

Cultural Factors Associated with Healthful Behaviors in India

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Resumen

Los diseñadores de políticas sociales, los profesionales de la salud y otros prestadores de servicios sociales tienen la responsabilidad ética de proveer de manera eficaz servicios a diversos subgrupos de la población. Dicha responsabilidad ética se extiende también al creciente número de inmigrantes de la India que residen en los Estados Unidos o en otros países del continente americano. El conocimiento de la identidad étnica de parte de médicos, psicólogos y trabajadores sociales no es suficiente para garantizar servicios que son culturalmente sensibles. El presente artículo identifica factores contextuales y culturales que pueden impactar las conductas en torno a la salud en comunidades hindúes como por ejemplo la discriminación de género y su impacto en la toma de decisiones referente a la salud; la tensión entre la medicina tradicional hindú y la medicina occidental; la discriminación racial y la inequidad; estrategias comunicativas; orientaciones espirituales y religiosos así como el concepto de tiempo y las actitudes. En el presente artículo se discuten las implicaciones de estos factores en función de estrategias de políticas de salud pública y la provisión de servicios de salud a comunidades hindúes en los Estados Unidos.

Abstract

Policy makers, healthcare professionals and other human service providers have an ethical responsibility to provide effective services to different population subgroups. This ethical responsibility is also extended to the increasing number of Indian immigrants in the United States and other countries. The author proposes that knowledge of the clients' ethnic identification is not enough to help human service providers provide culturally sensitive health and human services. This article identifies contextual as well as group based cultural factors that are likely to influence healthful behaviors. Such factors include: gender discrimination and the resulting inability of women to make decisions impacting their own health, tensions between Indian folk medicine and western medicine, social discrimination and the resulting inequitable access to health services by minority groups, culturally dictated forms of communication, the role of spirituality and religion, their culturally prescribed notion of time and attitudes towards time, group orientation and reliance on the family and friends during health crises. The article concludes with a discussion of the implications of specific Indian beliefs and behaviors for healthcare policy and service delivery.

Introduction

This article attempts to identify cultural and social elements that influence behaviors conducive to health among adult Indian citizens. Currently, cultural beliefs and the adherence to traditional health care systems motivate many Indians to not utilize

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available modern health care services and facilities (Bandyopadhyay and MacPhearson, 1998; Lambert, 1996; Manocha, Manocha and Vin, 1992; and Taylor, 1976). For this reason, knowledge of cultural beliefs that contribute to poor utilization of health care services and to other unhealthful behaviors is essential for designing outreach programs to improve well being of all members of the society.

The recent massive migration of Indians to America makes this article pertinent and relevant to policy makers in the new host countries given that a better understanding of elements of Indian cultures could facilitate the processes of policy making and service delivery. There have been three waves of Indian immigration to America (Weinstein and Pillai, 2001). The first wave began in the early part of the twentieth century, it involved a group of Punjabs that migrated to Canada, and lasted over two decades (Chandrasekhar, 1982). The second wave began after 1965 and involved highly educated and skilled personnel coming from various Indian states to the United States. This massive Indian migration was made possible by the passing of the Immigration Reform Act of 1965 (Ramisetty-Mikler, 1993). The third wave of Indian immigration consisted of the parents and relatives of the previously mentioned highly skilled immigrants and was made possible by the Family Reunification Act (Ramisetty-Mikler, 1993). The states that received the largest numbers of new Indian immigrants in 1996 were California, New York, Florida, Texas, New Jersey and Illinois (Gupta and Pillai, 2002).

This article proposes that cultural or ethnic identification alone can not provide policy makers and human service providers with the information and cultural competence necessary to effectively respond to the issue of underutilization of health care. For this reason, it contends that particular attention should be paid to specific cultural elements such as beliefs, behaviors, symbols and traditions. This article does not attempt to analyze each cultural subgroup in India given that the vast diversity of cultural groups in the country would make it impossible for anyone to discuss the peculiarities of each group in a single article. Instead, it seeks to identify specific cultural beliefs and behaviors that are common to a majority of Indians and tries to identify the way in which

these are related to healthful behaviors. The article is conceptual in nature and relies on available literature.

