

## Cultural Variation and the Practical Pediatrician

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**ABSTRACT** This paper examines the cultural factors affecting pediatric aspects in a community. Emphasizing the importance of culture in understanding variation in child rearing practices, the author examines child welfare clinics in West Bengal, providing an interaction that obtains between ethnomedical and biomedical practices. The need of a social anthropologist in undertaking this work is highlighted.

The term "culture" is frequently used in a somewhat narrow sense to apply more or less exclusively to the artistic, academic, and spiritual activities of a community. However, the social anthropologist considers it too restricting to equate culture only with such important phenomena as architecture, literature, and philosophy—a wider definition is required, for "Culture covers not only the arts, sciences, religions and philosophies to which the word is historically applied, but also the system of technology, the political practices, the small intimate habits of daily life, such as the way of preparing or eating food, or of hushing a child to sleep (Mead, 1953)." Similarly, Foster (1955) employs the following definition: "the common way of life shared by the members of a group, consisting of the totality of their tools, techniques, social institutions, behavior patterns, attitudes, beliefs, motivations, systems of values and the like."

### CULTURAL VARIATION

Culture patterns vary all over the world and, although ideally a knowledge of all interrelated aspects of the particular culture would be of great benefit to the practical pediatrician, certain facets are of especial significance, particularly customs relating to pregnancy and childbirth, methods employed in child rearing, local food ideology, and indigenous medical beliefs.

Unprejudiced analysis, based on dispassion-

ate and unbiased scientific observation clearly shows that both rational and irrational attitudes, and beneficial and injurious customs, are to be found in every part of the world, whether in Boston, Manchester, or Southeast Asia. The following examples may, for instance, be quoted as sometimes being of importance to a greater or lesser extent in the field of child health among different socio-economic groups in Britain—the prevalence of totally unnecessary "social" circumcision, overrigid attitudes towards toilet training and breast feeding, the use of proprietary "gripewater" types of medicines and potentially dangerous mercurial teething powders, the belief that fish is a specific "brain food" for infants, and such superstitions as the belief that a baby boy born in a caul is lucky and, in particular, will not be drowned. From the general nutritional point of view, it is worth noting that the universal prejudice in Britain against protein-rich frogs, snails, dogs, and insects is so great that, even during the period of maximal food shortage during the last war, no suggestion was made that these might be employed for the supplementary feeding of children, despite the fact that these items form customary, much relished and nutritious foods in other parts of the world.

### IMPORTANCE TO THE PEDIATRICIAN

If it is agreed that culture patterns, including the food habits and the practices associated with

pregnancy and methods of child rearing, vary greatly in different parts of India, it becomes necessary to consider in what practical ways a knowledge of these beliefs and attitudes is important to the scientific pediatrician.

A description of what appears to be the general logical trend in pediatrics will show the true value of this approach. It has become apparent to the thinking pediatrician that an exclusively curative approach to child health is almost shortsighted, and overexpensive. It is, for example, unsatisfactory to treat children with malaria and Guinea worm infection, with measles and malnutrition, if, at the same time, no effort is made to prevent the almost inevitable recurrence of these conditions when children leave the artificial surroundings of the hospital and return to their home environments. As a result of this mental evolution, the curative-preventive pediatrician has developed, with an appreciation of the importance of both overlapping and interdependent aspects of child health.

A consideration of the ways in which child health may be protected and improved suggests three main preventive approaches: (1) public health measures, such as an improved water supply, residual spraying with DDT, and immunization programs; (2) general socioeconomic measures, including increased employment and a higher standard of living, and the spread of adult education; and (3) health education. Important as are the first two of these, it is usually in the last—the field of health education—that the practical pediatrician has most chance to contribute personally, by means, for example, of counseling on infant feeding, given in the welfare clinic, or advice to parents when their children are discharged from hospital.

