

## Research Paper



## ECONOMIC ANALYSIS OF REPRODUCTIVE HEALTH STATUS OF SOLIGA TRIBAL WOMEN IN CHAMARAJANAGAR, DISTRICT - KARNATAKA

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### ABSTRACT

**The present research aimed to study the Economic Analysis of Reproductive Health Status of Soliga Tribal Women Chamarajanagar, District - Karnataka. 261 sample were selected based on stratified random sampling method. In order to examine the economic factors related to health care services on reproductive health among selected respondents. Well structured questionnaire were used for data collection. To test the hypotheses statistical tool such as Chi square test and t-test were used. Result found that respondents significantly differ in their health services on reproductive health status.**

**KEYWORDS:** Reproductive health services, Pregnancy knowledge, Health component and Mode HIV/AIDS transmission.

### INTRODUCTION

Humans' reproductive system is complex phenomenon, and a system it consists of vivid complicacy in term of health and health seeking related issues. primarily the health related issues in context with reproductive health it refers to morbidity, life attributes and its quality and mortality attributes of individuals reproductive system. this process and is experienced by all women and men after certain period of life, especially after puberty. in comparison men women experience more issues related to reproductive health due to their having natural ability of becoming pregnant and going through all the process before and after pregnancy. For example. Zurayk (1993) define reproductive health as "The ability of women to live through the reproductive years and beyond with reproductive choice, dignity, and successful childbearing, and be free of gynecological disease and risk". The international Conference on the Population and Development (ICPD, 1994) defined reproductive health in generic terms but stressed the importance of women's reproductive health.

Reproductive morbidity is a broad concept that encompasses health problems related to reproductive organs and functions, including and outside of childbearing. Reproductive morbidity can be broadly categorized into three subgroups: obstetric morbidity, gynecological morbidity includes health problems outside pregnancy such as RTIs, menstrual problems, cervical ectopic, infertility, cancers, prolepses and problems, related to intercourse. Contraceptive

morbidity includes conditions, which result from efforts to limit fertility includes conditions, which result from efforts to limit fertility whether they are traditional or modern methods. Reproductive morbidity in general, is an outcome of not just biological factors but of women's poverty, powerlessness and lack of control over resources as will. Malnutrition, infection, early and repeated childbearing and high fertility also play an important role in poor maternal health conditions in India.

Indian's maternal mortality ratio (MMR) is highest in South Asia; 540 deaths per 100,000 live births or one women dying roughly every five minutes. An estimated 1,36,000 women die in India every year due to pregnancy related setbacks. The number of maternity- related deaths which occur in a week in India is equivalent to a whole year in Europe. However government has not taken any effective measuring till date. Despite the fact that an high fatalities occur among women in a year due to poor reproductive health practices no one is exercised enough to create a movement for improving women's health.

Reproductive health is explained as a state of complete physical, mental and social well-being and not merely the absence of diseases, in all matters relating to reproductive system. It is pertinent to point out the reproductive a satisfying and safe sex life and that they have the capability to reproduce and freedom to decide their reproductive choices. Further, reproductive health problems such as early and unwanted childbearing, HIV and other sexually transmitted infections, and pregnancy- related illness



and death account for a significant part of the burden of disease among adolescents, adults and married of both sexes in developing countries. According to the World Development Report 2006, sexual and reproductive health, problems account of the burden among women of reproductive age. In other world, at least 18 percent of all disability adjusted life were caused by reproductive health problems.

Reproductive health problems are particularly concentrated among the poor who often lack access to minimum reproductive health care. As estimated 120 million wish to space and limit fertility but lack access to family planning (WDR, 2006), Prevention is the most-cost effective approach to addressing most reproductive health problems. Series problems are costly and very difficult to solve once manifest. The adverse consequences of poor reproductive health and the benefits of good reproductive health, extend well beyond health, and have an impact at the societal level. For example, early childbearing can have negative health and social consequences for young mothers and lasting health related effected on their children. On the other hand good reproductive health increases productivity and will-being of the people, facility and ultimately the nation and world at large.

## REVIEW OF LITERATURE

**Goldani, (2002)** Determined the trends of infant mortality from 1995 to 1999 according to a maternal education in porto -alegre in Rio Grande do sul, Brazil, They found out that the IMR, decreased steadily from 18.38 deaths per 1000 live births in 1998 to 12.21 in 1999 ( Chi-square from trend  $p < 0,001 >$ ). Both neonatal and post -Neonatal mortality rates decreased although the drop seemed to be steeper for the Post -Neonatal component. The higher decline was seen in proper areas. This paper conducted that inequality in IMR seen to have decreased due to a steeper reduction in both neonatal and Post- Neonatal component of infant mortality in lower maternal schooling area.

