CHAPTER - I

INTRODUCTION

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The mother plays an important role in the socio-cultural context as she influences all other areas of life. The world over women are caretakers of home. They perform the most vital tasks without which their families and communities would literally collapse. It does not matter if the women are old, young, pregnant or lactating. The crucial role they play continues relentlessly. They cook food, work on agricultural fields, fetch drinking water, look after children, fetch food, fuel and fodder, care for animals, 'yet as the weaker sex get discriminated against and the last to eat' (Nisha Rao: 1989).

Status of women it appears is generally viewed in relation to the status of men. In relative terms, the mother's status is an artifact of positions and roles she plays in social and economic life, as someone's mother and someone's wife (Bhagat: 1990). A study by the United Nations (1975: 5) on the status of women and family planning views that the best measure of status is the extent of control that a person has over his or
her own life, derived from the access to knowledge, economic resources and political power and the degree of the autonomy enjoyed in the process of decision making. If status depends upon the degree of decision making that a human being can enjoy, we as anthropologists also believe that this can only be achieved with in the means of culture.

It is said that mother's had a celebrated era in the field of education, arts and culture from 500 B.C. to 300 B.C., the time of Buddhism. Something went so evidently wrong that by the time British arrived, the entire female species stood illiterate (Premi 1982: 313). One reason may be that several invasions of the Muslim Kings ushered in Islamic influence, according to which women's role was relegated to that of a mere chattel. A mere child bearing object. Be it a mother or wife. This goes to validate the view that status can receive upgradation, modification, or total nullification, by different processes of culture change, which form, part of the subject matter of anthropology.

'Mother' in the Indian culture occupies a very special place. The salutation and thanks giving to the Mother at every dawn is beautifully expressed in the following verse: MATRU DEVO BHAVA,
what follows is: PITHRU DEVO BHAVA and ACHARYA DEVO BHAVA. In the context of child care she carries the child for nine months in her womb and gives birth, nurses, feeds, fondles, nurtures and loves the child. It is believed that her very presence close to her child will protect the child from evil spirits and evil eye. Mother has a greater role in the upbringing of the child and she influences various practices pertaining to social and cultural aspects. Thus it is the mother who contributes the first lessons in the process of socialisation of the child. One question that would come up here is, with such a high place of reverence in the culture and tradition, how has the importance gone down? Why it needs to be re-emphasised that the mother and child needs a priority in the context of development?

This thesis presents a comparative study of the cultural practices, related to mother and child care of the tribal, rural and urban slum communities from Visakhapatnam district of Andhra Pradesh, primarily in the context of emphasis of their health care. What do these different societies consider, while defining health in the context of Mother and Child care? Similarly, what does disease and getting rid of disease as process
mean to these cultures? Further, what type of facilities are available and how are they utilised? Do they have, reasonable explanations for acceptance or rejection of modern medical system in a culture? Finally what factors influence the choice of a medical system or usage of combination of medical systems such as, ayurveda, allopatherapy, ethnomedicine etc. The above questions are raised in this exploratory study.

In this study cultural patterns regarding mother and child care in tribal, rural and urban communities are comparatively analysed to give reasons for acceptance or rejection of modern medicine. This study argues that proper weightage must be accorded to traditional medicine in the overall planning and developing a health care delivery system in a country like ours. If all people in all cultures have to be better served or benefited, this perspective of health care would evidently call for more cooperation and collaboration between various systems of medicine. Thus an integrated approach that has a preventive and a promotive perspective within the socio-cultural milieu, is likely to make health goals of the country a reality.
It is well known fact that institutions arise out of human needs, the field of mother and child care is no exception. The field of Mother and Child care demands services in the pre-natal, natal and post-natal services. The need for treatment and cure of diseases that affect mother and child care in particular has been known to all cultures, each culture developing its own ways and means of dealing with these problems.

The researcher is conscious that the word health care carries, much more comprehensive treatment of the subject than mere offering of medical care for mothers and children. But, for the purpose of this study, a mechanism by which curative, preventive and promotive services are made accessible to relevant populations through an established institutional network of professionally organised services is being considered as health care delivery system.

