

CHAPTER 4

MATERNAL AND CHILD HEALTH CARE PRACTICES

Both tradition and culture determine the attitudes, belief, and practices in regard to the mother and child health care. Majority of the tribal communities in India live under abject poverty, yet it is not the culture of poverty, which determines the value of children for these groups, but the tribal worldview. Tribal philosophy regards children as gifts of the nature. Procreation is the essence of life for them. Whether male or female; children are not commodities for them but chains which bind life in continuity. Prevalence of bride price in many tribal communities makes women more important than men. Children are valued for being children and not for their positive values and negative costs. Mother and child health status amongst tribals become a victim of their ignorance, economic deprivation and inaccessibility to medical facilities. Tribal communities have evoked their own systems of prevention and cure. They also prescribe especial care for would-be-mothers and new mothers, but have no answer to tetanus, which is normally caused by the use of an un-sterilised sickle for cutting the umbilical cord (Mehata. 1989, p6-7). We shall deal with maternal care and child health care separately in a comparative perspective to have better understanding about the existing maternal and child health care, reasons for acceptance or non-acceptance of modern practices in the tribal worldview.

MATERNAL CARE

As per the India's Family Welfare Programmes, maternity care should be designed to prevent maternal mortality and morbidity and hence to ensure timely detection of pregnancy, management and referral of complications during pregnancy. Maternal care is an important aspect of health care given to the expectant women in order to maintain good health before and after delivery. It aims at facilitating delivery of a healthy baby and helps the mother for maintaining good health. Maternal mortality is reported to be high amongst tribals. As per the records of the Tagore Society for Rural Development two maternal deaths were recorded in the target villages during last one year. The records of the Primary

Health Centres are not sufficient enough to say the actual number of death due to maternal problem. Not a single death has been recorded during the time of investigation of the target and non-target villages. Tribals of both the target and non-target villages are very much concerned about maternal death but are also helpless.

The main cause of maternal mortality is unhygienic and primitive practices for parturition. Some of the other causes of maternal death may be described as hemorrhage, infection, obstructed labour, eclampsia etc. Poor tribal pregnant women during delivery may die of hemorrhaging, violently pumping blood onto the floor of bus or bullock cart or blood-soaked stretcher as their families and friends search in vain for help. Tribal pregnant women also goes through primitive practices of abortion mostly conducted by traditional *dais* and most of them survive, though often with crippling discomfort, pelvic inflammatory disease, and a continuing foul discharge. The rest do not survive with punctured uterus, infected wounds, and creeping sepsis. Some tribal pregnant women may die from brain and kidney damage in the convulsion of eclampsia. Sepsis, severe anemia, obstructed labour etc. Many injuries sustained during pregnancy and childbirth is distressingly obvious. Rupture of the uterus, prolapsed, pelvic inflammatory disease lower genital tract injuries and fistula make life miserable for the tribal women. Some of the aspects of maternal health like pre-natal and post-natal check-ups by the qualified health staff, special diet for the pregnant women, immunisation against tetanus, need for consulting modern doctors during pregnancy, gynaecological problems faced by the tribal women and their treatment, the changing trend of maternal care have been studied in a comparative perspective.

Tribal women are basically engaged in agricultural work, road, or other construction work. During pregnancy women are permitted to work unto the advance stage of the delivery. Most of the tribals of the target and non-target villages work till 7-9 months of their pregnancy. Though changes have already

been noticed in some cases among tribals of the target villages. It has been observed that some of the pregnant women of the target villages work till 6 months only. During pregnancy Rupa, wife of Biswanath Ekka of Chhiraikuri village, was permitted to work only upto 6 months so that she could maintain good health to facilitate an easy delivery. We have also been observed same kind of practices when Jamuna, wife of Esmail Oraon of Chamtakuri villages was pregnant. To understand the pattern of resumption of work outside the home after delivery, almost similar picture is being seen among the tribal women of the target and non-target villages. In general, most of the mothers resume work within three months of their delivery.

Pre-natal check-up

Pre-natal services can detect and manage complications such as anemia, infection, pre-eclampsia and mal-nutrition as well as can provide an opportunity for immunisation against tetanus, iron-supplementation, counselling on health, nutrition, and family planning, and the treatment of pre-existing diseases, such as tuberculosis, malaria etc. All these services are supposed to be provided by the Primary Health Centres. The concept of pre-natal checkups for pregnant women is not felt necessary among the tribals even a few years back. But now-a-days some of the tribals have felt that pre-natal checkups for the pregnant women is necessary for maintenance of good health of both the mother and the baby. Those women who have undergone pre-natal check-ups have consulted either local Primary Health Centres or other agencies such as Non Government Organisations like the Tagore Society for Rural Development, private doctors, or quacks. The Tagore Society for Rural Development provides pre-natal services in the target villages, which include check-ups by trained health staff, immunisation against tetanus, iron supplementing, counselling on health, nutrition and family planning and the treatment of pre-existing disorders, such as tuberculosis, malaria etc. The Tagore Society for Rural Development conducts immunisation session with the support of the Primary Health Centres. Iron tablets,

immunisations against titenus are also available with the private doctors and quacks.

Table 27 and table 28 show the evidence of slow changes in the perception of the tribals regarding pre-natal check-ups. Previously the concept of pre-natal check-ups was totally absent among the tribals and for any kind of problem during pre-natal period they mainly used to consult *ojha* for relief. Table 27 shows that in general, more than half of the respondents of the target villages are reported to have no check-up for pregnant women (53 per cent of the total respondents); of whom, 61.70 percent are illiterate and 32.76 per cent are literate. Tribe wise analysis shows almost same picture. Among the Santals of the target villages, 51.79 per have no check-ups for pregnant women, whereas, 55.17 per cent respondents belonging to the Oraons are not concerned for pre-natal check-ups. However, 61.84 per cent literate households belonging to the Santal community are concerned for pre-natal check-ups. And 61.54 per cent literate households belonging to the Oraons have followed suit. While 30.55 per cent Santal respondents are reported to have no check-up of the pregnant women, similarly, 36.36 per cent Oraon respondents have taken no step for the check-ups of the pregnant women.

The analysis of the source of the pre-natal checkup of the pregnant women shows interesting results. In general, it is observed that majority of the tribals consult either the staff of the Tagore Society for Rural Development or quacks for pre-natal check-ups. It is reported that in general, 33.66 per cent households consult the health staff of the Tagore Society for Rural Development for pre-natal check-ups of the pregnant women, and 60.34 per cent of the literate tribals and 22.70 per cent of the illiterate tribals consult those staff. However, rests of the respondents visit the local Primary Health Centre for pre-natal check-ups. Pregnant women basically consult quack for the treatment of the pre-existing diseases and also they get titenus injection and iron tonic from quacks. It has been observed that 13.06 percent tribals visit the Primary Health Centre for the

same purposes, of whom, 10.34 per cent are literate, and 14.18 per cent are illiterate (See Table-27).

Tribe wise analysis gives the interesting results (Table-27). In general, 33.03 per cent Santal respondents and 34.48 per cent Oraon respondents depend either on the Tagore Society for Rural Development or quacks for pre-natal check-ups. However, most of the literate Santals and Oraons depend either on the Tagore Society for Rural Development or quacks for pre-natal check-ups. It is reported that 58.33 percent literate Santals and 63.64 per cent literate Oraons consult either the Tagore Society for Rural Development or quacks for pre-natal check-ups. However, it is reported that 21.05 percent illiterate Santals and 24.62 per cent illiterate Oraons are on the same track of their literate counterparts. Most of the tribals have no faith on the Primary Health Centre for pre-natal check-ups during pregnancy. Non-availability of the health staff, indifferent attitude of the health staff towards tribals, distance of the health centre and the waiting time of the pregnant women at the health centre etc, are reported as some of the causes for non-visiting Primary Health Centre for pre-natal check-up during pregnancy. It is reported that only 15.18 per cent Santal respondents visit the Primary Health Centre for pre-natal check-ups of the pregnant women, whereas, only 11.11 per cent literate Santals and 17.11 per cent illiterate Santals depend merely on the Primary Health Centre for the pre-natal check-ups of the pregnant women.

In the non-target villages (Table-28), in general, most of the pregnant women among tribals have no check-ups during pregnancy. It is reported that in general, 83.97 percent of the tribals, 56.58 percent of the literate tribes, and 95.16 per cent of the illiterate tribes have reported to have no check-ups of the pregnant women. Tribe wise analysis shows almost the same picture. Among the Santals, 81.60 per cent have reported to have no check-ups of the pregnant women, whereas 94 per cent Oraon respondents are reported the same. It is reported that as many as 94 per cent illiterate Santal respondents and all-illiterate Oraon respondents have reported to have no check-ups of the pregnant women. However, 51.61 percent

literate Santals and 78.57 percent literate Oraons have not arranged check-ups of the pregnant women.

The analysis of the source of pre-natal check-ups of the pregnant women of the non-target villages (see Table-28) shows interesting results. In general majority of the tribals consult the Primary Health Centre for pre-natal check-ups of the pregnant women, though the literate tribals prefer to visit private doctors or even quacks for pre-natal check-up. In general, 7.63 per cent depend on the Primary Health Centre for the check-ups of the pregnant women, of whom, 11.84 per cent are literate, and 4.84 per cent are illiterate. The rest 8.40 per cent visit other agencies like private doctors, quacks etc. All of these tribes are literate and constitute 28.95 of the literate tribes. Tribe wise analysis gives the interesting results. In general, only 8.02 per cent Santal respondents and 6 per cent Oraon respondents depend merely on the Primary Health Centre for pre-natal check-ups of the pregnant women, whereas, 12.90 per cent literate Santals and 21.43 per cent literate Oraons depend merely on the Primary Health Centre for pre-natal check-ups of the pregnant. However, 10.38 per cent Santals in general, depend either on private doctors or quack for pre-natal check-ups of the pregnant women, whereas, no one among the Oraons depend either on quack or on private doctors. Likewise no one among the illiterate Santals depend on other agencies.

The wide difference in seeking services for pre-natal check-ups during pregnancy either from other agencies or the Primary Health Centre of the target villages is due to the mother care programmes of the Tagore Society for Rural Development. Health workers of the Tagore Society for Rural Development closely monitor the pregnant women for pre-natal check-ups through home visit, counselling etc. Most of the tribes of the target villages are basically depend on the Tagore Society for Rural Development for pre-natal check-ups of the pregnant women. This trend is much more among the literate tribals. The dependency of the literate Oraons of the target villages is slightly more than their Santal counterparts, whereas dependency of the Santals on the Primary Health Centre for pre-natal check-ups

is slightly more than the Oraons. This might be due to distances; the Oraon villages are slightly closer to the Tagore Society for Rural Development. Though there are large number of pregnant women (more than 50 per cent of the total households) is yet to be covered under the mother care programmes of the Tagore Society for Rural Development.

