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CHILD REARING PRACTICEN IN NORTH-EASTERN REGION

NATIONAL INSTITUTE OF PUBLIC COOPERATION & CHILD DEVELOPMENT,
Regional Centre-Guwahati

CHILD REARING PRACTICEN IN NORTH-EASTERN REGION

A REPORT

NATIONAL MINSTITUTE OF PUBLIC COOPERATION AND CHILD DEVELOPMENT, REGIONAL CENTRE-GUWAHATI

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PREFACE

Child Rearing is one of the most important responsibility of a family. There are various matters in rearing of a child .All these matters play tremendous role in determining children's growth and development. The unborn child receives nourishment from the mother when it is in the mother's womb. This talks about appropriate antenatal care which is necessary both for the mother and the unborn baby. In developing countries, including India, sizeable pregnant mothers are at risk. Therefore, appropriate maternal care is very important especially during antenatal and natal periods. After that, when the baby is born, it requires immediate appropriate attention which include -cleaning, breast feeding, vaccination and other health care. As a part of child care regime, it is imperative on the part of the family members to create a child friendly environment for the new baby.

Child rearing practices are not alike everywhere. It is influenced by certain factors such as- socioeconomic condition of the parents, beliefs and prejudices, cultural practices and norms of the society, and so on. Whatever the background may be, it is important for the family members and also the society to provide essential care for optimum growth and development of the child.

As child rearing practices vary from society to society and from place to place, it is important for the Planners to have access to the information on various aspects of child rearing practices pertaining to different societies and places so that, they can suitably plan schemes and programmes for the people of the area. Because of varied geographical locations and cultural traits, the North Eastern Region occupies a unique place in the cultural map of the country. This region is famous for various ethnic groups and their distinct cultural traits which has a reflection on its child rearing practices as well. Against this background, the Institute has conducted this research study entitled "Child Rearing Practices in North Eastern Region" to understand the child rearing practices in four tribal communities of this region.

While planning and conducting the study the Institute received various kinds of support from different individuals and institutions. I sincerely thank Dr. S. K. Dutta, Dy Director NIRD, Guwahati; Dr. R. Das, former Head, Deptt. of Anthropology, Gauhati University and Dr. Indrani Phukan, Head, Deptt. of Psychology, Gauhati University, for their valuable suggestions given before starting the study.

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(Bandana Bhuyan)
Regional Director

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CHAPTER I

THE PROBLEM AND THE STATEMENT

CHAPTER I

THE PROBLEM AND THE STATEMENT

Children are considered the most valuable assets in a nation. They are the future citizens and nation builders. Being the future of a nation, every child needs to be groomed adequately since its very early stage of life. The child being the living organism grows in a family, which is the basic unit of a society. Thus, the child starts with a biological foundation and grows up in a social environment. Since, the child lives and grows in a social context, the people in the environment, particularly the parents, family members and the members of the neighbourhood play a very significant role in determining the way in which the child develops.

Every family has to follow certain norms and rules of the particular society to get recognition and identity. In other words, every society has its traditionally and culturally practised norms for upbringing its children. Therefore, 'child rearing' may be considered as the upbringing of children in a family with the transmission of the culture of the group to the child. As home is the primary institute, these transmissions of culture of the group take place here. Thus child rearing includes all kinds of interaction of parents, their interests, beliefs, care taking and training behaviour to make their children the acceptable member of the society.

The child at home and its immediate environment needs all types of physical and mental care and protection. Amongst all mammals the human baby is born with most educable nature that can be moulded as desired to give a particular shape. The adult personality is formed on its foundation 'Childhood'. Though different psychologists and educationists have defined childhood period variedly, in terms of age, they all agreed to it that, this period is the most crucial one to form well formed adult personality. Therefore, it becomes imperative to nurture the child since beginning of life appropriately. Besides, the health and nutritional status of the child is one of the most prime requisites as it contribute to a large extent for better development of milestone during childhood. Moreover, the health and nutritional status of later life of an individual depend on the care received during early years of life.

As proper growth and development of a child depend on its health status before and after birth, it is very closely associated with its later life, thus care

during these periods also assumes importance. Direct care cannot be given to the child during prenatal period and it depends completely on its mother, therefore, encompasses care of mother during pregnancy and post partum period which include health and nutritional care, care of the newborn, feeding practices, other health care, toilet training, etc.

Proper nutrition with the adequate duration of breastfeeding, timely weaning, treatment of ailments, etc, and social beliefs are the utmost important factors during the formative stage. These are often influenced by certain cultural norms and also socio-economic status of the family. Therefore, parental education, occupation, income of the family, food habits, etc., are some of the factors, which influence on child rearing.

The mother is considered the first and basic trainer of the child in the family, later the family members and ultimately the society. Since, the family is considered the best workshop for the child, he/she should be given adequate opportunity to stimulate his / her responses, so that the child enables to adjust himself/herself with the new environment. Although, in all societies the young ones are nurtured, protected, yheir needs are attended, yet, the child rearing practices are not alike everywhere. It has been found that, the methods and ways of child rearing vary from culture to culture and society to society. All such methods knowingly or unknowingly adopted by the parents to up bring their children may not be scientifically acceptable. There are certain specific aspects / activities that need special attention of parents in order to regulate the growth and development of the child more appropriately. Many parents are

not aware or conscious of these and allow their children grow on their own and some are over conscious and want things to happen before the child is maturationally ready.

India is considered to be a rich country in terms of its distinct cultural wealth. The country also has a large section of population with various tribal groups, which is very different than rest of the population. Again each and every tribal society has its own cultural tradition and practices, economic and political backgrounds, religious and other rites and rituals, which are distinctively different from each other. A large section of the tribal population lives in the north eastern part of the country.

Research on child rearing is not a new concept. Several researchers have carried out various studies on child rearing. In earlier days, people put less importance to it and had neglected the children community. But now-a-days, it is well understood by the planners and researchers that they are the builders of the nation and should receive all kinds of support on time. Thus, to understand the situation and to find out ongoing facts relating to this area, a number of studies have been carried out in recent years. In North Eastern Region, although various studies on various aspects of child rearing were carried out in different tribal communities, yet studies emphasizing on child rearing covering all major areas together are rather scanty. Thus, a prominent gap of knowledge has been pertaining to us. Above all the health and nutritional status of children in this part of the country also needs attention. Hence, it is necessary to have proper scientific knowledge of every aspect of health in child in child

rearing and this can be achieved only through field investigation. Such type of findings are expected to be helpful for the planners to a great extent in planning appropriate plan programmes to shape these tender human beings by providing and ensuring a conducive environment so that our nation can make a place in the list of advanced countries. Therefore, understanding these, this attempt has been made to undertake the study relevant to prevailing child rearing practices of tribal communities of north eastern region.

Objectives of the study

The study will be conducted with the following objectives:

- to study the existing as well as traditional child rearing practices in terms of child birth, infant and young child feeding practices, related customs and beliefs among the tribes;
- to assess health and nutritional status of the children by finding out various health parameters, such as- weight foe age; immunization status; frequency and types of illnesses, etc.
- to study the effect of modernization in relation to the changing aspect of child rearing such as – feeding, child health care, play equipments, clothing, etc.; and
- to find out the attributed differences and similarities of child rearing practices among the tribes.

Review of Literature

Infant Mortality/Morbidity

Since, the child's mortality, morbidity, health and nutritional status, health care, etc. are directly or indirectly influenced by the child rearing practices, in tern, these indicate the care rendered to the children, thus, literatures are also collected in these areas

Gandotra and Das (2001) in a study conducted in Gujrat and Maharashtra, observed that, infant mortality was found to be high when (i) the marriage age of the mother was below 18 years; (ii) interval between last two live births was below 18 months and (iii) when the mother was illiterate. The study also obtained data on causes of infant deaths and observed that, pre-maturity, Hypoxia and Asphyxia are the main causes of infant deaths.

Study conducted by Bang, A.T., et-al., (2005) in Gadchilori district of Maharashtra estimates incidence of various neonatal morbidities and associated case fatality in home-based rural neonates and proportion of neonates who need health care and actually received it. The study revealed that, out of total sample 95 per cent live births occurred at home and out of which 75 per cent neonates were observed for the study and found that, 48.2 per cent neonates suffered high risk morbidities. Although 54.4 per cent neonates had indications of health care, only 2.6 per cent received medical

attention. Nearly half of the neonates in rural homes developed high risk morbidity and needed health care and actually none received it.

In another study conducted by the Indian Council of child Welfare Assam, in four districts in Assam (Darrang, Jorhat, Kamrup and Nagaon) observed that, the main causes of child mortality were diarrhoea, pneumonia, dysentery, antenatal tetanus, frure and K.T.I in the four districts of the state selected (2000).

The Ministry of Health and Family Welfare, India (MHFW, 2004) observed that, the new born health challenge faced by India is bigger than that experienced by any other country. WHO estimates showed that, India tops the list of nations burdened by Neonatal tetanus disease with 48,600 neonatal deaths annually due to this preventable disease. It also reveals that over 80per cent Low Birth Weight (LBW) neonates weigh between 2000-2499 gms. Maternal malnutrition and ill health, high fertility rate, teenage pregnancy and maternal infections are the possible major risk factors.

James and Subramaniam (2004) in a study by analysing the data of NFHS, 1998-99, observed that, children with previous birth interval less than 18-24 months had significantly lower chances of survival compared to children with more than 24 months birth interval. Mothers giving birth in the age group of 25-30 and birth order 3-6 had lower neonatal deaths than those giving birth during 18-24 years. Neonatal mortality was less among highly educated mothers compared to low educated mothers. Health behaviour of mother in

terms of smoking, drinking alcohol and chewing tobacco and injury variables was found to be insignificant.

In an analysis carried out by Pandey, et. al, (2004), by analysing the data of NFHS, 1998-99 and observed that, neonatal, post-neonatal and infant mortality was found to be much higher in rural areas compared to urban areas in all the major states in India. Neonatal mortality was higher among children of scheduled caste and scheduled tribe mothers compared to other backward community mothers. Mothers below 20 years and above 35 years have experienced higher neonatal mortality than those giving birth at age of 20-34 years. Higher neonatal mortality was found when the birth interval was less than 24 months in almost all the states. Mothers who had undergone three and above antenatal checkups had lowest neonatal mortality, which was found to be lower in all the states except Haryana.

Nandan, D., et. al.,(2005), in a study conducted in rural Community Setting Agra, observed that Hypothermia, pneumonia, birth asphyxia, prematurity and low birth weight emerged as major causes of neonatal deaths. Majority of deaths of infants and children 1-5 years of age were found to have occurred due to severe malnutrition and diarrhoea. The community realised that majority of the deaths occurred because of the delay in recognition of the seriousness of the problem.

Sharma and Gupta (2005) in a study in Sirmour district of Himachal Pradesh, identified 65per cent at risk children in 0-5 years age group,

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constituted 10.1 per cent of total population, Literacy of parents and prevalence of 'at risk' children had inverse relation. "At risk children" living in house with unsatisfactory lighting and ventilation were 68.4 per cent.

Feeding

Study conducted by Sharma, R. (1997) to assess the extent of use of three selected recommended child care practices such as weaning foods, oral rehydration Ttherapy and personal hygiene and sanitation by the rural mothers of district Gurdaspur, Punjab observed that, majority of the rural mothers (71.7%) were aware about 2-4 commonly used weaning foods. Less than 20 percent of the mothers had awareness regarding the number of weaning food processed by them. Majority of the mothers were aware of giving curd and dal soup during 4-6 months, whereas none had awareness regarding the use of fruit juice.

Gunasekaran, S., et. al., (2000) in a study conducted in Tamil Nadu, observed that, 29 per cent infants had the advantage of getting timely breast feeding, colostrum feeding, breast milk for minimum recommended period and solid food supplement at the right age. It also reveals that, place of residence, age at marriage, sex of the child, number of antenatal visits by ANM during pregnancy and place of delivery had a significant relationship with infant feeding practices.

In another study carried out in uttar Pradesh, Orissa and Rajasthan by Organisation for Applied Socio- Economic Systems, New Delhi (OASES, 2002) to assess the level of nutrition and health care of children and its effectiveness to evaluate the nutritional status of the children in terms of physical growth and to study the awareness level among parents of children about nutrition and health care. Results showed that about 82 per cent of the babies were breastfed immediately after birth and only 60.3 babies were breastfed up to two years.

A study conducted by Anderson E.S., et. al., (2002) on childcare decision made by inner city and Sub Urban mothers was undertaken. It was revealed that, inner city mothers were more likely to bottle feed, smoke and adopt risky infant sleeping positions. The inner city mothers smoked (72%) despite the known health risks and continued it postnatal (55%) mainly as means of relieving stress. In total, 30 per cent of inner city mothers wanted to breast feed. It was found that, bottle feeding helped both mother and child to have uninterrupted nights to sleep.

Barge, S. (2002) found that in a study conducted in Jharkhand to explore the breastfeeding practices among mothers and also to identify the areas of intensified interventions to improve breastfeeding practices found that, 81per cent of the women made all efforts to avail antenatal services and these services were mainly availed from government sources. The study also revealed that 60per cent mothers had knowledge that first milk of the mother should be given to the new born; 82 per cent knew that breastfeeding should be initiated within 8 hours of child birth. Fifty eight per cent were unaware about exclusive

breastfeeding up to first six months, 80 per cent initiated breastfeeding within eight hours of child birth and 66.7 per cent did not give pre-lactateal feed. Colostrum was given by most of the mothers.

Banerjee, A. (2002), in a study conducted in Varansi, Uttar Pradesh, found that, the practice of giving pre-lacteals was wide spread in rural and urban areas. The acceptance of colostrum was found to be more or less equal in rural (63.9%) and urban (64.1%) areas. 68.8 per cent mothers initiated breast milk within 24 hours of birth. More than 75 per cent rural and 61.5 per cent urban mothers started solids at 3-6 months of age. The mean calorie intake was found to be much lower than ICMR Standards, but the protein intake gm/kg body weight was more than the recommended norms given by ICMR. The study also found that faulty weaning practices were one of the root causes of malnutrition in the blocks studied.

Gupta and Gupta (2003) conducted a study at national level covering 49 districts of 25 states and union territories to assess the status of infant and young child feeding practices in India and the barriers to optimal breastfeeding practices. The study revealed that, nearly 28 per cent mothers initiated breastfeeding within one hour, 30 per cent within 1-4 hours and 42 per cent started breastfeeding after four hours or more. About 49 per cent mothers gave pre-lacteal feed to their babies. The study also showed that 54per cent children aged 0-3 months and 26per cent children aged 4-6 months were exclusively breastfed. Nineteen per cent mothers gave solid food to children aged 4-6 months along with breast milk. The percentage of exclusive breastfeeding (0-6

months) was highest in Manipur (89.9%) and lowest in Himachal Pradesh (3.8%). In all, this study, only 23 per cent mothers gave bottle feeding. About 32 per cent mothers continued breastfeeding for less than 18 months, 46 per cent mothers continued it for 18-24 months and 22 per cent continued beyond two years. 70 per cent mothers gave solid/ semi solid food to the children aged 6-9 months and 98.6 per cent mothers continued breast feeding. Introduction of complementary food during 6-9 months was highest in Kerela (95%) and lowest in Tripura (28.6%). Initiation of early breast feeding was higher among literate mothers (61%) and Schedule Tribe mothers compared to illiterate mothers (51%) and those who belonged to Scheduled Castes. More than 58 per cent illiterate mothers gave prelacteal feed to their infants compared to literate mothers (45%).

The study was on assessment of the Field Test Protocol on National Infant and Young Child Feeding (developed by WHO and was carried out by NIPCCD, Delhi, 2003), the strength and weakness of policies and programmers to promote; project and support optimal feeding practices and in determining supplements thereof. It revealed that 55 per cent of children in India were exclusively breastfed for the entire recommended period of four months. It also observed that, children in several states of north eastern region are likely to receive timely complementary feeding (DCWC, 2004).

Study conducted by Kameshwarao, A. (2004) in Latur and Osmanabad districts of Maharashrta to know different types of breastfeeding behaviour among mothers, found that Exclusive Breastfeeding Practice was inadequate

(39.5%). Exclusive Breastfeeding Practice improved with increasing parity and with age of marriage between 19-25 years. Exclusive Breastfeeding Practice was practiced more by urban mothers (49%) compared to rural mothers (37%). The study also found that, though Exclusive Breastfeeding Practice was not adequate, practice of prolonged breastfeeding up to 1-2 years was significant enough to combat malnutrition and infections.

A study conducted by IIPS (2005) in Uttaranchal, Pauri and Garwal, observed that about 69 per cent women kept their new born children exclusively on breast milk for four months. Immediately after birth the baby was given one drop of Oral Polio Zero Drops. The study also found that, the fully vaccinated status of children among SC/ST group was 57.7 per cent, of illiterate mothers was 46.6 per cent and economically poor families was 56.4 per cent. About 75 per cent women were aware of what to do if a child got diarrhoea the one of the most killer diseases..

Acharya, R., et. al, (2004) in a study covered by NFHS-II (1998-99) observed that, 15 per cent children in the age group of 0-35 months who were completely weaned, suffered from diarrhoea against 25 per cent who were not weaned and 20 per cent who were partially weaned. The prevalence of ARI increased drastically from 15per cent for completely weaned children to 26 per cent for children not weaned at all and 21 per cent among children who continued to be breastfed along with supplementary food. The study also revealed that, 63 per cent children who were partially weaned were under weight and 27 per cent were severely under weight. 50 per cent children in the

age group of 12-35 months who were completely weaned were stunted and 25 per cent of them were severely stunted. Those children who were given weaning foods as per schedule and breastfed for 18-23 months tended to be less underweight than those who were breastfed for less than a year. It was found that prolonged breastfeeding had a positive effect on weight and growth of babies.

Kulkarni, R.N., et.al, (2004) in a hospital based study in Kalambali, Navi Mumbai found that 36.1 per cent mothers gave pre-lacteals to their children, 70.2 per cent practised exclusive breast feeding and (7.4%) started bottle feeds to their babies. More than 61 per cent of the literate mothers against 43.7 per cent of the literate mothers initiated feeding within 6 hours of delivery.

Study conducted in Bihar by Yadav and Singh (2004) observed that, about 29 per cent of the mothers started breast feeding within 24 hours. About two third of the mothers discarded the colostrum. About 55 per cent mothers introduced supplements to their infants between 6-12 months. Rice was the main supplement given to children.

Kanani, S., et. al., (2005) in a study conducted in Vododara revealed that, malnutrition was present due to inadequate dietary intake due to poor household food security, poor health services and poor care of women especially the girl child. Poor nutrition during formative years (0-2 yrs) led to significant morbidity, mortality, delayed mental and motor development, impairments in intellectual performance, unfavourable reproductive outcomes and overall

health during adolescence and adulthood. There was high prevalence of malnutrition among under threes, especially during the period of 6-24 months when transition from breastfeeding to complementary feeding took place. The study found that, 40 per cent - 67per cent newborns were given pre-lacteals, mainly water and honey.

Nutritional Status

Study conducted by Sarkar and Saikia (2000) found that tribal babies of Changlang districts of Arunachal Pradesh are healthier than the babies of other non tribal groups. It was observed that the incidence of LBW among tribal babies was less than that of Bengali babies of Calcutta and Marathi babies of Pune district.

Pareek, S., et. al, (2001) in 2001, to bring out the prevailing profile of health and nutritional status of children aged 2-5 years attending the Balwadi and Anganwadi centres of Barawa Village of Udaipur district of Rajasthan and to draw out the most prevalent disorders, it was found that, out of 59 children, 14 children were born with weight less than 2.5 kgs. 42 per cent of the children were observed to be suffering from vitamin A deficiency and 46 per cent of the children were observed to be anaemic. About 79 per cent boys and 88 per cent girls had suffered from one of the respiratory infections in the last six months, 69 per cent children suffered from eye, ear and skin infections in the last one one year. Around 78 per cent of the children had long duration and 45 per cent children suffered from diarrhoea in the last one year.

Aneja, B., et. al., (2001) in a study conducted in urban slum in Delhi to asses PEM found that, majority (74%) of the children were in normal grade, whereas, 11 per cent, nine per cent two per cent and four per cent children were in grade I, II, III and IV category of under nutrition respectively. The non feeding of colostrum, lack of exclusive breastfeeding, late introduction of solid and semisolid food, dilution of top milk and use of bottle feed were common practices in urban slum communities. The study recommended dissemination of correct knowledge about breast feeding and complementary feeding practices among mothers.

Vir and Nigam (2001) in a study to assess Nutritional status of children in Uttar Pradesh found that 52 per cent children were underweight, 22.4 per cent were severely underweight and malnourished. The study suggests that feeding practices should be adopted to focus on child's abilities with reference to how, when and where. Highest priority may be accorded to care and feeding of infants, breast feeding, complementary feeding and suitable intervention measures may be adopted.

In another study conducted by Patel, V., et. al., (2002) in Goa, found that postnatal depression was strongly associated with being underweight at 6 months and with being short for age. It was found that babies with depressed mothers were more likely to be underweight at birth and had worse mental development scores.

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The Indira Gandhi Medical College (2001), in a study observed that, the high purpose of investment in obstetrics is to ensure that every newborn is physically sound in mind and body. Low birth weight is one of the most serious challenges facing maternal and child health programme planners facing in both developed and developing countries. The study carried out at Indira Gandhi College and Hospital, Nagpur, Maharashtra, observed that about 60 per cent LBW variations can be attributed to the environment in which the foetus grows. It also showed that, risk of delivering LBW babies is 4.43 times higher among mothers who have anaemia (Hb < 10 gm) than mothers who do not have anaemia (Hb > 10 gm). The risks of delivering LBW babies was three times higher in mothers who had the habit of chewing tobacco than mothers who did not chew tobacco.

Banerjee and Mandal (2005) in a community based intervention study in Midnapore, West Bengal observed that, prevalence of malnutrition was 50.67 per cent among the infants. Malnutrition was more common among girls than boys, but this was not significant (P>0.05). Grade I malnutrition was more among male babies, while grade II and grade III were more in female babies. None were suffering from grade IV malnutrition. Prevalence also increased with increasing age and it was significantly more (P< 0.001) among infants greater than 6 months of age than among those less than or equal to 6 months. Post intervention follow up after nutrition education of mothers showed an average increase of 80.81 gms of the weight of their severely malnourished infants.

Gragnolati, M., et. al, (2006) conducted a study, to see the dimensions of child under nutrition in India and examine the effectiveness of the ICDS programme in addressing them. It was found that 47 per cent children under 3 were underweight or severely underweight and a further 26per cent were mildly underweight. The study also showed that underweight prevalence was higher in rural areas (50%) than in urban areas (38%).

Kumar D., et. al, (2006) in a study conducted in Allahabad in Uttar Pradesh to observe the nutritional status of under five children and to observe whether infant feeding practices were associated with under nutrition in ICDS areas, found that, proper nutrition of children leading to adequate growth and good health is the essential foundation of human development. Results showed that 36.4 per cent were underweight, 51 per cent stunted and 10.6 per cent wasted. Maximum prevalence of underweight (45.5%) as well as stunting (81.8%) was found in the age group of 13-24 months. There was decline in the prevalence of stunting after the age of 24 months. Proportion of underweight was significantly less among children whose mothers reported initiation of breastfeeding within 6 hours of birth (30%), children who were fed colostrums (27.5%) and children who got complementary proper feeding (28.6%).

Mallik, S., et. al., (2006) in a study carried out among the children under five, attending OPD, Kolkata found that, 51per cent were malnourished as per IAP classification. Out of them 29 per cent were suffering from grade I, 14per cent from grade II, 6 per cent from grade III and two per cent from grade IV malnutrition. On clinical examination, it was observed that 52.7 per cent

children were suffering from pallor, 13.3 per cent from angular stomatities and 1.3 per cent from night blindness.

Chakraborty, S., et. al, (2006) in a study, Carried out in Jhansi, revealed that, the overall PEM in under 6 years children was observed to be 67 per cent, however it was found to be significantly higher (80.9%) in the age group of 1-3 years as compared to other age groups.

Study carried out in Mysore by Anitha and Begum (2008) found that the selected children beneficiaries of ICDS were considerably lower to the 50th centile but were found closer to 3rd centile. The short stature found among the children could be the consequence of environment in which they exist. The quantitative and qualitative dietary deficiencies form the primary causes for growth faltering. Secondly, high prevalence of morbidity drains out the nutrient reserves, which are already meagre, resulting in growth retardation.

Preventative Measures

Bhowmick and Samita (2001) in a study conducted in three districts of West Bengal on mortality and morbidity pattern among the rural and urban children 0-6 years attending anganwadi, found that, a good number of children in rural and urban areas of three districts have been suffering from one or more diseases frequently. The study also found that, there was no proper drainage system available in rural areas. Children in these houses lived in comparatively unhygienic conditions. On the contrary, awareness has been

noticed among the rural and urban mothers regarding safe drinking water. Children in rural areas take bath in ponds, being polluted water in the pond, causes skin infections and other water born diseases.

Bhatia, V., et.al, (2004) conducted a study to find out the Immunisation Coverage on Pulse Polio Day in urban, rural and slum areas of Chandigarh. It was found that 72.23 per cent children were fully immunised, 22.9 per cent children were immunised partially and 4.64per cent children were not immunised at all. Researchers have mentioned that Chandigarh being a modern city, it was expected that a high level of immunisation coverage would be achieved. The major reasons for lower coverage in Chandigarh were lack of monitoring, poor health infrastructure in slums, immigration from low coverage states, lack of information, etc.

Study conducted in Maharashtra, by Yadav and Singh (2004) found that about 61 per cent children received all the vaccines as against about 63 per cent at all India level. Further, only 42 per cent of pregnant women received full package of ANC.

Maternal behaviour

The study was conducted by Aruna and Vidyasagar (2001) in Andhra Pradesh to identify specific maternal child rearing behaviour, parental attributes and socioeconomic status of the family and analyse their association with positive deviance in their developmental status. Results indicated

significant association between maternal behaviour and psychosocial development of pre-schoolers. Children, whose mothers were responsive to their needs, were consistent in their interaction with them and were emotionally stable, were identified as "positive deviants", with regard to their development. Factors like parental literacy and nuclear family were also associated significantly with positive deviance in development. Significant association was also confirmed between nutrition and development.

The direct and indirect relations of maternal child rearing history, emotional stress and parenting practices when children were three years of age or four years were examined by Assel, et. al, (2002) in a sample of low income families. Greater negative maternal child rearing history indirectly influenced social initiating skills through its direct influences on maternal emotional stress. Prematurity and a more negative child rearing approach had a direct negative influence on the maternal report of social and attentional behavioural outcomes.

Study conducted by Phukan (2003) in Jorhat district of Assam to assess the needs and develop a media mix package for mothers of new born babies to analyse the characteristics and knowledge of mothers regarding child development revealed that, majority of the mothers felt that they had fair knowledge about child care and development but they could not give correct responses to various questions. Ninety one per cent of mothers wanted to enhance their knowledge on child care through media mix package; 70 per cent

felt that the package developed by the researcher would be handy to use and 95 per cent felt package to be highly useful.

The Institute for Research in medical Statistics (IRMS) undertook a study in Bihar to assess the knowledge, attitudes and practices of mothers related to breastfeeding and introduction of supplements. The study revealed that about 29 per cent of the mothers started breastfeeding within 24 hours. About two third of the mothers discarded colostrum. Majority of the mothers were of the opinion that a child should be breastfed for more than one year. The main reasons of starting supplements were mother's insufficient milk; child's demand and mother's opinion that supplements were required for proper growth (Yadav and Singh, 2004).

METHODOLOGY

Present study is exploratory in nature. It aims at understanding the child bearing and rearing practices in the four tribal communities selected for the study. Tribes chosen were the Khasis in Meghalays, Konyaks in Nagaland, Mizos in Mizoram and Nyishis in Arunachal Pradesh. The reason behind inclusion of these tribes was mainly their numerical strength and distinctive cultural traits and characteristics. Lack of adequate information on child bearing and rearing practices was also another deciding factor in this respect.

