CHAPTER II

THE BACKDROP

Introduction

It is a universal fact and an unquestionable one that the child's first and foremost contact is with his family, therefore, it goes without mentioning that the child care practices would be the major causative factor in the healthy development of children. Thus working with parents or care-takers of tribal children was the principle target in our approach. One of the major goals of the project was to increase the knowledge of tribal parents regarding better practices in the health, nutrition and other areas, and an awareness and initiative to utilize available community services.

The responsibility of educating the tribal parents can be entrusted with a balsevika or health functionary who directly come in contact with children and the parents. Their job responsibilities emphasise the health and nutrition education.

In the tribal setting, the preschool teacher's role is fulfilled by a balsevika, who is responsible not only for providing the basic education to the children, but also for a variety of other duties like organisation of supplementary nutrition to target groups (infants, preschoolers, pregnant and lactating mothers), imparting education to parents on health, nutrition and child care, and assisting the PHC staff in the implementation of the health component; eliciting community support and participating in the balwadi programme. Another important objectives of the project was to conduct an

in-service training programme for the balsevikas to equip them to perform their role more effectively and to utilise available resources to make the preschool experience more meaningful for the tribal children and their parents.

Since the health functionaries are a direct link between the agency and the beneficiaries their attitudes towards the people and the skills in communication become crucial. Also crucial is the aspect that their responsibilities stretch beyond the administrative, and organizational backdrop. The major commitments on part of health functionaries are not only to advocate better practices - hygiene, sanitation, immunization, epidemic control, methods of prevention of diseases, possible treatment, family planning etc. and to advocate them effectively. But also to educate parents in health related areas.

Keeping in view, these three important target groups responsible for the well being of the child, the Department of Child Development undertook a project entitled "Utilisation of health and welfare services in Panchmahals with special reference to infants and preschoolers". The following objectives were set for the total project.

Broad Objectives

1. To suggest strategies for maximum utilisation of programmes and services for children by the Government and voluntary agencies in the Panchmahals, a tribal district of Gujarat.

2. To conduct educational programmes for the tribal parents, balsevikas and health functionaries with the focus on the welfare of the young child.

Specific Objectives

1. To study the background of the village with specific reference to religious, political, family, education and economic system.
2. To assess the nutritional status and study child care practices of the children below the age of five years.
3. To conduct an educational programme for and with care-takers of young children to clarify their own role and the role of health and welfare services in well being of a young child.
4. To find out the existing conditions of balwadis with special reference to the programme and role of balsevikas therein.
5. To conduct an in-service training programme for better functioning of the balwadis.
6. To find out the knowledge content of the health functionaries in the areas of the health, nutrition and family planning as well as explore the strategies adopted by them in performing their duties.
7. To conduct an in-service training programme for the field level health functionaries and their supervisors for better functioning of the services.

The plan for the total project in three major phases is presented in a chart 1.

CHART I

Utilization of Health and Welfare Services in Panchmahals with Special Reference to Infants and Preschoolers

Phase I : Exploration

Phase II : Analysis and Planning

Phase III : Educational Programmes and Suggestions for concerned Agencies

Phase I : Exploration

(A) Background Information and Child Care Practices

i. Socio-economic, Religious and Political background of tribals of Panchmahals.

ii. Practices related to health, nutrition and family planning.

iii. Child care and role of care takers.

iv. Health services and role of health functionaries perceived by parents.

(B) Services and Inputs

i. Status of Health, Nutrition and Education Services and role of functionaties therein.

ii. Supervision and coordination.

iii. Problems of health functionaries.

iv. Tribal situation as perceived by health functionaries.

Phase II : Analysis and Planning

The data collected during the Phase I period were analysed and educational programmes were planned for parents, balsevikas and health functionaries.

Phase III : Educational Programmes and Suggestions for Concerned Agencies

(A) Parent Education

i. Implementing and evaluating parent education programmes in small and large groups on specific topics related to health, nutrition, education and economic aspects, play and recreation and responsible parenthood (family welfare).

ii. Suggestions for balsevikas and health functionaries in terms of contents, methods and use of A.V.aids while educating parents.

(B) In-Service Training Programmes for Balsevikas and Health Functionaries

i. Implementing and evaluating the in-service training programmes for balsevikas and health functionaries in separate groups with specific emphasis on areas related to their work.

ii. Job chart, classifications, skills and competencies required, supervision and coordination were emphasised for both the groups.

iii. Suggestions for trainers and administrators for better utilization of services.

Phase I : Exploration
Phase II : Analysis and planning
Phase III : Educational programmes and suggestions for concerned agencies.

Except for the present project i.e. in-service training of health functionaries, the earlier phases of the project were undertaken by six M.Sc. students for their these as part fulfilment of their requirements for the M.Sc. (Chart 2). Twelve B.Sc. students collected anthropometric data and gave home-based educational programmes to parents. The present investigator guided and supervised their work, in Panchmahals, which was the locus of the study.

Selection of the Locus and Samples

Out of the total population of 34 millions in Gujarat (1981 census), 72 per cent of the population resides in the villages and tribals form about 14 per cent of the total population. They mostly inhabit all the hilly and upland tracks of the eastern region of the state, bordering from Mount Abu in the North to Dangs in the South. The central belt is comprised of the tribal talukas in Panchmahals and Baroda district.

Panchmahals covers 8919 square kms of land and is comprised of eleven talukas (Map, p.). It has 23,21,689 of total population out of which 10,57,765 belong to the schedule caste and tribe. Majority of them are Bhils. Vyas (1978) states that in the tribal heritage of India, the Bhils have had a sub-standard contribution. Though the biggest tribe of Western India, known for its rich treasure of culture, it has

CHART 2

Framework of M.Sc. Students' Dissertations as Pilot Studies for the Total Project