In the non-target villages majority of the pregnant mothers (more than 80 per cent households) have no pre-natal check-ups. This picture has revealed the failure of mother care programmes of the Government Health Department. As per multipurpose scheme of the West Bengal Health Department, Health Workers are supposed to visit pregnant mothers at least thrice during pregnancy, which is not properly done. Health Workers are basically stationed either at district town Balurghat or some other places that is far away from their fields and they least bother to visit fields as per their prescribed duty. They mostly organise immunisation camp in their Sub-center twice a month only.

The tribals of the non-target villages is not yet aware of the need of the pre-natal check-ups during pregnancy. Very few tribals have reported to have pre-natal check-ups during pregnancy either at Balapur or at Tapan and most of them are literate. It is interesting to note that majority of the literate tribals prefer to visit private doctors or quacks during pregnancy. It has also been observed that the Santals of the non-target villages are slightly advanced than the Oraons in regard to the check-ups of the pregnant women. Majority of the tribals, who have visited the Primary Health Centres of both the target and non-target villages do not have a good notion about the services of the Primary Health Centres but they visit the Primary Health Centre due to their lack of sufficient means to consult private doctors. In addition to this, lack of awareness, lack of sufficient means to seek expensive care of private facilities are some of the reasons for avoiding check-ups during pregnancy.

Table 27

Sources of Pregnancy check-ups of the target villages

Tribal groups	Prenatal Checkup			Postnatal Checkup			Total
	Health center (%)	Other Agencies (%)	No-checkup (%)	Health center (%)	Other Agencies (%)	No-checkup (%)	
Santal	17 (15.18)	37 (33.04)	58 (51.79)	06 (5.36)	17 (15.18)	89 (79.46)	112 (100)
Literate	04 (11.11)	21 (58.33)	11 (30.56)	0 (0)	12 (33.33)	24 (66.67)	36 (32.14)
Illiterate	13 (17.11)	16 (21.05)	47 (61.84)	06 (7.89)	05 (6.58)	65 (85.53)	76 (67.86)
Oraon	09 (10.34)	30 (34.48)	48 (55.17)	0 (0)	0 (0)	87 (100)	87 (100)
Literate	02 (9.09)	14 (63.64)	08 (36.36)	0 (0)	0 (0)	22 (100)	22 (25.29)
Illiterate	07 (10.77)	16 (24.62)	40 (61.54)	0 (0)	0 (0)	65 (100)	65 (74.71)
Total	26 (13.06)	67 (33.67)	106 (53.27)	06 (3.02)	17 (8.54)	176 (88.44)	199 (100)
Literate	06 (10.34)	35 (60.34)	19 (32.76)	0 (0)	12 (20.69)	46 (79.31)	58 (29.15)
Illiterate	20 (14.18)	32 (22.70)	87 (61.70)	06 (4.26)	05 (3.55)	130 (92.20)	141 (70.85)

Table 28

Sources of Pregnancy check-ups of the non-target villages

Tribal groups	Prenatal Checkup			Postnatal Checkup			Total
	Health center (%)	Other Agencies (%)	No-checkup (%)	Health center (%)	Other Agencies (%)	No-checkup (%)	
Santal	17 (8.02)	22 (10.38)	173 (81.60)	0 (0)	0 (0)	212 (100)	212 (100)
Literate	08 (12.90)	22 (35.48)	32 (51.61)	0 (0)	0 (0)	62 (100)	62 (29.24)
Illiterate	09 (06)	0 (0)	141 (94)	0 (0)	0 (0)	150 (100)	150 (70.76)
Oraon	03 (06)	0 (0)	47 (94)	0 (0)	0 (0)	50 (100)	50 (100)
Literate	03 (21.43)	0 (0)	11 (78.57)	0 (0)	0 (0)	14 (100)	14 (28)
Illiterate	0 (0)	0 (0)	36 (100)	0 (0)	0 (0)	36 (100)	36 (72)
Total	20 (7.63)	22 (8.40)	220 (83.97)	0 (0)	0 (0)	262 (100)	262 (100)
Literate	11 (14.47)	22 (28.95)	43 (56.58)	0 (0)	0 (0)	76 (100)	76 (29)
Illiterate	09 (4.84)	0 (0)	177 (95.16)	0 (0)	0 (0)	186 (100)	186 (71)

Post-natal Check-up

A postpartum service includes early detection and management of infection; hemorrhage and counselling in breast-feeding, nutrition, and family planning. All these services are supposed to be available at the Primary Health Centres. Though the post-natal services are basically absent at the Primary Health Centre and limited to only the major complications, where doctor is needed to be consulted. Post-natal services available at the Tagore Society for Rural Development are limited to the counselling in breast-feeding, health, nutrition, and family planning. The concept of post-natal check-ups is not very common among the tribals of the target and non-target villages. However, the tribals of the non-target villages have reported to have no concept of post-natal check-ups after delivery. Only few tribals of the target villages have reported to have post-natal check-ups with the support of the Tagore Society for Rural Development . They visit quacks, Primary Health Centres, or private doctors for major problems after delivery.

Table 29 shows that 88.44 per cent tribals of the target villages, in general, do not go for post-natal check-ups after delivery, of whom, 79.31 per cent are literate tribals and 92.20 per cent are illiterate. However, 79.46 per cent Santal respondents have not undergone any post-natal check-ups, of which, 66.67 per cent literate and 85.53 per cent illiterate do not have post-natal check-ups. In case of the Oraons of the target villages, no one has post-natal check-ups. In general, 8.54 per cent tribals depend on the Tagore Society for Rural Development for post-natal check-ups; of whom, 20.69 per cent are literate, and only 3.55 per cent are illiterate. For post-natal check-ups, 15.18 per cent Santals in general depend mainly on the Tagore Society for Rural Development, of which, 33.33 per cent are literate Santals and 6.58 per cent are illiterate Santals.

Dependency on the Primary Health Centre among tribals of the target villages for post-natal check-ups is negligible. It is reported that only 3.02 per cent tribals consult the Primary Health Centre for post-natal check-ups. It has been observed that only 4.26 per cent illiterate tribes are reported to consult the Primary Health Centre for post-natal check-ups. In case of the Santals, only 5.35 per cent visit Primary Health Centre for post-natal check-ups and all are illiterate. Post-natal check-ups are limited to the problems related to mothers and child for which the support of a doctor is needed. None of the pregnant women of the non-target villages (Table 30) are reported to have done post-natal check-ups after delivery. Health workers of the Tagore Society for Rural Development do home visit regularly and meet the mother as a part of the post-natal care services. The coverage of pre-natal and post-natal care is low for both the Tagore Society for Rural Development and Primary Health Centres and need to be greatly extended. The health staffs of the Tagore Society for Rural Development have been reported that for maternity care services tribals have no other way but to depend on the Primary Health Centres, and that is the reason for low coverage. The slow awakening among the tribals regarding pre-natal and post-natal care is mainly due to the good efforts of the Tagore Society for Rural Development.

Pregnancy and Delivery

Traditional midwives (*dais*) deliver almost 2/3 of babies in the developing world. Tribals depend merely on traditional midwives for deliveries. Unhygienic and primitive practices for parturition are very common among the tribals. For example, some times delivery was conducted by the mother herself in a half squatting position, while holding a rope tied down from the roof of the hut. This helped her in applying pressure to deliver the child. In complicated labour this might lead to maternal as well as child mortality. The visit of modern doctor during pregnancy is not very common among the tribals of the study area. It has been observed that only 0.89 per cent of the households belonging to the Santal community in the target villages have visited doctors during 7-9 months of the pregnancy and all are literate. No one else has visited modern doctors any time of

their pregnancy. Table 29 shows that in general, 57.78 per cent respondents of the target villages have felt necessity to visit doctors during pregnancy at least in case of the emergency, while as many as 63.79 per cent of the literate respondents and 55.32 per cent of the illiterate respondents have felt the necessity of visiting doctors at least in case of the emergency during pregnancy. Among the Santals, in general, 53.57 per cent respondents have felt that the visit of doctors during pregnancy is a must at least during emergency, but 63.89 per cent of the literate Santals have felt the same necessity. Among the Oraons, in general, 51.72 per cent respondents have reported the necessity to visit doctors during pregnancy; 63.63 per cent of the literate Oraons and 47.69 per cent of illiterate Oraons have reported to have same view.

The picture of the non-target villages (table 30) depicts that most of the tribals irrespective of Santals and Oraons have indifferent view regarding the necessity of visiting doctors during pregnancy at least in case of the emergency. Only 21.76 per cent of the tribals have felt necessity to visit doctors when necessary. Tribe wise analysis also does not show any significant differences. It has been reported that 21.70 per cent of the Santals have felt the necessity of visiting doctors during pregnancy and similarly, 22 per cent Oraon respondents have felt the necessity of visiting doctors during pregnancy. Literacy wise analysis shows significant differences of practices. In general, 44.74 per cent literate tribals prefer to visit doctors if necessary, whereas only 16.13 per cent illiterate tribals have felt the same necessity. In case of the literate Santals, 45.16 per cent have felt the necessity to visit doctors during emergency and only 12 per cent illiterate Santals feel the same. However, 42.86 per cent of the literate Oraons have felt the necessity to visit doctors when necessary and only 13.89 per cent of the illiterate Oraons feel likewise.

The delivery among the tribals of both the target and non-target villages basically depends on the traditional midwives. The health staff of the Tagore Society for Rural Development reports the existence of trained *dais* in the target villages.

Institutional deliveries are almost absent. The deliveries conducted by the trained *dais* are much safer than those conducted by the traditional *dais*. The trained *dais* can identify high-risk pregnant women and for this they advise them to consult doctors. Table 29 also reflects that most of the pregnant mothers of the target villages have delivered their children with the help of traditional *dais*. And only 6.53 per cent households have reported to have institutional deliveries. Whereas among 9.82 per cent of the Santal houses, mothers have delivered their children either at block hospital or at district hospital and only 2.29 per cent households belonging to the Oraons have institutional deliveries. Literacy wise analysis shows slight differences in regard to the nature of delivery. In general, 8.62 per cent literate tribals depend on the health centres for delivery. However, among literate Santals and Oraons, 11.11 percent and 4.5 per cent respectively depend on health centres. Only 5.67 per cent illiterate tribals depend on health centres, while, 9.21 per cent illiterate Santals and 1.54 per cent illiterate Oraons respectively depend on the health centres for delivery.

