregnancies and having healthy babies. These are considered as the most important to gain or retain good health of women.

The finding also reveals that the responses of the respondents were theoretically correct. They had complete information on advantages of contraceptives in planning a family this component of Reproductive Health was covered through illustrative talk method. Hence the correct responses have contributed to the gain in knowledge.

SECTION 4.4: REACTIONS OF THE RESPONDENTS TOWARDS VARIOUS MEDIA

4.4.1 Reactions of the respondents towards Electronic Media (Power Point Presentations and Video Films)

Table 64: Frequency and Percentage Distribution of the Respondents According to their Reactions towards Power Point Presentations

(n=100)

S. No.	Details	%
	General Aspects	
1.	**Did you find the power point presentations were**	
	• Very interesting	54
	• Moderately interesting	45
	• Less interesting	1
2.	**The topic of power point presentations were**	
	• Common	16
	• Uncommon	84
3.	**The duration of the power point presentations were**	
	• Very long	6
	• Appropriate	94
	Educational Aspects	
1.	**Did the power point presentations were helpful to learn?**	
	• To great extent	77
	• To some extent	15
	• To less extent	8
2.	**The information given in power point presentations were**	
	• **Easy to understand**	**82**
	• **Difficult to understand**	**18**

Continued to next page

(Table 80) Continue from page no. 248

3.	**The information given in power point presentations were** • Very useful • Moderately useful • Less useful	 89 10 1
	Visual Aspects	
1.	**Visuals were correct and appropriate to subject matter** • To great extent • To some extent • To Less extent	 80 14 6
2.	**Visuals in power point presentations were easy to understand** • Were not easy • To great extent • To some extent • To Less extent	 2 77 15 6
3.	**The duration of visuals were** • Appropriate	 100
4.	**Visuals were interesting** • To great extent • To some extent	 94 6
5.	**Did you find any difficulty in watching the visuals** • Not at all	 100

General aspects

Regarding general aspects, it was found from Table 78 that more than half of the respondents i.e. 54 percent found power point presentations very interesting followed by 45 percent respondents who found it moderately interesting. No respondents stated that presentations were not interesting.

Maximum number of respondents stated that the topic of power point presentations was new while rest of them reported it common.

Regarding duration of the presentation maximum respondents found it appropriate rest of them reported this as very long duration. None of them reported that this is not interesting.

Educational aspects

A significant number of respondents (77%) stated that it was helpful to learn to great extent while 15 percent said that it was helpful to learn to a less extent. Only few of them told that it was less effective for learning. None of them said it was not helpful.

High majority of the respondents (82%) said that information given in power point presentations were easy to understand, in contrast to that only 18 percent said that it was difficult for them to understand from power point presentations. Very high majority (89%) stated that information in the power point presentations were very useful but only 10 percent said it was not so useful. In the same way no respondents felt this as unuseful.

Visual aspects

Visuals in the power point presentations were correct and very much relevant to the subject matter to a great extent stated by 80 percent. In contrary only 14 percent said it was appropriate to some extent while 6 percent said it was appropriate to a less extent. None of the respondents stated that they were not appropriate or not correct.

Visuals of the power point presentations were easy to understand to great extent concluded by 77 percent respondents.

All the respondents said the duration of the visuals were appropriate. Maximum respondents (94%) found that the visuals were interesting, while only few of them were reported about visuals were less interesting. All of them were found this as interesting. Hundred percent respondents didn't find any difficulty while watching visuals in the power point presentations, as they were very clear in appearance and the size of visuals were also appropriately visible.

Table 65: Frequency and Percentage Distribution of the Respondents According to their Reactions towards Video Films

(n=100)

S. No.	Details	%
	General Aspects	
1.	**Did you find the video films were**	
	• Very interesting	74
	• Moderately interesting	24
	• Less interesting	2
2.	**The topic of video films were**	
	• Common	33
	• New	67
3.	**The duration of the video films were**	
	• Very long	15
	• Appropriate	80
	• Less	5
	Educational Aspects	
1.	**Was it helpful to learn?**	
	• To great extent	84
	• To some extent	15
	• To less extent	1
2.	**The information given in the video films were**	
	• Easy to understand	94
	• Difficult to understand	6
3.	**The information given in the video films were**	
	• Very useful	97
	• Less useful	3

Continue to next page

(Table 81) Continued from page number 251)

	Commentary of the Films	
1.	**Language used in the films were** • Easy to understand • Difficult to understand	 96 4
2.	**Did you faced difficulty in hearing the commentary** • No difficulty found	 100
4.	**Speed of commentary of the films were** • Very fast • Exact and right • Very slow	 2 97 1
	Visual Aspects	
1.	**Visuals were correct and appropriate to subject matter** • Correct and appropriate to great extent • Correct and appropriate to some extent • Correct and appropriate to less extent	 88 10 2
2.	**Visuals were** • Difficult of understand • Easy to understand	 12 88
3.	**Visuals were interesting** • To great extent • To some extent • To less extent	 86 8 6
4.	**Duration of visuals were** • Very long • Appropriate • Short	 3 96 1
5.	**Did you find any difficulty in watching the visuals** • **Not found any difficulties**	 **100**

General Aspects

Data from Table 75 revealed that A considerable number of respondents i.e. 74% stated that video films were very interesting, followed by almost one fourth respondents (24%) found it moderately interesting.

