

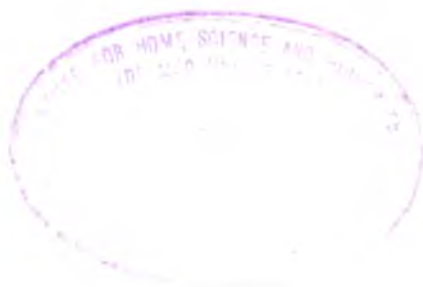
MARRIAGE, FAMILY SYSTEM AND TRADITIONAL MOTHER AND CHILD CARE PRACTICES OF 'HO' TRIBE OF BIHAR

ARTI SINHA



**A THESIS SUBMITTED TO THE AVINASHILINGAM INSTITUTE FOR HOME SCIENCE
AND HIGHER EDUCATION FOR WOMEN (DEEMED EDUCATION) COIMBATORE-641 043
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY IN HUMAN DEVELOPMENT**

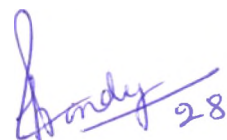
AUGUST, 1995



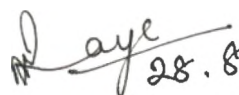
CERTIFICATE

This is to certify that the dissertation entitled "Marriage, Family System and Traditional Mother and Child Care Practices of 'Ho' Tribe of Bihar" submitted to the Avinashilingam Institute for Home Science and Higher Education for Women (Deemed University), Coimbatore, in partial fulfilment of the requirements for the award of the Degree of Doctor of Philosophy in Human Development is a record of original research work done by Mrs. ARTI SINHA during the period of her study in the Department of Human Development, Avinashilingam Institute for Home Science and Higher Education for Women (Deemed University), Coimbatore, under my supervision and guidance and the dissertation has not formed the basis for the award of any Degree/Diploma/ Associateship/Fellowship or other similar title to any candidate of any other university.

Forwarded

 28.8.95

Signature of the Guide
with date

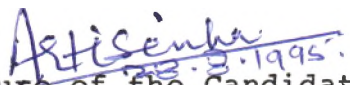
 28.8.95

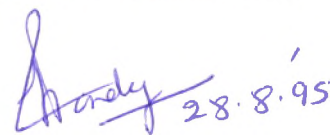
Signature of the Head of the Department
with date

DECLARATION

I hereby declare that the dissertation entitled "Marriage, Family System and Traditional Mother and Child Care Practices of 'Ho' Tribe of Bihar" submitted to the Avinashilingam Institute for Home Science and Higher Education for Women (Deemed University), Coimbatore, for requirements for the award of the Degree of Doctor of Philosophy in Human Development is a record of original research work done by me under the supervision and guidance of Dr. (Mrs) HEMA PANDEY, M.Sc., Ph.D. (Coimbatore), Principal, Avinashilingam Trainers' Training Centre and that it has not formed the basis for the award of any Degree/ Diploma/Associateship/Fellowship or other similar title to any candidate of any other university.

Forwarded


Signature of the Candidate


Signature of the Guide

ACKNOWLEDGEMENT

ACKNOWLEDGEMENT

I feel at a loss of words in expressing my sincere thanks and respects to Padmasri Dr. (Mrs) RAJAMMAL P. DEVADAS, M.A., M.Sc., Ph.D. (Ohio State), D.Sc. (Madras), Hon DHL (Oregon State), Chancellor, Avinashilingam Deemed University, Coimbatore, for giving an opportunity to carry out the research work.

I am grateful to Dr. (Mrs) LAKSHMI SANTA RAJAGOPAL, M.S. (Tennessee), Ph.D. (Madras), Vice-Chancellor, Avinashilingam Deemed University, Coimbatore, for providing the necessary infrastructure and support rendered for the conduct of the study.

My perfound sense of faithfulness and sincere thanks are due to Dr. (Mrs) SAROJA PRABHAKARAN, M.A., Dip. Ed. (Madras), Ph.D. (Mother Teresa), Registrar and Dr. (Tmt.) JANABAI GIRI, Ph.D. (Madras), Examination Controler, Avinashilingam Deemed University, Coimbatore, for their administrative help.

I extend her sincere thanks to Dr. (Mrs) USHA CHANDRASEKHAR, M.Sc. (Madras), Ph.D. (Purdue), Dean Faculty of Home Science, Avinashilingam Deemed University, Coimbatore, for the encouragement provided to carryout the study.

I have no word to express my deepest sense of gratitude to Dr. (Tmt.) N.JAYA, M.Sc., Ph.D. (Madras), Professor and Head, Department of Human Development, Avinashilingam Deemed University, Coimbatore, for her motherly treatment and constructive suggestions as and when required.

For completing this tough job, I consider myself fortunate enough to get an opportunity to work under the learned guidance of **Dr. (Mrs) HEMA PANDEY, M.Sc., Ph.D. (Coimbatore)**, Principal, Avinashilingam Training Centre, Avinashilingam Deemed University, Coimbatore. The author owes deep sense of gratitude to her reverend advisor for her abiding interest, most valuable guidance, close supervision, untiring efforts and helpful suggestions throughout this research work. Thanks are also due to her for motivating me to be more ambitious in life.

My heartfelt felicitations are due to **Dr. M.K.AYYASWAMI, M.Sc., Ph.D.**, Professor and Head, Department of Statistics, Tamil Nadu Agricultural University, Coimbatore, for his help and valuable guidance in the statistical analysis.

I extend my sincere thanks to the respondents of the study, my co-brother **Sri. R.R.VERMA, D.I.G., Patna, Bihar**, **Dr. R.M.SRIVASTAVA**, Director Extension, Birsa Agricultural University, Ranchi, Doctors, Multipurpose Health Worker of Rural Development Centre, A.C.C. Factory, Jhinkpani and Block Development Officers of Tonto and Jhinkpani Blocks for providing support during the research work.

Finally, I express my heartiest devotion to **Almighty** for his graceful blessing at every step without which nothing could have been accomplished.

CONTENTS

CONTENTS

Chapter	Title	Page No.
	LIST OF TABLES	
	LIST OF FIGURES	
	LIST OF PLATES	
	LIST OF APPENDICES	
I	INTRODUCTION	1
II	REVIEW OF LITERATURE	7
	A. Information on Tribes and their Population in India	7
	B. Background Information on 'Ho' Tribe of Bihar	12
	C. Marriage Pattern and Family System of Tribals	13
	D. Status of Women in Tribal Society	18
	E. Mother and Child Care Practices of Tribals	20
	F. Traditional Indigenous Remedies of Tribals for Health Care and	31
	G. Factors Affecting the Tribal Mother and Child Care Practices	32
III	RESEARCH METHODOLOGY	34
	A. Locale of the Study	34
	B. Sampling Plan	35
	C. Conceptual Model of Study	39
	D. Selection of Variables	39
	E. Selection of the Techniques and Tools	43
	F. Collection of Data	45
	G. Analysis and Interpretation of Data	46

IV	FINDINGS AND DISCUSSION	51
	A. Information on Family Background of Selected 'Ho' Respondents	51
	B. Marriage and Family System of 'Ho' Tribe	56
	C. Status of Women in 'Ho' Tribe	68
	D. Traditional Mother and Child Care Practices of 'Ho' Tribe	73
	E. Traditional Indigenous Health Care Practices of 'Ho' Tribe	136
	E. Relationship Between Family Background and Child Care Practices	149
	F. Conceptual Paradigm on Marriage, Family System and Traditional Mother and Child Care Practices of 'Ho' Tribe on the Basis of Findings	165
V	SUMMARY AND CONCLUSION	166
	BIBLIOGRAPHY	180
	APPENDICES	200

LIST OF TABLES

Table No.	Title	Page No.
1.	Population of Scheduled Tribes in the States/Union Territories of India	10
2.	Pattern of Tribal Family	18
3.	Distribution of Scores for Selected Independent and Dependent Variables.	47
4.	Distribution of Respondents' Family According to Marital Status, Family Type, Size and Number of Children.	52
5.	Percentage Distribution of Age of the Selected Couples	54
6.	Literacy Status of the Couples	54
7.	Occupation and Income of the Selected Households	55
8.	Types of Marriage System Prevailing in 'Ho' Community	57
9.	Age at Marriage of the Respondents and Spouses	58
10.	Factors Considered Important While Selecting the Mate	60
11.	Reasons Given for Dissolution of Marriage	65
12.	Percentage Distribution of Decision Making Patterns of the Selected Families	69
13.	Percentage Distribution of Data on Miscarriage, Still Birth and Neonatal Mortality	75
14.	Frequency of Health Check-up at Primary Health Centre during Pregnancy	76
15.	Reasons Stated for Not Going for Prenatal Check-up at PHC	77
16.	Complication during Pregnancy	78

17.	Percentage Female Death in the Reproductive Age and Stated Reasons	79
18.	Persons Attended Delivery for the Selected Respondents	81
19.	Immediate Care of Mother after Delivery	82
20.	Resumption of Household Work and Care of Body after the Delivery	84
21.	Food Items Restricted and Special Food Items Included in the Diet of Nursing Mothers Along with Reasons	85
22.	Respondents Awareness about Methods of Birth Control and their Source of Information	88
23.	Reasons Stated for Feeding Colostrum to the New Born	95
24.	Pattern of Feeding Schedule Adopted and Duration of Breast Feeding	95
25.	Introduction of Supplementary Feeding	97
26.	Weaning Methods Adopted and Problems Faced by Selected Mothers	99
27.	Clothing Pattern of New Born in Ho Tribe	100
28.	Health Habits being Adopted by Children	104
29.	Percentage Distribution of Irregular Immunization Adopted by their Mothers	109
30.	Safety Measures Adopted for Child Protection	110
31.	Behavioural Problems of Ho Children as Reported by Respondents	114
32.	Variables their Means, Standard Diviation and C.V. per cent	116
33.	Simple Correlation Co-efficients of Y with Different X Values	125
34.	Analysis of Variance	128

35.	Indigenous Remedies Used by 'Ho' Tribe for Health Care	137
36.	Herbs Commonly used by 'Ho' Tribe with their Scientifically Proven Therapeutic Value for Specific Health Problems	145
37.	Two-Way Table of Marital Status of Respondents and their Child Care Scores	150
38.	Two-Way Table of Family Type and Child Care Scores of Mothers	151
39.	Two-Way Table of Age of Spouses and child Care Scores of Respondents	153
40.	Two-Way Table of Age of Mother and their Child Care Scores	155
41.	Two-Way Table of Education Level of Spouses and Child Care Scores of Respondents	157
42.	Two-Way Table of Education Level of Mothers and their Child Care Scores	158
43.	Two-Way Table of Family Size and Child Care Scores of Selected Respondents	159
44.	Two-Way Table of Number of Children in the Family and Child Care Scores of Mothers	160
45.	Two-Way Table of Family Occupation and Child Care Scores of Selected Respondents	162
46.	Two-Way Table of Family Income and Child Care Scores of Selected Respondents	163

LIST OF FIGURES AND PLATES

Figures

Figure No.	Title	Page No.
1.	POPULATION OF SCHEDULED TRIBES IN THE STATE OF BIHAR	11
2.	FORMS OF TRIBAL MARRIAGES	16
3.	MAP OF BIHAR SHOWING TRIBAL AREAS OF WEST SINGHBHUM DISTRICT	36
4.	SAMPLING PLAN OF THE STUDY	36
5.	CONCEPTUAL MODEL OF THE STUDY	40
6.	ITEMS GENERALLY DEMANDED AS DOWRY	64
7.	PERCENTAGE DISTRIBUTION OF DECISION MAKING PATTERN OF SELECTED FAMILIES	70
8.	REASONS STATED FOR FEEDING COLOSTRUM TO THE NEW BORN BABY	96
9.	MEAN, STANDARD DEVIATION AND COEFFICIENT OF VARIATION BETWEEN TEN INDEPENDENT VARIABLES (X) AND DEPENDENT VARIABLE (Y)	117
10.	PARADIGM OF FACTORS INFLUENCING MOTHER AND CHILD CARE PRACTICES ON THE BASIS	165

Ø FINDINGS

Plate No.	Title	Page No.
1 and 2.	VIEW OF TRIBAL VILLAGES	38
3.	OILING TECHNIQUE USED BY TRIBAL MOTHER THRILLS THE CHILD	93
4.	CLOTHING PATTERN OF CHILDREN	101
5.	PREVALENCE OF SKIN DISEASE IN THE CHILD	108

6.	JUNK MATERIALS USED BY CHILDREN FOR PLAY	113
7.	INDIGENOUS MATERIALS USED TO PREPARE HERBAL MEDICINE	143

LIST OF APPENDICES

Appendix No.	Title	
I	INTERVIEW SCHEDULE TO ELICIT INFORMATION ON MARRIAGE, FAMILY SYSTEM AND TRADITIONAL MOTHER AND CHILD CARE PRACTICES OF 'HQ' TRIBE OF BIHAR	181
II	OBSERVATION INVENTORY	200

INTRODUCTION

INTRODUCTION

"If we want better people to make better world, we should begin where people are made in the family".

- Boutros Boutros Ghali

Adam and Eve are inseparable and as man and woman both have played complementary role in all aspects of human evolution. Marriage is a holy union between a man and a woman in most religions with the sole aim of begetting, nurturing and raising children. Although male appears to be physically strong, female has been bestowed with more of tenacity and endurance by nature. Thus female takes all the pain in procreation and by inherent nature she raises and rears the offspring painstakingly.

Culture and racial continuity are assured through the medium of parenthood, that is the family (Devadas, 1993). Jeshudasan (1994) stated that the family as a basic unit has existed from time immemorial both in animal and human kingdom. Woman is the central figure around whom the family, the society and the whole community moves.

Inspite of many changes in society that have altered its role and functions, the family continues to provide the natural framework for the emotional, financial and material support essential to the growth and development of its members particularly infants and children. The family remains a vital means of preserving and transmitting

cultural values. In a broader sense, it can and often does educate, train, motivate and support its individual members, thereby investing in their future growth and acting as a vital resource for development (Report, HSAI, 1994).

The status of woman in a society is the most crucial determinant for the health of children of a nation. The nurturing of young, the rearing into adulthood, the teaching of survival skills have always come from the family units. But today the marriage and family units are disintegrating due to various individual and societal factors (The Hindu, 1995). Saving the family requires effort both from inter and intra aspects of family it involves people and emotions, cooperation, adjustment and determination from each member (Devadas, 1993). A study conducted by Nalini (1988) indicated that, "Family is the child's first psychological laboratory". Any deficiency during this childhood period may cause irreparable damage to the future development of the child and no amount of subsequent attention may really make up for this loss. Naturally mother has more opportunity to influence child's behaviour and mould his personality. Many studies have also proved that the expressive role of mother is twice as that of father in the socialization process of children (Bhuyan, 1986).

As indicated by Devadas (1992) children are the most important assets of a nation and hence they need a conducive and congenial environment to develop into good citizens.

Childhood is considered as an important stage in the field of human development. The first few years of life have been identified by a great psychologist Sigmund Freud as critical in shaping human being (Suria Kanthi, 1989). Early childhood care and experience lays the foundation for the development of personality, cultivating social confidence, learning skills, habits and communicating capabilities of children (Punhani and Mahajan, 1989 and Jain, 1990). The development of child is influenced by the child rearing practices in the society (Sharma, 1981).

Child rearing is a broad concept. It includes the overall care, socialization and training of the growing individual in a particular culture. Socialization is a process of transmitting specific life style of the human to the offspring either consciously or unconsciously (Gokran, 1985). Child rearing practices include the mode of parental interaction with the children, the methods of care and protection of pregnant women, the attitudes, values, interests and beliefs as well as child care taking and training behaviours of the adults in a particular culture (Pandey and Punetha, 1989).

Although young children are fed, protected and their dependency needs are attended to by parents, yet these practices vary from culture to culture, generation to generation and from one ethnic group to another. A study on cultural differences on assistance during delivery and after

care observed by Shahida et al. (1970) indicated that in delivery and care of the infant the Badagas were assisted more by the relatives whereas the Irulas were helped by their own husbands. Khanna (1989) reported inter-generational differences in areas such as prenatal care of the mother, initiation and length of breast feeding, kind of weaning foods, types of play materials as well as the amount and nature of father-infant and siblings-infant interactions. All these studies reveal influence of ethnic groups, family culture and generation differences in the mothers and child rearing practices.

The tribal culture blooms in the isolated highlands and forests of India. Scheduled tribes are specified in accordance with Article 342 of the constitution. According to 1991 census, the total population of scheduled tribes were 67.8 million, constituting 8.08 per cent of the country's total population. Tribal children in the age range of 0-6 years form about 13.7 million of total tribal population in India (Census Abstract, 1991). These children live in isolated and inaccessible areas where nutritious food, medical care and education are not available. Sporadic research studies indicate that the tribal mothers are not adopting better child care practices due to illiteracy, poverty, lack of basic amenities and their strong rooted traditional child care practices (Tavkar, 1983; and Madhumathi, 1993).

The welfare programmes which have been introduced for raising the status of mother and children in tribal areas have not been able to show the desired impact (Dave and Tavkar, 1982; and Muthurayappa, 1993). Somehow there are problems of insufficient utilization of these services which could be two fold - either the services are not appropriate and catering to the needs of the people or the people are not aware of why and how to utilize these services.

The review of literature reveals that although a number of studies have been conducted on socio-economic status and cultural heritage of tribals, only a few studies have been conducted on marriage, family system and traditional mother and child care practices. As a result very little information is available on their family system and ways of bringing up their children. This is more true in case of Bihar. Despite a sizable tribal population very few systematic and indepth research studies are available. Against this back drop, the present research is an attempt to study the "marriage, family system and traditional mother and child care practices of 'Ho' tribe of Bihar". This research is concerned with Ho tribe of Bihar, which constitute about 5 lakhs of the total tribal population of Bihar. It is hoped that their study will bring to light various effective traditional mother and child care practices and tribal traditional health care methods useful for prevention and treatment of illness.

Objectives

The overall objectives of the research was to study the marriage, family system and traditional mother and child care practices of 'Ho' tribe of Bihar.

The specific objectives were to:

1. understand the marriage and family system of 'Ho' tribe;
2. study the status of women in 'Ho' tribe;
3. explore the hitherto unknown traditional mother and child care practices of 'Ho' tribe;
4. study the use of various traditional indigenous remedies in tribal health care and to elicit the reasons behind their faith in such traditional practices;
5. study the relationship between family background and child care practices; and to
6. develop a conceptual paradigm on marriage, family system and traditional mother and child care practices of 'Ho' tribe on the basis of findings.

Scope of the study

It is hoped that this study on marriage family system and traditional mother and child care practices of 'Ho' tribe will provide useful base informations for social scientists, planners and administrators. The insight so gained will be valuable in formulating realistic tribal welfare programmes.

Limitation of the study

Being a student's research project the present study suffers with the usual limitations of time, funds. The study will also be limited to a specific geographical area.

REVIEW OF LITERATURE

II. REVIEW OF LITERATURE

A review of tribal studies indicated that hardly any literature was available collectively on "Marriage, Family System and Traditional Mother and Child Care Practices of Ho Tribe of Bihar". Therefore, an attempt has been made to review the related sociological, psychological, anthropological studies and other available literature on tribals. The review has been presented under the following main heads:

- A. Information on Tribes and their Population in India;
- B. Background Information on 'Ho' Tribe of Bihar;
- C. Marriage Pattern and Family System of Tribals;
- D. Status of Women in Tribal Society;
- E. Mother and Child Care Practices of Tribals;
- F. Traditional Indigenous Remedies of Tribals for Health Care; and
- G. Factors Affecting the Tribal Mother and Child Care Practices.

A. Information on Tribes and their Population in India

Since pre-historic times, India has been the homeland of large numbers of ethnic and cultural groups. Many of these communities have more or less retained their social identity as far as their custom and regulations are concerned. These communities believed to be the earliest inhabitants of the country are known by various name the most extensively known term being 'Adibasi'. Other popular names used to designate these communities are Vanyajati, Vanvasi, Adimjati and Janjati. Various census reports since 1891, indicate that these communities have been enumerated under different censuses. (Srivastava, 1981).

There are altogether 427 tribal communities in India (Srivastava, 1981; Vidyarthi and Rai, 1985). Mahanthi (1993) reported that these tribal groups inhabit widely varying ecological, geoclimatic conditions in different concentrations throughout the country as denoted below:

1. North East India : Arunachalpradesh, Assam, Meghalaya, Nagaland, Mizoram, Manipur and Tripura.
2. Sub-Himalayan Region : West Bengal, Uttar Pradesh and Himachal Pradesh.
3. Central India : The Chotanagpur region - covering West Bengal, Bihar, Orissa and Madhya Pradesh.
4. Western India : Rajasthan, Gujarat, Maharashtra, Goa, Dadar and Nagar Haveli
5. Southern India : Andhra Pradesh, Tamil Nadu, Karnataka and Kerala
6. Island Region : Andaman and Nicobar and Lakshadweep Island.

Apart from geographic situation their language is also widely different. They speak about 105 languages and 225 subsidiary languages (Tripathi, 1985).

From the point of view of development, the tribal communities have been classified into three broad categories such as

1. the tribes who are living isolated in hills and dense forests and manage their living by food gathering and hunting as the Jarawa and sentenels.
2. the highly advanced tribes in respect of social, political and economical aspects like the tribes of North Eastern India - Naga and Mizos, Meena tribes of Rajasthan and Nagi tribes of Himachal Pradesh.

3. the tribes who came in between these two extreme categories form the major chunk of tribal population of India. The tribes of Central, Eastern and Western India can be listed under this category (Bhattacharya and Lakshmain, 1992).

According to 1991 census the total tribal population of India was 67.8 million, constituting about 8.08 per cent of the total population of India. The tribal are spread in 26 States and Union Territories. Table I gives the statewise break-up of tribal population in India.

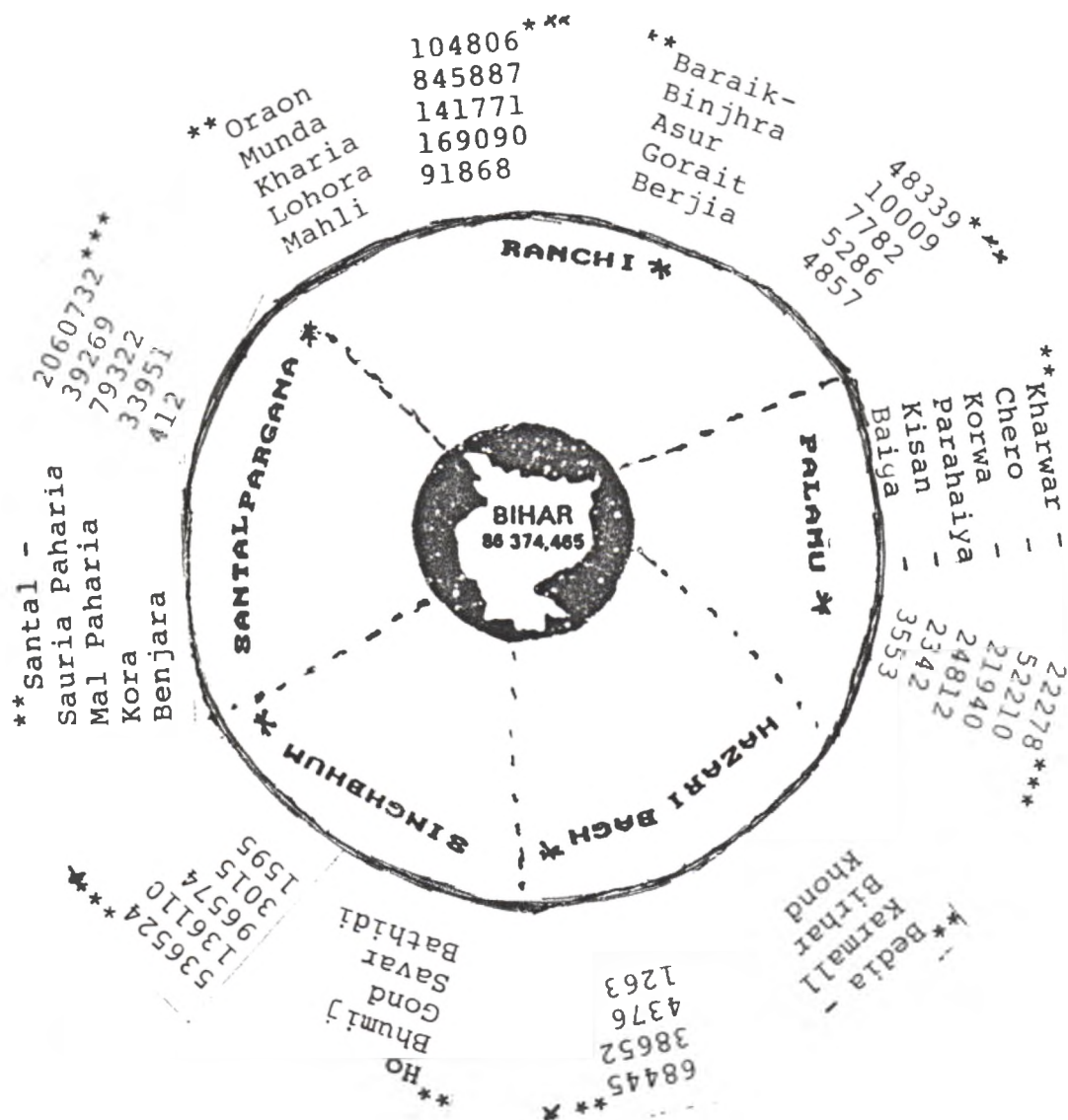
Bihar figures at fourth position in India in tribal population after Madhya Pradesh, Maharashtra and Orissa. Bihar habitates about 66,16,914 million tribes constituting 7.66 per cent of total population of India. Over 93 per cent of the total tribal population of the Bihar State is concentrated in Chotanagpur and Santal pargana . Figure 1 presents the information on type of tribe, their population and main concentration in the districts of Bihar (Singh, 1994).

Table 1. Population of Scheduled Tribes in the States/Union Territories of India

S1. No.	State/Union Territories	Scheduled tribe Population	Percentage of Scheduled Tribe in total population of State and Union Territories
1.	Madhya Pradesh	1,53,99,034	23.27
2.	Maharashtra	73,18,281	9.27
3.	Orissa	70,32,214	22.21
4.	Bihar	66,16,914	7.66
5.	Gujarat	61,61,775	14.92
6.	Rajasthan	52,74,881	12.44
7.	Andhra Pradesh	41,99,481	6.31
8.	West Bengal	38,08,760	5.59
9.	Assam	28,74,441	12.82
10.	Karnataka	19,15,691	4.26
11.	Meghalaya	15,17,927	85.33
12.	Nagaland	10,60,822	87.70
13.	Tripura	8,53,345	30.95
14.	Mizoram	6,53,656	94.75
15.	Manipur	6,32,173	43.41
16.	Tamil Nadu	5,74,194	1.03
17.	Arunachal Pradesh	5,50,351	63.66
18.	Kerala	3,20,967	1.10
19.	Uttar Pradesh	2,87,901	0.21
20.	Himachal Pradesh	2,18,349	4.22
21.	Sikkim	90,901	22.36
22.	Goa	376	0.03
23.	Jammu & Kashmir	-	-
24.	Haryana	-	-
25.	Punjab	-	-
Union Territories			
1.	Dadar and Nagar Haveli	1,09,380	78.99
2.	Lakshadweep Island	48,163	93.15
3.	Andaman & Nicobar Island	26,770	9.54
4.	Daman & Diu	11,724	11.54
5.	Chandigarh	-	-
6.	Delhi	-	-
7.	Pondicherry	-	-

Source: Singh (1994) Schedule Tribe, Manorama Year Book.

Fig. 1. POPULATION OF SCHEDULED TRIBES IN THE STATE OF BIHAR



- * Main concentration in the district
 ** Tribe of Bihar
 *** Tribal population of Bihar, 1981

Source: Census of India, 1981

B. Information on 'Ho' Tribe of Bihar

The Hos are chiefly concentrated in the district of Singhbhum. Their population is around 5 lakhs as per 1981 census. Although the Hos' do not have subtribes they are divided into many sects. They appear to have no traditions of origin or migration. Occupationally, they are primarily dependant on agriculture, they also supplement their food from forests which supply them roots, leaves flowers, fruits and grains. However, with the growth of mines and industries in the Singhbhum district they have been employed as labourers in large numbers (Bhuyan, 1986).

Majumdar and Madan (1989) observed that the Hos believe in the following widespread myth about their origin. That the self-created Singhbongs and Oteborm made the earth with grass and trees. Next they created animals, fruits those which were meant for domestication and the wild ones later. A boy and girl were created and put together in a cave to bring forth pregnancy. They were too innocent and would not copulate. therefore, Singhbongs taught them how to prepare illi (ricebeer) which excites the passions. Illi had its effects on them and in course of time, they brought forth 12 sons and 12 daughters. When all those children had been born, Singhbongs prepared a feast at which the flesh of buffaloes, bullocks, goats, sheep, pigs, fish, fowl and vegetables were served. Singhbonga divided the 24 siblings into 12 pairs of brother and sister and asked each pair to

choose the kind of food it wanted for sustenance before starting out into the world. The first pair chose flesh of bullocks and buffaloes and they became originator of the 'Ho' and the 'Bhumij'. The pair which chose vegetables became progenitor of Brahmins and so on.

C. Marriage Pattern and Family System of Tribes

In all tribal societies the custom of marriage is prevailing. The family is considered as the fundamental element in the tribal social structure.

Pattern of marriage

The tribal marriage is generally regarded as civil contract and not a religious sacrament and therefore, religious solemnization does not take place. There are two types of marriage, viz., (i) the regular and (ii) the irregular. All regular marriages are made by parents, while irregular marriages are effected through elopement, intrusion, capture and so on (Majumdar and Madan, 1956; and Vidyarthi and Rai, 1985). Vidyarthi and Rai (1985) and Hasuian (1987) stated that there are few specific ways of selecting life-partners amongst the tribals of India.

1. Marriage by capture

When a man forcibly snatches away a girl from her village and marries her, it is called marriage by 'capture'. Marriage by capture has been most popular among the Naga tribe of North East region. Among some other tribes like

Bhumij, Kharia, Munda, Santals, this practice has given place to mock capture as a 'survival' of the old practice in which after finalising the marriage the parents of the girl request the groom to come to an agreed place and capture their daughter. In a mock gesture, the girl (bride) also puts on symbolic resistance.

2. Marriage by exchange

Marriage by exchange has primarily been evolved as a means of avoiding the payment of high bride price. Under such a marriage two households exchange women with each other and thus avoid the payment of bride price. This practice is found in varying degrees, in Uralis of Kerala, Khasis of Assam and the Gaddis of Himachal Pradesh.

3. Marriage by Purchase

Marriage by purchase is highly prevalent throughout tribal India. All marriages arranged by the parents come under this category. Bride price is paid either in cash or in kind or partly in cash and partly in kind by the bride groom to the bride's father. This type of marriage is mainly prevalent among the Munda, Oraon, Ho, Santal, Bhotia, Bhil and so on.

4. Marriage by elopement

This way of acquiring mate is extensively present throughout tribal India. When a tribal young boy falls in love with a girl, he kidnaps her with her consent. Marriage

in this case is expedited and no customary bride price is required.

5. Marriage by service

This type of marriage is quite popular in Birhor, Munda and Oraon in Bihar, Urali-Kury-mans of Kerala and Gond of Madhya Pradesh and Maharashtra. This is a substitute method of paying the bride price in the form of service and is mainly resorted to by poor young men who cannot afford to pay the bride price in cash. The service to be rendered may be for a period varying from six months to years till the pre-arranged price is paid.

