Chapter 1

INTRODUCTION

Health and human development form integral components of overall socio-cultural and socio-economic development of a people or a nation. As a matter of fact, health and disease are measures of the effectiveness with which human groups, combining biological and cultural resources, adapt to their environments. And the same is reflected in the definition of 'health' given by the World Health Organization (1946) “health is a state of complete physical, mental and social well-being”. The fact that health and disease are related to biological as well as cultural factors underlines the convergence of the fields of medical science and cultural anthropology. It is significant to note that modern medicine with its origin in western society has adopted predominantly a biological orientation and has rarely looked into the relationship between health and disease with diverse social and cultural contexts. Consequently, in spite of tremendous advances made in the field of medicine and health technology, the health status of the people in the developing countries remains low.

In any community, mother and child constitute a priority group. The old saying that 'Child is the father of Man' is true in more sense than one. The qualities of a person imbibed as a child deepens as he/she grows and expresses in several ways obvious and subtle, in his/her conduct and character as an adult. Therefore, what affects the interest of the children also affects the well-being of the entire society of which the child is but one member.
In recent years there has been a growing concern for the health of women and children in developing countries including India. This is evident from the Government’s policy of adopting women’s health perspectives in strategies addressing child-survival, family planning and women’s developmental issues. Though the heightened importance has been given to the health of women and children, the intermediate variables, which affect the health of women, like her childbearing pattern, her use of health services and her health related practices that impinge on her susceptibility have not been effectively considered (Hawaldar et al., 1995).

There are varying views and perceptions about Maternity and Child Health (MCH) programmes as revealed by the existing literature and by the outcome of relevant schemes and plans in different societies. Of these, the biomedical perspectives bereft of the socio-cultural nuances which in fact constitute the matrix for the mother and child-care, is found to be the dominant perspective at various levels of planning and execution of the programmes meant for mother and child health.

Mothers and children not only constitute a large group of humanity (i.e. two third of humanity), but they also are a vulnerable or a special risk group. The risk is connected with childbearing in the case of women; and growth, development and survival in the case of infants and children. Fifty percent of all deaths in the developed world are occurring among people over 70, where as the same
proportion of deaths are occurring among children during the first five years of life in the developing world (Park and Park, 1981).

The problems affecting the health of mother and child are multi-factorial. Despite current efforts, the health of mother and child constitute one of the most serious problems affecting the society in the developing countries.

1.1 Mother and Child Health Perceptions of International Organizations

Considering the health problems of children, the United Nations Family Organizations took children seriously from the very first day of their existence, by establishing an emergency fund to help children. The fund was called the United Nations International Children's Emergency Fund (UNICEF) created in December 1946 and most of its initial efforts were directed to helping children in parts of Europe and Asia (who were most seriously affected by the World War during the latter half of the 1940's). UNICEF has been able to assist the developing countries to formulate national policies for children. At the same time, it induces the developed world and the international agencies to increase allocation to child development programmes.

While UNICEF led the way, the other organizations and programmes of the United Nation system became increasingly involved in assistance to the developing countries: first among them is the World Bank. Principal organizations, which are of direct relevance for children, were the United Nations Educational Scientific, and Cultural Organizations (UNESCO) set up in the year
1946, and the World Health Organization (WHO) set up in 1948. Nevertheless, the activities of other agencies were also more or less relevant to children. The work of the International Refugee Organization (IRO) later to become the United Nations High Commission for Refugee (UNHCR) established on January 1, 1951 is one such example.

In the past, maternal health and child health services were divorced from each other and were provided as piece-meal services in the form of ‘personal health services’ by different agencies. Later, the trend changed to provide integrated Mother and Child Health (MCH) services. This implies a close relationship of maternal health to child health and of maternal and child health to the health of family and of family health to the general health of the community.

MCH problems cover a broad spectrum. At one extreme, the most advanced countries are concerned with problems such as prenatal problems, congenital malformations and genetic and certain behavioral problems. At the other extreme, in developing countries, the primary concern is reduction of maternal and child mortality and morbidity, spacing of pregnancies, limiting of family size, prevention of communicable diseases, improvement of nutrition and promoting acceptance of health practices. India is not an exception for this.

India is the second most populous country in the world. Even now in the 21st century, majority of the population in India just manages with bare economic necessities. The economic development of the people compared to the developed world’s standards is still a farfetched dream for most Indians. In a scenario, where
the availability of a square meal per day for most people becomes a difficult proposition, thinking about their health and hygiene becomes a non-issue. This problem gets compounded when the target group of development happens to be the women and children who constitute the weaker section in the Indian rural society. Providing health and hygiene to this weaker section of the society especially to the mother, right from the conception to childbirth stage and the improvement of health of the child becomes a subject of immense significance in the overall development of the Indian society.

The MCH perceptions of India, National and International Organizations have been discussed below in two parts namely

1.1.1. Views on Maternal Care; and

1.1.2. Views on Child-Care

1.1.1 Views on Maternal Care

According to estimates in the year 1988 in India, about 130 million women were in their reproductive age group with 26 million births a year. There were 3-4 million induced abortions each year (Annual report: Department of Family Welfare, Government of India 1988). On an average, women in India experience 8 pregnancies and typically 4-5 live births in their reproductive age of 14-45 years. Further it has been estimated that women spend 80 percent of their reproductive period in the state of pregnancy or lactation (Annual report: Department of Family Welfare, Government of India, 1988). Thus reproductive morbidity including
reproductive tract infections has adverse influence on women’s reproductive role and their health profile.

Medical causes of maternal mortality are divided into direct, indirect and coincidental. Direct causes are diseases or complications, which occur only during pregnancy, or childbirth, like abortion, ectopic pregnancy, hypertensive diseases of pregnancy, antepartum and postpartum hemorrhage, obstructed labor and puerperal sepsis. Indirect causes are diseases, which may be present before but are aggravated by pregnancy, for instance, anemia or diabetes. Coincidental causes are factors not especially related to pregnancy like accidents (WHO, 1991).

The reasons for all these problems are widely claimed to be that women do not seek health care for many of their gynecological problems, partly because they cannot or will not divulge these problems to male doctors who outnumber female doctors, by considerable times (Pelto, 1982).

1.1.1.1 Intervening Variables affecting Mother’s Health

1.1.1.1.1 Energy Intake

During pregnancy the body needs more energy for the growth and maintenance of the fetus, placenta and maternal tissue. As estimated by Hytten and Leitch (1971), in a normal pregnancy, the total maternal weight gain amounts to 12.5 kgs. To accomplish this total maternal weight gain, a pregnant woman should take extra 300 kcal per day throughout the pregnancy (Annual report: FAO/WHO, 1985). In the Indian context, the Indian Council of Medical Research (ICMR) recommends 600 kcal more per day during the second and third trimester
of pregnancy (ICMR, 1990), keeping in mind the poor energy intake of Indian women.

