CHAPTER 1

INTRODUCTION

Health is defined by the World Health Organisation (WHO) as a ‘state of complete physical, mental and social well-being’ (WHO, 1948). Improved health is desirable not only in itself, but also because it leads to enhanced capability to work and to participate in economic development. Improved health and nutritional status contribute to increased life expectancy.

Health is a function and not only of medical care, it is the overall integrated development of the society- cultural, economic, educational, social and political. Each of these aspects has a deep influence on health, which in turn influences all these aspects. Hence, it is not possible to raise the health status and quality of life of people unless such efforts are integrated with the wider effort to bring about overall transformation of a society (Basu, 1990, 131-142). Among the tribal communities, their system of health care has been traditionally prevalent. The concept of health
among the tribals and their medical systems always involve social, cultural and environmental issues. When we consider the environmental factors of the diseases, the cultural traits become more evident. Every society has a theory of disease and provides an efficacious for treatment. The medical system prevalent in a society is a combination of traditions, beliefs, techniques, ecological adaptations etc. This system is an integral part of the culture of the society. It provides the means to the members of the society for maintaining health and preventing and curing disease (Medhi, 1995:61)

1.1 Reproductive Health

The concept of reproductive health has been defined as “a state in which people have the ability to reproduce and regulate their fertility; women are able to go through pregnancy and childbirth safely; the outcome of pregnancy is successful in terms of maternal and infant survival and well-being; and couples are able to have sexual relations free from fear of pregnancy and contracting diseases” (Fathalla, WHO, 1988). Reproductive health is understood in terms of women’s health, rights and empowerment rather than being viewed only as a media issue. The reproductive health status of an Indian woman is closely linked with the web of gender relations and power structures regulating their participation in decision making relating to their reproductive rights. In India, various cultural, social and economic factors influence reproductive health of women. Reproductive health services increases gender equality as it improve women’s and girls’ health, which enables them to be productive in their families, communities and economy.
Reproductive health implies that couples have choice and ability to reproduce, to control their fertility and to practice and enjoy sexual relationship. It is not only to be conceived as a state of reproductive process free from disease and disorder. Safe motherhood and family planning are two vital components of reproductive health. Reproductive Tract Infections (RTI’s), Urinary Tract Infections (UTI’s), Sexually Transmitted Diseases (STD’s), Unsafe abortion, Genital mutilation are most underlying causes of reproductive ill health of women.

The reproductive health of women generally confines to the female reproductive organs and is particularly related to child bearing. It begins at the time of onset of menarche and continues till the women attains menopause. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other methods of their choice for regulation of fertility which are not against the law, and the right to access to appropriate health-care services that will enable women to safely go through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Generally the discussion on women's health gets much more attention in the context of illness and death during pregnancy, childbirth and to some extent issues related to contraceptive use. However, to concentrate on reproductive health of women who are sexually active is limiting the understanding of the problem. Also, many of the problems arising during the reproductive years or related to reproductive performance
of women are rooted in their life before they become sexually active and also beyond their active life. The foundations for the reproductive health of women are laid in childhood and adolescence, and are influenced by factors such as nutrition, education, sexual roles and social status, cultural practices and the socio-economic environment.

In the International Conference on Population and Development Framework, reproductive health services are divided into three major components: family planning, prevention of sexually transmitted diseases (STD’s), including HIV and AIDS; and basic reproductive health services (e.g. safe motherhood programmes, abortion related services, reproductive health education and communication, STD diagnosis and treatment, and infertility prevention and treatment) (Postts et al., 1999). Programmes that adopted a holistic approach to reproductive health care will help women maintain good health, be productive and have the benefits of a safe and satisfying sexual life.

Reproductive health has become a current headline grabber in context of global health development. It has both medical and socio-cultural dimensions. Traditionally reproductive health was considered as matter of medical issue not responsive to local culture. It is a recognized fact that provision of medical services only could not alleviate the reproductive health status of women. The beliefs and perceptions of different reproductive illnesses, availability and accessibly of treatment and quality of cultural beliefs service provided will affect treatment-seeking behavior at different levels. Whether treatment is sought or not, and when and what kind of treatment is sought for what kind of reproductive illness will determine the reproductive health status of women. The education, exposure, personal hygiene, socio-economic status and occupation will affect women’s decision about treatment of reproductive illness.
The status of women in a society will determine their access to information and resources, which will affect their health behaviour. In addition to the above, the factors related to delivery of health services and their providers have a significant impact on women’s reproductive health behaviour.

In India, the reproductive health status of women is interrelated with social, cultural, and economic factors that influence all aspects of lives. Cultural stigmatizations of indepth sexual knowledge in many communities prevent a significant section of women from identifying the symptoms of reproductive ill health. In many communities ignorance about sex and low level of knowledge of sex related concerns are viewed as virtue. This cultural value has restricted a significant number of women in many conservative communities to acquire appropriate knowledge on reproductive biology and reproductive ill health. They consider many symptoms of STI such as itching, burning, discharge, discomfort and other symptoms as normal features of womanhood. They are restricted by such cultural stigmatization to take preventive and curative measures on reproductive ill health. In many communities sex and sexuality are considered as private issues which are neither to be debated openly nor to be discussed with strangers. Cultural restrictions on woman's personal freedom limit dramatically her access to health care. Women's mobility under these conditions is severely restricted. Again, having male doctors and health care workers limits women's ability to avail of their services.

The important areas covered under reproductive health include:

(a) The capacity to determine the number and spacing of births through the use of safe, effective, and acceptable contraceptive methods;
(b) The capacity to terminate an unwanted pregnancy safely, legally and affordably;
(c) The capacity to conceive or to cause conception when a pregnancy is desired;
(d) The capacity to carry a wanted pregnancy to term and to deliver a healthy baby under safe conditions, including the postpartum period;
(e) The capacity to breastfeed and to ensure the health and wellbeing of the newborn;
(f) Freedom from physical damage to the reproductive tract caused by childbirth, abortion or harmful traditional practices such as genital cutting;
(g) Freedom from reproductive tract infections (RTIs), including cancers of the reproductive tract, sexually transmitted diseases (STDs) and HIV/AIDS;
(h) Freedom from unwanted sexual relations and harmful or unwanted sexual practices, including violence and coercion within sexual relationships;
(i) the capacity to enjoy and sustain sexual relations in a spirit of affection and partnership;
(j) A basic understanding of sexual and reproductive processes of both sexes and how they change throughout the life cycle, including physical and emotional aspects;
(k) Full access to appropriate and high quality reproductive health services.

1.2 Importance of Reproductive Health in General Study

Reproductive health is a crucial part of general health and a central feature of human development. It is a reflection of health during childhood, and crucial during adolescence and adulthood, sets the stage for health beyond the reproductive years for
both women and men, and affects the health of the next generation. The health of the
newborn is largely a function of the mother's health and nutrition status and of her
access to health care. Reproductive health is a universal concern, but it is of special
importance for women particularly during the reproductive years. Although most
reproductive health problems arise during the reproductive years, in old age general
health continues to reflect earlier reproductive life events. The issues of women’s
reproductive health are numerous and complex which ranges from issues of abortion,
sexuality, maternal mortality, domestic violence, male dominance, sexual oppression
to issues of STI’s including HIV/AIDS epidemic. The life of millions of women have
been affected by such reproductive issues is different parts of the country. The
Government of India has made a policy shift from a population control approach to
reproductive health approach with a view to address these distinct reproductive issues
and promoting reproductive health of women as per recommendation of (ICPD, 1994).
But how far these policies and programmes have covered women’s health as a holistic
concept of their life involving their rights, empowerment and gender relation are to be
critically examined. The reproductive health programme will fail to achieve a long
lived success without addressing appropriately the issues of power inequality, gender
relation and socio-economic conditions. The reproductive rights of women are closely
related with their right to livelihood, right to safety and mobility, right to health care
and right to food security. The changing of power relations of women at family level,
and at community level largely depends upon various underlying social factors such
as participation in decision making, gender and sexual relations, their access to basic
needs, their choice and lack of choice, power etc. which determines the reproductive
health status of women. Any programme designed to promote reproductive health of women must cover these socio-cultural aspect appropriately.

