Children are the most valuable human resource in any nation. It is, therefore, vital to improve their health and well-being in order to achieve complete development in all perspective. Since the children represent the well-being of any society, their health needs cannot be left unmet. But, although they are the most priority group, they are also a vulnerable and a risk group in terms of their survival, growth and development.

The findings of this study have been presented elaborately in chapter III. In this chapter an attempt has been made to discuss the present findings in the light of some previous work of same nature from different parts of the globe including India.

In a total of 465 households having under five children, the total population stands at 2222. The age-sex distribution shows a regular pattern in all the communities. Except the age group of 0-4 years, we find the highest frequency in the total population in the age group of 25-29 years which gradually declines in both the higher and lower age groups with a slight fluctuation in between. Such a declining trend of population from 25-29 years age group is indicative of the fact that the fertility has declined in all the communities since last 25 years.

The abrupt increase in the number of males and females in the age group of 0-4 years which is the highest of all the groups is difficult to explain. However, it needs mention here that only those households having under five children were selected and surveyed for the present study. Thus, the highest number of males and females in the
age bracket of 0-4 years of all the communities might be because of this purposive selection.

On the basis of the distribution of child population, adult population and the old population, a population can be said as young or progressive having child population of 40 per cent (0-14 years), stationary having child population of 27 per cent and regressive having child population of 20 per cent. In that sense, all the communities under the present study can be said to be progressive because even with the inclusion of very high number of population in the age group of 0-4 years, the child population among the Bodos is 33.1 per cent, 37.2 per cent among the Garos and 34.8 per cent among the Caste Hindus.

The overall sex ratio of the study population is 1003/1000 males which is higher than the national average of 940 and the state average of 954 females per 1000 males (Census, 2011). It is to be mentioned here that the sex ratio of the study area is (1009.3/1000 males) as per Census, 2011. The sex-ratio of the present study is also higher than the national average as per NFHS-4 (2015-16) figure of 993/1000 males. However, the sex ratio of the Garos (960/1000 males) which is lower than the sex ratio of the Bodos (1031/1000) and the Caste Hindus (1007/1000) males is also well below the NFHS-4 (2015-16) figure. The state of Meghalaya is the homeland of the Garos. However, some Garos are also distributed in the state of Assam. The sample of the present study is drawn from the Rani area of Assam. The Garos of the present study show a lower sex ratio than the state average of Meghalaya (986/1000 males) as per 2011 census.

The under five children population constitute 25.7 per cent of the total population in the present study. Among the Bodos they constitute 23.7 per cent against 28.9 per cent among the Garos and 25.6 per cent among the Caste Hindus. The figures are well above the state (10.5%) and national (9.7%) average as reported by Census, 2011. Within the under five children population, a total of 18.4 per cent are infants and 81.6 per cent belong to 1- <5 years of age. Within the infants again, 56.2 per cent are males against 43.8 per cent female infants.
Besides age, the other important demographic character is the marital status of a given population. In the present study 54.2 per cent are married which is above the state average of 42.2 per cent and also above the national average of 47 per cent. Widow and widower, divorcee and separated constitute 4.8 per cent of the study population which is slightly lower than the state average of 4.9 per cent and also lower than the national average of 5.2 per cent. (Census, 2011)

The present study portrays a higher number of nuclear family (54.7%) than joint family (45.3%). Although the joint family system is predominant (53.2%) among the Bodos, nuclear families are higher among the Garos (66.7%) and Caste Hindus (52.5%).

Scholars throughout the world believe that the economic status is undoubtedly one of the most significant indicators for health care utilization. The U.S. Department of Health and Human Services (1990) stated that in developing as well as developed countries, it is the poorest segments whose children suffer the most. They are prone to sickness and have greater risk against ill health than children in families with high income group. The socio-economic status of a family can determine the health status and the health seeking behaviour of any population. It is a well accepted fact that better the socio-economic status of a family, the better is the health seeking behaviour. Following B.G. Prasad’s classification for socio-economic status (2013) it has been found that majority of the children in the two population groups viz. the Bodos (50.7%) and Garos (61.4%) belong to the lower category (Class IV) and 40 per cent among the Caste Hindus belong to the mid category of Class III socio-economic status (Table III.A.5).

A perusal of the literacy status of the parents of the under five children (Table III.A.6 and III.A.7) shows that the literacy is the highest among the Caste Hindus (Male- 90.5%, female 92.5%) followed by the Bodos (Male 82.6%, female 84.6%) and Garos (Male 74.8%, female 64.9%). Among the Bodos and the Caste Hindu literacy of the mothers is slightly higher than that of the fathers. The Garos on the other hand, show a higher literacy among the fathers than the mothers. The literacy level of the Bodos and the Caste Hindu parents is higher than the All India average of (74.04%) and that of the state of Assam (73.18%) as per 2011 Census. As against that,
the literacy level of the Garo parents is lower than the national average and that of Assam. Again, the overall literacy status among the mothers of the under five children of the present study is also found to be higher (81.6%) than the female literacy rate of India (71.8%). Similarly, the literacy rate of the fathers also stands high (84.6%) than the male literacy rate of India (82.8%) as per NFHS-4 data of 2015-16. However, it needs mention here that the literates of all the groups are mostly either barely literates or have read up to the tenth standard. There are a microscopic few who have read beyond XIIth standard. This is basically because there is no college in the area. The nearest college is about 15-20 kms from the villages and till a few years back the communication to the villages were extremely bad. Even the main road leading to Rani was in a deplorable condition. The lower literacy of the Garos may be because there is no high school in the area inhabited by them. Even for primary education, the children have to walk a few kilometers.

Most of the mothers are housewives and only a few are found to work as daily wage labourers. The highest number of families in all the communities are engaged in daily wage. Cultivation is the occupation next to daily wage among the Garos. Among the Bodos and the Caste Hindus a considerable number of fathers are found in petty business and small private sector service through which they can earn a minimal monthly income. It needs mention here that after the establishment of the Industrial Estate in Rani, quite a good number of small scale industries and factories have come up in the area which have given employment opportunities to the local people particularly in the unskilled sector with meagre salaries.

With regards to house type and toilet facility it is observed that kutch houses with earthen floor is predominant in all the communities. Again, majority of the people in the study population either use pit latrine or go for open air defaecation. The use of sanitary toilets which is 30.6 per cent in the present study is found to be lower than the national rural figure of 45.1 per cent for improved toilet (NFHS-4, 2015-16).
Care practices:

Antenatal care is a prerequisite for the health and welfare of the mother and the unborn child. It ensures a safe delivery, a healthy mother and child at the end thereby reducing infant and maternal mortality and also morbidity and mortality in children.