Sample

The sample comprised of four hundred mothers having children below the age of three years. Further, it was also kept in view that mothers who had only one child in this age group the child would must have completed one year at the time of data collection so that information regarding daily child care, feeding, immunisation, etc. could be collected. The number of mothers covered under each tribe was hundred. It was assumed that one hundred mothers chosen carefully would elicit information which could be more or less applicable to rest of that tribe.

Study area

The data was collected from eight developmental blocks located in five districts of Arunachal Pradesh, Meghalaya, Mizoram and Nagaland. Altogether data was collected from 32 villages, eight from each district of the selected states. The list of villages, blocks, etc., are given in table 1.1.

Table 1.1
Location of the Villages

State	District	Blocks	Villages	Inhabitant
Arunachal Pradesh	Papumpare	Kimin	Khud Upper Dumi, Hawa Camp, Dorpa-1	
	Lower Subansiri	Yachuli	Chullyu, Peni, Jath, Yachulli	Nyishi
Meghalaya	West Khasi Hills	Nongstoin	Ladweitang, Tiehsaw, Siejlieh, Mawrusyiar	Khasi
	East Khasi Hills	Mawkynrew	Thangaing, Jongksha, Rapleng, Laitdiengsai	
Mizoram	Kolasib	Thingdawl	Thingdawl, Bualpui (North), Salemveng, Bawktleng	
	Aizawl	Aibawk	Aibawk, Muallungthu, Melria, Hualngohmun	Mizo
Nagaland	Mon	Wakching	Wakching, Wanching, Shiyong, Tanhai	
		Mon	Chi, Gocking, Phuk Tong, Lamgang Sheanghai	Konyak

Districts and blocks in each state was selected on the basis of concentration of the respective tribe and their homogeneity in nature in relation to traditional and cultural elements. The map of the selected states in north eastern region can be seen in fig 1.1. The concentration of the chosen tribes and blocks visited can be seen in fig 1.2 and 1.3 respectively.

Sampling Procedure

The villages concentrated by the respective tribe were selected purposively according to the convenience and feasibility of the researcher. Although, initially random sampling was planned to reach to the samples, yet, purposive sampling had to be adopted since most of the villages are too small to get respondents having children below three years of age. Thus, those who fulfil the laid criterion were selected, as the scope for rejecting them was very little. However, care was taken not to choose blood relations or staying in the same house or compound. In this way one mother from one family was selected as respondent for the study.

Research Tools and Techniques

Three types of tools namely the interview schedule, the observation inventory and the village data schedule were used for collecting information.

The interview schedule, used as the main tool consisting mainly four of major parts (1) General background (2) Health and Nutritional care of mother and child and (3) socialisation and play of the child.

In the interview schedule a wide range of items were incorporated in relation to these areas. These are mainly pregnancy care, care of the new born, feeding, health care, childhood mortality, toilet training, play etc.,(the interview schedule is annexed at appendix-II). For most of the items, interview schedule was pre-coded. However, few open ended questions were also included in this tool.

The second tool, the observation inventory included some observational areas such as cleanliness, house type, play activities of the children, interaction with other family members, nutritional status. The intention behind collecting data on nutritional status was to relate with the data obtained through the interview schedule on child rearing practices. All these observations were carried out in the natural setting to which the children belonged to (the observation in entering schedule is annexed at appendix-III).

The third tool that is village data schedule was used to collect information of the village (schedule annexed at appendix IV). This schedule comprised of the queries on distance of the village from block headquarters, total population, information relating to general economy of the people, source of drinking water, educational institutions etc.

All these schedules were pre-tested in the field by interviewing ten respondents and later, neccessary modifications were made.

Methods of Data Collection

Information was gathered with the help of locally appointed investigators in each district. It was done so to minimise the communication barriers. The appointed investigators were well versed in English and also within the languages of the respective tribe. Before interviewing, they were given orientation to the schedule, its contents and method of interview. Later, they were observed while interviewing and necessary improvements were made tactfully. In some cases, interview was interrupted as the mothers could not sit at a stress due to various household chores. Thus, extra time had to be spent in those cases. Few mothers were interviewed in their agricultural field when they were working and observations were made after their returning back home. In such cases extra time had to be allotted. Since the village heads were contacted in advance and permission sought for collecting information with the help of ICDS functionaries, all people and the respondents were appeared quite cooperative.

Data Processing and Analysis

First of all, code book for the interview schedule was prepared. In addition to pre-coded questions, extra codes were made for feasible responses to the open ended questions. The data were then transferred to code sheets and

later these were decoded and frequency tables were prepared. The data collected through observation-inventory and village-data schedule were straightway processed and relevant tables were prepared.

Simple statistical techniques like average percentages, graphical representation, etc., were used to analyse the data.

Interpretation was done by using both statistical tools and descriptive illustrations.

CHAPTER II

ETHNOGRAPHIC PROFILE OF THE TRIBES

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The Khasis

The Khasis are the inhabitants of the Khasi Hills of Meghalaya. The Khasi Hills, designated as the Central Meghalaya covers an area of about 11,170 sq. kms. (Mathur, 1979). The area is divided into two districts namely – the East Khasi Hills and the West Khasi Hills District. At present, according to the 2001 census the total population of this community is 1,123,490.

The origin of the Khasis is not known to anyone. Although it is probable that the Khasis have inhabited their present abode for at any rate a considerable period, there seems to be a fairly general belief amongst them that they originally came from elsewhere. Mr. Shadwell, the oldest authority who had been in close touch with the Khasis for more than half a century, mentions a tradition amongst them that they originally came into Assam (then undivided

Assam with Meghalaya) via the Patkoi range, having followed the route of one of the Burmese invasions. They are of matriarchal society.

The Khasis are usually short in stature and skin colour varying from dark to a light yellowish brown. They generally have straight black hair. The Khasi people are cheerful in disposition and are light hearted in nature.

The greater proportion of the population subsists by cultivation. They practise both dry and wet cultivation of paddy. In addition, they generally grow crops like millet, maize, potato, ginger, turmeric, oilseeds, areca nuts and betel nuts, black pepper, other vegetables, etc. along with other winter horticultural ravi crops. Besides, a considerable number of Khasis earn their livelihood as porters, domestic help, baby sitters, etc. They also practise apiculture.

The Khasis are rice eaters. Their staple food is rice and dried fish. Generally they take two meals a day but labourers and other hard workers take midday meal in between. Though the staple food of the Khasis is rice and dried fish, but when rice cannot be obtained or is scarce, millets are used instead. The later is boiled and sort of porridge is cooked, which is eaten either hot or cold.

The Khasis are in the habit of regularly drinking considerable quantities either of a spirit distilled from rice or millet or rice beer. Rice beer is a necessary article for practically all Khasi religious ceremonies of importance.

Marriage is an extraordinarily serious matter for a Khasi as it is the starting point in the raising of a family. The most remarkable feature of the earlier days for the husband to live with his wife in his mother-in-law's house till the time his wife give birth to one or two children. After that he can take his wife to his own house. All the earnings of his wife will go to her mother's house for the maintenance of the family during the whole period of stay with her mother. There is no polygamy among the Khasis. Their strict adherence to the matrilineal system keeps away from it. The second marriage in Khasi society is generally looked down. The marriage in Khasi society may be arranged by the parents or by selection of the life partner. In the latter, the boy selects his life partner and after some association between the boy and the girl, they disclose to their parents. Their parents it finds no taboo, they generally agree. Due to exogamous character of society, a Khasi cannot marry a girl from his own clan.

Like the Jaintias and the Garos in Meghalaya, the Khasis also follow matrilineal system. Under this matrilineal tradition, the descent is reckoned from the female line and the children belong to the clan of the mother. The woman not only have the right to property but also have a right to choose their own life partners and to marry after her widowhood. The birth of a baby girl in a family is a happy occasion in Khasi society. In term of education and employment there is no discrimination against girls. Its the women who inherit the property. If a man acquires any property during his matrimonial life the prop at automatically belongs to his wife and inherited by her children.

The Konyaks

The Konyaks are inhabitants of Nagaland. Among the various tribal groups of Nagaland, the Konyak is one of them. The Nagas have numerous legends of origin and disposal of tribes. The tribes have mixed origin. They have incorporated Mongoloid, Austric, Aryan and even Negroid ethnic elements in them. The Konyaks, besides sharing similarities with the other tribal groups, have their own peculiarities that distinguish them out. (The tribe is divided into two major groups, on the basis of certain linguistic and institutional basis, the Thendu and the Thenkoh). Each Konyak village is divided into several wards, and each ward centred around a morung (male dormitories). The Konyak chief called Ang/Wongham, is deemed an autocrat, the final and highest embodiment of political, economic and religious authority.

The Konyaks, the one of the largest tribes of Nagaland are mostly concentrated in Mon district of Nagaland. According to the 2001 Census, the total population of Konyak tribe is 2,43,758.

The Konyaks are of medium stature, yellow brownish in complexion with mesocephalic head, platyrrhine nose and straight hair. They are ferocious and till 1961 they were head hunters. The Konyaks are somewhat backward and they tattoo their bodies with various designs.

Agriculture is the main occupation of the Konyaks. Agriculture is not only the means of livelihood but also the only source of wealth which enables

them to earn a name. They grow paddy, maize, other roots and seasonal vegetable. They relish meat and fish of all kinds.

Rice is the staple food of the Nagas. Every Naga relish all kinds of vegetables, meat and fishes. In time of scarcity they subsist on millet, maze and taro. The food is taken generally with one curry prepared with jungle leaves and vegetables or meat, and often with chutney of chilli with dry fish smoked meat, etc. The meat is generally cooked together with jungle leaves or some vegetables. Chilli is an important item in their meals. Boiling is the main method of cooking. People eat all type of meats of animals, birds etc and also worms of different kinds. Rice beer is the common drink of the people.

During the pre-Independence era when the British invaded the Naga Hills and planted poppy in the valley of Mon district so that they could control this fierce tribe easily, with the result, the Konyaks did get addicted to opium and became less enterprising.

Among the Konyaks, marriage is based on clan to clan exogamy. Persons of the same patrilineal clan do not intermarry and any kind of sexual relationship between them is strictly forbidden. Monogamy is mandatory for the commoners and a person other than the chief aspiring to marry a second wife must divorce the first one. The system of bride price and dowry are also prevalent.

The marriage custom in the society of the Konyaks is simple. The boys and girls start meeting in paddy houses, which are considered signs of prosperity. It is said, once the boy and girl decide to marry the girl must come with a child born of the prove her fertility. Among the Konyaks, as indeed among other Naga tribes, marriage is based on the principle of clan exogamy. Persons of the same patrilineal clan do not inter-marry and any kind of sexual relations between them are strictly forbidden. Incest is a cognizable offence and is generally punished by banishment. The Konyaks believe that such acts affect the whole community. Monogamy is mandatory for the commoners. A person other than the chief aspiring to marry a second wife must divorce the first wife before to fulfil his ambition. But, twice divorce in such cases involves the return of dowry and matching compensation to the parents of the divorce, and the consequent loss of property, it occurs very rarely. The system of bride-price and dowry are also prevalent (Choudhury, 1984).

In general, the status of women is very low in Konyak society. Apart from household chores, she has to attend the field and other family requirement. The Konyak women have to live under the domain of her husband and in many occasions, she is considered a more being for pleasure and for reproducing. In away walk of her life, she has to live within the various restrictions and tabos imposed on her (Zehol and Zehol, 1998).

The Mizos

The Mizos are a distant community of Mizoram. This is a generic term to denote several major and minor tribal communities of the state. Thus all the tribes who live in Mizoram come under the Mizo fold. Though Mizoram is the abode of the Mizos, they are also found in Assam, Manipur and Nagaland. The total population of the community is 646,117 as per 2001 census.

There is a general belief among the Mizos that the Mizo originally came out from a clan (Chhingulang), which perhaps situated in the east. Later on, they moved on to Tibet and Burma and then again moved to the present place. They also migrated to another place and established a village of Selsih. This is near to the capital Aizawl. They are a patriarchal people and descent is in the male or the father's name. The ancestors of the Mizos migrated to the present habitat from Myanmar between 17th and 18th century.

The Mizos, as a whole, are of the Mongoloid racial stock with well built features. Ecological conditions, nature of the country, amount of hard labour, necessity for climbing hills, all amalgamate together to give the people a stout, sturdy and proportionate figure. Physically, both the sexes are strong and hardy.

The Mizos are mainly an agricultural people and their life revolves around the village. Jhum cultivation is the traditional agriculture. Ninety per cent of them are cultivators. For the development of agriculture of perennial

cash crops was taken up in preference to perishable horticultural crops. Paddy is the main crop they grow. Besides, sugarcane and tobacco, etc. are also grown by them. They depend on shifting cultivation.

Since the Mizo people grow paddy, rice is the main staple food for the Mizos. Besides, maize and millet are also taken in large quantities. Their taste and preparation of food is most simple. They eat all kinds of vegetable in boiled form with chillies and salt. Pork is the most favourite meat for the Mizos. In addition to meats of domestic animals, they also eat meat of animals, birds, which are trapped or shot by gun. However, they do not eat cat, snake and tiger. Like other tribes in this region, rice beer is a most common and favourite drink among the Mizos.

Among the various dances of the Mizos, the bamboo dance (creraw) is a famous one. Originally, the dance was celebrated to wish the safe passage and victorious entry into the abode of the dead called Pietral for the soul of a mother who died at child birth.

The Mizos are patrilineal, patrilocal and patriarchal people. Mizo tribe has a numbers of clams. All these clams are not fully exogamous. Marriage between member of same clan is generally discouraged but it is not prohibited.

Thus, marriage between members of the same clan is possible. In traditional system of marriage the system of giving brides price is in vogue. The boy, whos parents cannot pay the bride price and subsidiary price, has to serve

in the house of his would be father-in-law for a period varying from one to three years. During this time he has to stay with his would be in-laws and work as a member of that family. In this case cohabitation is not prohibited.

Cohabitation is not permitted till have maximum liberty and premarital relations are not uncommon. In their society this type of affairs is not a matter to talk about. Monogang is normally practised by the Mizos. Polygamy is, however, seen among few rich people. Polyandry is never allowed. Marriage between paralleled first comsin is prohibited. Cross-cousin marriage is a popular choice among the Mizos. Widow remarriage is permissible. Divorce is allowed and simple and easy. They bond of matrimony among the Mizos is very loose.

The Mizo women are holding a high position. They are maintaining same status with cooperated to their men folk in office work, bazzar, household chores, etc. A large number of young Mizo women are serving at secretariat and also in other departments.

The married women have almost no right in the property of her father. All the movable and immovable property of her dead father is inherited by her brothers. A widow cannot yet any property of her husband except her own cash, ornaments etc. Which she got from her father at the time of marriage.

The Nyishis

The Nyishis are one of the major tribes of Arunachal Pradesh. Being the largest populous tribe in Arunachal Pradesh, they are the inhabitants of the districts of Papumpare, East Kameng, Lower Subansiri, Kurung Kumey and parts of Upper Subansiri of Arunachal Pradesh. According to census 2001, their population is 87,656. Linguistically, the Nishis belong to Tibeto Burman family, however the origin is disputed and no single concrete theory stands unchallenged.

Polygamy is prevalent among the Nyiahis. It signifies ones social status and economical stability and also proves handy during hard times like clan wars or social huntings and other social activities. They trace their descent patrilineally and are divided into several clans.

The Nyishis are agriculturists who practise shifting cultivation. The principal crops they generally grow are paddy and millet.

Rice is the staple food of the people, which is supplemented by fish, meat of various animals, edible tubers and leafy vegetables. A drink made from millet is used at all social gatherings and important events. Traditionally, being dependent on the forest, the Nyishis eat fruits, roots, bamboo shoots, fish, frogs, and even insects. Traditional ways of preparing foods include steaming, boiling, roasting and smoking.

The Nyishis are a patriarchal, clannish people. Clan exogamy is observed in selecting a mate. For, selecting a life partner, paternal aunt's daughter stands prohibited, whereas, mothers' sister and maternal aunt's daughter are permissible. Marriages are never entered into before the parties have attained maturity.

The Nyishis are polygynous, but not polyandrous. The only limiting factor in the acquisition of a new wife is the want of means and senescence. A rich man many have as many as eight wives. Addicted not hans for agricultural operations are the primary causes for polygyny. The widows are inherited. An old widow may be allowed to remain in the family without being inherited. A son of inherits the widows of his father with the exception of his actual mother. Inheritance of the new widow often dispense with the payment of bride-price in a acquiring a new wife. Besides, marriage by bride price, elopement and marriage by service are not common.

Though the Nyshis are polygynous, yet it doesn't mean that the ladies are no better than chattels. The senior wife is the mistress of the household. It is the duty of each wife to perform the household cares. A Nyshis women has no say in religious and political affairs of the community, but in all other matters she is listened to attentively.

CHAPTER III

THE SETTING

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Apart from the Cultural background of the family, the socio economic factors are also very influential and important variables in child rearning practices. The level of parental education, occupation, income, etc. of the family are very closely associated with child rearing practices. Realising this, in this chapter an attempt has been made to give a description of the villages and also the background of the families visited under the study.

Part I

PROFILE OF THE VILLAGES

Khasi Villages

In all, eight Khasi villages were visited. The names of the villages are already given in the Table 1.1 under Methodology of first chapter. These villages were selected from two districts of Meghalaya. The distance of the villages from the block head quarters ranged between 3-30 kms (approximately).

Agriculture is the basic economy of the people living in the villages. They generally grow paddy, potato, maize, cabbage, cauliflower etc. in large scale. A

section of the villagers also grew ginger and turmeric. More or less, every households grows winter crops, mainly vegetables. Besides, some families also rear fowls for consumption of egg and meat. Some families had service holders, some pursue business and some also work as daily wage labourers.

In all the eight villages visited, pre-primary educational institutions existed. Except one village, there are primary schools in all other villages. Out of eight, in five villages, Middle Schools and in four villages high schools were there.

The educational level of the villagers varied from illiterates to post graduates and professionals. In two villages, three professionals were reported. Post graduates ranging from 4-50 persons were found in four villages. A section of the villagers were intermediate and matriculate.

All the villages were connected with government water supply. But some of them also use spring water to take bath and wash clothes and utensils.

The health facilities to the villages are within the distance of 1-8 kms radius. In five villages health sub centres were found. Distances to the PHCs are between 3-8 kms. Out of eight villages, in five villages there were trained dais and only in two villages health committee were found.

Konyak Villages

As many as eight villages dominated by the Konyak tribe were visited for the study. These villages are scattered in two blocks in the same district. Since this tribe is mostly concentrated in Mon district, thus, data were collected only from that district.

The main economy of the konyak villages is agriculture. The villagers generally grow paddy, maize, millet, yum, orange, tapioca, etc. Besides, they also rear domestic birds and animals for self consumption as well as for economic support. Both man and women folks work in the agricultural field equally. In addition, service, business and daily wagers were also found in the villages.

Every visited Konyak village has pre-primary and primary schools. In one village (Wakching) seven primary schools (one govt. and six private) were found for a population of 9061. In four villages Middle Level Schools and in three villages high schools were found.

The educational levels of the people were from illiterates to higher educations. There were also professionals and post graduates in few villages. Villages had graduates ranging from 1-40 persons.

Out of eight, in five villages government water supply was found. Other villages used water from stream, katcha well and privately managed water supply.

Health services in terms of sub-centre or PHC were available within the radius of 1-11 kms. In all villages health sub centres are found. In all, only in three villages, trained dais were there. No where, any health committee was reported.

Mizo Villages

Like the Khasi and Konyak inhibited areas, eight villages in two districts of Mizoram were also visited for data collection. The distance to the villages from block headquarters ranged between 4-27 kms (approximately).

Except for a small section of villagers in two villages, all households in the other six villages were engaged in agriculture for their livelihood. Crops generally grown are paddy, turmeric, ginger, chilli, maize, sugarcane, etc. However, villagers also grow seasonal vegetables in small scales. They also domesticate birds and animals for their self consumption and also to support the family economically.

Every Mizo village has at least one each of pre-primary and primary educational institution. These schools are either government of privately run. Out of eight, in seven villages, middle level schools and in three villages, high

schools are there. All the villagers of the visited villages are literate. In a good number of villages, post graduates and professionals were reported. Every village had graduates.

As many as six villages were connected with government water supply. Other two villages used water by rain water harvesting.

Regarding accessibility to health facility, it was found that, the health sub centres are located within one kilometre radius in every village. In three villages there was no PHC nearby. Distance to PHC of the other five villages are between 1-10 kms. Three villages reported of having trained dais. In six villages, village level health committees existed.

Nyishi Villages

To collect data from the Nyishi tribe, altogether eight villages in two districts were visited. The villages are located approximately at a distance of 1-24 kilometers from the headquarters. Unlike the villages of the other three tribes, the Nyishi villages are smaller in size.

Agriculture is the main means of livelihood of the people in the selected villages. The crops they generally grow are paddy, maize, millet, colocasia, arum, sugarcane, orange, pineapple and ginger. As in the other three tribes under study, the Nyishis also domesticate birds and animals, especially fowls and pigs. At times, when there is a need, these domestic animals are used for

economic support of the families. In addition to agriculture, some of the villagers also managed to engage themselves in service, business, as daily wage labourer, etc. as their secondary occupation. School teachers were found in all villages.

There are pre-primary educational institution in all the villages. Out of eight villages, only in four villages, primary schools were there at the time of data collection. But, since the villages are small in size, the primary schools in other villages are accessible to the other nearby villages where there is no primary schools. In three villages middle level schools existed. High schools were found in two villages. All the educational institutions are within the reach of the children.

Out of eight villages under the study, there were three professionals, two Post Graduates and few graduates. Matriculate and intermediates were reported only in few villages. A substantial portion of the Nyishi population of the villages visited were either illiterate or with very low educational qualification.

In all, only five villages were connected with government water supply. Stream water was the main source of water in two villages. In another two villages with government water supply connection, stream water is also another source of water. In some villages use of water from pucca well was also found.

The health services were available within 1-8 kms from the villages. Health sub centres are found in three villages. Except one village, the distances

to the PHCs from the villages are within 1-5 kms. The distance of the only village which is most farest from the PHC is 8 kms. In none of the villages either trained dai or any health committee was found.

PART II

PROFILE OF THE FAMILIES

Size of the Population

Altogether, there were 2502 persons in 400 families. Data presented in table 3.1 reveals that the Konyak has the highest population than the other three tribes which is followed by the Khasis, Nyishis and the Mizos respectively.

Table 3.1
Tribe wise distribution of the population

Khasi	Konyak	Mizo	Nyishi	Total
684	735	467	616	2502

Age Structure

The data illustrated in table 3.2 shows that nearly 32 per cent of the study population is children in the age group of 0-6 years. In comparison to the all India data, which shows that, children below six years comprise nearly

17 per cent of the total population. At national level, there are 18.43 per cent Scheduled Tribe child population in the age group of 0-6 years to the total ST population in the country as per census 2001.

Table: 3.2

Tribe wise distribution of the population according to age

Age (year)	Khasi	Konyak	Mizo	Nyishi	Total (% age)
0-3	138	131	127	124	520 (20.78)
4-6	83	66	45	69	263 (10.51)
7-14	157	120	37	113	427 (17.07)
15-42	268	321	209	270	1068 (42.68)
43-60	29	60	33	29	151 (6.04)
61& above	9	37	16	11	73 (2.92)
Total	**684**	**735**	**467**	**616**	**2502 (100)**

Present data is almost double of it (31.49), indicating a high child population among the tribes. Among the study tribes, it is seen that, the Konyak is in first position with highest population followed by the Khasis and the Nyishis. The Mizos are in the last position with lowest population size. In all, it was also observed that, family welfare activities are not properly adopted and thus spacing between siblings is less, in turn increasing more child population. Children between the age group of 7-14 years are 17.07 per cent. Thus, the combined per centage of child bellow 14 years is as high as 48.36 per cent. To summarise, it can be said that nearly half of the population (42.69%) belongs to the age group between 15-42 years, i.e. the child bearing and rearing period. This percentage of population mostly takes care of the rest as most of

the population belonging to the other age groups are more or less dependent. Undoubtedly major portion of the dependent population is the children.

Data indicates very less number of elderly (above 60 years) people among the study population. This is mainly because of most of the families (except the Konyaks) visited for data collection was happened to be nuclear comprising husband, wife and their children. The percentages of extended and joint families are 13 and 10.75 respectively. In all, very few (0.5%) families were broken families. Both joint and extended types of families are higher among the Konyaks followed by the Mizos.

Male Female Population

The data presented in table 3.3 reveals that, in all, 1264 (50.78%) were male and 1238 (49.22%) were female in 400 studied families. Though the male population is more than its counterpart, but the difference is very less. Tribe wise variations shows that, among the Mizos and the Nyishis, female population outnumbered the male population, whereas in the other two tribes it is the opposite. In all, this sex difference of the population among the Khasis and the Mizos is very less. Such difference is highest among the Nyishis, followed by the Konyaks. As a whole, although the male population size outnumbers female and follows the same trend of the data at all India level (acc to 2001 census), yet the difference is very less.

Table: 3.3

Tribe wise distribution of population according to sex

Sex	Khasi	Konyak	Mizo	Nyishi	Total
Male	345	391	231	297	1264
Female	339	344	236	319	1238
Total	684	735	467	616	2502

Marital Status

Of all 2502 population, 987 were married and 1515 were unmarried. A very small portion (1%) of the population was either widow or widower. Such cases were found relatively high among the Nyishis than the others. Only 0.52 per cent separated/divorced cases were reported among the population. Such incidences were comparatively more among the Mizos and the Khasis than the other two tribes. No such case was found among the Nyishis. However, it was found that the cases of separation or divorce were not a very common practice among the tribes under study. This indicates a stable married life of the tribes. This may be also because of the custom of the tribes where separation or divorce is not readily accepted by the society and instead such incidences are seriously looked down upon. Such broken families are criticised by their respective societies. Thus, perhaps broken family were not much reported among the population.

Religion

Except eight Nyishi families of Arunachal Pradesh, rest belonged to the Christianity. The eight Nyishi families were followers of indigenous faith.

Family Size

More than half of the families (54.50%) have 4-6 numbers of family members. The second largest group of the families (25.25%) have 7-9 family members. In all, nine per cent of the families have 10-12 family members. Families with 13-15 members were found only in 1.25 per cent cases. More than 16 family members were found only in one family out of 400 families, 8.75 per cent have family members less than four. Tribe wise distribution shows that, highest number of Mizo families (83%) have 4-6 family members, followed by Nyishis (58%), Khasis (44%) and the Konyaks (33%). None of the Mizo families reported having family members more than nine. Comparatively, 20 per cent Konyaks, 17 per cent Khasis and six per cent Nyishi families were found to have more than nine family members.

Family Pattern

Majority (76.25%) of the study population adapted to nuclear family pattern. The Nyishis have the highest nuclear families with 93 per cent. The second highest nuclear families found among the Khasis in Meghalaya with

91 per cent. It was 72 per cent among the Mizos (72%) and found lowest in the Konyaks (49%).