The precise configuration of reproductive health needs and concerns, and the programmes and policies to address them, will vary from country to country and will depend on an assessment of each country's situation and the availability of appropriate interventions. Globally, however, both the epidemiological data and the expressed wishes of diverse constituencies indicate that reproductive health interventions are most likely to include attention to the issues of family planning, STD prevention and management and prevention of maternal and perinatal mortality and morbidity. Reproductive health should also address issues such as harmful practices, unwanted pregnancy, unsafe abortion, reproductive tract infections including sexually transmitted diseases and HIV/AIDS, gender-based violence, infertility, malnutrition and anemia, and reproductive tract cancers. Appropriate services must be accessible and include information, education, counselling, prevention, detection and management of health problems, care and rehabilitation.

Reproductive health strategies should be founded first and foremost on the health of individuals and families. Reproductive health care strategies to meet women's multiple needs include education for responsible and healthy sexuality, safe and appropriate contraception and services for sexually transmitted diseases, pregnancy, delivery and abortion. Such an approach accepts that the reproductive health issues of women are inextricably bound with their reproductive rights and freedom.

The status of girls and women in society, and how they are treated or mistreated, is a crucial determinant of their reproductive health. Indian society is
patriarchal, and there is a strong preference for sons in India. This bias sometimes results in the mistreatment of daughters. Further, Indian women have low levels of both education and formal labor force participation. Typically, they have little autonomy, living under the control of first their fathers, then their husbands, and finally their sons (Velkoff and Adlakha, 1998). Educational opportunities for girls and women powerfully affect their status and the control they have over their own lives and their health and fertility. The empowerment of women is therefore, an essential element for health. Lack of gender-sensitive education is also leading to new infections such as HIV/AIDS and other sexually transmitted diseases (Pramanik, Chartier & Koopman, 2006). According to the HIV Estimations 2012, the estimated number of people living with HIV/AIDS in India was 20.89 lakh in 2011. The adult (15-49 age-group). HIV prevalence at national level has continued its steady decline from estimated level of 0.41% in 2001 to 0.27% in 2011. But still, India is estimated to have the third highest number of estimated people living with HIV/AIDS, after South Africa and Nigeria. The adult HIV prevalence at national level has continued its steady decline from estimated level of 0.41% in 2001 through 0.35% in 2006 to 0.27% in 2011 HIV prevalence are sustained in all the high prevalence States (Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu) and other States such as Mizoram & Goa. However, some States in the North such as Odisha, Chhattisgarh, Jharkhand and Uttarakhand, some in the North West region including Punjab, Chandigarh and Delhi, and some low prevalence States of North East including Assam have shown rising trends in adult HIV prevalence. (NACO)
Undernourishment among women in India is high. In the Global Hunger index calculated by IFPRI (2008), India ranks 66th among 88 ranks (higher numbers show hunger). India also scores 23.7 with an ‘alarming’ hunger incidence (Gandhi, 2009). Women’s nutritional levels are lower than men since women face discrimination right from the time of breastfeeding to their adulthood (Pandey, 2009). According to estimates, 25-30% of Indian women in the reproductive age group and almost 50% in the third trimester are anemic. Anemia increases women’s susceptibility to diseases such as tuberculosis and reduces the energy women have available for daily activities such as household chores and child care.

Men too have reproductive health concerns and needs though their general health is affected by reproductive health to a lesser extent than is the case for women. Men also suffer from reproductive health problems, especially the sexually transmitted diseases (STDs). Women bear by far the greatest burden of reproductive health problems. These reasons are: Women are at risk of complications from pregnancy and childbirth; they also face risks in preventing unwanted pregnancy, suffer the complications of unsafe abortion, bear most of the burden of contraception, and are more exposed to contracting, and suffering the complications of reproductive tract infections, particularly sexually transmitted diseases (STDs). Among women of reproductive age, 36% of all healthy years of life is lost due to reproductive health problems such as unregulated fertility, maternal mortality and morbidity and sexually transmitted diseases including HIV/AIDS. By contrast, the equivalent figure for men is 12%, (UNFPA). However, men have particular roles and responsibilities in terms of
women's reproductive health because of their decision-making powers in reproductive health matters. Biological factors alone do not explain women's disparate burden. Their social, economic and political disadvantages have a detrimental impact on their reproductive health. Young people of both sexes, are also particularly vulnerable to reproductive health problems because of a lack of information and access to services.

WHO is working on additional indicators for global monitoring in reproductive health, including indicators on incidence and prevalence of sexually transmitted diseases, quality of family planning services, access to and quality of maternal health services, prevalence of female genital mutilation and prevalence and nature of obstetric and gynaecological morbidities.

Globally, the international community has already defined a number of indicators relevant to reproductive health, including:

(i) Maternal mortality
(ii) Percentage of pregnant women who have at least one antenatal visit
(iii) Percentage of pregnant women who have a trained attendant at delivery
(iv) Percentage of pregnant women immunized against tetanus contraceptive prevalence rate
(v) Percentage of infants weighing less than 2500 g at birth (a newborn indicator that reflects maternal reproductive health).
1.3 Gender Roles and Reproductive Health

Gender issues are especially important and in India, women and girls face severe discrimination in personal rights (e.g. sexual and reproductive choices) and access to personal services such as education, health facilities and family planning services (Luce, 2006). In India most of the societies favour a patriarchal setting, and as such the hierarchical gender relations and unequal gender norms impact women’s sexual and reproductive health and act as significant obstacles to access of services and facilities. Equally, the achievement of good sexual and reproductive health may be affected by factors such as poverty and malnutrition, early marriage and inadequate educational and health facilities. Although there are regional variations with women in the south facing somewhat fewer constraints than those in the north, undoubtedly women in both regions are far less empowered to have a say in their own lives than are men. From an early age, gender role differentials persist: compared to adolescent boys, females have limited autonomy and face huge constraints on decision making, mobility and access to resources. The women are supervised from the time of natal life till their old age. After marriage, a young woman is expected to remain largely under the authority of her husband’s family. She has little say in domestic decisions and little freedom of movement. Almost the only avenue available to enhance her prestige and even security in her husband’s home is through her fertility, and particularly the number of sons she bears. Women who have borne only daughters can be subjected to harassment, and childlessness can be grounds for divorce or abandonment. Gender roles have significant implications for sexual and reproductive health and choice. Lack of awareness, lack of spousal intimacy and communication on sexual matters, and
widespread gender-based violence compound women’s inability to negotiate safe sex, to seek appropriate health care or experience a healthy pregnancy. Finally, gender roles that perpetuate the ‘culture of silence’ inhibit women from communicating a health problem or seeking prompt treatment unless it inhibits them from carrying out their daily chores.

The relative power of men and women in the family and in the community is increasingly becoming an important aspect of reproductive and sexual health research. There is evidence that employment, educational attainment and other socio-economic characteristics greatly influence the ability of women to participate actively in decisions about child bearing, particularly contraceptive decisions and choice. However, relations between men and women vary considerably from culture to culture as does reproductive behavior, and these issues must be explored with great attention to the social context. While focusing on factors that improve women’s status is important, the role of men in fertility decisions cannot be ignored. Male involvement is central to improving reproductive health and to the incremental process of achieving gender equity. But “male involvement” is an ambiguous concept, and many responses to the call for involving men are more limited than what was envisioned by the ICPD’s Programme of Action or by health and rights advocates.

1.4 Reproductive Rights

Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and
individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human right documents.

Reproductive rights include (S.Ravindran, 2001):

(i) the right to life;
(ii) rights to bodily integrity and security of the person (against sexual violence, assault, compelled sterilization or abortion, denial of family planning services);
(iii) the right to privacy (in relation to sexuality);
(iv) the right to the benefits of scientific progress (e.g. control of reproduction);
(v) the right to seek, receive and impart information (informed choices);
(vi) the right to education (to allow full development of sexuality and the self);
(vii) the right to health (occupational, environmental);
(viii) the right to equality in marriage and divorce;
(ix) the right to non-discrimination (recognition of gender biases).

1.5 Reproductive and Child Health Programme

Reproductive and Child Health approach has been defined as “people have the ability to reproduce and regulate their fertility, women are able to go through pregnancy and child birth safely, the outcome of pregnancies is successful in terms of maternal and infant survival and well being, and couples are able to have sexual
relation free of fear of pregnancy and of contracting disease.” (MoHFW, 1997)

Promotion of maternal and child health has been one of the most important objectives of Family Welfare programmes in India. The Government of India took steps to strengthen maternal and child health services as early as the 1st and 2nd Five Year Plans (1951-56 and 1956-61). As part of the Minimum Needs Programme initiated during the 5th Five Year Plan (1974-79), maternal health, child health and nutrition services were integrated with family planning services.