The nutrition contents of the mother’s diet, which affect the growth and development of the fetus, are mainly calories, protein, calcium and iron (Mohapatra, 1989). According to various researchers, the greatest period of brain growth among human beings takes place in the last few weeks of gestation and in the first few weeks after childbirth. Malnutrition of the mother therefore, during the end period of her gestation and during her early postnatal period, results in the retarded bone development of the child which she delivers (Ranga Rao, 1973).

That is why maternal nutrition is often considered as an important requirement for the human fetal growth. The nutrition of a women not only during pregnancy but also even in her child-hood influences obstetric outcome (Mohapatra, 1989). The studies conducted in India show that women in India are malnourished and hence they need supplementary food (Mohapatra et al., 1989, Bharati P. et al., 1990, Chowdhary et al., 1995). Bhatnagar (1983) who conducted his study in the slums of Delhi, points out that there is a positive effect of weight gain of pregnant woman on birth weight of the infant.

1.1.1.2 Physical Exertion

The gap between energy intake and energy expenditure might be bridged by an adaptation of the metabolic response of food consumed or by adjustments in physical activity or increase in work efficiency. Women in developed countries live a more sedentary life (Durnin et al., 1986: Raay et al., 1986) where as women
in developing countries are more active throughout their pregnancy (NAS, 1990). The physical exertion could also have other independent effect on pregnancy and pregnancy outcome. Studies have shown that the people in rural areas of developing countries and people in traditional societies are active throughout their pregnancy, which enables them for an easy delivery (Read, 1959; Vanstone, 1962; Denton, 1962).

1.1.1.3 Morbidity during Pregnancy

Well-being of the pregnant woman and in turn the fetus depends to a considerable extent on the morbidity status during pregnancy. Morbidity during pregnancy affects maternal weight gain and pregnancy outcome through different mechanism (Kramer, 1987). Morbidity can also induce a reduction in food intake, which in the long run leads to lower weight gain and a decrease in energy available for the fetus.

Anemia is one such health problem of pregnant woman and plays an important role in the developing countries in the health of pregnant woman. Anemia is commonly defined by UNICEF (1991) as a hemoglobin level below 11 gm/dl. The studies conducted in India show that there is a high association between anemia, premature delivery and low birth weight (Prema, 1978; Raman, 1987). The people in rural areas are not aware of anemia as a health problem. Their idea of “weakness in a pregnant woman” which is associated with insufficient intake of food can be equated with “anemia”. Due to this lack of awareness there is a partial intake of iron tablets in rural areas (Hutter, 1994).
1.1.1.4 Age and Parity

Age of the mother affects the weight gain of women especially in developing countries (NAS, 1990), where pregnancies among adolescent women are more common. Young adolescents becoming pregnant within two years after marriage, showed a lower weight gain during pregnancy. Age is related to parity. Kleinman (1990) concludes that primiparae gain more weight than multiparous women. Tripathi et al., (1989) finds that primiparae women aged under 20 gain less weight than others. There is a trend of increasing birth weight with maternal age and there is drop in weight after the maternal age of 40 years (Ramamma et al., 1977; Bhattacharya, 1991).

In India, Grover (1982) concludes that women younger than 20 and older than 30-35 years are more at risk of having low birth weight children. There is an effect of age and parity on birth-weight; women younger than 20 and of first parity have children with a lower birth weight (Tripathi, 1987, Bhattacharya, 1991).

The variables, which affect the pregnancy of a woman, have direct relationship with the health of child to be born. That is why, Government of India, of late, has launched various health programmes to improve the health of women especially during pregnancy.

1.1.2 Views on Child-Care

Although infancy and childhood occupy only a small fraction of the life span, they are the most crucial years in determining and influencing the course of adult life. The needs of the child start with conception and pre-birth development.
It is born helpless and totally dependent with the vociferous demands for attention, care and security. According to the modern health practitioners, the indigenous midwives, who normally conduct the childbirth in rural areas use unhygienic place and material to conduct delivery, are untrained and lack a proper knowledge of maternal and child-care. Hence the rate of child mortality, morbidity in rural areas is high. In such areas, there is a necessity of either a trained midwife or a doctor during the delivery. In fact the childhood morbidity and mortality have become a global concern, and this concern is greatly so in the case of developing countries.

Though the care of a child begins indirectly during pregnancy the direct care begins after childbirth. The infectious diseases and malnutrition of children are said to be the main reasons for the high rate of child morbidity and mortality. The infectious diseases affect nutritional status and also result into the death of children. The following are the fatal diseases, which are commonly witnessed amongst children.

1.1.2.1 Diarrhea

Chronic or intermittent diarrhea is one such infectious disease, which is a common affliction during infancy and early childhood in rural and tribal areas as Draper (1996) says that, diarrhea in children impedes the digestion of food in the intestine and absorption of nutrients released during digestion. During the growth of a child, approximately 2% of the child’s body weight is lost each day due to acute diarrhea, with perhaps 5 or 6 attacks per year, each lasting about a week.
Much of the malnutrition caused by disease of diarrhea can be attributed to appetite loss among children.

1.1.2.2 Acute Respiratory Infection

Acute Respiratory Infection (ARI) is another infectious disease. In various regions in India, where rigorous data collection on ARI has been done, up to 36% of infant deaths have been associated with ARI. It is estimated that between 5,00,000 to 7,50,000 children die of ARI in India every year (Nichter, 1993). According to WHO (1988) estimates, the following disease complexes are responsible for ARI related mortality like pertusis (19%), post measles pneumonia (15%) and pneumonia without measles (70%). Infants are at greatest risk for respiratory related mortality. The malnourished child in India is three times as likely to experience bronchitis and 19 times as likely to experience pneumonia (Nichter, 1993).

1.1.2.3 Morbidity due to Malnutrition

Breast milk is the most nutritious, easily digestible and available food for children. Draper (1996) has pointed out that breast-feeding helps to prevent gastrointestinal and respiratory diseases and infectious as well as certain immunological disorders. Breast-feeding also reduces the likelihood of developing certain serious chronic adult diseases such as multiple sclerosis. Further she explains that, it not only helps the child but also the mother by providing maternal protection against breast cancer and osteoporoses as well. Human milk enhances intellectual, neurological, psychomotor and social development and is correlated with the
development of fewer dental caries among breast-fed toddlers. The May 1984 issue of ‘Diarrhea Dialogue’, which is a WHO supported quarterly journal, has clearly brought out that, the breast-fed infants are less prone to diarrheal attacks.

