KNOWLEDGE AND PRACTICES OF REPRODUCTIVE HEALTH AMONG TRIBAL WOMEN IN CHURACHANDPUR DISTRICT,MANIPUR

KHAWLNUNSANGI

Under the Supervision of

H. ELIZABETH

Assistant Professor

Submitted in partial fulfilment of the requirement for the Degree of Master of Philosophy in Social Work, Mizoram University, Aizawl

CHAPTER I

INTRODUCTION

CHAPTER II

REVIEW OF LITERATURE

CHAPTER III

METHODOLOGY

CHAPTER IV

RESULTS AND DISCUSSION

CHAPTER V

CONCLUSION

BIBLIOGRAPHY

MIZORAM UNIVERSITY

MAY, 2018

CERTIFICATE

This is to certify that the dissertation on **"Knowledge and Practices of Reproductive Health among Tribal Women in Churachandpur District, Manipur"** submitted by Khawlnunsangi for the award of Master of Philosophy in Social Work is carried out under my guidance and incorporates the student's bonafide research and this has not been submitted for award of any degree in this or any other university or institution of learning.

Dated: 14th May, 2018

Place: Aizawl, Mizoram

(H. ELIZABETH)
Research Supervisor
Department of Social Work
Mizoram University
Aizawl

MIZORAM UNIVERSITY

MAY, 2018

DECLARATION

I, Khawlnunsangi, hereby declare that the subject matter of this dissertation is the record of work done by me, that the contents of this dissertation did not form bias of the award of any previous degree to me or to the best of my knowledge, to anybody else; and that the dissertation has not been submitted by me for any research degree in any other University/institution.

This is being submitted to the Mizoram University for the degree of Master of Philosophy in Social Work Department.

Dated: May, 2018

Place: Aizawl, Mizoram

(KHAWLNUNSANGI)
Research Scholar

(H.ELIZABETH)
Research Supervisor
Department of Social Work
Mizoram University
Aizawl-796004

(C. DEVENDIRAN)
Head
Department of Social Work
Mizoram University
Aizawl-796004

ACKNOWLEDGEMENT

I would like to express my deepest gratitude to many people whose names may not be all enumerated for the completion of this research undertaking could not have been possible without the participation and their assistance. Their contributions are sincerely appreciated and gratefully acknowledge.

I greatly appreciate and express my deep sense of gratitude to my Research Supervisor Dr.H.Elizabeth for her constant guidance from the very beginning till the completion of my research work. I'm really grateful to Prof. Kanakaraj Easwaran for his constant mentorship and guidance throughout the process of my research work. I take this privileged to express my sincere thanks to Prof. C. Devandiran Head of Department for his words of encouragement, motivational support, presence and guidance during the progress of my research. Also, to all the Faculty members and non teaching staff at the Department of Social Work for their presence help and support in times of need I am indebted.

I express my sincere thanks to Director Health & Family Welfare Churachachandpur, Dr Zuii, and to all the women, and two villagers who were a part of my research study for their precious times and permission to be able to collect useful information. The study would not be accomplished without them.

To my parents, to all my friends especially Janet, Lily, Ronica, Marcious and others who in one way or another shared their support, either mentally, financially, physically and through prayers. Thank you.

Above all to the Great Almighty, for his many blessings and countless love.

Thank you.

Dated 14th May,2018 (KHAWLNUNSANGI)

Place: Aizawl, Mizoram Research Scholar

CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

1. AIDS	**:** Acquired Immune Deficiency Syndrome
2. ANC	**:** Ante-natal Care
3. ASHA	**:** Accredited Social Health Activist
4. CHC	**:** Community Health Centre
5. CSPro	**:** Census and Survey Processing System
6. GOI	**:** Government of India
7. HIV	**:** Human Immune- Deficiency Virus
8. IUD	**:** Intra- uterine Device
9. IIPS	**:** International Institute for Population Services
10. JSY	**:** Janani Suraksha Yojna
11. JSSK	**:** Janani Shishu Suraksha Karyakaram
12. MCH	**:** Maternal Child Health
13. NHFS	**:** National Health Family Survey
14. OCP	**:** Oral contraceptive Pill
15. PHC	**:** Public Health Centre
16. RH	**:** Reproductive Health
17. RCH	**:** Reproductive and Child Health
18. RTIs	**:** Reproductive Tract Infections
19. SPSS	**:** Statistical Package for Social Sciences
20. STIs	**:** Sexually Transmitted Infections
21. STDs	**:** Sexually Transmitted Diseases
22. TBA	**:** Traditional Birth Attendant
23. TT	**:** Tetanus Toxoid
24. UN	**:** United Nations
25. WHO	: World Health Organization

BIBLIOGRAPHY

Aarti,Srivastava.A.,Salini Singh,Seema Mehlotra.,Sushma Pandey,Anjoo Agarwal., & Vinita Das. (2008). Emergency contraceptive Knowledge, Attitude and Practice Among Women Attending a Teaching Hospital of North India (PP 72-77). *Journal of Family Welfare, 54 (2), 72-77. December 2008, ISSN-0022-1074.*

C. B. (2014). Reproductive Health Problems of Women in Rural Areas. *The International Journal of Social Sciences and Humanities Invention, 1* (2), 95-101.Retrieved March6,2017,from http://valleyinternational.net/index.php/theijsshi/article/view/

Census of India. (2011). Retrieved February23, 2017, from https://en.wikipedia.org/wiki/Scheduled_Castes_andScheduled_Tribes

District Census Handbook Churachandpur. (2011) *Part*- XII A ed.,. Imphal, Manipur: Directorate of Census Operation. (15) 1-280. Retrieved March 6, 2017, fromhttp://censusindia.gov.in/2011census/dchb/DCHB_A/14/1403_PART_A_DCHB_CHURACHANDPUR.pdf Census of India 2011 Manipur

District in Manipur Retrieve January 2018 from http://manipur.gov.in/?page_id=619

Gazette notification declaring creation of 7 new districts in Manipur. Retrieve, from February 2018 from http://manipur.gov.in/wp-content/uploads/2016/12/creation-of-7-district-1-2.pdf

Gangopadya,Bhaswati.,Das & D.N.(1997).Quality of Family Planning services in India. The user's perspectives, *The Journal of Family Welfare,* 42.December 1997.

Gupta,S.D. (1998). Reproductive Health Awareness Behavior amongst Adolescent: Multi centric study: ICMR. New Delhi.

Geeta, A., Joseph, S., Bhattacharjee, L., Abraham, J. Rao &P.S.S.(1997).General and Reproductive Health of Adolescent Girls in rural South India, Indian Pediatrics, 34 (3).

G. M. (2013). Prevalence of Reproductive Tract Infections among Rural Married Women in Tamil Nadu, India: A Community Based Study. *Journal of Pioneering Medical*

Sciences, 4 (1). Retrieved April 20, 2017, from http://www.jpmsonline.com/jpms-vol4-issue1-pages18-24-oa.html

Jejeebhoy,S.J.(1996). Adolescent Sexual and Reproductive Behaviour: A Review of the Evidence from India,Working Paper No.3, International Council for Research on Women.

Jejebhoy, S.J.(2000). Adolescence Sexual and Behavior: A review of the evidence from India. R.Ramasubban, S.Jejebhoy,(eds).Women's Reproductive Health in India, Jaipur: Rawat Publications.

Kishore, J., (2002): National Health Programmes in India- National Policies and Legislation related to Health, 4th edition, Century Publication, New Delhi, pp. 17-18.

Kumar,R.,Meenal,R.,& Ganguly M.K.(2009). Earlymid life and women's Health. Encyclopedia of women Health & Empowerment. New Delhi: Deep & Deep Publications.

Liamputtong Pranee.(2010). Focus Group Methodology: Introduction & History: RetrieveMarch4,fromhttp://www.sagepub.com/sites/default/files/upmbinaries/39360_978_1_84787_909_7.Pdf

List of District Manipur Retrieve March 2017 from https://census2011.co.in/census/state/districtlist/manipur.html

Manipur Population Census 2011/ Manipur Religion, Caste Data- Census 2011. Retrieved Febuary 2017 from https://www.censusindia.co.in/states/manipur

Maiti, S., Unisa, S., & Agrawal, P. K. (2005). Health Care and Health Among Tribal Women in Jharkhand: A Situational Analysis. *International Institute for Population Sciences, 3*(1), 37-46. Retrieved May 7, 2018, from http://krepublishers.com/02-Journals/T & T/T & T-03-0-000-000-2005-Web/T & T-03-1-000-000-2005-Abst-PDF/T & T-03-1-037-046-2005-050-Maiti-Sutapa/T & T-03-1-037-046-2005-050-Maiti-Sutapa-Full-Text.pdf

M. Devi Tineshwari (2010). Reproductive Health and Adolescent Girls, New Delhi: Akansha Publishing House.

MisraRajiv, Chateerjee Rache.,& Rao Sujatha.(2003). India Health Report. New Delhi: Oxford University Press.

Madani, M.(2004): New Priorities: Adolescent Reproductive Health in India. Retrieve January 13, 2017, from http://www.Ishtm.ac.uk/cps/dfid/100.html

Maternal Health in Manipur.(2012).Retrieved March11, 2017, from http://journalofdevelopment.wordpress.com/2012/10/05/maternal-health-in-manipur/

Prusty, R. K., & Gogoi, M. (n.d.). Reproductive Health Complications among Tribal Women in India: A Special Focus on North-East India. *Etawah Journal of Social Sciences,* 8-14. Retrieved March 7, 2017, from https://www.academia.edu/5144412/Reproductive_Health_Complications_among_Tribal_Women_in_India_A_Special_Focus_on_North-East_India

National Family Health Survey *(NFHS-4) 2015-16* (pp. 1-241, Rep.). (n.d.).Mumbai: IIPS: International Institute for Population Sciences (IIPS) and ICF. 2017. National Family Health Survey (NFHS-4), 2015-16: India. Retrieved April 28, 2018, from http://rchiips.org/NFHS/NFHS-4Reports/India.pdf

National Family Health Survey - 4 India. Factsheet. (2015-16). Retrieved March 13, 2017, from http://rchiips.org/NFHS/nfhs4.shtml

National Family Health Survey- 4 State. Factsheet.(2015-16). Retrieved March 13, 2017, from http://rchiips.org/NFHS/factsheet_NFHS-4.shtml

National Family Health Survey-4 District.Factsheet. (2015-2016). Retrieved March13, 2017, from http://rchiips.org/NFHS/districtfactsheet_NFHS-4.shtml

National Rural Health Mission. Retrieved March 10, 2017, from http://nhm.gov.in

http://nhm.gov.in/janani-shishu-suraksha-karyakram.html

National Rural Health Mission. Retrieved March 10, 2017, from http://nhm.gov.in

http://nhm.gov.in/images/pdf/programmes/guidelines-for-jssk.pdf

Naidu,T.(2007).Tribal Health in India: Problems and Future Prespectives.Ponducherry: Pinnacle computer offset.

Ngurte Village Population–Churachandpur Manipur. Retrieve March 13, 2017 from http://www.census2011.co.in/data/village/269661-ngurte-manipur.html

Prusty, R. K., & S. U. (n.d). Reproductive Tract Infections and Treatment Seeking Behavior among Married Adolescent Women in India. *International Institute for Population Sciences*. Retrieved March 2018 from

https://iussp.org/sites/default/files/event_call_for_papers/049IUSSP_RKP.pdf

Prasad, J. H., S. A., Kurz, K. M., George, V., Lalitha, M., John, R.Joseph, A. (2005). Reproductive Tract Infections Among Young Married Women in Tamil Nadu, India. *International Family Planning Perspectives, 31*(2), 73-82. Retrieved February6,2018,from https://pdfs.semanticscholar.org/4316/7a6531811ae73251a1af9472768896c0d8d8.pdf

Rao, Durga.P.(2007). Access to maternal and child health care services: A study among Racha Koyas of Warangal District of Andhra Pradesh.

Reddy,P.J.,Rani Usha.D.,Reddy.G.B & Reddy.K.K (2005). Reproductive Health constraints of Adolescent school girls. 66 (44), 431-441. *The Indian Journal of Social work, .October 2005, ISSN 0019-5634.*

Rose Nembiakim (2008). Reproductive Health Awareness among the Tribal women in Manipur. New Delhi: Concept Publishing Company.

Ramana, Usha Rani.(2014).Reproductive Health status – issues and concerns of tribal women in Andhra Pradesh. *Journal of Interantional Acedemic Research for Multi displinary Impact Factor* 1 (393).

Sangam, S. M.(2015).*Reproductive Health Status of Women in Rural Bijapur* (Unpublished master's thesis).Karnataka State Women's University. Retrieved April 28, 2017, from http://shodhganga.inflibnet.ac.in/handle/10603/73497

Salem Veng Population- Churachandpur, Manipur. Retrieved, May 15 2017 from http://www.census2011.co.in/data/village/269577-salem-veng-manipur.html

Sinha Sanjay.(2014).Health and Development in North-East India. New Delhi: Mittal for Mittal Publications.

Srinivasan.(2010).Reproductive Health care of tribal women in Kolli hills at Nammakal District, Tamil Nadu. Retrieved February 10, 2017, from www.academia.edu/5056156/

Sexual and Reproductive Health of young women in india. (2014, July). Retrieved March 14, 2017, from https://www.guttmacher.org/factsheet/2015/sexual-and-reproductive-health

Thilothammal N., Ramanujam, S., Banu, K.,Ratnam, S.randEzhilarisa. S.(1993). The Nutritional Status of South Indian women in Child bearing Age and its influence on Birth Weight and Maturity of Offspring. 43, (6) *The Journal of Obstetrics and Gynecology of India*.

United Nations Population Information Network (UN Population Division, Department of economic and Social Affairs, with support from the UN Population Fund (UNFPA), Guidelines. Retrieved March 9, 2017, from http://www.un.org/popin/unfpa/taskforce/guide/iatfreph.gdl.html

World Health Organization (WHO), (2010). Reproductive Health Indicators Guidelines for their generation interpretation and analysis of global monitoring. Retrieved March7, 2017, from http://whqlibdoc.who.int/publications/2006/92415635x_eng.pdf

Z. M., S. M., A. K., & S. G. (2001). Antenatal Care, Care-seeking and Morbidity in Rural Karnataka, India: Results of a Prospective Study. *Asia-Pacific Population Journal, 16, (2).* 27-28. doi:10.1136/sextrans-2013-051184.0538

Appendix

Knowledge and Practices of Reproductive Health among Tribal Women in Churachandpur District, Manipur.

Research Scholar
Khawlnunsangi
M.Phil Scholar
Department of Social Work
Mizoram University
Aizawl-796004, Mizoram

Research Supervisor
Dr. H. Elizabeth
Assistant Professor
Department of Social work
Mizoram University
Aizawl-796004, Mizoram

Interview Schedule

(Confidential and M.Phil Research purpose only)

Schedule no. : Village:

I. Section A: Demographic profile of the respondent

	Name	:	
1	Age at present	:	1).15-18 years☐, 2). 19- 25 years☐, 3). 26-31 years☐, 4) 32- 37 years☐, 5) 38 – 43 years☐, 6) 44-49 years ☐.
2	Age at marriage	:	1)15-18 years ☐, 2) 19- 25 years ☐ , 3) 26- 31 years ☐ 4) 32 years – 37 years ☐ , 5) 38-43☐ , 6) 44-49 years ☐
3	Educational Qualification	:	1)Illiterate ☐,2) Primary (Lower &Upper) ☐, 3) High School☐, 4) Higher Secondary☐,5) Graduate& above☐.
4	Marital status	:	1) Married ☐, 2) Unmarried ☐, 3) Widow ☐, 4) Divorced☐, 5) Single mother.
5	Religion	:	1). Hindu☐,2).Muslim☐,3).Christian ☐ 4) Local religion ☐, 5) Others ☐
6	Number of Children	:	1) 1-3 ☐, 2) 4-6 ☐ 3) 6 & above ☐ 4) Childless ☐
7	Type of Family	:	1) Nuclear☐ , 2) Extended☐, 3) Joint family☐.

Section B: Economic Characteristics

1	Occupation	:	1). Home maker☐ ,2) Daily wage labourer ☐,3)Cultivator☐, 4) Self- employee ☐, 5) Private entrepreneur☐ , 6).Government employee ☐,7) Others ☐
2	Skills/ certificate course obtained	:	0) None ☐, 1)Tailoring☐, 2)Weaving☐, 3)Dish wash& Detergent making☐,4) Mushroom planting☐ , 5) Basket making ☐, 6) Computer course ☐, 7) Others☐
3	Personal monthly income	:	0) None ☐, 1) >Rs.5000☐, 2). Rs.5001- Rs.10, 000☐, 3). Rs.10001- Rs.15000☐ , 4) Rs.15001-Rs. 20000☐, 5).Rs. 20001& above☐.

4	Occupation of spouse	:	0) None ☐,1)Home maker ☐ ,2) Daily wage laborer ☐,3) Cultivator 4) Self- employee ☐, 5) Private entrepreneur ☐ , 6)Govt. employee ☐,
5	Secondary occupation of the family	:	0)None ☐, 1) Cultivator ☐, 2)Small business ☐, 3)Pension ☐.
6	Annual Family income	:	1) > Rs.60,000 ☐, 2) Between Rs.60,001-Rs.1,20,000 ☐, 3) Rs. 1,20,001-Rs.1,80,000 ☐, 4) Rs. 1,80,001- Rs. 2,40,000 ☐, 5) Rs. 2, 40,001 – Rs.30, 0000 ☐, 6) Rs. 300001 &above ☐.

Section C: General Health &Hygiene (*Nutrition,Water & Sanitation*)

Sl.no	**Practices**	**Option *(Choice)***
1	How many times did you take meal in a day?	1).One ☐, 2).Twice ☐, 3).Thrice ☐,4). Four ☐
2	Do you feel that your food intake is sufficient?	1).Yes ☐ , 2). No ☐
2 (a)	If no, why?	0).None ☐, 1).Loss of appetite ☐,2).Shortage of money ☐,3). Non availability of food ☐, 4). Others ☐.
3	Are you aware of the required calorie-intake for an individual?	1).Yes ☐, 2).No ☐.
4	What do you usually take for food?	1).Rice ☐ , 2).Roti ☐ , 3).Maize ☐ , 4).Others ☐ .
5	Where do you get your water from?	1).Pipe water supply ☐,2).Well water ☐ 3).HandPump ☐, 4). Pond ☐, 5) River ☐
6	Do you have a safe drinking water facility at home?	1).Yes ☐ 2).No ☐.
6. (a)	Do you boil water for drinking facility?	1).Yes ☐, 2).No ☐.
6. (b)	How far do you need to walk from your home to fetch water?	1).Less than 1 Km ☐, 2).1-2Kms ☐ 3).3 & above Kms ☐
7	Did you regularly washing your hands with soap before eating?	1).Yes ☐, 2). No ☐.
7. (a)	If no,why?	1).Soap unavailable ☐, 2).Scarcity of water 3).Don't think necessary ☐, 4).Others ☐
8	Do you have a dustbin inside the house?	1).Yes ☐, 2).No ☐.
8 (a)	Where do you dispose your garbage?	1).Municipalcommunityvan ☐, 2).OwndumpingPit ☐ 3).Community dumping pit 4). Voluntary community collection ☐, 5). Burn ☐, 6) River ☐
8 (b)	Do you segregate the garbage before disposal?	1).Yes ☐, 2). No ☐
9	Do you have a toilet facility at home?	1).Yes ☐ , 2). No ☐
9.(a)	What type of toilet do you use?	1).Septik tank ☐,2)Pit latrine ☐, 3)Pour flush Pit latrine ☐, 4) Others ☐.

II. Reproductive health knowledge and Practice

Section A: Reproductive health knowledge

Sl .no		
1	Are you aware of your reproductive organs?	1).Yes ☐, 2).No ☐
1(a)	If yes, where from you get the information	0) NA ☐,1).School education ☐, 2).Media ☐, 3).Peers ☐ ,4).Health care providers ☐ ,5) From Parents ☐.
2	Have you ever experience the reproductive ill health problem(s)?	1).Yes ☐,2).No ☐
2(a)	If yes, What are they?	1). Vaginal discharge accompanied by itching/ fever/ bad odor/irritation around vaginal area ☐,2).Severe lower abdominal pain not related to menstruation ☐ 3).Pain or burning while urinating or frequent difficult urination,☐ Others. ☐
2(b)	To whom do you share when you encounter the problems?	0) NA ☐ Husband ☐ Mother-in-laws ☐ 3) Relatives ☐ ,4) Doctors ☐, 5)Pastor/Pries ☐, 6) Traditional healer ☐ ,7)Visionary ☐,Friends , ☐ 9).Relatives ☐.
2(C)	Have you sought any medical care regarding the problems?	0) NA ☐ Yes ,☐ No .☐
2(d)	If yes, how often?	0) NA ☐ 1).Always ☐ ,2). Sometimes ☐, 3). Rarely ☐ ,4).Never ☐
3	How was the reproductive health problem diagnosed?	0) NA ☐ 1).Through medical investigations ☐).Interpreted by elder women ☐, 3).Faith Healer ☐ 4).Others ☐
4	Where do you go to seek the treatment?	0) NA ☐ 1). Public health centre ☐ 2).Civil Hospital ☐ 3).Private Hospital/ clinic ☐,4) Others ☐
5	Have you heard of HIV/AIDS?	1).Yes ☐, 2).No ☐.
5 (a)	If yes, please mention the source of your information?	0) NA ☐ 1).Media ☐,2) Books ☐,3).Doctors/ Health care ☐ workers4),.Friends/Relatives ☐, 5) NGO's/ CBOs/FBOs . ☐
5 (b)	What are the modes of HIV/AIDS Transmission?	0) NA ☐ 1).Unprotected Sex ☐,2). Infected mother to new born child ☐, 3) Infected blood transfusion ☐ 4). Sharing of needles among IDU ☐ 5) All the above ☐ .
6	What are the advocated methods of HIV/AIDS Prevention?	0) NA ☐ 1). Condoms promotion ☐, 2).Screening of Blood Transfusion ☐, 3).One sexual partner ☐ ,4). Use only Sterile needles, ☐ 5)All the above ☐
7(a)	Are you aware of the reproductive ill health problems of white discharge?	1) Yes ☐, 2) No☐.
7(b)	Are you aware of the reproductive ill health problems of RTI/STI?	1)Yes☐ , 2) No☐..
7 (c)	Are you aware of the reproductive ill health problems of Vaginal itching?	1)Yes☐ , 2) No☐..
7 (d)	Please mention your source of information	0) NA ☐, 1)School Health education ☐, 2) Media ☐,

		3) Friends/Relatives ,4)Books ,5) Health care providers
7(e)	What are the common sign/symptoms of RTI/STI you are aware of?	0) NA , 1).Itching/rashes in the genital area,).Foul smelling discharge from genitalorgans ,3).Pain in lower abdomen ,4).Pain/burning sensation while urinating 5).Pain during intercourse.
8	In case of any reproductive health Problems where do you sought your Treatment from?	0) NA , 1).Public medical sector ,2)Private medical sector , 3).Did not seek any treatment , 4).Traditional healer
9	Have you ever attended an awareness Program on reproductive Health?	1).Yes , 2).No
9 (a)	If yes, Conducted by whom?	0) NA ,1).Govt , 2) NGO , 3) Church , 4).Others
10	Have you heard of reproductive health Progra	1).Yes , 2).No .
10 (a)	If Yes, mention your source of Information	0) NA 1) Media , 2) Relatives , 3) Friends , 4) Health care providers .
11	Are you aware of attainment of Menstrual cycle?	1).Yes , 2).No .
12	For how long you usually have mense?	1).Less than 2days, , 2).3-4 days , 3).5 days& above .
13	Is your menstrual cycle regular?	1).Yes , 2).No .
14	If irregularity, what could be the reason?	0) NA , 1).On medication ,2).conceiving, 3).Anaemia ,4).Others physical health problems .
14(a)	Have you undergone treatment when Irregular menses occur?	0) NA , 1).Always ,2).Sometimes ,3).Rarely ,4).Never .
15	When menstruation period is delay for a mon do you ascribe it?	1).Pregnant ,2).anaemic , 3).others physical health problems .

II. Section B. Reproductive Health Practices

Sl. no	Practices	Option
1	Do you have any knowledge on contraceptive use?	1).Yes , 2).No .
2	If yes, Who had informed you?	0) NA , 1).Health care providers ,2).Friends/ relatives ,3).Mother-in-law ,4).Husband , 5).Media .
3	Have you ever use any contraceptive method?	1).Yes 2).No .
4	If no, what are the reasons for not using?	0) NA , 1).Not comfortable Not easily available3).Weight gain , 4).Husband

		disagree 5).Weight loss,6).Fatigue , 7).Body pain ,8).Gidiness, 9).cuturalluy dispprove
5	Are you using any contraceptive at present?	1).Yes , 2).No .
5(a)	If yes, which method do you adopted?	0) NA 1).Condoms ,2) Lactational Amenorrhea Method (LAM) ,3) Oral Contraceptive pills (OCPs ,4).Intrauterine Contraceptive Device ,5) Female Sterilization .
5 (b)	Wheredo you procure your contraceptive from?	0) NA , 1).Hospital , 2).ASHA worker 3).Chemist , 4).Friends/relatives , 5) NGO's , 6) Others
6	Have you ever discuss with your spouse before using the contraception?	0) NA , 1).Yes 2). No .Sometimes .
	If no, why?	0) NA , 1).Fear of partners opposition , 2). Don't think necessary to involve husband decision , 3)Others .
7	Do you think women should initiate family planning?	1). Yes , 2) No .
	If yes, why?	0) NA , 1) To prevent unplan pregnancy , 2) To determine freely the number & spacing of children , 3)Others .
8	Do you think contraceptive use sometimes leads to health complications?	1). Yes ,2).No .
9	If yes, what are the health complications experienced by you?	0) NA , 1).Loss of apetite , 2).Headache , 3).Fever , 4).Weight gain , Weight Loss, Difficult in Conceiving, 7) Disturb menstrual cycle , Fatigue
10	What do you use during your menstrual cycle to absorb the blood flow?	1). Sanitary Pad , 2).Clean Cloth , 3)Any oth , 4).Oth .
11	How do you dispose the used materials?	1).Dustbin , 2).Pit , 3).Burn , 4)River 5) Others .
12	If you used a cloth do you wash it and re-use it again?	0) NA 1).Yes , 2). No
13	If Yes, how do you dry the menses cloth?	0) NA 1).Bathroom , 2).Sun dry , 3)Ironing 4).Others
14	Have you experience any social taboo with menstruation in the society/community?	1).Yes , 2).No.

III. Reproductive Health Challenges & Constraints.

Sl.no	Determinants	
1	Do you have any one of the health center in your locality?	1).Yes, 2). No.
2	How far is the distance of the health Centre from your home?	1). Below one Km, 2). One to four Kms 3).Five &Above.
3	During pregnancy did youhad regular health check-up?	1).Yes, 2). No.
4	If Yes, where did you go for health check-up?	0)NA , 1).Primary/Community health CentreC/CHC, 2).District hospital, 3).Private Clinic, 4). Others.
5	If no, what are the reasons for not going for regular health check-up?	0) NA , 1). Absence of health care workers ,2). Unable to meet the expenses 3). Distance &Lack transportation , 4). Don't think necessary ,5). Not allowed by husband/in-laws ,6). Against customary practice 7). Long duration of waiting time , 8).No one to accompany , 9).No time .
6	Have you ever experience any pregnancy related complication?	1).Yes 2). No .
6 (a)	If yes, what are the complications?	0) NA 1). Inadequate nutrition , 2)Miscarriage , 3)Obstructed labour , 4) Complications in a previous pregnancy , Others.
6 (b)	Have you sought medical treatment RELATED TO THE COMPLICATIONS?	0) NA, 1).Yes, 2). No .
6 (C)	If yes, where do you GO FOR treatment?	0) NA , 1).Primary Health Centre ,2). District hospital , 3). Private clinic , 4).Others .
7	Where have you gone for child delivery?	0) NA , 1). Home, Health care institutions
8	Who has attended the child delivery?	0) NA , 1).Doctor ,2).Nurse , 3).Traditional birth attendant , 4) Others
9	What was yourspecific reason for choosing the birth place?	0) NA , 1).Easily accessible).Low cost 3).More hygienic , 4).Less complication .
10	Did you go for post natal health check up within two months after your delivery?	0) NA , 1).Yes ,2).No .
10 (a)	If no, what is the reason for not attending health check-up?	0) NA 1).Don't think necessary ,2).Lack of transportation ,3).Inability to meet the costs , 4).Not allowed by the in-laws 5)No time to visit ,6).No one to accompan ,7) Distance .

11	Have you ever undergone through abortion?	1).Yes ,2). No .
12	Who has suggested you to undergo abortion?	0) NA , 1).Doctors , 2).Family pressure . 3).Self ,4)Others .
13	What is the reason for opting abortion?	0) NA 1).Mother health complication ,2).Unborn Child health complication 3).Unplan Pregnancy , 4).Too many children already .
14	Where was it done?	0) NA 1). District Hospital ,2).Private clinic , 3).Others .
15	Do you experience health complications related to abortion?	0) NA 1).Yes , 2).No .
15(a)	If yes, what are the complications?	0) NA , 1) Pelvic Infection , 2) Incomplete abortion , 3) Hea leeding , 4) Disturb future child bearing , 1) 5) Others

IV. Utilization of RCH services

Sl.no	Utilization pattern	
1	Are you aware about the JananiSurakshaYojana? .	1).Yes ,2).No
2	Did you receive monetary incentives of JSY?	0) NA , 1).Yes ,2).No
3	Are you aware of the free 'mother and child immunization services' available at government hospital?	1).Yes ,2).No ..
3 (a)	If yes, are you the recipient during pre-natal & postal natal period?	0) NA 1).Yes ,2).No
3(b)	If no, what is the reason for not taking vaccination?	0) NA , 1).Services are too far , 2).Unaware of Immunization 3).Unaware of the place of the Immunization 4).No time for immunization ..
4	Did you receive any free medication during pre-natal and post-natal period in the hospital?	0) NA 1).Yes , 2).No .

4 (a)	If Yes, what are they?	0) NA ☐ , 1).Iron and Folic Acid supplements ☐, 2).Deworming tablet ☐,3).Tetatus Injection ☐,4).Others ☐
5	Are you aware about the free counseling services available for family planning at civil hospital?	1).Yes ☐,2).No ☐.
6	Have you taken free examination of Abdomen examined?	0) NA ☐, 1) Yes ☐, No ☐
7	Have you taken free examination of Blood pressure measure?	0) NA ☐, 1) Yes ☐, 2)No ☐
8	Have you taken free examination of Bloodtest?	0) NA ☐, 1) Yes ☐, 2) No ☐

Suggestions:…….... .....

~Thank you~

PARTICULARS OF THE CANDIDATE

NAME OF THE CANDIDATE	: Khawlnunsangi
DEGREE	: M.Phil
DEPARTMENT	: Social Work
TITLE OF DISSERTATION	: Knowledge and Practices of Reproductive Health among Tribal Women on Churachandpur District, Manipur
DATE OF PAYMENT OF ADMISSION	: 18th August, 2016
COMMENCEMENT OF SECOND SEMESTER	: 18th February, 2017

1. BOARD OF PROFESSIONAL STUDIES : 9th May,2017
2. SCHOOL BOARD : 22nd May, 2017
3. REGISTRATION NO. & DATE : MZU/M.Phil/428 of 22.05.2017
4. DUE DATE OF SUBMISSION : 31st July, 2018
5. EXTENDION (IF ANY) : YES

(C. DEVANDIRAN)

Head

Department of Social Work

Mizoram University

BIODATA

Name	: Khawlnunsangi
Sex	: Female
Date of Birth	: 1st April, 1991
Age	: 27
Educational Qualifications	: Master of Social Work
Marital Status	: Unmarried
Contact No.	: 8731955065
Email ID	: sangi.duhlian@gmail.com
Address	: P.C Ruala street Lamka, Churachandpur, Manipur: 795128

Details of Educational Qualifications:

Sl.No	Class	Subject	Board/University	Percentage	Division
1	HSLC	-	BSEM	54%	Second
2	HSSLC	Arts	CoHSEM	57%	Second
3	Bachelor of Arts	Social Work	NEHU	57%	Second
4	Master of Social Work	Family & Child Welfare, Social Work	Dibrugargh University	70%	First

CHAPTER 1

INTRODUCTION

The present study is an attempt to understand the knowledge and practices of reproductive health among tribal women in Churachandpur district, Manipur.

