

Demography of the Tribal Groups of Rajasthan: 5. Dynamics of Family Planning Methods Usage

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KEYWORDS Fertility. Family Planning Methods. Tribal Groups. Rajasthan

ABSTRACT In the present study an attempt has been made to appraise women's knowledge of contraceptive methods and also the usage of family planning methods among tribal groups of Rajasthan. Knowledge of contraceptive methods is widespread among all population groups, particularly the permanent methods. However, usage of contraceptives is not that widespread. Among all the methods, the most commonly used are the permanent methods especially tubectomy. This is followed by IUDs.

INTRODUCTION

The control of fertility and use of family planning or contraceptive methods are of vital importance for all developing nations, like India, and states, like Rajasthan, where high fertility and declining mortality rates have led to an explosive growth of population. In other words, due to still untamed fertility rates hampering the human goals of development and well being, these nations/states advocate the need for Planned Parenthood, which refers to adoption of some birth control measures.

Even though India in 1952 became the first country of the world to adopt an official family planning programme, the results are not entirely satisfactory. In addition, a diverse picture regarding, knowledge, attitude and practice across the states of India is evident due to differentials in socio-economic, cultural factors, type of infrastructure availability. In India the programme promotes responsible parenthood with a two child family norm (regardless of the sex of the child) through the voluntary use of contraceptive methods and a variety of maternal and child health care schemes (Family Planning Programme in India, 1991-92).

The contraceptive methods provided by the programme are, vasectomy, tubectomy, intrauterine devices (IUD), oral pills, condoms, diaphragms etc. Besides, free services are provided for induced abortion or medical termination of pregnancy (MTP) as well. The family planning services are promulgated extensively through a

network of Sub-Centres, Primary Health Centres, Community Health Centres in rural areas, and hospitals, dispensaries in urban areas.

In the present, an attempt has been made to study the knowledge and usage of family planning methods and the effects of several physical environmental, economic and socio-cultural factors on the same among the Scheduled Tribe population of Rajasthan.

MATERIALS AND METHODS

The study sample comprised Scheduled Tribes, Sahariya, Mina, Bhil, Kathodi, Damor and Garasia belonging to 46 villages in Baran, Sawai Madhopur, Udaipur, Dungarpur and Sirohi districts, in Rajasthan. Altogether, a total of 900 nuclear families belonging to 661 households were randomly selected for the study (200 each from the first three Scheduled Tribes and 100 each from the last three Scheduled Tribes). A nuclear family was taken as the unit of the study.

For data collection, structured schedules developed for the purpose were utilized in addition to drawing genealogies and participant observation. The primary respondent was the ever-married woman in the household aged 15-54 years. However, the collected information was crosschecked from other members of the household as well as other locally important persons including paramedics (For details, see Bhasin and Nag, 2007).

RESULTS AND DISCUSSION

Knowledge of Family Planning Methods

Overall, in the Scheduled Tribe population,

Table 1: Knowledge and usage of family planning methods among Scheduled Tribes of Rajasthan

<i>Knowledge/Usage of Family Planning Methods</i>	<i>Sahariyas</i>	<i>Minas</i>	<i>Bhils</i>	<i>Kathodis</i>	<i>Damors</i>	<i>Garasias</i>	<i>Total</i>
<i>Knowledge of Family Planning Methods</i>							
None	0.6	-	-	-	-	1.3	0.1
Folk	87.3	78.8	82.5	76.6	78.8	53.9	78.8
Rhythm/Abstinence/Withdrawal	95.7	96.2	82.5	93.5	95.1	97.3	95.8
Condoms	89.7	90.2	90.5	79.2	83.8	55.2	84.9
I.U.D.	85.5	82.1	79.7	72.7	77.5	53.9	79.0
Pills	86.7	74.5	79.7	74.0	77.5	53.9	76.6
Tubectomy	96.9	95.7	97.3	90.9	98.8	98.6	96.5
Vasectomy	96.9	95.7	97.3	93.5	98.8	98.6	96.8
<i>Usage of Family Planning Methods</i>							
None	31.9	28.3	66.1	40.3	57.5	86.8	47.8
Folk	-	-	1.1	-	-	-	0.3
Rhythm/Abstinence/Withdrawal	28.3	17.4	7.3	-	-	9.2	13.0
Condoms	3.6	9.8	1.7	3.9	5.0	-	4.5
I.U.D.	0.6	3.3	-	2.6	-	-	1.2
Pills	3.0	12.0	2.3	2.6	3.8	-	4.7
Tubectomy	30.1	29.3	18.1	37.7	31.3	3.9	25.4
Vasectomy	2.4	-	3.4	13.0	2.5	-	2.9