Although to the uninitiated, the art of health education in this or any other context may appear to be a straightforward matter, easily accomplished by a display of logic and a marshaling of posters, experience has unfortunately shown this not to be the case, especially among peasant peoples in nonindustrialized tropical countries. The resistance, or lack of response, to standard

health education measures so often found, is related to the fact that attempts at altering people's habits, ways of life, and customary behaviour are never made *in vacuo*, but in competition with and against the resistance of, deep-rooted and time-hallowed indigenous beliefs. Foster (1951) expresses this view when he says: "The public health specialist is not working in a vacuum—rather he is working in an area in which the subject already has definite and hard-to-shake beliefs, which they are just as sure are correct as he is sure they are mistaken."

In brief, then, it has become clear—largely as a result of the work of Foster and his colleagues—that, in any health field, it is usually necessary to know a group's present attitudes and beliefs in order to modify them successfully by means of health education, and this applies perhaps with especial force to the field of child health. New knowledge will be accepted only in so far as it can be made to fit into the general pattern of custom and belief of the people (Foster, 1951, 1952, 1955).

Second, from the point of view of scientific medicine, it has become increasingly realized that detailed investigation of methods used in child rearing among different cultural groups may often help to contribute to world knowledge of child care. For example, the rigid "by-the-clock" system of breast feeding has now been largely abandoned in Western countries in favour of the so-called "self-demand" method, partly as a result of observation of more natural methods employed in other parts of the world. This cross-cultural type of approach promises, for example, to be particularly rewarding in improving our understanding of the effect of child training on personality development (Whiting and Child, 1953).

Finally, but certainly not least in importance, it seems probable that the pediatrician will be able to establish a better rapport with the families with which he is concerned, whether in the welfare clinic or as outpatients, and more easily earn their confidence, if he understands, appreciates, and learns to think in terms of their beliefs and attitudes.

## INVESTIGATION OF CULTURAL VARIATION

The correct approach to cultural variation may perhaps be illustrated best by assuming that the pediatrician finds himself in a part of the world which is far from his own *habitat*—as, for example, if an Indian pediatrician were to set up a child welfare clinic in the interior of Brazil. Under this type of circumstances, it would seem wise to conduct a preliminary investigation somewhat along the following lines: (1) investigate, so far as possible, relevant indigenous methods and practices; (2) make an *unprejudiced* analysis of these, based on scientific principles, but bearing in mind the local background (i.e., climatic, geographic, economic, agricultural, etc.); (3) divide the practices encountered into three groups—the beneficial, which should be encouraged, the harmless or neutral, which need not be interfered with, and the harmful, which should be overcome, if possible, by persuasion and demonstration, or integrated in some "neutralized" form, as will be described later.

## CORRECT AND INCORRECT ATTITUDES

From a practical point of view, various attitudes may be adopted by the scientific pediatrician with regard to indigenous customs, and these may be considered as falling into two groups—the incorrect and the correct.

### *Incorrect Attitudes*

**Lack of awareness:** With a foreigner, working outside his own country, and sometimes even with a national pediatrician, who is often town-bred and from the upper socioeconomic group, there may be considerable lack of awareness of the complexity of the indigenous beliefs and customs existing in the village. The fault here would appear to be mainly educational, as the pediatrician has usually not had his mind orientated during his training towards considering or investigating his patients' socioanthropological backgrounds.

**Refusal to recognize:** In some cases the pediatrician may be aware, to a varying extent, of local views and practices, but, often unconsciously, may adopt an attitude whereby he ignores them. In other words, he may compartmentalize his mind, so that in the clinic he deals only in terms of scientific pediatrics as laid down in the standard textbook, which is, anyway, usually written with a Western cultural background assumed.

**Derision:** Sometimes, unfortunately, the pediatrician may adopt an attitude of quite unwarranted superiority and look down on, or even *deride*, local village customs and traditional practices. This view that the methods of the villager are merely the inferior ways of an illiterate, ignorant peasantry is absolutely unwarranted—in many cases apparently strange practices may, in fact, represent timetested and wise adjustments to a harsh and hostile environment.

