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Status of Health among the Scheduled Caste Population of Kamrup District in Assam-an Appraisal

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Abstract

Health studies during recent years are witnessing abundant research, bringing both social scientists and medical scientists to suggest possible solutions to health-related issues. The role of social science in studying health issues is mainly confined to the nature of a specific type of disease in specific areas, socio-economic factors related to health hazards like drug abuse, lifestyle etc. The present study aims to study the health status of the scheduled caste population living in the Kamrup district of Assam with special reference to cancer among the inhabitants. About 2002 numbers of households belonging to the SC community have been enumerated to reach the objective of the research problem. GPS points of all hospitals, sub-centres, PHC, CHCS, colleges and schools are taken to delineate a buffer zone of service areas and unserved areas of the study area. The study reveals certain facts like the high rate of cancer patients among the inhabitants and a high rate of Infant Mortality (75.65%) among the surveyed population, which is much higher than that of the national average (i.e. 57.0%).

Keywords: Scheduled Caste, Health Status, Buffer Zones, Infant Mortality Rate

Introduction

The health status for a certain population or community group is multi-dimensional and complex to measure accurately. It can be studied through particular indicators such as awareness, mortality, illness, nutrition or calorie intake status, and life expectancy at birth. Among these indicators, mortality and life expectancy at birth are widely used to measure the health status of a population, as they are easily observed, objective and less prone to measurement errors. "An important consideration for addressing health care quality is the scope for clinical condition areas that should be included in the measure set" **(**Kelly et al. 2006)

The access to public health services and benefits from the public health system has been very uneven between the better endowed and the more vulnerable sections of society. Keeping this uneven access to health services in view, the **"National Health Policy-2002"** evolved a policy structure which reduces these inequities and allows the disadvantaged section of society fair access to public health services by various measures, including separate schemes and increasing sectoral outlays in the primary health sector.

Objectives

The main objectives of the study are:

1. to study the health conditions and awareness of the people to some common diseases residing in Kamrup district,

2. to suggest measures to make the all-around sustainable livelihood of the Scheduled Caste population.

Data and methods

Relevant data were collected with the help of household schedules, village schedule and schedule for resource persons (doctors and medical officers). Household schedule tries to capture different dimensions of health status. The village schedule attempts to bring together authentic data regarding the village under investigation.

The use of secondary data is a common research approach in health sectors such as epidemiology, health services research, and public health research, and includes analysis of patterns of occurrences, determinants, and natural history of the disease; evaluation of health care interventions and services; drug safety surveillance; and some genetic and social studies **(Lowrance, 2002; Lowrance and Collins, 2007).**

Location of the Study Area

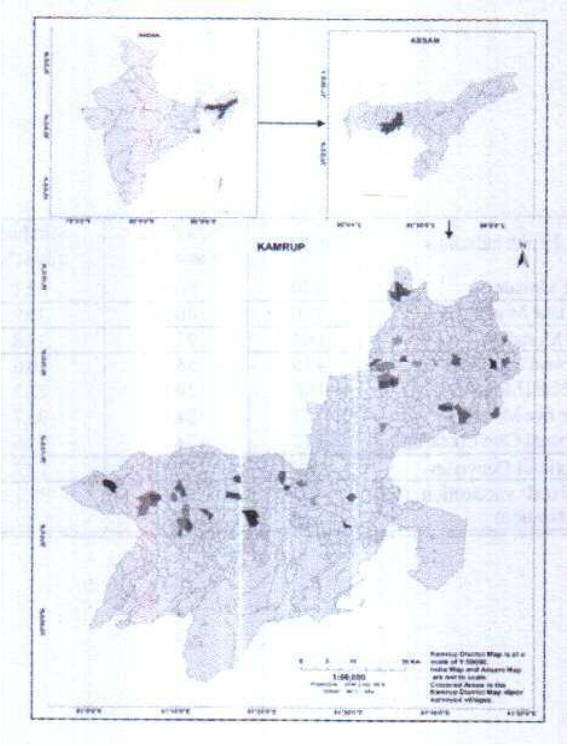

Figure 16.1: Location of the study area

Status of Health among the Scheduled Caste population

Health Studies have witnessed abundant research in recent years, bringing both social scientists and medical scientists to suggest possible solutions to health-related issues. The role of Social science in studying health issues is mainly confined to the nature of a specific type of disease in specific areas, socio-economic factors related to health hazards like drug abuse, sex, lifestyle, etc. In this regard, a multidisciplinary approach may provide an organised and efficient structure to streamline the definition and analysis of factors influencing human health, such as socio-economic, political, and geo-environmental factors.

