CHAPTER I
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INTRODUCTION

THE PROBLEM AND THE STATEMENT

Children are considered the most valuable asset of a nation. They are the future citizens and nation builders. To be a good citizen, an individual requires inculcating good personality and habits that depends on its foundation period 'childhood'. Hence, development of a nation always reflects how its children are being cared and brought up. A family, where the child belongs to, is the basic unit of society. Each and every family has to follow certain norms and rules of the particular society to get recognition and identity. In other words, every society has its traditionally and culturally practised norms and upbringing of its children. Home, being the primary institute of child rearing, the terms 'child rearing' may be considered as the upbringing of children in a family with all interactions among parents' interests, beliefs, care taking and training behaviour to make their children the acceptable member of the society.
Amongst all mammals, human being is born as the most dependent creature from all aspects. It needs all types of physical and mental care and protection. It is also born with most educable nature, which can be moulded as desired to give a particular shape. As mentioned above the adult personality is formed on its foundation 'childhood'. Though, different psychologists and educationists have defined childhood period in terms of years/age variedly, they all agreed to it that this period is a most crucial one, which later forms adult personality. Besides, the health and nutritional status of a child is very important as it is one of the strongest influential factors, that contributes for better milestone of development during childhood. In addition, a child's later health and nutritional status also largely depend on the care received during early years of life.

It would be misconceptioned of child rearing, if we consider over all care of a child only after birth. Since, proper growth and development of a child depend on its health status at birth and as it is very closely associated with its prenatal and natal period, hence, care during these periods is also assumes importance. Direct care cannot be given to the child during prenatal period and it depends completely on its mother, therefore, care of mother in all aspects is very necessary. Child rearing, therefore, encompasses care of mother during pregnancy and post partum period, including nutritional and health care, sleep and rest, care of the newborn and young children, such as breast feeding, weaning, complementary feeding, health care, toilet training, recreation, etc.
After birth, in the very beginning of human life, generally the mother is considered the first and basic trainer of the child in the family, later the family members and ultimately the society. Since, the family is considered the best workshop for the child, he should be given adequate opportunity to stimulate his responses, so that the child can enable to adjust himself with the new environment. Although in all the societies the young ones are fed, protected, nursed, dependency needs are attended, yet, the child rearing practices are not alike everywhere. Psychologists and Anthropologists have found that the ways of child rearing vary from culture to culture and society to society. Cultural factors have great influence on children since they are deeply rooted in socialisation of children. When a child is born, it enters into such an environment, which is surrounded, by a number of cultural laws and rules of the society and parents want to give all the bests to their children within their affordability. All methods, knowingly or unknowingly adopted by the parents to rear their children may not be scientifically acceptable. There are certain specific activities, which need special attention of parents in order to regulate and control the milestone of development of their children in a wholesome way. Many parents are not conscious of these factors and they allow their children to go their own way. Others become extra conscious and expect things to happen before the child is ready (Panda, 1990:93).

Moreover, proper development of a child largely depends on its general health status especially in the early part of childhood. Proper nutrition with the duration of breast feeding, timely weaning, immunization, treatment of
ailments, etc., and social beliefs are the utmost important factors during this formative stage. But, these are often interacted by cultural norms and socio economic status of the family. Therefore, parental education, occupation, income of the family, food habits, etc. are some of the factors that influence on child rearing.

India is considered as sub-continent for its rich and distinct cultural wealth. Cultural traits of the tribal population of the country are very much different from the rest of the country's population. Again each and every tribal society has its own cultural traditions and practices, economic and political backgrounds, religious and other rites and rituals, which are distinctively, differ from others. According to 1981 census, India has 39 million tribes belonging to 400 scheduled groups inhabiting different parts of the country (Bhuyan, 1993:3). A large number, over hundred of these groups live in the north-eastern region. Assam is one of the major states of this region, contributing to this scale of tribal population. According to 1991 census, the percentage of tribal population covers 12.82 per cent of the total population of the state.

Research on child rearing is not a very new concept. Several researchers have conducted various studies on child rearing. However, in earlier days people put little importance to it and neglected the large population of children community, the future of a nation. But, now a days, researchers have become enlightened on this subject and a number of studies have been carried out in recent years. In Assam, although many studies have been undertaken on the
tribal communities, yet studies emphasizing on child rearing are rather scanty. In this aspect the entire north-eastern region including Assam is far behind than others because of which a prominent gap of knowledge has been pertaining to us.

Since children are considered as future nation builders, it is very important to produce and build healthy children. Unfortunately, the health status of the children of our country including Assam is very poor in comparison to that of developed countries. Hence, it is necessary to have proper scientific knowledge of every aspect of health in child rearing and this can be achieved only through field-based investigation. Such type of findings are hoped to be helpful for the planners to a great extent in planning appropriate programmes to mould these tender human buds by providing and ensuring a conducive environment so that our nation can make a place in the list of advanced countries. Therefore, understanding these, this attempt has been made to undertake the study relevant to prevailing child rearing practices of tribal communities of Assam.

The study of child rearing practices assumes importance, as a child’s physical and mental growth; to a great extent is the outcome of the pattern of care received by him during early childhood. Viewing the child’s development as a whole, study on child rearing should cover as far as possible on all the parameters such as feeding, weaning, health care, toilet training, socialisation, recreation, etc. Keeping these in mind the present study is concerned to
understand the pattern of the pregnancy care, care of the newborn, infant feeding, weaning, treatment and preventive aspects of health, family welfare, nutritional status, toilet training, socialisation, play, etc. Since a child's development is very closely associated with its health status, therefore, an attempt has also been made to know the general health status of the tribal children by collecting information on mortality and morbidity of children as these two are very important indicators for understanding the health status of children of any area.

It was decided to conduct the study in three tribal communities of Assam and thought appropriate to cover different parts of the state covering from upper to lower Assam. Since many practices vary according to the habitat, it was felt necessary to select the tribes both from hills and plains of Assam. For selecting the tribes, distinctive cultural identities were the main considerations.

In Assam there are altogether 23 groups of communities that are recognized as schedule tribes (Sen, 1999:501-502). These are given below:

I) In the autonomous districts:

1. Chakma
2. Dimasa
3. Garo
4. Hajong
5. Hmar
6. Khasi, Jaintia, Pnar, War, Bhoi, Lyngam
7. Any Kuki tribes,
8. Lakher
9. Man (Tai speaking)
10. Any Mizo (Lushai) tribes,
11. Mikir
12. Any Naga tribes,
13. Pawi
14. Synteng

II) In the State of Assam excluding the autonomous districts:

1. Barmans in Cachar
2. Boro, Boro Kachari
3. Deori
4. Hojai
5. Kachari, Sonowal
6. Lalung
7. Mech
8. Miri
9. Rabha

The autonomous districts of Assam are namely the Karbi Anglong and the North Cachar Hill districts. The tribes inhabiting in both the hill districts are recognized as Hill Tribes. Therefore, there are 14 Hill Tribes and 9 plain tribes in Assam. Out of 23 tribes two tribes namely the Garo and Khasi are the only matrilineal tribes. From the above list, three tribes (one from plain tribe and two from hill tribes) are chosen for the study. These are the Deori, a plain tribe; the Garo and the Karbi belong to the hills. Again between the two hill tribes the Garos belong to the matrilineal society.
Objectives of the Study

1. To study the existing as well as traditional practices in terms of childbirth, feeding, weaning, relevant customs and beliefs among the tribes in relation to their economic status, education and socio-cultural factors,

2. to find out the attributed differences/similarities of child rearing practices among the tribes,

3. to study the impinging factors in child rearing, and

4. to assess various health parameters on nutritional and health status of children.