1.1 Background of the Study

Reproductive health is one of the major challenges faced by women and is a universal concern today. It is of immense importance because of its implications towards women's health, the health of their children, family members and socio-economic development of the society. Since women's health also involves the health need related to childbearing and child rearing, it is imperative to look at the health need of women comprehensively, historically and culturally. The reproductive health status of women, especially in a developing world including India, requires urgent attention. More than 1.2 billion people live in India, approximately twenty-six 26% (328 million) of whom are women of reproductive age (15-49) years (M.S. et al. 2014). Over one-third of all healthy lives lost among adult women are due to reproductive health problems (WHO, 1995).

The reproductive health of women's is one of a crucial component of the health of women, particularly during the reproductive years. It refers to the diseases, disorders, and conditions that affect the functioning of the reproductive systems during all stages of life. Within the framework of W.H.O's definition of health, Cairo in 1994 has defined the term reproductive health. It outlines the sexual and reproductive health is not merely about reproduction. Instead, it must be viewed as three interconnected domains which include universal rights, women's empowerment and health service provision.

Rural tribal women's health is impacted by various factors operating at different levels. The most common problems with the tribal women are lack of basic amenities such as food, lack of education and awareness, proper transportation and health care facilities and services. Poverty and lack of awareness among rural Indian population have a devastating impact on rural women's health. It can cause delays in seeking appropriate health services until a condition reaches its most critical stage (Sangam, 2015).

Culture and society also play an important role in rural tribal women's health status and access to services. The ethnic compositions, cultural background, beliefs, customs, and faith don't permit the individual and groups to discriminate their age-old practices and adopt a

new system. Many of the worldwide research and evaluation have shown that education of women is strongly associated with the confidence to adopt new ways and on the utilization of health care services, the lowering of child death rates, and the improvement of family health nutrition, the use of family planning services and reduction of overall family size. Tribal women in rural areas are one of the most disadvantaged people in terms of health status particularly on women and reproductive health concerned. As a host of social, cultural, political and economic factors increase rural women's vulnerabilities to early marriages, early pregnancy, and pre-term birth, deaths and disabilities, unsafe abortion, HIV/AIDS and other reproductive cancers (Sangam 2015). Early marriage is more common in rural areas and this can largely impact their health and well-being as their reproductive systems are not fully developed.

With a minimal educational level and limited access towards information on reproductive health and reproductive health services, the tribal women are mostly left on their own to manage their fertility, sexual and reproductive well-being.

1.2 Reproductive Health

Reproductive Health is a very broad concept defined by International Conference on Population and Development at Cairo as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so." (ICPD 1994). It implies on the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of family planning of their choice and also other methods which are not against the law, and access to appropriate health care services for women so that they will be able to go through pregnancy and childbirth safely, and provide the couples with the best chance of having a healthy infant (Ramasuban & Jejeehboy 2000).

The United Nation, (1994) proposed that Reproductive Health is appositive part of personal health and healthy living and it follows that “reproductive health education should be available to all as an important component of health promotion and services.’’

Therefore, reproductive health deals with the reproductive processes, functions, and systems at all stages of life.

1.3 Tribal Women

In the Constitution of India, the term tribe has not been defined clearly, only the term 'Scheduled Tribe' is explained as "the tribe or the tribal communities or parts of or groups within tribes or tribal communities" which the President may specify by public notification (Article 342). A woman who belongs to any of the Schedule Tribe is considered as a tribal woman for the present study.

The status of women in the tribal societies seems to be comparatively better than that of women in general society because tribal societies have been by and large characterized as egalitarian societies especially in relation to the hierarchical character of caste society (Varte, 2014). Although the status of tribal women is higher as compared to their non-tribal counterparts elsewhere in India, men in their own society do not treat them as equals (Nembiakkim, 2008). Thus, we find proverbs among the Mizos, which state that: Women's wisdom cannot extend beyond the bank of a river, a wife and an old fence can be replaced anytime.

A tribal woman plays a very significant role to the family and to the socio-economic structure of the society. Maintaining the household chores and providing food for the family is also a part of her responsibility.

1.4 Historical Development of the Concept

It is helpful to understand the concept and to examine its origins. During the 1960s, UNFPA established with a mandate to raise awareness about population "problems" and to assist developing countries in addressing them. At that time, the talk was of "standing room only", "population booms, demographic entrapment" and scarcity of food, water, and renewable resources. Concern about population growth (particularly in the developing world and among the poor) coincided with the rapid increase in availability of technologies for reducing fertility - the contraceptive pill became available during the 1960s along with the IUD and long-acting hormonal methods.

In 1972, WHO established the Special Program of Research, Development, and Research Training in Human Reproduction (HRP), whose mandate was focused on research into the development of new and improved methods of fertility regulation and issues of safety and efficacy of existing methods. Modern contraceptive methods were seen as reliable, independent of people's ability to practice restraint, and more effective than withdrawal,

condoms or periodic abstinence. Moreover, they held the promise of being able to prevent recourse to abortion (generally practiced in dangerous conditions) or infanticide. Population policies became widespread in developing countries during the 1970s and 1980s and were supported by United Nations (UN) agencies and a variety of Non government organizations (NGOs) of which international planned parenthood federation (IPPF) is perhaps the most well-known.

The dominant paradigm argued that rapid population growth would not only hinder development but was itself the cause of poverty and underdevelopment. Almost without exception, population policies focused on the need to restrain population growth; very little was said about other aspects of population, such as changes in population structure or in patterns of migration. Given their genesis among the social and economic elites, it is perhaps hardly surprising that the family planning programs that resulted were based on top-down hierarchical models and that their success was judged in terms of numeric goals and targets – numbers of family planning acceptors, couple-years of protection, numbers of tubal ligations performed. Donors, anxious to demonstrate that their aid money was being well-spent, encouraged such performance evaluation indicators. In the drive for efficiency and effectiveness, they supported the establishment of free-standing "vertical" family planning bodies, generally quite separate from other related government sectors such as health, often, indeed, set up within the office of the president or the prime minister as a mark of their importance.

Although the term “reproductive health” has been used since many years, its widespread acceptance came in 1994 with the adoption by 178 countries of the programme of Action of the ICPD held in Cairo, Egypt. The 1994 ICPD has been marked as the key event in the history of reproductive health. ICPD was a United Nations Conference, organized principally by the United Nations Population Fund (UNFPA) and the Population Division of the UN Department for Economic and Social Information and Policy Analysis. The Programme of Action (PoA) the International Conference on Population and Development clearly spelled out that human beings have to be the centre of concern for population and development. It further clarified that advancing gender equality and equity and the empowerment of women, elimination of all kinds of violence against women, and ensuring women's ability to control their fertility is the cornerstone of Population and development programmes. The ICPD (PoA) urges government to increase the ambit of population and development programmes to include concerns of the girl child, the adolescent, and the

elderly, to involve men, to focus on the special needs of indigenous people, migrants and displaced persons in addition to regular Sexual and Reproductive Health and Rights programmes.

The ICPD was the turning point of in policy-making on women's health and development, particularly in South Asia. At the ICPD, the issue of decriminalizing abortion and respecting women's reproductive rights received great media attention. In the South for many feminists development was the agenda for the issues of social, economic and political rights of women. The development demanded by these women of the south rejected the western paradigm of economic growth; instead, it was based on sustainable, equity-oriented model. These southern women's concept of development ensures meeting the basic needs of all the better living standards of the disadvantaged populations especially women. According to WHO (1995), women represent 70 % of the 1.3 billion people who live in poverty worldwide and therefore bear a burden of general health and reproductive illnesses. While the international conferences and instruments have drawn attention to equity issues and more specifically, gender issues, international agencies like WHO and the World Bank have continued to develop their policies and programmes only on population control without ensuring that suit the needs of women in the developing countries.

1.5 Millennium Development Goals (MDGs -2000), Sustainable Development Goals (SDGs-2015) and Reproductive Health.

The millennium development goals also focus in relation to the health aspect of women's and childrens health. Where we can see that in the goal, MDGs 1- To eradicate extreme poverty and hunger, 3- To promote gender equality and empower women are indirectly related to health also particularly on the health of women. MDGs-4 it focuses on Reduce child mortality, MDGs-5 on improves maternal health and MDGs-6 on combating HIV/AIDS, malaria and other diseases. Also, the World Summit 2005, declared universal access to reproductive health. "Sexual and reproductive health is fundamental to the social and economic development of communities and nations, and a key component of an equitable society" (The Lancet 2006).

The Sustainable Development Goals (SDGs) a collection of 17 global goals set by the United Nations were directly or indirectly related to women's health and wellbeing. Out of the 17 goals, the Sustainable Development Goals (SDGs) goal-3 on good health and wellbeing and Gender equality (Goal-5) is directly related to women's health and well-being.

1.6 Reproductive Health Issues at Global and National level

The basic elements of reproductive health include “responsible reproductive/sexual behaviour, widely available family planning services, effective maternal care and safe motherhood, effective control of reproductive tract infection(including sexually transmitted diseases), prevention and management of infertility, elimination of unsafe abortion and treatment of malignancies of reproductive organs"(WHO, 1978). In addition, reproductive health effects, and is affected by other aspects of health, especially HIV infection/Acquired Immune Deficiency Syndrome (AIDS), nutrition, infant and child health, adolescent health and sexuality, life-style and environmental factors including social and cultural factors (WHO, 1978).

Reproductive health is one of the major priorities of global health and is a fundamental and inalienable part of women's health due to child-bearing (Patel, Kirkwood & Pednekar, 2006).Motherhood at a very young age entails a risk of maternal mortality that far exceeds the average, and the children of young mothers tend to have higher levels of morbidity and mortality (South-East Asia’s Population in a Changing Asian Context, 2002).Reproductive Health affects the lives of women and men from conception to birth, through adolescence to old age, and includes the attainment and maintenance of good health as well as the prevention and treatment of ill health (WHO,2006).

The international perspective on Reproductive health considered the factors that influence the reproductive health matters such as social status, economic position and access to resources (Patel, et al., 2006). Reproductive health is defined as an organizational framework that incorporates maternal and child health programs, family planning, infertility, sexually transmitted diseases, post-natal infection and maternal and child health-related concerns (Dudgeon & Inhorn,2004). It is a state that reproductive health addresses reproductive process, functions, and systems at all stages of life (WHO, 2012). Reproductive health also refers to the right of men and women to be informed and have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice and the right of access to appropriate health care services that will enable women to experience a safe pregnancy and childbirth. In short, reproductive health addresses the reproductive process, functions, and systems at all stages of life (WHO, 2013; Wisconsin Alliance for Women's Health, 2012).In some Asian countries for example in India, Pakistan, and Bangladesh, there

is a high proportion of marriage during adolescence, resulting in a high rate of adolescent childbearing (South-East Asia's Population in a Changing Asian Context, 2002).

Assessing the needs for behaviour change, the Government of India initiated a Reproductive and Child Health (RCH) Programme in 1997, which aimed is to meet the reproductive health needs of women. Government is engaged in the task of promotin g reproductive health of women The National Family Health Survey 2015-16 (NFHS-4) provides information which is related to women and reproductive health status. Through this study, it shows in percentage regarding households using improved sanitation facility present urban seventy (70.3%), rural area thirty-six (36.7%). The total is forty-eight (48.4%) against to twenty nine (29.1%) in NFHS-3 (2005-06). In regards to the age at marriage, women in the age group of 20-24 years married before attainment of 18 years comprise of seventeen (17.5%) in the urban area and thirty-one (31.5 %) in the rural area. The NFHS-4 recorded an increase in institutional birth with eighty-eight (88.7%) in the urban area and seventy-five (75.1%) in rural areas. However, the under-five mortality rate is thirty-four (34%) in urban and fifty-six (56%) in rural India.

India has the largest concentration of tribal communities in the world except that in Africa. The tribal groups of India are known to be the autochthonous people of the land and the tribal groups comprise 8.6 % of total India's population (2011 census). The tribal groups inhabit widely different ecological and geo-climatic conditions in different concentrations throughout the country and are distinct biological isolates with characteristics cultural and socio-economic background (Mukhopadhay, 2002). The health aspect of women is very important. In the life of a woman, menarche is a biological phenomenon marking the onset of reproductive age. The reproductive age is also an age when women are more active. The status of women in a society is a significant reflection of the level of social justice in a society. Women status is often described in terms of their level of income, employment, education, health, and fertility as well as the roles they play within the family, the community, and the society. It has been observed that the status of tribal women is comparatively lower than that of tribal men (Ray and Jayanta, 1993).

Poor health status of women and children in terms of high mortality and morbidity was also another health priority in the country mainly within the northeast states. Health facilities like hospitals and health centres were established for providing Maternal and Child Health (MCH) care through ante-natal, pre-natal and post-natal services. In order to ensure

maximum benefit from these programmes to provide services in an integrated manner to this vulnerable group, the Child Survival and Safe Motherhood (CSSM) programme were implemented in India since 1992. Despite all these efforts, the desired impact on the population growth and health and development of women and children in the country could not be achieved and the need for a new approach to the problem was felt. In 1994, during ICPD, held in Cairo it was recommended that a new approach needs to be adapted to tackle the problem. Under this approach, it was decided that the family planning services should be provided as a component of the comprehensive reproductive health care. Accordingly, as a follow-up action to this conference, the Government of India launched the Reproductive and Child Health programme in October 1997.

The high magnitude of women's reproductive health problems is reflected by the high maternal mortality rate as well as the high burden of or reproductive morbidity like STI/RTI, gynaecological problems, cancer of reproductive tract etc. The Reproductive and Child Health (RCH) programme is being implemented in India with a major focus on rendering client-cantered and high-quality services to the community. Since women constitute the major client group/users of this programme, greatest attention needs to be given to this group.

The scenario of Manipur according to NFHS 2015-16 on households using improved sanitation facility shows 47.8 % in rural areas and 51.3% in urban areas, with a total of 49.9%. Women and fertility indicators show that women between the age of 20-24 years married before attaining the age of 18 years as 11% in urban and 14.3% in rural areas with a total of 13.1%.The total fertility rate (children per woman) rural 2.1, urban 2.9, the total is 2.6. The institutional birth shows 86.3% in urban and 60.5% in rural areas, with a total of 69.1%. An institutional birth in public facility shows 55.3% in urban areas and 40.9% in rural areas, with a total of 45.7%. Home delivery conducted by skilled health personnel (out of total deliveries), 5.9% in urban areas and 9.1% in rural areas with a total of 8.0%.

In addition, women who belong to the Age group of 15-49 Years who have Ever Undergone Examinations of Cervix, it shows that 17.4% in urban and 17.1% in rural areas with a total of 17.2%. With regards to examination of breast it shows that 5.7% in urban areas and 3.3% in rural areas with total of 4.3%. Towards knowledge of HIV/AIDS among adults (age 15-49 years) and women who have comprehensive knowledge of HIV/AIDS it shows that 45.8% in urban areas and 37.4% in rural areas with a total of 40.7%. With regards to menstruation and hygiene, women age 15-24 years who use hygienic methods (locally

prepared napkins, sanitary napkins, and tampons are considered as hygienic methods of protection) of protection during their menstrual period. It shows that 80.5% in urban areas and 73.3% in rural areas with a total of 76.1% used hygienic methods of protection.

1.7 Reproductive and Child Health (RCH) Programme, Phase - II

Reproductive and Child Health-II is a comprehensive programme under the National Rural Health Mission (NRHM) commenced with the main objective to bring about an improvement in mainly three critical indicators that are; reducing total fertility rate, infant mortality rate and maternal mortality rate. The programme is consistent with the outcomes envisioned in the Millennium Development Goals, National Population Policy 200, the National Health Policy 2002, the Tenth plan document, and Vision 2020 India. The target group of the programme is Women in the reproductive age group and children up to 5 years of age (Ministry of women and child development, GOI 2011).

Major elements of RCH Programmes

1. Responsible and healthy sexual behaviour
2. Intervention to promote safe motherhood
3. Prevention of unwanted pregnancies: increase access to contraceptives
4. Safe abortion
5. Pregnancy and delivery services
6. Management of Reproductive Tract Infection (RTIs) and Sexually Transmitted Infections (STIs).
7. Referral facilities by Government / private sector for a pregnant woman at risk.
8. Reproductive Health services for adolescents.
9. Screening and Treatment of infertility, cancers and other gynaecological disorders (Kishore, 2002).

1.8 National Rural Health Mission

The National Rural Health Mission (NRHM) is an initiative undertaken by the government of India to address the health needs of under-served rural areas. NRHM was launched on the 12th April 2005 by Indian Prime Minister Manmohan Singh. Under NRHM the Empowered Action Group (EAG) states, as well as the North Eastern States, Jammu and Kashmir and Himachal Pradesh, have been given special focus. The thrust of the mission is on establishing a fully functional, community owned, decentralized health delivery system with inter-sectorial convergence at all levels, to ensure simultaneously action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities. As per the 12th Plan document of the Planning Commission, the flagship programme of NRHM will be strengthened under the umbrella of National Health Mission. Accordingly, the Union Cabinet, in May 2013 has approved the launch of National Urban Health Mission (NUHM) as a submission of an overarching National Health Mission (NHM), with National Rural Health Mission (NRHM) being another submission of the National Health Mission. It was further extended in March 2018, to continue till March 2020.

Some of the major initiatives under National Health Mission (NHM) are as follows:

1. Accredited Social Health Activist: Community health volunteers' call Accredited Social Health Activists (ASHAs) have been engaged under the mission for establishing a link between community and health system. ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services in rural areas.

2. Janani Suraksha Yojana (JSY): JSY aims to reduce maternal mortality among pregnant women by encouraging them to deliver in government health facilities. Under the scheme, cash assistance is provided to eligible pregnant women for giving birth in a governmental health facility.

3. Janani Shishu Suraksha Karyakram (JSSK): As part of recent initiatives and further moving in the direction of universal health care, Janani Shishu Suraksha Karyakram (JSSK) was introduced on 1st June, 2011 to provide free transport, free medicine, free

diagnostic, free blood, free diet to pregnant women who come for delivery in public health institutions and sick infants up to one year.

1.9 Rationale of the Study

The term "Reproductive Health "is most often equated with one aspect of women's lives; motherhood. Complications associated with various maternal issues are indeed major contributors to poor reproductive health among millions of women worldwide. Half of the world's 2.6 billion women are now 15 – 49 years of age. Without proper health care services, this group is highly vulnerable to problems related to sexual intercourse, pregnancy, contraceptive side effects, etc. Death and illnesses from reproductive causes are the highest among poor women everywhere. In societies where women are disproportionately poor, illiterate, and politically powerless, high rates of reproductive illnesses and deaths are the norm. India is not an exception in this case.

Reproductive health indicates the level of self-determination, women's reproductive rights, and strength of tribal socio-political power. Social justice is also linked to the status of reproductive health of Indian tribal population as the right to have basic needs and an opportunity for the reproductive well-being of women is linked to their empowerment. The health status of the tribal population in India is very poor, deficient insanitary conditions, personal hygiene, and health education. Tribal mothers have high rates of anaemia, and girl children receive less than the desired nutritional intake. All told, the whole tribal community is deficient inadequate food intake. The extent of knowledge and practice of family planning was also found to be low among the Scheduled Tribes.

The awareness and knowledge of women regarding reproductive health problems certainly help in prevention and control of those problems. It is a challenging task to raise awareness regarding reproductive health care issues in women because of the social standing of women which distances them from the right source of information and also because of the taboos regarding the discussions on issues like safe sex, unsafe sexual practices etc. Despite the acknowledgment of a high rate of mortality by the government and non-government organizations (NGOs), there is inadequate research in regard to the Knowledge and Practice towards reproductive health among tribal women in Manipur. The study may be of immense significance for the policy imperatives and administering the reproductive health programmes in the tribal concentrated areas.

1.10 Statement of the problem

The RCH programme was introduced in the state of Manipur in the year 2000. Since its introduction, there has been a certain level of increase in the awareness regarding RCH and its components among the women of Manipur. However, there still remains a portion of women who have been not able to acquire any information about RCH and its facilities. This may be due to the problems of accessibility or its affordability pattern. The majority of the women who are deprived of RCH and its facilities are those belonging to the tribal region in Manipur. According to the National Family Health Survey 2015-16 (NFHS-4), provides state wise information on population, health, and nutrition for the first time, provides district-level estimates for many important indicators. The fact sheet shows information for rural areas and the district as a whole because Churachandpur district of Manipur has more than 70% rural population, which provides a sufficiently large sample to produce reliable estimates of most indicators for rural areas. The households using improved sanitation facility is 66.1%. The marriage age before 18 years is 13.5%. Mothers' iron-folic acid consumption for 100 days or more during pregnancy is 19.1%. An institutional birth is 60.9% out of which 34.5% in public facility. Further, 20.3% of all women age 15-49 years reported anaemic.

Tribal women face various obstacles in accessing the services due to lack of knowledge. One of which is receiving accurate information regarding the reproductive and sexual health. In addition, young women are hardly aware of the sources of care which when combined their limited knowledge hinders their ability to make informed choices to protect and practice well-being. Women are assumed not to be much comfortable with the subject of the study.

From the literature review, it is seen that many studies have been conducted on Adolescent and reproductive health but a study towards Reproductive health and tribal women particularly tribes from the northeast tribal women are limited. Against this backdrop, the researcher would like to attempt a study, find out, assess the existing knowledge and the prevalent practices among tribal women reproductive health. This study will examine two research questions. The first research question of the study will be on what is the Knowledge of tribal women towards reproductive health. The second research question of the study will be towards understanding their practice and their subsequent decisions about their reproductive health and the services that are available.

1.11 Objectives

The objectives of the present study are mentioned below:

1. To assess the knowledge and practices of reproductive health among tribal women in Churachandpur district.
2. To assess the women's utilization of reproductive health services.
3. To identify the reproductive health challenges and constraints to women reproductive health in the study area.
4. To probe into the relationship among knowledge, practices, and utilization of reproductive health services.
5. To suggest measures to improve service services utilization in the study area.

1.11.1 Hypotheses

To provide focus to the study the following hypotheses have been drawn and formulated:

1. Woman's Knowledge on Reproductive Health depends on their level of education and economic status.
2. Women's adoption of safe Reproductive health practices is positively related to their Knowledge
3. Woman's Utilization of RCH services is directly related to their knowledge on RCH.

The first and second hypotheses were drawn from the results of earlier studies (see: National Family Health Survey-4, (2015-16) and K.Van Egmond, et.al (2004) studies on Reproductive health in Afghanistan. While, the third hypothesis have been drawn intuitively.

1.12 Chapterization

The present study is presented in the following chapter scheme:

Chapter I: Introduction

Chapter II: Review of Literature

Chapter III: Methodology

Chapter IV: Results and Discussion

Chapter V: Conclusion

CHAPTER II

REVIEW OF LITERATURE

This chapter presents a review of available literature on the subject matter related to the present study. Studies conducted on knowledge and practices of reproductive health among women from different context have been reviewed to better understand the concepts and methods used which added in framing the present study.

2.1 Reproductive Health

Reproductive health is an important component of overall health and well-being. It is a major, positive part of personal health and healthy living and it follows that "reproductive health education should be available to all as an important component of health promotion and services" (UN,1994).

The International Conference on Population and Development (ICPD) report (United Nations,1995) states that reproductive health should include information and services for family planning, antenatal care, skilled attendance at birth, postnatal care, management of complications of abortions, and treatment of sexual illnesses. Even further, the report emphasizes the importance of women's involvement in the development, performance, and assessment of reproductive health care programs. In broad terms, health literacy encompasses the understanding and implementation of information provided by healthcare professionals and that it is critical in the identification of pregnancy complications and health care seeking behavior among women (Kohan, Ghasemi, & Dodangeh, 2007).

Reproductive health also represents the overall health condition of a population. The reproductive role of women insight from the most attaining menstruation to the post-menopausal period all through the process of gestation, birth, breastfeeding, and child-rearing practices her at the focal point of population's reproductive health (Shankar & Thamilarasan, 2003). Moreover, women are central to various social and economic activities in tribal communities requiring reciprocal interactions with the contributing factors of reproductive health. Women's access to 'power and resources' emerged as the important contributing factor to their reproductive health at the fourth world conference on women in 1995 held in Beijing which emphasizes increasing

women's economic and educational status, and as a consequence, women's reproductive rights (Pillai & Wang,1999).

'Women's health during the reproductive or fertile years (between the ages of 15 and 49 years) is not relevant not only to women themselves but also has an impact on the health of children and development for the family. Various health constraints during this period are the ones that only young girls and women experienced (NFHS-4, 2015-16).

2.2 Studies prevalence on Knowledge and Practices of Reproductive Health

Shahini and Debnath (2016) study on knowledge and perception of women towards reproductive health problems: a study of Bishnupriya Manipuri women of Silchar, Cachar district in Assam with an objective to identify the nature and types of reproductive health problems of women, to examine the socio-cultural factors influencing reproductive health and to find out the accessibility of healthcare service. The study is descriptive and analytical in nature. The findings of the study showed that very few of the women had knowledge of reproductive organs, and even the students knew better about the hygiene compared to the older women. The young girls used sanitary napkins and the elder women used cloth which is unhygienic and so suffer from infections which lead to infertility. Maximum of the respondents had awareness regarding HIV/AIDS and contraceptives but they had no knowledge of RTI. The study also found that ASHA worker and ANMs had played a vital role in giving the knowledge of family planning and contraceptive.

Devi (2013) study of 'Knowledge, Attitude and Practices of reproductive and child health (RCH) services among rural women in Manipur' found that the knowledge, attitude and practice of the women towards RCH are mostly depending on the type of the respondents' occupation. A woman who has a job outside and communicates with others has more knowledge about family planning than women who were confined at home. Due to financial constraints most of the respondents thirty (30%) had their deliveries at home, twenty five (25%) of them at district hospital and twenty (20%) of the deliveries in private hospitals and twenty (20%) in Community health centre or primary health centre (CHC/PHC). Due to a decisive problem of money and lack of health facilities seventy (70%) of the women were registered of antenatal care (ANC) with health facility services, thirty (30%) of them were not registered. Sixty(60%) of the women

received tetanus (TT) injection and forty (40%) of the women have not received TT injections due to inadequate health services in the village, lack of infrastructure facilities, shortage of medicines and non-availability of doctors and nurse in time of need and lack of health awareness.

Maiti, S et al. (2005) studies on health care and health among tribal women in Jharkhand a situational analysis. The study investigates the health care and health condition among the tribal women in comparison to the non-tribal women in the newly formed state of Jharkhand by drawing upon data from the National Family Health Survey-2, conducted during 1998-99. This survey was designed on the lines of the Demographic and Health Surveys (DHS) that have been conducted in many developing countries since the 1980s. NFHS-2 collected demographic, socioeconomic and health information from a nationally representative probability sample of 90,303 ever-married women age 15-49 residing in 92,486 households. All the states of India are represented in the sample (except the small Union Territories), covering more than(99 % of country's population. The sample is a multi-stage cluster sample with an overall response rate of 98%. For the state of Jharkhand, NFHS-2 has collected data of a representative probability sample of 1614 ever-married women age 15-49 years residing in 1642 households (IIPS & ORC Macro, 2001). The analysis here focuses on 1614 ever-married women age 15-49 years comprising of 469 tribal women and 1145 non-tribal women including Scheduled castes, other backward class, and general castes. Maternal health care of the tribal women in comparison with the non tribal women has been investigated with reference to the health problems and health care during pregnancy, antenatal checkups, antenatal advice, reasons for not receiving antenatal checkups, problem during and after delivery, place of delivery and assistance during delivery and also the post-natal health care of the mother as well as the baby. In addition to these, the situation of the tribal and non-tribal women in Jharkhand has also been seen in terms of their current reproductive health problems and contraceptive use and problems with the method currently in use. Simple bivariate analysis has been done for different health care and health parameters. The study showed that a sizeable gap has been noticed in educational attainment between tribal and nontribal women in Jharkhand. It was found that 89% of the tribal women were illiterate compared to71% of the non- tribal women. Only3% of tribal women completed education above high school compared to8% in case of non-tribal women.

In regards to antenatal problems and care, antenatal care (ANC) refers to pregnancy-related health care provided by a doctor or a health worker in a medical facility or at home. The Safe Motherhood Initiative proclaims that all pregnant women must receive basic professional antenatal care (Harrison,1990). The RCH programme of the Government of India recommends that as part of antenatal care, women should receive two doses of tetanus toxoid vaccines, adequate amount of iron and folic acid tablets or syrups to prevent and treat anemia, and at least three antenatal checkups that include blood pressure checks and other procedures to detect pregnancy complications (Ministry of Health and Family Welfare 1997; 1998). The pregnancy-related health problems commonly reported among both the tribal's and non-tribal women are excessive fatigue forty-nine and fifty-six (49 and 56% respectively). The second important pregnancy-related problem among the tribal women in Jharkhand is swelling of legs, body or face(49%). Thirty-eight (38%) percent of tribal women reported convulsions that were not from fever, compared to thirty-four (34%) among the non-tribal women. The reported problem of anemia is almost the same twenty-nine (29%) among both the groups of women in Jharkhand. Only two (2%) tribal women reported any vaginal bleeding compared to three (3%) non-tribal women. The effectiveness of antenatal check-up in ensuring safe motherhood depends in part on the test and measurements done and the advice given in during the check-ups. The condition of non-tribal women is comparatively better for the six check-ups. General check-up which includes weight and height measurements has been done by 50% of the tribal women compared to 57% among the non-tribal women. Abdomen examinations were most frequently carried out antenatal check-up by 53% and 70% of tribal and non-tribal women respectively. Only fifteen percent (15%) of births among tribal mothers were accompanied by an internal examination during the antenatal check-up. Again41% of tribal mothers had undergone a blood test and only 28% had their urine test. Most of these measurements or tests were performed 1.5 times more often during antenatal check-ups for non-tribal mothers than for tribal mothers. For all the items of antenatal advice, tribal women received less advice than their non-tribal counterparts.

The study also highlighted the delivery care. One of the important major thrust areas of the RCH Programme in India is to encourage and promote deliveries under proper hygienic conditions under the supervision of trained health professionals. The study found that only about

five (5%) of the deliveries of tribal mothers have been taken place in health facilities compared to eighteen (18%) among the non-tribal women.

In terms of the Post-partum check-ups Maiti, S et al. (2005) the health of a mother and her newborn child depends not only on the healthcare she receives during her pregnancy and delivery but also on the care she and the infant received during the first weeks after the delivery. The study shows that only eleven (11%) of the births among the tribal women were followed by a check-up within two months of the delivery compared to nineteen (19%) among the nontribal women. Fifty- nine (59%) of the check-ups took place within two days of births for the tribal women as compared to sixty - six (66%) in the case of non-tribal women.

Maiti, S et.al. (2005) study on contraceptives use and problem and reproductive health problems. Fifteen percent (15%) of the married tribal women were currently using some method of contraception and about 31% of the non-tribal women were doing so. One (1%) of the tribal women were using any traditional method and three (3%) were using other methods like folkloric methods. Modern methods of contraception were used by only one (1%) of tribal women and three (3%) of non-tribal women. Again, among the current contraceptive user, a terminal method was used by 9% of tribal women compared to 25% of non-tribal women. Also among the women who are currently using contraception,15% of the tribal women had some problem compared to 27% among the non-tribal women. In regards to reproductive health problems, an absence of reproductive tract infections (RTIs) is essential for the reproductive health of both women and men is critical for their ability to meet their reproductive goals. The reproductive health situation seems to be better among the tribal women in Jharkhand than their non-tribal counterparts. Overall forty three percent of the tribal women have any reproductive health problem compared to forty-six percent among non-tribal women. Of all reproductive health problems, urinary tract infection is higher among tribal women (28%) than non-tribal women with 26%.

The study clearly brings out the differential in the healthcare and health condition among the tribal women and non-tribal women in Jharkhand. The findings revealed that in each and every socio-economic, demographic as well as health parameters, the tribal women are very much poor than the non-tribal women. The utilization of maternal health care is also very less

among the tribal women than non- tribal women in Jharkhand. Use of modern methods of contraception is also significantly less among the tribal women. All these will likely to have not only an adverse long-term impact on the maternal health and well being but also on their children. It further suggested that in order to improve the health status of the tribal women in Jharkhand, the healthcare delivery system should be designed effectively to cater to the specific needs of the tribal women during pregnancy and at childbirth by ensuring their personal involvement. The study further suggested that health interventions must focus on tribal culture, medical training of the tribal people, and a knowledgeable health care delivery system catering to the needs of tribal women and the child.

