Chapter I

Introduction

Understanding of culture is so crucial in order to gain insight into health seeking behavior that, the practices of a particular people may appear meaningless to an outsider or health worker observing only the behavior and not the rationale behind it. Worthman (1995) says in fact, the increasing borrowing of western medicine, its concepts and practices has brought the realization that cultures and sub-cultures vary widely in their views of what constitutes health, how it is maintained, and how departures from a healthy state come about and the entailing treatment.

Anthropological interest in medicine stems from the fact that health and disease, though biological in nature, are defined and interpreted culturally as they relate to people’s social belief systems. The values and beliefs associated with ill-health are part of the wider culture, and cannot be studied in isolation from it. One cannot understand how people manage illness without an understanding of the culture they have grown up in - the lens through which they are perceiving and interpreting their world. In addition to understanding the culture, this process also throws light on the ‘health care system’- which includes the ways in which people become recognized as ill, what it is attributed to, the healers, and the ways that the illness is dealt with.

During the post World War II period, there appeared realization that human ailments may not simply be reduced to ‘biomedical thing’ (Fabrega 1975). As a result, ‘ethnomedicine’ began to gain importance and now receives considerable attention and is considered an indispensable starting point, even in biomedical approaches within Medical anthropology. It is a field that is rapidly growing and is becoming central to the discipline of anthropology. When Medical anthropology (of which ethnomedicine is an off-shoot) blossomed in the early 1970’s, the aims were:

- to obtain new understanding of the nature of health and illness through ongoing research;
also that anthropologists could contribute to reducing the worldwide tolls of disease, disability, and human suffering.

to uncover anthropology's potential for uniting theory and practice in a new health science at once cumulative, comparative, integrative, and methodologically sound.

Medical anthropology is about how people in different cultures and social groups explain the causes of ill-health, the types of treatment they believe in and to whom they turn if they do become ill. It aims to understand how these beliefs and practices relate to biological and psychological changes in the human organism, in both health and disease. Medical beliefs and practices constitute a major element in every culture; consequently on a theoretical level, they are interesting in their own right and also for the insights they provide into other aspects of culture of which, they are a part. On a practical level, knowledge of indigenous medical beliefs and practices is important in planning health programs and in delivering health services.

A hallmark of Social-Cultural Anthropology has been its insistence on cultural relativity in the analysis of ethnographic materials. Medical anthropology has been concerned by this problem as much as its parent discipline. To put this subject in perspective, therefore it is necessary to know something about the discipline of Anthropology itself, of which Medical anthropology is a comparatively new offshoot. Anthropology has been called the most scientific of the humanities and the most humane of the sciences. Its aim is nothing less than the holistic study of humankind. Klienman says, "Any disease is in part a cultural construct. Disease derives much of its form, the way it is expressed, the value it is given, the meaning it possesses, and the therapy appropriate to it, in large measure, from the governing system of symbolic meaning" (1974:209). Lieban points out that "Medical anthropology, encompasses the study of medical phenomena as they are influenced by social and cultural features, and social and cultural phenomena as they are illuminated by their medical aspects" (1973:1034).

Scientific approaches in Medical anthropology to develop the traditional concepts, classifications in the sense of 'ethnoscience' have profound value. The
traditional concepts, practices and institutions can, once integrated into the developing of health care system can lead to a better acceptance of modern medical intervention. The approach of ethnoscience serves as bedrock for the present study of ethnopediatrics as it does for studies in ‘ethnomedicine’. The prefix ‘ethno’ has to be understood in the sense as it refers to the system of knowledge and cognition typical of a given culture. Ethnoscience refers to ‘the reduction of chaos achieved by a particular culture’. Sturtvent says “a culture itself amounts to the sum of a given society’s folk classifications, all of that society’s ethnoscience, its particular ways of classifying its material and social universe. Goodenough in this context says that “ethnography should be conceived of as the discovery of the ‘conceptual models’ with which a society operates. The concentration is basically on discerning how people construe their world of experience from the way they talk about it” (cited in Sturtvent 1968).

The usage of expressions such as ‘emic’ or insider’s view in the ethnomedical approach however does not exclude interpretation by anthropologists, who are outsiders, even though these interpretations do not necessarily represent conscious formulations of the people themselves. In other words, “even when the people themselves are not conscious of the meaning of a symbol or of a pattern underlying their behavior, as long as the anthropologist’s interpretations represent abstractions from the people’s words and behavior, they are referred to as emic in anthropological literature” (Tierney 1981:31).

Medical anthropology studies a wide range of phenomena like public health, trans-cultural psychiatry/ethnopsychiatry, nursing, ethnopharmacopoeia, epidemiology, drug abuse, ethnomedicine. The ethnomedical approach in Medical anthropology is to basically study how a people perceive and deal with health and illness. This approach therefore, includes study of medical beliefs, medical practitioners, and healing techniques as these aspects represent the culture and society in which they are found. Ethnomedicine thus describes concepts of health, illness, and healing and healers among different cultures, and it is of this approach that ‘ethnopediatrics’ is a relatively new off-shoot.
The need for ethnomedical studies arises because of the following points. As Gonzalez (1989) points out:

- indigenous medicines include objectively efficacious substances and practices,
- human bodily functions are affected by emotions, diet, sanitary practices and general life style all of which are culturally determined and
- different cultures define disease symptoms and entities in different ways.

Ethnomedical systems consist of the understandings that societies hold about illness etiology, treatment, and cure. Browner et al. (1988) say, non-Western ethnomedical systems frequently recognize disease that have no apparent equivalent in bioscience, such illness are considered by biomedicine to be 'folk' illnesses in that their clustering of signs and symptoms do not conform to bioscientific diagnostic categories. Depending on the cause, the cure requires either that the spirit captors be appeased so that they will release the victim's soul or that the freely wandering soul be enticed back into the victim's body. The somatic and psychological symptoms as well as culturally specific symbols may involve the sick person's relationship to the community, to supernatural forces, or to the natural environment.

Keeping the *emic* perspective in view, the ethnomedical approach is to study how a particular people perceive and deal with health and illness. The approach characterizes it as viewing medical problems as socio-cultural phenomena. Illnesses are seen as culturally definable. This approach therefore, includes the study of magico religious-beliefs, healing techniques and medical practitioners as a part and parcel of the medical system of the people. Though studies in ethnomedicine have been many, focus on issues like reproductive health, child health are lacking.

The ICPD Cairo 1994 declaration has brought into focus the significance of integrated studies in the area of reproductive and child health. This conference brought a shift
from family planning to reproductive health.

> focus on women's health rather than only mother's health,

> population to people,

> target to informed choice,

> top down to bottom-up with participation of community,

> to situating reproductive health in context in which people live.

Though there are quite a few reproductive and child health programmes in action especially in developing countries like India, the crucial factor of people's perspective and context in which they live have often been ignored. And it is this people's perspective that is all too crucial in understanding and explaining behavior. Further, it is significant to remember that pursuing better health for mother and child has implications not only for the entire population but also for economic development of the nation as a whole. In-depth, micro level, emic studies among indigenous people like Kunabi (among whom no ethnographic studies have been conducted) will not only bring to light practices of child well-being but also the general cultural profile of the people.