Different communities have their own cultural way of providing care to the pregnant women apart from the medical care. Food prescription and food restriction which is almost universal is one such care practice seen in many societies. The idea behind food prescription is that the prescribed food will provide all the necessary nutrients thereby ensuring good health of the pregnant women, a safe delivery and also a healthy baby. Similarly, certain foods are restricted with the belief that such foods may bring complications or may have abortive substances which may be harmful for the foetus. However, with the advancement of education and accessibility to modern health care, such practices are not followed by many although in the present study a good number of women are found to follow the same. Followers of this tradition of food prescription is found to be the highest among the Bodos (43.8%) followed by the Caste Hindus (41%). Among the Garos, the prescribed food item is minimal, may be because of the fact that their traditional regular food consist of all the nutrients essential in pregnancy. Again, most of the food items prescribed by the Bodos and the Caste Hindus are part of the normal diet of the Garos. So whatever minimum prescribed foods exist, these are found to be followed by 31.6 per cent of pregnant women which is lower than that of the Bodos and the Caste Hindus.

Rao (2004) stated that food of animal origin is restricted in some areas with the belief that such food will make the foetus big thereby causing difficult labour. Similarly, jaggery and papaya are restricted fearing abortion. Bananas are also believed to result in one child sterility and hence restricted during pregnancy. Similar restrictions are also observed to be followed during pregnancy in the present study. Certain food like tamarind, star fruit and alkali are believed to be very strong and act as a deterrent to pregnancy. Such food items are found to be restricted in all the three groups of study population. Similarly, food believed to be hot like jack fruit, pumpkin, meat of pigeon, duck, etc. are also restricted during the gestation period. Almost all the restricted food
items during pregnancy are found to be similar for the Bodos, Garos and the Caste Hindus except bamboo shoot (*bah gaz*) which is prescribed among the Garos but at the same time restricted among the Bodos and the Caste Hindus.

Pica eating or consumption of non-food items during pregnancy is almost universal throughout the graticules. Although pica eating is occasionally seen in children and adolescents, it is more prevalent in pregnant women. This unusual craving may be due to some deficiency in the body like iron deficiency or it can be also because of multiple factors- psychological, cultural, etc. Pica eating is also found in the present study among a small section of antenatal women (6.6%), the highest consumption (7.5%) seen among the Caste Hindus. Potsherd, burnt clay, chalk are some of the non-edible items found to be consumed by women during their pregnancy.

Until a few years back home deliveries were more common compared to hospital deliveries. However, due to the development in the health infrastructure and also easy accessibility to health facilities, the scenario has changed immensely. A similar picture is also seen in the present study where most of the deliveries among the Bodos (94.5%) and the Caste Hindus (95.5%) have taken place in the hospitals (Table III.B.2). However, the situation is almost reverse among the Garos where only 49.1 per cent of deliveries have taken place at home. This high variation in the place of delivery between the Bodos and Caste Hindus on one side and the Garos on the other is mainly because of the fact that the areas inhabited by the Garos are quite far-off from the nearest health centre at Rani. Moreover, the road condition from their villages and the transport facilities available are such that they cannot think of bringing a pregnant woman to the health centre at Rani for delivery. Besides, in some of the villages though there are Sub-centres nearby, the health personnel are hardly found there. These health personnel neither prefer to stay in the area nor visit the centres regularly. As such, the facilities expected to be available in these centres become a cry. However, when all the three groups are clubbed together, it is found that institutional deliveries are well above the national average of 41 per cent (NFHS-3). Kalita (1997) working in the same area have observed 63.5 per cent and 89.5 per cent home deliveries among the Kalitas and Bodo-Kacharis respectively which is higher than the findings of the present study showing a clear improvement during a period of a decade and a half. Das *et al.* (2008)
in a study at Basirghat in rural West Bengal have found 83.6 per cent home deliveries which is enormously higher than the home deliveries (18.2%) found in the present study. In contrary, Das et al. (2014) found only 26 percent of home deliveries in Midnapur, West Bengal. However, Roy et al. (2013) in Chetla area of Kolkata, West Bengal and Saikia et al. (2014) in rural areas of Dibrugarh district, Assam observed 93.3 per cent and 94.2 per cent institutional deliveries respectively, which is higher than the present study.

A trained attendant, be it a doctor or a health personnel, always ensures the survival of the child and the mother. In the present study, 92.6 per cent deliveries have been attended by trained personnel which is well above the national figure of 49 per cent (NFHS-3, 2005-06) and also the all India rural average of 36.7 per cent (UNICEF, 2011). A higher percentage of deliveries conducted by midwife among the Garos (21.6%) are mainly linked with the high home deliveries among them (49.1%) (Table III.B.2). However, the present findings of 7.3 per cent deliveries conducted by midwives is found to be lower than that of Das et al. (2008) where the figure stands at 31.5 per cent. Similarly, birth attended by skilled personnel (92.6%) under present study is strikingly higher than that of rural India (36.7%) as reported by UNICEF, 2011.

Breastfeeding practices have a significant effect on the health and well-being of the under five children. It not only provides the necessary nutrients but also boosts the immunity status of the child and establishes a strong bond between the mother and the child. A healthy breastfeeding practice includes early initiation of breastfeeding, feeding of colostrum, non-feeding of prelacteal and exclusive breastfeeding up to six months of age. Breastfeeding is found to be universal in the present study. Early initiation of breastfeeding is found to be appreciably high (73.8%). All the three groups of population viz. the Bodos (67.2%), the Garos (87.1%) and the Caste Hindus (69%) show higher percentage of early initiation of breastfeeding which is above the national average of 55 per cent (NFHS-3). Similar studies by Hiregoudar et al. (2013) at Bellary, Karnataka, Das et al. (2008) at Basirghat in West Bengal and Srinivas et al. (2014) at Puducherry found 40 per cent, 67.9 per cent and 64.7 per cent respectively of early initiation of breastfeeding. The finding of the present study is also
higher than the results of the studies mentioned above. Early initiation of breastfeeding especially among the Bodos and the Caste Hindus may be attributed to high hospital deliveries where mothers are constantly motivated to practice the right kind of breastfeeding by the health personnel (Table III.B.4). Mehnaj et al. (2010) also had a similar observation and attributed appropriate feeding practices to institutional delivery where the mothers are in close contact with the health personnel. Similarly, among the Garos, inspite of high home deliveries, a high early initiation of breastfeeding is found among them. This may be due to the fact that beliefs like delay in initiation are not widely prevalent in this said population.