Chandrashekar (2014) conducted a study on reproductive health problems of women in rural areas in Manvi taluk of Raipur district which consisted of 170 villages. Out of 170, the researcher selected 9 villages. From the 9 villages, a total of 360 respondents were selected for the study. The researcher has encountered a lot of problems in eliciting information from the women respondents pertaining to their reproductive health. They hesitate and some of them were reluctant to respond. Some of the respondents even discourage the researcher as not to ask such questions pertaining to their reproductive health. Accordingly, 200 women respondent participated in response to the reproductive health problems which includes questions towards abortion, pregnancy-related problems, their opinion regarding the necessity of regular medical care during pregnancy, reasons for not using the medical facility during pregnancy, place of delivery and reasons for not going to delivery centers.

Among the 200 women respondents, four respondents which come with two (2%) reported the problem of abortion and most of the respondent did not reply properly to this question. About three-fourths (75%) of the respondents faced health-related problems during their pregnancy. Regarding the necessity of medical care to pregnant women that 63.85% stated that regular medical care is not necessary to women. Those respondents who stated medical care is not necessary were further asked to reveal why they feel the regular medical care is not necessary for pregnant women. Accordingly, 15.82 % of them stated that regular medical checkup to pregnant women is not necessary as pregnancy is a natural process and need not worry too much about pregnancy. Further, 6.77% of them remarked that there is a tradition among them not to go for regular medical care. Also, 18% feel it is more expensive, 6.77% of the

respondents complained due to lack of transportation facilities and 2.44% of them did not go for a regular checkup because their family members object on their regular visit to hospitals. Therefore, it is evident that in rural areas women face the problem of ‘unmet reproductive health demands'. Regarding the place of delivery more than half of the women respondents (54.23%) deliveries took place at their parent's house and, 32.22% of them reported that their children's delivery took place in their relative's house; only thirteen (13.55%) of them visited medical centers for their delivery. And the reasons for not opting medical centers for delivery are due to certain reasons as expensive in hospitals, economic constraints, lack of transportation and irregularity of doctors. The study found that women health, in particular, reproductive health, hardly gained prominence in rural areas. And stress further on the important to note that for an all health of the family, women health should attain utmost importance.

Sex education programmes can increase awareness about reproductive health, but in the absence of appropriate health services, this awareness does not always translate into safe and responsible sexual behavior (Mamdani, 2004). In a study among south Indian found a significantly high association between nutritional status and birth weight of new-born babies.

Ramana and Usha Rani (2014) studied on Reproductive health status - issues and concerns of tribal women in Andhra Pradesh, and focused on to assess and understand the reproductive health status of tribal women. Examination of reproductive health concerns of Tribal women was useful in assessing the extent to which population enjoyed the human rights to maximize their opportunity to enhance reproduction in a secured environment.

Srinivasan and Ilango (2010) focused on Reproductive health care of tribal women in Kolli Hills at Nammakal District, Tamil Nadu. The objectives were to study the antenatal care practice of tribal women, to and delivery related practice of tribal women, to identify misbelieves regarding food and working status of women during pregnancy. Gaps in knowledge regarding the health of tribal women have been identified and a plan of action has been suggested for improving their health.

Udhaya Kumar and Karunya’s study on ‘Reproductive Health and Rights: A powered tool for empowerment among married Kota tribal women in Kollimalai, the Nilgiris,Tamil Nadu’ found that the study on reproductive health and rights among married Kota indicated that the

present generation is educated and early marriage does not take place nowadays it has been changed as a culture of their community but the tribal women lack knowledge on reproductive rights and health.

Akhter S (2006) Knowledge, Attitudes, and Practices on reproductive health and rights of urban and rural women in Bangladesh.The study was mainly based on primary data and supported by secondary sources of information. It consists of both data gathering by questionnaire and in-depth interview among Bangladeshi married women who belong to the reproductive age group of 15 to 49 years old. The study was carried out through purposive random sampling. A total of 504 respondents were selected for the study, half of them from the rural areas and half of them from the urban areas were interviewed. Interviews, comprised of structured and semi-structured questions, conducted based on the results of the questionnaires. Altogether, 66 questions were given to each respondent in the structure part. These were comprised of several topics, including, socio-demographic information (age, educational, income level, and occupation). Also included were knowledge, attitude, and practices on reproductive health issues such as family planning and contraception, menstruation regulation and abortion, number, timing and birth spacing of children. Other topics were safe motherhood practices, sexual health and rights, gender consciousness, and decision- making processes on reproductive health.

The study tried to determine the rural-urban differences in reproductive health behaviours and practices. The results revealed that women's reproductive health and rights are directly related to women's education, age at marriage, income, empowerment, and self-consciousness. Rural and urban poor women are in further disadvantaged regarding knowledge of reproductive health issues compared to urban middle class. Urban women's level of knowledge is higher due to urban facilities, the higher the level of educational attainment, income, employment. Rural women are less advantageous due to lack of these facilities, education, and income. The researchers suggested for appropriate comprehensive special measures as well as balance development policies and programs should be taken by the Government, non-governmental organisations (NGO's), International organizations, policy makers and services providers to increase their awareness on these issues and improve the healthcare services and facilities and ensure reproductive rights of women in rural Bangladesh.

To assess the level of knowledge and use of family planning in Zimbabwe, Schwartz et al. (1999) conducted a study on 6083 women from major cities in Zimbabwe. The results showed that as compared to the1991 mother and child health survey, knowledge and coverage of family planning services have improved further, and in checking infection the introduction of contraceptives had proved a success.

Karel and Rasussen (1994) made an attempt to understand the knowledge and use of maternal and child health services by mothers in Papua New Guinea. The results indicated that use rate of a contraceptive method was very low among women who did not want to have another child within the subsequent two years. It was also observed that the most common methods were injection and pills.

Bolam, et al. (1998) evaluated the impact of postnatal health education for mothers on infants and on post-natal family planning practices among 540 mothers from Kathmandu, Nepal. The study suggests that the recommended practice of individual health education for postnatal mothers in poor communities had no impact on infant feeding, care, or immunization, although uptake of family planning has slightly enhanced.

According to Mother care matters (1995), revealed that young women's frequently limited knowledge of or confidence in accessing the health care systems results in limited prenatal care, which also contributes significantly to complications STIs also pose significant risk for adolescents which are found among young people age 20 to 24 (Noble et al,1996).

Gupta (1988) study shows that only one- half of the adolescent were aware of various family planning methods, and young people's Knowledge about spacing methods, such as through the use of intrauterine devices or oral contraceptive pills, were very low.

An Indian council of medical research (ICMR) (1992) study showed that knowledge and awareness about puberty, menstruation, physical changes in the body, reproduction, contraception pregnancy, childbearing, reproductive tract infections, sexually transmitted infections (STIs) and HIV were low among boys and girls in younger adolescents.

Jejeebhoy (1996) showed that adolescent fertility in India occurs mainly within the context of marriage and over half of all women aged 15-19 years have experienced pregnancy or

birth. Pregnancy, in a still growing girl, means an increase in nutritional requirements not only for the growth of the fetus but also for the mother herself. If they are not met, her future physical health may be impaired. According to Chhabra (1991), teenage mothers seem to be at higher risk of child-bearing with high prenatal risk. Further, closely spaced multiple births at a comparatively tender age contribute to the high rate of maternal mortality and gynaecological complications.

K.Van Egmond, et al. (2004) study on Reproductive Health in Afghanistan: Results of a knowledge, attitude and practices survey among Afghan women in Kabul. The study was carried out among 468 Afghan women of reproductive age (15-49) years to have a better understanding of women's reproductive health in Afghanistan, the use of reproductive health services including antenatal care and family-planning. Knowledge, attitude, practices regarding family planning, sexually transmitted infections and gender issues were also explored. It was found that a total of 79% of the women attended antenatal consultations during their last pregnancy, and 87%of them were mainly with a female gynaecologist (87%). The acceptability of antenatal-care services appeared to be good, as only five (5%) were unwilling to attend antenatal care in future. The main reason given for attending antenatal care includes learning the health status of the child by 39%, attended antenatal care because they felt sick by 28% and 13% to get a vaccination for free of cost.And fewer of 2% the women identified any obstacles to obtaining antenatal care. In univariate analysis, the use of antenatal health services was significantly associated with the educational level of the women, last delivery less than one year ago, ethnicity (higher attendance among Tajik) and having a husband with a qualified regular job. In family planning overall 40% of the women considered the desired to family size met, but the contraceptive prevalence rate was 23% indicating that there was still an unmet family-planning need. While 6% of the married women were using a modern family planning method andseven (7%) a natural family-planning method. Older women were more likely to use a family planning method than young women.Family-planning services appeared to be mainly used by Afghan women who wished to have no more children and rarely as a way to space pregnancies. Fifty-two (52%) of the married women did not know any method to delay or avoid pregnancy. Lack of knowledge can, therefore, be considered the most important obstacles to family-planning services.In multivariate analysis, family-planning use was significantly associated with several factors. Once again the educational level of the women seems to be the most important determinant. Regarding access to

family-planning services, socioeconomic factors are likely to play a role since women whose husbands had a permanent job were likely to use family planning than those whose husbands were unemployed.

The study also showed that even in a privileged group of Afghan women, reproductive-health indicators are poor and several potential risk factors for maternal mortality death can be identified. Among factors that contribute to maternal mortality, the literature usually distinguishes factors that first, delay arrival at a health facility; delay the decision to seek care; second, delay arrival at a health facility; and third, delay the provision of adequate care. Distance cost and quality of care are considered major obstacles. The study also found that several socio-cultural factors which can promote maternal deaths were identified such as early marriage, frequent childbirth, lack of spacing of pregnancies and low decision-making power of women to seek appropriate health-care or to negotiate terms of sex. These factors are strongly linked with the traditional attitudes that prevail in the Afghan society of today.

It is also clearly identified in the study that education as beneficial for women's reproductive-health status on an individual level. Women who attended school scored significantly better in getting skilled attendance at the birth, contraceptive prevalence rate, and antenatal coverage. Fewer adolescent pregnancies were observed among educated women and knowledge of sexual and reproductive health was significantly better. This finding is in line with data from other countries, which document that women with limited education have much higher pregnancy-related death (Grimes, 1994).

The important impact that social and cultural factors have on reproductive health, underlines the need to see reproductive health in Afghanistan in a broader perspective than from a "health-care provider' point of view alone. Not only poor quality or absence of reproductive-health services explains women's low health status in Afghanistan. Therefore, the study suggested that actions to improve reproductive health in Afghanistan should include efforts to empower women- including educating girls and providing economic opportunities to women and to educate men about women's reproductive needs through community –based programmes. Programmes should move beyond more ‘education’ to bring about a change in behavior.

Strategies should be developed which address women's decision-making power in the family. These will result in improved access for women to existing reproductive- health services.

Jejeebhoy (2000) revealed that adolescent in Indian society tends to be extremely poorly informed regarding their own physical well-being, their health, and physiological changes. Often they have incomplete knowledge and information and are subject to confusion.

Epstein and Chandra (2000) highlighted many obstacles that may discourage young people from seeking any health care. This includes an inability to access services independently from their families, fear of discovery by family or community members, inconvenient location and hours, unwilling to respect their confidentiality.

Prusty (2014) study analysis on Use of contraceptives and unmet need for family planning among tribal women in India and selected hilly states provides a comprehensive picture of knowledge and use of contraceptives among scheduled tribes (ST) of India and selected centrally hilly states where tribal population contributes more than 30% of the total tribal population of the country. An attempt is also made to know how far scheduled tribes differ from non-tribes in the states, namely Jharkhand, Madhya Pradesh, and Chhattisgarh, using information collected in the third round of District-level Household Survey (DLHS-RCH III: 2007-2008. Bivariate analysis was used for understanding the level of knowledge, use of unmet need for contraception among different tribal and non-tribal groups. Binary logistic regression was used for understanding the factors associated with the use of contraception and unmet need for family planning among tribal women. Knowledge and use of temporary contraceptive methods are considerably lower among tribal women compared to their non-tribal counterparts in the three states under study. Low acceptance due to the phobia of adverse health consequences, accessibility to and lack of knowledge of contraception are the leading reasons for not using contraceptives. The unmet need for family planning among them was quite high, especially in the state of Jharkhand. Multivariate analysis substantiated the role of women and husbands' education, an age of women, and the number of surviving boys in the use of any modern method of contraception. Educating women and their respective husbands about proper use and benefits of modern contraceptives is important to solve the problem of the high unmet need for family planning among these tribal women. The study suggested the need for simultaneous attention to

the health systems strengthening component is crucial for ensuring delivery of good-quality family planning services.

Women in rural areas, older women, women with little or no schooling, scheduled tribe women; Muslim women have less exposure to family planning messages. Marriage is almost universal in India. It is also showed that that urban women marry later than rural women and women attaining higher or more years of schooling marry much later than other women. The number of children that a woman bears has many factors such as the age of women on her first pregnancy, the birth spacing and her fecundity. The intervals between births have played a role towards the health consequences for women. Childbearing at a very young age is highly associated with an increased risk of complications during pregnancy and childbirth and higher neonatal mortality. Teenage pregnancy is found to be relatively high in rural areas, nearly 1 in every 10 women in rural areas 15-19 year's age group have begun child bearing. It is also found that teenage pregnancy decreases with an increasing level of schooling as well as their level of wealth (NFHS-4, 2015-16).

Towards antenatal care, used of skilled provider for antenatal care services is higher in urban areas than rural areas with (89% and 75% respectively). It is also found that used of skilled provider for antenatal care services increases with the rising education and awareness provided by the government through various schemes. In India, 87% to 91% of women who received antenatal care (ANC) for their most recent live birth in the past five years had their weight measured, a blood sample taken, a urine sample taken, abdomen examines and blood pressure measured. Also towards delivery services and postnatal care, institutional deliveries increased between 2005- 06 and 2015-16, from 39% to 79%. It is found that the mother's educational status is highly correlated with the place of delivery and used of skilled provider. 95% of women with 12 or more year of schooling had delivered a baby in a healthy facility compared to 62% of women with no schooling. With regards to postnatal care it is found that Schedule tribe women 59% are less likely to receive a postnatal check-up within two days than women from any other caste/tribe group. In India, less than half (43%) of women received their first postnatal check from a doctor; 22% from nurse, midwife and 2% from ASHA. Women with 12 or more years of schooling are more likely to receive a postnatal check up than women with no schooling (NFHS-4, 2015-16).

Prusty, R.K., and Gogoi, M (n.d).Studies on Reproductive Health Complications among Tribal Women in India: A special focus on North-East India. The study tries to examine the prevalence of reproductive health complications among tribal women and their treatment seeking behavior based on DLHS-3 (2007-08) data. For study purpose North-Eastern region of India is considered in the context of a concentration of tribal population. This study is based on secondary data where women were asked about their experience of ever having any morbidity and sought treatment related to reproductive health. The methodology is based on Bivariate and Multivariate analysis and reporting of any one symptom of reproductive morbidity and treatment sought from any source were taken as the dependent variable. The study result showed that tribal women from the North-Eastern part of India were less aware of symptoms of RTI/STI as compared to non-tribal women. Manipur it shows the highest awareness of RTI/STI (48%) among the studied states, but in case of Mizoram which is in the second position with 46%, tribal women were more aware of RTI/STI than that of non-tribal women and which is different from rest of the states. In North-Eastern region a very small proportion of women (27%) aware of reproductive morbidities. Where 32% of women belong to non-tribal and 24% belongs to a tribal group.

Prusty, R.K., and Gogoi, M (n.d).Studies among tribal and non-tribal women reveals a very high incidence of self-reported symptoms of gynaecological morbidity in north-eastern states of India. It also showed that problem of abnormal vaginal discharge and pain in lower abdomen not related menses is significantly higher reported by non-tribal women as reported by tribal women. Maximum of women reported of not having any treatment for her problems and it is found higher among tribal women. The researcher suggested that there should be an urgent to improve the health care services as well health providers for better treatment and accessibility in the remote areas of the country. Lack of knowledge regarding the gynecological problems or morbidities and fear to express them is a major cause of high prevalence. More education should be spread on the priority not only for the tribal population but also some awareness programme among non-tribal women which may help them to seek better treatment.

The focus of the paper, contraceptive knowledge, and practice by women attending an antenatal clinic in Ilea, Nigeria, by Ogunjuyige, et al. (1996) was to examine whether attendance

at antenatal clinics does increase the knowledge and attitude of women who attend antenatal health clinics and consequently increased their use of modern contraceptives.

Edwards, et al. (2000) studied women's knowledge and attitude towards contraceptive effectiveness and adverse health effects of women in Oxford. The result showed that women tended to overestimate the risks and underestimate the effectiveness of hormonal contraceptives. They were resistant to interference with their bleeding patterns and weight.

Srivastava, et al.(2008) study on "Emergency contraceptive Knowledge, Attitude and Practice Among women attending a Teaching Hospital of North India" highlighted that women in the study were under the misconception that emergency contraception was available only at government or private hospitals.

Jeanpiere (2006) study among the mothers and daughters of African American women and girls through the context of mother/daughter communication that examines how the negative construction of African American women's sexuality impacts upon the women's decision to seek preventive health care.

Prasad, et al. (2005) studied on Reproductive Tract Infections among young married women in Tamil Nadu, India. The studies followed a community-based, cross-sectional design was used to investigate RTIs, other gynecologic conditions and treatment seeking behavior among married women aged 16–22 in a rural community in southern India. Quantitative data were collected through a survey about symptoms, clinical examinations including laboratory tests. Qualitative data from interviews and focus groups were collected to supplement the quantitative findings. The studies showed that 53% of women reported gynaecologic symptoms and out of which 38% had laboratory findings of RTIs and 14% had clinically diagnosed pelvic inflammatory disease or cervicitis. According to laboratory diagnoses, 15% had sexually transmitted infections and 28% had endogenous infections. Multivariate analysis found that women who worked as agricultural laborers had an elevated likelihood of having a sexually transmitted infection (odds ratio, 2.4), as did those married five or more years two (2.1%). Two-thirds of symptomatic women had not sought any treatment; the reasons cited were an absence of a female provider in the nearby health care center, lack of privacy, distance from home, cost and a perception that their symptoms were normal. Young married women in this rural Indian

community have a high prevalence of RTIs but seldom seek treatment. Education and outreach are needed to reduce the stigma, embarrassment and lack of knowledge related to RTIs. The low social status of women, especially young women, appears to be a significant influence on their low rates of treatment for these conditions.

Bhatia and Cleland (1995); Rani and Bonu (2003) suggested that prevalence of RTIs and treatment seeking behavior could be influenced by a number of socioeconomic factors such as education, community, rural and urban residence as well as demographic factors such as age and sex. At the same time, the availability of health services is also a main factor. The prevalence of any symptom of RTI/STI is 24 .1% among currently married women in the age of range 15-44 years in the Northeastern state, slightly lower than the National level (29.7)% given in (IIPS, 2001).Poor health status of women and children in terms of high mortality and morbidity was also another health priority in the country mainly within the North East states. Health facilities like hospitals and health centers were established for providing Maternal and Child Health (MCH) care through ante-natal, pre-natal and post-natal services.

Prusty and Unisha (2013) analyzed the prevalence of Reproductive Tract Infections (RTIs) and treatment seeking behavior among married adolescent women in India aged 15-19 years. The data from the district level household survey (DLHS-2007-08) were used. The survey used multi-stage stratified systematic design and 50 census village. The study found that awareness among married adolescent women is very low with (25% of them are aware of any symptoms of RTI/STI. The awareness among older women is better than adolescent women. The treatment seeking for any RTI/STI infections is found to be poor in the study only three fifth of women discuss with their husband/partner and only a little more than one-fourth of them prefer to seek treatment. The awareness remains dismal among adolescent women who have very low knowledge of these infections. Not many of the women are aware that RTI/STI can be transmitted through unsafe delivery, unsafe abortion or intra-uterine device insertion in the presence of infections. It is also found that although the prevalence is not very high many of the women ignore these infections and keep taping for a long duration.

Ramana and Rani (2015) studied on knowledge awareness and perception among RTI/STDs on tribal women in the state of Andhra Pradesh. The study was carried out in three

districts; Vishakhapatnam, Warangal, and Kadapa among the tribal women with at least one living child in the age group of 25-45 years. The study adopted stratified random sampling technique, 400 tribal women were selected from each district, totaling a sample of 1200. The information pertaining to the source of knowledge, mode of transmission and discussion about RTI/STDs was gathered among the 1200 tribal women in the reproductive age group. The study results revealed that respondents from the districts of Kadapa have the highest awareness of 50% followed by Warangal district with 47% and Vishakhapatnam with 43% respectively.

Information and communication technology is the major source to know about RTI/STDs thatWarangal district with 61.25%, Kadapa district with 55.45% and Vishakhapatnam with 66.90% respectively. It is also found that 60% of the respondents from Warangal district and 51.50% from Kadapa and 73.50% from Vishakhapatnam didn't discuss RTI/STDs problems with their husbands or partners. Therefore, the study suggested that "Health education regarding the risk factors of unhygienic menstrual practices, non- institutional deliveries and illegal abortions must be imparted to the women in the study area in order to bring about behavior change to protect them from common communicable diseases.

Meenakshi, et.al (2015) studies the knowledge, care-seeking, and prevalence of reproductive tract infections in tribal women of Himachal Pradesh, India. The sampling frame included all the women in the reproductive age group (15-45 years) who were residents of Keylong valley and had consented to participate. Out of the total 442 residents, 187 were women of the reproductive age group of which 150 consented for inclusion in the study. The camp lasted for four days. During which all women visiting the camp irrespective of their complaints but given written consent to participate were subjected to a pre-tested interview schedule. The interview schedule contained information pertaining to socio-demographic profile and reproductive health profile of the subjects including knowledge about various family planning methods, age at marriage, and awareness of RTI including HIV.

The results showed that the prevalence of RTIs among the women participating in the study was found to be 14%. Which is higher than the study showed that less than half of the participants had heard of RTIs which is slightly lower than the all India average of 44% in

women. Which shows the poor level of awareness with regard to knowledge about the symptoms of STI and treatment as well as protective measures against RTIs. This reflects a major deficit in knowledge in these women.

Reddy, P.J et.al, (2005). Study on 'Reproductive health constraints of Adolescent school girls' found that out of the 232 adolescent menarcheal girls interviewed; only 13.8 percent of the girls had prior knowledge of menses. Consequently, nine out of every 10 girls (86.2 percent) were not at all aware of what happened on the attainment of menstruation. Knowledge about the process of menstruation was observed in only a quarter (24.5 percent) of the menarcheal girls.

Geeta, A et.al (1997), studies the general and reproductive health of adolescent girls in rural North Arcot district of Tamil Nadu, also reported the very low level of knowledge, especially of reproductive health, among adolescent girls. They also highlighted in their findings that mothers should be given scientific information on reproductive health and nutrition through women's groups and should be advised to pay special attention to the needs and problems of adolescents at the time of menses to make them feel more comfortable. Also mentioned in their study the need and importanceof mass media, particularly television, should be effectively utilized to encourage and motivate the adolescent girls to take care of their general as well as reproductive health disseminating appropriate messages involving popular figures having high credibility. Such measures would go a long way in improving the reproductive health status.

The foregoing reviews suggest that there is copious literature on women's reproductive health care in India. However, the following research gaps could be noted.

- In India, Studies were mostly on the utilization of RH services and schemes implemented by the GOI so as to have policy implications and formulations. Studies have also been conducted on Adolescent and Reproductive health but there is rarely any studyavailable on Women's Knowledge and practices of RH.
- There are a few studies on RH among tribal Women in North East India.
- Methodologically speaking most of the studies on RH are quantitative and based on field survey and there are very few qualitative studies. There are fewer studies which use

mixed methods. Use of mixed methods will contribute to deeper understanding of the RH problem.

This chapter reviewed the available literature on knowledge and practices of reproductive health which contribute to furnishing the present study. The next chapter presents the methodology applied to carry out the present study.

CHAPTER III

METHODOLOGY

This present chapter discussed the methods utilized in order to carry out the present study.

3.1 Area of the Study

The present study was conducted in two villages of Churachandpur, Manipur. The two villages were selected based on the geographical location and as well the female literacy record according to 2011 Census, the government of India.

3.2 The State of Manipur

Manipur is one of the states in Northeast India with the city of Imphal as its capital. It is bounded by Nagaland state to the north, Mizoram state to the South and Assam to the West with an international boundary of Burma (Myanmar) to east. The state covers an area of 23,327 square kilometers (8,628 sqm.) and its total population is 2,855,794 (2011 census, India). Out of which 58.9% live in the valley and the remaining 41.1% in the hilly regions. Manipur state consists of 9 full revenue district namely, Imphal West, Imphal East, Thoubal, Bishnupur, Churachandpur, Chandel, Ukhrul, Senapati and Tamenglong as per 2011 census. However, another 7 full revenue district was upgraded in the year 2016 as per Manipur gazette order No.16/20/2016-R. It has now become a 16 district state after 7 new districts were formed by dividing the 9 existing ones. The newly-created districts are Tengoupal bifurcated from Chandel district, Kamjong bifurcated from Ukhrul district, Pherzawl bifurcated from Chrachandpur district, Kangpokpi bifurcated from Senapati district, Jiribam bifurcated from Imphal east district and Noney bifurcated from Tamenglong district. The literacy rate of the state as per 2011 census is 79.8 percent.

The hills are inhabited mainly by the Kuki- Chin-Mizo and Naga, and smaller tribal communities and the valley (Plains) mainly by the Meiteis, Manipuri Brahmins (Bamons) and Pangal(Manipuri Muslims). Bishnupriya Manipuri, Naga and Kuki settlements are also found in the valley regions though less in numbers.

The Meitei ethnic group represents 53% of the population of Manipur state. The main language of the state is Meitei (also known as Manipuri). Tribes constituting about 20% of the state population are distinguished by dialects and cultures that are often village-based. Manipur ethnic groups practice a variety of religions. According to 2011 census, Hinduism is the major religion in the state, closely followed by Christianity.

3.3 Churachandpur District

The present study dealt with the scheduled tribe (ST) population of Churachandpur district which is situated in the southwest part of Manipur bounded by Senapati district in the north, Bishnupur and Chandel districts in the east, Assam and Mizoram in the west and Myanmar on the south. The total geographical area of Churachandpur district is 4,570 sq.km. The topography of the district is hilly. It is home to 274,143 of which male and female were 138,820 and 135,323 respectively according to 2011 census, dominated by 15 ethnic groups like Chin, Kuki, Mizo, Naga, and Zomi. The literacy rate according to 2011 census is 82.78 %, comprising of 86.54 % male literacy rate and 78.05 % of female literacy rate respectively.

3.4 Pilot Study

A pilot study was conducted in the area of the study where the researcher conducted case studies among the tribal women. The interview schedule was also pretested with few of the tribal women and was later administered after minor changes according to the need of the study.

3.5 Research Design

The present study is descriptive in design and cross-sectional in nature. Quantitative and qualitative methods were used. Quantitative data were collected through survey method by administering structured pre-tested interview schedule. The qualitative information was elicited by conducting in-depth interviews through case studies, focus group discussion (FGD) and key informant interviews (KIIs). A case study was conducted to collect qualitative information from three tribal women. Also, a focus group discussion (FGD) is conducted among the elderly tribal women who had crossed 50 years of age and who are not included in the survey. The FGD was held to understand mainly the traditional practices and challenges faced out of the practices and also the adopted coping strategies. In addition, the reality is also understood better by conducting

4 Key Informant Interviews (KIIs) with the health workers i.e accredited social health activist, gynaecology and the director of a district family health welfare department.

3.6 Sampling

Multi-stage sampling was used to select blocks and villages. Churachandpur sub-division was selected since it is the most developed sub-division in Churachandpur district. It has two tribal development (TD) blocks; Churachandpur TD Block which is one of the most developed block and Samulamlan TD block which is one of the least developed block. Salemveng village was selected from Churachandpur TD block since it has one of the highest female literacy rates of 94.85% (2011 census). On the other hand, Ngurte village was selected under Samulamlan TD Block which has one of the least female literacy rates with 86.59% (2011 census).

The third stage is on the selection of households. In the selected villages the list of the household as given in census 2011 was obtained from the village authorities. Finally, the Salemveng village has a total household of 262 and Ngurte village has a total household of 144 (2011 census, Government of India).

Using disproportionate stratified random sampling the total sample size of 160 households was selected, 80 from Salemveng Village and another 80 households from Ngurte village. So, every third household was selected from the salemveng village and every second household from Ngurte village was selected. Thus, in each of the selected household, one woman who meets the inclusion criteria of the present study were interviewed.

3.7 Unit of the Study

The unit of the study was the individual tribal women belonging to the age group of 15-49 years residing in Salemveng and Ngurte villages of Churachandpur, Manipur.

3.8 Tools of Data collection

Quantitative data were collected through the administration of structured interview schedule. The interview schedule consisted of four sections - demographic profile of the respondents which includes the personal profile, economic characteristics and general health and

hygiene (nutrition, water, and sanitation). The second section was on the reproductive health knowledge and practices.

The third section of the interview schedule was the reproductive health challenges and constraints and the fourth sections include the utilization of reproductive child health services (RCH).

3.9 Sources of Data

The primary data was collected directly from the respondents through structured interview schedule. Four key informant interviews were also conducted among the health care providers. Which include two (2) medical doctors who are directly involved in the treatment, service delivery and care of women reproductive health. And the other two interviews were with the ASHA workers

To have a more specific understanding of the issues related to women and reproductive health among tribal women of the area, a focus group discussion (FGD) was carried out with twelve (12) participants' members. The FGD focused on an understanding of reproductive health, coping and practices as experienced by the tribal women.

Further, three case- studies were conducted to probe the issues of reproductive health encountered/experience by tribal women.

3.10 Data Processing and Analysis

Census and Survey Processing System (CSPro) package and Statistical Package for Social Sciences (SPSS) were used to processed and analyze the collected data. Simple averages, percentages, 't' test and Karl Pearson's coefficient of correlation were conducted to test statistical relationship among the variables.

3.11 Limitation

The size of the sample is limited and the area of the study is confined to one district of Manipur. Hence, the generality of the finding is limited to a tribal population of Churachandpur district, Manipur.

3.12 Operational Definition of Concepts

Tribal Women

A woman refers to identify female humans irrespective of age. In this study ‘Women' is used to refer to female humans in a reproductive age group between 15-49 years inclusive of a single mother, widow, unmarried, divorced.

