Chapter 7

HEALTH STATUS OF THE WOMEN

Health is not only a matter of medical care but also the subject of composite development of social, cultural, economic, environmental, political and educational aspects of life. Each area of development has a direct influence on health and, reversely, health in return brings a positive impact on all these aspects. So society of any community and its health always run together. Generally tribal people live in hilly terrain with worst communication facilities. Pattern of their health practices including the uses of herbal medicines, taboos and restrictions always determine the behaviour and status of the tribal groups, particularly for their women folk (Basu 1996). Most of the hill tribal families are far below the poverty level. There is a powerful relationship between poverty and health which is characterised as bi-directional synergetic. Generally poor people have limited access to health inputs in the consumption of nutritious food, adequate health services and non-toxic environment. Poverty restricts the poor tribal people particularly the tribal women from getting nutritious food from forest where they collect some more valuable nutritious food and sell these to the nearby market to buy their daily commodities. Poverty as well as lack of education and communication also prevent tribal people particularly their womenfolk from getting the free health facilities. If any member from a poor tribal family falls ill, the entire family soon goes imbalanced. First of all, due to illness of a member, it reduces the household tasks and increases the economic vulnerabilities and leads the family towards the worst crisis. So in this situation, a poor villager at first rushes to local medicine man for getting solution for any type of disease. Let the health of the Karbi and Kuki respondents be discussed from the point of view of health care and social, cultural, economic, environmental and educational aspects of life. The discussion is begun with the biological status of women in the two communities.

SEX RATIO

Sex ratio in a community directly or indirectly determines the status of their womenfolk in the society. Tribal society is generally considered as gender-unbiased society, but due to the impact of various external factors the sex ratio is found not encouraging. The following table shows the sex wise populations of Karbi and Kuki villages in Cachar district:

Table 7.1
Sex-wise Distribution of Population among the Respondent's Family

Sex	Karbi population	Kuki population	Total
Male	858	628	1486
Female	743	562	1305
Total	1601	1190	2791
Sex Ratio (Number of female per 1000 male)	866	895	881

Source: Field Survey Conducted during June 2014 - December 2015.

The above table reflects the male female ratio of Karbi and Kuki villages. There are total 881 female per 1000 male: Karbi 866 and Kuki 895 female per 1000 male, which is very poor picture of sex ratio among the two communities of Cachar district. However, both the communities have very poor sex ratio as compared with the district, state and the national context. The trend of early marriage of girl child, high pregnancy rate of mother, lack of habit and inability to take nutritious food during pregnancies, dependencies of laymen medicine men for health problems in all occasions and other factors generally decreases the life expectancies of women also acted as important indicators for lower sex ratio. According to census 2011 report, the number of female per 1000 male in India is 940, in Assam 954 and in Cachar 958 (accessed from httpp://indiaonlin epages.com on 05.09.2015 at 6.15 am). However distances between health institutions from the habitations create direct impact on health awareness, for which sex ratio are comparatively better in Madhurapur (Boundary) and New Malidhor Karbi villages and Akai, Songhlu, Luipui (Bagbahar Part V), Kharzol, Zoar Lalpeing Punjee, and Bethal Kuki villages, where number of female are more than the male. Male female ratio is 1:1 in Boalchera Poila Number and Monai Hellot.

Comparatively sex ratio in Kuki community (895) is better than that of the Karbi community (866). The major reason behind this is that Kuki community has better educational level than Karbi which influences them to maintain the family size, adopt hygienic habits in their day to day life, etc.

Child marriage of womenfolk is the most vital among the all factors for low sex ratio found in both the tribal communities. But selection of age for marriage of a girl is also depending upon various factors like education, tradition, belief, urban effect etc. Whereas marriage age is not uniform in the two communities. The tendency of underage marriage of girl is always responsible for high pregnancies of mother and the lower sex ratio.

MORTALITY

Mortality is the death process in a given area or population which is generally used for the number of people died in a given population. Mathematically, mortality rate or Crude Death Rate (CDR) is expressed as the number of deaths occurred in a population of 1000 in a year. Mortality also differentiated according to age and sex, eg., child mortality, infant mortality, maternal Mortality etc. The following table shows the general mortality in respondents' families in the last 10 years:

Table 7.2
Mortality in Respondents' Families in the last 10 Years
(Percentage in Parentheses)

Type of Response	Karbi Respondents	Kuki Respondents	Total Respondents
Death took place	69(24.30)	58 (26.60)	127(25.30)
No death took place	215(75.70)	160(73.39)	375(74.70)
Total	284 (100)	218 (100)	502 (100)

Source: Field Survey Conducted during June 2014 - December 2015.