Traditionally colostrum feeding is considered to be impure, dirty and not easily digestible. Therefore, it is deliberately squeezed out before breastfeeding is initiated (Editorial, Indian Paediatrics, 2003). Similarly, Reissland and Burghart (1988), McDonald (1987), McGilvray (1982) Blanchet (1984) also viewed that colostrum is considered to highly undesirable in the Indian subcontinent and parts of Southeast Asia and prelacteal feeds are given in the first two to three days after birth. However, colostrum feeding is found to be high (77.6%) in the present study (Table III.B.4). In case of hospital delivery, the parturient mothers are not allowed to discard the colostrum as it is beneficial for the health of the newborn as is observed among the Bodos and the Caste Hindus where hospital deliveries are found to be higher. Since among the Garos quite a good number of deliveries take place at home and conducted by midwife, traditional practices continue to follow. Similar studies by Hiregaudar et al. (2013) at Bellary, Karnataka and Srinivas et al. (2014) in Puducherry have observed 97.5 per cent and 97.8 per cent colostrum feeding which are well above the findings of the present study. Similarly, Maiti et al. (2015) have observed 74.8 per cent of colostrum feeding in Odisha which is somewhat nearer to the present findings.

The practice of prelacteal feeding is almost universal. It probably came into being due to the situational need of the child in certain conditions like death of the mother, health of the mother when she is unable to feed her child, etc. In the present study, prelacteal feeding is found to be less in all the groups (26.2%), the least being observed among the Garos (15.2%) (Table III.B.4). The most common type of prelacteal feed found to be administered in newborn is honey. Boruah (1997) working
in the same area found that 89.6 per cent newborn did not receive any such feed. She also observed that honey and cow’s milk were the commonly used prelacteal feeds. Several studies across the country by Puri et al. (1976), Bhandari and Patel (1973), Madhabi et al. (1972) have reported different types of prelacteal feed like janam ghutti (a herbal mixture with honey), castor oil mixed with honey, cow’s milk, etc. It needs mention here that prelacteal feeding in the truest sense is not possible in hospital deliveries where the baby is put to breast milk immediately after birth. But once the mother and the newborn are put to bed, it is not possible to monitor them every minute. However, the belief of prelacteal feeding is so strong that anyhow it is stealthily administered to the newborn by the relatives, mostly the elderly women, before intensive breastfeeding starts. Das (1996) observed 79.5 per cent of prelacteal feeding in Shillong which is much higher than the present finding. Similarly, Das et al (2008) and Hiregaudar et al. (2013) found 78.2 per cent and 51.7 per cent of prelacteal feeding in their studies which is again much higher than the present finding. Roy et al. (2009) found 29.16 per cent prelacteal feeding which is somewhat nearer to the present finding. In contrary, Srinivas et al. found only 5.9 per cent of prelacteal feeding.

It is observed that exclusive breastfeeding practice (39.7%) is not as good as other breastfeeding practices in the study population (Table III.B.4) where early initiation stands at 73.8 per cent, feeding of colostrum 77.6 per cent and non-administration of prelacteal is found to be 73.8 per cent. This may be attributed again to high percentage of hospital deliveries where the mothers of the newborn are under the constant care and supervision of hospital staff and are also motivated to practise the right kind of breastfeeding. But once they are discharged from the hospital, societal norms and customs gets precedence over the Do’s and Don’ts of the advocated practices. It is observed that family members often pressurize the mother to start weaning before six months of age with the idea that breast milk is not sufficient for the child. Frequent cries of an infant are one of the indicators of the hunger of the child. Inspite of breastfeeding if the baby continues to cry to the point of irritation for others, alternative feeds are provided thinking that it would satisfy the hunger of the child. Harrison et al. (1993) also had a similar observation in Egypt where perception of insufficiency of breast milk was often based on the crying of the infant. Again, many mothers give water to their babies especially in summers thinking that breast milk is not
sufficient to quench the thirst of their infants. Feeding of formula milk has also become a status symbol more so among the Caste Hindus. Just to boost their status, often babies are given formula milk easily available in the markets. These are some of the vital reasons why exclusive breastfeeding is not much adhered to by many of the mothers in the present study. Exclusive breastfeeding in the present study is found to be low than the national average of 46 per cent (NFHS-3, 2005-06). The Bodos are, however, somewhat nearer (45.3%) to the national average. Medhi and Mahanta (2004) observed 69.3 per cent exclusive breastfeeding in the tea estates of Assam which is also much above than the present findings. Similar studies on breastfeeding by Srinivas et al. (2014.) and Maiti et al. (2015) show a higher percentage of exclusive breastfeeding (72% and 70.2%).

Another care practice for a pregnant mother is in the form of mobility restrictions. The idea behind such a traditional practice is to provide rest to the pregnant women. In the present study, 32.7 per cent of the pregnant women are restricted to distant movements (Table III.B.3). The Garos inhabiting the foothill areas and living near the forest are found to have more mobility restrictions (43.3%) compared to the Bodos and the Caste Hindus residing in the plain areas. Such restrictions among the Garos are probably meant for ensuring safety and security of the pregnant women, they being found to inhabit near the forests which shelter many wild animals. Superstitious beliefs like evil spirits doing harm to pregnant women if she does not abide societal norms are also found to be widely prevalent amongst them. However, an overall high per cent of non-restriction on mobility (67.3%) especially among the Bodos and the Caste Hindus shows that modern way of life prevails over the traditional practices.

A safe instrument used for cutting the umbilical cord after birth ensures the chances of survival of the infant and mother. Among the Caste Hindus, the blade is the only instrument found to be used whereas among the two tribes i.e. the Bodos and the Garos, different types of instruments like the blade, knife, scissor, bamboo splinter and sickle have been found to be used. The variety of instruments used for cutting the umbilical cord is wider among the Garos than the other two groups. This may be again due to high home deliveries and high deliveries conducted by midwives where different persons choose to prefer different instruments for the purpose.
Similarly, the application of substances in the umbilicus for healing is another care practice observed in many communities. Although the practice is found to be comparatively low among the Bodos (25.9%) and the Caste Hindus (29%), it is found to be immensely high among the Garos (44.4%). This high percentage among the Garos may again be related to high home deliveries and the mother’s lacking the necessary knowhow of safe healing. A good number of substances are found to be applied in the umbilicus in the study population, the most common being mustard oil, coconut oil, talcum powder, etc. However, the practice of applying vermillion in the umbilicus along with the other items is found only among the Caste Hindus.

The practice of bathing the newborn immediately after the delivery is found to be high among the Garos (41.5%) compared to the Bodos (10.4%) and the Caste Hindus (10%). The high percentage of bathing the newborn among the Garos may be linked to high home deliveries where the traditional practice of cleansing the baby after birth still continues to be prevalent. Das et al. (2008) observed that 17.6 per cent newborns were given their first bath which is nearer to the present finding of 19.6 per cent when all the communities are clubbed together.