The health staffs of the Tagore Society for Rural development have reported that the trained *dais* conducts all the home deliveries of the target villages. Though most of the deliveries of the non-target villages have conducted by the indigenous and untrained *dais*. It has been reported by the doctors of the health centres that the tribals come to the hospital at the last stage and for critical cases of delivery. As a result in most the cases either mother or child or both die. Table 30 shows that 93.46 per cent tribals of the non-target villages depend entirely on *dais*. However, 91.98 percent Santals and 96 per cent Oraons of the non-target villages respectively depend entirely on *dais* for delivery. The literacy wise analysis shows slight differences, which is not at all significant. In general, 90.79 per cent of the literate tribals depend on *dais*. It has been reported that 90.32 percent of the literate Santals and 92.86 percent of the literate Oraons depend on the services of *dais* for delivery. Among the illiterate, 93 per cent depend on *dais*. Where, 92.67 percent illiterate Santals and 94.44 percent illiterate Oraons depend on *dais* for delivery.

Table 29

Knowledge regarding the month of pregnancy during which women should contract doctor and the nature of delivery of the target villages

Tribal groups	Month of pregnancy during which women should contract doctor						Nature of Delivery		Total
	Every month	1 st -3 rd month	4 th -6 th month	7 th -9 th month	As and when necessary	Not essential	Traditional	Health Center	
Santal	0 (0)	0 (0)	0 (0)	02 (.89)	60 (53.57)	50 (44.64)	101 (90.17)	11 (9.83)	112 (100)
Literate	0 (0)	0 (0)	0 (0)	02 (5.56)	23 (63.89)	11 (30.56)	32 (88.89)	04 (11.11)	36 (32.14)
Illiterate	0 (0)	0 (0)	0 (0)	0 (0)	37 (48.68)	39 (51.34)	69 (90.79)	07 (9.21)	76 (67.86)
Oraon	0 (0)	0 (0)	0 (0)	0 (0)	45 (51.72)	42 (48.28)	85 (97.70)	02 (2.29)	87 (100)
Literate	0 (0)	0 (0)	0 (0)	0 (0)	14 (63.63)	08 (36.37)	21 (95.45)	01 (4.55)	22 (25.29)
Illiterate	0 (0)	0 (0)	0 (0)	0 (0)	31 (47.69)	34 (52.31)	64 (98.46)	01 (1.54)	65 (74.71)
Total	0 (0)	0 (0)	0 (0)	02 (1.00)	115 (57.78)	82 (41.20)	186 (93.46)	13 (6.53)	199 (100)
Literate	0 (0)	0 (0)	0 (0)	02 (3.45)	37 (63.79)	19 (32.76)	53 (91.38)	05 (8.62)	58 (29.15)
Illiterate	0 (0)	0 (0)	0 (0)	0 (0)	78 (55.32)	63 (44.68)	133 (94.33)	08 (5.67)	141 (70.85)

Table 30

Knowledge regarding the month of pregnancy during which women should contract doctor and the nature of delivery of the non-target villages

Tribal groups	Month of pregnancy during which women should contract doctor						Nature of Delivery		Total
	Every month	1 st -3 rd month	4 th -6 th month	7 th -9 th month	As and when necessary	Not essential	Traditional	Health Center	
Santal	0 (0)	0 (0)	0 (0)	0 (0)	46 (21.70)	166 (78.30)	195 (91.98)	17 (8.01)	212 (100)
Literate	0 (0)	0 (0)	0 (0)	0 (0)	28 (45.16)	34 (54.84)	56 (90.32)	06 (9.68)	62 (29.25)
Illiterate	0 (0)	0 (0)	0 (0)	0 (0)	18 (12)	132 (88)	139 (92.67)	11 (7.33)	150 (70.75)
Oraon	0 (0)	0 (0)	0 (0)	0 (0)	11 (22)	39 (78)	48 (96)	02 (04)	50 (100)
Literate	0 (0)	0 (0)	0 (0)	0 (0)	06 (42.86)	08 (57.14)	13 (92.86)	01 (7.14)	14 (28)
Illiterate	0 (0)	0 (0)	0 (0)	0 (0)	05 (13.89)	24 (66.67)	34 (94.44)	01 (2.78)	36 (72)
Total	0 (0)	0 (0)	0 (0)	0 (0)	57 (21.76)	205 (78.24)	242 (92.36)	20 (7.63)	262 (100)
Literate	0 (0)	0 (0)	0 (0)	0 (0)	34 (44.74)	42 (55.26)	69 (90.79)	07 (9.21)	76 (29)
Illiterate	0 (0)	0 (0)	0 (0)	0 (0)	30 (16.13)	156 (83.87)	173 (93)	13 (6.99)	186 (71)

Pregnancy related Diseases and the Treatments

Some of the pregnancy related problems are white discharge, back pain, prolapses, less bleeding, no breast milk supply and miscarriage. All the women have taken it granted, as their fate. Though the changes in the concept regarding the above problems have been noted in a health check-up camp organised by the Tagore Society for Rural Development, and participated by more than three hundred women. The result of the clinical and pathological test of the camp has been revealed that 90 percent of the women are suffering from reproductive tract infection and all the women have the problem of white discharge. The urge of the women for the test and for modern medicine for treatment indicates the change of perception about gynaecological problems.

There is a mix concept of the causes of diseases among women of the target and non-target villages. Most of the tribal women do not even consider white discharge as a disease. Those who consider this as a disease, describe that white menses, watery discharge, pain in legs and hands, weight loss and white discharge with bad smell are some of the symptoms of white discharge, while frequent intercourse, weakness and mental tension are identified as causes for above disease and no treatments are known by the participants of a focus group discussion. Heavy workload, frequent intercourse etc have been identified as causes of the back pain and except massage no treatment is known by the participants. Prolapsed is very much painful while walking and women cannot carry heavy loads. This condition is thought to be caused by mishandling at the time of delivery or due to miscarriage. Most of the women are not aware of the causes of this disease. The treatment is not clear to them. They consult *ojha* for the treatment of prolapses. *Ojha* tells that some times due to evil influence miscarriage takes place and causes prolapses. If immediate treatment to avoid the evil influence is not taken up, she cannot give live birth in future. The process of treatment is very long and *ojha* is not ready to explain it at all. Important symptom of miscarriage is heavy bleeding during pregnancy. The following modern and primitive causes have been identified as causes of this disease.

Heavy workload is identified as most important cause of miscarriage though some of the women explain that intercourse during pregnancy may be the cause of miscarriage. Few women in a focus group discussion argue that if the shadow of a menstruating female falls on the pregnant lady, pregnancy results in miscarriage.

Evil spirits are responsible for illness of some of the women, and consultation of *ojha* is to be needed though majority of the women are unaware of the treatment. For them death of mother during pregnancy is not due to Titenus or lack of proper care but some evil spirits possess the mothers during pregnancy. New mothers are also vulnerable to the influences of witches, and that is the reasons why fire is constantly kept burning for few days after delivery. The world of the modern medicine is not alien to them. The Tagore Society for Rural Development has been constantly trying to change the tribal worldview of maternal health care practices. Their problem is essentially a problem of availability and reach. Health workers of the Tagore Society for Rural Development merely depend on the health centres for services, and health centres are not at all equipped with instruments for delivery. If some one carries the pregnant women for delivery at the health centre at Malancha by a bullock cart, in most of the cases doctor refers the cases to the Balurghat District Hospital. They can hardly reach there, as there is no vehicle available to transport them to the Balurghat District Hospital.

Beliefs and Behaviour of the Tribals regarding Diet during Pregnancy

Food intake during pregnancy is partly the outcome of complex cultural beliefs, a fact that has been documented in a number of studies in different part of India (Ferro-Luzzi, 1980; Nichter and Nichter, 1983; Jesudasan and Shirur, 1980; Khan et al., 1986). A common belief is that the mother should avoid eating more during pregnancy so as to have a baby of manageable size and thus minimise the risk of a difficult labour. There are different perceptions about prescriptions for and restrictions on different kinds of food during pregnancy. One would expect larger food intakes during pregnancy to lead to increase weight

gains by the mothers and consequently to improve birth weights. Birth weight is the commonly used descriptive parameter of baby's size at birth, particularly in studies correlating pregnancy outcomes with maternal nutrition. It has been shown that weight gain during pregnancy, pre-pregnant weight of the mother and mother's height are most important among a large number of factors influencing birth weight. Together, these factors contribute around 14 per cent to the variation in birth weight, with weight gain during pregnancy being the largest contribution (Metcoff, 1981). Birth weight is also almost the only factor amenable to short term nutritional interventions. The reality is less straightforward.

The tribal women of the study area rarely take any special attention during their pregnancy for taking special diet before and after delivery. One of the important components of mother care programmes of the Tagore Society for Rural Development is health education regarding diet during pregnancy. The change in the knowledge of dietary habits of the mother is recorded in tables- 31 and 32. The poor socio-economic condition of the tribals is the reason for not taking any special kind of food during pre and post-natal period. Most of the tribal households provide rice, *shak* (green vegetables), fried rice etc to pregnant women. Potatoes are commonly used as vegetables; rarely other vegetables are used. *Dal*, meat, fish, egg etc considered as luxury food are rarely consumed. Though the meat of snail and diluted *dal* taken commonly, they consume fruits, milk etc rarely. Among beverages, tea with or without milk and salt is taken commonly. The use of rice-beer (*Haria*) is common among the tribal pregnant women. They usually take food item thrice a day; the morning food is basically *pantha* (rice gruel; rice prepared in the previous day), they take mid-day meal and a meal in the evening.

The analysis of the tables 31 and 32 show no differences in providing special diet before and after delivery of the target and non-target villages. In general, 11.56 percent respondents of the target villages have reported observance of the practice. Nearly 12.50 per cent Santal households have arranged special diet

before delivery, while it is only about 10.34 per cent belonging to the Oraons have observed this practice. In general, 31.03 per cent literate tribals have observed this practice, whereas, 3.55 per cent illiterate tribal households are keen in providing the same before delivery. However, 30.56 per cent of the literate Santals and 31.82 percent literate Oraons have reported observance of this practice. But, 3.95 percent illiterate Santals and 3.08 percent illiterate Oraons have taken that diet. The picture of providing special diet before delivery is different among the tribals of the non-target villages (Table- 32). Majority of the tribals of the non-target villages are not keen in providing special diet before delivery. In general, 5.72 per cent households have reported do observe the practice of providing special diet before delivery. However, 4.42 per cent households of the Santals and only 4 per cent households belonging to the Oraon community have reported providing special diet before delivery. Comparison between literates and illiterates shows slightly different picture. In general, 14.47 per cent literate households have reported in providing special diet before delivery, while 14.52 per cent literate households belonging to the Santal community and 14.29 per cent literate households belonging to the Oraons have provided special diet. However, among the illiterate tribals no concern in providing special diet before delivery is noticed. In general, it is observed that the consciousness in providing special diet after delivery is almost absent among the tribals of both the target and non-target villages. Only 8 per cent of the households of the Santals have followed the practice but all of them are literate, whereas no households belonging to the Oraons is keen in providing special diet after delivery. No one of the non-target villages also has shown concern in providing special diet after delivery.