REVIEW OF LITERATURE

Studies conducted on various aspects of child rearing have been reviewed to supplement and sharpen the various stages of this research study. It is seen that, studies covering all the aspects of child rearing are very few and those on tribes of North-East are even very fewer. Here attempt has been made
to review the relevant studies conducted on the various aspects of child rearing and these are presented under the following heads:

(a) Reproductive Health of Mothers

Study on reproductive life of women of Deshastha and Kokanastha of Poone, shows that, the age range for majority of the girls getting married was 17-19 years in Kokanasthas and 16-22 years in Deshasthas. In both the groups, the tendency to go to doctors for some sort or other type of medical check up was absent. Majority of the deliveries were done at home by local nurse (Kulkarni and Joshi, 1979:71-90).

Rajani, et al. (1979:317-319), conducted a pilot study in order to find out the existing sex ratios and impact of family planning in sex ratios in Visakhapatnam, Andhra Pradesh. It was found that, out of 174 families studied, 48.85 per cent of them were not favorable toward the family welfare programmes. Among them more than half (50.59%) were totally reluctant for the family planning programmes, while the rest would like to adopt the programme only after having one or two more children.

Mahapatra, et al. (1990:85-91), observed in their study conducted at Chiraigaon Block of Varansi, Uttar Pradesh, that, the mean intake of calorie, protein, iron, folic acid and calcium by pregnant women was much below the recommended ICMR dosage. The attributed causes for low intake of food
ingredients was found to be the lower literacy rate of the villages particularly that of women as well as ignorance of food and nutrient requirements during pregnancy.

Sharma and Khan (1990:446-453), found that, the Khairwar tribal woman exhibit 4.85 live births per mother and 145 infant deaths per thousand live births. Reproductive wastage due to abortions and stillbirths are 4.6 per cent of the total pregnancy. High infant deaths motivate couple to produce more children due to fear of losing infants by deaths. The researchers observed that lack of medical facilities and their worst environmental conditions were the attributed causes for high mortality and morbidity rates.

Study on attitudes towards fertility control showed that, higher income level and higher educational level, to a large extent were responsible for change of beliefs and attitudes towards adopting modern attitudes towards fertility control. Besides, age is also regarded as a major factor in motivating change. The maximum percentile frequency for modern attitude is noticed in the age group of 25-30 years (Muthal, 1992:97-103).

Majority of the studied sample of pregnant women of 50 households of a sub-urban area called Ghari of Manipur, prefer to have delivery to be done in hospital. However, among the studied sample 90 per cent of the delivery took place at home, but done by midwife. More than half of the sample (56.0%), used
bamboo edge to cut the umbilical cord and the after birth products are buried (Mao and Maisnam, 1994:87-89).

Pregnant women of Nocte tribe of Arunachal Pradesh do not show much interest in availing regular health check up. Home deliveries are common and generally attended by local women. For any complicacy they approach to the traditional medicine men (Swarankar, 1995:23-29).

A study conducted by Naik, and Sharma (cited in Kusuma, 1997:10), revealed that the age at marriage among Bhuiyan tribal women was 13-16 years, while for men 15-18 years. As the couple had no knowledge of family planning, fertility was generally high. It had been observed that money was the main incentive for adopting sterilization.

Rajaratnam, et al. (1997:31), found in their study among the Malto tribes of Bihar, that most of the deliveries (98.2%) were conducted at home. The delivery attendants were the mother herself (3.7%), husbands (16.7%), local dais (66.7%), mothers of the pregnant women (3.7%), sisters (1.8%), neighbour (3.7%) and nurses (1.8%). Most of them (63.0%) used bamboo to cut the umbilical cord, blade (22.2%), knife (3.7%) and sterilised blade (9.3%). Study also showed that majority (85.2%) of the studied population (mothers) did not receive a single antenatal check up and 87 per cent did not have TT vaccination during their pregnancy. Among them 83.3 per cent of the mothers did not take iron and folic acid tablets.
According to NFHS, as mentioned by Mishra, et al. (1998:4), in Assam, the percentage of receiving antenatal care is 49.3, percentage of knowing any family planning method is 97.5 and the percentage of knowing all the four methods of family planning is 45.2.

Pregnant mothers of Sonowal Kacharis of Assam, though they had no scientific ideas about taking the vaccination against tetanus, yet most of them took TT (tetanus toxoid) vaccine. However, some of the mothers took the vaccine only for the first or second issue, but in case of subsequent issues they did not show much interest. Regarding diet, majority of the pregnant women took normal diet and could not afford for extra food due to poor economic condition (Barua and Bora, 1999:334).

In a study conducted by Sood and Nagla (2000:37-52), attempted to develop a scale to measure the knowledge of rural women in Rohtak regarding maternal and child health and family planning. Out of 163 women included in the study, 47 per cent had formal schooling, 90.8 per cent of their husbands had formal schooling and 23 per cent belonged to under privileged communities. Nearly 64 per cent were from joint families. The mean score for maternal care, childcare and family planning was higher among women living near health institutions as compared to those in far off villages.

Study carried out in the State of Haryana found that one third of the respondents had adopted family planning. Out of them, in 76.56 per cent of cases respondent herself had gone for it by adopting tubectomy and in rest
husband had adopted vasectomy. It shows the important part played by women in adoption of family planning and thereby in improving the health of the children (Kaur, et al., 2001:49-56).

Survey carried out by NFHS-2 found that, the fertility rate in India is still high especially in adolescents (less than 20 years), which accounted for 19 per cent of the total fertility. Half of the young women were married below the age of 18 years. Only one of the five mothers received all the recommended components of antenatal care and only 40 per cent of deliveries were attended by a health professional and 52 per cent women in India had some degree of anaemia (cited in RCC Research Bulletin, 2001: 14).

(b) Pregnancy Taboos, Beliefs, etc.

Srivastava (1971:182-183) found that, pregnant mothers of Asalpur (Rajasthan) and Barigaon (Uttar Pradesh) at their advanced stages of pregnancies are not allowed to lift a heavy weight. They also avoid places believed to be haunted by evil spirits. Crossing a river or a culvert is also tabooed for them during pregnancy. In Barigaon, people believe that by crossing a river or a culvert something like while thread is rolled around the neck of the child in the womb. In both the villages, a pregnant woman avoids the earth tumbled by an ass. In Barigaon, she avoids the earth tumbled also by a pig. It is because of the belief of fear for evil spirit and illness of the unborn child. It is also believed that a pregnant mother during her eight-month of pregnancy she
should not cut her nails and apply *kajal* (lampblack) to her eyes. In Asalpur, these are avoided in order to distract the husband. In Barigaon, plaiting of hair is also forbidden at this stage believing that plaiting hair would make the child’s head pestle-like; applying *kajal* would make the penis of the child black and nail cutting would deform the child. In Asalpur, the pregnant woman in the advanced stage of her pregnancy also avoids the *chauraha* (cross-roads) and does not go anywhere applying mystle paste on her palms and feet so that evil spirits may not herm her and the child in her womb. In order to avoid miscarriages, she also avoids walking on heels. In both the villages, a pregnant woman avoids sleeping and looking at the reflection of an eclipse. Such avoidance is also found among the Mexican-Americans of South Texas (cited in Srivastava, 1971:183). They believe that seeing an eclipse by a pregnant woman creates squint eyes of the child in the womb. Besides, in Asalpur, a pregnant woman does not lock her room or house during an eclipse because it is believed that it splits the lips of the child. To avert the evil effects of the eclipse, she also distributes boiled wheat among five households. In Barigaon, she applies cow-dung around her belly in order to protect her child in the womb from physical deformity. Some Latin women wear a key suspended by a string belt over the abdomen in order to protect the embryonic child against deformity (cited in Srivastava, 1971:183).