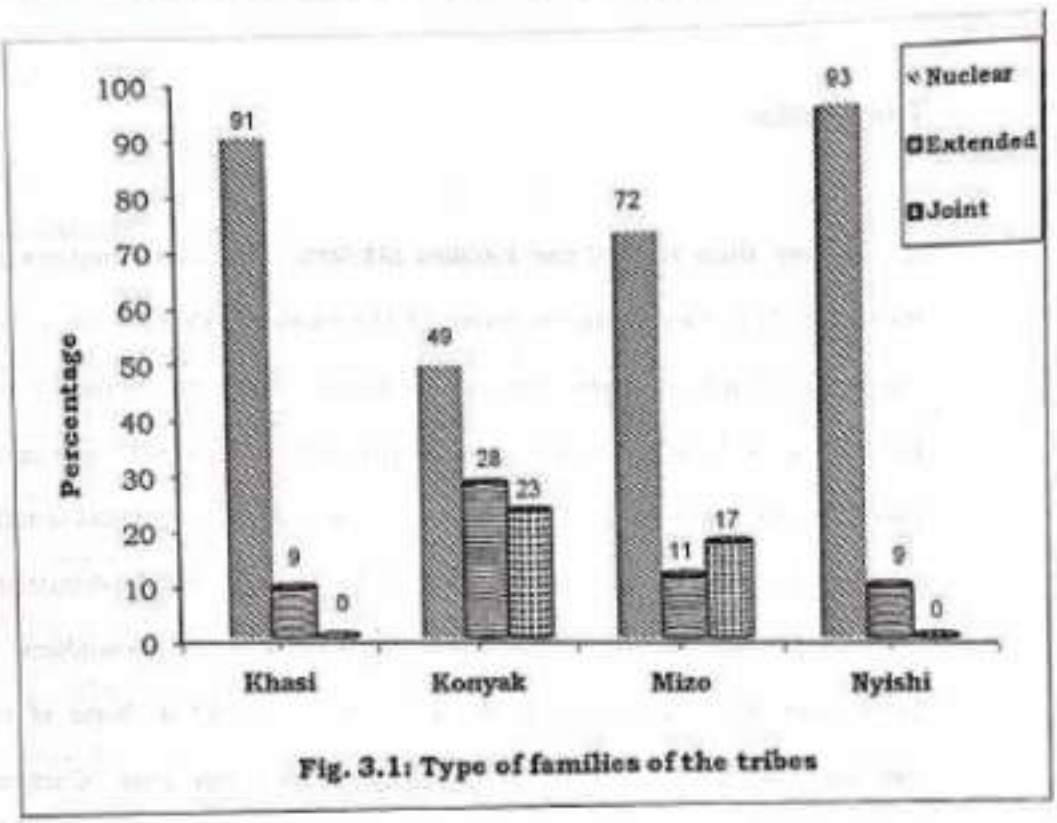

Fig. 3.1: Type of families of the tribes

Fig. 3.1 depicts the tribe wise pattern of families. Apart from nuclear families, 13 per cent and 10.75 per cent population comprised of extended and joint families respectively. In both the cases the Konyaks were in the first place. There was no joint family found among the Khasis. As a whole, it is seen that more or less the nuclear pattern of families were more common among the tribes.

Marital Status of the Respondents

Among the 400 respondents, six (1.5%) of them were widows, 11 (2.75%) were divorcee and four (1%) were separated.

Educational Status

The data presented in table 3.4 regarding literacy level of the population above 6 years depicts that, in all 16 per cent of the population are illiterate. Nearly two per cent of the total population are just literate. Highest (31.12%) number of population is primary pass. The second largest group (19.08%) belonged to the educational qualification under metric. Only 1.69 per cent of the population were graduate. Tribe wise variation shows that the Nyishis have highest number (3.56%) of graduates than the other tribes. Data show a different situation among the Nyishis in respect of educational qualification. The Nyishis displays highest number (23.64%) of illiterate people in one hand and reveals highest number of graduates as well on the other. This could perhaps be the reason that the people of two of the villages inhabited by the Nyishi tribe were quite advance in education than the other villages and thus the data reveals more graduates than the other tribes. Except the Konyaks, few post graduates were found in the other communities.

Table 3.4

Tribe wise distribution of population according to educational level

Educational Qualification	Khasi	Konyak	Mizo	Nyishi	Total (%)
Illiterate	72	103	0	100	275 (16.0)
Just Literate	0	30	1	2	33 (1.92)
Primary	200	128	77	130	535(31.12)
Upto Class V	71	87	37	43	238(13.85)
Upto Class VII	28	48	49	26	151(8.78)
Under Matric	71	113	82	62	328(19.08)
Matriculate	5	18	31	25	79(4.6)
Intermediate	7	7	12	18	44(2.56)
Graduate	6	4	4	15	29(1.69)
Post Graduate	3	0	2	2	7(0.41)
Total	**463**	**538**	**295**	**423**	**1719**

Literacy Levels of the Respondents

The mothers literacy assumes much importance as it has a very direct impact on child rearing. Data pertaining to the present study shows in table 3.6 that out of 400 mothers interviewed, highest (22.5%) number of them is under-metric. The second largest group (21.5%) of mothers are illiterate. Nearly 18 per cent mothers studied up to class seven and 15.75 per cent have educational qualification till primary level. In all, six per cent of the mothers are under-matric. Few mothers are (3.75%) just literate. Out of all, seven (1.75%) are intermediate and one each are graduate and post graduate. Tribe wise difference shows that (table 3.5), the Nyishis have highest illiterate mothers (46%) against zero illiteracy of Mizos mothers.

Table 3.5

Tribe wise distribution of the respondents according to the literacy levels

Educational Qualification	Khasi	Konyak	Mizo	Nyishi	Total
Illiterate	17	23	0	46	86 (21.5)
Just Literate	9	1	4	1	15 (3.75)
Primary Level	21	20	6	16	63 (15.75)
Upto Class V	12	16	8	6	42 (10.5)
Upto Class VII	17	18	29	7	71 (17.75)
Under Matric	14	22	38	16	90 (22.5)
Matric	5	0	12	7	24 (6)
Intermediate	4	0	2	1	7 (1.75)
Graduate	0	0	1	0	1 (0.25)
Post Graduate	1	0	0	0	1 (0.25)
Total	**100**	**100**	**100**	**100**	**400 (100)**

Occupation

Agriculture is the main occupation for 68.5 per cent families. They mostly cultivate paddy and other seasonal crops. In addition, some families in Khasi and Nyishi communities also have orange gardens. Table 3.6, displays the total areas of cultivable land possessed by the families.

Table 3.6
Tribe wise distribution of the families according to cultivable land

Land Possession	Khasi	Konyak	Mizo	Nyishi	Total
No Land	67	11	2	12	92 (23)
Below 4 Bighas	24	13	29	33	99 (24.75)
4-10 Bighas	8	11	27	27	73 (18.25)
11-20 Bighas	1	1	18	13	33 (8.25)
21-35 Bighas	0	1	8	12	21 (5.25)
36-50 Bighas	0	16	12	0	28 (7)
51-100 Bighas	0	22	4	3	29 (7.25)
Above 100 Bighas	0	25	0	0	25 (6.25)
Total	**100**	**100**	**100**	**100**	**400 (100)**

Data reveals that, in all, nearly one fourth of the families (24.75%) have cultivable land less than 4 bighas. The second largest group (23%) of the families have no land for cultivation. Out of 400 households, 18.25 per cent of them have land between 4-10 bighas. Rest of the families reported having land above 10 bighas. Highest possession of cultivable land was found among the Konyak community, whereas less possession of cultivable land was reported among the Khasi families. The second largest tribe with high possession of land is the Mizos. Only two Mizo families reported without any cultivable land.

Shifting cultivation is also practised more or less in all the study area. This is done mainly by the population who did not posses land.

CHAPTER IV

THE HEALTH CARE OF THE MOTHERS

CHAPTER IV

THE HEALTH CARE OF THE MOTHERS

The health of the mother is very important as only a healthy woman can give birth to a healthy child. A child's health grossly depends on the mother especially during prenatal period. Therefore, the reproductive health of a woman needs to be sound to produce a child without much health hazard. The concept of reproductive health was first developed by World Health Organisation (WHO) which simply means that, it is a complete physical, mental and social well-being and not merely the absence of diseases or infirmity, in all matters relating to the reproductive system and its functions and processes (Wang, 2001)

For proper growth, development and betterment of the baby, mother's health plays a very crucial role. But, the scenario in term of mother health in our country is very poor. Despite the development of medical science, the maternal mortality and morbidity in India are still very high. In India, 301 women died per 1000,000 live births in the year 2006 (NIPCCD, 2007). Many mothers are dying of pregnancy related causes in India. Induced abortions due to unwanted pregnancies, anaemia, unsafe and complicated delivery, poor accessibility to health care services, workload of the women, etc., are the various causes of maternal mortality and morbidity.

The National Family Health Survey of India-III (2000-01) states that, 56.2 per cent married women in the age groups 15-49 years and 79.2 per cent children in the age group of 6-35 months are anaemic. In the study areas, prevalence of anaemia among women is 48.9 per cent in Arunachal Pradesh, 45.4 per cent in Meghalaya and 38.2 per cent in Mizoram. Among the children these figures are 66.3 per cent in Arunachal Pradesh, 68.5 per cent in Meghalaya and 51.7 per cent in Mizoram. These figures are not available for Nagaland as per NFHS-3. According to NFHS-2, these figures in Nagaland are 38.4 per cent in women and 43.7 per cent in children

Poor health of women not only leads to maternal mortality but is also responsible for producing unhealthy baby. Maternal depletion, which is a result of early marriage, repeated pregnancies, inadequate diet, heavy work load, etc. are the main factors responsible for maternal mortality and morbidity. These factors often lead to some cumulative health hazards, that causes anaemia, general malnutrition with premature aging and early death. Moreover, it is an established fact that, early marriage as well as early pregnancy is very dangerous both for the mother and the baby.

As direct care cannot be given to the child when it is in the mother's womb and care has to pass through the mother, hence antenatal care is indispensable. It is again a very crucial period, when the baby is being delivered. It is a very delicate stage and both the mother and the child truly require support and care. After birth, during the very initial stage, the post parturient mother must be rendered care to regain her physical and mental health back.

Looking into the ill-effects of above factors, several researchers have carried out various studies to find out the relation between the health of the mother and pregnancy outcome and have proved the close link between these two. Thus, keeping these in view, the present study too attempted to collect information to understand such factors responsible for the same. These are given in the proceeding paragraphs.

CARE OF THE EXPECTANT WOMEN

The primary aim of the antenatal care is to achieve at the end of the pregnancy a healthy mother and a healthy baby. Ideally, care of an expectant mother should begin soon after conception and continue throughout the pregnancy. Care during pregnancy includes regular visit to the physician. As soon as the pregnancy is detected, the woman should visit a physician for her regular check ups and care as pregnancy progresses. These cares mainly includes studying physical examination, laboratory examination, haemoglobin estimate, iron and folic acid supplementation, vaccination against tetanus, instruction on nutrition, work and rest, family planning, self care, parenting, etc. Though the schedule for check up varies from woman to woman depending on resources and complicacies, but at least three visits are necessary if everything is normal. Besides, the expectant mother should eat more. Her diet should include all categories of food stuff. Special attention should be given on consumption of iron and calcium rich foods.

In all, the care of expectant women encompasses a systematic and periodic medical supervision of the woman and supporting her at any time if problem arises. It

aims to prevent maternal mortality and morbidity. Such types of care received by the studied population are described below:

Visit to a Doctor or Health Personnel

Ideally, the pregnant mother should receive first antenatal check-up within seven months of pregnancy, twice a month during the next two months and thereafter once a week if everything is normal. Since a large number of women in India go out for bread earning, it is not possible for them to go for health check-ups regularly. In these cases a minimum of three visits covering the entire period of pregnancy should be the target (Park, 2000). In this present study, out of 400 mothers interviewed, more than half of them (55.25) consulted a physician in all the cases of pregnancies, more than one fourth (28.25%) of the respondents consulted physician at least in one of the pregnancies and 16.5 per cent of them never consulted a doctor. The tribe wise breakup of this can be seen in table 4.1.

Table 4.1
Tribe wise distribution of the respondents according to the visit to a Physician

Consultation of doctor/ health personnel	Khasi	Konyak	Mizo	Nyishi	Total (%)
Yes in all cases	56	40	84	41	221 (55.25)
Not in all cases	44	22	12	35	113 (28.25)
Not at all	-	38	04	24	66 (16.5)
Total	**100**	**100**	**100**	**100**	**400 (100)**

The above table reveals that, among all the four tribes, highest number (84%) of Mizo respondents, consulted a physician in all their pregnancies, followed by the Khasis in Meghalaya (56%). Situation among the Nyishis and the Konyaks is almost

the same in this regard. The mothers who have never consulted a health personal was highest (38%) among the Konyaks. Hence, it is clear that the Mizo mothers are on the top in respect of consulting medical personnel during antenatal period.

It was also attempted to find out of the medical personnel whom they consulted and found that a large portion (87.72%) of the group consulted a physician followed by health worker (5.39%) and traditional health practitioner (who is an ethno medicine man, treating patients using local medicines and methods). Few of them (1.5%) visited the compounder and Anganwadi worker (1.26%). Only in Meghalaya four (1.2%) Khasi mothers found visiting a quack practitioner (a person who pretends to be able to diagnose or heal people, but is unqualified and incompetent). It was also found that, three fourth of the respondents (75.45%) consulted a doctor for regular checkups and rest of them (24.55%) consulted as because they had health problem during antenatal period and in this category the per centage is higher and nearly equal among the Nyishis and the Konyaks (40.79% and 41.94% respectively) than the other two tribes.

Frequency of such Consultation

The study also attempted to find out the frequency of antenatal visits of the respondents and found that altogether 334 respondents visited a doctor for antenatal check-up in their last issue

Table 4.2

Tribe wise distribution of the respondents according to the frequency of visiting medical personnel

Frequency	Khasis (per cent)	Konyaks (per cent)	Mizos (per cent)	Nyishis (per cent)	Total (per cent)
Once	29 (29)	23 (37.10)	34 (35.42)	23 (30.26)	109 (32.63)
Twice	22 (22)	17 (27.41)	21 (21.88)	22 (28.95)	82 (24.56)
Thrice	27 (27)	22 (35.49)	29 (30.20)	23 (30.26)	101 (30.23)
More than thrice	22 (22)	-	12 (12.5)	8 (10.53)	42 (12.58)
Total	**100**	**62**	**96**	**76**	**334**

The table 4.2 reveals that out of 334 mothers who consulted physician, for majority (30.94%), visit was only for once followed by thrice (30.23%). Only 13.13 per cent respondents visited a physician more than three times thrice. Among the tribes selected, all the Khasi mothers were on the top in this respect with 100 per cent followed by the Mizos with 96 per cent. The Nyishis and the Konyaks 76 per cent and 62 per cent respectively, are in third and fourth place with which are far behind of the other two tribes.

It was also tried to find out the reason for consulting physician and found that, out of 334 mothers, 75.45 per cent of them visited health personnel for regular health check-up and rest (24.55%) for some health problems.

In all, out of 334 mothers majority (315 no.) received some health care. The most common health care received by the mothers was vaccination against tetanus.

Nearly 64 per cent mothers received tetanus toxoid vaccine. Comparing to this, only 29.84 per cent of them received iron and folic acid tablets. Out of all the mothers who consulted medical personnel, only 4.13 per cent mentioned of receiving other types of health care, such as – checking blood pressure, foetal movement, weight, etc. Rest 2.54 per cent respondents received medicine for their other health problems aroused during antenatal period.

From the above data, it can be said that although majority of the respondents are aware about the need of health check up during antenatal period, yet, reporting of receiving appropriate health check-ups was found lacking. When compared with the total sample size of the study, it is seen that only half of them had received tetanus toxoid vaccine. Number of mothers receiving IFA supplement was very less. Only very few respondents (n 13) mentioned of receiving other physical checkups. Among all the tribes, the states of the Mizos and the Khasis are better than the Nyishis and Konyaks in terms of receiving health care during pregnancy.

Dietary Care

Diet of pregnant mother is considered to be of great importance. The foetus inside the mother's womb is completely dependent on its mother. The intrauterine growth and development of the foetus will be satisfactory if the expectant woman receives proper dietary attention. Moreover, proper dietary care to a large extent supports the mother to overcome minor health problems which arise during pregnancy as well as during delivery. An undernourishment in mother increases risk both for herself and for her baby. Poor health of the mother affects the growth and

development of the foetus and in such cases the new born may be of low birth weight (LBW), anaemic and susceptible to various infections (Bhargava, 1987). Besides, the babies, who survive remain small throughout childhood and never seem to catch up with normal babies (Ghose, 1985). Poor maternal nutrition also increases the risk of still-birth and death of baby within few weeks after birth and also causes some congenital deformities of the baby (Passmore and Eastwood, 1986).

Realising the importance of mother's dietary care and pregnancy output, it is very necessary for the expectant mother to eat extra during pregnancy, especially at third trimester. In this study, information was gathered to find out the kind of dietary attention given to the mothers in the selected tribal communities. It was found that most of them did not receive any dietary attention. In all, only 21.75 per cent of the respondents received some kind of dietary attention. Among the tribes studied, receiving some dietaty attention was reported highest among the Konyaks. Poor economic status, ignorance, reluctance, etc. are the reasons for not consumption of extra diet.

Table: 4.3

Tribe wise distribution according to the dietary attention received by the respondents during pregnancy

Consumed Extra Food	Khasi	Konyak	Mizo	Nyishi	Total
N.A	77	58	68	84	287 (71.75)
Regularly	12	14	09	03	38 (09.8)
Sometimes	03	20	14	12	49 (12.25)
Whenever felt hungry	08	08	09	01	26 (6.5)
Total	**100**	**100**	**100**	**100**	**400 (100)**

From table 4.3 it is very clear that the mothers were not given much dietary attention during this period. Similar kind of observation was also made among some other tribal communities of Assam (NIPCCD,1989; RCG, Bhuyan 1999; Regon, 2003). It is also seen that among the four tribes, the Konyak mothers are in the better position than the fellow tribes in receiving dietary attention. It is further to be noted that, the few mothers, who received some amount of dietary attention, were receiving it only sometimes. In all, only 9.5 per cent respondents informed of consuming extra food regularly. Rest mentioned of having extra food sometimes (12.25%) and when they felt hungry (6.5%). The most common food that the mothers consumed was rice, meat, fish and vegetable. Apart from these, 16.75 per cent respondents received special dietary attention to satisfy their cravings. The Mizo mothers are the most (27%) than the Khasis (26%), Konyaks (12%) and the Nyishis (2%).

Food items that most mothers received as special/additional items were – rice, soup of beef, fruits – mostly banana, citrus fruit, all kind of vegetables, milk, etc. The Khasi mothers received mostly soup of beef and the Konyaks had soup of any meat. Mothers of Mizo tribe took mostly fruits. The Nyishis preferred rice with soup of meat or fish. Since for all the four tribal communities, boiling is the most common method of food preparation, thus meat (of any kind), fish and vegetables are generally boiled and are consumed along with the soup. Other items the respondents consumed as special diet were tea, biscuits, dal, chapati, etc. Moreover, all who received such dietary care, very few of them consumed these everyday. It may be worth to mention here that, meat or fish are almost an integral part of their daily meals. Therefore indicates consumption of good quality protein daily.

Alcoholic Beverages and Tobacco Consumption

Consumption of alcohol and tobacco during pregnancy is not considered healthy. It may affect the baby leading to foetal alcohol syndrome. At birth, the baby may be of underweight and later, may manifest delayed milestone of development and may even have some degree of mental retardation. Abuse of alcohol in pregnancy may also increase the chances of abortion (Derek, 1983).

Among the tribal communities alcohol constitutes a part of life and used for daily consumption and to entertain guests. It is required in an integral part of various festivals and ceremonies in tribal societies. These are mostly home made alcoholic beverages. Generally, rice, millets, etc. are used to prepare these beverages. Understanding these, attempt was made to find out the status of alcohol and tobacco consumption among the tribes.

Understanding these, attempt was made to find out the statys of alcohol and tobacco consumption among the tribe. Data reveals that, except some mothers in the Nyishi community, others responded negative. Out of 400 mothers, only eight per cent reported consuming home made alcohol and they were from the Nyishi tribe. Again amongst them, 24 respondents informed of consuming it sometimes and six mentioned of taking it occasionally. Only two mothers reported consuming daily. It is observed that, due to Christianity, most of the respondents reported of not consuming alcohol, as Christianity does not support consumption of alcohol. Though they prepare and consume, people do not disclose it. However the Researchers convinced of their answers after cross questioning during interviewing the mothers.

Out of 400 respondents, majority (93.5%) answered in negative towards taking tobacco. Majority were Nyishis, followed by the Mizos and the Konyaks. Although, the Khasis are fond of taking betal nuts, none the respondents answered positive about consumption of tobacco. This could probably be the reason of inclusion of young Khasi mothers for the study who had have not yet started taking tobacco. The figure 6.5 per cent of tobacco consumer is almost equal with 7.0 per cent of National figure (Sharma, 2000).

Taboos during Pregnancy

Only 16.5 per cent of the studied group followed food taboos during pregnancy. As mentioned above, the Konyaks occupies the first place in following such food prohibition. Out of 100 interviewed mothers followed for one or more dietary prohibitions, it is 31 per cent among the Mizos, which is highest among the four tribes, 27 per cent Konyaks and only six per cent among the Nyishis. The reasons that the mothers mentioned except alcohol and baby's health others have no scientific base.

Taboos relating to pregnancy are not a new concept. Various taboos are prevalent in many societies. During pregnancy these are mainly of food, movement and certain acts. Like other tribes in India, the tribal communities in north eastern region are also governed by their own customs concerning pregnancies of the women. According to their customs many a time a pregnant mother's food and movements are restricted. There are not enough scientific evidences in support of these taboos, but

these are very rigidly followed. Avoidance of some food during pregnancy is common in all over the world. Certain taboos were also observed in Assam and Manipur (NIPCCD, 1998, Bhuyan, 1998 and Regon, 2003).

Restriction in Movements

Data of the present study too shows that in case of 30 per cent respondents, their movements and activities were restricted. These restrictions were most commonly found among in the Konyaks and Mizos. Table 4.4 reveals the tribe wise distribution according to the restriction of movements and activities.

Table 4.4

Tribe wise distribution of the respondents according to activities prohibited during pregnancy

Activity	Khasi	Konyak	Mizo	Nyishi	Total (%)
No prohibition	85	54	50	91	280 (70.0)
Killing of birds	01	19	41	02	63 (15.75)
Crossing of a river	04	04	-	01	09 (2.25)
Visiting the grave	04	09	-	-	13 (3.25)
Visiting the house of a deceased	-	01	-	03	04 (1.0)
Going to the forest	-	01	-	-	01 (0.25)
Killing of a snake	06	11	07	03	27 (6.75)
Knitting, stitching	-	01	-	-	01 (0.25)
Killing of any animals			02		02 (0.5)
Total	**100**	**100**	**100**	**100**	**400 (100)**

Among all types of activities, killing of birds was restricted by the most, followed by killing of snake. Restriction of these two activities was found among all the four tribes. Restriction of all the acts mentioned in table 4.5 was mostly for the wellbeing for the unborn baby, as the people believe.

Table 4.5

Tribe wise distribution of respondents according to the reason of activities prohibited during pregnancy

Activity	Khasi (per cent)	Konyak (per cent)	Mizo (per cent)	Nyishi (per cent)	Total (per cent)
Does not Know	2 (13.33)	-	2 (4)	-	4 (3.33)
Believed to be bad	-	5 (10.87)	20 (40)	6 (6.66)	31 (25.83)
Fear of ghost Lead to complication	7 (46.67)	2 (4.35)	13 (26)	3 (33.33)	25 (20.83)
It may harm the baby	6 (40)	39 (84.78)	15 (30)	0	60 (50)
Total	**15**	**46**	**50**	**9**	**120**

Data presented in table 4.5 shows the tribe wise distribution of common beliefs against these prohibitions. Out of 120 respondents who followed such prohibitions, four per cent of them informed of following these without any reason. In all, it was the fear of any harm to the unborn baby.

Food Restriction during Pregnancy

Like restriction in movements during pregnancy, prohibitions of certain food were also prevalent. There are wide ranges of food items which were prohibited during

pregnancy, especially among the Konyaks, followed by the Mizos and the Nyishis. The Khasi respondents did not follow any such restrictions. Table 4.6 presents data relating to food items that were restricted during pregnancy.

Table 4.6

Tribe wise distribution of respondents according to the Food Restricted During Pregnancy

Tribe	Food Items	Duration	Reason	Numbers
Khasi	No restriction	-	-	-
Konyak	i. Honey Bee	4 Months	Baby will be non creative	23
	ii. Worm	Entire period	Baby will be non creative	27
	iii. Ugly looking animals	Entire period	Evil spirits of the animal will harm the baby	19
	iv. Deer meat	Entire period	Bad for the health of the baby	12
	v. Meat of wild animals	Entire period	Lead to complicated delivery	22
	vi. Any meat	Entire period or 3 months	Lead to complicated delivery	16
	vii. Meat of funny animals (Monkey, dog, etc.)	Entire period	Baby will become like that animal	18
	viii. Pine apple	Entire period	Premature delivery	14
	ix. Mushroom	Entire period	Baby will vomit after birth	04
	x. Dry fish	Entire period after 3 months	Affect baby's health	06
Mizo	i. Dry fish	Entire period	Bad for health	31
	ii. Crab	Entire period	Causes allergy	24
Nyishi	Chilli	Entire period	Bad for baby's health	06

The mothers who followed these taboos during pregnancies mentioned of having the belief of ill effects on the unborn child if they do not follow the restriction. Not following much of commonly eaten food restriction by majority of them is a good trend

among the tribes as any such restrictions would have had affected their nutrition during pregnancy period.

Whatever restrictions, knowingly or unknowingly they followed, all because of the welfare of the unborn child. This indicates the mothers' concern for the unborn ones.

Rites Performed During Pregnancy

Performing rites during pregnancy for safe delivery and for obtaining a healthy child is in vogue among many societies. Several researchers have found such rites among various tribal communities of India. Goswami (1988) reports Jingknia-tap-kpoh, an important pregnancy related ritual among the Hindu Jaintias of Meghalaya. Bhuyan (1993) found such ceremony among the Karbis. The Sugalis of AndraPradesh perform two ceremonies in connection to pregnancy (Kusuma, 1997) Regon too (2003) observed such rites among the Karbis and the Deoris in Assam.

The data in this study shows that, very few (1.2%) of the respondent informed of performing rite during pregnancy. Since the studied tribal communities are followers of Christianity, they do not follow any other rites other than prayers. Whatever it is, it shows that, those few mothers had fear/belief about the birth processes and thus organised prayer at home and also church with relatives and neighbours.

Work Load and Rest during Pregnancy

Adequate sleep and rest are important for maintaining a good health. Whereas excessive rest and work are harmful for the expectant mother. The expectant mother should perform some amount of exercise in the form of house hold work. But, lifting heavy things, mopping floors, washing heavy clothes, etc. should be avoided. However, mother who do not perform any household work are advised to perform some sort of physical exercises under the supervision of a medical personnel. Likewise, adequate physical and mental rest is also important for the expectant mother. This study found that, out of 400 respondents, majority (93.75%) of them had carried out their normal routine work during pregnancy.

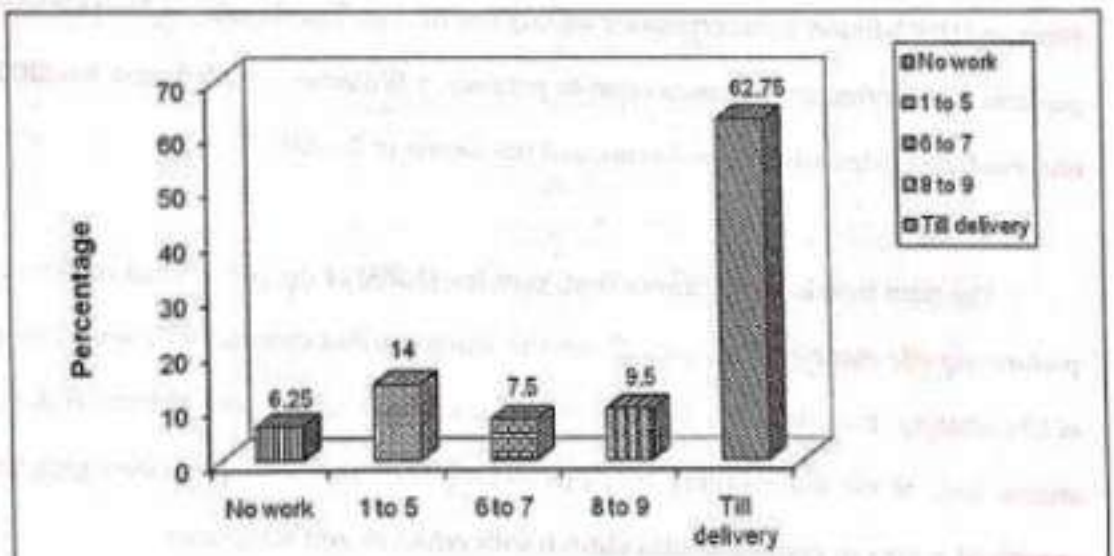

Fig 4.1: Months upto which normal routine work was carried out by the mothers

Data in the present study shows that 93.75 per cent mothers carried out their daily household activities. Figure 4.1 shows the distribution of mothers according to the tribe as per the duration they carried out their activities. It reveals that, out of 375 respondents, reported doing work during pregnancy, nearly 67 per cent of the respondents carried out normal routine work till the time of delivery. It seems that, majority of the respondents did not receive help in exemption from daily routine work till the end of pregnancy. Carrying out such daily chores till the end of pregnancy was found highest among the Konyak mothers, followed by the Nyishis and the Khasis with nearly 70 per cent respondents and lowest among the Mizos with 45.74 per cent. This reveals that, the Mozo mothers had more relaxation during pregnancy than the other three fellow tribes. Moreover, a small section (6.25%) of the respondents reported of not doing any work throughout the pregnancy. However, none of the Konyak respondent mentioned exempted from performing work during pregnancy.