6. Marriage by Intrusion

Marriage by intrusion is also found among the Indian tribes. This is instrumental in the case of a girl desirous of marrying an unwilling youngman. In such a case the girl thrust herself on the unwilling groom and his parents. She tries to serve the would-be man and his parents but is humiliated and tortured in return. If she persists she is finally accepted as daughter-in-law of the household.

7. Marriage by 'Trial'

In marriage by 'trial' the young boy is required to prove himself courageous and brave and is then free to choose his life partner. This is practiced by Bhil of Gujarat.

8. Marriage arranged by parents

Among tribes, marriage arranged by parents (Andi) by paying the bride price and fulfilling the pre-demands of the girls party is considered the most honoured way of selecting life-partner.

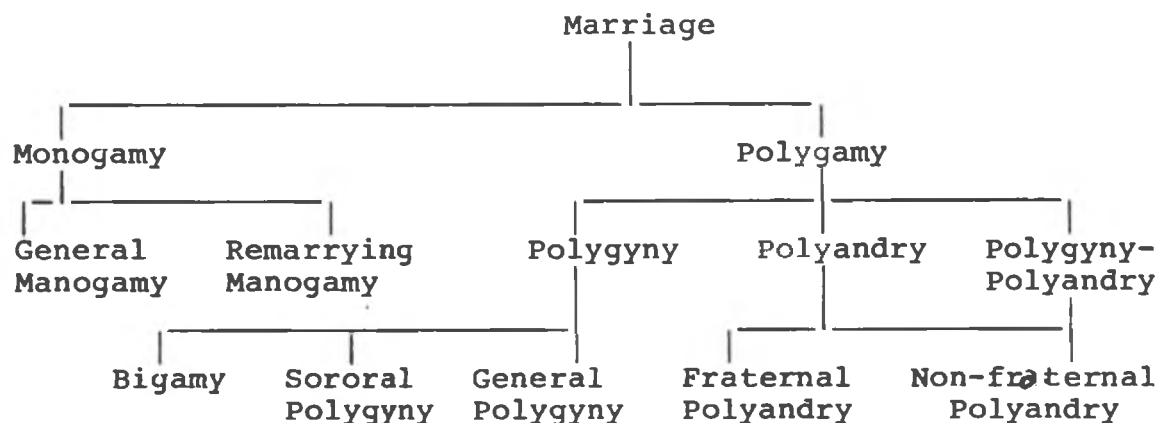
9. Marriage by Probation

In marriage by probation the prospective husband and wife are permitted to live together for some time in the bride's house. If they like each other and decide to marry, elders arrange their marriage. In case the couple do not find each other's temperament compatible they separate and the man has to pay cash compensation to the girl's parents.

Forms of Marriage

Indian tribes like tribes of other parts of the world practise several forms of marriage. Figure 2 depicts the forms of tribal marriages:

Fig. 2. FORMS OF TRIBAL MARRIAGES



Source : Vidyarthi and Rai (1985) The tribal culture of India.

Other aspects of tribal marriage

Age at Marriage

Early marriage (12 years in girl and 15 years in boys) is very much in practice among Gojars, Khokhas and Bombas of Kashmir Valley Lidhoo (1987) and Totos of West Bengal (Chaudhuri, 1992). Whereas child marriage is rare among Bhotias of Uttar Pradesh, the age at marriage is between 20-22 years for boys and above 18 years for girls (Manrol, 1990).

Dowry System

The corrupt practice of dowry is non-existent among the Gojars, Khokhas and Bombas of Kashmir Valley Lidhoo (1987), Munda and Oraon of Bihar Majumdar and Madan (1989), the hill tribe Bhotia Manrol (1990) and Bhils of Rajasthan (Swaminathan, 1994).

Rate of marriage dissolution

Among Garo of Nagaland and Assam, Bhotia of Uttar Pradesh, Bhils of Gujarat and Rajasthan dissolution of marriage and remarriage is an acceptable social trend. Adultery, refusal to work by wife and infertility were some of the major causes of divorce (Majumdar and Madan, 1989; Manrol, 1990; and Swaminathan, 1994).

Family System

Family is the basic social group. It is found all over the world. The universality of family exists in different

forms. The tribal family system can be summarised as in Table 2.

Table 2. Pattern of Tribal Family

A. Based on Condition	Family Form
1. Residence	a. Patrilocal Family b. Matrilocal Family c. Neolocal Family
2. Authority	a. Patriarchal Family b. Matriarchal Family
3. Succession	a. Patrilineal Family b. Matrilineal Family
4. Descent	a. Patronymic Family b. Matronymic Family c. Bilateral Family d. Double descent Family
 B. Based on Marital Ties	
1. Single	a. Monogamous Family
2. Multiple conjugal	a. Polygamous Family i. Polygynous ii. Polyandrous iii. Polygynous polyandrous
 C. Based on Composition	
1. Composed of mother and child	i. Matrifocal Family
2. Composed of father, mother and child	ii. Nuclear Family
3. Composed of a few nuclear families (of close bloodties)	iii. Joint Family
4. Composed of nuclear family and a few close relatives	iv. Extended Family

Source : Vidyarthi and Rai (1985) The Tribal culture of India.

D. Status of Women in Tribal Society

According to Mahadevan (1988), the general concept of status is a complex, dynamic and relative one, which

encompasses certain powers derived either from one's own achievements or from one's ancestors.

Among the Gonds, Garo, Khasi Bhotias, Lahul, Kinnaur, Ladakh and North east this freedom such as choice of a husband, premarital sex, seeking of divorce, inheritance of property and important decisions about the family matters in absence of male family members rested with the women (Majumdar and Madan, 1989; and Manrol, 1990). Even in patriarchal Tharus also the status of woman is high. The property is owned both by men and women and the latter spend their income without any advice given by their menfolk (Majumdar, 1950; and Srivastava, 1958).

In certain tribes such as Santal, Bhil and certain tribes of Bihar the status of women is low. Wife beating in intoxication is quite common; the woman is held responsible for misfortune in the family, the distribution of labour is very unequal except ploughing in the field most of the work in the fields and home including heavy work is undertaken by women (Rajalakshmi, 1992; Joshi, 1994; and Swaminathan, 1994).

E. Mother and child care practices of tribals

Child rearing practices are the techniques, used by the parents or others for bringing up their children. Child rearing practices refer generally to all the interaction between the parents and the children. In short, child rearing practices cover care of mother during pregnancy and

lactation which include nutrition, medical check-up, rest etc., care of the children such as breast feeding, weaning, supplementary feeding, toilet training, clothing, sleeping, education, recreation, socialization, health care. However these practices are not alike everywhere and differ from culture to culture and place to place (Phukan, 1988).

Mother and child rearing must be considered in cultural perspective because the cultures hold different concept of ideal child and their beliefs determine how parent will rear their children (Mussen et al., 1984). In the subsequent pages, review is presented regarding the mother and child care practices of tribals.

1. Mother Care

a. Medical Check-up and diet during pregnancy

Gupta and Singh (1985) indicated that tribal mothers were getting poor antenatal care.

Data on maternal immunization clearly indicate that nearly half of the women received both Tetanus Toxoid, Iron and Folic Acid tablets. These services were mainly rendered by the health workers, while rest (45%) of the women did not receive even a single dose of either Tetanus Toxoid or Iron and Folic Acid tablets (Muthurayappa, 1993).

Bhuyan (1986); Saxena (1989); and Mahanta et al. (1991) reported that tribal pregnant woman of Bihar and Madhya

Pradesh and Buiyan tribe do not receive any special attention during the prenatal period. There is neither restriction nor inclusion of any special food in the diet during pregnancy. But in North India the Pangewal tribe give fat in shape of ghee, to keep the pregnant mother in sound health. The Gujars feed nearly a litre of milk and 100 gms of ghee during pregnancy but stop giving gur, bajara and gum.

The Ao Naga expectant mother avoids eating twin fruits, hot chillis and tortoise (Vidyarthi and Rai, 1985). During lactation period there is both, restriction and inclusion of certain food stuffs among majority of the tribes in Bihar and Madhya Pradesh (Bhuyan, 1986).

b. Rest during pregnancy

Vidyarthi and Rai (1985) reported that in general the tribal expectant mother gets usual treatment from her family in all respects. Prenatal care finds somewhat a small place in the tribal people. The expectant mother continues to do her odd jobs and cannot enjoy any relaxation from the normal burden of domestic duties. She works till she is in labour, whether she is a member of a forest tribe of South India like the Chenchus or the agriculturist tribe of middle India. Singh (1989) states that pregnant woman is encouraged to do domestic work in a regulated manner, which facilitates the delivery.

c. After care of the mother

i. Labour management

Majumdar (1950); and Vidyarthi and Rai (1985) state that among the Munda, Oraon and Bhotia tribe of Uttar Pradesh, Manrol (1990) the pregnant woman in labour is kept in a corner of a room or in an out house (usually a shed) for ten to twelve days. Labour management is usually done by dai or relatives. The Ao Naga considered presence of the father a must at the birth of a child (Vidyarthi and Rai, 1985). The placenta is buried off to ward off the disease and spirits. After delivery the mother gets bed rest for some weeks and neonate is taken care by the senior siblings or a grand mother in a joint family system (Bhuyan, 1986; Saxena, 1989; and Muthurayappa, 1993).

ii. Pollution period and the care during that period

The tribals observe pollution (known as Bisi in Bihar and choot in Bhotias of Uttar Pradesh) after birth of the child. The period of pollution varies from tribe to tribe. Among the Hos of Bihar this period varies from five, eight and twenty one days (Bhuyan, 1986). While in Bhotia: tribe period of pollution is till tenth day after delivery. On the eleventh day, name giving ceremony takes place. On this day woman and the child were purified and then allowed to enter the house and touch water (Manrol, 1990). Also in the Bhotia tribe of Uttar Pradesh after completion of pollution period,

the entire home is sprinkled with 'Gomutra' which is considered sacred (Panday and Punetha, 1989).

iii. Food during pollution

The tribal communities in Manipur gave chicken or beef soup and boiled vegetables to lactating mother soon after the delivery (Singh, 1989). In majority of the tribal communities in Madhya Pradesh fasting is usually practised for a day or so after delivery and after that, a semi fluid food called Harira (made from jaggery, ghee, haldi, ginger, pepper etc.) is given as jaggery is considered to promote drainage of waste blood from the body during the post partum vaginal discharge. Intake of cold water is prohibited. After 2-3 days they start their normal diet like peji, rice, madia and locally available vegetables and fruits (Saxena, 1989). The hill tribe Bhotia gave panjiri, pureghee, fenugreek, ajwain and dry fruits. Because it is believed that panjiri helps in milk formation and gives warmth and strength to the mother's body (Pandey and Punetha, 1985).

iv. Waist binding

Among tribal communities of Manipur, Madhya Pradesh and Uttar Pradesh an old saree around mother's stomach was tied for a week to two because they believed that it added to comfort and prevents bloating of the stomach (Saxena, 1989; Singh, 1989; and Pandey and Punetha, 1989).

d. Methods used for birth control

Study conducted by Gurumurthy (1987) on yandi tribal women in Andhra Pradesh and Puri (1992) on some tribal families of Udaipur city in Rajasthan revealed that breast feeding played a major role as an effective natural contraceptive for the women who shy away from most of the modern contraceptive techniques.

Saxena (1989) found that majority of the tribes of Madhya Pradesh followed sterilization method for birth control with the influence of monetary incentives while Singh (1989) reported sexual abstinence, breast feeding and use of traditional methods were quite common practice for spacing among Manipur tribal communities.

2. Child care

a. Immediate care

i. Cutting of umbilical cord

In most of the tribals umbilical cord is cut by the midwife by using a blade or a knife. Traditionally the practice was to use unsterilized knife in certain tribes such as Bhotias. Traditionally the mother herself had to cut the umbilical cord. Gradually the concept of midwife or doctor doing this job is setting in (Pandey and Punetha, 1989). Whereas in Naga tribe the cord is ligated with boiled unstarched thread and the whole body of the baby specially the umbilical cord stump is smoked by burning some special leaves and dhup and application of dry heat (Singh, 1989).

ii. Bathing the new born

In most of the tribes new born was bathed with warm water and ordinary soap (Pandey and Punetha, 1989).

b. Feeding

i. Breast feeding

The onset of breast feeding appears to have cultural influence. For the tribal child in Panchamahar district, Gujarat breast feeding was started after three days. During early three days goat's milk is fed to the baby (Tavkar, 1983).

Among Bhils of Rajasthan breast feeding was universal. Majority started breast feeding within 24-48 hours. Prelactation was in form of jaggery, ajwain and ghee (Gupta and Singh, 1985). Maurya (1987) observed that amongst Irulas of Nilgiri, pre lactation food was introduced honey sugar water, glucose water, cow's milk, honey-caster oil or caster oil for two or four days before putting their neonate to breast.

ii. Feeding Schedule and Duration

According to Tavkar (1983) and Bhuyan (1986) in some tribes of Gujarat, Bihar and Madhya Pradesh mothers breast feed the child over demand and suckle the child for a duration of 1-8 minutes. Breast feeding was a universal practice till at least 6 months in rural, urban and tribal area of Gujarat and in many instances till 2 years (Gupta,

1981; Gopaldas, 1986; Gujral, 1987; and Seshadri, 1987). Sethi (1988) Pandey and Punetha (1989) found similar duration of breast feeding ie., two to three years among Bhotia's of Uttar Pradesh.

c. Weaning

According to Gopaldas (1986) 89 per cent of the mothers stop feeding their children irrespective of the child's age when they were pregnant. The main reasons stated was that breast feed was not good for current child's health; it makes him thin, weak and ill. Most of the tribal mothers preferred to follow gradual weaning, as observed by Maurya (1987) in Irulas of Nilgiri and by Tavkar (1983) in tribals of Gujarat. The common weanings foods were top milk, rabdi (Gupta 1981) or home food in mashed form (Seshadri 1987), mashed rice, dal, chapati, kicheri, dalia, juice, soups, (Pandey Punetha 1989) and Ragi, Kanji, (Maurya 1987). The feeding utensils were cup and spoon or traditional feeding cup (Gupta, 1981).

d. Clothing

Clothes were not considered as an important item for young children especially for male children in tribal area (Tavkar, 1983; and Bhuyan, 1986). Most of the time the children remain naked. Majority of the children both males and females were seen wearing an upper garment till the waist. The parents were rarely seen changing the clothes of the children.

Pandey and Punetha (1989) reported that majority of the Bhotia tribe used diapers made out of old saree for the baby, since the mother are away to the fields most of the day. From 4-5 months onwards the baby was made to wear an overall known as "Santraaj" which is open from the bottom front and back so that even if the baby defecated or passed urine the pant would not get dirty. As it is an overall, it covers the whole body and mother has to wash less number of clothes.

e. Bathing and body care

Bathing constitutes an important component of health and hygiene. Many diseases could be prevented with regular bathing (Dave and Tavkar, 1982; and Tavkar, 1983). Similarly among Bhotia tribe children were given bath daily in summers while twice a week in winter in majority of cases (Pandey and Punetha, 1989).

Bhuyan (1986) reported that almost all mothers in tribal area of Bihar and Madhya Pradesh the children were given bath every day. The use of soap and oil was not the same in all places. Likewise, use of cleaning agent for washing clothes also varied from place to place. Use of wood-ash as a detergent was also reported by 23 per cent of respondents.

f. Toilet training

The time of starting the toilet training ranged from 4 to 24 months among Bhotias of Uttar Pradesh Pandey and Punetha (1989) and majority of the tribes of Bihar and Madhya Pradesh (Bhuyan, 1986). Whereas, Dave and Tavkar (1982) reported that in certain tribes of Panchmahal district of Gujarat there was no particular age at which the mothers toilet trained the child. The mothers do not perceive the importance of toilet training as an aspect related to the health and diseases.

g. Rest and sleep**i. Bedding**

As observed by Dave and Tavkar (1982) in Panchmahal district by Bhuyan (1986) in Bihar and Madhya Pradesh, no special bedding, is prepared for the baby's rest and sleep. Separate thin mattresses, pillows and covering sheets are stitched for the baby out of old cotton saree in the Bhotia tribe of Uttar Pradesh. The filling used for mattresses and pillows is cotton wool or old cloth or paddy straw which is supposed to be warm (Pandey and Punetha, 1989).

ii. Mode of Sleeping

During the early days the child sleeps with the mother in her bed. As the child grows it gets used to sleeping on its own. Major techniques used for putting the child to sleep were placing it in the cradle and rocking till it was

asleep. None of the mothers consider sleep as an important component from the health point of view (Tavkar, 1983; and Bhuyan, 1986). In Bhotia tribe 53 per cent children slept on their own while 20 per cent slept while drinking milk, 13.3 per cent asked for story and 13.3 per cent cried before sleeping (Pandey and Punetha, 1989).

h. Health protection

Muthurayappa (1993) observed that generally, tribals do not go to hospitals for the treatment of the ailments they have. They follow the indigenous methods of health care; their health practices, therefore, depend upon the cultural and environmental conditions in which they live. However in Marati, Malakudia and Karaga tribes of Karnataka nearly 87 per cent of children were given B.C.G. vaccination, while over three fourth of the children were protected from D.P.T and polio. Children protected from measles were less than 10 per cent. It was seen that in Santal tribe only one . 5.7 per cent children had got immunized against common diseases (Rajalakshmi, 1992).

i. Play and recreation

Play for the tribal children was a matter of participation in the environment. They were most of the time seen playing in groups. The playmates were generally their own cousin or older siblings, neighbouring children and at times uncle or aunties of the same age. The involvement of

the family members other than children in the play sessions was missing. None of the family members took initiative to look after the child while he played. Most of them though being present there were seen involved in some other activity (Tavkar, 1983; and Bhuyan, 1986).

j. Discipline

Singh et al. (1986) investigated mode of parental discipline of Santal and Hindu Communities. The result revealed that Santal parents relied more on the use of power assertion and love withdrawal while non-santal parents generally preferred using induction in disciplining their children.

Pandey and Punetha (1989) reported that in the Bhotia tribes of Uttar Pradesh, 85 per cent of mothers gave physical punishment and severe scolding in case the child misbehaved. Only 15 per cent of the mothers used reasoning to discipline the child.

k. Superstitions

When the child falls sick, the Santal take it to their witch doctor. They call him 'ojha'. He recites some mantras or magic words which are supposed to drive away the evil spirits that are believed to cause illness (Shashi, 1978).

F. Traditional Indigenous Remedies of Tribals for Health Care

The tribal areas are isolated from well equipped medical centres. The result is that for the cure of many ailments and diseases, they have to rely on herbal remedies. Infact, there is a wealth of medicinal herbs readily available in tribal areas which may be put to scientific tests and profitably harnessed into the service of suffering humanity. The generation old prescriptions, decoctions and infusions known to the tribal elders and experts have a stronghold on tribal minds. They are still practised largely in tribal areas (Gupta, 1974).

Although, now there are block dispensaries and mobile hospitals, but the tribals still treat their people with the help of Jantra Mantra, indigenous medicines given by traditional medicine man. The remedies resorted to in various diseases are quite startling. The tribals have hit upon some herb in some way or other and found it effective. They have then tried the same for complaints other than those it was originally used for and have in this way, been guided by experience (Srivastava, 1981).

Tribals have their own 'Chikitsa' (treatment) because the hospital is away (Jagannathan, 1979). The needs and expectations of the villagers are readily met by indigenous faith healers who guarantee cure at low cost without any

elaborate operative procedures and extensive investigations (Singh, 1989).

G. Factors Affecting Tribal Mother and Child Care Practices

Jayanthi (1979) observed atmosphere as a determining factor in child rearing practices like family type, family size, financial status, educational qualification of the parents, payments and the status of the mother while, Rajavelam (1986) found family environment, parental attitude towards their children and method of teaching as important factors in rearing the child. Mendoka (1989) opined that the well-adjusted parents have a high probability of raising well adjusted children. In deviant and divorced families children become susceptible to develop the deviant characters and other personality syndromes (Nalini, 1988).

Palkar (1983) indicated that education plays a pivotal role in determining the child rearing attitude of the mothers. Age and type of family were not found to be significant singly but, when combined with family types and education it exerted noteworthy influence on their attitudes. Similarly Goswami (1988) also found education as an influencing factor for proper methods of child bearing and child rearing in the Jaintia tribal community.

According to Natu (1989) age old customs and cultural practices have strong hold on maternal and child health in urban and rural area.

Radhakrishanan and Rahgir (1992) studied the association between the child rearing methods like possession, domination, ignoring, adopted by adolescent children's mothers, with their socio-economic status. The result shows that there is an association between the socio-economic status of the mothers and the child rearing methods adopted by them.

On the basis of above studies reviewed it can be concluded that there exists a great relationship between parental attitude, education, customs, cultural practices, socio-economic status of the family, parental personality, their interpersonal adjustment with the child rearing practices adopted by them.

RESEARCH METHODOLOGY

III. RESEARCH METHODOLOGY

Methods of social research are built on a foundation of social science theory constructed on the basis of assumptions that are more often implicit than explicit. Since the present study deals with the tribal situation and the nature of study being exploratory, it has been ventured to combine positivist as well as phenomenological approach to conduct this indepth study on, "Marriage, Family System and Traditional Mother and Child Care Practices of 'Ho' Tribe of Bihar". The methodology adopted for this research has been discussed under the following subheadings :

- A. Locale of the Study
- B. Sampling Plan
- C. Conceptual Model of Study
- D. Selection of Variables
- E. Selection of the Techniques and Tools
- F. Collection of Data and
- G. Analysis and Interpretation of Data

A. Locale of the Study

The study was carried out on 'Ho' tribe of West Singhbhum district of Chotanagpur division of Bihar State. 'Ho' tribe of Bihar was chosen for study because of their peculiar marriage, family system, traditional mother and child care practices and indigenous system of health care. Out of 16 districts of South Bihar, Singhbhum district was selected purposively because the major concentration of 'Ho' population is in West Singhbhum district with an area of 8013.70 sq.km, with total population of 17,88,614

(1991 census). The total tribal population including 'Ho' population of this region stood at 9,74,100 which is about 54.4 per cent of the total population of Chotanagpur (1991 census). 'Ho' tribe was selected because of their traditional cultural customs in respect of mother and child care practices. The locale of the study is shown in (Fig. 3).

B. Sampling Plan

Keeping in view the objectives of the study, the Stratified Random Sampling method was used for the selection of the villages.

a. Selection of villages

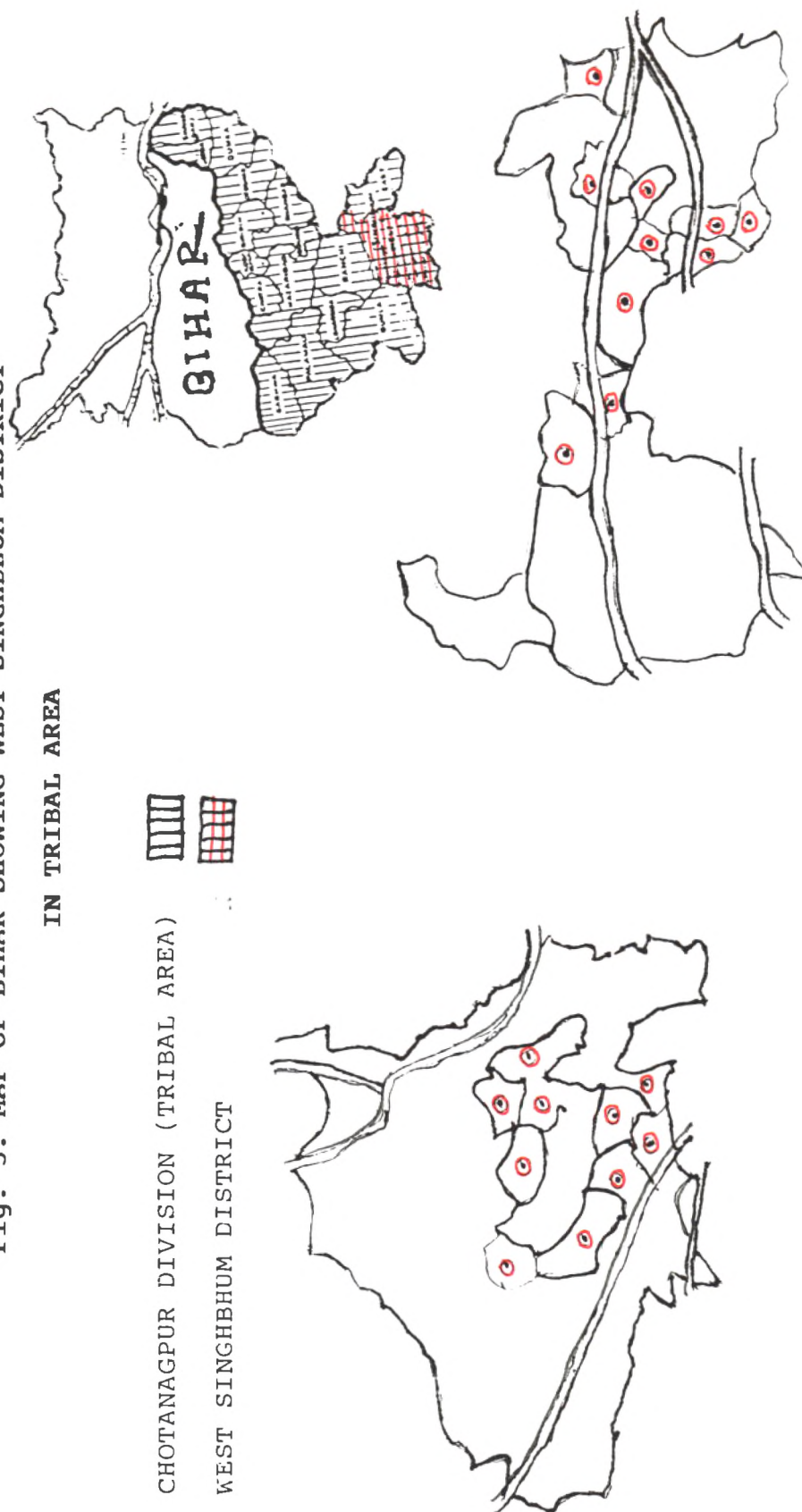
The initial step was to stratify, the universe into parts called 'Strata'. First of all out of 23 blocks in West Singhbhum district, two blocks which had more or less similar socio-economic characteristics were randomly selected. The information on socio-economic characteristics was gained from the Block Development Officers (B.D.O.) of the area. Ten villages were randomly selected from each block. The selection criterion was -

- i) easy accessibility to the village through transport and
- ii) better co-operation evinced from the Rural Development Center (R.D.C.), A.C.C. factory, Jhinkpani and from the key leaders of the villages.

The sampling plan is given in Fig. 4 and Plate 1 and 2 depicts the view of tribal villages.

Fig. 3. MAP OF BIHAR SHOWING WEST SINGHBHUM DISTRICT
IN TRIBAL AREA

CHOTANAGPUR DIVISION (TRIBAL AREA) 
WEST SINGHBHUM DISTRICT 



TONTO BLOCK

JHINKPANI BLOCK

LOCALE OF THE STUDY

Fig. 4 SAMPLING PLAN OF THE STUDY

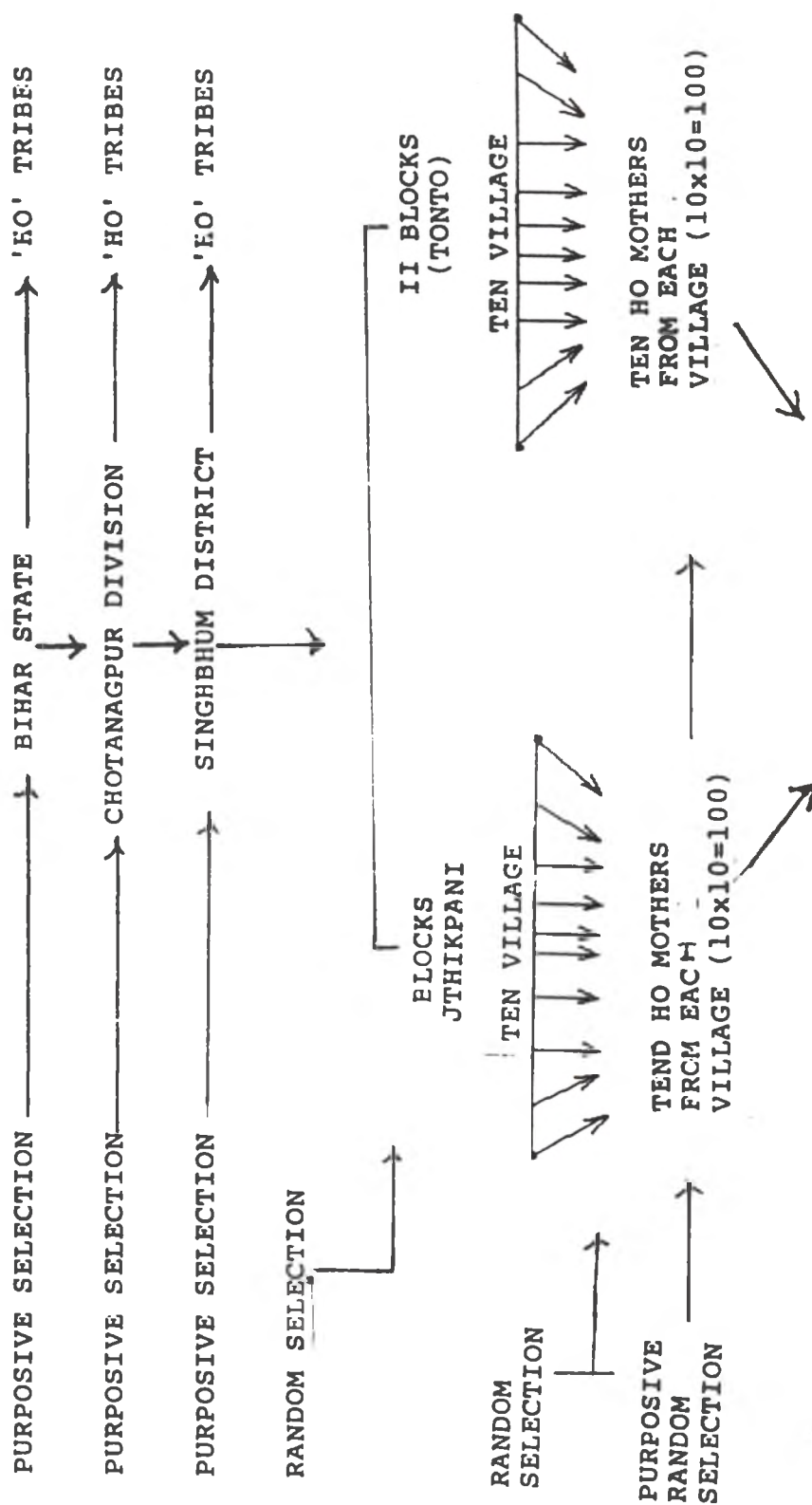




Plate 1 and 2. DEPICTING THE VIEW OF TRIBAL VILLAGES

b. Selection of respondents

From each village 10 mothers in the age group of 20-45 years having at least one child below six years, were selected purposively. Thus the total sample comprised of 200 mothers.

C. Conceptual Model of Study

This study aimed to gather a comprehensive picture of mother and child care practices of Ho tribe. To achieve this goal certain dimensions and variables were selected. The study being exploratory in nature, all the variables were considered as antecedents with the basic assumption that study of these variables would provide a comprehensive picture of mother and child care as being practiced by Ho tribe. On the basis of the aforesaid discussion a conceptual model has been developed as indicated in Fig. 5.

D. Selection of Variables

Considering the basic objective of the study, that is to have a comprehensive picture of traditional mother and child care practices of Ho tribe of Bihar, certain variables were selected in consultation with Human Development Experts and the review of existing literature. The selected variables and their operational definitions have been described in the subsequent pages.