The Alma Ata declaration of 'health for all' by 2000 A.D. has not yet been achieved because of the lacunae in the programs and drawbacks at the level of implementation, which can be improvised or altered by in-depth, culture sensitive studies such as the present study at micro level. Programs have often been undertaken from the vantage point of biomedicine and rarely from the perspective of the people and the context. It is precisely at this point that, the significance of studies in ethnomedicine like ethnopediatrics emerges. Because they can enable to understand health care practices for children, but also this knowledge can be utilized at the levels of planning and implementation of health programs.

Thus in the present study, ethnomedical approach has been utilized in order to understand child health with 'ethnopediatrics' as the framework. Ethnopediatrics is of crucial significance since, it aims at every level to understand people's way of looking at and managing child health and ill-health, and interactions with health providers. This aspect of interface which is understood in
the light of prevailing beliefs and practices of indigenous people like Kunabi can guide formulation of policy and implementation of programs successfully.

In modern medicine, this field of child health is dealt with by the branch of pediatrics. The term ‘pediatrics’ is derived from the Greek word *pedio-pais*, *paidos* meaning a child or denoting a relationship to a child (*pedo*), *iatrike* meaning surgery or medicine, that is treatment and *ics* the suffix of a subject of science. It has come to mean the ‘science of childcare’.

Historically, in all regions of the world, the emphasis on the concept of pediatrics has been limited to curative aspects of diseases peculiar to children. Hippocrates devoted a great part of his treatise to children and made many significant observations on diseases found in children. Soraneus in the second century A.D. wrote the first known manuscript devoted to pediatrics (Viswanath and Desai 1991).

In this context, one can note that Kashyapa and Jeevaka (6th Cen. B.C.) were Indians whose pioneering works on child care and children’s diseases are as relevant today as many of the modern concepts of child health. The chapter on *kumarabrita* (service to children) in *Susruta samhita*, the encyclopedia of Ayurvedic medicine, was perhaps the first record of pediatrics anywhere in the world. The colossal work was written by Susruta, and contains many aspects of child rearing such as infant feeding, diseases of childhood, including exanthematous fever, diseases of liver etc. Charaka (4th Cen. B.C.) wrote at length on the care and management of the newborn. The Siddha system of medicine in South India developed *paripasu* with Ayurveda and their section on pediatrics holds the concept that service to the child starts from the moment of conception (*Ibid.*).

Coming to modern day pediatrics, Gupte (1989) says, in India and other developing countries, the care provided is extended to children upto 10-12 years of age. In the developed countries pediatric care and child health programs cater to adolescents as well. In the present day, pediatrics includes planned preventive and curative care of children. There is also a crucial concept prevalent in pediatrics though not very popular about ‘community pediatrics’. Community pediatrics
According to Gupte "is a concept rather than a branch of pediatrics, implying that health is determined by interaction between the child, his environment and the society in which he lives'. It is by no means measurable quantity of this vital relationship. 'Community pediatrics' means 'pediatrics' as it applies to the child, his family and the community" (1989: 41).

In practice however, social and community pediatrics are ignored and only clinical aspects are taken into consideration. As a result of this gap, the health care services are not accepted, and the target groups are not able to take the benefits. This has been revealed also in the study conducted among Kunabi. The problems of communication, the differences in the people's and medical personnel's explanatory models, have been found to come in the way of effective utilization of health services.

According to Worthman a pioneer in the field of ethnopediatrics, 'with respect to children, the processes of illness-labeling, wellness-maintenance, and health-seeking are also grounded in adult's notions of human development' (1995:6). Identification of such aspects of health and illness among children lags behind compared to research conducted concerning adults (Ibid.).

In order for the health care services to be effective, it is essential to understand the culture in which the services are being implemented. It is essential to remember that the medical beliefs and practices of a people are to a large extent influenced by and are a part of their culture. Recognizing such facts therefore, eminent anthropologists like Carol Worthman, Robert Levine have been credited with giving birth to a new field of study through a workshop conducted in 1995 and termed it 'ethnopediatrics'. It has been developed to study child health from a different perspective. Framework of ‘ethnopediatrics’ serves as the basis for understanding the practices of the people and their implications. It has been developed for studying child well-being from people’s perspective. This framework which was developed in the workshop (conducted in 1995) helped in breaking ground for the emergence of the new branch of ethnomedicine—ethnopediatrics which can be of crucial value to health planners and policy makers and health workers.

‘Ethnopediatrics’, is now an emerging branch of ethnomedicine, focuses on the study of child health and care. ‘It is concerned with culturally determined sets of beliefs and attitudes about how development (physical, cognitive, social) and child survival occur and ways in which those notions inform the actions of parents and other caregivers’ (Worthman 1995:5).

Douglass says ‘according to those involved in this emerging field of ethnopediatrics, other cultures have a great deal to teach westerners about pregnancy, birth, and babies’ (http://www.asac.ab.ca/B_1_fall99/ review.html. As on 19/06/03). The ethnopediatric studies bring to light that the western child-rearing practices often popularized across the world are not necessarily the ideal. As anthropologist Small (1998) says, ethnopediatrics focuses on child-raising practices across cultures and how different parenting styles affect the physical and emotional health of infants. Researchers in this field include pediatricians, child development researchers, and anthropologists.

Douglass says ‘here are a few examples of the things we can learn from parents in other parts of the world’. Pregnancy is a life-altering experience and should be treated as such. "All over the world, pregnancy is seen as a transitional
stage in life— a time of transformation," notes Deborah Jackson (1999) in her book *With Child: Wisdom and Traditions for Pregnancy, Birth, and Motherhood*. "The nine months of waiting are a chance to prepare body and mind for the completely new focus of motherhood." Many cultures have rituals that encourage pregnant women to take a step back from everyday life and spend some time focusing on their newfound maternal status.

Small says, fathers have an important role to play in the birth. In some cultures, fathers stand guard near the birthing hut, praying for a healthy outcome for both mother and baby; in others, they catch their own babies. Whether they are actually present at the birth or not, they have an important role to play in welcoming their babies to the world.

The early hours after the birth are a special time for both mother and baby. Mbuti pygmy women in Zaire remain secluded with the baby for three days after the birth. And in many other cultures, new parents are routinely given time to "baby moon" with the new arrival before they are expected to assume all their usual responsibilities (http://www.asac.ab.ca).

Parents are "programmed" to want to respond to their babies' needs. Small notes in her book *Our Babies, Ourselves: How Biology and Culture Shape The Way We Parent* (1998), "A cry means someone should do something to put the baby and its environment back into equilibrium." According to Small, babies in non-Western cultures rarely cry. This is because their needs are met before or immediately after their first whimper.