**Morbidity:**

The health of the children is one of the important determinants of the overall development of the nation at large. The determinants of child morbidity may be very wide ranging from environmental to socio-cultural factors. Although ARI and diarrhoea are common in under five children, other diseases like measles, malaria or combination of several diseases also afflict them. Morbidity in children is mostly rooted in environmental and other social ills which can be averted with the right kind of action and intervention.

In the present study the average incidence of disease is found to be 68.5 per cent and it is the highest among the Bodos with 70.1 per cent sufferers followed by the Caste Hindus (69%) and the Garos (66.1%). Morbidity among the under five children is found to be higher in females than the males among the Bodos and the Garos, whereas among the Caste Hindus male morbidity is higher than the females. Higher male morbidity was also observed by Bhattacharya (2005). Gupta et al. (2012) also observed
that female under five children suffered from more number of episodes (5.6) than the male under five children (4). Infant morbidity is, however, higher in males among the Garos and the Caste Hindus and in females among the Bodos (Table III.B.8). Singh et al. (2013) and Gupta et al. (2012) found episodes of illness more in infants than in children above one year of age which is mostly in sync with the present findings.

The prevalence of ARI stands to be the highest in both male and female children in all the groups of population (Table III.B.11) followed by fever and diarrhoea. Joseph et al. (2010) and Goel et al. (2012) also observed a high prevalence of ARI (62.4% and 52% respectively) in their works in South India and Meerut. Similarly, Gupta et al. (2012) also observed that ARI was the principal cause of disease (47.3%) followed by diarrhoea (30.1%) and fever. Kapil and Sood (1989) also had a similar finding of high incidence of ARI followed by diarrhoea and fever. Das et al. (2014) in Lahoal, Dibrugarh observed a high incidence of ARI followed by measles and diarrhoea. Similarly, Yogesh et al. (2014) and Saikia at al. (2014) stated that the most common morbidities were ARI followed by diarrhoea and fever. The present findings also corroborate with the results of Karrar and Omer (1981) where they found that cough, fever and diarrhoea are the most common causes of morbidity in children. Similarly, Venkatesh and Bansal (1986) in their study also found that respiratory illness and diarrhoea accounted 64.9 per cent of all illness.

The prevalence of ARI which stands at 41.8 per cent is found to be the highest among the Bodos (47.8%) followed by the Caste Hindus (42.5%) and the Garos (33.9%) (Table III.B.14). The disease is also found to be predominant among the infants (44.8%) than the 1- <5 years children (41.1%) in all the communities under study. This is mainly because the infants’ immune system being weak, they are susceptible to catch cold easily. However, with the growing of age they build up their resistance which is why the prevalence is found to be less in the 1- <5 years of age group. A similar result was also made by Islam et al. (2013) where incidence of ARI was found to be higher in infants. A minute observation of the occurrence of ARI in all the groups shows that the incidence is the least among the Garo infants (31.8%), followed by the Bodos (44.2%) and the Caste Hindus (52.5%) (Table III.B.15). The traditional practice of belting the baby around the mother’s rear or front, commonly
seen among the tribal population, more so among the hill tribes, provides the much needed warmth, keeping diseases like ARI at bay. This may be one of the reasons why ARI is found to be less among the Garos and the Bodos than the Caste Hindus. Likewise, fever is also found to be high among the infants than the 1-<5 years age group in all the communities. With regards to sexwise morbidity of children, incidence of ARI is found to be higher among the female Garo and male Caste Hindu and Bodo children. The same is the trend in fever as well. Islam et al. (2013) also found a higher incidence of ARI among the females against male children. However, Acharya et al. (2003) in South India found the incidence of ARI to be almost same in both male and female children.

Incidence of diarrhoea follows ARI and bouts of fever. The overall prevalence of diarrhoea in the present study stands at 20.5 per cent. Bora et al. (2014) in Dibrugarh district of Assam and Singh et al. (2013) in Manipur have observed 26.2 per cent and 35 per cent of incidence of diarrhoea respectively which is higher than the prevalence found in the present study. Comparatively the Caste Hindu children (22%) show a slightly higher percentage of prevalence compared to the Bodos (20.4%) and the Garos (18.7%) (Table III.B.17). Again, it is also observed that the prevalence of the disease is higher in 1-<5 years of children (21%) than the infants (18.1%) (Table III.B.18). Joseph et al. (2010) in South India, however, found a higher prevalence among the infants (42.8%) which is strikingly above the prevalence among the infants of the study population. Diarrhoea which is higher in the 1-<5 years group of children compared to the infants is more so because once the child starts growing, s/he is given food from the family pot which the child may not be able to digest easily triggering diarrhoea. Maintenance of personal hygiene by the mothers while preparing the food and also while feeding the child cannot be ignored here. Likewise, the hygiene of the child who develops the habit of eating by himself or herself by 2-3 years of age also cannot be ignored. Again, the market being over flooded with junk food and all kinds of unhealthy food items, usually relished by the children, is also another cause of high incidence of diarrhoea among the children in the age bracket of 1-<5 years. The overall incidence of the disease is slightly higher in the male children (20.7%) than the females (20.1%) (Table III.B.19). Wyrsch et al. (1998) in New Guinea also found incidence of
diarrhoea more in male children. Borah et al. (2014), however, found the incidence more in female children.

It again needs to be mentioned here that malaria is found to be the highest among the Garos (6.6%) as they reside in the foothills which is endemic to vector-borne diseases. At the other side of the coin, no incidence of malaria is found among the Caste Hindus and only a negligible number (0.6%) is present among the Bodos. Both these groups are found to reside in the plains.

Any child may suffer from multiple diseases at one point of time. This may be due to both primary and secondary infections affecting the child at a time. It may also be due to the signs and symptoms in the child prior to the onset of the primary disease thus showing multiple diseases at a time. The present study shows that 25.9 per cent children under five years of age suffer from two diseases at a time. The highest (28.9%) is found among the Bodos followed by the Caste Hindus (27%). Sufferers of a single disease stand at 25.7 per cent, the highest being found among the Garos (33.9%). There is a dwindling count of sufferers of children with the increase in the number of diseases (Table III.B.9).

It is also observed that the combination of ARI-fever is the highest followed by ARI-measles, ARI-diarrhoea and diarrhoea-measles. Fever in many cases is associated with ARI. Similarly, the signs and symptoms of measles are also fever and respiratory tract infection (Park, 2013). Since ARI is associated with a number of diseases, more disease combination with ARI is well expected (Table III.B.13).