Title	Locus	Sample	Tools used	Name of the student	Year
1. Socio-cultural practices and beliefs of a tribal village in Gujarat	Taluka Jhalod-A cluster from village Sampoi	A total sample of 31 Bhil children with 16 males and 15 females below the age of 5 yrs. None of the children were enrolled in Balwadi or Special Nutrition programme	Interview and observation schedules included background information, beliefs and practices, services and inputs with special reference, to marriage and family pattern, religion, recreation, politics and education.	Ms.Dalaya Veena	1981
2. Practices and services related to economic aspects, health, dietary patterns and family planning in a tribal village of Gujarat	Taluka Jhalod-A cluster from village Sampoi	A total sample of 31 Bhil children with 6 males and 15 females below the age of 5 yrs. None of the children were enrolled in Balwadi or Special Nutrition Programme	Interview and observation schedules included background information, beliefs and practices, services and inputs with special reference to economic aspects, health and medicine, diet pattern and family planning.	Ms.Hakim Mushira	1981
3. Problems perceived by functionaries in	Taluka Limkheda PHCs- Limkheda Dudhia Dhanpur	21 health functionaries from primarly health center, sub-centers & dispensaries, rural family welfare & special nutritional programme were selected	A semi-structured interview schedule included background of the functionaries and agency needs, problems and characteristics of target group as perceived by the functionaries, personal and professional problems, their suggestions for better functioning of health services.	Ms.Majithia Vanita	1982
4. Audio-visual aids for tribal parent education programme with special reference to health, nutrition and family planning	16 agencies from Ahmedabad Baroda New Delhi Bhopal	The evaluation of existing aids, tool and lesson plans by 13 experts. The fueld-testing of prepared aids with groups of 10 to 20 parents.	183 existing audio-visual aids in health, nutrition and family planning were evaluated. Five audio-visual aids were prepared and field tested. For field testing base-line interview proto-type lessons, post-test evaluation criteria and observation check-list were prepared.	Ms.Kathuria Rekha	1982

Title	Locus	Sample	Tools used	Name of the student	Year
	Lucknow, Dahod, Pune. Field testing in ~~two~~ 2 villages in Limkheda				
5.Child care amongst the tribals of Panchmahals, Gujarat.	Taluka Limkheda ~~four~~ 4 villages	Twenty children below the age of five years, registered in birth records. All children were equally distributed in age and sex groups.	Interview and observation schedule covering background information, ~~background~~, feeding practices, toilet training, sleep, play and care of a sick child.	Ms.Tavkar Nivedita	1983
6.The assessment of the nutritional status of the under five year old children of Panchmahals, Gujarat.	Taluka Limkheda 15 villages	A total sample consisted of 180 children below the age of 5 yrs with equal number of sexes and registered in birth records.The subjects were further categorized into 6 different age groups 0-6 months, 7-12 months, 13-24 months, 25-36 months, 37-48 months & 49-60 months & in each of these age groups there were 30 children to be compared with reference standards.	(a) Interview check-list was incorporated which consisted of the four following areas: 1) Socio-economic aspects. 2) Child health. 3) Family composition and family planning practices. 4) Diet pattern. (b) For anthropometric measurements flexible steel tape, beam balance, scale and bathroom scale were used.	Ms.Divakaran Meena	1983

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MAP OF PANCHMAHALS

MAP OF LIMKHEDA

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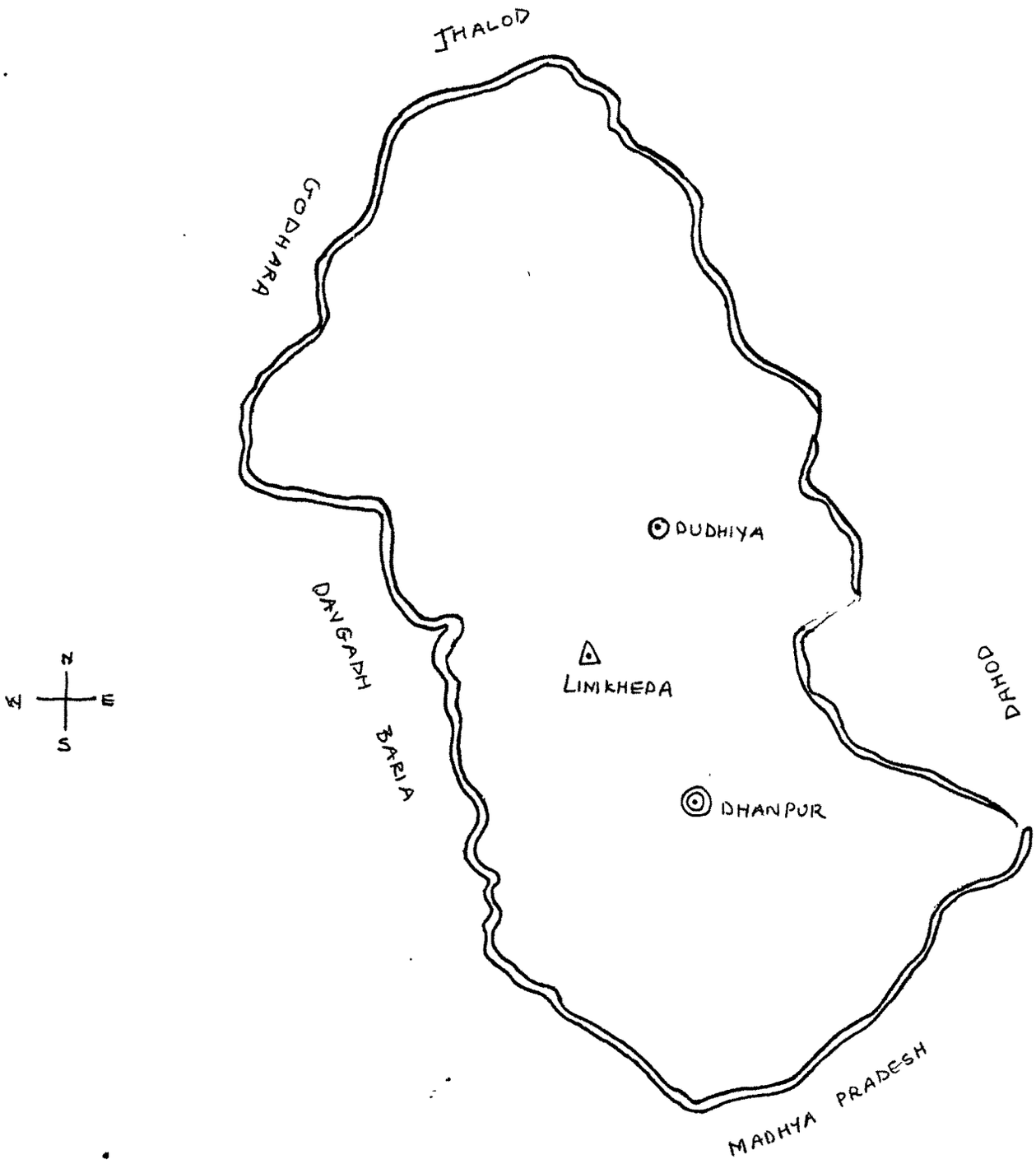
LIMKHEDA TALUKA.