Pool (1986:251-257), in his study found that, people of Bharuch district of Gujarat (which is classified as tribal area) have the belief on hot and cold foods, which forms the most important conceptual model for folk explanations.
of disease. It is believed that, diseases especially during summer are caused by consumption of hot foods, exposure to environmental heat and much physical exertion or to a hot bodily constitution. Likewise, a person with cold constitution who is exposed to environmental cold is likely to get a cold disease. During early part of pregnancy the pregnant woman avoids hot foods because it is thought that those foods cause a build-up of heat in body, which may lead to abortion or to the disease called rativa. They also said that, all cold foods should be avoided during the later part of the pregnancy to prevent a difficult delivery, as it is believed to cause a sticky layer of fat to form around the foetus, causing it to get stuck in the womb. In contrast, consumption of hot foods during last months of pregnancy is thought to facilitate delivery and the same reasoning appears to be behind the recommendation that cold foods be eaten during the early pregnancy. They believe that abortions are the result of too much heat, which causes the foetus to be expelled from the womb.

Study conducted by Bhuyan (1993:81-95), among the four tribes of Assam observed that, 29 per cent of the respondents followed certain dietary restrictions during pregnancy. These tabooed foods are, flesh of dead animal, animals or birds killed by predatory animals, crab, fresh water eel, tortoise, ginger, dry fish, egg with red spot inside and certain vegetables. The main reasons restricting these foods were because of delivering a stillborn baby, difficult and prolonged delivery and fear of baby's health problem or any physical abnormality. Besides food taboos the study also revealed restrictions against certain acts and movements by the pregnant mothers, such as - funeral
ground, house of a deceased person, forest, deserted place, etc. because of the fear of evil spirits or ghosts that may harm the unborn baby.

Sinha (cited in Kusuma, 1997:11) reported about pregnancy taboos of Bhilala tribe of Madhya Pradesh, Gujarat and Rajasthan. The taboos were crossing a broomstick and the tying ropes of horse, ass and mare. They had a belief that the above said animals deliver their babies only in twelve months. Thus, a violation of the above taboo may lead to the same consequence to a pregnant woman and deliver a baby in the twelfth month. Another taboo also observed and that was seeing a dead body.

Study showed that, during antenatal period, 74.1 per cent mothers belonging to the Malto tribes of Bihar did not have any restriction over the food. Food taboo was followed by 25.9 per cent mothers. Food items restricted were jack fruit (13.0%), meat (5.5%), potato (11.1%), dhal (9.2%), brinjal (3.7%) and chana dhal (1.0%) (Rajarathram, et al., 1997:31).

Study conducted by Barua and Bora (1999:331-345) on childcare and motherhood of Sonowal Kacharies of Assam, found that a pregnant woman is not subject to any restriction on any type of work. She handles her duties till her health allows. However, although there are no very strict rules of avoidance during pregnancy, yet the pregnant woman never touches any cooked food item, which is sent from a family where death occurred recently. They are not allowed to stitch any torn cloth and majority of them keep a knife or mustard
seeds with them. They avoid eating joint or double fruit, as they believe that 
birth of twins is related to eating joint fruits. Pregnant women are also advised 
not to eat alkaline food like papaya, brinjal, silikha (*Terminalia chebula*), etc. 
During pregnancy, the husband is not allowed to kill or harm any animal. They 
also do not bury anything during that period.

Study conducted in a sample size of 100 nursing mothers in the age 
group of 20-30 years in Maternity Centers of Coimbatore Corporation, found 
that, most of the mothers were most conscious to omit foods like brinjal, cluster 
beans, bottle gourd, potato, colocasia and egg - as these were considered to 
produce either allergy, knee joint pains or fear of counteracting effects on the 
beneficial effects of herbs. Buttermilk, curd, ragi and watermelon were also 
avoidable, as they are believed to be cold foods. On the contrary to increase 
breast milk; milk, green leafy vegetables, roti, mutton, spinach, dhal, tomato 
and ghee are included in diet (Devadas, et al., 1999:1-11).

**(c) Pregnancy Rites**

A comparative study, conducted by Srivastava (1971:181) in two villages 
namely Asalpur in Rajasthan and Barigaon in Uttar Pradesh, found that, a 
ritual is performed during seventh or eight mouth of pregnancy called *athavan 
poojana* by all the castes in Asalpur village but by none in Barigaon.
Rites relating to pregnancy are limited to the first pregnancy among the Patidar Community of Gujarat. The first ceremony is the thread-tying ceremony, performed at the girl's father's house at her fourth or fifth month where her husband's sister ties around her arm a simple ribbon in which an amulet has been attached for averting of the evil eye. In the seventh month, the second ceremony simant takes place and begins at the girl's father's house and continues till her husband's family. This ceremony is called lap-filling ceremony, where a woman who has already given birth to a healthy son and has not lost a child, pours rice into the pregnant girl's lap. Her husband's sister ties a thread round her wrist to avert evil, after her arrival at her husband's house (Pocock, 1972:113-115).

(d) Rites/Beliefs relating to Childbirth

Pandey (cited in Srivastava, 1971:184), mentioned that the hair braids of the expectant mother of the villages of Asalpur (Rajasthan) and Barigaon (Uttar Pradesh) are untied and all the knots in the house are loosened. It symbolizes the loosening of the fetus in the womb of the mother. The women of both the villages believe that, with all these precautions the expectant child easily comes out. In Barigaon the women also uncover all the covered things of the room and unlock the boxes for this purpose. This type of corresponding custom is also found in Germany where people open all the doors and locks of the house (Srivastava, 1971:184).
In Asalpur, a little ghee-mixed sugar or jaggery with a rupee coin is put into the month of the newborn child. In case of male child it is given by the grandfather and in case of female child by the grand mother. This is known as ghutti dena. In Barigaon, as soon as the child is born, a woman taking some rice and water into her mouth spills over the mouth of the newborn child. This is known as Kula dalana. In Asalpur, the younger brother of the child’s father buries the umbilical cord, the placenta and 7 varieties of grains together in the courtyard. In Barigaon, these are buried in the confinement room by the dai. In both the villages, it is believed that if these are not buried and thrown out, dogs will eat them on account of which the child and the mother may fall ill or die. In both the villages people believe that if these are not buried in the house, the child may not have any attraction for its home. In both the villages, a purification or sun worship ceremony is performed after childbirth. This ceremony is performed either on Tuesday, Thursday and Sunday, and the fifth, seventh, ninth and eleventh days, because these are considered as auspicious days for Suraj Pujan (sun worship) or nahavan (purification ceremony) (Srivastava, 1971:184-189).

Among the Patidars of Gujarat, in case of a male child the first haircut ceremony is an important one. In this occasion the father’s sister is called to receive the hair (Pocock, 1972:118).