Ahmed et al., (1977) conclude in their study that breast milk protects the child from infectious diseases such as marasmus, diarrhea, rickets and iron-deficiency anemia.

In view of all these benefits of breast-feeding, World Summit in the year 1990 at the Convention of the Rights of the Child, called attention at the global level about the importance of breast-feeding. In February 1991, major international organizations set up the World Alliance for Breast-feeding Action (WABA) for protection, promotion and support of breast-feeding. In India also, the Government of India adopted a code called India National Code for protection and promotion of breast-feeding (Banerajee, 1994).

Nancie et al., (1964) say that, in many underdeveloped countries, studies on breast feeding and nursing have brought to light the following information. A long nursing period lasting from 18 months to 3 years is customary for almost all live-born children (Dods, 1952; Goodman, 1951). Solid or other supplementary foods are added to the infant’s diet at a fairly late age, usually not until the later part of the first year (Watt, 1959; Jelliffe et al., 1961; Gopalan et al., 1989). The lactation performance of even poorly nourished women is remarkably good from the point of view of both quantity and quality (Gopalan, 1990; Gallez, 1960; Jansen, 1960).
All these studies show that, the practice of breast-feeding for longer duration is beneficial to the child in underdeveloped countries which the WHO, UNICEF, WABA say as necessary. After the introduction of commercial foods in India, the period of breast-feeding is getting reduced. Keeping this in mind, a study by Nutritional Foundation of India (NFI, 1984) warned on “Infant feeding practices with special reference to the use of commercial infant Foods”. It says that increased income of the families may make people to use commercial infant foods, which are not better than the breast-feeding and these foods progressively erode current breast-feeding practices in India (Balasubramanyan, 1984). The NFI funded by UNICEF highlights that the most valuable colostrums-rich mother’s milk is discarded by most of the women in India. The studies have shown that breast-feeding period varies with socio-economic condition. Income level and educational level are also directly related with period of breast-feeding (Vimal, 1984). Breast-feeding is longer among the pastoral and agricultural people and shorter among the people who are shifting to modern economic activities such as business and services (Basu, 1996). The ‘rich’ has a lower probability of breast-feeding than the ‘poor’ (Sharma, 1983; Das et al., 1982). Higher the economic level, shorter will be the period of breast-feeding (Vimal, 1984).

The period of weaning and types of supplementary foods given varies from society to society. If children are not fed with either breast milk or other foods, it affects the health of the child. Because, malnutrition adversely affects mental development, physical development and the span of working years, all of which
significantly influence the economic potential of the individuals. Malnutrition
during fetal period and in infancy is associated with intellectual impairment
(Laxmi Devi, 1998).

The children, who are not getting enough food or the right food, tend to
develop protein energy malnutrition, which is a serious health problem (Arup,
1996). The three main effects of protein energy malnutrition are marasmus or
starvation due to severe lack of calories, often brought on, when an infant is
starved in an effort to cure prolonged diarrhea caused by inadequate and
unsanitary bottle feeding; Kwashiorkor is caused due to severe protein deficiency;
and nutritional growth retardation due to inadequate food intake, usually
associated with recurrent infections.

In India, there are about 100 million pre-school children, out of whom 3-4
million suffer from severe types of malnutrition and about a million die because of
this cause every year. It has been found that 30% of school children are
malnourished (Laxmi Devi, 1998).

1.1.2.4 Other Diseases of Children

Other than malnutrition and infectious diseases, children also suffer from
intestinal parasites such as hookworm and tapeworm common in tropical and
semi-tropical climates of many less developed countries. It reduces the absorption
of protein and certain vitamins and this causes malnutrition even in a child who
has a relatively good diet.
1.1.2.5 Socio-Economic Factors affecting Infant and Child Mortality

The infant and child mortality not only depends on fertility, age of woman during childbirth, nutrition of the pregnant woman, spacing between two births but also depends on socio-economic condition of the family and education of woman (Carolyn et al., 1996; Arvind Pandey et al., 1996). Poor economic condition of the family gets the children poor in health condition (Geeta et al., 1996; Mukharjee, 1988; Mohapatra et al., 1989). There is a retardation of growth of children belonging to poor economic and overcrowded families (Anandlaxmi, 1993; Shreenath et al., 1978). Maternal education has positive role on mortality of infant and child (Mukharjee, 1988; Saha et al., 1991). Whereas, Bharati who has studied Bengalis, say that “there is negative relationship between maternal education and mortality of the children and fertility of the mothers” (1998). She points out that mere education of mothers is not enough and for a favourable effect of maternal education, suitable awareness and economic condition are also essential. Thus a woman’s fertility and child’s mortality depends not only on biological defects but also on socio-economic factors.

1.1.3 Mother and Child Health Related Programmes of Government of India

In view of the prevalence of morbidity and mortality of mother and child, recent studies have witnessed an increasing concern for the health of mother and child in India. The policy makers have been constantly making a plea for improving maternal and child health services as a result of which various
programme and projects have been designed and implemented (Jesurathnam, 1992). To start with, the programmes launched were focused on planning the family and subsequently the attention was directed towards the health of the mother and child. Indeed, India is the first country in the world, which started the Family Planning Programme in the year 1921. Right from 1921 to 1970’s the health planners gave attention to only population control (Khan et al., 1988). To control the population growth, birth clinics were established and various devices such as artificial contraceptives like condoms, jelly and Intra Uterine Device (IUD) methods were introduced in different Five Years Plans (Jolly, 1984; Khan et al., 1988). The planners never thought about the health care of mother and child through which population could be controlled. In 1960s and 1970s the maternal mortality, infant mortality and child mortality rates were very high. When people were experiencing high mortality of their children, they never thought about controlling the family size, which in fact contributed to the population growth. Hence, inspite of the birth control devices, the rate of growth of population was increasing. Then the health planners realized that population growth could be controlled by improving the health of mother and child rather than through birth control devices. Hence, in the year 1975, with the establishment of Integrated Child Development Service (ICDS) the emphasis shifted to the health of both mother and child. The main goals of ICDS have been to deliver a basic minimum package of health in addition to immunization of children against six deadly diseases, immunization of pregnant women against tetanus, nutrition and
educational services in an integrated manner to the vulnerable mother and the young child (0-6 years). The centre of the ICDS is anganawādi (literally meaning “courtyard”) and the anganawādis were established in rural areas, urban slums and tribal areas, where higher rates of maternal and child morbidity and mortality were noticed by the health planners. According to them, people in these areas are illiterate, malnourished and lack awareness about health programmes. Hence they have high maternal and child morbidity and mortality rates.