TALUKA's CENTRE — LIMKHEDA
TOTAL NO. OF. VILLAGES — 242.
TOTAL AREA — 1064 Sq. K.M.
TOTAL POPULATION — 211470.

I PHCs
1. Limkheda.
2. Dudhiya.
3. Dhanpur.
II Anganwadis — 50.

all throughout remained very sporadically explored and this invites more investigation.

Amongst the total population of men, 74.04 per cent are farmers and 7.76 per cent are farm labourers. The total literacy is 28.14 per cent, out of which 40.80 per cent are men and 14.92 per cent are women (Census, 1981).

It was decided to undertake the project in this area because Panchmahals have very large tribal population, it is sporadically explored, the health and welfare services are very much underutilised (data presented later), it was suggested by Government officials and it was only about 150-200 kms to reach from Baroda.

Initially, on the suggestion of the Secretary of Tribal Development of Government of Gujarat, Jhalod taluka of Panchmahals was selected as the locus of the study. After visiting five villages, Sampoi was chosen because it seemed less urbanised. Other more interior and less accessible villages could have been selected but for the problems of lodging and conveyance.

During the course of this initial survey, it came to light that Limkheda taluka was the most deprived and underpriveledged (as per survey of 1978) and therefore strongly recommended by the Project Administrator, Dahod (Map, p.). Limkheda encompasses 1064 square kms and supports a population of 211470 scattered among 242 villages. It is a hilly region and there are great distances from village to village and house to house. About 60 per cent of its population is

tribal. It has the lowest percentage of literacy (i.e..7.2 per cent) compared to all other talukas. It has no urban population. There are no cinema houses or theatres. There is only one full fledged post cum telegraph office.

There is one Government hospital, three primary health centres and three family planning centres. There are 48 beds which were occupied by 118 patients during the year 1981, out of whom there were 13 men, 56 women and 49 children. The out patients during the same year were 20080 out of whom 7288 were men, 6382 were women and 6610 were children. This is hardly 10 per cent of the total population of Limkheda. There are twelve doctors and twenty-three nurses. The statistics clearly indicate the need to find out the reasons for underutilization of health services.

From the interviews and visits to PHC's and Talati's office it was found that not all children's births were registered. The death records were also incomplete. This is also evident from the 1981 census. Limkheda is one of two talukas of Panchmahals where the birth and death records are not available. Since it was decided to ascertain the age of children below five years, it was very difficult to get the sample. Another problem was the names recorded in the register were different than the way the child was known. Sometimes even parents did not know this difference because a relative had gone and got the child registered. e.g. 'Somli' was recorded as 'Sumitra'.

A total of 548 children below the age of five years

from 23 villages formed the sample for the anthropometric survey, and total of 65 children for the clinical and bio-chemical survey.

Background information regarding occupation, education, food availability, diet pattern, pregnancy and child birth and family planning were collected by interviewing parents of these 548 children. Besides, 20 children were observed from four villages to find out more details of child care practices.

The information presented hereafter is obtained from the following sources:

i. Observations of children and their caretakers.

ii. Interview of beneficiaries and functionaries.

II. Socio Cultural Background

Until a given population is understood in its socio-cultural context, one may not be able to plan educational programmes realistically. To understand the socio-cultural background of the tribals, many factors such as socio-economic aspects, religion, recreation and marriage and family pattern have to be considered.

1. Socio-Economic Aspects

Most of the tribals are farmers or work as farm labourers. Occassionally they migrate to the cities to supplement their meagre and unsteady income from the land. Labour provides them with the daily wages of Rs.8 to Rs.10. About 54 per cent of the sample earned less than Rs.50 per month. The per capita land holdings were less than two Beeghas for 63 per cent of the sample. Besides land, cattle is also considered to be an

asset. Unfortunately very few own enough cattle to consume milk at home. Most of them sell the milk to the dairy and try to earn some money.

Per Capita Income per Month

Rupees per person	%
Less than 25	34.30
26-50	20.25
51-75	6.56
76-100	5.29
101 and above	6.38
No response	27.28

Per Capita Land Holdings

Beeghas	%
Less than 1	45.98
1.1 - 2	17.70
2.1 - 3	6.56
3.1 - 4	3.46
4.1 - 5	0.18
5.1 and above	1.49
No response	24.63

Maximum expenditure is on food, followed by intoxicants and clothes. Indebtedness is almost a way of life with debts incurred on farming and marriage contracts. The local money lender reigns supreme and is preferred over the cooperative banks.

2. Religion

The Bhils of Panchmahals believe in 'Animism' i.e. they pray to natural objects like trees, stones, rivers etc., and believe in animal sacrifice to please their Gods and Godesses. They also raise 'totems' in the name of the deceased and worship

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these too. They offer prayers occassionally on religious festivals, after a desire has been fulfilled or a patient gets cured. This is done once in a while through offering a fowl, goat or buffalo with a pot of liquor (Mahuda). Preparing a death memorial is a part of their worship.

Alongside religious beliefs and practices are their superstitions. There is a superstition attached to almost every day life happening e.g. braying is a sign of good luck, whereas a dog howling is associated with death or any casuality.

As a guard against witches, sorcerers, and magicians, the Bhils have witch-finders. They are said to be in possession of supernatural powers. With this they help in curing diseases and other human sufferings caused by malevalent spirit intrusion. Such experts are differently known as Bhopa, Balwa, Bhuva and Bhagat. A Bhagat, need not act only as a witch-finder, but he is also the village medicine man. He does a lot of faith curing and establish considerable faith in the villagers. Even if he fails in his efforts, their beliefs are not Shaken. e.g. In one of the clusters of Sampoi village, there was not a single child below the age of five years whereas in the rest of the village it was rare to find a house without one. On inquiry, it was found that all the children had died of small-pox a few years back. On further inquiry, on role of the Bhagat (who was highly respected for his ability to cure patients, and claimed to get patients from Bombay etc.), during this epidemic, the reaction was "people of this cluster must have done some sin which

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cannot be forgiven and therefore the Bhagat's medicine did not work".