Wilson (cited in Pool, 1986:255) and Manderson (cited in Pool, 1986: 255), found that, in most parts of India women are thought to be polluted for 40
days after delivery and in other parts of South-east Asia women who have delivered are required to observe various taboos for some period of time.

Prevalence of some rites in connection to childbirth was reported among the tribes of Assam (the Lalung and the Rabha) and Manipur (the Mao). Among the Lalungs, two birth ceremonies were performed. The first one is performed on the seventh or ninth day (after falling off the umbilicus). The women who helped in delivery chew some black pepper and leaves and blow the vapour out of the mouth to the babies face. That day the baby is shown to the sun. The oldest woman of the clan draws 7 lines (horizontally and vertically) and brings little earth from the center. This she puts on the forehead, ears, chest, sole and feet of the baby. The second ceremony is performed later according to the convenience of the family where all the relatives and villagers are given feast. Till the ceremonies are performed the parents of the baby cannot participate in any religious function and are considered unholy. The Rabhas observe a simple function on the completion of one month after childbirth, where ceremonial cleaning of the house, washing utensils and cloths take place. On that day, the elderly village people are invited and treated with rice beer, tea, etc. Among the Maos in Manipur, a simple function is held on third or fifth day after birth. On that day the baby is brought outside for the first time. Two pieces of pinewoods are lighted and carried by the father of the baby up to the door. The mother of the baby follows him with the baby. A young child (of same sex as well as with the baby) takes out the hand of the baby and says, 'you have seen the first light and you may shine like the morning sun'. The firewood will be let to burn till
the end. However, many people are not very particular about the observation of this ritual (NIPCCD, 1998:44-46).

After birth, the placenta is deeply buried by the husband in the bedroom of the couple of the Sonowal Kacharis of Assam. They never bury it outside as it is believed that it may be affected by spirit or evil eyes (Barua and Bora, 1999:335-336).

Among the Tai Khamyangs, the placenta is burned within the compound and they never give any pressure on it. It is believed that if pressed heavily, the child may face difficulty in breathing. It is also believed that the deeper the pit is longer the gap between the two issues (cited in Barua and Bora, 1999:336).

Study conducted by Banerjee (cited in Barua and Bora, 1999:336) shows that, among the Sikligars, after birth the placenta is buried deeply. They believe that the deeper is, the better will be the health of the mother and the child. It is buried with great caution and without any delay. Because, according to their belief, if a barren woman happens to have it, she can trouble the baby a lot.

Among the Sonowal Kacharis, bajkaran or baj-uluh, the first ceremony of taking out the newborn from confinement to outside and Suddhi Sabah, i.e. the purification ceremony after childbirth, are the two main ceremonies performed in relation to childbirth (Barua and Bora, 1999:344).
(e) Feeding Practices

In Asalpur village of Rajasthan, the newborn is fed with gur (jaggery) and parsley (ajavain) mixed water until the mother's milk comes. And in Barigaon village of Uttar Pradesh, the child is fed with goat milk (Srivastava, 1971:188).

Jelliffe and Jelliffe (1979:162) mentioned in their book that most often the initial feeding of the baby is with breast milk alone, but in some cultures, pre-lacteal feeds may also be given prior to nursing. For example, in parts of Malaysia, mashed ripe banana is fed to the breast fed baby in the first day of life. Often this is undertaken in part to 'clean out the meconium'.

Study conducted on child rearing practices (3-6 years) of Assamese mothers of Jorhat town, by Phukan and Goswami (1985:43-49) observed that, majority of the mothers' (63.0%) mode of feeding was both breast as well as bottle feeding. Largest group of mothers (42.0%) breast fed their babies between 6-12 months and most of them fed their babies according to the schedule. Most of them (86.7%) started weaning between the ages of 3-6 months.

Study conducted in Ghari village of Manipur found that, mothers breast fed their babies for two years. For weaning away 86.0 per cent of them applied bitter substances on their nipple. For weaning, a ceremony called Chakumba puja, is performed at the odd month (5/7 months) for girls and even month (6/8 months) for boys. For eating, the child is trained with spoon feeding (88.0%),
which consists of rice, vegetables, fish and eggs (Mao and Maisnam, 1994:87-89).

Study showed that, 80.9 per cent of the mothers of the Malto tribes of Bihar gave colostrum to their neonates. Out of the studied population, 37.7 per cent had initiated breast feeding within 4 hours, 14.7 per cent within 5-12 hours, 23.5 per cent between 12 and 24 hours, 14.7 per cent between 1 and 2 days, 2.9 per cent between 2 and 3 days and 4.4 per cent had started only after 3 days. Mothers reported giving breast milk to their children even up to 4-5 years. The study also found that, among the Malto tribes of Bihar, only 1.5 per cent of the mothers had started weaning food at the fourth month, 8.8 per cent at the fifth month, 13.2 per cent at the sixth month, 33.8 per cent at seventh month and 23.5 per cent after eighth months (Rajaratnam, et al., 1997:31-32).

Study revealed that, in Manipur, 60 per cent the families of the Kabui tribe initiated supplementary feeding very early (before 3 months) and the mothers of the Mao tribe initiated it between 4-9 months. Among the tribes of Assam (the Lalung and the Rabha) introduction of semisolid was found late that is only after 7 months (NIPCCD, 1998:52-53).

Among the Sonowal Kacharis of Assam, the age at weaning varies from family to family and also within the children of the same families. The majority of the sample women of a study conducted by Borua and Bora (1999:344-338), tried to wean their children between 1½ to 2 year. In some cases, children were
weaned before the third month, due to shortage of breast milk. The period of breast feeding is shorter among those who were able to supplement or replace breast milk, with cow's or tinned baby milk powder from 3-4 months after delivery. Those women who continued breast feeding till the next pregnancy or delivery were mainly from poorer family. *Annaprasana*, ceremony for making the child acquainted with the cooked food for the first time, is performed between 9-12 month of birth by the Sonowal Kacharis of Assam (Barua and Bora, 1999:344).

Devadas, et al. (1999:1-11), observed in their study at Coimbatore that, mothers of the higher socio-economic status had greater chances of feeding colostrum than the poor income group as most of their delivery took place in nursing homes. In all, 80 per cent middle and 95 per cent high-income groups reported giving colostrum. Sugar water, honey, milk and jaggery are used as pre-lacteal feeds and believed to be as cleansing agents. Depriving the infants of breast milk during 8-24 hours is a common practice in this study. Mothers of higher educational level and higher economic level commenced within one hour of delivery. Mothers without any basic educational level delayed initiating breastfeeding because of the custom of giving first feed as pre-lacteal feeds by the grand mothers or son-in-law as laxative.

Study conducted by Ram, et al. (cited in RCC Research Bulletin, NIPCCD, 2000:20), in Darjiling district of West Bengal, revealed that 85.5 per cent mothers initiated breastfeeding within 7-18 hours after delivery and 100
per cent mothers started within 24 hours. Socio-economic and educational status of mothers had significant association with duration of breast feeding. Shorter duration was noted among educated mothers with high education and socio-economic status as compared to illiterate mothers with poor status.

Study conducted by Sinha and Pandey (2000:338-339), among the Ho tribes of Bihar, observed that weaning foods were introduced to the young children between 12-18 months of age by 46.5 per cent mothers, followed by 35 per cent between 8-12 months. Majority of them (62.5%) weaned their children completely at 3 years of age. Frightening, making the child understand and applying physical punishment were the methods adopted for weaning the child for some of the mothers.