Table: 4.7
Tribe wise distribution of the respondents according to the help received from family members

Help Received	Khasi	Konyak	Mizo	Nyishi	Total
No help at all	14	28	13	19	74 (18.5)
Everyday	24	52	26	06	108 (27)
Quite often	16	06	15	14	51 (12.75)
Sometimes	27	12	14	13	66 (16.50)
Whenever necessary	19	02	32	48	101 (25.25)
Total	**100**	**100**	**100**	**100**	**400 (100)**

It was also found that (table 4.7), one fourth of the mothers received help during pregnancy whenever there was necessity. The family members rendered help to

the respondents in all sorts of daily chores. Generally, the respondents received relaxation in performing hard physical chores, such as-fetching water, hoeing, cutting fire woods, carrying heavy loads, pounding rice, etc.

Data was also collected in respect of rest during day time and found that a large majority (82%) of them took rest during day time. In all, half of the respondents informed of taking rest for 1-2 hours in a day. In this category the Mizo mothers are on top with 56 per cent followed by the Khasi mothers with 54 per cent. Fig 4.2 shows the tribe wise distribution of mothers according to the duration of rest during day time.

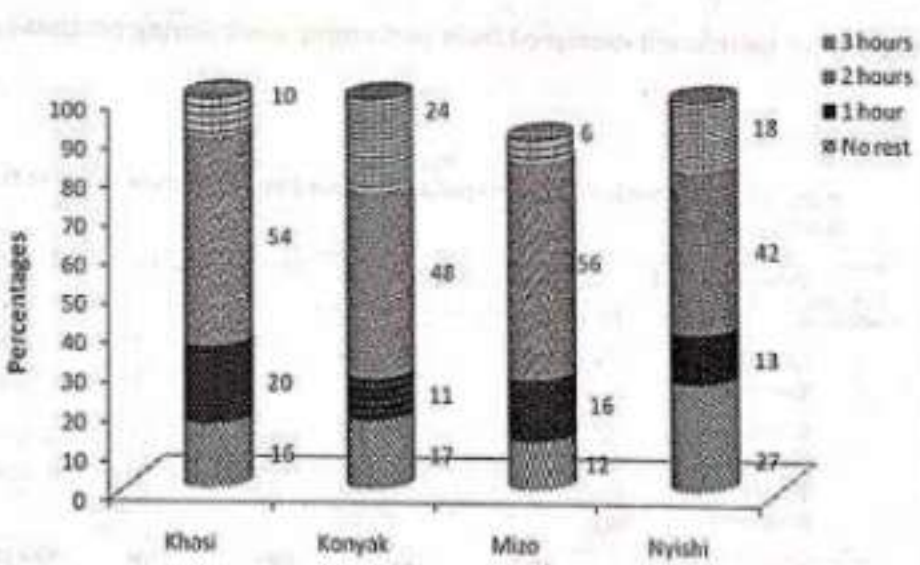

Figure. 4.2: Distribution of mothers according to the duration of rest during pregnancy

Attempt was also made to understand various daily activities performed by the tribal mothers. Table 4.8 displays data about the types of activities performed.

Table 4.8

Tribe wise distribution of the respondents according to the type of normal routine work performed during pregnancy

Type of Work	Number of Respondents				
	Khasi	Konyak	Mizo	Nyishi	Total (%)
Pounding	31	34	Nil	64	129 (32.25)
Working in the Fields	2	40	23	48	113 (28.25)
Drawing Water	56	38	100	52	146 (36.5)
Cooking	64	76	100	91	231 (57.75)
Carrying Heavy Load	9	24	Nil	25	58 (14.5)
Washing Clothes/ Utensils	48	74	100	71	193 (48.25)
Collecting Fire-wood	Nil	51	30	43	124 (31.00)
Taking Care of Children	16	62	70	69	147 (36.75)

The data in table 4.8 shows that, cooking was the common activity that majority (57.75%) of the respondents performed in all the four tribal communities. After that, washing clothes and utensils was the second highest activity (48.25%) that the mothers carried out, taking care of children (36.75%) and drawing of water (36.25%) are the other two activities that the mothers perform. Tribe wise variations show that pounding rice and working in the fields were observed to be highest among the Nyishi tribe followed by the Konyaks. Again, carrying heavy loads was also seen in these two tribes, approximately by one fourth of the mothers. Relatively, mothers of these two tribes were found more laborious than the other two tribes in carrying out the activities listed in table 4.8. Very few Khasi respondents and little less than one fourth of the Mizo mothers mentioned of working in the field. Further, carrying heavy

loads was nil among the Mizos and very few among the Khasis. In all, the data in table 4.9 shows that the mothers in Nyishi community performed most of the listed activities and the Mizos enjoyed highest relaxation daily pregnancy among the studied tribes.

PROCESS OF DELIVERY

Delivery is a natural but very crucial process and generally there should not be any problem if everything is normal. But, certain difficulties or complications may arise during the process and therefore, precautions should be taken beforehand. A successful delivery reduces the mortality and morbidity of both mother and child. Thus delivery complicacies can be minimised if delivery is conducted by a trained personnel. Institutional delivery certainly reduces dangers associated to delivery.

Place of Delivery

In this present study, information regarding places of delivery was collected only for the children below three years of age, at the time of data collection. It is seen that, purely hospital delivery was reported by 43 per cent mothers. More than 50 per cent mothers had their deliveries at home and 6.25 per cent respondents, having more than one child (below three years) delivered at home as well as at hospital. Fig 4.3 displays the data of places of delivery by the respondents of the selected tribes for the study.

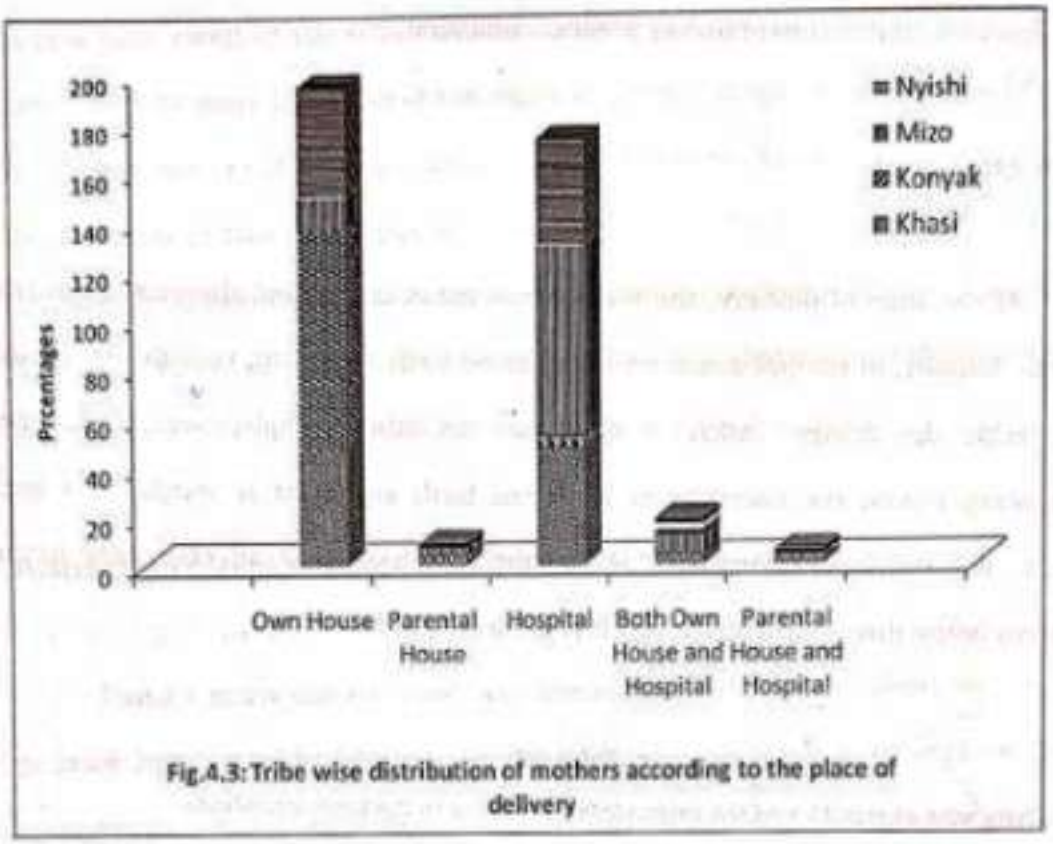

Fig.4.3: Tribe wise distribution of mothers according to the place of delivery

It is seen in the figure 4.3 that, the Mizo mothers are on the top with highest number (76%) of mothers who delivered their babies in hospital. The Khasi mothers occupy the second place with 47 per cent followed by the Nyishis (43%) and the Konyaks (6%). In all, home deliveries were highest among the Konyaks than the other fellow tribal communities. The reasons behind the highest number of institutional delivery among the Mizos may be their better educational and economic position than the fellow tribes. The Khasis being in second position may be because of better status of women in their society. Contrary to this, the Khasis are also in second place in regard of home deliveries. This could be because of their poor economic condition. The

Konyak being in the first position with maximum home deliveries may be because of poor economic status, low status of women, education, etc.

Birth Attendant

At the time of delivery, the birth attendant is considered the most important person. Usually, in normal cases, an experienced birth attendant, though not trained, can tackle the delivery safely, if there are no other complications. But, when complicacy arises, the necessity of a trained birth attendant is sought to a great extent. The collected information about birth attendants of all the cases having children below three years of age which is presented in table 4.9.

Table 4.9

Tribe wise distribution of the respondents according to the birth attendants

Delivery attended by	Khasi	Konyak	Mizo	Nyishi	Total (%)
Doctor	64	14	60	78	216 (38.5)
Paramedical Staff	4	8	84	10	106 (18.89)
Dai	25	5	19	-	49 (8.73)
Village women	13	45	3	31	92 (16.40)
Mother-in-law/ sister in-law	4	35	3	12	54 (9.63)
Mother / Sister	5	15	-	8	28 (4.99)
Husband	6	-	4	1	11 (1.96)
Any other	1	-	-	4	05 (0.89)
Total	**122**	**122**	**173**	**144**	**561 (100)**

The data in table 4.9 shows that, in respect of 561 children (below three years), in majority of the cases (38.5%) physicians attended deliveries. The second highest cases (18.89%) were carried out by paramedical staff. It shows that, nearly 58 per cent deliveries were attended by health personnel, followed by untrained village women

(17.29%). Other birth attendants were family members and in few case the husbands. It is a good trend of the tribes having medical and paramedical personnel as birth attendants by more than half of the cases (57.39%t). It can be commented here that, in spite of poor road communication, poor accessibility to health centres, the tribal communities of this study put an effort to get delivery done by trained personnel, which is praiseworthy. Tribe wise variations show that, in all, the highest Mizo mothers (83.24%) accessed to the medical personnel as delivery attendant, followed by the Nyishis (61.11%), Khasis (55.74%) and the Konyaks (18.03%).

Instruments Used for Cutting Umbilical Cord

Using a clean and sterilized instrument for cutting the umbilical cord is a must to avoid infections. Though, new blades are easily available everywhere, use of other instruments are also in vogue among the different groups. The respondents of the present study too mentioned such instruments. Table 4.10 presents data relating to instruments used for cutting the cord.

Table: 4.10

Tribe wise distribution of respondents according to the instruments Used for Cutting Umbilical Cord

Instument Used	Khasi	Konyak	Mizo	Nyishi	Total
Blade	26	69	14	30	139 (34.75)
Knife	01	-	-	14	15 (3.75)
Scissor	14	05	05	02	26 (6.5)
Bamboo Splinter	12	20	-	11	43 (10.75)
Does not know	47	06	81	43	177 (44.25)
Total	**100**	**100**	**100**	**100**	**400**

Most of the mothers (44.25%) could not tell about the type of instrument used for cutting the umbilical cord. It is mostly the cases that were delivered at hospital and also where the birth attendants were medical or paramedical personnel. In all, 34.75 per cent mentioned of using blades for it. Use of bamboo splinters, scissors, knives, was also found to be used more or less by selected communities. Regarding sterilisation of these, 37 per cent of the respondents answered in affirmative. Sixteen per cent answered in negative and a large majority of the group were not aware about of it. Among the four tribal groups, the Konyaks (63%) mentioned of sterilising the instrument, followed by the Khasis (32%), Nyishis (31%) and the Mizos (22%). Since highest hospital deliveries were taken place in the case of Mizo mothers (78%), sterilisation of the instrument might not be known by them. Likewise, information regarding washing hands before delivery was also not known by a large portion (56.75%) of the studied tribe.

It can be mentioned here that, a large section of the studied population are not aware about the need of sterilisation of instruments and washing of hands before delivery. Thus, they do not give importance in these aspects.

Data reveals that, in case of 97 per cent respondents no problem aroused during delivery. Among the rest, who had problems, five were the Konyaks, four were the Mizos and three were the Khasis. None of the Nyishis reported of any kind of problem during delivery. Being Christians none had performed any kind of rite during delivery.

Dietary Care of Post Parturient Mothers

Like care during antenatal period, postnatal care also assumes much importance. Besides personal and environmental cleanliness, dietary care is also of great importance. Nutritious balanced diet helps the mother to regain strength and re-establish maternal depletion at the earliest. Data was collected regarding dietary care received by the mothers and was found that 54.75 per cent mothers received dietary attention soon after delivery. Tribe wise distribution shows that, majority of the mothers in Meghalaya (72%) received post partum dietary attention. The Mizo and Nyishi mothers are in second and third places with 51 per cent and 44 per cent respectively. The Konyak mothers are in the last position with only 14 per cent positive responses.

Data reveals on various types of food items received by the respondents after delivery. Among the four tribes, the majority of the mothers of the Konyak and Nyishi tribes consumed either boiled meat or soup of meat. The chicken soup was mostly preferred by the respondents. Besides, some of them also had taken beef and fish soups. Except for Konyaks, in other three tribes few mothers reported consuming fruits and milk. Foods like sugarcane, sugar, honey, sweets are prevalent only among the Mizos. Only few Konyak respondents reported of having dal. The rice beer, although indispensable in the life of the tribal people, among the studied population, only one Khasi mother had it soon after delivery. Like dal, consuming pork was found only among the Konyaks. It is seen that, the diet they received soon after delivery is basically rich in meat protein. Only few Mizo mothers reported of carbohydrate rich foods. The mothers, who did not receive any special care after delivery, just followed

their normal meals as before. The reasons stated to be behind consuming such food items are to get the strength back, these are good for increasing blood lost during delivery, to enhance milk productivity and overall health of the mother and the baby. Though the duration of dietary attention ranges from one week to six months, however in most cases received this care is only for one week.

It was also tried to find out if there is any dietary restriction for the mothers after delivery and found that, there was no such restriction for 66.5 per cent respondents. Dietary restrictions were highest among the Konyaks. Among them, 75 per cent mothers answered positive of following certain restrictions. Table 4.11, presents data regarding the tribe wise distribution, according to the dietary restriction after delivery.

Table 4.11

Tribe wise distribution of the respondents according to the postpartum dietary restriction

Status	Khasi	Konyak	Mizo	Nyishi	Total
No restriction	88	25	73	80	266 (66.5)
Followed restriction	12	75	27	20	134 (33.5)
Total	**100**	**100**	**100**	**100**	**400 (100)**

The after delivery food restriction was lowest among the Khasi mothers interviewed for this study.

Data relating to food restriction after delivery shows that, mostly chilly was restricted by the mothers in all the tribal groups except the Mizos. The Mizos mainly avoided strong flavoured food, spices and dry fish. Most of the Konyak mothers

avoided black tea and bitter food. Avoidance of such food ranges from one month to three months, especially when the babies were only breast fed. The main reasons behind such restrictions are given in table 4.12.

Table 4.12

Tribe wise distribution according to the reasons of restriction of various food items

Tribes	Name food items	Reasons for restriction
Khasi	Fermented peas	Stomach problems in child
	Chilli	Stomach problems in child
	Cold food	Stomach problems in child
Kanyak	Bitter food	Obstruct breast milk flow
	Citrus fruits, colocasia, chilli	Less milk production
	Tea (Black)	Cause diseases in the new born
	Sour food	Delay teeth eruption and other developments
	Too warm food	Any complication to mother and child
Mizo	Dry fish	Bad for mother's health
	Meat/spices	Bad for baby's health
Nyishi	Oily food and Cold Water	Cough
	Chilli	Stomach Problem of the baby
	Beef	Baby becomes lazy
	Rice beer	Bad for baby's health
	Rotten meat	Bad for baby's health
	Colocasia	Weak teeth in the baby
	Pumpkin and Green Vegetables	Pain in the abdomen of mother

Special Diet for Enhancement of Breast Milk

The lactating mothers should eat a little extra to nurture and support her health for at least six months of her delivery. Although mother's extra dietary care is not directly responsible for increasing milk production and it is only the baby's sucking and psychological support, which help in milk production enhancement, yet,

many mothers have the belief that certain food helps in production of milk flow. Thus the present study attempted to understand such beliefs among the mothers and found that half of the interviewed mothers consumed certain food for increasing milk production.

Among all other food items, papaya was widely used by the mothers for enhancement of breast milk production. However, the Mizo mothers mainly used ginger and meat soup than papaya. Other food they mentioned for increasing milk production were colocacia, ginger and meat or meat soup. Use of certain herb was mentioned by only two Khasi mothers. Rice beer was taken by few Khasi and Nyishi mothers. Consumption of dal was found among few Konyak mothers. Only one Mizo mother used supplementation in the form of tonic. This belief in such food items for enhancement of milk, was highest among the Konyaks (67%) followed by the Nyishis (54%), Khasis (44%) and the Mizos (35%).

The above findings in this chapter shows that, care of mothers in the studied tribes are not equal and alike. Child bearing consisting combination of both traditional as well as modern processes. Mothers avail possible health services or consult health personal and receive tetanus vaccines, IFA supplementations, which indicates that the mothers are aware about these necessities of health care. At the same time the section of mothers who did not receive these care tell that health services are still inadequate to reach the mothers in these areas. A large section of the mothers delivering their babies at home by untrained person again a threat to the service providers. By not taking proper dietary care, not sterilising the instrument for cutting the umbilical cord, not following appropriate family welfare activities for proper spacing between

children (44.25% mothers had two children below three years) shows that the mothers as well as children's health is in danger. However, there is not much food restriction in terms of food items and number of respondents, which is a healthy sign.

CHAPTER V

CARE OF THE CHILD

CHAPTER V

CARE OF THE CHILD

Care of the child is one of the most prime necessities in human life. As mentioned elsewhere in this report, human beings are perhaps the most delicate one amongst all living beings in the world. Younger the age, higher the quality of care required. In the beginning these cares mostly lie with health and nutrition. Although these child care practices vary from society to society and community to community, yet, it is must to fulfil the physiological needs of every child. Understanding these, the present study collected information relating to such care of the child, which is presented in the following paragraphs.

CARE OF THE NEWBORN

Care of the Newborn is very crucial than later stage. The baby's life inside the mother's womb is much protected. It receives all types of care received from the body of the mother. But, after birth the baby has to adjust with the immediate environment depending on its own body and organs inside. Certain functions like lungs, central nervous system, digestive, endocrinal, immunological, body's temperature maintenance, etc. take place immediately and independently by announcing its independent existence in the world. Immediate newborn care including cleaning the baby is very crucial and thus

the newborn should be handled with great gentleness and care. This is so, because the newborn is very vulnerable and if proper care is not given it may acquire infection and chances of life expectancy reduces to a large extent. The newborn may even die if the baby is deprived of proper care and favourable environment.

Bathing and Clothing

As per the health guidelines, the newborn should not be given deep bath for one week to avoid hypothermia and thereby to reduce the risk of mortality and morbidity. More than half of the mothers of this present study (53.25%) informed of giving deep bath to the newborns. In all, 40.5 per cent mentioned of giving sponge bath and 6.25 per cent reported of being unaware about ill effects of immediate bathing. Table 5.1 presents the tribe wise distribution of the respondents as per the data on bathing babies soon after birth.

Table: 5.1

Tribe wise distribution of mothers according to the types of bath given to the newborn

Types of bath	Khasi	Konyak	Mizo	Nyishi	Total
Deep bath	53	72	36	52	213 (53.25)
Sponge bath	38	19	58	47	162 (40.5)
Does not know	09	09	06	01	25 (6.25)
Total	100	100	100	100	400 (100)

It is seen from table 5.1 that the highest percentage of mothers (58%) in Mizoram mentioned of giving sponge bath. This is mostly because of number of hospital deliveries. Whatever it is, data displayed in the table shows that a large portion of the newborns received deep bath just after birth. Among those cases receiving deep bath, majority of the newborn were given bath with tepid warm

water followed by warm water with soap. Few reported of giving bath with cold water. Use of cold water was reported more among the Khasis and it was nil among the Konyaks. Information on the type of fabrics used to wrap the neonate was also collected and found that, three fourth (75.75%) of the studied sample used washed new cotton fabric to wrap up the new born. Use of such fabric was found highest among the Mizos (95%). The Konyak mothers are in second with 78 per cent, Khasis in third with 70 per cent and the Nyishis at the last with 60 per cent. The second widely used fabric was washed old cotton fabric (16%) and the Khasi mothers (29%) used such fabric more than the other tribes. Preference of cotton fabric was common among all the tribes under study.

Table 5.2 presented data regarding types of fabric used to wrap up the newborns.

Table 5.2

Tribe wise distribution of mothers according to the type of clothes used for wrapping up the neonates

Type of fabric	Khasi	Konyak	Mizo	Nyishi	Total (%)
Washed new cotton fabric	70	78	95	60	303 (75.75)
Washed old cotton fabric	29	13	5	17	64 (16)
Unwashed cotton fabric	1	1	-	23	25 (6.25)
Unwashed new cloth	0	8	-	-	8 (2)
Total	**100**	**100**	**100**	**100**	**400 (100)**

Care of the Naval

Naval care of the neonates is very important to save the child from neonatal tetanus, a dreadful infection with high mortality rate. Infection

generally occurs if the delivery is conducted under a very unhygienic environment, use of dirty un-sterilised instrument for cutting umbilical cord and treating the naval with disease causing germ carrying any materials. Though the mothers are given tetanus toxoid vaccine to prevent this infection, but cleanliness of the immediate surroundings and proper cord dressing assume importance.

Majority of the informants of this study also treated naval of the newborns with various materials. Data obtained from the mothers of the tribe studied.

Table: 5.3

Tribe wise distribution of the respondents according to the naval care of the neonates

Substances Applied	Khasi	Konyak	Mizo	Nyishi	Total (%)
Used nothing	15	63	24	34	136 (34)
Oil	11	26	31	06	74 (18.5)
Dettol/ Ointment	13	03	33	21	70 (17.5)
Powder	47	-	-	-	47 (11.75)
Tumeric	06	02	-	24	32 (8)
Soil	06	01	05	02	14 (3.5)
Wood Ash	-		-	12	12 (3)
Dried spider mixed with oil	-	-	07	-	07 (1.75)
Breast milk	-	02	-	01	03 (0.75)
Cow Dung	-	02	-	-	02 (0.5)
Spittle of Betel	02	-	-	-	02 (0.5)
Mud / Plaster	-	01	-	-	01(0.25)
Total	100	100	100	100	400 (100)

Data presented in table 5.3 shows that, 66 per cent respondents applied various materials to the naval of the neonates. Among all such materials, use of various oil such as mustard, coconut, etc. was found highest (18.5%), which was followed by dettol or ointment (17.5%). Tribe wise variations shows that,

majority (47%) of the Khasi mothers used powder, most of the Konyas (26%) and Mizo respondents used (31%) oil, highest Nyishi mothers (24%) reported of using turmeric. Use of soil was also reported by some mothers in all the tribes. Use of mud plaster and cow-dung was reported only by some mothers in the Konyak Society. Use of wood ash was reported only in the Nyishi Society. Likewise, use of dried spider mixed with oil reported by seven per cent Mizo mothers. Besides, breast milk was also found to be used by a few Konyak and Nyishi mothers. In all, 34 per cent respondents did not apply any such item to the naval of the neonates.

Initiation of Breast Feeding

Mother's milk is a special gift for the neonates and young children. Being the prime source of all the nutrients required by the baby, breast feeding is the best for the baby. The first yellowish milk called colostrum should be the first vaccine to the newborn. It is so nutritious and protective for the baby that, in any means the child should not be deprived of it. The colostrum contains some live cells to protect the baby from infectious germs. But in many places babies are deprived of colostrum leaving them from being benefited out of it.

Scientifically, initiation of breast feeding should be as early as possible after birth. It is best to initiate within half an hour of birth. If not, it should not be delayed later than an hour. This is so, as because baby's sucking stimulates the hormonal reflexes in mother's body to produce and secrete milk.

Thus, it is imperative to initiate breast feeding within an hour. According to the data pertaining to initiation of breast feeding in our country, the NFHS-3 shows that, in India only 33 per cent neonates are receiving breast milk within half an hour, whereas it should be 90 per cent and more. This is very unfortunate. Realising these, attempt was made to gather information in this regard. Table 5.4 presents data relating to initiation of breast feeding by the respondents of the studied tribes.

Table 5.4

Tribe wise distribution of respondents according to the time of initiation of breast feeding

Time of Initiation of Breast Feeding	Khasi	Konyak	Mizo	Nyishi	Total (%)
No Breast Feeding	01	0	03	05	09 (2.25)
Immediately After Birth	50	04	61	77	192 (48)
Within One Hour	17	01	09	16	43 (10.75)
On the 1st Day	13	06	16	0	35 (8.75)
On the 2nd Day	12	15	04	0	31 (7.75)
On the 3rd Day	03	44	02	0	49 (12.25)
Between 3rd & 4th Day	03	28	02	01	34 (8.5)
Between 4th & 5th Day	01	01	0	0	02 (0.5)
After 5th Day	0	01	03	01	05 ((1.25)
Total	**100**	**100**	**100**	**100**	**400 (100)**

Table 5.4 reveals that, although majority of the mothers (58.75%) initiated breast feeding within an hour, yet, a large portion of the neonates were deprived of it. Among those mothers who initiated within an hour, majority belonged to the Nyishi tribe with 93 per cent. Mothers in the Mizo society occupied the second place with 70 per cent, Khasi mothers with 67 per cent and the Konyaks in last with only five per cent. Most of the Konyak mothers

(44%) initiated only on the third day. However, there was no custom associated with late introduction of breast feeding. As the mothers informed, it was of simply because there was no milk after birth. Moreover, the Konyak mothers have the concept that just after birth for few days the breasts generally do not contain any milk. Among the four tribes, initiation of breast feeding trend among the Nyishi mothers is better. This is according to the prevailing practice among the tribes. Though educationally the Mizos were in better position, but, in this aspect they are behind the Nyishis. Thus, it may be due to the prevailing practices of the tribes.

Pre-lacteal feeds

The term pre-lacteal denotes the food introduced to the baby before giving mother's milk. These Pre-lacteal feeds are generally given to the babies who are delayed to put into breast. It is also given in many societies even though breast feeding is not delayed. Whatever it is, introduction of such foods is not at all a good practice. It may be dangerous, because there is a great chance of entering disease causing microbes into the body of the tender neonate through these outside foods. The newborn is very much susceptible to any infection and therefore, the practice of giving pre-lacteal feeds must not be encouraged at all.