knowledge of family planning methods is almost universal (Table 1), with 99 percent of currently married women recognizing at least one method of family planning. Among all the methods, sterilisation (vasectomy /tubectomy) is the most well known method, with about 97 percent of married women reporting knowledge about it. It is closely followed by the traditional methods like abstinence, rhythm (96 percent). As compared to these methods, condoms (85 percent) and modern methods like IUD (79 percent) and pill (77 percent) are relatively less known. Even knowledge of any folk method is reported by only 79 percent of married women.

Among the individual tribes, while the knowledge of at least one method is found nearly universal, when it comes to specific temporary methods, variations have been noticed. The percentages of married women having knowledge of IUDs and/or pills are the highest among Sahariyas and the lowest among Garasias. The latter group also has shown relatively poor knowledge of condoms.

According to Srikantan (1981) by 1973, knowledge of family planning methods had attained the threshold level of social acceptability and had been disseminated successfully by the government to meet the needs of eligible women for such methods in both rural and urban areas. The NFHS (National Family Health Survey, 1992-93) also found contraceptive knowledge to be nearly universal in India, with 96 percent of

currently married women having heard of at least one modern family planning method.

Usage of Family Planning Methods

In spite of knowledge of family planning methods being nearly universal among the present Scheduled Tribe population in Rajasthan, particularly the knowledge of sterilization, the percentage of ever-users of this or other family planning methods is quite low (47.8 percent). That is, slightly more than one-half of currently married women have never used any family planning method. The most commonly used method is female sterilization (25.4 percent), followed by rhythm/abstinence methods (13.0 percent). The percentages of ever-users for methods like pills, IUD, condoms, vasectomy, folk ones are very low (5 percent or less).

At the individual tribal level, the percentage of ever-users seems to vary from a low of 13.2 percent among Garasias to a high of 71.7 percent among Minas. Again, percentages of ever-users adopting female sterilization is the maximum amongst each tribe excepting Garasias, amongst whom rhythm/abstinence seem to be the most common. These traditional temporary methods are the second most commonly used ones among all others barring Kathodis, where vasectomy occupies that position (Table 1).

In India as a whole, too, it has been evident that even though the knowledge of contraception

is nearly universal, the level of usage is rather low, which remains a point of concern. According to the Ministry of Health and Family Welfare, increase in use has occurred in the past decade with the couple protection rate jumping from 22.8 in 1981 to 44.1 in 1991. However, this is still relatively low. In 1994, the percentages of eligible couples (currently) protected due to all methods, was 51.3 percent (Ministry of Health and Family Welfare, 1997).

Of all methods, sterilization is found to be highly accepted method all over country. According to the 1994 estimates, the percentage of currently protected was 30.3 percent, while in Kerala, it was 44.5 percent and in Rajasthan, it was 22.3 percent. However, the acceptance of other methods is very low. The percentage of currently protected couples in India in 1994 by conventional contraceptives was only 11.2 percent. In Kerala, as well as in Rajasthan, the estimate was only about 6 percent. And, still lesser percentages have been currently protected by IUD. Oral Pills seem to be the least accepted method, with only 2.0 percent of eligible couples in India, being protected by the same.