Out of the total of 2002 households, 8.67 per cent of people are suffering from Diarrhea, indicating the picture of poor health conditions in the study area. Moreover, 8.3 per cent of the enumerated households have no access to a public hospital within a 5-kilometre range

Besides household surveys to know the status of health among the Scheduled

Caste population in the Kamrup district, interviews of expert doctors working in or near the Scheduled Caste inhabited areas have been conducted to extract a meaningful conclusion from the study.

The health situation of the SCs based on various health indicators has been reflected in the following Table.

Table 16.1: Status of key health indicators among the Scheduled Caste population in India, 2009-10 and survey villages 2014

Sl. No	Health indicators	Total (%)	Scheduled Caste (%)	Scheduled tribes (%)	Surveyed (2014)
1	Infant Mortality	57.0	66.4	62.1	75.65
2	Neo-natal Mortality	39.0	46.3	39.9	25.21
3	Child Mortality	18.4	23.2	35.8	-
4	Peri-Natal Mortality	48.5	55.0	40.6	-
5	Post-Natal Mortality	18.0	20.1	22.3	-
6	Under five Mortality	74.3	88.1	95.7	-
7	Anti-Natal Care Check-up	77.2	74.1	70.6	-
8	Institutional Deliveries	38.6	33.0	17.7	92.63
9	Childhood vaccination (full immunization)	43.5	39.7	31.3	61.13

Source: National Family Health Survey - III (NFHS) India 2009-10, Vol.-1

Infant mortality is very high in the surveyed villages of Kamrup district, with 75.65, which is more than the national average of 66.4. This resulted in the consciousness of the Scheduled Caste population of the surveyed areas, and an increase in the percentage of institutional delivery is recorded to be 92.63 per cent. In regards to the anti-natal care checkup and institutionalised deliveries among the women concerned, the figure in the Table reveals that only 74.1 per cent of Scheduled Caste women and 70.6 per cent of scheduled tribe women preferred anti-natal care checkups during their pregnancies as against the total anti-natal care checkup of 77.2 per cent. The total percentage of women who use public/private health services to deliver their babies is 38.6 per cent. In the case of institutional deliveries among the Scheduled Caste and Scheduled tribe women, the data show that nearly 77 per cent of SC women and more than 82 per cent of ST women gave birth to their children at home. So the above analyses reflect that although there is improvement in the health status of Scheduled Caste and scheduled tribes, there still exists a substantial gap in the various dimensions of key health indicators relating to morbidity and mortality of children and women.

Status of health among the surveyed population

The term 'Good health' is often used daily; however, its indicators are still vague as different resource persons have alternative ideas regarding the term

Good health. In the present study, the status of good health is quantified in numerical numbers based on the scoring of primary health indicators taken from health indexes and verified by doctors interviewed during the survey. Based on the response from the doctors and other sources like literature related to health and the internet, sixteen numbers of indicators of good health are selected.

A study of the health status among the Scheduled Caste population of forty-four surveyed villages of Kamrup district is tabulated in table 4. all the surveyed households are enumerated and based on scoring of health, five numbers of the class are formed, namely poor health, adjustable health, average health, good health and healthy.

From table number 5.3 it is observed that Tulshibari village has the lowest per cent of people with poor health (9.49 per cent), and Ambari village has the highest proportion of respondents in this category. The highest number of people in adjustable health is found in Bichennala village, 31.71 per cent, and the lowest per cent share is in SingimariHabi village (14.13 per cent). In the next category of health status, i.e. average health, Debok no. 1 village has 30.34 per cent of the total surveyed population, the highest in this category, and the lowest is Simalubari village with 19.67 per cent. In the good health section highest number of people with good health is found in Tulshibari village (31.39) and the lowest in the Simila village with 14.29 per cent. The last group is of healthy people in which Balisatra village has the highest proportion of healthy people among the surveyed population with 21.18 per cent, and Dari village is at the bottom of this group with 8.65 per cent population.

The spatial pattern of variation in the status of health shows a very uneven distribution among the people of the surveyed villages.