The Reproductive and Child Health Programme, Phase I was launched in October 15, 1997 incorporating a new approach to population and development issues. The programme integrated and strengthened the services/interventions under the Child Survival and Safe Motherhood (CSSM) Programme and Family Planning Services and added to the basket of services, new areas on Reproductive Tract/Sexually Transmitted infections (RTI/STI). Some of the new interventions that were added to this programme, in addition to the CSSM programme were essential obstetric care, 24-hour delivery services at PHCs/CHCs, emergency obstetric care, essential newborn care, Medical Termination of Pregnancy, prevention of reproductive tract infection (RTI) and sexually transmitted diseases (STD). However, it did not go without some limitations such as central focus, weak decentralised planning process, multiple funding organisation, improper monitoring system, limited role of the private sector etc which undermined its efficacy and led to less than expected results. The second phase of the RCH programme, launched in 2005, has been introduced keeping in mind the weaknesses of the first phase. The primary focus is on reducing the regional imbalances in Reproductive and Child Health services. RCH will be integrated, focussed, participatory programme aiming to meet the unmet demands of the target
The major aim of reproductive and child health (RCH) programme is to improve the survival status of mothers as well as children of a community or nation because women are a particularly vulnerable segment of a society and suffer from social, economic and nutritional deprivation to a far greater extent than men.

1.6 Statement of the Problem

The present study deals with the concept of health with special reference of Karbi women inhabiting in the Kamrup district of Assam. It also aimed at understanding those aspects of women's health that are affected by their childbearing role (fertility and contraception) as well as because they are marginalized as women whose health per se is not accorded due importance. These Karbis are basically rural inhabitants but have become part and parcel of a fast developing city in the recent years. So the study was aimed to find out how these people residing in city have affected their reproductive health of Karbi women.

There are only few studies on the status of tribal women in India, Singh (1988) and Chauhan (1990). There are a large number of studies on tribal communities but only a few are focused on tribal women. Reviewing the studies of tribal women, Singh (1988) has concluded that there is "need for generating studies which can fill the information gap about variations that exist and about the role and status of tribal women from one region to another and one community to another". Singh (1993) has also reiterated that there are material on tribals in general but the existing literature specifically on tribal women is limited. Health statistics also give an overall picture.
and data on gender differentiation of longevity, level of health, extent of mortality, infant mortality, nutrition, etc. are not available.

In tribal regions Indian women, are expected to perform a variety of strenuous tasks within the household, on family lands and in some regions for wages. These occupations often have serious consequences for undernourished females who maybe required to carry heavy loads or to adopt unnatural postures for prolonged periods. In today’s world women not only look after the household chores but also work thereby combining the role of ‘homemaker’ with that of a ‘bread earner’. As a result, overwork and stress have affected their health. Cultural norms and customs also affect women’s health. Traditional practices and social conventions regarding early age at marriage, values are attached to fertility and the sex of the child. Hence it has become essential to study the socio-cultural aspects of tribal health and to explore the different factors of hindrances in the acceptance of modern health practices of the tribals. Customs associated with pregnancy have implications for health problems of women. Again, women are less often taken for treatment to hospitals and, therefore, succumb to their illness due to starvation as well as neglect.

Women’s health and nutritional status is inextricably bound up with social, cultural and economic factors that influence all aspects of their lives, and it has consequences not only for the women themselves but also for the well being of their children (particularly females), the functioning of households and the distribution of resources. Women and children constitute a marginalized section within tribal communities. Women face difficulties in discussing their health problems with doctors, most of whom are men. They are less often taken for treatment to hospitals
and therefore succumb to their illness due to starvation as well as neglect. As a result even minor health problems, which could be easily treated in the initial stage assume chronic and serious proportions.

Heavy workload and poor nutrition make matter worse for women. The low literacy rate amongst girls and early marriage are others issues which need to be addressed. Health issues affecting children are also a cause of concern. All these factors have a bearing on the health and well being of women and children. Due to the predominantly patriarchal order, women are confined with an oppressive environment. Differences are frequently noted between health and nutritional status of men and women. Nutritional survey have indicated high rates of inadequacies among females as compared to males. Female infants and children are subject to neglect in respect of nutrition and health care.

Poor quality of care can inhibit women from seeking health care, women's lack of autonomy in decision making or movement is also an important constraint on women's health seeking. Women are, by and large, taught self-denial and modesty from an early age and are hence unlikely to acknowledge a health problem, and particularly a gynaecological problem, unless it is very advanced. For example, large numbers of women experience white discharge but consider it as part of their lives and rarely seek medical care for such a problem. Lack of decision making, freedom of movement and time can restrict visits to health centres, even where a health problem has been recognized. Moreover, pelvic examinations are strongly resisted by women. And even if a problem has been diagnosed, treatment is frequently not followed through because it is seen as an unnecessary expense or too demanding. There is,
unfortunately, little rigorous research on women's constraints to health seeking in the area of reproductive health.

1.7 Rationale of the Study

1.7.1 General Health of Indian Women

Health is considered as a fundamental human right and a world wide social quality of life. A person can be considered as healthy only if she/he is physically, mentally and socially well. A person is healthy only if she/he is free from diseases and all the organs of the body function normally in relation to age and sex. Health of women is not merely a state of physical well-being but also an expression of many roles they play as wives, mothers, health care providers in the family and in the changed scenario even as wage earners. Women in the past have suffered on account of neglect and discrimination, as a result of which, their health status has remained below the desired levels. Women have been subdued and continue to be so under the dominance of a complex socio-cultural web, which conditions them to cope silently and not complain regarding their multifaceted health problems.

In the Indian context the female children before, during and after the birth have suffered a neglect, which is reflected in their higher infant mortalities, low proportion in the total population, female infanticide and even feticides, and lower levels of nutrition. Besides hospitalized health care, female children are being neglected even in terms of feeding practices as well. Due to lack of education, superstitions and taboos are still in vogue in our country. The reasons for the gap between what is the what ought to be may be the cumulative effect of lack of information, lack of education and
awareness, prevalent myths, misconceptions, superstitions, etc. the ethnic composition, cultural background, beliefs, customs and faith that don’t permit the individual and groups to discriminate their age old practices and to adopt new system. Hundreds of worldwide research and evaluation have shown that education of women is strongly associated with the confidence to adopt new ways, the willingness to do and use health services, the lowering of child death rates, the improvement of family health nutrition, the use of family planning services and reduction of overall family size.

Recognition of the long standing discrimination against women in many aspects of their lives has led to a broader understanding that women’s status is a key factor in their ability and desire to control their fertility. In many part of the world, women are more likely than men to be malnourished poor, and illiterate; they have fewer opportunities to earn income and less access to health care and education. These factors influence women’s sense of personal security and consequently affect their reproductive decisions. In some societies low status of females is reflected in their unequal access to food and medical care which leads to malnutrition, deficient growth and development and increased sickness and death in childhood. Girls who survive tend to have smaller pelvic bones, so if they become pregnant they face a greater risk of obstructed labour which would affect the health of their own and lead to the baby’s death. This risk is compounded by early marriage which is the social norm in many developing countries.
1.7.2 Factors Contributing to Reproductive Ill-health of Indian Women

There is a complex interplay of socioeconomic, environmental, and cultural factors that contribute to the reproductive ill-health of populations, particularly women, in developing countries. Poverty, ignorance, illiteracy and malnutrition are major determinants of women's health status. Also significant are the age at marriage and pregnancy, the number and frequency of childbearing, and the numbers of unwanted pregnancies and abortions that contribute to morbidity and mortality among women and their babies. The lower the status and worth of women in society, the higher the maternal mortality and not least important, are the health service-related factors such as lack of access to quality reproductive health services.

1.7.3. Tribal Women Health

The women in the tribal community, as in other communities, constitute around half of the tribal population. The well-being of the tribal community, as that of any other community, depends importantly on the status of their women. The popular image and perception of the tribal women is that of being better off than their non-tribal counterparts. There is no child marriage, no stigma on widowhood. She enjoys the right to decide about her marriage, etc. Instead of dowry there is bride price indicating high social status of the tribal woman. A tribal woman can divorce and remarry easily. Again, there are many facts, which indicates a low status for the tribal women. For example, she does not have property rights except in a matrilineal society, which is small proportion of the tribal population. She is paid less wages than her male counterpart for the same work. Several taboos discriminating against tribal
women exist in certain tribal groups implying impurity and low status. The tribal women cannot hold the office of a priest. There are taboos related to menstruation as in non-tribal communities.