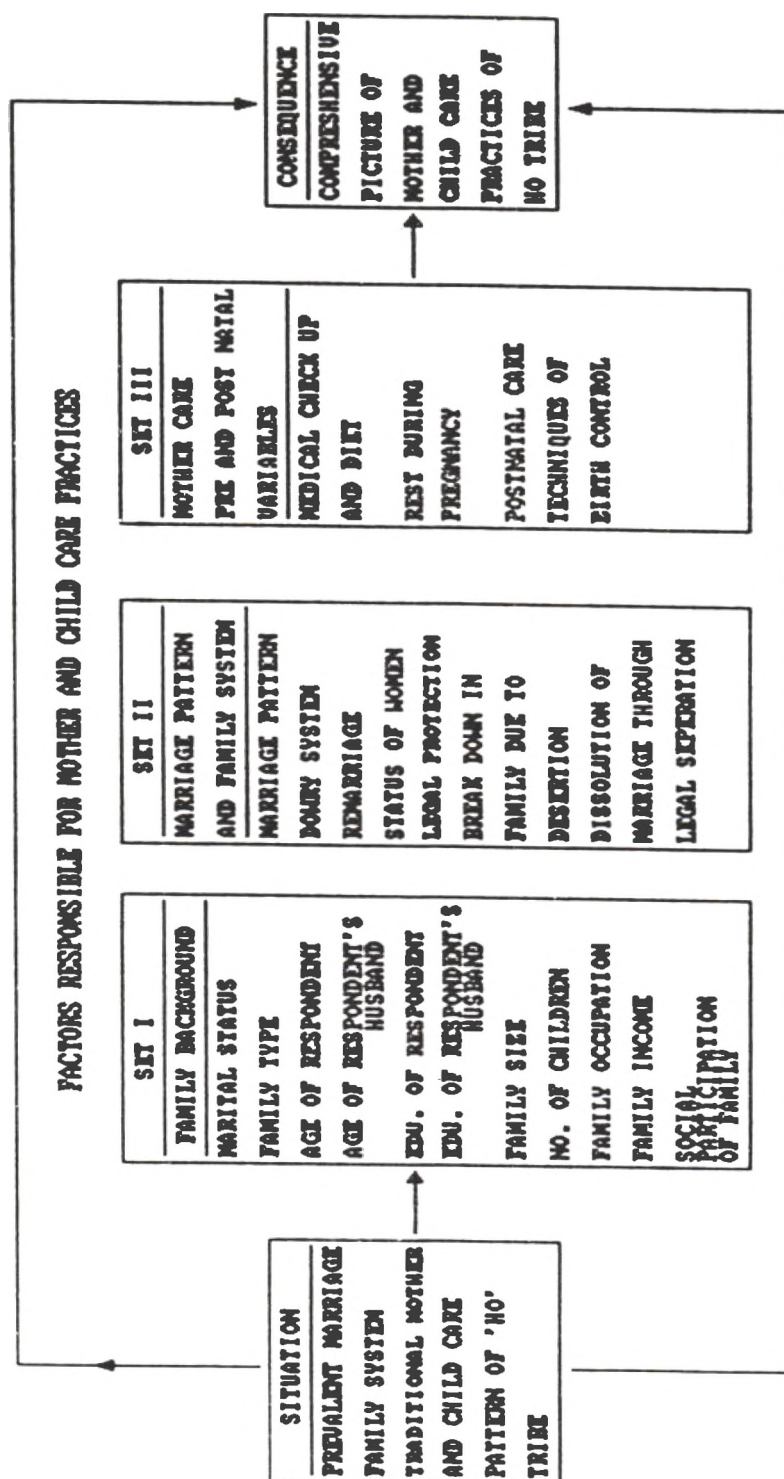


FIG. 3 CONCEPTUAL MODEL OF THE STUDY

1. Socio-economic status variables

Some of the socio-personal characteristics and the factors indicating the economic status of the respondents were selected for study as background variables. These variables were measured with the help of a schedule developed for the purpose.

i. **Marital status:** It refers to the marital status of the selected respondents at the time of the interview like married, widow or remarried.

ii. **Types of family:** It refers to the kind of family set up of the selected household at the time of interview such as joint, extended and nuclear.

iii. **Size of family:** The size of family refers to the number of individuals of both sexes living together in a household.

iv. **Number of children in family:** It refers to the number of children in a family.

v. **Social status:** It refers to their family wealth, participation and involvement of selected respondents in any formal as well as informal organisations and institutions.

vi. **Age:** It refers to the chronological age of the respondents and their spouses rounded to the nearest whole number at the time of investigation.

vii. **Education:** It refers to the academic qualification acquired through formal schooling.

viii. **Family occupation:** This refers to the family occupation of the respondents. The respondents were

classified into 5 categories on the basis of occupations predominantly prevalent in the study area. The five predominant occupations were agricultured cum cattle rearing, unskilled labour, skilled labour (pottery, fishing, ricebeer making), service and petty business.

ix. **Family income:** This refer to the total income of a selected household per month.

2. Marriage and Family System of Ho Tribe

One of the objective of the study was to understand the existing pattern of marriage and family among Ho tribe and its influence on their mother and child care practices. This was determined by observation and personal interview of selected respondents.

3. Status of women in Ho tribe

Status of women was operationalized as decision making powers accorded to Ho tribe women in their day to day family activities.

4. Traditional mother and child care practices

Mother and child care practices: The term mother and child care practices refers to the care of mother during pregnancy, lactation and recovery which includes food given and prohibited, rest, hygiene, medical check-up and preparation for confinement and care of the baby such as immediate care, breast feeding, weaning and supplementary

feeding, clothing, bathing and body care, toilet training, rest and sleep, health protection, play, recreation and disciplining.

5. Traditional indigenous remedies for tribal health care

The term indigenous remedies refers to the use of any plant/herb and (locally available items) by tribals for health care practices.

E. Selection of the Techniques and Tools

Keeping in view the nature of the study and the tribal setting, the approach followed in this study was "positivist cum phenomenological approach" which embodies in its domain both quantitative as well as qualitative methodologies. This approach allows the researcher to get close to the data, thereby developing the analytical, conceptual and categorical components of explanation from the data itself. Since the cannons of the scientific method are not enough and the researcher needs inter subjective and trans objective understanding of the data, this approach was employed. Personal interview technique was used for data collection, since it is the best of method of data collection as opined by Shukla and Gulshan (1983), Kaul (1984) and Sadhu (1985) who stated that in the interview method of collecting data the investigator personally comes in contact with the persons from whom the information is being obtained.

Besides the interview it was decided to use participatory observation technique for obtaining information on more intricate socio-cultural issues of Ho tribe. Kothari (1993) explained that under observation method, the information is sought by way of investigator's own direct observation without asking from the respondents. The tools used were

- a. Personal interview schedule and
- b. Observation inventory.

a. Personal interview schedule

In light of the objectives of the study and on the basis of literature collected, personal experience and discussion with experts, the relevant questions were included in the interview schedule. Care was taken to include both open ended and structured questions. The schedule so prepared was sent to experts in the field and their suggestions were incorporated. Further the schedule was tested in a none sampling village. Based on the results of pre-testing the schedule was modified. The final schedule included relevant questions to elicit information on family background, marriage, family system and traditional mother and child care practices and indegenous remedies used for family health care (Appendix I).

b. Observation inventory

An observation inventory was formulated for recording the observation. The components to be discussed were marriage and family system, status of women, traditional

mother and child care practices and indigenous remedies of tribal health care. The observations were made in order to supplement the information collected through the interview schedule. The observation schedule is given in Appendix II.

F. Conduct of the Study

Data was collected using the interview schedule and observation inventory. Each of the 200 respondents were personally interviewed. Prior to filling up of the interview schedule and the observation inventory form, efforts were made to establish rapport with the respondents. The purpose of the study was explained and time for the interview was fixed with the respondents. The interview was conducted in the local Ho language with the help of the multipurpose health worker (M.P.H.W.) of Rural Development Centre, A.C.C. factory, Jhinkpani. The investigator was always present with the M.P.H.W. during interview. Hindi knowing respondents were interviewed directly by the investigator. Incidental observations which could reveal more about beliefs and practices of the Ho tribe were also recorded. Both structured and informal, directive interviews were conducted in 2-3 sessions, adjusting to the subject's convenience and mood. The interviews were carried out in as much privacy as possible. The responses were recorded on the spot or immediately after the interview. At the end of each day, interview responses were translated and items were checked against the name of the interviewee on the master chart.

To supplement the information gained through the structured interview schedule, observation inventory was used. Observations were made by various indirect ways such as informal talk with people and observing them in different situations. Data regarding information on indigenous remedies for family health care was collected from 10 well known tribal medicine men and women with the indepth interview.

Analysis and Interpretation of Data

After completing the field work, interview schedules were checked for their completion. Thereafter data was compiled and tabulated before subjecting it to statistical analysis. The statistical analysis used were

1. Percentage analysis
2. Chi-square analysis
3. Multiple correlation and regression analysis and their significance-'F' test

1. Percentage analysis

Percentage analysis was done to make simple comparison wherever necessary.

For certain questions of the selected variables, data had to be quantified for further statistical application, therefore, the items in the tool were scored. For each tribal woman the over all child care scores were assessed through the 11 components of child care practices and thus a total score for each Ho mother was arrived at. The scoring method is described in the subsequent page. Thus the total child care scores obtained by respondents were ready for

critical, technical and indepth statistical analysis. Distribution of scores for selected independent and dependent variables is presented in Table 3.

Table 3. Distribution of Scores for Selected Independent and Dependent Variables

Aspects	Number of scores for selected questions	
	Maximum	Minimum
Independent Variables (X)		
Marriage pattern and family system		
Marriage system (X_1)	16	4
Remarriage (X_2)	2	1
Status of Women (X_3)	44	15
Availability of legal protection for 'Ho' women (X_4)	8	4
Breakdown in family due to desertion (X_5)	8	2
Dissolution of marriage through legal separation (X_6)	8	2
Traditional mother care		
Prenatal care (medical and diets) (X_7)	31	10
Rest during pregnancy (X_8)	13	5
Postnatal care (X_9)	19	6
Techniques of family planning (X_{10})	13	4
Total	162	53
Dependent Variable (Y)		
Child care		
Immediate care	40	11
Feeding practices	34	10
Weaning practices	21	6
Clothing	4	2
Toilet training	12	4
Bathing and Body care	11	3
Rest and sleep	20	9
Health protection	21	7
Safety measures adopted for child protection	2	1
Play and recreation	12	4
Discipline	11	5
Total	108	62

Scoring Method

Initially, the data collected were in the form of ticks, crosses and hence qualitative. Each item in the tool was ranked. For positive items, the weights were 5-4-3-2-1 in order and for negative items the weights were 1-2-3-4-5 in order. For each 'yes' question 2 marks were assigned while for 'no' 1 mark. Again if there are several reasons under 'yes' and 'no', they were multiplied with positive and negative weights given to the each item respectively. Care was taken that negative scores should not increase than positive scores. For the purpose of statistical analysis, possible alternatives for each question were given, scores in suitable scale and the scores for groups of items were added for each individual respondent. Finally mean and standard deviation were computed to get upper and lower limit by using formula :

$$\begin{array}{l}
 \text{S.D.} \\
 \text{S.E.} := \frac{\text{S.D.}}{\sqrt{n}} \\
 \text{Mean} \pm 2 \text{ S.E.} \\
 \text{Mean} + 2 \text{ S.E. Upper limit} \\
 \text{Mean} - 2 \text{ S.E. Lower limit}
 \end{array}$$

The score totals thus obtained were treated as quantitative variables. A tabulation plan was prepared for the utilisation of the master tables on the basis of quantified data to prepare suitable two way tables.

2. Chi-square analysis

The chi-square (χ^2) test of independence was extensively used to identify the family background factors or variables influencing significantly or insignificantly the child care scores of mothers. In order to know the relationship between family background factors and child care scores of mothers, the following formula was used

$$\chi^2 = \sum \frac{(O - E)^2}{E}$$

(r-1)(c-1) n

Where, O = The observed frequencies
 E = The expected frequencies
 r = No. of rows,
 c = No. of columns, and
 n = No. of class

3. Multiple correlation and regression analysis

Since simple correlations would speak of the direct relationship of the dependent variable with the independent variables, to assess the relative influence, of the different independent variables, a multiple regression analysis was attempted. The following is the algebraic model of the multiple regression equation.

$$y = a + b_1 x_1 + b_2 x_2 + b_3 x_3 + b_4 x_4 + b_5 x_5 + b_6 x_6 + b_7 x_7 + b_8 x_8 + b_9 x_9 + b_{10} x_{10}$$

Where, y = child care
 x_1 = Marriage pattern
 x_2 = Remarriage
 x_3 = Status of women
 x_4 = Availability of legal protection for 'Ho' women
 x_5 = Dissolution of the family
 x_6 = Legal crises (divorce)
 x_7 = Prenatal care of mother (medical and diet)

X_8 = Rest during pregnancy
 X_9 = Postnatal care of the mother or after care of the mother
 X_{10} = Techniques used for birth control
 a = 'y' intercept (constant)
 b_i = The partial regression co-efficients
 x of y or $x_1, x_2, x_3, x_4, x_5, x_6, x_7, x_8, x_9$ and x_{10}

The multiple regression equations were used to obtain predicted values of the child care scores corresponding to selected combinations of the scores values of significant factors treated as independent variables.

FINDINGS AND DISCUSSION

IV. FINDINGS AND DISCUSSION

This research study aimed at studying the Marriage, Family System and Traditional Mother and Child Care Practices of 'Ho' Tribe of Bihar. This chapter presents the critical analysis of the data and interpretations of the findings under the following broad dimensions :

- A. Information on Family Background of Selected 'Ho' Respondents;
- B. Marriage and Family System of 'Ho' Tribe;
- C. Status of Women in 'Ho' Tribe;
- D. Traditional Mother and Child Care Practices of 'Ho' Tribe;
- E. Traditional Indigenous Health Care Practices of 'Ho' Tribe;
- F. Relationship Between Family Background and Child Care Practices; and
- G. Conceptual Paradigm on Marriage, Family System and Traditional Mother and Child Care Practices of 'Ho' Tribe on the Basis of Findings.

A. Information on Family Background of Selected 'Ho' Respondents

The analysis done in this chapter has been rigorous using relevant statistical tools and techniques. The data on family background of the respondents are summarised under two sub-heads:

- 1. Socio-personal characteristics
- 2. Economic status

1. Socio-personal characteristics

Information on the socio-personal characteristics of the selected respondents included marital status, type and size of the family, number of children, social status, age and education of respondents and their spouses at the time

of interview. The percentage distribution of socio-personal characteristics of respondents is given in Table 4, 5 and 6.

Table 4. Distribution of Respondents' Family According to Marital Status, Family Type, Size and Number of Children

Variables	Percentage Responses
Marital Status	
Married	86.50
Widow	2.50
Remarried	11.00
Type of Family	
Joint	7.50
Extended	26.50
Nuclear	66.00
Size of family	
3 - 4 members	27.50
5 - 6 members	40.00
7 - 8 members	16.00
8 and above	16.50
Number of Children in Family	
One	21.00
Two	24.50
Three	17.50
Four	15.50
Five	12.00
Six and above	9.50

Above table shows that cent per cent of the selected respondents were Hindu scheduled tribe. In the local language they referred themselves to be belonging to sarana religion. The findings on socio-personal characteristics revealed that 86.50 per cent of respondents were married, only 2.50 per cent were widows. Remarriage was found in

11.00 per cent of respondents. Only married respondents were selected since the criterion for selection of respondents was to have a mother with at least six year old child. In 'Ho' tribe widow remarriage was found to be a permitted trend but in most of the cases a widow usually married a widower.

Regarding type of family the data revealed that majority of the respondents (66%) belonged to nuclear family whereas 26.50 per cent belonged to extended and 7.50 per cent to joint family set up. The result indicated that generally the 'Ho' family consists of a man, his wife and their children but some times it follows the Hindu joint family system also. It was found that even if the respondents were in joint or extended family set up, they were cooking separately indicating change in pattern of living.

With regards to the size of the family 40 per cent of respondents were having 5-6 members in their families, 27.50 per cent had 3-4 members. Almost equal number of respondents (16.00%) and (16.50%) respectively had 7-8 and more than eight members in their families.

The above data reveals that about 50 per cent of the households had one to two children. Only a few respondents (12%) and (9.50%) had five, six and above children

respectively. This might be because majority of the selected respondents were in the younger age group.

Table 5. Percentage Distribution of Age of the Selected Couples

Age range in years	Age of	
	Respondent	Husband
20 - 24	17.50	16.00
25 - 29	28.00	33.00
30 - 34	30.50	13.50
35 - 39	9.50	26.00
40 and above	14.50	9.00

As the table reflects more than one third of husbands were in the age range of 25-29 years. Only a small percentage (9%) of them were above 40 years. Whereas comparatively more percentage (14.50%) of respondents were in the age range of 40 and above. This is because in the Ho tribe the bride can be elder to her husband and most of the times the widow is expected to marry husband's younger brother after his demise.

Table 6. Literacy Status of the Couples

Literacy Status	Percentage Responses	
	Respondent	Husband
Illiterate	71.50	60.00
Literate	28.50	40.00

Data on literacy status of selected couples showed that only 40 per cent of males and 28 per cent of females were

literate. The literacy level ranged from proficiency in putting the signature to pre-primary and primary level only. This indicates that within this limited literacy level also tribal women were left behind.

Social Status

Regarding social status it was found that cent per cent respondents were living in own house, none of them were tax payers. They hosted feasts occasionally and none of them had joined any social organisation.

2. Economic Status

The purpose of this study, two important areas included to judge the economic status were occupation and income of the households.

Table 7 shows the occupation and income of the selected households.

Table 7. Occupation and Income of the Selected Households

Economic status	Percentage Responses
Occupation	
Agriculture and cattle rearing	66.50
Unskilled	25.00
Skilled	2.00
Service	1.50
Business	4.00
Income in rupees per month	
Below 500	69.50
500 - 1000	29.00
Above 1000	1.50

The family occupation of the majority (66.50%) of the respondents was agriculture coupled with live stock rearing. This was closely followed by unskilled labourers (25%), working mainly as labourers in the agriculture field or near by factories or as domestic servants. The skilled (2%) category included working in fishing, pottery and rice beer making. The percentage of families involved in service (1.50%) and petty business (4%) was very negligible. Due to poor soil fertility, unassured irrigation facilities only monocropping was possible. Hence, agriculture though their main occupation was not able to provide them year long food. The tribal people were compelled to go in for subsidiary occupation mainly as unskilled labourers. Analysis of the income pattern revealed that 69.50 per cent of the selected families could earn below 500 rupees per month. Only a negligible per cent (1.50%) of the families had income above 1000 rupees.

B. Marriage and Family Systems of 'Ho' Tribe

Marital relationship and family system prevailing in any community influence the child care practices. Hence, it was considered important to study these variables. For this purpose, five major components on marriage pattern and family system were examined in terms of percentage distribution and multiple regression analysis. Marriage and family system of 'Ho' tribe is discussed under the following sub-heads :

Percentage Analysis

1. Marriage system

a. Form of marriage prevalent in Ho tribe

Analysis of the data of present study reflected that 65 per cent respondents practised monogamy. Twenty five per cent of them followed bigamy and only 10 per cent respondents had gone in for polygamy. Reasons indicated for bigamy and polygamy were infertility in the existing wife and marrying several women was considered prestigious.

b. Types of Marriage

The data pertaining to the types of marriage prevailing in the community is presented in Table 8.

Table 8. Types of Marriage System Prevailing in Ho Community

Types of marriage	Percentage Responses
Andi	13.50
Diku-andi	4.50
Opertipi	34.50
Razikhusi	37.50
Anadar	10.00

As evident from the above table, 37.50 per cent of the respondents got married by Razikhusi (marriage by mutual consent) and 34.50 per cent followed opertipi (marriage by capture) type of marriage. Both these type of marriages were popular as elaborate ceremonies and payment of exorbitant bride price was not involved. This finding is akin to the

findings of Vidyarthi and Rai (1985) and Hasuain (1987) who reported exorbitant bride price often leads to marriage by capture. Only 13.50 per cent of respondents followed Andi (an expensive marriage ceremony) type of marriage. Anadar (10%) and Diku andi (4.50%) type of marriage was least present.

c. Age at marriage

Age at marriage of the respondents and spouses is tabulated below.

Table 9. Age at Marriage of the Respondents and Spouses

Age range in year	Percentage Responses	
	Respondents	Spouses
18 - 21	25.50	01.00
22 - 25	33.50	26.50
26 - 29	24.00	49.00
30 - 33	9.50	19.00
34 and above	7.50	04.50

It was found that 33.50 per cent of respondents got married between the age range of 22-25 years. Only one eighth of them got married between the age range of 30 to 34 and above, Thus indicating that marriage of girls was performed at a right age and also that child marriage was non-existent in the Ho tribe, in contrast to the Gojars, Khokh^h, Bombas of Kashmir Valley Lidhoo (1987) and Totos of West Bengal, Chaudhuri (1992) where marriage of girls was performed in tender age range of 12-15 years.

Analysis of the age of spouses at marriage revealed that nearly half (49%) of them got married in the age range of 26-29 years. A very nominal (1%) of spouses got married in the age range of 18-21 years. This finding is similar to study of Manrol (1990), who found that among Bhotia tribe of Uttar Pradesh, child marriage was rare. An interesting observation was that in the age range of 34 and above years more number (7.50%) of respondents were married as against (4.50%) of spouses. This trend could be probably due to high bride price which delayed marriage for both boys and girls.

d. Persons whose help is taken for mate selection

In the Ho tribe mate selection is generally done with the help of dutam, relatives, parents, friends and self preference. The data revealed that for 49 per cent of the respondents mate was selected by combined efforts of dutam (negotiator), relatives and parents. Thirty per cent of them reported that they had depended on their own decision and dutam. While 14 per cent of respondents made their own individual decisions with the help of friends and a few (4.50%) took their own decision.

Regarding obtaining the consent of concerned boy and girl about the selection of the partner, it was interesting to note that cent per cent tribal parents took consent of boys and girls before arranging their marriage.

e. Factors considered important while selecting the mate

The factors considered important while selecting the mate are given in the Table 10.

Table 10. Factors Considered Important While Selecting the Mate

Factors	Percentage Responses
Caste, age, job, health, good character, education and family wealth	45.00
Caste, age, job, health and good character	40.00
Caste, age, job and health	15.00

Analysis of the data on factors considered important while mate selecting revealed that cent per cent of the respondents checked the caste, age, job and health status, of the prospective partner for their ward. Forty five per cent respondents considered good character, education and family wealth as important factors. Although the 'Ho' tribe is considered to be an isolated entity, but the factors they consider in selecting a mate matches with the prevalent marriage system in the modern society.

f. Marital discord

In the 'Ho' tribe families, couples in distress turn to elders and relatives for help. In the present study 57 per cent respondents took the help of elders in the family while 25.50 per cent of them approached relatives and friends to solve marital problems. The least (17.50%) number of respondents expressed that they were helped by killi members during marital problems.

g. Conflict prone marriage type

Out of the prevalent marriage system of Ho tribe, an attempt was made to find out the conflict prone marriage type. The analysis of data indicated that about 28 per cent of respondents felt that conflicts occur in all kinds of marriage systems. The type of marriages in order of conflicts were opertipi (26%) anadar (18%), razikhusi (15.50%) and (11%) and diku and (1.50%) respectively. The probable explanation for more chances of conflicts for opertipi type of marriage may be ascribed to the fact that in this type of marriage capture is generally the way out in case the parents' consent is not forthcoming and in due course this practice often involve some kind of tension in the bargain of bride price. In many cases of opertipi the bride's parents often claim bride price even after the couple have settled down as husband and wife.

2. Dowry system

An indispensable ritual and the age old custom in a marriage alliance is 'dowry'. The system of dowry can be traced back to pre-vedic times. The practice of giving dowry both in cash and kind has emanated from the concept of giving the daughter as 'Dhan' hence named as 'Kanyadan' or 'Stridhan'. The practice of giving dowry to assist a newly married couple to start their new life with ease has now degenerated into a sordid, commercial transaction in which monetary consideration receives priority over the merits of

the bride. In contrast to the above, in most of the Indian tribes dowry ~~is not prevalent. However~~ or bride price, which the bride groom is supposed to pay adding status to the tribal women.

a. ~~Bride price~~ prevailing in various types of 'Ho' marriages

Dowry system among Ho's is unique. When the respondents were asked regarding prevalence of ~~bride price~~ among Ho tribe cent per cent of the respondents reported existence of ~~bride price~~ in form of bride price called GONANG. This finding is similar to the findings of Manrol (1990) for Bhotia tribe of Uttar Pradesh and of that of Swaminathan (1994) for Bhils of Rajasthan. Although the rate of Gonang (bridal price) depends upon the social position of the families concerned, 64 per cent of the respondents expressed that bridal price was more in Andi and Diku andi type of marriages, followed by Opertipi (36%). This fact may be responsible for more people going in for Razikhusi and Opertipi system of marriage in Ho tribe.

b. Items generally demanded as ~~dowry~~ ~~bride price~~

Regarding items demanded as dowry, more than 53.50 per cent of the respondents indicated that cash, cattle and rice beer were settled as bride price. Whereas 35 per cent respondents reported that in addition to cash, cattle and rice beer and ornaments were also taken as bride price. Very few number of respondents (5%) and (6.50%) reported that

cash and cattle, and cash, cattle and ornaments respectively were demanded by parents as bride price as depicted in Fig. 6.

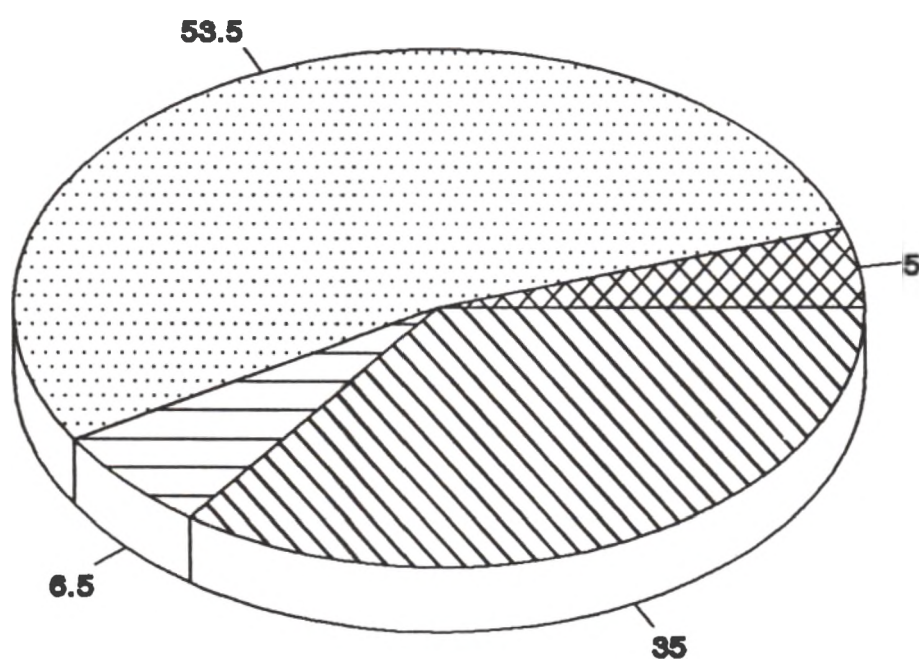
3. System of remarriage of women in Ho tribe

An investigation on system of remarriage of women amongst Ho tribe brought to light that remarriage of women was an accepted phenomenon. This fact was confirmed by cent per cent respondents.

4. Break down of family

Unlike Hindus, marriage is not a religious sacrament among the tribals of India. Hence separation, divorce or dissolution of marriage is not only possible but widely practised. Family crisis like separation due to desertion, divorce/dissolution of marriage do occur in the Ho tribe because of their traditional customs, mores and ways of living. It was noticed that although separation was a normal phenomenon in the study area as reported by the cent per cent of respondents yet, formal legal divorce was least prevalent as indicated by 86 per cent of the respondents. However, none of the respondents included in the study were divorced or separated. Although the Ho tribe couples did not approach tribal panchayat/courts for divorce, when couples were unable to adjust with each other they were free to separate or remarry as per their wish. There were varied reasons for separation or annulment of marriage as expressed by the selected respondents. The reasons of dissolution of

Fig. 6. ITEMS GENERALLY DEMANDED AS BRIDE PRICE



1 2 3 4

- | | |
|-------------------------------|--|
| 1. Cash and cattle; | 3. Cash, cattle and ornament |
| 2. Cash, cattle and rice beer | 4. Cash, cattle, ornaments and rice beer |

marriage as expressed by selected respondents are given in Table 11.

Table 11. Reasons Given for Dissolution of Marriage

Reasons	Percentage stating
Maltreatment	35.50
Adultery	10.00
Bigamy/polygamy	12.50
Economic burden	29.00
Lack of issue	8.00
Misunderstanding	5.00

The above table presents the reasons responsible for annulment of marriage. Nearly 35.50 per cent respondents expressed that maltreatment by husbands may be the main cause leading to dissolution of marriage. The brunt of economic burden may be another factor in view of 29 per cent respondents. Nearly equal percentage of respondents expressed adultery, bigamy/polygamy and lack of children being reasons responsible for dissolution of marriage. Majumdar and Madan (1989), highlighted that adultery and refusal to work lead to dissolution of marriage in Garo tribe. Further Hasuain (1987) in study of Gond and Kharia tribes found that marital infidelity, sterility and laziness were the factors responsible for break down of family.

a. Custody of children after annulment of marriage

Since annulment of marriage and remarriage of both men and women of Ho tribe was socially acceptable norm it was imperative to investigate the issue of custody of children.

The custody of children in Ho tribe was settled by tribal panchayat. It was observed that in case of minor children custody was always granted to mother and in case of major children custody naturally went to father. It was also noticed that of the women having children remarried, the child was eligible to claim his natural father's property. Although when minor the child ~~was settled~~ ^{was followed} ~~to stay~~ with mother, upon growing up the father can claim the child. There is mutual consent in such type of arrangement and normally problems do not arise. If problem occurs the tribal panchayat or the elders in the village and families settle the issues with mutual consent. However, in a few cases where both mother and father remarry the children are left in the care of grand parents and relatives.

b. Maintenance for separated, divorced and deserted women and their children

As indicated earlier, in the Ho tribe, all the cases related with the dissolution of marriage were handled either with the mutual consent of the parties concerned or were settled through the tribal panchayat law. It was indicated that in case of deserted, divorced and separated women and their children maintenance was allowed from husband and husband's father if the aggrieved women approached the Kolhan superintendent (Head man of the tribal panchayat). In case the woman remarried after annulment of marriage no maintenance is allowed.

5. Availability of Legal Protection for Ho Women and their Awareness Regarding Legal Protection Available for them in the Indian Constitution

Analysis of data on the above aspects indicated that equal share in the ancestral property was not available to the women in Ho tribe. About 89 per cent of the respondents stated that equal share in the ancestral property was not available to women due to the traditional custom and the remaining respondents put forth that ancestral property was generally given to the sons because they are expected to look after their parents in the old age.

Similarly when they were asked whether women protested for equal share in ancestral property, nearly 60 per cent of them reported that women do not protest because they respected traditional kolhan custom. The remaining respondents expressed that they were unable to protest because they were ignorant about the laws available for women.