Though, from the health point of view, the practice of giving pre-lacteal feeds is a harmful one, still this practice exists in many parts of our country. In this present study also, introduction of pre-lacteal feeds was reported. In all, 35.75 per cent mothers informed of introducing such feeds to the neonates. It

was found highest among the Khasi mothers and out of hundred mothers interviewed, 95 per cent of them reported of introducing pre-lacteal feeds to them. It was followed by the Mizos (47%) and Konyaks (49%). This practice is not much prevalent among the Nyishis (11%). Table 5.4 presents data of pre-lacteal feeds introduced.

Table 5.5

Tribe wise distribution of respondents according to the types of pre-lacteal feed introduced

Types of the feed	Khasi	Konyak	Mizo	Nyishi	Total
Nothing	5	51	53	89	198 (49.5)
Plain water	40	17	25	4	86 (21.5)
Sweetened water (With Honey/Sugar)	42	06	08	01	57 (14.25)
Animal milk	04	03	09	02	18 (4.5)
Gripe water	2	14	0	0	16 (4.0)
Tinned milk	01	05	-	01	7 (1.75)
Starch water	02	04	-	-	6 (1.5)
Honey	04	-	01	-	5 (1.25)
Syrup of *rasgulla*	-	-	4	-	4 (1.0)
Drop of rice beer	-	-	-	3	3 (0.75)
Total	**100**	**100**	**100**	**100**	**400 (100)**

Little more than half (50.5%) of the studied population informed of introducing pre-lacteal food to the newborns. In all, water sweetened with either sugar or honey was the most commonly used pre-lacteal feeds (14.25%). Tribe wise variations shows that most of the Khasi mothers preferred sweetened water (42%) and plain water (40%). The Konyak mothers (17%) gave plain water, the Mizos (25%) and the Nyishi (4%) mothers also introduced plain water to the new borns. Drop of rice beer was reported only by few Mizo mothers. Introduction of such feeds were due to the advice of the elders in the family. The respondents could not give and specific reason of introducing such feeds. In few cases, the mothers gave such feeds as there was no breast milk.

Bed and Sleep of the New Born

The bed for the new born should usually be soft, comfortable and clean. In this study most of the mothers (88.75%) reported of making the neonates sleep with them in the same bed. In all, 9.75 per cent respondents mentioned of making separate beddings in the same bed with the mother. They made the beds with old cotton clothes. These clothes are folded in several layers and spread over the bed of the mother. Very few babies were made to sleep in a basket and cradle. None of them reported of using oil cloth or plastic while making the bed for the babies. Information was collected regarding pillow for the new borns. In all, 58.25 per cent of the interviewed mothers informed of making separate pillow for the new borns. Table 5.6 reveals data regarding type of pillow made for the baby.

Table 5.6

Tribe wise distribution of mothers according to the type of pillow made for the neonate

Materials Used for Pillow	Khasi	Konyak	Mizo	Nyishi	Total
No Pillow	10	24	75	58	167 (41.75)
Cotton Wool	21	52	21	11	105 (26.25)
Old Cloth	49	14	-	2	65 (16.25)
Mustard Seeds	04	01	04	29	35 (8.75)
Synthetic/Silk/Cotton	14	03	03	-	20 (5.0)
Sponge	02	06	-	-	8 (2.0)
Total	**100**	**100**	**100**	**100**	**400 (100)**

Data in table 5.6 reveals that, 41.75 per cent of the studied population did not use pillow for the neonate. Among the four tribes, it was the Mizos, majority (75%) of whom did not use pillows for their babies. Likewise more than

half of the Nyishi (58%) mothers also reported of not using pillow for the new borns. Among those who used pillow, majority (26.25%) used cotton wool to make separate pillow for the young ones followed by old cloth. The Khasis and the Konyaks used a wide variety of materials to make pillow for the new borns. Old cotton clothes were mostly used by the Khasis. Highest Konyak and Mizo mothers informed of using cotton wool and mustard seeds by the Nyishis.

FEEDING PRACTICES

Proper nutrition is one of the essential necessities for the children, especially when they are very young. After birth, mother's milk is the main food to supply all the required nutrients to the new born. The child grows very rapidly in the first year of life. At this period the child gains around 600 grams weight every month. The weight gain includes weights of skeletal structure, adipose tissues, tissues of organs and brain, etc. the brain develops very rapidly during first two years of life and by the age of four, brain development reaches 80 – 90 per cent of its adult size.

The term 'development' implies to the functional maturity of the baby as it grows, so that the baby enables itself to perform certain developmental tasks. The functional maturity has a very close relation with the growth of the child. Although the pattern or rate of growth varies from child to child, yet a normal and healthy baby must attain growth and development according to age. The feeding practices of children are one of the most important factors in attaining proper growth and development.

In this study it was tried to find out the feeding practices prevalent among the tribes under study. Such kind of investigation includes duration of breast feeding, introduction of artificial feeds, introduction of complementary food, food taboos, etc. The study also made an attempt to explore the beliefs associated with these practices and also the growth pattern of children.

Breast Feeding

Elsewhere in the previous para, it was mentioned that, more than half of the respondents initiated breast feeding within an hour. It means that more than half of the hildren in the studied population had a good start of breast feeding. Actually, the new born should receive exclusive breast feeding till the age of six months without introduction of any other food. After that, breast feeding should be continued till two years and beyond along with complementary foods. Table 5.7 presents the data relating to duration of exclusive breast feeding by the mothers under study.

Table 5.7
Tribe wise distribution of respondents according to the duration of exclusive breast feeding

Exclusive Breast Feeding	Khasi	Konyak	Mizo	Nyishi	Total
Not following exclusive breast feeding	95	49	47	11	202 (50.50)
Less than 4 months	05	05	06	16	32 (8.0)
Till 4 months	0	30	04	43	97 (24.25)
Till 6 months	0	10	12	06	28 (7.0)
Till 1 year	0	01	02	07	10 (2.5)
Till 2 Years	0	02	03	11	16 (4.0)
More than 2 Years	0	01	05	05	11 (2.75)
Till Next Conception	0	0	01	0	01 (0.25)
Till Next Baby	0	02	0	0	02 (0.5)
As Long as the Child Wants	0	0	0	01	01 (0.25)
Total	**100**	**100**	**100**	**100**	**400 (100)**

Data presented in table 5.7 reveals that in all, nearly one fourth (24.25%) mothers reported of continuing exclusive breast feeding till four months of their babies. Eight per cent respondents exclusively breast fed their babies less than four months. Section of mothers (10.25%) continued exclusive breast feeding for a longer duration that is beyond six months. Very few mothers reported of exclusive breast feeding till six months of age of the baby. Tribe wise analysis on exclusive breast feeding trend shows that among all the tribes, the Nyishi mothers (49%) exclusively breast fed their babies till 4-6 months compared to the Konyak and Mizo mothers. The Konyaks and Mizos reported exclusive breast feeding till 4-6 months of age were 40 per cent and 36 per cent respectively. The Khasi mothers displayed poorest trend in this respect. Exclusive breast feeding continuing till late months, i.e. later than six months, was reported by some of the mothers. In this aspect, the number of Nyishi mothers was found more than the other three tribes. None of the Khasi mothers reported exclusive breast feeding in this category. It was observed that, most of the respondent mothers were not aware about actual duration of exclusive breast feeding. Some of the mothers hurried in introducing semisolid foods as they felt that, the breast milk was not sufficient for the baby. Though the health and Social welfare departments have been working for establishing scientific ways of infant feeding, but, it seems that, the approach is not up to the appreciable level.

An attempt was also made to find out various types of milk or drinks given to the children along with breast feeding. It was found that, a wide variety of other milk or drinks were given to the babies and young children. The cow's milk was preferred more (27.83%) among all other liquid feeds, which was

followed by plain water (25.9%), tinned milk (18.77%) and gripe water (13.92%). These drinks were given more or less by all the four tribes studied. However, the Nyishis did not mention of giving plain water to the young ones, instead 14 per cent of them mentioned of giving rice water. Giving black tea was reported only by few Mizo mothers.

Among all the four tribes, introduction of such milk or drinks was most common among the Konyaks (92%). It was not very common among the Nyishis (30%). The data obtained regarding the reasons for introducing such items shows that, highest section of the mothers (37.86%) introduced such liquid foods because of inadequate breast milk. The second highest group of respondents (17.15%) informed of giving such items without any specific reasons and they think that these types of food are supplied to be given to the children. Other reasons that the interviewed mothers stated are that, these are good for health (16.83 %), baby's problem in sucking (11%), illness of the mother (7.44%), baby's refusal (4.53%), mother has to go out for work (4.21%) and due to next pregnancy (0.97%).

Most of the mothers (44.98%) introduced such liquid food using feeding bottles, followed by bowl with a spoon (36.57%) and directly from a cup/glass/ small bowl (18.45%). Use of feeding bottle was found highest among the Mizos, followed by the Khasis, Konyaks and the Nyishis. Data also obtained in regard of frequency of giving such liquid foods and seen that among those who introduced such food, 42.07 per cent respondents reported giving twice a day, 35.28 per cent informed of giving these thrice a day, 17.48 per cent said once a day and 5.18 mentioned of giving it more than three times a day. Tribe wise

variations show that most of the Khasi mothers gave such food 2-3 times a day than other tribes. However, few mothers in all the three tribes, except the Konyaks, informed of giving such feeds more than three times. In all, nearly 70 per cent respondents mentioned of diluting these various milky foods in varied degrees. Mothers who reported giving tinned milk did not properly follow the instructions written. They prepared such milk on the basis of approximation. These milky foods are diluted from a little to half dilution. However, 30.1 per cent respondents mentioned of giving such foods without dilution. Mothers of this category mostly used cow's milk. Very few, who used tinned powder milk reported of following the instructions. In all, 8.09 per cent respondents could not reply in this regard as their babies were fed by the family members when they went out to work.

Cleaning of Feeding Utensils

Cleaning of utensils is very important from health point of view, especially when it deals with young children. Normally, the utensils like cup, small pot, bowl of with wide openings, spoon, and glass can be cleaned with soap or detergents and must be rinsed adequately with fresh water and should be sun dried.

Since sterilisation is necessary to kill the microbes in the utensils, it assumes importance to ensure safety and cleanliness for the tiny human beings. All the interviewed mothers who used to give other milky foods mentioned of cleaning the utensils. Majority of them reported cleaning such utensils every time after feeding the baby. Other respondents said that, it depends on the situation such as if the child cannot finish the milk/drink, it is

kept in the same utensil till the next feed and so on. But, compulsorily once a day they used to clean baby's feeding utensils. Generally, they use detergent bar or powder to clean the utensils. But, few respondents reported that, at times, they also used wood ash, mud, sand and only with plain water. Use of detergent powder or bars and plain water reported in all the four tribes. For other cleaning materials, tribe wise variation shows that, a few of the Konyaks and the Nyishis used wood ash. It is not found among the Khasis and the Mizos. In all use of mud and sand was reported by few mothers in the Mizos and Konyaks respectively. Use of such cleansing materials other than detergent powder and bar was not found among the other two tribes.

Regarding sterilisation of utensils, it was seen that, half of the studied population mentioned sterilising the feeding utensils of the children. Out of 400 interviewed mothers, 36.5 per cent of them reported sterilising the feeding utensils everyday, 9.75 per cent mentioned of sterilising every alternate day, very few mentioned twice in a week and few mentioned sterilising once in a week.

Weaning

The term weaning denotes the process of transferring the infant from milky diet to semi solid ones. Generally, breast milk supplies all the required nutrients to the baby till six months of age. Introducing semisolid should be started only after completion of six month of the baby. The weaning food is termed as complementary food because till two years breast milk should be the major source of nutrients for the young child and the semisolids should be given only to complement it. Weaning may be partial or complete. In partial

weaning the baby is introduced other foods in the form of liquid, semi solid, semi liquid or solid foods. Complete weaning is considered to begin only when the baby is totally detached from mother's breast. The process of weaning may have grave psychological and physiological consequences. Therefore, appropriate and timely introduction of semisolid is very important to maintain optimum growth and development of the child. The present study, it was found that, 43.0 per cent mothers informed of introducing semi-solid food between 6-12 months of the baby. In this category it was highest among the Konyaks followed by the Khasis, Nyishis and Mizos.

In all the second highest group (20.25 %) introduced semi-solid foods before six months of age of the babies. Data regarding age at weaning of the tribes under study is presented in table 5.8

Table: 5.8

Tribe-wise distribution of mothers according to the time introducing semisolid foods

Age at Weaning	Khasi	Konyak	Mizo	Nyishi	Total
Not yet started	02	08	08	0	18 (4.5)
Before 6 months	23	07	24	27	81 (20.25)
Between 6 to 12 months	36	76	23	35	172 (43.0)
Between 12 to 18 months	17	03	22	12	54(13.5)
Between 18 to 24 months	08	0	11	07	26 (6.5)
Till next conception	03	0	06	05	14 (3.5)
Till next child is born	03	01	01	06	11(2.75)
After 24 months	03	02	05	0	10 (2.5)
when the child can eat other foods	03	0	0	04	07 (1.75)
No specific time	02	01	0	04	07 (1.75)
Total	**100**	**100**	**100**	**100**	**400 (100)**

In all, 4.5 per cent mothers with children above one year were continuing breast feeding without introducing semisolid food. Such responses were found in all the three tribes other than the Nyishis. Early introduction of semisolid food (before six month) was prevalent in case of 20.25 per cent cases. Except few of the Konyak respondents, more or less equal section of mothers informed of introducing semisolid foods early. Late introduction of semisolid food was found highest among the Mizos, followed by the Khasis and Nyishis. Introduction of such food was late only in few cases of the Konyaks. A few mothers could not tell exactly when the semisolid food was introduced. No where, performing of any rite prior to giving rice was reported.

The study also attempted to find out the duration of breast feeding. It was found that, in all, large section of the respondents (32.75%) of the interviewed mothers informed of continuing breast feeding till two years of age. The second highest group continued till 12 months (19.5%) and 12.25 per cent mothers continued breast feeding till three years of age. Some (10.75%) mothers continued breast feeding for a very short period, that is till six months and few mothers (9.25%) could not breast fed their babies at all. At the time of data collection a few mothers were continuing feeding their babies. Among the three tribes, highest Nyishi mothers (65%) continued breast feeding till two years and beyond. In all, on an average 38.33 per cent mothers in the other three tribes continued breast feeding till two years and beyond. However, 17 per cent mothers among the Konyaks could not breast feed their babies at all, which is highest among all the other three tribes.

The study also found the practice adopted to completely wean away the babies. Information in this regard is placed in table 5.9

Table 5.9

Tribe wise distribution of mothers according to the method of wean away the babies

Child Weaned By	Khasi	Konyak	Mizo	Nyishi	Total (%)
Applying some items	12	19	39	25	95 (23.75)
Child refused	05	25	18	47	95 (23.75)
Continuing breast feeding	11	40	20	13	84 (21)
Scolding	31	16	15	05	67 (16.75)
Diverting attention	17	0	08	08	33 (8.25)
Just not allowing	18	0	0	0	18 (4.5)
Criticising	04	0	0	02	06 (1.5)
Physical punishment	02	0	0	0	02 (0.5)
Total	**100**	**100**	**100**	**100**	**400 (100)**

Data revels that, highest and equal numbers of mothers (23.75%) informed that the babies refused the breast on their own and another group mentioned of applying some items on the nipples to wean away their babies. In all 16.75 per cent mothers informed of weaning away their children by scolding. Tribe wise variations shows that, among the Nyishis, highest number of mothers (47%) reported of refusing of breast by the child, it was also reported by more of the Konyak mothers (25%). Highest Mizo mothers (39%) mentioned about applying some items, especially of bitter taste and the Khasis mostly mentioned of (31%) scolding.

Feeding Pattern of Children

It has already been mentioned in previous paragraph of this chapter that, feeding of young ones is one of the very essentials for proper growth and

development of the child. Usually, the child should be fed complementary food after completion of sixth month with home made recipes. It is so as because the child should be accustomed with the taste of home made food and should like to eat the food what ever other family members eat. Moreover home made food adds variety of taste and textures to the child's diet. Such type of food should be prepared with locally available stuff. However, it is important to prepare a balanced diet choosing food from the three basic food groups. Such preparation should be rich in carbohydrates, proteins, fats, vitamins and minerals. The complementary foods initially should be given in small quantity. It should not be either of very thin as watery or very thick as solid. At the beginning the complementary food should be cereal based and should taste blend and small in quantity. Gradually, as the baby grows, the quantity and consistency should be increased. By the age of one year, the child should be able to eat family diet with less spice. Realising these, the present study attempted to find out the type, frequency of such food in the four tribal societies.

Feeding pattern below one year

It was found that, 92 per cent respondents informed of giving rice to their young ones. Among them, nearly 94 per cent reported giving everyday. Rest of them mentioned of giving sometimes and occasionally. Tribe wise variation shows that, except the Khasis, more than 90 per cent of the other three tribes preferred giving rice. It was 86 per cent Khasi mothers of this study mentioned giving rice. In all, most of them reported of giving rice everyday. Only two Konyak and 22 Khasi mothers gave it sometimes or occasionally.

Items like biscuits and bread also reported giving by 70.5 per cent mothers. Except the Konyaks, 75-80 per cent mothers of the other three communities reported giving this category of food to their children below one year. In all, it was 42.2 per cent and 45.45 per cent mothers who gave such foods everyday and sometimes respectively. A section of respondents (11.35%) gave occasionally.

The mothers of the four tribal communities, 65.5 per cent reported feeding non-vegetarian food stuff (meat/fish/egg) to children below one year of age. Most of the Nyishis (82%) reported giving these foods in comparison to the fellow communities. However, majority (63.74%) mentioned giving these items sometimes. Among the Nyishis, in all, 20 per cent of mothers gave these everyday followed by Khasis (7%) and the Konyaks (2%).

Next to non-vegetarian food items, it is the vegetable group (63%) other than roots and tubers. Altogether, 52.78 per cent respondents gave vegetable everyday, 42.46 per cent respondents said giving these sometimes and few (4.76 %) gave occasionally. Tribe wise distribution shows that, more than half of the Nyishi interviewed mothers included vegetables daily in the diet of young ones, followed by the Khasis, Mizos and the Konyaks.

The study also found that, nearly half of the study population (49.25%) reported feeding young children the commercial baby food. This is mostly the Mizos (82%) feeding such food than the other tribes under study. Fig 5.1 shows the tribe wise distribution according to the use of commercial infant food.

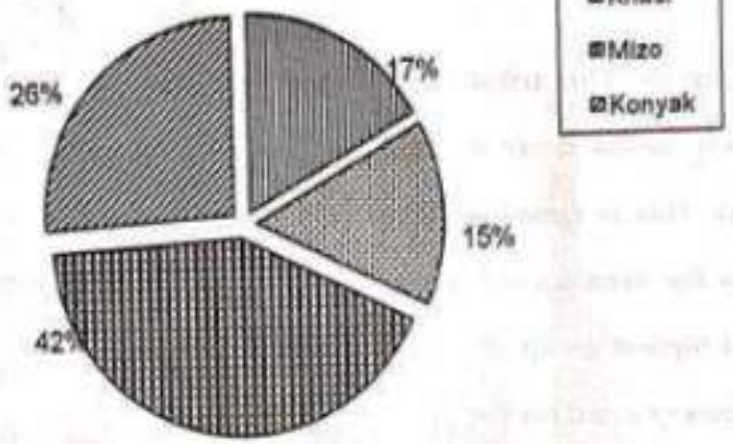

Fig. 5.1: Tribe wise distribution according to the commercial baby food fed to the baby

Data also reveals that, the mothers belonging to the Mizo tribe mostly mentioned of giving commercial baby foods daily than the other three tribes. Inclusion of pulses and legumes in the diet of the infants was found only in case of 36.25 per cent mothers. This is mostly the Mizos (68%), who included this category of food stuff. However, most of them informed giving it sometimes. Use of pulses and legumes was lowest among the Konyaks (9%). Including pulses and legumes in baby's diet was reported by 40 per cent Khasis and 28 per cent Nyishis. In all, only 13.79 per cent gave pulses every day to the infants.

Unlike the above food items, giving fruits to the children below one year of age was reported by a very small section (3.5%) of mothers. That too only the

Khasis and the Konyaks informed of feeding fruits. None of the mothers in the other two tribal communities reported giving fruits at this age of the child.

Among the four tribal communities, 57.5 per cent respondents found feeding their babies thrice a day with the food stuff described in the above paragraphs. This is mostly in Mizos (71%) who fed their babies thrice a day followed by the Konyaks (62%), the Nyishis (49%) and the Khasis 48%. In all, the second highest group (29.75%) fed their babies twice a day and few (3.5%) fed four times or more per day.

Preparation of food and Person Who Feeds

The study also explored that 62.5 per cent mothers prepare baby food separately, 27 per cent feed from a part of food prepared for adults and rest 10.5 per cent feed following the ways. Fig. 5.2 reveals the tribe wise distribution according to the food preparation of the tribes.

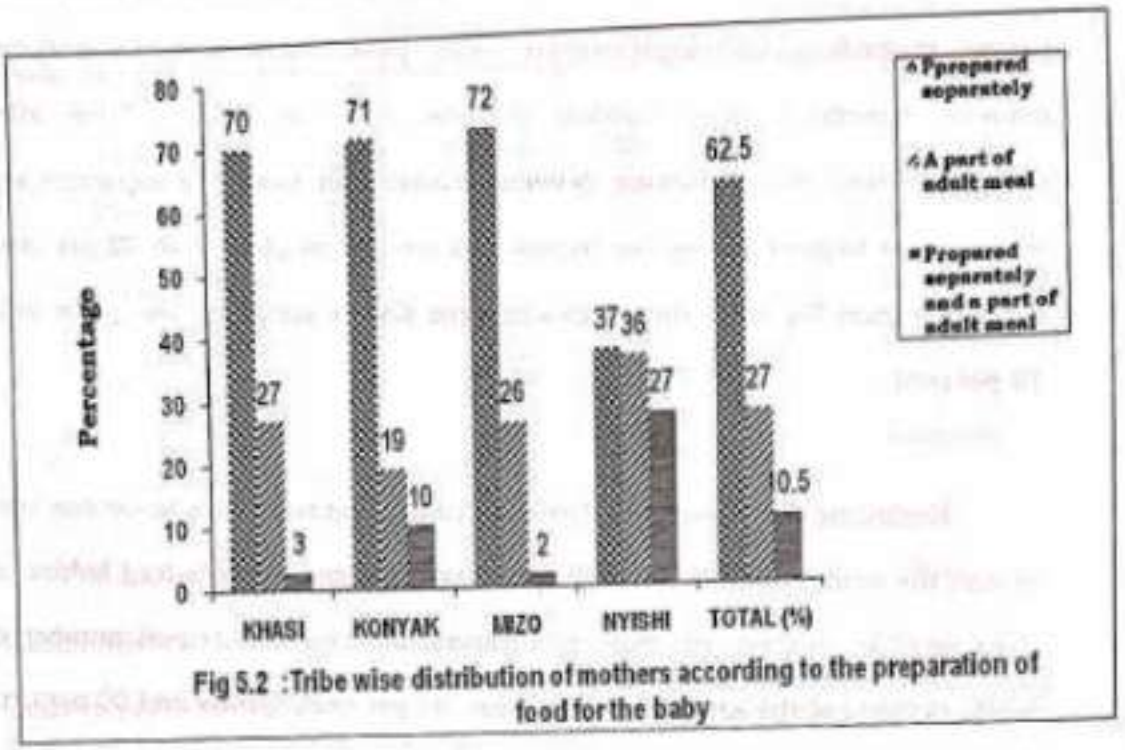

Fig 5.2 :Tribe wise distribution of mothers according to the preparation of food for the baby

The figure 5.2 shows that, except the Nyishis, on an average 70.67 per cent mothers of the other three tribes prepared food separately for their babies. Almost equal numbers of Nyishi mothers prepared food either separately or giving a portion of the adult meal.

It was also found that, majority (70.75%) of the mothers fed the young ones from a separate plate. The second majority (21.5%) fed from their own plate and rest few (7.75%) mentioned of feeding from the same plate with other siblings. The latter pattern of feeding was found highest among the Nyishis (18%).

Almost three fourth of the interviewed mothers followed scheduled pattern of feeding the complementary foods. However, most of the mothers followed demand feeding schedule in case of breast feeding. Tribe wise variations show that, following demand schedule in case of complementary feeding, it is highest among the Nyshis and are at first place with 32 per cent responses than the other three tribes and the Khasis are at the last place with 19 per cent.

Regarding the person who feeds the complementary foods below one year of age, the study found that, in all, 91.75 per cent respondents feed babies on their own. In this regard, tribe wise variations show that, equal number of mothers (98%) of the Khasis and the Mizos, 91 per cent Nyishis and 80 per cent Konyak mothers feed their young children on their own. Feeding by fathers also reported by few cases (2.75%) except in the Khasi community. Seven per cent Nyishi fathers found feeding their children. It was three and one in the Konyaks and the Mizos. Among all the four tribes, feeding children by the other family members was mostly reported by the Konyaks. Feeding very few infants by domestic help (37.75%) was reported in the Nyishis and by elder siblings was reported by the Khasis (2%).

Finding of the study showed that, majority of the study population who had children above one year was continuing feeding by elders at the time of data collection. Such cases were found highest among the Mizo society with 70 per cent mothers, followed by 53 per cent Konyaks, 24 per cent the Khasis and only four per cent in the Nyishis. Table 5.10 presents data regarding tribe wise distribution of respondents and age of children till fed by the others.

Table 5.10

Tribe wise distribution of the mothers according to the age of feeding the child by others

Child Fed by Others till	Khasi	Konyak	Mizo	Nyishi	Total (%)
Continuing feeding	24	53	70	04	151 (37.75)
1 Year	13	14	12	10	49 (12.25)
1 ½ years	22	11	06	35	74 (18.5)
2 Years	19	14	09	38	80 (20)
3 Years	22	08	03	13	46 (11.5)
Total	**100**	**100**	**100**	**100**	**400 (100)**

It shows that, majority of the mothers informed feeding children by themselves till later than one year of age. Among those highest group of mothers (20%) fed till two years of age of their children. In all, 11.5 per cent of the respondents reported of continuing feeding till the age of three years of the child by adults. Tribe wise variations show that, the trend of feeding children by adults for a longer duration was more or less same among all the four tribes.

The study also found that, for majority (73.5%) there was no any food restriction for children below one year of age. Little more than one fourth of the interviewed mothers followed some food restrictions for their young ones. Such food restriction was reported by highest by the Khasis (33%) followed by the Nyishis (32%), Mizos (22%) and the Konyaks (19%). Table 5.11 presents data relating to food restriction for below one year children.

Table 5.11

Tribe wise distribution of mothers according to Food Restriction for children below one year

Tribe Group	Name of the Food Item	No. of Mothers	Reasons for Restriction
Khasi	Chilli	33	Bad for Stomach
	Sour Food	06	
	RTE Packed Food	01	
	Chicken/Beef Soup	03	Bad for Health
Konyak	Oily Food	07	Cause Stomach Problems
	Insects	07	
	Snails	05	Difficult to Digest
Mizo	Dry Fish & Spices	06	Bad for Health
	Dry Fish, Meat, Spices	03	
	Meat /Spices	04	Difficult to Digest
	Chilli & Meat	03	Cause Stomach Problem
	Oily Food & Spices	02	
Nyishi	Any Unclean Food	15	Harmful for Stomach & Cause Diseases
	Chilli	10	Harmful for Stomach and Hearth
	Fried Food	07	Harmful for Stomach

It is seen that, chilli is the common item restricted by some of the mothers in all the three tribes except the Konyaks. Few mothers in Khasi and in the Mizos societies restricted either meat/fish or soup of these. Except the Khasis, some mothers reported restricting oily foods for the babies. In all, the few Konyak respondents also mentioned of restricting snails and insects.

Feeding Children above One Year

Like feeding children below one year of age, the study also attempted to find out the feeding pattern of children above one year of age. It was found that, in all, equal sections of (88.25%) respondents mentioned of giving rice and meat, fish, etc. to the children above one year of age. On an average,

87 per cent mothers in all the tribes under study reported feeding rice everyday. Among all the four tribes, 21 per cent Nyishi mothers reported giving most of these non-vegetarian items everyday in comparison to other three tribes. However, majority of the mothers mentioned of giving these non-vegetarian food items sometimes.

