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A STUDY OF MATERNITY AND CHILD HEALTH CARE IN A NOMADIC COMMUNITY OF RAJASTHAN KNOWN AS *RAIKA*

Pastoral nomads are those groups whose nomadism is connected with the needs of their herds. They move about with their herds in search of food and shelter. *Khanabadosh* are herdless and homeless people roaming from place to place and working as food gatherers, musicians, quack surgeons, traders or artisans like blacksmith, basket-makers, bamboo-workers, etc. Semi-nomadic tribes include those who own homes and agricultural land but who wander periodically or during certain seasons of the year following vocations like those of *khanabadosh.*

The Population of Rajasthan is 7,10,41,283. Nearly ninety percent of Rajasthan's population is Hindu with Muslims making up the largest minority with eight percent of the populations. Jains - the merchant and traders from Rajasthan constitute a significant presence. Scheduled Castes (ST) and Scheduled Tribes (ST) form about seventy percent and twelve percent of the state population respectively. The population of the tribes in Rajasthan is nearly a double of the national average, with original inhabitants Bhils and the Meenas forming the largest group. Lesser known tribes like Sahariyas, Damariyas, Garasias, Lohars still form an important groups. The main nomadic tribes of Rajasthan are Guduliya Lohars, Raika, Nat and Kalbelia.

Raika are pastoral nomads and they earn their living by rearing sheep, goat and camel. They are the main pastoral nomads of Rajasthan and the present study is focused on them.

Raikas represent the predominant pastoral group of western Rajasthan. Though they are also called Rebari or Dewasi, but 'Raika' seems to be the most frequently used terms for these people. In this study also the term 'Raika' is used to represent the community because Raika is most frequently used for them in Rajasthan, while term Rebari is frequently used for them in Gujrat. The Rebari does not necessarily refer to caste membership. It was used in northern India for cattlemen or for people knowledgeable about cattle. The term *rewar* in colloquial language in the region is used for a herd

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of cattle. The term Dewasi derives from the fact that Raika society is governed by ten *(das)* rules. According to Westphal-Hellbusch and Westphal the term Raika was originally reserved for those Rebaris who served as camel mounted messengers to the royal courts of Rajputs. Mainly spreading from western Rajasthan to the Kutch region of Gujarat, the Raika / Rebari hamlets survive in a harsh climatic zone. In Rajasthan, the mean annual rainfall varies from 100 mm on the Indo-Pakistan border and 210 mm at Jaisalmer to about 350 mm to 400 mm in parts situated more towards the eastern region. But the thorny vegetation of the entire area has supported a significant population of both sheep and camel. Salzman writes that less than 5 percent of the village population in Rajasthan owns about 50% of the livestock, with regard to the camel population. Rajasthan had 72% of the 1.10 million camels in India. The sheep can subsist, and often flourish, on coarse feed not relished by other domestic animals. A similar ecological adaptation applies to the camel. What is admired by camel tenders (and also by people in general) is the camel's fortitude under conditions of extreme heat and its ability to cross-vast expanses of desert without drinking water.

Raikas combine camel and sheep in their herds in varying proportions. In Bikaner, Jodhpur, Pali and Kota certain Raika hamlets are observed having several camel herds, but flocks of sheep also exist in these hamlets. As we move towards Bikaner, camel herds are larger whereas sheep herds are smaller. In Pali camel herds are smaller but sheep are reared in large number. In Marwar, although the herds do have a couple of camels, which are the beasts of burden, the Raika mainly specialize in sheep breeding and tending. Raikas of Jalore and Sirohi are predominantly sheep breeding communities. As an exception certain Raika hamlets like Jojawar in Pali and Ghum-ki-dhani in Kota are famous for owning large camel herds numbering 2 to 3 thousand animals. Kohler-Rollefson in one of her papers, mentions an exclusively camel oriented Raika community in Pali which not only had a collection of memorable statue depicting camel mounted ancestors but also self-made clay camels with which local children played. Raikas of the district of Mandsour (Madhya Pradesh) breed camels, they do not keep sheep but rear buffaloes and engage in crop cultivation. In Gujrat, although, the traditional image of Rebaris as camel breeders still holds, their economy has diversified. They breed the world's best tropical cattle.

Raikas are engaged only in sheep, goat and camel breeding, but they have traditionally herded and taken care of the livestock of other castes as well. As has been said earlier, although a few Raikas are specialized camel herders, the community as a whole identifies itself closely with this animal. Camels were owned in the past by royal lineages and rich castes. A peasant family aspired to own a camel. No community except Raikas and Sindhi Muslims has occupational specialization regarding everything pertaining to the camel. In places (like in Marwar, Jalore, Sirohi) where the herds are

predominantly of sheep, the knowledge of the Raikas about the camel and its upkeep is not insignificant. A Raika family, whether in Bikaner, Pali or Marwar, aspires to own a couple of camels. Its ownership even raises the status and prestige of the family within the community. Many Raikas say that tending camels is their duty. Against all odds and meagre economic benefits, the Raikas think they must domesticate camels rather than letting other casters take over their traditional occupation.