Nearly similar picture has been portrayed by the NFHS, India, 1992-93 too. According to this survey, current contraceptive prevalence is moderate, with 41 percent of currently married women aged 13-49 years practising family planning. Sterilization, particularly female sterilization seems to be the mainstay of the family planning programme in India, as revealed by this survey too, with 27 percent of users mentioning the same. Whereas another 3 percent seem to have accepted male sterilization, popularity of other methods such as, IUDs, pills, condoms appear rather low (only 1-2 percent of users).

In most of the major states, including Kerala and Rajasthan, more or less same scenario has been revealed by the NFHS, 1992-93. However, in Kerala the usage of sterilization, condoms and IUDs (48.3, 2.9, 3.5 percent, respectively), seem to be higher than those noticed in Rajasthan (27.7, 1.5, 1.2 percent, respectively), although in case

of usage of pills, no such difference can be seen (0.5 percent in each state).

The differential performance by state has been attributed to various socio-economic factors, which seem to be influencing the usage of family planning methods in the present Scheduled Tribe population as well (elaborated later). Jejeebhoy (1984) has investigated the causes of the transition from natural to controlled fertility in India by comparing couples who have ever used contraception with those who remained under natural fertility conditions. The results indicate that primarily the improvements in child mortality and its effects through intervening factors, which account for transition.

Age at Sterilization and Average Number of Surviving Children at the Time of Sterilization

The average age of married women at sterilization for the present Scheduled Tribe population is 31 years (Table 2). Among the individual tribal groups, the age at sterilization seem to vary within a narrow range of 28 years (among Kathodis) to 34 years (among Garasias).

The average number of living children at the time of sterilization, i.e., a permanent method, in the Scheduled Tribe population studied, is 4.44. This means that eligible couples are adopting a permanent method only when they have more than four children, which is rather damaging for demographically background population. At the individual level, the average number of surviving children is found varying from 3.18 (among Kathodis) to 5.67 (among Garasias).

Differential Usage of Family Planning Methods

Family Planning Methods Used by Age of Woman: In the present Scheduled Tribe population, the usage of family planning methods seems to increase with the increase in age of wife from 15-19 years to 35-39 years, and then decrease at ages 40-44 years. It appears that as married women realize their fertility goals by late thirties,

Table 2: Age at sterilization and average number of surviving children at the time of sterilization among Scheduled Tribes of Rajasthan

Particulars	Sahariyas	Minas	Bhils	Kathodis	Damors	Garasias	Total
Average Age at Sterilization	32	33	30	28	29	34	31
Average Number of Surviving Children at the Time of Sterilization	5.33	4.35	4.89	3.18	3.89	5.67	4.44

the usage is maximum. The women at ages 40-44 years are already the older lot, who are nearing the end of their reproductive career, so may not be using any method. Individual Tribes have also shown more or less similar picture, barring minor variations (Table 3).

Family Planning Methods Used by Occupation of Husband: The usage of family planning methods seems to be the maximum, when the husbands are working as agricultural and or casual labourers, in the present Scheduled Tribe population. The second highest percentage of users (40 percent) is seen in the category, where the husbands are engaged in cultivation. On the other hand, usage of family planning methods seems rather less, when husbands are in the service sector or when they are engaged in business. However, larger sample size may bring out a different picture. At the individual tribal level too, nearly similar differentials are noticed, barring certain exceptions. Among Minas, however, the usage is found maximum, when husbands are pursuing cultivation, and the second highest when husbands are engaged in the service sector (Table 3).

Family Planning Methods Used by Occupation of Wife: When the occupation of wife is considered, the usage is found the highest when they are economically inactive, and the second highest, when they are engaged as agricultural / casual labourers (Table 3). The usage is relatively lower when wives are pursuing cultivation, and the lowest, when they are in the service sector. Individually speaking, most of the tribes studied, excepting Sahariyas and Minas have registered this trend. While among Sahariyas, the usage level is found the highest, when women are working as agricultural or casual labourers, among Minas, the maximum usage is noticed when they are pursuing cultivation.