Regarding their awareness of legal protection available for women in India, majority (67.50%) of the respondents expressed that they were not aware of legal protection available for the women in India. In contrast to this 32.50 per cent of respondents had some knowledge regarding laws available for women's protection. Nineteen per cent gathered this knowledge from mass media and 13.50 per cent from interpersonal communication. When the respondents were asked

about their desire to have awareness campaign on legal protection for women, 50 per cent desired to attend such awareness campaign to know about laws for women, out of the willing respondents 20.50 per cent wanted to attend such camps to know about laws, 16.50 per cent to enable themselves to fight for their rights and for emancipation of women(only 13 per cent).

C. Status of Women in Ho Tribe

The traditional Indian social structure is heavily fitted in favour of man, giving him all the authority and prestige and reducing the woman to the lower status confining to the kitchen (Sikar, 1985). For thorough understanding of the status of women we have to dig time and space, the status of woman has been like a moving equilibrium at various times in different societies, including the tribal ones. Theoritically, the low status of woman is accepted even in a majority of tribal societies, exception being the matriarchal, matrilineal and polyandrous society (Manrol, 1990).

To elicit information on status of Ho women the aspect investigated were as follows:

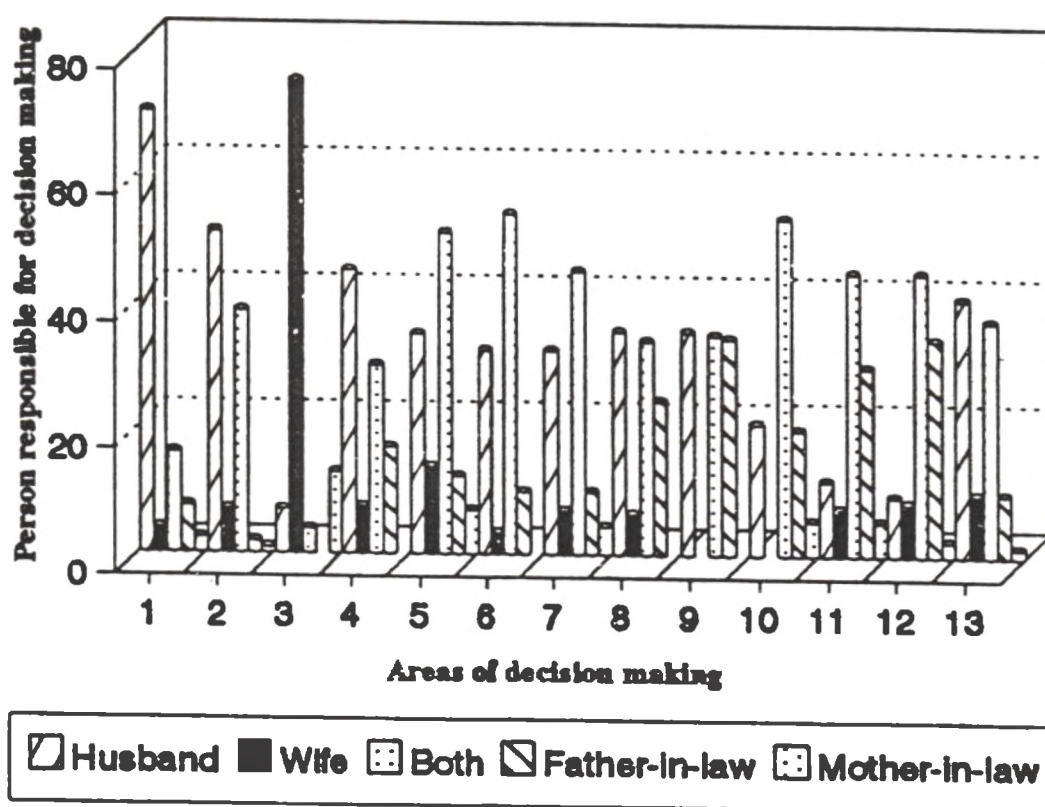
1. Decision Making Pattern of Ho Respondents

Decision making pattern of selected resopondents is given in Table 12 and Fig. 7.

Table 12. Percentage Distribution of Decision Making Patterns of the Selected Families

Areas of decision making	Person responsible for decision making				
	Husband	Wife	Both	Father-in-law	Mother-in-law
1. Family size	70.00	4.00	16.00	7.50	2.50
2. Selection of clothing	51.00	7.00	38.50	2.00	1.00
3. Choice of food for family	7.00	75.00	4.00	-	13.00
4. Education of children	45.00	7.50	30.00	17.00	-
5. Health care	35.00	14.00	51.00	12.50	7.00
6. Recreation	32.50	3.50	54.00	10.00	-
7. Money management	32.50	7.00	45.00	10.00	4.50
8. Decision on mate selection for children	35.50	6.50	34.00	24.50	-
9. Decision of children's vocation	35.50	-	35.00	34.50	-
10. Overall management of the house	21.00	-	53.50	20.00	5.50
11. Seed purchase	12.00	7.50	45.00	30.00	5.50
12. Crop to be sown	9.50	8.50	45.00	34.50	2.50
13. Free to spend money	41.00	10.00	37.50	10.00	1.50

Fig. 7. PERCENTAGE DISTRIBUTION OF DECISION MAKING PATTERNS OF THE SELECTED FAMILIES



The critical analysis of decision making power accorded to Ho tribe women reveals that out of 13 major areas of decision making almost all the respondents had privilege of joint decision making along with their spouses in seven areas such as family recreation (54%), health care (51%), money management (45%), mate selection for children (34%), vocation of children (35%), overall management of the house (53.50%), crops to be sown (45%) and purchase of seeds (45%), indicating that women's views also were considered important in Ho tribe in general family decision making. In (75%) of households women were given sole responsibility for selection of food for the family. It was brought to light that men were responsible for deciding the family size in 70 per cent of households and more number of men (41%) as against only 10 per cent of women could take independent decision on spending money. In the selected families much importance was not given to the in-laws to take family decision. Probably nuclear families could be the reason for less privilege to in-laws. This study is in line with Manrol (1990) who reported among Bhotias of Uttar Pradesh women always take decision on behalf of their spouses in their absence.

2. Reaction of respondents on decision given by husbands

Majority 77 per cent of the Ho women accepted their husbands' decision without any protest. The reasons for such acceptance were mainly financial dependency (33% of

respondents), to have harmony in the family (24% of respondents), due to helplessness (16.50% of respondents) and due to fear 3.50 per cent of respondents. As such the selected Ho respondents had almost equal chances of decision making along with their husbands. This indicates that women in Ho tribe are not subjected to much of the suppression of feelings.

3. Reaction of respondents towards women's harassment in their tribe

On hearing or seeing harassment of women in the community 83 per cent of respondents felt pity, another 10.50 per cent of respondents went to help, a negligible per cent (6.50%) of respondents did not feel any thing about it.

4. Opinion of women on girls education

As far as the opinion of respondents towards girls education was concerned, 67 per cent of the respondents were convinced that basic education was sufficient. In contrast (16.50%) of respondents opined that higher education is needed. Rest of the respondents (15%) expressed that there was no need of education in the case of girls in tribal areas. Probably this has something to do with their socio-personal characteristics, illiteracy and lack of educational facilities in the study area.

5. Medical aid provided to men and women

Disparity was found in the medical aid given to men and women. Two third of respondents reported that in case of illness immediate care was available to men while the women were neglected or seeking medical assistance for women was postponed. While one third of respondents expressed that in their households equal medical care was given to both men and women.

D. Traditional Mother and Child Care Practices of 'Ho' Tribe

Under this dimension, an attempt has been made to study in depth various mother and child care practices being followed in selected Ho tribe villages. The results have been discussed and presented under the following sub-headings:

1. Mother care practices during pre and postnatal period
2. Child Care Practices

1. Mother care practices during pre and postnatal period

Mother plays a central role in child's growth and development from conception till delivery and after-care for the mother and her baby should be given priority (Natu, 1989). The health and survival of new born baby is dependent upon the health status of the mother and care rendered to mother during pre and postnatal stages. Even the Ministry of Health has now come up with a blue print for a "Child

Survival and Safe Motherhood Programme (CSSM)" (Gopalan, 1993). So proper pre and postnatal care is essential for the sound overall development of the child (Walters and Stihnet, 1971; and Sharma, 1981).

The mother care practices of the Ho tribe are discussed below:

1.1 Mother care during pregnancy

Throughout pregnancy the growing foetus is entirely dependent on its mother. The mother's diet, her general state of health and the amount of physical work done by the mother has its own effect. Therefore, proper antenatal care throughout pregnancy is essential (Ghosh, 1989). To know the mother care during pregnancy in the study area percentage analysis and multiple regression analysis has been worked out.

Percentage analysis:

For the purpose of this study it was decided to include women at least with one child. However, it was found that none of the respondents were pregnant at the time of the interview. Fifty per cent of respondent had one to two children while remaining 50 per cent had more than two children.

Table 13 gives the data on miscarriage, still birth and neonatal mortality.

Table 13. Percentage Distribution of Data on Miscarriage, Still Birth and Neonatal Mortality

Particulars of miscarriage, still birth and neonatal mortality	Out of (N=661) number of pregnancies		Causes of miscarriage, still birth and neonatal mortality	
	N	Per cent	N=57	Per cent
Miscarriage	25	3.78	Illiteracy 20	35.08
Still birth	14	2.12	Poor health care facilities 10	17.54
Neonatal mortality	18	2.74	Poverty 19	33.34
Number of children alive	604	91.37	Under-nutrition 8	14.04

It was observed that out of 661 pregnancies of selected respondents 3.78 per cent and 2.12 per cent resulted in miscarriage and still birth respectively and 94 per cent were live births, out of which there was neonatal mortality of 2.74 per cent. This low mortality rate may be due to the appropriate use of indigenous medicines by tribal mothers. The major causes of miscarriage, still birth and child mortality as expressed by respondents were illiteracy (35.08%) and poverty (33.34%). The causes of infant mortality and wasted pregnancies found in this study are similar to the findings of Goswami (1988) and WHO (1990) wherein it was found that wide spread poverty, illiteracy, malnutrition, inadequate health and living condition were the reasons for infant and child mortality.

a. Health check-up during pregnancy

i. Frequency of health check-up

Frequency of health check-up during pregnancy in the selected areas is given in the Table 14.

Table 14. Frequency of Health Check-up at Primary Health Centre during Pregnancy

Frequency	Percentage stating
Fortnightly	-
Once in a month	-
Once in two months	-
When sick	46.50
When serious	17.00
Not at all	36.50

The above table indicates that the prescribed norms of medical check at primary health centre during pregnancy were not followed by tribal women. So none of the respondents had undergone prenatal tests like blood, urine test and weight check-up. More than one third of them never under went any prenatal check-up. The rest of them consulted doctors either when sick or very serious. This shows that among 'Ho' tribe the state of pregnancy was considered natural for women which they felt did not require any medical amenities assistance.

Regarding inclusion of supplements like iron, folic acid and calcium the data revealed that iron supplement was taken by nine per cent, folic acid by four per cent and calcium supplement by 12 per cent of respondents. Only two

per cent of them had taken tetanus toxoid injection between 6-9 months of pregnancy.

The reasons for not going in for prenatal check-up at PHC are enumerated in the Table 15.

Table 15. Reasons Stated for Not Going for Prenatal Check-up at Primary Health Centre

Reasons	Percentage stating
Due to laziness	3.70
Too much work	3.70
Opposed by the husband	-
Financial problems	9.26
Non-availability of medicines	9.26
Ignorance	74.09

The major reasons for not availing the facilities of Primary Health Centre provided by the Government for welfare of the rural and tribal families was ignorance (74%). The remaining few respondents narrated that the reasons for not going to primary health centre were financial problems, non-availability of medicines, laziness and too much work.

As indicated above the tribal women did not avail the services of Primary Health Centre for prenatal check-up. Pregnancy and its problems were handled very beautifully by the elderly women or local dais. It was found that in case of majority (51.50%) of respondents, check-up during pregnancy was done by dai. Only 16.50 per cent women contacted doctors due to seriousness. The rest of them had

not needed any check-up during pregnancy. The services of local dai were availed by paying in cash or kind as per the situation.

The complications suffered by 'Ho' tribe women during pregnancy are listed in Table 16.

Table 16. Complications during Pregnancy

Complications	Percentage stating
Anaemia	35.00
Sudden pain	6.00
Oedema	13.00
Malarial fever	17.00
Loss of weight	5.00

The data in the table reflects that majority (35%) of pregnant women suffered with anaemia, followed by malarial fever and oedema 17 and 13 per cent respectively. Lack of proper diet, long and tedious hours of work and lack of protection from mosquitoes may be reasons for their suffering. Bhuyan (1986) reported similar complications in the pregnant women of certain tribes like Santal, Munda, Oraon and Gond of Bihar and Madhya Pradesh.

The information on female death in the households in the age of 15-35 years and its reasons is presented in Table 17.

Table 17. Percentage Female Death in the Reproductive Age and Stated Reasons

Female death in the reproductive age and reasons	Percentage stating
Yes	15.00
No	85.00
Lack of adequate medical care due to poverty	10.00
Disease/sickness	2.50
During pregnancy	-
During delivery	2.50

It was revealed that female death in the age group of 15-35 years range had occurred only in 15 per cent households. None of the women died during pregnancy, about 2.5 per cent died during child birth. Lack of adequate medical care due to poverty was expressed as a major cause of female death (10%).

d. Diet during pregnancy

An interesting observation was that during pregnancy the Ho women did not observe any restriction on food. Only a negligible 8.50 per cent of respondents claimed that they consumed special food items such as fowl, fish, seasonal fruits and pulses (black gram and lentil) during the vulnerable period to maintain good health. Similar results were found by Saxena (1989) regarding tribals of Baster in Madhya Pradesh.

1.2 Rest and preparation for confinement

It was found that in Ho tribe cent per cent of respondents worked till arrival of new born baby. Might be

because of their poor socio-economic status and belief that pregnancy is natural state for women and also that working upto the third trimester of pregnancy facilitates the delivery. This finding is similar to the finding of Vidyarthi and Rai (1985), who reported that pregnant woman of Chenchu forest tribe of South India worked till she goes in labour.

Regarding preparation for delivery it was found that 65 per cent women prepared for delivery in the form of collecting old cloth. None of the other things like cotton, soap and oil were collected in advance in the Ho tribe.

a. Place of delivery

In the tribals majority of the deliveries take place at home. In the present study also a majority of (85.50%) deliveries took place at homes. Only 15 per cent women with complications are taken to the hospital. Regarding the preparation of place for home delivery it was observed that in Ho tribe the pregnant woman's husband was supposed to construct a temporary hut out side the house for confinement. However, in low socio-economic strata a corner of the house was earmarked for conducting the delivery. Duboogress, locally made mat, paddy straw and burning fire is most useful requisite for this room. Muthurayappa (1993) also reported that in Marati, Malakudia and Karaga tribes of Karnataka home deliveries were popular.

Data on persons attending the delivery is given in the Table 18.

Table 18. Persons Attended Delivery for the Selected Respondents

Persons	Percentage responses
Husband	14.00
Untrained Local Woman (Dai)	28.50
Both Husband and Local Woman	51.00
Mid wife/nurse	5.50
Doctor	1.00
Trained birth attendant	-
Trained attendant	-

In case of more than half of the selected respondents delivery was conducted jointly by husband and the local woman. In very few cases (6.50%) of respondents delivery was attended by the trained medical personnel.

b. Responsibility of husband at the time of delivery

Nearly half (47.50%) of respondents stated that at the time of delivery their husband's main responsibility was taking care of them and their baby. Whereas, the remaining 11 per cent of respondents expressed that they received both care and counselling from their husbands at the time of delivery.

An interesting observation regarding the Ho tribe was that husbands were supposed to be with their wives during delivery and confinement period for looking after the needs of the wife and the new born baby.

Regarding observance of any ritual for safe delivery more than 50 per cent of respondents denied the observance of any ritual while remaining (38%) indicated having performed the sacrifices of the red and gray colour fowls before wife entered the delivery room to please (Singhbonga) their God.

1.3 After care of the mother

Data pertaining to the after care of the mother is discussed below.

a. Immediate care

Information on the immediate care of the mother after delivery is presented in Table 19.

Table 19. Immediate Care of Mother after Delivery

Immediate care	Percentage responses
Massage with special oil	36.50
Allow to sleep	34.50
Massage and sleep	29.00

In the Ho tribe soon after the delivery the mother were given body massage to relieve the body pain. They used special oil made by boiling garlic in the mustard oil.

Thirty six per cent of respondents reported that soon after delivery they were given body massage. About one third of them were simply allowed to sleep. After 7-8 hours of rest the mother is made to drink hot water with turmeric to

purify the blood. After this hot rice and salt is fed to the mother.

b. Observation of ritual/function soon after child birth

Regarding observation of rituals/function soon after birth it was found that in the Ho tribe no celebration took place soon after the child's birth as they observed bisi (pollution period) during which the mother and the baby were necessarily kept in isolation.

During this period outsiders visiting the mother and baby had to wash their hands and feet and smoked on fire before entering the room. The new born and the mother were not allowed to participate in any work and functions during pollution period.

The bisi period varied from 5-21 days. Majority (80.50%) of respondents of this study observed bisi only for eight days. This custom provides the needed rest to the mothers and also keeps the infection away. At the end of the bisi the couple along with the baby is given the ceremonial bath known as the purification bath, the baby is also named on this day. Thereafter a feast is organised for the kin members.

Pollution period is observed by majority of the tribal people in India. This good custom is the only rest period available to the over worked women. Vidyarthi and Rai (1985)

made similar observation for Munda and Oraon tribes and Manrol (1990) found similar custom for Bhotia tribe of Uttar Pradesh wherein the mothers were allowed to rest for 22 days.

c. Resumption of house work and care of body after delivery

The information on resumption of house work and care of body is presented in Table 20.

Table 20. Resumption of Household Work and Care of Body after the Delivery

----- Period of rest availed and care of body -----	Percentage stating
Period of rest	
One week/from fifth day	1.00
With in a fort-night	65.50
One month/from twenty one day	33.50
More than one month	-
Care of body	
Massage with special oil	2.00
Drink rash	6.00
Both body massage and drinking rash	90.00
No care	1.00

More than half of the selected respondents resumed normal household work on eighth or on ninth day after delivery that is immediately after the purification ceremony was over. To regain the body strength after the delivery 90 per cent of the selected tribal women followed practices such as drinking rash (top layer of rice beer) and body

massage with special oil (karanj or mustard oil boiled with a bit of garlic). Majority (80.50%) of respondents of this study observed bisi only for eight days.

d. Food items restricted and special food items included in the nursing mother's diet

Table 21 shows food items restricted and special food item included in the diet of nursing mothers and the reasons for the same.

Table 21. Food Items Restricted and Special Food Items Included in the Diet of Nursing Mothers along with Reasons

Food items restricted/included	Percentage stating	Reasons
Food items restricted		
Non-vegetarian	1.50	Inadequate secretion of breast milk
Vegetables such as brinjal, lady's finger, green leafy vegetable	5.00	Diarrhoea and colic pain in the child
Oil, spices and curd	8.50	Cold and Diarrhoea
Restricted all above - non-vegetarian, vegetables - brinjal, lady's finger, green leafy vegetable, oil, spices and curds.	85.00	Due to all the above listed reasons
Special food items included		
Mandi, sathavari herb and fermented rice	11.50	
Mandi, rash, papaya and herb sathavari	3.50	
Mandi, rash, fermented rice, turmeric soup, black gram dal, papaya, sathavari herb and onion seeds	85.00	

The data highlights the common foods prohibited and included during lactation wherein the traditional system of 'hot' 'cold' foods was widely followed. Food taboos in lactation were practiced out of fear that the child would be adversely affected through the breast milk if the mother consumed certain foods. In the present study 85 per cent of respondents restricted non-vegetarian foods and vegetables like lady's finger, brinjal, green leafy vegetables, oil, spices and curds as they believed that it would cause colic pain and diarrhoea and 'green stools' in the child. It would also lead to inadequate secretion of breast milk in mother. In the tribes of Gujarat, Gopaldas (1986) observed that brinjal was considered to cause delayed healing of the wound in mother and child; oil and spices were believed to 'heat up' the body systems and cold foods like curds were avoided by lactating women so that the child is protected from 'colds'; consequently, these foods were avoided.

For lactating women inclusion of certain special food items was a universal phenomenon. Eighty five per cent of respondents reported that the special foods consumed by the Ho tribe lactating mothers were mandi (rice cooked with lots of water), rash (top layer of rice beer), cooked rice fermented for overnight with common salt, turmeric soup, dried onion seeds, black gram dal, papaya and sathavari herb. All these food items are supposed to help in milk production.

1.4 Family planning techniques of tribe

Investigation on practices of birth control revealed that 24 per cent of the respondents did not practice any family planning measures. Majority (55.50%) of respondents revealed that for family control herbal medicines such as root of Karpendu (*Ruellia sufruticosa*) and Ankoadaru (*Alangium lamaruii*) was effectively being used by them for aborting the foetus. For ceasing the unwanted pregnancy, women ground and boiled the roots of either *Ruellia sufruticosa* or *Alangium lamaruii* and drank the concoction which leads to spontaneous bleeding and abortion. The respondents reported that this is done soon after the periods are missed. Later the village dai massages the stomach to remove the dirty blood. Eight per cent of them followed coitus interruptus. While remaining 12.50 per cent used traditional and modern method of family planning like use of pills distributed by multipurpose health workers, tying of amulet near the waist. This amulet is given by tribal medicine man (ojha) or local woman (dai) and breast feeding. It was observed that the family planning techniques prevalent in Ho tribe were quite useful as reflected by existence of less number of children in their families. This study got ample support from the study of Gurumurthy (1987) on Yandi tribal women in Andhra Pradesh and Puri (1992) on some tribal families of Udaipur city revealed that breast feeding played a major role as an effective natural

contraceptive for the women who shy away from most of the modern contraceptive techniques.

b. Reliability of prevalent methods

Regarding reliability of prevalent methods 46 per cent respondents felt that the prevalent methods were quite reliable. In contrast to above 37.50 per cent of them stated that it was not reliable. Thirteen per cent of respondents felt that these methods used were very reliable. Only three per cent suggested to be reliable.

c. Respondents awareness about methods of family planning

Table 22 presents the awareness of respondents about methods of family planning and their source of information.

Table 22. Respondents Awareness about Methods of Family Planning and their Source of Information

Awareness of modern methods of family planning	Awareness* per cent	Source of information of family planning measures	Per cent
Sterlization (male and female)	75.00	Interpersonal communication	31.00
Copper T	-	Mass media	4.50
Rhythme (safe period)	-	Multipurpose health worker	50.50
Oral contraceptive	-		
Condom	75.00	Trained birth attendant	5.00
None of above	10.00		

* - Multiple responses

Family Planning is a National problem and there was normal notion that tribals being primitive in nature living in isolated hamlets may not be aware of the birth control practices but contrary to this Table 22, reveals that Ho respondents were aware of the Family Planning measures like sterilization and condom as reported by 75 per cent respondents.

Regarding their source of information on family planning measures it was noted that 50.00 per cent of the respondents attributed the source of information to multipurpose health workers (MPHW) of A.C.C. factory, Jhinkpani, followed by 31.50 per cent respondents who gained information from interpersonal communication. Mass media was responsible only in 4.50 per cent of respondents. This might be due to the non-availability to T.V. and Radio in their houses. Majority (75%) of them were also aware about any financial incentive available from Government for adoption of family planning methods. This awareness was also due to the fact that many of the respondents were working as labourers in A.C.C. factory in Jhinkpani where they come in contact with doctors and nurses of A.C.C. factory's hospital. Probably it was the reason of their high percentage of awareness.

2. Child Care

The care of the child is discussed in terms of the traditional beliefs and practices given to the child after birth.

2.1 Immediate care after birth

a. Cutting of umbilical cord

The analysed data revealed that for cutting the umbilical cord after the birth of the child knife was being used by about 63.50 per cent of the respondents. Another 13.50 per cent used cob sheath. The remaining members used blade and bamboo knife. It was pleasant to note that these instruments were being sterilized in the burning fire before use by 63.50 per cent of respondents. Thirty per cent of those who sterilized the instruments stated that it was customary to heat the instrument in the fire. Twenty per cent maintained that it was the doctors' advice and the remaining (13.50%) stated that since every body was doing it they were also following. Those who did not sterilize the instruments gave reasons like ignorance (25%). About 12 per cent stated that sterilization was not common in tribal community.

b. Disposal of placenta

Almost all (90%) Ho respondents buried the placenta just after cutting the umbilical cord, to ward off the evil from the new born child. This kind of superstition was also

observed by Bhuyan (1986) in the Santal, Munda, Oraon and Gond tribes of Bihar and Madhya Pradesh.

c. Medication for healing the cord

For expediting the process of healing the cord wound they used indigenous things like mustard oil (32.50% respondent), karanj oil (18% respondents) and mobil (9% respondents), cow dung ash (5% respondents) and wood paste (21% respondents). So it was clear that the Ho tribe took immediate care of the child with the help of their traditional means.

i. Incidences of cord wound

Regarding the incidences of occurrence of cord wound 62 per cent of the respondents reported that there was no occurrence of wound after cutting the cord. Only 38 per cent of respondents reported occurrence of wound of which 18.50 per cent were minor wound, 12 per cent swelling and only 7.50 per cent were major wounds. Further it was emphasized that almost all the wounds were treated by local medicine men.

d. Bathing the newborn

In majority of the cases (80.50%) the first bath was given to the baby immediately after the birth with luke warm water. Almost an equal percentage of respondents used kanji water (8%) and tepid water (9.50%) for baby's first bath. Almost all (91%) the babies were given herbal massage with

mustard oil and turmeric paste immediately after bath to remove the vernix-caseosa.

e. Massaging the baby

Cent per cent babies were massaged at least twice a day. Sixty six per cent mothers used mustard oil while 26 per cent of them used karanj oil. Massage is supposed to (a) strengthen the baby's muscles, (b) help in getting relaxed sleep and (c) provides warmth to the baby. The oiling techniques followed were putting the child on the legs applying oil all over the body (Plate 3). Soon after massaging the child was put in the sun for half an hour in summer and about 3-4 hours in winter. This was observed by majority (87%) of the respondents.

2.2 Feeding practices

Feeding practices among infants have always been an area of special interest where child rearing practices are concerned. There are different cultural practices, attitudes, values and beliefs regarding the infant feeding. There are cultural variations regarding on set of feeding, kind of feeding, duration of feeding and introduction of semi solid, solid food in the baby's diet. The analysis pertaining to the feeding practices is presented below.



Plate 3. OILING TECHNIQUE USED BY TRIBAL MOTHER THRILLS THE CHILD

a. Feeding

Breast feeding was a universal phenomenon amongst the 'Ho' mothers. Therefore, cent per cent of respondents breast fed their babies. The babies were usually put to the breast within 9-12 hours. But in the present study only 45 per cent of respondents could feed during this period. Thirty eight per cent and 17 per cent of the respondents breast fed to the baby after 24 and 48 hours respectively, because of lack of milk secretion. Rice starch (16%), cow's milk (6%), goat's milk (8.50%), honey mixed water (2%) were the kind of liquids introduced as pre-lactation by about one third of respondents. The pre lactation liquid was given with the help of cotton or small piece of cloth soaked in the solution. Whereas Tavkar (1983) in her study of tribals of Gujarat, Gupta and Singh (1985) in their study on tribals of Rajasthan and Maurya (1987) in her research on Irulas of Nilgiri brought to light that babies were put to breast for their first feed within 24 hours to 96 hours after birth. The pre lactation liquids introduced were generally, goat's milk, jaggery, ajwain and ghee, honey and sugar water, glucose water and cow's milk and castor oil and honey, indicating that major portion of colostrum is wasted by the women of above tribes.

Feeding of colostrum

Colostrum feeding was common in Ho tribe. Reasons for colostrum feeding are given in the Table 23 and Fig 8.

Table 23. Reasons Stated for Feeding Colostrum to the New Born

Reasons for feeding colostrum	Percentage responses
Family practice	10.00
Good for health	7.50
Doctor's advise	23.00
Health worker's advise	42.50

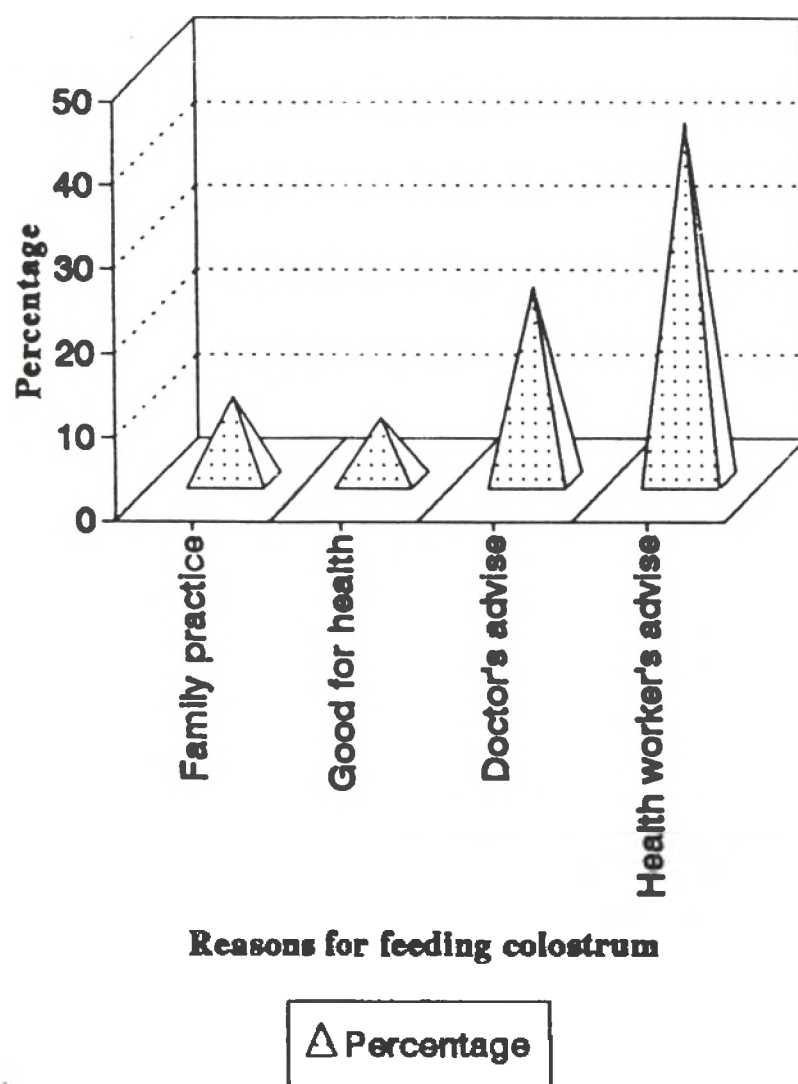
As discussed earlier majority of mothers started breast feeding between 6-24 hours, thus feeding colostrum to the baby. As the table shows, 83 per cent of them gave colostrum and the reasons for this practice was attributed mainly to the advise of health workers (42.50%) and doctor's (23%) of nearby A.C.C. factory, Jhinkpani. Gopaldas (1986) also reported that majority of tribal mothers in Gujarat believed that colostrum was good for the baby and did not discard it.

Table 24 deals with the pattern and length of breast feeding practiced by the selected respondents.

Table 24. Pattern of Feeding Schedule Adopted and Duration of Breast Feeding

Pattern and length of feeding	Percentage responses
Pattern of feeding adopted	
Demand	89.00
Schedule	5.00
As per the will of mothers	6.00
Length of breast feeding	
Upto one year	5.50
Upto two years	79.50
More than two years	15.00

Fig. 8. REASONS STATED FOR FEEDING COLOSTRUM TO THE NEW BORN



Majority of the respondents (89%) breast fed their infants on demand ie., when ever the child cried it was put to breast. Mostly (79.50%) breast feeding was continued upto 2 years of age. Taking the child off the breast at the age of one was very rare (5.50%). Gupta (1981); Gopaldas (1986); Gujral (1987) and Seshadri (1987) also got similar results in their study of Gujarat tribes.