A study was conducted by Gunasekaran, et al. (cited in RCC Research Bulletin, 2001:24-25), on a sample of 912 children born during 1990-94 in Tamil Nadu, to study the existing infant feeding practices. Results revealed that, 29 per cent infants had the advantage of getting finally breastfeeding, colostrum feeding, breast milk for a minimum recommended period and solid food supplement at the right age. More urban women (32.0%) practiced ideal infant feeding compared to their rural counterparts (22.0%). Place of residence, age at marriage, sex of the child, number of antenatal visits by the ANM during pregnancy and place of delivery had a significant relationship with infant feeding practices.
In most African communities, when the child is 4 months old, a special rite, *ukupoko mwana* (the taking of the child), is performed by the father and mother, and after this physical relation may be allowed between the parents, but it considered very dangerous for the mother to become pregnant before her first baby has been successfully weaned. It is believed that the child will fall ill of a particular disease called *ukulwale lunse*, of which the symptoms are coughing, wasting or diarrhoea (Richards, 1950:67).

Dave, et al. (1984:11-14), observed in their study on childcare amongst the tribals of Gujarat, that mothers gave bath to their children till they reach 5 years of age. Common cold was the most commonly suffered ailments of the children in which no any attention was given. People strongly believed on supernatural powers as causative as well as curative factors of diseases. Hence the tribal people usually availed medicine from the village *Bhagat* and approached to allopathic treatment if the local measures were exhausted.

Tying a waist string of various coloured is a common cultural practice among South Indians. Reasons for tying the strings are - to add beauty, increase the growth of the waist, help in tying loin cloth, estimate the quantity of food taken, prevent indigestion, prevent the spread of infection from one half of the body to the other, as a traditional sacrament and to protect from evil
spirits. In addition to these, during periods of acute illness or malnutrition, there is probably wasting of the tissues, especially fat, at the level of the waist and therefore, certain inference can be drawn that one of nutritional significance (Abel, 1985:73-77).

Dash (1985:217-221), reported that the concept and treatment of various diseases, among the Paraja tribe of Orissa, are very much associated with the megico-religious beliefs. They believed that most of the diseases are caused due to the wrath of the deities, spirit intrusion, casting of evil eye and breach of social-cultural norms. Use of herbal medicines for treating various diseases is an important measure for the tribal people.

Study conducted by Das and Ghose (1985:147-157), among the Santhals of Bihar to observe the health care of their children and found that, if the folk medicines given by ojha (folk practitioner) for the treatment of any illness of the children do not immediately respond then they seek the help of modern doctors.

Mukharji (1988:252-257), in his study conducted in a sub-urban area of Hooghly district of West Bengal, found that, the amount of educational attainment of the mothers plays the most important role in the incidence of infant mortality. His study showed that the infant deaths were highest among the nonliterate group and lowest among the higher level of educated group.
The belief on supernatural powers, evil eyes, ghosts, etc. which cause various diseases, is also prevalent among the Jaunsori people of India. To cite a few — evil eye has the worst effect on children, kodh (leprosy) is considered to be due to the wrath of a god or goddess for sins committed by the individual, goddess Sitala is worshipped as she is the controlling goddess of epidemic of cholera and small pox, phaash (measles) is considered to be the curse of a goddess, etc. People worship, mantras are chanted by priest to appease those gods and goddesses (Rizvi, 1991:179-187).

Twin babies in Nocte tribe of Arunachal Pradesh are not allowed to live in the society. Such babies are killed immediately after birth, as twins are considered unnatural. Moreover, beliefs on various supernatural powers and forces as causative factors for various diseases are prevalent among the Nocte tribes of Arunachal Pradesh. People consult the diviner for necessary curative measures. However, for certain disease they do not restrict to take modern medicines (Swarankar, 1995:23-29).

Dastidar and Gupta (1996:63-69), in their study found that, the death at neonatal stage shows higher values among the Muslim slum dwellers of Calcutta city than the Hindus. Post neonatal deaths also show a higher trend among the Muslims than the Hindus.

APAU (cited in Kusuma, 1997:20), reported on profile of tribal families in East Godavari district that fever, respiratory infection, gastroenteritis and
scabies were most common ailments in children. For treatment, about 40-50 per cent of them were going for allopathic treatment for common diseases. Even the rest, who were not going for allopathic treatment might be due to inaccessibility of health center rather than their disapproval. A significant number were dependent on local men who give herbal medicines for common illnesses.

Chowdhuri and Debnath (cited in Kusuma, 1997:21), conducted a survey on impact of prevalent diseases among the tribals of tribal concentrated areas of West Bengal and found that the tribal people were quite ignorant of many diseases and the knowledge of health and hygiene practices were also more or less absent. People still hold on traditional cultural beliefs and practices in regard of treatment of various diseases.

Study conducted among the Malto Tribes of Bihar showed that, people do not have the habit of taking the children to the health center for immunization. Among the studied sample of children, BCG was not given to any of the children. Only 45.6 per cent of the children were given the first dose of DPT, 26.5 per cent second dose, 8.8 per cent third dose and only 1.5 per cent booster dose (Rajaratnam, et al., 1997:29-34).

Scheme in Delhi, observed that, all births in the control group had occurred at home where as the experimental group had given birth to their children in hospital. Significant difference between the nutritional and immunization status of the two groups was observed and the experimental group was positively better. The awareness level of the experimental group on matters related to food, nutrition and health of the family was significantly higher than the control group.

Barua and Bora (1999:336), in their study among the Sonowal Kacharis of Assam found that the fallen off umbilical cord of the child is preserved, usually in a cage of a cocoon, and is believed that the water extracted from this dry cord in very useful for treating the child in certain diseases like dysentery, fever, etc. It is also believed that if a child wears it, he will be healthy and strong.

Study was conducted in four resettlement colonies of trans Yamuna area of Delhi from May 1997 to March 1998 in order to observe the immunization coverage levels of children and also to observe whether there are any changes in coverage levels over a period of five years. It was observed that immunization coverage in the area was peaked during 1995-96 and declined thereafter due to fall in IEC activities (Salhotra and Sharma, 1999:120-123).
Study conducted by Agarwal (cited in RCC Research Bulletin, NIPCCD, 2000:9), showed that, massage improved the weight, length and mid-arm and mid leg circumference compared to non-massaged groups of infants.

Anand and Gerg (2000:47-52), conducted a study in Maharastra to find out the socio-economic and maternal factors responsible for low birth weight babies (LBW). It showed the overall mean birth weight of the newborns was 2.58 ± 0.42 kg. The percentage of LBW babies was 23.4 per cent in case of mothers who attended antenatal care clinic and 50 per cent in the case of mothers who did not visit antenatal clinic. The factors, which were significant for LBW, were antenatal care during pregnancy, maternal education, occupation, per capita income, poverty, bad obstetric history, pre-delivery weight and haemoglobin concentration.