Reproductive Health

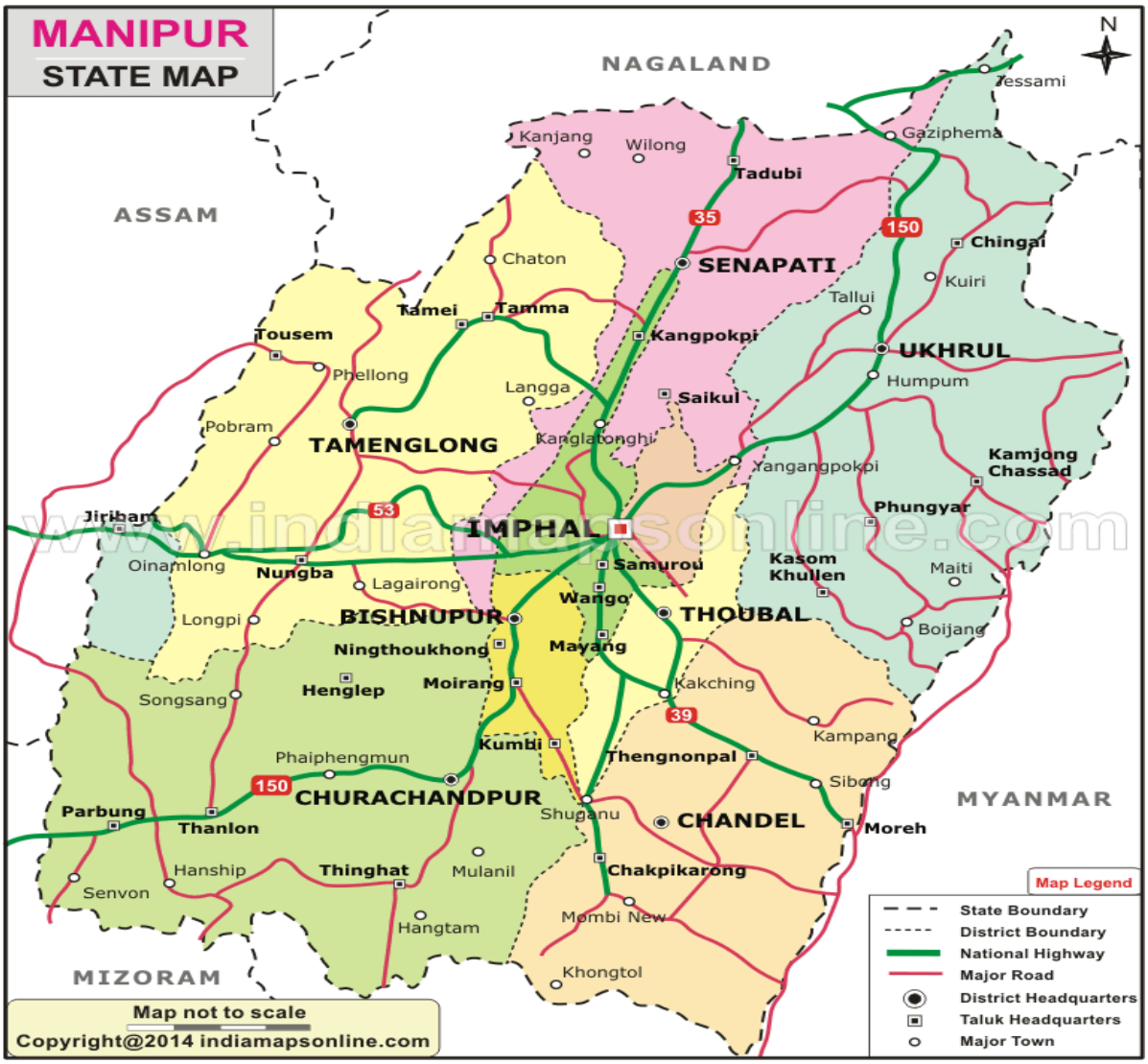
Reproductive health relates to the health of women in all matters related to the reproductive system, and to its functions and processes. Reproductive health is one of the fundamental human rights. The UN defines reproductive health “as a state of complete physical, mental and social well being and not merely the absence of diseases or infirmities, in all matters relating to the reproductive systems and its processes". The agenda gives a special focus on ‘safe sex' and ‘freedom to choose and access to family planning services' to ensure safe motherhood. It also lays emphasis on sexual health and to improve personal relationships with an aim to ensure that an individual is free from reproductive tract infections (RTIs) and sexually transmitted diseases (STDs). Thus reproductive health has to be looked at from a holistic point of view.

Reproductive Age Group

Women of reproductive age refer to all women aged 15-49 years. In some census and surveys estimates, the upper age is taken as 44 years and the last age group is thus 40-44 years. More recently, it has been recommended that total fertility rates be shown by using both 15 to 44 and 15 to 49 age groups (WHO, 2006). However, for the present study, the later age group 15-49 age group has been used as the reproductive age group.

Figure 1

Manipur Map



Source: http://www.indmaps.com/state-map/manipur/

Figure 2

Map of Churachandpur

Source: https://www.mapsofindia.com/maps/manipur/tehsil/churachandpur.html

CHAPTER IV

RESULTS AND DISCUSSION

The previous chapter described the research methodology that was applied to frame this study and the tools that were employed to collect data from the respondents. The present chapter is a discussion results on quantitative and qualitative data collected.

4.1 Demographic Profile of the Respondents

The demographic characteristics of the respondents set the background the study. This section highlights the demographic background of the respondents that includes age group, age at the time of marriage, marital status and educational qualification. All these aspects are discussed in detail as presented in the Table 1 Socio- demographic profile of the respondents.

Table 1 is on the age of the respondent showing that the maximum of one fourth (25.6%) of the total respondents are belonging to the age group of 38 to 43 years. There is an equal distribution of 21.3% who belong to the age group of 19 to 25 years and 26-31 years respectively. Another 20.6% of the respondents are belonging to the age group of 32 to 37 years of age. Also, another 8.1% and 1.9% of the respondents belonging to the age group of 44-49 years and 15 to 18 years respectively.

The age of respondents at the time of marriage shows that more than half (58.8%) of the respondents got married between the age of 19 to 25 years and nearly one fourth (24.4%) got married between the age of 15 to 18 years. This is followed 12.5% who had married between the ages of 26 to 31years. Thus, a minimum of 4.4% got married between the ages of 32-37 years. The data shows that early marriage that is before the completion of 18 years was also present with a little less than one fourth (24.4%) among the respondents. In addition, less than 5% of late marriage which is unusual in tribal society was also observed among the respondents.

The marital status of the respondents is explored. The table shows that more than three third (87.5%) of the respondents are married. However, less than ten percent of the respondents (6.3%) were widows and 4.4% were divorcees. Further a minimal of 1.3% and 0.6% are single mother and also unmarried.

The educational status of the respondents shows that nearly half (49.4%) of the respondents had education up till standard VI followed by nearly one third (31.3%) of the

respondents had attained till high school education. Another 12.5% of the respondents had completed till higher secondary education and while only 3.8% of the respondents are graduated. However, there are 3.1% of the respondents who were illiterates. The table on the educational status of the respondents shows a decreasing pattern in enrolment and completion of higher education. Further, there is less than a total of 10 % of the respondents who had continued their education up till higher secondary and degree level courses.

Table 1 Socio- Demographic Profile of the Respondents.

Sl. No	Characteristics	Frequency N =160	Percent
1	**Age**		
	15 to 18	3	1.9
	19 to 25	36	22.5
	26 to 31	34	21.3
	32 to 37	33	20.06
	38 to 43	41	25.6
	44 to 49	13	8.1
2	**Age at Marriage**		
	15 to 18	39	24.4
	19 to 25	94	58.8
	26 to 31	20	12.5
	32 to 37	7	4.4
3	**Marital Status**		
	Married	140	87.5
	Widow	10	6.3
	Divorced	7	4.4
	Unmarried	1	0.6
	Single Mother	2	1.3
4	**Educational status**		
	Illiterate	5	3.1
	Primary(Lower & Upper)	79	49.4
	High School	50	31.3
	Higher Secondary	20	12.5
	Graduate & above	6	3.8

Source: Computed

4.1.1 Familial Characteristics

Familial characteristics are important to understand the background of the respondents. It is also an indicator of an individual's well being and their support system. The present study considered two forms of familial characteristics - the type of family and the number of children.

Table 2 Familial Characteristics of the Respondents

Sl. No	Characteristics	Frequency N=160	Percent
1	**Type of Family**		
	Nuclear	91	56.9
	Extended	36	22.5
	Joint	33	20.6
2	**No. of Children**		
	One to three	109	68.1
	Four to six	47	29.4
	Six and above	1	0.6
	Childless	3	1.9

Source: Computed

Table 2 on the familial characteristics of the respondents exhibits the distribution of respondents according to their type of family. It shows that more than half (56.9%) of the respondents are belonging to nuclear family, followed by less than a fourth (22.5%) of the respondents belonging to extended family. The remaining 20.6% of the respondent belongs to joint family.

The number of children held by the respondents is shown in table 2. A maximum of more than half (68.1%) of the respondents have a range of one to three children, followed by 29.4% who have four to six children. And 0.6% of the respondents have six and above children. Meanwhile, the study included 1.9% of the respondents who are childless.

4.1.2 Economic Characteristics of the Respondents and Family

The economic profile of the respondents indicates the individual livelihood and overall standard of family living. The present study considered the economic characteristics such as occupation of the respondent, occupation of spouse, skills or certified course obtained by the respondents and secondary occupation of the family. This is also relevant to understand the economic status of the respondents in relation to the utilization of reproductive health care and services.

Table 3 Economic Characteristics of the Respondents and Family

Sl. No	Characteristics	Frequency N=160	Percent
1	**Occupation**		
	Homemaker	77	48.1
	Self-employee	49	30.6
	Daily Wage Labourer	18	11.3
	Private entrepreneur	10	6.3
	Government employee	4	2.5
	Cultivator	2	1.3
2	**Occupation of Spouse**		
	Cultivator	50	31.3
	Daily Wage Labourer	38	23.8
	Self-employed	25	15.6
	Private entrepreneur	17	10.6
	Government employee	7	4.4
	Homemaker	3	1.9
	NA	20	12.5
3	**Skills of the Respondent**		
	Handloom weaving	76	47.5
	Tailoring	27	16.9
	DishWash Making	7	4.4
	Computer Course	6	3.8
	Flower & Candle Making	6	3.8
	Basket Making	5	3.1
	Mushroom Planting	1	0.6
	None	32	20
4	**Secondary Occupation of Family**		
	Cultivator	64	40
	Small Business	29	18.1
	None	67	41.9

Source: Computed

Table 3 is on the economic characteristics of the respondents and their family. The occupational status of the tribal women respondents shows that nearly half (48.1%) of the entire respondents are engaging in homemaking or housewife and more than one fourth (30.6%) of the respondents were self- employee. Over all, less than ten percent each of the respondents were unskilled daily wage labourer, private entrepreneur, government employee and Cultivator. Further the occupation of the respondents is one of the indicators of the individual economic status reflecting the accessibility to reproductive health care and hence a purchasing power.

With regards to the occupation of the respondents spouse as shown in table 3 it is shown that a maximum of 31.3% of the respondent's spouse are engaged in cultivation, 23.8% of the respondent's spouse are daily wage labourer. Another 15.6 % of the respondent's spouses are self-employee and another 10.6% of the respondent's spouse is engaging in private entrepreneurship. Hence only 4.4% of the respondent's spouse was government employee and a few of just 1.9% are homemaker. It is important to note that the enquiry is not applicable to 12.5% of the respondent's husbands mainly because the respondents were either single mother, divorced or widow.

The economic characteristics were also defined through the skills or certified course obtained by the respondents which could in turn adding the family income. The table 3 shows that nearly half (47.5%) of the respondents have obtained skills or certificate in handloom weaving, 16.9% had a skills training on tailoring. While, 4.4% and 3.8% had obtained expertise in dish-wash making or detergent making and training in flower making and candle making. There is a distribution of 3.1% and 0.3% of the respondents who had obtained skills in basket making and mushroom planting. Thus, 3.8% of the entire respondents had undergone basic computer course. This is significantly acknowledged in line with the educational status of the respondents who had completed degree course or equivalent.

The secondary occupation of the family of the respondents shows that more than one third (41.9%) of the respondents family does not engaged in secondary occupation. On the other hand, almost an equal number of 40% of the respondents have adopted cultivation as their secondary occupation as well as secondary source of family income. Also another 18.1% of the respondents are having small business like petty shops as their secondary occupation.

4.1.3 Living Conditions of the Respondents and Family

Understanding the personal income and annual family income is one of the indicators to understand the living conditions of an individual and standard of family living conditions.

Table 4 indicates the personal income of respondents and their family annual income. The personal monthly income of the respondents shows that half (50.6%) of the respondents are earning below Rs. 5000 per month. This is followed by 20.6% of the respondents who has a personal income between Rs 5001 to Rs.10, 000 per month. It is found that less than 5 % of the respondents earned between Rs.15,001 to Rs.20,000 and Rs.10,001 to Rs.15,000 per

month. The data also shows that 15.6% of the respondents do not have any income and depends upon the spouse income.

The data shows that half of the respondents are not having individual source of income which highlights the nature of dependency for their personal needs. And only few of the entire respondents are having regular monthly personal income.

Table 4 Living Conditions of Respondents and Family

Sl. No	Characteristics	Frequency N=160	Percent
1	**Personal Monthly Income**		
	No Income	25	15.6
	Below Rs.5000	81	50.6
	Rs 5001 to 10,000	33	20.6
	Rs.10,001 to Rs.15,000	6	3.8
	Rs.15,001 to 20,000	7	4.4
2	**Annual Family income**		
	Below Rs.60,000	34	21.3
	Rs.60,001 to Rs.1,20,000	84	52.5
	Rs.1,20,001 to Rs.1,80,000	32	20
	Rs.1,80,001 to Rs.2,40,000	10	6.3

Source: Computed

The annual family incomes of the respondents are also explored in table 4. A maximum of just more than a half (52.5%) of the respondents' family annual income range between Rs. 60,001 to Rs. 1,20,000. Secondly, one fifth (21.3%) of the respondents had an annual family income that is below Rs. 60,000. Similarly, another one fifth (20%) of the entire respondents had an annual income between Rs. 1,20,001 to Rs.1,80,000. Thus, a few respondents of 6.3% have an annual family income of Rs.1, 80,001 to Rs.2, 40,000.

4.1.4 General Health (Nutrition)

The table 5 on general health and nutrition indicates that the entire respondents are taking rice and is their main stable food. The general health and hygiene of the respondents consisted of food items held by the respondents, number of meal intake in a day, sufficiency of intake and the reasons for insufficiency of food intake.

In regards to the frequency of meal taken by the respondents family in a day ,the data shows that more than two-third (72.5%) of the respondent families had a square meal a day , and more than one fourth (27.5%) of the respondents families had their meal three times in a day. In connection to this, the respondents were satisfied with the quantity of their food

intake, of which almost majority (94.4%) of the respondents feels that the quantity was sufficient for them. On the other hand, another 5.6% of the respondents feel that the quantity of the food intake in a day was insufficient or not enough. The reasons for feeling insufficient food intake are mainly due to shortage of money and due to loss of appetite as 3.1% and 2.5% respectively.

Table 5 Food and Nutrition

Sl.No	Characteristics	Frequency N=160	Percent
1	**Food items Intake(**Rice)	160	100
2	**No. of meal taken in a day**		
	Twice a day	116	72.5
	Thrice	44	27.5
3	**Food Intake Sufficient**	151	94.4
4	**Reason for Food Insufficiency**		
	NA	151	94.4
	Loss of Appetite	4	2.5
	Inadequate Income	5	3.1

Source: Computed

4.1.5 Availability and Utilization of Water

Table 6 represents on the availability and utilization of Water. The main source of water, distance for fetching water, availability of safe drinking water at their home, water treatment for drinking was explored. The source of water of the respondents and their families shows that more than one third (40%) of the entire respondents depends on water hand pump as their main source of water, one fourth (26%) of the respondents depends on pipe water supply, little less than one fourth (23.1%) of the respondents are using well water. While 10% depends on river water, and a few of 0.6% of the respondents depends on pond water as their main source of water.

In connection to this, the distance to fetch water from their house was explored. The data shows that nearly two third (62.5%) of the respondents travel less than a kilometre to fetch water, another one third (33.8%) of the respondents travel between one to two (1kilometre to 2 kilometres) and a few (3.8%) of the respondents needs to travel 3kilometres or more in order to fetch water for their daily consumption. It is also reported that majority (96.9%) of the respondents had safe drinking water at home and the remaining 3.8% of the respondents does not have proper safe drinking water at home. In regards to the treatment of

drinking water that nearly two third (65.6%) had boil water before consumption and the remaining one third (34.4%) of the respondents directly drink the water without any separate treatment.

Table 6 Access to Water

Sl. No	Characteristics	Frequency N=160	Percent
1	**Source of Water**		
	Hand pump	64	40
	Pipe water supply	42	26.3
	Well water	37	23.1
	Pond water	1	0.6
	River water	16	10
2	**Distance for fetching water**		
	Less than 1 Kilometre	100	62.5
	1 to 2 Kilometre	54	33.8
	3 Kilometre & above	6	3.8
3	**Availability of safe drinking water**	155	96.9
4	**Boiling water for drinking**	105	65.6

Source: Computed

4.1.6 Access to Sanitation

In order to understand towards sanitation practices table 7 represents on the hand washing with soap before eating, reasons for not washing, locate dustbin inside the house, disposal of garbage, and the availability of sanitation facility at home was explored.

Exploring towards the hygiene and sanitation practised by the respondents table 7 shows that 43.1% of the respondents regularly wash their hand with soap before eating and more than half (56.9%) of the respondents does not practice washing hands with soap before eating. The reason for not practicing washing hands with soap before eating were reported as feeling of unnecessary by the respondents (55.6%). There is an equal distribution of reasons by 0.6% of the respondents due to unavailability of soap and also due to scarcity of water.

To understand the sanitation practiced by the respondents, the data shows that nearly two-third (60%) of the respondents have located dustbin inside the house and the other two fifth (40%) of the respondents kept the dustbin outside their house. This is connected with the waste disposal practices that nearly half of the respondents disposed garbage through the voluntary community collection, another 19.4% dispose it in their own dumping pit, and the

other 18.8% burned their own garbage. Also, another 10.6% of the respondents dump their garbage in the river. It is observed that a few of the respondents disposed their garbage through municipal community van (3.1%) and through community dumping pit (1.9%).

Table 7 Access to Sanitation

Sl. No	Characteristics	Frequency N=160	Percent
1	**Regular washing hands with soap before eating**	69	43.1
2	**Reason for Not Washing**		
	NA	69	43.1
	Soap Unavailable	1	0.6
	Scarcity of water	1	0.6
	Don't think necessary	89	55.6
3	**Have dustbin inside the house**	96	60
4	**Where do you dispose your garbage**		
	Voluntary community collection	74	46.3
	Own dumping pit	31	19.4
	Burn	30	18.8
	River	17	10.6
	Municipal community van	5	3.1
	Community dumping pit	3	1.9
5	**Type of toilet used**		
	Septic tank	79	49.4
	Pit latrine	66	41.2
	Pour flush pit latrine	15	9.4

Source: Computed

In regards to toilet facilities used by the respondents the data shows that nearly half (49.4%) of the respondents used septic tank toilets and more than two fifth (41.2%) used pit latrine and less than tenth (9.4%) used Pour flush pit latrine.

4.2 Reproductive Health Knowledge

This section covers the information on the reproductive health knowledge of the respondents. It consisted of the respondent's awareness on their reproductive organs, their source of information regarding reproductive health,

The Table 8 reproductive health knowledge reveals that more than three fourth (83.1%) of the respondents aware of the reproductive organs while the remaining 16.9% of the respondents were found to be not aware of it. The source of information received by the respondent's shows that nearly half of the respondents were informed by the health care providers. This is followed by 18.1 % of the respondents who had received information

through health education curriculum of the school health programme. On the other hand this particular query is found to be not applicable by 16.9% of the respondent because awareness on reproductive health of a woman is still limited among the tribal population. Another important factor similar to other population is that 10% of the respondents received the reproductive health information through their peers. The presence of parental communication mostly the mother is revealed by 6.3% of the respondents. In contrary to many other society 4.4% of the respondents had received information from the media such as television, radio and local news papers.

Table 8 Knowledge on Reproductive Health

Sl. No	Characteristics	Frequency N=160	Percent
1	**Awareness on reproductive organs**	133	83.1
2	**Source of Information**		
	Health Care Providers	71	44.4
	School Education	29	18.1
	Peers	16	10
	From Parents	10	6.3
	Media	7	4.4
	NA	27	16.9

Source: *Computed*

4.2.1 Reproductive Health Challenges and Health Care Seeking

The respondents experience of reproductive ill health problems, to whom do they share their experiences, place of treatment, how often they took care of reproductive health problems and how was it diagnosed were explored on table 9.

Table 9 represents on the respondents' experienced on several reproductive ill health problems among which nearly half the respondents (48.1%) had experience vaginal white discharge accompanied by itching/fever/bad odour/irritation around vaginal area. Nearly one fourth (23.1%) of the respondents had experienced severe abdominal pain that is not necessarily related to menstruation. It is important to note that another 16.9% of the respondents had experienced pain or burning while urinating or frequent difficult urination, for less than tenth (2.5%) they had experienced others related reproductive health complaints such as continuous back pain and frequent heat sensation on feet and feeling thirsty

Surprisingly, 3.1% and 0.6% of the respondents had shared their reproductive ill health problems to visionary and also with the priests or their local pastors. Thus, the enquiry is not applicable to 10% of the respondents as they do experience reproductive ill health problems.

Table 9 Reproductive Health Challenges and Health Care Seeking

Sl. No	Characteristics	Frequency N=160	Percent
1	**Experienced Reproductive Health Problems**		
	Vaginal discharge accompanied by itching/fever/bad odour/irritation around vaginal area	77	48.1
	Severe lower abdominal pain not related to menstruation	37	23.1
	Pain or burning while urinating or frequent difficult urination	27	16.9
	Others	4	2.5
	NA	15	9.4
2	**Mode of diagnosis**		
	Through medical investigations	109	68.1
	Interpreted by elder women	23	14.3
	Others	3	1.9
	Faith healer	2	1.3
	NA	23	14.4
3	**Report Reproductive Health problems to**		
	Husband	87	54.4
	Relatives	27	16.9
	Mother-in-laws	11	6.9
	Friends	7	4.4
	Doctors	6	3.8
	Pastor/Priest	1	0.6
	Visionary	5	3.1
	NA	16	10
4	**Place of Treatment**		
	Private medical sector	77	48.1
	Public medical sector	45	28.1
	Did not seek any treatment	29	18.1
	Traditional Healer	1	0.6
	NA	8	5
5	**Frequency of Health Care Seeking**		
	Always	47	29.4
	Sometimes	60	37.5
	Rarely	11	6.9
	Never	1	0.6
	NA	41	25.6

Source: *Computed*

In regards to the diagnosis of the reproductive health problems that more than two third (68.1%) of the total respondents were diagnosed through medical investigations. The data also shows that 15% of the respondents came across understanding the reproductive health problems through the interpretation of the elder women. This is not applicable to 14.4% of the respondents as they cannot mention any exact place of their diagnosis. While another 1.9% of the respondents came to understand the reproductive ill health problems through their friends and relatives who had already experienced it. It is self reported that

1.3% of the respondents had diagnosed their reproductive health problems through the faith healer. While encountering such reproductive health problems the data shows that more than half (54.4%) of the respondents shared it with their husbands, followed by 16.9% of the respondents who had shared it with their relatives and 6.9% of the respondents used to share it to their mother in-laws and 4.4% of the respondents share among their friends. In fact, only 3.8% of the respondents had disclosed the matters to physician or doctors.

It is relevant to know the treatment seeking behaviour of the respondents. The data shows that nearly half (48.1%) of the respondents seeks private medical care and more than one fourth (28.1%) seek treatment from the public government medical care. However, 18.1% of the respondents do not seek at all any treatment. Further, the remaining 5% does not report any particular place of treatment and had sought the treatment depending upon the availability. It is worthwhile to mention that 0.6%of the respondents have gone to traditional healers for the reproductive health complaints.

In respect to the frequency of health care seeking by the respondents is rated using 4 point scale -always, sometime, rarely and never. The data shows that more than one third (37.5%) of the respondents only sometimes seeks for treatment and less than one third (29.4%) of the respondents does not always seek treatment when the face reproductive health problems. On the other hand, this particular enquiry is not applicable as the respondents does not experience reproductive health problems, some of the respondents cannot recall whether they seek for treatment or not. Thus, 6.9% of the respondents rarely seek for treatment, and 0.6% of the respondents never went for treatment.

4.2.2 Reproductive Health and Menstruation

Table 10 on the awareness on reproductive health and menstruation presents the accounted data on reproductive health and menstruation amongst the respondents. The enquiry was made with regards to their awareness in relation to menstruation. Respondents were asked on their awareness about menstruation, number of days for menstrual flow, regularity of menstrual cycle, reasons and sought in case of irregular menstruation.

According to the data it is vividly highlighted that a maximum of 88.1% of the respondents confirmed their awareness on attainment of menstrual cycle and the remaining 11.9% of the respondents are unable to keep trace on the attainment of their menstrual cycle. More than two-third (67.5%) affirmed to continue menstrual flow for 3 to 4 days and slightly more than a fifth (21.3%) of the respondents stated of being continued their menstrual flow

for 5 days and more.While11.3% of the respondents reported menstrual flow for less than 2 days. The enquiry on menstrual behaviour shows more than three-fourth (76.3%) of the respondents are having regular menstrual cycle and a little less than one-fourth (23.8%) of the respondents reported to have irregular menstrual cycle.

Table 10 Menstruation: Awareness and Care

Sl. No	Characteristics	Frequency N=160	Percent
1	**Awareness on attainment of Menstrual cycle**		
	Yes	141	88.1
	No	19	11.9
2	**Duration of Menstruation**		
	Less than 2 days	18	11.3
	3 to 4 days	108	67.5
	5 days and more	34	21.3
3	**Regularity of Menstrual Cycle**		
	Yes	122	76.3
	No	38	23.8
4	**Reasons for Menstrual irregularity**		
	On medication	74	46.3
	Conceiving	19	11.9
	Anaemia	5	3.1
	Other physical health problems	62	38.8
5	**Treatment seeking for Menstrual irregularity**		
	Always	20	12.5
	Sometimes	49	30.6
	Rarely	40	25
	Never	50	31.3
	NA	1	0.6
6	**Perceived delayed menstruation**		
	Pregnant	75	46.9
	Other Physical health Problems	84	52.5
	Anaemic	1	0.6

Source: *Computed*

The seeking treatment on menstrual irregularity had explored among the respondents as always, sometimes, rarely, never. Of these respondents who have experienced

menstrual irregularity, the respondents never sought for treatment and the respondents who had sought treatment sometimes only are 31.3% and 30.6% respectively. Also another 25% and 12.5% of the respondents had rarely undergone treatment and frequently undergone treatment in case of menstrual irregularity.

Further the possible reason for irregular menstrual cycle on table 10 shows that a maximum of nearly half (46.3%) of the respondents attributed the reason due to on medication leading to irregularity of their monthly cycle while another 38.8% of the respondents rested the reason on other physical health problems. According to 11.9% of the respondents the cause of menstrual irregularity is due to conceiving or pregnancy and anaemia as also another causing factor to menstrual irregularity mentioned by 3.1% of the respondents.

It was further explore on the respondents management on delay of menstrual cycle and on what possible understanding arise out of such circumstance could be the cause or what did it is being ascribed to. The data on table 10 shows that nearly half (46.9%) of the respondents ascribed delay of the menstrual cycle as conceiving. On the other hand more than a half (52.5%) of the respondents ascribed delay of menstrual cycle to as other physical health problems. However the remaining 0.6% of the respondents perceived such a situation arose mainly due to being anaemia

4.2.3 Menstruation and Management

Maintaining a hygienic method of menstrual protection is important for women's health and personal hygiene. In India, (42%) use sanitary napkins, (62%) use cloth and (16%) use locally prepared napkins (NFHS-4).The personal hygiene and cleanliness is a basal factor for overall good health including reproductive health. This is pre conditioned by the nature of sanitation maintained to protect the menstrual flow used by the respondents. The kind of menstrual material/protection method used, disposal of used sanitary pads or other used material; treatment and experienced social taboo with regards to menstruation during was asked among the respondents were enquired in table 11.

The data on table 11 shows that more than half (54.4%) of the respondents used sanitary pads while more than one-third (35%) of the respondents used any available clean cloth and another 10% of the respondents reported that they used materials both clean cloths and sanitary pads based on the availability. In connection to this the way of disposal of used menstrual protection were explored.

The data shows that nearly half (43.1%) of the respondents often disposed it off to dustbin while the other nearly one-third (32.5%) of the respondents burn it. It is observed that

23.1% and 0.6% of the respondents have the habit to dispose of into a pit and the habit of throwing away into the nearby river. It is assume that the respondents dispose the used menstrual protection method after wrapping with paper. Further, among the respondents who used cloth more than two third (84.4%) of the respondents reused the same cloth. Out of which, 86.9% of the respondents stated that they reused after washing and sun-drying off the cloth. It is also observed majority of 98.8% of the respondents' had never experienced any kind of social taboo associated to menstruation.

Table 11 Menstruation: Management

Sl. No	Characteristics	Frequency N=160	Percent
1	**Kinds of menstrual protection adopted**		
	Sanitary Pad	87	54.4
	Clean Cloth	56	35
	Any cloth	16	10
	Others	1	0.6
2	**Disposal of used menstrual protection**		
	Dustbin	69	43.1
	Burn	52	32.5
	Pit	37	23.1
	River	1	0.6
	Others	1	0.6
3	**Usage of cloth, wash it & reused**		
	Yes	135	84.4
	No	25	15.6
4	**Manner of drying off**		
	Sundry	139	86.9
	Bathroom	8	5
	NA	13	8.1
5	**Social Taboo and Menstruation**		
	Yes	2	1.3
	No	158	98.8

Source: Computed

4.2.3 Reproductive Health Problems

Table 12 on reproductive health problems represents the awareness and experienced of the respondents towards the reproductive health problems particularly on white discharge, Reproductive Tract Infections/ Sexually Transmitted Infections (RTIs/STIs) and vaginal itching. Further, the source of information regarding reproductive health problems and their awareness on common sign and symptoms of RTI/STI were explored.

The data shows that majority (98.1%) of the respondents are aware of the reproductive health problems of white discharge while only a few of 1.9% of the respondents does not have awareness on it. In terms of awareness towards RTIs/STIs more than half (56.3%) of the respondents are not aware of the problem while the other 43.8% of the respondents were found to have awareness on RTI/STI. The finding is in line with Meenakshi et.al (2015) who had found that women have poor level of awareness with regard to knowledge and symptoms of STIs. Thus, majority (95%) of the respondents had awareness on vaginal itching.

Table 12 Reproductive Health Problems: Awareness and Experience

Sl. No	Characteristics	Frequency N=160	Percent
1	**Awareness on White Discharge**	157	98.1
2	**Awareness on RTI/STI**	70	43.8
3	**Awareness on Vaginal itching**	152	95
4	**Source of information**		
	None	2	1.3
	School Health Education	7	4.4
	Media	3	1.9
	Friends/Relatives	48	30
	Books	1	0.6
	Health care providers	99	61.9
5	**Aware of Common symptoms of RTIs/STIs**		
	None	82	51.3
	Foul Smelling discharge	46	28.8
	Burning sensation while urinating	13	8.1
	Itching/rashes in the genital area	7	4.4
	Pain in lower abdomen	7	4.4
	Pain during intercourse	5	3.1

Source: *Computed*

The source of information on the awareness reproductive health problems reported by the respondents as shown in the data, nearly two third (61.9%) of them got the information through health care providers and less than one third (30%) received information through their friends and relatives. In addition table 12 shows that the remaining 4.4%, 1.9%and 0.6% of the respondents came to know out of health education curriculum, media and book. While this was not applicable to 1.3% of the respondents as they were not aware about it.

The awareness of the respondents on the common signs and symptoms shows that more than half (51.3%) didn't knew about the symptoms of RTI/STI. On the other hand nearly one fourth (28.8%) mentioned foul smelling discharge from genital organs and another less than tenth (8.1%) mentioned pain or burning sensation while urinating. Further, 4.4% each mentioned about the pain in lower abdomen and itching or rashes in the genital area. Moreover, a fewer of 3.1% of the respondent's mentioned the experienced of pain during sexual intercourse as they were aware of some of the RTI/STI symptoms.

4.2.4 Knowledge on Reproductive Health and HIV/AIDS

Started in 1992; India's national AIDS Control Programme (NACP) has taken a comprehensive approach to the prevention and control of HIV/AIDs in India. The focus was on awareness generation among the high risk populations. In India, 76% of women have heard of HIV/AIDS (NFHS-4). It was also observed that in the 10 years since NFHS-3, knowledge on HIV/AIDS has increased more among women than among men (NFHS-4, 2015-2016).

Table 13 represents the awareness on the knowledge on HIV/AIDS, source of information, mode of transmission of HIV/AIDS and the suggested methods of prevention. The relevant enquiry shows that majority (98.12%) had awareness on HIV/AIDS while, 1.9%does not have awareness of it. With regards to their source of information on HIV/AIDS the data shows more than one third (41.3%) of the respondents got information through media like television, newspapers and radio. Less than one third (30%) got the information on HIV/AIDS through their peers and relatives, 17.5%of the respondents were informed by doctors or health care providers, 7.5% of the respondents received information from various non-governmental organization, community based organization and faith based organizations. The remaining 1.9% of the respondents received the information through books.

It is as well important for the respondents to know the mode of transmission of HIV/AIDS. The data shows that more than two third (78.8%) of the respondents had mentioned the four modes of HIV/AIDS transmission - unprotected sex, sharing of unclean needles among IDU's (Intravenous drug users), infected blood transfusion and from infected

mother to new born child. However the other respondents knew only one mode of transmission of HIV/AIDS as 8.8%of the respondents through unprotected sex, 5.6%of the respondents knew only sharing of needles among intravenous drug users as mode of transmission of HIV/AIDS, 4.4%of the respondents had mentioned infected blood transfusion, and a minimal of 0.6%of the respondents mentioned that HIV /AIDS can be transmitted from an infected mother to the new born child. This particular enquiry is not applicable to 1.9% of the respondents.