2.3 Weaning practices

The weaning period is the most important period in the life of the baby. Psychologists regard that weaning may cause great frustration. Sudden weaning may even have the effect of a trauma (Bhogal, 1978). Introduction of supplementary feeding is shown in the Table 25.

Table 25. Introduction of Supplementary Feeding

Supplementary foods	Percentage responses
Age of on set of weaning	
Between 4-8 months	2.00
Between 8 months to 12 months	35.00
Between 12 months to 18 months	46.50
More than 18 months	16.50
Age of completion of weaning	
Within one year	1.50
Within two years	31.50
Within three years	62.50
More than three years	5.00
Supplementary foods introduced	
Mandi	38.00
Soaked rice with salt	19.00
Mandi added with drum stick leaves, papaya, khichari and potato	42.50

It is seen that weaning foods were introduced to the young child between 12 to 18 months of age by 46.50 per cent of Ho mothers. Followed by 35 per cent mothers who supplemented the child's diet between 8-12 months of age. However, in the study of Seshadri (1987), age of introduction of weaning foods was 6-11 months. Similarly in tribal families studied by Gupta (1981), the age of introduction of weaning food was the age of teeth eruption, around 8 months.

The age of completion of weaning in case of majority of Ho children was within three years. In case of 32 per cent of children weaning was completed within 2 years.

More than 80 per cent of the mothers interviewed stated that they supplemented the child's diet with mandi (in which some times drum stick leaves were added), papaya, potatoes, rice and dal cooked together. Other special weaning foods mentioned by 19 per cent of respondents were soaked rice with salt (fermented rice) and on special occasion rice-dal, fish and fowl's meat. On personal observation it was found that some tribal families (2.50%) gave rash (Top layer of rice beer) to infants, believing it to be strength giving.

Hence, it can be concluded that no readymade weaning mixes sold in the market were being used by tribal mothers. Baby's diet was modified out of the family kitchen.

Table 26. Weaning Methods Adopted and Problems Faced by Selected Mothers

Weaning methods	Percentage responses
Methods of weaning	
Gradual	95.50
Sudden	4.50
Methods adopted for weaning the child	
Applying neem paste	-
Applying bitter medicines	-
Frightening	20.50
Making child understand	12.50
Physical punishment	12.00
Problems faced while weaning the child	
Excessive crying	10.00
Irritative behaviour	28.50
No problem	61.50

Almost all (95%) Ho mothers weaned their babies gradually. More than half of the respondents stated that they did not adopt any special method for weaning the child. The child automatically got weaned either by arrival of new baby or due to their long absence from home.

When they become around three years of age they themselves give up the habit of breast feeding. The remaining 45 per cent had to wean the baby, off the breast by frightening (20.50%), physical punishment (12%) and reasoning with the child (12.50%). As reported by more than half of the Ho mothers, regarding problems during feeding, only 10 per cent of respondents stated that excessive crying of the child was observed while weaning. In contrast to this

study of Pandey and Punetha (1989) who found that in Bhotia tribe of Uttar Pradesh mothers mostly weaned the babies by using bitter tasting material on their breast.

2.4 Clothing

Clothing pattern prevalent for new born babies in Ho tribe is given in the Table 25 and Plate 4.

Table 27. Clothing Pattern of New Born in Ho Tribe

Pattern of Clothing	Percentage responses
Dressing of new born soon after the birth	
Old cotton garments of elder siblings	15.00
In old cotton cloth	85.00
Material used for children's clothing	
Cotton clothes	25.00
Both cotton and synthetic	75.00

In the present study almost all the respondents wrapped the new born in clean cotton cloth. The materials used for children's dress was both synthetic as well as cotton as narrated by 75 per cent of the Ho mothers. It was observed that clothes were not considered an important item for young children especially for males. Usually children below two were found naked, (Plate 4). Little older children were partially clad. However, girls were completely dressed. Similar observation were made by Tavkar (1983) for tribes of Gujarat and by Bhuyan (1986) for tribals of Madhya Pradesh.



Plate 4. CLOTHING PATTERN OF CHILDREN

2.5 Toilet training

Toilet training is usually associated with the phase of psycho-sexual development, which has been considered very important for the development of personality. Generally speaking, babies gradually gain control of their bowels and bladders as they grow. At the most what a mother needs to do is to watch her child in what stage of readiness he is and give him some positive encouragement (Rahame, 1988). The following illustrates the toilet training practices of selected Ho mothers.

a. Toilet training practices of Ho

Majority (65%) of the Ho mothers were not particular about toilet training their children, because of laxed attitude (20%) and lack of interest in toilet training (45%). Only 35 per cent of the respondents claimed that they toilet trained their children for reasons like keeping the environment clean (21%) and for inculcating good habits (14%) among their children.

b. Age of toilet training

The age of starting the toilet training amongst Ho mothers ranged from nine months to more than one year. Out of the 35 per cent of the respondents who believed in toilet training their babies. Twenty per cent introduced the toilet training at the age of more than one year, while 12 per cent mothers did so between nine months to one year.

The training subjects did not have any fixed age of toilet training. The procedure adopted for toilet training was making the baby sit on the mother's feet for defecation.

Regarding the time fixation for toilet training almost all the mothers had not fixed any time.

The reasons given for lack of time schedule for toilet training were illiteracy by nearly half number of respondents, the remaining half of the respondents give reasons such as ignorance (9%) and tight work schedule (7%).

c. Bed wetting

Regarding bed wetting cent per cent of the respondents reported that bed wetting was prevalent among their children below two years of age. Mothers differed greatly in their reaction to bed wetting. Sixty per cent of the mothers warned their child and remaining 40 per cent of mothers scolded the child.

2.6 Bathing and body care

Bathing is an important component of health and hygiene. Many diseases could be prevented with regular bathing. A bath can be a lovely experience and most babies enjoy it (Ghosh, 1989). Regarding frequency of bathing it was observed that only 35.50 per cent of respondents bath their children daily while rest followed either alternate (34%) or weekly (30%). Table 28 depicts the health habits being adopted by children of Ho mothers.

Table 28. Health Habits being Adopted by Children

Health habits	Percentage responses
Washing hand before eating	9.50
Brushing the teeth	45.00
Taking bath daily	35.50
Washing mouth after eating	-
Cutting nails on regular interval	-
Keeping hair free from lice	-
Washing hair once a week	23.00
Combing hair daily	15.00
Changing dress daily	4.50
Keeping the place neat	100.00
Drinking clean water	80.50
Eating in hygienic way	34.00
Toilet habits (going toilet at regular time)	2.00
Using clean towel and handkerchief	-

Investigation regarding inculcation of health habits revealed that out of fourteen health habits only two habits such as keeping the place neat and drinking clean water was insisted upon by almost all the mothers. While none of the selected respondents insisted upon washing their mouth after eating, cutting the nails on regular intervals, keeping hair free from lice and using clean towel.

The other neglected health habits by majority of children included washing hands before eating (9.50%) regular toilet habits (34%), combing hair and changing dress daily (15 and 4.50% respectively). While, remaining four habits like brushing teeth, taking bath daily, washing hair once a week and eating in hygienic way was quite common practices by less than half of the Ho children. Bhuyan

(1986) reported that in certain tribes of Bihar and Madhya Pradesh the children were given bath everyday.

2.7 Rest and sleep

It was noticed that in majority (83%) of the cases mother was responsible for putting the child to the bed. Occasionally, little children slept either with their grand mothers or their fathers (13.50 and 3.50%) respectively.

Regarding bedding facilities it was observed that no special preparation was done for baby's rest and sleep. Normally in low socio-economic tribal community it was a common practice to sleep on the ground and the cot was used only for the guest. The common bedding used for the child by 56 per cent of respondents was mat and kantha or goodali made out of old clothes and sarees. In 27.50 per cent families only cot was used without bedding, while in a limited number of respondents (6.50%) cot along with kantha was used for the baby's bedding. In contrast to present study Pandey and Punetha (1989) reported that among Bhotia tribe of hills of Uttar Pradesh some preparation is done for baby's rest and sleep by making a separate bedding.

Mode of sleeping

The most popular method for making the child sleep was breast feeding in case of 43 per cent respondents, followed by keeping the child on the lap and patting (28.50%). The remaining respondents adopted either tying the baby on back

while working (8%) or rocking the baby (3%). Only 17 per cent of respondents did not adopt any method for making the child sleep.

2.8 Health care and protection

Health is a part of total well being. Good health enables individual to develop maximum to their potential. An understanding of health care practices of people is very important. Therefore, data was collected on traditional health care practices adopted for children by Ho tribe mothers. Child health care practices of Ho mothers is discussed below.

a. Frequency of health check-up of infant

Generally, tribals do not go to hospitals for regular check-up for minor ailments. They follow the indigenous method of health care. On analysis of data it was found that health care was quite neglected in Ho community, as expressed by 62 per cent of respondents. Child is taken to the hospital only when seriously ill. The rest of respondents (38%) reported that for minor sickness in children as far as possible indigenous remedies prescribed by the local medicine men were used. The Hos also took their children to witch doctor who recited some mantras or magic words which are supposed to drive away evil spirits that are believed to cause illness. Shashi (1978) also found similar practices among the santal tribe.

Prevalence of common diseases among children of Ho tribe

Worms infestation and malarial fever was the most commonly prevalent problem in the study area among the younger children as reported by 46.50 per cent and 31.50 per cent of the mothers respectively. Next problem was frequent occurrence of diarrhoea (13.50%) and skin disease (8.50%) (Plate 5).

All these common health problems may be due to unhygienic living conditions and way of living, lack of good quality of drinking water and breeding of mosquitoes due to dense forest and bushes in their surroundings. Hence, there is a vicious circle of unhygienic living conditions, ill health and diseases.

Immunization schedule - its awareness and adoption

Almost all (85.50%) of the respondents were generally aware of immunization schedule. But it was disheartening to note that they did not follow it. The coverage of immunization was quite poor and irregular in the study area, as reported by 69.50 per cent of respondents. About 31 per cent of respondents did not immunize their children at all. Similarly, Bhuyan (1986) also reported that only two per cent of respondents in her tribal study of Bihar followed immunization schedule regularly. In contrast Muthurayappa (1993) reported that Karaga and Malkudia tribes of Karnataka who were living in colonies adopted better immunization practices than those who are not living in colonies.



Plate 5. PREVALENCE OF SKIN DISEASE IN THE CHILD

The following Table 29 gives the percentage distribution of types of immunization followed by 69.50 per cent of the mothers who claimed to have immunized their children some time or the others.

Table 29. Percentage Distribution of Irregular Immunization Adopted by their Mothers

Immunization schedule	Percentage stating
T.B.	6.50
Diptheria (D.P.T)	
I dose	14.00
II dose	14.00
III dose	-
Polio (O.P.V.)	
I dose	17.50
II dose	17.50
III dose	-
Measles	-
Booster dose	
D.P.T.	-
Polio	-

On analysis of the data on mothers' adoption of immunization schedule it was clear that 69.50 per cent of respondents adopted the vaccination schedule yet sequence of schedule was not followed by majority of the respondents. From the above data it is clear that an equal number (17.50%) of mothers practiced first and second dose of polio injections, followed by an equal number (14%) of mothers who also practiced two doses of D.P.T. injections.

Only 6.50 per cent mothers had followed about B.C.G. or T.B. vaccine. This irregularity in sequence of immunization schedule might be because of predominance of illiteracy in the study area.

Regarding type of remedies followed by mothers, it was noticed that 65 per cent of the respondents took their children to the ojha (local medicine man) for the cure, followed by home made remedies (20.50%) and allopathy medicine (14%).

Cent per cent of respondents provided equal amount of care without any discrimination among boy and girl child. Similarly, all the mothers expressed their view for use of indigenous remedies for health care of their children.

2.9 Safety measures adopted for child protection

Data pertaining to safety measures taken by tribal mothers for child protection are presented in the Table 30.

Table 30. Safety Measures Adopted for Child Protection

Safety measures adopted	Percentage stating
Keeping medicine away from children	4.50
Keeping surrounding free from accident prone objects	73.50
Keeping children away from fire	22.00
Careful supervision while play	-

Most of the Ho mothers, (73.50%) tried to make their surroundings as accident proof as possible so as to enable

the youngsters to play around unsupervised without hurting themselves. Keeping the child away from the fire (22%) and keeping the medicines away from children (4.5%) were other measures taken for child protection.

2.10 Play and recreation

Play is nature's mode of education in the sense of adaptation to environment. It is a spontaneous and natural activity of the young child engaged in for enjoyment. Play time is the most enjoyable time in a child's life. Toys have a big role in play time activities. They are the earliest and the best friends of the child, because they come closest to him in his affection after his parents. Toys are not just play things. They fulfill many functions, the most important of which is to help the development of an integrated personality (NCERT, 1978). The information pertaining to play and recreation is given below :

a. Importance of play and interaction of parents with child during play

Almost one third (76%) of the respondents considered that play was important for young children. However, only 25 per cent of parents could spend time playing with their children due to their own busy schedule. In line with the present study Tavkar (1983) and Bhuyan (1986) also found that in the tribal communities studied by them involvement of the family members, other than children in the child's play sessions was missing.

Further it was investigated whether parents made any toy for their children. It was observed that none of the respondents made any toys for their children. The reasons stated by them were that they did not know to make the toys (52%) and lack of sufficient time (48%) due to over work. Regarding play materials provided by Ho parents for amusement to their children, it was found that nothing special was provided. The tribal child's play material included generally natural things like clay, mud, sand, flowers, leaves and other things like old tin utensils, seeds, beads, broken pieces of pitcher, rope and so on. It was indeed interesting to watch the children play with the resources available in the environment (Plate 6).

2.11 Discipline

Discipline is one of the most essential components of child rearing. The aim of disciplining is not to control the freedom of the child, but to give him greater freedom, within manageable limits. The disciplinary practices adopted by selected respondents are discussed below.

1. Parents' opinion on disciplining the children

Eighty per cent of the respondents opined that disciplining the children was necessary for inculcating good habits (43%), to socialize the child (23.50%) and to make child a good citizen (12%).



Plate 6. JUNK MATERIALS USED BY CHILDREN FOR PLAY

2. Behavioural problems prevalent in Ho children

Behavioural problems amongst the Ho children as reported by the respondents are depicted in Table 31.

Table 31. Behaviour Problems of 'Ho' Children as Reported by Respondents

Behavioural problems	Percentage responses
Stealing	5.00
Telling lie	17.50
Putting finger in mouth	35.00
Bed wetting	-
Thumb sucking	2.50
Headbanging against floor and wall	-
Temper tantrum	-
Stammering	-
Bullying	37.50
Hitting children	55.00
Biting other children	2.50

On critical analysis of data it was found that hitting (55%), bullying (37.50), putting finger in mouth (35%) and telling lie (17.50%) were reported by the Ho mothers as common behavioural problems of children. Mothers felt that their children were grossly being neglected thus being unguided and idle, they probably indulged in problem behaviour such as hitting each other and so on, which at least got them some parental attention.

Due to poor socio-economic conditions parents were compelled to work from dawn to dusk for making both the ends meet. After reaching home from work they had household responsibilities hence, they were left with very little

energy and interest to look into the children and their problems including the disciplining aspects.

3. Methods adopted for disciplining the child

It was observed that mothers used punitive ways to discipline the child. It may be because of less education and more work in the house which made her irritable and less patient. The data on methods adopted for disciplining the child revealed that 28.50 per cent of mothers gave physical punishment and 40.50 per cent moderate to mild scolding in case the child misbehaved. Ignoring the child's bad behaviour was noticed among 31 per cent of respondents. Pandey and Punetha (1989) found similar observation among Bhotias of Uttar Pradesh who also gave physical punishment and severe scolding in case the child misbehaved.

Cent per cent respondents narrated that they did not discriminate between boys and girls with regard to disciplining them. For Ho tribe boys and girls are equally important as boys are expected to take care of parents in old age while girls will bring gonang (bride price).

Multiple correlation and Regression Analysis of the Child Care Scores of Mothers and its Relationship with a Set of Selected Identified and Defined Variables of Ho Tribe Mothers

Problem setting

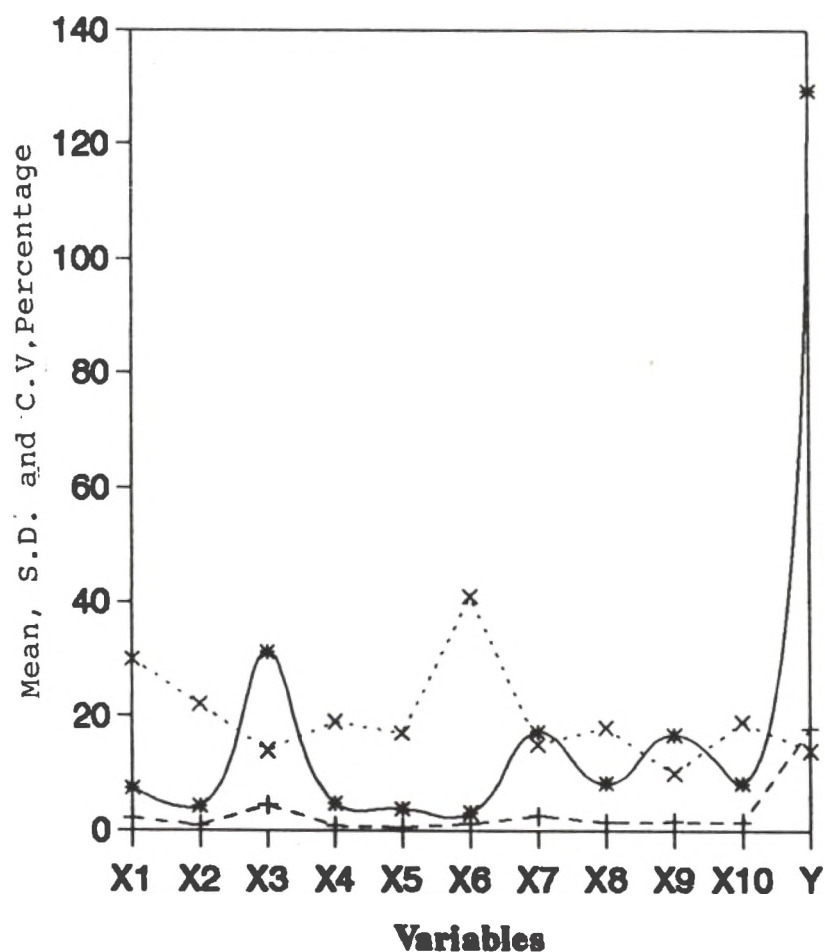
In the earlier discussion the data on dependent variable (scores of mothers on child care practices) and

selected independent variables such as marriage pattern, remarriage, status of women, legal protection for Ho women, break down in family due to diseration, the dissolution of marriage through legal separation, prenatal care (medical and diet), rest during pregnancy, postnatal care and techniques of family planning used by selected respondents have analysed by way of percentage analysis. The present part of the analysis is presents the variability between the selected ten independent variables. The extent of variability and consistency along with their mean values. Table 32 and Fig. 9 present selected variables, their means, standard deviation and coefficient of variation (C.V. per cent).

Table 32. Variables, their Means, Standard Deviation and Coefficient of Variation (C.V. per cent)

Name of variables	Symbol	Mean	S.D.	C.V. (%)
Marriage pattern	X ₁	7.3900	2.1913	30
Remarriage	X ₂	4.2400	0.9523	22
Status of women	X ₃	31.2700	4.4561	14
Legal protection for Ho women	X ₄	4.8000	0.9023	19
Break down in family due to desertion	X ₅	3.7700	0.6396	17
Dissolution of marriage through legal separation	X ₆	3.0900	1.2649	41
Prenatal care (medical and diet)	X ₇	17.2400	2.6031	15
Rest during pregnancy	X ₈	8.2800	1.5275	18
Postnatal care	X ₉	16.7050	1.6313	10
Techniques of family planning	X ₁₀	8.2900	1.5743	19
Dependent variable	Y	129.5300	17.8812	14

Fig. 10. MEANS, STANDARD DEVIATION AND COEFFICIENT OF VARIATION BETWEEN TEN INDEPENDENT VARIABLES (X) AND DEPENDENT VARIABLE (Y)



- X₁ - Marriage pattern
- X₂ - Remarriage
- X₃ - Status of women
- X₄ - Legal protection for Ho women
- X₅ - Break down in family due to desertion
- X₆ - Dissolution of marriage due to legal separation
- X₇ - Prenatal care (medical and diet)
- X₈ - Rest during pregnancy
- X₉ - Postnatal care
- X₁₀ - Postnatal care
- X₁₁ - Techniques of family planning
- Y - Dependent variable

1. Marriage Pattern (X_1)

The score assigned to the marriage pattern ranged from 16-4 indicating wide variation in the pattern of marriage variable. The average of this character has been 7.39 with standard deviation of 2.1913 and the C.V. has been 30 per cent indicating that wide variation existed in the marriage pattern of the selected families. This is true because respondents followed different kinds of marriage pattern i.e., (Andi, Diku andi Razikhusi, Opertipi and Anadar) as already discussed in part B of the findings and discussion. On the basis of the coefficient variation in the marriage pattern of the respondents and the descriptive analysis it was anticipated that marriage pattern might affect the child care practices of selected mothers.

2. Remarriage (X_2)

The quantified score for this variable ranged from 2-1. Again yielding a considerable or wide distribution of scores in selected 200 samples. The average has been 4.24 being nearer to the minimum score, implying that remarriage was permissible trend in majority of the cases leaving some extreme cases of the remaining number of families. This has again been considerably a high percentage of C.V. (22%). Due to the high C.V. percentage it could be inferred that this variable might also influence child care practices of respondents.

3. Status of Women (X_3)

This character had a maximum of 44 scores followed by a minimum of 15. The mean value being 31.27 with S.D. 4.4561. From the mean, maximum and minimum values it could be inferred that in majority of the cases there has been a high dimension when compared to a few cases where status has been considerably at a lower level. The C.V. is also only 14 per cent indicating a considerable uniformity in the status of women in the area of the study. This is true again with the fact that out of 13 major areas which are concern with the day to day aspects of decision making, in seven areas decisions were taken jointly by the husband and wife in the family. Therefore, naturally the status of women would score more than from a situation where an individual alone is responsible for taking the decision in the family affairs. The uniformity in the status of women might influence child care scores of the Ho respondents.

4. Availability of legal protection for Ho women (X_4)

This character has been quantified based on many items. The range has been scored 8-4. The average as 4.8 with S.D. 0.9023 with a C.V. 19 per cent. Based on the mean value, it could be inferred that availability of legal protection was at lower level. Only in a few cases a high level of legal protection was available. This was also evident from the percentage analysis in the previous part. Child care practices adopted by mothers might be influenced by legal protection available to Ho mothers in the study area.

5. Breakdown in the Family due to Desertion (X_5)

The score assigned to the break down in family due to desertion varied from 8-2. The mean value was 3.77 with standard deviation 0.6396 and C.V. 17 per cent, again indicating uniform variation in desertion among the selected families, which might have influence on child care practices of Ho mothers in the study area.

6. Dissolution of marriage through legal separation (Decided by tribal panchayats) (X_6)

The quantified scores of this variable ranged from 8-2. Again yeilding a considerable distribution of scores in selected samples. The mean value being 3.0900 with S.D., 1.2649 and C.V. 41 per cent. The high percentage of C.V. value (41%) indicates that there would be extreame cases of separation which might have tremendous influence on mother's child care practices in the study area.

7. Prenatal care (Medical and diet) (X_7)

Prenatal period is the most exciting period of expectation and fulfilment in a woman's life. It is a period of great anabolic activities when the most rapid rate of growth takes place in the foetus at the expense of mother. The environment in which the unborn child grows has tremendous influence on h e subsequent pattern of physical and psychological growth. Hence, to know the existing pattern in term of prenatal care, medical and diet, mean, S.D. and C.V. value were worked out. The scores assigned to

the prenatal care ranged from 31-10. The mean of this character has been 17.24 with standard deviation 2.6031 and C.V. was 15 per cent, indicating considerable uniformity of care (medical and diet) received by selected respondents. This might be due to similarity in socio-personal characteristics of selected respondents and inadequate medical facilities available to them. This in turn might influence the scores on child care practices of selected mothers.

8. Rest during pregnancy (X_8)

During this period mothers need proper care and attention by the family members, because of many physical and psychological changes.

The scores assigned to this variable varied from 13-5 with average 8.28, S.D. 1.5275 and C.V. value was 18 per cent, indicating least variation in prenatal physical care or in other word almost all the mothers had been getting similar prenatal physical care. The least variation in care received by pregnant women might have similar impact on child care scores of the mothers in the selected villages.

9. Postnatal care (X_9)

The postnatal care of the mothers include several aspects such as immediate care of mother and new born, amount of rest and diet of the lactating mother, her digestion and physical fitness.

The scores have maximum 19 followed by a minimum 6. The mean value being 16.70 with standard deviation 1.6313 and coefficient of variation 10 per cent, indicating least variation in postnatal care rendered to the Ho mothers in the study area. This least variation might be due to inadequate medical facilities in the study area. This least variation might influence the scores of mothers in child rearing practices.

10. Techniques of family planning (X_{10})

The scores of techniques of family planning methods used by 'Ho' mothers ranged from 13-4 with average 8.2900, standard deviation 1.5743 and C.V. 19 per cent, indicating considerable uniformity in the techniques of family planning method used by respondents. It is assumed in general that the Family Planning Methods followed will have little effect on the child care scores. Since, it is a health care practices for the mother not for the child.

Child care scores (Dependent variable Y)

The child care scores obtained for a incumbent in the study is cumulative effect of the child care practices adopted by tribal mothers. Since the child care practices vice-versa child care scores again depend upon many contributing components like the family background, economic status, the literacy level, exposure to social activities, awareness of the child care practices. Therefore, the

dependent variable (child care scores) has been carefully defined in the study. Since the analysis mainly relates to the above variable may be through the identified and explanatory variables or the components that constitute the child care scores for example the major components that could be responsible for determining the explained variable that is child care scores like immediate care, feeding practices, weaning and supplementary feeding practices, clothing, toilet training, bathing and body care, rest and sleep, health protection, safety measures used to protect the child, play, recreation and disciplining the child.

Since the area of investigation exhibited much variation in the other explanatory variables the same trend of variability is also expected to exist in the case of child care scores also. With the above view when the scores assigned to the 200 respondents were analysed it was found that the maximum score was 188 and the minimum being 62 points only. Thus the range (difference between maximum and minimum) 126 that is double of the minimum value. This means the variability of this variable would be remarkably high. But when the C.V. was worked out for this variable it was only 14 per cent indicating almost all the women had uniform scores as far as this variable was concerned. Then how to account for a greater range by this it was implied that the women who scored extremely high child care scores have been a few, leaving the rest to record a uniform pattern of child

care scores. This has been again explained by the mean value which is 129.53 only, with a S.D. of 17.88.

Based on the above analysis it can be said that a more consistant group of tribal women were considered analysing the child care scores which is manifested by the child care practices followed by them in the study area.

Correlation and Regression Analysis

Simple correlation coefficients between the level of child care scores of mothers and the selected ten independent variables.

The selected contributing variables and also the child care scores of the selected two hundred tribal women in the area of investigation have been discussed earlier with reference to their variability, extent of variability and consistency along with their mean values. Now an attempt has been made to find out the type of relationship between these contributing variables and the level of child care scores recorded for the 200 respondents.

A critical scrutiny of the simple correlation coefficients of Y with the different X values has been furnished in column (1) of the correlation matrix is given in Table 33.

Table 36. Simple Correlation Coefficients of Y with the Different X Values

Y	X ₁	X ₂	X ₃	X ₄	X ₅	X ₆	X ₇	X ₈	X ₉	X ₁₀
Y	1.00000									
X ₁	.87587	1.00000								
X ₂	.73318	.76159	1.00000							
X ₃	.58553	.58098	.45476	1.00000						
X ₄	.72922	.73859	.69945	.42471	1.00000					
X ₅	.42282	.32244	.40455	.15236	.39924	1.00000				
X ₆	.77817	.80311	.67448	.52347	.70275	.28658	1.00000			
X ₇	.50066	.48036	.38003	.26124	.39924	.24457	.38411	1.00000		
X ₈	.51060	.56021	.46483	.46502	.44191	.14853	.50707	.56182	1.00000	
X ₉	.62417	.52434	.51805	.36702	.43768	.37770	.50730	.41199	.43058	1.00000
X ₁₀	.33440	.30063	.18462	.38134	.20024	.10649	.27452	.36306	.43416	.40917
Critical Value (1 - Tail, .05) = + or -.1168										
Critical Value (2 - Tail, .05) = +/- .13877										

On examination it was found that all the simple correlation coefficients of the selected ten independent variables with the level of child care scores turned to be positive and significant even at ($P = 0.01$ level). This indicated that high order of positive relationship existed between the level of child care scores and the different ten independent variables. This clearly revealed that the ten identified variables have really contributed their might in increasing the level of child care score individually. That is any increase in this ten variables individually; either by natural phenomenon or by some introduced phenomenon the level of child care scores would definitely increase in the positive direction which is a healthy aspect in the analysis and also an evidence for the correct identification of the independent variables in the study.

Since all the simple correlation coefficients were highly significant it was decided to compare their degree of relationships. With the numerical values of the correlation coefficients with Y (level of child care scores). The following was the order of the variables ie., marriage pattern, dissolution of marriage through legal separation, remarriage, availability of legal protection for Ho tribe women, postnatal care, status of women, rest during pregnancy, prenatal care (medical and diet), breakdown in the family and techniques of family planning.

Multiple Correlation and Regression Analysis

Since the simple correlation coefficients explain only the direct relationship with 'Y'; to find out the overall scenario of the independent variables put together on the dependent variables the multiple regression analysis has been instituted in this study. The basic model assuming an additive relationships of all the variables with inter and intra effects has been explained elsewhere.

The multiple regression equation fitted by the method of least square principles is furnished below.

Regression Equation

$$\begin{aligned}
 Y = & 25.6331 + 4.0995 X_1^{**} + 0.4823 X_2^{NS} + 0.4440 X_3^{**} \\
 & (0.5103) \quad (0.9362) \quad (0.1526) \\
 & + 2.1349 X_4^{**} + .6637 X_5^{*} + 1.7110 X_6^{*} + 0.5628 X_7^{*} \\
 & (0.9316) \quad (0.9228) \quad (0.7348) \quad (0.2592) \\
 & - 0.8801 X_8^{**} + 1.7203 X_9^{*} + 0.1171 X_{10}^{NS} \\
 & (0.4795) \quad (0.4237) \quad (0.3995)
 \end{aligned}$$

$$R^2 = 0.8403$$

$$\text{Multiple } R = 0.9167$$

$$\text{Standard error of estimate} = 7.3324$$

* : Significant at P = 0.05 level

** : Significant at P = 0.01 level

NS : Not significant

Value in the parenthesis are thS.E. (standard error) of coefficients.

Analysis of variance is given in the Table 34.

Table 34. Analysis of Variance

Source	Sum of squares	D.F.	Mean square	'F' Ratio
Regression	53466.2884	10	5346.6288	99.445
Residual	10161.5316	189	53.7647	
Total	63627.8200	199		

D.F. - Degree of freedom

The predictability coefficients $R^2 = 0.8403$ which is highly significant even at $P = 0.01$ level. This implies that multiple regression equation as a whole is highly significant and any prediction made from this equation will be highly relevant and perfectly applicable to a situation similar to that of one under which the present investigation has been carried out.