Blair, et al. (cited in RCC Research Bulletin, NIPCCD, 2000:14), in their study investigated the risks of the sudden infant death syndrome and factors responsible to unsafe sleeping environment, revealed that infants who shared their parent's bed and were then put back in their own cot had no increased risk. While infants who shared the bed for the whole sleep duration with parents had increased risk. The risk linked with bed sharing among younger infants is associated with alcohol consumption, overcrowded housing condition, parental tiredness, etc.
Chaudhury, et al. (cited in RCC Research Bulletin, NIPCCD 2000:14-15), in their study on mortality and morbidity in high risk infants observed that, out of 40 deaths which occurred during the study period, 38 occurred in the first year of life, 60 per cent occurring in the first 3 months. Mortality was significantly higher in the very low birth weight group. Out of the 22 hospital deaths, 72.7 per cent were due to infection. There was a high significant difference in the mortality rate between the groups, which attended the High Risk Clinic regularly (6.4%) as compared to that of defaulters (27.6%).

In another study in Haryana, conducted by Kumar, et al. (2000:411-417), found that the variables which were significantly associated with risk of under five deaths were not received measles vaccine, history of sibling death, maternal literacy, not adopted family planning measures and having more than 4 children.

Srivastava (2000:1) revealed that, in Delhi 47 infants out of 1,000 die at childbirth and 33.4 per cent of the births take place at home, without trained midwives.

Study examined the determinants of severe under-nutrition among the children aged 12-47 months using NFHS data. The percentage of children of severely underweight and stunted was 27.4 per cent and 36.5 per cent respectively. The percentage of undernourished children was highest in Bihar (72.4%). According to the data available, among the North-East states in Assam
it was 60 per cent and in Mizoram it was 32.8 per cent (Rajaretnam, 2000:179-200).

Sarkar and Saikia (2000:419-421), conducted a study on birth weight in Arunachal Pradesh. Results revealed that tribal babies of Changlang district were found to be heavier than the babies of other groups (non-tribals). It was also observed that incidence of LBW among tribal babies of Changlang was less than that of Bengali babies of Calcutta and Marathi babies of Pune and tribal babies were healthier than other babies of North-East India.

The study of 150 children with their respective mothers belonging to low socio-economic group assessed the etiological factors responsible for Protein Energy Malnutrition (PEM) in infants in two urban slum communities in Delhi and revealed that 74.0 per cent of the children were in normal nutritional grade. Among the rest, 11, 9, 2 and 4 per cent children were in Grades I, II, III and IV category of under nutrition respectively. The non-feeding of colostrum, lack of exclusive breast feeding, late introduction of solid, semi solid foods, dilution of top milk and use of bottle milk were common practices in urban slum communities (Aneja, et al., 2001:160-165).

IIPS (cited in RCC Research Bulletin, NIPCCD, 2001:14) mentioned that, the NFHS-2 carried out survey in two phases and covered more than 90,000 women and their children below 3 years in 26 states. The survey revealed that
almost half of the children in India were underweight, although the percentage of underweight children declined from 52 per cent to 47 per cent since the time of NFHS-1 (1992-93). Nearly three fourth of Indian children were anaemic. One in 15 children still died before reaching 1 year of age. IMR was 110 for closely spaced births compared to 39 for spaced births.

Swami (2001:10) of AIIMS revealed that, almost 50 per cent of the children under 3 years of age in India are underweight.

Field work conducted among four major tribes of Maharastra showed that, the beliefs of people on natural factors such as heat, cold, diet, wind, etc. as well as cultural factors such as visitation and wrath of Gods and Goddesses, ancestral spirit, possession by evil spirits, witch craft, evil eye, etc. are the causative factors of various illnesses (Tribhuwan and Gambhir, 2001:4-7).

Survey was carried out by Vir and Nigam (cited in RCC Research Bulletin, NIPCCD, 2001:27), in five economic regions (Bundelkhand, Central, Eastern Hill and Western region) of Uttar Pradesh to collect data on the nutrition profile of children and women. The target groups were children 3-59 months and even married women in the age group of 15-45 years. Results revealed that 52 per cent children were under weight and 22.4 per cent were severely underweight and malnourished. The maximum incidence of under weight was observed among children aged 12-23 months. It also showed that, malnutrition accelerates during the second half of infancy.
Study conducted by Sidana and Sinha (1973:50-60), in Kanpur, to find out the relationship between the child rearing practices of the parents and the development of fears in children showed that children who were less punished by their parents had fewer fears than those who were more often punished.

Study conducted by Singh and Kaur (1981:7-16), to observe the mother-child interaction in rural and urban areas of India. Results revealed that the rural mothers interacted more with girls than boys because they felt that girls require more instruction than boys. The mother-child interaction was more when the mother had more education. Both the rural and urban mothers used some tactics to discipline their children such as - scolding, spanking, discouragement, etc.

Srivastava (1985:19-29), observed in his study conducted in Lucknow that, high degree of association between parent and child in middle class families as compared to that in the families of high and lower class groups. Middle class being at mid-point provides a balanced and more favorable atmosphere for more associative relationship between them. He also observed that at all levels of social class mother is more emotional support to her children and with the result the children too identify more with her.
According to Hurlock (1987:38-352), parents come from different socioeconomic status, there is likely to be friction in their interpersonal relationship in regards to method of child rearing.

Parenting practices and developmental expectations were examined in a sample of 138 mothers with very young children from Mexico and United States, the striking similarities between the two cultures suggest that at least for young children, the demands of parenting are similar across the cultures. Moreover, parents of similar educational backgrounds from different but similarly developed countries may respond in similar ways to young children (Fox, 1995:591-599).

Study on child rearing practices, conducted by NIPCCD (1998:75) among the tribals in North East India, revealed that, nearly 21 per cent of the families reported of performing some functions in relation to giving name to their children. Majority of them were from the Mao and the Kabui tribes of Manipur.

Cardona, et al. (2000:357-365), examined parenting practices and developmental expectations between 38 Hispanic and 38 Anglo-American mothers living in the United States. The study found that, the Hispanic and higher socio-economic mothers reported higher discipline and lower nurturing scores than did the Anglo-American and lower socio-economic status mothers.
Tripathi (cited in RCC Research Bulletin, NIPCCD, 2000:12-13), carried out a study on aggression in children revealed that, aggression increased with advancing age in early childhood. Family environment also played a significant role in inducing aggression. Hostile behaviour in male children could be attributed to the cultural setting. Deficiency in family child interaction leads to hostility among children.

Study conducted by Aruna and Vidyasagar (2001:332-339), indicated significant association between maternal behavior and psycho-social development of pre-schoolers (1-5 years). Factors like parental literacy and nuclear family were also associated significantly with the deviance in development. Significant association was also confirmed between nutrition and development provision of food/milk to children on demand, disciplining and training children without resort to physical abuse but meaningful dialogue and bringing up children in an environment free of gender distribution is associated with the deviance in Child Development.

Study to examine the conflictual maternal behaviour and child behaviour in a community sample of 78 families with 3-year-old children by Frosch and Mangelsdorf (2001:502-519), and findings indicated that display of greater marital conflict in the presence of children leads to exhibition of more behavioural problems among the pre-schoolers. Most hostile behaviour increases children's vulnerability to the negative affects of marital behaviour.
Kaur, et al. (2001:49-56), found in their study that, time devoted by the women in care of children which included time in feeding, bathing, preparing for school and helping in home work, was up to 80 min by majority (26.84%) of the women followed by 81 to 160 min by 21.05 per cent and more than 160 min by 5.53 per cent mothers. There were 46.59 per cent respondents who were not involved in care of children. In 15 per cent of the households males were involved in looking after the children.