Contextual Factors

The 2000 census of India counted more than 1 billion people (Bose, 2001; <http://www.censusindia.net>). About 25 percent of the population is urban and the rest rural. The Indian Union is composed of 29 States and six centrally administered union territories. Each geographic and political subdivision possesses a distinct culture and often a unique language. In spite of the immense diversity that exists in languages and customs, the country shares a common culture brought about by Hinduism. The main religions found in India are: Hinduism, Islam, Christianity, Sikh, Buddhism, and Jains (Pachua, 2003; <http://www.censusindia.net>).

It is of vital importance to understand the modern concepts of health and health care services, gender inequality, and social discrimination as we explore the societal context of culture and healthful behaviors in India. There is considerable neglect of sexual health education in India. Information about puberty, sex, and sexual diseases is not publicly available and there is a shred of secrecy about sexual concerns. Jejeebhoy (1998) reports that awareness among females about menstruation and other puberty related physical changes appears to be poor. Gender biases are associated with the considerable sexual health knowledge disparity between young men and women. In a study of sexual knowledge in slums, nearly 67 percent of the girls and about 50 percent of the boys possessed adequate knowledge about sex within marriage (Bhende, 1994).

The unwillingness of most Indian families to discuss individual sexuality at the family level has aggravated the AIDS epidemic in the country. Within the next ten years, it is believed that India will become the epicenter of the world's AIDS epidemic resulting in extremely high rates of adult mortality. It has been estimated that one third of the population is infected with sexually transmitted diseases (STDs) and the incidence of

STDs is on the rise (Evans and Lambert, 1997; Bhattacharya, G; Cleland, C & Holland, S., 2000; Jejeebhoy, 1998).

In India female mortality rates surpass male mortality rates at all ages below 35-39 (Dyson, 1987). The disadvantages that females face in India leading to higher mortality rates stem from socially accepted gender inequality (Basu, 1992). Indian families are patrilineal. Women are expected to be submissive and acquiescent. They are expected to depend upon males throughout their lives and they are forced to stay dependent by societal constraints. A number of decisions with regard to women's healthcare are made by males in the family and this lack of freedom to control one's own body is a serious threat to women's health and reproductive health in India.

Societal prejudices and discrimination contribute to the poor health of Indian tribes as compared to the population at large. The scheduled tribes are groups recognized by the Indian government for the purpose of affirmative action. These oppressed groups score lower than the population at large in relation to health indicators and other human development indicators such as life expectancy. The life expectancy is about 38 years for males and about 40 years for females among the Bastar tribal groups in Madhya Pradesh (Basu and Kshatriya, 1989). They usually live in areas poorly served by transportation and other modern facilities, little access to potable water, and in dilapidated housing under unsanitary conditions. Almost ninety percent of the Bhils, a tribal group in Madhya Pradesh, are malnourished. Their infant mortality rate is high as a result of the malnutrition, lack of prenatal care, and the hard labor during the course of pregnancy. Alcohol consumption and the incidence of tetanus infection are very high among the tribal populations (Basu and Kshatriya, 1989).

The process of diagnosis practiced by western medicine is rendered at times ineffective and inapplicable due to socio-cultural characteristics, including communication patterns. Women seldom make eye contact with other men. Even though men make direct eye contact with each other, they may not do so with men who are either older or possess more authority. Non-verbal communication is used extensively. Hand

gesture and head movements are part of the communication process. Most men and women also avoid hugging and embracing. Physicians will have to become adept at reading non-verbal language extensively used by their clients (Bandyopadhyay and MacPhearson, 1998).

Cultural Health-Related Beliefs

Any physical or mental condition that constrains day to day activities may be defined as illness. Feeling ill is often associated with a lack of ability to perform fully in any aspect of physical, mental and spiritual functioning (Edmundson, Sukhatme, & Edmundson, 1992). In India, most adults believe that diseases are caused by lack of appropriate attention to a number of social, physical and spiritual activities. For example, too much sexual activity may be associated with having tuberculosis (Taylor, I 976). Diseases are often classified into two categories, those stemming from the fact that the body is over heated and the other from the body being too cold. The loss of equilibrium between hot and cold states in the body is believed to be a major reason for illnesses. Cooling diets are prescribed for illness resulting from the body being too hot. Most self medications, including diets, attempt to achieve a balance between hot and cold.