According to their myth of origin, the first Raika was created by Lord Shiva or Mahadev (the great god) for the specific purpose of looking after the first camel that Parvati, the *ardhangini* (wife) of Lord Shiva, created from clay.

Raikas in Rajasthan invariably live outside the main village in their own hamlet locally known as *dhani*. Sometimes these *dhanis* are a few kilometers away from the main village. A *dhani* is usually a kin based group comprising all those who claim a common descent. In a big *dhani* a couple or more of such descent lines may be present. Raikas live in multi-caste villages. Though a *dhani* is a closed group in spatial terms, it is not self-sufficient. For various services Raikas depend upon other castes with whom they have patron-client relations, like in occasions of marriage and death, or for buying or selling commodities in markets.

Many Raikas own small stretch of land, but these are more in the manner of keeping village ties rather than as an economic activity, although a pattern of 'take-a-chance' cultivation is often practiced. While in no way considered an 'unclean caste', the Raikas are nonetheless treated as different by sedentary villagers, the derogatory name for them being *bhoot* meaning ghost. Within Rajasthan, the districts from which pastoral migration usually takes place are Barmer, Jaisalmer, Nagaur, Jodhpur, Pali, Sirohi, and to a limited extent Ajmer. Broadly speaking, the direction of migration is towards bordering states of Haryana, Uttar Pradesh, Madhya Pradesh and Gujarat.

Raikas are the largest group of nomadic pastoralists of India. Each year after the rains, hundreds and thousands of shepherds embark in collective camps on migratory journeys that can span distance of up to 1200 kms and last up to nine months. They camp in a new location almost everyday leaving at least two villages for new campsite. Each *dang* (mobile camp) is organized into 15-20 roughly equal sized flocks and can embrace as many as 4000- 5000 sheep and 50-100 camels, goats and donkeys accompanied by 90-95 men, 25-30 children of varying age groups. Smooth coordination of the movement of such a large group becomes possible because individual shepherd in the camp delegate much decision making responsibility either to the leader of the camp, the Nambardar or to a 'council of elders'. They reserve for themselves only the control over day- to-day management of their own flocks. They return to their home once in a year around the festival of Holi.

Demographic Profile of Raika

Though the present Raikas are concentrated in Rajasthan and Gujrat, they also inhabit some villages in the states of Haryana, Punjab, Uttar Pradesh and Madhya Pradesh. According to an estimate by Srivastava, there are at least thirty-two villages in Haryana having Raika population. In Bikaner district there are thirty-six villages with Raika hamlets. In Jodhpur and Pali-Marwar, there are some big Raika hamlets of more than a hundred houses. Number of Raikas is even higher than this in districts of Sirohi and Jalore.

According to the earliest census report (of 1891) on the castes of Marwar called "Report: Mardumshumari Raj Marwar" (hereinafter, the Raj Marwar Census), there were 98,406 Raikas (52,808 men and 45,598 women) in this region. The second document, Report on the Census of Marwar and Mallani[14] (Barmer) of 26 February 1891, recorded 112,096 Raikas (55,261 men and 56,835 women) in Marwar and 10,572 (5495 men and 5077 women) in Barmer. Thus the second report counted 13,690 more Raikas (2453 men and 11,237 women) in Marwar.

Census of India 1931 recorded 135,820 Raikas in Rajasthan. Thus, it can be said that no reliable information is there about the population of Raikas in Rajasthan. The Census of India after 1931 does not carry any information on the total number of Raikas of Rajasthan.

The present situation is that no government department or any other organization has any knowledge of the total Raika population in Rajasthan or India as a whole. One reason for this is that, one of the steps the Indian government has taken to eradicate casteism from the social framework is not to classfy people in the Census Report according to their castes. Westphal - Hellbusch reports, Raikas in all parts of India are not less than four hundred thousand people; their number should be between 350 and 400 thousand. According to Kohler Rollefsen, India had in 1991 around 2 lakh Raika families. Assuming an average Raika household family to be 5, it would mean that 10 lakh Raikas lived in 1991, which is an inflated figure. According to Srivastava, ,a moderate estimate is that both Rajasthan and Gujrat have around 5 to 6 lakh Raika/Rebaris.

Rationale of Study

Enumerating certain sociological areas that require urgent research, Shah notes the conspicuous absence of studies of nomadic groups such as Banzaras in several parts of India, and the Bharavads and Rebaris in Gujarat. Although Shah does not include Raikas (Rebaris) of Rajasthan in his list, we agree with him that social anthropologists and sociologists have paid little attention to pastoral-nomadic and semi-nomadic groups. Pastoral groups have received only marginal attention in our planning and development programmes where emphasis is laid on agriculture and industrialization. Guided by the policy

of 'grow more food', the tracts of land which hitherto were pastures were colonized for agriculture purposes. Between 1956 and 1987 common property resources decreased by 32% while the net cultivated area increased from 28.6% in 1951 to 47% in 1981. After independence expansion of agriculture and industry was interpreted as the sign of development but increase of animal herds or pastures were not included in the planning of general economics development.