The birth weight of a child is a strong indicator not only for child survival but also for good health and well-being of the child. A baby born with low birth weight i.e. less than 2.5 kg (which is the cut off for high risk group of newborns) are prone to diseases than babies born with birth weight greater than 2.5 kg. This is also evident in the present study where children with low birth weight show higher incidence of diseases than children with birth weight greater than 2.5 kg. (Table III.B.20). Venkatacharya (1985) also stated that birth weight of the child is an important determinant of child morbidity in developing countries. However, the difference in
morbidity between the children with underweight and normal weight is found to be statistically significant ($\chi^2 = 5.29$, df=1, p=.02) in the present study.

The type of house can affect the morbidity status of children. Dhanalakshmi (1993) viewed that the better the house type, the lower is the incidence of diseases. Similarly Singh and Nayar (1996) and Sharma et al. (2013) have found morbidity more in kutcha houses. Findings of Islam (2005) and Bhattacharya (2005) also show a higher incidence of ARI in kutcha houses than pucca houses. However, a reverse condition is observed in the present study where incidence of morbidity is higher in pucca houses compared to kutcha houses (Table III.B.22). Although incidence of diseases are found to be higher in pucca houses among the Bodos and the Garos, the difference in child morbidity between the two types of houses i.e. kutcha and pucca is not found to be significant in the present study. Elizabeth and Raj (2012) in Odisha observed prevalence of ARI more in pucca houses (5.1%) than kutcha houses (4.4%) which is in conformity with the findings of the Bodo and the Garo population here. Among the Caste Hindus, however, morbidity is found to be higher in kutcha houses which conform to the findings of the studies mentioned earlier.

It is a general assumption that boiled and filtered water kills germs and keeps disease at bay, more specifically in children. The same principle is, however, not applicable in the present study because incidence of morbidity is found to be higher in children irrespective of whether water consumed is treated or untreated (Table III.B.24). On further probing it was found that the people simply heat the drinking water in the smouldering ambers which is not enough to kill the germs as is done by roll boil. Again, it is also observed that only to save fuel, it is a regular-practice not to roll boil the water but simply heat. There is a common misconception that simply heating the water is equivalent to boiling. This process which does not kill the germs and bacteria is responsible for several water-borne diseases in under five children. Again, diarrhoea which is also a water-borne disease is found to be high in children consuming filtered water (22.3%). It needs mention here that filtering is done in the conventional way with sand and charcoal which is seldom cleaned. Moreover these filters are kept open making it free for further contamination. Such filtering process may perhaps help in removing only the iron content in the water. A similar observation
was also made by Elizabeth and Raj (2012) where morbidity, more specifically diarrhoea, was found to be higher in improved drinking water.

The source of drinking water is a major cause of prevalence of diarrhoea in any population. In the present study 24.1 per cent sufferers of diarrhoea are seen in children consuming water from kutchha well (Table III.B.30). Bora et al. (2014) in Dibrugarh found 60 per cent sufferers of diarrhoea consuming water from kutchha well which is much higher than the present findings. In the present study a somewhat higher percentage of (19.6) of diarrhoea cases are seen in children drinking water from tap. Tap water which is not continuous but intermittent may be another reason for the cause of diarrhoea in under five children. The water pipes in the area are found to be not properly maintained by the Public Health Department. Perforation is also seen in the pipes because of rusting. As a result dirty water with mud from the surrounding areas finds its way inside the pipes. Moreover, there is no regular flow of water because of blockade making vacuum inside the pipes. Thus, water gets easily infested because of these reasons. The water source from the tube-well is found to be comparatively safe for under five children so far as diarrhoea is concerned.

The type of toilet is a factor for morbidity in under five children. Unhygienic sanitary conditions due to open air defaecation and even in pit-latrines cause many water-borne diseases like diarrhoea, dysentery, jaundice, etc. Studies have shown that children who live in houses with sanitary toilets and who defaecate in the latrines have lower morbidity rate. Yohannes et al. (1992) in their study in Ethiopia made similar observations. Singh et al. (2013) in Manipur also attributed the high prevalence of diarrhoea to insanitary type of toilet. The Loktak Lake which is the main source of drinking water is contaminated by the sewage discharged from house-holds located nearby.

Toilet facility which is categorized into sanitary and insanitary (pit and open-air defaecation) in the present study also shows a strong association between morbidity and type of toilet. Sufferers of any kind of diseases are found to be more in children in houses with insanitary toilet facility among the Bodos and the Caste Hindus (Table III.B.23). The findings of the present study also shows a higher prevalence of diarrhoea where the toilet is either pit or open-air (Table III.B.32). Ironically, among
the Garos incidence of morbidity is found to be higher in children using sanitary toilet facilities over insanitary toilet facility. Similar observations were also made by Elizabeth and Raj (2012) where prevalence of morbidity was found to be higher in the improved type of toilet. However, in the present study the difference in morbidity between children of families having sanitary facilities and without it is not statistically significant.

The type of family may also have an effect on morbidity status of under five children. It is a general observation that morbidity, more specifically the communicable diseases, is higher in joint families because of higher number of family members living in close contact under one roof. In the present study it has been found that morbidity in under five children is higher in joint families compared to the nuclear families in all the communities (Table III.B.21). The present findings corroborates with that of Islam et al. (2005) and Bhattacharjee (2005) where morbidity (ARI) was found to be higher in joint families.

Parental education plays a key role in influencing the morbidity status of the children more specifically the under five. It is a general assumption that higher the educational status of parents the lower will be the incidence of disease in their children. Streatfield (1990), Shea (1991), Gokhale et al. (2002) have observed that literacy of mothers are influential in lessening the disease in under five children. Similarly, Ali et al. (2011) and Joseph et al. (2013) also viewed that the benefit of parental literacy, more specifically maternal, flows to the child. This is, however, in sharp contrast with the present findings because morbidity is found to be higher in children whose parental educational status is high. It is to be mentioned here that even though the number of literates among the parents is higher, their educational level is limited to secondary level only. Moreover, such educated parents having acquired their education in their own local areas have not ventured out beyond their locality and as such their knowledge regarding care and health seeking behaviour is also limited. The traditional system of health care and superstitious beliefs also persists. Many a times their reliance on modern medicine ebbs. It is also to be mentioned here that education is also associated with occupation and income which finally affects morbidity. In this regard, Joshi (1994) and Barrera (1990) observed that women with better education are more
likely to utilize available health care facilities than those with no education. No statistically significant difference in morbidity between children of different educational categories of the parents is, however, found in the present study.