Popular cultural misconceptions related to AIDS infection include believing that one can get AIDS by sharing clothes, school wash rooms, kitchen utensils, kissing, hugging, and shaking hands (Raju, February 2002; Bhattacharya, Cleland and Holland, 2000). The Rapid Household Survey of Reproductive and Child health conducted in India suggests that even in a highly literate state such as Kerala, as many as 60% of respondents share these misconceptions about AIDS (Indian Institute of Population Science, 1998).

In India there are many diseases labeled "Gupt Rog". The term means 'secret disease'. These diseases are often associated with the perceived state of sexual health and sexual performance and considered as either extremely personal or secret. A survey of 'Gupt Rog' among slum dwellers in Mumbai, India found that respondents were more concerned about illnesses related to sexual functioning than those resulting from sexual

contact with others. A wide variety of symptoms were termed 'Kanjori' (weakness). Consequently, a large number of terms and words are present in the local language to refer to various states of Kanjori. In the Indian tradition, the term 'Virya' stands for vigor and semen (Nag, 1996). The loss of semen through nocturnal emission or masturbation is believed to be harmful for emotional, physical and spiritual well being. A large number of traditional healers cater to men who believe that they suffer from 'Gupt Rog'. (Verma, Rangaiyan, Narkhede, Aggarwal, Singh, & Pelto, 1998).

Yet, another source of illness emanates from the displeasure of Gods. Family deities are ceremoniously worshiped and appeased in order to receive physical, mental and financial security. Wrongful actions and failure to be mindful of the presence of Gods may incur their wrath resulting in disease, mental illness and poverty. Indians often combine ceremonial worship of deities along with receiving treatment. Cultural factors associated with major diseases and health disparities occurrence of diseases is influenced by culturally dictated dietary habits (Bandyopadhyay and McPhearson, 1998).

There are fundamental differences between modern and traditional ideas of causation. Modern medicine places considerable emphasis on relevant events immediately prior to one falling ill. Detailed account of events in the immediate past is relevant for diagnosis. The Indian measure of time is seldom precise. The past involves a number of events that can be recalled. Events in the present are not of any more importance than the ones that were experienced a long time ago. This view of time emerges from Indian perspectives on life.

Adherence and compliance to medicinal prescriptions is fundamental to the healing process. Indians often tend to disregard suggested timings for medicine intake and at times skip the prescribed daily dosages. This is in part due to a lack of appreciation for strict mechanical time regulated activities in day to day life. In addition, Indians may not fully realize the importance of keeping an appointment at the precise time scheduled. All these may hinder diagnostic procedures followed in modern medicine. There is widespread ignorance about the fundamental positivistic assumptions of Western

medicine. Lack of understanding of the western medical system combined with lack of compliance is likely to delay the healing process unless Indian clients are adequately counseled about the need to comply and stick to prescribed dosages and regimens (Bandyopadhyay and MacPhearson, 1998).

Indians believe that each individual is made up of several metaphysical components such as Atma and Jeevatma. Atma is indestructible. It is the presence of God in a person. The Jeevatma, on the other hand, is the sum total of all past experiences that propels one into the future. Righteous actions (Karma) lead to positive experiences. Actions that do not contribute to physical, social and spiritual well being of others result in undesirable consequences to the self. Some of these consequences may be experienced during this life while the rest may be experienced during the course of the next life. Thus, current sufferings and illness have their roots in an inconceivable past composed of several births during which a person accumulated ill effects of bad deeds and actions. The focus is on taking the right actions in the present. The force of the Jeevatma can not be changed. Events in the immediate past may not be recollected specifically unless probed and asked about in detail through skilled interviews.

Health Seeking Behaviors

Indian cultural practices and beliefs influence the decision to seek health care as well as effective utilization of available health care services. The role of cultural factors on health care practices is evident in ways people utilize health care during all too common occurrences such as pregnancy and childbirth. Pregnancy brings about changes in dietary habits. Manocha, Manocha and Dharam (1992) in a study of three villages in Haryana found that the consumption of citrus fruits, mango, guava, red chilies and all kinds of pickles increased during pregnancy. They report that a high proportion of these women craved, and many ate, ash from the hearth, mud and clay. Consumption of milk during pregnancy did not increase in spite of the fact that survey villages had abundant supply of milk produced by local dairy farms owned by most of the villagers. A high proportion of the women do not believe that it is necessary to increase caloric intake during pregnancy.