Family Planning Methods Used by Income: In the present Scheduled Tribe population the usage of family planning methods seems to show somewhat fluctuating trend when income is taken into consideration. The usage level is the highest when the income level is the highest, at Rs. 10,000 or less, and the lowest, when income is between Rs. 20,000 - 40,000. At the individual tribal level, the maximum usage is also seen at the lowest income level of Rs. 10,000 or less

Table 3: Differentials in usage of family planning methods (in percentage) among Scheduled Tribes of Rajasthan, by some independent determinants

<i>Independent determinants</i>	<i>Sahariyas</i>	<i>Minas</i>	<i>Bhils</i>	<i>Kathodis</i>	<i>Damors</i>	<i>Garasias</i>	<i>Total</i>
<i>Present Age of Woman (in yrs.)</i>							
15-19	8.8	0.8	1.7	2.2	5.9	-	3.8
20-24	9.7	9.8	13.3	6.5	17.6	10.0	10.6
25-29	27.4	18.2	21.7	32.6	17.6	10.0	22.8
30-34	20.4	22.0	25.0	21.7	23.5	40.0	22.5
35-39	27.4	36.4	25.0	19.6	8.8	10.0	27.1
40-44	6.2	12.9	13.3	17.4	26.5	30.0	13.2
<i>Occupation of Husband</i>							
Economically Inactive	0.9	1.5	-	-	-	-	0.8
Agricultural/Casual Labour	77.9	2.5	55.0	97.8	50.0	80.0	49.9
Cultivation	13.3	81.8	38.3	-	29.4	20.0	40.0
Petty Business	0.9	3.0	1.7	2.2	2.9	-	2.0
Service	7.1	11.4	5.0	-	17.6	-	8.1
<i>Occupation of Wife</i>							
Economically Inactive	8.0	47.0	95.0	47.8	70.6	100.0	46.6
Agricultural/Casual Labour	88.5	0.8	3.3	34.8	17.6	-	31.6
Cultivation	-	50.8	-	17.4	8.8	-	19.7
Petty Business	-	-	-	-	-	-	-
Service	3.5	1.5	1.7	-	2.9	-	2.0
<i>Income (in Rs. per annum)</i>							
0-10000	30.1	3.0	83.3	93.5	70.6	80.0	41.3
10001-20000	56.6	6.8	15.0	6.5	26.5	10.0	24.1
20001-30000	13.3	15.9	1.7	-	2.9	-	9.6
30001-40000	-	3.8	-	-	-	-	1.3
40001-50000	-	15.2	-	-	-	-	5.1
50001-100000	-	34.1	-	-	-	10.0	11.6
100000+	-	21.2	-	-	-	-	7.1

Table 3: Contd....

