

### 3. Reproductive Performance of the Boro Kachari Women in Barama Area, Baksa District, Assam

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#### **Abstract**

*India's tribal population's poor health condition is reflected in the status of their reproductive health associated with their individual and household social and economic conditions (Middleberg, 2003). Reproductive health represents the overall health condition of a population. Women's reproductive role all through the process of gestation, birth, breastfeeding, and childbearing places her at the focal point of a population's reproductive health (Shankar and Thamilasaran, 2003). Various studies show that the health particularly reproductive health of the tribal women in India varies according to their socio-economic, socio-cultural and economic settings. The present study focuses on the reproductive health of the Boro-Kachari women of the Barama area of Baksa district to understand the overall condition of tribal reproductive health. It can be said that India's tribal fall behind the non-tribal population in respect to health indicators. The following table presents the disparity in health indicators between the tribal and non-tribal population in India.*

**Key Words** - *Reproductive Health, Tribal women, Antenatal care*

#### **Introduction**

The world health organization (WHO) has defined health in 1946 as "A state of complete physical, mental and social well being and not merely the absence of disease or infirmity." Provision of healthcare should be considered as a fundamental right. All the signatories acknowledged this definition to the Alma-Ata Declaration on health adopted by the 31<sup>st</sup> World Health Assembly in 1978. This declaration accepted that primary health care was key to attaining this goal.

Men and women have the right to be informed and have access to the safe, effective, affordable and acceptable method of their choice to regulate fertility and the right to access the appropriate health care services. Women's health has long been a concern for WHO, but today it has become an urgent priority. It is a fact that apart from the general health requirements, women have special health requirements related to their role in childbearing and rearing. Women's reproductive health is an indispensable and crucial component of a women's general health. Reproductive health is lifelong, beginning even before women and men attain their sexual maturity and continuing beyond women's childbearing years. Women are the key to the provision of health services for the family and society. Traditionally, in Indian communities, women are viewed as a reproductive agent. As Mandelbum (1974) pointed out, their fertility is generally prized that "mark of her success as a person is her living and thriving children". The mother is the central figure who provides child care, nutrition, hygiene and even primary health care. Despite this, in most of the societies, less attention is paid to the problem of maternal and child health.

Rural women's health is ignored due to a web of interconnected factors working at different levels. The most common problems with the women are women lacking basic needs such as food, water, fuel and health facilities. Poverty among rural Indian populations has a devastating impact on rural women's health. It can cause delays in seeking health services until a condition reaches its most serious phase. On the other hand society and culture play an essential role in rural women's health status and health-seeking behaviours.

Maternal complications are familiar to women and cure for such complications is always associated with factors like income, education, customs and belief, the status of women in the society and family etc. in the presence of the adverse structural condition, pregnant women cannot imagine to look for care or use maternal health services ( Chamberlain et al.. 2007). Incidence of maternal mortality also reflects gender biases, gender-related discrimination within a society. Therefore, maternal mortality is a key indicator of a population's health status and provides insight into women's status and gender equality.

Majority of the Indian population are non-tribal and mainly followers of the Hindu religion (Census of India, 2011). It is important to mention here that not all the tribes in India are Hindu by religion. In the

states of the high proportion of tribal populations like Manipur, Nagaland, Mizoram and Meghalaya of North East India, most tribes are Christian by religion (Chaube, 1999).

Various studies have shown that the factors that influenced the health of the tribal population are also applicable to tribal women. In his research in 1993, Kar has pointed out that the reproductive behaviour of Nocte women in Arunachal Pradesh is very much related to their value system and cultural tradition. The women are considered to be healthy if she gives birth to four or five children. Malnutrition, lack of hygiene, environmental sanitation and non-availability of safe drinking water influenced their health. Illiteracy, ignorance and superstitious belief among the tribe made them more vulnerable to health problems. It is also seen that there is less number of health institution and nonfunctioning of the existed institution made the situation worse for the tribal so far as reproductive health is a concern. The health of the mother and child are unsafe because of these causes in tribal areas. Due to poor environmental sanitation, infectious diseases take their toll on children's lives and ill health due to fever being widespread among them in the rainy season.