Purohit, Mathur and Sharma (1973) observe that a reduction in dietary intake often occurs due to fear of having a large fetus, causing obstruction and pain during delivery. Adherence to the previously-mentioned practices motivates many women not to seek prenatal care.

Manocha, Manocha and Dharam (1995) report that only fifty percent of women in the study village receive a prenatal check up. Most pregnant women visit the primary health care center located in the village only if complications arise. Deliveries often take place at home. In most instances, a closed room with poor ventilation is chosen for the delivery which is attended by either a mid wife or a selected elderly woman. During cold season, the room is heated by using either wood charcoal or dry cow dung cakes. The burning of these materials produces high levels of carbon-dioxide and carbon monoxide. Prolonged exposure to these gases is an important cause of infant mortality and maternal death in India. (Chandrasekhar, 1982).

Indians have an eclectic approach toward treatment. In the main there are three systems of medicine; Ayurvedic, Siddha and Unani. In addition, the Allopathic (western medicine) and homeopathic system are also widely used. Ayurvedic medicine is deep rooted in Indian traditions. It views illness as an outcome of imbalances in the three fundamental body elements; Vatha, (wind); Pitha (Bile) and Kabha (phlegm). The imbalances occur owing to either inadequate or incorrect intake of foods. Owing to this view, the healing process involves rigid compliance to dietary regulations. Ayurvedic medicine believes that good health results from adequate functioning of mind, body, soul and senses. In spite of widespread knowledge of traditional systems of medicine, the Indian public is not averse to western medicine. Most Indian consumers of western medicine do not understand the scientific approach toward diagnosis, treatment and prognosis. However, western medicine is seen as an effective system of medicine capable of curing disease symptoms. The two systems of medicine, the traditional and the western, provide two strong choices to seek medical assistance. In many instances, they combine the two in desirable amounts. In general, there is widespread trust in the effectiveness of western medicine. The cure stems from not only the effectiveness of the

medicine but also in the special power of the physician. Demand for instant cure is high and as a result physicians prescribe powerful drugs and large dosages (Evans and Lambert, 1997).

Many Indians will have engaged in self diagnosis and self medication before they seek professional medical help. Over the counter medications are easily available in India. A study of prenatal care in Rural Karnataka found that a very high proportion of women engaged in self medication. Most women took a "green medicine" obtained from tree bark to avoid labor complications and to ensure a healthy baby (Matthews, Mahendra, Kilaru and Ganapathy, 2001).

Indians in general have a fatalist attitude toward chronic illness. It is seen as an outcome of bad deeds performed during this life or in past lives. There is also hopefulness in that the next life will be less burdensome and painful as one has already grieved and paid for his/her undesirable activities in the past. The stage in life during which the chronic illness occurs is likely to influence the seriousness with which remedies are sought. If the person is elderly, he or she is more likely to spend time focusing on spiritual well being and is likely to be less concerned about aggressively curing the disease. Death is therefore not seen as an end in itself. It is more a transition point from one life to another. For this reason, Indians are less likely to seek aggressive life prolonging treatments involving life support systems. The eldest son has a prominent role in enabling the course of the journey of his from this world to the other, especially in relation to the death of male family members. The eldest son is to light the funeral pyre. His presence is required all through the cremation ceremonies. Daughters play an important role in the process of handling the bodies of deceased female family members (Laungani, 1996; Abraham, 1999; Basu, and Kshatriya, 1989).

Social networks and social support

Indians rely on a wide network of friends and relatives for support during health crises. Marriage alliances widen the social network of relatives. Marriages are arranged by the

parents of the bridegroom and bride. Potential spouses are selected from the same caste groups. Once marriage is consummated, it is considered to be a contract between the spouses, and their families and kin groups. Events such as the arrival of the first child are attended by a large number of family members. Elder members from the neighborhood and village offer help and counsel the young. Women are entrusted with all aspects of care giving. The responsibility for eldercare giving is on the son. However, daughter in laws take an active role in elder care giving (Gupta and Pillai, 2001). Women's health tends to be overlooked and ignored as they focus on their care giving roles. However, due to close bonds that exist within the joint family system, the sick role is accepted without any feeling of guilt. The responsibility for caring for the sick is shared among all family members.