**Rajoice, (2012)** This research has been taken to reproductive health status of Scheduled Caste married women, regarding in rural areas of Thiruvavur district of Tamil Nadu state. Multistage stratified random sampling technique was applied to select the respondent from the Thiruvavur district. There were 1164 households with the target population. Totally 1203 women in the age group of 15-25 were identified in all the five blocks. A total of 605 respondents were selected by systematic random sampling Nearly three-fifth of the scheduled cast women experienced any one kind of health problem during their pregnancy period (58.2 percent ) and also half of the SC women experienced any one kind of delivery complication during their latest child delivery (49.4 percent). It is observed that education of women, standard of living condition, age at marriage and number of ANC visit were satisfactory significant with the prevalence of any one pregnancy related health problem among SC population.

**Subarna Roy (2014)**, The south Indian state of Karnataka, one part of several kingdom and princely status of repute in the Deccan peninsula, is rich in its historic, and anthropological heritage. The state is the home to 42,48,987 tribal people, of whom 50,870 belong to the primitive group. there are as many as 50 different tribal notified by the Government of India, living in Karnataka, of which 14 tribes including two primitive ones, are primarily natives of this state. Extreme poverty and neglect over generation have life them in poor state of health and nutrition. It is however, interesting to note that most of these tribes who had been original native of the forests of the Western Ghats have been privy to an enormous of knowledge about various medicinal plants and their use in traditional medicine and these practice have been the subject matter of various scientific studies. this article is an attempt to list and map the various tribes of the status of Karnataka.

## METHODOLOGY

### Objectives

1. To analysis of reproductive health status of soliga tribal women.
2. To identify the type of Health centre availed by the respondents for reproductive health services.
3. To know the pregnancy primary sources of knowledge based on taluk wise distribution.

### Hypothesis

- There is no association between respondents type of Health centre availed by the respondents for reproductive health services.
- There is no association between respondents' pregnancy primary sources of knowledge based on taluk wise distribution.
- There is no association between respondents component of RPH knowledge based on taluk wise distribution.
- There is no association between respondents' knowledge mode HIV/AIDS transmission based on taluk wise distribution.

### Sampling

261 sample were selected based on stratified random sampling method.

### Method of data collection

Well structured questionnaire were used for data collection.

### Statistical tools used

Statistical tool such as Chi square test and t-test were used.

**RESULT AND DISCUSSION****Table-1 Type of Health centre availed by the respondents for reproductive health services**

S. No	Taluk wise distribution	Agencies avail Service in tribal villages				Total
		Govt	Private	PPP Health Initiative	Personal visiting	
1	Gundlupet	30 (30.92)	15 (28.85)	26 (33.33)	7 (20.59)	78 (29.88)
2	Chamarajanagar	26 (26.80)	12 (23.07)	24 (30.77)	10 (29.41)	72 (27.59)
3	Yelandur	25 (25.78)	16 (30.77)	13 (16.67)	9 (26.48)	63 (24.13)
4	Kollegal	16 (16.50)	9 (17.31)	15 (19.23)	8 (23.52)	48 (18.40)
Total		97 (100.0)	52 (100.0)	78 (100.0)	34 (100.0)	261 (100.0)

ANOVA						
Source of Variation	SS	df	MS	F	P-value	F crit
Rows	704368	4	140873.6	7.992496	0.000758	2.901295
Columns	265100	4	88366.67	5.013503	0.013246	3.287382
Error	264386	16	17625.73			
Total	1233854	24				

It is observed from that the taluk wise distribution and agencies avail service in tribal villages. The obtained result proved that, in the Gundlupet taluk, 30.92% of the respondents avail government services, 28.85% of the respondents avail private services, 33.33% of the respondents avail public private partnership health initiative and 20.59% of the respondents do personal visiting. Also in Chamarajanagar taluk, 26.80% of the respondents are government, 23.07% of the respondents are private, 30.77% of the respondents are public private partnership health initiative and 29.41% of the respondents do personal visiting. In Yelandur taluk, 25.78% of the respondents avail government services, 30.77% of the respondents avail private services, 16.67% of the respondents are public private partnership health initiative and 26.48% of the respondents do personal

visiting. Further in Kollegal taluk, 16.50% of the respondents avail government services, 17.31% of the respondents avail private services, 19.23% of the respondents are public private partnership health initiative and 23.52% of the respondents are personal visiting.