The above table finds that death did not take place in about three-fourth (74.70%) of the respondents' families in last 10 years: 75.70% of the Karbi respondents and 73.39% of the Kuki respondents' families. Whereas, over one fourth (25.30%) of the respondents claimed that death take place in their families

in the last 10 years: 26.60% of the Kuki and 24.30% of the Karbi respondents. The mortality rate is much higher in both the communities, as according to Census 2011, report, Crude Death Rate (CDR) in Assam is 8.0 per 1000 population whereas in India which is 7.1 per 1000 population in a year (www.censusindia.gov.in/vital_statistics/SRC_Report/11chap%204%20%202011 accessed on 05.09.2016 at 5.45 am). Child marriage of girls, lower education and remoteness of habitations are the root cause of high CDR in Karbi and Kuki villages of Cachar district. Lower sex ratio also clearly indicates the greater female mortality than that of male.

Comparatively, Kuki community (26.60%) has experienced more mortality than Karbi community (24.30%). Advantage of location for their habitation, Karbi people helps to avail more health facilities than Kuki. But according to the villagers of both the communities, the life expectancy of the tribal people has been increased after launching of NRHM. Thus, the death rate of the tribal population is either reduced or stagnant so far life span is concerned.

Infant mortality

Infant mortality is described as the death of child before reaching 1 year of age. But Infant Mortality Rate (IMR) is measured by the number of deaths occurred under 1 year of age per 1000 live birth. The following table shows the infant mortality in the respondent's families in the last 10 years:

Table 7.3
Infant Mortality in the Families in the last 10 Years
(Percentage in Parentheses)

Response type	Karbi respondents	Kuki respondents	Total
Infant death occurred	22 (7.75)	19 (8.72)	41(8.16)
No infant death occurred	262 (92.25)	199 (91.28)	461 (91.83)
Total	284 (100)	218 (100)	502 (100)

Source: Field Survey Conducted during June 2014 - December 2015.

The table finds that most (91.83%) of the respondent families have no any instance of infant mortality in their families: 92.25% of the Karbi and 91.28% Kuki respondent families. Whereas, only about one tenth (8.16%) of the

respondents family have faced infant mortality. 7.75% of the Karbi respondents and 8.72% of the Kuki respondents have experienced mishap like infant mortality in their respective families in last ten years.

Thus, though tribal people are living in substandard life facing multiple problems including health, education and communication but still the survival of infants is the highest, which indicates that their indigenous life style may have the answer for the same. Though these peoples belonging from the tribal communities are facing various problems like financial constraints, mal nutrition, lack of proper medical support and worst communication system, but still their indigenous life style along with the modern health care (if required) holds the key of their Kids. However the villagers claimed that the infant mortality decreases in the last 10 years due to availability of health services for the kids than before.

Maternal mortality

Maternal mortality is the number of death of mother occurred during pregnancy, child birth or within 42 days of delivery for any cause. But Maternal Mortality Rate (MMR) is the death of mothers for the same condition and within the same period of time per ’00000 lives births in a year (accessed from www.indexmundi.ccom/ india /maternal_mortality_rate.html on 25.08.2015 at 5.45 pm). The following table presents the maternal mortality in respondents’ families in the last 10 years:

Table 7.4
Maternal Mortality in their Families in the Last 10 Years
(Percentage in Parentheses)

Response Type	Karbi	Kuki	Total
Mother died	13 (4.58)	16 (7.34)	29 (5.78)
No mother died	271 (95.42)	202(92.66)	473(94.22)
Total	284 (100)	218 (100)	502 (100)

Source: Field Survey Conducted during June 2014 - December 2015.

The above table reveals that in most (94.22%) of the respondents’ families have no any cases of death of mother within 42 days of delivery in last

10 years: 95.42% of the Karbi and 92.66% of the Kuki respondents' families. In the same time, a very negligible part (5.78%) of families all together experienced maternal mortality in last 10 years. Of these, 4.58% of the Karbi respondents and (7.34%) of Kuki respondents had experienced maternal mortality in their respective families in this period. So, maternal mortality is still very low among tribal communities though they are living a kind of sub-standard life. According to the villagers, now-a-days tribal people not totally depend upon the traditional methods for child's births, but through the services of NHM, they get acquainted with the modern health facilities and thus maternal mortality have been reduced in around ten years for getting additional support from modern medical system.

However, comparatively Karbi (4.58%) experienced less maternal mortality than Kuki (7.37) due to their easy access to modern health facilities according to needs than their Kuki counterparts.

However, infant mortality as well as maternal mortality is less whereas, crude death rate is the both tribal community is very high which affects the sex ratio, as female mortality is higher than the male. The main reason for female mortality particularly death of a married women in tribal community is due to the underage marriage and more number of pregnancies.

Number of Pregnancies per Mother (with complete and incomplete reproductive cycles)

Number of pregnancies per mother is the important determinant for the size and type of the family. Similarly age-at-marriage influences the number of pregnancies per mother.

