# SOCIO- ECONOMIC PROFILE OF TOBACCO RELATED CANCER PATIENTS

This chapter deals with the socio-economic status (SES) of the patients suffering from Tobacco Related Cancer (TRC) and the chapter is divided into two sections namely socio-economic status and illness pattern. SES is an economic and sociological combination, total measure of a person's work experience and of an individual's or family's economic and social position in relation to others, based on income, education, and occupation. There is a very robust correlation between socioeconomic status and health. This correlation suggests that it is not only the poor who tend to be sick when everyone else is healthy, but that there is a continual gradient, from the top to the bottom of the socio-economic ladder, relating status to health. This phenomenon is often called the "Gradient". Lower socio-economic status has been linked to chronic stress, disease, ulcers, diabetes, cancer, and premature aging. As the respondents are from poor community often they suffer from ill health and poor health services and also deprived of proper education. It is also found that the respondents are economically very weak for which they are not in a position to send their wards for schooling. The socio-economic status of the respondents do not

confirm that the disease is characteristic of the socio-economically disadvantaged because of the research setting: patients cannot afford for the treatment in private and it is understood that they are going for treatment in private hospital because they don't have any alternative.

Socio-economic background of a family, literacy levels, and awareness are interdependent. Education is very important for both patient and the care giver. No human being can able to survive properly without basic education or basic needs. By means of education only one's potential can be used to a maximum extent. Education helps people how to think, how to act properly, how to take decision. Education is most important in life like our basic needs foods, cloths, and shelter. Education can also help to understand the symptoms and signs of cancer, which may help in first detection of cancer, because early detection can cure cancer.

**(A) <u>Socio-Economic Status</u>**

**Table: 5.1**

| **Education** | **Gender of Patients** | | **Total** |
|---|---|---|---|
| | **Male** | **Female** | |
| Illiterate | 31 (40.3%) | 29 (39.7%) | 60 (40.0%) |
| Literate | 8 (10.4%) | 10 (13.7%) | 18 (12.0%) |
| Primary | 15 (19.5%) | 17 (23.3%) | 32 (21.3%) |
| Middle | 7 (9.1%) | 11 (15.1%) | 18 (12.0%) |
| Secondary | 9 (11.7%) | 5 (6.8%) | 14 (9.3%) |
| College and above | 7 (9.1%) | 1 (1.4%) | 8 (5.3%) |
| **Total** | 77 (100%) | 73 (100%) | 150 (100%) |

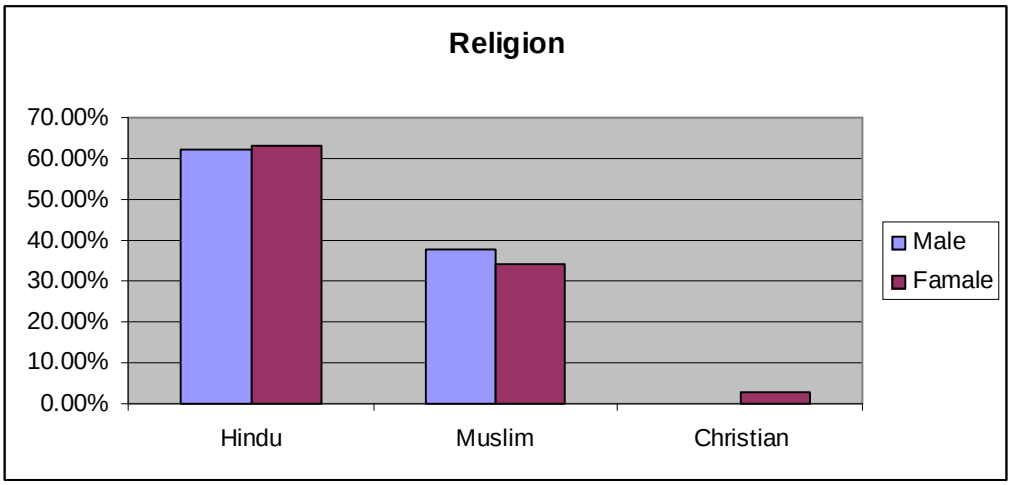
***Source: Primary Data***

Education is one of the chief instruments of human development. Education helps an individual to live a healthy and pleasant life. People who are well educated can lead a better life than uneducated in every aspect. Education is recognized as an important determinant of health because an educated person is always conscious about their health. It is important that people should be aware about the disease and it is a must for all to know how the disease is caused. A study done in Kolkata among female students reflected low level of knowledge of cervical cancer and its risk factors and only 11% and 15% were found aware of cervical cancer (A. Saha, 2010). This indicates that even individuals, who are educated, having very low level of knowledge about cancer. The above table indicates that out of 150 respondents 60 (40.0%) respondents are illiterate, 18 (21.0%) are literate, 32 (21.3%) are educated up to primary level, middle level educated respondents are 18 (12.0%), 14 (9.3%) of the respondents have received secondary level education, and only eight respondents (5.3%)could access to college level.

Among the males 31 (40.3%) are illiterate, 8 (10.4%) are literate, 15 (19.5%) are educated up to primary level, middle level educated are 7 (9.1%), secondary level educated males are 9 (11.7%), and rest are above college level educated i.e.7 (9.1%). And among females 29 (39.7%) are illiterate and above college level educated female is only 1 (i.e.1.4%).