Health care delivery system in India particularly in the context of mother and child care appear, consisting of curative, preventive, promotive and rehabilitative services to the client system.
Various provisions have also been made, statutorily, to make services available at three levels, throughout the length and breadth of the country. These three levels are:

1. Primary level - primary health centres and sub-centres

2. Secondary level - Taluk and district hospitals which are referral centres and

3. Tertiary level - which includes hospitals and specialised institutions at the regional and state level.

Besides these both governmental and non-governmental services, exist in addition to folk health care, (ethnomedicine) of herbalists, vaidyas and other traditional practitioners.

The services in the field of mother and child care provided by the government sector are the pre-natal care, safe delivery, post-natal care, immunization, family planning, treatment of minor ailments, control of communicable diseases and referral services.
The health care delivery system as said before operates primarily within the Government system as also supplemented and supported by the non-governmental institutions and non-institutional services. It is an accepted fact that in the last four decades of Indian Independence, the development and proliferation of allopathic facilities, medical schools and speciality hospitals has received tremendous impetus.

However, the impact of such an impetus has not actually percolated down, to the larger sections of the poor, in our society.

As said earlier, other schools of medicine such as Homeopathy, Ayurveda, Unani, Naturopathy, Yoga and ethnomedical systems exists in our country. But many of them way behind official patronage. One might say that the poorer sections of the country have not been totally deprived because of atleast the presence of these systems. The state patronage and allocation of funds for other than modern medicine or allopathic medicine, is appallingly low.
As such it is imperative to the study to include in its objectives, the accessibility, affordability, and viability of various forms of medical systems, from the point of view of the client.
1. The Focus of the Study

In order to understand the relevance of health services it is useful to study the cultural practices which are so closely linked to health practices. The present study is limited to the understanding of cultural health practices of mother and child care. The comparative discussion of the tribal, rural and urban cultures of the Visakhapatnam district, the study region, will provide us with an understanding of concepts of health, illness and causation. The following questions have been raised in the study.

How does the concept of health, disease and illness differ from culture to culture? Is there a commonalty at the level of nominal understanding of the definitions of health, disease and illness? Are there any culture specific pre-natal and post-natal practices?

Similarly does child care differ from urban to rural to tribal cultures?

What influence does geography and climate exercise on the food practices of mother and
children? How does the utilisation of health seem to differ from one community to another? Is utilisation of health dependent on the beliefs and practices of the communities and finally as different forms of system and services are available such as modern medicine, ayurveda, ethnomedicine etc., do communities switch from one system to another or do they suggest simultaneous utilisation?

These and related questions are addressed in the primary study. Apart from the primary study and its findings the present work addresses in a brief manner critical variables such as accessibility, acceptability and availability of the health care delivery system meant for serving the communities, by deploying the case study method.

2. Objectives of the Study

More specially the objectives of the study are

1) To examine the concepts of health and disease with reference to expectant and nursing mothers in tribal, rural and urban communities.

2) To compare various aspects of health care
practices related to mother and child care in the three communities.

3) To list out various food practices among the communities with reference to mothers and children.

4) To critically review the aspects of health care delivery system in the state and district, and

5) To analyse factors contributing to acceptance or rejection of modern medical system.

3. Health and Culture - Inter relationship

Are all cultures health conscious? Yes indeed. It appears that almost all cultures have provided in their own way certain safeguards to protect the health of its members. However, the explanation of the cause of illness varies. Some explain illness as a result of supernatural phenomena while others may have rather rational and seemingly scientific explanations. Take for instance, the Measles - disease. It is believed in most of the tribal cultures in India that the disease is caused by the visit of a Goddess. The rural as well as migrant urban poor share the same belief. While the ethnomedical explanation stands as 'ejection of heat out of human body', ayurveda

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recognises and also shares the same explanation as such in its prescription, several foods, which are expected to cool the body are recommended. The alopaths came with a different explanation, that it is due to virus, and that it is preventable but there is no cure. From the time of Adam, questions for which rational and scientific explanations have not been given by medical men, for diseases, cultures have recognised, their origin in the supernatural. Issues for which rational answers are not provided and yet persist are left to nature itself. Culture has responded to such enigmas in its own way.