Table 13 Knowledge on Reproductive Health and HIV/AIDS

Sl. No	Characteristics	Frequency N=160	Percent
1	**Awareness on HIV/AIDS**		
	Yes	157	98.12
	No	3	1.9
2	**Source of information**		
	Media	66	41.3
	Books	3	1.9
	Doctors/Health care workers	28	17.5
	Friends/Relatives	48	30
	NGO's/CBOs/FBOs	12	7.5
	NA	3	1.9
3	**Modes of HIV/AIDS Transmission**		
	Unprotected sex	14	8.8
	Infected mother to new born child	1	0.6
	Infected Blood transfusion	7	4.4
	Sharing of needles among IDU	9	5.6
	All the above	126	78.8
	NA	3	1.9
4	**Awareness on Advocated methods of HIV/AIDS prevention**		
	Condoms Promotion	17	10.6
	Screening of Blood Transfusion	7	4.4
	One sexual partner	51	31.9
	Use only Sterile needles	9	5.6
	All the above	73	45.6
	NA	3	1.9

Source: *Computed*

In fact, the respondents were assessed on their awareness on advocated methods of HIV/AIDS prevention - having only one sexual partner, through condoms promotion, use of only sterile needles and screening of blood transfusion. It shows that nearly half (45.6%) of the respondents had awareness on all the four advocated methods of HIV/AIDS prevention. Meanwhile, nearly one third (31.9%) of the respondents had awareness on having only one sexual partner, 10.6%of the respondents had awareness on condom promotion as a preventive measure, 5.6% of the respondents had awareness on the uses of only sterile needles. Hence,

the other 4.4% of the respondents had awareness on the advocated method of screening of blood before any blood transfusion.

4.3 Reproductive Health Knowledge and Practices

The adoption of contraceptive as a family planning method is used in order to limit or maintain the birth spacing of the number of children. Knowledge of contraceptive methods is universal in India, with 99% of currently married women and men in the age group of 15-49 years know at least one method of contraception (NFHS-4).

Table 14 on reproductive health knowledge and practices represents the nature, used of contraceptives and its related health complications experienced amongst the respondents. The basal points of its measurement related to the knowledge about contraceptives, its procurement, reasons being used, woman's opinion on their initiative, consent between the spouse and contraceptives related health complications are taken into consideration. The data reveals that majority (95.6%) of the respondents had aware of the contraceptive methods and which more than two third (71.9%) have adopted contraceptive methods. But more than a fourth (28.1%) of the respondents denied using any contraceptive out of which a maximum of one fourth (21.3%) stated not being comfortable using it. In another case 1.3% of the respondents stated their reason of not being affirmed to use contraceptive as due to uneasy availability and culturally disapproved practices and 1.9% of the respondents specified the reasons of not being affirmed to use of contraceptive mainly due to husband's disapproval and fatigue associated to it.

Another important dimension is the initiation of family planning. The respondents were asked whether women should take the initiatives for family planning or not. An interesting depiction is found according to the data that 84.4% of the respondents advocated that women should take the initiative for family planning in contrary to 15.6% of the respondents stated that it is not necessary for the women to initiate family planning.

On the other hand, of those who had once adopted contraceptive methods, table 14 shows that nearly half (48.1%) of the entire respondents revealed that they are still continue using contraceptive method while just more than a half (51.9%) of the respondents have already discontinue using it. The exploration on the three types of contraception adopted by the respondent's that a maximum of 24.4% of the respondents resorted to oral contraceptive pills and followed by 21.3% of the other section of the respondents who are using intrauterine contraceptive device. Only a few of 3.8% adopted female sterilization as contraceptive method.

Table 14 Reproductive Health Knowledge and Practices

Sl. No	Characteristics	Frequency N=160	Percent
1	**Knowledge on contraceptive use**		
	Yes	153	95.6
	No	7	4.4
2	**Used contraceptive**		
	Yes	115	71.9
	No	45	28.1
3	**Reason for not using contraceptive**		
	Not comfortable	34	21.3
	Not easily available	2	1.3
	Husband disagree	3	1.9
	Fatigue	3	1.9
	Culturally disapprove	2	1.3
	NA	116	72.5
4	**Using contraceptive at present**		
	Yes	77	48.1
	No	83	51.9
	Total	160	100
	Method Adopted		
	NA	81	50.6
	Oral Contraceptive Pills	39	24.4
	Intrauterine Contraceptive Device	34	21.3
	Female sterilization	6	3.8
	Total	160	100
5	**Procurement of contraceptive**		
	Hospital	51	31.9
	ASHA worker	9	5.6
	Chemist	44	27.5
	Friends/Relatives	1	0.6
	NA	55	34.4
6	**Discuss with spouse before using contraception**		
	Yes	107	66.9
	No	2	1.3
	Sometimes	2	1.3
	NA	49	30.6
7	**Women should initiate family planning**		
	Yes	135	84.4
	No	25	15.6
8	**Contraceptive induced health complications**		
	Yes	109	68.1
	No	51	31.9
9	**Experienced contraceptive related heath complications**		
	Loss of appetite	15	9.4
	Fatigue	14	8.8
	Weight loss	12	7.5
	Difficulty in conceiving	11	6.9
	Headache	11	6.9
	Disturb menstrual cycle	11	6.9
	Weight gain	6	3.8
	Fever	1	0.6
	NA	79	49.4

Source: *Computed*

Further, with regards to the source of procurement of adopted contraception a maximum of almost one-third (31.9%) of the respondents revealed that they procured the contraceptive items from the hospital while just more than one fourth (27.5%) of the respondents availed the contraceptive items from the chemist. And the remaining 5.6% of the respondents stated that they procure the contraceptive items from the accredited social health activist (ASHA) workers.

It is interesting to enquire the presence of mutual consent between the couple while adopting contraception. The data from table 12 also shows that two-third (66.9%) of the respondents affirmed that they had consulted their husbands before using any contraceptives whereas there is an equal distribution of 1.3% of the respondents who had sometimes discussed with their husbands and not at all discussed with their husbands. Hence, this is not applicable to 30.6% of the respondents who had not adopted it.

Among the respondents who had adopted contraceptives, more than two-third (68.1%) of the respondents agreed that contraceptive used can sometimes lead to health complications in contrary to 31.9% of the women respondents' does agreed a relationship between the use of contraceptives and health complications. The reported response based on their experiences shows that 9.4% of the respondents have loss of appetite, 8.8% of the respondents experienced fatigue and another 7.5% of the respondents experienced weight loss due to the use of contraceptive. In addition, another 6.9% of the respondents complaint their experienced of headache, difficulty in conceiving and disturb menstrual cycle. On the other hand, 3.8% and 0.6% of the respondents having accounted for being experienced from weight gain and fever due to the use of contraceptive.

4.4 Access to Health Care Centre

The table 15 access to health care centre highlights the availability of health care centre in the areas. The availability of health care centre can be directly link to the improved health condition of the citizens. It is therefore, the availability of health care centre to determine the health conditions of the people is a major significant variable.

The data from table 15 shows that there is no health care centre available in their villages and it is confirmed by the majority of the respondents. The health care centre is available to only 1.3% of the respondents. In line with this, the distance of travelling to health care centre for accessibility of health care service is also relevant. A maximum of more than half (51.9%) of the total respondents have to travel between 1 to 3 (one to three) kilometres to avail the nearest health care facilities. It is followed by another 46% of the total respondents who had travelled between 4 to5 (four - five) kilometres or more to access the

facilities. This is important to identify because the distance of availability of health care services has great implications on their access pattern.

Table 15 Access to Health Care Centre

Sl. No	Health Care facilities	Frequency N=160	Percent
1	**Availability of health centre**		
	Yes	2	1.3
	No	158	98.8
2	**Distance to health centre from home**		
	Below 1(one) Kilometre	2	1.3
	1 to 3 (One-three) Kilometre	83	51.9
	4 to 5(four to five) Kilometres & above	75	46.9

Source: Computed

4.4.1 Utilization of Health Care Services

The following table 16 represents the scenario of utilization of pregnancy health care services in the study area. In regards to regular health check-up during pregnancy the data shows that almost three-fourth (74.4%) of the entire respondents affirmed that they went for regular check up during pregnancy whereas the remaining 20% of the respondents did not have the practice of undergoing regular check up during pregnancy.

Similarly, the table 16 shows the place of health check-up among those respondents during pregnancy. Out of the total respondents where almost one-third (32.5%) of the respondents had visited the district hospital whereas another section of which is slightly more than one-fourth (28.1%) of respondents visited private clinic for health check-ups during pregnancy. On the other hand, those respondents who were not used to undergo regular checkups during pregnancy attributed to various reasons being specified. It is accounted in a descending manner that 7.9%, 6.3% respondents stated that they did not visit health care centre due to an unable to meet the expenses and because the respondents don't think it necessary respectively. Equally another 2.5% of respondents stated the reasons due as not allowed by husband/in laws and no time factor. Moreover, equally 1.9% respondents gave the reasons as absence of health care worker, distance of the health centre and also due to lack of transportation and long duration of waiting etc. The remaining 1.3% of the respondents stated that they had no one to accompany them and therefore they could not visit a health care centre during pregnancy.

Table 16 Utilization of Health Care Services

Sl. No	Characteristics	Frequency N=160	Percent
1	**Regular check-up during pregnancy**		
	Yes	119	74.4
	No	41	25.6
2	**Place for health check up**		
	District Hospital	52	32.5
	Private clinic	45	28.1
	Primary/Community Health Centre	25	15.6
	NA	38	23.8
3	**Reasons for irregular health check-up**		
	Unable to meet the expenses	12	7.5
	Don't think necessary	10	6.3
	No time	4	2.5
	Not allowed by husband/ in-laws	4	2.5
	Absence of Health care workers	3	1.9
	Distance & Lack of transportation	3	1.9
	Long duration of waiting time	3	1.9
	No one to accompany	2	1.3
	NA	119	74.4

Source: Computed

4.5 Pregnancy related Complications

The study further explores the pregnancy related complications among the respondents and it is self-reported that almost all the respondents i.e. 90% of the respondents in their last pregnancies in the five years preceding the survey ended to live birth, and the remaining 10% pregnancy was terminated due to abortion, miscarriages, and stillbirth. Miscarriages is the most common type of live-birth, accounting for six (6%) of all pregnancies, and abortions account for another three 3% (NFHS-4).

Table 17 comprises of the study dimensions on the pregnancy related complications among the respondents. The first set of enquiry attempted to highlight the prevalence of pregnancy related complications among the respondents and to identify the types of complications. Further, an attempt was being made to understand the coping strategies

adopted by the respondents. The data reveals that more than one-third (35.6%) of the respondents reported their experienced of certain complications during pregnancy and nearly two–third (64.4%) of the respondents were void of any complications. Amongst those who experienced pregnancy related complicacy, 15.6% of the respondents went through miscarriage and followed by 8.1% of the respondents accounted for inadequate nutritional status. Moreover, 7.5% of the respondents were accounted for having obstructed labour complication and a minimum of 4.4% of the respondents accounted for having complications out of the previous pregnancy.

Table 17 Pregnancy related Complications

Sl. No	Characteristics	Frequency N=160	Percent
1	**Experienced pregnancy related complications**		
	Yes	57	35.6
	No	103	64.4
2	**Types of pregnancy related complications**		
	Miscarriage	25	15.6
	Inadequate nutrition	13	8.1
	Obstructed labour	12	7.5
	Complications in a previous pregnancy	7	4.4
	NA	103	64.4
3	**Seeking medical treatment on Pregnancy related health complications**		
	Yes	43	26.9
	No	14	8.8
	NA	103	64.4
4	**Place for treatment**		
	District Hospital	21	13.1
	Private clinic	17	10.6
	Others	12	7.5
	Primary/Community Health centre	7	4.4
	NA	103	64.4

Source: Computed

In regards to seeking of treatment on pregnancy related complications, the data shows that one-fourth (26.9%) of the entire respondents sought for medical treatment. In contrary, another 8.8% of the respondents do not at all go for medical treatment. Amongst those who sought for medical treatment a maximum of 13.1% of the respondents visited district hospital and this is followed by 10.6% and 4.4% of the respondents who had visited private clinic and primary/community health centre respectively. Interestingly, another7.5% of the respondent

visited the visionary and traditional healer mainly within the village for their treatment pregnancy related complications.

4.5.1 Access on Child Delivery Services

Increasing institutional deliveries is an important factor in reducing maternal and neonatal mortality (NFHS-4).

Table 18 is on the child delivery services accessed by the respondents. The study on the child delivery services and practices amongst the respondents were on the basis of five components viz; place for delivery, child delivery attendance, factors influencing in selection of the birth place, post natal check up within two months and reasons for not attending health check up after birth.

The data shows that a maximum of two-third of the total respondents delivered baby at the health care institutions whereas less than one-third (30%) of the entire respondents delivered their babies at home or else in any possible place in case of an emergency. Of the total respondents more than two-fifth (43.8%) of the respondents were attended by professional doctor during delivery of babies and one- fourth (26.9%) of the respondents were attended by the health nurse during child delivery. In times of not able to access or unavailability of proper health centre or services in times of need, the traditional birth attendants (TBAs) play a significant roles in the child delivery. The data shows that 22.5% of the respondents were attended by the TBAs in their child delivery and another 5% of the respondents were attended by others that are not specifically mentioned. This is possible in emergency cases depending upon the availability and conveniences.

Further, another important factor relating to child delivery is the place of delivery or the birth place. The data shows that a maximum of nearly two thirds (60%) of the total respondents choose hospital as a place for delivery due to the fact of less complications. While another 30%of the respondents' choice of place dependent upon easy accessibility for child delivery. Moreover, another 5.6% and 2.5% of the respondent's options were influenced by the nature of low cost expenditure and base on the hygienic conditions respectively.

Table 18 Child Delivery Services

Sl. No	Characteristics	Frequency N=160	Percent
1	**Place for child delivery**		
	Health care institutions	107	66.9
	Home	48	30
	NA	5	3.1
2	**Child delivery attendance**		
	Doctor	70	43.8
	Nurse	43	26.9
	Traditional birth attendant	36	22.5
	Others	8	5
	NA	3	1.9
3	**Factors influencing in selection of the birth place**		
	Less complications	96	60
	Easily accessible	48	30
	Low cost	9	5.6
	More hygienic	4	2.5
	NA	3	1.9
4	**Post natal check up within two months**		
	Yes	72	45
	No	85	53.1
	NA	3	1.9
5	**Reason for not attending health check up**		
	Don't think necessary	35	22
	Inability to meet the costs	16	10
	Lack of transportation	13	8.1
	No time to visit	10	6.3
	Distance	6	3.8
	No one to accompany	3	1.9
	Not allowed by in-laws	2	1.3
	NA	75	47

Source: Computed

In addition, post natal check-up within two months after delivery was enquired among the respondents. The data shows that 53% of the respondents did not have post-natal check-up after delivery. While, less than half (45%) of the respondents went for check-up within two months after delivery. The reasons for not going for post natal check-up within two months of child delivery includes a feeling of unnecessary for post natal check-up as reported by 22% of the respondents followed by 10% of the respondents not being able to meet the expenses incurred by post natal check-up, 8.1%, did not have post natal check-up due to lack of transportation, 6.3%, of the respondents did not find time to visit the centre and 3.8% of the respondents mentioned the far distance of health centre from their home . While, a few of

1.9% and 1.3% of the respondents claimed for absence of accompanying person and also due not allowing by their in-laws.

4.6 Woman's Reproductive Health and Abortion

A woman in India dies every two hours because an abortion goes wrong (United Nations, 2015). The problem of unsafe abortion is acute and many unsafe abortion are performed on married women mostly who are unable to obtain contraception treatment and unable to travel to a registered clinic, who for economic and personal reasons do not wish to have another child (United Nations, 2015).

Table 19 is on woman's reproductive health and abortion. The table represents the scenario of women's reproductive health and abortion of the respondents. It comprised of six interrelated dimensions as whether the respondents were already undergone abortion in the past or not, the factors responsible to undergo abortion, reason for opting abortion, place where abortion was conducted, experienced health complications related to abortion and the nature of complications. The data shows that one-fourth of the respondents reported that they had earlier undergone abortion in the past. Of which 20% of the respondents assured that they decided to undergo abortion on medical ground as advice by the doctor whereas, another 2.5% and 1.9% of the respondents confided to personnel decision and also due to family pressure respectively. But the remaining 0.6% of the respondent had not disclosed their influencing factor to undergo abortion.

However, behind the actors who influenced them to undergo abortion must there be certain valid reasons for the respondents to give-in to such an extreme life threatening undertakings. The accounted data shows that a maximum of 18.8% of the respondents underwent abortion due to their health complications but it was not the same reason for another 2.5% of the respondents who had undergone abortion due to unplanned pregnancy. On the other hand, an equal distribution of 1.9% each of the respondents who had undergone abortion due to the foetus health complications and also due to already large size of the family. In respect to the place of abortion, the data shows that a maximum of 13.1% of the respondents conducted abortion at district hospital and another 10.6%in private clinic. However, another 13% of the respondents had conducted abortion at other unspecified place that is not disclosed. Despite the nature of life threatening health consequences associated to abortion, less such ramification could be inferred from the data as only 8.75% of the respondents experienced health complications after undergoing of abortion as against to

16.25% of the total respondents who did not experience any health complications after abortion. Amongst the respondents who experienced health complications related to abortion a maximum of 3.1% of the respondents reported as having experienced of heavy bleeding but the other 2.5% of the respondents did not specifically mention the complications. Further, 1.9% of the respondents affirmed that they experienced complication relating to child bearing. Also, there is an equal distribution of 0.6% of the respondents who had reported pelvic infection and with the experience of incomplete abortion.

Table 19 Woman's Reproductive Health and Abortion

Sl. No	Characteristics	Frequency N=160	Percent
1	**Ever undergone abortion**		
	Yes	40	25
	No	120	75
2	**Influencing party to undergo abortion**		
	Doctors	32	20
	Self	4	2.5
	Family pressure	3	1.9
	Others	1	0.6
	NA	120	75
3	**Reason for opting abortion**		
	Mother health complications	30	18.8
	Unplanned Pregnancy	4	2.5
	Unborn child health complication	3	1.9
	Too many children already	3	1.9
	NA	120	75
4	**Place where abortion was conducted**		
	District Hospital	21	13.1
	Private clinic	17	10.6
	Others	2	1.3
	NA	120	75
5	**Experienced health complications related to abortion**		
	Yes	14	8.75
	No	26	16.25
	NA	120	75
6	**Post abortion health complications**		
	Heavy Bleeding	5	3.1
	Disturb future childbearing	3	1.9
	Pelvic infection	1	0.6
	Incomplete abortion	1	0.6
	Others	4	2.5
	NA	146	91.25

Source: Computed

4.7 Utilization of Reproductive and Child Health Services

The awareness of the respondents on Janani Suhraksha Yojana (JSY) and its incentives is presented on table 20. The JSY is a scheme implemented under Janani Shishu Suhraksha Karyakaram (JSSK) initiated on 1st June, 2011for pregnant women to access government hospitals to encourage institutional delivery. The following are the entitlements of pregnant women at free of cost such as free and cashless delivery, free C-section, free drugs and consumables, free diagnostics, free diet during stay in the health institutions, free provision of blood, exemption from user charges, free transport from home to health institutions, free transport between facilities in case of referral, free drop back from institutions to home after 48hrs stay.

Table 20 Utilization of RCH Services

Sl. No	Characteristics	Frequency N=160	Percent
1	**Aware about Janani SurakshaYojana**		
	Yes	116	72.5
	No	44	27.5
2	**Received monetary incentives of JSSK**		
	Yes	50	31.3
	No	106	66.3
	NA	4	2.5

Source: *Computed*

From table 20, the data shows that almost three-fourth (72.5%) of the respondents had awareness on the JSY against to 27.5% of the respondents who does not have an awareness of the JSY scheme. Further, two-third of the respondents claims that they never received any incentives under JKSS against to 31.3% of the respondents who had reported that they have received incentives under the scheme.

4.7.1 Access to Mother and Child Health Care Services

The enquiry on women access to mother and child health care services is represented in Table 21. It comprised of 9 (nine) components that measures the usage of health care facilities which are available at the government hospital on free counselling services on family planning at district hospital, awareness on free mother and child immunization services, prenatal and post natal immunization, reason for not taking vaccination, received free medication during pre and post natal period, types of medicines received at free of cost,

received free abdominal examination, access to free examination of blood pressure, and access to free blood testing facilities.

The data shows that the availability of free counselling services for family planning at district hospital was known by 21.3% of the respondents and yet more than three-fourth (78.8%) of the total respondents does not aware of the services availability. The awareness on free mother and child immunization services shows that 80% of the respondents had aware of such services and another 20% of the respondents does not aware of it. Meanwhile, half of the respondents affirmed of receiving prenatal and post natal immunizations at free of cost as against to 43.8% of the respondents who had reported of not receiving any kinds of immunizations. Among the respondents who does not receive prenatal and postnatal immunizations, 4.4% of the respondents claimed for unavailability of time for immunization and the other 3.8% of the respondents does not take vaccination due to lack of awareness on the availability of immunization service at free of cost. On the other hand, equally 1.3% of the respondents reported that due to the lack of awareness about the place of immunization and also due to long distance obstruct in taking vaccination as their reasons for not taking immunization. This is limited to the respondents who had accessed to only the government health institutions.

In regards to the services of prenatal and post natal medication, a maximum of more than two-fourth (43.1%) reported that they received prenatal and postnatal medication whereas more than one-third (37.5%) of the entire respondents does not received any prenatal and postnatal medication. Amongst those who received medication, equally a maximum of 21.3% of the respondents received iron &folic acid supplement and tetanus injection. More over in another case equally 1.3% each of the respondents received deworming tablet and other medicines but that were not able to specify by the respondents.

In regards to medical examination of blood and abdominal related, maximum of equally more than two-fifth (42.5%) of the respondents affirmed to received free abdominal examination, blood pressure examination and blood test on the other hand equally 13.1% of the respondents do not access the free examination of abdomen, examination of blood pressure and blood test.

Table 21 Access to Mother and Child Health Care Services

Sl. No	Characteristics	Frequency N=160	Percent
1	**Awareness about free counselling services available for family planning at district hospital**		
	Yes	34	21.3
	No	126	78.8
2	**Aware of free mother and child immunization services**		
	Yes	128	80
	No	32	20
3	**Received any Prenatal & postnatal Immunizations**		
	NA	10	6.3
	Yes	80	50
	No	70	43.8
4	**Reason for not taking any vaccinations during Prenatal & Post natal period**		
	NA	143	89.4
	Services too far	2	1.3
	Unaware of Immunization	6	3.8
	Unaware of the place of immunization	2	1.3
	No time for Immunization	7	4.4
5	**Received free medication during prenatal & postnatal period in the hospital**		
	Yes	69	43.1
	No	60	37.5
	NA	31	19.4
6	**Medicine received**		
	Iron & Folic Acid supplement	34	21.3
	Deworming tablet	2	1.3
	Tetanus injection	34	21.3
	Others	2	1.3
	NA	88	55
7	**Received free Abdominal examination**		
	Yes	68	42.5
	No	21	13.1
	NA	71	44.4
8	**Accessed to free examination of Blood pressure**		
	Yes	68	42.5
	No	22	13.8
	NA	70	43.8
9	**Accessed to free Blood Test facilities**		
	Yes	68	42.5
	No	21	13.1
	NA	71	44.4

Source: Computed

4.8 Hypotheses Testing

To find the significance of difference between the most and least developed villages in the woman's knowledge on RCH, knowledge on HIV/AIDS and STI/RTI and on the utilization of RCH services.t-test has been used

4.8.1 Village Development and Knowledge on Reproductive and Child Health

Table 22 depicted the knowledge on reproductive and child health components. It shows that most of the respondents across the least and most developed villages are aware of various reproductive health components comprises of women and child health.

Table 22 Village Development and Woman's Knowledge on RCH

Sl. No	Indicator	Village Development				Total N = 160		't'
		Least Developed n = 80		Most Developed n = 80				
		Frequency	Per Cent	Frequency	Percent	Frequency	Per cent	
1	Problem of White Discharge	78	98	79	99	157	98	0.58
2	Contraceptive Use	74	93	79	99	153	96	1.94*
3	Vaginal Itching	73	91	79	99	152	95	2.2*
4	Attainment of Menstrual Cycle	65	81	76	95	141	88	2.73**
5	Women Initiate Family Planning	62	78	73	91	135	84	2.42**
6	Reproductive Organs	55	69	78	98	133	83	5.23**
7	Free Mother and Child Immunisation	61	76	67	84	128	80	1.18
8	Janani Suraksha Yojana (JSY)	62	78	54	68	116	73	1.42
9	Complication of Contraceptive	54	68	55	69	109	68	0.17
10	RCH Programme	37	46	69	86	106	66	5.87**
11	RTIs/STIs	16	20	54	68	70	44	6.85**
12	Free Counselling on Family Planning	8	10	26	33	34	21	3.6**
	Knowledge on RCH(Total)	*54*	*67*	*66*	*82*	*120*	*75*	*6.45***

Source: Computed * P< 0.05 ** P<0.01

Regarding RCH, RTIs/STIs, and free counselling services on family planning in the district hospital it is seen that the awareness/knowledge level is low in the same manner in

both the least and most developed villages. It also shows that there is significant difference between the least and most developed villages on women's knowledge on RCH as the t computed (6.45) was significant at 1 per cent level. As expected the woman's knowledge on RCH was significantly higher in the most developed villages (66) tothat of the least developed villages (54).

The table 22 on knowledge on reproductive and child health components it is seen that most of the respondents across the least and most developed villages are aware on reproductive child health components. Regarding RCH, RTIs/STIs, and free counselling services on family planning implemented under the district hospital shows that the awareness/knowledge level is low in the same manner in both at the least and at the most developed villages.

The t- tests conducted between the most develop villages and the least develop villages in regard to awareness on RCH. The t test value on contraceptive use (t=1.94),vaginal itching (t=2.2) shows significant differencebetween the two villages at 0.05 level of significance. The t test value on attainment of menstrual cycle (t=2.73),family planning (t=2.42), reproductive organs (t=5.23), RCH programme (t=5.87), RTI/STI (t=6.85), free counselling on family planning (t=3.6) has significant differences in the two villages at 0.01 level of significance.

The total awareness on RCH in the least developedvillages and most developed villages has significant difference (t=6.45) at 0.01 level of significance.

4.8.2 t- test Knowledge on HIV/AIDS and RTIs/STIs

Table 23 presents the knowledge on HIV/AIDS and RTIs/STIs among the respondents. It is seen that as a whole the knowledge/awareness level on HIV/AIDS and RTI/STI is at average level (58%). However, awareness on methods of prevention is 46%, symptoms of RTIs/STIs as 49% which is slightly lowerthanthe knowledge on the modes of transmission of HIV/AIDS and RTI/STI (79%).

The t test conducted on awareness on HIV/AIDS and STIs/RTIs. The t tests conducted between the most develop and the least develop villages in regard to awareness on HIV/AIDS modes of transmission (t=3.17), methods of prevention (t=7.05) and symptoms of RTIs/STIs (t=6.34) shows significant differences in the two villages at 0.01 level of significance.

Table 23 Knowledge on HIV/AIDS and RTIs/STIs

Sl.no	Indicator	Village Development				Total N = 160		't'
		Least Developed n = 80		Most Developed n = 80				
		Frequency	Percent	Frequency	Percent	Frequency	Percent	
1	Modes of Transmission	55	69	71	89	126	79	3.17**
2	Methods of Prevention	17	21	56	70	73	46	7.05**
3	Symptoms of RTIs/STIs	21	26	57	71	78	49	6.34**
4	Awareness on RTIs/STIs and HIV/AIDS	31	39	61	77	92	58	8.34**

Source: Computed * P< 0.05 ** P<0.01

The total awareness on RTIs/STIs in the least developed and most developed villages has significant difference (t=8.34) at 0.01 level of significance.

Although there is statistically significant difference across the least developed and most developed, it is seen that there is higher awareness (knowledge) level on HIV/AIDS and RTIs/STIs among most developed. In least developed, although the awareness on modes of HIV/AIDS transmission is high (69%), the level of awareness regarding methods of prevention (21%) and symptoms of RTIs/ STIs (26%) remains low.

4.8.3 t test Utilization of RCH

Table 24 presents utilization of RCH. Across the least developed and most developed, utilization on some of RCH such as uses of contraceptive and regular check up during pregnancy is high. However, utilization of other RCH services is low across both the least developed and most developed. There are statistically significant differences across various indicators, and it is seen that in the least developed villages they avail more of the services under RCH programme. The accessibility of health care services on account of government initiatives through rural health care services make available some of the basic health services to villages which are located at a distance away from the nearest district hospital.

On further probing, among the respondents of most developed, in terms of their low utilization of RCH services it was noted that most of them prefer to services rendered through private clinics and doctors.

The t test conducted on utilization of RCH services such as regular check up during pregnancy (t=2.38), institutional delivery (t=2.45) has significant differences between the least and most developed villages at (0.05) level of significance.

Table 24 Utilization of RCH Services

Sl. No	Indicator	Village Development				Total N = 160		't'
		Least Developed n = 80		Most Developed n = 80				
		Frequency	Percent	Frequency	Percent	Frequency	Percent	
1	Regularly Washing Hands	6	7.5	63	78.75	69.0	43.12	13.02**
2	Ever Use Contraceptives	46	57.5	69	86.25	115.0	71.88	4.24**
3	Contraceptive Use Present	37	46.25	40	50	77.0	48.12	0.47
4	Regular Check-up during Pregnancy	53	66.25	66	82.5	119.0	74.38	*2.38**
5	Postnatal Check Up	16	20	56	70	72.0	45	7.31**
6	Receipt of Monetary Incentive JSSY	43	53.75	7	8.75	50.0	31.25	*6.98***
7	Free medication Pre and Postnatal	48	60	32	40	80.0	50	2.57**
8	Free Examination of abdomen	47	58.75	21	26.25	68.0	42.5	4.38**
9	Free Examination of Blood Pressure	47	58.75	21	26.25	68.0	42.5	4.38**
10	Free Blood Test	47	58.75	21	26.25	68.0	42.5	4.38**
11	Institutional Delivery	31	38.75	17	21.25	48	30.00	*2.45**
12	Utilization of RCH Services	38	47.84	38	46.93	76	47.39	0.24

Source: Computed * P< 0.05 ** P<0.01

Table 24 also represents t value of ever use of contraceptive (t=4.24), post-natal check up (t=7.31), receive of monetary incentives (t=6.98), free medication during pre and post-natal (t=2.57), free examination of abdomen (t=4.38), free examination of blood pressure (t=4.38),free blood test (t=4.38) has significant differences at (0.01) level of significance.

4.9 Demographic, Economic Variables and Utilization of RCH Services

Karl Pearson's correlation coefficientis used to find the association between two variables and also to find out the direction of the relationship between the two variables. For the purpose of the present study co-relationship between demographic economic variables,

knowledge/awareness and Utilization of RCH services of the respondents has been calculated using.

Table 25 Demographic, Economic Variables, Knowledge and Utilization of RCH Services: Pearson's R

Sl. No	Variable	Awareness on RCH	Awareness on RTI/STI and HIV/AIDS	Utilisation of RCH Services
1	Age	0.005	0.192*	0.391**
2	Age at Marriage	0.244**	0.393**	0.006
3	Educational Qualification	0.365**	0.580**	0.182*
4	Number of Children	0.113	0.159*	0.280**
5	Personal Monthly Income	0.341**	0.390**	0.013
6	Annual Family Income	0.298**	0.368**	0.078
7	Distance of health centre from your home	0.463**	0.469**	0.039
8	Attended Awareness on Reproductive Health	0.190*	0.361**	0.077
9	Knowledge on RCH	1	0.608**	0.451**
10	Awareness on RTIs/STIs and HIV/AIDS	0.608**	1	0.132
11	Utilisation of RCH Services	0.451**	0.132	1

Source: Computed* P< 0.05 ** P<0.01

The co-relationship between demographic- Economic Variables, knowledge and Utilization of RCH Services of the respondents was assessed using Karl Pearson's correlation coefficient table 25. At the onset it was assumed that all the variables such as demographic, economic, knowledge and utilization of RCH services to be significantly related. Among the components knowledge on RCH is positively related on RTIs/STIs and HIV/AIDS. Also, it is positively related to utilization of RCH services, while there is no significant relationship among the other components.

As presented in the table 25 positive correlation is found between age of the respondents and the awareness on RTIs/STIs and HIV/AIDS (0.192) at 0.05 significance level. The age of the respondents also had a relationship with the utilization of RCH services by the respondents (0.391) at 0.01 level of significance.