So, by analyzing table number 5.1, it can be said that maximum number of respondents both males and females are illiterate i.e. 60 (40.0%).

**Chart: 5.1**




***Source: Primary Data***

The age distributions of the selected sample are as follows. The predominant 24 percent of the respondents belongs to the age group of 45-55 years, 22.7 percent are in the age group of 35-45 years. Another 18 percent are in the age group of 55-65 years, which is followed by 14 percentages of respondents whose age is between 65-75 years, 8.7 percent of respondents are in the age group of 25-35 years. Only four percent of the respondents belong to the age group of 75-85 years, 3.3 percent of the respondents are below 18 years of age and the rest negligible 0.7 percent belongs to the age group which is above 85years. From this it is clear that all age groups are affected by this disease. Sometimes unhygienic condition and poor lifestyle can help a person to have this disease. Here, more than 50

percent of the respondents belong to weaker sections, which are not afforded to follow proper lifestyle and hygienic living. According to K. R. Nayar (2007), poverty and social exclusion are important socio-economic variables which are often taken for granted while considering ill-health effects. Social exclusion mainly refers to the inability of our society to keep all groups and individuals within reach of what we expect as society to realize their full potential. In the Indian context, caste may be considered broadly as a proxy for socio-economic status and poverty. In the identification of the poor, Scheduled Caste and Scheduled Tribes and in some cases the other backward castes are considered as socially disadvantaged groups and such groups have a higher probability of living under adverse conditions and poverty. The health status and utilization patterns of such groups give an indication of their social exclusion as well as an idea of the linkages between poverty and health. From the study the researcher has found that, in Hindus, 62.3 percent males and 63.0 percent females are suffering from this illness, which is maximum in number or it can be said that they come forward for treatment. In case of Muslims respondents 37.7 percent are males and 34.2 percent are females and it is understood that they are lagging behind due to their tradition and culture and lastly in Christian, it has been found very minimum in number i.e. 2.7 percent in female only. Our society

is a mixture of numerous religions which result in substantial variation in lifestyle patters and customs followed by individuals due to different religious faiths. Religion sometimes comes as an obstacle for maintaining a healthy life because females are not given freedom to take any decision even in case of their health. They are there to serve the males and responsible for the household works. Family members of cancer patients may experience significant financial burden while playing the role of caregiver. It can be said that low economic status affects health seeking behaviour among those who are ill because prior to illness they are able to work and earn their livelihood in a proper way, which is now impossible due to this disease.

**Table 5.2: Family Income**

| **Family Income of the Respondents** | **Gender of Patients** | | **Total** |
|---|---|---|---|
| | **Male** | **Female** | |
| Below Rs. 5000/- | 27 (35.1%) | 16 (21.9%) | 43(28.7%) |
| Rs. 5001 – 10000/- | 27 (35.1%) | 32 (43.8%) | 59(39.3%) |
| Rs. 10000/- and above | 23 (29.9%) | 25 (34.2%) | 48(32.0%) |
| **Total** | 77 (100%) | 73 (100%) | 150 (100%) |

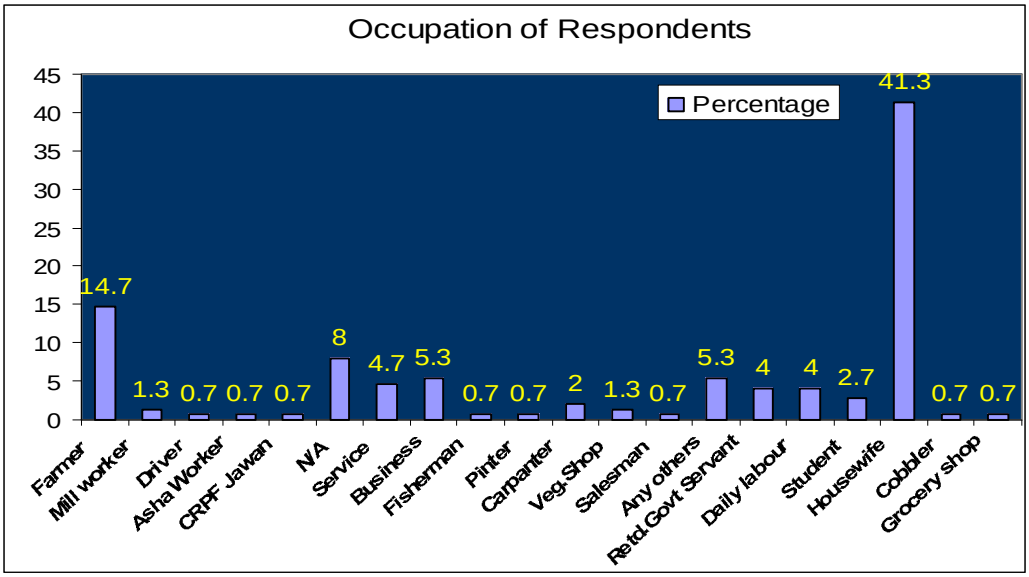
***Source: Primary Data***

In the present study, the researcher has categorized the income of respondents i.e. below Rs. 5000/- as low income group, Rs. 5001-10000 is average income group and above Rs. 10000 as high income group.

