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Women in India's Conflict Zones

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The palm leaf thatched house of the powerful 'Angh' (chief) of Longwa village in Nagaland, marks the international boundary line. His kitchen is in India and living room in Myanmar. The village is enveloped by thick jungles and towering mountain ranges, and south-east Asia stretches into the shimmering green beyond. Life stirs here at first cock crow, as the women of the Konyak Naga tribe ready for another day. The beauty and peace of the dawn however, brings little respite to them who live in India's conflict zones.

The Naga underground factions come to this village secretly at night. The villagers, including the women, are systematically selected from each home to carry their rations and luggage to hideouts across the border, or feed them. Each family is forced to pay them a tax of Rs.500 a year. And when the armies of India or Myanmar come to know, the villagers face their wrath as well.

When asked what is their main health problem, the women of Longwa can only articulate the complaint, ''We always feel so weak and tired''. This refrain is echoed by Naga woman everywhere in the interior districts. But behind this complaint emerges the story of excessive work burden, lack of access to preventive and curative health services, repeated child bearing, under nutrition and stress due to the political and economic turmoil that grips this insurgency torn area.

At dawn, the women in the villages of Mon district spend three hours collecting firewood and one hour fetching water. Deforestation and drought is forcing them to now walk further. Apart from all the household chores, the women work through the day in the steep jhum fields. At dusk, when they return home, they collect wild jungle leaves, which garnishes their supper of rice, chillies and some meat. On top of this routine, they bear an average of five to ten children.

In Longwa, the primary health centre has been locked as long as the villagers can remember. The nearest medical facilities requires a full day's trek to Mon town. Even where motorable roads exist, access to health services are no better. The Civil Hospital in Mon, the main district refferal centre, is devoid of competent doctors, basic diagnostic equipment and essential life saving medicines.

Maternal and infant mortality in these remote districts is grossly under-estimated. Hospital based data does not reflect the reality of illness and death taking place in the villages. Patients have no faith in the services there and come only when they are gasping for their last breath. In July-August this year, an estimated 600 persons died in the villages of Mon district from malaria, typhoid and jaundice, that could have been easily treated and prevented.

In Mon district, the Konyak Baptist Church with 45,000 members, and the Konyak Women's Association are the only sources recording maternal and infant deaths, and their findings are alarming.

But if the state government records are to be believed, Nagaland has already attained 'nirvana'. Its indicators surpass even the affluent Scandinavian countries! Maternal mortality is claimed to be below one per 1,000 and infant mortality is 7 per 1,000 live births!

Budgetary cuts ensure that officials cannot even buy petrol to travel to interior districts to see reality for themselves. Sitting in Kohima, a health official says, "Our women are strong, they have stamina. They hardly go to a doctor with much complications. They deliver their children safely at home".

The central government's new policy thrust on "reproductive health' as a means to safeguard the health of women and children has no understanding of the needs of the Nagas. When basic survival cannot be guaranteed, the resistance to agendas such as birth control is not surprising.

Phekao, a newly married young woman in Longwa says, "I want at least five children. We are farmers. We have to help one another do the cooking, farming, firewood and water collection. If there are not enough people in the family how are we going to finish all this work? To get this help, I need more children.'

This aversion to birth control in Longwa, one of the more isolated communities, contrasted sharply to the great desire for information amongst younger women in other villages, where new realities are impinging.

Seeing the rising numbers of jobless, uneducated youth turning to drug addiction, violence and extortion, these women realise they cannot look after so many children. They express an urgent need for information on birth control methods, access to medical services and health education.