Such beliefs and practices have a direct influence on the health of the people. Whenever someone falls ill, he/she is first taken to the Bhagat. Only when the situation worsens, one ~~he~~ may be taken to an ANM or a doctor.

3. Recreation

The tribals are basically hard working people. Agriculture is their main occupation. As a result their entire life style rotates around climatic seasons, and the success and failure of crops. Majority of the men are engaged in ploughing, irrigating or harvesting. Women's duties include tending the cattle, fetching water from wells, bringing wood for fuel, cooking and cleaning, taking care of children and helping on the farms. In a day of 24 hours, she spends 16 hours in doing all these chores and rests for 6 hours which leaves her with approximately two "so called" leisure hours".

Recreation in the daily routine includes music and dancing almost every evening. Besides this men consume liquor regularly whereas women and children consume only occassionally. Women are found to chat and sleep in the afternoons in the periods when their help on the farm is not required. Celebrations of festivals especially Holi and Diwali and occassions such as elaborate engagement and wedding ceremonies are the main sources of recreation.

Their recreational pattern is group oriented. Groups are formed on the basis of marital status, sex and age. Children

between the age of 6-12 years spend their leisure hours in games like 'kabbadi', 'hide and seek', 'gilli-danda'. These are played by the boys, whereas the girls play 'hopscoth' tagging a younger sibling around. The children between 3-6 years usually follow their elder siblings wherever they go and when the elder sibling is involved in play the younger one is left by himself. Children under the age of 2 years are usually with their mothers. They are given a broken article or a piece of wood etc. to play with. Older children sing songs which are humurous or sarcastic. On the whole Bhils are fun-loving and enjoy being in a group.

4. Marriage and Family Pattern

The Bhils consider marriage essential for the community and recognize the importance and desirability of it. It is considered a contrast by them. It gives rise to certain patterns of selecting mates which is still followed when the boy and girls are in their early adolescence. Their rituals related to engagement and wedding ceremonies are rather elaborate and continue for three to five days. They also serve as major events for celebrations and recreation.

As marriage is considered a contract between two families, bride-price in cash or kind is paid. In case of divorce, it is returned to the boy's party. Remarriage is possible for the women and men. The children born from earlier marriage are considered man's responsibility.

The basic co-residential group is the elementary family comprising of husband, his wife/wives and their unmarried

A TRIBAL HUT

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children. Since they form a single economic unit there are usually no rivalries among them. A feeling of solidarity and a sense of 'belongingness' exist among the members.

III. Environmental Conditions

Housing

Majority of the houses are made from mud with two or three compartments or rooms. The cattle which is considered as the wealth of tribals, is kept inside the house. There is a big room in which a corner is used as a kitchen and the other portion is to keep the cattle. Flies and mosquitoes were observed in many instances.

Household articles include mainly mud or brass utensils. Furniture consists solely of cots which are made of wooden frames filled with woven rope. They have about three to four such cots. Only a few have a wooden cupboard. The cooking is done on a mud 'chulla' with wood as the fuel. The mattresses are hand-made from old clothes.

They store extra grains in huge mud drums. Besides, they have a grinding stone, a bucket, a lantern, and one or two musical instruments. In exceptional cases, a family may possess a clock, a transistor radio or a cycle.

Water Supply

Since wells are the only source of water, and as the whole region is hilly, there is an acute problems of water which takes a particularly ugly shape from April to June, when nearly all the wells run dry. The tribals are forced to drink the muddy water of the wells or dirty stagnant water of some pools or ditches. Take for e.g. Sampoi comprising of an area of 1448 acres, it has only 175 acres of irrigated land. Water supply facilities consist of two Government wells, of which one is dry. The other is situated at one end of the village. There

are several kucha wells, but no pump wells. It takes a long time for the women to fetch water and demands more than three-four trips to and fro. Washing of clothes and bathing is usually done near the wells.

The persons responsible for the purification of water are the Community Health Worker and the Multi-purpose Health Worker. This includes chlorination twice a month in summer and once a month in winter and monsoon in theory but not in practice. This is only done for Government wells. If purification is required for a private wells, an application must go through the Sarpanch and Talati of the village, with the result that due to high percentage of illiteracy and botheration of formalities, private wells are never purified.

Water samples from the wells near the balwadi, school and dispensary of three different villages namely Motibandibar, Dhadhela, and Dudhiadhara were analysed at the Vaccine Institute of Baroda. Their reports indicated that all the water samples had more than 1800 coliform bacteria at which level is causes intestinal infection. As the water was collected from wells near a balwadi, school and a dispensory, one can imagine the plight of the young children who along with the poor diet intake have to consume such unhygienic water.

IV. Health, Nutrition and Family Planning

Personal Cleanliness of Young Children

It is observed that while breast feeding, the mother's breasts are not particularly dirty but they wear unwashed blouses, the child's mouth is covered with dirt and flies

surround the area of which the mother takes no notice. When older children start eating by themselves they do not wash their hands before eating. The following observations are indicative of the neglect of basic hygienic habits among the tribals.

1. The mother was sweeping the floor where the children were sitting and eating their meal.
2. A dog was eating from a child's plate and the mother shouted at the child to drive the dog away. The child did so and continued eating.
3. Children had running noses with flies surrounding and they continued eating.
4. Children picked up food particles from the floor and ate.
5. Mother picked up a stick and used it as a spoon to cool the semi liquid food item.

Contrary to this, however the brass vessels used for cooking and serving were spic and span. They were cleaned with ashes of wood and then left in the sun to dry.

Tribal mothers appears to believe that the child will take care of cleaning himself once he acquires full bladder and bowel control. Although the mothers are not aware of the older children cleaning themselves, the younger children would generally ask to get cleaned and the mothers would help them.

All the children irrespective of their age and sex, once they could move on their own, used one corner in the house for urinating. As the floor is smeared with cow-dung, it absorbs the water quickly, but pollution of air cannot be escaped.