Among males, family income of 27 (35.1%) respondents is common in both the groups, i.e. below Rs. 5000/- and Rs. 5000-10000/- and family

income of 23 (29.9%) respondents is above Rs.10000/-. In case of females, family income of 16 (21.9%) respondents is below Rs. 5000/-, 32 (43.8%) respondents belongs to the average family income group and 25 (34.2%) respondents earn above Rs. 10000/-. The self-employed respondents are particularly badly affected, most of the respondents have been found engaged in work even after diagnosis to maintain their livelihood.

**Chart 5.2: Occupation**




***Source: Primary Data***

Occupational status is an important component of socio-economic status, summarizing the power, income, and educational requirements associated with various positions in the occupational structure. Occupational status has several advantages over the other major indicators. First, occupational status reflects the outcome of educational attainment, provides

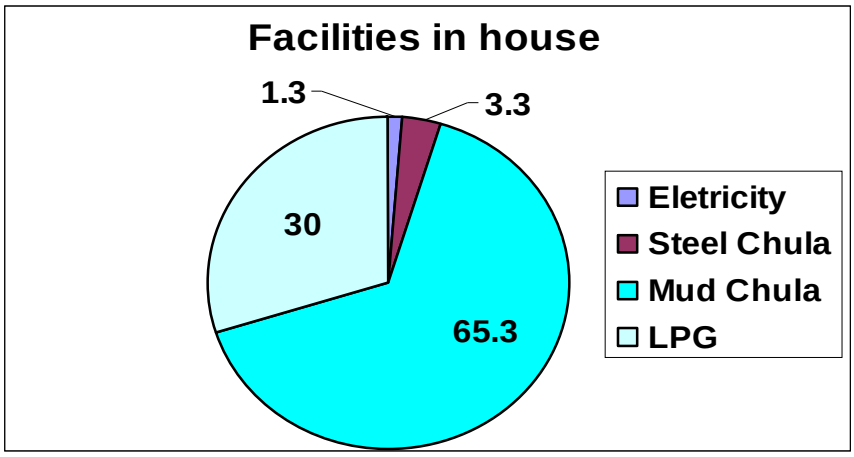
information about the skills and credentials required to obtain a job and the associated monetary and other rewards. For example, professionals are differentiated from manual workers by selection on educational attainment that influences patterns of remuneration. Occupational status is also likely to be a better indicator of income over the long term than is income information collected at any single point in time, because in the short-term, income can be quite volatile (Williams and Collins 1995).

In this study, it can be seen that the maximum respondents are housewives i.e. 41.3%, the second highest is farmer (14.7%) and 8% are dependent respondents. The lowest is (0.7%) cobblers, grocery shop holders, salesman, fisherman, painter, CRPF jawan, Asha workers, drivers etc. The four percent represents retired govt. servants and daily labours. Rest belongs to mill workers, servicemen, businessmen, carpenters, students etc. Due to this illness, the occupation of respondents got hampered, i.e. they are unable to go for work regularly or perform their duties as the respondents are not well. For the treatment of the disease, the respondents usually go for chemotherapy and as a result of which they become weak and fatigue. Due to this they can’t go for work regularly but it is understood that after some times the body will get use of these medicines and the patients will feel better physically.

The study reflects that maximum number of respondents (76.0%) is married, 12.0% respondents are unmarried, 8.7% are widow and rest 3.3% are widower. In case of males, they cannot go out to earn their livelihood and females are unable to perform domestic works which creates problems with family members.

Facilities at the residence indicate the socio-economic status of a family or it can also be said that type of house reflects the socio-economic and cultural status of a family which helps to keep a family healthy. The size of the area, number of room, walls, windows, doors, and construction material used are related to the socio- economic condition and the artifacts in the house speak about the cultural orientation of the residents. The houses are not only physical residences of family members but also a central place to share love and affection which is very important for cancer patients. Community level social determinants of health include both the physical and social environment. For example, the physical environment includes measures of housing, such as the availability of good quality housing, adequate water, and waste management (Edwards, 2002; Dunn et al., 2003).

**Chart 5.3: Facilities in house**




***Source: Primary Data***

The maximum number of respondents, found in the present study, is not economically sound, so with lack of basic facilities create problems for both the caregiver and the patient. Only 1.3% respondents are having the electricity facility in their houses. The electrification of houses is an important factor in modernizing the family which keeps direct affect on individual's health. Most of the respondents do not have electricity supply in their houses and they use kerosene lamps. Steel *Chula* is being used by 3.3% respondents. LPG is used by only 30.0% of the respondents as against Mud *Chula* which is predominantly used by 65.3% respondents. The respondents with Mud *Chula* generally use fire woods and cow dung cakes as fuel for cooking food. While cooking, the smoke makes the environment polluted and also makes the room suffocating and this may be the risk factor for the