Figure 16. 2: Health status of the surveyed villages, 2014

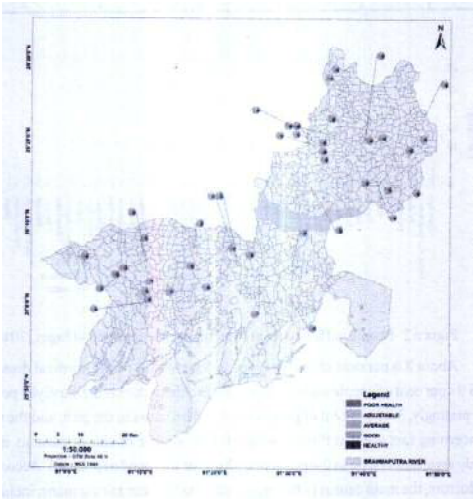

Table 16.2: People suffering from diseases in the surveyed villages, 2014 (in per cent)

Name	Cancer	AIDS	Hepatitis	Diarrhea	Malaria	Dengue	Chronic dysentery	Skin disease	Bronchial problem
Chanmaguri	0.00	0	7.69	13.85	3.08	0.00	7.692	13.85	1.538
Debok No.1	0.69	0	4.14	7.59	2.07	0.00	6.207	8.966	1.379
Tulsibari	1.46	0	2.92	7.30	1.46	0.49	7.299	10.22	1.46
Bichennala	0.49	0	3.90	5.85	0.98	1.92	9.268	4.878	1.463
Dari	0.00	0	0.00	3.85	0.96	1.43	6.731	4.808	0.962
Simila	0.00	0	0.00	17.14	2.86	0.00	4.286	5.714	1.429
Narenga	0.84	0	1.67	13.39	1.67	3.85	6.276	8.787	1.674
Jalukbari	0.00	0	0.00	3.85	0.00	0.00	5.769	15.38	3.846
Soneswar	0.00	0	3.85	1.28	1.28	0.24	6.41	10.26	1.282
Baihata	0.73	0	3.41	1.71	0.24	3.85	5.366	8.293	0.976
Haldha	0.00	0	7.69	1.92	0.00	0.00	7.692	11.54	3.846
Khehenipara	0.52	0	5.21	1.56	0.52	0.99	5.729	17.19	1.563
DakshinSingra	0.00	0	3.96	2.97	0.00	0.17	5.941	14.85	2.97
Dihina	0.51	0	2.03	6.94	0.51	0.45	1.354	5.753	0.846
No.1 Bagta	0.30	0	1.66	1.36	0.15	0.68	1.815	6.354	0.908
No.2 Bagta	0.00	0	1.37	4.11	0.68	0.14	2.74	9.589	1.37
Kukur Mara	0.28	0	1.66	7.34	0.69	0.66	1.662	7.064	0.97
Choudhuri Para	0.33	0	6.64	0.66	0.00	5.26	2.99	7.973	0.997
Makeli	0.00	0	7.02	5.26	1.75	2.08	7.018	12.28	3.509
Akchalia F.V.	0.00	0	4.17	4.17	0.00	0.36	6.25	14.58	2.083
SingimariHabi	1.09	0	5.07	18.48	1.45	0.83	3.261	14.13	1.449
TariGaon	0.83	0	3.31	14.05	1.65	0.51	4.132	16.94	2.066
Ambari	0.00	0	2.04	18.88	2.04	4.92	0.51	5.612	2.041
Simalu Bari	1.64	0	3.28	3.28	0.00	0.25	4.918	13.11	3.279
Salmara	0.25	0	1.97	8.87	0.74	1.32	5.172	10.34	1.478
HowliTari	0.38	0	1.13	9.64	0.95	1.20	3.403	9.641	1.323
Puthi Mari	0.40	0	1.59	10.76	1.20	1.32	5.578	9.96	1.594