Children are also seen defecating either in front of the house, fields or streets. The soiled clothes of the infants were removed when the mother was free from whatever task she was performing and were hung on the rope nearby. The mother/grandmother did not clean the place if it was the field but if it was within or in front of the house, mud was spread on the place after she picked up the faeces with a spade and threw it in the fields which is adjacent to the house. Garbage too is disposed off in front of the house or in the fields. Flies are constantly present around the child's surroundings, cattle are also tied near the child's sleeping place. In many instances, the family shares their sleeping quarters with the cattle. The mothers used water from pots to clean the child. No cleansing agents, such as ash or mud were used to wash the hands after cleaning the child.

The children look unkempt all the time, with a lot of dust on them because they play with mud outside the house. Nasal discharge is a common sight, as are the flies hovering around. Nevertheless, most of the mothers bathe the children everyday. Bathing, however, means pouring of water over the child's body and scrubbing with hands. Children are made to stand in the sun to dry themselves, and the same dirty clothes are worn after the bath.

Feeding Practices and Nutritional Status

Majority of the mothers start breast feeding after the third day of birth, till then the children were given goat's milk. There are two beliefs prevalent in this connection.

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A few people believed that mother's milk is unhygienic for the first few days but many of them believed that goat's milk make the children 'intelligent'.

The duration of breast feeding range from 1-8 minutes. It was observed that the frequency of breast feeding is higher in case of short duration of feeding at a time.

In most of the cases the child is weaned from the breast around one and half to two years of ages. The reasons given for beginning weaning, were such as, when the child is able to eat solids, when mother can no longer feed, when next child comes. The supplementary food like khichdi or thuli and sometimes milk are given. In about one third of the responses it was evident that they are given directly solid food such as Rotla after the teeth are errupted. Not a single mother was aware of the need to supplement breast milk as early as four to six months of age.

A steady increase in the percentage of malnourished children with advancement in age is seen. From the total sample of 548 children (296 males and 252 females), 78.08 per cent (out of which 74.16 per cent males and 82.00 per cent of females) children were malnourished. However, no apparent differences were found in feeding male and female children.

All the families who were surveyed, indicated maize as the staple food in their diet. The tribals consume maize in the form of 'rotla' or 'thuli' (gruel). This is infrequently supplemented by dal or a vegetable or onions and chillis. No special diet is followed during pregnancy or lactation. In

some villages, the diet is even reduced during pregnancy. They believe that less food during pregnancy will prevent indigestion and help in easy delivery. Extreme poverty compelsethe adults to sleep without consuming any food at least, a few days during the year.

The observations which were made during different seasons of the year, revealed that the seasonal fruits such as guava, bor, sitaphal and mango were consumed freely by the children whenever they were available.

Illness and Disease

The common childhood illnesses in Panchmahals are diarrhoea, eye infection and scabies. About 40 per cent of the deaths reported by parents are because of diarrhoea. None of the parents knew about oral rehydration therapy.

Besides diarrhoea as the major reasons for child mortality fever was reported the next. Miscarriages, still births and premature births were also reported. In about 50 per cent of the child deaths, the reasons were not known.

Common cold and cough were also noticed. As mentioned earlier, PCM is present in 78.08 per cent of children but unfortunately is not perceived as a health problem.

Clinical examination of 65 children indicated that prevalence of iron deficiency in about 65 per cent of children whereas the haemoglobin analysis showed iron deficiency in 100 per cent of these 65 children.

Children when sick, were initially treated at home. If they did not recover in a few days they were taken to a Bhagat. If they were not cured even then, in some instances they were

taken to an ANM or a doctor.

A sick child is a worry to the parents, yet no special care is taken in terms of feeding, clothing and sleeping. Preventive aspect of health is neglected and he grows up without the safeguard of immunization in most of the cases. It was surprising that approximately 600 homes were visited and except for 4 cases of pilio, no other disability or handicap was noticed in children.

Child Birth and Family Planning

The number of children each couple had, ranged from one to twelve children. About 60 per cent of the couples had three or less number of children but most of the couples were still in the reproductive stage.

The average pregnancies of 548 mothers as indicated are 4.48. This figure coincides with the national fertility rate for Indian women estimated at 4.6 (1978).

Table 1. Number of Pregnancies and Child Birth.

Category	Frequency	Average number per mother
Pregnancies	2459	4.48
Miscarriages	37	-
Live births	2422	4.41
Deaths during infancy	173	-
Alive children	2249	4.10

Table 1 indicates number of pregnancies and child births as reported by 548 mothers.

Ninety four per cent of mothers had got their child delivered with the assistance of a local mid-wife (Dai). The ANM was called in the case of complication, such as delayed delivery

or having twins, but the local mid-wife also was present. Only two mothers reported going to the PHC for the delivery because they were having severe labour pains and the child birth was delayed. There were two deliveries assisted by the men of the families.

When asked for their preference for the size of the family, 86 per cent of the mothers showed preference for a large family and only 14 per cent showed preference for a small family.

The Table 2 presented indicate the reasons for their preference for a large or small family.

Table 2. Preference for Large Families.

No.	Reasons
1.	Only a few will survive.
2.	More children, more hands to work on the farm.
3.	More earning.
4.	Desire to have a son.
5.	For social status.
6.	Children are God's gift.
7.	For security in old age.

Table 3. Preference fof Small Families.

No.	Reasons
1.	Can feed the children better.
2.	Land does not get fragmented.
3.	Better care and facilities for children.
4.	Food and money is a problem.
5.	Can provide education to them.
6.	Overall progress of the family.

Whilst family planning as an idea was known to the people here, its acceptance was low. Three major factors at work here seem to be the belief in large families, the desire for sons and the fear of operation. Abortion as a proposition was condemed by the villagers who felt it was unthinkable. Spacing of children was deemed necessary for the health of the mother but not put into practice, 1-2 years being the usual difference between children. The misconception that family planning means merely operations for sterility was prevalent here.

Parents are aware about other methods of family planning but the use seems very limited. In Sampoi village, children were observed playing with condoms.

As such the subject of family planning has a strong taboo value and is not discussed.

V. Services and Inputs

It is necessary to know the efforts which Government and voluntary agencies have made for the welfare of young children and what is the response of parents. It is also important to find out how the functionaries perceive the tribal situation and what are the working conditions in which they have to function. Government and voluntary services and inputs are presented herewith.