Similarly treatment practices also, differ. The tribals have considered measles as visit by the health goddess, one who contracts measles is kept and hidden so that the health goddess does not come in contact with other children. Children in fact are totally withdrawn into the confines of homes as soon as the community gets to know that the Goddess has visited one home. Belief systems do not stop here. The child gets nothing to eat. At times, malnourishment sets in. Such is the power of culture specific belief system.

Therefore, social and cultural factors related to health and nutrition assist us in answering some of the practical problems involved
in implementing health programmes. The socio-cultural perspective, affords us an understanding of existing habits of the people, the interlinking amongst these habits, thus pointing towards identifying major barriers in the implementation of health programmes (Paul, 1955).

In order to ensure the social integrity of the people the best methods or harmonising interventions are required. For this reasons working understanding of the cultural principles which govern behaviour in the culture is needed. Questions such as why a programme worked? why a certain programme did not work? and how the programme can be better designed to work? often form part of evaluations. These are constantly raised and answered. However, it is always better that even before a programme is launched in a community the socio-cultural aspects of life of the communities are understood.

Socio-cultural studies, help us, show the rationale behind decisions which otherwise appear to have been randomly made without assigning good reasons. Studies can show full implications of introducing a specific change into societies. They can give insights into people's belief systems and
attitudes to health and disease. They can suggest how to ensure in a population, the best cooperation with, participation in and appreciation of health work carried out by personnel trained even in an alien system of belief.

Socio-cultural factors influence individuals directly and very likely to change the course of conduct that an individual may be compelled to take. For instance the rural client may have strong notions that foods have heat producing or cold producing effects on him. It is perhaps not so easy to convince him about the scientific invalidity of these notions.

Certainly, the idea of including socio-cultural factors in studying the distribution and etiology of disease is not new. It is said that it is as old as Hippocrates. Social and cultural factors are no more clues to disease but have become part of the cause of all morbid episodes (Kosa 1969, Pfifferling 1975). One can recall that the association between social sciences and medicine, is atleast a century old.

In the past, many studies examined the socio-cultural aspects of health. These studies were carried out within India as well as abroad. It
appears that, early writers held in great esteem and remembered as pioneers have analysed the interrelationships between social sciences and medicine. Examples include Dubos (1959), Sigerist (1960) and Polgar (1962).

But even after this long historical awareness about the importance of socio-behavioural factors for medicine and public health, the attitudes of the medical scientists and social scientists have not changed much. Each, remain in their domain and consider each other with distrust and doubt. In their study, Duff and Hollingshead (1968) reported that the behaviour of the physician in treating a disease is still mechanistically oriented. Most physicians think socio-cultural factors are neither significant nor directly related to diseases. This, the researcher attributes to inadequate orientation to preventive and promotive aspects of health.

Dubos’s (1965) in his writings reflected that the greatest advances in the health of the people were probably indirect results of better housing and working conditions, the general availability of soap, or linen for under clothing, of glass for windows and the humanitarian concern for higher living standards.

Kosa (1969), and Nelson (1975) in their
writings argued on the same lines, that the
discovery of Tubercle Bacillus has no relation to
the decline of Tuberculosis in the Western World.
Tuberculosis started declining in U.S.A. and Europe
several decades before the discovery of Tubercle
Bacillus in 1882 and the disease was more or less
restricted to very low levels even before
Penicillin was discovered as the effective remedy.
In the Indian context too, this is the reason why,
Wahi (1970) called for treating medical science as
intrinsically and essentially a social science and
forewarned that unless such a recognition is
awarded, no proper benefits could be enjoyed in the
direction of health practice.

Lyle Saunders (1962) an American
anthropologist with his experience of Latin
American health problems found that social and
cultural behaviours were important factors in the
etiology, prevalence and distribution of many
diseases. How people live, what they eat, what
they believe, what they value, what technology they
command, are significant determinants of their
individual and collective health. (Saunders 1962;
Mead 1966). This concern was developed into a
major area of contribution by medical sociologists
and anthropologists (Polgar 1962; Scotch 1963;
Fabrega 1972).
In a way before Anthropology was recognised as a discipline, medical researchers were studying how the prevalence of illness was related to the location of the individuals in the society (Kendall and Reader 1972). Health problems and social problems have a "reversible" relationship. Some social problems create health hazards as in the case of slums, wherein lack of healthy ventilated housing leads to diseases and problems (Suchman 1963).