<i>Independent determinants</i>	<i>Sahariyas</i>	<i>Minas</i>	<i>Bhils</i>	<i>Kathodis</i>	<i>Damors</i>	<i>Garasias</i>	<i>Total</i>
<i>Cultivable Landholding (in kanals)</i>							
0	27.4	-	-	21.7	5.9	-	10.9
1-5	35.4	7.6	66.7	71.7	47.1	80.0	37.2
6-10	22.1	18.2	28.3	6.5	20.6	10.0	19.5
11-15	8.0	18.2	3.3	-	11.8	10.0	10.1
16-20	6.2	16.7	1.7	-	14.7	-	8.9
21-25	0.9	12.1	-	-	-	-	4.3
26-50	-	13.6	-	-	-	-	4.6
50+	-	13.6	-	-	-	-	4.6
<i>Family Structure</i>							
Joint	36.3	52.3	20.0	30.4	52.9	40.0	40.0
Nuclear	63.7	47.7	80.0	69.6	47.1	60.0	60.0
<i>Educational Level of Husband</i>							
Illiterate	89.4	62.9	88.4	91.3	35.3	100.0	76.2
Literate	10.7	37.1	11.6	8.7	64.7	-	23.8
Primary	6.2	5.3	3.3	2.2	20.6	-	6.1
Middle	1.8	24.2	8.3	4.3	29.4	-	12.9
High school	2.7	2.3	-	2.2	14.7	-	3.0
Higher Secondary School	-	5.3	-	-	-	-	1.8
<i>Education of Wife</i>							
Illiterate	99.1	98.5	100.0	97.8	88.2	100.0	97.8
Literate	0.9	1.6	-	2.2	11.7	-	2.0
Primary	0.9	-	-	-	2.9	-	0.5
Middle	-	0.8	-	2.2	8.8	-	1.3
High school	-	-	-	-	-	-	-
Higher Secondary School	-	0.8	-	-	-	-	0.2
<i>Age at Marriage of Husband (in yrs.)</i>							
6-10	2.7	13.6	-	-	-	-	5.3
11-12	27.4	22.7	1.7	-	-	-	15.7
13-14	34.5	37.1	3.3	2.2	-	-	23.0
15-16	25.7	19.7	13.3	15.2	2.9	20.0	18.5
17-18	8.0	3.0	26.7	28.3	44.1	60.0	15.9
19-20	1.8	2.3	36.7	28.3	52.9	20.0	15.2
21-29	-	1.5	8.3	26.1	-	-	6.3
<i>Age at Marriage of Wife (in yrs.)</i>							
6-10	32.7	54.5	-	-	-	-	27.6
11-12	35.4	25.0	8.3	2.2	-	-	20.0
13-14	27.4	17.4	11.7	10.9	5.9	30.0	18.0
15-16	4.4	2.3	51.7	56.5	52.9	70.0	22.8
17-18	-	-	21.7	30.4	38.2	-	10.1
19-20	-	0.8	1.7	-	2.9	-	0.8
21-29	-	-	5.0	-	-	-	0.8
<i>Educational Facility Available</i>							
None	-	-	-	-	-	-	-
Primary	54.9	61.4	63.3	-	-	-	45.8
Primary/Middle Schools	8.0	20.5	3.3	100.0	100.0	100.0	32.4
Primary/Middle/High Schools	-	18.2	16.7	-	-	-	8.6
Prim./Mid./High/Hr. Sec. Schools	37.2	-	16.7	-	-	-	13.2
<i>Approach to Village (Road)</i>							
Kuchcha	17.7	62.1	-	19.6	-	-	28.1
Pucca	82.3	37.9	100.0	80.4	100.0	100.0	71.9
<i>Medical Facility Available</i>							
None	26.5	-	-	-	-	-	7.6
Sub-Centre/Medical Aid Centre	5.3	13.6	85.0	28.3	73.5	100.0	31.1
Primary Health Centre/ Regd. Pvt. Practitioner	25.7	63.6	5.0	71.7	26.5	-	40.0
Community Health Centre/ Hospital etc.	42.8	22.7	10.0	-	-	-	21.3
<i>Housing Conditions</i>							
Type of House							
Kuchcha	100.0	32.6	98.3	93.5	100.0	100.0	76.5
Pucca	-	67.4	1.7	6.5	-	-	23.5
<i>Number of Rooms</i>							
1	87.6	13.6	86.7	87.0	41.2	80.0	58.5
2	12.4	25.8	8.3	8.7	29.4	10.0	17.2
3-9	-	60.6	5.0	4.3	29.4	10.0	24.3

amongst most groups, excepting Sahariyas and Minas. Whereas among the former, the maximum usage of family planning methods is noticed when the income level is between Rs. 10,000-20,000, amongst the latter group, the maximum usage is noticed when the income level is relatively very high at Rs. 50,000-1,00,000 (Table 3).