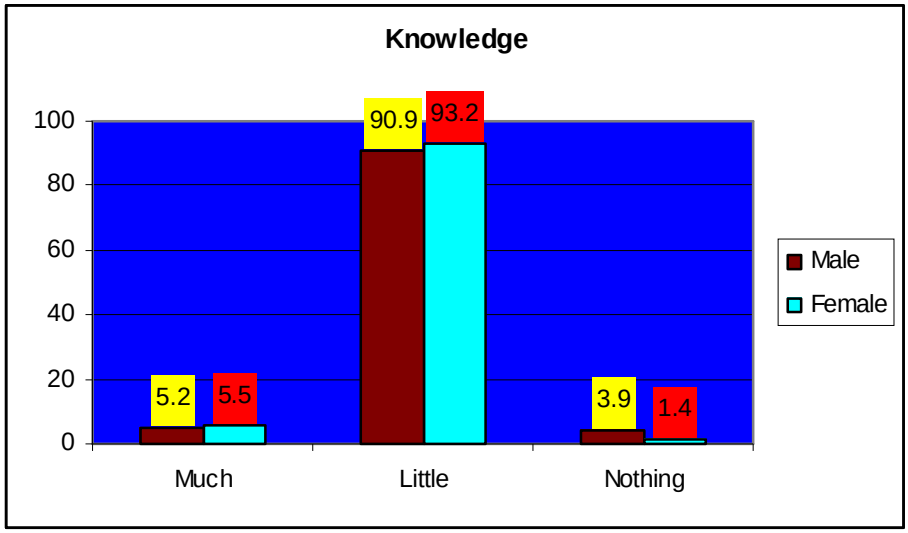
cause of cancer of esophagus (gullet) and stomach. Most of the people know that smoking is a major risk factor for lung cancer.

It is understood that most of the respondents (64.7%) are living in houses made of bamboo, which is very common in this region and this may be due to financial condition for which they cannot afford to build *pucca* houses. But, most of the families have large spaces in front of their houses, where they spend most of the time during day time. Respondents who are living in Assam type houses are of 26.7%, those who are living in Brick and Slab made houses are of 7.3% and rest 1.3% of respondents are living in the houses provided under the scheme 'Indira Awas' etc. Most of the houses have one or two rooms which they use for cooking, dinning, and sitting purposes. A house should be with proper air and light ventilation because these two things are very vital for a healthy living. In a properly ventilated house with hygiene can make a patient to feel better.

If an individual is having the knowledge about health, than it is a "degree by itself to which individuals can obtain, process and understand the basic health information and services they need to make appropriate health decisions" and if an individual doesn't have any knowledge about health than it can lead to further deterioration of patient's health. Education and knowledge are primary instruments for the improvement of quality of life of

the human being. In this study, it has been found that majority of the respondents are not having any knowledge about cancer.

**Chart 5.4: Knowledge of Cancer**




***Source: Primary Data***

This chart indicates that maximum percentages of respondents are having little knowledge about cancer due to lack of proper education. These respondents are from low income group of rural area and due to this some of them are not well acquainted with the instruments of mass communication like T.V., radio etc. which are the prime source of acquiring knowledge about cancer. From the study it reflects that only 5.2% of males and 5.5% of females know much about cancer and 3.9% of males and 1.4% of females do not have any knowledge regarding cancer. A well educated person may not have enough information or knowledge about cancer but if he/she

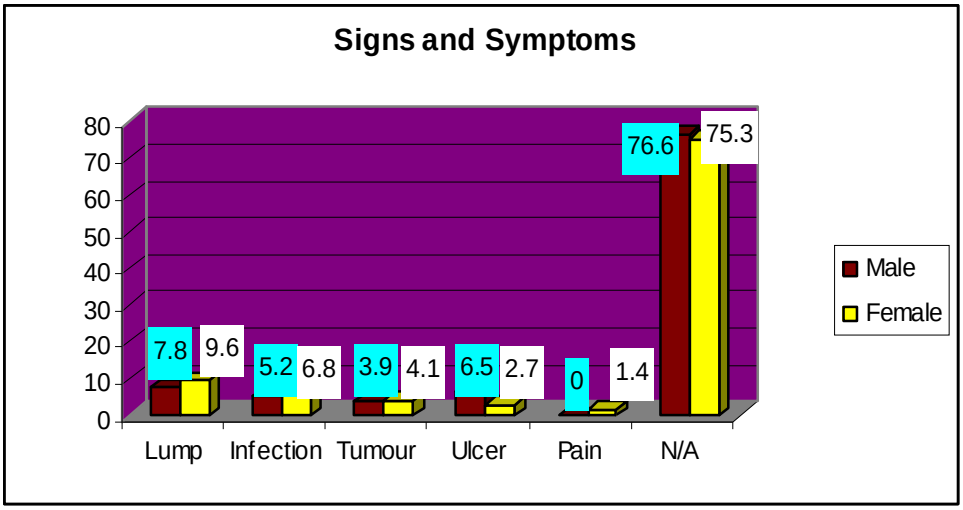
acquires little knowledge about cancer, it will be helpful in future. One of the major unresolved questions in health-seeking behaviour studies is how far knowledge actually determines practice. It is most common to assume, implicitly or explicitly that changing knowledge entails behaviour change.

Knowledge is power, if an individual has any knowledge or understands the signs and symptoms of cancer, he/she can be detected at the early stage which is curable, and they can survive with a good health too. Symptoms of cancer can be both acute and chronic and can occur during and after treatment. Physical symptoms may include pain, fatigue, hair loss, and many others depending on the cancer site and the types of treatment. Major physical issues that affect long-term survival cancers, premature aging, and organ /system failure. The findings of the study made by A. Oakley et. al. (1995) which deals with knowledge of children and young people regarding cancer goes in line with the finding of the present study. The present study also reveals the fact of awareness among the cancer patients regarding the disease which is very much essential in the part of early diagnosis and treatment.