Here, 42 Karbi and 19 Kuki respondents were found either unmarried or not having any pregnancies. Of the 502 respondents, 460 are mothers and the rest are not. The respondents are divided into five categories according to the number of pregnancies, where mother from both complete and incomplete reproductive

cycles are taken. The distribution of mothers by number of pregnancies among the Karbi and Kuki respondents is shown in the following table:

Table 7.5
Number of Pregnancies among the Respondents
(completed and incomplete reproductive cycle)
(Percentage in Parentheses)

No. of Pregnancies	Karbi Respondents	Kuki Respondents	Total Respondents
0-1	24 (9.56)	28 (13.40)	52 (11.30)
2-3	31(12.35)	41 (19.62)	72 (15.65)
4-5	92(36.65)	72 (34.45)	164 (35.65)
6-7	59(23.51)	39 (18.66)	98 (21.30)
Above 7	45 (17.93)	29 (13.88)	74 (16.09)
Total	251 (100)	209 (100)	460 (100)

Source: Field Survey Conducted during June 2014 - December 2015.

The above table reveals that mothers having 4-5 pregnancies constituted the largest group in the respondents of both the tribes: About two fifths (36.65%) of the mothers (respondents) all having 4-5 pregnancies (35.95% Karbi and 34.45% Kuki mothers). Of the respondents, over one fourth (26.85%) had 0-3 pregnancies and nearly two fifths (37.39%) had above 5 pregnancies. Thus most of them (73.15%) had above 4 pregnancies. However, it clearly appears from the data that more Kuki mother respondents (30.02%) have 0-3 pregnancies as compared with the Karbi mother respondents (21.92%) while more of the Karbi mother respondents (88.08%) have over 3 pregnancies as compared with their Kuki counterparts (69.98%). This means that the Karbi respondents have a greater number of pregnancies than their Kuki counterparts. This is because of the impact of education, as Kuki community is more educated including their womenfolk.

The pregnancy rate per mother is high in both the tribes. However, Karbis have a higher rate than Kukis. The high pregnancy rate per mother in both the tribe is due to the early marriage of women, low literacy rate, lack of health awareness of female etc. But as the Kuki women are more educated than Karbi, and are clearly visible in the rate of their pregnancies.

ACCESS TO HEALTH WORKER IN THE RURAL HEALTH

National Health Mission (NHM) had introduced various programmes for the health of rural people, particularly women and children. Female health worker is the major strength of total rural health. ASHA (Accredited Social Health Activist) is the female health worker deputed in rural areas to provide all types of medical support, particularly to women and children. NHM implements its objectives for the rural people through ASHA worker who acts as a bridge between rural people and health centers. But in remote areas particularly in tribal villages presence or visit of health worker is not adequate. Even they never visit some interior areas where there is no proper communication. ASHA workers are not salaried employee of the health department and they are given only fixed incentives according to their activities of health support particularly to pregnant women and the children. The incentives are fixed for different stages of pregnant women, children, family planning programme etc. The following chart shows the major areas of health support provided by ASHA workers and incentives particularly for the general cases of pregnant women and children.

Chart 7.1
Major Activities of ASHA Workers with Incentives

Health Service/Activities	For	Stage	Incentives in rupees
Health Checkup including Institutional Delivery	Pregnant women for first and second mother	3,5,8 and 9Months	600/-
Do	Pregnant women for third mother	Do	400/-
Do	Pregnant women for fourth mother	Do	200/-
Full Antenatal Checkup (ANC)	Pregnant women	_	150/-
Home Based Newborn baby Care (HBNC)	Newborn Baby	Up to 1 year	250/-
Full immunization with booster dose.	Child	Up to 1 year	150/-
Providing Home Based New Born Care	Child	Up to 42 days after birth	250/-
Monthly routine activities	--	--	1000/- per month

Source : www.nrhmassam.in accessed on 3rd September, 2016.

The above chart classifies that the ASHA worker completely depends upon the incentives received after providing health services to beneficiaries. The major health services are for the pregnant women (under Janani Suraksha Yojana), children and couples who agree to adopt family planning methods. Only Rs.1000/- is given for their routine work. But their visits to the tribal villages are not adequate. The following table reflects the visit of health worker in the villages of the Karbi and Kuki respondents:

Table 7.6
Health Worker's Visit to the Respondents' Villages
(Percentage in Parentheses)

Whether health Worker Visited	Karbi Respondents	Kuki Respondents	Total Respondents
Visit	162 (57.04)	69 (31.65)	231 (46.02)
Never Visit	122 (42.95)	149 (68.35)	271 (53.98)
Total	284 (100)	218 (100)	502 (100)

Source: Field Survey Conducted during June 2014 - December 2015.

The above table informs that over half of the respondents (53.98%) were not visited by ASHA worker at all: 42.98% of the Karbi and 68.35% of the Kuki respondents. Health workers' visit to Karbi locations is much more (57.04%) than that to Kuki locations (31.65%).

Thus, the tribal women are neglected by health workers in providing health services. Besides, there is difference of the two communities due to poor or no access to their villages and traditional beliefs. The villages which are located in the remote part of the district with worst communication get the least services from ASHA worker. Besides, due to some social belief a large number of Kuki pregnant women do not like to visit doctors during pregnancy for taking advice and they prefer home delivery with traditional methods. Hence tendency of ASHA worker's visit to the Kuki villages is poor than the Karbi villages.