Immunisation and Iron Tablet Supplementation during Pregnancy

The status of immunisation against Titenus and the taking of iron tablet supplementation during pregnancy show the concern of the tribals regarding modern maternal care practices. Tables 31 and 32 show the status of immunisation against Titenus and iron tablet supplementation during pregnancy.

In general, 57.28 per cent respondents of the target villages have reported to receive two doses of Titenus toxide immunisation and 100-iron folic supplementation, commonly known as I.F.A. (Iron Folic Acid) tablets during pregnancy (Table-31). While among the Santals, 56.25 per cent have received two doses of Titenus toxide immunisation and iron tablet supplementation during pregnancy, 58.62 per cent households belonging to the Oraons have received this immunisation and iron folic supplementation during this period. The comparison between literate and illiterate tribals shows a big difference in respect of taking Titenus toxide immunisation and iron folic tablets during pregnancy. In general, 82.76 per cent belonging to the literate tribal community have received two doses of immunisation and iron folic supplementation. Tribe-wise analysis shows almost same picture. Among the literate Santals, 83.33 per cent have reported that pregnant women have received two doses of titenus toxide immunisation and iron folic supplementation, while among the literate Oraons, 81.82 per cent have reported that their pregnant women have availed these two medicines. In case of illiterate tribals, as a whole, 46.81 per cent respondents have received these medicines. However, 43.42 percent illiterate Santals and 50.77 percent illiterate Oraons have received two doses of titenus toxide immunisation and 100-iron folic supplementation.

The picture of the non-target villages is different in respect of recipients of the Titenus toxide immunisation during pregnancy (Table-32). In general, 25.66 per cent pregnant women have received two doses of Titenus toxide immunisation, while 24.52 per cent women belonging to the Santal community and 20 per cent pregnant women belonging to the Oraon community have received the same. The comparison between literate and illiterate tribals of the non-target villages shows slightly a different picture. In general, 42.11 per cent pregnant women belonging to the literate tribals have received two doses of Titenus toxide immunisation, while, 17.20 per cent illiterate households have reported to receive two doses of Titenus toxide immunisation. In case of the Oraons, 42.86 per cent belonging to the literate households and only 16.67 per cent belonging to the illiterate Oraon

households have received Titenus toxide immunisation during pregnancy. Among the Santals, 41.94 per cent literate respondents and 17.33 per cent illiterate respondents have received two doses of Titenus toxide immunisation (see table-32). It is reported that 21.37 per cent pregnant women of the non-target villages have received 100-iron tablets during pregnancy. However, 21.69 per cent pregnant women belonging to the Santals and 20 per cent pregnant women belonging to the Oraons have received the same numbers of iron tablets. It is reported that 42.11 per cent tribal pregnant women of the non-target villages belonging to the literate households are found to receive iron folic supplementation, while 41.94 per cent of the pregnant women belonging to the literate Santals and 42.86 per cent of the pregnant women belonging to the literate Oraon households are reported to receive iron folic supplementation. However, 12.90 per cent pregnant women belonging to the illiterate households have received iron folic supplementation, out of them, 13.33 per cent belong to the Santals households and 16.67 per cent of the pregnant women belonging to the Oraons.

It has been observed that the percentage of beneficiaries of titenus toxide immunisation and iron supplementation of the target villages is same, whereas we find the difference in respect of the percentage of availing of Titenus toxide immunisation and iron folic supplementation by the pregnant women of the non-target villages. Tribal pregnant women come to the Primary Health Centre basically to receive the Titenus toxide immunisation and iron supplementation on a same day, either 2nd or 4th Wednesday of every month. These days are immunisation-days. On that particular day, iron tablet may not be available at the Primary Health Centre. Tribals mostly ignore to come again to the Primary Health Centre to collect the iron tablets as some times they fail to get the iron tablets after coming there for three to four times. The tribals are not interested to purchase iron tablet from the open market mainly for their poor economic condition and lack of awareness regarding the need of iron tablet supplementation during pregnancy.

Table 31
Care of Pregnant women of the target villages

Tribal groups	Special diet before delivery (%)	Special diet after delivery (%)	Iron tablet supplementation (%)	TT-immunization (%)	Total (%)
Santal	14 (12.50)	08 (7.14)	63 (56.25)	63 (56.25)	112 (100)
Literate	11 (30.56)	08 (22.22)	30 (83.33)	30 (83.33)	36 (32.14)
Illiterate	03 (3.95)	0 (0)	33 (43.42)	33 (43.42)	76 (67.86)
Oraon	09 (10.34)	0 (0)	51 (58.62)	51 (58.62)	87 (100)
Literate	07 (31.82)	0 (0)	18 (81.82)	18 (81.82)	22 (25.29)
Illiterate	02 (3.08)	0 (0)	33 (50.77)	33 (50.77)	65 (74.71)
Total	23 (11.56)	08 (4.02)	114 (57.28)	114 (57.28)	199 (100)
Literate	18 (31.03)	08 (13.79)	48 (82.76)	48 (82.76)	58 (29.15)
Illiterate	05 (3.55)	0 (0)	66 (46.81)	66 (46.81)	141 (70.85)

Table 32
Care of Pregnant women of the non-target villages

Tribal groups	Special diet before delivery (%)	Special diet after delivery (%)	Iron tablet supplementation (%)	TT-immunization (%)	Total (%)
Santal	09 (4.24)	0 (0)	46 (21.69)	52 (24.52)	212 (100)
Literate	09 (14.52)	0 (0)	26 (41.94)	26 (41.94)	62 (29.25)
Illiterate	0 (0)	0 (0)	20 (13.33)	26 (17.33)	150 (70.75)
Oraon	02 (04)	0 (0)	10 (20)	10 (20)	50 (100)
Literate	02 (14.29)	0 (0)	06 (42.86)	06 (42.86)	14 (28)
Illiterate	0 (0)	0 (0)	04 (16.67)	04 (16.67)	36 (72)
Total	11 (4.20)	0 (0)	56 (21.37)	62 (25.66)	262 (100)
Literate	11 (14.47)	0 (0)	32 (42.11)	32 (42.11)	76 (29)
Illiterate	0 (0)	0 (0)	24 (12.90)	32 (17.20)	186 (71)

Awareness of the Titenus Toxide- Immunisation

As per the report of the Tagore Society for Rural Development, titenus toxide immunisation coverage of both the target and non-target villages is satisfactory. The immunisation is no more refused by the tribal pregnant women. But the knowledge and awareness level of the tribals regarding titenus toxide-immunization is very poor at both the target and non-target villages (see Table 33 and Table 34). The health staff of the Tagore Society for Rural Development mobilises pregnant women for titenus toxide immunisation camp, mainly organised by the Society in collaboration with the Primary Health Centre. The Tagore Society for Rural Development organises series of awareness camp on mother immunisation.

The analysis of the table 33 reflects interesting results. The results to the questions on (i) usefulness of two doses of titenus toxide immunisation, (ii) the worst possible result of non-immunisation by titenus toxide injection and (iii) the effects of taking only one dose of titenus toxide injection are quite different. As high as 62.50 per cent Santal respondents and 79.79 per cent respondents belonging to the Oraons, are not aware of the usefulness of titenus toxide immunisation. The picture in cases of the literate tribals is slightly different. It is observed that 52.78 percent literate Santals and 58.33 percent literate Oraons respectively are unaware of the outcomes of the usefulness of titenus toxide immunisation. The table 33 further puts clearly the responses of the tribals of target villages' different outcomes of the use of titenus toxide immunisation and reflects their poor level of awareness. It has been reported that 2.5 per cent Santal respondents of the target villages have responded that; titenus toxide toxide immunisation maintain good health, 1.67 per cent think that it prevents sickness, 16.67 per cent consider that it prevents disability as well as death.

In case of literate Santal respondents, 5.55 per cent have responded that the use of titenus toxide immunisation prevents sickness, though 22.22 per cent of them

realise that it prevents disability and 19.44 per cent of the literate Santals consider that it prevents death. On the other hand, 3.97 per cent of the illiterate Santals have the conviction that it maintains health, while 14.29 of them have reported that it prevents disability, and to 15.48 percent of them it prevents death. In case to the Oraons, it has been observed that only 1.06 per cent in general and 4.17 per cent literate have the idea that it prevents sickness and to 12.77 per cent it prevents disability and to 6.38 per cent it prevents death. It has also been observed that 16.67 per cent and 11.43 per cent of the literate and illiterate Oraons respectively are aware of the fact that the use of titenus toxide immunisation prevents disability, though 20.83 per cent and 1.43 per cent of the literate and illiterate Oraons realises that it prevents death (see table 33).

They do not have any knowledge of what may happen if a mother is not immunised with titenus toxide injections. We have found that 65 per cent of the Santals and 79.79 per cent of the Oraons are not aware of the worst possible outcome, if a mother is not immunised. However, 52.78 per cent of the literate Santal respondents and 66.67 per cent of the literate Oraon respondents are also not aware of the titenus injection incidences among the non-immunised mothers. Further analysis gives us interesting findings in regard to the poor awareness level among the tribals. It has been observed that 11.67 per cent of the Santals have reported about the illness of mother and 21.67 per cent have reported about death of mothers, whereas, very few of them (only 1.67 percent) have reported about disability as worst possible outcome (Table 33).

Literacy wise analysis reflects that 47.22 per cent of the literate Santals have responded only death as the worst possible outcome, though 16.67 per cent illiterate Santals have reported illness as the worst possible result and 10.71 per cent have marked death and 2.38 per cent, disability if mothers not immunised with titenus injections. In case of Oraons, 11.66 per cent believe that mothers will be ill, and 21.66 per cent believe in death of mothers, whereas very few (only 1.66 percent) have reported disability of mothers. Literacy wise analysis reflects that

10.63 per cent of the literate Oraons have responded about mothers' illness and 14.29 per cent of the illiterate Oraons possess the same view. Only 8.51 per cent of the literate Oraons have recorded death of non-immunised mothers, whereas a very few literate and illiterate respondents i.e, 1.06 per cent and 1.43 per cent respectively have recorded disability if a mother is not immunised (see Table 33).