In spite of the fact that there are only two communities, Raikas and Sindhi Muslims in India which breed camels and own the largest number of sheep in Rajasthan, none of them has been intensively studied. Raikas have been studied along with other communities, by scholars like K.S. Singh, G.S. Sharma, Tambs-Lachye, Salzaman and some others. Kavoori has taken only economic and ecological aspects of Raikas in his study while Arun Agarwal has taken their political and market economy as a field of his inquiry. Vinay Kumar Srivastava has done an intensive study on religious aspects of Raikas focusing on renounces in the community. Certain studies like Tribal Health Problems, Disease Burden and Ameliorative Challenges in Tribal Communities with Special Emphasis on Tribes of Orissa by R.S. Balgir, Health Status of Tribal Women in India. Social Change by Basu. S.K.: Mehta, book on Fertility Behaviour of Tribals in Rajasthan, Patel, Tulsi, about health behavior of tribal & rural areas has been done but none has touched the maternity and child health care of Raikas. Present work is an attempt in this direction.

Health is an essential component of the well-being of mankind and is a prerequisite for human development. If general health of an average non-tribal Indian is inferior to the Western and even many Asian counterparts, the health of an average Indian tribal is found to be much poorer compared to the non-tribal counterpart.

The health status of tribal populations is very poor and worst of primitive tribes because of the isolation, remoteness and being largely unaffected by the developmental process going on in India. The situation becomes worse for a nomadic community like Raika. The United Nations (UN) members met in 2000 and set themselves eight goals to be achieved by 2015. Of these goals, reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases related to the health segment were included. The first goal 'of eradicating extreme poverty and hunger' also contains a nutritional element which is health related. In the developing world, death rates in children under five are dropping, but not fast enough. Eleven million children are still dying every year, from preventable or treatable causes. More than half a million women die each year during pregnancy or childbirth. Clearly, the challenges for India are multi-faceted. In tribal areas, reducing child mortality and improving maternal health are major challenges Health care in India has been neglected because of insufficient spending by the government. So, the study about maternity & child health care of a nomadic community like Raika itself determines its rationality in present scenario.

Humanization of knowledge is an essential aspect of research whether in natural sciences or in social sciences. We must be able to apply accumulated knowledge for the betterment of humanity. It is with this understanding that an integral approach has been taken for the study of maternity & child health care practice of Raikas as a migratory tribal community. A holistic view has been adopted to study this group so that it may facilitate the government, and those interested in their socio-economic progress, to prepare plans of action for their development.

Questions are sometimes asked as to why one should deploy so much of time and energy on the study of such a small and insignificant group of people like Raikas. The answer lies in the fact that in a fast changing scenario of Indian society where everything is bearing the impact of modernization, this small group presents itself as an antique that deserves conservation and protection in its original form. The way this community cherishes its old values and its traditional ways of nomadic life, migrating and moving from place to place for procuring feed for their herd, without being disturbed by the changes occurring in the surroundings, deserves appreciation and understanding.

It shall not be out of place to introduce a word of caution about the terms 'conservation and protection'. When we propose to conserve and protect this community in its original form, we do not mean that the benefits of modernization and development should not be passed over to them for their benefit. It is essential to provide them all opportunities of socio-political, educational and medical facilities that come through modernization, but such processes should not interfere with their traditional values and lifestyles.

The present paper is an attempt to study the maternity and child health care among Raika. Fieldwork has been done in two villages predominantly inhabitated by Raikas namely; Raika Ki Dhani and Manpur Bakdi in Pali Sirohi Belt of Rajasthan. Maternity health care refers to the health care of expecting and lactating mothers, which among Raikas generally starts from the act of delivering a child. The process of delivery of a child is called *jaapaa*, in which *jaa* means birth and *paa* means to receive. A new mother is said to be in the state of *jaapaa* and she receives some extra care and attention. The new mother is called *jachcha*. Child health care is determined by interaction between the child on one hand and the environment, along with the society in which he lives, on the other hand.

Universe and Methodology

Manpur is a small multicaste village situated at a distance of 10 Km on north-eastern side of Pali city. In this village 75 families belong to other castes, namely Baniya, Brahmin, Rajput, Lohar, Kumawat and Meghwal. 30 families belong to Raikas. Of the Raika families only four are of Godwar sub-caste and the rest are of Maru sub-caste. Raikas live at the periphery of the village and their houses are quite close to each other. All other castes live

inside the village. Houses of villagers of one community are close to each other, but are apart from houses of other communities. Houses of Raikas are generally *kaccha*; only two houses were observed to be *pucca*. One house was observed to be exceptionally large among the Raika households. It also had assets like cooler, television set, bed and so on. Owner of this household possesses a large land holding and a good number of animals in his herd. Some houses also had a small temple like structure at their courtyard, in which a small idol of an ancestor is seated. In their local dialect they call it Bomyaji and they worship it in their own ritualistic fashion.

The other village chosen for study is Raika-ki-dhani. It is a small village situated at the periphery of Pali city. Total number of families living in the village is 50 and of them 15 are Raika households. It is approximately 5 km. from Manpur. Among Raika household five families belong to Godwar sub-caste and the rest are Maru. This also is a multicaste village and other castes that occupy the village are Baniya, Kumawat, Soni and Meghwal. Like in other Raika hamlets, here also Raikas reside at the periphery of the village and lead their lives away from villagers of other castes. Earlier, only Raikas used to reside in Raika-ki-dhani but for the past some years this trend has changed, and people of other castes have also started living there. Houses of the families of other castes, especially Baniyas, are quite good, but those of Raikas are *kaccha*. Bhomyaji is installed and worshipped in almost each household belonging to Raikas.