Though, government health workers are actually appointed to cover the interior habitations, in Cachar district different tribal communities are largely deprived from the government's health services despite the slogan of "health for all." Inadequate communication system, remoteness of habitations or both the

factors are mainly responsible for fewer visits. Tribal organizations need to work in tandem with the government not only to provide health services but more importantly to make the tribal people aware of health and related facilities, especially tribal women.

For general health related problems, tribal people do not depend upon the health centers. Further they try to solve these problems either traditionally or with the help of the layman medicine man. However, in order to develop a healthy family, a proper size of the family is very necessary.

AWARENESS OF FAMILY PLANNING

Family planning is meant for population control and maintaining the gender balance. But like some orthodox non-tribal groups, tribal communities have also remained away from family planning. For family planning awareness of people is very important. The following table shows the awareness level of family planning among the respondents of the two tribal communities.

Table 7.7
Distribution of Respondents on the basis of Awareness of Family Planning
(Percentage in Parentheses)

Response type	Karbi Respondents	Kuki Respondents	Total Respondents
I am aware	147 (51.76)	111 (50.92)	258 (51.39)
I am not aware	89 (31.34)	93 (42.66)	182 (36.25)
No response	52 (18.31)	14 (6.42)	66 (13.15)
Total	284 (100)	218 (100)	502 (100)

Source: Field Survey Conducted during June 2014 - December 2015.

The above table indicates that over half (51.39%) of the respondents are aware about the family planning and over one third (36.25%) of them are not aware. Besides, over one-tenth of the respondents did not respond. Similar pattern of awareness is observed across the respondents of the two communities; however, a difference is perceived between the respondents of the two communities who are not aware about family planning, i.e.; more of the Kuki respondents (42.66%) than of the Karbi respondents (31.34%) are not aware about family planning.

Thus, though family planning is known to the respondents, a significant portion of them is not aware. Besides, more Kuki respondents are unaware (42.66%) due to the remote location of their habitation and absence of ASHA worker than the Karbi (31.34%) respondents. Despite having the knowledge about family planning, its practice in both the communities is rare. So the government and non-government organisations should focus on intensive awareness programme in the tribal areas, especially tribal women because habitations of Karbi and Kuki tribal communities are located in remote areas of Cachar district and therefore medical facilities as well as awareness of various diseases are not adequate among the people.

Few personal habits determine the health consciousness of a person for leading the smooth and healthy life. Similarly, lack of awareness regarding health seeking habits is the major cause for various diseases and also for ill health. Let this health seeking behavior of the respondents be examined in terms of hygiene.

HYGIENIC HABIT

Habits and practices performed in order to protect the life from diseases are termed as hygienic habits. This is the by-product of the culture of a person wherein he or she lives. The culture also influences to adopt those scientific habits which minimize the risk of viral infection to a person to the community. According to World Health Organisation (WHO), "Hygiene refers to conditions and practices that help to maintain the health and prevent the spread of the diseases' (http://en.wikipedia.org/wiki/Hygiene accessed on 2nd September, 2016 at 6.05 am). Hence hygienic habit is the scientific way of life to maintain good health. Various habits together save a person from diseases. These are like washing hands before taking meal, regular washing clothes, bathing, cleaning teeth in the morning and after taking meals, washing hands after coming out from latrine etc. Among the personal hygienic practices, washing hands in proper and scientific way after coming out from latrine is the most important habit. Not only

cleaning of hands is important but cleaning of hands with some wash agents like detergent is scientific to protect from a disease.

The following table speaks of the habit of cleaning hands after coming out from latrine among the respondents:

Table 7.8
Habit of Washing Hands after Coming Out from Latrine among Respondents
(Percentage in Parentheses)

Wash Agent	Karbi Respondents	Kuki Respondents	Total of Respondents
Soap	49 (17.25)	86 (39.45)	135 (26.89)
Sand & ashes	73 (27.70)	54 (24.77)	127 (25.30)
Plain water (Add no wash agent)	162 (57.04)	78 (35.78)	240 (47.81)
Total	284 (100)	218 (100)	502 (100)

Source: Field Survey Conducted during June 2014 - December 2015.

The table reveals that near about half (47.81%) of the respondents clean their hands after coming out from latrine simply with plain water and use no wash agent: 57.04% Karbi and 35.78% of the Kuki respondents. Over one fourth of them use wash agents such as soap (26.89%) and sand & ashes (25.30%) to clean hands after coming out from latrine. Here, more of the Kuki respondents (39.45%) as compared with their Karbi counterparts (17.25%) use wash agents while more of the Karbi (27.70%) respondents and their family member use sand and ashes as compared with their Kuki counterparts (24.77%).

Thus, half of the respondents use no clean agent to clean their hands after coming out from toilet which puts them to risk of health hazards. Lack of awareness of hygiene habit and its effect among the both tribal communities is the root cause of health problems like dysentery, jaundice, tuberculosis etc. Awareness of hygienic habit to some extent depends upon their culture and society.

Distance of health institutions from their habitation is also responsible for lack of the hygienic habit and health consciousness among the people. Presence

of health worker in the nearby areas of habitations and the visit to these villages also has a great impact in the field of hygiene and health.