The leafy vegetables preferred by third highest group of mothers (79.75%) for feeding children of this age group. An average of nearly 45 per cent respondents included vegetables in daily meals of the children. Otherwise, rest of them reported giving sometimes (27.27%) and some (18.8%) mentioned occasionally.

Almost more or less equal per cent respondent included fruits (72.25%) and bread/biscuits (71%) in the meals of their children. Majority reported giving both categories of food stuff sometimes. In all, 12-16 per cent respondents reported giving these foods occasionally.

Use of other vegetables was reported by 61.25 per cent respondents. On an average more than one forth of the mothers found including those vegetable in the diet of the children. Out of four tribes, the Nyishis reported feeding vegetables frequently in comparison to the others.

Use of pulses and legumes and milk and milk products was less in comparison to other types of food categories. Feeding both categories of foods were reported by nearly half of the respondents. It was found highest among the Mizos. The Konyaks are at the last in this aspect.

The study also found that, majority (66.75%) of the children were fed three times a day and second highest group (22.25%) reported giving two times a day.

Introduction of alcoholic beverages (rice beer) was reported mainly by one fourth of the Nyishi respondents. However, none of them reported giving it daily. Among the Nyishis 14 per cent of the respondents mentioned of giving rice beer sometimes to their children above one year of age, ten per cent reported of giving it occasionally and two per cent gave rarely. Only one Konyak mother mentioned giving rice beer to her child rarely. Giving any kind of alcohol to children was not reported at all among the Khasis and the Mizos. Out of 26 per cent Nyishi mothers who reported giving alcoholic beverages, 13 of them informed of introducing it before completion of one year.

From the above discussion it is seen that, the studied population followed both traditional as well as modern practices in regard to child care. Although, deep bath was given to majority of the newborns, yet, a large section of the neonates were given sponge bath according to the modern medical advice. More than half of the interviewed mothers initiated breast feeding within one hour of birth, still a large group of babies are left behind from early initiation. The mothers of the Konyaks were far behind of this practice by late initiating breast feeding and giving pre-lacteal feed to their children. Practices like, inadequate exclusive breast feeding by majority of the mothers and in few cases only breast feeding beyond six months, feeding other milk/drink, use of bottle for feeding young infants, late introduction of complementary food by a

large portion of mothers, etc. show that, feeding practices of young children needs lot of attention. Again, continuing breast feeding till longer duration is a good sign. Though use of commercially available baby foods is also found, by half of the interviewed mothers, but, use of locally available food stuff for feeding young ones, is a good practice prevailing among the communities. Apart from these, the tribal children are mostly fed with rice, and other foods such as bread, roots and tubers etc.

However, use of pulses, legumes, milk and milk products, was not very common. Instead children are fed with non-vegetarian items from very young age. Though alcohol in the form of rice/millet beer is a common drink of the tribal people, but, very less interviewed mothers informed of introducing this to the children. Children are mostly fed with home-made food. Since, boiling is the main method of food preparation for the whole family, thus it tastes blend which is recommended according to the feeding guidelines, especially for young children. Besides, food restrictions were not found much in the four tribes. It was also found that most of them use detergent bar/powder while washing utensils of the child and a large section of them also sterilise the utensils. There is no any rite performed while giving rice to the children. Regarding feeding pattern, most of the mothers follow demand feeding while breast feeding is concerned and scheduled pattern of feeding in case of complementary food. Moreover, feeding children from a separate plate is a good practice while feeding children by adults till later age needs to be addressed.

CHAPTER VI

HEALTH AND HYGIENE PRACTICES IN CHILDREN

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HEALTH AND HYGIENE PRACTICES IN CHILDREN

Health care is very important at any stage of life. But it assumes much importance in the early part of life, i.e.- during childhood, since it is very tender period and children are very susceptible to any kinds of illness. Thus extra care, in terms of preventive care, gives long lasting better health by reducing mortality and morbidity than treatment. Preventive measures such as personal as well as environmental sanitation both are equally important to keep diseases away. In addition, immunising children is also an integral part of modern health care system. Therefore, an attempt was made to study such health and hygiene practices in the four tribes under study. These are discussed below.

PROTECTIVE MEASURES

Housing and Surroundings

The housing and immediate surroundings both are very important for child rearing. It is not so important, whether the house is concrete, semi concrete or made up of bamboo, thatch, etc. but proper cleanliness and adequate ventilation are necessary for the child. Lack of provision for air passage, damp unclean floors, walls, etc. is good shelter for many disease causing germs.

Likewise, dirty environment, such as garbage, sheds of domestic animals and birds, open defecation, unclean source of water, uncovered drains are good and favourable place for the disease causing microbes. The child should be kept away from such environment. Providing a healthy environment to the child is very essential.

Households

In all, 28.75 per cent households was completely concrete house. Concrete houses were found mostly in the areas dominated by the Khasis (28.75%). Kutcha houses were seen in 16.25 per cent cases of the surveyed households. Rest 55 per cent households were the combination of traditional piled and kutcha houses either with tinned roof or thatched.

It was seen that all well built concrete houses are having well ventilation with adequate light. Poor ventilation was seen in traditional houses. In the areas dominated by the Nyishis, most of the houses were having poor ventilation. Almost all traditional houses in the Konyak dominated areas had no windows at all. Generally the Konyak houses had only door. Ventilation was good in the Mizo and the Khasi houses.

Since there is no proper ventilation in the traditional houses, especially the houses of the Konyaks, the smoke of the kitchen remains inside the house for a long time, making it unhealthy for the young ones.

Drinking Water Facility

More or less majority households of the respondents were having water supplied by the Government. However, every household was not connected with such supply. Supply was seen in certain points of the villages from where the villagers carry water home. Few Nyishi households built water tanks on the hill top and made their own water connections individually. Besides, few families in Nyishi villages reported collecting water from natural streams. Use of well water by families was negligible.

Apart from government supplied water, a section of households also used stream water and rain water. Use of steam water was found highest by the Nyishi community and the highest use of rain water found among the Mizos. Use of well was not very common and very few households in Konyak tribe found using well water.

Environmental Sanitation

In all, the immediate surrounding was found clean and tidy only for one fourth of the visited households. In case of 43.75 per cent of the household surroundings found clean to some extent and in case of 31 per cent it was not clean at all. Tribe wise distribution shows surroundings of the Mizo households were (34%) cleaner in comparison to villages of the other three tribes. Whereas, immediate environment of the villages of Nyishi community was found dirtier then the other villages of the fellow tribes.

Toilet Facilities

More than half of the households of the interviewed mothers had pit latrine at the time of data collection. Use of this type of latrine was highest among the Konyaks with 75 per cent. The next highest group was the Mizos with 61 per cent. This kind of latrine was reported by 58 per cent Khasi and 31 per cent Nyishi respondents. In 116 (29%) households sanitary latrines were found. It was found highest (49%) in Nyishi households followed by the Khasi (30%), Mizo (25%) and the Konyak households (12%).

The house hold who did not have latrines (14.75%) reported of defecating in the backyard and little far away from the campus. Going to the forest was highest than the other two places. The study also attempted to find out the places, where children go for defecation. It was found that, out of 400 mothers interviewed, 57.75 per cent mentioned of latrine where they take their children for defecation. In this regard, it was found that, children who can walk properly generally go to the latrines. The second highest group (26.25%) reported using backyard for children's defecation. The other places mentioned were fields, forests and outside the household campus. Tribe wise variation shows, that 81 per cent Mizo mothers take their children to latrines for defecation and 19 per cent reported using old newspapers, polythene bags, etc. for young children which later they throw away. The Khasi mothers, apart from latrines, they take their children to the backyards. Other places were not found in these two tribes. However, taking children to the other places for defication other than latrines was found in the families of the Nyishis and the Konyaks.

Immunisation

The term immunisation derived from the word *immunity*. Immunity is the body's resistance power against the diseases causing microbes. Each and every person irrespective of age and sex, possesses its own immune system and it varies from individual to individual. Immunisation is protection against a particular disease by taking preventive measures. It entails artificial production of immune bodies or antibodies to protect the baby against invasion by certain diseases. It provides protection against specific bacterial and viral infections. The six common but killer diseases of children against which a baby can be immunised are whooping cough, measles, poliomyelitis, tetanus, diphtheria and tuberculosis. In India immunisation is one of the most important national health programmes. There is a standard schedule to immunise children against these six killer diseases and vaccines are available at free of cost in all government health centres. All children must receive these vaccination at right age.

In this study, a total of 561 children under three years of age were covered to find out the immunisation status of the children. In all, 25.31 per cent children were found receiving all primary vaccines and 44.92 per cent children were continuing immunisation at the time of data collection. It was discontinued in case of 5.7 per cent children and immunisation was not yet started in 14.62 per cent cases. Out of 561 children, 9.45 per cent children were deprived of immunisation. Tribe wise distribution of the children according to the status of immunisation is presented in table 6.1.

Table 6.1
Tribe wise distribution of children according to the immunisation status

Immunisation Status	Khasi (%) (%)	Konyak (%) (%)	Mizo (%) (%)	Nyishi (%) (%)	Total (%)
Immunisation done	17 (11.97) (13.93)	07 (4.93) (5.74)	70 (49.30) (40.46)	48 (33.80) (33.33)	142 (25.31)
Continuing	62 (24.60) (50.82)	72 (28.57) (59.02)	86 (34.13) (49.71)	32 (12.70) (22.22)	252 (44.92)
Not yet started	20 (24.39) (16.39)	26 (31.71) (21.31)	04 (4.88) (2.31)	32 (39.02) (22.22)	82 (14.62)
Discontinued	14 (43.75) (11.48)	09 (28.13) (7.38)	-	09 (28.13) (6.25)	32 (5.7)
Not received at all	09 (16.98) (7.38)	08 (15.09) (6.56)	13 (24.53) (7.51)	23 (43.4) (15.97)	53 (9.45)
Total	**122**	**122**	**173**	**144**	**561**

Data presented in table 6.1 reveals that immunisation status was highest among the Mizos with 40.46 per cent followed by 33.33 per cent children of the Nyishis. It was very low among the Khasis and the lowest among the Konyaks. However, among the children whose immunisation was continuing, in 59.02 per cent Konyak and 50.82 per cent Khasi children were continuation immunisation. It was 49.71 per cent among Mizos and 22.22 per cent among Nyishis. Children whose immunisation was not yet started till the time of data collection, was found highest among the Nyishis, followed by the Konyaks, Khasis and the Mizos. Discontinued Immunisation was found highest among the Khasis than the fellow tribes. It was nil in the Mizos. The data also showed that, children not receiving immunisation were highest among the Nyishis than the other tribes. In this case next to the Nyishis is the Mizos. It was lowest among the Konyaks followed by the Khasis.

PERSONAL CLEANLINESS

Bathing

Bathing is one of the most important aspects of personal hygiene. Bathing at least once in a day keeps the body and mind healthy. Daily bathing should be habituated since childhood.

Bathing below one year: In this present study, it was found that regular bathing was given to younger children who are below one year of age. Giving daily bath to the children at the age of below two months varies among the four tribes.

It is mostly the Mizos (100%) who mentioned giving daily bath to the children of this age group followed by the Konyaks (80%), Nyishis (60%) and the Khasis (36%). Rest of the mothers in the other three tribes, mentioned of giving bath to their children of this age group in every after 1-2 days or once in a week. More or less, almost all children belonged to the age group between 2-12 months were given bath everyday.

Bathing above one year: Unlike children below one year of age, children in the age group of 1-3 years were getting bath less frequently.

Table: 6.2

Tribe wise distribution om the respondents according to the bath given to children above one year

Bath given	Khasi	Konyak	Mizo	Nyishi	Total (%)
Every alternate Day	57	43	56	38	194 (48.5)
Twice a week	27	29	32	38	126 (31.5)
Once a week	-	15	-	16	31 (7.75)
Not given any bath	-	13	-	07	20 (5)
Every day	16	-	-	-	16 (4)
More than twice a day	-	-	12	-	12 (3)
When ever the child gets dirty	-	-	-	01	01(0.25)
Total	**100**	**100**	**100**	**100**	**400 (100)**

Table 6.2 presents data relating to the data pertaining to frequency of bath given to the children between 1-3 years, shows that, almost half of the mothers (48.5%) reported giving bath to their children of this age group, every alternate day, Next highest group (31.5%) per cent mentioned twice a week. Some (7.75%) were given bath once a week. Only 16 per cent out of 100 Khasi mothers reported giving daily bath to their children of this age group. Contrary to these, 12 per cent Mizo mothers mentioned giving bath twice a day and except 16 per cent the Khasis, none of the other three tribes reported giving daily bath. In addition, some Konyak (13%) and Nyishi mothers (7%) reported of not giving bath to their children of this age group. However, the respondents reported using soap, whenever they give bath to their children between 1-3 years.

From the above description, it is observed that, younger children are getting more attention in respect of receiving frequent bath than the older ones.

Cleanliness of Body Parts

The study also attempted to find out the cleanliness of various body parts of children of the tribes under study.

It was observed that in the study population, children of younger age (below one year) are generally cleaner than the children who are above one year. This is so, because young children are carried by mothers or other family members most of the time and there is very less scope to get dirty. Only some children of this age group were having cold at the time of data collection showed blowing nose and dirty cheeks. However, in some cases smell of urine was found from their clothing. In this aspect, the Khasi and the Mizo children were observed enjoying better cleanliness than the Konyaks and the Nyishis.

Children generally above one year of age who can walk independently get dirty soon. Thus, children between 1-3 years are found dirtier than the younger ones. The dirtiest part in the body was the nail. Majority of the children displayed dirty nails. Children in Nyishi and the Konyak tribes were mostly having untrimmed and dirty nails. Next to nails, hair of children was the dirty part in body. The hair of children were not trimmed, oiled and combed properly. The Nyishi children were found more untidy in regard to hair. The children of the Khasi and the Mizos were bit cleaner. But some Mizo children were found their

hair dyed by the elders. After the nail and hair, the nose was the next dirty part of the body. Children having runny nose playing with dust outside with other children get dirty very soon and thus the skin of their face becomes very dirty. Again, the Khasi and the Mizo children were in a better position in comparison to the other two tribes. In all, the eyes of children were found more or less cleaner than the other parts of the body.

The clothing of most of the children in the Konyak and Nyishis were found dirty. Clothings of the Mizo children were clean and tidy among all the four tribes. The Khasis are in the second position. The smell of urine was found in the clothings of the Nyishi children. However, use of hair band, lipstick, nail polish by the girl children was observed. Such kind of fashion among girl children was found more among the Khasis. Although, cotton dresses were found wearing by the children, yet synthetic fabric was also found in use.

CURATIVE MEASURES

Curative measures or treatment of diseases and ailments denote the measures that they adopt during illness, so that the child gets relieved and come out of the danger. Besides, modern medical treatment, people in many societies also follow their own traditional measures and practices prevailing from generation to generation. At times, many of them try those measures one after another or simultaneously two or more than two measures at a time.

In this present study, it was found that, majority of the respondents preferred to visit a physician when their children fall sick. In all, an average of 80 per cent of the studied population informed of approaching to a physician. Among the four tribes studied, all mothers of the Mizo community visited the Physician for seeking treatment of their children. More than 70 per cent of the respondents of the other three tribes mentioned of seeking treatment from the physician. However, except the Mizos, a section of respondents of the other three tribes also consulted traditional health practioners. Some of the Nyishi mothers (18%) reported more than the other two tribes. Besides, bringing medicine directly from the pharmacy was also reported by 10 per cent of the respondents. In all, nearly one fourth of the respondents informed of organising prayer in addition to other means of treatment for the early relief from the health problems. It was mostly the Nyishis (73%) who organised such prayer, followed by the Konyaks (16%) and the Khasis (4%). None of the Mizo respondents reported holding of any type of prayer. In all, 22 per cent mothers of the Nyishi tribe mentioned of doing nothing for treatment of their children. Children of those mothers did not have major health problem. Four respondents in the Konyak tribe too answered the same.

Home Remedies of Common Childhood Ailments

In every household and society, home remedies to common childhood ailments are very common. However, it may vary from society to society and place to place. Generally, home remedies are used for treating minor ailments like common cold, cough, fever, stomach ache, etc.

The present study aims to find out the home remedies in practice among the four tribes. It was found that, except the Mizos, mothers of the other tribes used home remedies for treating their children at the initial stage of illness. The most common home remedies that the respondents followed is presented in table 6.3. however, none of the Mizo respondents mentioned of any home remedies, except keeping the children warm during fever.

Table: 6.3
Home remedies for various illnesses

Illnesses	Khasi	Konyak	Nyishi
Common cold/ cough	Keeps the children warm and give warm water to drink	Mustard oil mixed with kerosene and applied on the chest	Given juice of ginger, basil leaf and honey
Fever	Fried garlic with oil is given to eat.	Cold compression on forehead	Cold compression on forehead
Diarrhoea & Dysentery	i) Given lemon water to drink ii) Given ORS	i) Tender guava leaves is given to eat ii) Opium (Kani) is fed.	Tender guava leaves given to eat.
Measels	-	-	-
Stomach Ache	Wood ash – rub on the stomach	i) Kind of shrub (Kaheng) with mint like smell is fed. ii) Lime water to drink	"Rangku" (Root of a tree)- given to eat
Cut	Leaves of Merry gold tree rubbed and applied on the wound.	Pour boiled and cooled tea leaves and its water on the wounds.	Apply- "Pasu Payu" (leaf of a tree)
Burn	Apply tooth paste on the wound	-	-

Table 6.3 reveals that, except measles, more or less for the other ailments mothers mentioned of having some home remedies. It is also clear from the above table that, home remedies are not alike among all the tribes. In case of fever and diarrhoea, home remedies are almost alike in the Konyak and Nyishi

communities. Home remedies in case of burn injury, only the Khasis have reported.

In every society restricting certain food items during sickness is a common practice. Such kind of food items which may either obstruct the healing process or may worsen the condition.

The present study too attempted to find out such restriction during illness of the children and found that, the practice of food restriction was prevalent among all the tribes. Table 6.4 presented data in this regard.

Table: 6.4
Tribe wise distribution of food items restricted during illness of the children

Illnesses	Khasi	Konyak	Mizo	Nyishi
Fever	Egg, banana, citrus fruits, sweets, and ice cream	Cold water and any oily food	Rice and cucumber	Cold food & cold water
Diarrhoea	Sour fruits, egg meat and potato	Biscuits, chilly and meat	Oily foods, fruits, milk, spices	Spicy, chilly, any meat, any fried items and green leafy vegetable
Cough & Cold	Egg, banana and dry fish	Cold water , sweets	Any cold food	Sweets, cold water and salt
Measels	-	-	-	-
Stomach Ache	Potato, meat & egg	Biscuits & sweets	Fruits, spices and meat	Any meat, chilly, green vegetable and food they feel hot.
Vomiting	-	-	Sweets	Sweets and egg

From the table 6.4 it is obvious that, except measles, there are dietary restrictions for the sick children in all the tribes.

Food items such as cold water, cold food, cucumber, ice-cream, etc. are restricted during fever is mainly due to the fear of getting aggravated the

condition. Rice, oily foods, sweets, etc. are restricted because they believe that these items will be difficult for the child to digest. Food stuffs avoided during diarrhoea, dysentery and stomach ache are because of difficulty in digestion and flatulence. Likewise, foods avoided in cold and cough are due to the fear of further deterioration of the condition and also because of delay in healing. Only the Mizos and Nyishi mothers mentioned about restricting few items in vomiting.

Health Status of Children

The health status of children generally indicates the child's overall well being. Broadly, the mortality and morbidity and general nutritional status are the main indications to know the overall health status of the children of a particular society.

After understanding the preventive as well as curative measures of the studied population, it becomes imperative to know the health status of the children under study. Therefore, information relating to childhood mortality, types and frequencies of ailments suffered by the children and the nutritional status of the children below three years of age were gathered. Findings in these aspects are presented in the following paragraphs.

Childhood Mortality

The childhood mortality is an important index of assessing the health of the children in any society. The infancy and early childhood period are very

vulnerable to any danger. In India, childhood mortality rate is very high in comparison to the developed country. The Infant Mortality Rate (IMR) refers to the deaths of babies in a year before completion of one year of age per 1000 live births. However, in this present study, data was collected in regard of total number of children's death occurred in studied population before completion of five years of the child.

Table 6.5
Tribe wise distribution according to the number of Child Mortality Status of the tribes

Age Groups	Khasi (n)	Konyak (n)	Mizo (n)	Nyishi (n)	Total (n)
0 to 1 week	12	04	0	09	**25**
1 week to 1 month	04	03	0	01	**08**
1 month to 12 months	08	06	0	07	**21**
12 months to 36 months	05	04	0	08	**17**
36 months to 60 months	02	04	0	04	**10**
Total	**31**	**21**	**0**	**29**	**81**

Data presented in table 6.5 shows that there are incidences of childhood deaths at various age before five, of the studied population. In all, a total of 81 childhood deaths reported among the 400 respondents of the study. Tribe wise distribution shows that, there was no any childhood death reported among the studied population of the Mizos. Data shows that, among all the ages, childhood death was more in the early part of life i.e. within one month (33 n) of birth. Incidence of childhood mortality was highest among the Khasis than the other three tribal communities. The trend of childhood death decreases as the child

grown. It was also tried to find out the causes of these deaths and most of the mothers informed of these deaths were due to sickness of their children. However, others could not tell the actual name or any signs and symptoms of the sickness. The illnesses, the respondents mentioned were like fever, diarrhoea, breathing problem, vomiting, measles, malaria, accident, too much crying by the child, very weak even to suckle breast milk, typhoid, pneumonia, turned blue after birth, accident, etc. It was found that, most of the mothers were ignorant of the actual illness of their children. Here, it may be pointed to the deep bath given to a large section of new born immediately after birth because of which babies would have died due to hypothermia, as reported, in few cases of the Khasi and the Konyak new born babies, cold water was used to give bath to the neonate. In addition, it was observed in the study areas that the grown up children are left with their elder brothers/sisters/neighbourhood children and the parents go out to work. Perhaps the children were not attended in the beginning of such illness or the parents were ignorant about the severity of the illness. Tribe wise variations show that the Khasis had maximum childhood deaths followed by the Nyishis and the Konyaks.

Morbidity

Information gathered regarding morbidity of the children in the studied population shows that, a large section of children suffered from either one or more illness at least once in their lifetime till the time of data collection. Out of 561 total children 459 children suffered from illness.

Table: 6.6
Tribe wise distribution of children according to the frequency of childhood illness

Illness	Khasi		Konyak		Mizo		Nyishi		Total	
	Once	Twice	Once	Twice	Once	Twice	Once	Twice	Once	Twice
Cold & cough	31	24	19	06	11	-	34	26	95	56
Diarrhoea	45	12	34	09	08	-	26	21	113	42
Fever	36	24	21	04	16	-	14	04	87	32
Malaria	-	-	-	07	02	-	-	-	02	07
Measles	01	-	04	-	-	-	11	04	16	04
Stomach ache	-	-	02	-	-	-	-	-	02	-
Pneumonia	-	-	-	-	02	-	-	-	02	-
Asthma	-	-	-	-	1	-	-	-	1	-
Total	**113**	**60**	**80**	**26**	**40**	**-**	**85**	**55**	**318**	**141**

Data presented in table 6.6 reveals that children mostly suffer from diarrhoea, cold and cough and fever than the other ailments. Tribe wise variations show that, comparatively highest number of the Khasi children had suffered from once or twice from any of the sickness, followed by the Nyishis, Konyaks and the Mizos. It would be worth mentioning here that, whatever the illness is, none of the Mizo child had second attack till the time of data collection. However, none of the children had suffered more than twice with any of the illnesses.

Nutritional Status

Growth is an increase in size and weight and rapid growth takes place in the first few years of life. It is very important to see that the child should attain growth to its full capacity. All this stage, if growth failure occurs, it becomes difficult to recover the deficit what the child has already lost. There are various ways to measure growth, but the most sensitive and accurate measure is checking weight gain. Growth of a child has a direct link with its nutritional

status. In other words, checking growth regularly is an important index to know the nutritional status of the child. Thus, it is also important to know the nutritional status of the children as because nutritional status during childhood assumes importance of the health of the adult life.

In this present study, out of 561 children below three years of the respondents, 516 were weighed. Rests were not present at the time of data collection. All the weights were plotted in a standard chart. The growth chart that is mainly meant for the Indian children was used to see the growth pattern and nutritional status.

Table: 6.7
Tribe wise distribution of children according to the nutritional status of children

Nutritional ststus/Grades	Khasi	Konyak	Mizo	Nyishi	Total
Normal	80 (68.38)	95 (78.51)	126 (88.11)	106 (78.52)	407 (78.88)
Grade-I	24 (20.51)	20 (16.53)	15 (10.47)	19 (14.07)	78 (15.15)
Grade-II	13 (11.11)	03 (2.48)	02 (1.4)	06 (4.44)	24 (4.65)
Grade-III	-	03 (2.48)	-	03 (2.23)	06 (1.16)
Grade-IV	-	-	-	01 (0.74)	01 (0.19)
Total	**117**	**121**	**143**	**135**	**516**

Data presented in table 6.7 shows that, more than three fourth of the children were normal. Rest of them were in various degrees of undernourishment. Tribe wise analysis shows that, in all, the highest Mizo children (88.11%) were in normal grade, followed by the Konyak and the Nyishi children who display almost equal section (78.51% and 78.52% respectively) of children in normal grade. Comparatively, less number of children in Khasi community (68.38%) were in normal grade of nutritional status than the other threes. There was no case of third grade undernourishment in the Mizo and the Khasi communities. Few

incidences were reported among the Konyaks and the Nyishis. Except one in Nyishis, there was no severely undernourished child. Although, the data presented in table 6.7 shows that majority of the children were in normal state of the growth chart, yet, the trend of their nutritional status right from birth could not be found as growth curves were not available. Collected data indicates that, though majority were in normal grade, some children displayed one or more other sorts of other undernourishment such as-protrude belly, anaemia, lightening of hair, dryness of skin, etc. However, in comparison to national level data of NFHS-3, tribal children under study are seems to bein better position.

The findings mentioned in the above paragraph displays a mixed pattern of health and hygiene practices among the study population. Out of four tribes under study, comparatively the Mizos are in better position from the health and hygiene practices point of view, than the other three tribes. The housing and immediate surrounding of the Mizo households were comparatively better. Better immunisation status, no incidence of childhood death of the respondents, less frequency of illness of the children, highest normal children in nutritional grades etc. place the Mizos on top. However, in using sanitary latrines, the Mizos were behind than the Nyishis.

CHAPTER VII

SOCIALISATION AND EDUCATION

CHAPTER VII

SOCIALISATION AND EDUCATION

The term socialisation refers to the process by which the child is being prepared to be a member of the society. Every society is governed by its own cultural traits, motives, values, rules and code of conduct. The child has to pass through all these to be an acceptable member of the society. Through socialisation the child is trained about the norms and rules of the society and the child acquires the attitudes and values of that culture to adjust in that socio-cultural environment with culturally approved behaviour. It is a practical problem of child rearing by which the child is prepared to make himself an adequate adult member of the society to which he belongs. There is a very close relationship between the parental practices in the upbringing of children and the behaviour patterns of adults. There are two ways in which unique types of thinking, feeling and mode of acting of a particular group of people get transmitted to the next generation (a) directly and formally as in educational programme and (b) informally through interactions between parents and their children which occur in the course of child rearing. These interactions include the parents' expression of attitudes, values, interests and beliefs as well as their care taking and training behaviour. Some of the informal learning arises though

interactions with relatives, neighbours and peer groups and teachers (Kuppuswami, 1980).

In view of the importance and significance of socialisation in child learning and development of the child, data were collected to understand the process of socialising the child in the tribal population of the study. Since, the children below three years do not go for formal education, therefore, in this study the term education mainly caters to the training or teaching child about different behaviours and aspects of socialisation only in the home and nearby social environment. The mothers were interviewed in various aspects such as process of name giving, toilet training, disciplinary measures, story telling, etc. In addition, observation was made in regard of play activities, parent-child interactions, interaction with family members, etc. In this chapter the different aspects of socialisation of the children are presented.