An overview of the current and past research shows that, no significant effort was made to identify the crucial processes in the cultures and to relate these practices to the etiology of prevailing diseases. In this regard, Cassesl et al. (1980) pointed out that there is a gap between a unified body of theory within the social sciences and categorisation of the health relevant social and cultural processes. Anthropology to a large extent has provided structural schemes, but conclusive agreement as to which processes are relevant to health? how many crucial processes there are? and how these processes are linked to the health status of individuals and groups? has not yet found a place in the syntheses. However, it ought not to be construed that there is no
theoretical framework in Social anthropology to explain the social causes of disease.

Over the years, interest in the interrelationship of culture to health, grew into a major branch of research in Anthropology in the present century under the name 'Medical Anthropology'. Now as it stands it is an interdisciplinary field of research combining the concepts and methods of medical sciences and those of social sciences in order to understand the medico-social problems much better. There is now considerable amount of research available which has taken social and cultural factors into consideration for understanding the disease in question. Some selected studies are mentioned here:

1. that mental illness was related to social causes (Hollingshead and Redlich, 1958).

2. that social stress plays a role in social disorganization in mental health (Leighton, 1959).

3. that childhood and adulthood experiences reflect on the mental health of populations (Srole, 1965).

4. that depressions are related to social causes (Brown 1978).
5. that in the same way social factors were related to heart diseases (Dowber et. al. 1959); Tyroler and Cassel (1964); Suchman (1967); House (1974).

6. that diseases like arthritis were related to some social factors (Cobb et. al. 1957).

7. that cancer was studied in relation to certain social and cultural factors (Wynder, 1954).

8. that hookworm infection was related to cultural and environmental factors (Kochar et. al. 1976).

Djurfeldt and Lindberg (1975) in their work titled "Pills against poverty" have identified two different views in the field of medical research with two different views in the field of medical research with two different concepts of disease. The first approach studies the "illness" as a "cultural category" and as a result "culturally related events". This type of study take a group as the unit of analysis. The second approach studies the disease from a biological view point. This approach gives emphasis to the abnormality in the structure and function of any system in the body which it defines as disease.
Brown (1976) in his book ‘Social causes of disease’ identified two main sociological approaches to the study of disease. The first approach starts with ‘intensive study of the individual’s milieu’ and through a series of such studies tries to reduce the results as relatable to the ‘immediate social factors to broader social processes’. The second approach he identified, is ‘with a much broader canvass and hopes that findings can be brought to bear on the individual and his immediate milieu’. As an example for the first approach, he mentioned the studies of Cobb et. al (1968) which related rheumatoid arthritis in adults to early punitive parental behaviour. As an example for the second approach, he mentioned the Midtown Manhattan study by Srole et. al (1962) which showed that 23% of a sample of 1,660 inhabitants close to the centre of New York were considered psychiatrically impaired.

In addition to the above mentioned studies, Jenkens (1971) reviewed ‘Psychological and social precursors of coronary heart disease’, wherein he could list 162 other relevant studies. Thus it is amply clear that the volume of the research done and the popularity of the approach is gaining both a new momentum as also leading to new pathways of understanding.
Among the best known studies in India on health and cultural practices are those of Matthews (1979) 'Health and Culture in a South Indian Village.' This study scores the importance of culture and belief systems about the causes of disease in the South Indian Village setting, Kodyur near Vellore, in Tamil Nadu State. Different types of treatment with a variety of healing practices were identified in the field of maternal and child-health and family planning aspects. The implications of Matthews' findings for health education are: (a) that it is important to understand beliefs of the people and (b) that such an understanding can bridge the communication gap between the doctor as an expert and the patient as the recipient. Matthews found that many pregnant women in the rural areas did not see the need for ante-natal care and their diet was severely restricted in post-delivery.

Hasan (1967) in his study 'Cultural Frontier of Health in Village India', dealt with social and cultural factors affecting the health status of the rural community, gave evidence of the interplay between the cultural aspects and those related to
health and went on to record that indigenous medicine was capable of improving the health and promoting medical care to the people.