Thus in the two villages chosen for study the total number of Raika households is 45 and all have been taken up in the sample. Total number of Raikas in these 45 households is 405.

Several tools have been used for the purpose of this study. While a schedule has been used as a basic tool, help of interview guides, interview with key informants and observation have been taken for studying the sedentary life and general life pattern of the community. This basic tool, i.e. schedule has been further substantiated both by quasi-participant observation as well as interviews for studying the migratory pattern of their life. Group interactions and focused group interviews have also been used to some extent. One group of migrant Raikas i.e. one migratory group has been studied in depth through quasi-participant observation. However, on the whole a leisurological approach was used for deeper probing and understanding of the various facets of their life. Every possible effort was made to share the leisure and free time of the respondents to draw the truth of their lives so that the closest reconstruction of reality of the Raika community could be accomplished.

Apart from fieldwork, a study was made concerning unpublished and published documentary material from government and other records. Appropriate references have been made to this material at places where it has been used to substantiate any point in the study. In order to get first hand

information from person occupying position of prestige in the community a few meetings were held with the leader of Ghumakkad Bhed Palak Sangh, (migratory shepherd union) of the Raikas. It was very useful to attend a meeting of Raikas at Pushkar and other fairs where their caste congregations are organized.

A study of nomadic community like Raikas would be incomplete if for a spot study, one does not accompany a group of them on their migratory journey. Therefore, we decided to contact one group belonging to Manpur at the periphery of Pali city. It was necessary to convince the leaders of the group about our purpose. Having done so, our association with the group became easy and educative. We had selected the route beginning from the suburb of Pali leading to Gujrat through Barmer and again returning to Manpura. Since the entire route takes about 9 months to cover the on and return journey, we chose to accompany the group from Pali to Sadri, which took nine days. This provided sufficient insights with regard to the life of Raikas on migration.

Salient Features of Maternity Care

Attitude towards Pregnancy: Among Raikas, pregnancy is considered as a normal and desirable condition for a young and married woman. For most of the period of pregnancy, a woman does her normal work like any other woman in the community. She is expected to accompany her husband and other members of the family if they are proceeding on migration. It is only during the last days of pregnancy that she is prohibited from lifting heavy loads. Through out the period of pregnancy she is encouraged by elderly women of the family to grind grain on the hand mill (*chakki*), as it is considered to facilitate smooth childbirth. It is a common belief among the community that regular physical activity involved in daily routine of their life facilitates labour and makes delivery less painful.

Anxiety associated with pregnancy is non-existent among Raika women. The knowledge about childbirth and child bearing is derived much early in life. Being pastoral nomadic community, it is common for children to witness animals giving birth. Moreover, young girls assist elderly women and *dai* in conducting deliveries at home and in the process gain some knowledge about child bearing and childbirth much before they themselves attain that age. The common image of a labouring woman among Raikas is one who takes her pains silently. It is believed that a woman who has sinned shall have a painful delivery while a noble and pious woman shall have smooth and painless delivery.

Delivery Practices: In case of most Raikas, delivery of a child is conducted by a *dai*, who is a socially recognized maternity help from the community itself, and is commonly addressed as Gauri Maa. For the purpose

of delivery she is preferred to any regular medical aid because she is one among them, well acquainted with their habits and family traditions, and she possess the essential experience of conducting deliveries for many years. Another reason why Gauri Maa is preferred to a regular ANM from the PHC for this purpose is that the expenditure on this local help for conducting delivery is much less than on the trained ANM. Gauri Maa is both expert and affordable.

In a large number of families even the service of Gauri Maa are not requisitioned on the occasion. Elderly women conduct delivery with the assistance of other women of neighborhood. Gauri Maa is called only when a woman is delivering for the first time or when a complication is apprehended. When a delivery takes place during migration, elderly women within the *dera* manage everything and there have been instances when the caravan had to move with their one-day-old child as well.

The office and position of a *dai* among Raikas, as also in certain other Indian communities is socially recognized as an art that is transmitted among women of a family from one generation to another. The work of attending to and conducting deliveries is adopted by the women folk of certain families as a profession. This is the case with Raika community as well. To be a Gauri Maa one has only to adopt the family profession carried from mother to daughter(s). Younger ones accompany their mothers on the errand whenever she is called. In due course of time they learn the tact and can handle a case independently without the supervision of the experienced mother. In turn they train their daughters for the job and the tradition goes on. Raika women have unflinching faith that only a Gauri Ma can conduct a safe delivery.

A Gauri Maa *dai* is preferred over an ANM for various reasons. *Dai* or Gauri Ma is adept in the local traditions of conducting deliveries which is more acceptable to people. She is always available in the village locality and, unlike ANM, shall come immediately even if called at odd hours. She also does some additional services such as cleaning effluvia and placenta, burying the placenta, cleaning the delivery room and mopping it with mud and cow dung, bathing the baby and giving post natal massage to the child and the mother. All these services cannot be expected from ANMs or other staff of the PHC.