However, more of the Kuki respondents are compared with their Karbi counterparts, have the hygienic/scientific habit of washing their hands with wash agents and it indicates that education has a great role in inculcating hygienic habits in people because Kukis have better educational level than Karbis.

MODE OF TREATMENT

Traditionally herbal medicine was widely practiced among the tribal population in Cachar district. But now-a-days, tribal people also like to use allopathic medicine in any health problem, except for some special cases. However, in some Karbi and Kuki villages, like Ratachera, Haibong etc traditional herbal health care is much popular. Like Allopath and traditional medicine, homeopathy is also used for treatment of diseases. The following table presents the modes of treatment among the respondents:

Table 7.9
Modes of Treatment among Respondents
(Percentage in Parentheses)

Mode of Treatment	Karbi Respondents	Kuki Respondents	Total Respondents
Homeopathic and Allopathic	62 (21.83)	34(15.60)	96(19.12)
Allopathic and Traditional	57(20.08)	51(24.50)	108(21.51)
Allopathic	165(58.10)	133(61.01)	298(59.36)
Total	284 (100)	218 (100)	502 (100)

Source: Field Survey Conducted during June 2014 - December 2015.

The table shows that majority, three fifths (59.36%), of the respondents goes for allopathic treatment only and almost similar trend is observed in both the communities. But, over one fifth (21.51%) of the respondents prefer the combine allopathic treatment with traditional one: Karbis' 20.08% and Kukis' 24.50% respondents and about one fifth (19.12%) of them prefer combine homeopathic and allopathic treatment: 21.83% of the Karbi and 15.60% of the Kuki respondents.

Thus allopathic medicine is most accepted in both the tribal communities. Traditional and indigenous medicine systems are on decline. Traditional and indigenous mode of treatment has been declining from the Karbi and Kuki villages in Cachar district. Few senior people in some villages are found practicing the traditional medicine system. But due to lack of interest, the young generation has no interest in the tradition. However, some traditional beliefs and restrictions related to women during the change in their reproductive period are still widely practiced in both the tribal communities.

CULTURAL RESTRICTIONS FOR WOMEN DURING BIOLOGICAL CHANGE

In some nontribal societies, during their biological changes, of women are imposed upon some restrictions. In the Karbi and Kuki communities different types of restrictions on women are still prevalent. But intensity of restrictions is not uniform in all villages and even in the same community of different villages. The following table shows the community wise picture of restrictions imposed upon women during mensuration and pregnancy in the respondents' families:

Table 7.10
Restrictions upon Women during Mensuration and Pregnancy in Respondents' Families
(Percentage in Parentheses)

Response Type	Karbi Respondents	Kuki Respondents	Total Respondents
Yes	208 (73.24)	183 (83.94)	391 (77.89)
No	76 (26.76)	35 (16.06)	111 (22.11)
Total	284 (100)	218 (100)	502 (100)

Source: Field Survey Conducted during June 2014 - December 2015.

The table points out that over three fifths (77.89%) of the respondents have experienced restriction on them during their menstruation and pregnancy periods: near about three fourths (73.24%) of the Karbi and most of Kuki (83.94%) respondents. Karbi women have fewer restrictions in these periods. So in one sense Karbi women receive more care during pregnancy period.

Thus, Karbis are ahead of Kukis as their women have less restriction during pregnancy. Yet, both the communities need health advice for their pregnant women from trained health workers. During pregnancy both the communities have some sorts of restrictions on the woman. But regarding food habits during pregnancy, in some villages some traditional beliefs are found in practice.

CONSUMPTION OF NUTRITIOUS FOOD DURING PREGNANCY

Taking nutritious food like fruits, fish, eggs, milk etc. during pregnancy is very essential for both the mother and the coming baby. But generally both the tribal communities are unaware regarding this. The following table shows the picture of consumption nutritious food during pregnancies by the pregnant women in the Respondents' families:

Table 7.11
Consumption of Nutritious Food during Pregnancy in Respondents' Families
(Percentage in Parentheses)

Whether family provide nutritious food during pregnancy	Karbi Respondents	Kuki Respondents	Total Respondents
Yes	67 (23.59)	46 (21.10)	113 (22.51)
No	217 (76.41)	172 (78.90)	389 (77.49)
Total	284 (100)	218 (100)	502(100)

Source: Field Survey Conducted during June 2014 - December 2015.

The table reveals that, in over three fourths (77.49%) of the respondents' families, women do not take nutritious food during pregnancy. This pattern is similar among the respondents of the two communities. Only over one fifth (22.51%) of the respondents' families provide adequate food during pregnancy to the pregnant women: 23.59% of the Karbi and 21.10% of the Kuki respondents. In this respect the women in the Karbi respondents' families have relatively better condition. Their poor financial condition, remoteness of location, and lack of awareness and least scope for medical facilities are the prime factors responsible for this. This picture will change if their economy, communication system and medical facilities are developed.