A comprehensive review of the health status of tribal women has been prepared by Basu (1993). His paper discusses, inter alia, the following dimensions: sex ratio, age at marriage, fertility and mortality, life expectancy, nutritional status, maternal mortality, mother and child health care practices, family welfare programmes and sexually transmitted diseases. The main conclusions of the paper are:

(a) Higher infant mortality rate in the tribals compared to the national average,

(b) Low nutritional status of the tribals,

(c) Lower life-expectancy in the tribals than the national average,

(d) High incidence of Sickle Cell disease (HBss) and Glucose-to-Phosphate Enzyme Deficiency (G-6-80) in some tribal groups,

(e) Higher fertility rate in tribal women compared to the national women compared to the national average.

The health status of the tribals have been discussed in Status of the Tribals in India, (Basu, 1993). The factors which influence the health status of the tribal population in general, are also applicable to the tribal women, in fact, more so. For example, it has been found that illiteracy, in tribal, as also in non-tribal population, is positively correlated with ill-health. The tribal women, as women in all social groups, are more illiterate than men. The tribal women share, with women of other social groups, problems related to reproductive health.
1.7.4 India’s Urbanization and Poverty Scenario

India has been witnessing rapid urbanization in recent decades. In fact, India’s urban population is increasing at a faster rate than its total population. It is predicted that 41% (575 million people) of India’s population will be living in cities and towns by 2030, from the present level of 28% (286 million people). According to estimates of National Planning Commission of India, about 26% of urban population in India is living below the poverty line (Planning Commission, 2007). The ratio of urban poverty in some of the larger states is higher than that of rural poverty in some of the smaller states. This is called the phenomenon of ‘Urbanization of Poverty’. With the world rapidly urbanizing, the health of the urban poor requires increased attention. In India, 41 percent of the population will be living in urban areas by 2030. As urbanization and the Indian population increase, so will urban poverty (Ministry of Housing and Urban Poverty Alleviation, 2009). Urban poverty correlates with problems of housing, clean water, sanitation, healthcare, access to education and social security. Current trends in urban poverty suggest that the number of urban poor is set to increase considerably in future in the absence of a well-planned, long-term intervention strategy. In the continuum of urban poverty, special needs of vulnerable groups like women, children and the aged are paramount. Poor people live in slums which are overcrowded, often environmentally polluted and lack basic civic amenities like clean drinking water, sanitation and health facilities. It is an accepted fact that basic health-care, family planning and obstetric services are essential for women, yet these facilities remain unavailable to millions of them in the developing world. Moreover, many believe that the health of families and communities are tied to the health of women. The illness or
death of a woman has serious and far reaching consequences for the health of her children, family and community.

1.7.5 Research in Urban Health

It was in the year 1920’s to the 1940’s that the research related to urban health developed when large scale of urbanization took place after the First world war. However, ironically, although a substantial proportion of the research on poverty and health emerged from the cities in the pre-independence era, urban health was not at the focus of public health practice in the years after independence. India was viewed largely as rural society, and thus the governments conception of primary healthcare was almost entirely rural oriented. With rapid urbanization, as in most developing countries, public health problems in India are increasingly assuming an urban dimension. In 2001 census, 27.81% of the population was found to be living in urban areas. Between 1991 and 2001, 14.3 million people were added to the urban population due to migration. At present the rural population in India is 68.84% and urban population is 31.16%. Level of urbanization increased from 27.81% in 2001 Census to 31.16% in 2011 census. For the first time in India since independence the absolute increase in population is more in urban areas than in rural areas. The proportion of rural population declined from 72.19% to 68.84% (Source, GOI, Census 2011).

To understand the public health needs in urban areas requires a different conceptual framework. Traditionally it is understood that alleviation of poverty is the most important precursor of improving general health. But in urban areas the marginal
increase in income for the poor, in itself, does not assure better living condition due to
wide disparities, which make descent accommodation and clean water and air
unaffordable. Moreover, certain necessitites, which existed as free goods, in rural
settings, are commodities in urban areas, such as drinking water, cooking fuel, etc. the
relative difference in income and wealth is much more stark in urban areas. The higher
purchasing power of the rich drives up the prices of food and healthcare goods, thus
making these items unaffordable to the poor.

The Millennium Development Goal which was set in the year 2000, by 189
countries considered improvement of maternal health as one of the important goal to
be achieved and targeted of reducing maternal mortality by three-fourths by 2015. In
2007, the world’s leaders added a second target under MDG-5: achieve universal
access to reproductive health. Almost all maternal deaths occur in developing countries
especially vulnerable are poor women. In order to improve maternal, newborn and
reproductive health certain strategies should to be taken:

(a) Access to family planning: counseling, services supplies
(b) Access to quality care for pregnancy and child birth:
(c) Antenatal care, skilled attendance at birth including emergency obstetric
and neonatal care, immediate postnatal care for mothers and newborns.
(d) Access to safe abortion services.

1.7.6 Health of Karbi women

The women are the protective and retentive factor in any society. The Karbi
women are decidedly not the vocal arbiter of the society. She is the silent performer
behind the ‘din and bustle’ of the society. Like any society the Karbi women rejoice in her domination at home and here she reigns supreme. Three important duties which the women do at home are (i) preparation of food (ii) rearing children and (iii) brings firewood from the jungles. Karbi women play important roles in the family, especially in its socio-religious activities. After marriage, the women retains her surname, as such a part of her individual identity, unlike in caste societies where the change of name makes the married women’s identity synonymous with that of her husband. The important economic role played by Karbi women further strengthens their social position. Whether in cultivation, weeding, clearing jungles for jhum or collecting fruits, Karbi women work side by side with men. However, social and religious taboos also exits within them. For example, they are not allowed to attend a village court or partake food along with men in religious and community feasts.

Health is the basic need of a human being and denying women their health needs has seriously affected their productive and reproductive roles. It can be said that little work has been done on reproductive health of tribal women, although a lot of work has been done on physiological changes during pregnancy and lactation. Reproductive health problems of different tribal and scheduled caste communities located at various stages of development are full of obscurities and very little scientific information is available due to lack of systematic and comprehensive research investigations. The present investigation was undertaken to study the reproductive health of the Karbi tribe residing in the fringe area of Guwahati city.

Reproductive health is one of major issues today. It has come into focus primarily due to reasons – firstly the fact that population control policies are being
enforced through women’s bodies as they are seen as cause and solution for population
growth and secondly because of alarmingly increasingly problem of HIV and AIDS.
Serious problems such as increasing spread of SITs, increasing number of adolescent
pregnancies, the growing incidence of reproductive tract infections, maternal and child
mortality and morbidity highlight the urgent need for appropriate and effective
interventions of sex related matters and access to reproductive health services and
information.

1.8 Review of Literature

Reproductive health behaviour includes behaviour related to age at marriage,
family planning practices, breast-feeding, childcare, etc. Here an attempt has been
made to give a brief account of the studies conducted on different aspects of health
with special emphasis on reproductive health (e.g. age at marriage, family planning
and the fertility of the tribal population). With availability of vast published studies on
the tribal communities in India, the researcher has chosen to highlight only those
studies which is directly connected to the women’s health. In developing countries, the
focus on women’s reproductive health is usually directed towards pregnancy,
childbirth and contraception, leading to the creation of several intervention programs
(Rice and Manderson, 1996; UNFPA; 2006).

In conducting a research, the first step of a researcher is to learn from previous
researchers and then pool together the research findings to bring out their policy and
programme implications. As this study focuses on reproductive health of women,
therefore, all the literature available regarding the various aspects of reproductive
health of women are reviewed and presented in this chapter under the following headings.

### 1.8.1 Demographic Factor

(a) Maternal Age

Babies who have an increased risk of dying before their first birthday fall into two broad categories: those born to very young mothers and those born to women past their prime childbearing years. Many adolescent women, especially in poor countries, are physically immature, which increases their risk of suffering from obstetric complications. For example, malnourished young women may not have developed sufficiently for the baby’s head to be able to pass safely through the birth canal. Teenage mothers also have an increased risk of giving birth to an infant who is premature or low-birth-weight—conditions that reduce the resilience and stamina babies need to overcome infection or trauma early in life. Additionally, pregnant adolescents are less likely than older women to receive good prenatal care and skilled medical care at delivery, and to be able to provide adequate care for an infant. Childbearing for women in India also is early. Among married women in their reproductive years (ages 20 to 49 years), the median age at which they first gave birth is 19.6 years. Nearly half of married women (ages 15 to 19 years) have had at least one child (Indian Institute of Population Sciences and ORC Macro, 2000).