NeulDova	0.44	0	0.00	3.08	0.44	1.73	6.608	10.13	2.203
MandiraPathar	1.16	0	3.47	6.94	0.58	0.29	7.514	10.4	1.156
Pujupara	0.29	0	1.45	9.13	0.87	0.58	5.507	8.406	1.159
Nichalamari	0.58	0	0.00	11.82	1.15	0.14	6.052	1.729	1.441
MalibariSatra	0.28	0	1.68	9.24	0.84	1.28	4.762	9.944	1.261
Kandulimari	0.64	0	2.56	17.31	1.92	4.24	7.051	9.615	1.282
JarabariGaon	1.69	0	0.00	9.32	0.85	25.00	11.02	10.17	1.695
Gatuwa	0.00	0	6.25	12.50	0.00	0.00	6.25	12.5	0
Chayani									
Rangamati	0.61	0	4.85	11.52	1.82	1.30	4.242	6.667	1.212
DakhinLenga	0.00	0	0.00	14.29	1.30	0.00	5.195	6.494	1.299
Dhopatari	0.00	0	1.50	12.73	1.12	1.10	6.367	7.865	0.749
Silbharal	0.37	0	1.10	9.89	1.10	2.63	6.96	6.96	0.733
Numalijalah	0.00	0	6.58	12.50	1.32	3.51	7.237	5.921	0.658
Purnakhumdum	0.00	0	7.02	7.02	0.00	1.52	7.018	7.018	0
Garpot	1.52	0	3.03	9.09	1.52	0.00	7.576	7.576	0
Souramuri	0.00	0	3.74	11.56	1.02	2.35	3.061	7.143	0.68
Balisatra	0.00	0	4.71	17.65	1.18	0.02	9.412	7.059	0
Average	0.42	0	3.08	8.67	1.00	1.79	5.62	9.402	1.451

Source: Primary Survey, 2014

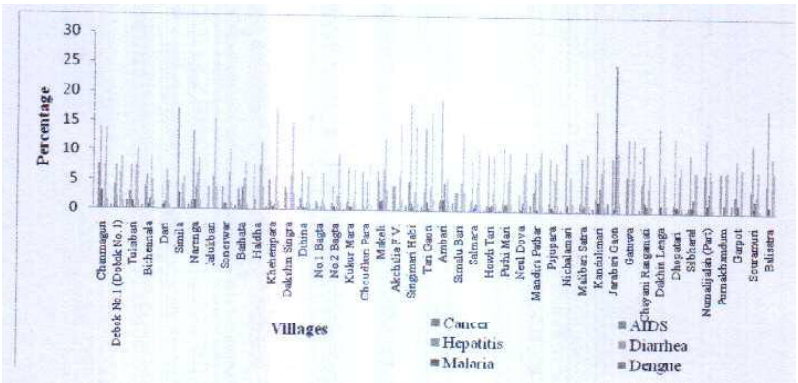

Figure 16. 3: People suffering from diseases in the surveyed villages, 2014

About 8.6 per cent of the surveyed villages suffer from Diarrheal diseases, and 9.4per cent of people suffered from skin problems during the surveyed period. Surprisingly, 3.08 per cent of people have had hepatitis in the past, and the most concerning fact are that there is a significant number of cancer patients in the study area, amounting to 0.4 per cent of the total surveyed population. According to doctors, the main causes of this particular fatal disease are too many, including consuming tobacco, alcohol, and other narcotics, a few cases of genetic origin, contaminated water, and high rate of pollution etc. A huge campaign to drive cancer awareness is essential so that people may be aware of its severity and get proper treatment in the early stages.

Crude Birth Rate (CBR) and Crude Death Rate (CDR)

Crude Birth Rate (CBR) is more often used as a standard tool for calculating fertility as it is more available than refined measures like TFR etc**. (E. Barbara, 1981).**In 2011, CBR for India is recorded as 21.8, the same in rural India is 23.3, and in Urban, India is 17.6. Similarly, in the same year, CBR for Assam is recorded as 22.8, the same for rural Assam is 24.0, and for Urban, Assam is 15.5. The survey villages have a midyear population of 10,214, and 119 babies were born last year in that area, thereby resulting Crude Birth Rate is 11.65 per 1000, which is lower than the state and nation's average, the formula used for calculation of CBR is:

$$\text{CBR} = \frac{\text{Number of live births during the year}}{\text{Mid year population}} \times 1000$$

Crude Birth Rate is11.65 in the surveyed villages, which is lower than that of the state average of 22.8.

The CBR is "crude" as it does not consider age or sex differences among the population. CBR accounting for more than 30 per 1000 persons is considered high, and those of less than 18 per 1000 persons is considered low. According to reports, the global Crude Birth Rate in 2005 was 20.15 per 1000.