There is positive correlation of age at marriage of the respondents with the awareness level on RCH (0.244) and awareness on RTIs/STIs and HIV/AIDS (0.393) at 0.01 significance level.

There is positive correlation of educational qualification of the respondents with the awareness level on RCH (0.365) and awareness on RTIs/STIs and HIV/AIDS (0.580) at 0.01 level of significance.Similarly, a positive correlation is found with the utilization of RCH services (0.182) at (0.05) level of significance.

Further, with regards to the number of children held by the respondents, there is positive correlation between the awareness level on RTIs/STIs and HIV/AIDS (0.159) at (0.05) level of significance withtheutilization of RCH services (0.280) at (0.01) level of significance.

The respondents' personal monthly income has positive correlation with awareness on RCH (0.341) and awareness on RTIs/STIs and HIV/AIDS (0.390) at (0.01) level of significance. Also, the respondents' annual family income has positive correlation with awareness on RCH (0.298) and awareness on RTIs/STIs and HIV/AIDS (0.368) at (0.01) level of significance.

In terms of the distance of health centre of the respondents there is positive correlation between the distance of health centre with that of the awareness on RCH (0.463) and on awareness on RTIs/STIs and HIV/AIDS (0.469) at 0.01 level of significance.

Finally, the awareness on reproductive health of the respondents has a positive correlation with the awareness on RCH (0.190) at (0.05) level of significance and with awareness on RTIs/STIs and HIV/AIDS (0.361) at 0.01 level of significance.

In conclusion, awareness on RCH of the respondents has positive correlation with awareness on RTIs/STIs and HIV/AIDS (0.608) and utilization of RCH services (0.451) at (0.01) level of significance.

4.10 Key Informant Interview

Key informant Interview is an expert source of information. The key informant technique is an ethnographic research method which was originally used in the field of cultural anthropology and is now being used more widely in other branches of social sciences investigations.

Four key informant interviews were conducted among the health care providers (two Doctors) who are directly involved with the treatment and care of women with regards to reproductive health issues and the service delivery. Another two interviews were with the ASHA workers who are involved with the service delivery towards women and reproductive health care.

4.10.1 Key Informant Interview with District Family Welfare Officer

The family welfare office is located in the district hospital, Lamka. Though there are PHC/ CHC available in each block of the district many people go to the district hospital for seeking the health care facility. The following is an extract of interview with the District Family Welfare Officer (DFWO).

Dr.Vumchinpau is the District Family Welfare Officer (DFWO) as well as the Reproductive and Child Health (RCH) programme officer for the district. He joined in the district hospital as DFWO in 21st June 2012. In Manipur, Reproductive Child Health Programme was initiated since 2000 and its implementation in Churachandpur district was on 2005. The District Reproductive Child Health Centre in Churachandpur is situated in Lamka. Under this there is also one Adolescent Health Clinic available at Lamka District Hospital which was established in the year 2014-15 on words. There is a facility for gynecological OPD as well as STD clinic in the district hospital. Till date there are 15 RCH Centres in the district. The RCH programme relates to the current policy of the target free approach at the grassroots level under the new reproductive and child health initiative of the Government of India.

According to Dr. Vumchinpau Tonsing around 50 percent of the women in the district seek care regarding RCH in the district hospital. This has been a recent development compared to the earlier times when the women were not comfortable in consulting the health care workers for reproductive care. The development of the practices and awareness is mainly because of the layers of multiple delivery services available in the district. As of now there is

gynecological OPD (Out Patient Department) as well as STD clinic in the hospital. Some major chances which can be seen, comparing to earlier times, after the RCH was implemented are:

i) Due to the services delivery, quality of the care facilities improved.

ii) Health of the mother in the district improves due to services.

iii) Disposal of hospital waste was maintained and improve in terms of hygiene in the hospital.

He further mentioned that under the RCH program facilities provided under Family Planning methods are those of Tubectomy, Nose scapal vasectomy (NSV), Copper-T, Post-Partum Intra Uterine Contraceptive Device, Condom distribution through ASHA worker, OCP (Oral Contraceptive Pills) and Emergency Contraceptive pill (ECP). They are supplied free of cost by the Urban Family Welfare Centre. And in the Post Partum centre, Family Planning advice is given as well as the operation is undertaken. This has helped many couples to choose their contraceptive method and take decision accordingly. He also mentioned that according to the hospital records, the Temporary method of Birth control is more prevalent.

In the 1980s, Immunization started in the district and a large number of expecting mother as well as the Infants were immunized. In the year 2003-04, the Intensified Pulse Polio Immunization (IPPI) was started under the District Welfare Unit. The World Population Day, World Deworming Day was also observed in the district by organizing various Outreach programs, Fourth-night mobilization at different villages especially to that of the region where facilities are not available.

Table 26 District Performance of Family Programme for 2016-17

Sl. No	Activity	Target	Achievement
1	Female sterilization camp	1	6
2	No. of Female Sterilization	300	112
3	No Scalpel Vasectomy (NSV) Camp	1	3
4	No.of male sterilization	30	18
5	Intrauterine Contraceptive Device insertion	800	526
6	PPIUCD Insertion	250	40

Source: District Family Welfare Office record.

He also emphasized that Information Education and Communication (IEC) activities are an integral part of the RCH Programme. Thus in order to increase the awareness among the people, posters and banners with RCH messages were put up within the headquarters area and in the nearby villages. Media advertisements were also done through local channel in the local dialect. According to him, this has led to an increased awareness about the Family planning Programmes. For those who were far away from the district hospitals or PHC/CHC, difficult to access health services due to geographical terrain, no proper transportation he opined that the government recognize the unmet needs of those people who lives in a villages that they used to organize a health camp accordingly in their villages. He also mentioned in particular that ASHA worker played a very important role in terms of mobilizing the community, women in particular, towards reproductive health awareness and practices towards adopting Family planning methods.

4.10.2 Key Informant Interview with (Gynecologist) OPD Gynae ward, District Hospital.

Dr.Zuii Hauzel is based in Gynae ward (OPD) in the District Hospital since the year 2004. She is one of the most prominent female doctors in Churachandpur district when it comes to women health issues especially towards reproductive health, Pre and Post Natal care for women. According to her, in Churachandpur district hospital under the Gynae-ward, women who came for treatment has several reproductive health problems of which one

common complains which she observed was women and white discharge, back and lower abdomen pain due to certain abnormalities in the cervix. She opined that having white discharge alone is not a disease every woman has it but when one experience heavy discharge with unpleasant smell or cause irritation and certain pain than it becomes a disease which should be taken care of as early as possible.

Since District Hospital is the health care headquarters in Churachandpur district, women from different villages come there for their treatment. She also mentioned that for women in order to adopt any methods of family planning, it is always better to consult an expert medical practitioner first instead of adopting/practicing according to their own convenience. In terms of birth spacing/ to avoid unwanted pregnancy she further suggested more of condom used than of oral pills since there are also some women who cannot take this pills. In order to prevent themselves from certain side effects for their own health instead of adopting the contraceptives oral pills they can also go for other option on family planning methods such as condom used which is also one of the option they have for birth spacing and also to prevent other related STI/STD infections.

She also suggested that creating more awareness in Churchandpur district on health care also one of considered important measures for women development and to focus more on women health & hygiene, STI/STD awareness.

Dr. Zuii stressed further that for women in order to take care or prevent themselves from certain kinds of reproductive problems, women must maintain their personal hygiene especially on genital area, taking proper diet and also taking regular checkup was suggested and to always consult doctors on time for early detection, prevention and treatment of their reproductive health problem.

Findings:

From the two key informantinterviews with the wecan see the various programmes and facilities which were initiated at the district for the improvement of women and reproductive health care under the RCH programmes. We can see the certain changes especially in facilities provide which was provided in the hospitals after the implementation of RCH programmes by the government. Also, the initiations were done for the community who are far away from the district hospitals by utilizing various Information education and communication source.

Though there has been an initiation to start the awareness on the current government programmes and schemes for women under RCH the need for spreading more awareness was required for women focusing on women and reproductive health care.

4.10.3 Key Informant interview with ASHA worker from least developed village (Village I)

Name: Boinu (Fictitious name)

Age: 43

Village : I. Ngurte

Mrs. Boinu is an ASHA worker from Ngurte village since the year 2007. She acted as a health activist and a promoter of good health practices in the community who creates awareness on health such as (nutrition, basic sanitation and hygiene practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health and family welfare services) and its social determinants and mobilize the community towards local health planning and increase utilization and accountability of the existing health services. Concerning about the health and hygiene about the community, she proposed that every locality should keep one dustbin each in their village so that garbage are not littered and throwing of garbage in the river will decrease. Considering her proposal as an important need for the village, the community started putting a dustbin in each locality in the year 2017 on words.

During her years of service as a volunteer ASHA worker so far, Mrs. Boinu has accompanied around 80 women in the health sub-centre out of which 20 women were accompanied for their delivery. She also had been awarded as one of the best promising ASHA worker in the district in the year 2015 by the District Family Welfare Department, Churachandpur, Manipur. She also shared that since the time when ASHA worker had been introduced in the village, there has been an increase in accessibility and utilization of public health centre and the service facilities has also very much improved. From the training and workshop which she had attended under the District Family welfare Department, she used to inform the women in the village of birth preparedness, importance of safe delivery, immunization of children and pregnant women and contraceptive use. She mentioned further that when it comes to family planning issues, women are not open about it and that they still feel uncomfortable about these issues and hardly approach her for all these needs, even

though she as a depot holder of essentials provisions like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), Disposable Delver Kits (DDK) Oral Pills & condoms. Therefore, whenever she goes for house visit, she informs them about it and also provides to them their need.

Mrs. Boinu also mentioned that one of the challenges as an ASHA worker she faces is that they need to give more of their time for the community and hence she hardly have time of her own. Moreover when accompanying the pregnant women for immunization or deliveries to heath centre, they need to spend money from their own pockets which is quite difficult for her. Earlier years though they used to get incentives regularly for their service, since the last two years all these incentives were not regular and there are many guidelines which they need to fulfill in order to get the incentives for accompanying the women to health centre. Therefore, for her it became quite difficult and challenging to make herself always available to work.

She also mentioned that though she is not an expert regarding women and reproductive health care like the health care professionals, she informs them on the importance of going for regular check-ups and the kind of facility and services which are available in the health centre. Since most of the women were engaged in labor work and not highly educated, she considered it important if the health care providers organize awareness at village level related to women reproductive health and practices.

4.10.4 Key Informant Interview with ASHA worker from most developed village (Village-II)

Name: Vanlalruati (fictitious name)

Age: 38

Village: II. Salemveng

Mrs. Vanlalruati was appointed as an ASHA worker on 2015. Since her time of working as a volunteer ASHA worker, she had attended trainings on district Malaria campaign and immunization. Some of her roles include accompanying pregnant women for regular medical check-ups , record the number of pregnant women, observed village nutrition

health day, conduct awareness on Health and Hygiene (hand washing), antenatal care, and also on consumer rights.

She mentioned that women in her village were still uncomfortable or felt it as a taboo to talk openly about women reproductive health and family planning. So far in her service as a volunteer ASHA worker, she didn't accompany any women for delivery since the district hospital is nearby the village. Since it's difficult to called the women together and organize separate awareness on women health and family planning issues, during the house visits she tells them about the importance of eating healthy food especially for a pregnant mother, maintaining cleanliness, the facilities available in the health centre for women in regards to reproductive health and also about the various methods available for family planning.

She mentioned that though they are the volunteer worker, the kind of work they did was very demanding and challenging and hence she considered it important for them to get regular incentives. She observed that in her village, people prefer to approach private clinic than government health centre due to poor facilities, the time of waiting and sometimes because of the limited facilities. Apart from being a volunteer worker she mentioned that after she joined as an ASHA worker, she learned a lot through this experience about the important of child immunization, maintaining healthy practice and reproductive care of women. She also felt the need of more awareness in regard to women and reproductive health from the health care providers in her village.

Findings:

From the interaction with the two ASHA worker from the two selected village it can be concluded that though the ASHA workers face a lot of challenges as a voluntary worker with irregular incentives, they carried out their work very sincerely for the community. It is observed that they play an important role in mobilizing, bringing awareness to the community in accessing health and health related services available at the health centers. It is also learned from them that the women in the tribal community were not so open to talk about reproductive health care and family planning issues. It is also mentioned that due to limited and poor facilities and longer waiting time at the government hospital, practices of approaching private clinic is more.

It is found that both the ASHA worker stressed on the importance of giving more awareness on women and reproductive health care at the village level by health care providers.

4.11 Focus Group Discussion

The current section will present the results of the Focus Group Discussion dealing with the issues related to women and reproductive health among women of reproductive age group and elderly women.A focus group discussion is popularly conducted in the health and social sciencesresearch. A focus group is a qualitative tool and is a good way to gather together people from similar backgrounds or experiences to discuss a specific topic of interest. As a research method, the focus group is sometimes referred to as a focus group interview, a group interview or a group in-depth interview (Liamputtong, 2010).

Focus group methodology is useful in exploring and examining what people think and how they give an importance to the issue. It is also an effective way to learn from the community members (participants) and gain insight, and also it make participants feel like they were a part of the study and thus have a deeper contribution for the research success.

In the present study FGD was conducted among the women who were in their reproductive age and women who already attained 50 years and above to have a better understanding of their perspectives. Twelve women participated in the discussion and the researcher facilitated the process of the discussion. During the discussion, each of the participants was encouraged to share their experiences and understanding on the particular topics discussed. The following points highlight a summary of the focus group discussion.

Understanding of women and reproductive health

The participants cited that when it comes to women and reproductive health the first things that come to their understanding was about their physical health. The most shared about, when it comes to women and reproductive health, are women and physical changes once they reach puberty, menstruation, reproduction and family planning. They also cited that reproductive health includes their overall health and well-being throughout their reproductive years and after attaining their menopause which also largely influence their mental health.

Some of the members also cited that reproductive health means the way they took care of themselves towards their health and reproduction which includes taking the nutritive

food, hygiene practice, maternal health care that includes antenatal, delivery and postnatal care. They further mentioned that although they have not received any formal education or information on reproductive health knowledge,the information they have are entirely from their life experience.

Practices of reproductive health care

The participants cited that they were not aware of and informed about menstrual cycle and they became aware of it only once it occurred to them. They mentioned further that before all the commercial pads were introduce in their place, they used any cloth available for their menstrual flow or they drape two to three "Puan" (traditional cloth wrapped around the waist) which was later washed, sundry and reused again for the next month. The participants also shared that there was no social taboo practices towards women during their menstrual cycle. They were allowed to perform the usual activity and were allowed to gather in any kinds of social and church gatherings.

The participants cited that though they were not much aware about the reproductive organs, they knew about some of the reproductive ill-health problems which are commonly experienced by them such as vaginal white discharge, irritation and sometimes irregular menstruation. They did not considered these health problems to be a serious one as most of the women experience it. In earlier days before the modern medicine were easily available, the elder participants of the group cited that whenever that develop these health problems, they practice washing their private parts with "Chingal" (a traditional liquid concentration filtered out of ashes mixed with water) or sometimes women practice washing their private parts with a mixture of boiling water with salt. They mentioned that these were the practice in order to cope with the irritation and also a part of their hygiene practice on reproductive health care.

In terms of delivery and pre-natal care, the older participants mentioned that during their times, delivery would just take place. There is no such proper preparation when and where the delivery would take place. It can take place anywhere, sometimes at home with the help of traditional birth attendant or sometimes even in the paddy field where they were working without any support. They will start working on their normal daily activity as usual after one to two weeks of delivery. But the younger participants of the group mentioned that their delivery takes place in the hospitals.

Reproductive Health Problems/Challenges Faced by Women

One of the major challenges that the participants cited are that of lack of awareness towards reproductive health and health care. This makes the women sometimes suffer and bear the pain silently not able to discuss openly about the issues to their spouse and their in-laws when encountering any of reproductive health problems. Secondly, the participants cited that they werenot much aware about the care and services which are available and provided in the government hospitals. The distance involved with no proper transportation facilities especially on rainy days and in times of emergency to reach the nearest place of health care services availableadded challenges for the women to access the health care services.

Need for the community to achieve or improve reproductive health care

The members cited that the problems that women face with regard to their reproductive health were that of silence about the issues. Women were shy to talk about and open up on issues of reproductive health. It was hardly discussed openly in the family and community at large. Sometimes it is only shared within close friends, which were not enough in order to develop and gain their knowledge on reproductive health care. Therefore, to break this silence would be one of the first important needs of the women and community in attaining reproductive health care. Secondly, the health facilities and services on reproductive health care should be accessible to the community. And thirdly, there should be more awareness on women and reproductive health care. The younger mother must be prepare and must be made awareon family health education and information about reproductive health awareness should be pass on to the child andinform the girl child before they attain puberty on the various physical body changes which will occur once they attained puberty and how to take care of the certain changes which will occur in their bodies and also on hygiene practice with regard to menstrual cycle.

4.12 Case Studies

Three in-depth interviews in the form of case studies were conducted to probe the reproductive health challenges experienced by tribal women.

4.12.1 Case 1:

Naomi (fictitious name) belonging to Hmar communityis a 27 years old woman from saikot village who was married when she was 20 years of age at Ngurte village. She completed her education till class eight standards.Her husband is of the same age with her and they live together with her husband's mother and father. She have three children, all of them are boys.The eldest is 5 years old studying in class B, the second son is 3 years old and studying in class A, the youngest son is only 6 months old. They are from a poor economic background who belong to the BPL category. Agriculture is their main source of livelihood. Naomi doesn't have any permanent income source apart from selling the vegetables which they get sometimes from their own agriculture land. She remains mostly at home taking care of the household chores especially after having three children.

She faced certain difficulties when it comes to her reproductive health especially after having three children. After the third child was born she started experiencing regular vaginal itching , pain during intercourse and back pain which makes her very uncomfortable, especially to stay in public places like (church service, funeral service etc) for long hours so she chooses to remain at home most of the time and she cannot wear pants at all . One day she shared her problem, as she could not bear the pain anymore, to her mother in law who suggested her to visit the nearest PHC or District hospital for check-up. Her mother in-laws prepared for her first aid like boiling water with salt which is used for cleaning the private parts, in their times her mother-in-laws also mentioned that they used to prepared ashes water called (Chingal) locally in order to treat or prevent all kinds of skin disease . After a week or so she went to district hospital for her checkup and the doctor informed her that the stitches she got after her delivery was not healed properly and it got septic which is making her experience all these pain inside. She was also suggested by the doctor not to conceive a child until and unless these wounds were heal properly from inside.

At present she was under medication but not regularly as the medicine was costly and she doesn't always feel like asking her husband and in-laws for the expenses. She already finished one course of medication and now even though she really wants to continue with the medication, she was not able to do so due to financial difficulties.

Analysis of Case 1

The case of Naomi reveals certain challenges faced by a young woman. Firstly, we see that within the seven years of her marriage she already bore 3 children without much knowledge about her own reproductive health and health care. Secondly, it highlights that in tribal society women and reproductive health matters are not discussed openly which makes the young women not able to share openly to their own husbands regarding the difficulties and pain experienced by them. Instead they used to bear the pain silently. It also highlights the cultural hygiene practices like salt water, 'chingal' (ashes water) without modern medication in order to heal certain physical health problems.It also shows how poverty affects the provisions of basic needs especially on accesses to health care.

4.12.2 Case 2:

Hnemi (fictitious name) is a 42 year old woman who was married when she was barely 19 years of age. She lives with her husband along with her four children. She didn't attend any formal schooling but was able to read her own local dialect. Her eldest daughter, 21 years of age already completed till her sixth standard schooling dropped out since they cannot afford to send her to the nearest high school from their village which was about 5kms away and cannot pay for her school fees. Her daughter now started learning how to weave and help the mother in earning some incomes for their family. The other three children were still studying in the nearest primary school in their village. Hnemi belongs to Hmar community, weaving and cultivation is their main source of livelihood.

She mentioned that her first delivery was at home and since there were no nurses in the villages and it was not possible for them to go to the PHC and District hospital due to no proper transportation facilities and financial challenges, the delivery was attended by the traditional birth attendant which was very much common during those times but not found this days anymore in their villages. For her second child she had her delivery while working in the field. She mentioned that since her husband was not there around nearby their field, her neighbor who works in the next paddy field heard her shouting in pain and they came to rescue her and the baby's umbilical cord was cut by a normal knife which was used for working in the field. She thanked God for protecting her baby and her life and she did not have any much complication after the delivery.

She recalled that during their times they hardly went for medical check-ups, except only when the doctors or nurses team used to visit the village for tetanus injection, pulse polio drops. Regarding women reproductive health, she never attended any awareness program yet the only information which she told to her daughter about menstruation was when she started developing her first periods, she let her used any unused clothes which was available. She also mentioned that nowadays things are changing especially after the ASHA workers were available in the villages and they used to accompany the pregnant women to nearest PHC or District hospital and sometimes gave them free medication as well. And women groups in the community and in church also talked about the importance of health and hygiene for a women and mother during women's church conference which was not seen during their youth days.

The case of Mrs.Hnemi is almost similar to the case of Naomi with regards to poor economic background, and access to health care facilities. The case also highlighted the practice of delivery in times when there were no doctors especially before the 1990's where they relay so much on the traditional birth attendant. It also shows how she faced difficulties where there was no proper access to health care, such as distance and lack of proper transportation and financial constraints.

Analysis of Case 2

We also see the lack of awareness regarding the importance of reproductive health care and hardly were it discussed openly.It also highlighted how women bear the pain silently unable to share it out or talk about openly when it comes to reproductive health concern. In both the cases we can see that the role of husband involvement was not mentioned which shows that hardly male were consulted or involved when it comes to women's reproductive health concern.

In both the cases,it can be seen that the information regarding reproductive health care and practice was passed on from mother to child or from women to women. It also shows that the tribal women were much relying on modern medication now after the introduction of various health care programs from the government.

4.12.3 Case 3

Mrs.Sawmi (fictitious name) is a 39 years old woman who was a divorcee. She is a single mother now as she took all her three children with her. She lives with her widow mother and grandmother. She come from a low economic background and belongs to the BPL category. She was married when she was only 18 years old which was right after her 10th board exam. Weaving and sometimes going for labor works was her main source of income and livelihood beside her mother who work as a sweeper in one of the private schools.

It was only after she got married that she started experiencing all kinds of reproductive health illness. These happened when she had her first miscarriage. She experience severe bleeding where she also underwent major surgery in the hospital after which she undertook birth spacing called the (copper-T) for 3 years. Until her divorce, since she has certain physical related health problems,she took the oral pill called (Mala-D) which was provided by the ASHA workers and consumer regularly on time and also bought it individually from the pharmacy. She started developing back-pain, some gestational problems, loss of appetite and loss of weight. Since her physical health doesn't allowed her to take the contraceptive she stopped using it and she doesn't wants to have more children anymore.

Her husband did not agree with her choice and thus she was pregnant with the fourth child where she experienced miscarriage for the second time in her life. After this incident, she came back to her mother's house as she felt that her husband was not supporting and understanding her physical health problems and she feltthat she can't make her husband happy which wassometimes very stressful. Sawmi feels that she was not accepted by her husband because of her reproductive health status and she suffers from mental disturbance. She started developing insomnia, anxiety, and loss of appetite. That is when she decided to come back to her parent's house with all her three children.

Analysis of Case 3

The case of Sawmi shows that how young women face certain multiple challenges when it comes to child bearing and other physical health related concerns. Though she belongs to poor economic background, it shows that she took important measures for her health. Unlike the other two cases, in this particular case it can be seen that she had

completed till her high school which seems to have an impact on concern to her own physical health needs.

Sawmi's problems could have been managed if her husband had knowledge about women's reproductive health care which could have made him understand his wife and support her choice. This case illustrates the constraints that exist within married couples as well when it comes to reproductive health of women that sometimes creates or lead to developing mental trauma and emotional imbalances in women. One positive indication in this case is that Sawmi feels that she made the right choice for her well being and for her children. She hopes for a healthy and better future with her children.

CHAPTER V

CONCLUSION

The present study was an attempt to find out, assess the existing knowledge and the prevalent practices among tribal women towards their reproductive health. This chapter highlights the whole gist of the research study and the research major findings. It is summarized below:

The first chapter of the study introduces the background of the present study, the issues, concerns and scenario of reproductive health status of tribal women. Rationale, statement of the problem, objectives of the study, hypotheses, and chapterization are presented in the first chapter.

The second chapter presented the review of literature. Studies on women reproductive health and the studies prevalence on knowledge and practices on women reproductive health and the research gaps were discussed.

The third chapter discussed on the methods applied for the present study. The study was conducted in two villages of Churachandpur, Manipur, India. The two villages were selected based on the geographical location and female literacy record (2011, census of India). The present study is descriptive in design and cross sectional in nature. Mixed method approach was applied. Multi stage sampling technique was used to select blocks, villages, households and respondents. Using disproportionate stratified random sampling a total of 160 respondents was selected. Structured interview schedule was employed to collect quantitative data. Processing and analyzing of the data was done using Census and Survey Processing System (CSPro) package and Statistical packages for Social Sciences (SPSS) were used to processed and analyze the data where percentages, correlation and t test were conducted. Four Key Informant Interviews (KIIs), one FGD and three case studies were utilized to understand the qualitative dimensions of the study.

The fourth chapter presented the tables generated through SPSS such as t test and correlation and the inferences drawn from the tables are discussed in detail.

The fifth chapter presents the summarization of the previous chapters, it highlights the major findings of the study and suggest measures for effective intervention and thus concludes the study.

5.1 Major Findings:

The major findings of the present study are presented based on the objectives of the study. The first study was to assess the knowledge and practices on reproductive health among tribal women in Churachandpur district. The second part of the study was to assess on the utilizations of reproductive health services. Thirdly, to identify on the reproductive health challenges and constraints and fourthly, to probe into the relationships among knowledge, practices and utilization of reproductive health services.

5.1.1 Profile of the Respondents

The maximum of the total respondents belong to the age group of 38 to 43 years. And half of the respondents get married between the age of 19 to 25 years and most of the respondents were married and engaged in homemaking or housewife where they did not have any individual income to fulfill their personal needs or contributed on the family income. Nearly half of the respondents had completed their education only up to the level of class VIstandards.

On the characteristics of family it is found that more than half of the respondents were belonging to nuclear family and a maximum of the respondents had one to three children. Therefore, small family was common among the respondents.

5.1.2 Economic Characteristics of the Respondents and Family

The economic characteristics of the respondents and their family shows that half of the respondents had a monthly income of below Rs.5000 and the most popular skilled obtained by the respondents were that of handloom weaving. The main occupation of the spouse of the respondents was cultivation. Cultivation is also the most popular secondary source of income for the respondent’s family and hence, half of the entire respondents annual family income range between Rs.60,001 to Rs. 1,20,000.

5.1.3 Living Conditions

Rice is the main stable food for the entire respondents and more than two third of the respondent families had a square meal per day and that majority of the respondents felt satisfied with the quantity of their daily food intake.

The main source of water for the respondents and their families are that of water hand pump and few of the respondents depends upon pond water. And most of the respondents need to travel less than a kilometer to fetch water while a few of the respondents still needs to travel a distance of 3 kilometers or more in order to fetch water for their daily consumption. Majority of the respondents had a safe drinking water at home and for a few (3.8%) does not have proper safe drinking water at home. Nearly two-third of the respondents practice boiling water treatment before consumption and one third of the respondents directly drink the water without any treatment.

In regards to hand washing, more than half of the respondent doesn't practice hand washing with soap before eating and their main reasons for not practicing were feeling of unnecessary to wash. Also, two third of the respondents have located dustbin inside the house and nearly half of the respondents disposed their garbage through voluntary community collection. In terms of toilet facility used it is found that all the respondents had toilet facility and nearly half of the respondents used septic tank toilets.

5.1.2 Knowledge on Reproductive Health

The respondent's awareness on their reproductive organs, their source of information regarding reproductive health shows that more than three fourth of the respondents had aware of the reproductive organs and their source of information is mainly from the health care providers. While, the other (16.9%) of the respondents were found not aware of their reproductive organs.

In regards to awareness on menstruation, amaximum of the total respondents had awareness on their attainment of menstrual cycle. In case of irregular menstrual cycle nearly half of the entire respondents attributed the reason as delayed of their menstruation is due to conceiving and on for which on medication. In addition, the other few of the respondents also stated anemia as one of the potential causing factor to their menstrual irregularity. Of the

respondents who had experience menstruation irregularityfew of the respondents had soughed medicaltreatment only sometimes.

The reproductive health problems, the awareness and experienced of the respondents towards the reproductive health problems particularly on white discharge, Reproductive Tract Infections/ Sexually Transmitted Infections (RTIs/STIs) and vaginal itching shows that majority of the respondents had awareness on the reproductive health problems of white discharge. Further, more than half of the respondent does not aware of RTIs/STIs. Among the respondents who had awareness on RTIs/STIsmore than half of the respondents were not aware about the common sign and symptoms of RTIs/STIs. The finding is in line with Meenakshi et.al (2015) studies found that women have poor level of awareness with regard to knowledge and symptoms of STIs. In addition, majority of the respondents had awareness onvaginal itching.In connection to the source of information about reproductive ill health problems nearly two third of the respondents received information from the health care providers and less than third of the respondents receivedinformationthrough communication with their friends and relatives.

Thus, majority of the respondents had awareness on HIV/AIDS and their sources of information revealed that more than one third of the entire respondents had awareness throughmass media like television, newspapers and radio. More than two third of the respondents had awareness on the four modes of HIV/AIDS transmission - unprotected sex, sharing of needles among IDUs, infected blood transmission and from infected mother to new born child. With regards to the awareness on the advocated methods of HIV/AIDS prevention nearly half of the respondents had awareness on the four advocated methods of prevention- condoms promotion, screening of blood transfusion, one sexual partner and use of only sterile needles.

With regards to family planning more than half of the respondents' had awareness on the family planning methods of oral contraceptive pills, intrauterine contraceptive device, and female sterilization. More than half of the respondents agree that women should take initiative towards family planning. At the same time, majority of the respondents had awareness on the contraceptive methods and out of which more than two third of the respondents had adopted the contraception.

5.1.3 Reproductive Health Practices

It is implicit to understand the reproductive health practices among the respondents**.** With regards to menstruation and hygiene more than half of the respondents used sanitary pads and more than one-third used any available clean cloth. However, few of the respondents were found using any cloth available to absorb the menstrual flow. The disposal of used sanitary pads shows that nearly half of the respondents disposed it into dustbin and one third of the respondents burnt it. While,more than two third of the respondents who used cloth to absorb their menstrual flow reused the same cloth after washing and sun drying. Furthermore, majority of the respondents never had an experience of any kind of social taboo associated to menstruation.

With the seeking of treatment on reproductive ill health problems it is found that nearly half of the respondents seek private medical care and more than one third of the respondents only sometimes seek for treatment. But, it was shown that still some of the respondents did not even seek any treatment with regards to reproductive ill health problems. Also the reproductive ill health problems experienced by more than two third of the respondents were diagnosed through medical investigations.

The practice of family planning shows that more than two third of the respondents had adopted contraceptive methods, more than a fourth of the respondents denied using any contraceptive of which a maximum of one fourth stated as not being comfortable to adopt it. Of the respondents who had once adopted contraceptive methods almost half of the respondents continue using it and other half discontinue using it. A maximum of the respondents adopted using the method of oral contraceptive pill (OCP) and Intra uterine device (IUD). While few of the respondents practiced female sterilization. Interestingly, two third of the respondents affirmed the presence of mutual consent between the couple that they had consulted their husbands before using/adopting any method of family planning.

The exploration on the practices related to prenatal and post-natal care shows that almost three fourth of the entire respondents practice going for regular checkup during pregnancy and the remaining one fifth of the respondents does not practice medical check-up during pregnancy. The occurrence of pregnancy related complications affirmed that one fourth of the respondents sought for medical treatment of which 13.1% of the respondents visited district hospitals for

seeking medical treatment. However, few of the respondents were found visiting visionary and traditional healer for any pregnancy related complications.

The results on post natal care shows that half of the respondents does not went for post-natal check-up within two months after delivery and less than half of the respondents went for post natal check-up. The reasons for not going for post natal check-up by some of the respondents was due to feeling of unnecessary, not able to meet the expenses incurred by medical check-up, due to lack of transportation and also due to not having time to visit the health centre.

The practice related to delivery care received by the respondents a maximum of two third of the total respondents had institutional delivery and less than one third of the respondents had home delivery. A maximum of three fifth of the total respondents had chosen hospital/ health care institutions for the right place of delivery due to the fact that institutional delivery had less complications to the mother and new born babies. However, less than one third of the respondent's choice for delivery place depends on easy accessibility during the emergency.