Family Planning Methods Used by Cultivable Landholding: The level of usage of family planning methods is found the highest when the size of cultivable landholding is only 1-5 kanals, and the second highest, when it is 6-10 kanals in the Scheduled Tribe population under study. All the individual Tribal groups, excepting Minas also show the highest level of usage when the size of landholding is 1-5 kanals. Among Minas, the maximum level of usage is seen, when the size of cultivable land is relatively high, i.e., 6-15 kanals (Table 3).

Family Planning Methods Used by Family Structure: The usage of family planning methods seems more when the couples are living in nuclear family organization than when they are living in joint family set-ups (Table 3). At the individual level, most of the tribes studied, excepting Minas and Damors have shown similar trend. These two tribes seem to register the opposite one.

Family Planning Methods Used by Education of Husband: In the Scheduled Tribe population studied, the level of usage of family planning methods seems higher when husbands are illiterate, than when they are literate. Individually, the same trend is seen amongst all tribes under study, excepting Damors, who show the opposite trend. When the education level vis-à-vis usage of family planning methods is considered, the transition from primary to middle level show an increase in usage, but the same trend is not seen thereafter, which can be due to small sample size. Individually, all excepting the Sahariyas have registered similar pattern (Table 3).

Family Planning Methods Used by Education of Wife: In the present Scheduled Tribe population, the usage of family planning methods is much higher in case of illiterate than literate wives, most probably due to small sample size, as well as very few literate women in the population. Individual tribal groups have also shown such a trend (Table 3).

Family Planning Methods Used by Age at Marriage of Husband The level of usage of family planning methods by age at marriage of

husband shows varying trend, with the lowest level at ages less than 10 years and the highest level at ages, 13-14 years. This can be due to small sample size, and/or overriding or simultaneous effects of other factors on contraception. Individual tribal groups have also shown such varying trend (Table 3).

Family Planning Methods Used by Age at Marriage of Wife: As in case of the above variable, the usage of family planning methods by age at marriage of wife also shows varying trend (Table 3). However, those who married at relatively younger ages seem to show more usage than those who got married at relatively older ages. However, larger sample size is required for a clearer picture as in the older age groups, number of cases is very few. At the individual tribal level, however, the trend appears more fluctuating, probably because of involvement of influence of several other factors on usage of family planning methods.

Family Planning Methods Used by Educational Facility Available: The usage of family planning methods is found the highest when there is a primary school nearby, and the second highest when there are both primary and middle schools within 5 km of residence, in the present Scheduled Tribe population. Individually, the maximum usage of methods, when primary schools are present within 5 km of residence, has been noticed among Sahariyas, Minas and Bhils (Table 3).

Family Planning Methods Used by Approach to Village (Road): The usage level of family planning methods is found higher when the approach to village is a 'pucca' or metalled road, than when there is 'kuchcha' or unmetalled one in the Scheduled Tribe population studied. The former situation may be enhancing the villagers' exposure to the outside world, including relatively easy access to family planning services, which may be changing their outlook leading to greater acceptance of contraception. All individual Tribes studied, excepting Minas, show similar picture (Table 3). Among Minas, probably several other factors are influencing contraceptive usage, simultaneously.

Family Planning Methods Used by Medical Facility Available: In the present Scheduled Tribe population, the level of usage of family planning methods is the highest, when there is a Primary Health Centre (PHC) and/or a Registered Private Practitioner is present within 5 km of

residence, while it is the lowest when there is no medical facility nearby. This broadly shows that qualified medical personal (based in rural areas) may be more successful in communicating across the need for contraception and benefits of planned family. At the individual tribal level, however, slightly varying trend is noticed. Whereas among Minas and Kathodis, maximum usage is seen when there is a PHC and/or registered private doctor is present, as mentioned above, among Bhils, Damors and Garasias, the usage level is the highest when there is a Sub-Centre and/or a Medical Aid Centre is present within 5 km of residence. In case of Sahariyas on the other hand, maximum usage is seen when there is a Community Health Centre and/or a Hospital is present (Table 3).