In Indian context, feminine as gender is not supposed to take part in decision making even if the decision is to be taken about herself. Even the most important decisions of life are taken by family members without taken consent of girls. They are
supposed to be the subject for the implementation of decisions. Same is the case while taking decision about marriage of girl child. Girls were also poorly informed about sexual and reproductive health matters and most had a limited role in marriage-related matters, (Council and Prerana, 2009). The timing of the marriage is an important dimension of women's reproductive behaviour with far-reaching consequences, particularly for their reproductive health and social status. Child marriage typically culminates in child-bearing at a young age. Early pregnancy poses great health risks for a young woman and, if she carries the pregnancy to term, for her infant too. These risks are exacerbated by poverty, malnutrition, and inadequate access to maternal and child health care services (SANLAAP, 2005). Sharma and Khan (1990) found that the Khariwar tribal women exhibit 4.85 live births per mother and 145 infant deaths per thousand live births.

(b) Birth Order

A very young mother is biologically not matured, so that the probability of pregnancy-related complications are high. Children born after a short interval to the previous birth, generally present higher mortality rates. The key factor determining this relationship is the physical and nutritional depletion of mothers (Boerma and Bicego, 1993). The complex relationship between birth order and mortality is not well understood. In general, mortality is higher among first birth, which is usually explained by the observation that many mothers have their first child before having reached physical and reproductive maturity (Sullivan, 1994).
(c) Birth Interval

Another factor that compounds the effect of age and parity on infant mortality is the length of the preceding birth interval. The shorter the birth interval the higher the infant deaths (Gondotra et al. 1982). Infant mortality risks increase sharply as the length of the birth interval decreases. Infant mortality is more than three times as high for infants with a preceding birth interval of less than 24 months, as compared for children with a proceeding interval of 48 months or more (130 compared to 42/1000 of live births). Lengthening the birth interval from less than 24 months to 24-47 months have a much stronger association with the child survival than does to lengthening the interval from 24-47 months to 48 months or more.

(d) Socio-Economic Factors

As the socio-economic status influence the reproductive health of women so studies on married women’s socio-economic status variables were reviewed. Socio-economic indicators such as urban residence (Addai, 1998), household living conditions (Magadi et. al. 2000) and household income (Kavitha and Audinarayana ,1997) have also proven to be strong predictors of a woman’s likelihood of utilizing reproductive health services. Nair and Nair (2002) in their study found encouraging picture on reproductive health status of younger women in Kerala. They attributed that higher age at marriage, smaller family size, higher educational attainment, higher female status and higher accessibility and better utilization of health services delivery systems have a good affect on the health. But altogether a different picture may be seen in the rural Tamil Nadu. Pregnant women need to eat well but due to various misconceptions, they are deprived of nutrition which is critical for them. This leads to
under nourishment of the infant to be born and anaemic condition and malnourishment of the mother (Samuel and Manohar, 2001). The poor health condition of the Indian tribals is reflected in the status of their reproductive health correlated with individual and household social and economic conditions (Middleberg, 2003).

The extensive literature on this linkage shows that women’s education increases the use of maternal health services, independent of related factors such as urban/rural residence or socioeconomic status and across the range of services and stages of maternal care. Studies found a significant positive relationship between education and use of antenatal care, delivery care, and postnatal care. Several authors found that educated women are more likely than uneducated women to use ante-natal care, to use it early and frequently, and to use trained providers and medical institutions (Bhatia and Cleland, 1995; Govindasamy, 2000; Beegle, Frankenberg et al. 2001; Bloom, Wypij et al. 2001).

(e) Education

Mason (1984, 1986) and Chatterjee (1991) pointed out that women’s education is associated with the later age at marriage, contraceptive use, and lower fertility. Bourne and Walker (1991) confirmed that mother’s education in India has greater effect on the survival of her daughters than sons. Elo (1992) suggested that there is positive effect of maternal schooling on the use of pre-natal care and delivery assistance. Education enhances women’s knowledge of modern health care facilities, improves her ability to communicate with modern health-care providers and thereby have a good health (Caldwell, 1979; Schultz, 1984; Caldwell and Caldwell, 1988).


1.8.2 Age Variables Related to Initiation to Reproductive Life

Age variables such as age at menarche, age at marriage, age at first pregnancy/delivery, age at consummation of marriage and time interval between pregnancies or birth spacing are reviewed here as they exert their impact on the reproductive health status of the women. As such the related studies were reviewed here.

(a) Age at Menarche

Rakshit (1960) studied the age of menarche of the Assameses girls, Das et.al. (1967), Srivastava and Goswami (1968), Gogoi (1972), reported variations in age at menarche in different caste populations in Assam. Deb (2009) studied the variation in the Age at Menarche of the Assamese and Bengali Girls of Guwahati, Assam, and found that the median age, estimated, is 12.45 ± 0.02 year among Assamese girls and 12.25 ± 0.03 year among the Bengali girls, respectively. The Saharia tribal mothers of Madhya Pradesh has found to have slightly lower mean age at menarche (13.5 years) and also mean age at menopause (44.6 years) compared to present women (Biswas and Kapoor, 2003). Mean menarcheal age of Oraons tribe of Assam is 13.26 years (Gogoi and Sengupta 2003).

(b) Age at Marriage

India has one of the highest rates of child marriage in the world, which increases reproductive health problems for girls because of early childbearing. Age of marriage directly influences the reproductive health of tribal women by determining the age at entry to sexual union which is a strong determinant of fertility. Marriage at
younger age increases the risk of abortions, miscarriages, maternal mortality and still-births (Basu, 1994). Marriage at delayed or matured age may attribute to higher level of economical and educational attainment by the women, which in turn can influence their reproductive health.

The median age at marriage for women (ages 20-24 years) is 16.7 years (Pande et al., 2006). Men are typically older than women when they marry, 72% of men ages 25 to 29 when they get married. In rural India, 40% of girls (ages 15 to 19 years) are married, compared to 8% of boys at the same age. Accordingly, childbearing for women in India is also early; among married women in their reproductive years (ages 20 to 49 years), the median age at which they first gave birth is 19.6 years (Pande et al., 2006:5). Ray and Roth (1991) studied the fertility pattern of Juangs of Orissa. It was observed that the marital age specific fertility rate was highest (0.36%) among mothers in the 20-24 year age group whereas it was lowest (0.44%) among the 45-49 year age group. The total marital age-specific fertility rate was 1.157 among the Juang mothers. It was also observed that the index of overall fertility and the index of marital fertility among the Juangs were 0.49 and 0.50, respectively. Early age at marriage is one of the factors that leads to higher fertility of the population (Pandey and Talwar, 1987; Maheo, 2004; Bhasin and Nag, 2007). In Orissa, the study on Bhumija women reveals that the mean age at marriage is 16 years; the mean age at first child-birth is 18.14 years (Goswami, Dash and Dash, 2009). A study conducted by Naik and Sharma (cited in Kusuma, 1997: 10) revealed that the age at marriage among Bhumija tribal women was 13-16 years, while for men 15-18 years. As the couple had no
knowledge of family planning, fertility was generally high. It has been observed that money was the main incentive for adopting sterilization.

Demographic factors that have been shown to increase the likelihood of using reproductive health services are low parity (Magadi et al., 2000; Kavitha and Audinarayana, 1997) and younger maternal age (Bhatia and Cleland, 1995). Both demographic and socio-economic determinants of reproductive health service utilization are mediated by cultural influences on health service behaviour (Basu, 1990). The health care behaviour of individuals is often mediated by community beliefs and norms, such that individual behaviour is influenced by community perceptions of individual actions (Foreit et. al, 1978). Although individual demographic and socio-economic may shape an individual’s desire and ability to use a service, the cultural environment in which he/she lives exerts a strong influence on the extent to which these factors actually lead to service utilization. Stephenson and Hennink (2004) have taken all the five dimensions of access to health care, namely economic, cognitive, psychosocial, administrative and physical, in their studies on the Pakistan-data to predict the major barriers to the utilization of contraceptive services.