Crude Death Rate is the ratio of the number of deaths in a year to the midyear population of that particular area.

CDR= 88/10214 × 1000 = 8.62

Infant Mortality Rate

Infant Mortality Rate is the ratio number of infant deaths divided by number of live births during the year × 1000. As the number of live birth are 119 therefore

IMR (Infant Mortality Rate) =119/9 × 1000 = 75.63

The result is unfortunate that IMR is very high among the surveyed population, indicating poor child and maternal health conditions. The main causes behind this are deficiency of iron among the mothers during the pregnancy period,

ignorance towards health care facilities during the pregnancy period, etc. according to NRHM, Assam Government IMRin the same year is 54 in Assam and 40 in India

Child death is recorded in No. 1 and No.2 Bagta, Tari Gaon, Ambari, Salmara, Howlitari, Pujupara, Malibariand Narega villages, all of which are located on the south bank of the Brahmaputra river except the Dihina village.

General Fertility Rate

The general fertility rate is the total number of live births per 1000 women of the childbearing age group (15-49); during the survey year total 119 live births were recorded during the survey and total women population in the reproductive age group are 2934, and the general fertility rate is Calculated at 40.56.

Age-Specific Fertility Rate (ASFR)

Age-Specific Fertility Rates (ASFR) is done in 5-year age groups for women between the ages of 15 – 49(or 18 – 49), depending on the available data and population. The formula for the Age-Specific Fertility Rate is:

Age-Specific Fertility Rate (ASFR) = (Number of births to women in the age group *i* / number of women in age group *i*) x 1000

Table 16.3: Age-Specific Fertility Rate (ASFR) 2014

Sl. No.	Age Group	Total Number of Women	Live births in this category	Birth per 1000 women (Column 3 by column 2 × 1000)	Projected resulting birth during age interval (5 × column 4)
	1	2	3	4	5
1	15-20	441	2	4.53515	22.6757
2	21-25	421	17	40.38	201.9
3	26-30	501	38	75.8483	379.242
4	31-35	394	29	73.6041	368.02
5	36-40	433	22	50.8083	254.042
6	41-45	357	11	30.8123	154.062
7	46-49	387	0	0	0
Total	15-49	2934	119		1378.94

Source: Primary survey, 2014

Total Fertility Rate (TFR)

The total Fertility Rate is a very good fertility index than the Crude Birth Rate. After calculating all of the Age-Specific Fertility Rates for the population, the researcher can move on to calculate the Total Fertility Rate. The formula for the Total Fertility Rate is:

Total Fertility Rate (TFR) = (The sum of the Age-Specific Fertility Rate, The number of years in each age group) / 1000

The TFR in the present study is calculated is 1378.94 x 5 / 1000 = 6.89, which is very high. The total Fertility rate of Assam in the year 2013-2014 is 2.4, which is again 2.4 in India in the same year (NRHM, Government of Assam)

Location of Health Facilities in the Study area

From the spatial distribution of the different categories of health centres, it is evident that the periphery areas of the district are deprived of their health care facilities due to the non-availability of Government health care services in the said areas. The south Kamrup part of Goroimari, Nagarbera and Chamaria sub-district, which are visibly deprived of health care facilities, is mostly located in the chor and chapori areas, making them more inaccessible.

Moreover, the buffer zone of TRB civil hospital in figure 5.3 shows some areas of the south bank of Kamrup district, but the people from the south bank mostly prefer to go to hospitals in Guwahati city instead of going to the TRB district civil hospital.

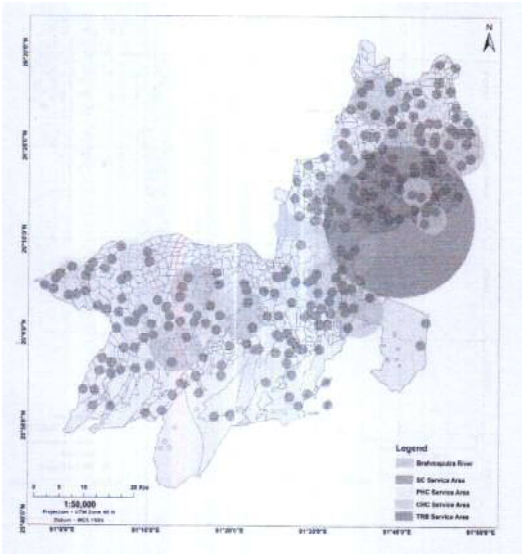

Figure 16.4: Location and service area of hospitals in Kamrup district, 2014 Source: GPS points collected from the field, 2014-2015