New mothers require some nurturing themselves. According to Carroll Dunham, author of *Mamatoto: A Celebration of Birth* (1991), in many parts of the world, women who are about to give birth return to their parents' home so that they can be mothered by their own mothers during the early weeks after the birth. And in many cultures, a new mother is massaged with healing oils and pastes that are believed to help her body recover from the rigors of giving birth.

Breastfeeding is much more than a method of feeding a baby. It is a whole way of mothering. In their book *Babies Celebrated* (1995), Beatrice Fontanel and Claire d' Harcourt describe how African mothers use their breasts to nurture their
babies: "The breast plays the role of nipple, toy, or pacifier." This flies in the face of long-held western ideas about infant feeding, but it is very much in synch with what parents practicing "attachment-parenting" believe. Most children in the world today are breastfed. It is convenient and is nutritionally the best source of food for infants, providing important antibodies and other health benefits. But in the past few decades bottle-feeding has (until recently) been promoted as if it were the best method for feeding infants. The increased numbers of mothers in underdeveloped nations opting for bottle-feeding has resulted in high infant mortality. "And so the method chosen for feeding infants has become a political hot potato and a health issue, as well as a cultural phenomenon."

Currently the World Health Organization recommends breastfeeding a baby for at least a year, ideally two. According to Small's research, human infants are designed to wean between two-and-a-half and seven years of age. As long as they are being breastfed, children receive the same benefits as infants receive, such as increased immunity to illness and close parental contact. As well, breastfeeding correlates with health benefits later in life, including lower incidences of inflammatory bowel syndrome, juvenile diabetes, breast cancer, malignant lymphoma, asthma, allergies, and ear infections.

Ethnopediatricians, find that solitary sleep is the opposite of the naturally evolved sleep situation for babies - sleeping alone is not what a baby really needs. Furthermore, sleeping through the night, in childhood or adulthood, is not biologically dictated (biologically we should have an afternoon nap) nor a cultural universal (lots of cultures expect people to awaken during the night).

Crying is a signal from the infant that something is out of balance, and ignoring the cries only makes the situation worse. Babies in many cultures cry less frequently than babies in the West because they are held more often and because someone responds very quickly to a cry rather than allowing the infant to wail. Infant state is not regulated by the infant alone, but is partly a function of the baby's relationships with its mother and father and others in its social circle.

Ethnopediatricians say, cross-culturally, the most common sleeping arrangement is mother and child together and father in another place. Less
commonly, babies sleep with both their mother and father (this arrangement is more common in colder climates). In almost all cultures around the globe today, babies sleep with an adult and children sleep with parents or other siblings. Only in North America and some European countries do family members sleep alone. And only in North America do babies routinely spend the night alone.

According to Small’s research, the best remedy for crying is simple human contact. It was found that babies who were carried about an hour and a half more per day than "normal" cried just as often as the babies who were carried less, but the babies carried more cried for about half as long. Similarly, cross-cultural studies show that babies in different cultures cry equally frequently, but in the West they cry for a lot longer (1998).

How children are raised thus differs greatly from society to society, with many cultures responding differently to such questions as- how a parent should respond to a crying child, how often a baby should be nursed, and at what age a child should learn to sleep alone. Small asserts that, our ideas about how to raise our children are as much a result of our culture as our biology, and that, in fact, many of the values we place on child-rearing practices are based in culture rather than biology. So she says, "Every act by parents, every goal that molds that act, has a foundation in what is appropriate for that particular culture. In this sense, no parenting style is 'right' and no style is 'wrong.' It is appropriate or inappropriate only according to the culture" (Ibid.).

Is there a "correct" method of parenting? Are some methods more appropriate than others for a given environment? These are questions that health planners must keep in mind. Because, what holds good for one culture may not hold for another. This can be understood when the childcare package is understood as seen by the people of a culture. As one can see, the developing field of ethnopediatrics is providing child rearing experts around the world with plenty of food for thought (http: // www.canoe.ca/Health Pregnancy Zone Columns/020130. html 29-06-03). It can lay out in great detail an understanding for policy makers, that the indigenous practices of the people are not irrational. Their practices carry meaning which aim at the well-being of the child. This perspective
therefore, allows one to look at child well-being from the way the caregivers see and not from the perspective of the western notions and bio-medical perspective. Studies conducted on child well-being generally keep the bio-medical model and western notions as the units/base for comparison. Therefore, the ethnopediatric perspective can in fact provide the planners, policy makers, health workers guidelines for making feasible programs.

According to Worthman and others, ethnopediatrics is "a provisional term to signal the need both to pay attention to perceptions, beliefs and motivations of all actors who influence child well-being, and to view health and development of the young as socially and ecologically situated" (1995:7). It is concerned with culturally determined sets of beliefs and attitudes about how development (physical, social, cognitive) and child survival occur, and ways in which those notions inform about the actions of parents and other 'caregivers'. These beliefs are rarely arbitrary; they are grounded in observations, interpretations and emphases of experienced reality. Furthermore, the actions of caregivers are seldom capricious, but respond to or are shaped by actions, attainments, and perceptions of the child.

The need to recognize the "perspective of the actors" involved in caregiving is crucial and is being acknowledged in the studies on health and illness. Hence ethnopediatrics is conceived to provide an integrative view of child health. It can be conceived of ... “as a field of inquiry which explicitly aims, first to characterize local understandings and practices that inform behavior and second to determine their relationships to child well being” (Worthman 1995:6).

In this pursuit, the explanatory models of the people provide grounds for the understanding of child health from the perspective of the people and also to give meaning to the boundaries that exists between the people and the health providers. Klienman’s explanatory model (EM) provides a useful way of looking at the way illness is patterned, interpreted and treated. It is defined as 'the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process' (cited in Helman 1994). EMs are held by both
patients and practitioners, and they offer explanations of sickness and treatment to guide choices among available therapies and therapists.

The explanatory model of illness is a crucial part of the child well-being. For the understanding of the people’s explanatory model of child well-being, certain basic categories were formulated which would be appropriate for understanding child well-being. Klienmann’s model was modified to suit the needs for understanding the perceptions and behavior of the caregivers. They are:

- Preventive and promotive measures considered appropriate for children
- The etiology of illnesses of children.
- A classification of the names of diseases and illnesses, and their signs, symptoms, and relative severity that parents recognize that characterize illness and disease.
- Hierarchy of resorts that care givers opt (home remedies and treatment providers outside the home).
- The patterns of health and treatment seeking behavior for each of the childhood diseases in terms of onset, recognition, diagnosis and treatment and outcome.
- Economic, and socio-cultural factors influencing the acceptance and non-acceptance of a particular treatment.

The *emic*, culture specific explanatory models, of childhood illnesses and the way these affect people’s choices of disease management served as pathways to understand ethnopediatrics among Kunabi to a large extent. The etiology therefore, focuses on natural and supernatural factors that Kunabi reason as cause of ill-health condition. In matters of diagnosis, they try to reason out what has happened before the onset of the symptoms. The symptoms enable them to understand what must be wrong with the child.