Sixty seven percent respondents expressed that the topics of video films were new and 33 percent said that the topic was common.

Maximum respondents (80%) expressed that the duration of video films were appropriate in contrast to that 15 percent stated that the duration was very long.

Eighty four percent respondents found the watching video films as helpful to learn something to a great extent.

Almost hundred percent respondents' i.e.97 percent found the information given in the video films as very useful while only 3 percent found it as less useful. None of them reported that they are not interesting.

Educational Aspect

Majority of the respondents (84%) said that the films were helpful to learn to high extent and only one percent stated it was less useful. High majority (94%) of the respondents reported it as easy to understand while rest of them had found difficulty to understand.

None of the respondent stated that it was not useful or moderately useful. Almost all the respondents (97%) found it very useful and rest of them said it is less useful.

Commentary of the Video Films

Regarding language used in the films, 96 percent of the respondents found it was easy to understand while only 4 percent found it difficult to understand.

No difficulties were faced by the respondents during hearing the commentary of films. Like softness of sound, echo sound, loud sound. No extra noise or humming was faced by the respondents.

Speed of commentary of the films was appreciated and had a good pace for learning through it, as reported by very high majority i.e. 97 percent of the respondents.

Significantly high percentage of respondents (88%) stated that the subject matter of the video films was correct and appropriate to subject matter. Similar number of the respondents found the visuals were easy to understand.

Visual Aspect

Eighty eight percent respondents stated that subject matter was appropriate and correct to great extent, followed by ten percent and two percent respondents reported that it was appropriate to some extent and less extent respectively. None of them said that they were not appropriate or incorrect.

Visuals of the films were interesting to great extent, reported by 86 percent respondents, whereas 8 percent and 6 percent found the visuals were moderately interesting and less interesting.

None of the respondents found any difficulty in watching the visuals. As they were clear with appropriate speed and size.

Overall it has been concluded that majority of women in this study suggested electronic media is interesting (54 percent), helpful in learning (77 percent) and relevant (80 percent) in accessing Reproductive Health information and knowledge. As mentioned above, many other positive responses have been enlisted by most women for general, visual and education aspects for electronic media.

This shift in paradigm for accessing information regarding Reproductive Health has been observed for electronic media could be for a reason - 'change' that has been witnessed over a period of time. Change is an unavoidable ingredient of our life. Throughout our existence we keep putting in efforts to bring change in our lives. Change in our reactions, change in our perceptions, change in our attitudes, change in our lifestyle and so many other changes we keep striving to bring in. These changes are commonly known as development. We act in certain manner to acquire these changes. We get educated; we acquire information about what is happening around us and we create our reactions accordingly. We use different media to acquire knowledge about plethora of things. It is impossible to collage information without using any media in current stage. Keeping this in mind, it is not unfair to say media works as change agent in the current period of 'Information Explosion' even for a subject as sensitive as Reproductive Health.

Especially the electronic media has been truly proved as a change agent in completely changing the scenario for accessing even the most sensitive information such as Reproductive Health and now it has been reaching to every home in any remote area. Such analysis has been supported by many researches and theories such as "*the **'Magic Bullet'** theory that graphically assumes - the media's message is a bullet fired from the 'media gun' into the viewer's 'head' and similarly, the **'Hypodermic Needle Model'** uses the same idea of the 'shooting' paradigm*". Both these theories suggested that the media injects its messages straight into the women respondent's mind causing changes in their behavior and psyche towards the message and they reacted positively without any hesitation. Similarly, many researches supported this theory that media can act as a positive agent of change for some people (Johnson, 2000 and Thussu, 2009) while impeding and obstructing change for others.

Contradictory findings have been reviewed in few literatures in the similar context, Parkavi K. (2016); found "although media play vital role in dissemination of information and considered as democratic pillar of 'democratic polity', the role and responsibility of media in rural women's health is completely absent moreover the mental health of urban women is affected by their stereotyping body images in electronic media". Very interesting study conducted on young unmarried rural Indian men has revealed that their sexual and reproductive health (SRH) knowledge is limited, although electronic media (67%) was the prime source of reproductive health information (Char et al., 2011). Can this be interpreted as women are more susceptible towards electronic media than their male counter parts in accessing Reproductive Health information?

This implies a need for detail investigation by public health professionals and media experts to acquire perceptions and reactions towards electronic media for accessing reproductive health information through comparative analysis for men and women.