Like education, occupational status of parents can also determine the levels of morbidity in under five children. A higher occupational level is said to improve the overall health of the children and also their health seeking behaviour. This trend is, however, not observed in the present study where morbidity is found to be higher among children whose mothers are working and fathers are in higher level of occupation for the Bodos and to some extent among the Garos. Although business and service are considered as higher level of occupation, it needs to be mentioned here that those in business are petty businessmen like owners of pan shop, grocery, small retail shop, etc. Again those in service are either grade III and grade IV government employees or unskilled workers employed in the small-scale factories which dot the Rani area. Hence, not much variation may be observed between those in service and business on the one hand, and those who work as cultivators or skilled/unskilled workers on the other. Therefore, the variation in morbidity in children between different levels of occupation of fathers is not found to be significant.

The association between the presence of morbidity in under five children and socio-economic status of the family has been focused by scholars like Biswas et al. (1999), Islam et al. (2005), Joseph et al. (2013) and many others. In the present study, however, not much variation in morbidity among children between different categories of socio-economic status is observed. India being a tropical country, the role of climatic condition in the occurrence of diseases cannot be denied irrespective of the socio-economic status of the family. Again, children being more susceptible to diseases can easily be infected from any family members suffering from diseases. The same is also applicable for children going to the anganwadi centres or pre-schools where the chances of acquiring communicable diseases are also high. Thus, socio-economic status of the family does not play a vital role in the morbidity of children in the present study. Scholars like Neumark et al. (1992), Schellenberg et al. (1992), Dreze et al. (1995), Engle et al. (1997) have emphasized that economic status is one of the most significant indicator for seeking medical care and not for occurrence of morbidity.
Exclusive breastfeeding for the first few months of life can bring significant improvement in the health and well-being of the child. It reduces diarrhoeal morbidity and provides newborns with the best possible nourishment as well as antibodies against common infections. The present findings also give a similar picture where incidence of ARI and diarrhoea is absent among the Bodo and the Garo exclusively breastfed infants. The incidence of morbidity is also negligible where exclusively breastfeeding is practised among the Caste Hindus. Ramachandran and Gopalan (2009), Joseph et al. (2013) also stated that incidence of morbidity was least in exclusively breastfed children. Similarly, Selvaraj et al. (2014) stated that breastfeeding is one of the life-saving tools in prevention of various diseases. Deb (1998), Story and Parish (2008) also found a protective relationship between exclusive breastfeeding and incidence of diarrhoea and pneumonia and other severe diseases. Similar observations were also made by Boggard (1991), Shahidullah (1994) and Oddy et al. (2003).

The health care seeking behaviour is found to be related to the type of diseases suffered by the under five children. For diseases like diarrhoea, ARI, fever, etc, the Bodos and the Caste Hindus, are found to seek the modern medical care. Over the counter getting medicines from the pharmacist is also found to be a common practice among them. However, the Garos are found to seek comparatively less modern medical care owing to the fact that the health facilities are far off as mentioned earlier. The practice of giving home remedies for common morbidities is also found to be prevalent. Some common home remedies are honey mixed with extract of *tulsi* (basil) or ginger for cough and cold, unripe banana as a vegetable for diarrhoea, etc. In recent years, the mothers more specifically the young mothers, shows an inclination for modern medicine over the traditional one. However, a pluralistic way of dealing with diseases is prevalent in all the communities.

For diseases like measles and jaundice, all the communities under study seek the traditional medicine over modern medicine. In case of measles, the children are confined to their houses. Restrictions in food are also observed and hygiene of the child as well as the whole household is taken care of. Rituals like *Aai naam* are also observed among the Bodos and the Caste Hindus. Similarly, food items like oil, turmeric, spices, etc. are restricted when one is suffering from jaundice.
Mortality:

Mortality, as a demographic parameter, is important to determine the growth of any population. Infant, infant and child mortality are indicators of the overall health of a population and in sharp contrast to it, it can also denote the well-being of the said population. The loss of a child not only brings emotional trauma to the bereaved family but also takes a toll on the health of the mother.

An examination of infant and under five child mortality in the present study reveals that mortality is high in the first one year of birth and then gradually reduces with the advancement in age (Table III.C.2). The infant mortality rate in the present study is found to be 33.1 which is lower than the all India IMR of 57/1000 live births and 66/1000 live births for the state of Assam (NFHS-3, 2005-06). The IMR of the Bodos (37.6), the Garos (48.6) and the Assamese Caste Hindus (14.6) are well below the state average like Uttar Pradesh and Chhattisgarh where IMR is the highest (70/1000 live births). It is also to be mentioned here that IMR of the Caste Hindus is slightly lower than the states like Kerala and Goa where IMR (15/1000 live births), is the lowest in the country (NFHS-3, 2005-6). The recent NFHS-4 (2015-16) data for IMR which stands at 48/1000 for the nation is also higher than the IMR of the present study. Within the infants, it is observed that neonatal mortality (1.25) is lower than the post neonatal mortality of 2.15 per cent. Phukan and Mahanta (1996) observed the neonatal mortality of 46.5/1000 live births in Dibrugarh, Assam. This figure is strikingly higher than the findings of the present study where neonatal mortality is 12.5/1000 live births. Similarly, Choudhury (1993) observed a high infant mortality of 19.34 per cent among the Mishmis of Arunachal Pradesh. Though the IMR in the present study groups is lower than the national average for rural areas (44/1000 males) and that of the state average (56/1000 males), it is still higher than that of many states in India (SRS, 2014.)

The under five mortality is also lower than the all India rural mortality of 98.9 (UNICEF, 2011). It is also observed in the present study that mortality is higher in the two tribal groups i.e. the Bodos and the Garos in comparison to the Caste Hindus. Das et al. (2010) have also found a high number of child deaths between 1- <5 years among the tribal population. They have stated that an average Indian child has a 25 per
cent lower likelihood of dying under the age of five compared to a tribal child. The study also revealed that between 0-1 years both tribal and non-tribal faces similar odds to the risk of death. However, in the present study, the tribal infants show a higher mortality rate than the Caste Hindus.

It is to be mentioned here that mortality among the Garos is comparatively higher than the other two groups of population which can be attributed to several causes. The Garos inhabiting the foothill region of Rani area is not in proximity to the health care facilities. Moreover, due to problems in transport and communication they seldom bring their children to the health centre and rather prefer the traditional methods of cure. Again, it is also observed that the literacy level of the parents of the Garo children is lower than the other two groups of population (Table III.A.6 and Table III.A.7). Occupationwise also most of the Garo mothers are housewives (97.7%) and the fathers are mostly daily wage labourers (38%), skilled workers (12.3%) and cultivators (34.5%) (Table III.A.9). Socio-economically also majority of the children belong to the lower strata of class IV (Table III.A.5). All the above mentioned factors clearly reflect that the Garos comparatively belongs to a low rung of the socio-economic ladder. These may be some of the causes of higher infant and child mortality among the Garos compared to the Bodos and the Caste Hindus.