In case of children therefore, it is the parents or other caregivers who interpret the pathophysiological processes involved. Further, it is the decision of the caregivers as to who or what should be sought for the child’s condition. Therefore, it is crucial to recognize the perspectives of the caregivers in order to obtain an insight into the realm of child health. Further, when it comes to decision
making, the notions of the caregivers guide as to whom to seek for treatment of
the child. In this process, it is also crucial to see how the modern doctor and
modern health care services figure into the hierarchy of resorts of the people, and
the notions that are prevalent regarding modern health care.

Helman (1994) points out that several studies have examined the reasons
why some people consult a doctor- whether modern or indigenous while others
with the same complaint do not. In understanding this behavior non-physiological
factors that influence are crucial. Zola calls these factors the ‘pathways to the
doctor’. They are:

- How the people perceive the problem.
- How others around them perceive it.
- The failure or success of treatments in the indigenous sectors.
- The availability of medical care.
- Whether the people can afford it (cited in Helman 1994).

In the process of understanding child health and illness it is important to
remember that environment in general sets broad limits to the possibilities of
human life. Further, any specific environment to some extent influences the way
of living of the people and provides materials, which are utilized by the people to
satisfy their needs. For instance, in any culture food can be important from two
view points, one, the nutritional, satisfying the energy requirements and biological
need of hunger, and the sociological, as a means of expressing and manifesting
social relationships.

When the same concept of food is analyzed on an etic level, it can be said
that an ordinary human diet should have six main components: Carbohydrates
(sugars and starches), fat and proteins (complex chemical substances containing
nitrogen, found in all living matter. E.g. white of egg). Mineral salts (of calcium,
iron), “accessory” substances (vitamins), and water. However, viewed from a
cultural angle it has different dimensions. Food in cultural dimension can be
viewed as sacred, profane, tabooed, for adults, for young ones, for ritual purposes,
for day-to-day consumption, for festive occasions, for the dead, for the deities, and
so on.
The factors of physical environment play an important part in regulating the food supply of a people, especially on the qualitative side, and may have striking results on their health and physique. Kunabi identify this when they compare their food habits with those of their landlords. They associate their strength to the kind of rice they consume, to the use of spices and consumption of meat.

It may be argued that a people’s medical beliefs and practices persist from generation to generation because they answer some instrumental needs of the people and are empirically effective for them. Therefore, the implementation of health programs may appear pointless when seen through the view point of the indigenous people. However viewing of health and illness as the responsibility of the State (at the etic level) to provide what it considers as the optimal health and development for its citizens. It is explicitly at this point that the significance of culture in health seeking behavior gets magnified. Because the State has to provide health care on its tenet of ‘health for all’, but cultures and sub-cultures vary in their medical traditions and the ideologies of the State and the various cultures may not be in tune with each other. Therefore, understanding of cultures and their medicare practices becomes crucial in planning of health programs. This would create better acceptance and would lead to fulfilling of the promise of ‘Health for All’.

What people do and why they do would be the only key to understand their practices. This can then throw light as to what could be done to change their behavior pattern. Change here might appear to be imposing an outsider’s judgment of the need for change, which from the emic point of view would appear inappropriate. Therefore, the question that needs to be clarified here first is, whether children can be left to be crippled, let to die prematurely or grow up without realizing his/her fullest potentialities, because the culture in which one is born regards infant mortality or morbidity as not out of line. This being an ethical question, the line of action could be that health care programs in the first and foremost place be culture-specific and then programs be formulated in such way
that they are culturally acceptable. This is not a high order call this is quite possible and could be done successfully.

The point here is neither that western medical notions which often act as guidelines for planners are the 'ideal' nor that the indigenous medicare systems have to be proved to be effective from the standpoint of Western medical notions. Nor that they always bring the results, which the people hope for. That a people have their practices and beliefs regarding healthcare is a social reality, also that, there exists morbidity and mortality that too which could be prevented is also a truth. Therefore, the perspective here is that human wastage could be prevented, by understanding why people do what they do. This understanding could translate into actions to reduce infant and child morbidity and mortality so that children grow up into 'healthy' adults who contribute productively to the nation's development.

It is worthwhile to look into the development of programmes formulated by the Government in the field of reproductive and child health with special reference to children. The Government of India under the Reproductive and Child Health programs has undertaken provision of various health care services. These services include antenatal care like, provision of antenatal care advice, safe delivery, provision of Iron Folic-Acid tablets, tetanus toxoid injections, and immunization of children.

Nutritional deficiencies in women are said to be often exacerbated during pregnancy, because of the additional nutrient requirements for the fetal growth. Iron deficiency anemia, is the most common micronutrient deficiency in the world. It is said to be a major threat to safe motherhood and to the health and survival of infants, because it contributes to lowered resistance to infection, impaired cognitive development, decreased work capacity, and low birth weight (NFHS 1998-99). Studies in different parts of India have estimated that a large proportion of births, are low birth weight babies, with a birth weight being less than 2,500 grams. Overall, about one-third of newborn children in India are of low birth weight (less than 2.5 kg), indicating that many pregnant women in India suffer from nutritional deficiencies (Reddy 1992).
Provision of Iron and Folic Acid tablets to pregnant women (to prevent nutritional anemia) therefore, forms an integral part of the safe motherhood services offered as part of the Reproductive and Child Health Programme. In Karnataka, the hemoglobin levels were tested for 94 percent of women compared with 88 percent of women in India as a whole/overall 42 percent of women have some degree of anemia. 27 percent of women are mildly anemic, 13 percent moderately anemic, and 2 percent are severely anemic. IFA coverage in Karnataka is lower in rural areas (76 percent) there are also differences in terms of percentage of women who have received IFA and those who have consumed the supply. More than 1/5th of women still do not receive any IFA during their pregnancies (NFHS 1998-99).

The Tetanus Toxoid immunization programme for expectant mothers was initiated in India, in 1975-76 and was integrated with the Expanded Programme on Immunization (EPI) in 1978. To step up the pace of immunization programme, Universal Immunization Programme (UIP) was initiated in 1985-86. An important objective of the UIP was to vaccinate all pregnant women against tetanus by 1990. In 1992-93 the UIP was integrated into the Child Survival and Safe Motherhood Programme.

There has been 56 percent coverage among the women belonging to tribes in Karnataka. The NFHS opines from the statistics obtained that, despite generally improving coverage of Tetanus Toxoid (TT) vaccinations, the coverage of TT vaccinations, for socio-economically disadvantaged women lags behind the level for the state as a whole (NFHS-2 1998-99).

Another important thrust of the Reproductive and Child Health Programme in India is to encourage deliveries under proper hygienic conditions under the supervision of trained health professionals. The NFHS report reveals that people belonging Scheduled Tribes are more likely to have home deliveries than others (Ibid.).

The vaccination of children against six deadly diseases is considered as cornerstone of the child health care system in India. Immunization against poliomyelitis was introduced in 1979-80. Immunization against tuberculosis
(BCG) was brought under the EPI in 1981-82. In 1985-86, immunization against measles was added to the program. Child immunization is an important component of child-survival programs in India, with efforts focusing on six serious but preventable diseases—tuberculosis, diphtheria, pertussis, tetanus, polio, and measles.