Yet another study, 'Pills Against Poverty' by Djurfedlt and Lindbert (1975) (A study of the Introduction of Western Medicine in a Tamil Village), in Thaiyur, Chengalput District of Tamil Nadu, critically reviewed the ideology and dominating health practices both in the 'Third World' and the West. The health situation the authors saw in the Village was a consequence of the prevailing economic social and political order. The critique did make a comparison of the effectiveness of Western medical technology in the light of already existing indigenous health systems.

Another study is by Trakroo (1981) on the social pattern of seeking medical care - a study of curative behaviour in rural areas. This study investigated the social patterns of seeking medical care in rural areas of Haryana. This study found that socio economic status as a main and potent determining factor that has influenced utilisation.
As interaction between man and his environment is well discussed by field researchers, sociologists and anthropologists, and often complemented each other in their approaches. Let us now look at a few approaches to study health and disease. There appear to be four different approaches subscribing to this direction.

4. Approaches to study health and disease

4.1 Environmental approach

The first approach called the environmental approach developed by Gordon (1966) divided the environment into three basic components, namely, the physical, the biological and the social environments. Gordon felt that in the matters of health it is not enough if we observe the individual as a biological unit but we should observe the community as the 'eco-system' which is far reaching in its elements. When we are searching for the cause of disease, we cannot ignore any of these three components.

![The Environmental Approach](image.png)
4.2 Social Epidemiological approach

The second approach known as Social-epidemiological approach, studies the disease as the result of mutual interaction and balance between the human individual as a 'Host' to the disease, the infectious 'Agent' as the carrier of the disease and the 'Environment' as the surrounding medium which affects both the resistance of the host and the virulence of the agent, and the contact been the two. This understanding was provided by Suchman (1963).

Fig: 2 The epidemiological explanation of disease.
4.3 Multiple Causation approach

The third approach to the study of disease is known as the 'multiple causation'. According to this approach, social factors are analyzed as only one part of a complex causal nexus in which no single factor is a necessary and can afford sufficient explanation of the occurrence of the disease (Suchman 1963).

4.4 Time Person Place approach

The fourth approach which tries to compare the variables related to person, place and time is known as Time, Person Place approach. Mac Mohan and Pugh (1970) pointed out that all epidemiological analysis requires awareness of the interactions between person, place and time in the causation of disease. An example for this kind of approach is studying the role of migrant population in the spread of infectious diseases.

5. Holistic Model

Man lives in an environment - the dimensions of which are the physical, the biological and the social. (see fig.1.3) When we speak of environment, we speak of various kinds of living and non-living matter and these have a
Fig: 1.3 Concept of Health and Disease
A Holistic Model
(adapted from Srinivasan, S et.al 1982:489)
definite relationship to human growth and development. The air we breathe, the water we drink, the elements with which we interact and use, the plants and animals, the bacteria living in nature. Some with predatory and some with symbiotic life styles can be spoken of as the interactive environment. Amidst such a physical interface the human being as part of the group, community and culture have found interactive ways of contributing to his or her own health both in positive as well as in negative terms.

Negative health i.e., illness of the individual tends to assume physical, mental and social dimensions. We include under the physical dimensions the structure and function of the body leading to productive life by enjoying the basic requirements of life - the food, water, air, sanitation, living environment and working conditions. Under the mental dimension we include the well-being of the mind based on physical health in relation to the social setting. The mental dimension assumes well being at the psychological and spiritual level. The social dimension aims to achieve equal opportunities for full growth and development of an individual in a society. Thus individual and community's health become the two sides of the same coin.
Health by a such a definition is not a static state but a dynamic state continuously evolving. It moves and changes to positive and negative directions. The positive direction points to the total or holistic health and negative direction to total death — physical and mental. Another way of explaining would be that health, when it starts degenerating, will lead to slowly to ill-health, disease and disability, further on leading to death. Ill-health can begin anywhere in the physical, mental or social levels leading to sickness, disease and disability and death. Human being with interaction can use usher harmony into the environment and thus bring or upgrade total health at the level of the community.