Conclusion and Implications

This section will provide a reflection and an analysis of key widespread Indian cultural beliefs and behaviors that may have major significance to policy makers in the United States and other countries with significant numbers of Indian immigrants.

As previously stated, gender biases represent a major source of oppression for women in India. This has led to the neglect of sexual education and to the inability of many Indian women to actively participate in the decision making directly impacting their health. This pattern of behavior may become a major obstacle for Indian women in America needing to seek healthcare. They may lack the initiative or they may be simply feel unable to do it given the cultural restrictions imposed on them by males in positions of authority. This situation strongly suggests the need of providing health and socio-cultural education to all members of Indian families in the United States. Husbands and fathers will need as much education as the women themselves. Indian parents in America should also be made aware of laws requiring the provision of timely healthcare to minors in their host country.

The fact that Indian ethnic minorities and other socially oppressed groups in India score very low in relation to most health indicators should also concern health policy makers in America. First of all, Indian immigrants from the lower socio-economic levels may come to this country with poor health. Furthermore, once in America they may lack the financial resources or the knowledge of the American healthcare system necessary for the effective utilization of services. For this reason healthcare professionals are advised to inquire about the ethnic and socio-economic backgrounds of Indian families coming to them for services and to educate them in terms of how to access available healthcare resources.

Healthcare professionals in the United States and other countries should also be cognizant of the existing tensions between folk medicine and western medicine among Indians given that over utilization of the first may lead to under utilization of the latter. Indian folk medicine often calls for self diagnosis and self medication. It concerns itself with maintaining a balance in the body between hot and cold states and with not displeasing their gods. Professionals are encouraged to start working with patients or clients wherever they are at in an effort to make them feel comfortable with the therapeutic relationship and in this way earn their trust and respect. Whenever possible, efforts must be made to practice western medicine within the context of their cultural belief system while at the same time providing pertinent health education.

Other cultural factors of relevance to healthcare include the beliefs that women should not maintain eye contact with men and that men should not maintain eye contact with people in positions of power. We should be careful of not necessarily interpreting these behaviors as indicative of a psychosocial dysfunction. Instead, we should view these behaviors as indicative of cultural norms. Furthermore, the practice of having very limited physical contact is likely to interfere with physical examinations and with certain forms of therapy requiring such contact. Again we must be sensitive to this cultural reality and we should make an effort to practice western medicine within the context of their culture.

Indian culture is very group oriented. Because of this, Indians tend to rely heavily on the extended family and on social networks during health crisis. This cultural trait strongly suggests that health professionals should do everything possible to involve significant others in the education, diagnosis and treatment process.

The delivery of health services is also likely to be impacted by the Indian notion of time. Their time keeping tends to be imprecise given their tendency to be event oriented. Their conception of the past, for instance, includes not only the immediate past but also the far past including events associated to a previous life. The Indian time orientation may have direct implications for the timing of medicine intake and for the keeping of medical appointments. Human service professionals are encouraged to use walk-in and first-come first-served approaches with Indian immigrant groups given that they may respond better to them than to the usual professional appointment for service system.

Finally, we need to take the common Hindu belief in reincarnation into account. The concept of Jeevatma refers to the sum of all past experiences that propel a person into the future. Jeevatma encourages Hindus to do what is good and morally right. Good and morally right actions include trying to preserve one's life in order to do good deeds. For this reason, contrary to the idea that the belief in reincarnation may turn people careless in relation to their healthcare, Jeevatma is more likely to motivate them to seek care for their illnesses. Practitioners of western medicine may want to refer to this concept as they try to motivate Indians to adhere to the prescribed treatment plan. On the other hand, we must be aware that their fatalistic view of chronic illness may discourage them from adhering to a prescribed treatment plan.

Given the strong influences of culture on health care practices, it is essential to train social workers and healthcare professionals and others to become culturally competent. Cultural competency refers to the ability of health care givers to take into account the cultural beliefs and practices of health care recipients. In addition to being

knowledgeable about Indian culture, interventions must be designed to maximize the likelihood of service utilization.

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