The objective of the Universal Immunization Program (UIP) was to extend immunization coverage against these diseases to at least 85 percent of infants by 1990. As part of the national health policy, the national immunization program is being implemented on a priority basis. The Expanded Program on Immunization (EPI) was initiated by the Government of India in 1978 with the objective of reducing morbidity, mortality, and disabilities from these six diseases by making free vaccination services easily available to all eligible children. The Universal Immunization Program (UIP) was introduced in 1985-86 with the following objectives: to cover at least 85 percent of all infants against the six ‘vaccine-preventable’ diseases by 1990 and to achieve self-sufficiency in vaccine production and the manufacture of cold chain equipment. This scheme has been introduced in every district of the country. And the target now is to achieve 100 percent immunization coverage (NFHS 1998-99).

Pulse polio immunization campaigns began in December 1995, as a part of a major national campaign to eliminate polio. The standard immunization schedule developed for the child immunization program specifies the age at which each vaccine is to be administered, the number of doses to be given, the age and route of vaccination (intramuscular, oral, or subcutaneous). Routine vaccinations received by infants and children are usually recorded on a vaccination card that is issued for the child.

In Karnataka, 60 percent of children ages 12-23 months are fully vaccinated, another 32 percent have received some, but not all of the recommended vaccinations, and 8 percent have not been vaccinated at all. Although DPT and polio vaccinations are given at the same time as part of the immunization programme, the coverage rates are slightly higher for polio than for DPT, undoubtedly because of the Pulse Polio campaign. (NFHS-2 1998-99)
The Government of India as a part of Maternal and Child health services, recommends that breast-feeding should begin immediately after childbirth and that infants should be exclusively breast-fed for about the first four months of life. International recommendations have recently been revised to promote exclusive breast-feeding up to six months of age. Although breast-feeding is nearly universal in Karnataka, very few children begin breastfeeding immediately after birth. And, 19 percent begin in the first hour and 42 percent in the first day. Two thirds of children under four months of age are exclusively breast-fed. The median duration of breast-feeding is 20 months, and the median duration of exclusive breast-feeding is 3 months. At age 6-9 months, all children should be receiving solid or mushy food in addition to breast milk. However, only 38 percent of children 6-9 months receive the recommended combination of breast milk and solid/mushy foods (NFHS 1998-99).

Integrated Child Development Services (ICDS) is the largest nutrition programme implemented by Government of India, which caters to 22.36 million beneficiaries with supplementary nutrition. This includes 18.2 million children and 3.8 million expectant and nursing mothers from poor socioeconomic groups. This scheme was launched in 1975 in pursuance of national policy for children in 33 experimental blocks. As on 31. 03. 1996, the number of ICDS projects sanctioned in Karnataka are 185 (Umesh, Sanjiv Kumar 1998).

Regarding family planning, the NFHS data reveals that female sterilization is the most widely known method of contraception in Karnataka. 52 percent of women in Karnataka have used the method sterilization. The use of female sterilization is more prominent in rural areas than in urban areas (NFHS1998-99).

The targets set are not reached hundred percent whether in case of immunization or reduction of child mortality and morbidity since the regional indigenous practices are not always in line with international standards. In some aspects behaviors come up to the levels fixed but not in case of majority. It is important to remember that even though uniform programs have been implemented through out the country, local populations have their own notions and health care practices. Whatever success or failures can be attributed partly to
lack of cultural perspectives, notions and beliefs. The significance of paying attention to the context in which the behavior is taking place is revealed in the studies conducted since 1950.

Understanding of a particular culture can enable better implementation health care programs also because, it enables one to understand whether a state of a person’s being is regarded as being sick at all by the people. This is revealed when we look into the following studies. Adam (1953), found among Mayan Indians (Guatemala) that they regarded worm infestation as an unpleasant but fairly common condition. Saunders (1954) found that worms were so endemic among Yap Islanders that, they were considered necessary for digestion. Mano (Africa) feel that primary and secondary yaws are so common that they say everybody has that and it is not a sickness at all (Cited in Hughes 1968).

Not only does culture define ‘what is illness’ but also provides etiologies, curative and preventive measures. Further, when it comes to health and sickness of children, it is the caregivers’ notions and beliefs as to what may be wrong with the child and what course of action has to be taken that are crucial for further actions. Therefore, what signs they look in for, how they interpret them and how do they categorize them in terms of causation assume immense significance. Because children, unlike adults, are unable to express their discomfort or the cause for it and reaction to illness in children is different from that of adults.

Therefore, the entire indigenous ‘caregiving package’ has to be understood in order to understand the child health. Because, one has to depend on the interpretation of the adults that something must be wrong with an infant or young child when it is not behaving in the expected pattern of behavior. Thus, in order to understand and explain why ethnomedical beliefs and practices persist, it is necessary to discover their practical and social meanings. Young (1976) says the meanings can be comprehended if illness episodes are understood in terms of expectations of the actors, the ‘narrative – building character’ of disease etiologies and the processual nature of cures. Furthermore, analysis of practical meaning focuses on the empirical character of indigenous medicine. This means distinguishing between what people hope for from their medical traditions and to
what extent they achieve satisfaction from them. Also recognizing the processes, which make indigenous medical beliefs and practices both plausible and useful is important.

Culture is thus crucial in influencing people's beliefs and indigenous cultural means could be employed in bringing about a change in those beliefs. In fact, a study of health, occurrence of illness and the ways of coping can throw light on the manner in which people perceive the structure of their social system and their social values. Thus the present study acquires immense significance because:

- Targets have not been reached as per the standards set in the area of child health and development.
- Tribal pockets such as Kunabi and their health care practices and health problems have not been documented.

In India since a large number of tribal communities are present with varied socio-cultural traditions, economy, interaction with outside world, the concepts of disease and nature of treatment are likely to be different. If a health policy meant for the tribals is to be formulated, it is important to study the indigenous practices and their implications for modern medicine. Choudhuri (1994) says unfortunately, data on health, the concept of disease and the nature of treatment are rather scanty and specific studies on this topic covering the different facets are practically non existent and also very little work has been done on the interaction between primitive and modern medical practices. This is further true for child health issues. The present study is therefore, an endeavor in the direction of understanding child health from the perspective of the people. In this context, focus has also been on interface between indigenous and modern medical practices.

The tribal population constitutes about 8 percent of the total population of India. However, there are also many tribal populations which are not scheduled. They are dispersed in most of the states in India. They do not represent a homogenous group, but show considerable variations in socio-cultural tradition, economy, language and even physical features. They live in varied geo-climatic and environmental conditions and their economy is largely influenced by the
concerned environment. Many populations with characteristics of tribe have neither been listed nor brought under the list of Scheduled Tribe by the constitution, Kunabi is one such tribe. As the chapter on the cultural profile of Kunabi reveals Kunabi have characteristics that anthropologists have listed as features of a tribe.