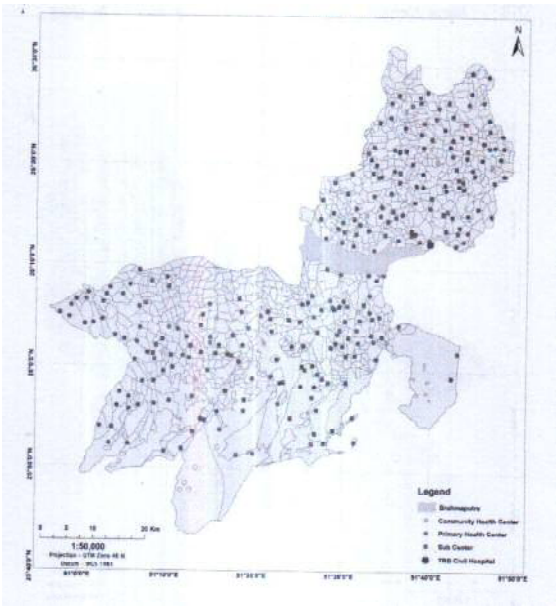

Figure 16.5: Locations of SC, PHC, CHC and TRB civil hospital

Source: GPS points collected from the field, 2014-2015

Health awareness among the surveyed population

Knowledge about the diseases helps to adopt preventive measures to get rid of them. Diseases like HIV- AIDS, flu, malnutrition, water-borne diseases etc., can be prevented by taking precautionary measures.

To study the health awareness among the people of the study area, a list of ten common and fatal diseases has been prepared, and three basic questions regarding the same are being asked, i.e. Features, causes, and precautions. The ten mentioned diseases are AIDS, Cancer, Hepatitis, Malaria, Dengue, Diabetes, CAD, TB, Diarrhea, and Japanese Encephalitis. It is observed that most people have a very vague idea about these diseases. The tables and figures below will give a clearer picture of the scenario about the level of awareness about the common diseases. It is observed that people have a sound awareness about cancer, i.e. about 75.70 per cent of the surveyed population have awareness about cancer. Awareness level is lowest in cases of CAD (Coronary Artary Disease) or Heart-related diseases and Bronchial problems in almost all the villages. Awareness about heart diseases is low as most heart disease symptoms are difficult to identify until a severe state is not reached; moreover, low educational attainment is also

associated with health awareness. Few present diseases are taken from pioneer health care organisations like OECD. **OECD Reviews of Health Systems** are in-depth studies of the health system of member countries, with a particular focus on economic issues. (OECD, 2003).

HIV/AIDS awareness is recorded highest in Simila village, with 92.86 per cent of the aware population of the disease. Souramuri village of Koya sub-district has the lowest number of people aware of AIDS. Cancer awareness is highest in Jalukbari village (96.15 per cent), and lowest in Dhopatari village (51.31 per cent). Awareness about hepatitis is highest in Simila village (85.71 per cent) and lowest at Akchalia FV (54.17 per cent). Japanese Encephalitis is a very serious disease which needs very much awareness to get rid of it, Female population of Gatuwa village have 100 percent awareness about Japanese Encephalitis., whereas 77.78 per cent of the surveyed male population have awareness about Japanese Encephalitis. Awareness about Dengue is highest at Kukurmara village with 84.13 per cent of surveyed population and lowest at Gatuwa village (31.25 per cent), Khehenipara village tops the list about awareness of Malaria with 92.18 per cent aware people.

