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# EMPOWERMENT OF TRIBAL WOMEN FOR HEALTH DEVELOPMENT

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## Abstract

Maternal and reproductive health is a social phenomenon as much as a medical event. Where access to and use of maternal and reproductive health care services are influenced by contextual factors. The failure of reaching the targets of MDG 5 is increasingly being analyzed and discussed in terms of equality and, recently, there have been calls for a greater understanding of the patterns of inequality in health within different contexts. Culyer has suggested that because of their vulnerability, disadvantaged groups should be identified as a first step towards rectifying inequities in health. Further, there is a need to go beyond identifying single determinants if inequality in health, and to illuminate the inter-relationship between social and structural determinants.

**Keywords:- Health Profile of Tribal Women, Empowerment for Health Care Seeking, Women Empowerment and Health, Impact of Gender Bias on Health and Nutrition of the Tribal Women, Reproductive Health, Empowerment of Tribal Women.**

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## Introduction

Inequalities in health are not only the unequal distribution of health but also the unfair distribution of health due to unfair or inadequate social arrangements. Key features of health inequities are that they are socially produced, systematic in their distribution across the population, and unfair. Defining and identifying health inequities thus involves analysis with respect to social justice and the social determinants of health. To enhance the understanding of how inequities in health are rooted in societal structures, the commission on social determinants of health (CSDH) developed a conceptual framework of the social determinants of health inequities.[1] This is an action-oriented framework, applicable to identify entry points for interventions and policy that could reduce inequities in health in a specific setting. It is based on the notion that health inequities emerge from a systematically unequal distribution of power, prestige, and resources among groups in society.

## Health Profile of Tribal Women

In the present study, the health from the perspectives of mortality patterns and selected infectious and non-infectious illnesses were reviewed. The prevalence of sexual transmitted disease syndromes in adults tribal population of central India reported that of 2568 individuals interviewed, 326 (12.7 per cent) carried at least one STD syndrome.

The iodine deficiency disorder, namely goiter, was found among 4.2 per cent to 6.0per cent of individuals. The morbidities in children were acute respiratory infections followed by acute diarrheal diseases, conjunctivitis and skin infections. The various measures of infant and child mortality among tribal population were high as compared to any other segment of the population. The average number of

illnesses per elderly person was 3.0 common disabilities like vision and hearing impairment and mobility-related problems were found in considerable numbers.[2]

Tuberculosis TB is an infectious disease that poses a major threat to women's health security and its burden is enormous. Women are at increased risk of progression to TB during their reproductive years. Prevalence of TB infection was estimated from tuberculin survey and the computed annual risk of tuberculosis inflection (ARTI) is an indicator to assess the extent of transmission of infection with Mycobacterium tuberculosis. In India the ARTI rates ranged between. 1.0per cent and 1.9 per cent in different zones of the country according to in a nationwide survey conducted during 2000-2003. Very little information is available on the ARTI among tribal populations of India. A survey carried out in a tribal population of north Arcot district in south India showed an inflection prevalence of 5 per cent with computed ARTI of 1.1 per cent. In a survey conducted among Saharia, a tribal community of Madhya Pradesh, the prevalence of infection and ARTI were very high being 16.9per cent and 3.6 per cent respectively. Another survey carried out in tribal community of car Nicobar island showed that the prevalence of infection and ARTI were 16.4 per cent and 2.4 per cent respectively.[3]

National family health survey (NFHS-3) is the first national survey in India to include HIV testing. It was designed to provide a national estmate of HIV in the household population of women aged 15-49 years. The prevalence of HIV among tribal population is very low-0.25 (female 0.12 and male 0.39). There is lack access it services and opportunities for women to protect themselves and negotiate for the safe sex, which endangers them to a greater risk of HIV infection.

## Empowerment for Health Care Seeking

Health service utilization has been associated with several sociodemographic factors such as age, gender and socio-economic status. A study on the health seeking behaviour and acceptability of provided health facilities among the tribal of west Godavari district in Andra Pradesh showed that despite the socio-economic background of the tribals, their attitude towards health and health facilities learned towards modern medicine and 96per cent of the respondents were of the opinion that there was a difference in the present day health seeking behaviour as compared to that of their ancestors. However, NFHS-3 reported that the likelihood of having received any antenatal care and care from a doctor is lower among the tribal mothers. Only 18 per cent of births among scheduled tribe are delivered with health facilities. The common beliefs, customs, practices related to health and diseases in turn influence the health seeking behaviour of the community.[4] The necessary bahavioural changes and managerial control of women can significantly contribute women for making necessary changes regarding their health care seeking bahaviour.

## Women Empowerment and Health

Due to variety of reasons, tribal health is less optimal as compared to the health of general population. And, women need to be empowered to bridge the gap in different spheres. The empowerment of women has been widely acknowledged as an important factor that influences health and social outcomes, yet only few studies have examined this. Women are the prime targets of programmes that aim at improving maternal and child health and achieving other desired demographic goals.

An understanding of the status and empowerment of women in society and within their households in thus critical to promoting changes societies. Notably; the national population policy, 2000 specifically identified the low status of women in India as an important barrier to the achievement of population and maternal and child welfare goals. 41 the world bank has identified empowerment as one of the key constituent elements of poverty reduction, and as a primary development assistance goal.[5] The bank has also made gender mainstreaming a priority in development assistance, and is in the process of implementing an ambitious strategy to this effect. The promotion of women empowerment as a development goal is based on the argument that social justice is an important aspect of human welfare and is intrinsically worth pursuing, and that women empowerment is a means to meet other needs.