#### Health indicators of the tribal and non-tribal population in India

Indicators	Tribal population	Non-tribal population	
		sc	obc
Neo-natal mortality	31.3	33.0	30.5
Infant mortality	44.4	45.2	42.1
Child mortality	13.4	11.1	9.0
Under 5 mortality	57.2	55.9	50.8
Total fertility rate	2.48	2.16	2.22
Pregnant mothers who received antenatal care from health professionals	72.9	77.5	78.2
Mothers who delivered in a health facility	68.0	78.3	79.8
Birth assisted by health professionals	71.5	80.7	82.0
Knowledge of HIV/AIDS	64.2	73.0	74.3

Source- National Family Health Survey-4, 2015-16

### Objectives of the study

1. To see the reproductive performance of the women in the study village.
2. To understand the existing health care practices of the women in the village.

### Methodology

The study is concentrated on the reproductive health status of the Boro kachari women in Baska District of Assam. This paper is based on both primary and secondary data. A total of 112 married women residing in three villages of Baska District such as Kaljhar, Kharua and alagjhar were selected for the study. The women belonging to age group 15-49 years who have at least one child below 6 years were included in the study. The reason for selecting these women was to get accurate and recent information on their reproductive behaviour and health care practices. Both quantitative and qualitative data are collected to cover the various issues related to women's reproductive health in the study area.

### The study area

The present study area is concentrated on the Barama area of Baksa district. Barama is a large village located in Barama circle of Baksa district. There are 10,238 houses and 36 villages in Barama block. The Boro Kacharis of Assam predominantly inhabits the study area. The Boro kachari is one of the plain tribe of Assam and forms an important segment of the population in Barama area of Baksa district.

### Results

Human fertility is considered as the actual reproductive performance of women. It indicates the number of live births which are produced by women in her reproductive span of life. It is the major determinants of reproductive health of women. Several reproductive determinates have been studied among the Boro-kachari women of Barama area of Baksa district such as age at menarche, age at marriage, age at first conception, the total number of live birth, reproductive wastage, antenatal care etc.

The age at marriage of the women mostly depends on their social class, educational attainment, economic status, religion, employment, family background etc (Goswami, 2012). In India age at marriage differs by states. The states like Nagaland, Assam, Tripura, Mizoram and Manipur have

higher mean age at marriage than the national average (23.14) according to census 2011. On the other hand, states like Meghalaya, Arunachal Pradesh and Sikkim have lower age at marriage.

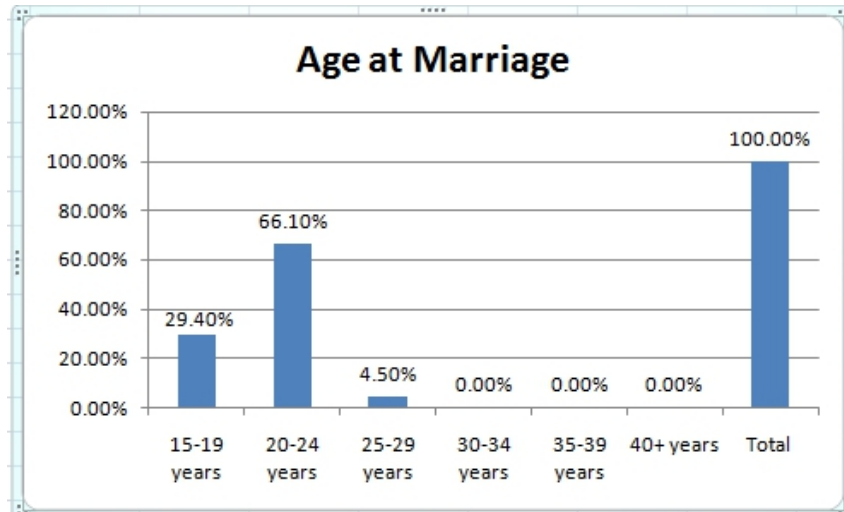
Women's reproductive performance is affected by numbers of social factors like age at marriage, education, caste, occupation, religion, etc, family type, status of women, gender preference, etc. Early marriage leads to early childbearing and thereby provide a longer reproductive span. Early age at marriage could be a reason for high fertility in India.