Table16. 4: Health awareness among the surveyed population about common diseases, 2014 (in per cent)

VILLAGE	AIDS	CANCER	HEPATITIS	DENGUE	MALERIA	TB	HEART (CAD)	DIABETES	DIARRHEA	JAPANESE ENCEPHALITIS
Chanmaguri	89.23	80	70.769	67.692	84.615	83.077	40	75.385	64.706	75.385
Debok No.1	90.35	93.793	82.069	84.138	88.966	87.586	26.897	89.655	70.667	78.621
Tulsibari	92.7	92.701	70.073	68.613	89.781	89.781	40.146	90.511	71.831	75.912
Bichennala	89.27	84.39	69.268	60.976	87.317	85.366	22.439	81.951	73.585	73.659
Dari	89.42	77.885	84.615	64.423	85.577	86.538	41.346	85.577	81.818	72.115
Simila	92.86	78.571	85.714	70.00	87.143	82.857	44.286	82.857	76.923	68.571
Narenga	84.1	84.519	77.82	73.222	83.264	83.264	40.167	84.1	74.59	66.946
Jalukbari	92.31	96.154	78.85	67.308	82.692	88.462	48.077	88.462	72.414	75.00
Soneswar	83.33	82.051	75.64	61.538	78.21	85.897	65.385	82.051	70.732	71.79
Baihata	87.81	73.902	71.22	67.073	86.83	82.195	42.927	79.268	77.114	67.07
Haldha	86.54	76.923	76.923	63.462	80.77	84.615	59.61	80.769	68.966	67.31
Khehenipara	92.71	88.021	76.563	67.708	92.19	87.5	40.62	86.979	79.798	74.48
DakshinSingra	84.16	84.158	79.21	70.297	87.129	86.139	65.347	86.139	75.472	67.33
Dihina	67.51	60.914	77.157	65.482	57.53	53.469	20.98	67.174	62.626	52.79
No.1 Bagta	88.96	87.292	78.517	71.71	90.32	81.24	30.56	88.502	77.778	70.04
No.2 Bagta	83.56	84.932	79.452	65.068	82.192	77.397	33.56	85.616	73.333	69.86
Kukur Mara	86.84	84.072	85.042	72.715	86.57	77.839	30.748	83.657	79.178	80.19
Choudhuri Para	82.72	80.40	79.402	66.113	81.395	78.738	31.229	79.07	78.71	68.106
Makeli	80.7	78.95	63.158	56.14	73.684	82.456	50.877	82.456	76.667	73.68
Akchalia F.V.	72.92	62.50	54.167	47.917	75	60.417	43.7	64.583	65.385	62.5
SingimariIlabi	62.68	61.96	60.51	57.61	65.94	68.841	20.65	63.043	54.68	52.54
TariGaon	71.9	71.488	68.182	66.942	70.248	79.752	24.38	73.14	63.415	61.983

Ambari	69.39	68.367	65.816	63.265	68.878	70.918	18.367	69.898	65.657	64.286
Simalu Bari	80.33	73.771	72.131	60.656	72.131	80.328	57.377	77.049	56.25	60.656
Salmara	87.93	83.99	78.079	75.616	86.7	85.961	46.798	81.281	72.549	77.34
HowliTari	78.83	80.34	75.236	72.023	78.261	79.395	41.21	78.45	76.981	77.316
Puthi Mari	68.92	70.518	66.932	63.347	67.331	77.689	55.378	70.916	64.286	64.94
NeulDova	67.401	64.758	65.198	59.471	63.877	66.079	61.233	65.639	62.609	61.674
Mandira Pathar	63.584	53.757	56.069	50.289	73.41	58.382	55.491	61.272	68.539	58.382
Pujupara	78.841	81.739	73.913	73.478	77.681	76.377	47.826	80.435	74.64	75.362
Nichalamari	76.945	77.522	75.216	72.911	75.793	74.928	50.72	78.098	71.429	66.282
MalibariSatra	80.112	82.353	74.23	71.429	78.992	76.331	28.291	82.633	69.624	70.588
Kandulimari	82.692	78.205	66.667	64.744	80.128	77.564	39.744	79.487	76.543	76.923
JarabariGaon	83.898	85.593	79.661	73.729	81.356	79.661	36.441	87.288	66.129	70.339
Gatuwa	87.5	87.5	56.25	31.25	75	75	31.25	81.25	77.778	87.5
Chayani										
Rangamati	74.545	75.758	71.515	67.273	72.121	75.758	26.667	76.97	71.765	71.515
DakhinLenga	77.922	74.026	71.429	62.338	74.026	74.026	41.558	76.623	70.732	70.13
Dhopatari	62.921	51.311	61.049	55.056	71.91	58.801	23.596	59.551	57.037	56.18
Silbharal	61.905	60.44	60.073	57.143	60.44	61.905	25.275	64.103	56.429	56.41
Numalijalah	69.737	57.895	66.447	61.842	69.079	65.132	39.474	65.789	74.684	75
Purna										
Khumdum	77.193	68.421	68.421	56.14	71.93	68.421	42.105	70.175	66.667	73.684
Garpot	72.727	60.606	62.121	54.545	83.333	68.182	45.455	72.727	62.857	72.727
Souramuri	59.184	54.422	57.143	55.102	65.306	61.565	54.422	65.306	53.642	54.762
Balisatra	74.118	74.118	70.588	48.235	80	75.294	57.647	68.235	64.444	49.412
AVERAGE	79.3	75.704	71.33	63.682	77.842	76.389	40.689	77.139	69.81	68.575