The predictability coefficients (0.8403), which is beyond the minimum expectation (0.80) explains that the set of ten independent variables have explained 84 per cent of the variation in the child care practices that is to say the accountability of the independent variables has been 84 per cent. To be more clear, 84 per cent of the reasons that go to explain the child care practices are available from these ten variables leaving only 16 per cent to the environmental influence or the external factors. Therefore, any inference drawn from this analysis would be real, remarkable, consistent and stable. This aspect has further been established by a very high multiple correlation coefficient $R = 0.9167$. This value indicates the closeness of fit

between the observed value and the values estimated from the above equation, (R value can be at the most equal to 1.0000). The standard error of the estimate has also been considerable smaller, giving scope for many variables in the analysis to turn to be significant contributors.

An overall understanding of the regression analysis is that analysis of the ten variables put together and when the total effect is considered, eight of them have turned to be significant while two variables (remarriage and techniques of family planning) were non-significant. Among the eight significant contributors the rest during pregnancy variable is the only variable which has given a negative regression coefficient but being significant. While the remaining are positive and significant. Within the eight variables which had significantly contributed (X_1 marriage pattern, X_3 status of the women in the family and X_4 availability legal protection for Ho women) have been highly significant and respective partial regression coefficients have been also highly significant. The variables rest during pregnancy X_8 , X_5 break down in the family due to desertion, X_6 dissolution of marriage through legal separation in the family, X_7 prenatal care (medical and diet) and X_9 postnatal care have all been significant with the respective partial regression coefficients, been significant at 0.05 level.

Marriage pattern (X_1)

The partial regression coefficients of Y (child care scores) on X_1 has been 4.0955 with standard error 0.5103. From the significance of the values it could be definitely told that the child care score will increase by 4.0955 units, if there is one unit increase in the marriage pattern score. In this analysis this value has been the maximum, meaning the contribution of the marriage pattern towards the child care score has been the highest. That is the pattern of the marriage namely Razikhusi and Opertipi are two desirable patterns which will ultimately decide the child care in the tribal women and as such these patterns are to be encouraged. The positive regression coefficient indicated that there is further scope for increasing these two patterns in the area of the study.

Remarriage (X_2)

The regression coefficient (b_2) which is 0.4823 with standard error of 0.9362 turned to be a non-significant coefficient, that is this variable namely the remarriage has nothing to do with either increasing or decreasing the child care scores, ie., how many times the tribal women remarried have the same degree of child care scores.

Status of women (X_3)

The partial regression coefficients in this case has been 0.4440 with standard error of 0.1526. From this it is

implied that the child care score would increase by 0.4440 unit for every one unit increase in the status of women score. Even 0.4440 unit increase has turned to be highly significant quantity might be due to the smallest standard error observed for the variable in this analysis. The status of women means giving due recognition and accord to a woman in decision making in all activities of the family and also involving her in all aspects of the family as a whole. Since in the area of study the above two aspects have been considerably in a larger dimension the status of woman has turned to be highly significant contributing variable, which is a healthy trend noticed in the study area. Since the coefficient is positive it is understood that there is further scope for encouraging the participation of women in the family activities in the study area.

4. Availability of legal protection for Ho women (X_4)

The partial regression coefficient correlation, variable has been 2.1399 with Standard Error 0.9316. The regression coefficient was highly significant and it could be definitely stated that the child care score would increase by 2.1349 units for every additional increase of one unit in the legal protection variable, that is the child care increases by two units for every additional one unit increase in the legal protection for women. This implies that when a tribal woman is assured of some security in her life and further assured by the society that too by legal

means naturally the amount of care taken by her towards her children would also be definitely more. This could have been the reason for the above variable turning to be a significant contributor in the analysis.

5. Break down in family due to disortion (X_5)

The partial regression coefficient of the child care scores on family crisis variable was 2.6637 with a Standard Error of 0.9228. This was significant at $P = 0.05$. From the value it is seen that for every one unit increase in the family crisis score there has been an increase of 2.6637 in the child care score. This looks like an odd event or case but if the situation in the area as far as this variable is concerned is understood clearly and correctly then the oddness will go and the proper understanding would emerge forth. In this area whether a woman is living with her husband or separated or a divorcy (permanent separation) the women carry on their business in the life unaltered in a routine manner. This normal behaviour of the women under all conditions in their life would have contributed for her family crisis scores variable turning a significant contribution towards her child care scores in the study.

Dissolution of marriage through legal separation (Decided by tribal panchayat) (X_6)

This variable namely legal crisis in family also had a regression coefficient to a tune of 1.7110 with standard

Error 0.7348. Same trend as that in the family crisis variable persisted here and the same type of explanation also can be given here both in the case of men and women in the area.

Prenatal care (medical and diet) X_7

The partial regression coefficient of child care on the prenatal care (medical and diet) has been significant at $P = 0.05$ level. The regression coefficient has been 0.5628 with Standard Error of 0.2592, that is there has been 0.6 unit increase. Even it increase in the child care score for every unit increase in the prenatal care (medical and diet) score even though the increase in the different variable is less than a unit yet it is significant. It implies that prenatal care (medical and diet) is not in existence up to a expected level in the area. This might have been due to inadequacy in the facilities for the prenatal care (medical and diet) in the study area. The medical centre run by ACC factory, Jhinkpani is the only maternal care centre as available. Which is inadequate when the area of coverage is concerned. The positive value also indicates wide scope for increasing this aspect which means establishing some more effective maternal care centres in the study area. As such the women are not getting enough prenatal care (medical and diet) as per the analysis.

Rest during pregnancy (X_8)

The regression coefficient corresponding to this variable has been 0.8801 with Standard Error of 0.4795 but this has been a highly significant quantity. From the negative value any body will infer that any one unit increase in the maternal rest will pull down the child care score by 0.8801 units. This implies that the exercise a tribal pregnant woman gets during household and field work facilitate easy normal delivery and quick recovery and resumption to her child care responsibilities. More rest during pregnancy may have adverse effects.

Postnatal care (X_9)

The partial regression of child care on the postnatal care of the mother has been significant. The coefficient has been 1.7203 with standard Error 0.4237. The value has been positive. It is inferred that every unit increase in the postnatal care would increase 1.72 units in the child care score and as such it is advantageous. Since the postnatal care will influence the physical and mental state of a woman in general. This variable plays an important role in setting up the mother's mind emotionally and psychologically for a future living with the child. Therefore, the magnitude of love and affection and care taken about the child in the future solely dependent upon the postnatal care given to the mother. The positive value indicates that the postnatal care with reference to the child care has not been up to the

expected level in the area. This may be due to the social or economic backwardness of the tribal families. Then it is suggested that a government or a private organisation should come forward for extending a helping hand for increasing these facilities for tribal women in the study area.

Techniques of Family Planning (X_{10})

The partial regression coefficient has been non-significant even though the Standard Error of the coefficient is meagre. This implies that the family planning methods have nothing to do with the child care practices. Therefore, when the child care scores of mothers or the child care practices or problem related to child care practices are discussed the family planning methods need not be considered as a source of contribution towards the above aspects.

Summation of the partial regressions ($\sum b_i$)

To understand the total contribution of all the independent variables towards the dependent variable b_i was computed. This quantity turned to be 13.0515 implying that there is remarkable increasing trend in the child care scores of mothers, for every unit increase in the independent variables. This along with the predictability coefficient (R^2) it is proved without any doubt, that independent variables such as marriage pattern, status of women, legal protection, break down in the family due to

desertion, dissolution of marriage through legal separation, prenatal care (medical and diet) and postnatal care positively contributed towards the child care scores of the mothers. Thus there exists a positive relation between the child care scores of mothers and the above mentioned independent variables.

E. Traditional Indigenous Health Care Practices of 'Ho' Tribe

With the objective to explore the age old indigenous methods of health care and treatment of diseases, an effort was made to compile some of the traditional health care practices of 'Ho' tribe. For getting the information on these practices, long discussions and indepth interviews were held with respondents and local medicine men/women engaged in treatment of human diseases with indigenous medicines. It was found that most of the indigenous medicines were successfully used in surgical, digestive, respiratory, skin, contagious, infectious and miscellaneous diseases.

Table 35 gives information on indigenous remedies for various illhealth conditions, quantity of ingredients and method of preparation, form, dose and frequency of use and shelf life of the indigeneously prepared medicine. The indigenous materials used to prepare herbal medicine is shown in the Plate 7.

Table 35. Indigenous Remedies Used by 'Ho' Tribe for Health Care

Sl. No.	Disease	Ingredients, quantity and method of preparation (2)	Form (3)	Application and dose (4)	Frequency (5)	Shelf life of the product (6)
1.	Surgical					
a.	Wound					
		Neem leaves: About 20-30 neem leaves are washed and boiled in a glass of water for 10-15 minutes. The extract is taken out.	Liquid	The neem leaves extract is used for washing the wound.	Twice a day	About 20-30 minutes after boiling
		Cow dung ash: Cow dung ash is prepared by burning a cup of dry dung.	Powder	A pinch of this ash is used to check the bleeding.	Twice a day	Many years
		Wood paste: Wood paste is prepared by rubbing the wood on a stone. One tea spoon of water is mixed to make the paste.	Semi solid	To check bleeding from the cord stump tribal use a little wood paste.	Twice a day	No shelf life
		Mobil: About half to one tea spoon mobil is used	Semi solid	To check bleeding from the cord stump tribal use a little mobil.	Twice a day	Many years
		Karanj oil and dry mango seeds: One dry mango seed is roasted in the fire and powdered, to this powder a table spoon of karanj oil (a herbal seed) is mixed.	Semi solid	One tea spoon paste is applied in the affected part.	Twice or thrice a day	Many years

- b. Fracture
- Turneric powder, tamarind leaves and lime (calcium carbonate) :**
 A table spoon of turmeric powder, Semi paste of one cup of tamarind solid leaves one to half tea spoon of lime is mixed together. The mixture is heated for about 5-10 minutes to make a poultice (Note: The mixture quantity can be increased according to fracture)
- A cup of mixture in the luke warm condition can be applied in the affected area.
- Twice or thrice a day
- 1-2 days
2. Digestive
- a. Stomach pain
- Mustard oil and ajwain:**
 In a table spoon of mustard oil a tea spoon of ajwain is added and heated.
- About half a tea spoon freshly prepared luke warm oil and ajwain is massaged on the stomach.
- Twice or thrice as needed
- Prepared oil can be stored many years. It must be warmed before each application
- b. Colic
- Maize, black salt, rock salt:**
 Dried maize stem is burnt, pounded and mixed with a pinch each of black salt and rock salt. A little water is added to shape the mixture in the form of pea size balls.
- One pill can be taken at a time.
- Twice a day
- About a week.
- c. Diarrhoea
- Gum of sal tree and fresh butter milk:**
 About a tea spoon of gum from sal tree is powdered and added with a cup of freshly prepared butter milk.
- A cup of freshly prepared butter milk can be drunk at a time.
- Two to three times a day
- Powdered gum can be stored for a year but mixture only for a day.

Back of Ranga Banam, rice

powder and sal leaf:

About two inch piece of bark of Ranga Banam is ground and mixed with a table spoon of rice powder.

A dough is made by adding 2-4 spoon of water. The dough so prepared is put into sal leaf and roasted for 10-15 minutes, then cut into small pieces.

Solid

One piece can be swallowed Twice a day at a time

One week

d. Dysentery

Bark of mango and milk:

About 1-2" bark of mango tree is crushed and mixed with a cup of boiled milk and strained.

Liquid

One cup of strained liquid can be drunk at a time.

Twice a day

One day

Bark of black berry, cup of water:

About 3" long black berry bark is crushed and mixed with a cup of water and strained.

Liquid

One table spoon of liquid is administered internally to cure dysentery.

Twice a day

One day

Bark of Baher and water:

Two to three inches of bark of baher is crushed and mixed with a cup of water and strained.

Liquid

About a cup of strained liquid can be drunk.

Two to three times a day

Crushed bark can be kept for 2-3 days

e. Burning stomach

Barley, turmeric powder and jaggery:

One table spoon of barley, half to one tea spoon of turmeric powder and one tea spoon of jaggery mixed with half cup of water.

Liquid

Half cup mixture can be drunk

Two to three times a day

One day

3. Respiratory

- a. **Fever**
- Ghorbacha and water:**
A bunch of ghorbacha root is ground and added with 2-3 table spoons of water to make it in semi solid form for application.
- Pathalkohra and water:**
A bunch of root is ground with one to two tea spoon water and thus decoction is prepared.
- Black pepper corns, honey and water:**
Corns of black pepper are ground and mixed with water. In case of children honey is added to it.
- c. **Dry cough**
- Gum of Babul tree and water:**
A table spoon of powdered gum of babul tree and water.
- d. **Cold**
- Garlic and mustard oil:**
In a table spoon of mustard oil and three to five pods of garlic are boiled.
- The semi solid mixture**
is massaged over the children's body from upper extremity to the lower and vice-versa
- One tea spoon of**
pathalkohra paste is orally administered in fever including malaria.
- Twice a day**
2-3 days
- One tea spoon**
Three times in a day years.
- Three times**
in a day years.
- One tea spoon**
Dry black kepper store for many years.
- About half tea spoon**
Twice a day More than a month powdered gum with a cup of water
- One tea spoon of the**
Morning and More than a year. prepared oil is massaged evening but should be on the baby's chest and warmed before use back either under the sun or in a dark room.
- The prepared decoction**
Two to three Many years can be applied on the times a day affected part with the help of or hen feather.

4. Skin infection

- a. **Eczena**
- Mustard oil, scorpion, asofoetida:**
Decoction is made by boiling a scorpion along with a cup of mustard oil and a pinch of

b. Scabies, lice, infection and skin eruption	Karanj oil: About a kg of karanj seeds are ground to make oil.	Liquid	A spoon full of Karanj oil can be massaged regularly on the affected parts.	Twice a day	Many years
5. Contagious: a. Small pox and measles	Gum of sal tree and jaggery:	Fumigation	Gum of sal tree and jaggery are burnt over fire wood to fumigate the room of patient, while the patient is still in it.	Once a day generally in the evening	
	Neem leaves: A tiny bunch of neem leaves.	Leaves	A tiny bunch of neem leaves are touched all over the diseased to give relief from itching.	After every 10-15 minutes	One day
6. Infectious a. Worms	Kernal of Bahera, water: One Kernal of baher's seed is ground and mixed with water stem and leaves of chirauta, neem and water.	Liquid	One tea spoon of this mixture is given as a remedy.	Twice a day	Mixture can stay for a day
	Stem and leaves of chirauta, neem leaves and water: A stem and 10-12 leaves of chirauta and neem is boiled with a glass of water and strained.	Liquid	In a day one table spoon of strained liquid.	Daily for 7-10 days	For a day
b. Jaundice	Mustard oil and lime (calcium carbonate) : One table spoon of mustard oil, mixed with a pinch of lime to prepare a mixture.	Liquid	The prepared mixture is rubbed over the body. This is said to be an effective cure.	Daily for a week	For a day

7. Miscellaneous

- a. **Burn**
Fat of hen and pig:
 About a gram of fat of hen or pig is burnt in an aluminium vessel the residual oil is kept in air tight bottle for use.
 A tea spoon of residual oil is applied on burns. times a day
 Many years in a air tight jar or bottle.
- b. **Bleeding of nose**
Fresh cow dung:
 A tea spoon of fresh cow dung.
 Semi solid
 A cure is said to be affected by smelling a tea spoon of fresh cow dung.
 One to two times a day
 An hour
- c. **Constipation**
Barhar:
 Three to four seeds of barhar is ground.
 Solid (Powder)
 About half a tea spoon of ground seed is administered to children as a purgative.
 Once in a day
 More than a month
- d. **Anaemia**
Gum and leaves of simal, sugar and water:
 About a quarter spoon of gum of simal swallowed with water.
 Semi solid
 About 250 gms of gum of simal can be swallowed with help of water.
 Once in day
 More than a month
- About 2-3 leaves of simal is boiled with a glass of water, added with sugar and strained.
 Liquid
 About a cup of strained mixture can be drunk a day
 Once or twice a day
 One day
-



Plate 7. INDIGENOUS MATERIALS USED TO PREPARE HERBAL MEDICINE

- | | | |
|-------|--|--------------------------------|
| Index | 1. Seed and Bark of Mango | 11. Garlic |
| | 2. Bark of Black Berry | 12. Dhatura
Root and Fruits |
| | 3. Simal Leaves | 13. Rice Powder |
| | 4. Bark of Baheer | 14. Turmeric Powder |
| | 5. Stem, Leaves and
Fruits of Babul | 15. Honey |
| | 6. Tamarind Leaves | 16. Ajwain |
| | 7. Neem Leaves | 17. Black Pepper |
| | 8. Onion | 18. Asafoetida |
| | 9. Scorpion | 19. Karanj oil |
| | 10. Karanj Leaves and Seeds | 20. Rock Salt |

In order to find out whether the indigenous remedies used by 'Ho' tribe for health care had any scientific value at all, books on herbal remedies/ayurvedic medicines were reviewed. It was interesting to note that some remedies used by tribal from generations blindly because their ancestors used it have scientifically proven value.

The Table 36 presents information on herbs commonly used by Ho tribe, with their scientifically proven therapeutic value for specific health problems.

Table 36. Herbs Commonly used by 'Ho' Tribe with their Scientifically Proven Therapeutic Value for Specific Health Problems

Sl. No.	Herb.	Botanical name of herb.	Effectively used for	Method of preparation and application	Scientifically proven therapeutic value
1.	Asafoetida	Ferula Narthex Boiss	Skin disease, eczema	A decoction made by boiling scorpion along with mustard oil and a pinch of asafoetida applied on affected part said to be relief in eczema.	It is very useful in indigestion, pneumonia and bronchitis in children. It also used externally for skin infection. It has some sedative properties. (Jain, 1994).
2.	Babul	Acacia arborea	Weakness and diarrhoea	The fruit is ground and mixed with sugar and given in case of weakness.	From babul stem a gum is obtained which is used in diarrhoea, dysentery and in diabetes. It has some sedative properties (Jain, 1994).
			Dry cough	Its gum is crushed and given in case of dry cough.	Bark is astringent.
3.	Bahera	Balleria myrobalan	Worm, body pain headache and diarrhoea	The kernal of seed is ground and mixed with water and given as a remedy for worms. Its oil is used on body for cooling. The fruit is used in headache and diarrhoea.	The dried fruits of the tree constitute the drug Behera. The fruit is useful in stomach disorder, indigestion, diarrhoea. The half ripe fruit is considered to be purgative but the ripe and dried fruit has the opposite properties (Jain, 1994).

4. **Dhatura** *Phyllanthus emblica* **Swollen finger, pain due to milk accumulation in the breast.** The root of this shrub is pounded with water and applied like poultice to swollen fingers and its fruit is sliced into rings and put on fingers of a women in whose breast too much milk has accumulated. Due to its inflammation relieving property exudate from fruit is used in inflammation of eyes. Boiled fruit having oily consistency is given in measles. Dried fruit is used in haemorrhage, diarrhoea and dysentery (Lindley, 1981).
5. **Garlic** *Allium sativum* **Headache** The bulbs act as a local irritant, when taken in to the stomach as a stimulant, expectorant, diuretic and Vermifuge. The infusions rubbed night and morning into the skin of patient is said to give relief. Garlic can significantly lower cholesterol (Kirtikar, and Basu, 1980).
6. **Ghorbach** *Acorus calamus L.* **Fever in children, flatulence, lack of ground with water and appetite, diarrhoea, dysentery, bronchitis** The root of ghorbach is It relieves flatulence, and feeling of fullness of stomach. It increases appetite. Due to its essential oil contents it act as an expectorant, from the upper extremity it promotes flow of bronchial to the lower and vice-versa twice a day. secretions and useful in asthma, diarrhoea and dysentery (Jain, 1994).
- Body pain and Headache** The entire herb is crushed and rubbed on the aching parts at bed time daily till pain persists.

- | | | | | |
|------------|--------------------------|---|---|---|
| 7. Harjora | Vitis
Quadrangularis | Reduces pain after
child birth, bone
fracture | The stem and leaves of
this creeper are pounded
with water and given
internally to a woman
after child birth. Fresh
twig of Harjora and
Thunghi are given to chew
for five days after the
fracture. | Powdered root is specific for the
fracture of the bone with same effect
as plaster of paris (Srivastava, 1981). |
| 8. Harra | Cebulic
myrobalan | Purgative, Blood
pressure ulcer
wound inflammation
of mucous membrane
of mouth. | The fruit is ground and
used as a purgative | The dried fruits of the tree
constitute the drug commonly known
as harra. It has some effect on blood
pressure as cardiac tonic. Its roots
cure scabies and dry skin. Externally
applied on chronic ulcer wound and
for gargling in inflammation of
mucous membrane of mouth (Jain, 1994). |
| 9. Jamun | Eugenia
Jambolana lam | Dysentery | The juice of bark of
Jamun tree is expressed
and administered
internally as a cure
for dysentery. | Fruits and seeds of the tree have
medicinal value. Bark is very
astringent and is used in sore
throats, bronchitis, asthma, ulcer
and dysentery. Fresh juice of bark
with goat's milk is given in diarrhoea
(Kirtikar and Basu, 1980). |
| 10. Mango | Mangifera indica | Dysentery | The bark of the mango
tree is crushed and
mixed with milk. The
liquid is strained and
given twice a day. Fresh
flowers and leaves are
it strained and given
twice a day. | The roots and bark of mango the
acrid, cooling, stringent to the
bowel its flowers and leaves are
good in dysentery (Kirtikar and
Basu, 1975). |

11. Maize Zeamays Colic and cold
The old stem of a cob of Maize plant does as much as its maize is burnt, pounded synthetic competitors to relief and mixed with a pinch cold and influenza each of black salt and The Economist, 1995). rock salt. Pea size balls are made of it and swallowed. Twice a day roasted corn is said to reduce cold.
12. Neem Melia Azedarach Skin disease
The leaves are boiled and used for curing skin diseases. Neem leaves are better, used in enlargement of spleen and heart complain, strengthen the teeth, cure scabies, dry skin. The oil from seed is brain tonic, laxative, use in liver disorder (Kirtikar and Basu, 1980).
13. Onion Allium cepa Fever, Bronchitis, Colic and Rheumatic pain
Roasted bulbs of onion crushed and strained and its juice is given for fever and bronchitis. One tea spoon of onion juice is added with a pinch of salt used in colic. Crushed onion mixed musted oil is good in rheumatic pain. The act as a stimulant, duratic, expectorant and rubenefient. It is also recommended in dropsy a (Kirtikar and Basu, 1980).
14. Simal Bombax malabaricum Dysentery, anaemia
Root is stimulant and given in impotency. Flowers and fruits are used in snake bite. Gum is used in diarrhoea and dysentery (Lindley, 1981). anaemia.

Tribal faith on indigenous medicines were due to the following:

1. their ancestors used indigenous medicine for curing the diseases
2. indigenous remedies are easily available and effective for cure of many diseases.
3. medication given by their tribal medicine men is least expensive and has minimum side effects.
4. influence of religious myth, magic and they believe that indigenously prepared medicines have high curative properties.

F. Relationship Between Family Background and Child Care Practices

One of the objective of the present study was to investigate whether or not the scores of child care practices of mothers were influenced by the family background: namely, marital status, parents age and education, family type, size and number of children, family occupation and income in respect of each of the above factors. Two-way tables with the concerned factor levels as one and child care practices scores of mothers as the other way, were formed for the purpose of carrying out chi-square (χ^2) and tested for significance.

Association between marital status and child care scores of mothers

Association between marital status and child care scores of Ho mothers was worked out on the basis of scores obtained by mother in child rearing practices. The appropriate two-way data pooled over marital status and

mother's scores on child care practices are given in Table 37.

Table 37. Two-Way Table of Marital Status of Respondents and their Child Care Scores

Child care scores of mothers	Marital status of respondents						
	Married		Widow		Remarried		Grand
	No.	%	No.	%	No.	%	Total
0 - 127	78	45.09	3	60	9	40.90	90
127 - 132	20	11.56	-	-	3	13.64	23
132 and above	75	43.35	2	40	10	45.46	87
Total	173	100.00	5	100.00	22	100.00	200

$\chi^2 = 1.0249^{NS}$, 4 d.f. NS: Not Significant

A critical analysis of the Table revealed that 86.50 per cent of the respondents were under the married category 2.50 per cent in widow and 11 per cent in remarried category. when the percentages were worked out based on child care scores, it was noticed that 45 per cent of the mothers were in the low category and 43.35³⁵ per cent in higher. From the percentage analysis it could be inferred that the women married for the first time surpassed the other two categories and the child care scores were minimal in the widow group. It could be inferred that the women married for the first time took slightly higher child care scores followed by the remarried. It is obvious that the married or remarried when they become mother taking more care for children would be definitely they are under normal conditions, with the above view in mind it was decided to

find out whether the marital status as a whole has anything to do with the scores in child care. Chi-square (χ^2) analysis was applied to find out the association if any between the two attributes namely the marital status and the degree of child care scores. The χ^2 value was found to be non-significant indicating that the marital status and intensity of child care scores are independent attributes. It is inferred from the analysis that whatever may be the marital status the degree of child care score is unaltered. Therefore, the marital status of a woman cannot be taken as a yard stick to determine the quantum of care taken by the mothers on their children.

Association between family type and child care practices

Association between family type and child care scores of mothers was examined for all the two hundred respondents, individually. The two-way data on family type and child care scores of mothers are presented in Table 38.

Table 38. Two-Way Table of Family Type and Child Care Scores of Mothers

Child care scores of mothers	Family Type						
	Joint		Extended		Nuclear		Grand Total
	No.	%	No.	%	No.	%	
0 - 127	5	33.34	23	43.39	64	48.48	92
127 - 132	1	6.66	5	9.44	16	12.12	22
132 above	9	60.00	25	47.17	52	39.40	86
Total	15	100.00	53	100.00	132	100.00	200

$\chi^2 = 2.925^{NS}$, 4 d.f. NS: Not Significant

The above table indicates that about 66 per cent of the women interviewed belonged to nuclear type of family, followed by 26.50 per cent from the extended family and about 7.50 per cent from the joint family. The percentage of the women in the low child care category was 46 per cent and in the medium 11 per cent while in the high score group 43 per cent. The percentage given indicated a similar trend that of the marital status associated with degree of child care score revealing that irrespective of the type of family to which women belonged they behave independently with regards to their degree of child care practices. Thus in true sense it can be inferred that the type of the family alone is not responsible for making a remarkable change in the degree of child care practice but there are many influencing factors such as harmony of the family, the adjustment of the family members towards common issues and also the sharing of love and care towards the children irrespective of the family type.

Association between spouses' age and child care practices

To find out whether the spouses' age had anything to do with the respondents child care score, a chi-square analysis was carried out between the level of child care scores of mother and spouses age. The appropriate two-way data pooled over age of spouses and child care scores are given in Table 39.

Table 39. Two-Way Table of Age of Spouses and Child Care Scores of Respondents

Child care scores of mothers	Spouses' age group (in years)										Grand Total
	20 - 24		25 - 29		30 - 34		35 - 39		40 and above		
	No.	%	No.	%	No.	%	No.	%	No.	%	
0 - 127	15	46.87	30	45.45	10	37.03	25	48.08	5	27.77	85
127 - 132	5	15.63	7	10.61	6	22.23	4	7.70	2	11.11	24
132 and above	12	37.50	29	43.94	11	40.74	23	44.22	11	61.12	86
Total	32	100.00	66	100.00	27	100.00	52	100.00	18	100.00	195
$\chi^2 = 6.793_{NS}$, 8 d.f. NS : Not significant											

$\chi^2 = 6.793_{NS}$, 8 d.f. *NS? Not significant*

The frequency distribution of the spouses' age ranged from 20 years to 40 and above. Majority (72%) of the spouses were in the age group of 25-39 years and the rest 28 per cent belonged either to 20-24 age group or 40 and above age group. Since a vast majority of them happened to be fairly youngsters it was decided to find out whether the level of child care scores of mothers and the age of spouses were associated or dissociated attributes. The χ^2 value for 8 degree of freedom (d.f.) turned to be a non-significant quantity indicating that the spouses' age has nothing to do with the level of respondents' child care scores.

It is evident from the analysis that irrespective of their age some fathers took good amount of care for their children and the trend continued to be the same in all the age groups. Therefore, to derive maximum child care support from the spouses, the spouses of all the age group should be encouraged to participate in the child care.

Association between mothers' age and their child care scores

An attempt was made to find out whether the mothers' age and their child care scores are associated. For this purpose, taking into consideration child care scores of all three classes (low, middle and high), χ^2 analysis was worked out, Table 40 depicts association between mothers' age and child care practices.

Table 40. Two-Way Table of Age of Mother and their Child Care Scores

Child care scores of mothers	Mothers' age group (in years)										Grand Total
	20 - 24		25 - 29		30 - 34		35 - 39		40 and above		
	No.	%	No.	%	No.	%	No.	%	No.	%	
0 - 127	16	45.72	24	42.86	34	55.74	5	26.32	9	31.03	88
127 - 132	7	20.00	9	16.07	5	8.19	3	15.78	-	-	24
132 and above	12	34.28	23	11.09	22	36.06	11	57.90	20	68.97	88
Total	35	100.00	56	100.00	61	100.00	19	100.00	29	100.00	200
X ² = 18.165*, 8 d.f. *% Significant at p=0.05 level											

$\chi^2 = 18.165^*$, 8 d.f. *% Significant at $p = 0.05$ level

Since the spouses' age and the level of mothers' child care scores were independent attributes indicating all the spouses of all the age groups has a similar degree of care towards their children. To establish whether the mothers of the children had similar trend or otherwise, again a χ^2 analysis between the mother's age and her level of child care scores was worked out. Majority of the mothers about 76 per cent of them were in the age group of 20 - 35 years and the rest 32 per cent were in the upper age group of above 35 years. The χ^2 value for 8 degree of freedom was found to be significant. It could be inferred from the test that the age of the mother and their level of child care scores are associated attributes as the mothers' age advances from 20 - 40 years and above the level of care taken for their children also increasing. This could be the reason for the significant chi-square value and the association of the two attributes.

Association between spouses education and child care score of respondents

Chi-square analysis on data pertaining to spouses' education and child care scores of mothers was worked out. The data revealed significant association between spouses' education and child care scores of respondents. The data on association between spouses' education and child care scores of respondents is given in Table 41.

Table 41. Two-Way Table of Education Level of Spouses and Child Care Scores of Respondents

Child care scores of mothers	Literacy level of spouses				
	Illiterate		Literate		Grand Total
	No.	%	No.	%	
0 - 127	67	55.83	20	25	87
127 - 132	14	11.67	12	15	26
132 and above	39	32.50	48	60	87
Total	120	100.00	80	100.00	200

$\chi^2 = 19.246, **$ 2 d.f. *** : Significant at $P = 0.01$ level*

Generally the level of education has a positive association with any desirable phenomenon under normal conditions. Since the present investigation relates to the child care which is an important attribute therefore, an attempt has been made to find out whether the level of education of spouses and level of child care scores of mothers were associated characters or otherwise. In the present analysis out of 200 spouses, 60 per cent had no education and only the rest of the 40 per cent had certain education ranging from Pre-primary, primary to graduate. Only three out of 200 were graduates. The analysis of chi-square revealed that the most care scores illiterate mothers received low child care scores, i.e., 127 and below, whereas in the literate group of spouses about 60 per cent mothers possessed the higher level of child care scores. The χ^2 test for two degree of freedom was highly significant indicating that the level of spouses' education and the

level of child care scores of mothers were associated attributes. To conclude it can be stated that the higher the literacy level of the spouses the higher will be the level child care scores of the mothers.

Association between educational level of respondents and their child care scores

The χ^2 analysis carried out on the data on the individual child care scores and educational level of the mothers is given in Table 42.