It is inferred from the ANOVA table that the calculated P-value is significant.  $P < 0.01$ . So the null hypothesis is rejected and alternate hypothesis is accepted. So it is concluded that there is a significant difference in respondents availing of various agencies for their health service. Most of the respondent's preferred/availed health services from government and public private pattern health initiative. The reason for preferring there two agencies are low expenditure and availability. The study also proved many of the tribal village's utilised government and PPP for their health services.

**Table-2 Chi square test between taluk wise distribution and reproductive health and pregnancy knowledge of the respondents**

S. No	Taluk wise distribution	Pregnancy primary sources of knowledge					Total
		Female friends	Radio-TV	Health care Providers	Parents	Newspaper	
1	Gundlupet	37 (35.58)	6 (40.00)	21 (19.27)	7 (29.17)	7 (77.78)	78 (29.88)
2	Chamarajanagar	25 (24.03)	3 (20.00)	37 (33.94)	6 (25.00)	1 (11.11)	72 (27.59)
3	Yelandur	24 (23.08)	3 (20.00)	30 (27.52)	6 (25.00)	-	63 (24.13)
4	Kollegal	18 (17.31)	3 (20.00)	21 (19.27)	5 (20.83)	1 (11.11)	48 (18.40)
Total		104 (100.0)	15 (100.0)	109 (100.0)	24 (100.0)	9 (100.0)	261 (100.0)

Chi square	Df	P-value
19.32	12	0.01 Significant

The above table shows that the chi square test between taluk wise distribution and pregnancy primary sources of knowledge. The obtained result shows that, in the Gundlupet taluk, 35.58% of the respondents are female friends, 40% of the respondents are Radio TV, 19.27% of the respondents are health care providers, 29.17% of the

respondents are parents and 77.78% of the respondents are newspaper. In Chamarajanagar taluk, 24.03% of the respondents are female friends, 20% of the respondents are Radio TV, 33.94% of the respondents are health care providers, 25% of the respondents are parents and 11.11% of the respondents are newspaper. Also in Yelandur taluk,

23.08% of the respondents are female friends, 20% of the respondents are Radio TV, 27.52% of the respondents are health care providers and 25% of the respondents are parents. Further in Kollegal taluk, 17.31% of the respondents are female friends, 20% of the respondents are Radio TV, 19.27% of the respondents are health care providers, 20.83% of the respondents are parents and 11.11% of the respondents are newspaper.

The Chi square test is applied for further discussion. The calculated chi square value 19.32 at 12 degrees of freedom is significant at 0.01 level. Therefore, it is concluded that the alternative hypothesis that “there is an association between respondents’ pregnancy primary sources of knowledge based on taluk wise distribution” is accepted. Therefore, the null hypothesis is rejected. Therefore the study shows that most of the respondents received knowledge from friends and health care provide. **Balwan Singh (2014)** also supported the present study.

**Table-3 Chi square test between taluk wise distribution and respondents reproductive health component knowledge**

S. No	Taluk wise distribution	Component of RPH Knowledge					Total
		Family planning	Ante-natal care	Natal-care	Post-Natal care	Abortion	
1	Gundlupet	23 (48.93)	26 (24.53)	11 (16.41)	11 (39.29)	7 (53.84)	78 (29.88)
2	Chamarajanagar	7 (14.90)	34 (32.07)	25 (37.32)	5 (17.86)	1 (7.70)	72 (27.59)
3	Yelandur	7 (14.90)	26 (24.53)	18 (26.87)	9 (32.14)	3 (23.07)	63 (24.13)
4	Kollegal	10 (21.27)	20 (18.87)	13 (19.40)	3 (10.71)	2 (15.39)	48 (18.40)
Total		47 (100.0)	106 (100.0)	67 (100.0)	28 (100.0)	13 (100.0)	261 (100.0)

  

Chi square	Df	P-value
26.61	12	0.001 Significant

The table 2 shows that the chi square test between taluk wise distribution and component of RPH knowledge. The obtained result shows that, in the Gundlupet taluk, 48.93% of the respondents are family planning, 24.53% of the respondents are ante-natal care, 16.41% of the respondents are natal-care, 39.29% of the respondents are post natal-care and 53.84% of the respondents are abortion. In Chamarajanagar taluk, 14.90% of the respondents are family planning, 32.07% of the respondents are ante-natal care, 37.32% of the respondents are natal-care, 17.86% of the respondents are post natal-care and 7.70% of the respondents are abortion. Also in Yelandur taluk, 14.90% of the respondents are family planning, 24.53% of the respondents are ante-natal care, 26.87% of the respondents are natal-care,

32.14% of the respondents are post natal-care and 23.07% of the respondents are abortion. Further in Kollegal taluk, 21.27% of the respondents are family planning, 18.87% of the respondents are ante-natal care, 19.40% of the respondents are natal-care, 10.71% of the respondents are post natal-care and 15.39% of the respondents are abortion.