1.1.3.1 Maternal Mortality

In India, maternal mortality (deaths related to pregnancy and child birth) is commonly estimated to be 400-500 per 100,000 live births (UNICEF, 1991). But due to under-reporting, an estimate of 800 per 100,000 live births seems to be more realistic (Jeejeboy et al., 1992). In rural areas, rates as high as 1,360 have been reported (UNICEF, 1991). Given a Total Fertility Rate (TFR) of 4 to 5 and a maternal mortality rate of 500 per 100,000 live births, the life-time risk of dying from pregnancy and child birth related causes for an Indian woman is one in 27 (Hutter, 1994).

Therefore, another programme called Child Survival and Safe Motherhood (CSSM) was started in August 1992 (GOI, 1994). The programme was launched with an integrated package of interventions for improving the health status of women and children and reducing the MMR, MmR, IMR and ImR (maternal morbidity and mortality rates and infant morbidity and mortality rates). The goals of the programme are antenatal care, postnatal care, child-care, training of dāī,
Oral Rehydration Therapy (ORT), and initiating programmes for controlling the Acute Respiratory Tract Infection (ART) in children.

1.1.3.2 Infant and Child Mortality

The infant mortality rate is a sensitive index of the total cultural milieu of a community or a country. It reflects the state of public health and hygiene, environmental sanitation, cultural mores about feeding and clothing.

Though all kinds of steps are taken to prevent the infant and child mortality, the rates are high in India (GOI Year Book, 1993). The Infant Mortality Rate (IMR) is 74/1000 births and in case of children aged 5 and less, annual mortality is still 43 million deaths per year (Year Book, 1995) which are considered as still high by the Government of India.

All these earlier MCH programmes as well as the subsequent family welfare programmes of Government of India fell short in reaching their targets. The things took a different turn with the International Conference on Population and development (ICPD) in Cairo held in 1994. The concept of Reproductive and Child Health (RCH) was conceptualized and the Government of India integrated it into the Family Welfare Programmes in 1996. The concept of MCH was replaced by the RCH, because of its broader ambit as revealed by the following definition.

The definition given by Fathalla (1994) in the International Conference on Population and Development (ICPD) was accepted by most of the participants in the conference. The definition says, "Reproductive health is the state in which people have ability to reproduce and regulate their fertility. Women are able to go
through pregnancy and childbirth safely, the outcome of pregnancy is successful in terms of maternal and infant survival and well-being and couples are able to have sexual relations free of the fear of pregnancy and of contracting diseases”. As a result of the RCH programme the MMR has reduced 407/100,000 (Registrar General of India, 1998) and the IMR has reduced to 70/1,000 (Population Reference Bureau, 2001).

In all these programmes, there is a common thread, in that the health programmes of mother and child have been addressed with a biomedical and economic perspective giving scant attention to the indigenous socio-cultural sensitivities that have a major bearing on the health status of an individual at the grass-root level. Therefore in India, the impact of these programmes pertaining to maternity and child-care have not come up to the stated objective, which has also been pointed out by Pisharoti (2000). He further says that the present programmes are fragmented in their approach and the target (numerical) oriented Family Planning Programme driven additionally by monetary incentives, has distorted to a large extent the implementation of the overall policies of the Government in the field of health of mother and child.

There is a conspicuous lack of socio-cultural understanding of mother and child health in the mindset of health planners. Because the concept of pregnancy is associated with several aspects of life, which are cultural reflections of the society. As a matter of fact, the entire process of pregnancy and childbirth occurs in a socio-cultural context and is guided at different stages by a number of cultural
notions and ceremonies prescribed by the society. These are regarded as crucial for the well-being of the mother and child. In traditional societies, the well-being of mother and child is seen holistically and is considered as the well-being of whole culture and community. Thus the whole issue of health of mother and child need to be looked at in its proper socio-cultural context with an integrated perspective without undermining the biological and physiological aspects. This is more suitably provided by the medical anthropological perspective, which is nourished by ethnographic studies.

1.2 Importance of Ethnographic understanding Vis-à-vis Maternity and Child Health

Loudon (1973) has pointed out that health and disease are fundamentally connected with the reproduction, quality of life, preservation and loss of life. It is not surprising that an anthropological study of health and occurrence and means of coping with disease involves one deeply in the characteristic of human social systems, social values and manner in which people perceive their world. In this perspective, medical anthropology is not only a way of looking at the states of health and disease in society but also a way of viewing society itself.

Every culture, irrespective of its simplicity or complexity, has its own indigenous system of medicine along with beliefs and practices, to tackle diseases in its own way. To show that health is associated with religion, Elwin (1955) has noted various Gods associated with children's diseases; cold, cough, blindness, madness and also diseases associated with pregnancy. He further explains that,
propitiating the respective God associated with a disease either directly or through the priests, cures most of these diseases.

The life cycle rituals, which form a part of the beliefs and notions of the people, are also important in the health care of an individual. Comparing life-cycle rituals in a number of societies, Van Gennep, noted in his classic work of "Les Rites de Passage" (1909) that "most societies have rituals making the transition of an individual or a group of individuals from one important status to another". These rituals particularly associated with birth, maturation, procreation and death are found in the human societies, although obviously they are celebrated in different manner.

Some studies have shown that health is related to ecological setting and social customs. The work of Whiting (1951) shows that, the post-partum sexual taboo of parents helps in the well-being of their children. In his analysis, Whiting says that, post-partum sexual taboos and late weaning play important role in protecting infants against Kwashiorkor which is largely confined to the areas of high temperatures and humidity. The roots and fruits of these areas are low in protein. A mother gives her low protein milk, which she has produced because of low protein roots and fruits for a longer period, otherwise reduction in the breast-feeding period results in disease of the child. This is possible only by delay in the subsequent pregnancy, which they achieve by abstaining from sexual intercourse for a long time.
The work of May (1960) in China shows that one's profession and economy is related with one's health. The people in China who were rice cultivators had the problem of serious infection by hookworms, because these people had come in contact with mud mixed with night soil. The other villagers who were engaged in silkworm farming had contact with mulberry leaves did not get affected by this.