1.8.3 Medical Care Factor

(a) Antenatal care

Bhatia (1995) found that economic status and religion of mothers are significant predictors for the use of maternal health services. Effective utilization of the antenatal care services has a positive influence on the health of the mother and child. As such the related studies were reviewed here. Maternal and childcare is an
important aspect of health seeking behaviour, which is largely neglected among the tribal groups (Basu et al, 1990).

Mothers who had not received good quality antenatal care were found to be more at risk of having low birth weight babies (Nair et al., 2000) and there is clear association between infant mortality rate and lack of or poor quality antenatal care (Chandrashkehar et al., 1998). Ideally, this should begin soon after conception and continue throughout the pregnancy (Park and Park, 1991). Nayak and Babu (2001) studied on the utilization of services for safe motherhood, ante-natal care (ANC), among the schedule caste and schedule tribes of Orissa. It was found that ANC services were much poorer in case of SC and ST as compared to general population. Maiti et al. (2005) also concluded that around 72 per cent of tribal mothers did not have any ante-natal care (ANC), did not consider having a check-up necessary or customary. The causes for poor utilization may lie in the socio-economic background, cultural setting and attitudes. Aggarwal et al., (2007) also suggested that women should be educated about the importance of antenatal registration and regular check-ups during pregnancy in order to avoid complications. Chandrekar et al. (2009) studied the Reproductive and Child Health among the Dhur Gond Tribal Community of Mahasamund District, Chhattisgarh, India and the study revealed that high percentages of mother had not taken ante-natal check-up (51.72%), tetanus injection (41.38%) and iron and folic acid tablets (56.32%) during pregnancies. 94.83 percent deliveries performed at home and 57.47 percent birth were done mainly by untrained 
*dai* (traditional birth attendant’s). Infant and child mortality rate was 5.92 and 4.28 per 100 live births respectively.
Nanda and Niranjan (1999) reported that antenatal care of a particular community is dependent on their place of residence, occupational status, educational level, medical services, etc. among various scheduled tribes of India. The utilization of ANC services is low among ST women in Jharkhand as compared to Chhattisgarh. It can also be observed that ST women in Chhattisgarh avail ANC facilities more from public health centers whereas in Jharkhand, more women go to other health service providers.

(b) Place of Delivery

In many tribal communities, majority of births occur without the help of a skilled assistant (defined as a midwife, nurse trained as midwife, or a doctor) at some or in other non-hospital settings (WHO, 1996). Home deliveries in the absence of skilled professionals/attendants have been associated with adverse infant and maternal outcome (Browvere et al. 1998). Similarly, education was associated with a safe delivery in many studies (Govindasamy, 2000; Beegle, Frankenberg et al. 2001; Bloom, Wypij et al. 2001). One study reviewed also found a positive relationship between education and utilization of postnatal care (Bhatia and Cleland, 1995). Additionally, female education, along with trained delivery assistance, is a strong predictor of maternal mortality, independent of per capita income (Shiffman, 2000).

Pregnant women of Nocte tribe of Arunachal Pradesh do not show much interest in availing regular health check-up. Home deliveries are common and generally attended by local women. For any complicacy they approach to the traditional medicine men (Kar, 1993).
1.8.4 Variables Related to Maternity

(a) Fertility

Human fertility helps in the biological replacement as well as in the maintenance of the human society. It is a positive force through which the population expands counteracting the force of attraction caused by mortality (Bhende and Kanitkar, 2004). Fertility is generally used to indicate the actual reproductive performance of a woman or groups of women (Thompson and Lewis, 1965).

Though fertility is a biological phenomenon there are a number of other factors influencing the levels and differentials of fertility among tribal’s. Demographers usually measure the fertility differentials by taking into account women’s income, occupation, education, family type, age at menarche, age at marriage, etc. (Roy Burman, 1961; Nag, 1962; Das, 1973; Thomson and Lewis, 1965; Vidyarthi and Rai, 1977; Sahu, 1983; Basu and Kshatriya, 1989). Primarily, in the Indian context, socio-cultural norms, beliefs and practices play a pivotal role in making women more vulnerable to reproductive health problems. In India, it has been suggested that the reporting of abnormal vaginal discharge may be more an expression of underlying psychosocial distress than evidence of infection (Patel and Oommen, 1999). Women’s education has a positive impact on fertility regulation that has been established by many others (Nag Mani, 1989; Bulanto et al. 1993; Khakhar and Gulati 2000; Dwivedi and Rajaram 2004). Singh (2005) found that the majority of women don’t have any knowledge of available reproductive health services and have not utilized those health services available to them. Singh (2006), has also reported that there is a tendency of increasing number of live-births with the increasing chronological age of mother due
to longer exposure of married life. Women’s status is an important variable responsible for various demographic outcomes such as higher fertility levels and tried to predict the interplay of various factors behind it (Bardhan, 1974).

Gogoi (1990) found that during (1961-71), the rate of growth of tribal population in North-East India was lower than that of the general population. This was mainly because of a very low natural growth rate of the tribal population in the region. Pandey (1990) observed high fertility and mortality in Mishmi tribe of Arunachal Pradesh groups and attributed it to the low level of education and income lack of knowledge of family planning method and importance of small family size poor medical facilities, lack of proper sanitation and drinking water. Barua (1982) studied 196 ever pregnant women belonging to the Hajong tribe of West Garo hills district of Meghalaya. High infant mortality (18.2%) and prenatal mortality (3.1%) were reported among them. Das et al. (1982) studied two Lepcha village of northern Sikkim namely Lachen and Lachung and found the total fertility rate for Lachung and Lachen to be 4.66 and 3.79, respectively. The results on total fertility rate were more or less similar to the Indian national population. Prakask and Malik (1990) showed that high altitude Bodos had higher fertility than the low altitude Bodos. They also had higher mean number of children (4.11 per mother) as compared to the low altitude Bods (3.63 per mother). The altitudinal differences in fertility have been explained in terms of socio-cultural factors such as education, awareness, urban contact, advancement in medical facilities which were higher at low altitude. Early marriage leads to high fertility and increased population momentum, the two largest drivers of population growth. It also contributes to high maternal and child mortality (Jain and Kurz, 2007).
In addition, girls who marry at a young age do so with limited experience and information on reproductive and sexual health. Early marriage is also associated with poor educational attainment and limiting girls’ economic opportunities and security.

(b) Mortality

Buzarbarua and Phukan (1988) observed some effect of birth order on perinatal/prenatal mortality. They suggested that the mortality is comparatively high in first birth order and gradually decrease with the increasing birth orders. Deka and Patojoshi (1977) also noted that abortion is very high in the lower age groups. In a case study conducted by Rani Band and other in the state of Maharashtra had shown that out of 650 women studied, 55% had complained of gynaecological problems, while on medical examination 92% of them were found to be suffering from one or more gynaecological problems. (Bang., 1989).

A study in Bangladesh reveals that high infant and child mortality is influenced by limited use of health care services by mothers (Kabir and Choudhury 1993). Khan (1993) while investigating the Dongria Kondhs of Orissa found average pregnancies per mother and the infant mortality rate as 4.07% and 53.11% respectively. Sharma and Khan (1990) observed that the average fertility rate among the Kharwars of Sarguja district (M.P.) was 4.85. The highest reproductive wastage (9.67%) was observed in the age group of 40-44 years and the pre-reproductive mortality was highest (6.84%) among mothers in age group 35-39 years. Singh et al. (1993) show that as compared to other castes, the neo-natal mortality among scheduled tribes is high and only two percent of the deliveries of scheduled tribes are attended by auxiliary nubirse midwives (ANMs) or trained dais.
According to Pandey et al. (2006) anaemia is also rampant among young Indian women, which ultimately affects the maternal mortality as well as foetal outcome. In their study they found out that the education is directly related to maternal deaths due to anaemia. Their study shows that lesser the education of females higher is the death rate among them when they become pregnant. The maternal mortality rate in 15-19 years age group is one of the highest in India. It appears that over 3,00,000 children of adolescent (15-19 years) mothers die in infancy. This is due to frequent pregnancy, which affect the health of the adolescent mother who becomes anaemic with the consequence of delivering underweight child (Santhya and Jejeebhoy, 2003).