Gauri Ma accepts payment for her services in both cash and kind. In kind she may be given meals, old and used garments, new *saree* or sweets. The payment to a *dai* may be deferred or made in installments over a period of time depending on financial resources whereas an ANM will ask for the fees in cash and on the spot, which may not be possible for a Raika family.

Of late some young couples have, under the impact of modernization, started preferring delivery to be conducted by ANM or the doctor of the local PHC. They are informed by visiting health workers and others, in contact with whom they come during migration that trained ANMs have better

knowledge and equipment for the purpose as compared to local *dai*. Therefore, in spite of the opposition of elderly folk, these youngsters prefer delivery at the PHC although it involves some extra expenditure.

This trend is exhibited by the fact that out of 45 deliveries taking place during the period from 2000 to 2010, 60% were conducted by Gauri Maa, 33.3% by ANMs and 6.7% at home by elderly women folk of the community.

As for the place of delivery, 66.8% of them were conducted at home and 33.3% at the PHC. Although the deliveries taking place at the PHC are free of cost but the expenditure on post-delivery treatment and medicines is prohibitive.

A Case Story : Radha, a young Raika woman, aged 26, was brought to PHC, Pali. She was a married woman suffering from labour pains for a few days, yet the delivery of the child was not in sight. Family members were insisting that they should wait for some more time for the delivery to happen, but some influential persons and educated villagers advised them to take the women to the hospital. It, however, so happened that the child was delivered soon after Radha was admitted to the PHC and the delivery was normal. It was time now for the elderly women to have their say. They murmured to each other "tabar kan mu su nee khire" which is an old saying, meaning that a child does not drop from the ear. What they meant to emphasize was that childbirth is just a normal process, yet it is not a child's play either. It is just a matter of time, and they should have waited for some more time instead of spending so much money taking Radha to the PHC.

Expenditure involved in Delivery: Since childbirth is considered a normal phenomenon, spending money on it is considered a waste. A nurse is called only when elderly women in the family and the neighborhood, or the Gauri Maa have applied all the knowledge at their disposal to make the woman deliver. Even when a nurse is called or the labouring mother is taken to the hospital, all efforts are made to avoid medicines or injection in order to prevent unnecessary expenditure. The attitude of accompanying members of the family is that of 'wait and see', and not to spend money on medicines for such a normal thing as childbirth.

Some ceremonial expenditure is, however, an essential practice. At the birth of a male child, Gauri Maa is offered money depending on the economic condition of the family. In addition something is given in kind as well, which could be some silver or *gillette* ornament like earrings, bangles or *bichhia* (decorative rings worn by married women in fingers of the feet). Birth of a girl child is not always welcome and therefore on such occasions the Gauri Ma also accepts less payment. If some near relative conducts the delivery, she is also offered a *saree* or silver ornaments along with rupees 11 or 21 as a *shagun* (a good omen).

Cultural and Social Organization of Childbirth: It is a custom among Raikas that a married woman delivers the first child at her natal (parental)

home and subsequent deliveries can take place in in-law's house. It is believed that a young woman needs great emotional and physical care at the time of first delivery, which she can easily get at her parental home, where she can easily and frankly communicate with the women of the house. In in-laws house she has to observe *purdah* or *ghoonghat* (veil) and she cannot directly communicate with the elders.

Thus, during the later days of the first pregnancy the woman is brought to parent's house and the entire expenses on the process of childbirth are borne by her parents. At the time of second delivery the woman can stay with the in-laws, but her parents take clothes and sweets for the mother and the child. The expenses of third and subsequent deliveries are borne entirely by the in-laws.

Childbirth raises the status of a married woman in her in-laws house. She commands more respect in the household when she becomes a mother and her children survive.

The community has a strong gender bias in favour of male children. When a male child is born in the family they exhibit their pleasure by ringing a metal plate (*thali*) with the help of a spoon, so as to let the news spread fast to the neighborhood. On the other hand when a girl child is born they only move a *soop* in the air. (A *soop* is a handy device made of straw for weaning chaff from the grain. It creates no sound when moved in the air.)

Care of *Jachcha* (Lactating Mother) after Delivery: In spite of the fact that Raikas treat the phenomenon of delivery as a common and normal event, yet they take some special steps in respect of the mother and the child. Some of these are as follows :

- The new mother is prohibited from taking bath for they believe that after delivering the child, the body of the mother is in cold state.
- A cloth is wrapped over her head to protect her from sudden stroke of air, which they believe could harm her.
- She is made to lie down and rest on the cot with the child even during day time, although almost late in her pregnancy she was made to work. This complete bed rest continues for 5 days from the day of delivery, which is supposed to be a period of ritual impurity called *sua*.
- A sheet of cloth is tightly wrapped round the waist so that it could help her regain its shape.
- If the *jachcha* complains of backache, a brick heated on fire and wrapped in a cotton cloth is applied slowly to the affected area. It helps in subsiding pain as it works as fomentation on any kind of internal swelling.