All these studies indicate that health and disease in a population bears intricate relationship with their total life-style and culture. Thus for a meaningful understanding of people's behaviour related to their health care system, an in-depth ethnographic investigation is imperative. Though there is an increasing awareness among the health planners of the role of culture in medicine and health, there is hardly any attempt to understand how various non-medical aspects are integrated and interrelated to the health practices of the various people. Nowhere this shortcoming is more marked than in the study of maternity and child-care by various social scientists and medical scholars, as it has already been pointed out earlier. Whereas anthropologically oriented studies of different cultures make it clear as to how pregnancy, maternity, childbirth and child-care manifest an intricate relation with the various aspects of peoples' culture.

1.2.1 Pregnancy

Conception in its obstetric sense means the union of male and female elements of procreation from which a new being develops. However, people of several cultures do not recognize causal sequences to associate sexual intercourse
with conception. The fact that not every sexual union results in conception is said to have led to this belief. Therefore only coitus is not sufficient to become pregnant, the role of blessings of ancestors or God, as the Indians believe, is recognized (Srivastava, 1971). Even the people of Tepozetlan of Mexico carry the same notion. Among the Kaksa Indians, a child himself may admit reincarnation by announcing, “I know this country, I have been here before”. This belief indicates that the child is the reincarnation of the ancestral spirit who has slipped into the womb of the mother to be regenerated. Hoebel and Weaver (1979) point out that among the Australian Aborigines, this belief is raised to the status of dogma so strong that the natives deny direct relation between the sexual intercourse and conception and admit that the womb must first be opened so that the ancestral spirits may enter. Since the notion of not every sexual act leads to pregnancy, the physiological fact is quite congruent with the fairly common belief that repeated copulation is needed to complete the conception (Honigmann 1954).

1.2.1.1 Signs of Pregnancy

The first sign of pregnancy that people recognize is, cessation of menstruation. For instance, the Dobu reason from the observed fact of cessation of menstruation during gestation that, the clotting of blood is to form the baby and this stops the regular flow (Chapple et al., 1942). Other than this, there are number of externally observable biological alterations that occur in woman after conception. Notable among them are enlargement of breasts and nipples, abdominal enlargement, nausea and morning sickness. Various Oceanic and
African tribes take note of breast changes, whereas the Arunta of Australia, the Pukapuka of Polynesia record morning sickness as the sign of pregnancy (Hoebel et al., 1979).

In simple and traditional societies, children and males are kept aloof from the matters such as menstruation, pregnancy and childbirth, which are considered to be the domain of women. The Ngoni women of Nyasaland like to assert their authority and ascendancy on those occasions and therefore exclude the men from the knowledge of pregnancy (Read, 1959). But in Semai of Malaya (Denton, 1962) it is the husband who first comes to know about the matter and calls a midwife to help them. The participation of husband during pregnancy and childbirth of his wife is noted among the Hos of Kolhan (Majumdar, 1925).

1.2.1.2 Taboos during Pregnancy

Pregnancy in itself is a crisis situation. People view taboos during gestation period as calling for a relief of anxieties. The chief anxieties are the fears that the child will not develop ideally, that the woman may miscarry and that birth may be difficult. Pregnancy taboos and injunctions are supposed to prevent the problems and to bring freedom from those anxieties and fears. Some times, the restrictions are connected to the growth of the fetus and fear of begetting abnormal or malformed child or fear of injury to the unborn. Thus among the Sanpoil Indians of Washington, as Ray (1942) points out, a child bearing woman and her husband could not eat trout (a kind of fish) lest the child gets weak legs. Ray, goes further to say that pregnant woman should not go outside alone at noon and dusk, for the
fear of evil spirits, and also she should not cross the river. Among the Alor (Dubois, 1960), a pregnant woman should not place new pot on the fire, because, if it gets blackened, her child will be born with patches of darker pigment on skin. Further she should not eat only belly portion of the rat, lest her child’s limbs will spread at birth like those of a rat for roasting. Her husband should not straighten arrows, lest the child would then be born with eyes rolled to one side. Semai pregnant woman and her mid-wife should be ceremonially bathed in water made fragrant by magical plants, to assure that, the child will come out as easily as the water flows from its container (Denton, 1962). In Sri Lanka (De Silvia, 1995), a pregnant woman avoids sewing of stuffed pillowcases, striking nails, tightening knot in the belief that, by doing so the child will be struck during its birth. In rural India, a prospective mother should not work or go out during eclipse, lest she gets a malformed child (Hutter, 1994). Coitus is avoided in most of the societies during pregnancy as it leads to abortion.

Certain foods are prohibited for the reason that, they develop in the fetus characters attributed to them. In Sri Lanka (De Silvia, 1995), many say pineapple, yams, blood fish, parboiled rice, papaya are largely avoided during pregnancy, as they are said to produce excess heat in the body and thereby may cause abortion or ill-health of the child to be born. Even among the Mexicans and Spanish, the foods like chillie, pepper, goats’ milk, cereal grains are avoided for the same reason (Srivastava, 1971). Several studies conducted in different parts of India mention about the avoidance of the papaya during
pregnancy (Khanum et al., 1976, Mullapudi, 1984; Reddy, 1988; Jeffery et al., 1989; Hutter, 1994). According to these studies, papaya, classified as heat-producer, is supposed to induce an abortion. The studies mention several other foods to be avoided during pregnancy such as eggs, jaggery, meat, sesame and chillies. Egg and jamun fruits are to be avoided since they cause red and purple patches on the child's face (Khanum et al., 1976), and eggs are supposed to cause the child to have a bald head (Mullapudi, 1984).

Craving of a pregnant woman is also an important aspect, which is taken into consideration in almost all societies. The common belief in India is that the non-fulfillment of the cravings causes the birth of a cleft ear-lobed or cleft-lipped child. In Semai of Malaya (Denton, 1962) cravings for 'sweet and acidic' foods are common during pregnancy. The cravings vary from society to society.

Pregnancy is also accompanied by various rites and rituals, which are said to be necessary for the well-being of mother and child. *Kubasa* and *Simantonnayana* are such rituals performed in South and North Indian Villages respectively during pregnancy (Hutter, 1994; Srivastava, 1971).

1.2.1.3 Physical Activities

During pregnancy, in most of the traditional societies, women carry on the routine domestic activities, as it is believed that it facilitates easy delivery. Human beings have a difficult birth, because evolution has matched the size of the new
born human brain very closely to the limits of the mother’s body. It is an alarming compromise that the mother’s pelvis needs to be strong enough for which exercises like walking and to remain active are necessary to make the pelvis as capacious as the birth canal (Gebbie, 1981). The women among the Alor (Dubois, 1962) and also women in rural south India (Hutter, 1994) work all through their pregnancies, often doing fairly heavy field-labour. However, it is also recognized that, work that is too heavy and exceeds the limit may produce miscarriages and hence women also take care to see that they do not overstrain themselves. Among the Ngoni of Nyasaland (Read, 1959), an expectant mother carries on with her normal work in the household including cooking for her husband.