Government Efforts

The major programmes concerning children were Balwadis and Primary Health Care. As it was already found that these remain underutilised, an attempt is made to present some reasons as

put forward by parents and functionaries.

Parents Views and Experiences

In Sampoi village, the cluster which was selected as the locus of the study was about $2\frac{1}{2}$ kms from Balwadi and about 3 kms from SNP centre. As a result, none of the children availed of these services.

In case of Balsevika, there existed a role confusion. She was expected to bring the children from each house to balwadi, give them bath, cut their nails, comb their hair etc. besides giving the regular programme.

Regarding the distance of SNP centre, a parent pointed out "The child has to walk 6 kms to and from to get very little food which he will digest in no time". What he meant was that energy output will be far more than energy input.

Some parents in other villages complained that balsevika or SNP Sanchalika consumes the ingredients for her own family instead of using them for children.

Regarding the primary health centre, it was found that on either side of Sampoi at about 6 kms there was a PHC, namely in Jhalod and Limdi, still, by the geographical division of villages, Sampoi was under Pethapur PHC which was at a distance of 22 kms. Parents indicated their inability to go so far and spend more on transport with a sick child. They had never seen the medical officer of Pethapur. But they knew the MPHW who visited sometimes. They were sympathetic towards him because he had to walk long distance.

All the PHC staff, irrespective of their designation and

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WHAT HE PRACTICES

WHAT HE PREACHES

duties were perceived as family planning workers and hence feared. A healthy baby competition was organized by the investigators and it helped in perceiving the medical officer and ANMs differently.

During the later stages of exploration it was found that the PHC staff was not perceived as friendly and cooperative, rather the parents felt that they were treated sub-humanly. They had to wait for long hours if they went to the PHC. They were neither explained the disease or treatment. They were just told to follow the instructions. Some Medical Officers charged fees, according to the tribal parents.

The cases which were not cured were highlighted by the parents wanting to emphasize the incompetence of the PHC staff. For example, there were two cases, where vasectomy had failed and the wives became pregnant. They were blamed for having extra-marital relations. Out of these two cases one man had undergone vasectomy thrice.

PHC staff was not viewed as educators rather their job was perceived as distributing medicine and preparing cases for family planning. Parents were not convinced, for sterilization and put forward their reactions as "The M.O. himself had three daughters, then a son and then only he underwent vasectomy. How can he expect us to have only two children even if they are daughters?" Besides narrating such examples, there was a general complaint for lack of follow-up after sterilization or any other illness.

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In some instances it was mentioned by the parents that the ANM takes her own children to a Bhagat, when they are sick. This could be another reason for not developing trust in medical services.

On the whole, it was found that many parents were unaware of the responsibilities of functionaries.

On the other hand it was important to find out about how the functionaries had perceived the tribal parents, what were their own personal and professional problems that would hinder the functioning of services.

Functionaries' Perceptions and Problems

Balsevikas perceived parents as not interested in child's development and therefore not taking any interest in the balwadi programme. According to them the parents had very high and irrelevant expectations. ~~From balwadi,~~ the health functionaries perceived the tribals in general having poor living conditions, having poor health, indulging in excessive drinking and sex, having many misconceptions regarding health aspects and consulting Bhagat for health problems. Some of them were labelled as aggressive. Their laziness was accounted for not coming regularly to the centre.

A comment by a M.O. when asked, "how can we help them lead a healthier life?" was "These people can never change, can never improve, the government is unnecessarily wasting money on them. If they spend this amount on our children, they would shine out". This reflects having no faith in the tribals and also a very negative attitude towards them.

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Reasons given for underutilisation of health services were two fold. On one hand the beneficiaries were blamed for their background and characteristics. While on the other hand problems were realised by field level health functionaries because the nature of the services offered. The reasons given were such as unsuitable timings, inability to provide basic health needs, negative attitude towards beneficiaries, lack of cooperation among the functionaries and lack of facilities at the centre.

Field level health functionaries also brought out some problems which were similar to balsevika's problems such as insufficient salary, inadequate housing facilities, and travelling allowance. As they were employed on permanent basis they did not have problems such as taking leave or getting promotion. They enjoyed better status than balsevikas and were satisfied with it.

They thought it was important to create awareness of programme utility, conduct house to house survey, increase literacy level of people and work in coordination with other services. They did realise the utility of follow up of programmes especially to prevent failures.

Supervisor's role was perceived to check records such as log book, attendance, home visits and target numbers reached. Only a few mentioned his role as a guide.

This was the feeling among the functionaries that Limkheda and especially the more remote parts of it were the 'punishment area', no one wanted to stay in such a place, so he/she lost interest in the work. It was also mentioned that the functio-

functionaries, including the M.O.s who cannot get a better job and is not very competent will be placed in this area. This has a direct bearing on the self concept.

B. Voluntary Efforts

There are very few voluntary agencies in Panchmahals catering to health and welfare of tribal children. In Limkheda, Gujarat Adivasi Yuvak Mandal and Adivasi Vikas Parishad are the two. Their main activities are sports, cultural programmes and education.

There are two voluntary agencies not catering to the population of Limkheda, but Dahod and Jhalod as well as other remote areas, they are Bhil Seva Mandal and Sadguru Seva Sangh. A brief account of their functioning is presented here, since there are none in Limkheda.

Bhil Seva Mandal-is one of the oldest agency founded by late Shri A.V. Thakkar fondly known as 'Thakkar Bapa', for the uplift of the tribals. The main activities are education and welfare. It is not surprising that the residential schools of the mandal have no problem of enrollment, because the education is relevant to their living and occupation. The children are taught farming etc. besides attending the regular classes. This makes the education relevant. The basic needs of the children are taken care of suchas clothing, food and they are encouraged to be selfsufficient. Cleanliness is also encouraged.

The other activities include helping the tribal people to overcome habits, such as consuming alcoholic drinks. The mandal has been very successful in this area also. The workers are

highly dedicated and gradually the past students of the schools are encouraged to take up the responsibilities of running the organization.

Sadguru Seva Sangh

This is another voluntary agency successfully reaching to the people in Dahod and Jhalod. It is founded by Mafatlal group of mills with the assistance from other sources as well. The main activities are agriculture and irrigation.