Name Giving

In every society each and every child is named to give him or her identity in the society. Organising a function or ceremony on the occasion of giving a name to the child is very common in many societies in India. In this present study too, in all, 34.25 per cent mothers informed of performing name giving functions. It was highest among the Konyak (92%), followed by the Nyishis (28%); Khasis (10%) and the Mizos (7%). Since the tribal groups under study were Christians, nobody followed any traditional rituals while naming their children. They organised prayer meetings for the child after birth either at home

or at church and name was given to the new-born. Information was collected regarding the person who named the child and is presented in table 7.1

Table: 7.1
Tribe wise distribution according to the information regarding the person who named the child

Person who Named the Child	Khasi	Konyak	Mizo	Nyishi	Total (%)
Grand Parents	08	61	72	15	156 (39)
Priest / Religious Leader	22	20	11	43	96 (24)
Parents	13	18	11	35	77 (19.25)
Maternal Uncle	50	01	03	02	56 (14)
Anybody				05	05 (1.25)
Not Yet Given	-	-	03	-	03 (0.75)
Total	100	100	100	100	400 (100)

It is seen that, in majority of the cases (39%) children were named by their grand parents. Next highest group of children (24%) were named by the religious leaders. In 19.25 per cent cases, children were named by the parents. Tribe wise variation shows that, among the Konyaks and the Mizos, in majority of the cases children were named by their grand parents. Among the Nyishis, it was mostly by the religious leaders and it was maternal uncle among the Khasis.

Data shows that, 33.25 % of the children were named either soon after birth. Thirty eight per cent babies were named after the first day but, within one week of birth. However, some of children were also named later than a week. Besides, in 5.5 per cent cases, parents and family members were a bit reluctant in early naming.

From the above it is seen that, though the studied population did not have any elaborate name giving ceremony, but most of them seem to be conscious about the importance of early naming of the children. Involvement of kins and community members in naming the children in all the four tribal societies is note worthy as a part of socialisation of the children.

Family, Neighbourhood and the Child

The family is the first basic unit of a society and the home is the first workshop in which the child's socialisation begins. The new born first experiences the warmth and value of love at home. The child also experiences and learns the dealings with other family members. The child who cannot get along with the other siblings and elders in the family may have difficulty in getting along with his peer group. The traditions, customs, beliefs, etc. of the society is at first learnt by the child in the environment of home.

Next to the environment at home, is the neighbourhood where the child gets chances to be acquainted with the other members of the society. The child comes into contact with the other adults, children and peers in the neighbouring environment. He or she learns many things from the neighbourhood through these social agents. Such learning sometimes is advantageous and sometimes disadvantageous.

Healthy and cultured home and society are, therefore, very important agents to play significant roles in socialising process of child development. In

this study attempt was made to understand the home as well as the neighbouring environment of the studied tribes and are discussed below.

Family and the Child

Within the family atmosphere, parents are the main socialising agents and the child learns about himself, his other siblings, parents and their expectations from him. The process of instruction in the family is sometimes planned and sometimes incidental, but either way, the family culture is transmitted to the child. The interaction between parents and the child takes place in various aspects of care taking such as – feeding, bathing, playing, care during illness, etc. Proper and adequate interaction between parents and children promotes physical as well as mental growth of the child.

Present study observed that, in majority of the cases parents do the most needful towards their child and allow them to grow naturally without extra stimulation for growth and development. Young children get attention when they cry. In many cases it was seen that mothers, especially in nuclear families, perform their household works such as cooking, washing, etc. and even during working in cultivation field, carry their babies on her back. Very few mothers in the Mizo and the Khasi societies sing in a low voice while walking around in rhythm to make the baby sleep. Otherwise in most of the cases, mothers were not found singing any lullaby for any of her children. Children who are little grown up and can walk generally stays with other older children and get attention of the mother only when they are hungry, sleepy or unwell. Otherwise,

parents were not found giving extra attention to their children by talking, singing, playing with them during care giving activities. It was also observed that, fathers' involvement was much less in all the care giving activities than the mothers. They are generally out of the home in most of the time during the day. Thus, interaction between father and the child is only for some duration in 24 hours. Apart from spending his time with their children, fathers were found affectionate. However, the love and affection towards their children are internal and not much shown openly. This is only because of the nature of the tribal people of the selected communities. However, some of the mothers while breast feeding, observed doing cuddling, talking, mild messaging the body, etc. to their young ones. Likewise, few fathers of the babies, of course found doing hugging, cuddling, baby talking, etc. with their children. Although, nearly 40 per cent informed of playing with children, yet, frequency and duration are very less. This is because of lack of time on their part. Moreover, since the mothers mostly feed, bath, clean their children, they get more scope to deal with the child than their counterparts. Besides, it was also seen that, families who were economically sound, or the child's father has a job, children get a little extra care than the rest of the families. In addition, the reason of lack of time of not giving much attention to their children in these regards are also due to ignorance of importance of such activities, not feeling to do so because of tiredness or other problems and also because of the feeling of too young to play (especially infants).

Parents' attachment with their children is more in nuclear families than the joint families. This is so as because in nuclear families parents have the

compulsion of taking care of their children. Whereas, in joint families, parents to a large extent depend on the family members. The parents in the tribal communities, although their interactions with their children are not so intense in one hand, yet, they are also not very strict, rough, rude or aggressive to their children in the other.

In general, it can be said that, the parent-child interaction among the surveyed tribal population is average. It is neither very intense nor very neglected. People allow their children to grow freely and naturally and whenever needs arise they take care of those.

Children in joint families are very much attached with their grand parents. Generally, if the grand parents are old enough and unable to go for work and stay at home or within the campus they spend time with their grand children. It was also observed that, many elder siblings fasten their younger brother or sister on their back and go around to play. Besides, the lady members in the family fulfils the needs of the child- such as feeding, sleeping, cleaning, bathing, changing garments, etc. Therefore, the children do not feel much about the absence of their mothers. However, the mothers of breastfed babies do not spend much time away from their babies. Children in nuclear families do not get such environment. In this case, either the child is taken to the work place or the mother stays back at home. In few cases, a helper as baby sitter was also seen in nuclear families, especially among the Khasis.

A general impression in this aspect is that, the overall interactions between the family members and the child is very cooperative. Even the older children do not feel much annoyed to carry their younger brothers and sisters with them.

Neighbourhood and the Child

Next to the home environment, the neighbourhood plays a very crucial role in child rearing. A very positive trend was observed regarding the interactions between the children and the neighbourhood. As mentioned elsewhere in previous para, that the young ones stay and play with the older children in the neighbourhood. The older children while playing marble, ball etc. keep an eye on the young ones. It was observed that, most of the older children unknowingly develop the sense of responsibility of protection towards the younger ones. In addition, any adult in the neighbourhood pay attention whenever need arises in absence of the mother of the particular child. As a whole, a bonding is seen between the children of this age group and the neighbourhood.

Disciplinary Measures

The term 'discipline' primarily refers to control, especially over the undesirable behaviour of children. In other sense, it is any kind of influence designed to help the child to learn the socially approved behaviour. Discipline does not mean giving punishment and imply of strict rules on children. The

three main elements of discipline are education, reward and punishment. By birth, the child does not come with the sense of judging behaviour that are socially approved or disapproved. This tender human bud needs to be trained with great care, blending the three features of discipline in right proportion and at the correct age. Rules in educating or training the child are very essential because they acquaint the child with the standards of conduct acceptable to the group and they restrain the undesirable behaviour (Kuppuswami, 1980:186). Likewise, giving reward or praising the child is also important, because it promotes and facilitates learning through brightening and contributing healthy emotional growth. Again, punishment is also needed to make the child understand about his misconducts. In both the cases, it should be kept in mind that, there must be objectives in rewarding or punishing the child and should be explained about it, otherwise the child may be confused.

Understanding these, attempt was made to find out the disciplinary measures adopted by the parents to train their children. Findings of these are explained below.

(a) Reasons of Disciplining

Disobedience was the main reason amongst all others for which most of the children are taught discipline. In all, 44.25 per cent respondents mentioned this reason of disciplining their children. Next to this, it was the reason of fighting with other siblings, reported by 19.25 per cent respondents. This was followed by telling lies (17.25%), disturbing in work (8.25%) and roaming around (5.8%).

(b) Measures of Discipline

Nearly 85 per cent respondents reported punishing their children for the aforesaid reasons. All mothers mentioned of scolding their children by the elders. In all, it was mostly the mothers (76.02%) who scolds the children. Scolding children by the father was reported only by 14.04 per cent respondents. Besides, a small section of children were also scolded by their uncles or aunts (8.19%). In very few cases, grand parents reported scolding.

In addition to scolding, children were also beaten up by the elders. Adopting this category of disciplinary measures also mostly done by the mothers (42.25%). In 16.75 per cent cases children are beaten up by both the parents. However, 32 per cent respondents do not beat up their children. In majority of the cases, beating children up quite often was due to disobedience. Apart from this, children were beaten up sometimes or occasionally for one or the other reasons. However, parents were not found to be very rude towards their children. Strict rules and regulations for disciplining their children at home environment are not observed much. Rewarding or praising children arises only when they can perform certain tasks such as standing, walking, jumping, throwing, etc. especially for the first time. Apart from these milestones, children are not praised much. Generally, the parents, in all the four tribes under study more or less feel that, their children will learn things naturally by themselves, as they grow.

(c) Toilet Training

Toilet training refers to the habit, that the child has to develop to control his bladder as well as bowel. Although, there is no specific time of starting toilet training, yet, it assumes importance that the child learns to control over these activities. Generally, it occurs as soon as the child attains maturity. Toilet training if started too early may exert some adverse effect such as – negativism, aggression or timidity. Contrary to this, if the child is not given training on proper time, the child will not be able to control the organs of eliminations and may develop complexity in front of peer group. Therefore, the mother should understand the readiness of the child for it and should train accordingly.

Data reveals that, majority (54.5%) of the respondents started giving training on bladder control before six months of the child. In all, 39 per cent respondents started bladder control training in varied times between the age of 6-24 months. A section of respondents found a bit reluctant in imparting bladder training to their children. Out of all the four tribes studied the mothers in Nyishi community were found little relaxed in imparting toilet training than the other three tribes. It was found that, majority (53.03%) of the children were able to control bladder between the age of 6-12 months. Data also reveals that, the Mizo and the Khasi children learnt bladder control earlier than the other two communities. In all, bladder control was little late (18-36 months) in 22 per cent Nyishi children, whereas these per centages were three, five and two in the Khasi, Konyak and the Mizo tribes respectively.

Unlike bladder control, giving training towards control of bowel was little late. In all, bowel training given before six months of age was reported by only 19.25 per cent respondents. However, half of the (50.75%) respondents reported giving bowel training before one year and 44.75 per cent reported of training on it after completion of one year. In case of 4.5 per cent, the respondents did not give bowel training to their children till data collection and feels that, they will learn on their own as they grow. Mothers, who had given bowel training after one year, were highest among the Khasis (75%), followed by the Nyishis (58 %), Konyaks (28%) and the Mizos (18%). Bowel training given after two years was highest among the Nyishis (15%) in comparison to others. These per centages are seven per cent among the Khasis and 6 per cent among the Konyaks. None of the Mizo respondents found giving bowel training after two years of age. Majority (42.75%) of the children learnt controlling bowel between the age of 12-24 months. For the next highest group (24%) it was in the age group of 24-36 months.

The mother generally understands her young child's tendency of toileting and takes the child out on time. In addition, on regular intervals she takes the child out and makes some 'sizzle' sound to stimulate the child, by holding him / her in a particular position. In most of the cases, toilet training was given in the court yard for the younger ones and the grown up children who can walk and can express verbally are taken to a bit far or to a latrine. In very few cases among the Mizos and the Khasis use of potty was seen for bowel training. Nowhere, giving punishment for toilet training was seen or reported. Mothers generally wait till the child's maturity to this act and thus, there is no any hard

and fast rule for toilet training. They give enough time to their children to develop toilet habits. However, cases were also found, where children passes urine when the mother or others carry the child on back and hence smell of urine was found while interviewing the mother or while weighing the child.

Play

Play begins at the very early stage after birth. It is a spontaneous activity through which the child gets joy and satisfaction. He becomes familiar with the immediate surroundings through play. The child learns all these by touching, seeing, listening to sounds, tasting, pulling and pushing, breaking, etc. by using his senses. According to Jean Piaget the period from birth to two years is known a sensory motor stage and generally in this period the child learns about his environment through motor actions coordinated with his perceptions (Goonesinghe, 1984:91).

In our country play is not given much importance, especially among those who are economically poor. Due to ignorance and misconception, for many people play and games are luxurious items. A section of children are engaged in bread earning since their early childhood. Many of them are thus deprived of these play activities. Whereas, play activities are important for each and every child for its all-round development. Combination of different play activities like-outdoor, indoor, solitary, group, free, guided, etc. contribute a lot in physical, intellectual, emotional and social development of the child.

The present study collected data on types of play activities of the children, play materials attitude of parents towards play, etc. these are briefly narrated below.

Types of Play Activities and Play Materials

Children in the age of below three years of the study population mostly observed playing free plays and usually in groups. Children of this age found generally playing ball, toys, locally made carts, etc. by carrying, throwing, pulling, pushing, jumping, running, kicking, manipulating to explore the play materials, etc. Some children also found playing with water, when they were given bath. Some of them also followed washing clothes by their mothers. Besides, the elder sibling found trying to bath their younger ones, while playing with water at the time of bath. The children below three years too try to follow them. However, very young infants are restricted to such activities. Children also play marbles, pushing a small metal wheel with a metal ended rod, pulling or pushing a locally made cart where one child will be sitting on it, etc. (Photographs relating to play materials and activities are given in .....) actually these play activities are mostly played by the older children and the younger ones observe and try to participate. Usually, the young children, who cannot walk, are not allowed to go freely. But, children who can walk have little freedom to play with the older children nearby. Such children very often get dirty since they play with dust and other natural materials available nearby.

In all, little more than half of the households visited possessed some play materials for the children.

Table: 7.2

Tribe wise distribution of the respondents according to the Play materials given to children

Play Materials	Khasi	Konyak	Mizo	Nyishi	Total (%)
Market	41	24	57	34	156 (39.0)
Market and home made	36	24	37	22	119 (29.75)
Not given any	11	23	03	28	65 (16.25)
Home made	12	29	03	16	60 (15.0)
Total	**100**	**100**	**100**	**100**	**400 (100)**

Data presented in table 7.2 reveals that, in all, 83.75 per cent of the study population reported supplying play materials to their children. These play materials were mostly procured from the market (39%). Next highest group (29.75%) reported providing play materials both procured from market and prepared at home. Providing play materials from the market was found highest among the Mizos (57%), followed by the Khasis, Nyishis and the Konyaks. Whereas, use of only home made play materials was reported mostly among the Konyaks (29%) than the fellow tribes. However, nearly equal section of the Mizos and the Khasis (37% and 36% respectively) reported providing play materials procured both from the market and home made. Almost equal section of the Konyaks (24%) and the Nyishi (22%) respondents also mentioned providing both market and home made play materials. In all, 16.25 per cent respondents reported of not providing any play materials to their children. However, this group of children get chance to handle play materials when they are in groups.

It was observed, that, parents generally do not have extra time to play with their children. They play, at the time of feeding, bathing, etc. and sometimes when ever they are at home. In true sense, parents were found ignorant of importance of play, but they generally do not resist children from playing. However, young ones are restricted with vigorous play activities such as cricket, football, etc. with older children. It was also observed that whenever there is time and the child wants to play, the parents, elder family members and neighbours cooperate with the children. This type of attitudes of parents and other adult members was observed more or less in all the four tribes.

Telling Stories

The study also tried to find out whether the parents or anybody in the family tells stories to their children or not. In this context, it was found that, nearly three fourth of the respondents reported telling stories to their children. It is mostly the mother (39.5 %) who tells stories to their children.

Table: 7.3

Distribution of tribes according to story telling activity

Stories told by	Khasi	Konyak	Mizo	Nyishi	Total
No story telling	09	34	46	17	106 (26.5)
Mother	57	24	19	58	158 (39.5)
Father	06	03	06	12	27 (6.75)
Both	16	04	27	10	57 (14.25)
Grand parents	12	29	01	02	44 (11.0)
Uncle/Aunt	-	01	01	-	02 (0.5)
Elder siblings	-	05	-	01	06 (1.5)
Total	**100**	**100**	**100**	**100**	**400 (100)**

Table 7.3 displays data relating to the persons who narrate story to the young ones. Besides the mothers the next highest group (14.25%) comprises both parents followed by the grand parents who tell stories to the young ones. Tribe-wise variations show that, story telling was most common among the Khasis (91%) and the Nyishis (83%) than the Konyaks (66%) and the Mizos (54%). Besides story telling by the parents, this activity was found promoting by the grand parents mostly among the Konyaks and the Khasis. However, while telling stories, generally older children also used to be present and it was not done frequently.

Singing lullabies was observed in very few cases among the Mizos and the Khasis. These were actually murmuring of any song at low voice, that the mothers use to make the child sleep.

From the foregoing description it can be opined that, although the children are not restricted from playing, learning, etc. Yet, parents are not aware about the importance and benefits of these activities in chid development. The impression received from visiting the households and villages that, the parents and the other members of the family allow the children to grow freely and think certain things such as play, songs, dance, etc. will be learnt by the child spontaneously as the child grows. Such attitude of parents is praiseworthy in one way, as they do not restrict the children's movement and instinct in playing, but in other way their lack of awareness about stimulating activities in this aspect of child development needs to be educated.

CHAPTER VIII

CONCLUSION

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Children are the future citizens of a nation. These future citizen are needed to be moulded, groomed and maintained appropriately since their very beginning of their life so that, later, they can build a strong nation. The childhood is the foundation period of every adult of a society. It is imperative for the family and the society to provide a child friendly environment so that the future citizens are flourished to their optimum extent. After birth, the home is the immediate environment for the child, where he/she learns the basic lessons of life as a member of the society. Although, the fulfilment of needs of a child is more or less taken care of by the family members, yet, the child rearing practices are also governed by certain cultural laws and rules of every society and thus vary from society to society.

India, the subcontinent, is rich with numerous societies and cultures. The North Eastern Region of the country again is abode of a various castes and sub castes with very colourful cultures. The tribal communities of north-eastern region of India constitute a major tribal population of the country. Each and every tribe is different from the other because of their distinct cultural heritage. Though several research studies among the various ethnic groups were carried

out by the researchers, yet, studies relating to child rearing are rather scanty. Thus, it was felt important to conduct this research study on child rearing to understand the existing child rearing practices with the similarities and differences in this area among the four selected tribes in the states of Arunachal Pradesh, Meghalaya, Mizoram and Nagaland. The study also attempted to find out the impinging factors in child rearing and also the health and nutritional status of the children. The four tribes under study namely the Khasis in Meghalaya, Konyaks in Nagaland, Mizos in Mizoram and the Nyishis in Arunachal Pradesh, are selected on the basis of their numerical strength in the respective states.

Data were gathered from 32 villages of eight developmental blocks of the four states selected. While selecting the villages tribewise inhabitants and homogeneity were kept in mind. In all, the sample of the study comprised of 400 families of the selected tribes. Hundred households were selected from each tribe. Households were selected with the criteria of having having one or more children and also having at least one child below three years of age. Families who had only one child in this category, had to complete at least one year.

The size and population of the villages are varied in nature. Some villages are small, whereas, some are big. But all the villages are located in hilly regions. More or less, for majority of villagers, agriculture is the main occupation of the tribes. Besides, service holders, professionals and businessmen are also found in the villages as their secondary occupation. More or less all the villages are within the reach of education and primary health services.

Among the households of the study population, the Konyak displayed highest population and the Mizos lowest. But, the child population below three years was found highest among the Khasis. The Mizos had lowest in this category. In all, although sex wise differences were not much, yet, female population was less than its counterpart. It is mainly the Nyishis, where female population was more than the males. Majority of the families comprised of nuclear family pattern. The extended and joint families were found mainly among the Konyaks. In all, 16 percent population is illiterate. There was no illiterate person among the Mizos.

Among the respondents, almost one fourth of them were illiterate. It was highest among the Nyishis, whereas, it was nil among the Mizos. In context with the occupation of the households, agriculture is the main source of earning of the people. According to the land possession, the Konyaks have highest cultivable land and the Khasis have lowest. The Khasis mostly cultivate in others' land mainly on daily wage basis. Economically the Khasis seems to be poorer than the other three tribes and the Mizos are in better position than the other three.

Since health care of the mothers, specially during antenatal period, assumes much more importance, the study attempted to find out the health care of the mothers of the study population. Findings show that, health care received by the mothers is not alike and equal among all the four tribes. Though, a large section of the respondents consulted physician during

antenatal period, but a substantial portion is left out from the services. However, the mothers who visited the physicians, majority consulted three times and more. This finding shows that mothers are aware about health cares to be received during antenatal period. The study also shows that respondents are far behind of getting dietary care required during this period. The study shows a good practice among the tribe, of not having any alcoholic beverage or tobacco during pregnancy by a large majority of the respondents. It was found that, certain taboos during pregnancy are prevalent among the tribes. Though there is no any scientific base of these taboos, but gives psychological benefits to the respondents. Except the Khasis, certain foods are tabooed among the other three tribes. However, only a small portion of the respondents found following these taboos. Thus, can be said that food taboos are not much affecting the mothers' nutritional status among the tribes and is a good practice that can be encouraged.

There are no practices of performing any rites during pregnancy. Visiting to a physician, observing certain restrictions, etc. displays that how the mothers/family members care for the welfare of the unborn baby as well as the mother. But, contrary to this, the finding also reveals that, most of the mothers continued their daily household chores either till later part of the pregnancy or till delivery, without much help from the family members. The study also found that although hospital deliveries or deliveries conducted by trained personnel were there, yet for a substantial number of respondents, health services are yet to reach them. The entire population are not aware about the importance of five cleans of deliveries. Though post partum dietary restriction was followed by a

remarkable section of the population, but as per information regarding restricted food items, it can be commented that except few, there was not much nutritious foods that the mother restricted. Likewise, a remarkable section of mothers also received immediate dietary attention after delivery, that displays care given to them by the family members.

The study found a mixture of both positive as well as negative practices in regard of health care of the mothers during pregnancy.

The study reveals that more than half of the newborns received deep bath soon after birth, which is not a good practice. Use of unsterilized instrument for cutting the umbilical cord was also in practice. Besides, application of certain items in umbilical cord was also reported by the tribes. Although, more than half of the newborns were initiated breast feeding within one hour of birth, yet, a large section of the neonates were deprived of early initiation. Prevalence of introducing pre-lacteal feed also displays poor trend in exclusive breast feeding. However, it was found that, most of the babies are breast fed for a longer duration. Initiation of semisolid was also found a bit early in the study population. The most positive trend in introducing semisolid to their babies is feeding home based food prepared separately for their babies by most of the respondents. But that type of food is not always nutritious. Children above one year are given the family foods. Other foods such as biscuits, breads, etc. are also given subject to the availability at home. But use of such foods was not found much. As a whole, it can be said that, the feeding of the infants and the young ones of the study population needs to be improved

according to the national guidelines of the infant and young child feeding. The good practices- such as feeding home made family food, feeding children from a separate plate, encouraging self feeding, etc. should be encouraged by ICDS and health functionaries.

The health and hygiene practices showed that, majority of the houses of the tribes visited have no proper ventilation, especially the houses in the areas inhibited by the Konyaks. Though, the households under study, found using different latrines, but a portion also go to field, forest, etc. for defecation. Young children mostly taken out to the backyard. However, children who are grown up and can walk properly are encouraged to go to the latrines. Most of the villages are connected with government water supply. Additionally, some also use stream and rain water also. Surroundings of the households of the villages visited were more or less clean. Households being on the top of the hills, generally the rain, washes off the dirt and thus the immediate household surroundings were found more or less clean.

The young children were observed cleaner than their elder ones. This is because the young children are generally carried by their mothers or elder ones in the family and get less chance to get dirty. But, children who can walk and get along with the older grown up children get dirty early. Accordingly, their clothings were also observed dirty. Regarding immunisation, it was found that, majority of the respondents were aware about immunisation, and a positive approach in this context is seen. However, some dropout cases were also found. Generally, family members are found sensitive towards health care of their

children and try to adopt all the possible measures within their reach to treat the illness. Except the Mizos, home remedies for various illnesses were found among the other three tribes. Food restrictions for children during illness of the children are also found among the tribes. Some of these have no scientific base.

The study also found childhood mortality at various ages among the samples. Highest of which was found within one week of birth. The study population has to be educated towards proper newborn care. The most common illnesses from which the children suffer from are cold, cough, diarrhoea and fever. The Nyishi children suffer more in comparison to the others. Contrary to this none of the Mizo child reported to be suffering from any illness more than once.

The nutritional status of the children shows that, majority of the children are in normal grade. Only a small portion of children are undernourished. Few Grade III undernourished children were found among the Konyaks and the Nyishis. There was only one grade IV malnourished Nyishi child in the entire study population. In all, it is found that, the Mizo children are enjoying better health in comparision to the other tribes. It can be said that, though all health care practices adopted by the respective tribes for the betterment of their children are not up to the satisfactory level, but, since children are being reared under most natural settings, their nutritional status is mostly normal.

Beside, health care of the children, parents of all tribes are found quite particular in naming their children early. The grand parents of the children

mostly named them. In addition, the priest/religious leaders, other family members also named their children. However, there was no any name giving ceremony organised. Many times, parents go out for work, leaving their young ones at home depending either on other family members or the neighbour. The home as well as the neighbourhood is neither very strict nor very permissive. Parents allow their children to grow up naturally. Parents, family members, neighbourhood, etc. are affectionate towards their children. However, the adults do not have extra time to spend with children for playing, singing, story telling etc. This is also because of lack of awareness. Some home made and market available play materials are seen in the households visited. The play materials purchased from market, were mostly seen in the families who are economically sound. Toilet training also found giving around half of the population. In this aspect the Nyishis are a bit behind then the other three tribes.

From these findings of the study, the following can be suggested:-

1. The population should be made aware about family welfare activities.
2. Though majority of the mothers are aware about importance of antenatal visits to physician, but a large portion of them were deprived of TT vaccination and other health care for antenatal period. Thus, these services have to be made available through appropriate service delivery by them and creating awareness.
3. Awareness towards need of consumption of additional foods during pregnancy should be generated.
4. Mothers should also be made aware about the need of rest during pregnancy.

5. Hospital delivery should be encouraged and government should initiate all needful to the mothers for hospital deliveries.

6. Awareness generation activities are strongly recommended to remove the unhealthy practices irespect of newborn care such as giving deep bath to the neonate, feeding pre-lacteal feed, proper and timely introduction of breast feeding and complementary feeding.

7. Beneficial home remedies should be encouraged for treatment of various childhood ailments. Parents and community should be made aware towards utilisation of health services and also for complete immunisation. Such practices should also be highlighted and well documented for wider dissemination.

8. Service delivery of AWCs under ICDS should be strengthened through appropriate supervision and monitoring and also ensuring proper implementation.

9. At the end it is suggested to build up a proper networking with government NGO and the community for implementing the government run programmes successfully.