- In a rare case, the mother gets a massage from another woman of the house or from Gauri Maa.
- She is made to sleep on a cot on her back with legs close to each other, so as to heal vaginal injury caused by delivery. Sometimes oil and turmeric powder (an anti-septic home remedy) is also applied to the affected area to accelerate healing process.
- Immediate steps are taken to prevent the mother and the child from the invasion of evil spirits or evil eye, and for that the child is marked with a black spot on the forehead, while a black thread is tied around the wrist of the mother and the child. Sometimes an amulet (*tabeej*) is put round the neck or the arm.

Some other steps taken to avert the invasion of envious evil-eye or evil spirits are :

- *Lun mirch karna* in which some salt and dried red chilies are held inside closed palm that is rotated 7 times round the mother and the child. This material is then thrown over burning fire. It is believed that if it does not produce a pungent smell, the mother and the child are under the spell of evil spirit.
- During the period of *sutak* – a period of five days of ritual impurity – the mother and the child are not allowed any exposure outside.
- The new mother is made to take her *hareera* in privacy, away from the eyes of any other person.
- Even after the period of *sutak* the mother is prohibited from moving out alone in the afternoon and evening for a period of one month. She is allowed this liberty only when the *chuda* is changed. In this ritual, held after a month of the childbirth, the old bangles of the mother, which she was wearing at the time of delivery, are replaced with new ones as a mark of purification.
- While breast-feeding, the head of a lactating mother and the face of the child should always be covered with the *odhni* or a towel in order to avert evil influence on them.
- If in spite of all these precautions evil spirits affects the mother and the child they take recourse to *jhad-phoonk* by *pir baba*.
- At night, a certain iron object, an instrument like knife or anything else, is kept at the head side, in order to keep evil spirits away.
- A bag filled with a thick layer of sand is placed under the lower part of post parturient woman, from hips to the knees, which serves them as a no-cost local substitute for expensive sanitary towels.

Certain physical and dietary restrictions are observed in respect of new mother:

She is kept within the bound of a room, or a covered space (where the delivery took place and which they call *sobar*) and is all the time covered with a sheet of cloth (or a quilt in winters) because she is vulnerable to the seasonal effects of summer, winter and rainy season.

- She is not allowed intake of excessive liquid, as they believe it would swell and de-shape the body. She is made to sip hot water, instead.
- As long as she is on the herbal potion of *hareera* she is restricted from eating curds or any other eatable made of curds or gram flour.
- After the period of *sutak* she is allowed to eat semi-solid diets such as *khichri*, *dalia* and *lapsi*, instead of *chapatti* and vegetables.

Hareera – the sweet, rich herbal potion made in *ghee* or oil – is culturally a valued savory for new mothers, and women in general look forward for an opportunity to enjoy it. It is believed that this preparation has a special medical value and it helps women regain their physical energy faster after the physical crisis of childbirth. Even women of other castes (supposed to be higher castes) in the northern regions also take this preparation for a few days immediately following delivery.

The new mother becomes ritually impure for a period of five days and this period is called *sutak* during which this impurity extends to all the members of the household. It is a tradition in which the relatives of the woman also symbolically participate in the event of childbirth. Whether the child is born at parental home, or during migration or at the house of in-laws, *sutak* extends to the members of both families as soon as the news reaches them. Although couvades is not practiced among Raikas on the pattern of other tribal societies, but kin participate in the event in a various way, which gives the new mother a feeling of security and importance. There is no worship or a sacred act during this period. It is interesting to note that the word *sutak* has Sanskrit origin and the ritual is observed in other castes as well. Any contact with those or accepting food or water from those in the state of *sutak*, is prohibited. On the 5th day, after giving ritual bath to the mother, the women of the house worship sun (*surya pooja*) in which the mother also participates as a mark of purging and freedom from *sutak*.

Rituals for Easy Delivery: Raikas observe some simple rituals under the belief that this will facilitate smooth and easy delivery without demanding any medical intervention or uncalled for expenditure. Some of these interesting sin induced rituals are as follows :

- A thread of red and yellow colour - Mauli believed to be sacred among Hindus – is tied round the wrist of the woman when she goes for her first delivery to her parent's house.

- When the daughter-in-law departs from her *sasural* (in-law's house) for delivery, her mother-in-law observes a ritual called *god-bharna*, in which the expectant mother sits down and spreads her *odhni* over her lap. This is then filled with sweets and fruits that she carries to her parent's house and puts them before the household deities as a mark of devotion and respect. It is believed that this expression of respect would bring upon her the grace of god during delivery.
- As a precursor to easy delivery the locks of boxes and the doors of the grain store are opened and the hair of the woman is untied to accelerate the process.
- Elderly women of the family instruct the expectant mother not to scream or groan during labour pains – at least not to the extent of being audible to the men folk – otherwise pains shall increase and become intolerable. Moreover, a painful delivery is supposed to be an indication that the woman has committed some sin in the past.