The holistic approach to the study of health and disease rests primarily on the singular or plural interface of these environmental components with man and the results thereof. This model provides a much more comprehensive understanding of the issues raised, by anthropology in relation to the mother and child care. The organisation of health care delivery system, the role of support institutions and above all the role of culture plays an important role in achieving peoples health. Before we move further on into the
study it is pertinent here in this chapter to clarify various concepts and definitions used in the study.

6. Concepts and definitions

1. Health

Health is defined as a state of complete physical, mental, social well-being and not merely absence of disease or infirmity (WHO, 1947).

2. Disease

Disease is defined as a biological phenomenon where the physical body gets affected when it may not function or function in an abnormal way.

Disease refers to a medical conception of pathological abnormality which is indicated by signs and symptoms.

3. Illness

Illness is defined as a psychological phenomenon or one's feelings about the physical functioning of the body.

Illness refers to a person's subjective experience of disease and is indicated by a person's feelings of pain, discomfort and the like.

4. Sickness

Sickness is related to social dimension
of disease wherein the society sanctions time to recoup in the form of permission from working or granting light work, complete bed rest, including privileges of an attendant or isolation for the period of the disease.

5. *Traditional Medical Systems*

Traditional Medical Systems include both Indian System of Medicine, Homeopathy and ethnomedicine.

**Indian Medical System and Homeopathy**

Indian Medical System includes Ayurveda, Sidha, Unani, Naturopathy and Yoga and also Homeopathy.

**Ethnomedicine**

Ethnomedicine includes folk systems of health care concerned with specific tribal or rural culture of communities.

6. *Traditional Healers*

Traditional Healers may be defined by the way in which they were trained, their methods of healing or the ailments they treat by super natural or rational or both considerations (Katz et.al 1982).

7. *Modern medicine*

Modern Medical System is synonymous with
Western, Scientific and Cosmopolitan medical systems.

8. Medical pluralism

Medical pluralism is defined as a condition of accessibility of various medical, diagnostic and treatment procedures in a given society.

9. Multiple Utilisation

Multiple Utilisation is defined as the use of any single medical system or simultaneous use of more than one or all medical systems through their practitioners for solving health problems of individuals and communities and maintaining their health.

10. Cultural Change

Cultural change is defined as a process of which people in one cultural group borrow, initiate or assimilate and incorporate ideas, things or values into their way of life (Mc. Elroy and Townsend 1985, Boyce and Boyce 1983, Brown 1982).

This may further be explained as the processes of diffusion, acculturation, assimilation and ethnic revitalisation.
11. Health Care Delivery System

It is a mechanism by which curative, preventive and promotive services are made accessible to the population by the State through an established institutional network of professionally organised services.

7. Organisation of the Study

The Study is organised into six chapters subsequent to Introduction. The second chapter explains the research methods techniques and tools used for the research along with the sampling methods. The methodology adopted for the research is both qualitative and quantitative. The techniques of observation and in-depth interviews were used for the case of studies, and structured interviews for the sample survey. Quantitative data supplemented the qualitative data.

The third chapter considers the concept of health, illness and causation, in a comparative perspective. It also brings out nominal understanding of these concepts among the three cultures and how these concepts are very closely interlinked with their socio-cultural milieu.
The fourth chapter discusses health care practices of the three communities relating to i) pregnancy, prenatal care and practices associated with it; ii) practices related to delivery and neo-natal care; iii) post-natal practices and iv) and child care practices. The qualitative data presented here is supplemented by the quantitative data.

The fifth chapter critically looks at the organisational structure and services provided by the government in the tribal, rural and urban communities. It also considers health services available in the study area. It further discusses the utilisation of services and factors associated with and contributing to the utilisation of health services by the people.

The sixth chapter presents a discussion on the acceptance or rejection of modern medical system through different case studies. It analyses factors influencing acceptance or rejection. The case studies presented here illustrate, how closely, people are linked with a particular health care delivery system within their socio-cultural milieu, and how their beliefs and practices contributes to the acceptance or rejection of a particular health care system.
The seventh and last chapter discusses various cultural practices related to mother and child care, (the harmful practices and useful practices) and their significance in these three communities. Finally it discusses the kind of health care delivery system in practice, the problems identified from the study and the need for more collaboration between traditional and modern systems in order to improve health status of mothers and children within the socio-cultural context.