In addition to the above, to study the reactions towards electronic media in accessing Reproductive Health, the factors associated with it requires to be studied in depth. Some of the factors could be gender discrimination depicted in electronic media,

timeliness in accessing information, geographic variation, content development of messages, social stigma, and policy barriers combined with personal and cultural fears predispose people to poor knowledge, attitude, and practices regarding Reproductive Health. Since, very little or no researches have been found in this area, researcher indicates a need for in depth study in this arena.

4.3.2 Reactions of the respondents towards Print Media

Table 66: Frequency and Percentage Distribution of the Respondents of their Reactions towards Chart (n=100)

S. No.	Details	GE	SE	LE	NA
		%	%	%	%
1.	**General aspects**				
	Did You find them interesting	87	11	2	-
	Topic of these material was relevant	93	7	-	-
	Duration of use of the material was sufficient	99	-	-	1
2.	**Educational aspects**				
	Was it helpful to learn the content	95	3	1	1
	Information was proper	100	-	-	-
	Information was sufficient	98	2	-	-
3.	**Visual aspect**				
	The visuals were appropriate to subject matter	74	22	3	1
	Visuals were easy to understand	100	-	-	-
	Visuals were interesting	65	33	-	2
	Display time of the material was sufficient	100	-	-	-
4.	**Commentary**				
	Voice of commentary was proper	100	-	-	-
	Speed of commentary was with pace	100	-	-	-
	Language of commentator was clear	100	-	-	-

General aspects

Ninety nine percent respondents were satisfied with the duration of use of material to great extent. While 93 percent were found the topic was relevant to great extent, followed by 87 percent respondents who stated that it was interesting to great extent. Only 11 percent respondents find it interesting to some extent and 2 percent reported this as less interesting.

Educational aspects

Hundred percent respondents reported that information given was proper to great extent, followed by 98 percent who stated that information was sufficient to great extent. 95 percent reported that the content was learning to great extent. Just one percent respondent stated that content was not helpful to learn.

Commentary

Reactions of the respondents also revealed that the voice, speed with pace and language were clear to great extent. Table 76

Table 67: Frequency and Percentage Distribution of the Respondents according to their Reactions towards Posters (n=100)

S. No.	Details	GE	SE	LE	NA
		%	%	%	%
1.	**General aspect**				
	You find them interesting	84	16	-	-
	Topic of the material was relevant	79	14	7	-
	Duration of use of the material was sufficient	87	12	-	1
2.	**Educational aspects**				
	It was helpful to learn the content	70	25	5	-
	Information was proper	95	-	-	5
	Information was sufficient	93	-	7	-
3.	**Visual aspects**				
	The visuals were appropriate to subject matter	71	27	2	-
	Visuals were easy to understand	100	-	-	-
	Visuals were interesting	100	-	-	-
	Display time of the materials were sufficient	91	2	7	-
4.	**Commentary**				
	Voice of commentary was proper	100	-	-	-
	Speed of commentary was with pace	90	2	8	-
	Language of commentator was clear	100	-	-	-

General aspects

Table 77 revealed Regarding general aspects of posters, 87 percent respondents stated that the duration of use of the posters was sufficient to great extent while imparting the educational programme, followed by 84 percent respondents who stated that the topics of these were very interesting. In line of that 79 percent respondents find posters as very interesting. Almost equal number of respondents stated that posters were fairly interesting (16%), topic was relevant to some extent and (14%) and duration was sufficient to moderate extent (12%).

Educational aspects

Information given in the posters was proper and sufficient to a great extent reported by 95 percent and 93 percent respectively. In difference to that a little less (70%) respondents said that the content of the posters was helpful to learn to great extent.

One fourth respondents reported about the content covered in the posters was moderately helpful to learn, while seven percent and five percent stated that information in the posters was less sufficient and it was less helpful to learn. Table 71

Visual aspects

All the respondents found visuals of posters were easy to understand and interesting to a great extent. Whereas ninety one and seventy one percent stated that the time used for displaying posters were sufficient and visuals were appropriate to its subject matter to a great extent.

Commentary

Hundred percent respondents were satisfied with voice and language of the commentary, followed by ninety percent respondents who reported about the speed of commentary was with pace to great extent. Very few of them reported that the speed of commentary was with pace to some extent and less extent.

Table 68: Frequency and Percentage Distribution of the Respondents according to Their Reactions towards Self Learning Cards (n=100)

S. No.	Details	GE	SE	LE	NA
		%	%	%	%
1.	**General aspects**				
	You found them interesting	80	11	9	-
	Topic of these materials were relevant	68	22	8	2
	Duration of use of the materials was sufficient	100	-	-	-
2.	**Educational aspects**				
	Was it helpful to learn the content	93	3	-	4
	Information was proper	97	2	1	-
	Information was sufficient	100	-	-	-
3.	**Visual aspect**				
	The visuals were appropriate to subject matter	100	-	-	-
	Visuals were easy to understand	100	-	-	-
	Visuals were interesting	80	11	7	2
	Display time of the materials were sufficient	93	-	4	3
4.	**Commentary**				
	Voice of commentary was proper	100	-	-	-
	Speed of commentary was with pace	100	-	-	-
	Language of commentator was clear	100	-	-	-

General aspects

All of the respondents reported to great extent that duration of use of picture cards was sufficient, followed by 80 percent and 68 percent found this as interesting and relevance of the topic to a great extent. 22 percent told that the topic was relevant to some extent while 8 percent reported its relevance to less extent while 2 percent respondents denied its relevance with its topic.