Lewis (1968) says, the concept “tribal society”, although having general utility as an idealized type of society, is in no sense an absolute category. Some societies are merely more or less tribal than others. Although tribe, caste, sect, racial group and class are the various types of social groups found in India, it is the tribe and the caste which dominate, the former among the so called ‘primitive communities’ and the latter in Hindu society. Much confusion has arisen in the past due to the indiscriminate use of these two words; they have been used by many as synonyms, and therefore, many tribes have been used by many tribes have been described as castes while a number of castes have received tribal designation.

The notification of tribal groups as ‘Scheduled Tribes’ by the Indian Parliament as Haimendrof (1982) says, clarifies in most cases at least, the legal position. Yet, there remain borderline cases. Political reasons may motivate a state government to include a particular community in the list of scheduled tribes, whereas in neighboring state more resistant to pressure groups the same community may not be notified as a Scheduled Tribe, and hence may not be enjoy the privileges granted to kinsmen on the other side of the state boundary (e.g Lamani, Gonds). In so far as the tribes included in the foregoing list are concerned, there can be little doubt that they deserve the politically advantageous classification of scheduled tribes. (Notification— is a legal term used in India – as in other previously British territories— for the promulgation of laws and government ordinances in the official gazette. Tribes notified as belonging to the ‘Scheduled Tribes’ and notified tribal areas are those whose special legal status was established by a ‘notification’ in the government gazette (Ibid.).

Looking into the Indian context Majumdar and Madan (1986) provide a comprehensive list of features of Indian tribes and these features are also present
among Kunabi. Kinship ties, common territory, one political organization, absence of internecine strife have all been referred to as the main characteristics of a tribe. The features described by Majumdar is an encompassing description of a tribe. Some anthropologists have not only, not accepted some of the above characteristics, and have denied some of them to be even characteristics of a tribe. The only conclusion one can draw from such diversity of learned opinion is that the views of each anthropologist arise from the type of data with which he is most familiar. One may, therefore, make a list of universal characteristics, some would define a tribe anywhere.

Keeping in view the features delineated by Majumdar, in tribal India a ‘tribe’ is definitely a territorial group; a tribe has a traditional territory, and emigrants always refer to it as their home. The Santhal for instance, working in the Assam tea gardens refer to particular regions of Bihar or Bengal as their home. For Kunabi, territory bounds them in a strong bond. In fact going beyond the territorial boundaries was considered as an offense. Customarily, Kunabi do not go out of their boundaries for work.

All members of a tribe are not kin of each other, but within every Indian tribe, kinship operates as a strong, associative regulative and integrating principle. The consequence is tribal endogamy and the division of a tribe into clans and sub-clans and so on. These clans etcetera, being kin groups, are exogamous. Similarly among Kunabi also kinship is crucial in the continuity of the group. It operates also on after-death level.

Members of an Indian tribe speak one common language, their own or/and that of their neighbors. Kunabi have a dialect that is spoken by them alone. It differs from the language spoken by other Kunabi elsewhere like those in Goa or Maharashtra or elsewhere in Karnataka.

Intra-tribal conflict on a group-scale is not a feature of Indian tribes. Joint ownership of property, wherever present, as for instance among the Ho, is not exclusive. Politically Indian tribes are under the control of the State governments, but within a tribe there may be a number of panchayats corresponding to the
heterogeneity, racial and cultural, of the constituent population in a village or in adjacent villages.

Therefore, Majumdar’s exposition of meaning of a tribe gives a lucid picture of salient features of Indian tribes, which are also found among Kunabi. Further, Kunabi are economically backward, settlements are situated in hilly regions with thick forests and lack basic infrastructure facilities. Their customs and practices are different from the contiguous population and this is also reflected in their rituals and beliefs. Taking note of these features, the State Government has come forward to recommend to include Kunabi as a Scheduled Tribe.

“The State Government has proposed to recommend to the Union Government to provide ST tag to Kunabis. According to this report “the Kunabis are basically forest dwellers and are spread over Karwar, Ankola, Yellapur and Haliyal taluk of UK district, Khanapur of Belgaum district and Goa. According to the survey conducted by Department of Backward Classes and minorities, Kunabis are the most backward among the tribal groups. Though the Devraj Urs Research Foundation prepared a comprehensive plan for their development in 1996, the Government is yet to implement it”(The Hindu Friday June 28, 2002:3).

Tribal populations in Karnataka have not gained the same attention by social scientists as other populations. The local writers who have written about Kunabi have attempted at documenting contrast of Kunabi to other local populations and is born out of curiosity. Therefore, the present study has aimed at an ethnographic sketch of Kunabi. The objectives of the present study are:

- To document the culture of the people (Kunabi).
- To understand behaviors relating to child health and illness by probing the ‘caregiving package’ embedded in every day setting.
- To explore the hierarchy of resorts, their reasons and implications
- To document the perceptions, beliefs and practices of the people relating to health and illness.
- To find out areas of conflicting goals and values between institutional health providers and child’s caregivers.
Conceptual map

This conceptual map has been formulated based on studies conducted by social scientists in the field of child health. This was done in order to attain a holistic perspective of the field of child health. The factors isolated can act upon and influence child health in isolation or in combination in different contexts.

Methodology

In contrast to other behavioral scientists anthropologists carry out their research in a relatively unstructured, wide ranging, exploratory fashion. As Foster and Anderson (1978) point out, anthropologists are less concerned to isolate tight little research designs than to hit on general broad problems that will lead the anthropologist along many lines of discovery. Anthropological research methodology stems not from the laboratory or from statistical correlations but from a natural history type commitment to field investigation where the essential mandate is to go out and find what is there. The primary data gathering technique evolved by anthropologists is “participant observation”. Ideally, this means that the anthropologist lives in a community, participates in many aspects of its life and observes firsthand the behavior of the members of the group. It is in these lines that the present study on ethnopediatrics among Kunabi has been conducted.
Sample size for the household survey has been 114 households from different Kunabi settlements spread out in the region. Out of the different settlements, three settlements were selected for prolonged stay, wherein one settlement was in the interior of the forest, with no roads, no transportation facility, the second settlement was nearer to road; third settlement had transportation facility and anganawādi. In addition to the settlements, for a comprehensive understanding of health and treatment seeking behavior, another settlement which has transportation facility, anganawādi as well as the health center was visited often.

The fieldwork was conducted in three different Kunabi settlements. The first settlement was situated deep in the forest on the hill. It had a shaman and medicine man. This settlement was not connected to the road. A steep and narrow path was the only route through which this settlement and its neighboring settlements could be reached on foot. The period of stay in this settlement was three months that is from May 2001 to July 2001. The ritual chief of the settlement allowed me to stay in his house. He was also a shaman. Though staying in the chief’s house helped me get a sense of things quickly, it also had its own drawbacks. People who did not like him were not willing to talk to me in the beginning. But gradually, their attitudes toward me changed.