It has been observed that majority of the mothers of the target villages are unaware of the merits and demerits of partial immunization (table 33). About 66.67 per cent of the Santals as a whole and 63.89 percent of the literate Santals are unaware of the results of the partial immunisation. But 79.59 per cent of the respondents belonging to the Oraon community are not aware of the effects of the partial immunisation, while 66.67 per cent of this literate person and 80 per cent of their illiterate persons are unaware of the result of partial immunisation. Further analysis of the positive responses shows the poor awareness among the tribals regarding partial immunisation.

It has been observed that 2.5 per cent of the Santals have admitted of partial benefit from only one dose of titenus toxide injection given to a mother. However, 9.17 per cent of them have marked single dose of titenus toxide immunisation as harmful and 21.67 per cent have admitted it to be of no use. The knowledge of the Oraons regarding partial immunisation is almost same. Only 2.12 per cent of them know that partial immunisation is harmful and 21.27 percent of them have reported that partial immunisation is of no use. Comparison between literate and illiterate respondents gives us interesting findings. It has been reported that 8.33 per cent of the literate Santals and 2.86 per cent of the illiterate Oraons have admitted that partial immunisation to be harmful. However, 27.78 per cent of the literate and 19.05 per cent of the illiterate Santals have marked partial immunisation is of no use. But 33.33 per cent of the literate and 17.14 per cent of the illiterate Oraons have opined the same (see Table 33).

Table 33
Showing the awareness of the TT-Immunization during pregnancy of the target villages

Question asked	Responses		Number of individuals			Number of individuals		
			Santal (%)	Literate (%)	Illiterate (%)	Oraon (%)	Literate (%)	Illiterate (%)
What is the use of TT-Immunization?	1.	Maintain health	03 (2.5)	0 (0)	03 (3.97)	0 (0)	0 (0)	0 (0)
	2.	Prevent Sickness	02 (1.67)	02 (5.56)	0 (0)	01 (1.06)	01 (4.17)	0 (0)
	3.	Prevent Disability	20 (16.67)	08 (22.22)	12 (14.29)	12 (12.77)	04 (16.67)	08 (11.43)
	4.	Prevent death	20 (16.67)	07 (19.44)	13 (15.48)	06 (6.38)	05 (20.83)	01 (1.43)
	5.	Don't Know	75 (62.50)	19 (52.78)	56 (66.67)	75 (79.79)	14 (58.33)	61 (57.14)
	Total		120 (100)	36 (30)	84 (70)	94 (100)	24 (25.53)	70 (74.47)
What is worst possible outcome if a mother is not immunized?	1.	Disease	14 (11.67)	0 (0)	14 (16.67)	10 (11.67)	0 (0)	10 (14.29)
	2.	Death	26 (21.67)	17 (47.22)	09 (10.71)	08 (21.66)	08 (8.51)	0 (0)
	3.	Disability	02 (1.67)	0 (0)	02 (2.38)	01 (1.66)	0 (0)	01 (1.43)
	4.	Don't know	78 (65)	19 (52.78)	59 (70.24)	75 (79.79)	16 (66.67)	59 (84.29)
	Total		120 (100)	36 (30)	84 (70)	94 (100)	24 (25.53)	70 (74.47)
What will happen if only one injection of TT is given to a mother?		Full benefit	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
		Partial benefit	03 (2.5)	0 (0)	03 (3.57)	0 (0)	0 (0)	0 (0)
		Harmful	11 (9.17)	03 (8.33)	08 (9.52)	02 (2.12)	0 (0)	02 (2.86)
		Not use	26 (21.67)	10 (27.78)	16 (19.05)	20 (21.27)	08 (33.33)	12 (17.14)
		Don't know	80 (66.67)	23 (63.89)	57 (67.86)	72 (76.59)	16 (66.67)	56 (80)
	Total		120 (100)	36 (30)	84 (70)	94 (100)	24 (25.53)	70 (74.47)

It appears from the table 34 that majority of the tribals of the non-target villages are totally ignorant of the usefulness of titenus toxide immunisation. They also lack the knowledge of the worst possible outcomes if mothers are not immunised and also they don't know the merits and demerits of the single dose of titenus injection. It has been observed that 97.72 per cent of the respondents belonging to the Santals are unaware of the effectiveness of titenus toxide immunisation, whereas, 91.94 per cent of the literate belonging to the Santals are unaware of the benefit of the same injections. About 98 per cent of the Oraons are not aware of the outcome of titenus toxide immunisation, while 92.86 per cent of their literate persons are unaware of the result of the same.

It is also observed that 96.36 per cent of the Santals and 98 per cent of the Oraons lack the knowledge of the worst possible outcomes, if mothers are not immunised. However, 88.71 per cent of the respondents belonging to the literate Santal community and 92.86 per cent of the respondents belonging to the literate Oraon community respectively are unaware of the worst possible outcomes, if mothers are not immunised. Again 94.09 per cent of the respondents belonging to the Santals and 94 per cent of the respondents belonging to the Oraons respectively are unaware of the merits and demerits of the single dose of titenus toxide immunisation. However, 90.32 per cent and 78.57 per cent of the literate Santals and literate Oraons respectively are not aware of the merits and demerits of the partial immunisation, i.e. single dose of titenus toxide immunisation. Those who have responded positively have different concepts regarding usefulness of titenua toxide injection; the worst possible outcome if a mother is not immunised and partial immunisation. It gives ample proof of the poor awareness level of the tribals of the non-target villages (Table-34).

Considering the above discussion, it can be mentioned here that the role of health workers of both the Tagore Society for Rural Development and the Government Health Department in health education regarding the titenus toxide immunisation is not at all satisfactory. Tagore Society for Rural Development organise meetings

and group discussions to promote titerus toxide immunisation among the tribal pregnant women. Along with the group discussions, slides and short films, effective communication strategy by involving tribal folk art carefully on chosen themes, e.g. the horrors of titerus etc, should be used to educate the tribal folk regarding the titerus toxide immunisation, which is not yet taken up by the Tagore Society for Rural Development even. The Tagore Society for Rural Development can play a vital role in creating awareness of the community for bringing changes about the understanding of the community regarding titerus toxide immunisation. The role of Government health functionaries in this regard is very important. Titerus toxide immunisation is mostly available at the Sub-centres and Primary Health Centres in the immunisation day. The poor information, education and communication programmes of the Government Health Departments are not sufficient to change the understanding of the tribals on titerus toxide immunisation.

The health care of the tribal women still depends mostly on the traditional *dais*, *ojha* etc. The benefit of modern medicine is not yet fully utilised by the tribal women. The problem remains not only with the tribal women, but also faulty implementation of health programmes is responsible for this. ' A serious attempt to improve the health of the women must deal firstly with their biased social customs and cultural traditions that play an important role in maintaining their health status'. (Health and Family Welfare Policy Document of the Government of India, 1992). This statement clearly articulates the need to adopt an integrated and holistic approach towards improving the health of the women. The programme implementation process does not reflect this thinking in the health and family welfare policy document of the Government of India. Health Programmes direct towards improving the health of the women. Though the focus is still on family planning.

Table 34
Showing the awareness of the TT-Immunization during pregnancy of the Non-target villages

Question asked	Responses		Number of individuals			Number of individuals		
			Santal (%)	Literate (%)	Illiterate (%)	Oraon (%)	Literate (%)	Illiterate (%)
What is the use of TT-Immunization?	1.	Maintain health	05 (2.27)	05 (8.06)	0 (0)	0 (0)	0 (0)	0 (0)
	2.	Prevent Sickness	0 (0)	0 (0)	0 (0)	01 (02)	01 (7.14)	0 (0)
	3.	Prevent Disability	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
	4.	Prevent death	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
	5.	Don't Know	215 (97.72)	57 (91.94)	158 (100)	49 (98)	13 (92.86)	36 (100)
	Total		220 (100)	62 (28.18)	158 (71.82)	50 (100)	14 (28)	36 (72)
What is worst possible outcome if a mother is not immunized?	1.	Disease	08 (3.64)	07 (11.29)	01 (0.63)	0 (0)	0 (0)	0 (0)
	2.	Death	0 (0)	0 (0)	0 (0)	03 (06)	03 (21.43)	0 (0)
	3.	Disability	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
	4.	Don't know	212 (96.36)	55 (88.71)	157 (99.37)	47 (94)	11 (78.57)	36 (100)
	Total		220 (100)	62 (28.18)	158 (71.82)	50 (100)	14 (28)	36 (72)
What will happen if only one injection of TT is given to a mother?		Full benefit	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
		Partial benefit	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
		Harmful	02 (0.90)	0 (0)	02 (1.27)	0 (0)	0 (0)	0 (0)
		Not use	11 (05)	06 (9.68)	05 (3.16)	03 (06)	03 (21.43)	0 (0)
		Don't know	207 (94.09)	56 (90.32)	151 (95.57)	47 (94)	11 (78.57)	36 (100)
	Total		220 (100)	62 (28.18)	158 (71.82)	50 (100)	14 (28)	36 (72)

CHILD HEALTH CARE

Child health can be determined by interaction between the children on the one hand and the environment along with the society in which he lives on the other (Das & Ghosh, 1986, p, 146). It is hardly possible to measure or evaluate condition of the child health without the aid of specific parameters. Social factors concerned with the childcare in a society relate particularly to the neighbourhood and of course the family. The family has the duty to prepare the child so that he/she can live with others. The process of socialisation starts almost as soon as the infant is born. Culturally defined methods of bringing up children may either improve child health or cause health problems in child development.

India, according to the United Nations report, is making steady progress in child survival and family planning, but its performance in combating child malnutrition and promoting the status of girls and women remains weak. The son is much preferred to a daughter because of the economic gains from and obligations of the sons to their parents. Malnutrition, diarrhoea etc are very common among the tribals. Life of a child among the tribals is regarded less precious than that of an adult and very little attention is paid to them when they are sick. It is commonly known that high infant mortality rate among people with low social and economic status is due to the adults' lack of interest in the childhood years. Very often tribals depend on *Guniyas* or *Ojhas* for treatment of any kind of child diseases.