The fact of taking no nutritious food during pregnancy is very alarming for both the tribal communities. This may owe to different factors. Hence, to overcome the malnutrition it is most important to know the causes for not providing nutritious food to the pregnant women during pregnancy. The following table exhibits the reasons for not taking nutritious meal by women in the respondents' families:

Table 7.12
Reasons for Not Taking Nutritious Food during Pregnancy
(Percentage in Parentheses)

Type of Cause	Karbi Respondents	Kuki Respondents	Total Respondents
Economic	91 (41.94)	78 (45.35)	169 (43.44)
Traditional	4 (1.84)	9 (5.23)	13 (3.34)
Unawareness	122 (56.22)	85 (49.42)	207 (53.21)
Total	217 (100)	172 (100)	389 (100)

Source: Field Survey Conducted during June 2014 - December 2015.

The table reveals that over half (53.21%) of the respondents' families do not provide nutritious food to pregnant women due to unawareness, followed by those respondents' family which cannot afford economically to provide such food while a small fraction of the respondents have families which do not provide such food due to traditional belief like nutritious food leads to the pregnant women for surgery during delivery as these food may cause for over growth of the coming baby. Thus unawareness, followed by poor economy is the main hurdle to provide nutritious food to the pregnant women in the two communities. However, unawareness has greater role in the Karbi respondents' families (56.22%) and poor economic condition is more responsible in the Kuki respondents' families (43.35%) for not providing nutritious food to pregnant women. For developing awareness about health, the government initiative for pregnant women is yet to be reached in the remote tribal areas. The concerned health workers do not visit frequently to advise them during pregnancy. Besides, though Kuki women have better education, they cannot afford nutritious food due to poor economic condition.

Health awareness during pregnancy is very important for both, a pregnant woman and her family-members particularly husband and other mature women

members. But, practically, in the tribal communities of Cachar district, the health of pregnant women is not given priority in the family. This is basically due to the unawareness clubbed with poor economy. The following table throws light on the awareness of family members about health of pregnant women in the family of respondents:

Table 7.13
Family Attitude towards Pregnant Women's Health among the Respondents'
(Percentage in Parentheses)

Response type	Karbi Respondents	Kuki Respondents	Total Respondents
Family is concerned	67(22.18)	42(19.27)	109(21.71)
Family is not concerned at all	186(65.49)	167(76.61)	353(70.32)
No responses	31(10.92)	09(4.13)	40(7.97)
Total	284 (100)	218 (100)	502 (100)

Source: Field Survey Conducted from June 2014 to December 2015.

The table report that over two thirds (70.32%) of the respondents' families are not concerned about women's health: 65.49% Karbi and 76.61% Kuki respondents' families. Only over one fifth (21.71%) of the respondents families are concerned about their pregnant women's health. Less than one tenth (7.97%) respondents did not respond to the query. Thus, a large section of the pregnant tribal women do not get support for health from their family members due to various reasons like their financial constraints, remote and inaccessible geographical location, for health workers and lack of their awareness.

Hence, lack of awareness becomes the root cause for various health-related problems in both the tribal communities. However, number of pregnancies and lack of family planning knowledge also add to the health problems in the tribal communities. Like other factors, family planning is the most important to have a good health for a married woman as well as her family. Let the family planning awareness of the respondents be examined.

AWARENESS OF DISEASES

Most of the Karbi and Kuki villages are located in the hilly terrain while some villages located in the remotest areas of the district. Some villages are also

disease-prone, and the villagers have no awareness about diseases. The following table shows the awareness about diseases among the respondents of the two communities:

Table 7.14
Awareness about Diseases among the Respondents
(Percentage in Parentheses)

Types of Diseases	Karbi Respondents N=284	Kuki Respondents N=218	Total N=502
AIDS	18(6.34)	27(12.39)	35(6.97)
Malaria	284(100)	218(100)	502(100)
Tuberculosis	226(79.58)	212(97.25)	438(87.25)
Cancer	284(0.00)	218(0.00)	502(100)
Rabies	09(3.17)	17(7.80)	26(5.18)
Anemia	93(32.75)	73(25.70)	166(33.07)
Goiters	16(5.63)	19(8.71)	35(6.97)
Diarrhea	284(100)	218(100)	502(100)
Chicken Pox	128(45.07)	103(47.25)	246(49.00)
Diabetes	43(15.14)	54(24.77)	97(19.32)
Polio	95(33.45)	84(38.53)	179(35.66)
Glaucoma	45(15.84)	33(15.14)	78(15.54)
Pyorrhea	63(22.18)	59(27.06)	122(24.30)
Jaundice	232(81.69)	203(93.12)	435(86.65)

Source: Field Survey Conducted from June 2014 to December 2015.

The table exhibits that all the respondents of both the communities are well-aware about diseases like malaria, diarrhea, and cancer and then jaundice by the most (81.69%) of the Karbi and almost all (97.71%) of the Kuki respondents are well aware about these diseases, as these are the pre-dominant in these areas. Tuberculosis is ranked third in both the communities. Over three fourths (79.58%) of the Karbi and almost all (97.25%) of the Kuki are aware about this. Then, the less known diseases are rabies (3.17%) among the Karbi and goiter (7.80%) among the Kuki respondents. Again 5.63% of Karbi and 7.80% of Kuki has got the information regarding Goiters and Rabies respectively.