The Chi square test is applied for further discussion. The calculated chi square value 26.61 at 12 degrees of freedom is significant at 0.001 level. Therefore, it is concluded that the alternative hypothesis that “there is an association between respondents’ component of RPH knowledge based on taluk wise distribution” is accepted. Therefore, the null hypothesis is rejected. So, most of them have knowledge about ante natal care.

**Table-4 Chi square test between taluk wise distribution and respondents knowledge mode HIV/AIDS transmission**

S.No	Taluk wise Distribution	HIV /AIDS Transmission				Total
		Sexual Intercourse	Blood transfusion	Syringes	Mother to child	
1	Gundlupet	54 (27.28)	1 (100.00)	9 (47.36)	14 (32.56)	78 (29.88)
2	Chamarajanagar	5 (27.78)	-	3 (15.79)	14 (32.56)	72 (27.59)
3	Yelandur	53 (26.76)	-	4 (21.05)	6 (13.95)	72 (27.58)
4	Kollegal	36 (18.18)	-	3 (15.79)	9 (20.93)	48 (18.40)
Total		198 (100.0)	1 (100.0)	19 (100.0)	43 (100.0)	261 (100.0)

  

Chi square	Df	P-value
36.79	9	0.001 Significant

The above table shows that the chi square test between taluk wise distribution and respondents knowledge mode HIV/AIDA transmission. The obtained result shows that, in the Gundlupet taluk, 27.28% of the respondents are sexual intercourse, 100% of the respondents are blood

transfusion, 47.36% of the respondents are syringes and 32.56% of the respondents are mother to child. In Chamarajanagar taluk, 27.28% of the respondents are sexual intercourse, 15.79% of the respondents are syringes and 32.56% of the respondents are mother to child. Also in

Yelandur taluk, 26.76% of the respondents are sexual intercourse, 21.05% of the respondents are syringes and 13.95% of the respondents are mother to child. Further in Kollegal taluk, 18.18% of the respondents are sexual intercourse, 15.79% of the respondents are syringes and 20.93% of the respondents are mother to child.

The Chi square test is applied for further discussion. The calculated chi square value 36.79 at 9 degrees of freedom is significant at 0.001 level. Therefore, it is concluded that the alternative hypothesis that "there is an association between respondents' knowledge mode HIV/AIDS transmission based on taluk wise distribution" is accepted. Therefore, the null hypothesis is rejected. Most of them received knowledge that through sexual intercourse the HIV/ AIDS spread.

## FINDINGS

**Based on the statistical analysis the following findings are arrived. They are:**

- ◆ Result shows that the alternative hypothesis that "there is an association between respondents' pregnancy primary sources of knowledge based on taluk wise distribution" is accepted.
- ◆ Survey exhibits that the alternative hypothesis that "there is an association between respondents' component of RPH knowledge based on taluk wise distribution" is accepted. Therefore, the null hypothesis is rejected. So, most of them have knowledge about ante natal care.
- ◆ Research proved that the alternative hypothesis that "there is an association between respondents' knowledge mode HIV/AIDS transmission based on taluk wise distribution" is accepted. Therefore, the null hypothesis is rejected. Most of them received knowledge that through sexual intercourse the HIV/ AIDS spread.

## SUGGESTION

Regarding economic analysis of reproductive health status of soliga tribal women the present study identified that the primary health centre is only available near to their residence. So the government hospital with all facilities has to be made accessible. This will help to avail all the health services. For their reproductive health, most of them accessed home remedy. Since they have low knowledge related to health education and have low income. Because of low income they are unable to receive good services. Therefore the concerned department should take necessary steps to create employment and to develop their economic position. Also the NGOs and health department should take necessary steps to create awareness about health education. This will help to improve their awareness. Also the study identified that they need improvement in the quality of services provided by public health sector. So the government allotment found for that should also take necessary action to improve their income generation.

## REFERENCE

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