In the study area, in most of the cases irrespective of the Santals and Oraons of the target and non-target villages, the midwife or any other near relative who acts during delivery takes primary health care of a newborn baby. The process includes after detaching the umbilical cord and washing of the mouth with honey by a piece of cloth. Most of the families of the Santals and Oraons are found to massage their children with turmeric mixed oil for about twenty days to one month and cleaning of the newborn is done with tepid water. Some families have been found to take more care by giving their children regular bath, massaging the

children with warm mustard oil and cleaning their dress daily. It has been observed that some of the families have become interested to modern care while some others are found to protect their children from witchcraft with the help of *ojha*.

Child Rearing Practices: Belief and Tradition connected with the method of Feeding

Under child rearing practices the tribal concept of breast feeding, weaning and of the age of the baby when solid food is to be given, child immunisation and the existence of traditional practices regarding child health have been studied to assess the tribal concept of child health in a comparative perspective.

Mothers' breast milk is the main form of food for the infants. No other stable diet has been introduced to the baby until is five or six months old. Tribal mothers breast feed their child for a longer period of time. There are certain beliefs among the tribals regarding breast-feeding. They believe that breast milk of a sick mother is harmful to the health of a baby. In such cases cow milk is preferred as alternative of the mothers' milk. Another very important belief among the tribals is that the baby is to be deprived of mothers' milk for one to three days after birth. During this period honey, water, cow milk etc is given. Das and Ghosh have pointed out that Santals do not know the positive aspects of breast-feeding but it is provided with scientific approaches (Das and Ghosh; 1986, p148).

The use of canned food is not yet introduced in the tribal villages. Ellestad-Sayed et al. (1979, p.295-298) mention in their paper that breast-feeding protects against infection of Indian infants and have pointed out, "Fully bottle-fed infants were hospitalised with infectious diseases 10 times more often and spend 10 times more days in hospital during the first year of life than breast-fed infants... Breast-feeding is strongly protective against severe infection requiring hospital admission and also against minor infection. The protective effect, which lasts

even after discontinuation of breast-feeding, is independent of family size, overcrowding in the home, family income and education of parents. Measures to achieve breast-feeding, virtually for all infants, particularly in northern communities, should be given high priority'.

The analysis of table 35 shows almost 80 per cent of the mothers of the target villages breast-feed their children for a long period (more than two years). The analysis of the literate and illiterate tribals reflects that illiterate tribal breast-feed their children slightly longer time than their literate counterparts. It is observed that only 20.10 per cent of the tribals of the target villages prefer to breast-feed their children till 12 months to 2 years of their child age. Where as 22.41 per cent of the literate tribals of the target villages prefer to breast feed their children till 12 months to 2 years of their child age, however, only 19.15 per cent of the illiterate tribals of the target villages do breast-feed their children for the same period. Tribe wise analysis gives us interesting results. In case of the Santals, it has been observed that as a whole 80.36 per cent of the mothers breast-feed their children for more than 2 years, while 77.78 per cent of the literate Santal mothers and 81.58 per cent of the illiterate Santal mothers follow the same practice. However, it is reported that 19.64 per cent of the Santal mothers breast feed their children till 12 months to 2 years, while 22.22 per cent of the literate Santals and about 18.42 per cent of the Santal mothers belonging to the illiterate families breast feed their children for the same period.

In case of the Oraons of the target villages, same table shows that as a whole 79.31 per cent of the respondents breast-feed their children for more than 2 years of their age. But 77.27 per cent of the literate Oraon respondents and 80 per cent of the mothers belonging to the illiterate Oraon families breast-feed their children for more than 2 years. It has been reported that 20.69 per cent of the Oraon mothers breast-feed their children till 12 months to 2 years of their age, while 22.73 per cent of the literate respondents and 20 per cent of the illiterate respondents respectively have reported that they breast feed their child till 12

months to 2 years of their child. The same table (Table 35) reflects the weaning practices of the tribals and the age of the child when normal food is given to the children. In general, scientific concept of weaning practices reflects not only the health consciousness on the part of mothers but also that of the community to which she belongs and it is almost missing among the tribals of the study area. In certain age of their children, tribals provide some semisolid food in addition to the breast milk, is considered as weaning food. They occasionally provide rice-water, vegetables, melted rice etc in the form of weaning food and after that a child eats whatever an adults take. In general, 53.27 per cent of the tribal respondents of the target villages start weaning within 6 months of their age, while 48.28 per cent of the literate tribal mothers and 55.32 per cent of the illiterate tribal mothers start weaning within 6 months of age of their children. However, 46.73 per cent of the tribals of the target villages and 51.72 per cent of the literate tribal mothers have reported to start weaning when their babies reach the age of 7-9 months and 44.68 per cent of the illiterate tribal mothers followed suit the literate tribal mothers.

The tribe wise analysis of the target villages shows almost the same picture. In general, 54.46 per cent of the Santal mothers have started weaning within 6 months of the age of their children but 50 per cent of the literate Santal mothers and 56.58 per cent of the illiterate Santal mothers have reported to start weaning within 6 months age of their children. It has been reported that 45.54 per cent of the Santal mothers have weaned their babies when their babies reached the age of 7-9 months, while 50 per cent of the literate Santals and 43.42 per cent of the illiterate Santal mothers have reported to start weaning their babies at their age of 7-9 months. It has been observed that the Oraon mothers of the target villages have followed more or less similar practices. In general, 51.72 per cent of the Oraon mothers have started weaning within 6 months of the age of their children, while 45.45 per cent of the literate mothers and about 53.85 per cent of the illiterate Oraon mothers have started weaning within 6 months of birth of their children. About 48.28 per cent of the Oraon mothers have weaned their babies

when their babies reached the age of 7-9 months, while 54.55 per cent of the literate Oraons and 46.15 per cent of the illiterate Oraon mothers have started weaning when their babies have reached the age of 7-9 months (see Table 35).

As far as giving solid foods (adults food) to babies is concerned, it has been observed from the same table that 68.84 per cent of the tribal mothers of the target villages have started the practice of giving solid food to their babies below the age of 9 months, while 63.79 per cent of the tribal mothers belonging to literate families and about 70.92 per cent of the illiterate mothers have given solid foods to their babies at the same age. However, 31.16 per cent of the tribal mothers have given solid foods when their babies are 10-12 months old, while 36.21 per cent of the literate tribals and about 29.08 per cent of the illiterate tribals have started to give solid foods to their babies when they are 10-12 months old.

Tribe wise analysis gives us the same picture regarding use of solid foods. It has been reported that 69.64 per cent of the Santal mothers, in general, 63.89 per cent of the literate Santal mothers and about 72.37 per cent of the illiterate mothers respectively give solid foods to their children below the age of 9 months. However, 30.36 per cent of the Santals as a whole give adult type of foods to their babies when their babies are 10-12 months old, while about 36.11 per cent of the Santal families belonging to the literate community and 27.63 per cent of the illiterate Santals give adult foods to their children when their babies are 10-12 months old. In case of the Oraons , it has been observed that as a whole 67.82 per cent give solid foods, when their babies are below the age of 9 months, while 63.64 per cent of the Oraon mothers belonging to the literate families and about 69.23 per cent of the Oraon mothers belonging to the illiterate families give solid foods to their babies below the age of 9 months. However, 32.18 per cent of the Oraon mothers, in general, give solid foods to their babies at the age of 10-12 months, while 36.36 per cent of the Oraon mothers belonging to the literate families and about 30.77 per cent of the Oraons belonging to the illiterate families provide solid foods to their babies aged 10-12 months (see Table 35).

Table 35

Age of baby till breast-feed is given, age at weaning and age of baby when normal food is given of the target villages.

Tribal groups	Age of baby till breast-feed is given				Age at weaning				Age of normal food is given			Total (%)
	Below 9 month (%)	10-12 month (%)	12 month- 2 years (%)	More than 2 years (%)	6 month (%)	7-9 month (%)	10- 12 month (%)	12-18 month (%)	Below 9 month (%)	10- 12 mo(%)nth	12 month and above (%)	
Santal	0 (0)	0 (0)	22 (19.64)	90 (80.36)	61 (54.46)	51 (45.54)	0 (0)	0 (0)	78 (69.64)	34 (30.36)	0 (0)	112 (100)
Literate	0 (0)	0 (0)	08 (22.22)	28 (77.78)	18 (50)	18 (50)	0 (0)	0 (0)	23 (63.89)	13 (36.11)	0 (0)	36 (32.14)
Illiterate	0 (0)	0 (0)	14 (18.42)	62 (81.58)	43 (56.38)	33 (43.42)	0 (0)	0 (0)	55 (73.37)	21 (27.63)	0 (0)	76 (67.86)
Oraon	0 (0)	0 (0)	18 (20.69)	69 (79.31)	45 (51.72)	42 (48.28)	0 (0)	0 (0)	59 (67.82)	28 (32.18)	0 (0)	87 (100)
Literate	0 (0)	0 (0)	05 (22.73)	17 (77.27)	10 (45.45)	12 (54.55)	0 (0)	0 (0)	14 (63.64)	08 (36.36)	0 (0)	22 (25.29)
Illiterate	0 (0)	0 (0)	13 (20)	52 (80)	35 (53.85)	30 (46.15)	0 (0)	0 (0)	45 (69.23)	20 (30.77)	0 (0)	65 (74.71)
Total	0 (0)	0 (0)	40 (20.10)	159 (79.90)	106 (53.27)	93 (46.73)	0 (0)	0 (0)	137 (68.84)	62 (31.16)	0 (0)	199 (100)
Literate	0 (0)	0 (0)	13 (22.41)	45 (77.59)	28 (48.28)	30 (51.72)	0 (0)	0 (0)	37 (63.79)	21 (36.21)	0 (0)	58 (29.15)
Illiterate	0 (0)	0 (0)	27 (19.15)	114 (80.85)	78 (55.32)	63 (44.68)	0 (0)	0 (0)	100 (70.92)	41 (29.08)	0 (0)	141 (70.85)

It can be noted here that the Tagore Society for Rural Development provided packed weaning food for the infants as a part of its health and nutrition programmes during 1993 and 1994 to all the children of the target villages and from 1995 onwards the Tagore Society for Rural Development has stopped providing weaning food considering the cost involved on that and in no way the tribals can afford the expense without the support of the Tagore Society for Rural Development. The Tagore Society for Rural Development now gives emphasis on nutritional education programmes and organises nutritional demonstration training for the mothers so that they can be able to prepare low cost weaning food within the available means at their home by using rice, *dal*, vegetables etc.