1.2.2 Childbirth and Child-Care

Most of the anxiety over the crisis of childbirth is seen among many societies, to be before and not during the event of delivery. Practice of Magic, rituals and taboos dominate the prenatal period, yet, when the moment of birth is reached, the obstetrical problems in normal cases, are handled with matter-of-fact effectiveness. For the most part, birth is strictly a woman’s affair. However, a few societies permit or require the husband to assist or to be present like Hos of Kolhan (Majumdar, 1925) and Ladino of Guatemala (Gonzalez, 1963).

When the labor pain begins, the elderly women in the family inform the neighboring women and mid-wife to assist during childbirth. Among the Alor (Dubois, 1962), a pregnant woman herself goes to the house of Kinswoman, if possible. If no kinswoman’s house is nearby, she may give birth in her own home.
The neighboring woman may be a relative, or someone who herself has given birth and hence knows what to expect during such a time. Childbirth usually occurs at home. Kinsmen and neighbors drop in during the course of childbirth to see, how things are progressing and in difficulties they may help. Sometimes, a priest or a shaman is called to assist at an especially difficult delivery. Various practices like loosening the knots in the house, unlocking the locks, drinking of herbal concoction, and massages are performed to ensure easy delivery.

The position in which a woman gives birth also varies. She may give birth while occupying a sitting position or less commonly kneeling or squatting. Among the Alor (Dubois, 1962), mother sits with her legs spread and at the rafter overhead to help in her labour. The midwife sits directly opposite with her legs outside of or parallel to those of mother. In Ngoni, all the belongings of husband are sent out of the hut (Read, 1959). Only old mats, clothes and pots are used during labour. It is the mother-in-law and her co-wives who direct the operation of childbirth. The woman is made to sit on a mat leaning back against the knees of another woman and experienced midwife sits in front to receive the child in her hands. In Nagas (Hutton, 1969), it is the female relatives of the woman who help or assist during the childbirth.

Practically, all people have special emergency medical practices for difficult birth. In case of long drawn-out labour, indigenous medicine men and women are hastily called. The Cheyennes make use of an indigenous medicine man who has derived power from the supernatural beings (Hobel et al., 1979).
All these instances show that, most of the societies have patterned sets of beliefs and practices concerning pregnancy and childbirth. Some societies have specialists who are primarily concerned with these matters. The specialists are none other than the midwives (Shaila, 1982).

1.2.2.1 The Midwife

Midwife is any elderly woman who has no formal training in midwifery but is usually wellversed in conducting deliveries and also in folklore relating to maternal and infant cares. She has children of her own and likely to be among the most highly respected members in her community. But according to WHO, a midwife should have at least secondary school education and training in scientific medicine. This midwife may be an unmarried female, and very rarely it may be a male.

Even though the midwives are formally trained, the people in western or developed countries have a different story to tell. There is decline of midwifery with the rise of obstetricians and other medical specialists in some countries viz., U.S. (Browner, 1985; Stern, 1972), Norway (Haire, 1972), Mexico and Japan (Fiedler, 1996). Browner describes some of the prenatal care practices of U.S. women, which help to consolidate biomedical health centre programmes, eliminating the local medicines and practices. Fiedler (1996) makes similar kind of observation about practices in Japan. He says, as in the U.S., there is a marked change from home treatment to resorting to health care institutions.
In traditional societies, the midwife plays a significant role during and after childbirth, till five or ten days after childbirth. In this period, along with taking care of mother and infant, she also bathes both of them, as they are secluded in the family. In many societies, the mother is secluded either in a special hut or a separate portion of the house (Ford, 1945; Read, 1959; Dubois, 1960; Denton, 1962; Hutton, 1969). This isolation is due to the belief that the mother and child are in a polluted state and that they are highly susceptible to physical and supernatural dangers. In some parts of India, birth is highly secretive. The house is shut and the woman is not supposed to cry out while delivering (Gordon et al., 1964). This is to protect her from spirits and people who might want to do her harm. In societies like Navajo and Iban event of giving birth is a more communal and public affair, there is no seclusion and relatives and neighbors may attend it.

1.2.2.2 The Placenta

The placenta is usually expelled without manual assistance. In cases of delayed expulsion, techniques like massage or abdominal pressure, medication, attempts to make the woman gag, sneeze or vomit are made. Failure to remove it results in the death of the woman.

Traditional methods of cutting the umbilical cord and dressing it, have been criticized as possible factors causing tetanus, neonatarum, either because the cutting instrument is not clean or the dressing material is contaminated (Shaila, 1983). Cutting tools include bamboo, shell, broken glass, knife, scissors, shears, sickles, trowels and razors. Conglin (1943) reports that in Vietnam, considerable number of
tetanus cases result according to the medical sources from the use of bamboo or glass. In parts of Mexico and Guatemala, midwife cauterizes the cord with either a candle flame, a burning end of the stick or a red-hot blade or hot candle wax (Mackay, 1993; Gerdel, 1949; Romney et al., 1963; Soliende et al., 1966). Gardon, Gideon and Wyon (1964) who made studies in Punjab conclude that cutting the cord with sickle and dressing the cord with ash of cow dung and earth are the main reasons for neonatal deaths due to tetanus.

The placenta is disposed of in various ways in different societies. The placenta is burnt, buried, placed in a pot on the roof or thrown out to be eaten by dogs. The notion commonly held is that careless disposal of the placenta risks its discovery by a sorcerer, into whose hands it is believed that the child's life would be committed. In Asalpur, as Srivastava (1971) points out, the placenta is buried by the infant's paternal uncle, where as in Barigaon, it is the dāi who does this job. In Egypt, the placenta is thrown out at night, left to be eaten by the dogs so that the woman would bear as many children as the bitch bears puppies. In rural South India, the placenta is buried in front of the house (Hutter, 1994).

This is the main reason why the women in traditional societies do not like to go for hospital deliveries. They think that, if the placenta is not disposed off properly, it will have an adverse effect on the health of mother and child. Whereas women in western countries, prefer hospital deliveries to home deliveries.
1.2.3 Postnatal Care

Seclusion of puerperal woman and newborn is adaptive. It reduces the chances of the mother who has open wounds being infected through social contacts and protects the infants also. The period of isolation further ensures that the mother will not resume customary activities until her body has had some chance to heal. The period of seclusion goes on varying from society to society. In Ngoni the period is five days (Read, 1959) whereas in Japan it is 30 days (Sofue et al., 1965). The range of pollution depends on sex of newborn in Japan. It is believed that, girls are more polluted than boys; hence mother and newborn should observe pollution for a longer period.