(h) Toilet Training

Majority of the mothers (34.66%) of Jorhat town of Assam started training their children to control bladder at the age of 6 months to 12 months. Age for initiating bowel training too, by majority of the mothers was 6-12 months (Phukan and Goswami, 1985:43-49).

Mao and Maisnam (1994:87-89), in their study in Ghari village of Manipur found that, they give toilet and bowel training to their children by showing the right places for toileting and defecation. Among them 80 per cent scolded their children and 20 per cent had beat while training.

Study carried out by Dave, et al. (1984:11-14), on child-care practices of Gujarat showed that there was no particular age of toilet training of children by the mothers.
Study conducted by NIPCCD (1998:75-76) among four tribal communities of north-eastern region, namely-the Lalung, Rabha, Mao and the Kabui, showed that almost all the respondents (298) stated of having trained their children on bladder control. Majority (73.0%) of them mentioned of training their children between 1-2 years of age. In addition to bladder training, 73 per cent mothers stated of initiating bowel training after completion of 1 ½ year.

Study among the Sonowal Kacharis of Assam shows that majority of the children learnt toilet training between the ages of 1-2½ years. It was noted that a large proportion of families in which both husband and wife or only wife was illiterate or slightly educated, did not give any emphasis in bladder and bowel control to their children. Children in most of the houses had to use gutter or open space for defecation till the age of 6 to 7 years, though those houses possess a kutcha latrine. A curry of patimutura (a kind of fish) fish is believed to be effective to control bladder if the child is fed who continued to wet bed even after 5 years. However, now a days they prefer to avail medical treatment in those cases. Use of rubber or oilcloth is also reported under the linen of the child, use of which was not in the past (Barua and Bora, 1999:339).
(i) Disciplinary Measures, etc.

Various studies revealed that lower class people prefer more authoritarian discipline than other classes (Travers, 1977:344).

Study conducted in Jorhat town of Assam showed that, 60 per cent of mothers punished their children for doing wrong things. Suggestion was the main mode for majority of the mothers (62.66%) in making their children to follow instruction. Most of the mothers (95.0%) found encouraging their children for achieving something (Phukan and Goswami, 1985:43-47).

Mao and Maisnam (1994:87-89), in their study, in Ghari village of Manipur observed that, 84 per cent of the respondents train their children when they show their aggressive behaviour by not bothering them. Corporal punishment is also given like beating (54.0%), scolding (26.0%) and spanking (20.0%). Child's reaction to corporal punishment is that 26 per cent cries, 22 per cent do not cry and 16 per cent keep silent.

Follow-up tests of studies carried out by Holden, et al. (cited in RCC Research Bulletin, NIPCCD, 2000:15), indicated that, frequently spanked kids engaged in more frequent misbehaviour than kids of the never spank group.
(j) Play

Jyothi and Sheela (1993:105-108), showed in their study conducted in selected villages of Devanahalli Taluk, Bangalore, that, time spent for child care by the mothers of non working group was maximum (240 min per day) than the partially working group (180 min per day) and working group (100 min per day).

Children of Ghari village of Manipur usually play group games. Most common game played is hide-and-seek (Mao and Manisnam, 1994:87-89)

Plastic teething rings and other soft chewy toys could be slowly injecting poisonous chemicals into infants. An investigation by an environment NGO, Green peace, into soft toys reported that, a total of 71 toys from 71 countries were purchased and analyzed, including five from India. Two of the toys purchased from India contained 11.4 and 13.9 per cent diethylhexyles phthalate. This was amongst the highest and found in the 71 toys sampled (Singh, 1999:13).

METHODODOLOGY

The study is exploratory in nature. It aims at understanding the child bearing and rearing practices in three chosen tribal communities. As mentioned earlier, out of nine plain tribes, the Deori is one of the important plain tribes and hence covered under the study. Out of 14 hill tribes, the Garos and Karbis in Assam covered a major population and therefore, selected for the study.
Fig: 1.1 Map showing north-eastern region in India

Scale = 1:30,000,000
Fig. 1.2 Map showing the concentration of tribes in different districts of Assam.
Fig. 1.3 Map showing the location of blocks where field work was conducted.
Moreover, the Garos are encompassed for the study to explore the child rearing practices among a matrilineal tribe of northeastern India. Besides, studies relating to child rearing of these three tribes are very few and therefore, covered under this study. Fig. 1.1 shows the North Eastern part of India.

(a) Study Area

The data was collected from 8 developmental blocks located in 6 districts of Assam. These are Dhekargarah, Dimow, Kakapathar, Boko, Balijana, Krisnai, Manja and Lumbajan. Blocks Dhekargarah, Dimow and Kakapathar of the districts of Jorhat, Sivasagar and Tinsukia respectively were visited to reach the Deori population for the study. For the sample of the Garo, Boko block of Kamrup district and Balijana and Krisnai blocks of Goalpara district were visited. Karbi Anglong is an autonomous district dominated mostly by the Karbis and therefore, two blocks namely Manja and Lumbajan were visited. The concentration of the chosen tribes may be seen in fig. 1.2 and the blocks visited by the researcher are given at fig. 1.3. In all, the researcher visited 18 villages of 8 developmental blocks to gather the information. The list of the villages can be seen in table 1.1.
Table 1.1  
Location of the villages

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>District</th>
<th>Block</th>
<th>Village</th>
<th>Inhabitant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Jorhat</td>
<td>Dhekargarah</td>
<td>i. Uppar Deori</td>
<td>Deori</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ii. Nam Deori</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Sivasagar</td>
<td>Dimow</td>
<td>i. Samaguri</td>
<td>Deori</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ii. Katiari</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Tinsukia</td>
<td>Kakapather</td>
<td>Sonapur</td>
<td>Deori</td>
</tr>
<tr>
<td>4</td>
<td>Kamrup</td>
<td>Boko</td>
<td>i. Dhanhati</td>
<td>Garo</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>ii. Gohalkana</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>iii. Lankana</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Goalpara</td>
<td>Balijana</td>
<td>i. Bhandra</td>
<td>Garo</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ii. Dalek</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>iii. Haldibari</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Krisnai Foffonga Garopara</td>
<td>Garo</td>
</tr>
<tr>
<td>6</td>
<td>Karbi Angong</td>
<td>Manja</td>
<td>i. Onbey</td>
<td>Karbi</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ii. Sanmari Ronkimi</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>iii. Srikangnep</td>
<td>Karbi</td>
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<td></td>
<td></td>
<td></td>
<td>iv. Rongsingba</td>
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<tr>
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<td></td>
<td>v. Sonarsing Teron</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Lumbajan Sing Tisso</td>
<td>Karbi</td>
</tr>
</tbody>
</table>

All these villages were selected seeing their inhabitants by one tribe and homogeneity in nature in relation to traditional cultural elements and also for easy accessibility for fieldwork.
(b) Sample of the Study

The sample of the present study comprised of 300 families of the Deoris, Garos and the Karbis. A total of 100 families from each tribe were covered for data collection. Since the topic of research study is a vast one, it was decided to concentrate on the child rearing practices only to 100 families of each tribe having at least one child aged below 4 years. Moreover it was also thought that a systematic study of 100 families would be able to represent the tribe reasonably well. Total 100 mothers from each tribe having children below 4 years were drawn as the main respondents to gather information required for the study. The reason behind selecting these mothers was to collect accurate information for the study rather than a vague and generalised ones. It was thought that, mothers would find it difficult to recall various aspects of child rearing if their children are older than 4 years. In addition to collecting information from the mothers, some other experienced and knowledgeable persons were also contacted by the researcher to collect information about beliefs, customs, practices, etc. related to child bearing and rearing of the particular tribal communities. The sample also comprised all the children (below 4 years) of these 300 mothers for assessment of health and nutritional status to see the impact of child rearing practices on health status of the children.
(c) Sampling Procedure