In this way, the above mentioned literature review found to be significant and can pave a way towards achieving the objectives of the study.

The present study explains that out of 150 respondents, 7.8% male respondents understand that if any lump is seen in the body it may turn into cancer and 9.6% female respondents are having very little knowledge. Like that 5.2% males and 6.8% females have stated that infection can cause cancer but maximum respondents of both genders have expressed that they know nothing about signs and symptoms of cancer. Some cancers have very specific symptoms and some are very silent in the early stages. Some cancers are diagnosed by accident, while some are being investigated or treated in case of problem faced by a patient. Cancer can't be diagnosed based on signs and symptoms alone. Investigations such as x-rays, scans, cytology, biopsy etc. are always needed to make a diagnosis.

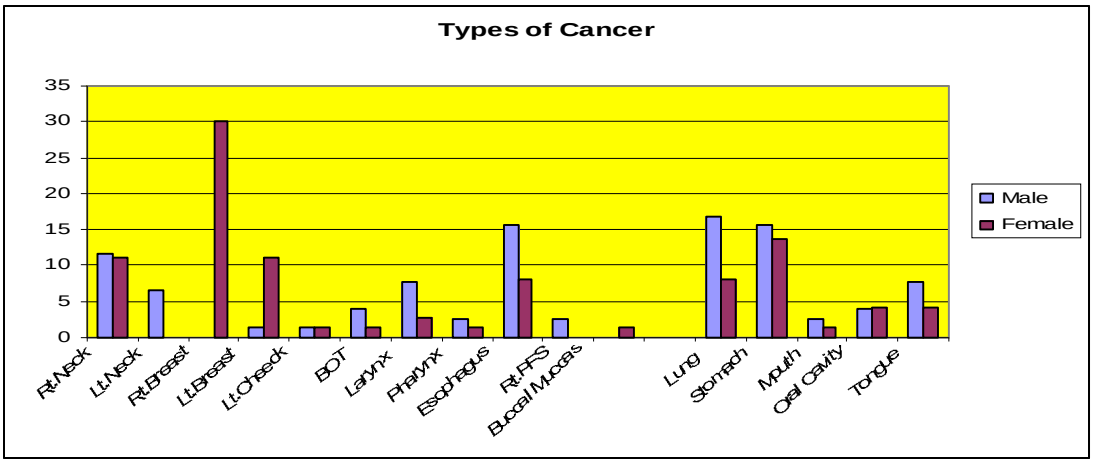
**Chart 5.5: Signs and Symptoms**




***Source: Primary Data***

The researcher has observed that if awareness is spread properly about cancer and the side affects of tobacco use, change may definitely come. Awareness can change the attitude of the people. The key factor of maintaining a good health is taking good care of oneself. Lack of awareness of signs and symptoms and risk factors of cancer can lead to late presentation of the disease and that contributes to poor survival of cancer patients. From the study it is clear that the awareness of respondents about this disease is not adequate. The study of M. R. Kazaura et. al. (2007), goes similarly with the present study, they focused on the fact that interventions should be started to improve health care seeking behaviour of cancer patients. They also have discussed about health education in their study.

**Chart 5.6: Types of Cancer**




***Source: Primary Data***

There are several types of cancer but this study has been focused on tobacco related cancer. It is clear from the study that out of 150 respondents,

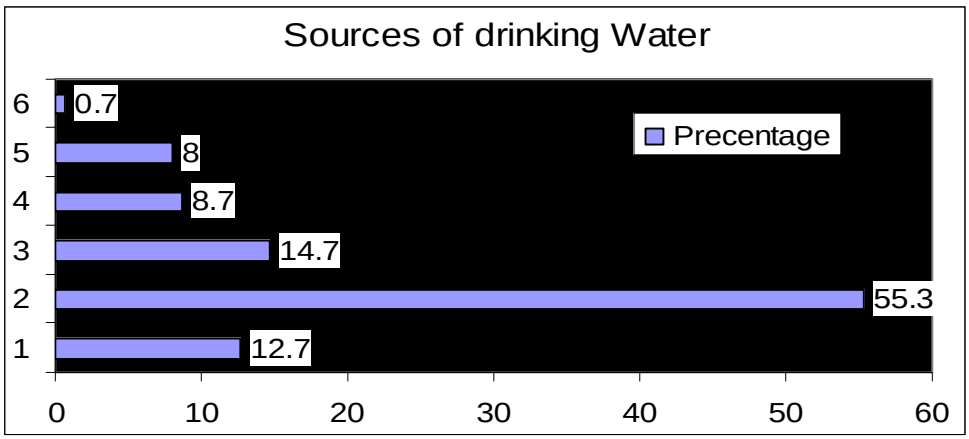
females are much aware about the types of cancer. So, 11% of females understand that it can occur in neck, both in right and left side and 1.4% of females know about the cancer of Base of Tongue and maximum females (13.7%) have idea that cancer can affect stomach. And in case of male respondents, maximum (16.9%) have expressed that cancer can attack lung at the same time they also have admitted that smoking is the main cause of cancer. Alcohol use clearly raises the risk of getting cancer on mouth, larynx, pharynx, and esophagus.