In a study conducted by Wyon and Gordon in rural Punjab in 1971, it was found that infant mortality is also not independent of child-rearing practices in the societies where boys are highly valued and receive more favourable medical and nutritional treatment. Female education is said to influence infant and child mortality in several ways. The first is through birth spacing. Better educated women are more likely to practice birth control methods than less educated women (Cochrane, 1983). Sharma and Khan (1990), reported that reproductive wastage due to abortions and stillbirths are 4.6 percent of the total pregnancy. High infant deaths motivate couple to produce more children due to the fear of losing infants by deaths. The researcher observed that lack of medical facilities and their worst environmental conditions were the attributed causes for high mortality and morbidity rates.
(c) Family Planning

Utilization of family planning measures both temporary and permanent methods influence the health status of women by delaying the future child bearing or stop the child bearing. As such, in order to know their use, the studies were reviewed.

Family planning is one of the most cost effective development instruments to achieve all eight of the United Nation’s Millennium Development Goals (Cates, 2010; Cleland, Bernstein, Ezeh, Faundes Glasier and Innis, 2006; Potts and Fotso, 2007). Singh (2005) found that the majority of women don’t have any knowledge of available reproductive health services and have not utilized those health services available to them. Attitudes towards fertility regulation, knowledge of birth-control methods, access to the means of fertility regulation and communication between husband and wife about desired family size are essential for effective family planning (Dabral and Malik 2004). Various factors governs the acceptance of contraception e.g., religion (NFHS 1998-99, 2002), number of sons in family (Bhasin and Nag, 2002), and education of husband and wife (Bhasin and Nag, 2002), etc. Besides, spousal communication also increases the likelihood of contraceptive use (Kamal 1999; Ghosh 2001).

Sterilization is usually accepted when the couple is sure that they have completed their family size and gender preference (Bhasin and Nag, 2002). According to Santhya (2003), the contraceptive prevalence rate in Meghalya is just 4.7% (2.8% for sterilization and1.9% for other temporary methods), which is lowest in the whole India. Study carried out in the state of Haryana found that one-third of the respondents had adopted family planning. Out of them in 76.56% of cases respondent herself had
gone for it by adopting tubectomy and in rest husband had adopted vasectomy. It shows the important part played by women in adoption of family planning and thereby improving the health of the children. (Kaur et al., 2001)

1.8.5 Some International studies on Reproductive Health

In the following paragraphs a review of literature on reproductive health of women has been described which was undertaken by various international researchers

Many studies on health seeking behavior of women have been explored in non-western countries inorder to find reasons why women do not use biomedical healthcare services during reproductive complications. They have found numerous factors which includes women’s autonomy as well as economic status and education, costs as an important factors in this regard as well as the role of accessibility of healthcare services. For example, in Namibia, women cannot use maternal services because such services are not equally available in all areas of the country (Zere et al. 2010). Women underutilized maternal healthcare services in Southern Tanzania as they were not aware of these services and the services were yet to expand in every area (Mpembeni et al. 2007). Women in Kathmandu, Nepal, high-caste Hindu women could not use biomedical services because they did not have any decision-making power (Brunson 2010). The unavailability of prenatal and postnatal care and the lack of trained personnel to assist during pregnancies have significant influences on women in seeking maternal services during reproductive complications in Bangladesh (Chen 1983, Chowdhury et al. 2004).
Socio-economic status is another factor which plays a important roles in health seeking services. For example, in Peru, educated women utilize maternal health services more than their uneducated counterparts (Elo 1992). High-status women in Nepal, who had formal education, employment, and power to make intra-household decisions, had a better possibility to use maternal health services than low-status women (Matsumara and Gubhaju 2001). Rural women in Bangladesh underutilized the existing biomedical health services (Afsana and Rashid 2000). The costs of healthcare services and purdah, a socio-cultural practice, hinder women’s access to cosmopolitan healthcare services.

Sometimes, broader cultural and ideological assumptions also play an important role in individual’s use of healthcare services. For example, in Ghana, religious leaders played an important role in utilizing maternal health services for fertility and contraception by women (Gyimah et al. 2006). They influenced women’s decision-making related to the use of maternal health services. Muslim women were less likely to use these services than Christian women because the former women were less educated and more obedient to their religious mentors.

It is also necessary to have an idea about the cultural conceptions of the female body to understand women’s health seeking because such cultural notions influence women's decisions about treatment during pregnancy, childbirth, and reproductive complications. In cultures where biomedicine is dominant, the female body is treated like a machine (Thompson, 2002) in South Asian cultures like those in India and Bangladesh, the female body is frequently linked with the ideas of purity and pollution. In northern India the womb is considered both as “a dirty pit and a space of
life” (Pinto, 2008:80). On the one hand, childbirth is a period of pollution and on the other it is a joyful event. People do not perform any religious ritual in a birthing room since they consider it as a “polluted” place for worshipping any god or goddess. Since pregnancy and childbirth involve pollution, women are a target of attack by malevolent spirits during such times. Women should perform various rituals and observe taboos to keep their bodies “pure” (Rozario and Samuel 2002, van Hollen 2002, Jeffery and Jeffery 1993, Pinto 2008). It is believed that a woman’s body becomes “hot” during pregnancies and “cold” during post-partum periods (Rozario and Samuel 2002). In these traditions, this notion suggests that women should follow different diets before and after childbirth (van Hollen 2002). It is implied that women are vulnerable for physiological reasons and they bear the responsibility of protecting themselves. If anything goes wrong, women can seek treatment from the healers who are able to remove malevolent spirits from a possessed body. Although the notions of purity and pollution are strongly associated with the Hindu caste system, in this region of Bangladesh these are somewhat different and reflect the influences of Islamic beliefs and practices.

Although women and men can be affected by infertility, but it is women who are mostly blamed for childlessness in patrilineal societies (Gerrits 2002). Sargent’s research on the Bariba women of Benin shows that women largely derive the decisions regarding the utilization of alternative medical services from the sharing of assumptions about the diagnosis and treatment of the sickness or disorder (Sargent, 1982). Bariba women would prefer traditional midwives when they faced complications during deliveries since they and traditional midwives shared similar
etiological explanations, diagnoses, and beliefs related to pregnancy and had similar expectations. Women’s fewer visits to nurse midwives, are the result of differences between their own and nurse midwives’ explanations of the etiologies of complications and related treatment processes. In urban Ecuador, people would seek folk healers for treating the illnesses that they thought occurred due to supernatural causes (Kroeger, 1983). In rural India (Kapur, 1979) and Taiwan (Kleinman and Sung, 1979), people sought folk healers for mental illnesses.

Rumanucci-Ross (1977) has further elaborated the idea of sequential therapy seeking who argued that people choose therapy or therapies, creating a hierarchy of resort. Sometimes people began their treatment with “modern” medicine, such as biomedicine, and sequentially moved toward the earlier modes of treatment, creating an “acculturative hierarchy of resort”. In some cases, people began their treatment with the earlier modes of treatment and gradually moved toward the “modern” medicine, creating a “counter-acculturative hierarchy of resort”. People choose therapies sequentially according to the perceived success of the treatment. They moved from one therapy to the next when the first therapy failed to cure the illness.

Women need assistance from other people during childbirth and the assistant depends on how a society perceives childbirth. For example, childbirth is considered a “medical procedure” in the U.S., a “stressful but normal part of family life” in the Yucatan, a “natural process” in Holland and “an intensely personal, fulfilling achievement” in Sweden (Jordan 1978:34). These differential understandings of childbirth are expressed through the differential prenatal care provided in these cultures. In the Yucatan, a pregnant woman receives instructions for wellbeing from
other people such as experienced family members, neighbors, or friends during childbirth (Jordan, 1978).

In Sweden and Holland a group of people including the female parent, a midwife, an assistant to the midwife, and other “non-specialist” attendants (e.g. husband, sisters, and friends) usually attend a woman during labor and delivery. All these participants work as a therapy management team and their interactions with the birthing woman are friendly (Jordan, 1978). The midwife makes the decision in case of the use of medication for the birthing woman. Midwives do not see parturient women as patients but as persons who are quite capable of delivering babies on their own. The job of a midwife during childbirth is to watch parturient women and do some technical tasks such as cutting the umbilical cord (Jordan, 1978). The status of the birth attendant is an important consideration in understanding the choices that women make. In the Indian context, midwives called dai are considered the cleaners of “birth pollution”, not skilled persons (Rozario and Samuel, 2002), and are not involved in any prenatal or postnatal care. They do not have any control over the birth process; they just follow the instructions of other senior female attendants such as mother-in-law in a delivery process (Jeffery and Jeffery, 1993, Rozario and Samuel, 2002). In Bangladesh, dais receive the same treatment as in India, as usually women from the low status groups work as dais (McConville, 1989). Women’s kin networks influence their use of birth attendants during uncomplicated pregnancy and childbirth in Bangladesh (Edmonds et al. 2012).