Coitus is forbidden for the mother for periods ranging from several months to years following the birth (Whitings, 1962). Communities cite the woman's uncleanliness after childbirth or her weakness as a reason for enforcing postnatal sexual continence and to provide longer period of breast-feeding to the infant for its nourishment.

In the postnatal period, mother and infant observe many restrictions including food (Hutter, 1994). In most of the societies, the mother is given only 'heat' producing food, as it is believed by them that, after giving birth to child, a woman loses her body energy, making her body constitution cold. To strike a balance, heat producing foods and energy providing foods are given, which vary from society to society. Apart from this, she is not allowed to go out until the appropriate ceremonies are performed. Some of the significant ceremonies are,
purification ceremony, naming ceremony, ear-piercing ceremony, and teething ceremony.

1.2.3.1 Breast-Feeding and Child-Care

Breast-feeding is the initial stage of nursing the child. Breast-feeding is the relationship, which is part of the process of socialization to the Mandinkans (Whittmore et al., 1996). The children are breastfed as long as the mother lactates. Next pregnancy is the main cause of weaning (Rajguru, 1981; Read, 1962; Vanstone, 1962). It is considered that mother’s milk gets impure and may harm the health of the child after the fourth month of pregnancy. Other than this, ill-health of the mother, working in the heat of the sun are other reasons for mother’s milk getting spoilt. These are some of the reasons to wean the children (Whittmore et al., 1996). Applying unpleasant or bitter substance on the breast, sending the child away from mother and threatening the child are the common techniques of weaning. Constant crying, rejection of substitute food, irritability, loss of appetite, vomiting tendencies, kicking and biting the mother and thumb-sucking are some of the reactions of the child to weaning.

Children are looked after with special care till they attain the age of maturity. This prolonged process involves taking care of children, not only physically but also socially and emotionally. The period of childhood is of special interest to many analysts of culture and personality because of widely accepted belief that, experiences of early life have important influences on the development of the personality of the individual, as he/she matures to adulthood. Hence the
concern over the well-being and successful development of child is multiplied after birth. The importance of early childhood experiences on adult personality was first stressed by Freud (1920). Later on psychologists and anthropologists like Kardinar, Cora Dubois, Mead, Benedict, Sapir, Linton, Dollard and others have advocated different theories of child-rearing practices with a view to explain personality development (Kaplan, 1961). The newborn child remains helpless for long period to maintain its own survival. It requires special and easily digestible food and it must be kept clean and needs protection. The child rearing practices in all cultures meets these survival needs.

The life-cycle rituals and ceremonies play important role in the well-being of the child. These rituals and ceremonies vary from culture to culture. The rationalizations behind these rituals as well as ceremonies are meaningful only in that particular culture. Purification-ceremony, naming-ceremony, ear-piercing ceremony and initiation-ceremony are some of the commonly performed ceremonies in various cultures across the world.

Some of the main diseases, which are affecting the children and resulting in their deaths in traditional societies are, diarrhea, malnutrition, tetanus, measles, tuberculosis, polio, pertusis, marasmus, kwashiorkor and ARI. When these diseases are seen from the cultural point of view, their causes vary. For instance, diarrhea is expected and treated without giving any attention in such contexts, like diarrhea at the time of teething, weaning, walking, dietary change and climatic change (Nichter, 1993; Lozoff et al., 1975). Verion et al., (1976) say
that, the process of weaning is the common reason for diseases due to malnutrition. During this period, a child not only loses his primary and perhaps sole source of protein, but he often undergoes considerable physical and psychological trauma in adjusting to a different diet and lack of his mother's attention. The net result is loss of appetite, which pushes him to a severe kwashiorkor. Every culture has its own way of looking at disease and its own forms of treatment.

1.3 Methodology

The purpose of this study is to gain a comprehensive and holistic understanding of maternity and child-care in a rural setting of North Karnataka. Hence, the focus of ethnographic investigation has not only been on indigenous health perspectives on maternity and child-care, but also on the influences of modern health care systems and modern education on the health practices of rural people. It is for this purpose that a thorough, in-depth investigation and comparison was undertaken in two villages, wherein the first village is lacking in modern health and educational facilities and the second village has modern health facilities such as health centre, clinics, doctors and educational institutions like high school and college.

The ethnographic investigation was conducted in two stages: the first stage, for a period of twelve months that is from July 1996 to June 1997 in the first
village and the second stage for a period of six months, from August 1997 to January 1998. In all, the field-work was done for a period of eighteen months.

First village was the focus of in-depth ethnographic investigation. This was undertaken for a period of twelve months by staying in a house, located almost in the centre of the village. This facilitated to establish a sound rapport with the members of several castes and also for a closer observation of daily interaction of the villagers. Especially, events like deliveries, minute details of the rituals and mystical activities pertaining to maternity and child-care performed by the village priest-cum-astrologer, whose house was situated near-by. This would not have been possible, had I stayed elsewhere in the village.

Second village is a bigger village with various modern health facilities, educational institutions, and people of this village are exposed to modern influences more than the people of first village. The health-seeking behaviour of the people of both the villages has been compared to understand their perception about the modern health facilities and health practices concerning maternity and child-care.

I started my field-work by collecting information on the socio-economic background of the families. The household-census schedules were helpful to get such quantitative information as, types of family, order of birth, sources of income, educational status of the individuals, place where childbirth is conducted and period of breast-feeding, to delineate the relationship between various socio-cultural factors and maternity and child-care.
Until I established a close relationship with the villagers, I was just an observer. Initially, observation of the various rituals and ceremonies relating to the well being of mother and child, as well as amulets given by the village priest for different ailments, helped me in gaining closer access to the people's intimate activities.

Establishment of close relationship with the people, participation in their routine activities and longer stay in the village, were of immense help in gaining insight not only into the socio-cultural life the of first village but also into their indigenous ideas related to the health care of mother and child. This also enabled me to delineate the relationship between economic condition of the family, educational status and awareness of the people with maternity and child-care. Understanding was also gained in the villagers' ideas about the effects of parity, spacing and period of breast-feeding on health of mother and child.

Participation in the services rendered by modern health providers, like, immunization of children and supplementation of nutritious food in the anganawādi by the teacher, were helpful to know about the attitude and behaviour of the people toward these services. The villagers do not really have positive attitudes toward the modern medicines which was evident in their partial acceptance of modern medicines. Because, it is believed that unlike indigenous medicines, modern medicines cause side effects and harm. Hence, many of the health programmes related to maternity and child-care have not been fully successful. Modern health providers have not been able to convince or mobilize
the villagers’ confidence in modern medicine and to make them accept the services. This is mainly due to lack of effective communication between both of them.