From the study it can be said that diet is also very important factor for cancer patients. The people of Cachar District have the habit of taking rice twice or thrice in a day but intake of fruits and vegetable are very less in quantity. The maximum percentage of respondents consumes both vegetarian and non-vegetarian foods. Non-vegetarian foods are the major part of the diet in Cachar, probably because of the climatic condition. During the study, the researcher has found that smoked and fermented food is also taken in high rate. The respondents often suffer from weakness and this is often caused by taking of impure and unhygienic drinking water, irregularities in intake of food as well as unhygienic food consumption.

For an individual, pure drinking water is very important to lead a healthy life because no one can survive without water. A person can survive

for about a month without food but only about a week without water. Drinking adequate amount of water can decrease the risk of getting certain types of cancer including colon cancer, bladder cancer and breast cancer. (allaboutwater.org.)

**Chart 5.7: Sources of drinking water**

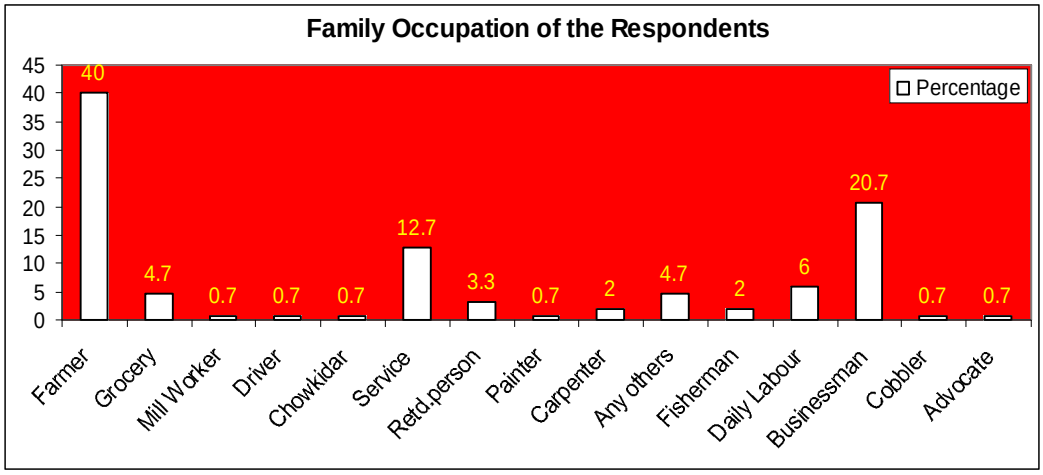



***Source: Primary Data***

In the present study, it is found that respondents consume water without purification, due to which the common diseases like malaria; T.B, diabetes etc. are reported by the respondents. In this study, it is found that maximum respondents (55.3%) are taking supply water directly. The second highest percentage (12.7%) of respondents drink pond water and rest of the respondents are taking water from other sources like open well (14.7%), deep tube well (8.7%), hand pump (8.0%) and others (7%). The respondents living in rural areas with their own water wells are also at risk of drinking potentially cancer-causing chemicals, fertilizer, insecticides etc. The study

reveals that only 27.3% of the respondents take treated water and 72.7% of the respondents take untreated water because they are less aware about the diseases which untreated water carries and at the same time they are not bothered. A study conducted by Omeo Kumar Das also reveals that the source of drinking water prevailing in Assam, available and access to safe drinking water has been the most crucial factor involving serious health concerns in rural as well as in urban areas, river and pond water which is 31 percent, is major drinking water source in this district. Boiled water is good to a certain extent, where there is no alternative. Boiling water for at least 20 minutes may kill most of the bacteria inside but it does not remove any of the inorganic minerals in the water. It is reveled that maximum number of respondents are very much lagging behind in health care awareness, this might be due to poverty ignorance and lack of alien to hygienic.

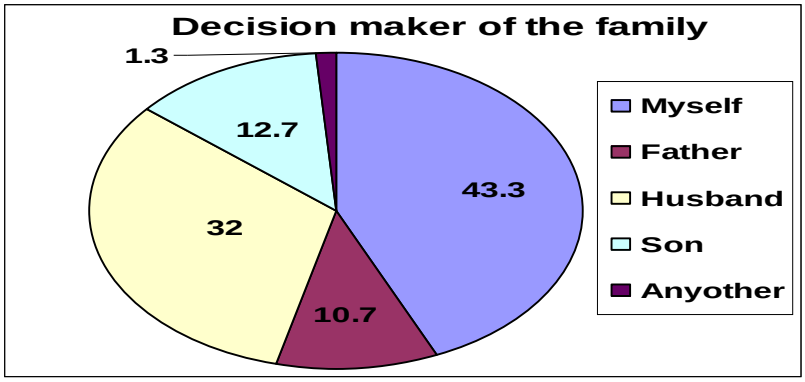
**Chart 5.8: Family Occupation**




***Source: Primary Data***

This chart explains about the occupation of the family members of respondents, which is most important because if income is high, health care can be taken properly. The highest percentage of respondents, 45.5% of males, and 34.2% of females are engaged in farming to earn their livelihood. This is followed by businessman, 15.6% of males, and 26.0% of female members engage in business. This is very good to know that women of this region are at par with men or it can be said that they are above them. Only 1.3% of male respondents are engaged as mill worker, chowkidar, services, pension holder, painter, carpenter, fisherman, and cobbler. Occupation does matter a lot because stability in income helps to carry on the responsibilities and the respondents can spend the money for their treatment on priority basis.