In case of the tribals of the non-target villages' almost same practices are followed regarding breast-feeding, weaning food and normal food of their children (Table 36). The analysis of the table 36 reflects that 79 per cent of the tribals breast-feed their children for more than 2 years, while 73.68 per cent of the tribals belonging to the literate families and about 81.19 per cent of the tribals belonging to the illiterate families prefer to breast feed their children for more than 2 years. However, 21 per cent of the tribals, in general, and 26.32 per cent of the tribals belonging to the literate families breast-feed their children till 10- 12 months age of the children, but about 18.82 per cent of the tribals belonging to the illiterate families have reported to breast feed their children of 10- 12 months age. Tribe wise analysis shows almost the same picture. In case of the Santals, 80.18 per cent of the mothers breast-feed their children for more than 2 years, while 74.19 per cent of the literate Santals and 82.67 per cent of the illiterate Santal mothers breast-feed their children for more than 2 years. However, it has been reported that 19.81 per cent of the Santal mothers breast feed their children when their babies reach the age of 12 months to 2 years, while 25.80 per cent of the literate Santals and about 17.33 per cent of the Santal mothers belonging to the illiterate families breast-feed their children till 12 months to 2 years of the age of their children (Table 36). In case of the Oraons, as a whole, 74 per cent breast-feed their children for more than 2 years of their age, whereas 71.43 per cent of the

literate respondents and 77.78 per cent of the mothers belonging to the illiterate Oraon families breast-feed their children aged more than 2 years. of their child age. However, 26 per cent of the Oraon mothers breast-feed their children till 12 months to 2 years of their age, while 28.57 per cent of the literate respondents and 22.22 per cent of the illiterate Oraon respondents have reported to breast-feed up to the same age of their children (see Table 36). In regard to the weaning practices of the non-target villages (Table 36), it has been observed that nearly 45.04 per cent of the tribals, in general, and 42.11 per cent of the literate tribals and 46.24 per cent of the illiterate tribal mothers have started weaning within 6 months of the age of their children respectively. However, 54.96 per cent of the tribals have reported to start weaning when their babies reached the age of 7-9 months, Among them 57.89 per cent are literate tribals mothers and about 53.76 per cent belonging to the illiterate families.

The tribe wise analysis of the non-target villages shows almost the same picture (Table 36). In general, 44.81 per cent of the Santal mothers have started weaning within 6 months' age of their children, however, 41.94 per cent of the literate Santal mothers and about 46 per cent of the illiterate Santal mothers start weaning of their children aged 6 months. However, 55.19 per cent of the Santal mothers have weaned their babies when their babies reached the age of 7-9 months, while 58.06 per cent of the literate Santals and 54 per cent of the illiterate Santal mothers start weaning their babies on their reaching 7-9 months' age. In case of Oraons, it has been observed that 46 per cent mothers have started weaning within 6 months of their child age, while 42.86 per cent of the literate mothers and about 47.22 per cent of the illiterate mothers have started weaning within 6 months' age of their children. However 54 per cent of the Oraon mothers have weaned their babies when their babies reached the age of 7-9 months, while 57.14 per cent of the literate Oraons and about 52.78 per cent of the illiterate Oraon mothers have started weaning when their babies have reached the age of 7-9 months. As far as giving solid food (adults food) to babies of the non-target villages, it has observed from the same table that 51.91 per cent of the tribal

mothers have started the practice of giving solid food when their babies age below the age of 9 months, while 50 per cent of the tribal mothers belonging to literate families and about 52.69 per cent of the illiterate mothers have given solid foods to their babies below the age of 9 months. However, 48.09 per cent of the tribal mothers, in general, 50 per cent of the literate tribals and about 47.31 per cent of the illiterate tribals give solid food when their babies are 10-12 months old respectively.

Tribe wise analysis gives us slightly different picture regarding use of solid food (Table 36). It has been reported that 51.89 per cent of the Santal mothers give solid foods to their babies aged below 9 months, while 48.39 per cent of the literate Santal mothers and about 53.33 per cent of the illiterate mothers give solid food to their children reaching the age of 9 months. However, 48.11 per cent of the Santals, as a whole, have reported to give adult type of food to their babies when their babies are 10-12 months old, while about 51.61 per cent of the Santal families belonging to the literate community and 46.67 per cent of the illiterate Santals give adult food to their children when their babies are 10-12 months old. In case of the Oraons (Table 36), it has been observed that as a whole 52 per cent give solid food when their babies are aged below 9 months, while 57.14 per cent of the Oraon mothers belonging to the literate families and about 50 per cent of the Oraon mothers belonging to the illiterate families give solid foods to their babies aged below 9 months. However, 48 per cent of the Oraon mothers, 42.86 per cent of the Oraon mothers belonging to the literate families and about 50 per cent of the Oraons belonging to the illiterate families are giving solid food when their babies are 10-12 months old.

Tribal mothers breast-feed their children till a subsequent one is born. Mothers do not feed the babies spontaneously or at regular intervals. They feed the babies when they cry for it, thereby indicating hunger. The difference in observation of weaning practices of the target and non-target villages belonging to the literate families is easily noticed. Some of the tribals of both the target and non-target

villages have expressed that the children may be given all sorts of solid food except animal protein after the sucking period is over. They believe that protein food should be given at the later age. The average diet of the children is rice, pulse and vegetables. Only in few families the children are found to take milk. In some of the families fish or meat are given to the children once in a week with rice, pulse and vegetables.

In theory, the infants of the tribals should be better off as most of the tribal mothers breast-feed their babies for a long period of time. But they are not. Evidence from the study area suggests that the growth curve of many tribal infants begins to fall as early as from the fourth month of the age of their children. Breast-feeding meets all the nutritional needs of a child for the first six months. There are some possibilities. One is the breast-feeding is somehow inadequate because babies are not being breast-feed in the right way. If feeding is not frequent enough, then the child's nutritional needs will obviously not be met. If breast-feeding is not started within a few hours of birth, then this may hamper lactation. The difference between the period of breast-feeding and the timing of the introduction of other food, at this vital and vulnerable stage of a child's growth is possibly the most important reason for malnutrition of the tribal children.

Child Immunization

There are six killer diseases, which are commonly known as vaccine preventable diseases. These diseases are Tuberculosis, Diphtheria, Tetanus, Whooping Cough, Polio and Measles. All these diseases are common among the children below the age of 5 years. The vaccination programme of the health department is meant to reduce the prevalence of the vaccine preventable diseases. Vaccine for tuberculosis, D.P.T., polio doses and vaccine for measles should be taken within one year of the age of a child, though there are booster doses also. Booster doses may be taken till 16 years age of a child. Tribal knowledge on immunization against these diseases, the age limit of the child immunisation, and on the six killer diseases has been studied in a comparative perspective.

Table 36

Age of baby till breast-feed is given, age at weaning and age of baby when normal food is given of the non-target villages.

Tribal groups	Age of baby till breast-feed is given				Age at weaning				Age of normal food is given			Total (%)
	Below 9 month (%)	10-12 month (%)	12 month- 2 years (%)	More than 2 years (%)	6 month (%)	7-9 month (%)	10- 12 month (%)	12-18 month (%)	Below 9 month (%)	10- 12 month (%)	12 month and above (%)	
Santal	0 (0)	0 (0)	42 (19.81)	170 (80.19)	95 (44.81)	117 (55.19)	0 (0)	0 (0)	110 (51.89)	102 (48.11)	0 (0)	212 (100)
Literate	0 (0)	0 (0)	16 (25.81)	46 (74.19)	26 (41.94)	36 (58.06)	0 (0)	0 (0)	30 (48.39)	32 (51.61)	0 (0)	62 (29.25)
Illiterate	0 (0)	0 (0)	26 (17.33)	124 (82.67)	69 (46)	81 (54)	0 (0)	0 (0)	80 (53.33)	70 (46.67)	0 (0)	150 (70.75)
Oraon	0 (0)	0 (0)	13 (26)	37 (74)	23 (46)	27 (54)	0 (0)	0 (0)	26 (52)	24 (48)	0 (0)	50 (100)
Literate	0 (0)	0 (0)	04 (28.57)	10 (71.43)	06 (42.86)	08 (57.14)	0 (0)	0 (0)	08 (57.14)	06 (42.86)	0 (0)	14 (28)
Illiterate	0 (0)	0 (0)	08 (22.22)	28 (77.78)	17 (47.22)	19 (52.78)	0 (0)	0 (0)	18 (50)	18 (50)	0 (0)	36 (972)
Total	0 (0)	0 (0)	55 (21)	207 (79)	118 (45.04)	144 (54.96)	0 (0)	0 (0)	136 (51.91)	126 (48.09)	0 (0)	262 (100)
Literate	0 (0)	0 (0)	20 (26.32)	56 (73.68)	32 (42.11)	44 (57.89)	0 (0)	0 (0)	38 (50)	38 (50)	0 (0)	76 (29.01)
Illiterate	0 (0)	0 (0)	35 (18.82)	151 (81.18)	86 (46.24)	100 (53.76)	0 (0)	0 (0)	98 (52.69)	88 (47.31)	0 (0)	186 (70.99)

The analysis of the table 37 and 38 gives us sharp differences regarding knowledge of the tribals of the target and non-target villages and also between the literate and illiterate tribals of the target and non-target villages on the aspects of immunisation. The analysis of the table 37 reflects that 51.78 per cent of the tribals of the target villages have immunised their children against six killer diseases. The comparison between the literate and illiterate tribals of the target villages shows that 63.79 per cent families belonging to the literate families and 46.81 per cent of the families belonging to the illiterate families have immunised their children against six killer diseases. Tribe wise analysis shows that in general immunisation coverage of the Santal families is slightly more (56.25 per cent) than that of the Oraon families (45.97 per cent). Whereas almost same percentage of literate families (63.89 per cent and 63.63 per cent) belonging to the Santal and Oraon communities have reported to immunise their children against six killer diseases. While 53.63 per cent of the families belonging to the illiterate Santals have immunised their children, 40 per cent of the illiterate families belonging to the Oraon community have immunized their children against these diseases. The families who have not vaccinated their children do not take up any alternative measures against these diseases.

The knowledge of the tribals of the target villages on the age limit of child immunisation is not at all commendable (Table 37). In general, 42.99 per cent respondents know the age limit of the child immunisation. Literate respondents are slightly more aware (52.62 per cent) than their illiterate counterparts (41.13 per cent). The same trend has been observed between the Santals and the Oraons. In general, 45 per cent of the Santals have the knowledge of age limit of the child immunisation, while 55.56 per cent of the literate Santal families and 44.74 per cent of the illiterate Santals know the age limit of the child immunisation. In case of the Oraons, 40.42 per cent, in general, and 63.63 per cent of the literate families and 36.92 per cent of the illiterate families respectively are familiar with the age limit.