In-depth interviews with the knowledgeable persons of the village who play main role in maternity and child-care, like elderly women, village priest, indigenous midwife and headmistress of the school helped in knowing minute details like process of conception and process of childbirth. Interviewing the village priest was of immense value to gain knowledge about different kinds of ailments for which he gives amulets and ritualistic solutions and an overall relationship between religion and health of mother and child.

The understanding of the phenomenon of maternity and child-care would not have been complete, had the investigation been confined to the indigenous perspectives. The views and ideas of the modern health providers like ANM doctors at the government hospitals and other health practitioners who involved in the health care of mother and child have also been sought through interviews and scrutiny of official records. Interview with the doctors and other health providers gave an opportunity to know about the health problems of mother and child in the village, and the reasons for those health problems. The dependency on indigenous beliefs and practices, notion about the modern medicines and poor economic condition of the people are the main causes for the health problems.

It is in this methodological context that the ethnographic data, after a thorough analysis, has been arranged in the following chapters.
(The first chapter attempts to introduce the topic of investigation in the backdrop of several studies on mother) and child-care. A critical review of earlier international and national level programmes reveal an overemphasis on western model of biomedical health care system with scant regard for micro level socio-cultural sensitivity of the populations. It is this emphasis, which quite often comes in the way of fuller realisation of the objectives of the various schemes. Therefore, there is an urgent need to formulate and view the mother and child health issues from a bottom-up perspective.

Since the ethnographic investigation was on maternity and child-care in a rural setting, the details about the people and geographical location, climatic condition and settlement pattern of the village have been studied to delineate the relationship between these aspects and maternity and child-care. These details constitute the content of the second chapter. Apart from these aspects, various socio-cultural institutions, religion, caste-hierarchy, families and households, marriage system, sources of income, educational institutions, political system in the village, health care of the villagers and beliefs and practices relating to the health of mother and child have been presented to provide a holistic perspective to the understanding of maternal and child health.

The third chapter encompasses the indigenous beliefs and practices about pregnancy, sterility, childbirth and child-care, as they have significant role to play in maternity and child-care. The whole gamut of maternity and child-care in the village depends on ‘hot’ and ‘cold’ concept to such an extent that, even the
modern medicines are consumed only partially, with the belief that such medicines increase heat in the body. The maintenance of health of mother and child in the rural areas is based on these beliefs, practices, taboos and precautionary measures even in the presence of modern health practices.

The rituals and ceremonies, which are part of indigenous beliefs, and practices, are equally important as that of precautionary measures and taboos. Hence various rituals and ceremonies are performed at different stages from pregnancy to childhood for the well-being of mother and child. It is precisely on these rituals and ceremonies that the fourth chapter dwells upon.

The fifth chapter outlines the reasons for the health problems of mother and child. The poor economic condition, higher parity, shorter spacing, shorter period of breast-feeding, small sized family, illiteracy, lack of awareness of modern health system, reasons are attributed to indigenous beliefs of health and disease are the major reasons for the health problems of mother and child. The malnutrition has resulted into anemia among these people. Miscarriage, low birth weight babies and premature deliveries are caused due to anemia. Among children it is malnutrition, which has made them vulnerable to various health problems. The ailments such as backache, loinache, poor appetite and body weakness of the mothers persist throughout their life. The body weakness and lower appetite make children vulnerable to various health problems. It also brings out the people who lack awareness about modern health care system not utilizing them. They depend on indigenous practice so much that, they do not recognize the immediate benefits of the modern health care system.
Whereas, the other category of people who have acquired the considerable knowledge about modern health care system have benefited by the modern health care system. The former people use the modern medicine in the later stage of ailment. Their adoption of modern health care is seen more in the case of children than in women.

It is the sixth chapter, which deals with various health programmes operated by the State as well as the Central Governments for mother and child, and the perception of the villagers about these programmes. The important components of these programmes are, distribution of Iron-Folic acid tablets, tetanus injections and supplementation of nutritious food during antenatal period, providing trained dāi and postnatal care in the postnatal period, and immunization of children and ‘healthy baby show’. The people who are educated and who possess awareness accept and utilize the services to a greater extent, whereas the uneducated and those who lack awareness have accepted the modern facilities partially due to their indigenous beliefs and notions.

The central focus of the seventh chapter is on the health-seeking behaviour about maternity and child-care. The behaviour encompasses not only indigenous health care system but also modern health care system. There is a significant difference between people who are educated and knowledgeable from those who are uneducated and lack knowledge about modern health care system. When it comes to the latter, for any kind of ailment, they initiate treatment with indigenous home remedies and only in case of failure of such medicine, they go to the modern doctors. While the former often resort directly to modern treatments. Even problems such as
cold, cough and body ache are dealt with modern home medicines. When the problems get accentuated, modern doctors are consulted. The ailments, which are not treated by home remedies, are looked at as major health problems that need the attention of a modern doctor. Both categories of people behave similarly when it comes to health problems like measles and effect of 'evil-eye'. In such situations, educated people would go for dual treatment, that is, indigenous as well as modern treatment. Whereas, the uneducated people totally avoid the modern treatment. There is a perceptible attitudinal difference between the junior generation parents from that of senior generation parents, where in junior generation parents are moving towards the modern treatments compared to the seniors who always go for indigenous treatments.

The accessibility to modern health facilities, as well as high school and college level educational facilities, constitute the direct sources of gaining awareness about modern health care system. These facilities make significant impact on the health-seeking behavior of the people in rural areas. It is precisely to ascertain the differential impact of the presence or absence of these facilities and the treatment-seeking behavior of the people, that two villages have been compared in the eighth chapter. The treatment-seeking behavior of people of Myadpur who are deprived of such facilities is compared with the people of Unkur who have direct access to these facilities. The accessibility of educational institution has facilitated more number of people in Unkur to be educated upto high school and college levels, which in turn has made them to gain awareness about modern health care system. However, in the case
of Myadpur, lack of educational facilities and reluctance to send their children outside the village has deprived them of these benefits. The non-availability of health facilities in Myadpur has not only restricted them from total use of modern health care, even among those few who possess awareness through education. Despite lacking high school and college education among many of the people at Unkur, mere proximity of these people to modern health facilities, has brought about considerable behavioral changes as they go to consult doctors during pregnancy, child birth, immunization of children and other health problems.

The ninth chapter consists of summary of all previous chapters and the conclusions drawn on the basis of the study conducted.