**Chart 5.9: Decision Maker**



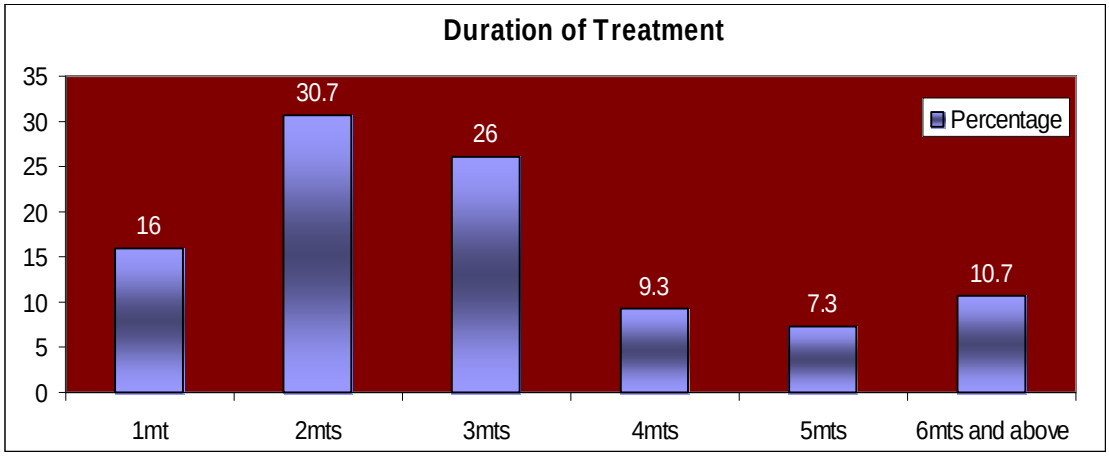

***Source: Primary Data***

This chart shows that 43.3% of the respondents take their own decision and in case of 10.7% of the respondents the decision making power

is with their father. The husbands are the decision maker of 32.0% respondents and son is the decision maker of 12.7% of respondents. The decision of rest 1.3% of respondents is taken by someone else. So, the data speak that till date the females are not allowed to raise voice or to take part in decision making even though they face any health problems and this is due to hegemony of patriarchal system prevailing in our society.

**(B) <u>Illness pattern</u>**

**Chart 5.10: Duration of Treatment**




***Source: Primary Data***

During this study, it is observed that 16.0% of the respondents are under treatment for one month and highest percentage (30.7%) of the respondents is under treatment for two months. The 26.0% of the respondents are under treatment for three months and 9.3%, 7.3% & 10.7%

of respondents are suffering from the disease for four months, five months, & more than six months respectively.

Cancer treatment including many of the chemotherapy medications can directly influence the way people feel emotionally and physically. Common side effects of chemotherapy treatments include fatigue, nausea, loss of appetite, sleep disruption and many symptoms of depression & anxiety. Some people receiving chemotherapy may also experience difficulty with concentration or attention. More severe side effects may include confusion, disorientation, or hallucination.

**Table 5.3: Satisfaction**

| **Satisfaction regarding Health Services** | **Gender of Patients** | | **Total** |
|---|---|---|---|
| | **Male** | **Female** | |
| Yes | 74 (96.1%) | 70 (95.9%) | 144 (96.0%) |
| No | 3 (3.9%) | 3 (4.1%) | 6 (4.0%) |
| **Total** | 77 (100%) | 73 (100%) | 150 (100%) |

***Source: Primary Data***

Though PHCs play an important role in development of rural health but there is lack of sufficient infrastructure facilities such as beds, medical equipments for treatment, medicines to treat in emergency situations etc. The standard of cancer treatment in PHCs is also not adequate in comparison to the well equipped private hospitals in the near by town. But the PHCs are the only options for the preliminary treatment of rural cancer

patients of this District. In this table the respondents have expressed or made the researcher understand about their satisfaction level of the health services.

Now, according to the objectives the researcher has found correlation between socio-economic status and health seeking behaviour of cancer patients of this particular district. The table below explains it in a better way.

**Table 5.4: Correlation between Socio-Economic Background and Health Seeking Behaviour of Tobacco Related Cancer Patients.**