Some Common Beliefs Relating to Gender of Expected Child

- During the course of investigations related to this study it transpired that Raikas cherish some common beliefs associated with the pregnant women that indicate whether the child will be a girl or a boy.
- It is believed that if due to extra enlargement of foetus the abdomen of a pregnant woman is extended more than normal, she will give birth to a male child, whereas in case of fewer enlargements, a female child shall be born. Similarly, if the delivery takes place before the completion of 9 months, a male child is born, and if the period is extended beyond this period, the child shall be a girl.
- It is also believed that if the labour pains start at the abdomen, it is the indication of a female child, and if it starts at the back, the child shall be a boy.
- As already stated, the food likings of a pregnant woman are also an indication of the gender of the coming child. Likings for sour and salty foods indicate a female child while likings for sweets indicate a male child.
- Raikas strongly believe that a physically deformed (blind, disabled or albino) child shall be born if a woman watches eclipse during the period of pregnancy.
- Delivery takes place generally in a small room or covered space. The woman rests after the delivery in a space not frequently used by men folk. The woman wears old and worn out clothes during the process because they are soiled and have to be discarded.

- If the delivery takes place at home, the tools used are common household appliances. A kitchen knife or a sickle is used to segregate the umbilical cord. These instruments are not sterilized as medically prescribed, but only scrubbed clean with the help of sand and water, and quite often even this small precaution if not taken. Heat in the place is provided with the help of a bowl of coal, or burning wood or even bricks heated on fire. Heat according to them helps in contraction of body muscles that are extended and relaxed in the process of delivery. Certain herbs and kitchen spices believed to have heating impact on the body are also given to the woman for facilitating contraction of muscles. *Dai* or elderly women assisting delivery also apply some pressure on the abdomen for removing any unwanted material from inside the body.

Salient Features of Child Health Care

Primary Care of Newborn

Primary care of the newborn among Raikas is taken by *dai* or elderly women of the house, if the delivery is conducted at home which is generally the case. The umbilical cord of the baby is severed with the help of a knife or a sickle, which does not conform to medical standards of cleanliness, and therefore it is likely to cause septic. Their past experience in this regard has perhaps taught them to apply turmeric powder mixed with oil, which is an anti-septic home remedy, to the affected area.

The mouth of the newborn is then cleaned with honey drops soaked on a piece of soft cotton cloth. The paste of turmeric powder and oil is also applied all over the body of the child before it is cleaned with lukewarm water by some elderly lady. In order to ensure that the child is normal and has proper vision and hearing power, the women assisting delivery perform some crude tests. For example, a finger is placed in front of the eyes, and if the child blinks, it is deemed that the eyesight is normal. Similarly, a sound is produced close to the child and if he startles with the sound, it is presumed that the child has normal hearing power.

In case delivery takes place at the PHC, it is the duty of the ANM and other medical subordinates there to take primary care of the health of the child. The staff of PHC was interviewed for finding out the details of the procedure. It was revealed that the younger generations of Raikas have started making use of maternity facilities available at these centers. The staff informed that they provide full medical care to the mother and the child whenever a delivery takes place under their supervision. Immediately after delivery the newborn is held upside down on its feet to allow any swallowed secretions to flow out and to clear air passage. Liquid and vaginal material is wiped gently away from the mouth and nose. It is ensured that the baby must breathe and

cry. Umbilical cord is severed with a properly sterilized knife and tied into a knot when it stops pulsating. It is ensured that the instruments do not cause any septic or tetanus. Before the child opens the eyes, margins of eyelids are cleaned with sterile wet swabs, and the child is given first bath with lukewarm water when it is few hours old.

Home Therapies for Health Care of Child

The naval of the child is compressed with the thumb to hasten the process of drying up. This procedure is conducted by an elderly woman of the family and is called *nadi dekhna.* In case the naval turns septic, they apply some dust of the bedstead and generally do not take the child to the PHC. An amulet procured from *pir baba* is also tied to the arm or neck of the child.

If the child vomits after being breast fed, it is believed that the mother's digestion is not proper and that she should control her diet to prevent excessive milk. In order to protect the child against mosquitoes they apply *mahua* oil to the body and face.

Except for these small cautions and measures no special attention is given either to the mother or the child. Raikas are a simple lot and they do not take any thing seriously. They want to see their children normal and healthy; but at the same time they believe that ailments get cured by themselves in due course with the passage of time and therefore they are not much worried if there is some health problem in the family.

Child Rearing Practices

Breast-feeding, according to Raikas is the chief source of nourishment to infants. If, however, the mother is seriously ill she is prohibited from feeding the child as it may cause illness to the child as well. In such case the child is provided milk of cow or goat. In case there is scarcity of lactation with the mother she is given *kala zeera* mixed with starch of rice, at least once a day.

Lactating mothers do not have any fixed time or fixed duration for breast-feeding the child. It is believed that the child shall cry to call the mother if it is hungry. Whether at home or in the field on work, she shall take out some time to feed the child whenever it cries for it. Normally the child is breast-fed up to the age of 2 years in spite of the fact that it takes supplementary diet. This feeding is stopped earlier if another child is born.