The second settlement was connected through road to Alavi wherein the Primary Health Unit is situated and also to Yellapur, the nearest town. The period of stay in the second settlement was six months August 2002 to January 2002. This settlement was bigger than the first settlement. Here I stayed in the house of the local postman who was a Havik Brahmin. Staying in the Havik Brahmin house enabled me to understand the intricacies of relationship between the Havik Brahmin and Kunabi. This stay gave me a sense as to how the information passes on from Havik Brahmin to Kunabi and the mutual interdependence that exists between the two communities.

The third settlement had transportation facility as well as an anganawādi. In this settlement the family with which I stayed was quite large with four sons their mother, their wives, and their young children. This helped me a great deal to
understand their values about family from Kunabi perspective. The duration of stay in this settlement was five months from February 2002 to June 2002.

Different settlements were visited throughout the duration of the stay for household survey. The settlement in which the Primary Health Unit is situated was visited frequently. The visits to the Primary Health Unit provided opportunities to understand doctor-patient interactions, and the attitudes of health providers towards the people's health and treatment seeking behavior.

Household surveys were conducted through use of census schedule. This provided basic background information regarding income, number of children, breast-feeding and weaning and so on. Participant observation and interview, key informants were the methods utilized for collecting data. Living with the people helped to get a sense of their life and information kept flowing in without a conscious effort. Writing notes sitting with the family with whom I stayed were memorable experiences of learning. Participating in the agricultural activities, rituals, festivals made it possible to understand worldview. The women were delighted to teach me their traditional dance and children loved to laugh at my amateur attempts. These small attempts helped in breaking the ice and enabled to develop a warm relationship. Interviews with doctors, and interactive sessions with auxiliary nurse midwives, visiting different settlements with them, being in the anganawadi, talking to the anganawadi worker, participating in the immunization camps, all provided an understanding and insight into the working of health workers and also to know their attitudes and perceptions. In order to respect the sensibilities of the people, the original names of informants and settlements have been concealed and pseudonyms have been used.

All was not a smooth sail. There were difficulties first of all in accessing the settlements. Since they are situated deep into the forest and often long treks were required. The settlements are often small with four to five houses and as a result, doing the household survey involved great many adventurous treks to different settlements. The heavy rains and leach bites often accompanied these treks. Problems were also encountered when a NGO began a kindergarten and
people suspected it to be Christian missionary and associated me with the conversion campaign. It was a drawback in the growth of relationship with Kunabi. This misunderstanding was later set right by the Kunabi themselves and trust was restored. Further, the death of one of my key informants was a tremendous and unbearable loss and an emotional setback.

Thus fieldwork was conducted for little over a year and the data thus collected through fieldwork are presented in the following chapters. The chapter scheme is as follows:

**First chapter**: First chapter is on introduction to ethnopediatrics and its place in medical anthropology. This chapter makes an effort to bring home the relevance of culture sensitive studies. It also reveals the programs of the Government for the mother and child health, and focus of recent works of ethnopediatricians. The chapter also includes a discussion on the tribal features and the concept of tribe in order to place Kunabi as a community in a proper perspective. The objectives of the study, the conceptual map and methodology also have been discussed.

**Second chapter**: The focus of the second chapter is to sketch the cultural profile of the Kunabi. It entails an explanation about the economic, religious, political, aspects and also the settlement pattern, amenities, dress pattern, food habits, and general life pattern of Kunabi life. It is in the light of this cultural background that the subsequent chapters on ethnopediatrics of Kunabi have been attempted.

**Third chapter**: The third chapter deals with pregnancy and childbirth. The chapter tries to analyze the taboos regarding food and activities for the pregnant woman, rituals, routine of work, and also the concept of infertility, miscarriage. The beliefs as to how the stage of pregnancy and the stage even before conception can affect the well-being of the child has been delineated.

**Fourth chapter**: The objective of the fourth chapter is to outline the “caregiving package” of children. In this process the day-to-day childcare practices from the moment a child is born like bathing, massages, and feeding,
sleeping pattern have been analyzed. The rituals that are performed in the stage of childhood, the developmental phases are also analyzed.

**Fifth chapter:** The fifth chapter analyses the concepts related to health and illness. The natural causes of ill-health like climate, hot-cold imbalance, food and water and supernatural causes of ill-health like spirits, deities, breach of taboo have been described. The process of supernatural healing, the shaman and the deities as seen by Kunabi has been explained.

**Sixth chapter:** The focus of the sixth chapter is on different illnesses, their symptoms and the entailing treatment seeking behavior. The perceptions of the medicine men, different home remedies utilized in the process of treatment, chemical composition of the herbs used in treatment have been explained.

**Seventh chapter:** The seventh chapter is about the interface. It explores the boundaries of modern health services, and of people’s notions. It is an attempt to see where the boundaries merge, where there exists gaps and what the reasons for the gap are. It also tries to look into the perceptions and attitudes of the modern health care providers toward the people.

**Eighth chapter:** The eighth chapter deals with the summary and conclusions of the study.
Reflective commentary on methodology:

Household survey has been conducted with the use of census schedule (census schedule has been attached). The census was conducted to obtain basic background information about the study population and to also gain some basic insights into the child care practices. The census schedule was developed based on the literature reviewed.

Specific objectives for census were for collecting information regarding: Economy land holdings, average income, material possessions, type of family (family details, age, sex), house types, educational status, woman's health status during and after pregnancy, place of child birth and birth attendants, immunization of mother and child, illness suffered by the child and treatment options sought.

Data for the census schedule was obtained from 10 settlements and all the households were surveyed. The total number of households surveyed thus was 115. The researcher collected the data using census schedules. The researcher was accompanied by one of the informants for the visit to these different settlements, for two reasons: settlements were deep into the forests and one needs a local person to reach the settlement and the informants were of great help in getting introduced, and for explaining the purpose of the visit.

It is customary that the head of the household provides the information about matters such as land, income, so the head of the family was sought for information. The details regarding mother and child health, the mother would answer (husband would ask her to talk, some would leave some would stay behind and contribute). So in the column on source of information whoever has provided the information would be noted down. And elderly like the mother-in-law would also contribute, and they were noted down at the back of the census schedule. Non-response or reluctance to respond was with regard to income. However, approximate income was required and the reluctance did not affect the data analysis. The village panchayat records indicated that very few Kunabi families were above the poverty line (as defined by the village panchayat).
The data obtained was utilized to take percentages. The data was compiled manually. The study is basically qualitative and the quantified data were useful so far as understanding behaviors such as home Vs institutional deliveries, immunization are concerned.

Participant observation is the crux of anthropological studies. And with studies such as ethnopediatrics, where emic perspective is the way to understand behavior, participant observation is most appropriate. The reasons for the selection of this method are: for acceptance by the people, so that the researcher no longer stands out as a stranger peering over a person’s shoulder; and for in-depth understanding of the people’s way of life. As efficacy has been noted by Nichter and Nichter. ‘Caregivers possess knowledge about children’s illness. Much of the knowledge is not amenable to discovery by KAP type surveys. Much of it is embodied not objectified and where explanatory models of prototypical illness do exist, they are often embedded in narrative. What caretakers know is often contextualized, practice-based, and emergent at times of illness episodes. This knowledge needs to be captured by a variety of research methods including observation of actual illness, and responses to culturally relevant illness scenarios modeled after illness stories and even short video presentations of ill children that trigger recall of experiences’ (Nichter and Nichter 1990).