| | Starting Age of Tobacco Chewing | Frequency Of Chewing | Duration of Smoking | Duration of Taking Alcohol | Knowledge about signs & symptoms | Knowledge about cancer | Frequency of visit to the health centre | Frequency of Visiting Doctor | Expenses Incurred on Treatment | Satisfaction level |
|---|---|---|---|---|---|---|---|---|---|---|
| Age | -0.14 | *-0.16** | *-0.18** | 0.02 | 0.13 | -0.05 | 0.03 | -0.05 | -0.15 | -0.01 |
| Gender | 0.34 | 0.14 | -0.68** | -0.21** | 0.02 | -0.05 | -0.01 | -0.07 | 0.07 | 0.01 |
| Education Status | 0.09 | 0.09 | 0.06 | 0.09 | 0.49** | 0.25** | 0.08 | 0.03 | -0.01 | 0.14 |
| Caste Category | 0.06 | 0.07 | -0.10 | -0.12 | -0.02 | 0.05 | -0.02 | 0.05 | *0.16** | *-0.16** |
| Household Income | -0.07 | 0.01 | 0.22* | 0.28* | 0.32** | 0.27** | -0.02 | 0.01 | 0.06 | -0.14 |
| Starting Age of Tobacco Chewing | 1.00 | -0.72** | -0.31* | -0.22** | 0.10 | 0.05 | -0.06 | 0.06 | 0.11 | -0.02 |
| Frequency of chewing | -0.72 | 1 | 0.15 | 0.18* | -0.11 | -0.13 | -0.06 | 0.10 | 0.13 | -0.13 |
| Duration of Smoking | 0.31 | 0.15 | 1 | 0.35** | -0.09 | -0.07 | -0.01 | 0.03 | 0.11 | -0.06 |
| Duration of Taking Alcohol | -0.22* | *0.18** | 0.35** | 1.00 | -0.14 | -0.03 | -0.05 | 0.19 | 0.25 | -0.22 |
| Knowledge about the signs & symptoms | -0.10 | -0.11 | -0.09 | -0.14 | 1 | 0.23** | -0.15 | 0.00 | -0.04 | -0.05 |
| Knowledge about cancer | -0.05 | -0.13 | -0.07 | -0.03 | 0.23** | 1 | -0.10 | -0.02 | -0.02 | 0.02 |
| Frequency of visit to the health center | -0.06 | -0.06 | -0.01 | -0.05 | -0.15 | -0.10 | 1.00 | -0.15 | -0.21 | 0.31 |
| Frequency of visiting doctor | 0.06 | 0.10 | 0.03 | 0.19 | 0.00 | -0.02 | -0.15 | 1 | 0.30** | -0.39** |
| Expenses Incurred on Treatment | 0.11 | 0.13 | 0.11 | 0.25** | -0.04 | -0.02 | -0.21* | 0.30** | 1 | *-0.66* |
| Satisfaction level | -0.02 | -0.13 | -0.06 | -0.22** | -0.05 | 0.02 | 0.31** | -0.39** | -0.66 | 1 |

***Source- Primary Data***

Among male respondents, 74 (96.1%) are satisfied with the health services in their community and 3 (3.9%) are not satisfied. And among female respondents, 70 (95.9%) are satisfied and 3 (4.1%) are dissatisfied with the services. The reasons behind the dissatisfaction of 6 (4.0%) respondents are that most of the time doctors and staff remain absent i.e. they are not available round the clock, the services of the health centers are very poor etc.

The researcher has come to conclusion that lower the age higher is the frequency of chewing of tobacco and higher the age lower the frequency of tobacco chewing. Regarding duration of smoking, higher the age lower the frequency of chewing and smoking tobacco and as compared to male women are having higher age of starting tobacco chewing. After that another correlation is that lower the age of starting tobacco chewing higher is the frequency of chewing of tobacco, higher the duration of smoking and also the alcohol consumption. And duration of taking alcohol is positively related. Higher the duration of taking alcohol higher is the frequency of chewing tobacco and taking alcohol. Knowledge about signs and symptoms and knowledge about cancer is not having any significant relation with health seeking behaviour. Frequency of visit to health centers and frequency of visiting doctors are negatively related and frequency of visiting health

center is negatively related to the expenses incurred on treatment. And frequency of visiting doctor is positively related to expenses incurred on treatment and expenses incurred on treatment are negatively related to frequency of visiting doctors. Age, gender, and educational status have no significant relationship with frequency of visiting health centers. Higher the caste is higher the expenses incurred on treatment and lower the satisfaction level.

**Conclusion**

After studying the demographic profile of the respondents in this chapter, it can be understood that most of the respondents are from poor socio-economic background and due to which they often suffer from ill-health. They are also deprived from many health services and health education. It is also found that most of the respondents are illiterate. Education plays a significant role in molding individual's behaviour towards avowed goals which indirectly helps to proceed towards health development. It is understood that education is very important for both the respondent/patient and the caregiver. However, the relationship between education and health is not as simple as it appears to be. In fact, the impact of education on health depends basically on what an expert teaches and how much the receiver receives. Another feature has been noticed that most of

the middle aged people are more exposed to this deadly disease and they have the habit of smoking and taking tobacco. Financial burden is another important factor which badly affects maximum number of respondent's families. Related to occupation it has been found that housewives are more affected than farmers. Pure and safe drinking water is also very much important to keep an individual healthy because the study reveals that most of the respondents are not taking safe drinking water. The findings of the study speaks that most of the respondents are not well aware about this disease may be due to their inadequate education. During the study, it has been found that women are more concerned about the health of their children than that of their own health. According to the respondents, women are very much busy with their domestic works even they are ill. The poverty and illiteracy are the high risk factors for ill health. Facilities in house indicate socio-economic status of an individual, which helps the family to stay healthy. The knowledge of the respondents is very poor regarding cancer and its signs and symptoms. Intake of key nutrients by the respondents is very poor. So, nutrition counseling assumes special significance in Cachar because the respondents are not having proper knowledge regarding food habits and they are ignorant about the value of food rotation. Water if not purified properly can lead to many diseases, in

this current study it is found that maximum number of respondents is not taking treated or purified water. The family occupations of the respondents are farming, business, services and rest are drivers, cobblers etc. Occupation is very important because if the income of an individual is high, it becomes easier for the respondents to carry on the treatment. The male members are the decision makers of the family. Regarding satisfaction of health services, maximum numbers of respondents are satisfied although health services are not very poor, it needs serious attention.