The knowledge of six killer diseases of the tribals of the target villages is poor. In general, 34.11 per cent of the tribals of the target villages have reported to have knowledge of six killer diseases, while 39.66 per cent of the literate families and 35.46 per cent of the illiterate tribals have reported to know about these six killer diseases. Tribe wise analysis shows that in general, 35.50 per cent of the Santal families know about these diseases, while 41.67 per cent of the literate Santals and 39.47 per cent of the illiterate Santals are acquainted with these diseases. In case of the Oraons, in general, 29.78 per cent are familiar with these six killer diseases, while 36.36 per cent of the literate families and 30.37 per cent of the illiterate families respectively are well known with these diseases.

The analysis of the table 38 gives the picture of non-target villages, which is entirely different from the picture of the target villages. In general, 21.75 per cent of the tribals of the non-target villages have immunised their children against six killer diseases. The comparison between the literate and illiterate tribals shows that 35.52 per cent literate family and 15.46 per cent illiterate families have immunised their children against six killer diseases. Tribe wise analysis shows that 22.64 per cent of the Santals have immunised their children, while 35.48 per cent of the literate Santals and only 16.46 per cent of the illiterate Santals have immunised their children against these six killer diseases. In case of the Oraon families, in general 18 percent immunises their children against six killer diseases, whereas 37.71 per cent of the literate families and only 11 per cent families belonging to the illiterate Oraons have immunised their children against these diseases.

The knowledge of the tribals of the non-target villages on the age limit of child immunisation is very poor as compared to the families of the target villages. In general, 11.11 per cent of the respondents know the age limit of the child immunisation. Literate respondents are more aware (23.68 per cent) than their illiterate counterparts (6.19 per cent). The same trends have been seen among the Santals and the Oraons. In general, 11.36 per cent of the Santals have the

knowledge of age limit of the child immunization, while 24.19 per cent of the literate Santal families and 6.33 per cent of the illiterate Santals respectively know the age limit of the child immunisation. In case of the Oraons, 10 per cent have the knowledge of age limit of the child immunisation, while 21.43 per cent of the literate families and 5.56 per cent of the illiterate families respectively are aware of the age limit of the child immunisation (Table-37).

The knowledge of six killer diseases of the tribals of the non-target villages is poor (Table -37). In general, 10.74 per cent of the tribals have reported to know about these diseases, while 22.37 per cent of the literate families and 6.19 per cent of the illiterate tribals have reported to have the knowledge of the same disease. Tribe wise analysis shows that in general, 11.36 per cent of the Santal families have this knowledge, while 22.58 per cent of the literate Santals and only 6.96 per cent of the illiterate Santals have the same knowledge. In case of the Oraons, in general only 8 per cent of the families are acquainted with the knowledge of six killer diseases, while 21.43 per cent of the literate families and 2.78 per cent of the illiterate families respectively know those diseases.

Vaccination of the children is not very popular to the tribals of the non-target villages. This is largely due to the lack of awareness among them. Most of the tribals do not know anything about usefulness of vaccination as well as the need for vaccination. However, some tribals are aware of it but due to lack of facilities they could not vaccinate their children in time. The Tagore Society for Rural Development arranges vaccination camp in every fortnight with the help of the Block Medical Officer of Health of Tapan Primary Health Center at their target villages. On the other hand, the vaccination programmes of the non-target villages merely depend on the will of the health staff of Government Primary Health Centres.

Table 37

Knowledge of child immunization against six killer diseases of the target villages

Tribal Groups	Immunization against six killer disease	Age limit of child immunization	Knowledge of the six killer disease	Total
Santal	63 (56.25)	54 (45.00)	45 (37.50)	112 (100)
Literate	23 (63.89)	20 (55.56)	15 (41.67)	36 (32.14)
Illiterate	40 (52.63)	34 (44.74)	30 (39.47)	76 (67.86)
Oraon	40 (45.97)	38 (40.42)	28 (29.78)	87 (100)
Literate	14 (63.63)	14 (63.63)	08 (36.36)	22 (25.29)
Illiterate	26 (40)	24 (36.92)	20 (30.77)	65 (74.71)
Total	103 (51.78)	92 (42.99)	73 (34.11)	199 (100)
Literate	37 (63.79)	34 (58.62)	23 (39.66)	58 (29.15)
Illiterate	66 (46.81)	58 (41.13)	50 (35.46)	141 (70.85)

N= 112 & 87

Table 38

Knowledge of child immunization against six killer diseases of the non-target villages

Tribal Groups	Immunization against six killer disease	Age limit of child immunization	Knowledge of the six killer disease	Total
Santal	48 (22.64)	25 (11.36)	25 (11.36)	212 (100)
Literate	22 (35.48)	15 (24.19)	14 (22.58)	62 (28.18)
Illiterate	26 (16.46)	10 (6.33)	11 (6.96)	158 (71.82)
Oraon	09 (18)	05 (10)	04 (8)	50 (100)
Literate	05 (35.71)	03 (21.43)	03 (21.43)	14 (28)
Illiterate	04 (11.11)	02 (5.56)	01 (2.78)	36 (72)
Total	57 (21.75)	30 (11.11)	29 (10.74)	270 (100)
Literate	27 (35.53)	18 (23.68)	17 (22.37)	76 (28.15)
Illiterate	30 (15.46)	12 (6.19)	12 (6.19)	194 (71.85)

N= 212 and 50

Traditional Child Rearing Practices

Some traditional practices regarding child health care are also observed in some of the families of both the target and non-target villages. We will discuss here some of the traditional measures and intervention of the Tagore Society for Rural Development to get rid off the traditional practices, if they were wrong. It has been observed that normally for examining the normal eyesight, finger is placed in front of the eyes. If they blink it is believed that their eyesight is normal. Making sound on vessels is testing the normal listening power of the child and his response to giggle is observed. Besides this, smearing of oil for normal development is performed. Among the tribals in most cases of sickness of the child, family treatment is tried first. If it fails, they pay visit to the folk healers or *ojha*. Though now-a-days, it is observed that most of the tribals visit health centre for seeking modern treatment. It also reveals that if children are seriously ill and do not respond to the domestic medicine or medicine given by the *ojha*, then only they take the child to the modern doctors.

A tribal prefer and has belief in the folk healers, *ojha*, as additional charm with him increases their faith. Decision regarding whom to consult is based on the form of illness, belief, course, type of sickness, and past family experiences. Some examples collected during the fieldwork, may be cited here with the view to understanding the situation. One of the common beliefs of the tribals of both the target and non-target villages connected with the health and diseases of the children is the effect of the evil eye, is still prevalent. Whenever anyone remarks that a child is very beautiful, strong and intelligent, the child immediately develops signal of some disease; gets weaker and weaker and becomes pale. Certain preventive measures are taken against the influences of the evil eye. A black spot is marked on the forehead of the child with the carbon deposited in the *chula*. The idea is that due to the black spot the spectator will not be able to judge the beauty correctly and for this, the spectator will not be able to comment on the

beauty of the child. If a child is being affected by the evil eye, an *ojha* instead of a modern doctor is consulted for getting the child cured.

Two years old daughter of Nirmal Hembram and Chumki Mardi of Dakshin Keshrail village was suffering from stomachache. Family treatment with the massage of water and oil on the stomach and also application of hot massages were offered. No change of the symptoms was noticed. They took the child to the *ojha*, Bharat, who treated the child with rituals and local herbs. There was no change in symptoms but the family felt that the child showed improvement. At last they brought the child to the homeopathic clinic of the Tagore Society for Rural Development and with the homeopathic treatment the patient got cured.

Here are two examples of refusal of modern medicine; causes of refusal and the reasons for faith on the *ojha* from the case studies where researcher personally involved having a better understanding of tribal beliefs and practices through participatory observation. Suryamoni and Dulali are two young girls of around 12 years old and reading in class IV in a Mission School. They live in Mallickpur village, one of the target villages of the Tagore Society for Rural Development. They have been suffering from some diseases for the last one-month. They have undergone the treatment of Sunil Ekka, a local *ojha*. When we arrived at Mallickpur, Dulali and Suryamoni along with their parents and other village people had assembled at Sunil's house. We also sat at the terrace of Sunil's house and tried to understand the situation. Within a moment we came to know that they were suffering from some sort of severe brain ache and both the girls were almost sense-less. Villagers believed that witchery effected their trouble. We also had a discussion regarding this with Krishnapada, a tribal youth who worked as a Non-formal school teacher and a health worker of the Tagore Society for Rural Development. He received training in the primary health care from the Tagore Society for Rural Development. He was also under the impression that the two girls were under the influence of witchcraft. Few months' back there was a death of a person. The local *ojha* treated the person before his death. The *ojha*

identified the wife of Biswanath as *Daiin* and as a result Biswanath and his wife were forced to leave the village. They had been rehabilitated in the village after the intervention of the Tagore Society for Rural Development. Now again villagers along with local *ojha* have identified her as a witch and charged on her the responsibility for the diseases of the two girls.

We have decided to bring these children away from the *ojha's* house. Very next day we along with the Medical Officer of Malancha Primary Health Center managed to motivate the parents of Suryamoni to admit her at the Block Primary Health Centre. The condition of the health centre is not better than a stable. All the indoor beds are without mattress. After initial clinical checkup the doctor suspected the case as brain tumor. The treatment is expensive. Patient has to be shifted either to Malda or to Siliguri Medical College. He prescribed lots of medicine including injections most of these were not available at the Primary Health Centre and were very much costly. We purchased medicines with the help of the Tagore Society for Rural Development. We had spent the whole day at the hospital and next day morning I found that all the villagers assembled near the hospital and complained the negligence of the doctor and the health staff. There was no improvement of the patient also. We assessed the situation and found out that after our departure the doctor or other staff had not taken any attention and even the medicines were not given. Villagers were forced to release the patient. Lastly, in the evening, they had taken back the patient to their village again and started her treatment under an *ojha*. She underwent prolong treatment and villagers felt that girls had been showing gradual improvement.

Another case of refusal of modern medicine has been noted at Sondapukur. Bijan, a one-year-old son of Gopal and Sumi Murmu suffered from diarrhea. They took the child to the Primary Health Centre at Malancha at midnight. No one attended the child at night at the health centre and they had no other way but to take the child to a local *ojha*. *Ojha* identified that the evil spirit caused the disease. He prescribed medicines along with a *tabeej*. Gopal felt that after the treatment

the child showed improvement. Traditionally, a number of ceremonial rituals are observed to some extent among the tribals of both the target and non-target villages. The changes of practices are also being observed particularly for preventive measures. The tribals are now coming forward for child immunisation, for diarrhoea management. The inhabitants' tribals of the target villages have come to know the scientific home management procedure to tackle diarrhoea.