Along with these programmes, they have health and education programmes too. They have a mobile dispensary which has fixed hours for different villages during the week. It was a real contrast to what was observed in the PHCs. People were actually waiting for the van to come, whereas in PHCs the doctors keep waiting and patients don't come. Some of the reasons could be - the health visitor is always in touch with the people, explains and educates them, the van always comes in time, patients are dealt humanly and politely. One of the major reasons, for the success of the programme could be, effective supervision. The team of social workers who supervise the complete project, accompanies the medical team from time to time. They genuinely help in solving problems. They encourage the staff to attend training programmes and appreciate their efforts.

The agency has been very successful in getting the farmers loans from banks and seeing to it that the loan is repaid by the farmers with interest within the time limit.

The non-formal education in cleanliness, health, and family planning, and child care is also one of their major contributions. They have successfully conducted workshops for 3-4 days for women.

This experience strengthens the opinion that health and welfare services can be utilized fully if planned and implemented realistically with dedication. The most important individual is the grassroot level worker who comes in direct contact with the people. The supervisor's role in helping and guiding him/her is also vital.

Based on the need-based surveys information collected from the three important target groups responsible for a tribal child's healthy development, the educational programmes were planned. These programmes were as follows:

1. Parent education programmes.
2. In-service training programme for balsevikas.
3. In-service training programme for health functionaries.

The first two are summarised in this chapter whereas the third i.e. the present project on in-service training programme of health functionaries is presented in the remaining chapters.

Based on the surveys, the needs to educate the target groups responsible for a young child's healthy development were assessed. The following programmes were conducted:

1. Parent education programme.
2. In-service training programme for balsevikas.
3. In-service training programme for health functionaries.

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understanding about importance and methods of child care, health, nutrition and education these having had the greatest impact. Perhaps this selective retention also indicated their most crying needs.

Regarding the topics covered, one subject gave the suggestion that there should have been more emphasis on the harm caused by drinking. The following topics were found irrelevant for this groups of parents- motor, mental, and socio-emotional developments. It was decided to concentrate mainly on health, nutrition, recreation, education, economic aspects and responsible parenthood.

It gave extreme satisfaction to observe changes in the behaviour of some subjects after a session. For instance after the talk on the need for washing and combing hair regularly and bathing children daily, one woman did so on the following days.

The day after the Healthy Baby Competition, it was encouraging to note that one man came and asked what can he do for immunising his child. Using a few promising subjects, an attempt was made to reinforce their efforts as well as help others to change the practices which affected their health adversely.

On the basis of this initial experience of conducting Parent Education Programme on too many topics with a large group of tribal parents and not having enough audio-visual aids it was decided to conduct home-based programmes for small group of parents only on topics that seemed relevant to them. An additional component of evaluating the existing aids and preparing new aids was added.

VI. Education and Training

A. Parent Education Programme

Objectives of the Programme

Broadly, to plan, conduct, and evaluate an educational programme for the tribal parents of infants and preschoolers. Specifically-

a. To boost the parents to better cater to the allround development of the children.

b. To increase knowledge regarding better practices in the areas of economic aspects, education, health, nutrition and family planning.

c. To encourage self help and initiative in the community and increase awareness and utilisation of services available for them.

Programme Implementation

The Parent Education Programme was conducted by 2 graduate students of child development. It consisted of 10 sessions of approximately $1\frac{1}{2}$ hours duration each. Initially the people had to be cajoled into attending the session, where towards the end it created interest and parents started coming on their own. Maximum emphasis was given to the Nutrition and Health aspects which were the frontline issues in the village problems.

Programme Evaluation

A one-shot concentrated doze of knowledge content, however well planned and painstakingly imparted cannot hope to go too far, as far as adoption and practices are concerned. Creating awareness is another matter. However, subjects did indicate an

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Audio-Visual Aids.

As the importance of the use of audio-visual aids were highlighted in the previous studies and since appropriate aids were not easily available, it was decided to explore the status of existing aids. Out of 183 total aids available from 16 agencies and 7 cities, there were 75 charts, 74 posters, 17 sets of flash cards, 3 films and 14 sets of slides. On nutrition there were 41, on health 111 and family planning 31 audio-visual aids were available for evaluation. The experts, on a pre-decided criteria evaluated 135 aids and rated 38 as can be used as they are, 12 as modifiable and rejected 83.

It was surprising that family planning is one of the priority areas of Government of India but only 31 audio-visual aids were available and only 4 were rated as usable by the experts, none were considered modifiable and the rest were rejected.

A further attempt was made to prepare five audio-visual aids which were field-tested in Panchmahals in three different settings, modified and used for parent education programme during the health functionaries' training. These aids were extremely useful for the home-based programmes and also served as examples for preparing new aids.

B. Home-Based Parent Education Programmes

Evaluation of the parent education programme led to the conclusion that even the most carefully planned, need oriented programme is a waste if the audience does not come, comes irregularly, comes but does not listen and digest, or is co-operative only in lip-service. Thus, in such a set-up if a

home-based programme is conducted for 5-6 families, giving immediate suggestions, suited to observed needs and problems and using individual attention - it will help to spread the message better by these five model families. Hence Home-based Programmes were planned and implemented by undergraduate students of child development on the ~~following areas~~ relevant topics:

As the results of the previous parent education programme had indicated the importance of use of audio-visual aids to arouse cusiosity, attract attention and communicate messages more effectively, audio-visual aids such as rod puppets, glove puppets, cassette recording, posters and flash cards were prepared to accompany delivery of messages. The messages were presented in the form of skits and role play.

The home based programmes were given in rotation to five selected homes in a village, each session lasting for a period of 1 to $1\frac{1}{2}$ hours.

Evaluation of the Home Based Programme for tribal parents indicated an increased awareness in subjects related to health, education, economic aspects and responsible parenthood.

In-service Training Programme for the Balsevikas

Realising the importance of balwadi as an important experience for a child and the role of balsevika in bringing awareness to the parents regarding healthy development of the child, an in-service training programme was conducted for them. The specific objectives of this programme were:

1. To equip the balsevikas with elementary knowledge regarding Balwadi Programme.

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2. To make them aware of utilization of resources available in their own surroundings and hence make the preschool education more meaningful.
3. To provide them with an opportunity to express their problems in running the balwadi and guide them in finding solutions to these.
4. To help them accept the situations which cannot be changed and how to cope with them.