Thus, the diseases which are very common in the remote areas are known to them and the diseases which are not so frequent or pre-dominant are less known. Their life style and food habit are also dominant factor of the diseases they suffered. Awareness of diseases also helps the people to know causes and

prevent common diseases like tuberculosis, malaria, jaundice etc in both the communities. But in the interior tribal villages of Cachar district, people have no adequate awareness of many diseases. In most of the cases, people depend upon the medicine man for any disease and hence, in some cases simple diseases become more critical.

In brief, the foregoing analysis of the data has revealed the following patterns:

1. Sex ratio in both the communities is very poor as compared in the context of district, state and the national level. There are total 881 females per 1000 males: Karbi-866 and Kuki-895 female per 1000 male. Comparatively, sex ratio in Kuki community (895) is better than in the Karbi community (866). This is because the Kukis have better educational level than the Karbis which influences them to maintain the family size and also to adopt hygienic habits in their day to day life. The trend of underage marriage of girl child and high pregnancy rate of mother are also responsible for early death of women which imbalances the sex ratio. According to the census 2011 report, the number of female per 1000 males in India is 940, in Assam 954 and in Cachar 958 (indiaonlinepages.com). The distance of health institutions from the habitations has direct impact on their health awareness, for which sex ratio is comparatively better in some villages – Madhurapur and New Malidhor Karbi villages and Akai, Songhlu, Luipui (Bagbahar Part V), Kharzol, Zoar Lalpeing Punjee, and Bethal Kuki villages, where number of females are more than males. Male-female ratio is 1:1 in Boalchera Poila Number and Monai Hellot Karbi villages.

2. Regarding the mortality among the two communities, one finds that over one fourth (25.30%) of the respondents' families have had deaths in the last 10 years: 26.60% of the Kuki and 24.30% of the Karbi respondents. The mortality rate is much higher in both the communities, when compared with the figures of the Census 2011, report, where Crude Death Rate (CDR) (death occurred in a

year per 1000 population) in Assam is 8.0 and in India it is 7.1.www.censusindia. gov.in/vital_statistics/ SRC_Report/11chap %2 04% 20-%2 020 11 accessed on 05.09.2016 at 6.25 am). Underage marriage of girls, lower education and remoteness of habitations are the root causes of high death rate in the Karbi and Kuki villages. Only about one tenth (8.16%) of the respondents' families have faced infant death (death of a child within 1 year of birth). About 7.75% of the Karbi respondents and near about 8.72% of the Kuki respondents have experienced infant deaths in their families in the last ten years. Also a negligible section (5.78%) of the families have experienced maternal deaths (death of mother within 42 days of delivery) in last 10 years: 4.58% of the Karbi and 7.34% of the Kuki respondents. For infant and maternal health care, traditional along with modern health services show remarkable impact, and reducing the maternal as well as infant mortality.

3. More number of pregnancies per mother are very common and mothers having 4-5 pregnancies constituted the largest group in the two community's respondents: About two fifths (36.65%) of the mothers (respondents) are having 4-5 pregnancies (35.95% of the Karbi and 34.45% of the Kuki mothers). Of the respondents, over one fourth (26.85%) had 0-3 pregnancies and nearly two fifths (37.39%) had above 5 pregnancies. Thus, most of them (73.15%) had above 4 pregnancies. However, more Kuki mother respondents (30.02%) have 0-3 pregnancies as compared with the Karbi mother respondents (21.92 %%) while more of the Karbi mother respondents (88.08%) have over 3 pregnancies as compared with their Kuki counterparts (69.98%). Comparatively, the Karbi respondents have a greater number of pregnancies than their Kuki counterparts. This is because of the impact of education, as Kuki community is more educated including their womenfolk. The high pregnancy rate per mother in both the tribes is due to early marriage of women, low literacy rate, lack of health awareness of female etc. But more education of the Kuki women than Karbi women is clearly visible in the rate of their pregnancies.

4. About family planning, over half (51.39%) of the respondents are aware and over one third (36.25%) of them are not aware. Besides, over one tenth of the respondents did not respond. Similar pattern of awareness is observed across the respondents of the two communities; however, a difference is perceived between the respondents of the two communities who are not aware about family planning, i.e.; more of the Kuki respondents (42.66%) than the Karbi respondents (31.34%) are not aware about family planning, due to the remote location of most of the Kuki habitations and less visit of ASHA worker. Over half of the respondents (53.98%) are not visited by ASHA worker at all: 42.98% of the Karbi and 68.35% of the Kuki respondents. However, in spite of having the knowledge about family planning, its practice in both the communities is rare. So the government and non-government organisations should focus on intensive awareness programme in the tribal areas, especially among tribal women, because the habitations of Karbi and Kuki tribal communities are located in remote areas and therefore medical facility as well as awareness about various diseases is not adequate among the people.