### *Correct Attitudes*

Primarily, then, it is necessary for the pediatrician to be aware of and sympathetic toward local views, attitudes, and customs. Depending upon whether they are considered scientifically desirable or not, so one of the following lines of approach may be used:

**Adoption:** If a custom or practice appears to be beneficial in the particular local background then it should be encouraged and adopted into the pediatrician's health teaching. For example, breast feeding prolonged into the second year of life may be judged biologically necessary for the growth and survival of infants in many subtropical and tropical communities, especially, for example, in the tsetse fly belt of equatorial Africa, where cattle cannot be raised. Under these circumstances, the pediatrician will have to reorientate his ideas and methods (Jelliffe, 1955).

**Persuasion:** Numerous indigenous practices

may be found to be absolutely undesirable when judged by scientific criteria—as, for example, the use of cow dung as a dressing on the umbilicus of the newborn child, or the failure to introduce supplementary foods, to an infant until he can walk. Under the circumstances, the correct approach for the pediatrician is undoubtedly to attempt to alter the parents' belief in the particular custom by means of persuasion, strengthened, wherever possible, by convincing, practical demonstration of the superiority of his methods. This may be extremely difficult, or even impossible, especially with an essentially pragmatic peasant population, when dealing with such long-term aspects of child health as the nutritional benefits of different methods of infant feeding. It is usually easier to convince when the results are rapidly and easily demonstrated, as, for example, the superiority of benzyl benzoate emulsion over herbal preparations in the treatment of scabies, or the efficacy of penicillin therapy in yaws.

In any case, in order to use persuasion to best advantage, the pediatrician must fully understand the resistances that are likely to arise against his advice, and this he can do best by being conversant with the local culture pattern.

*Integration:* Sometimes customs and attitudes considered undesirable by the scientific pediatrician may be rendered harmless by modification and integration. Thus, if orange and other fruit juices are classified as "cold" (*tonda*) in a particular food ideology and because of this cannot be given during the winter months, it would seem legitimate to make use of the culturally acceptable and scientifically harmless technique of neutralizing the essential inherent "coldness" of the juice by adding a little honey, which is "hot" (*garam*), if by this means the mother will be more willing to allow the infant to take the ascorbic acid-containing juice.

Similarly, sometimes by retaining and integrating, or at least not opposing, a particular custom, which to the scientific viewpoint may seem quite immaterial to the child's health, it may be pos-

sible to keep or increase the parents' confidence. In this avoidance of unnecessary conflict, major difficulties may be circumvented by carefully "charting a course along the reefs of culture, instead of crashing precipitously upon them" (Kelly, 1956).

For example, in many parts of the world, the exact method of disposal of the placenta is felt to be of real moment. In these circumstances, allowing a relative to remove the placenta for burial, or whatever other method is employed, may encourage mothers needing special obstetrical care to come into the maternity hospital and so lessen the risk of birth trauma, a major pediatric concern.

In the sameway, a knowledge of and, so far as possible, a respect for such conceptions as especially suitable days for medical procedures, such as medicines, should be cultivated. These practices can often be quietly adhered to—and may ensure that the patient will receive the main essentials of a particular form of therapy more willingly.

It may be argued that by adopting this type of method, the pediatrician is helping to perpetuate what are, when judged by present scientific knowledge, irrational beliefs. If alteration of ideas by persuasion were an easy matter, this sort of approach would certainly be unnecessary. Unfortunately this is definitely not the case, so that some type of integration may have to be employed as an interim measure until the spread of education causes many of these irrational attitudes to disappear. It is not suggested, however, that the health worker should give his advice using, for example, the terms and reasoning of the local food ideology, but rather that he should work within this framework, making use of it without supporting it. In the instance already cited, the pediatrician, knowing the customs and attitudes of the particular group, would advise the use of fruit juice with a little added honey, without either mentioning or condoning the "hot-cold" food classification, which he knows to be the basis of the difficulty.

The correct attitude towards any particular

custom—whether, for example, to attempt to persuade or to integrate temporarily—will have to be decided by the health worker. There is no absolute rule, and a decision will depend upon such factors as the pediatrician's estimate of local attitudes and resistances, and on the amount of time available in the clinic.

### CHILD WELFARE CLINIC IN WEST BENGAL

The following examples, based on personal experience in a rural child welfare clinic in West Bengal, will illustrate a practical application of the type of approach outlined in the present paper. In almost all instances, mothers bringing their children to the clinic were illiterate Bengali villagers of the lower socio-economic group and of the Hindu religion.