Sexwise distribution of mortality in under five children in the three communities reveals that male mortality is higher among the Bodos. It is also to be mentioned here that although female mortality is higher among the Garos and the Caste Hindus, it is only by a very small margin (Table III.C.3). Infant and child mortality rates for females were also found to be higher by Rajaratinam (1989) and Dasgupta (1990). Since boys are biologically stated to be weaker (Karkel and Pandey, 1989) higher male mortality is observed across the world. India is, however, exception to this where female mortality is higher than the males. The sex difference in under five mortality is not statistically significant.

The higher incidence of mortality in under five children in any population may be due to many reasons. Although advent of disease in a child may be one of the main causes of mortality, biological and other associated factors like age of the mother
Morbidity of any type may be the cause of death in children. It is to be mentioned here that diarrhoea is one of the leading causes of death in under five children across the world (UNICEF, 2015). It is also the third leading cause of childhood mortality in India and is responsible for 13 per cent of all deaths per year in children under five years of age (Lakshminarayanan and Jayalakshmy, 2015). In the present study, diarrhoea (25%) is also found to be one of the major causes of death when all the three groups are clubbed together (Table III.C.4). Among the Caste Hindus and the Garos, death caused by diarrhoea stands to be the highest than any other morbidities. Deka (1991) in Orissa and Kalita (1997) working in the same area of the present study i.e. Rani also reported high infant deaths caused by diarrhoea. Low birth weight (<2.5 kg) is another cause of high mortality in the population under study. Medical literatures support the fact that a newborn weighing less than 2.5 kg. at birth have lesser chances of child survival and automatically fall in the high risk group. Again, a high incidence of mortality in the study population is also because of some unknown reasons. These causes are rooted in their superstitious beliefs, which according to them are either due to wrath of God or evil spirits. Many of the respondents opined that if a mother does not adhere to the norms dictated by the society, especially during pregnancy, an evil spirit may cast its spell on both the mother and the newborn by causing death or by afflicting the duo with misfortunes. Kalita (1997) also observed respiratory problems and change of colour of the body at the time of death, to be some of the major causes of deaths among the infants in the same area. He also reported a high percentage of infant deaths (Kalita-30% and Bodo-Kacharis-20%) due to the wrath of evil spirit which also corroborates with the present study.

Mother’s age at the time of birth of the child affects not only the health of the duo, but also can result in the mortality of the newborn. Again, a high infant mortality especially in case of first delivery among older women may be due to biological complications that may occur due to old age. In the present study a high mortality in infants and children is found in women who are 30 years and above in all the groups of population (Table III.C.5). However, no mortality has been found of
mothers below the age of 20 years except among the Garos. Perkin (1968) also observed that pregnancies in young mothers and old mothers are high risk indicators for infant and child mortality. Mahadeven (1979) also observed higher incidence of infant and child mortality among women of older age in three cultural groups. Similarly, Bhandari et al. (1988) and Roy and Jeyachandran (1996) were also of the view that extremes in the mother’s age (<20 and >30 years) poses a threat to the survival chances of the infant. Kalita (1997) also found higher infant and child mortality among the mothers whose age is above 40 years.

Birth weight is considered to be an important indicator for infant mortality. Generally, babies with low birth weight (< 2.5 kg) have a lesser chance of survival than the babies with normal birth weight (> 2.5 kg). This is also evident in the present study where a higher infant mortality is found where the recorded birth weight of the newborn is less than 2.5 kg (Table III.C.6). However, mortality is found to be less in 1-<5 years of children among the Garos and the Caste Hindus. This is, however, not applicable among the Bodos where a high mortality in 1-<5 years of children is seen. The present study is in conformity with NFHS-3 (2005-06) data which reported that one-third of the neonatal deaths in India are due to low birth weight. IANS, London 2016 have reported that babies born with low birth weight are at greater risk of death till adolescence. It also stated that death occurred 130 times more frequently in those born with a very low birth weight. Of the 1,23,55,251 live births between 1993 to 2011, 77 per cent of deaths have occurred in infants. Borah and Baruah (2014) also stated that high incidence of low birth weight in Assam (26%) is an important public health problem and associated with both morbidity and mortality in children.

In the present study mortality is found to be higher in normal deliveries among the Bodos and the Garos. This is applicable for both infant and child mortality (Table III.C.8). However, in the Caste Hindus, mortality among the children is found to be higher in cases where caesarean section was necessary for delivery.

Hygiene and care at the time of delivery are very important for the safety and survival of newborns. Children born in the hospital thus have a low risk of death because of the utmost safety precautions, care and hygiene in the hospitals. On the other hand, children born at homes are more prone to death because of unsafe delivery.
practices. The present study shows a high mortality in home deliveries. A strikingly high infant mortality of 20 per cent is seen among the Bodos followed by the Caste Hindus (9.1%). Comparatively the Garos show a lower infant and child mortality in home deliveries than the other two population groups (Table III.C.9). The traditional delivery practices among the Garos still continues to be high due to factors mentioned earlier and hence this may have acted as a catalyst for the efficiency of midwife to conduct a safe delivery. Moreover, it needs to be mentioned here that all the Garos of the present study profess Christianity. Cleanliness and hygiene as propagated by Christianity is seen to be maintained by the Garos in the present study. So it can be well assumed that hygiene is also maintained during delivery more specifically by preparing a clean bed where delivery takes place. Choudhury (1993) observed that high infant mortality among the Mishmis of Arunachal Pradesh is related to the customary practice related to child birth, wherein the parturient mother stealthily move out of their house accompanied by elderly women to the forest, where she delivers the baby where hygiene is actually not maintained.

On the other hand, the Bodos and the Caste Hindus are at a close proximity to the health care facility. It is also observed that the grassroots level workers mainly the ASHAs are constantly motivating the pregnant women to go for hospital delivery. The incentive provided by the Government to the beneficiary mother who delivers her child in the hospital is another motivating factor for the increase in hospital deliveries amongst them. Thus, the increase in hospital deliveries may have lowered the efficiency of the traditional delivery attendants among the Bodos and the Caste Hindus resulting in higher infant mortality among them. However, the finding of the present study is in conformity with the studies conducted by Rajaram (1990) and Pandey et al. (2002) who have also observed that institutional deliveries increases the chances of survival of newborns.