5. Some hygienic habits always protect people from various diseases and also help in maintaining the good health. But near about half (47.81%) of the respondents wash their hands after coming out from latrine simply with plain water and use no wash agent: 57.04% of theKarbi and 35.78% of the Kuki respondents, which puts them to risk of health hazards. Over one fourth of them use wash agents such as soap (26.89%) and sand & ashes (25.30%) to wash hands after coming out from latrine. Here, more of the Kuki respondents (39.45%) as compared with their Karbi counterparts (17.25%) use wash agents while more of the Karbi (27.70%) respondents and their family members use sand and ashes as compared with their Kuki counterparts (24.77%). Lack of awareness of hygienic habit and its effect in the two communities is the root cause of health problems like dysentery, jaundice, tuberculosis etc. Awareness of hygienic habit to some extent depends upon their culture and society.

6. Allopathic medicine is most accepted in both the tribal communities. Traditional and indigenous medicine systems are on decline. A few old people in some villages are practicing the traditional medicine system. The young generation is getting less interested about these; rather they like to use allopathic medicine for any health problem. Three fifths (59.36%) of the respondents go for allopath only in both the communities. But over one fifth (21.51%) of them prefer to combine allopathic treatment with traditional one: Karbis 20.08% and Kukis 24.50%. Besides, about one fifth (19.12%) of them use both homeopathic and allopathic treatment: 21.83% of the Karbi and 15.60% of the Kuki respondents.

7. In both the communities some restrictions are imposed on women during their biological cycles like mensuration and pregnancy. Over three fifths (77.89%) of the respondents have experienced restrictions imposed during these cycles: near about three fourths (73.24%) of the Karbi and most of the Kuki (83.94%) respondents. Karbi women have less restriction. So, in one sense Karbi women receive more care during pregnancy period. But in some villages some traditional beliefs are found in practice during pregnancy. Women in over three fourths (77.49%) of the respondents' families do not take nutritious food during pregnancy in the two communities. Only over one fifth (22.51%) of the respondents' families provide adequate food during pregnancy to pregnant women: 23.59% of the Karbi and 21.10% of the Kuki respondents. In this respect the women in the Karbi respondents' families have relatively better condition.

8. Nutritious food is not provided regularly to pregnant women during pregnancy in both the communities. Poor financial condition, remoteness of location, and lack of awareness and the least scope for medical facilities are the prime factors responsible for not providing proper nutritious food to pregnant women. Over half (53.21%) of the respondents' families do not provide nutritious food to pregnant women due to unawareness, followed by those respondents' families which cannot afford to provide such food, while a small fraction of the respondents' families do not provide such food due to traditional belief as they believe that nutritious food lead to the over growth of the baby in womb and

leads the pregnant women to surgery for delivery. Thus, unawareness, followed by poor economy is the main hurdle to provide nutritious food to the pregnant women in the two communities. However, unawareness has greater role in the Karbi respondents' families (56.22%) and poor economic condition is more responsible in the Kuki respondents' families (43.35%) for not providing nutritious food to pregnant women.

9. Health of pregnant women is not a priority in most of the families. A large section of the pregnant tribal women do not get support for health from their family members. Due to various reasons like financial constraints, remote and inaccessible geographical location and lack of awareness, the women become ill after delivery in most of the cases. Over two thirds (70.32%) of the respondents' families are not concerned about women's health: 65.49% of the Karbi and 76.61% of the Kuki respondents. Only over one fifth (21.71%) of the respondents' families are concerned about their pregnant women's health. Less than one tenth (7.97%) of the respondents did not respond to the query.

10. Both the communities do not have adequate knowledge about the causes and the preventive measures for various diseases. Their life style and food habits are also dominant factor for the diseases they suffer. Awareness of diseases also helps the people to know causes and prevent common diseases in both the communities. In most of the cases people depend upon the quack for any disease and, hence, in some cases simple diseases become incurable. However, the effect of diseases like malaria, diarrhoea, cancer and jaundice are known by the most (81.69%) of the Karbi and almost all (97.71%) the Kuki respondents, as these are the major diseases among them. Tuberculosis is also a common disease in both the communities. Over three fourths (79.58%) of the Karbi and almost all (97.25%) of the Kuki are aware about this.

Thus after analyzing the above tables, it is evolved that due to various reason like child marriage, remote locations of habitations, age-old myth regarding health and treatment of people in general and women in particular,

dependency of layman medicine men for every health problems etc., had made significant impact in the health of women. Thus, in both the communities, sex-ratios are far behind than the national, state and even from the district sex ratio. However because of comparatively having better location of Karbi habitation than Kuki and impact of urbanization in the community, Karbi have better sex-ratio than Kuki. But due to having better awareness regarding health and education, child marriage is very less in Kuki than Karbi and, accordingly, number of pregnancies per mother was also found less in Kuki than the Karbi. But in last ten years numbers of total mortality, infant mortality and maternal mortality are much less in numbers and almost same trend were observed in both the communities. However due to remote locations and the more restrictions imposed to the pregnant women in the society Kuki community experienced more such mortality cases than the Karbi.

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