Source: Primary survey, 2014

Maternal and Child Health

Mother's health is one of the most important areas of concern while addressing the health issues of a certain group of people. In the present study, the female population of the forty-four surveyed villages is 5000. Out of which only 217 women agreed to discuss maternal health, and 189 (87.09 per cent) of them have a positive response towards taking medical help during the pregnancy and delivery period. 201 (92.63 per cent) women had a delivery under government and private medical supervision under a registered physician, out of which 154 (70.97 per cent) delivery were cesarean, and 63 (29.03 per cent) were normal delivery. Among all the live births, 2 children died within a week, and 1 died within one month. Moreover, it is observed that most females do not prefer to take the iron supplement tablet provided by the government during pregnancy.

Findings

In case of health status, Kamrup districts has an alarmingly high number of people suffering from cancer, both in the case of general and Scheduled Caste populations. The list of people at the village level suffering from various diseases

reveals that the maximum number of people are suffering from skin problems, Diarrhea, Chronic dysentery, and hepatitis, which are the result of personal hygiene practices, food, hand washing practices etc.

In the case of the Infant Mortality Rate, it is very unfortunate that IMR is very high among the surveyed population, indicating poor child and maternal health conditions. The main causes behind this are deficiency of iron among the mothers during pregnancy, ignorance towards health care facilities during pregnancy, etc.

Child death is recorded in No. 1 and No.2 Bagta, Tari Gaon, Ambari, Salmara, Howlitari, Pujupara, Malibari and Narega villages, all of which are located on the south bank of the Brahmaputra River except the Dihina village.

In the case of maternal health, out of 217 women, 87.09 per cent have a positive response towards medical help during pregnancy and delivery.92.63 per cent of women had a delivery in government and private medical supervision under registered physicians. Total 70.97 per cent of deliveries were cesarean, and 29.03 were normal delivery. Among all the live births, 2 children died within a week, and 1 died within one month. It is found that the majority of females hesitate to take the iron supplement tablet provided by the government during the pregnancy period.

It is important to mention that Kamrup district has one of the highest proportions of cancer patients in Assam; though the root cause is not known, doctors identified some of them to be the causes of the disease like genetic causes, consumption of adulterated food, excessive use of chemical fertilisers in food products, low fibre food is some of them. Kamrup district alone registered 4416 cancer patients during 2011(NCRP), of which 2508 were male and 1908 were female.

Conclusion

The study of health status among a specific group of people by an investigator of non-medical background is a herculean task. Health status is calculated based on certain parameters with due consultation from resource persons, including doctors and Medical officers.

It may be mentioned that health conditions are not directly proportional to the level of education in the surveyed area. The main causes are that literacy is higher in the sub-urban areas and relatively lower in the rural and interior areas. Still, the health condition of people hailing from rural areas is better due to factors other than literacy, mainly unadulterated dietary habits, hard work, sustainable lifestyle, better environmental condition etc.

Awareness is calculated for the most common and fatal diseases that have taken many lives in recent years. Ten such diseases are considered: AIDS, Cancer,

Hepatitis, Malaria, Dengue, diabetes, CBD, TB, Diarrhea, and Japanese Encephalitis. The surveyed people have a sound awareness of cancer (75.70 per cent), Hepatitis71.33percent and HIV and AIDS 75.70 per cent.

From the analysis of the data provided by the census of India and the surveyed data about the forty-four villages of the Kamrup district, it is found that in most of the villages, the literacy and occupation pattern is similar to that of the general literacy of the village, which proves that in the study area scheduled castes population cannot be termed as the backward class community in terms of literacy and occupation, the same about health cannot be considered as the health awareness table is not provided by the census of India.

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