According to Jolly (1981), India's birth rate could be reduced to half if the minimum age of marriage for girls increases to 20 years and at least 10 years of schooling. Agarwal (1962) has mentioned that if all the girls in India get married after the age of 19, then there would be a 30 per cent decrease in the country's birth rate.

In the present study, maximum women got married between 20 to 24 years, followed by 15-19 years (74). It is also seen that among the women of 20-24 years, the percentage of pregnancy success rate is 90.32% followed by 87.80% in the age group of 25-29 years.

Table 1: Age at marriage

Present age group of women	Age at marriage
15-19 years	33 (29.40%)
20-24 years	74 (66.10%)
25-29 years	5 (4.50%)
30-34 years	0 (0%)
35-39 years	0 (0%)
40+ years	112 (100%)



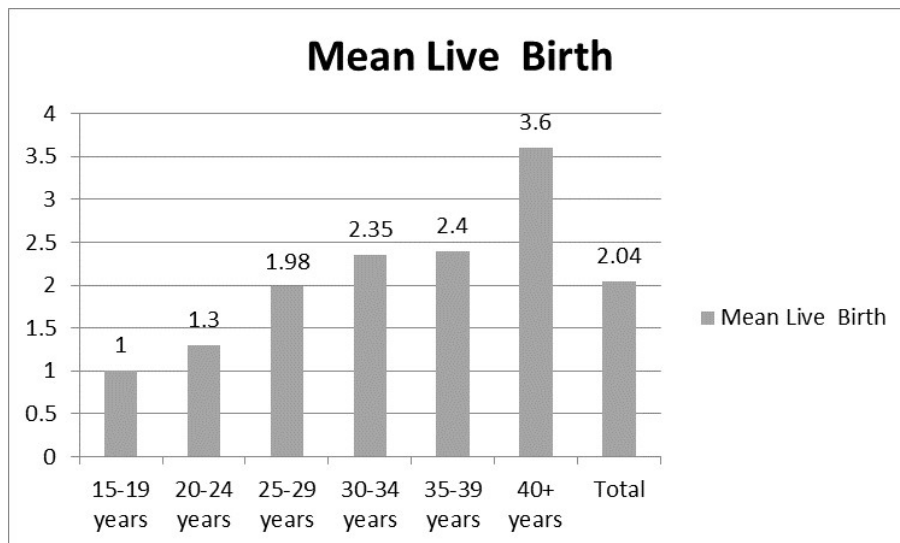
It is seen from Table 2 that the highest per cent of successful conception (93.75) is seen among the women of in the age group 30-34 years of age. It is followed by women in the age group of 20-24 years and 35-39 years, the percentages being. It is seen that the percentage of conception and fertility is quite high among the women whose age is above 30 years. The percentage of conception is less among the young married women, and their mean live birth is also low.

Table 2: Total number of conception

Present age group	No of women	Age at marriage	No of conception	L B	% of successful
15-19	1	13	1	1	100
20-24	21	76	31	28	90.32
25-29	37	5	80	72	87.80
30-34	44		112	105	93.75
35-39	8		22	20	90.90
40+	1		3	3	100
Total	112		249	229	91.96

Table 3: Mean live births

Present age group	No of women	L b	Mean L B
15-19	1	1	1
20-24	21	28	1.3
25-29	37	72	1.94
30-34	44	105	2.38
35-39	8	20	2.5
40+	1	3	3
Total	112	229	2.04



In Table 3, the mean number of children of the Boro women is found to be 2.04. The highest number of children's are found among the women belongs to 40+ years (3) followed by 35-39 years (2.5) and 30-34 years (2.38). It is seen in the table that the mean number of live birth is increased with the increasing age of the mother.

Table 4 shows the order of pregnancy among Boro women. There are 18 women found in the first order of their pregnancy followed by 54 women in the second order of pregnancy and 36 women in

the third order of pregnancy and 4 women in the fourth-order of pregnancy. In the first order of pregnancy maximum women are found in the age group 20-24 years. In the second order of pregnancy 19 women are found in 25-29 years followed by 23 women in the age group 30-35 years. In the third-order pregnancy maximum, women are located in the 30-34 years group followed by 13 women in the 25-29 years group. In the fourth-order of pregnancy, a small number of women is found.