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PHOTO PLATES

ANNEXURES

PHOTO PLATES

Plate 1: A mother feeding her child boiled rice and boiled fish to her child (Konyak)

Plate 2: Boiled rice is pasted with wooden grinder this way to feed young babies (Konyak)

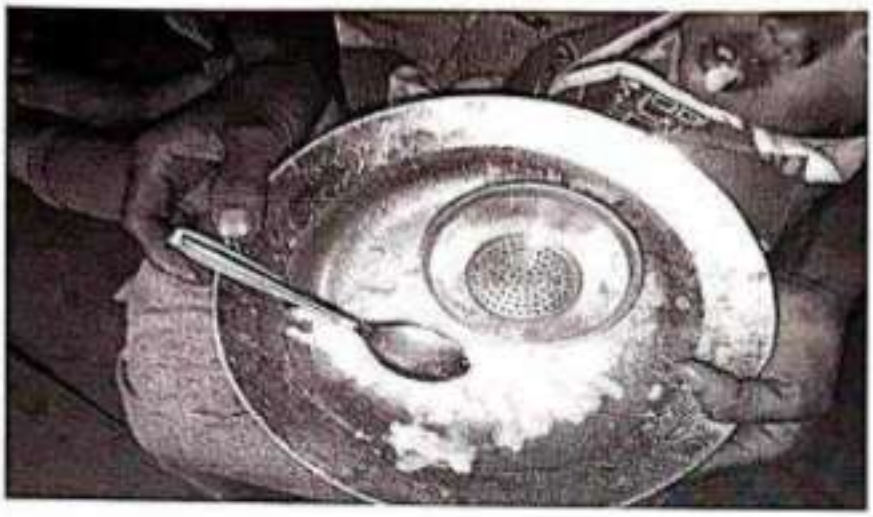

Plate 3: Boiled rice being pressed with strainer to feed young babies (Khasi)

Plate 4: A child having boiled rice with black tea (Khasi)

Plate 5: A child is being breast fed (Khasi)

Plate 6: A child is being breast fed (Nyishi)

Plate 7: A mother feeding her child bread and milk (Konyak)

Plate 8: A mother feeding her child bread and black tea (Mizo)

Plate 9: A baby with a pacifier in mouth (Khasi)

Plate 10: A baby with a pacifier in mouth (Khasi)

Plate 11: A baby is being toilet trained (Konyak)

Plate 12: A baby is being toilet trained (Mizo)

Plate 13: A baby is given bath (Mizo)

Plate 14: A mother is giving bath to her children in a stream (Nyishi)

Plate 15: A child with coloured hair (Mizo)

Plate 16: Elder sibling carrying younger one (Khasi)

Plate 17: Elder sibling playing with the younger one (Konyak)

Plate 18: Baby clothes are being dried by burning coal and ash (Konyak)

Plate 19: Children playing with a homemade toy (wooden cart) (Konyak)

Plate 20: Children playing with a homemade wooden cart (Mizo)

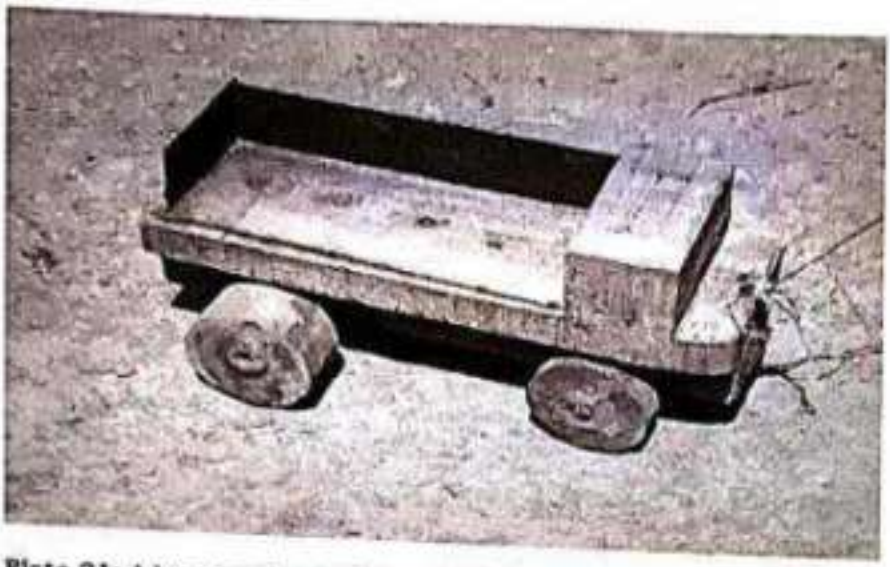

Plate 21: A homemade wooden cart (Meghalaya)

Plate 22: A child with a homemade wooden toy pistol (Khasi)

Plate 23: Children washing (playing) clothes with mother (Khasi)

Plate 24: A father carrying his child with play materials procured from market (Konyak)

Plate 25: A mother carrying her child with homemade ball (Konyak)

Plate 26: A child with readymade play materials (Konyak)

Plate 27: A child with readymade play materials (Mizo)

Plate 28: A set of readymade play materials (Mizo)

Annexure-II

NATIONAL INSTITUTE OF
PUBLIC COOPERATION & CHILD DEVELOPMENT
Regional Centre, Guwahati

CHILD REARING PRACTICES IN NORTH EASTERN REGION

(INTERVIEW SCHEDULE FOR MOTHER)

Sl. No. [ ][ ][ ]

A. BACKGROUND INFORMATION

1. **Name of the respondent :**

2. **Age of the respondent :**

Below 18 years	☐	Between 30-35 years	☐
Between 18-22 years	☐	Between 36-42 years	☐
Between 23-29 years	☐	Above 42 years	☐

3. **Educational level of the respondent**

Illiterate	☐	Just literate	☐
Up to Primary level	☐	Up to V	☐
Up to VII	☐	Under Metric	☐
Matriculate	☐	Intermediate	☐
Graduate	☐	Post Graduate	☐

4. **Marital status of the respondent**

Married	☐	Widow	☐
Divorcee	☐	Separated	☐

5. **Tribal Group**

Adi	☐	Ao	☐
Khasi	☐	Mizo	☐

6. **Religion**

Hindu	☐	Christian	☐
Muslim	☐	Buddhism	☐
Any other (specify)	☐		

7. **Name of the Village** :

8. **Police Station** :

9. **Block** :

10. **District** :

11. **State** Arunachal Pradesh ☐ Meghalaya ☐

Mizoram ☐ Nagaland ☐

12. **Household information**

a) **Land & Agriculture**

Total area of Cultivable land

No land ☐ Below 4 bighas ☐

Between 4-10 bighas ☐ Between 11-20 bighas ☐

Between 21-35 bighas ☐ Between 36-50 bighas ☐

Between 51-100 bighas ☐ Above 100 bighas ☐

b) **Crops usually grown**

Paddy ☐ Peas ☐

Blackgram ☐ Mustard ☐

Arhar ☐ Jute ☐

Any other (specify) ☐

c) Family members background

Sl. No	Name	Relationship with respondent	Sex	Age	Educational qualification	Marital Status	Any abnormality	Occupation	Annual income

Total No. of family members: Respondent

1. Nuclear family
2. Extended family
3. Joint family

d) Information about Childhood Death, if any.

N.A. ☐

Sex	Period of death						
	Within 1 week of birth	Within 1 week to 1 month	1-12 months	12-36 months	37-60 months	Causes of death	Treatment measures adopted
Male							
Female							

B. ANTENATAL CARE

13. Observation of Rites, etc.

a) Rite perform during pregnancy if yes, when?

N.A. ☐ Within 3 months ☐

Between 3-6 months ☐ Between 6-9 months ☐

Just before delivery ☐

b) What is the purpose of that rite/function?

N.A. ☐ For safe delivery ☐

or welfare of the baby ☐ For welfare of the mother ☐

Does not know ☐ Customary to observe ☐

c) Is that function performed in subsequent pregnancies as well

N.A. ☐

Yes ☐

No. ☐

d) Is there any activity i.e. prohibited during pregnancy, if yes which those?

N.A.	☐	Killing of a bird	☐
Crossing for a river	☐	Crossing an *aral*	☐
Visiting the grave	☐	Visiting the house of a deceased	☐
Going to forest	☐	Killing of a snake	☐
Knitting, stitching etc	☐	Performing puja etc.	☐

e) Common belief against these prohibitions?

N.A.	☐	Does not know	☐
Believed to be bad	☐	Fear of ghosts, etc.	☐
Lead to complication in child birth	☐	It may harm the baby	☐

14. Nutritional Care during Pregnancy

a) Any dietary restriction followed? If so, what were those?

Sl. No.	Food stuff	During which period	Reasons of restriction
☐			

b). Consumed extra food? If yes,

N.A.	☐
Regularly	☐
Sometimes	☐
Whenever felt hungry	☐

c) Special dietary attention received

Yes ☐ No ☐

d) If yes, give details

Sl. No.	Name of the Food Stuff	Everyday	Sometimes	Quite Often	Period of Inclusion	Reasons of Inclusion
1.		☐	☐	☐		
2.		☐	☐	☐		
3.		☐	☐	☐		
4.		☐	☐	☐		
5.		☐	☐	☐		
6.		☐	☐	☐		
7.		☐	☐	☐		

e) Consumed alcoholic beverages? If yes, how frequently?

N.A. ☐ Everyday ☐

Sometimes ☐ Occasionally ☐

15. Health Care during Antenatal Period

a) Consulted doctor or any other health personnel

Yes, in all the cases ☐ Not in all the cases ☐

Not at all ☐

b) Whom did you consult?

N.A. ☐ Medical Doctor ☐

Health Practitioner ☐ Compounder ☐

Medical & practitioner ☐ Health Worker/Health Guide ☐

Anganwadi Worker ☐ Any other (specify) ☐

c) Reason for consultation

N.A. ☐

Regular check-up ☐

For a health problem ☐

d) **Care received (in case of Medical Physician/Personnel)**

N.A.	☐	Other antenatal check-up (Weighed, blood pressure checked up, fetal movement, anaemia, etc.)	☐
TT Vaccine	☐	Received medicine (other than IFA Tablets)	☐
IFA Tablets	☐		

e) **Frequency of visit to the physician**

Once	☐	Twice	☐
Thrice	☐	More than three times (specify)	☐

f) **In case of traditional care, give details about it**

16. **Work load and Rest**

a) Any help received from family member(s) in carrying out normal routine work? If yes, how often

N.A.	☐	Everyday	☐
Quite often	☐	Sometimes	☐
Whenever necessary	☐		

b) **Till which month normal routine work was carried out by you?**

N.A.	☐	0-5 months	☐
6-7 months	☐	8-9 months	☐
Till the time of deli	☐		

c) **Type of Normal Routine Work Carried out**

Pounding rice, etc.	☐	Working in the field	☐
Drawing water from well	☐	Collecting fire wood from forest	☐
Carrying heavy load	☐	Cooking	☐
Washing clothes/Utensils	☐	Taking care of children	☐
Any others (Specify)	☐		

d) Rest during daytime

N.A.	☐	1 hour	☐
1-2 hours	☐	3 hours and more	☐

C) NATAL CARE

17. Information regarding Delivery

a) Delivery was attended by

	First Child	Second Child
Medical Doctor	☐	☐
Para-medical staff	☐	☐
Dai	☐	☐
Village women	☐	☐
Mother-in-law/ sister-in-law	☐	☐
Mother/Sister	☐	☐
Husband	☐	☐
Any other (specify)	☐	☐

b) Delivery was taken place at

Own house	☐	Parental house	☐
Hospital	☐	Both own house and hospital (in case of more than one child)	☐
Parental house and hospital (in case of more than one child)	☐		

c) Instrument used for cutting umbilical cord

Blade	☐	Knife	☐
Scissor	☐	Bamboo splinter	☐
Thread	☐	Any other (specify)	☐

d) **Instrument and thread sterilized**

Yes ☐ No ☐

Does not know ☐

e) **Delivery Attendant(s) Washed hands before delivery.**

Yes ☐ No ☐

Does not know ☐

f) **Any custom associated with the cutting of umbilical cord? If yes, give details.**

N.A. ☐

Details:

18. **Any problem during delivery? If yes, give details.**

N.A. ☐

Details:

19. **Preserve the fallen off portion of naval cord of the baby? If yes, for what purpose?**

N.A. ☐ For treatment of certain diseases of children ☐

To ward off evil spirit ☐ For welfare of the child ☐

It is customary ☐ Just like that ☐

Any other (Specify) ☐

20. **Any rite performed during delivery? If so, what and how?**

N.A. ☐

Details:

(D) NEO-NATAL CARE

21. Bathing/Cleaning the New born

a) After birth the baby was given:

- ☐ Sponge Bath
- ☐ Deep Bath
- ☐ Does not know

b) If deep bath, What was used for that?

- ☐ Plain water (cold)
- ☐ Tepid worm water
- ☐ Worm water and soup
- ☐ Water and herbal medicine
- ☐ Water with rice, grass, etc.

22. Any substance applied to promote draying of the naval? If yes, what was it?

- ☐ N.A.
- ☐ Oil
- ☐ Turmeric
- ☐ Excavated soil
- ☐ Mud or plaster of wall
- ☐ Cow dung
- ☐ Dettol/Oinment, etc.
- ☐ Wood ash
- ☐ Spittle of betel nut/ tobacco, etc.
- ☐ Any other (specify)

23. Time of initiation of breast feeding

- ☐ N.A.
- ☐ Immediately after birth (within ½ hour)
- ☐ Within ½-1 hour of birth
- ☐ On the 1st day
- ☐ On the 2nd day
- ☐ On the 3rd day
- ☐ Between 3rd and 4th day
- ☐ Between 4th and 5th day
- ☐ After 5th day

24. Any Pre-lacteal feed introduced

- N.A. ☐
- Mixed with sugar/ Jaggery/ honey, etc ☐
- Honey ☐
- Starch water ☐
- Any other (specify) ☐
- Plain water ☐
- Animal milk (cow's, buffalo's/ goat's/yak's) ☐
- Tinned milk ☐
- Drop of rice beer ☐

25. Type of clothes used for wrapping up the neonate

- Washed old cotton fabric ☐
- Unwashed cotton fabric ☐
- Washed new cotton fabric ☐
- Any other (specify) ☐

26. New born sleeps with

- In the bed with mother ☐
- In a basket ☐
- Separate bed ☐
- In the same bed with mother, but separate bedding ☐
- In a cradle ☐
- Any other (specify) ☐

27. Is there separate pillow for the new born? If yes, what is use for stuffing it and what was the region?

Reason

- N.A. ☐
- Cotton wool ☐
- Mustard sheets ☐
- Silk cotton ☐
- Old cloth ☐
- Any other (specify) ☐

E) CARE OF YOUNG CHILDREN

28. Breast Feeding

a) Exclusive breast feeding

N.A.	☐	Less than 4 months	☐
Till 4 months	☐	Till 6 months	☐
Till 1 year	☐	Till 2 years	☐
More than 2 years	☐	Till the next conception occurs	☐
Till the next baby is born	☐	As long as the child wants	☐

b) Any other milk/drink given in addition to breast milk? It yes, what?

Type	Age when started		Age when started
N.A.	☐	Cow's milk	☐
Goat's milk	☐	Buffalo's milk	☐
Yak's milk	☐	Tinned milk	☐
Cow's and Tinned milk	☐	Plain water	☐
Gripe water	☐	Any other (specify)	☐

c) Reason for introducing such item

N.A.	☐	Inadequate breast milk	☐
Illness of mother	☐	Child did not like mother's milk	☐
Problems of sucking	☐	Mother has to go out for work	☐
Just like that	☐	Good for health	☐
Next conception occurs	☐	Any other (specify)	☐

d) Mode of giving such item

N.A.	☐	From a bottle	☐
From a bowl with s[illegible]n	☐	From a bowl/cup/glass	☐
Any other (specify)	☐		

e) **Frequency of giving such item**

N.A.	☐	Once in a day	☐
Twice in a day	☐	Thrice in a day	☐
More than 3 times (Specify)	☐		

f) **Any dilution of such milk**

N.A.	☐	No dilution	☐
One fourth dilution	☐	Half dilution	☐
A little dilution	☐	Could not specify	☐

g) **Frequency of cleaning feeding utensils**

N.A.	☐	Once in a day	☐
Twice in a day	☐	Thrice in a day	☐
After every feed	☐		

h) **With what utensils are cleaned**

N.A.	☐	Soup	☐
Detergent powder/b	☐	Ash	☐
Mud	☐	Sand	☐
Only water	☐	Any other (specify)	☐

i) **Frequency of sterilization of utensils**

N.A.	☐	No sterilization	☐
Everyday	☐	Every alternate day	☐
Twice in a week	☐	Once in a week	☐

29. Weaning

a) Age at weaning

N.A.	☐	Before 6 months (specify the month)	☐
Between 6-12 months	☐	Between 12-18 months	☐
Between 18-24 months	☐	After 24 months	☐
When next conception occurs	☐	When next child is born	☐
When the child starts having other food	☐	No specific time	☐

b) Any rite/ceremony prior to giving cereal (rice)? If yes, give details.

N.A. ☐

Details:

c) Type of complementary food introduced for the first time

Food Stuff		Methods of Preparation			
Food group	Food item	Porridge	Mashed	Soup/juice	Softly cooked/mashed
Cereal					
Pulses					
Vegetables					
Meat/fish					
Biscuits/bread, etc.					

d) **Child is completely weaned away by**

N.A.	☐	Physical punishment	☐
Scolding	☐	Criticizing	☐
Child himself refused	☐	Applying some items	☐
Diverting child's attention	☐	Any other (specify)	☐

e) **How long breast feeding continued along with complementary food?**

N.A.	☐	Continuing	☐
Till 6 months	☐	Till 12 months	☐
Till 2 years	☐	Till 3 years	☐
Continuing (in case of first child)	☐		

30. **Information of Feeding of Babies**

a) **Food generally given to the baby below 1year**

	Everyday	Some times	Occasionally
Rice	☐	☐	☐
Roots and tubers	☐	☐	☐
Meat/fish/egg	☐	☐	☐
Vegetable	☐	☐	☐
Pulses and legumes	☐	☐	☐
Commercial baby food	☐	☐	☐
Biscuits/bread, etc.	☐	☐	☐
Any other (specify)	☐	☐	☐

b) Frequency of feeding such food per day

- N.A. ☐
- Only once ☐
- Twice ☐
- Thrice ☐
- Four times and more ☐

c) Food cooked for the baby

- Prepared separately ☐
- Apart of adult's meal is given ☐
- Both mentioned above ☐
- Any other (specify) ☐

d) How do feed your young children?

- From separate place/bowl ☐
- From your own place ☐
- From the same plates with other siblings ☐

e) Pattern for feeding children

- Demand ☐
- Scheduled ☐

f) Person usually feeds the child

- N.A. ☐
- Mother ☐
- Father ☐
- Grand mother ☐
- Grand father ☐
- Aunt ☐
- Any other (specify) ☐

g) Child is fed by others till

- N.A. ☐
- 1 year ☐
- 1 ½ year ☐
- 2 years ☐
- 3 years ☐

h) Any food restriction for children? If yes, give details

N.A. ☐

Sl. No.	Food Stuff	Reason of restriction
1.		
2.		
3.		
4.		
5.		

31. Information of Deeding Children above 1 year

a) Foods given to the child above one year

	Every day	Some times	Occasionally
N.A.	☐		
Rice/other cereals	☐	☐	☐
Pulses/legumes	☐	☐	☐
Leafy Vegetables	☐	☐	☐
Other vegetables	☐	☐	☐
Fruits	☐	☐	☐
Meat/Fish/Egg	☐	☐	☐
Milk/Curd	☐	☐	☐
Bread/biscuits, etc.	☐	☐	☐
Any other (specify)	☐	☐	☐

b) Frequency of feeding such food per day

N.A. ☐ Only once ☐

Twice ☐ Thrice ☐

Four times and more ☐

c) **Frequency of giving alcoholic beverages to children.**

N.A.	☐	Daily	☐
Sometimes	☐	Occasionally	☐
Rarely	☐		

d) **Age of introduction of alcoholic beverages.**

N.A.	☐	Before 6 moths	☐
Between 6-12 months	☐	Between 12-24 months	☐
Between 24-36 months	☐		

(F) DIET OF NURSING MOTHERS

32. Information of diet of Post-parturient Mother

a) **Any special dietary care soon after delivery? If yes, give following information**

N.A. ☐

Details:

Sl. No.	Food Stuff	Duration of inclusion	Reason (s) of inclusion

b) **Inclusion of special item in diet for enhancement of milk production?**

N.A.	☐	Colocasia	☐
Papaya	☐	Herb	☐
Rice Beer	☐	Any other (Specify)	☐

c) **Food restriction after delivery? If yes, give details**

N.A. ☐

Details:

Sl .No.	Restricted food stuff	Duration of restriction	Reason (s) of restriction

G) HEALTH CARE OF CHILDREN

33. Information regarding Vaccination

a) **Children's Immunization status:**

	First Child	Second Child
Not yet started	☐	☐
Continuing	☐	☐
Discontinued	☐	
Done	☐	

b) **Place of immunization**

N.A.	☐	At home	☐
At Sub Centre	☐	At AWC	☐
At Private Clinic	☐		

34. Ailment and Treatment Measures

a) **Measures taken when children fall ill**

N.A.	☐	Go to Medical Doctor	☐
Go to traditional Health Practitioner	☐	Offer Puja, etc.	☐
Bring medicine from Pharmacy	☐	Organize prayer	☐
Approach Homeopath	☐	Nothing	☐
Any other (Specify)	☐		

b) What are the measures taken when your child suffer from:

- N.A. ☐
- Cold & Cough
- Fever
- Diarrhoea/Dysentery
- Measles
- Stomach ache
- Cut
- Burn
- Others (Specify)

c) Frequency of Childhood ailments

N.A. ☐

	First Child	Second Child
Fever		
Diarrhoea/Dysentery		
Cold & Cough		
Measles		
Any others (specify)		

d) Allow Children to take normal diet when he is sick? If no, food items restricted in the following conditions:

N.A. ☐

	Food Items
Fever	☐
Diarrhoea/Dysentery	☐
Cold & Cough	☐
Measles	☐
Stomach-ache	☐
Vomiting	☐
Any other (specify)	☐

35. Personal Cleanliness

a) Daily bath given to your baby (below 1 year)

	Yes	No	If no, frequency
1 month old	☐	☐	
2 – 3 months old	☐	☐	
4 - 5 months old	☐	☐	
6 – 12 months old	☐	☐	

b) Daily bath given for other children (1- 3 years), if no, how frequently:

N.A.	☐	Every alternate day	☐
Twice in a week	☐	Once in a weak	☐
Any other (Specify)	☐		

c) Frequency of use of soap for children

N.A.	☐	Every day	☐
Once in a week	☐	Twice in a week	☐
Occasionally	☐		

d) Type of latrine at home

N.A.	☐	Sanitary	☐
Service	☐	Pit	☐

e) If no, where do you go?

N.A.	☐	Field	☐
To forest	☐	Backyard	☐
Little far	☐	Public latrine	☐
Any other (specify)	☐		

f) Where do the children go for defecation?

Latrine	☐	Field	☐
Yard	☐	Forest	☐
Little far	☐	Any other (Specify)	☐

36. Toilet Training

a) Age of giving training on bladder control

- N.A. ☐
- Before 6 months ☐
- Between 6-9 months ☐
- Between 0-12 months ☐
- Between 12-18 years ☐
- Between 18-24 months ☐
- Any other (Specify) ☐

b) Age they are able to achieve control on bladder

- Before 6 months ☐
- Between 6-9 months ☐
- Between 0-12 months ☐
- Between 12-18 years ☐
- Between 18-24 months ☐
- Between 24-36 months ☐
- Any other (Specify) ☐

c) Age giving training on bowel control

- N.A. ☐
- Before 6 months ☐
- Between 6-9 months ☐
- Between 9-12 months ☐
- Between 12-18 months ☐
- Between 18-24 months ☐
- After 24 months ☐
- Any other (Specify) ☐

d) Age they are able to achieve control on bowl

- Before 6 months ☐
- Between 6-9 months ☐
- Between 9-12 months ☐
- Between 12-18 months ☐
- Between 18-24 months ☐
- Between 24-36 months ☐

e) Mode of giving bladder and bowel training:

H) SOCIALISATION AND PLAY

37. Naming

a) Children are named at the age of

- Soon after birth ☐
- Within I week of birth ☐
- Within 1 month ☐
- Within 6 months ☐
- Within 6-12 months ☐
- No specific time ☐

b) Person who name the children

Priest/Religious leader	☐	Grand Parents	☐
Parents	☐	Maternal Uncle	☐
Astrologer	☐	Anybody (Specify)	☐

c) Any name giving function? If yes, detail of the function

N.A. ☐

Details:

38. Disciplinary measures/punishment

a) Children are scolded because of

N.A.	☐	Disobedience	☐
Telling lies	☐	Roaming around	☐
Disturbing in work	☐		

b) Persons who scolds children

N.A.	☐	Mother	☐
Father	☐	Uncle/Aunt	☐
Grandfather	☐	Grandmother	☐
Any other (Specify)	☐		

c) Are children beaten up? If yes, why and how often?

	Everyday	Quite often	Some times	Occasionally
N.A.	☐			
Disobedience	☐	☐	☐	☐
Fighting with sibling/ other children	☐	☐	☐	☐
Telling lies	☐	☐	☐	☐
Roaming around	☐	☐	☐	☐
Disturbing in work	☐	☐	☐	☐

d) Who beats the children?

N.A.	☐	Mother	☐
Father	☐	Both the parents	☐
Grand parents	☐	Uncle/Aunt	☐

39. Play and Recreation of Children

a) Persons who play with the children

	Everyday	Quite often	Some times	Occasionally
N.A. ☐				
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Both the parents	☐	☐	☐	☐
Grand parents	☐	☐	☐	☐
Uncle/Aunt	☐	☐	☐	☐
Neighborhood Children	☐	☐	☐	☐

b) Play materials for children

N.A.	☐	From market	☐
Home made	☐	Both from market & at home	☐

c) Story telling to children at home

N.A.	☐	Mother	☐
Father	☐	Both the parents	☐
Grand parents	☐	Uncle/Aunt	☐
Other elder siblings	☐		

Name & Signature of the Enumerator
(With date)

Annexure-III

OBSERVATION CHECK LIST

A) Cleanliness in and around the house

Clean and tidy ☐ Clean to some extent ☐

Not at all clean ☐

B) House Type

Kutcha and in poor condition ☐ Kutcha but well built ☐

Kutcha house with tinned roof ☐ Pucca house ☐

Pucca house with thatched roof ☐ Any other (Specify) ☐

C) Observation of the children

I) Personal cleanliness

	First child	Second child
Hair		
Nail		
Eyes		
Clothes		

II) Dresses

	First child	Second child
Dirty		
Moderately clean		
Clean		
Clean & Tidy		

III) Activities of Children

Play

Eating

Bathing

Dressing

Sleep and rest

Household activities

Other activities (Specify)

D) Interaction of Children with other Family Members

Parents

Grand Parents

Other siblings

Uncle/Aunt

Others (Specify)

E) materials/Equipments Children Play with

F) Activities of Mothers related to Child Care

Breast feeding

Feeding other food

Interaction with the children

Cleaning children

Any other activities

G) Additional Observation:

Checked by:

Signature:

Date:

Enumerator's Signature:

Enumerator's Name:

Date:

Time: from.....to .....

CHILD REARING PRACTICES IN NORTH EASTERN REGION
VILLAGE DATA SCHEDULE
(Information to be collected from Village Headman/Anganwadi Worker/Local Leader/Panchayat Member)

Sl.No. [ ][ ][ ]

1. Name of the respondent :

2. Name of the village :

3. Name of the block :

4. District :

5. State : Arunachal Pradesh ☐ Meghalaya ☐
Mizoram ☐ Nagaland ☐

6. Distance of the village from the Block HQs. :

7. Population of the village : Male
Female

8. Schedule Tribe Population :

9. Major tribes :
a)
b)
c)

10. Educational Institutions

	Yes	No
Pre-primary school (balwadi/Anganwadi/Any other)		
Primary school	☐	☐
M.E. Graduates	☐	☐
High school	☐	

11. Educational Status of the Community

No. of matriculates	[ ][ ][ ]
No. of Intermediates	[ ][ ][ ]
No. of Graduates	[ ][ ][ ]
No. of Post Graduates	[ ][ ][ ]
No. of Professionals (Specify)	[ ][ ][ ]

12. Occupation of the Community

Agriculture			
School teacher			
Businessman			
Service holder			
Daily Wager/Agricultural			
Labour			
Others (Specify)			

13. Crops generally grown in the village

a.
b.
c.
d.

14. Sources of drinking water in the village?

Govt. Supply water	☐	Katcha Well	☐
Pucca Well	☐	Deep Tube well	☐
Pond	☐	Stream	☐
River	☐	Rain Water	☐
Spring Water	☐	Any other (Specify)	☐

15. Distance of health Sub-Centre from the village

16. Distance of state dispensary/PHC from the village

17. Any trained dai in the village, if yes, mention the number

18. Any health committee

Information collected by:

Signature:

Name:

Date:

23/3/10