Educational aspects

Information on the picture cards was sufficient to a great extent perceived by all the respondents. Information given in the cards was proper and the content was helpful to learn to great extent reported by ninety seven and ninety three percent respondents respectively. Very few (4%) stated that it was not helpful to learn. Table 78

Visual aspects

Visuals were appropriate to subject matter and easy to understand to a great extent stated by all the respondents. Ninety three and eighty percent respondents reported about the display time of picture cards were sufficient and visuals were interesting to great extent. Only 11 percent found it as moderately interesting, seven percent found it less interesting and 2 percent said that it was not interesting.

Commentary

All of the respondents stated that the voice, speed and language of the commentator were very clear and proper to a great extent.

Table 69: Frequency and Percentage Distribution of the Respondents according to their Reactions towards Flip Book (n=100)

S. No.	Details	GE	SE	LE	NA
		%	%	%	%
1.	**General aspects**				
	You found them interesting	100	-	-	-
	Topic of these materials was relevant	100	-	-	-
	Duration of use of the materials was sufficient	96	2	-	2
2.	**Educational aspects**				
	Was it helpful to learn the content	82	16	2	-
	Information was proper	77	22	-	1
	Information was sufficient	97	3	-	-
3.	**Visual aspects**				
	The visuals were appropriate to subject matter	78	13	9	-
	Visuals were easy to understand	100	-	-	-
	Visuals were interesting	100	-	-	-
	Display time of the materials were sufficient	100	-	-	-
4.	**Commentary**				
	Voice of commentary was proper	100	-	-	-
	Speed of commentary was with pace	100	-	-	-
	Language of commentator was clear	100	-	-	-

General aspects

All of them were flip book as interesting medium of gain information to a great extent and topic was also relevant to great extent. 96 percent of the found the sufficient duration of use of flip book to great extent.

Visual aspects

Seventy eight percent respondents reported that that the visuals were appropriate of subject matter to a great extent. Only 13 percent and 9 percent quoted that it was appropriate to subject matter to moderate and less extent.

Hundred percent respondents were satisfied with duration of display and meaning of the flip book.

Commentary

Findings also revealed that all the respondents were satisfied with voice speed and language clarity of the commentator.

Table 70: Frequency and Percentage Distribution of the Respondents according to their Reactions towards Flash Cards (n=100)

S. No.	Details	GE	SE	LE	NA
		%	%	%	%
1.	**General aspects**				
	You found them interesting	88	12	-	-
	Topic of these material was relevant	74	14	11	1
	Duration of use of the materials were sufficient	100	-	-	-
2.	**Educational aspects**				
	Was it helpful to learn the content	72	25	-	3
	Information was proper	99	-	-	1
	Information was sufficient	66	32	2	-
3.	**Visual aspects**				
	The visuals were appropriate to subject matter	89	11	-	-
	Visuals were easy to understand	100	-	-	-
	Visuals were interesting	100	-	-	-
	Display time of the materials was sufficient	100	-	-	-
4.	**Commentary**				
	Voice of commentary was proper	100	-	-	-
	Speed of commentary was with pace	100	-	-	-
	Language of commentator was clear	100	-	-	-

General aspects

Hundred percent respondents were satisfied with the duration of the use of material to great extent. A remarkable number of respondents (74%) stated that topic was relevant to the material to a great extent, followed by 14 percent who reported that the material was less relevant to the topic. 11 percent reported its relevance with topic to less extent.

Educational aspects

Ninety nine percent respondents quoted that the information was proper to great extent while one percent found it was not proper. Sixty six percent respondents were agreed that information on cards were sufficient to great extent while thirty two percent were found it sufficient to some extent. Findings of the study also reveals that 32 percent respondents stated that the information on was sufficient to some extent. While only two percent were found this information was sufficient to less extent.

Visual aspects

All of the respondents said that the visuals in the flash cards were easy to understand, interesting and the display time of this was also sufficient to a great extent.

While eighty nine percent said that it was appropriate to subject matter to great extent, while only 11 percent found appropriate to a less extent.

Commentary

All of the respondents were satisfied with all the aspects of commentary to a great extent.