*Foods and Illness*—Apart from the fundamental Hindu division of foods into *amish* (non-vegetarian) and *niramish* (vegetarian) the dominant food ideology among the village mothers attending the clinic was found to be the "hot-cold" (*garam-tonda*) classification, based upon supposed inherent properties of foodstuffs.\* According to this view, egg, meat, milk, *musuridhal* (*Lens esculenta*), honey, sugar, and cod-liver oil are regarded as being to varying degrees *garam*; while lemon, orange, rice, water, acid buttermilk (*lassi*) and curd (*dahi* or Indian yoghurt) are classified as *tonda*.

Apart from difficulties in infant feeding that may arise as a result of a reluctance to give such *garam* items as eggs and cod-liver oil during the

warm weather, of greater importance is the fact that illnesses are also classified as being *garam* or *tonda*, and that "hot" or "cold" foods cannot be given during like illnesses.

*Bronchitis*—For example, an upper respiratory tract infection, such as bronchitis, is regarded as a "cold" or *tonda* malady. Scientifically, in this type of case it may be desirable to advise the mother to give sulfonamides, together with plenty of water to drink and the lighter portion of the normal diet, including rice preparations. This, however, would not be considered as satisfactory by the mother, as both water and rice are classified as *tonda* and, therefore, to be avoided in this type of illness.

In this instance persuasion may be possible but often may not be successful against such a deeply ingrained food belief, and, in this case, the two attitudes—that of the pediatrician and that of the mother—can be successfully integrated by advising the mother to give sulfonamides, together with water flavored with honey and rice cooked in milk. The mother will accept this advice much more readily, as the honey and the milk are thought to neutralize the "cold" in the water and in the rice, and scientifically the same end point has been reached.

*Diarrhea*—In children recovering from diarrhea, mothers are frequently reluctant to introduce milk, even if diluted, as both the food and the illness are classified as *garam*, so much so that continued feeding with carbohydrate gruels may, in this type of case, act as the starting point for the subsequent development of the protein deficiency syndrome known as kwashiorkor.

Frequently, in this sort of situation it is desirable, from a scientific point of view, that the child should be given a bland, easily absorbable, low residue carbohydrate gruel, a water-absorbing, pectin-containing food, and dilute milk. In a West Bengal rural child welfare clinic, it appears that this is best achieved by adopting three local dietary remedies, which appear to coincide exactly with the scientific viewpoint. By using the

\* A similar classification of disease and diet (*caliente-frio*) is also prevalent among some Latin American peasant groups (Foster, 1951). This appears to stem ultimately from the humoral pathology of Hippocrates and Galen, which reached medieval Europe via the Arab world and was transmitted to Hispanic America by the conquistadors. As this concept appears to be an ancient one in India, stemming back to early Sanskrit Ayurvedic literature, it is possible that it may have originated in India and spread to influence and mold early Greek thought in this respect.

carbohydrate *chira mondu* (hand-mashed flat rice) and as the pectin food, a *sherbet* made of the Indian wood apple (*Aegle marmelos*), one is employing traditional dietetic treatments. In dilute *lassi* (acid buttermilk), one has an acceptable and familiar remedy. The buttermilk being both acidified and defatted, and *chira mondu* is particularly suitable from all points of view.

**Vaccination**—As in certain other parts of the world, smallpox, partly perhaps because of its striking and characteristic appearance and high mortality, is often regarded by villagers in West Bengal as due to divine visitation of the goddess *Shitala*, and, because of this some years back, in the early days of the health center, vaccination was actively refused. At the present time, however, a great change has come about, so that vaccination is now-a-days welcomed and even sought after by village mothers. This is, of course, an excellent example of successful health education by persuasion and demonstration, as mothers have themselves come to observe that, if their children are vaccinated, they are no longer liable to be blinded, disfigured, or killed by smallpox.