Since I was living with a family I was a part of their day to day life. As such I was considered acceptable. I quite often got the opportunity to participate in such activities as sowing paddy seedlings with them, went cattle grazing with their children, and collected areca nuts. Gradually my presence was no longer an intrusion.

Some of the illness episodes and the entailing treatment seeking behavior were observed and some were obtained from the detailed narratives by the informants. Sometimes the information turned up at least expected situations e.g.: a family fulfilling a vow during festival. When the reasons were asked the information about a sickness episode would come up. I accompanied them whenever they went to the health center, Brahmin priest, and shaman medicine man and I was able to understand
a great deal about the treatment seeking behavior though observing the interactions and also conversations during the long walks to the healers.

Rituals observed were purification rituals after menstruation and delivery, and rituals pertaining to naming, tonsure, and marriage. I participated in all the major festivals celebrated by Kunabi. Day to day child care practices was also observed, and written down in detail at the end of the day. Questions were asked about the acts and information elicited was recorded. Such activities were discussed with the key informant and information was cross checked.

Certain events like birth, hunting were not observed. This was because of my status as unmarried girl in case of child birth and in case of hunting because of my gender. But exceptions were also made as in the case of a ritual during one of the festivals that involved only men. But the Kunabi insisted that I could join them to see and write it down and also to photograph!!

My courage and curiosity made it possible to visit the remotest of the Kunabi settlements and this was often pointed out by the Kunabi themselves ‘even we have not been to that settlement’. This also made me more acceptable to the people and also admired. They felt that I am like them and can sleep on the mats, eat with them stay in the smallest of the huts without any pretences. They also felt concerned about me wandering in the forests alone especially after dark. They made me wear amulet for my safety. They insisted on accompanying me to the house where I stayed especially after dark.

All information obtained through observation and interviews were recorded in the field dairy along with the doubts and issues requiring further clarification. Information collection was opportunistic as well as systematic because of the participant observation.

The data was analyzed by triangulating the information obtained through interviews and all the sources discussed above.

Key informants were identified over the course of time. Some were identified by me and some were self appointed. The key informants selected were: medicine man, shaman, Brahmin priest, settlement chief, the grandmother in the family with
whom I stayed, a couple of children in the different settlements and a couple of Kunabi men and women. They were chosen because of their understandings, expertise, and ability to communicate clearly and also in some cases the clarity they possessed about the work I was doing. Things discussed with them varied from the area of their expertise to general Kunabi behavior and wide range of topics. All the information obtained was recorded, sitting with them. At times interview guides were used for specific information and at other times a question would open a great deal of discussion on varied topics.

The permission to stay with the community was obtained through the chairman of a local cooperative society who is respected and is popular. Initially this person was contacted and the research details were discussed with him. Initially he had to be convinced about the need for a girl to stay with the community for prolonged period of time. The process that followed:

I visited different settlements with the chairman. He introduced me to the chiefs of different settlements the whole day through. He explained to them that I wanted to study about them by living with them. He made it point to explain to them that I would like to study about how they raise their children and also about their culture, their festivals. After the first visit, the chairman said he would be in touch with the chiefs and tell me what decision they would take. For a month or two there was no response. Again I went to the settlements accompanied by my sister. The chairman said they were hesitant to permit because they have had a bad experience with a Christian missionary a decade back. The missionaries came in the pretext of starting kindergarten and then tried to convert the local community. Being shy of strangers, they were apprehensive to permit me to stay. And he also said some of them did not take seriously because they did not think that it was possible for a city bred person, that too a girl to come and stay in the remote hills with absolutely no modern conveniences. Over the course next two three months, I regularly visited the settlements with my sister (because it is difficult for them to understand how parents can send a young unmarried girl alone).
I talked to the chiefs some of whom were conversant with a dialect of the language I speak (Kannada). I explained to them that I am studying about how child health is taken care of by people and Kunabi community has not been documented at all and this way their practices would also be documented. This they appreciated because they felt their practices were being forgotten. And gradually chief of one of the remote settlements agreed to give me place to stay.

When I went to settle in for my prolonged stay my whole family accompanied me and this made them to accept in a much better way because family plays an important role in their own lives. Seeing my sister cry while leaving me and me crying for weeks because I was missing my family, made them realize that I was not so different from them after all. Even though they said they found it difficult to understand why a girl needs to stay away from the family under such difficult circumstances and study, my explanation about the kind of culture I come from and the importance given to education was gradually accepted.

I stayed in the hut they built for me adjoining their house. The chiefs family with whom I stayed helped me learn the language and also conversing and listening to the people over a period of time made it possible to learn their tongue. Some of the people could also speak in the dialect of Kannada, so that also helped me understand the people and their ways. The local terms used in the thesis have been understood first from the Kunabi who speak in Kannada and also from Havik Brahmins and then translated in English.

They gradually came to understand that I was interested in learning their ways and what child care means to them. They started refering to me as a person who will write a book. They proudly introduced me to their kin or even the Havik Brahmin landlords that I was there to write a book about them. When I would explain about how someone else in a different state and even country would read and tell me whether I pass or fail in the exam, even though it was difficult for them to understand how a person who hasn't seen them can do so, they would often tell me it takes great courage to do what I am doing and I would 'pass'.
Photographs were always taken with permission and the photographs which have been used in the thesis were taken with the oral consent. A copy of the photographs taken has also been given to those who asked for them during the stay. The thesis after finalization was taken to show to people and as a token of thanks photographs taken during the stay were given. Photographs mean a great deal to them because they say it helps to remember a person even if the person is far away. I have also been their official photographer for different ceremonies like marriages, naming ceremonies and festival dances. Their allowing me to photograph them is a part of their acceptance of me in their lives. At later stages, they would come and say such and such a thing is taking place come and photograph it.

Because of I was living with them and eating with them most of the time, and stayed through the rainy season (considered to be unbearable for outsiders and even to some of their own people), they began to take me seriously that I was committed. I being a Brahmin and eating with them was often discussed and I would have to explain about my world view. They would serve me only vegetarian dishes. Women in the beginning and later on, even older men began to tell me what kind of dresses to wear. If I wore salwar kameez they would say I should wear long skirts and I began to wear as such clothes which were agreeable. They would suggest I wear flowers in my hair and often they would bring me orchids to wear and how could I refuse! My mother visiting me also made me more acceptable and my family was not so strange after all.

Regarding the ethical guidelines laid by the Karnatak University have been followed in the present research. The presence of the researcher among the people was explained as a requirement for the research and no pretences or portrayal was adopted. This honesty helped the researcher to build a sound rapport during the investigation.