Table 71: Frequency and Percentage Distribution of the Respondents according to their Reactions towards Booklet (n=100)

S. No.	Details	GE	SE	LE	NA
		%	%	%	%
1.	**General aspects**				
	You found them interesting	88	12	-	-
	Topic of these materials was relevant	100	-	-	-
	Duration of use of the materials were sufficient	86	9	5	-
2.	**Educational aspects**				
	Was it helpful to learn the content	92	8	-	-
	Information was proper	78	19	-	3
	Information was sufficient	100	-	-	-
3.	**Visual aspects**				
	The visuals were appropriate to subject matter	100	-	-	-
	Visuals were easy to understand	100	-	-	-
	Visuals were interesting	100	-	-	-
	Display time of the materials were sufficient	100	-	-	-
4.	**Commentary**				
	Voice of commentary was proper	100	-	-	-
	Speed of commentary was with pace	100	-	-	-
	Language of commentator was clear	100	-	-	-

General aspects

Majority of the respondents (88% and 86%) found that the booklet was interesting and the duration was sufficient to a great extent respectively. 100 percent found the matter was appropriate to great extent.

Educational aspects

The information given in booklet was sufficient to a great extent was reported by 100 percent respondents, followed by 92 percent who stated that the content was very helpful to learn.

Visual aspects and commentary

All the visual aspects were satisfactorily stated by all the respondents and Commentary was also found satisfactory from all the respondents.

Table 72: Frequency and Percentage Distribution of the Respondents according to their Reactions towards Pamphlets (n=100)

S. No.	Details	GE	SE	LE	NA
		%	%	%	%
1.	**General aspects**				
	You found them interesting	76	22	-	2
	Topic of these materials was relevant	55	34	11	-
	Duration of use of the materials were sufficient	100	-	-	-
2.	**Educational aspects**				
	Was it helpful to learn the content	100	-	-	-
	Information was proper	100	-	-	-
	Information was sufficient	100	-	-	-
3.	**Visual aspects**				
	The visuals were appropriate to subject matter	100	-	-	-
	Visuals were easy to understand	88	12	-	-
	Visuals were interesting	80	9	10	1
	Display time of the materials were sufficient	100	-	-	-
4.	**Commentary**				
	Voice of commentary was proper	100	-	-	-
	Speed of commentary was with pace	100	-	-	-
	Language of commentator was clear	100	-	-	-

General aspects

More than half of the respondents found the topic relevant to a great extent, a significantly increased number of respondents (76%) said that it was interesting to great extent, while all of them were satisfied with its display time to great extent.

To some extent satisfied respondents were 34 percent in regards to relevance of the topic of material and 22 percent found it interesting to some extent, while 11 percent found less interesting the topic was.

Educational aspects

All the respondents found satisfied with all the educational aspects of the leaflets and pamphlets to great extent.

Visual aspects

Hundred percent respondents were satisfied with appropriateness of content and sufficient display time of material to a great extent. Eighty eight and eight percent respondents found it easy to understand to great extent. 10 percent respondents found it less easy to understand while 1 percent denied it.

Commentary

All the respondents were satisfied with every aspects of commentary to great extent.

Table 73: Frequency and Percentage Distribution of the Respondents according to their Reactions towards Aprons (n=100)

S. No.	Details	GE	SE	LE	NA
		%	%	%	%
1.	**General aspects**				
	You found them interesting	100	-	-	-
	Topic of these materials was relevant	89	11	-	-
	Duration of use of the materials were sufficient	73	17	3	7
2.	**Educational aspects**				
	Was it helpful to learn the content	66	34	-	-
	Information was proper	72	28	-	-
	Information was sufficient	57	29	14	-
3.	**Visual aspects**				
	The visuals were appropriate to subject matter	81	11	-	NR8
	Visuals were easy to understand	71	14	15	-
	Visuals were interesting	88	1	11	-
	Display time of materials were sufficient	100	-	-	-
4.	**Commentary**				
	Voice of commentary was proper	100	-	-	-
	Speed of commentary was with pace	100	-	-	-
	Language of commentator was clear	100	-	-	-

NR = No Response

General Aspect

It was revealed from the data from table 83 that all the respondents found apron as interesting medium of the gaining information, followed by 89 percent respondents who stated that the topic of the material was relevant. Nearly three fourth (73%) respondents reported that the duration of use of material was sufficient. While very few respondents i.e. 17% and 11% said that the topic was somewhat relevant and duration of use was also sufficient to some extent.

Educational Aspects

Data revealed that 66 percent and 72 percent respondents reported that it was helpful to learn to a great extent and information in the material was proper respectively. Whereas 57 percent respondents revealed that information in the material was sufficient to great extent. In contrast to that 34 percent and 29 percent respondents concluded that it was helpful to learn to some extent and information was also sufficient to some extent. Eighteen percent reported that information was somewhat proper in the material.