Pilot Work

The pilot work began about 3 months prior to the implementation of the programme. For getting information about the present situation of the balwadis, the Education Officers of Taluka Development Offices at Jhalod and Limkheda were approached. Details, like the number of balwadis in the two above mentioned talukas, the student-teacher ratio, the responsibilities of Balsevikas in the actual setting, etc., were asked for. But, to the investigator's disappointment, the information provided was neither very clear nor sufficient. Hence it was thought best to visit a few balwadis and get first-hand information to enable appropriate programme planning.

In all, 4 balwadis of Jhalod taluka and 3 balwadis of Limkheda taluka were visited. Inspite of informing each balsevika prior to the visit, one was absent during the visit and hence only 6 balsevikas could be interviewed.

The observational findings are as follows:

1. There was one separate building with only one empty room allotted to the Balwadi, There were no play

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equipments, materials or toys in most of the balwadis, whereas few of the balwadis where there were play materials, they were stored on a shelf.

2. The children who attended the balwadi programme (excluding the SNP group of children) were very few.
3. The balsevikas mainly concentrated on making the children sit quietly or asking them to repeat whatever was taught.
4. The registers of almost all the balwadis were very well maintained. In fact the information seemed unbelievable.

The visits were beneficial in terms of collecting the information and observing the programme. This gave a clearer picture regarding the "what" and the "how" of the in-service training programme for these balsevikas.

The findings of the interviews are as follows:

1. They never planned or evaluated the programme though they did have a framework.
2. Lack of knowledge regarding use of play material.
3. Supervision was almost nil. The Mukhya sevika visited them only once or twice a year.
4. Low pay scale and additional expenditure.

Participants

Twenty-three balsevikas from Jhalod and Limkheda talukas participated in the programme. Most of them fell within the age-range of 21 to 30 years and came from joint families. A majority of them belonged to the income group of Rs.100. Most

of them had passed S.S.C. or equivalent and had 2 to 5 years of teaching experience. Several of them claimed to be interested in children.

Evaluation of the In-service Training Programme

The suggestions given by them for any such in-service training programme are as follows:

1. Such programmes should be organised regularly in various talukas of the entire district of Panchmahals.
2. The execution of the programme should be demonstrated in the Balwadi setting itself and mistakes of the Balsevikas should be corrected on the spot.
3. A variety of indigenous materials should be used to make the programme really meaningful.

Problems Faced

1. Lack of vacations.
2. Low pay scale.
3. Irregularity in attendance of children.
4. Parents sending a younger or older sibling along with the Balwadi child.
5. No storage space for play material.
6. Difficulty in conveyance and transport.
7. Ad-hoc evaluation and inspection.

The Balsevikas did not mention any problems related to coordination with other agencies, such as the health services. One of the reasons could be that they are mainly bothered with their day to day personal and professional problems and hence cannot think about the programme with a broader perspective.

To sum up, the wealth of information availed from all the earlier phases of the larger project serves as the rationale for the present project.

Rationale for the Present Project

The data collected and analysed during the earlier phases of the larger project have clearly brought out the importance of educating the tribal parents for healthy child care practices. As the field level health functionaries come in direct contact with children and their parents and as they are supposed to educate the parents in matters related to health, it was thought best to conduct an in-service training programme for them.

Keeping in mind the health functionaries' own personal and professional problems, how they perceive the situation of tribal children and their parents, what knowledge, skills and competencies are necessary to educate the parents and how do their supervisors guide them to undertake their responsibilities, the training programme was planned.

On the basis of the information presented in this chapter the following guidelines are prepared for the training of field level health functionaries and the training of their supervisors.

A. Guidelines for Training the Field Level Health Functionaries to Educate Tribal Parents for Better Child Care Practices

General

1. Parent education should be geared to utilisation of health services.

2. Need to clarify the objectives of the health programmes with special reference to services for children.
3. Need to remove misconceptions and fears related to health, nutrition and family planning practices and services.
4. Encourage parents participation in planning and evaluation of the programmes.
5. Need and priorities of the target groups in their cultural context should be assessed before offering the services.
6. Orienting parents about healthy practices related to child care.

Health and Hygiene

1. Healthy personal habits and cleanliness of surroundings.
2. Purification of water at home.
3. Water borne and air borne diseases - parent's role in prevention and cure. e.g. immunization and oral rehydration.
4. Use of indeginous and locally available materials e.g. neem leaves in making paste for scabies.
5. Proper disposal of waste.
6. Importance of regular health check-ups.

Nutrition

1. Importance of proper diet during pregnancy and lactation.

2. Importance of breast feeding the child from the first day so that the child receives colostrum.
3. Importance of supplementary feeding at the age of 4 months.
4. Simple weaning food receipes.
5. Balanced diet and its impact on child's health.
6. Proper cooking methods to conserve nutrients.
7. Importance of kitchen garden.

Family Planning

1. Clarifying concept of welfare in family planning.
2. Idea of responsible parenthood.
3. Advantages of having small families.
4. Advantages of proper spacing between children.
5. Clear instructions regarding use of family planning methods.

Approach and Method

1. Enable the parents to be self-sufficient in expressing their felt needs.
2. Home-based programmes with individual and informal approach.
3. Use of audio-visual aids in imparting health education to parents.

B. Guidelines for Training the Supervisors

1. Emphasize the need for training the health functionaries.
2. Importance of checking and supplying stocks of tablets and chlorine powder.

3. Need to be alert towards any specific health problem or situation detrimental to health of people in general and children in particular.
4. Need to guide and examine regular health check-ups of children.
5. Examine the records and reports of the functionaries and guide them to use this data for future planning.
6. Need to project his image as a guide and a helper besides being an administrator.
7. Need to accompany the functionaries on the field to encourage and motivate by appreciating his efforts and offering suggestions to improve.
8. Need to act as a liason between the functionaries and the administrators.
9. Need to convey the existing problems and needs of the target groups and the existing conditions of PHC to the administrator.

The above mentioned suggestions derived from the larger project, helped in planning the present project, i.e. "Module for in-service training of health functionaries in Panchmahals". The next chapter consists of the details regarding the project design.