Mothers breast-feed their children for as long as they can because they believe it is not appropriate to feed them on animal milk. Buffalo milk is supposed to be heavy and inappropriate for the digestive system of infants and children. Cow's milk is generally prohibited under the belief that it deprives the calf of its own right to mother's milk. It is said that such calves that are deprived of udder feeding, yield no milk themselves when they grow up as

cows. For the same reason they do not provide even goat's milk except in emergent situations. Moreover it is believed that children brought up on the milk of goat or sheep become mischievous and restless youths. Therefore breast-feeding by mothers is practiced as a routine for as long as they can.

Supplementary food refers to food given to children in addition to mother's milk. Following Table No. - 1 throws some light on the pattern of introduction of supplementary food to children during their early age.

In spite of all this the food generally available to children is not nutritive enough. Mal-nutrition is rampant among Raika children, as a result of which they start all their normal activities such as turning on back, sitting, crawling, walking and speaking later than other normal children.

Immunization

An important aspect of government intervention in the field of child health is the introduction of free immunization of expectant mothers and infants against various diseases that in the past have caused a large number of infantile deaths or disfigurement of children. Immunization refers to development of immunity or resistance among pregnant mothers and infants against some common diseases through oral or injectable vaccines.

During the course of interview it was found that Raikas are not aware of the uses and the necessity of immunization of pregnant women. They pay no heed to it and elderly women discard it as useless saying that they have in the past given birth to several children without this un-necessary appendage. They are illiterate and they are seldom approached by social or medical workers to be apprised of the need or utility of immunization procedures. In fact their life-style is such that they cannot adhere to the immunization schedule even if they want to follow it. Even during pregnancy they are on the move while migrating.

Of the 45 families under study only 8.9% women were found to be immunized during pregnancy, and even among these only 50% went to the PHC for this purpose. The other 50% had gone to the PHC for some other health problem and the ANM, on knowing during diagnosis that they are pregnant, immunized them against tetanus, and informed them about it later.

In the two villages where this study was conducted there were a total number of 53 children within the age group of '1-day –18 months'. Their parents were interviewed for finding out the state of their immunization. It was revealed that they know about some kind of camps organized at the PHC by the government from time to time for giving *tika* (vaccine) to children. They also told that on some occasions the ANM of PHC and health workers of some non-government organizations come to their village and try to make them understand the need for immunization. Still the impact is not as it should be,

either because the efforts are not sincere, or that the facilities are not available when needed, or that the life-style of Raikas is not responsive to these details of child health care. The table hereunder shows the number of infants immunized during last 6 months from the time of study.

It can thus be seen from the above data that Raikas are neither aware not careful about immunization of children against diseases. Out of 53 children below 18 months, 52.8% are not immunized at all and it is only to 5.7% children that immunization is done according to schedule. Government and other welfare organizations working in the field of health must make some serious and whole-hearted efforts to socially educate members of Raikas community to adopt regular methods of immunization of pregnant women, infants and children, and to avail free services offered by the government in this regard.

Thus it can be concluded that child bearing is viewed as desirable and essential for a woman in community. Status of women in her in-laws house increases only when she becomes a mother (especially of sons) and her children survive. Childlessness is considered as a curse and a woman who does not conceive is believed to have done some sin.

Among Raikas pregnancy is taken very lightly as a normal and desirable condition for a young married woman. For most of the period of pregnancy, she does the normal household work like any other woman of the family. But, during the last days of pregnancy, she is prohibited from lifting heavy loads. However, they are encouraged to grind grains on hand mill (*chakki*) as it is believed to facilitate the childbirth. Anxiety associated with pregnancy does not exist among Raika women. The knowledge about childbirth and child bearing is derived much early in life. For instance, Raika being mainly a pastoral community, it is common for children to see animals giving birth. Moreover, as most of the deliveries take place at home by *dai* (local mid wife) young girls often assist them and thus gain some knowledge about child bearing and child birth before they themselves attain the age of puberty. The common image of labouring women among them is one, who takes her pains silently. It is believed among them, that a woman, who has done sin, has very painful delivery and the one, who is kind and noble has smooth and less painful delivery. This feeling of sin induced delivery facilitation is imbibed in the life pattern of girl children as a part of their general socialization and affects them unconsciously to bear suffering with grace.

Table 1
Pattern of Introduction of Supplementary Food

Age of the child	Pattern of food	No. of families adopting the pattern N=45	%
Up to 4 months.	Totally breast-fed.	All the 45 families.	100
Above 4 months up to about 18 months.	Supplementary food such as water portion of boiled rice or boiled Moong *dal* is gradually introduced and occasionally given, depending upon the digestive capacity of the child.	30 families.	66.6
Above 18 months up to the age of 3 years.	Semi solid foods such as *dalia*, *khichri*, boiled rice, vegetables are introduced in a regular manner.	15 families.	33.3
Above 3 years of age.	As far as diet and nutrition is concerned, the child is considered equal to any other member of the family and no special treatment is given.	All the 45 families.	100

Table 2
Number of Infants Immunized in a period of 6 Months

S. No.	Status of Immunization	Number of Infants N=53 Frequency (f)	%
1	No immunization at all.	28	52.8
2	Only O.P.V.	14	26.4
3	Measles and B.C.G.	5	09.4
4	D.T.P., O.P.V. and B.C.G.	3	05.7
5	All immunizations according to the schedule.	3	05.7
	——	Total - 53	100.0