Family Planning Methods Used by Type of

House: In the present Scheduled Tribe population, the usage level of family planning methods is higher, when the house type is 'kuchcha' than when it is 'pucca', i.e., with a concrete roof and cemented walls, floor. All individual tribes studied have shown the same trend, excepting Minas, who registered the opposite (Table 3).

Family Planning Methods Used by Number of Rooms Present: The usage level of family planning methods is found the highest when there is only one room, and the second highest, when there are 3-9 rooms in the house, in the Scheduled Tribe population, on the whole. All the individual tribal groups, excepting Minas, have registered that usage of family planning methods is maximum when there is only one room. Among Minas, the highest level of usage has been observed when there are 3-9 rooms (Table 3).

The above results broadly indicate that even though there is diffused knowledge of family planning methods among the Schedule Tribes, the level of usage is rather low. Moreover, the permanent method is used mostly when the family size is three or more. Relatively high level of infant and child mortality, preference for sex, high economic value of children, near absence of proper follow-up care etc., are some of the main reasons for non-use, which should be looked into. Besides, of variety of economic, socio-cultural factors seem to be influencing the usage of family planning methods and differentials in these appear to be responsible for intra- and inter-population differentials, which eventually are reflected in the pooled data. Therefore,

to be more effective and successful, the family planning programme needs to be more sensitive to the needs of the people rather than just achieving the targets.

It may be mentioned that the government institutions in tribal areas require immediate attention with regard to paucity of staff due to unfilled vacancies and unwillingness among many non-local staff to serve in the tribal areas; as well as shortage of family welfare supplies. Besides, the remoter areas which till now do not have any medical facility must be considered for the same. Quality improvements are also required to ensure that proper communication is made to the seekers of family planning methods and to convince the demographically vulnerable group. Regular monitoring and supervision are required in various medical centres/ institutions by the higher authorities to rectify the lacunae and bottlenecks.

There is an urgent need to spread awareness messages about benefits of small family and adoption of family planning methods, in addition to the need for immunization of the children and pregnant women to prevent several diseases and morbid conditions. Attention is also to be given to promote ante and post-natal care among the tribals, in view of very high infant and child mortality. This, if done effectively, can go a long way in the improvement of health status of the tribal women as well as demographic scenario in the tribal areas of Rajasthan. The traditional birth attendants may be trained through workshops, so that scientific and hygienic routines are followed before and after birth.

Under the present Reproductive and Child Health (RCH) programme, the information, education and communication have been generalized. There is a strong need to adapt the generalized messages under the programme to suit the cultural behaviour and intellectual level of the tribal groups. To achieve these, it is important to launch community needs assessment studies and studies on health seeking behaviour. Based on the findings of these studies, new messages needed to be designed to drive the point home about small family and its benefits as well as related aspects, shunning of child marriages, as well as early and frequent child bearing etc. More so, because in case of the Scheduled Tribes of Rajasthan, potentials for population growth appears rather high as

manifested in terms of such demographically backward characteristics as, high infant mortality, high fertility etc. The role of local traditional faith healers, priests, herbalists in the society is to be properly investigated, particularly their structural position to develop guidelines as to how they can be utilized to disseminate small family norms and change associated behaviour. Family Welfare activities are to be further strengthened by promoting both spacing and permanent methods since early marriage and early and frequent child bearing are common in the entire tribal belt, as already mentioned. However, there is a need to look into the cash benefit scheme after sterilization, as it has been observed that couples adopt a permanent method, after they have done the damage demographically. The non-governmental organizations, religious bodies, local leaders who have a strong hold on the local populace, may be asked to participate in the IEC programme, apart from other sectors, particularly the education sector.

In addition to the improvement in the medical facilities in the tribal areas, development of

communication, educational infrastructures need to be looked into.

Therefore, by manipulating various factors by policy measures relating to promotion of Family Welfare Programmes as well as overall socio-economic development in the present Schedule Tribe population, the demographic scenario can be improved substantially.

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