The study further examine the pregnancy related complications and abortion done by the respondents. The result found that one fourth of the entire respondents had undergoes abortion of which one fifth of the respondents underwent on medical grounds as advice by the doctors. Whereas the remaining few of the respondents who had undergone abortion other than medical prescription were due to family pressure as they already had too many children, unplanned pregnancy, fetus health complications etc.The place of abortion of the respondents shows that a maximum of 13.1% underwent abortion at district hospital and 10.6% in a private hospital.And few of the respondents do not disclose the place of abortion. But, the particular query was not applicable to 75% of the total respondents.

In regards to experienced health complications related to abortion by the respondents the results shows that 8.75% had experienced health complications due to underwent abortion. Few of the respondents had experience health complications of heavy bleeding, complication to child bearing and pelvic infection. But, for more than half this particular query was not applicable.

5.1.4 Utilization on Reproductive Health Services

The utilization of family planning method shows that out of the two third respondents who had adopted contraceptive methodsa maximum of one third respondents procured the contraceptive items from hospital and few of them also procured it from the ASHA worker.

The utilization on prenatal check-up shows that one third of the respondents held prenatal check-up in the district hospital. More than half of the respondents had awareness on Janani Suraksha Yojana(JSY) scheme which advocated on institutional delivery. Where two third of the respondents claimed that they had never received any incentives under Janani Shishu Suraksha Karyakram (JSSK). This happened in spite of institutional delivery practice because sometimes the respondent does not access the government health institutions and the other reason were due to not able to follow all the criteria rules in order to received the JSSK incentives. Therefore, the JSSK was received by a total of 31.3% of the respondents who had institutional delivery at government health care institutions.

In respect to the mother and child health (MCH) services more than three fourth of the total respondents had no awareness of the free counseling services available on family planning provided at the district hospital. However, nearly half of the respondents had aware on free mother and child immunizations services provided in the government health care institutions. By and large half of the total respondents received prenatal and post natal immunizations at free of cost but more than 40% of the respondents are not receiving immunizations at free of cost. Thus the enquiry on the free immunization under JSY scheme was not applicable to some of the respondents.

In regards to the receiving of free medicine under JSSK during the prenatal and post natal period was explored among the respondents. It was found that a maximum of more half of the entire respondents received medicine at frees of cost and commonlyself-reported medicines were Iron Folic acid tablet and tetanus injection.While more than one-third of the respondents do not receive it. So, the utilization of the service shows that an equal number of 42.5% of the respondents had accessedto abdominal examination, blood pressure and blood testing at free of cost in the government hospital.

5.1.5 Reproductive Health Challenges and Constraints

The study identifies the reproductive health challenges and constraints encountered by the respondents. Nearly half of the respondents had experienced reproductive ill health problems of vaginal white discharge accompanied by itching/fever/bad odour/irritation around vaginal area. And while encountering reproductive ill health problems more than half of the total respondents disclosed to their husbands and the other few of the respondents disclosed the problems only to the health care workers such as doctors. Also, there were respondents who shared reproductive ill health problems to the visionary, priest or other faith healer.

Among the respondents who had adopted contraceptives more than two-third of the respondents agreed that the using of contraception sometimes affects their health, where some of the respondents had reported an experienced of loss of appetite, fatigue, weight loss, headache, difficulty in conceiving and disturbance on regularity ofthe menstrual cycle.

The other reproductive health challenges and constraints encountered by the respondents were accessibility to health care services. Majority of the respondents has no health care center available in their own villages and the distance to the nearest health center wasmore than 5 kilometers. Furthermore, the most common mode of transportation was on foot/walking. Due to this fact, many of the respondents were not able to access the nearest health center even in times of delivery or else emergency. And, the traditional birth attendants (TBAs) play significant roles in conducting the delivery care for a mother

The utilization of reproductive health services by the respondentswas another challenge and constraint. The study found that many of the respondents do not have regular medical check-up during pregnancy. The self-reported reasons attributed to unable to meet the expenses, do not think necessary to go for check –up unless experiencing of health problem, due to poor transportation and communication, the distance of health center, prolong waiting time and absence of accompanying person.

Hence, the study found that more than one third of the respondents'experienced of pregnancy related complication such as miscarriages, inadequate nutritional condition during pregnancy and obstructed labor in child delivery. This is another challenging area to improve reproductive health services to the respondents.

5.1.6 Relationship among Knowledge, Practices and Utilization of Reproductive Health Services.

The relationship among the knowledge, practices and utilization of reproductive health services by the respondents was statistically tested using t-test and Karl Pearson's coefficient of correlation.

The t test results on knowledge/ awareness of RCH on contraceptive, reproductive ill health problems on vaginal itching, attainment of menstrual cycle, family planning, reproductive organs, RCH programme, RTIs/STIs, free counseling on family planning in the least developed and most developed villages has significant difference.

The total awareness on RTIs/STIs in the least developed and most developed villages has significant difference.

The utilization on some of RCH such as a use of contraceptive and regular checkup during pregnancy was highacross the least developed and most developed villages. However, utilization of other RCH services is low across both at the least developed and most developed villages. There are statistically significant differences across various indicators, and it is seen that more of the services under RCH programme was availed in the least developed villages. The accessibility to health care services on account of government initiatives through rural health care services make available some of the basic health services to villages which are located at a distance away from the nearest district hospital.

On further probing, in terms of their low utilization of RCH servicesamong the respondents belonging to the most developed villages it was noted that most of the respondents prefer utilization of services rendered through private clinics and doctors.

The t test results on utilization of RCH services such as regular checkup during pregnancy, institutional delivery, ever use of contraceptive, post-natal checkup, receive of monetary incentives, free medication during pre-natal and post-natal, free examination of abdomen, free examination of blood pressure, free blood test showed significant differences between the least developed villagesand the most developed villages.

The knowledge on RCH of the respondents has positive correlation with awareness on RTIs /STIs and HIV/AIDS and utilization of RCH services.

Correlation relationship on knowledge of reproductive health, educational and socio-economic status of the respondents showed that there is a positive correlation on the respondents' educational qualification and their knowledge towards reproductive health. Similarly, a positive correlation is found with the utilization of RCH services. The respondents' monthly income has positive correlation with the knowledge/awareness on RCH. Also, the respondents' annual family income has positive correlation with the awareness on RCH. Correlation relationship on knowledge on RCH is directly related to their utilization of RCH services.

Henceforth, the present study confirmed and accepted the hypotheses that the woman's knowledge on reproductive health depends on their education and socio economic status (K.VanEgmond,et.al 2004) , women's adoption of safe reproductive health practices is positively related to their knowledge (National Family Health Survey-4,2015-16). And the utilization of RCH services is directly related to their knowledge on reproductive health .

5.2 Major Findings from Qualitative study

The qualitative findings showed that in spite of the fact that the women not receiving reproductive health education formally, their knowledge and practices on reproductive care are purely based on their experiences.

One of the major challenges that the women facedwere lack of awareness towards reproductive health and health care. And secondly they belonged to poor economic background; women were shy to talk about and uncomfortable to open up on issues of reproductive health. It was hardly discussed openly in the family and communities at large. Sometime suffer and bear the pain silently and was unable to discuss openly about the issues even to their spouse and their in-laws when encountering any of reproductive health problems. Thus, communication on reproductive health and health care issues was minimal and limited both at familial and societal level.

The women were not much aware about the care and services which are available and provided in the government hospitals. The distance involved with no proper transportation

facilities especially on rainy days and in times of emergency to reach the nearest place of health care services available added challenges to the women to access the health care services.

The RCH programmes were implemented and the facilities were mostly available only in the district hospital and were not provided all in the nearest public health center or community health center. This makes it difficult for the women to access the facilities due to unavailability of proper transportations, intra and interroad connectivity for the villagers and to the health care workers as well to reach the far villages.

We can also see some of the practices which the women adopted in times of no medicine or before the adoption of modern medicines were easily available in the villages. With regards to practices on menstruation and hygienebefore the introduction or availability of commercial sanitary pads in the villages, women were found using any available cloth or drape two or three '*Puan*' (traditional cloth wrapped around the waist) and they did not faced any social taboo in relation towards women and menstruation. Before modern medicine were easily available at the time of encountering reproductive ill health problems such as vaginal white discharge and irritation the women practice washing their private parts with *"Chingal"* (a traditional liquid concentration filtered out of ashes mixed with water) or sometimes women practice washing their private parts with a mixture of boiling water with salt. This was the traditional practices which they used in order to cope with the irritation also a part of their hygiene practice towards reproductive care.

In addition, the qualitative findings showed that the health care providers also suggested that the need for awareness on women reproductive health andreproductive health care. The emphasis on the awareness focus more on personal hygiene, RTIs and STDs awareness, also to always consult a medical practitioner before adopting any family planning methods.

5.3 Conclusion

The present study attempted to understand about the existing knowledge and the prevalent practices of tribal women towards their reproductive health. As tribal women faced various obstacles in accessing and utilizing services due to their place of location, poor socio-economic condition and lack of knowledge towards reproductive health which in turn limited their knowledge to protect themselves from certain reproductive ill health problems. Having the

right source of information or knowledge about women and reproductive health problems will certainly help women in the prevention and control of certain reproductive health problems.

The present study examines two research questions. The first question of the study focus on their knowledge of tribal women towards reproductive health and the second is based on understanding their practices and subsequent decisions about their reproductive health and the services that are available.

The findings of the present study indicates that though some of the tribal women have knowledge about the reproductive health there were still many tribal women who are ignorant about reproductive health of women.It is seen that tribal women in both the two villages (Ngurte & Salemveng) have more relay on modern medicine than that of practicing traditional methods. The tribal women need to get information from proper source that will in turn increase their knowledge about the reproductive health and that the women will be able to adopt the right kind of practices and prevent them from certain reproductive health problems. If the health of the women is to be improved the community or society must be willing to provide easy accessibility and availability of services to women who are in their reproductive age. Since the high status of reproductive health of women largely influence the health of the children as well. That is why Chandrashekar (2014) stated that 'for an over-all health of the family, women's health should attain utmost importance'.

5.4 Suggestions

The present study aimed to suggest measures based on the research findings. Following are the suggestions for social work intervention, for policy making, government and non-government organizations working directly with the community on development issues.

1. Awareness on women and reproductive health and health care concerns also on the availability of RCH services should be strengthens to the public.
2. Improve awareness and health care quality through partnership with various civil society organization/ Non-government Organizations (NGO's) and community organizations who work with health issues and government must partner with such organizations.
3. To include community participation in framing any development policy which will directly related to the context of the community.

4. Improve health care through community organizations and proper monitoring of health programmes implemented by the government and took quality health care facilities availability.
5. Extensive social research based study particularly on tribal women needs to be done to show the prevalence of reproductive health issues and concerns.

KNOWLEDGE AND PRACTICES OF REPRODUCTIVE HEALTH AMONG TRIBAL WOMEN IN CHURACHANDPUR DISTRICT, MANIPUR

ABSTRACT

KHAWLNUNSANGI

Under the Supervision of

Dr. H. Elizabeth

Assistant Professor

DEPARTMENT OF SOCIAL WORK

MIZORAM UNIVERSITY

AIZAWL – 796004

MAY 2018

KNOWLEDGE AND PRACTICES OF REPRODUCTIVE HEALTH AMONG TRIBAL WOMEN IN CHURACHANDPUR DISTRICT, MANIPUR

ABSTRACT

KHAWLNUNSANGI

DEPARTMENT OF SOCIAL WORK

MIZORAM UNIVERSITY

AIZAWL – 796004

MAY 2018

Introduction

Reproductive health is one of the major challenges faced by women and is a universal concern today. It is of immense importance because of its implications towards women's health, the health of their children, family members and socio-economic development of the society. Since women's health also involves the health need related to childbearing and child rearing, it is imperative to look at the health need of women comprehensively, historically and culturally. The reproductive health status of women, especially in a developing world including India, requires urgent attention. More than 1.2 billion people live in India, approximately twenty-six 26% (328 million) of whom are women of reproductive age (15-49) years (M.S. et al. 2014). Over one-third of all healthy lives lost among adult women are due to reproductive health problems (WHO, 1995).

The reproductive health of women's is one of a crucial component of the health of women, particularly during the reproductive years. It refers to the diseases, disorders, and conditions that affect the functioning of the reproductive systems during all stages of life. Within the framework of W.H.O's definition of health, Cairo in 1994 has defined the term reproductive health. It outlines the sexual and reproductive health is not merely about reproduction. Instead, it must be viewed as three interconnected domains which include universal rights, women's empowerment and health service provision.

Rural tribal women's health is impacted by various factors operating at different levels. The most common problems with the tribal women are lack of basic amenities such as food, lack of education and awareness, proper transportation and health care facilities and services. Poverty and lack of awareness among rural Indian population have a devastating impact on rural women's health. It can cause delays in seeking appropriate health services until a condition reaches its most critical stage (Sangam, 2015).

Culture and society also play an important role in rural tribal women's health status and access to services. The ethnic compositions, cultural background, beliefs, customs, and faith don't permit the individual and groups to discriminate their age-old practices and adopt a new system. Many of the worldwide research and evaluation have shown that education of women is strongly associated with the confidence to adopt new ways and on the utilization of health care

services, the lowering of child death rates, and the improvement of family health nutrition, the use of family planning services and reduction of overall family size. Tribal women in rural areas are one of the most disadvantaged people in terms of health status particularly on women and reproductive health concerned. As a host of social, cultural, political and economic factors increase rural women's vulnerabilities to early marriages, early pregnancy, and pre-term birth, deaths and disabilities, unsafe abortion, HIV/AIDS and other reproductive cancers (Sangam 2015). Early marriage is more common in rural areas and this can largely impact their health and well-being as their reproductive systems are not fully developed.

With a minimal educational level and limited access towards information on reproductive health and reproductive health services, the tribal women are mostly left on their own to manage their fertility, sexual and reproductive well-being.

Reproductive Health

Reproductive Health is a very broad concept defined by International Conference on Population and Development at Cairo as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so." (ICPD 1994). It implies on the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of family planning of their choice and also other methods which are not against the law, and access to appropriate health care services for women so that they will be able to go through pregnancy and childbirth safely, and provide the couples with the best chance of having a healthy infant (Ramasuban & Jejeehboy 2000).

The United Nation, (1994) proposed that Reproductive Health is appositive part of personal health and healthy living and it follows that “reproductive health education should be available to all as an important component of health promotion and services.’’

Therefore, reproductive health deals with the reproductive processes, functions, and systems at all stages of life.

Tribal Women

In the Constitution of India, the term tribe has not been defined clearly, only the term 'Scheduled Tribe' is explained as "the tribe or the tribal communities or parts of or groups within tribes or tribal communities" which the President may specify by public notification (Article 342). A woman who belongs to any of the Schedule Tribe is considered as a tribal woman for the present study.

The status of women in the tribal societies seems to be comparatively better than that of women in general society because tribal societies have been by and large characterized as egalitarian societies especially in relation to the hierarchical character of caste society (Varte, 2014). Although the status of tribal women is higher as compared to their non-tribal counterparts elsewhere in India, men in their own society do not treat them as equals (Nembiakkim, 2008). Thus, we find proverbs among the Mizos, which state that: Women's wisdom cannot extend beyond the bank of a river, a wife and an old fence can be replaced anytime.

A tribal woman plays a very significant role to the family and to the socio-economic structure of the society. Maintaining the household chores and providing food for the family is also a part of her responsibility.

Reproductive Health Issues at Global, National and Regional level

The basic elements of reproductive health include "responsible reproductive/sexual behaviour, widely available family planning services, effective maternal care and safe motherhood, effective control of reproductive tract infection(including sexually transmitted diseases), prevention and management of infertility, elimination of unsafe abortion and treatment of malignancies of reproductive organs"(WHO, 1978). In addition, reproductive health effects, and is affected by other aspects of health, especially HIV infection/Acquired Immune Deficiency Syndrome (AIDS), nutrition, infant and child health, adolescent health and sexuality, life-style and environmental factors including social and cultural factors (WHO, 1978).

Reproductive health is one of the major priorities of global health and is a fundamental and inalienable part of women's health due to child-bearing (Patel, Kirkwood & Pednekar, 2006).Motherhood at a very young age entails a risk of maternal mortality that far exceeds the

average, and the children of young mothers tend to have higher levels of morbidity and mortality (South-East Asia's Population in a Changing Asian Context, 2002).Reproductive Health affects the lives of women and men from conception to birth, through adolescence to old age, and includes the attainment and maintenance of good health as well as the prevention and treatment of ill health (WHO,2006).

The international perspective on Reproductive health considered the factors that influence the reproductive health matters such as social status, economic position and access to resources (Patel, et al., 2006). Reproductive health is defined as an organizational framework that incorporates maternal and child health programs, family planning, infertility, sexually transmitted diseases, post-natal infection and maternal and child health-related concerns (Dudgeon & Inhorn,2004). It is a state that reproductive health addresses reproductive process, functions, and systems at all stages of life (WHO, 2012). Reproductive health also refers to the right of men and women to be informed and have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice and the right of access to appropriate health care services that will enable women to experience a safe pregnancy and childbirth. In short, reproductive health addresses the reproductive process, functions, and systems at all stages of life (WHO, 2013; Wisconsin Alliance for Women's Health, 2012).In some Asian countries for example in India, Pakistan, and Bangladesh, there is a high proportion of marriage during adolescence, resulting in a high rate of adolescent childbearing (South-East Asia's Population in a Changing Asian Context, 2002).

Assessing the needs for behaviour change, the Government of India initiated a Reproductive and Child Health (RCH) Programme in 1997,which aimed is to meet the reproductive health needs of women. Government is engaged in the task of promoting r eproductive health of women The National Family Health Survey 2015-16 (NFHS-4) provides information which is related to women and reproductive health status. Through this study, it shows in percentage regarding households using improved sanitation facility present urban seventy (70.3%), rural area thirty-six (36.7%). The total is forty-eight (48.4%) against to twenty nine (29.1%) in NFHS-3 (2005-06). In regards to the age at marriage, women in the age group of 20-24 years married before attainment of 18 years comprise of seventeen (17.5%) in the urban area and thirty-one (31.5 %) in the rural area. The NFHS-4 recorded an increase in institutional

birth with eighty-eight (88.7%) in the urban area and seventy-five (75.1%) in rural areas. However, the under-five mortality rate is thirty-four (34%) in urban and fifty-six (56%) in rural India.

India has the largest concentration of tribal communities in the world except that in Africa. The tribal groups of India are known to be the autochthonous people of the land and the tribal groups comprise 8.6 % of total India's population (2011 census). The tribal groups inhabit widely different ecological and geo-climatic conditions in different concentrations throughout the country and are distinct biological isolates with characteristics cultural and socio-economic background (Mukhopadhay, 2002). The health aspect of women is very important. In the life of a woman, menarche is a biological phenomenon marking the onset of reproductive age. The reproductive age is also an age when women are more active. The status of women in a society is a significant reflection of the level of social justice in a society. Women status is often described in terms of their level of income, employment, education, health, and fertility as well as the roles they play within the family, the community, and the society. It has been observed that the status of tribal women is comparatively lower than that of tribal men (Ray and Jayanta, 1993).

Poor health status of women and children in terms of high mortality and morbidity was also another health priority in the country mainly within the northeast states. Health facilities like hospitals and health centres were established for providing Maternal and Child Health (MCH) care through ante-natal, pre-natal and post-natal services. In order to ensure maximum benefit from these programmes to provide services in an integrated manner to this vulnerable group, the Child Survival and Safe Motherhood (CSSM) programme were implemented in India since 1992. Despite all these efforts, the desired impact on the population growth and health and development of women and children in the country could not be achieved and the need for a new approach to the problem was felt. In 1994, during ICPD, held in Cairo it was recommended that a new approach needs to be adapted to tackle the problem. Under this approach, it was decided that the family planning services should be provided as a component of the comprehensive reproductive health care. Accordingly, as a follow-up action to this conference, the Government of India launched the Reproductive and Child Health programme in October 1997.

The high magnitude of women’s reproductive health problems is reflected by the high maternal mortality rate as well as the high burden of or reproductive morbidity like STI/RTI,

gynaecological problems, cancer of reproductive tract etc. The Reproductive and Child Health (RCH) programme is being implemented in India with a major focus on rendering client-cantered and high-quality services to the community. Since women constitute the major client group/users of this programme, greatest attention needs to be given to this group.

The scenario of Manipur according to NFHS 2015-16 on households using improved sanitation facility shows 47.8 % in rural areas and 51.3% in urban areas, with a total of 49.9%. Women and fertility indicators show that women between the age of 20-24 years married before attaining the age of 18 years as 11% in urban and 14.3% in rural areas with a total of 13.1%.The total fertility rate (children per woman) rural 2.1, urban 2.9, the total is 2.6. The institutional birth shows 86.3% in urban and 60.5% in rural areas, with a total of 69.1%. An institutional birth in public facility shows 55.3% in urban areas and 40.9% in rural areas, with a total of 45.7%. Home delivery conducted by skilled health personnel (out of total deliveries), 5.9% in urban areas and 9.1% in rural areas with a total of 8.0%.

Overview of Literature

Reproductive health is an important component of overall health and well-being. It is a major, positive part of personal health and healthy living and it follows that "reproductive health education should be available to all as an important component of health promotion and services" (UN, 1994).

The International Conference on Population and Development (ICPD) report (United Nations, 1995) states that reproductive health should include information and services for family planning, antenatal care, skilled attendance at birth, postnatal care, management of complications of abortions, and treatment of sexual illnesses. Even further, the report emphasizes the importance of women's involvement in the development, performance, and assessment of reproductive health care programs. In broad terms, health literacy encompasses the understanding and implementation of information provided by healthcare professionals and that it is critical in the identification of pregnancy complications and health care seeking behavior among women. (Kohan, Ghasemi, & Dodangeh, 2007).

'Women's health during the reproductive or fertile years (between the ages of 15 and 49 years) is not relevant not only to women themselves but also has an impact on the health of

children and development for the family. Various health constraints during this period are the ones that only young girls and women experienced.(NFHS-4, 2015-16).

2.2 Studies prevalence on Knowledge and Practices of Reproductive Health

Shahini and Debnath (2016) study on knowledge and perception of women towards reproductive health problems: a study of Bishnupriya Manipuri women of Silchar, Cachar district in Assam with an objective to identify the nature and types of reproductive health problems of women, to examine the socio-cultural factors influencing reproductive health and to find out the accessibility of healthcare service. The study is descriptive and analytical in nature. The findings of the study showed that very few of the women had knowledge of reproductive organs, and even the students knew better about the hygiene compared to the older women. The young girls used sanitary napkins and the elder women used cloth which is unhygienic and so suffer from infections which lead to infertility. Maximum of the respondents had awareness regarding HIV/AIDS and contraceptives but they had no knowledge of RTI. The study also found that ASHA worker and ANMs had played a vital role in giving the knowledge of family planning and contraceptive.

Devi (2013) study of 'Knowledge, Attitude and Practices of reproductive and child health (RCH) services among rural women in Manipur' found that the knowledge, attitude and practice of the women towards RCH are mostly depending on the type of the respondents' occupation. A woman who has a job outside and communicates with others has more knowledge about family planning than women who were confined at home. Due to financial constraints most of the respondents thirty (30%) had their deliveries at home, twenty five (25%) of them at district hospital and twenty (20%) of the deliveries in private hospitals and twenty (20%) in Community health centre or primary health centre (CHC/PHC). Due to a decisive problem of money and lack of health facilities seventy (70%) of the women were registered of antenatal care (ANC) with health facility services, thirty (30%) of them were not registered. Sixty(60%) of the women received tetanus (TT) injection and forty (40%) of the women have not received TT injections due to inadequate health services in the village, lack of infrastructure facilities, shortage of medicines and non-availability of doctors and nurse in time of need and lack of health awareness.

In terms of the Post-partum check-ups Maiti, S et al. (2005) the health of a mother and her newborn child depends not only on the healthcare she receives during her pregnancy and delivery but also on the care she and the infant received during the first weeks after the delivery. The study shows that only eleven (11%) of the births among the tribal women were followed by a check-up within two months of the delivery compared to nineteen (19%) among the nontribal women. Fifty- nine (59%) of the check-ups took place within two days of births for the tribal women as compared to sixty - six (66%) in the case of non-tribal women.

Maiti, S et.al. (2005) study on contraceptives use and problem and reproductive health problems. Fifteen percent (15%) of the married tribal women were currently using some method of contraception and about 31% of the non-tribal women were doing so. One (1%) of the tribal women were using any traditional method and three (3%) were using other methods like folkloric methods. Modern methods of contraception were used by only one (1%) of tribal women and three (3%) of non-tribal women. Again, among the current contraceptive user, a terminal method was used by 9% of tribal women compared to 25% of non-tribal women. Also among the women who are currently using contraception,15% of the tribal women had some problem compared to 27% among the non-tribal women. In regards to reproductive health problems, an absence of reproductive tract infections (RTIs) is essential for the reproductive health of both women and men is critical for their ability to meet their reproductive goals. The reproductive health situation seems to be better among the tribal women in Jharkhand than their non-tribal counterparts. Overall forty three percent of the tribal women have any reproductive health problem compared to forty-six percent among non-tribal women. Of all reproductive health problems, urinary tract infection is higher among tribal women (28%) than non-tribal women with 26%.

The study clearly brings out the differential in the healthcare and health condition among the tribal women and non-tribal women in Jharkhand. The findings revealed that in each and every socio-economic, demographic as well as health parameters, the tribal women are very much poor than the non-tribal women. The utilization of maternal health care is also very less among the tribal women than non- tribal women in Jharkhand. Use of modern methods of contraception is also significantly less among the tribal women. All these will likely to have not only an adverse long-term impact on the maternal health and well being but also on their

children. It further suggested that in order to improve the health status of the tribal women in Jharkhand, the healthcare delivery system should be designed effectively to cater to the specific needs of the tribal women during pregnancy and at childbirth by ensuring their personal involvement. The study further suggested that health interventions must focus on tribal culture, medical training of the tribal people, and a knowledgeable health care delivery system catering to the needs of tribal women and the child.

Chandrashekar (2014) conducted a study on reproductive health problems of women in rural areas in Manvi taluk of Raipur district which consisted of 170 villages. Out of 170, the researcher selected 9 villages. From the 9 villages, a total of 360 respondents were selected for the study. Accordingly, 200 women respondent participated in response to the reproductive health problems which includes questions towards abortion, pregnancy-related problems, their opinion regarding the necessity of regular medical care during pregnancy, reasons for not using the medical facility during pregnancy, place of delivery and reasons for not going to delivery centers. The study found that women health, in particular, reproductive health, hardly gained prominence in rural areas. And stress further on the important to note that for an all health of the family, women health should attain utmost importance.

Ramana and Usha Rani (2014) studied on Reproductive health status - issues and concerns of tribal women in Andhra Pradesh, and focused on to assess and understand the reproductive health status of tribal women. Examination of reproductive health concerns of Tribal women was useful in assessing the extent to which population enjoyed the human rights to maximize their opportunity to enhance reproduction in a secured environment.

Srinivasan and Ilango (2010) focused on Reproductive health care of tribal women in Kolli Hills at Nammakal District, Tamil Nadu. The objectives were to study the antenatal care practice of tribal women, to and delivery related practice of tribal women, to identify misbelieves regarding food and working status of women during pregnancy. Gaps in knowledge regarding the health of tribal women have been identified and a plan of action has been suggested for improving their health.

Jejeebhoy (1996) showed that adolescent fertility in India occurs mainly within the context of marriage and over half of all women aged 15-19 years have experienced pregnancy or

birth. Pregnancy, in a still growing girl, means an increase in nutritional requirements not only for the growth of the fetus but also for the mother herself. If they are not met, her future physical health may be impaired. According to Chhabra (1991), teenage mothers seem to be at higher risk of child-bearing with high prenatal risk. Further, closely spaced multiple births at a comparatively tender age contribute to the high rate of maternal mortality and gynaecological complications.

K.Van Egmond, et al. (2004) study on Reproductive Health in Afghanistan: Results of a knowledge, attitude and practices survey among Afghan women in Kabul. The study was carried out among 468 Afghan women of reproductive age (15-49) years to have a better understanding of women's reproductive health in Afghanistan, the use of reproductive health services including antenatal care and family-planning. Knowledge, attitude, practices regarding family planning, sexually transmitted infections and gender issues were also explored. The study also showed that even in a privileged group of Afghan women, reproductive-health indicators are poor and several potential risk factors for maternal mortality death can be identified. Among factors that contribute to maternal mortality, the literature usually distinguishes factors that first, delay arrival at a health facility; delay the decision to seek care; second, delay arrival at a health facility; and third, delay the provision of adequate care. Distance cost and quality of care are considered major obstacles. The study also found that several socio-cultural factors which can promote maternal deaths were identified such as early marriage, frequent childbirth, lack of spacing of pregnancies and low decision-making power of women to seek appropriate health-care or to negotiate terms of sex. These factors are strongly linked with the traditional attitudes that prevail in the Afghan society of today.

It is also clearly identified in the study that education as beneficial for women's reproductive-health status on an individual level. Women who attended school scored significantly better in getting skilled attendance at the birth, contraceptive prevalence rate, and antenatal coverage. Fewer adolescent pregnancies were observed among educated women and knowledge of sexual and reproductive health was significantly better. This finding is in line with data from other countries, which document that women with limited education have much higher pregnancy-related death (Grimes, 1994).

The important impact that social and cultural factors have on reproductive health, underlines the need to see reproductive health in Afghanistan in a broader perspective than from a "health-care provider' point of view alone. Not only poor quality or absence of reproductive-health services explains women's low health status in Afghanistan. Therefore, the study suggested that actions to improve reproductive health in Afghanistan should include efforts to empower women- including educating girls and providing economic opportunities to women and to educate men about women's reproductive needs through community –based programmes. Programmes should move beyond more 'education' to bring about a change in behavior. Strategies should be developed which address women's decision-making power in the family. These will result in improved access for women to existing reproductive- health services.

Jejeebhoy (2000) revealed that adolescent in Indian society tends to be extremely poorly informed regarding their own physical well-being, their health, and physiological changes. Often they have incomplete knowledge and information and are subject to confusion.

Prusty (2014) study analysis on Use of contraceptives and unmet need for family planning among tribal women in India and selected hilly states provides a comprehensive picture of knowledge and use of contraceptives among scheduled tribes (ST) of India and selected centrally hilly states where tribal population contributes more than 30% of the total tribal population of the country. An attempt is also made to know how far scheduled tribes differ from non-tribes in the states, namely Jharkhand, Madhya Pradesh, and Chhattisgarh, using information collected in the third round of District-level Household Survey (DLHS-RCH III: 2007-2008. Bivariate analysis was used for understanding the level of knowledge, use of unmet need for contraception among different tribal and non-tribal groups. Binary logistic regression was used for understanding the factors associated with the use of contraception and unmet need for family planning among tribal women. Knowledge and use of temporary contraceptive methods are considerably lower among tribal women compared to their non-tribal counterparts in the three states under study. Low acceptance due to the phobia of adverse health consequences, accessibility to and lack of knowledge of contraception are the leading reasons for not using contraceptives. The unmet need for family planning among them was quite high, especially in the state of Jharkhand. Multivariate analysis substantiated the role of women and husbands' education, an age of women, and the number of surviving boys in the use of any modern method

of contraception. Educating women and their respective husbands about proper use and benefits of modern contraceptives is important to solve the problem of the high unmet need for family planning among these tribal women.

Women in rural areas, older women, women with little or no schooling, scheduled tribe women; Muslim women have less exposure to family planning messages. Marriage is almost universal in India. It is also showed that urban women marry later than rural women and women attaining higher or more years of schooling marry much later than other women. The number of children that a woman bears has many factors such as the age of women on her first pregnancy, the birth spacing and her fecundity. The intervals between births have played a role towards the health consequences for women. Childbearing at a very young age is highly associated with an increased risk of complications during pregnancy and childbirth and higher neonatal mortality. Teenage pregnancy is found to be relatively high in rural areas, nearly 1 in every 10 women in rural areas 15-19 year's age group have begun child bearing. It is also found that teenage pregnancy decreases with an increasing level of schooling as well as their level of wealth (NFHS-4, 2015-16).