It is well accepted that the survival chance is higher when the child birth is attended by a skilled birth attendant. The present study also supports this. A higher infant and child mortality is observed among children where delivery has been conducted by the midwife than those conducted by doctors or other skilled health personnels (Table III.C.10). Several studies have also supported the fact that deliveries
conducted by skilled birth attendant have a better chance of survival. Upadhyay et al. (2012) have stated that neonatal mortality in India is still high and skewed towards rural areas. Many of the deaths are due to the non-availability of trained birth attendants. However, it needs mention here that deliveries conducted by midwives among the Garos are low compared to the Bodos and the Caste Hindus.

Care during pregnancy is pivotal in the overall development of the baby in the mother’s womb. The administration of tetanus toxoid vaccine not only protects the mother but also ensures a safe delivery. Similarly, administration of IFA boost the haemoglobin level of pregnant mothers which is very crucial at the time of delivery. Heavy blood loss during pregnancy may cause post partum haemorage, shock or death of the parturient mother if the haemoglobin level is < 11gm/dl. Moreover, mild anaemia may cause weakness, fatigue and other associated problems during pregnancy whereas severe anaemia may lead to intra-uterine growth retardation (IUGR) and low birth weight of the babies (Park, 2013).

The current finding shows that a high infant and child mortality have occurred among those mothers who have not received the tetanus and iron folic acids during their pregnancy (Table III.C.7). When the two tribal groups of the present study is taken into consideration it is observed that infant mortality is higher among the Bodo mothers who have not received the said health care compared to the Garo mothers. As stated earlier the Garos residing in the fringe areas have less accessibility to medical facilities. Singh et al. (2012) have observed in their study in rural north India that substantial gains in newborn survival could be achieved through increased coverage of antenatal TT vaccination. Gunasekaran (2008) have quoted Rajaratiram’s observation that a comparative study of infant mortality between two development blocks in Tamil Nadu found that the infant mortality rate was lower among children of mothers who have received antenatal checkups along with tetanus toxoid. Thus, the present findings, especially of the Bodos and the Caste Hindus are in conformity with the studies mentioned here.

A safe delivery is always associated with safe delivery practices followed during childbirth. Instruments used for cutting the umbilical cord also play a crucial role for safe delivery and child survival. Among the Caste Hindus, blade is the only
instrument used to cut the umbilical cord. However, among the Bodos and the Garos other types of instruments are also found to be used (Table III.C.11). Shah et al. (2013) have observed that a spectrum of instruments were being used (shaving blades, household knives, etc.). The dais (midwife) were also found to use special equipments for cord-cutting. Baqui et al. (2007) observed that 72.7 per cent sterilized instruments were used for cord-cutting at childbirth. The use of knife among the Bodos and both knife and scissor among the Garos does not show any mortality. Similarly, sickle used only among the Garos also shows low mortality. These tools are fully sterilized in fire before being used. However, in the two tribal communities i.e. the Bodos and the Garos, bamboo splinter is found to cause the highest infant mortality (Bodos 28.6% and Garos 13.5%) proving that it is an unsafe practice. Bamboo being a plant has more chances of possessing germs and bacteria. Moreover, it cannot be sterilized in fire. The use of unsterilized raw bamboo splinter may lead to tetanus and other infections which may ultimately lead to high infant and child mortality.

The role of immunization in reducing mortality of children is noteworthy. UNICEF (2006) observed that children in India continue to lose their life due to vaccine preventable diseases. The findings of NFHS 1, 2 and 3 have also revealed that child mortality can be reduced by effective immunization of the child. The findings of the current study also depicts that mortality reduces with immunization. In all the three communities both infant and child mortality is found to be absent where there is full immunization of the child. Thus, an inverse relationship between mortality and immunization is found in the three groups of population under study. (Table III.C.12).

It is observed by Dhanalakshmi (1993) that in nuclear families, due to quick decision-making, chances of incidence of mortality and morbidity of under five children is low compared to the joint or extended families, the cause largely attributed to the slow decision-making process in the latter. This situation is observed among the Caste Hindus of the present study. However, among the Bodos and the Garos, child mortality is found to be higher in the nuclear families (Table III. C.13). Similar high infant and child mortality in the nuclear families were also observed by Baruah (1980), Sarma (1991) and Kalita (1997).
Educational status of parents can play a key role in lowering infant and child mortality. Educated parents have a better knowhow about child rearing practices, better understanding about adverse effect of unhygienic living conditions on health, etc. They are also aware of the many facilities available for promotion of health and prevention of diseases and thus develop a positive and better health seeking behaviour. The impact of educational status of the parents more specifically maternal education on child mortality is also seen in the present study where mortality is found to be high in children whose maternal education is low (illiterates and barely literates). Under the illiterates and barely illiterates category of mother’s educational status, mortality is found to be 25.4 per cent among the Bodos, 19.9 per cent among the Garos and 6.7 per cent among the Caste Hindus (Table III.C.14). Again, it is found that father’s educational status does not play a key role in mortality of under five children among the Bodos and Garos. However, among the Caste Hindus, child mortality is found to be higher among fathers with lower level of education (Table III.C.15). Cleland et al. (1988) were of the view that on an average there is a 7-9 per cent fall in mortality in under five children when there is an increase in maternal education each year. Streatfield (1990) also observed that mother’s educational level is twice as effective as education of the father’s in lowering infant and child mortality. Similarly, Shea (1991) in a detailed study of 28 countries have found inverse relationship between child mortality and mother’s education. Ali et al. (2011) were also of the view that the real benefit of literate mothers flows to the child in terms of reduced risk. Bhende and Kanitkar (1982) have stated that the educational attainment of the parents, more specifically maternal education, have a significant relationship with infant mortality. Bharati et al. (1990) and Gokhale (2002) et al. opined that infant mortality can be reduced by 2.5 deaths per thousands if there is 10 per cent reduction in female illiteracy. However, the finding of the current study does not wholly tally with the results of the above mentioned works.

Most of the mothers of under five children in all the communities are housewives. Mothers of only about 5 per cent Bodo, 3 per cent Garo and 4 per cent Caste Hindu live births are working women who are working as wage labourers (Table III.C.16). Although occupational difference is there between working mothers and housewives, however, no distinction is observed in terms of their status, income,
etc. It is, therefore, difficult in the present study to ascertain the relationship between the mothers’ occupation and infant and child mortality. So is the case with fathers’ occupation. Though the fathers are seen to be engaged in different occupation, it hardly makes any difference in their economy because they do petty business and those who are in service are employed as Grade III and Grade IV staff. As a result no clear-cut relation between fathers’ occupation and infant and child mortality could be observed (Table III.C.17).

Various authorities have observed that morbidity and mortality in children is influenced by family income. However, in the present study, no clear-cut difference in mortality according to economic status could be found.