The review of literature shows that in various parts of the world various factors influence the reproductive health of women such as the availability of healthcare
services and the role of women’s socio-economic status, the influence of knowledge and assistance in childbirth which affects the health of women. Thus, the UN adopted the elimination of maternal mortality in developing countries as a new millennium development goal.

1.9. Objectives

It should be noted here that studies in Karbi women is very limited; so the researcher felt the necessity of studying the Karbi community. in the case of the North East India, it demands a special treatment.

The specific objectives of the study are:

(i) to examine the affect of socio-economic, cultural and educational factors on their health;

(ii) to explore the impact of modern health care facilities in their maternal health care;

(iii) to study the maternal health care practices of Karbi women

(iv) to study the levels of fertility and and impact of various socio-demographic factors among them.

(v) to evaluates the use of traditional and modern birth control practices;

In a welfare state like India, the administrative policies have direct bearing on the people's economic aspects ultimately leading to several issues in health related sector. It is apparent that the government does not generally recognize the traditional medical systems. Bryant (1988) sees the involvement of the individual and the local
community in primary health care not as a social nicety; rather as a medical necessity. However the services that are delivered by the government or private sectors have little effect unless absorbed by the individual and the community. It has been revealed that the diverse and deep-rooted social and cultural phenomenon of a society play important and many a time decisive role in deciding acceptance or non-acceptance of particular health care option. Thus, a study regarding nature and extent of acceptance of modern health care facilities among the studied group was felt imperative to know a community of a particular area.

1.10 Methodology

The study is concentrated on the reproductive health of the mother which includes fertility, maternal health care, family planning and mortality of the infant. The sample of the present study comprises of 300 Karbi families residing in Guwahati city. The data was collected by simple random sampling method from seven different dominant Karbi localities such as Barbari, Birkuchi, Dhalbhoma, Japarigog, Kenduguri, Narikalbasti and Pillankata of Urban area in Guwahati city. In all, 354 ever married women belonging to age group 15-49 years having at least one surviving child aged less than 10 years were interviewed for this research work. The reason behind selecting these mother was to collect accurate information for the study rather than a vague and generalized ones.

As a first step of creating the universe of this study, secondary data on reproductive health of tribal women was collected through intensive library work. Relevant information was collected from various sources like books, documents,
reports, dissertations, research journals, published and unpublished documents, newspapers etc. from the various institutions and libraries of Guwahati and Delhi. Intensive library work was undertaken in the libraries of the Department of Anthropology, Gauhati University, (Guwahati), Krishna Kanta Handique Library, Gauhati University (Guwahati), Assam Institute of Research for Tribals and Scheduled Castes (Guwahati), Nabin Chandra Bordoloi Hall (Guwahati), National Institute of Public Co-operation and Child Development (Guwahati and Delhi), Indian Council of Social Science Research (ICSSR), Delhi, North Eastern Hill University (Shillong); Women’s Studies Research Centre, Guwahati, and Omeo Kumar Das Institute of Social Change and Development (Guwahati).

A research design for the present study was prepared after the completion of the library work. Thus on the basis of the library work conducted, interview guides, schedules and observational checklists have been prepared. An interview schedule was used as the main tool, which was planned and prepared with care to obtain information from the Karbi women. The interview schedule consisted mainly of four parts—i) General background ii) Fertility iii) Maternal Health Care and iv) Family Planning.

Information in regards of family background, income, educational status, occupational structure etc. is collected under the general background. To know about the age of menarche, age at marriage, age at first conception, children ever born, etc. were collected under the fertility structure. Karbi mother’s health care such as antenatal care, place of delivery, special attention to diet, etc. were collected under the maternal health care. The study also unearthed traditional beliefs customs and rites and rituals in respect of pre- and post partum periods. Lastly, the family planning methods
such as knowledge of family planning methods, reasons for use of family planning methods etc. are collected from the family planning structure. The Karbi population which were taken for the study was mainly considered from the Guwahati city. The Karbi population of Barbari, Birkuchi, Dhalbhoma, Japarigog, Kenduguri, Narikalbasti and Pillankata ranges from 40-80 individuals, it should be mentioned here that none of the area is a homogenous one as many other non-tribal people have also entered inside these localities. The field work was conducted between the year 2009-2010, covering a period of fifteen to thirty days in each of the visits. Data for the study have been collected by using various research methods like interview method, observation method, case studies, group discussions etc. Besides the various methods mentioned above, informal chats with people were also made in order to gather information about Karbi social life and to have an overall idea of the community. Indepth case studies were collected from some Karbi mothers in order to understand rituals at the time of pregnancy, their knowledge in aspects of fertility and family planning method.

The researcher first approached the goan bura of every village to seek permission to conduct the research survey in the respective villages. The objective behind the study was first explained to the headmen and distinguished persons prior to the start of the research study. During the interviews many respondents came forward willingly for the interviews and answered the questions asked to them. However, some respondents and their family members enquired about the likely benefits that they would get from the entire exercise. Once the reason behind the study was explained to them, some got satisfied, whereas some others still insisted to remember them incase
of implementation of any benefit programme in future. Since most of the questions were related to health, few women even tried to seek medical advice from the investigators on their health problems. Some people queried about the financial support derived from the study. They wanted to know whether the study was a part of any project funded by any N.G.O or government/external agency and hence the likely financial benefits for the researcher. As a whole it could be summed up that the researcher got good co-operation and support from different people and had very pleasant and healthy interaction with them.

The data collected from the field work were systematically arranged and were entered into the computer for analyzing the data. A sophisticated statistical package SPSS and MS Excel was used for analyzing the data. In statistical analysis, mean, percentages and standard deviation were estimated for age at menarche, age at first child and age at marriage. Using univariate and bivariate analysis, the researcher studied the co-relation between different socio-demographic characteristics with the maternal health care practices i.e during the ante-natal, and delivery periods. Chi-square test was used for evaluating association between antenatal care, delivery with socio-demographic aspects such as education and occupation. 'P' value less than 0.05 was considered statistically significant.

1.11 Conceptual Framework

Conceptualization of a problem is very necessary for any research problem. Therefore, for better understanding of the research problem in hand, a conceptual framework has been developed. The framework encompasses the socio-economic
demographic factors and some of the intermediate factors that affect fertility and reproductive health behavior. Infact, this framework is an integration of the analytical framework of the intermediate variables by Davis and Blake (1956), conceptual model developed by Freedman (1975) and some of the proximate determinants of Bongaarts (1978) and Bongarts and Potter (1983). However, necessary modifications are made in the framework to meet the requirements of the present study.

The various background variables such as women’s current age, age at menarche, women’s age at marriage, birth order, type of family, education of the women and husband, occupation of the women and husband are some of the factors which affect fertility and reproductive health behavior both directly and indirectly.

## 1.12 Organization of the thesis

The materials collected for the present study has been organized into six chapters in this thesis. The first chapter deals with introduction part of the reproductive health, the statement of the problem, rationale for selection of the study and researches on various aspects of reproductive health such as fertility, mortality, ante natal care etc. based on literature survey as focused by different authors.

In Chapter II, a brief description about history and migration of the Karbis, their material culture, economic life and their social structure has been presented.

Chapter III, presents the ethnographic profile of the seven villages, viz. Barbari, Birkuchi, Dhalbhoma, Japarigog, Kenduguri, Narikalbasti and Pillankata found in urban area of Guwahati city. The chapter profiles these seven villages as a
setting. The settlement pattern, dress and ornaments, food habits and a their access to health facilities has been described briefly in this chapter.

Chapter IV describes the fertility performance of the Karbi women and the influence of various independent variables such as age at marriage, education and economic status on fertility has been studied. The various components of fertility such as age at menarche, age at marriage, age at first conception of the sample women have been described in this chapter. An attempt has also been made to study the knowledge and use of family planning methods among the Karbis of the study area.

Chapter V attempts to understand the utilization for safe motherhood, particularly, the antenatal care (ANC) and place of delivery among the Karbis residing in the fringe areas of Guwahati. It also studies the various socio-demographic factors such as education and occupation affecting the maternal health care of Karbi women.

Chapter VI is the concluding chapter which contains the discussion on the findings of the preceding chapters. In this chapter the study has been summarized and conclusions have also been drawn.