**Childbirth and the Maternity Home**—All over the world, the life crisis of childbirth is associated with special customs, *rites de passage*, and precautionary practices. This is equally true in rural West Bengal and it is of interest to see how these can be dovetailed and integrated into the otherwise alien background of the small maternity hospital attached to the rural center.

As no particular beliefs appear to be held concerning the length at which the cord should be cut, as in some countries, no difficulty arises here. With regard to the placenta, in the traditional home delivery this is buried by the *daai* (hereditary indigenous midwife). However, the exact details of this practice do not appear to be very important in this locality, so that mothers seem to be quite content for the placenta to be disposed of by the maternity home staff in a deeply dug rubbish pit. The ritual seclusion universally practiced by Hindu mothers after birth can be adhered

to, at least functionally, by visitors' not approaching nearer than a few feet from the bed, and by the food's being brought from home by relatives and emptied into the mother's plate, which she leaves just outside the ward. In this case, care is taken not to touch the mother's plate with the food container during the process of pouring.

Attitudes toward the disposal of the shriveled umbilical stump vary. Many mothers do not seem to mind if this is thrown away, although some are in the habit of using it in a *maduli* (protective charm) worn round the baby's neck. In the latter case, the maternity home staff raise no objection.

Various ceremonies are performed in the neonatal period. One of these, *Jata Karman*, can be and is carried out in substance by the mother herself, putting a drop of honey on the neonate's tongue. Similarly, on the sixth evening, the mother will be anxious to be home for the night vigil kept during *Shosti puja* (dedication of the baby to *Shosti*, the goddess of children). However if the mother has to stay in the maternity home longer than this, a satisfactory compromise can be achieved by the relatives' doing a part of the ceremony in the home, while the rest can be completed by the mother on the twenty-first day, when she has returned home. There are, however, two days on which the mother is very anxious to be home—the first is on the eighth day, for the ceremony of *atkore-batkore*, and the second on the tenth day, when the ritual purificatory bath is taken. Knowing this, the maternity home staff will make every effort to see that the mother leaves the hospital in time.

It can be seen, then, that, owing to the sensibly flexible attitude of the staff, an excellent working arrangement has been built up whereby the practices and beliefs of the mothers have been suitably integrated into the background of a modern maternity home.

**Mixed Diet in Infant Feeding**—As in many parts of India, in rural West Bengal one of the ancient Hindu rites which is always observed is

*annaprasan* (rice-feeding ceremony), which is here performed at 6 months of age for a boy and at 7 months for a girl.

It would seem likely that the original purpose of this custom was both to celebrate the baby's having survived the dangerous first half year of independent existence, and at the same time, to commence widening the infant's diet. Investigation shows, however, that a not inconsiderable percentage of present-day villagers perform the ceremony punctiliously, but do not continue with rice and other foods thereafter, sometimes not introducing them until the child can walk or has teeth in both upper and lower jaws.

Nutritionally it is, of course necessary for the infant to have foods other than milk, at least from about the end of the first six months onward, and it would seem profitable to use a reference to this wise and ancient practice as a practical lever in health education to persuade village mothers of the need for foods other than milk after the age of 6 months.

### CONCLUSION

To understand fully the motivations behind the customs and beliefs of a particular people needs the skill of a trained socioanthropologist, who not only knows the language but has been able to live with the particular group unobtrusively and on equal terms. The assistance of such a person should always be sought—if possible in person, if not, in the available literature. Usually, however, the pediatrician working in a technically developing tropical region will himself have to attempt, some what amateurishly, to piece together at least the more relevant features of the particular culture pattern, especially the customs affecting children and pregnant women. He will then find himself better able to understand his patients' problems and to gain the confidence

more fully. In addition, he will be able to plan out and put into effect scientifically based preventive and curative measures in ways that are interwoven into the local pattern of beliefs and, therefore, the more likely to succeed.

From a wider perspective, it is highly desirable that world-wide investigation should continue into cultural variation and its effects on child health and development. Scientific medicine, of which pediatrics is one important discipline, has its ultimate historical roots in knowledge from all over the world. The next phase may well be the further incorporation and fusion of the valuable and worth while from the cultural group into an enriched, expanded, and truly global system of child care.

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