Table 4: Order of pregnancy

Present age group	No of women	1 <sup>st</sup> order	2 <sup>nd</sup> order	3 <sup>rd</sup>	4th	Total
15-19	1	1				1
20-24	21	12	8	1		21
25-29	37	5	19	13		37
30-34	44		23	18	3	44
35-39	8		4	3	1	8
40+	1			1		1
Total	112	18	54	36	4	112

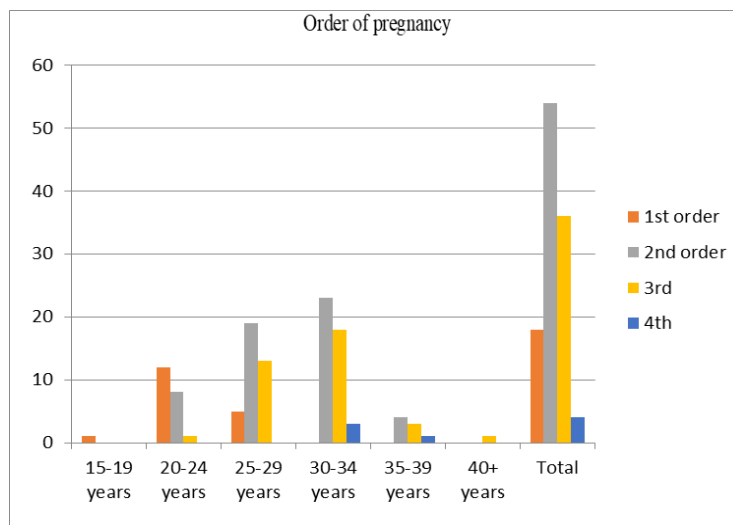
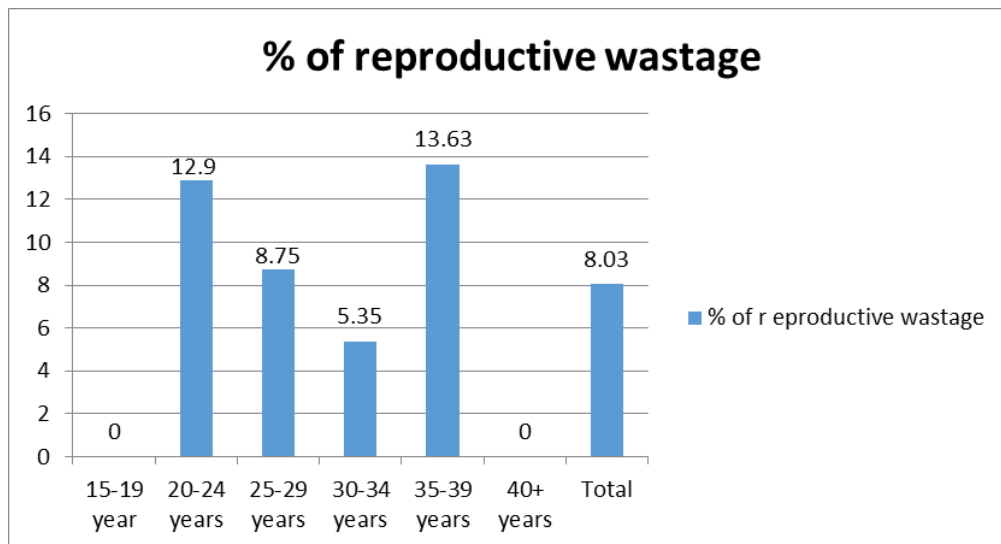




Table 5: Reproductive wastage

Present age group	No of women	No of conception	Reproductive wastage	L B	% of r w
15-19	1	1	0	1	0
20-24	21	31	4	28	12.90
25-29	37	80	7	72	8.75
30-34	44	112	6	105	5.35
35-39	8	22	3	20	13.63
40+	1	3	0	3	0
Total	112	249	20	229	8.03



Reproductive wastage includes abortion, miscarriage and stillbirths.