Visual Aspect

All the respondents were found its display time sufficient to a great extent, followed by 88% and 81% concluded that visuals were interesting and appropriate to the subject matter to great extent. Majority of them (71%) found the visuals were easy to understand to great extent

Unlike traditional modes of print media – Newspaper and Magazine, the present study included Charts, Posters, Flash cards, Flip books, Apron, Self-learning cards, Booklets and Leaflets/Pamphlets in IEC package to study the reactions of selected respondents on various media developed for increasing knowledge regarding Reproductive Health aspects. On the basis of above findings, it can be said that most tribal women's reactions for print media was that they found it interesting. Most women stated it was helpful to learn the content through this media platform. Moreover this media provided proper and sufficient information.

The present study was conducted in tribal villages of Rajasthan for the inclusion of tribal women as respondents. These reactions for print media in tribal women might raise few queries in the mind of intellectuals as in recent time, it is considered to be one of the most conventional media platform for sharing knowledge or information especially the ones that has been considered as 'sensitive'. Secondly, print media has been considered as 'media for literate people'. Lastly, accessibility of print media in tribal areas can be a challenge too.

Analysis of resent trends in print media may toss some light on the query regarding accessibility as according to an Audit Bureau of Circulation (ABC) report published

in 2017, *"Newspaper circulation in India has grown from 39.1 million copies in 2006 to 62.8 million in 2016 – a 60 percent increase. The report also suggested that a comparable data for the past year 2015 show that while newspaper circulation grew by 12 percent in India, it fell in almost every other major print media market: by 12 percent in the UK, 7 percent in the US and 3 percent in Germany and France".* Although it considered to be conventional media, it can clarify that over a period of time, circulation and the access to print media has increased due to many reasons and one of them could be development in infrastructure. Sharing knowledge and information regarding a topic that was considered to be a taboo a decade ago now is easily accessible through print media to advocate and promote health issues such as sex, sexuality and other reproductive health aspects. For example, adolescent and young adult readers indicated that they turned to print media as a valued source of advice about their personal lives (Kaiser Family Foundation, 2004) and for information about reproductive health (Treise & Gotthoffer, 2002).

Extensive review of recent literatures suggested, print media is not only easily accessible but also there is a significant association between media literacy and health literacy (Ochako et al., 2017. Significant positive association has been found between mass media and health literacy in the review of available literatures. A study conducted by Akbarinejad et al., (2017) found that media literacy of respondents was significantly lower than average 61.5% of pregnant women have inadequate reproductive health literacy and 18.8% had marginal reproductive health literacy hence, there was a significant positive relationship between media literacy and health literacy among pregnant women. Another study conducted by Asamoah et al., (2017) indicated that women with increased knowledge regarding HIV/AIDS and frequent exposure to mass media had lesser tendency to stigmatize or act as agents of stigma towards PLHA.

None the less quiet conflicting views were observed in a study conducted by Parkavi K (2016) that although health literacy is an essential resource in health care and health promotion due to unavoidability of its importance in regards to guiding strategic health behaviors, treatments and decisions, the Indian media's role in creating health awareness among women in India is very minimal. This discussion raised another

question, can formal education be one of the determinants for media literacy and health literacy?

Formal education has been considered as one of the variables for overall effectiveness of developed IEC package for selected Reproductive Health aspect in the present study. In this context, one of the interesting finding of the present study emerged, more than half tribal women (58 percent) were illiterate and lacked any sort of formal education.

However, most women found to have increased knowledge in Reproductive Health aspects in post-test analysis. comprehensive review of other literatures discussed that the education alters identity, increasing self-confidence to lead women for forming enhanced self-perceptions and to practice new health seeking behaviors (Robinson-Pant 2000 and Acharya et al., 2010) Contended literature argue that the education transmits behavioral norms such as openness to practice new behaviors such as 'adopting modern medicines' and adherence to the schedules and bureaucratic processes that health systems require (Frost MB et al., 2005). This intrigued to study whether formal education determines media literacy or exposure that leads to health literacy. A detailed study conducted at Bangladesh in 2007 on 'Media and education play a tremendous role in mounting AIDS awareness among married couples' revealed education indicate better occupation, better income and better income eases media exposure and this signifies more knowledge and awareness about Reproductive Health. The present study investigated that most tribal women had no formal education gave positive reactions for print media such as posters, charts, flip books, flash cards, booklets in general aspects, visual aspects and educational aspects. This reflects education might or might not be a determinant for media literacy that leads to health literacy. However, this significantly denies the above query that 'this media is only for literates.

Such discussions require in depth investigations that currently reflects a scarcity in the published literatures. Also, this raises need for policy development in print media in terms of including more health promotion targeting women from urban and rural India and acquiring more of visuals and pictorials for easy

understanding of health information for the mass who have been deprived from formal education.