Table 42. Two-Way Table of Education Level of Mothers and their Child Care Scores

Child care scores of mothers	Education level of mothers				Grand Total
	Illiterate		Literate		
	No.	%	No.	%	
0 - 127	93	65.03	-	-	93
127 - 132	18	12.59	-3	5.26	21
132 and above	32	22.38	54	94.74	86
Total	143	100.00	57	100.00	200

$\chi^2 = 88.780, **$ 2 d.f. ****! Significant at $P=0.01$ level*

A two way contingency table with the education level of the mothers and their child care scores was formed. The cell frequency indicated that among 65 per cent of the illiterate mothers the child care scores were the least. While in the literate groups about 95 per cent of the mothers, having some education possessed the highest level of child care scores. The χ^2 value for two degree of freedom was found to

be highly significant indicating that a significant association existed between the literacy level of mothers and their child care scores.

Association between family size and child care scores of mothers

The two-way data on family size and child care scores of mothers are given in the Table 43.

Table 43. Two-Way Table of Family Size and Child Care Scores of Selected Respondents

Child care scores of mothers	Family size (numbers of members)								Grand Total
	3 - 4		5 - 6		7 - 8		8 and above		
	No.	%	No.	%	No.	%	No.	%	
0 - 127	26	47.29	37	46.25	14	43.75	12	36.36	89
127 - 132	8	14.55	10	12.50	4	12.50	2	6.07	24
132 and above	21	38.18	33	41.25	14	43.75	19	57.57	87
Total	55	100.00	80	100.00	32	100.00	33	100.00	200
$\chi^2 = 3.882^{NS}$, 5 d.f. NS? Not Significant									

A chi-square analysis was carried out between the family size and the child care scores of mothers. The χ^2 test was found to be insignificant, indicating nil association between family size and child care scores of mothers.

Since it has been proved elsewhere that the father and mother are mainly responsible for child care therefore, the number of members in the family cannot be a criterion for determining the degree of the care available to the child. This result indicates that child care scores of the mothers and their family size are independent factors.

Association between number of children and child care scores of the mothers

Association between number of children and child care scores of the mothers was worked out. The two-way data on number of children and child care scores of mothers are presented in the Table 44.

Table 44. Two-Way Table of Number of Children in the Family and Child Care Scores of Mothers

Child care scores of mothers	Number of children in family												Grand Total
	One		Two		Three		Four		Five		Six and above		
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
0 - 127	19	45.24	25	51.04	3	37.15	16	51.62	11	45.87	6	31.57	90
127 - 132	4	9.53	6	12.25	8	22.85	2	6.44	1	4.16	2	10.54	23
132 and above	19	45.23	18	36.73	14	40.00	13	11.94	12	50.00	11	57.89	87
Total	42	100.00	49	100.00	25	100.00	31	100.00	24	100.00	19	100.00	200
$\chi^2 = 9.662$ NS, 10 d.f. NS! Not Significant													

$\chi^2 = 9.662^{NS}$, 10 d.f. NS! Not Significant

Since the family size and the level of child care scores of mothers was found to be a dissociated character, an attempt has been made to find out whether the number of children a mother had, had anything to do with her level of child care scores. Chi-square analysis between these two attributes was carried out.

The percentage analysis revealed that there were 50 per cent of the households with one or two children while the other 50 per cent had more than two children. The χ^2 value again was found to be a non-significant one indicating that the number of children a mother has does not have any

influence on her level of child care. This is true because mother's affection and care are not halted by the number of children she has.

Association between family occupation and child care scores of mothers

Association between family occupation and child care scores of mothers was analysed. The two-way data on family occupation and child cares scores of mothers are given in the Table 45.

Chi-square test was carried out between the family occupation and level of child care scores of mothers. Since the χ^2 value was found to be non-significant, it was indicated that the family occupation and child care scores of mothers are dissociated attributes.

Association between family income child care scores of respondents

A χ^2 analysis was worked out to see the association between the family income and child care scores of mothers. The appropriate two-way data of family income and child care scores of mothers are given in Table 46.

Table 46. Two-Way Table of Family Income and Child Care Scores of Selected Respondents

Child care scores of mothers	Family income (in rupees)						Grand Total
	Below 500		500 - 1000		1000 and above		
	No.	%	No.	%	No.	%	
0 - 127	72	51.80	17	29.32	-	-	89
127 - 132	16	11.50	6	10.34	1	25	23
132 and above	51	36.70	35	60.34	8	75	89
Total	139	100.00	58	100.00	4	100.00	200

$\chi^2 = 12.833^*$, 4 d.f. * : Significant at $P = 0.05$ level

Since income directly influences child care measures, the level of income of the family has been associated with child care scores of mothers in the present study. It was observed that about 98 per cent of the families have an income ranging from below Rs. 500 and 500 to 1000 leaving

only 2 per cent in the higher income group. A χ^2 value for 4 degree of freedom was found to be a significant quantity indicating that income level and level of child care scores of mothers were associated attributes. Hence, it can be said that the more the family income the greater will be the child care. This is evident from the fact that higher child care score of mother was found for the families having more than 1000 rupees (75 per cent) income, while the lowest child care scores of mothers have been recorded in the lowest income (below 500 rupees) group families (52 per cent).

G. Conceptual Paradigm on Marriage, Family System and Traditional Mother and Child Care Practices of 'Ho' Tribe on the Basis of Findings

Figure 10 presents a paradigm of overall factors influencing mother and child care practice. These factors have been classified under these major heads : i) Factors assumed to influence mother and child care; ii) Factors found influencing mother and child care and iii) Implication.

FIG. PARADIGM OF FACTORS INFLUENCING MOTHER AND CHILD CARE PRACTICES ON THE BASIS OF FINDINGS

FACTORS ASSUMED TO INFLUENCE

△ DEMOGRAPHIC VARIABLE/FACTORS

- . MARITAL STATUS
- . TYPES OF FAMILY
- . AGE OF RESPONDENT
- . AGE OF RESPONDENT'S HUSBAND
- . EDUCATION OF RESPONDENT
- . EDUCATION OF RESPONDENT'S HUSBAND
- . SIZE OF FAMILY
- . NUMBER OF CHILDREN
- . FAMILY OCCUPATION
- . FAMILY INCOME

△ MARRIAGE & FAMILY SYSTEM FACTORS

- . MARRIAGE PATTERN
- . DOWRY SYSTEM
- . REMARRIAGE
- . BREAK DOWN IN FAMILY DUE - TO DESERTION
- . TO DISSOLUTION OF MARRIAGE THROUGH LEGAL SEPERATION
- . LEGAL PROTECTION
- . STATUS OF WOMEN

△ MOTHER CARE PRACTICES FACTORS

- . PRENATAL CARE
- . - MEDICAL AND DIET
- . REST DURING PREGNANCY
- . TECHNIQUES OF BIRTH
- . CONTROL OF NO TRIBE

FACTORS FOUND TO INFLUENCE THE CHILD CARE PRACTICES

△ DEMOGRAPHIC VARIABLE/FACTORS

- . AGE OF RESPONDENTS
- . EDUCATION OF PARENTS
- . FAMILY INCOME

△ MARRIAGE & FAMILY SYSTEM FACTORS

- . MARRIAGE PATTERN - RAZINHUSI
- . BREAK DOWN IN FAMILY DUE TO DESERTION
- . TO DISSOLUTION OF MARRIAGE THROUGH LEGAL SEPERATION
- . LEGAL PROTECTION
- . STATUS OF WOMEN

△ MOTHER CARE PRACTICES FACTORS

- . PRENATAL CARE
- . - MEDICAL AND DIET
- . POSTNATAL CARE

IMPLICATIONS ON MOTHER AND CHILD CARE

- . ENCOURAGE LATE MARRIAGE FOR GOOD MOTHERHOOD
- . IMPROVE EDUCATION STATUS OF GIRLS
- . IMPROVE INCOME LEVEL OF FAMILY
- . PATTERN OF MARRIAGE ie., RAZINHUSI SHOULD BE ENCOURAGED
- . PEACEFUL FAMILY RELATIONSHIP SHOULD BE ENCOURAGED
- . PROVIDING LEGAL PROTECTION OF WOMEN FOR CHILD CARE
- . ENCOURAGING WOMEN'S PARTICIPATION IN THE FAMILY DECISION MAKING
- . IMPROVE MEDICINE FACILITIES AND ENCOURAGE HEALTHY DIETARY PATTERN
- . IMPROVE POSTNATAL CARE TO ENHANCE PHYSICAL AND MENTAL STATE OF A MOTHER

MOTHER AND
CHILD CARE
PRACTICES

SUMMARY AND CONCLUSION

V. SUMMARY AND CONCLUSION

Marriage is a holy union between a man and a woman in most religions with the sole aim of begetting, nurturing and raising children. The family as a basic unit has existed from time immemorial, to provide the natural frame work for the physical, emotional, financial and material support essential to the growth and development of its members particularly infants and children.

The child bearing and child rearing are directly related and both have tremendous influence on child's growth and development, which affect the intelligence throughout life for all round development. Development of the child is influenced by child rearing practices adopted by mothers in their cultural context. Child rearing practices followed by families are influenced by income level, educational status, customs, traditional family pattern and family environment.

The tribal children in the age range of 0-6 years form about 13.7 million of total tribal population. These children live in isolated and inaccessible areas where nutritious food, medical care and education are not available. The tribal mothers are not adopting better child care practices due to illiteracy, poverty, lack of basic amenities and their strong rooted traditional child care practices.

The present research is an attempt to study the "Marriage, Family System and Traditional Mother and Child Care Practices of 'Ho' Tribe of Bihar". The specific objectives of the present research were to:

1. understand the marriage and family system of 'Ho' tribe;
2. study the status of women in 'Ho' tribe;
3. explore the hitherto unknown traditional mother and child care practices of 'Ho' tribe;
4. study the use of various traditional indigenous remedies in tribal health care and to elicit the reasons behind their faith in such traditional practices;
5. study the relationship between family background and child care practices; and to
6. develop a conceptual paradigm on marriage, family system and traditional mother and child care practices of 'Ho' tribe on the basis of findings.

Research Methodology

Sampling Plan

Keeping in view the objectives of the study, first of all Chotanagpur division of Bihar State was selected. Out of 23 blocks in West Singhbhum District, two blocks which had more or less similiar socio-economic status were randomly selected. Out of the above blocks further ten villages were randomly selected from each block. From each village ten mothers in the age group of 18-45 years with almost similar family background having at least one child below 6 years age were selected purposively. Thus the total sample comprised of 200 mothers.

Selection of Tools

Considering the nature of the study and the tribal setting, the following tools were used:

- i. Interview Schedule.
- ii. Observation Inventory.

In order to collect the data on family background, marriage system, break down in the family, availability of legal protection for women, status of women, mother and child care practices and indigenous remedies of family health care, a personal interview schedule was constructed, field tested and used. The data collected through the personal interview schedule was further supplemented by information gathered through the participatory observation scheduled.

Collection of Data

To gather information on demographic variables, marriage, family system and traditional mother and child care practices, each respondent was interviewed in 2-3 sessions in the local Ho language with the help of the multipurpose health worker of Rural Development Centre of A.C.C. Factory, Jhinkpani. To supplement the above information observations were recorded during participatory observations.

The information on traditional indigenous remedies used by Ho tribe for health care was collected with the help of

interview schedule and indepth interview with ten local medicine men/women.

Analysis of Data

For the analysis of data the statistical techniques used were percentage analysis, chi-square analysis and multiple correlation and regression analysis.

Findings of the Study

The analysis of the study included the following aspects.

A. Information on Family Background of selected 'Ho' Respondents

Majority (86.50%) of the respondents were married. Most (76%) belonged to 20-34 years age group, most (71.50%) were illiterate, had nuclear family setup (66.00%) with moderate family size (5-6 members) with one to two children (50%) and low social participation.

Majority of the respondents (66.50%) were engaged in agriculture coupled with cattle rearing and unskilled labour. About 70 per cent of the households of respondents, had income below five hundred rupees per month.

B. Marriage and Family System of 'Ho' Tribe

Marriage system

- a. Sixty five per cent respondents practiced monogamy, 25 per cent of them followed bigamy and only 10 per cent respondents had gone in for polygamy.

- b. Regarding the type of marriage system followed by the Ho tribe respondents 37.50 per cent of respondents got married by Razikhusi and 34.50 per cent followed Opertipi type of marriage. Both these types of marriages were popular as elaborate ceremonies and payment of exorbitant bride price was not involved.
- c. It was found that 33.50 per cent of respondents got married between the age range 22-25 years. Only one eighth of them got married between the age of 30 to 34 years and above.
- d. Nearly half (49%) of spouses got married in the age range of 26-29 years. A very nominal (1%) of spouses got married in the age range of 22-25 years. More number (7.50) of respondents were married as against (4.50%) of spouses, in the age range of 34 and above.
- e. For nearly a half of respondents mate was selected by combined efforts of dutam, relatives and parents.
- f. Cent per cent of the respondents considered it important to check the caste, age, job and health status of the prospective partner for their ward.
- g. In Ho tribe families, couple in distress turn to elders (57%), to relatives and friends (25.50%), while least (17.50%) took help from kili members to solve their marital problems.
- h. More number of marital conflicts were found in opertipi (26%) and Anadar (18%) type of marriages.

2. Dowry System

- a. In the 'Ho' bride price was cent per cent compulsory, Sixty four per cent of the respondents expressed that bridal price was more in Andi and Diku andi type of marriage followed by Opertipi (36%).
- b. More than 50 per cent of the respondents indicated that cash, cattle and rice beer were settled as bride price.

3. Remarriage

- a. Amongst Ho tribe remarriage of women was an accepted, phenomenon as confirmed by cent per cent respondents.

4. Break Down in Family

- a. Separation was a normal phenomenon in the study area, yet formal divorce was least prevalent. However, none

of the respondents included in the study were divorced or separated.

- b. The main reasons of dissolution of marriage were maltreatment (35.50%), economic burden (29%), bigamy/polygamy (12.50%), adultery (10%) lack of issue and misunderstanding (8 and 5% respectively).
- c. The custody of children in Ho tribe was settled by tribal panchayat. In case of minor children custody, was always granted to mother and in case of major children custody naturally went to father.
- d. In case of deserted, divorced and separated women and their children maintenance was allowed from husband's father.

5. Availability of Legal Protection for Ho Women

- a. Eighty nine per cent of the respondents did not get equal share in the ancestral property due to the traditional custom.
- b. Despite disparity and discrimination in the distribution of family property majority (60%) women do not protest because of Kolhan custom and 40 per cent because of ignorant.
- c. Only one third of respondents had some knowledge regarding laws available for women's protection.
- d. Approximately half of the of respondents desired to have awareness campaign on legal protection for women.

C. Status of Women in Ho Tribe

- a. Almost all the respondents had privilege of joint decision making along with their spouses in seven areas such as family recreation (54%), health care (51%), money management (45%), mate selection for children (34%), vocation for children (35%), overall family management (53.50%), crops to be sown (45%) and purchase of seeds (45%).
- b. In majority of households (70%) none of women had the privilege of deciding the family size.
- c. Majority (70%) of the Ho women accepted their husbands' decision without any protest due to financial dependency (33%). to have harmony in the family (24%), due to helplessness (16.50%) and due to fear (3.50%).
- d. Regarding the need for educating the girls 67 per cent of the respondents were satisfied with basic education

for them. Only 16.50 per cent of respondents opined that higher education is needed.

D. Traditional Mother and Child Care Practices of 'Ho' Tribe

1. Mother care

- a. None of the respondents were pregnant at the time of interview. However all of them had at least one child.
- b. Out of 661 pregnancies of selected respondents, 3.78 per cent and 2.12 per cent resulted in miscarriage and still birth respectively and 94 per cent were live births, out of which there was neonatal mortality of 2.74 per cent.
- c. The major causes of miscarriage, still birth and child mortality were illiteracy (35.08%) and poverty (33.34%).
- d. More than one third of the respondents never underwent any prenatal check up.
- e. Only limited number of respondents were found to have supplemented tonics in their diet during pregnancy iron supplement (9%), folic acid (4%) and calcium supplements (12%). Only 2 per cent of them had taken tetanus toxoid injection between 6-9 months of pregnancy.
- f. The main reason for not availing the facilities of PHC was ignorance (74.09%).
- g. For majority of respondents (51.50%) check-up during pregnancy was done by dai. Only 16.50 per cent of women contacted doctors when complication developed during pregnancy.
- h. Thirty five per cent of pregnant women suffered with anaemia, 17 per cent with malarial fever and 13 per cent with oedema.
- i. Female death in the age group of 15-35 years had occurred only in 15 per cent households. Lack of adequate medical care, due to poverty was found to be the major cause of female death (10%).
- j. During pregnancy the Ho women did not observe any restriction on food. All the tribal pregnant women worked without taking rest till the arrival of new born baby.

- k. Only 65 per cent women prepared for delivery in the form of collecting old cloth. None of the other things like cotton, soap and oil were collected in advance.
- l. Eighty five per cent deliveries took place at home in a corner of a room on mat or ground.
- m. In case of more than half of the selected respondents delivery was conducted jointly by husband and the local women.
- n. In Ho tribe during delivery confinement husband was supposed to be with his wife for looking after her and the new born baby.
- o. In order to please the Singhbonga (tribal God) a little more than one third of respondents sacrificed a red and gray colour fowl before, entering the delivery area.
- p. In variably soon after the delivery almost all the mothers were given body massage with special oil to relieve the body pain. After 7-8 hours of rest the mother is made to drink hot water with turmeric to purify the blood. After this hot rice and salt is fed to the mother.
- q. No celebration took place soon after the child's birth as they observed bisi (pollution period) the duration of which ranged from 5-21 days during bisi mother and the baby were necessarily kept in isolation to keep away the infection and provide to rest to the mother and baby.
- r. Eighty per cent of the selected respondent started doing normal work on eighth or ninth day after the purification ceremony was over. To gain the body strength after the delivery almost all tribal women followed practices such as drinking rash and body massage with karanj or mustard oil with a bit of garlic.
- s. Eighty five per cent of respondents reported that the restriction and inclusion of certain food items were common practices during the lactation period. The special food items consumed by the lactating mothers were mandi, rash, fermented rice, turmeric soup, black gram dal, papaya and sathavari herb, to help in milk production.
- t. Fifty five per cent of respondents revealed that for family control herbal medicines such as root of Karpendu (Ruellia Sufruticosa) and Ankoadaru (Alangium Lamaruii) was effectively being used by them for aborting the foetus. The remaining respondents used

other birth control measures such as coitus interruption, pills, tying of amulet on the waist and breast feeding.

- u. Seventy five per cent of respondents were aware of the family planning measures like sterilization and use of condom.

2. Child care

Immediate care

- a. Umbilical cord of the baby was cut by a sterilized knife by 63.50 per cent of the respondents,
- b. To ward off the evil from the new born child the placenta was buried in almost all cases.
- c. Indigenous things like karanj oil, mustard oil was applied by the tribe for expediting the process of healing of cord wound.
- d. Almost all the babies were given bath and herbal massage with mustard oil and turmeric paste immediately after the birth.

Feeding practices

- a. Cent per cent mothers breast feed their babies upto 2 years on demand as a matter of practice in Ho tribe. The baby is usually put to the breast within 9-12 hours after birth.
- b. About 83 per cent of respondents gave colostrum.

Weaning practices

- a. Forty six per cent of Ho mothers introduced weaning foods between 12 to 18 months of age and completed weaning the child within three years.
- b. The child's diet was mainly supplemented with mandi, papaya, potatoes, rice and dal cooked together.
- c. Gradual weaning was adopted by almost all mothers. Only 10 per cent of respondents reported excessive crying of the child while weaning.

Clothing

- a. Almost all the respondents wrapped the new born in clean cotton cloth. The materials generally used for children's clothing was synthetic and cotton (75%).

Toilet training

- a. Majority of the Ho mothers (65%) were not particular of about toilet training their children, because of laxed attitudes (20%) and lack of interest in toilet training (45%).
- b. Those mothers who toilet trained their babies started it between the age of nine months to one year.

Bathing and body care

- a. Only 35.50 per cent of respondents bath their children daily, while rest followed either alternate (34%) or weekly (30%) bathing schedule.
- b. Out of fourteen health habits only two habits such as keeping the place neat and drinking clean water was insisted upon almost all the mothers.

Rest and sleep

- a. In majority (83%) of the cases mother was responsible for putting the child to the bed and no special preparation was done for baby's rest and sleep. The common bedding used for the child by 56 per cent of respondents was mat and Kantha or goodali and popular method for making the child sleep was breast feeding in case of 43 per cent respondents.

Health protection

- a. Sixty two per cent of the respondents stated that child was taken to the hospital only when seriously ill. Health care was quite neglected.
- b. Thirty eight per cent respondents reported that for minor sickness in children, as far as possible indigenous remedies prescribed by the local medicine men were used.
- c. Worms infestation (46.50%) and malarial fever (31.50%) was the most commonly prevalent problem in the study area among the younger children.
- e. Although 85.50 per cent of the respondents were generally aware of immunization schedule but its coverage was quite poor and irregular as reported by 69.50 per cent of respondents.

Safety measures used to protect the child

- a. Most of the Ho mothers (73.50%) tried to make their surrounding as accident proof as possible so as to

enable the youngster to play around unsupervised without hurting themselves.

Play and recreation

- a. Seventy six per cent of the respondents considered that play was important for young children.
- b. Only 25 per cent of parents could spend time playing with their children.
- c. None of the respondents made any toys and nothing special was provided to their children to play with. The tribal child's play materials included generally natural things like clay, mud, sand, flowers, leaves and other things like tin's, utensils, seeds, beads, rope and broken pieces of pitcher.

Disciplining the child

- a. Eighty per cent of the respondents opined that disciplining the children was necessary.
- b. The common behavioural problems found in children were hitting (55%) bullying (37%) putting finger in mouth (35%) and telling lie (17.50%).
- c. Twenty eight per cent of mothers gave physical punishment, 40.50 per cent moderate to mild scolding and 31 per cent ignored.

Multiple correlation regression analysis

- a. The C.V. per cent of marriage pattern, remarriage and dissolution of marriage, through legal separation was 30, 22 and 41 per cent respectively, indicating wide variation, whereas for the remaining variables such as breakdown in family due to desertion (17%), availability of legal protection for women (19%), status of women (14%), prenatal care (medical and diet) 15 per cent, rest during pregnancy was (18%), postnatal care (10%) techniques of birth control (18%) and child care scores (Y) 14 per cent respectively, indicating considerable uniformity or least variation in the particular variables.
- b. On examination it was found that all the simple correlation coefficients of the selected ten independent variables with the level of child care scores turned to be positive and significant even at ($P = 0.01$ level).
- c. Correlation and regression analysis indicated that child care scores of the mothers were influenced by

most of the independent contributing variables such as marriage pattern, status of women, legal protection, break down in family due to desertion and dissolution of marriage, prenatal care (medical and diet), rest during pregnancy (highly significant but negative) and postnatal care of the mothers. While the remaining two variables like remarriage and techniques of birth control was non-significant indicating that remarriage and techniques of birth control have nothing to do with the child care scores of the mothers. How many times ever a woman marries, she may have the same degree of affection for her children.

E. Traditional Indigenous Health Care Practices of 'Ho' Tribe

- a. Exploration about the indigenous health care practices of Ho tribe brought to light effective use of various locally available products for health care. It was found that most of the indigenous preparation/concoction were successfully being used in the following problems:
- b. In wound the neem leaves extract is used for washing the wound. In case of fracture a cup of mixture made out of tamarind leaves, turmeric powder and calcium carbonate is applied in the luke warm condition in the affected area.
- b. For treating colic problem, maize stem, black salt and rock salt is used.
- c. In fever ground gorbacha root is massaged over the child's body from upper extremity to the lower and vice-versa.
- d. For skin disease like eczema, the tribals use a decoction made by boiling scorpion along with mustard oil and a pinch of asofoetidas.
- e. In contagious diseases such as small pox and measles the tribals fumigate by burning gum of sall tree and jaggery over the fire.
- f. To check worm infection kernal of bahera seed is ground and mixed with water.
- g. In case of miscellaneous disease like burn, a gram of fat of hen or pig is burnt in an aluminium vessel, the residual oil is kept in air tight bottle for use.
- h. Review of ayurveda books revealed that some of the indigenous remedies used by Ho tribe have scientifically proved therapeutic value. It was also

brought to light that some of the herbs/roots/seeds are of much more value than what the tribals use them for such as asafoetida (skin infection), babul (weakness, diarrhoea), bahera (worms and diarrhoea), dhatura (swollen fingers and pain due to milk accumulation in the breast).

F. Relationship Between Family Background and Child Care Practices

- a. To study the relationship between family background and child care practices of mothers, chisquare (X^2) analysis was worked out and tested for significance. Out of ten attributes namely, marital status, respondent's and spouse's age, education and family type, size, number of children, occupation and income level, only respondent's age and income were found to be significant at 0.05 per cent level while education was highly significant (at 0.01 per cent level), establishing association between the above three attributes with the level of child care scores of the mothers.

The present study brought to light that mother and child care practices were influenced by demographic factors, marriage and family system and the state of mother's health during the antenatal and postnatal period.

Recommendations and Suggestions

1. Free vocational training should be introduced in tribal areas in local dialects. Effort must be made to involve more and more tribals in various formal and informal programmes of the Governmental and Non Governmental organisation.
2. Through tribal development programmes efforts should be made to supplement settled agriculture with other subsidiary occupations like dairy, forestry.
3. Razikhusi a type of marriage by mutual consent, without an elaborate ceremony and payment of exorbitant bride price should be encouraged in the study area and other areas also.
4. In most of the Indian tribes, ~~bride price~~ ^{bride price} prevails. In the study area, which the bride groom is supposed to pay adding status to the tribal women, this system should be encouraged in other communities also.

5. Cleanliness in living conditions should be stressed to avoid risks of infections. The child should be protected from mosquitoes, flies and other insects. Construction and use of low cost Janata toilets should be promoted.
6. Mobile medical should be introduced so as to provide medication to the tribals at their door steps.
7. The good practices of 'Ho' tribe such as body massage, practice of breast feeding, isolation of mother and child during parturation period and the practice of husbands giving care to the wife throghout the pollution period. should be preserved and extended in other tribal and non-tribal areas also.
8. The Singhbhum distrctit is very rich resources for indigenous medicines, some of the age old medications of 'Ho' tribe are very effective hence it is recommended that tribal health care practices must be popularized and widely used.
9. Further the skills of the local medicine men should be fully explored to provide quality care to the tribals living in the far flunged areas. These local medicine men need to under go training in hygienic handling of the products.
10. The health workers of primary health centre's located in the tribal areas should be given training on indigenous health practices by local medicine men/women so as to widely use the knowledge of indigenous medication. *11. Literacy of women (and men) should be encouraged, because the data show that good child care practices are strongly related to literacy of both parents.*

Suggestions for Future Research

1. The tribal indigenous remedies for health care need to be extensively studied for finding out their scientific authensity.
2. Studies on traditional mother and child care practices of various tribes can be undertaken.

BIBLIOGRAPHY

BIBLIOGRAPHY

- Basu, B.D. and Kirtikar, K.R. (1975), Indian Medicinal Plants. Allahabad, 2nd Ed., Vol. I, Published by Lalit Mohan Basu, pp. 543.
- Basu, B.D. and Kirtikar, K.R. (1980), Indian Medicinal Plants. Allahabad, 2nd Ed., Vol. II, Published by Lalit Mohan Basu, pp.1017, 1018.
- Bhattacharya, S. and Lakshmiah, T. (1992), Development Perspectives for Tribals. Yojana, Vol. 36, No. 3, p. 20.
- Bhogal, S. (1978), Child rearing practices among three cultures. Social Change, 8, No. 3, pp. 3-13.
- Bhuyan, B. (1986), Child-care practices among the tribal of Bihar and Madhya Pradesh. Lucknow, NIPCCD Regional Centre, pp. 1-7, 16-35, 138-144.
- Census of India (1981), Series-4, Bihar Part-IX (IV) Special tables for scheduled tribes. (Tribes ST-4 to ST-7), B.B. Lal of the Indian Administrative Service Directorate of Census Operation, pp. XII, 125.
- Census of India (1991), Union Primary Census Abstract for Scheduled Tribes. New Delhi, p. 44.
- Census of India (1991), Bihar Population at a Glance. Based on final population totals computerised in collaboration with N.I.C. Unit, Patna, Directorate of Census Operations, pp. 9-10, 20.
- Census of India (1991), Bihar Population at a Glance. Based on final population totals computerised in collaboration with N.I.C. Unit, Chaibasa, Directorate of Census Operations, pp. 9-10, 20.
- Chaudhuri, K. (1992), A Dwelling Tribe - the Totos of West Bengal, Frontline, Bombay, Published by S.Rangarajan on behalf of Messers Kasturi and Sons Ltd., Vol. 9, No. 13, pp. 64-65.
- Dave, P. and Tavkar, N. (1982), Child care amongst the tribals of anmahal, Gujarat. Report, Department of Child Development, M.S. University of Baroda, New Delhi, Sponsored by Ministry of Home Affairs, pp. 1-15.

- Devadas, R.P. (1992), Cited in impact of selected learning experiences on scientific perception of primary school children. Jayapoorani, N., 1994, Unpublished Ph.D. Thesis, Avinashilingam Deemed University, Coimbatore, p. 1.
- Devadas, R.P. (1993), 1994-The International year of the family and home science. XX Biennial Conference of the Home Science Association of India, Coimbatore, 21-23, December, pp. 1-15.
- Ghosh, S. (1989), You and Your Child, Voluntary Health Association of India. New Delhi, pp. 3-10, 15, 31-43, 44-50, 51-53, 54-58, 83, 86, 100-104, 106-110.
- Gokran, N.A. (1985), "Child rearing practices in India viewed through content of care". ICCW News Bulletin, XXXIII, 3, pp. 1, 2.
- Gopalan, C. (1993), Child Care in India : Emerging Challenges. Yojana, 15th June, Vol. 37, No. 11, pp. 6-8.
- Gopalan, C. (1993), Child Care in India : Emerging Challenges. Yojana, 30th June, Vol. 37, No. 10, pp. 21-25.
- Gopaladas, T. (1986), Cited in Review of Traditional Practices in Mother and Child Care in Gujarat. Gopaldas, T. 1989, Seminar Report, (27-28 Feb.), pp. 42-68.
- Goswami, L.C. (1988), Child bearing in Jaintia Tribal Community of Meghalaya: A Study of Some of its beliefs, Seminar Report (22-24 June), NIPCCD, p. 22.
- Gujral, S. (1987), Cited in Review of Traditional Practices in Mother and Child Care in Gujarat. Gopaldas, T. 1989, Seminar Report (27-28 Feb.), NIPCCD, pp. 69-79.
- Gupta, S.P. (1974), Tribes of Chotanagpur Plateau - An Ethno Natural and Pharmacological Cross Section. Bihar Tribal Welfare, Research Institute, Bihar Welfare Department, p. IV.
- Gupta, S.P. (1993), Statistical Methods. New Delhi, Sultan Chand and Sons, pp. E.3.5., 3.13-14, 3.24.
- Gupta, K.D. and Singh, R.N. (1985), A Study of Child Rearing Practices under 6 years of age in one of the tribal areas of Rajasthan (Pendwara block of Sirohi District). Abstract, Jodhpur, Department of Pediatrics, p. 1.