Towards antenatal care, used of skilled provider for antenatal care services is higher in urban areas than rural areas with (89% and 75% respectively). It is also found that used of skilled provider for antenatal care services increases with the rising education and awareness provided by the government through various schemes. In India, 87% to 91% of women who received antenatal care (ANC) for their most recent live birth in the past five years had their weight measured, a blood sample taken, a urine sample taken, abdomen examines and blood pressure measured. Also towards delivery services and postnatal care, institutional deliveries increased between 2005- 06 and 2015-16, from 39% to 79%. It is found that the mother's educational status is highly correlated with the place of delivery and used of skilled provider. 95% of women with 12 or more year of schooling had delivered a baby in a healthy facility compared to 62% of women with no schooling. With regards to postnatal care it is found that Schedule tribe women 59% are less likely to receive a postnatal check-up within two days than women from any other caste/tribe group. In India, less than half (43%) of women received their first postnatal check from a doctor; 22% from nurse, midwife and 2% from ASHA. Women with 12 or more years of

schooling are more likely to receive a postnatal check up than women with no schooling (NFHS-4, 2015-16).

Statement of the problem

The RCH programme was introduced in the state of Manipur in the year 2000. Since its introduction, there has been a certain level of increase in the awareness regarding RCH and its components among the women of Manipur. However, there still remains a portion of women who have been not able to acquire any information about RCH and its facilities. This may be due to the problems of accessibility or its affordability pattern. The majority of the women who are deprived of RCH and its facilities are those belonging to the tribal region in Manipur. According to the National Family Health Survey 2015-16 (NFHS-4), provides state wise information on population, health, and nutrition for the first time, provides district-level estimates for many important indicators. The fact sheet shows information for rural areas and the district as a whole because Churachandpur district of Manipur has more than 70% rural population, which provides a sufficiently large sample to produce reliable estimates of most indicators for rural areas. The households using improved sanitation facility is 66.1%. The marriage age before 18 years is 13.5%. Mothers' iron-folic acid consumption for 100 days or more during pregnancy is 19.1%. An institutional birth is 60.9% out of which 34.5% in public facility. Further, 20.3% of all women age 15-49 years reported anemic.

Tribal women face various obstacles in accessing the services due to lack of knowledge. One of which is receiving accurate information regarding the reproductive and sexual health. In addition, young women are hardly aware of the sources of care which when combined their limited knowledge hinders their ability to make informed choices to protect and practice well-being. Women are assumed not to be much comfortable with the subject of the study.

From the literature review, it is seen that many studies have been conducted on Adolescent and reproductive health but a study towards Reproductive health and tribal women particularly tribes from the northeast tribal women are limited. Against this backdrop, the researcher would like to attempt a study, find out, assess the existing knowledge and the prevalent practices among tribal women reproductive health. This study will examine two research questions. The first research question of the study will be on what is the Knowledge of

tribal women towards reproductive health. The second research question of the study will be towards understanding their practice and their subsequent decisions about their reproductive health and the services that are available.

Objectives

The objectives of the present study are mentioned below:

1. To assess the knowledge and practices of reproductive health among tribal women in Churachandpur district.
2. To assess the women's utilization of reproductive health services.
3. To identify the reproductive health challenges and constraints to women reproductive health in the study area.
4. To probe into the relationship among knowledge, practices, and utilization of reproductive health services.
5. To suggest measures to improve service services utilization in the study area.

Hypotheses

To provide focus to the study the following hypotheses have been drawn and formulated:

1. Woman's Knowledge on Reproductive Health depends on their level of education and economic status.
2. Women's adoption of safe Reproductive health practices is positively related to their Knowledge
3. Woman's Utilization of RCH services is directly related to their knowledge on RCH.

The first and second hypotheses were drawn from the results of earlier studies (see: National Family Health Survey-4, (2015-16) and K.Van Egmond, et.al (2004) studies on Reproductive health in Afghanistan. While, the third hypothesis have been drawn intuitively.

Research Design

The present study is descriptive in design and cross-sectional in nature. Quantitative and qualitative methods were used. Quantitative data were collected through survey method by administering structured pre-tested interview schedule. The qualitative information was elicited by conducting in-depth interviews through case studies, focus group discussion (FGD) and key informant interviews (KIIs). A case study was conducted to collect qualitative information from three tribal women. Also, a focus group discussion (FGD) is conducted among the elderly tribal women who had crossed 50 years of age and who are not included in the survey. The FGD was held to understand mainly the traditional practices and challenges faced out of the practices and also the adopted coping strategies. In addition, the reality is also understood better by conducting 4 Key Informant Interviews (KIIs) with the health workers i.e accredited social health activist, gynecology and the director of a district family health welfare department.

Sampling

Multi-stage sampling was used to select blocks and villages. Churachandpur sub-division was selected since it is the most developed sub-division in Churachandpur district. It has two tribal development (TD) blocks; Churachandpur TD Block which is one of the most developed block and Samulamlan TD block which is one of the least developed block. Salemveng village was selected from Churachandpur TD block since it has one of the highest female literacy rates of 94.85% (2011 census). On the other hand, Ngurte village was selected under Samulamlan TD Block which has one of the least female literacy rates with 86.59% (2011 census).

The third stage is on the selection of households. In the selected villages the list of the household as given in census 2011 was obtained from the village authorities. Finally, the Salemveng village has a total household of 262 and Ngurte village has a total household of 144 (2011 census, Government of India).

Using disproportionate stratified random sampling the total sample size of 160 households was selected, 80 from Salemveng Village and another 80 households from Ngurte village. So, every third household was selected from the salemveng village and every second household from Ngurte village was selected. Thus, in each of the selected household, one woman who meets the inclusion criteria of the present study were interviewed.

Tools of Data Collection

Quantitative data were collected through the administration of structured interview schedule. The interview schedule consisted of four sections - demographic profile of the respondents which includes the personal profile, economic characteristics and general health and hygiene (nutrition, water, and sanitation). The second section was on the reproductive health knowledge and practices.

The third section of the interview schedule was the reproductive health challenges and constraints and the fourth sections include the utilization of reproductive child health services (RCH).

Data Processing and Analysis

Census and Survey Processing System (CSPro) package and Statistical Package for Social Sciences (SPSS) were used to processed and analyze the collected data. Simple averages, percentages,'t' test and Karl Pearson's coefficient of correlation were conducted to test statistical relationship among the variables.

Operational Definitions

Tribal Women

A woman refers to identify female humans irrespective of age. In this study 'Women' is used to refer to female humans in a reproductive age group between 15-49 years inclusive of a single mother, widow, unmarried, divorced.

Reproductive Health

Reproductive health relates to the health of women in all matters related to the reproductive system, and to its functions and processes. Reproductive health is one of the fundamental human rights. The UN defines reproductive health "as a state of complete physical, mental and social well being and not merely the absence of diseases or infirmities, in all matters relating to the reproductive systems and its processes". The agenda gives a special focus on 'safe sex' and 'freedom to choose and access to family planning services' to ensure safe motherhood. It also lays emphasis on sexual health and to improve personal relationships with an aim to ensure

that an individual is free from reproductive tract infections (RTIs) and sexually transmitted diseases (STDs). Thus reproductive health has to be looked at from a holistic point of view.

Reproductive Age Group

Women of reproductive age refer to all women aged 15-49 years. In some census and surveys estimates, the upper age is taken as 44 years and the last age group is thus 40-44 years. More recently, it has been recommended that total fertility rates be shown by using both 15 to 44 and 15 to 49 age groups (WHO, 2006). However, for the present study, the later age group 15-49 age group has been used as the reproductive age group.

Limitation

The size of the sample is limited and the area of the study is confined to one district of Manipur. Hence, the generality of the finding is limited to a tribal population of Churachandpur district, Manipur.

Findings

The respondent's awareness on their reproductive organs, their source of information regarding reproductive health shows that more than three fourth of the respondents had aware of the reproductive organs and their source of information is mainly from the health care providers. While, the other (16.9%) of the respondents were found not aware of their reproductive organs.

In regards to awareness on menstruation, a maximum of the total respondents had awareness on their attainment of menstrual cycle. In case of irregular menstrual cycle nearly half of the entire respondents attributed the reason as delayed of their menstruation is due to conceiving and on for which on medication. In addition, the other few of the respondents also stated anemia as one of the potential causing factor to their menstrual irregularity. Of the respondents who had experience menstruation irregularity few of the respondents had soughed medical treatment only sometimes.

The reproductive health problems, the awareness and experienced of the respondents towards the reproductive health problems particularly on white discharge, Reproductive Tract Infections/ Sexually Transmitted Infections (RTIs/STIs) and vaginal itching shows that majority

of the respondents had awareness on the reproductive health problems of white discharge. Further, more than half of the respondent does not aware of RTIs/STIs. Among the respondents who had awareness on RTIs/STIs more than half of the respondents were not aware about the common sign and symptoms of RTIs/STIs. The finding is in line with Meenakshi et.al (2015) studies found that women have poor level of awareness with regard to knowledge and symptoms of STIs. In addition, majority of the respondents had awareness on vaginal itching. In connection to the source of information about reproductive ill health problems nearly two third of the respondents received information from the health care providers and less than third of the respondents received information through communication with their friends and relatives.

Thus, majority of the respondents had awareness on HIV/AIDS and their sources of information revealed that more than one third of the entire respondents had awareness throughmass media like television, newspapers and radio. More than two third of the respondents had awareness on the four modes of HIV/AIDS transmission - unprotected sex, sharing of needles among IDUs, infected blood transmission and from infected mother to new born child. With regards to the awareness on the advocated methods of HIV/AIDS prevention nearly half of the respondents had awareness on the four advocated methods of prevention- condoms promotion, screening of blood transfusion, one sexual partner and use of only sterile needles.

With regards to family planning more than half of the respondents' had awareness on the family planning methods of oral contraceptive pills, intrauterine contraceptive device, and female sterilization. More than half of the respondents agree that women should take initiative towards family planning. At the same time, majority of the respondents had awareness on the contraceptive methods and out of which more than two third of the respondents had adopted the contraception.

Reproductive Health Practices

It is implicit to understand the reproductive health practices among the respondents**.** With regards to menstruation and hygiene more than half of the respondents used sanitary pads and more than one-third used any available clean cloth. However, few of the respondents were found using any cloth available to absorb the menstrual flow. The disposal of used sanitary pads shows that nearly half of the respondents disposed it into dustbin and one third of the respondents burnt

it. While, more than two third of the respondents who used cloth to absorb their menstrual flow reused the same cloth after washing and sun drying. Furthermore, majority of the respondents never had an experience of any kind of social taboo associated to menstruation.

With the seeking of treatment on reproductive ill health problems it is found that nearly half of the respondents seek private medical care and more than one third of the respondents only sometimes seek for treatment. But, it was shown that still some of the respondents did not even seek any treatment with regards to reproductive ill health problems. Also the reproductive ill health problems experienced by more than two third of the respondents were diagnosed through medical investigations.

The practice of family planning shows that more than two third of the respondents had adopted contraceptive methods, more than a fourth of the respondents denied using any contraceptive of which a maximum of one fourth stated as not being comfortable to adopt it. Of the respondents who had once adopted contraceptive methods almost half of the respondents continue using it and other half discontinue using it. A maximum of the respondents adopted using the method of oral contraceptive pill (OCP) and Intra uterine device (IUD). While few of the respondents practiced female sterilization. Interestingly, two third of the respondents affirmed the presence of mutual consent between the couple that they had consulted their husbands before using/adopting any method of family planning.

The exploration on the practices related to prenatal and post-natal care shows that almost three fourth of the entire respondents practice going for regular checkup during pregnancy and the remaining one fifth of the respondents does not practice medical check-up during pregnancy. The occurrence of pregnancy related complications affirmed that one fourth of the respondents sought for medical treatment of which 13.1% of the respondents visited district hospitals for seeking medical treatment. However, few of the respondents were found visiting visionary and traditional healer for any pregnancy related complications.

The results on post natal care shows that half of the respondents does not went for post-natal check-up within two months after delivery and less than half of the respondents went for post natal check-up. The reasons for not going for post natal check-up by some of the respondents was due to feeling of unnecessary, not able to meet the expenses incurred by

medical check-up, due to lack of transportation and also due to not having time to visit the health centre.

The practice related to delivery care received by the respondents a maximum of two third of the total respondents had institutional delivery and less than one third of the respondents had home delivery. A maximum of three fifth of the total respondents had chosen hospital/ health care institutions for the right place of delivery due to the fact that institutional delivery had less complications to the mother and new born babies. However, less than one third of the respondent's choice for delivery place depends on easy accessibility during the emergency.

The study further examine the pregnancy related complications and abortion done by the respondents. The result found that one fourth of the entire respondents had undergoes abortion of which one fifth of the respondents underwent on medical grounds as advice by the doctors. Whereas the remaining few of the respondents who had undergone abortion other than medical prescription were due to family pressure as they already had too many children, unplanned pregnancy, fetus health complications etc. The place of abortion of the respondents shows that a maximum of 13.1% underwent abortion at district hospital and 10.6% in a private hospital. And few of the respondents do not disclose the place of abortion. But, the particular query was not applicable to 75% of the total respondents.

In regards to experienced health complications related to abortion by the respondents the results shows that 8.75% had experienced health complications due to underwent abortion. Few of the respondents had experience health complications of heavy bleeding, complication to child bearing and pelvic infection. For more than half this particular query was not applicable.

Utilization on Reproductive Health Services

The utilization of family planning method shows that out of the two third respondents who had adopted contraceptive methods a maximum of one third respondents procured the contraceptive items from hospital and few of them also procured it from the ASHA worker.

The utilization on prenatal check-up shows that one third of the respondents held prenatal check-up in the district hospital. More than half of the respondents had awareness on Janani Suraksha Yojana(JSY) scheme which advocated on institutional delivery. Where two third of the

respondents claimed that they had never received any incentives under Janani Shishu Suraksha Karyakram (JSSK). This happened in spite of institutional delivery practice because sometimes the respondent does not access the government health institutions and the other reason were due to not able to follow all the criteria rules in order to received the JSSK incentives. Therefore, the JSSK was received by a total of 31.3% of the respondents who had institutional delivery at government health care institutions.

In respect to the mother and child health (MCH) services more than three fourth of the total respondents had no awareness of the free counseling services available on family planning provided at the district hospital. However, nearly half of the respondents had aware on free mother and child immunizations services provided in the government health care institutions. By and large half of the total respondents received prenatal and post natal immunizations at free of cost but more than 40% of the respondents are not receiving immunizations at free of cost. Thus the enquiry on the free immunization under JSY scheme was not applicable to some of the respondents.

In regards to the receiving of free medicine under JSSK during the prenatal and post natal period was explored among the respondents. It was found that a maximum of more half of the entire respondents received medicine at frees of cost and commonly self-reported medicines were Iron Folic acid tablet and tetanus injection. While more than one-third of the respondents do not receive it. So, the utilization of the service shows that an equal number of 42.5% of the respondents had accessedto abdominal examination, blood pressure and blood testing at free of cost in the government hospital.

Reproductive Health Challenges and Constraints

The study identifies the reproductive health challenges and constraints encountered by the respondents. Nearly half of the respondents had experienced reproductive ill health problems of vaginal white discharge accompanied by itching/fever/bad odour/irritation around vaginal area. And while encountering reproductive ill health problems more than half of the total respondents disclosed to their husbands and the other few of the respondents disclosed the problems only to the health care workers such as doctors. Also, there were respondents who shared reproductive ill health problems to the visionary, priest or other faith healer.

Among the respondents who had adopted contraceptives more than two-third of the respondents agreed that the using of contraception sometimes affects their health, where some of the respondents had reported an experienced of loss of appetite, fatigue, weight loss, headache, difficulty in conceiving and disturbance on regularity of the menstrual cycle.

The other reproductive health challenges and constraints encountered by the respondents were accessibility to health care services. Majority of the respondents has no health care center available in their own villages and the distance to the nearest health center was more than 5 kilometers. Furthermore, the most common mode of transportation was on foot/walking. Due to this fact, many of the respondents were not able to access the nearest health center even in times of delivery or else emergency. And, the traditional birth attendants (TBAs) play significant roles in conducting the delivery care for a mother

The utilization of reproductive health services by the respondents was another challenge and constraint. The study found that many of the respondents do not have regular medical check-up during pregnancy. The self-reported reasons attributed to unable to meet the expenses, do not think necessary to go for check –up unless experiencing of health problem, due to poor transportation and communication, the distance of health center, prolong waiting time and absence of accompanying person.

Hence, the study found that more than one third of the respondents' experienced of pregnancy related complication such as miscarriages, inadequate nutritional condition during pregnancy and obstructed labor in child delivery. This is another challenging area to improve reproductive health services to the respondents.

Relationship among Knowledge, Practices and Utilization of Reproductive Health Services.

The relationship among the knowledge, practices and utilization of reproductive health services by the respondents was statistically tested using t-test and Karl Pearson's coefficient of correlation.

The t test results on knowledge/ awareness of RCH on contraceptive, reproductive ill health problems on vaginal itching, attainment of menstrual cycle, family planning, reproductive

organs, RCH programme, RTIs/STIs, free counseling on family planning in the least developed and most developed villages has significant difference.

The total awareness on RTIs/STIs in the least developed and most developed villages has significant difference.

The utilization on some of RCH such as a use of contraceptive and regular checkup during pregnancy was high across the least developed and most developed villages. However, utilization of other RCH services is low across both at the least developed and most developed villages. There are statistically significant differences across various indicators, and it is seen that more of the services under RCH programme was availed in the least developed villages. The accessibility to health care services on account of government initiatives through rural health care services make available some of the basic health services to villages which are located at a distance away from the nearest district hospital.

On further probing, in terms of their low utilization of RCH services among the respondents belonging to the most developed villages it was noted that most of the respondents prefer utilization of services rendered through private clinics and doctors.

The t test results on utilization of RCH services such as regular checkup during pregnancy, institutional delivery, ever use of contraceptive, post-natal checkup, receive of monetary incentives, free medication during pre-natal and post-natal, free examination of abdomen, free examination of blood pressure, free blood test showed significant differences between the least developed villages and the most developed villages.

The knowledge on RCH of the respondents has positive correlation with awareness on RTIs /STIs and HIV/AIDS and utilization of RCH services.

Correlation relationship on knowledge of reproductive health, educational and socio-economic status of the respondents showed that there is a positive correlation on the respondents' educational qualification and their knowledge towards reproductive health. Similarly, a positive correlation is found with the utilization of RCH services. The respondents' monthly income has positive correlation with the knowledge/awareness on RCH. Also, the respondents' annual

family income has positive correlation with the awareness on RCH. Correlation relationship on knowledge on RCH is directly related to their utilization of RCH services.

Henceforth, the present study confirmed and accepted the hypotheses that the woman's knowledge on reproductive health depends on their education and socio economic status (K.VanEgmond,et.al 2004) , women's adoption of safe reproductive health practices is positively related to their knowledge (National Family Health Survey-4,2015-16). And the utilization of RCH services is directly related to their knowledge on reproductive health .

Major Findings from Qualitative study

The qualitative findings showed that in spite of the fact that the women not receiving reproductive health education formally, their knowledge and practices on reproductive care are purely based on their experiences.

One of the major challenges that the women faced were lack of awareness towards reproductive health and health care. And secondly they belonged to poor economic background; women were shy to talk about and uncomfortable to open up on issues of reproductive health. It was hardly discussed openly in the family and communities at large. Sometime suffer and bear the pain silently and was unable to discuss openly about the issues even to their spouse and their in-laws when encountering any of reproductive health problems. Thus, communication on reproductive health and health care issues was minimal and limited both at familial and societal level.

The women were not much aware about the care and services which are available and provided in the government hospitals. The distance involved with no proper transportation facilities especially on rainy days and in times of emergency to reach the nearest place of health care services available added challenges to the women to access the health care services.

The RCH programmes were implemented and the facilities were mostly available only in the district hospital and were not provided all in the nearest public health center or community health center. This makes it difficult for the women to access the facilities due to unavailability of proper transportations, intra and inter-road connectivity for the villagers and to the health care workers as well to reach the far villages.

We can also see some of the practices which the women adopted in times of no medicine or before the adoption of modern medicines were easily available in the villages. With regards to practices on menstruation and hygiene before the introduction or availability of commercial sanitary pads in the villages, women were found using any available cloth or drape two or three '*Puan*' (traditional cloth wrapped around the waist) and they did not faced any social taboo in relation towards women and menstruation. Before modern medicine were easily available at the time of encountering reproductive ill health problems such as vaginal white discharge and irritation the women practice washing their private parts with *"Chingal"* (a traditional liquid concentration filtered out of ashes mixed with water) or sometimes women practice washing their private parts with a mixture of boiling water with salt. This was the traditional practices which they used in order to cope with the irritation also a part of their hygiene practice towards reproductive care.

In addition, the qualitative findings showed that the health care providers also suggested that the need for awareness on women reproductive health and reproductive health care. The emphasis on the awareness focus more on personal hygiene, RTIs and STDs awareness, also to always consult a medical practitioner before adopting any family planning methods.

5.3 Conclusion

The present study attempted to understand about the existing knowledge and the prevalent practices of tribal women towards their reproductive health. As tribal women faced various obstacles in accessing and utilizing services due to their place of location, poor socio-economic condition and lack of knowledge towards reproductive health which in turn limited their knowledge to protect themselves from certain reproductive ill health problems. Having the right source of information or knowledge about women and reproductive health problems will certainly help women in the prevention and control of certain reproductive health problems.

The present study examines two research questions. The first question of the study focus on their knowledge of tribal women towards reproductive health and the second is based on understanding their practices and subsequent decisions about their reproductive health and the services that are available.

The findings of the present study indicates that though some of the tribal women have knowledge about the reproductive health there were still many tribal women who are ignorant about reproductive health of women. It is seen that tribal women in both the two villages (Ngurte & Salemveng) have more relay on modern medicine than that of practicing traditional methods. The tribal women need to get information from proper source that will in turn increase their knowledge about the reproductive health and that the women will be able to adopt the right kind of practices and prevent them from certain reproductive health problems. If the health of the women is to be improved the community or society must be willing to provide easy accessibility and availability of services to women who are in their reproductive age. Since the high status of reproductive health of women largely influence the health of the children as well. That is why Chandrashekar (2014) stated that 'for an over-all health of the family, women's health should attain utmost importance'.

Suggestions

The present study aimed to suggest measures based on the research findings. Following are the suggestions for social work intervention, for policy making, government and non-government organizations working directly with the community on development issues.

1. Awareness on women and reproductive health and health care concerns also on the availability of RCH services should be strengthens to the public.
2. Improve awareness and health care quality through partnership with various civil society organization/ Non-government Organizations (NGO's) and community organizations who work with health issues and government must partner with such organizations.
3. To include community participation in framing any development policy which will directly related to the context of the community.
4. Improve health care through community organizations and proper monitoring of health programmes implemented by the government and took quality health care facilities availability.
5. Extensive social research based study particularly on tribal women needs to be done to show the prevalence of reproductive health issues and concerns.

BIBLIOGRAPHY

Aarti,Srivastava.A.,Salini Singh,Seema Mehlotra.,Sushma Pandey,Anjoo Agarwal., & Vinita Das. (2008). Emergency contraceptive Knowledge, Attitude and Practice Among Women Attending a Teaching Hospital of North India (PP 72-77). *Journal of Family Welfare, 54 (2), 72-77. December 2008, ISSN-0022-1074.*

C. B. (2014). Reproductive Health Problems of Women in Rural Areas. *The International Journal of Social Sciences and Humanities Invention, 1* (2), 95-101.Retrieved March6,2017,from http://valleyinternational.net/index.php/theijsshi/article/view/

Census of India. (2011). Retrieved February23, 2017, from https://en.wikipedia.org/wiki/Scheduled_Castes_andScheduled_Tribes

District Census Handbook Churachandpur. (2011) *Part*- XII A ed.,. Imphal, Manipur: Directorate of Census Operation. (15) 1-280. Retrieved March 6, 2017, fromhttp://censusindia.gov.in/2011census/dchb/DCHB_A/14/1403_PART_A_DCHB_CHURACHANDPUR.pdf Census of India 2011 Manipur

District in Manipur Retrieve January 2018 from http://manipur.gov.in/?page_id=619

Gazette notification declaring creation of 7 new districts in Manipur. Retrieve, from February 2018 from http://manipur.gov.in/wp-content/uploads/2016/12/creation-of-7-district-1-2.pdf

Gangopadya,Bhaswati.,Das & D.N.(1997).Quality of Family Planning services in India. The user's perspectives, *The Journal of Family Welfare*, 42.December 1997.

Gupta,S.D. (1998). Reproductive Health Awareness Behavior amongst Adolescent: Multi centric study: ICMR. New Delhi.

Geeta, A., Joseph, S., Bhattacharjee, L., Abraham, J. Rao &P.S.S.(1997).General and Reproductive Health of Adolescent Girls in rural South India, Indian Pediatrics, 34 (3).

G. M. (2013). Prevalence of Reproductive Tract Infections among Rural Married Women in Tamil Nadu, India: A Community Based Study. *Journal of Pioneering Medical*

Sciences, 4 (1). Retrieved April 20, 2017, from http://www.jpmsonline.com/jpms-vol4-issue1-pages18-24-oa.html

Jejeebhoy,S.J.(1996). Adolescent Sexual and Reproductive Behaviour: A Review of the Evidence from India,Working Paper No.3, International Council for Research on Women.

Jejebhoy, S.J.(2000). Adolescence Sexual and Behavior: A review of the evidence from India. R.Ramasubban, S.Jejebhoy,(eds).Women's Reproductive Health in India, Jaipur: Rawat Publications.

Kishore, J., (2002): National Health Programmes in India- National Policies and Legislation related to Health, 4th edition, Century Publication, New Delhi, pp. 17-18.

Kumar,R.,Meenal,R.,& Ganguly M.K.(2009). Earlymid life and women's Health. Encyclopedia of women Health & Empowerment. New Delhi: Deep & Deep Publications.

Liamputtong Pranee.(2010). Focus Group Methodology: Introduction & History: RetrieveMarch4,fromhttp://www.sagepub.com/sites/default/files/upmbinaries/39360_978_1_84787_909_7.Pdf

List of District Manipur Retrieve March 2017 from https://census2011.co.in/census/state/districtlist/manipur.html

Manipur Population Census 2011/ Manipur Religion, Caste Data- Census 2011. Retrieved Febuary 2017 from https://www.censusindia.co.in/states/manipur

Maiti, S., Unisa, S., & Agrawal, P. K. (2005). Health Care and Health Among Tribal Women in Jharkhand: A Situational Analysis. *International Institute for Population Sciences, 3*(1), 37-46. Retrieved May 7, 2018, from http://krepublishers.com/02-Journals/T & T/T & T-03-0-000-000-2005-Web/T & T-03-1-000-000-2005-Abst-PDF/T & T-03-1-037-046-2005-050-Maiti-Sutapa/T & T-03-1-037-046-2005-050-Maiti-Sutapa-Full-Text.pdf

M. Devi Tineshwari (2010). Reproductive Health and Adolescent Girls, New Delhi: Akansha Publishing House.

MisraRajiv, Chateerjee Rache.,& Rao Sujatha.(2003). India Health Report. New Delhi: Oxford University Press.

Madani, M.(2004): New Priorities: Adolescent Reproductive Health in India. Retrieve January 13, 2017, from http://www.Ishtm.ac.uk/cps/dfid/100.html

Maternal Health in Manipur.(2012).Retrieved March11, 2017, from http://journalofdevelopment.wordpress.com/2012/10/05/maternal-health-in-manipur/

Prusty, R. K., & Gogoi, M. (n.d.). Reproductive Health Complications among Tribal Women in India: A Special Focus on North-East India. *Etawah Journal of Social Sciences*, 8-14. Retrieved March 7, 2017, from https://www.academia.edu/5144412/Reproductive_Health_Complications_among_Tribal_Women_in_India_A_Special_Focus_on_North-East_India

National Family Health Survey *(NFHS-4) 2015-16* (pp. 1-241, Rep.). (n.d.).Mumbai: IIPS: International Institute for Population Sciences (IIPS) and ICF. 2017. National Family Health Survey (NFHS-4), 2015-16: India. Retrieved April 28, 2018, from http://rchiips.org/NFHS/NFHS-4Reports/India.pdf

National Family Health Survey - 4 India. Factsheet. (2015-16). Retrieved March 13, 2017, from http://rchiips.org/NFHS/nfhs4.shtml

National Family Health Survey- 4 State. Factsheet.(2015-16). Retrieved March 13, 2017, from http://rchiips.org/NFHS/factsheet_NFHS-4.shtml

National Family Health Survey-4 District.Factsheet. (2015-2016). Retrieved March13, 2017, from http://rchiips.org/NFHS/districtfactsheet_NFHS-4.shtml

National Rural Health Mission. Retrieved March 10, 2017, from http://nhm.gov.in

http://nhm.gov.in/janani-shishu-suraksha-karyakram.html

National Rural Health Mission. Retrieved March 10, 2017, from http://nhm.gov.in

http://nhm.gov.in/images/pdf/programmes/guidelines-for-jssk.pdf

Naidu,T.(2007).Tribal Health in India: Problems and Future Prespectives.Ponducherry: Pinnacle computer offset.

Ngurte Village Population–Churachandpur Manipur. Retrieve March 13, 2017 from http://www.census2011.co.in/data/village/269661-ngurte-manipur.html

Prusty, R. K., & S. U. (n.d). Reproductive Tract Infections and Treatment Seeking Behavior among Married Adolescent Women in India. *International Institute for Population Sciences*. Retrieved March 2018 from

https://iussp.org/sites/default/files/event_call_for_papers/049IUSSP_RKP.pdf

Prasad, J. H., S. A., Kurz, K. M., George, V., Lalitha, M., John, R.Joseph, A. (2005). Reproductive Tract Infections Among Young Married Women in Tamil Nadu, India. *International Family Planning Perspectives, 31*(2), 73-82. Retrieved February6,2018,from https://pdfs.semanticscholar.org/4316/7a6531811ae73251a1af9472768896c0d8d8.pdf

Rao, Durga.P.(2007). Access to maternal and child health care services: A study among Racha Koyas of Warangal District of Andhra Pradesh.

Reddy,P.J.,Rani Usha.D.,Reddy.G.B & Reddy.K.K (2005). Reproductive Health constraints of Adolescent school girls. 66 (44), 431-441. *The Indian Journal of Social work, .October 2005, ISSN 0019-5634.*

Rose Nembiakim (2008). Reproductive Health Awareness among the Tribal women in Manipur. New Delhi: Concept Publishing Company.

Ramana, Usha Rani.(2014).Reproductive Health status – issues and concerns of tribal women in Andhra Pradesh. *Journal of Interantional Acedemic Research for Multi displinary Impact Factor* 1 (393).

Sangam, S. M.(2015).*Reproductive Health Status of Women in Rural Bijapur* (Unpublished master's thesis).Karnataka State Women's University. Retrieved April 28, 2017, from http://shodhganga.inflibnet.ac.in/handle/10603/73497

Salem Veng Population- Churachandpur, Manipur. Retrieved, May 15 2017 from http://www.census2011.co.in/data/village/269577-salem-veng-manipur.html

Sinha Sanjay.(2014).Health and Development in North-East India. New Delhi: Mittal for Mittal Publications.

Srinivasan.(2010).Reproductive Health care of tribal women in Kolli hills at Nammakal District, Tamil Nadu. Retrieved February 10, 2017, from www.academia.edu/5056156/

Sexual and Reproductive Health of young women in india. (2014, July). Retrieved March 14, 2017, from https://www.guttmacher.org/factsheet/2015/sexual-and-reproductive-health

Thilothammal N., Ramanujam, S., Banu, K.,Ratnam, S.randEzhilarisa. S.(1993). The Nutritional Status of South Indian women in Child bearing Age and its influence on Birth Weight and Maturity of Offspring. 43, (6) *The Journal of Obstetrics and Gynecology of India*.

United Nations Population Information Network (UN Population Division, Department of economic and Social Affairs, with support from the UN Population Fund (UNFPA), Guidelines. Retrieved March 9, 2017, from http://www.un.org/popin/unfpa/taskforce/guide/iatfreph.gdl.html

World Health Organization (WHO), (2010). Reproductive Health Indicators Guidelines for their generation interpretation and analysis of global monitoring. Retrieved March7, 2017, from http://whqlibdoc.who.int/publications/2006/92415635 x_eng.pdf

Z. M., S. M., A. K., & S. G. (2001). Antenatal Care, Care-seeking and Morbidity in Rural Karnataka, India: Results of a Prospective Study. *Asia-Pacific Population Journal, 16, (2).* 27-28. doi:10.1136/sextrans-2013-051184.0538