**Impact of Gender Bias on Health and Nutrition of the Tribal Women**

It is well known that Indian treats its women badly. The world economic forum (WEF) measuring gender equality around and world has placed India shockingly at the bottom, at the 113$^{th}$ position out of 130 countries, such as Bangladesh and the United Arab Emirates. The ranking which were topped by Norway, are based on how much progress the nations have made in the areas of jobs, education, politics and health as a measure of gender parity. While India has scored remarkably well in the area of political empowerment-owing perhaps to reservations for women in village panchayats-in the areas of economic participation and health and survival, Indian women are worse off than all of the counterparts. Particularly, the significant is the abysmal ranking India has achieved in the health and survival category. India's ranking 128 out of the 130 countries surveyed, manages to place ahead only of Azerbajjan and Armenia.

Gender based disparity includes any kind of verbal or physical force, coercion or life threatening deprivation, directed at an individual, girl or women. This deprivation may cause the physical or psychological harm, humiliation or deprivation.

The inequality is not due to sex, but due to the social attributes which govern the living of men and women. The biological difference in sex at birth does not determine the preferential environment created for male and female in our society. Gender is socially learned behaviour associated with men women with the expectations.[6] In the Indian society, different roles are ascribed to two sexes. The expected behaviour from each sex is different and there is discrimination in vesting power and control in the family and community. Men and women do not enjoy equal opportunities in decision making and they do not have equal access to and control over various kinds of resources in the family. Women's opinions are seldom valued even in the matters of pregnancy, abortions often bring in adverse consequences like anemia, reproductive tract infections, uterine prolepses and urinary incontinence.

This subordinate status of women in the Indian society deeply influences their health status. Excessive emphasis on one biological aspect (child bearing) leads to early marriage, repeated pregnancies, abortions (preference to male child) and reproductive problem are compounded. Added to this, lack of adequate nutrition-party due to poverty and partly due to lack of freedom-limited or no opportunity to rest and relax further aggravates women's reproductive health.

Gender inequality in every domain of life is setting back the achievement of the millennium development goals (MDGs). A thorough commitment to accountability

towards women alone holds the key to realizing these goals. That's the message given by "progress of the world's women 2008/2009: who answer to women". Unless gender equality becomes a standard against which all public decision and outcomes are gauged, accountability to women cannot be ensured. This requires that egalitarian norms be ensures. This requires that egalitarian norms be brought in force where they are absent, and existing ones enforced to ensure that women get their due in politics and governance, in access to public services, in economic opportunities, justice, and even in the distribution of assistance for development and security.

**Reproductive Health**

Another worrying global fact is that maternal mortality is dropping very slowly-at just 0.4 per cent a year, compared to the 5.5 percent needed to meet the MDG to improve maternal health. This has been attributed to the fact that health services and schools are often too far off or too costly, and agricultural services are male oriented. Thus, the litmus test of government accountability is service delivery that responds to women's needs. But this is a formidable challenge in many parts of the world including in India. The very meaning of accountability undergoes a shift when women come into the picture, as women's experiences and perceptions are significantly different from men's. so women perceive higher levels of corruption in public services.

Maternal mortality ratio (MMR) is the number of maternal deaths (during pregnancy, childbirth and puerperal period) per one lack live births, but unfortunately, no reliable significant data available on these aspects even on general population in India, what to talk about tribal people.

**Empowerment of Women**

To ensure gender equality and empowerment of women in terms of educational parity should be within reach. But to replicate this in political representation and employment is still a distant reality. Greater political representation of women ensures a greater silence of women's issues in policy making. However, at the present rate of increase, it will take 40 years for women in developing countries to reach the parity zone of 40 to 60 per cent of seats in assemblies and in the parliament of the country.

The national population policy (NPP) 2000 and reproductive and child health (RCH) programme in India has reflected paradigm shift from earlier demographically driven target oriented coercive policy to emphasis on human development, gender equality, adolescent reproductive health and rights, and development of issues related to stabilizing Indian population.

The female age at marriage is low relative to the legal minimum age of 18 years in comparison to men (21 years). Age at marriage has far reaching consequences on fertility rates, child bearing, and other health issues such as infant and maternal mortality, menarche or the onset of menstruation cycle constitute the land mark for female entry into the institution of marriage.[7] Women are pressurized to have children soon after their marriage in order to prove their fertility and worth. Hence adolescent marriage becomes synonymous with adolescent child bearing. Early marriage has adverse effects on the health of mother and child. The high rate of maternal, neo-natal infant and child deaths are positively associated with early marriages. Female education and raising investment on adolescents social and economic prospects, and enhancing their self esteem can do a lot of improvement in their health, nutrition and development.

## Conclusion

Findings from studies among tribal groups in Bastar district shows maternal and childcare is largely neglected. Proper and preventive health practices like immunization and vaccination of expectant mothers as well as new borns was largely absent. From inception to termination of pregnancy, no specific nutritious diet is consumed by women. The consumption of iron calcium and vitamins during pregnancy is poor. More than 90 per cent of deliveries are conducted at home attended by elderly ladies of the household. In addition a lot of females suffer from ill health due to pregnancy and childbirth in the absence of well defined concept of health consciousness.

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