- Gupta, A. (1981), Cited in Review of Traditional Practices in Mother and Child care in Gujarat. Gopaldas, T., 1989, Seminar Report (27-28 Feb.), NIPCCD, pp. 68-72.
- Gurumurthy, G. (1987), Popularising breast feeding as a method of contraception - A Study of Yamadi tribal Women in Andhra Pradesh. *Swasth hind*, 31(5), pp. 122-129.
- Hasuain, N. (1987), Tribal India Today. New Delhi, Harnam Publication, pp. 31-32.
- Home Science Association of India (1994), International Year of the Family. Baroda, Report, Published by HSAI, Indumathi Mahal, p. 2.
- Jain, B. (1990), Linking ICDS Schemes with Minimum Needs Programme, 37, p. 59.
- Jain, S.K. (1994), India - The land and the people medicinal plants. New Delhi, Publisher Director National Book Trust, pp. 1-4, 10, 87-88.
- Jasudasan, U. (1995), There is no place like home. *The Hindu*, p. V.
- Jagannathan, M. (1979), The Tribal Face. *Yojana*, XXVIII, 11, p. 32.
- Jayanthi, B. (1979), Effect of selected family characteristics on child rearing practices, Unpublished M.Sc. Thesis, University of Madras, pp. 1, 9, 93-103.
- Joshi, (1994), Witchcraft of Tribals. *The Hindustan*, p. 5.
- Kaul, L. (1984), Methodology of Educational Research. New Delhi, Jain Educational Press, pp. 149-200.
- Khanna, S. (1989), Infant care in Punjabi Households: Implications for early stimulation. New Delhi, Department of Child Development, Lady Irwin College, Delhi University, pp. 1-2, 27-35.
- Kothari, C.R. (1993), Research Methods and Techniques. New Delhi, 2nd Ed., V.S.Joshi Wiley Eastern Ltd., pp. 39-69, 277-299, 368-402, 403-422.
- Lidhoo, M.L. (1987), Child Rearing and Psycho-social Development. New Delhi, Ashish Publishing House, pp. 1, 5, 5-55.
- Lindley, J. (1981), Flora Medica A Botanical Account of all the More Important Plants Used in Medicine. New Delhi, Published by Ajay Book Service, pp. 529-530.

- Madhumathi, A. (1993), The effect of development educational material on the knowledge content of tribal mother in child care. Abstract, Unpublished M.Sc. Thesis, A.P.A.U., Hyderabad, pp. 1-2.
- Mahadevan, K. (1988), Cited in "Status of Women", Mahadevan, K., 1990, Policies and Strategies for Child Survival. New Delhi, Publicating Corporation Division (P) Ltd., pp. 1, 425.
- Mahanti, N. (1993), Caring for the tribal children. Social Welfare, XXXIX, 10, pp. 9-13.
- Majumdar, D.K. (1950), The Affairs of a Tribe - A study in Tribal Dynamics. Lucknow, The Universal Publishers Ltd., pp. 123-176, 177-188, 226-239, 64-65, 78-80, 81.
- Majumdar, D.N. and Madan, T.N. (1956), An Introduction to Social Anthropology. Bombay, Asia Publishing House, pp. 25-45, 51-75.
- Majumdar, D.N. (1985), Cites in Marriage Pattern of Tribes, Tribal India Today. Hasuain, N., New Delhi, Harnam Publication, pp. 31-32.
- Majumdar, D.N. and Madan, T.N. (1989), An Introduction of a Social Anthropology. New Delhi, National Publishing House, 4th Edition, pp. 50-85.
- Manrol, D.M. (1990), Tradition and Social Milieu of Bhotia Women, Tribal Women Changing Spectrum in India. New Delhi, Manroe, Classical Publishing Co., pp. 79-110.
- Maurya, S. (1987), Feeding and health care of children among Irula Tribals. The Indian Journal of Home Science, 17:2 Dec., pp. 55-58.
- Mendoca, (1989), Cited in Modernity in Tribal Hindus. Sahay, M., 1990. Ph.D., Thesis, Department of Psychology, Ranchi University, Ranchi, pp. 21-25.
- Mohanty, M.K. (1990), Tribal Society Programme Planning and Economic Changing. Allahabad, Chugh Publications, pp. 10-22.
- Mohanty, A.K., Behere, D.K., Sarkar and Mohanty, D.R. (1991), Dietary Pattern of the Expectant and Nursing Mothers among the Plain Bhuiyan Tribe. Man in Asia, pp. IV, 11, 5-13.
- Mussen, P.H., Conger, J.J., Kagan, J. and Huston, A.C. (1984), Socialisation in the Family, Child Development and Personality. New York, Harper and Row Publishers, pp. 380-411.

- Muthurayappa, R. (1993), Health Care Practices among Tribes. Kurukshetra, Vol. XLI, No. II, pp. 29-30.
- Nalini, N. (1988), A study on the impact of child rearing practices of mothers on personality development of children at reception house. Unpublished M.A. Thesis, Department of Social Work, Kamaraj University, Madurai, pp. 1, 3, 6-8, 59-62.
- National Council of Educational Research and Training (1978), Play and play materials of Tamil Nadu. A Manual for Teachers, Coimbatore, Vidya Vikashini School, pp. 3-7.
- Natu, M. (1939), Review of Traditional Practices in Mother and Child Care in Maharashtra. Report (27-28 Feb.), New Delhi, NIPCCD, pp. 80-89.
- National Institute of Public Cooperation and Child Development, (1994), Statistics on Children in India. New Delhi, Hauzkhaz, pp. 1-10.
- Palkar, V. (1983), A study of mental attitudes toward child rearing. Social Welfare, pp. 31-35.
- Pandey, H. and Punetha, S. (1989), Traditional mother and child care practices of Bhotia (Shauka) - A Pilot Research Study. Report (27-28 Feb.), New Delhi, NIPCCD, pp. 191-200.
- Phukan, M. (1988), Health care of expectant women and child rearing practices in the tea garden of Assam, Seminar Report on Child Care Practices in North Eastern Region (22-27 June), NIPCCD, p. 3.
- Punhani, R. and Mahajan, (1989), Research on ICDS, Vol. 1, New Delhi, NIPCCD, pp. 229-234.
- Puri, D. (1992), Breast feeding among tribals : An Aid to Fertility Control. Journal of Family Welfare, XXXVIII (2), pp. 55-59.
- Radhakrishnan, O.R. and Rahgir, S.P. (1992), Child rearing methods in relation to socio-economic status. Indian Psychological Review, Vol. 38, (9-10), pp. 18-20.
- Rahame, P. (1988), A study of attitudes and opinions of educated and uneducated mothers regarding toilet training. Journal of Human Development, L.A.B.D. College for Women of Arts, Commerce and Science, Nagpur, pp. 46-48.

- Rajavelam, R. (1986), A Comparative Study on Awareness of Child Care among Urban and Rural mothers. Alankanallur Block and Madurai City, Unpublished M.A. Thesis, Madurai Kamaraj University, pp. 1-4, 8, 15, 95-101.
- Rajalakshmi, C. (1992), Santal Women : Areas of Health Ignorance. Social Change, pp. 18-34.
- Sadhu, A.N. (1985), Research Methodology in Social Science. Bombay, Himalaya Publishing House, p. 127.
- Saxena, V.B. (1989), Review of Traditional (including tribal) Practices in Mother and Child Care in Madhya Pradesh. Report (27-28 Feb.), New Delhi, NIPCCD, pp. 24-39.
- Seshadri, S. (1987), Studies on nutrition health education in the ICDS set up. Baroda, Ph.D. Thesis, Department of Foods and Nutrition, M.S.University, p. 50.
- Sethi, J. (1988), Cited in Review of traditional practices in mother and child care in Gujarat. Gopaldas, T. 1989, Seminar Report (27-28 Feb.), New Delhi, NIPCCD, pp. 42-68.
- Shashi, S.S. (1978), The santal children. Our Tribal Children, Patiala House, New Delhi. Publication Division, Ministry of Information and Broadcasting. Govt. of India, p. 12.
- Shahida, P., Indira, R. and Devadas, R.P. (1970), Cross Cultural Study of Child-Rearing Practices in Badagas and Irulas in Nilgiris and Coimbatore Districts. Indian Journal of Home Science, 4 (1), pp. 51-56.
- Sharma, V.P. (1981), Indian Urban Families. Child Rearing Practices and Child Growth, New Delhi: NCERT, pp. 3, 9.
- Shukla, M.C. and Gulshan, S.S. (1983), Elements of Statistics. New Delhi, Sultan Chand and Company Ltd., pp. 16-22.
- Sikar, (1985), Cited in the status and role of women in a tribal community, Man in India. Jahagirdar, M.P., 1988, p. 424.
- Singh, L.B., Sinha, B., Singh, C.B.P. and Kumari, R. (1986), Modes of Parental Discipline among Santal and Hindus: Assessment Across Communities. The Indian Journal of Social Work, Vol. XLVII, No. 3, p. 315.

- Singh, J. (1989). Review of traditional practices in mother and child care in Manipur. Report (27-28 Feb.), New Delhi, NIPCCD, 71-78.
- Singh, B. (1994), Sheduled Tribe, Manorama Year Book. Kottayam, Malayala Manorama Corporation Ltd., pp. 28, 30, 32.
- Srivastava, A. (1958), Cited in Traditional Social Miliell of Bhotia Women, Tribal Women: Changing Spectrumia India. Manrol, D.M., 1990, New Delhi, Classical Publishing Co., p. 80.
- Srivastava, R.M. (1981), Cattle in culture and economy of Tribal Mundas of Bihar. Ph.D. Thesis, Kurukshetra University, Kurukshetra, pp. 1-2, 176-179.
- Suriyakanthi, A. (1989), Child Development - An Introduction. Gandhigram, Kavitha Publications, pp. 14-16.
- Swaminathan, (1994), The Bhils of Rajasthan. The Hindustan, p. 5.
- Tavkar, N. (1983), Child Care amongst the tribals of Panchmahals. Human Development, Early Childhood Care and Education, Family Welfare, Report of ECCE, pp. 13-15.
- The Economist (1995), A sprinkling of herbs. The Hindustan Times, p. III.
- The Hindu (1995), Hand.cuffing Marriage, February 5, p. VII.
- The Hindu (1995), 'Tribals have special talent in herbal medicines'. 7th April, p. 5.
- Tripathi, C.B. (1988), Approaches to Tribal development and experience, Man in India, p. 335.
- Vidyarthi, L.P. and Rai, B.K. (1985), The Tribal Culture of India. New Delhi, Concept Publishing Co., pp. 159, 184-189, 279-296, 407-406, 420-438.
- Walter, J. and Stinnet, N. (1971), Marriage and Family, 33 : 70, pp. 1-3.
- WHO, (1990), Cited in Santal Women : Areas of Health Ignorance. Rajayalakshmi, C., 1992, Social Change, p. 20.

APPENDICES

APPENDIX I

INTERVIEW SCHEDULE TO ELICIT INFORMATION ON MARRIAGE, FAMILY SYSTEM AND TRADITIONAL MOTHER AND CHILD CARE PRACTICES OF 'Ho' TRIBE OF BINAR

Identification Details

Block :
Panchayat :
Village :
Name of the respondents :
Address :

PART - A

Information on Socio-economic Status

Family particulars (Please mark [] the appropriate answer)

Sl.No.	Particulars	Mother	Father
I. Socio-personal characteristics			
1.	Name		
2.	Religion		
3.	Caste		
4.	Marital status	: Married/Single/Widow/Remarried	
5.	Types of family	: Joint/Extended/Nuclear	
6.	Age range in years	: Mother	Father
7.	Education	:	
	i. Illiterate		
	ii. Literate		
	a. Pre-primary; b. Primary; c. Middle; d. Secondary; e. Graduate/Diploma;		
	f. Post-graduate		
8.	Number of children in the family		
	i. One child; ii. Two children; iii. Three children; iv. Four children;		
	v. Five children; vi. Six and above		
9.	Size of the family		
	2-3 member; 3-4 member; 5-6 member; 7-8 member; 8 and above members		
10.	Social status		
	i. Living in own house; ii. Hosting feast regularly; iii. Paying income tax;		
	iv. Are you member of any organisation/association		

II. Economic status

1. Occupation

i. Agriculture coupled with cattle rearing; ii. Unskilled; iii. Semiskilled;
iv. Service; v. Business

2. Family income per month in Rs.

i. Below - 500; ii. 500 - 1000; iii. Above 1000

PART - B

Detail Information on Marriage and Family System of 'Ho' Tribe

1. Marriage

1.1 What form of marriage popular in your community ?

1.2 What type of marriage system prevails in your tribe ?

i. Andl; ii. Diku Andl; iii. Opartipi; iv. Razikhushi; v. Anadar; vi. Any other

1.3 Generally at what age do the boys/girls are married ?

Sl.No.	Age in years	Boys	Girls	Reasons
i.	18 - 21			
ii.	22 - 23			
iii.	26 - 29			
iv.	30 - 33			
v.	34 and above			

1.4 Who selects the mate in your family

i. Parents; ii. Relatives; iii. Dutam; iv. Friend; v. Them selves

1.5 If mate is selected by parents do parents take the consent of boy/girl before
arranging the marriage No/Yes

1.6 What factors are taken into consideration while selecting a mate ?

S.No.	Factors
i.	Caste
ii.	Age difference
iii.	Family wealth and position
iv.	Personal qualities
v.	Educational level
vi.	Good job
vii.	Good character
viii.	Health
ix.	His physical appearance
x.	No. of siblings
xi.	Birth order
xii.	Interest/hobbies
xiii.	Matching horoscope
xiv.	Other if any specify

1.7 In case of marital discord who helps the couple ?

- i. Elders in the family; ii. Priest; iii. Doctor; iv. Relatives and Friends;
- v. Any other

1.8 According to you in what type of marriage, chances of conflicts are more ?

- i. Arranged; ii. Love; iii. Any other

2. Dowry System of Tribe

2.1 Does dowry system prevail in your community ?

Yes/No

If no, why ?

- i. Traditional custom; ii. God will punish; iii. Any other

If yes, in what type of marriage dowry problems prevail in your tribe.

- i. Andi; ii. Diku andi; iii. Opertipi; iv. Razikhushi; v. Anadar; vi. Any other

2.2 Mention the items usually demanded as dowry ?

3. Remarriage

3.1 Is remarriage of women prevalent in your community ?

Yes/No

4. Break Down in Family

Dissolution of Marriage

4.1 Does dissolution of marriage take place in your tribe ? Yes/No

Separation

Divorce

If yes, reasons of dissolution of marriage

4.2 As per community panchayat after annulment of marriage generally who keeps the custody of children ?

B. Maintenance

Are divorced deserted and separated women eligible to claim and for maintenance for themselves and their children, if it is through the tribal panchayat ? Yes/No

If no, reasons

5. Availability of Legal Protection for 'No' Women

5.1 Do women get equal share in the ancestral property ? Yes/No

If no, reason ?

i. Due to traditional custom

ii. Property is given to the sons because they look after the parents in old age.

iii. Any other

5.2 Do you protest for equal share in ancestral property ? Yes/No

If no, why ?

5.3 Are you aware of legal protection available for you in India? Yes/No

5.4 What is your source of knowledge on legal protection?

1. No where; 2. Mass media; 3. Interpersonal communication

5.5 Would you like to have awareness campaign on legal protection available for women in India? Yes/No

If yes reasons

a) To know about laws; b) To fight for their rights; c) For emancipation of women

6. Status of Women

Decision Making Power

6.1 Who takes the decision regarding the following aspects in your family

Sl. No.	Pattern of expenditure	Person responsible for decision making				
		Husband	Wife	Both	Mother in law	Father in law
i.	Family size					
ii.	Selection of clothing					
iii.	Choice of food for family					
vi.	Education of children					
vi.	Health care					
vii.	Recreation					
viii.	Money management					
ix.	Decision on mate selection for children					
x.	Decision of children's vocation settlement					
xi.	Overall management of the house					
xii.	Seed purchase					
xiii.	Crops to sown					
xiv.	Free to spend money					
xv.	Any other					

6.2 If the decision is taken by husband do you accept the decision without protest? Yes/No

If yes, give reason

- i. To have harmony in the family; ii. Due to fear; iii. Due to helplessness; iv. Due to financial dependance on him; v. Any other

6.3 Do you think that decision taken by you is respected by your husband ? Yes/No

6.4 What is your reaction when you see or hear about women being harrassed in your tribe?

- i. Feel pity; ii. Went to help her; iii. No reaction; iv. Any other

6.5 Do in your tribe girls allowed for education what is your opinion regarding girls education ?

- i. Girls should be educated as much as they wish; ii. Basic education is enough; iii. No need of giving education to them; iv. Any other

6.6 Are men and women given medical treatment when they are sick ? Yes/No

21

PART C

Interview Schedule to Elicit Information on Traditional Mother and Child Care Practices

A Mother care during pregnancy

1. Medical check-up and diets

1.1 Are you pregnant? Yes/No

1.2 If yes, is this your first pregnancy Yes/No

1.3 Please mention following particulars of miscarriage still birth and neonatal mortality

Sl.No	Particulars of child birth	Number	Causes
i)	Miscarriage		
ii)	Still birth		
iii)	Neonatal mortality		

1.4 What is the frequency of health check-up during pregnancy at primary health centre

i) Every fortnightly; ii) Monthly; iii) Once in two months; iv) When sick;
v) When serious; vi) Not at all

1.5 Have you undergone/underwent/undergoing the following prenatal check-up regularly ?
Yes/No

If Yes, mention

i) Blood test; ii) Urine test; iii) Weight check-up; iv) Iron supplements;
v) Supplementary folic acid; vi) Calcium-supplements; vii) Tetanus toxoid injection

If No, reason for negligence basis?

i) Due to laziness; ii) Too much work; iii) Opposed by the husband;
iv) Financial problems; v) Non-availability of medicines; vi) Any other

1.6 Mention the month of pregnancy when tetanus toxoid injection was taken

1.7 Who is doing prenatal check-up locally?

1.8 Are you getting these prenatal check-up free of cost or on payment basis?

1.9 Have you suffered/suffering the following prenatal complications?

If yes, mention

Yes/No

i) Oedema; ii) Fever; iii) Bleeding; iv) Sudden pain; v) Loss of weight; vi) Any other

1.10 Has any death occurred in the reproductive (15-35) age among the female in your family? Yes/No

If yes, what were the reasons?

- i) Poverty; ii) Lack of adequate medical care; iii) Sickness/disease;
- iv) During pregnancy; v) During delivery; vi) Any other

1.11 Foods restricted during pregnancy

Sl.No	Name of the food item restricted	Duration	Reasons
-------	----------------------------------	----------	---------

1.12 Special foods given to pregnant woman Yes/No

If yes, give detail information

Sl.No	Name of the food items	Duration	Reasons
-------	------------------------	----------	---------

2. Rest and Preparation for Delivery

2.1 Till how long did you work at home, farm and outside during pregnancy?

- i) Till first trimester of pregnancy; ii) Till second trimester of pregnancy;
- iii) Till third trimester of pregnancy; iv) Any other

2.2 Do you do any preparation for delivery? Yes/No

If yes, what were they?

- i) Cotton packet; ii) Old cloth; iii) Oil; iv) Soap; v) Any other

2.3 Where did/will the delivery take place?

- i) Government hospital; ii) Private clinic; iii) At home; iv) Any other

2.4 Who attend the delivery?

- i) Doctor; ii) Midwife; iii) Relatives; iv) Local women;
- v) Traditional birth attendant; vi) Trained attendant; vii) Untrained attendant;
- viii) Any other

2.5 What is the responsibilities of the husband at time of delivery in the tribe?

- i) Counselling wife; ii) Taking care of children; iii) Taking wife to the hospital;
iv) Both above; v) None of it; vi) Any other

2.6 Do you observe any ritual or function for safe delivery Yes/No

If yes, give particulars

- i) Name of ritual or function; ii) Time of performance; iii) Place of performance;
iv) Procedure of function

3. After Care of the Mother

3.1 What immediate care is given to the mother soon after child bith?

Sl.No	Immediate care	Reasons
-------	----------------	---------

3.2 Do you perform any ritual or function after the birth of the child? Yes/No

If yes, name them

3.3 Do you perform purification ceremony of the mother after the child birth ? Yes/No

If yes, how

3.4 After how many days of delivery do you start doing the house work?

- i) Within a week; ii) Fortnight; iii) A month; iv) More than one month; v) Any other

3.5 How do you take care of your body after the delivery?

3.6 What food items are restricted after child birth?

If restricted give the list

None

Sl.No	Name of the food item restricted	Duration	Reasons
-------	----------------------------------	----------	---------

3.7 What special food items are given to the nursing mothers

S1.No	Name of the special food items	Reason
-------	--------------------------------	--------

4. Family planning techniques of Ho tribe

4.1 What are the family planning techniques prevalent in your tribes ?

i) Herbs; ii) Safe period/coitus interruption/sexual abstain; iii) Home made remedies;
iv) Allopathic medicine; iv) Fruits; v) Breast feeding; vi) Any other

4.2 How far these methods are reliable for birth control?

i) Very reliable; ii) Reliable to some extent; iii) Not reliable; iv) Any other

4.3 What are the other methods of family planning known to you?

i) Female/Male sterilization; ii) Intra uterine contraceptive device (Copper T);
iii) Rhythem (Safe period); vi) Oral contraceptive (Mala D); v) Condom;
vi) Any other all

4.4 Who told you about the above methods?

i) Interpersonal communication; ii) Mass media; iii) Family planning workers;
iv) Any other

4.5 Do you know how much monetary incentive is given for adoption of different family planning methods now-a-days? Yes/No

If yes, amount in Rs.

B. Care of the Child

1. Immediate care

1.1 What instrument was used for cutting the umbilical cord?

i) Blade; ii) Knife; iii) Any other

1.2 Whether it was sterilized before use? Yes/No

If yes, reason

i) Doctor's advice; ii) Custom; iii) Every body is sterilizing; iv) Any other

If no, reason

- i) Lack of information; ii) It is not done in our community; iii) Custom;
iv) Any other

1.3 How do you disposed the placenta ?

1.4 What medicine or herbs are used for healing the cord?

None

Sl.No	Name of medicine	Name of herbs	Reasons

1.5 Did your child get any kind of wound after cutting the cord?

Yes/No

If yes, kind of wound

1.6 Do you bath your child immediately after birth?

Yes/No

If yes, why and how?

1.7 What kind of water are you using for bathing the child?

- i) Cold water; ii) Hot water; iii) Luke warm water; iv) Any other

1.8 Are you using any herbal cleaning agent while bathing the child?

1.9 What oil are using for oiling the baby ?

Sl. No.	Name of oil	Oiling technique	Frequency of oiling			
			Once in a week	Twice in a week	Daily	Any other
	i) Mustard oil					
	ii) Baby oil					
	iii) Commercial oil					
	iv) Karanj oil					
	v) Any other					

1.9 Are you putting your child in the sun after massaging?

Yes/No

If yes, how often?

2 Feeding

2.1 What kind of feed do you give your child?

i) Breast feed; ii) Artificial feed

2.2 When did you start feeding your child after birth?

2.3 If milk is not given what alternative liquid did you introduce to the baby as prelactation?

i) Honey mixed water; ii) Plain water; iii) Glucose; iv) Sugar solution; v) Any other

2.4 Was the colostrum given to the baby Yes/No

If yes, reasons

i) Doctor's advice; ii) Elder's advice; iii) Family practice; iv) Good for health; v) Any other

If no, reasons

i) Ignorance; ii) Bad for health; iii) Custom; iv) Any other

2.5 Do you give artificial feed to your baby? Yes/No

If yes, what exactly do you give

i) Cow's milk; ii) Buffalo's milk; iii) Goat's milk; vi) Tinned milk

2.6 What kind of bottle, vessel do you use to feed the child ?

i) Home made feeder, feeding bottle; ii) Tumbler; iii) Bowl and spoon; iv) Any other

2.7 How often do you clean and sterilize the bottle or vessel

i) After every feed; ii) Twice a day; iii) Thrice a day; iv) Any other

2.8 What cleaning agent do you use for cleaning the bottle/vessel ?

2.9 What pattern of feeding did you adopt for your child ?

Sl.No.	Pattern of feeding	Yes	No	Duration of feeding	
				Month	Year
i.	On demand				
ii.	On schedule				
iii.	For wish of mothers				

2.10 Length of breast/artificial feeding?

Sl.No.	Length of feeding	Breast feeding	Artificial feeding
i.	Upto 6 months		
ii.	Upto 1 year		
iii.	Upto 2 year		
iv.	Any other		

3. Weaning

3.1 At what age do you start weaning your child ?

- i) Between 3-4 months; ii) Between 5-6 months; iii) Between 8-9 months;
iv) Between 10-11 month; v) More than one year; vi) Any other

3.2 Mention the supplementary food given to the child ?

Sl. No.	Food introduced	Age	Reasons
---------	-----------------	-----	---------

3.3 How was the weaning done ?

- i) Gradual; ii) Sudden; iii) Any other

3.4 Methods adopted for weaning the child

3.5 Problems faced while weaning the child ?

Sl.No.	Problem faced	Method of solving	Who helped you and how
--------	---------------	-------------------	------------------------

4. Clothing

4.1 How do you dress your child soon after birth ?

- i) Old dress; ii) New dress; iii) New but home stitched dress;
iv) Dress stitched out of an elderly person's garments; v) Any other

4.2 Which material is generally used for children's garment ?

5. Toilet Training

5.1 Do you toilet train the child ?

Yes/No

If yes, why?

i) For inculcating good habits; ii) For keeping the environment clean; iii) Any other

If no, reason

i) Laxed attitude; ii) Ignorance; iii) Lack of interest in toilet training;
iv) Any other

5.2 At what age do you start toilet training to your child ?

i) 3-6 months; ii) 7 months - 1 year; iii) More than one year; iv) Any other

5.3 Do you have specific timings set for your children for going to latrine?

Yes/No

If no, why ?

i) Too busy schedule; ii) Ignorance; iii) Illiteracy; iv) Any other

Procedure followed for toilet training.

5.4 Does your child have habit of bed wetting ?

Yes/No

If yes, how did you tackle ?

6. Bathing and Body Care

6.1 How often do you bath your child

Sl.No.	Frequency of bathing	Reasons
i.	Once a day	
ii.	Twice a day	
iii.	Alternate day	
iv.	Once a week	
v.	When dirty	
vi.	Any other	

6.2 Do you insist on the following healthy habits in your child ?

Sl.No.	Health habits	Yes	No
i)	Washing hand before eating		
ii)	Brushing the teeth		
iii)	Taking bath daily		
iv)	Washing the mouth after eating		
v)	Cutting nail in regular intervals		
vi)	Keeping hair free from lice		
vii)	Washing hair once a week		
viii)	Combing hair daily		
ix)	Changing dress daily		
x)	Using clean towel & handkerchief		
xi)	Keeping the place neat		
xii)	Drinking clean water		
xiii)	Eating manners		
xiv)	Toilet habits		

If no, reasons

i) Lack of time; ii) Ignorance; iii) Illiteracy; iv) Any other

7. Rest and Sleep

7.1 Who makes the child sleep?

i) Grand Mother/Grand Father; ii) Mother; iii) Any other

7.2 What type of bedding facilities are available for your child ?

i) Wooden cradle; ii) Cloth cradle; iii) Mat; iv) Locally made cot; v) Any other

7.3 What method is used to make the child sleep ?

i) Just pat them; ii) Sing lullaby; iii) Tie on the back; iv) Rock; v) Any other

8. Health Protection

8.1 How often do you take the child for medical check up ?

i) Monthly; ii) Yearly; iii) When child is serious; iv) Never

8.2 What are the common diseases prevalent among tribal children ?

i) Skin disease; ii) Measles; iii) Diarrhoea; iv) Worms; v) Fever; vi) Anaemia;
vii) Any other

8.3 Are you aware of the various preventive vaccines given to the children ?

Yes/No

8.4 Did you adopt the immunization schedule ? Yes/No

If yes, mention

i) T.B.; ii) Diphtheria; iii) Polio; iv) Tetanus; v) Whooping cough; vi) Typhoid

8.5 What type of remedies do you follow when he/she is sick ?

Remedies

i) Home remedies; ii) Medical remedies; iii) Any other

8.6 Who is given preference for medical care ?

i) Male child; ii) Female child; iii) Both; iv) Any other

9. Safety Measures

9.1 What safety measures do you follow for protecting your children ?

i) Keeping medicine away from children; ii) Keeping children away from fire; iii) Keeping surrounding free from accident prone objects; iv) Any other

10. Play and Recreation

10.1 Do you think play is important for children ? Yes/No

10.2 Do you play with your children ? Yes/No

10.3 Do you make toys for your children ? Yes/No

If yes, list items

If no, reasons

i) Do not know; ii) Laziness; iv) Too much work; v) Any other

10.4 What play materials do you provide for recreation of your children?

Sl.No.	Play material	How used	Reasons

11. Disciplining

11.1 Do you think discipline is necessary for your children ? Yes/No

If yes, reason

- i) To make the child good citizen; ii) For inculcating good habits;
- iii) To socialize the child

If no, reason

- i) Ignorance; ii) Illiteracy; iii) Any other

11.2 Do you observe the following behaviour in your child ?

Sl. No.	Behaviour	Yes/No	Reason perceived by mother for that behaviour
i)	Stealing		
ii)	Telling lie		
iii)	Nail biting		
iv)	Bed wetting		
v)	Thumb sucking		
vi)	Head banging against wall floor		
vii)	Temper tantrum		
viii)	Stammering		
ix)	Bullying		
x)	Fighting		
xi)	Biting others		
xii)	Any other		

11.3 What method did you follow for disciplining your child

Sl.No.	Method Used	Method followed
i)	Physical punishment	
ii)	Verbal expression	
iii)	Depriving him from play and food	
iv)	Ignoring the child	
v)	Any other	

11.4 Are you practising the same disciplinary measures with both boys and girls ? Yes/No

If yes, reasons

PART - D

**Interview Schedule to be Used for Local Medicine Men/Women on Traditional
Indigenous Remedies for Family Health Care**

1. What indigenous remedies do you give for the following common health problems ?

Disease	Ingredients, their proportion and method of preparation	Form	Application and dose	Frequency	Shelf life of the product
1. Surgical :					
a. Wound					
b. Fracture					
c. Any other					
2. Digestive :					
a. Stomach pain					
b. Colic					
c. Diarrhoea					
d. Dysentery					
e. Burning stomach					
f. Any other					
3. Respiratory					
a. Fever					
b. Cough					
c. Dry cough					
d. Cold					
e. Any other					
4. Skin infection					
a. Eczema					
b. Scabies					
c. Any other					
5. Contagious					
a. Small pox					
b. Measles					
c. Any other					
6. Infectious					
a. Worms					
b. Jaundice					
c. Any other					
7. Miscellaneous					
a. Burn					
b. Bleeding of nose					
c. Constipation					
d. Anaemia					
e. Any other					

2. Evaluation of the scientific value of the locally used indigenous preparation ?

APPENDIX II

OBSERVATION INVENTORY

A. Identification Details

1. Block
2. Panchayat
3. Village
4. Name of the head of the family
5. Address

SAILENT FACTORS OF OBSERVATION

B. Marriage and Family System of Ho Tribe

1. Dowry and Remarriage - its root cause
2. Breakdown of family
3. Availability of legal protection for 'Ho' women
4. Oppression faced by women

C. Status of Women in Ho Tribe

1. Decision making power
2. Medical aid provided to men and women

D. Traditional Mother and Child Care

1. Mother care practices

- 1.1 Mother care during pregnancy
- 1.2 Rest and preparation for confinement
- 1.3 After care of the mother

2. Child care practices

2.1 Immediate care

- 2.1 Immediate care
- 2.2 Feeding of children
- 2.3 Handling weaning food
- 2.4 Clothing of children
- 2.5 Toilet training practices
- 2.6 Personal cleanliness of the children
- 2.7 Sleep and rest
- 2.8 Health protection for various ailments
- 2.9 Safety measures adopted for child protection
- 2.10 Play and recreation
- 2.11 Disciplinary techniques followed

E. Indigenous Remedies Used for Family Health Care