4.4.3 Reactions of the respondents towards Educational Games

Table 74: Frequency and Percentage Distribution of the Respondents according to their Reactions towards Educational Games (n=100)

S. No.	Details	GE	SE	LE	NA
		%	%	%	%
1.	**General aspects**				
	You found them interesting	100	-	-	-
	Topic of these materials were relevant	100	-	-	-
	Duration of use of the materials were sufficient	78	12	10	-
2.	**Educational aspects**				
	Was it helpful to learn the content	100	-	-	-
	Information was proper	100	-	-	-
	Information was sufficient	78	17	5	-
3.	**Visual aspects**				
	The visuals were appropriate to subject matter	76	15	9	-
	Visuals were easy to understand	65	35	-	-
	Visuals were interesting	100	-	-	-
	Display time of the materials were sufficient	100	-	-	-
4.	**Commentary**				
	Voice of commentary was proper	100	-	-	-
	Speed of commentary was with pace	100	-	-	-
	Language of commentator was clear	100	-	-	-

General Aspects

Hundred percent respondents found games as interesting and the topic of the games was relevant to a great extent, while 78 percent stated that duration of display was sufficient and to great extent. Only 12 percent and 10 percent were found display time sufficient to some extent and less extent.

Educational aspects

The content was useful and to learn and information was proper reported by 100 percent respondents followed by 78 percent respondents found the information was sufficient to a great extent. In line with that 17 percent and 5 percent found it sufficient to some extent and less extent.

Commentary

Hundred percent respondents were satisfied in all the aspects of commentary to a great extent.

Present study has incorporated a new concept of 'edutainment' in the package of IEC for studying the reactions of selected respondents and for increasing knowledge regarding Reproductive Health aspects. "Edutainment is a derived word that states a mixture of entertainment and education or marriage of education with entertainment" (Colace, et. al., 2006). This was mainly developed to support education with entertainment. The main purpose of edutainment is to attract audience's attention and to make him focus on events and teaching materials during learning (Okan, 2003). If the aim is to teach new things to the next generation and to provide permanence of the teaching, teaching methods should be ordered in the direction of audiences' needs and wishes. For raising awareness, increasing knowledge, creating favorable attitudes, and ultimately motivating people to take socially responsible action in their own lives, this Entertainment-Education (E-E) strategy involved incorporating an educational message into popular entertainment content. A mass education expert 'David Buckingham' in England indicated that the concept of edutainment which needs visual material is a style of teaching type mixed with game.

The games used in the present study were ‘Snakes and Ladders’, ‘Nishana Lagao’ and ‘Passing the Ball’. Findings from Table 88 indicated, all women (100 percent) of this study found these games and visuals used were interesting. Moreover, all women’s (100 percent) reaction for content was – ‘it was helpful to learn’. Research suggests that games provide an opportunity for users to find health information as well as rehearse health behaviours and other meaningful activities (Edgerton, 2009). These days more than conventional ground games such as kabbadi, football or volleyball, youth like to play online games.

Online games provide players to interact with each other, sending instant messages of using voice-over-Internet protocols that allow them to meet others and socialize as they play.66 However such socializing aspects of online gaming may put youth at risk in some ways for example, by increasing opportunities for accessing unreliable health knowledge and sexual contents. More so it’s vague to say whether online gaming might influence sexual attitudes or behavior. Review of literature suggested no published literature has been found that addressed issues of sexual content in online games or in online gamers' interactions, nor did we uncover studies that identified sexual attitudes or behaviors as correlates of using those games. Since games play major role in adopting new behaviours and acquiring knowledge as a mean of mass media in reproductive health, according to most theories of media effects, the influence of media depends largely on the content it contains.

Few theories such as ‘The Integrative Model of Behavior Change’ (Fishbein & Azjen, 2010), Theory of Reasoned Action (TRA; Fishbein & Ajzen, 1975) and Theory of Planned Behavior (TPB; Azjen, 1991), was developed and tested in the domain of Health thus to predict that new media exposure will influence behavior through shifts in behavioral intentions, which are themselves a function of attitudes, norms, and perceptions of self-efficacy acquired through media and other sources. Thus, through edutainment women learned not only what is likely to be the outcome of Reproductive Health but also related skills to retain the knowledge.

Scarcity of literatures observed in this domain calls for social scientists to investigate the correlation or variance between edutainment and reproductive health.

SECTION 4.5: CONCLUSION

On the basis of findings, it can be concluding that most of the respondents were found illiterate, however the educational facility was available in the area. Though the respondents varied according to their age as well as marital status hence the educational status may vary according to their age. Moreover, if the respondents belonged to older age and found illiterate may be at that time educational facility was not available, similarly disinclination towards girl's education (especially in tribal's) may also be responsible for the same.

Many of women were married early as early marriages were little prevalent in the area, but it was also found that most of them were married before the legal marriageable age.

Occupation of women may always give her freedom to take decisions about her professional as well as personal life, on the other hand in the male dominated society women are bounded to follow the decisions either taken by her husband and or by the other family member like parent, grandparent etcetera. In the present study it was discovered that very few of them were sitting ideally at home that too due to their poor health conditions, whereas maximum women were either doing farming, working with the employment schemes, doing labor in other's farm or were studying.