The villages concentrated by the respective tribe were selected purposively according to the convenience and feasibility of the researcher. To reach the respondents in those villages, first of all it was decided to select the sample using a random number table. But, while performing fieldwork extreme difficulty was experienced for which the idea of this sampling had to be dropped out. The size of the population and the total number of households of all the villages were very varied in nature. Total number of households in these villages ranges from 16-330. Among all the three tribes the Karbi villages are very small in size in comparison to other two tribes. In addition to this, all the families did not have children below 4 years of age. Moreover, many mothers, eligible for the study were not in their houses for long period everyday because of their engagement in agricultural activities, fishing, collecting firewood, etc.; further some mothers who could not give accurate information because of shyness and uncomfortable to talk when they were alone at home and showed reluctance to reply, those mothers had to be eliminated from the study. Therefore, whoever were found available and giving correct answers, all of them were incorporated and hence the sample selected for the study was more or less a purposively selected sample.

The data was collected during 1997-2000 with some gap periods in between, specially in rainy seasons. First of all, any village leader or elder was approached, by letting him/her understand the purpose of the researcher's visit
and also collected the primary information about the village from him/her. Most of the village leaders also extended help to the researcher by deputing a person to facilitate the fieldwork mainly to identify the households, building rapport with the family members and interpreting the conversation when there was a language problem. On an average 2-3 hours time was devoted to each family to gather information. In most of the cases the data was collected in one sitting. However, in some cases more than one visit had to make since the mother could not sit for a longer duration at a stretch due to her household works and also to observe the awakened child, who was sleeping at first visit, and the interaction between mother and child. The time in between was utilized either by conversing with the family members to gather information or by visiting other families if nearby. Furthermore, conversations with other family members specially the husbands of the respondents were quite beneficial as the researcher could obtain much valuable information from them. This type of conversation was more useful in those cases, where the mothers were found to be hesitated to talk. Time allocation to those cases was little more since extra time had to give for rapport building and creating a homely environment so that they feel free and do not hesitate to give correct information.

Therefore, though previously it was intended to interview only the mothers, but later on in few cases help had to sought from the other family members too. In few cases the respondents were met in their work places mainly in agricultural fields and information were collected. Later on, after their
returning home second visit was made to collect information through observation.

(d) Research Tools and Techniques

The investigator selected interview as the technique for securing information from the mothers. This method was adopted because of its conveniences to develop better understanding through face-to-face contact with the respondents to get first hand and accurate information. In addition, it also has the other advantages as it provides scope for clearing doubts or seeking for explanation, enables to develop faith and confidence on the researcher, etc. Besides, the researcher can also observe the current happenings, which is a simple but very powerful technique to supplement many valuable information for the study.

(i) Interview Schedule

An interview schedule was used as the main tool, which was planned and prepared with care after referring to related studies (Appendix-I). The interview schedule consisted mainly of three parts: (1) general background (2) marriage and family, and (3) child rearing practices.

Information in regards of family background, income, educational status, house, etc. is collected under he general background to get a general idea of the
sample. Under the marriage and family head, data related to mother's previous history of child bearing and rearing practices and prohibitions in relation to pregnancy, etc. are incorporated. The third part of the schedule includes care of the newborn, rites and ceremonies performed for the child, feeding and weaning practices, disease and treatment, socialization, toilet training, bathing, disciplinary measures, play and recreation, etc.

(ii) Observation Checklist

Using an observation checklist data were collected in various aspects (Appendix-II). This included information items relating to health and nutritional status, personal and environmental hygiene, mother-child interaction, any disease/ailment that the children were suffering, feeding, play activities and materials, etc. The intention behind collecting data on nutritional status was to relate with the data obtain through the interview schedule on child rearing practices. All these observations were carried out in the natural setting to which the children belonged to.

(iii) Village Data Schedule

Another schedule was applied to collect the information of the village (Appendix-III). This schedule comprised the queries on road condition, mode of transport and distance to block Hqs., total population, information relating to
agriculture, educational institutions, medical facilities, source of drinking water, voluntary organization of the village, etc.

All the schedules were pre-tested in the field by interviewing 6 respondents and later necessary modifications were made according to the experience gained.

(iv) Case Study

A number of case studies were taken in regard of various aspects of child rearing, in order to acquire more clear ideas and knowledge, which would contribute in understanding the actual situations of those aspects in the tribal areas of the study. However, due to some personal reasons, the real names of the persons are not mentioned, instead, a pseudo-name is used in all the case studies.

(e) Difficulties Faced in Data Collection

As a whole, the investigator enriched her with very valuable experiences through visiting various villages and interviewing mothers of the scheduled tribes during fieldwork. By and large people in all the study areas were found co-operative and helpful. As mentioned elsewhere, the extent of help of the village leaders would be worth mentioning for which the investigator could overcome many field problems to a great extent. However, quite a few people,
especially the family members of the respondents were found more interested in knowing if they would get any benefit from government side. Hence, many of them had the intention not to give correct information regarding their agricultural land and production, livestock, monthly income, etc., hoping to get any help or benefit from government. Another problem was faced in some cases was language problem. This problem was faced more or less in every village of all the tribes. However, this communication barrier could be overcome to a great extent through the help of the assistance received by the local leader, teacher, Anganwadi Worker and anybody from the village who know both the languages. Difficulty was also faced in assessment of age of the children, as many of the mothers were unable to tell the exact date of birth, which is an essential element to assess nutritional status of the children. In this case also the researcher had to be dependent on many indirect methods to ascertain age. The questionnaire being a long one, in some cases respondents felt a bit annoyed in sitting for a long time for answering.

(f) Data Processing and Analysis

A codebook was prepared first for systematic arrangement of the collected data. Major portions of the responses were pre-coded in the interview schedule. In other cases additional codes were used on the basis of the responses received. After transmitting the data into code sheets, frequency tables were prepared. Simple statistical techniques such as finding out
percentages, averages, etc. have been used to make the data easily understandable.

(g) **Presentation of Data**

The report has been divided into various chapters, keeping in view the sequences. These chapters are mainly – introduction, ethnographic profile of the tribes, the settings, reproductive health of the mother, care of the mother, care of the newborn, feeding and weaning practices, health care of the young children, socialisation; and conclusion. Maps, statistical tables and diagrams, photographs, etc. have also been used in each chapter wherever felt necessary.

(h) **Limitations of the Study**

(1) It was not possible to make an intensive study by covering sample from all the geographical locations of the state due to limited resources and time.

(2) Being a single investigator it was difficult to increase the sample size and thus had to confine to 100 families of each tribe.

(3) Only those mothers with children below 4 years were included for the study, because of which problem was faced in getting sample easily.
(4) Mostly, only the mother-child interaction could be observed because most of the fathers either were not available at the time of interview or could not stay for long time to observe father-child interaction for their engagement in other work.

(5) Unnecessary questions of the people had to be clarified to motivate them and therefore time consumption was more in those cases.

(6) Ages of family members are assumed approximately. In case of children, where mothers could not tell the exact date of birth, only the month and year of birth could be calculated.