Reproductive wastage includes miscarriage, abortion and stillbirth of women which occur during pregnancy. There are many factors associated with reproductive wastage such as ill-health of the mother, unwanted pregnancy, anemia, poor socio-economic status etc. In the present study, the

percentage of reproductive wastage is 8.03%. It is found more among the young age women. The incidence of abortion is very less in the present study. Maharana (2011) studied the incidence of abortion in rural and urban areas of eight state of India such as Assam, West Bengal, Orissa, Uttar Pradesh, Maharashtra, Punjab, Tamil Nadu, and Kerala. The study found that the incidence of abortion in these eight states is less than the national average. The incidence of induced abortion is high in urban areas than in rural areas.

Table 6: Antenatal check-up

Age group	Completed 3 antenatal Check up (N=112)	
	Yes	No
15-19	1	0
20-24	15	6
25-29	24	13
30-34	26	18
35-39	5	3
40+	1	0
Total	72 (64.28%)	40 (35.71%)

Antenatal care during pregnancy is important care that can provide safeguard to both mother and child. Antenatal care aims to get a healthy mother and a healthy baby at the end of a pregnancy. Mother who had received antenatal care was more at risk of low birth weight babies (Nair et al, 2000). There is a close association between infant mortality rate and lack of antenatal care

(Chandrasekhar et al, 1998). Antenatal care should be started from conception and should be continued throughout the pregnancy (Park and Park, 1991). In India the utilization of antenatal care varies according to region, community and place. Again the socio-economic status, educational attainment, cultural beliefs etc have influenced the utilization of antenatal care among couples. The utilization of ANC is only about 64.28% in the village. Most of the women did not complete their ANC check-up. They just complete first and sometimes second ANC check-up. It is very important to complete all the check-up to go through a safe pregnancy and childbirth.

Table 7: Place of delivery

Age group	Govt. hospital	Private hospital	Home	Total	%
15-19	1	0	0	1	100%
20-24	16	3	2	21	90.47%
25-29	23	9	5	37	86.48%
30-34	25	11	8	44	8.81%
35-39	6	0	2	8	75%
40-44	1	0	0	1	100%
Total	72	23	17	112	84.82%

In Assam institutional delivery improved from 23.8% in DLHS-1 and 26.8% in DLHS-2 to 35.1% in DLHS-3 (2007-08). The percentage of institutional delivery ranges from 15.9% in Dhubri district to 65.4% in Kamrup district. In Assam, 40% of deliveries, either institutional or home were safe

delivery, assisted by the skilled person. The better performing districts in terms of safe delivery are Dibrugarh (52.95%), Jorhat (54.4%), Sibsagar (57.4%) and Kamrup (70.8%). The woman (63.8%) who had home deliveries reported that the reasons for not delivering in health institution were not necessary (35.0%), no time to go to the hospital (29.2%), lack of cost (18.0%) (DLHS-3).

About three-fourths of the births (71%) in Assam take place in the health facility, and 29% take place at home (NFHS-4). The percentage of births in a health facility has been increased tremendously in the last 10 years between NFHS-3 and NFHS-4, from 22% in NFHS-3 to 71 per cent. It is interesting to see that institutional deliveries are more among the women who had received antenatal care. It is also high among the Hindus. The home deliveries (29%) were assisted by skilled professional (73%) and traditional birth attendants (17%) in Assam. In Baksa district, the percentage of institutional delivery was 88% (NFHS-4). In the study village, the percentage of institutional delivery was 84.82%, which is a good sign of maternal health. The percentage is high among young mothers.

### Summary

The present paper is based on the study carried out among the Boro Kachari women of Barama, Baksa District, Assam. A total of 112 women are studied, and their reproductive performance is analyzed with statistical methods.

The highest number of children in the women belongs to 40+ years (3) followed by 35-39 years (2.5). It is seen in the table that the mean number of live birth is increased with the increasing age of the mother. There are 18 women found in the first order of their pregnancy followed by 54 women in the second order of pregnancy and 36 women in the third order of pregnancy and 4 women in the fourth-order of pregnancy. The utilization of ANC is also found less among women. Most of the women delivered their child in the government hospital. But home deliveries are also found in the village. There is a need to focus more on the reproductive health of women in the study area. Though it is a tribal area, the illiteracy rate is also low among women.

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