Majority of the respondents belonged to Low Socio – Economic Background. It was also found that most of the respondent's family income was purely depended on the farming, but due to the lack of rain, they were found to be doing subsidiary occupations.

Getting married at the right age, always contributes to sustained good health of women, since growing old is not enough but growing old healthily helps women to attain the goals in a right manner. For having this, right practices and attitude towards life and related things is the most important. To begin with the menstrual practices, it was found that very less number of respondents was using sanitary napkin, while more of them were using ordinary cotton cloth. In developing country like India menstrual blood is considered as impure and female also feel shy to share about this with anybody. They usually share with either their mother or with their friends. Again,

refusing showering during menstrual bleeding was also responsible for poor health, as it may lead to infections in genital areas.

Regarding food and diet related practices again it was noted that they were eating less vegetable and very few amounts of fruits rarely. Although consuming fruits daily by the Low - Socio Economic always put a question to buy it. Of course, they can eat cheap fruits like banana regularly, as it is cost effective yet nutritious too, but again the attitude towards practices refuse them to do so. Though their knowledge was quite significant, towards diet during pregnancy and lactation. Apart from that social, cultural practices and traditional myths and beliefs was quite highly widespread amongst the people the selected area. For example, breastfeeding the baby within an hour of delivery, bathing women or feeding women with normal food after delivery was not in the practices of the respondents.

Adopting family planning methods and using contraceptives helps to prevent STDs and RTIs, but unfortunately very less number of people was using it as protective and preventive measure. Despite the fact that they were acquaint with the contraceptive and its availability in their area. The domination factor again found to be interrupting between the attitude and adoption of the good family planning practices. Regarding practices good reproductive health practices was adopted by less number of the respondents. While more than half of the respondents were not having good reproductive health practices. Though they were found to be aware about the good practices, but the myths beliefs and faith in the group they found reluctant to have favorable attitude about the correct reproductive health practices. Rather female sterilization was more popular than the male sterilization as well as the women of old age category (who have not reached menopause) was not using any medicines. They were found to be suffering from RTIs and STDs as well.

Regarding overall awareness about all the “Reproductive Health Aspects” marked significantly high in the mean of post-test. So, this reflects that they are quite comfortable to gain information if the right source is provided them effectively.

If we see the aspect wise gain in knowledge Regarding stages of reproductive health, age wise mean score was found increased in post treatment data but in relation to other

variables it was found non-significant, as it was containing information on puberty, menstruation and male and female organ as well as menopause. The findings revealed that more number of respondents belonged to the younger and middle age group they were going through this stages of reproductive health hence they may found this information very useful to gain.

Similarly taking care during maternity gives base to good reproductive recovery and is applicable to young and middle age respondents. In this section again, age was the responsible factor to improve their knowledge about various reproductive health care and the other variable remained constant.

The more the education, more the solution of any problem can be obtained either on the basis of information grabbed or can be obtained from the various available sources. The access to health services play a very important to resolve the health-related issue with a low cost affair. In the same context the gain in knowledge about STDs and RTIs found more but not in relation to educational status of the respondents.

To prevent STDs and RTIs contraceptives (male and female condom) play an important and can be obtained free of cost from governmental health sectors. Thus the knowledge was found high after implementing the package and also found that none of the variable was interfering in gain in knowledge about family planning issues.

Regarding reactions, it was found that games and pamphlets were more effective as they were sustaining it with them and participatory approach was there.

As it is well known by the researchers and other extension functionaries, that using any interactive media, for teaching learning process, always put a long term sustained impact of any information. In the present investigation researcher used various media altogether like electronic media, print media along with the educational games to see and check the gain in knowledge was found an effective strategy. Than reactions of the respondents regarding these media was found very effective for increase in their knowledge.

To summarize, the present research entitled “Effectiveness of Developed Reproductive Health Package for Tribal Women of “Kerwas” village of Pratapgarh

District (Rajasthan India) and Identification of Their Reproductive Health Practices", contributed to the gain in knowledge of the tribal women selected as respondents from the "Kerwas" village of Pratapgarh District, regarding the four aspects namely Stages of Reproductive Health, Maternal Care, Sexually Transmitted Diseases and Reproductive Tract Infections and Family Planning of the Reproductive Health of a woman. The Information Education and Communication Package developed, comprised of various methods like, Illustrative talk, Focus Group Discussion demonstration and materials which prepared like charts, posters etcetera, and few materials which were borrowed from various source. The research design included pre-post experimental design without any control group. The other objective focused upon gathering the data regarding the Reproductive Health Practices prevalent amongst the tribal people.

Thus, the present study's findings resulted into the gain in knowledge of the respondents regarding selected aspects of Reproductive Health and also knowing their prevalent Reproductive Health Practices. With the culmination of the present research the findings generated may contribute in the reshaping national and state level policies related to Reproductive Health of tribal population of our country and its various states. The Information Education and Communication Package which proved to be effective communication strategies for tribal people can be standardized and used for effective coverage of the tribal men and women people across the country.