approaches to development underscore, as a minimum, the heuristic value of this perspective. In challenging common understandings of both culture and development, and in laying the ground for innovative research on a wide range of developmental topics, our explorations of a practice perspective serve a specific case of the generation of the "formative" in interdisciplinary conversations both among committee members and with valued non-committee colleagues.

Ethnopediatrics: An Outline

by Carol Worthman*

At present, international variation in life expectancy arises largely from mortality differences in infancy and childhood. Efforts to ameliorate these differences have largely focused on structural conditional factors, but the uneven success of these attempts has led to a new focus on more specific, cultural-behavioral factors. Specifically, cultural-behavioral factors such as local conceptions and customary practices, rather than pathogens per se, have been found to play a central role in infant and child survival and well-being. The increasing export or borrowing of Western medicine, its concepts and practices, has brought the realization that cultures and subcultures vary widely in their views of what constitutes health, how it is maintained, and how departures from a healthy state come about and may be treated. This variation in beliefs and practices affects the response to and effectiveness of new forms of health care.

The need to recognize the "perspective of the actor" is therefore increasingly acknowledged in studies of adults and their illnesses. In Angel and Thoits' terms, it "has been lacking in the epidemiological approach to the study of the impact of culture on illness and the understanding of the cognitive structures that mediate the illness-labelling and help-seeking process at different points." For adult states of health and illness, local cognitive structures or conceptions—only one dimension of what we term "local biology"—are seen as including the vocabularies available for labeling states of health and illness, the granting of importance and a probable cause to various states, the dimensions used to categorize forms of illness, and the decisions or considerations that lead people to either ignore "symptoms" or take action.

With respect to children, the processes of illness-labelling, well-being, and health-seeking are also grounded in adults' notions of human development. As discussed before, in this domain relevant issues include: local understanding of acceptable ranges of behavior, function, and maturational status for developmental stage or age; beliefs about necessary and appropriate antecedents for and responses to the child's developmental change or deviation; and concepts of developmental vulnerability or resiliency that influence the perceived linkage of early maturation and health experiences with adult outcomes. Identification of such aspects of health and illness among children clearly lags behind research conducted concerning adults. Gaines makes this point in his analysis of case histories for children of immigrant workers in California. These histories, he notes, leave "unexamined the conceptions, beliefs, logic, understanding or anything else about the patient or his or her significant others." For example, with reference to a child with a heart condition, brought in the first time for treatment at age nine, he asks: "What were the perceptions of parents of a, lookless child of abnorrmal stature and clubbed fingers? What did they


standing behaviors relating to child health and illness and, to this end, promote dialogue among the social sciences, medicine, and public health policy; (2) suggest methods for investigation in this area, including linkages between qualitative and quantitative data; (3) highlight areas and conceptual issues that either urgently require work or would provide critical tests of the approach; and (4) conclude by raising the issue of how the conflicting goals and values concerning child health. This last goal relates directly to decision-making about policy and allocation of resources.

Committee work in this area so far has been primarily conceptual in nature ("Ethnopediatrics: Concepts and Practices Related to Health and Illness in Children"), held at the Carter Center at Emory University in October 1993. Organized by Carol Wortman, Jacqueline Goodnow, and Robert LeVine, the workshop sought to advance the overall committee goal of bringing together social science, biomedicine, public health and policy by focusing on a specific developmental period (infancy) in specific domains (survival and growth). Participants came from psychology, public health and medical anthropology, pediatrics, and anthropology. Importantly, young scholars and students who have worked in various committees also participated.

The workshop aimed to identify conceptual, analytical, and practical problems or issues. Viewed from the vantages of the various disciplines represented at the meeting, sketch out models for understanding these issues; and, ultimately, to evaluate whether an ethno pediatric perspective might add extra purchase on the complex issues of child survival and development. The

24 Among the few studies of such issues relating to children, Frankel and Phillip Brown's work on the differential acceptance of the social health approach by Jewish and American immigrants is rich.

March 1995
meeting format involved the use of four published case studies as springboards for half-day discussion sessions. These case studies were: infant feeding, crying and colic (Ron Barr); dietary management of diarrhea (Margaret Bentley); cultural beliefs, infant feeding practices, and growth following (Catherine Panco-Brick). In a final half-day discussion, participants sought to outline general themes, identify disciplinary and practical needs, and advise on next steps.

What, then, are some of the key issues and ideas that framed the workshop? We suggest that ethno-epidemiology can provide an integrated conceptual framework that will support fruitful comparative research and provide a basis for policy formation. Such a framework can be expected to incorporate elements such as the following:

**Categories for states of health and illness among children.** Societies differ in their etiologies and taxonomies of disease. They also differ in categories for assigning vulnerability and resistance to disorders. For instance, cultural groups in Central and North America differ in their categorization of adult illnesses, and in the bases from which these groupings are derived. They also vary in the degree to which they categorize in terms of children’s versus old persons’ illnesses. And within societies one may find multiple, perhaps competing or conflicting conceptual schemata relating to wellness/illness, as well as subcultural diversity in these schemata. We now need ways to determine the dimensions used for identifying children’s illnesses, the attributions made for health or illness, and the beliefs of vulnerability and resilience that are attached to various ages, genders, or phases in development.

Responsibility. Notions of agency, or who is responsible for child well-being maintenance, often allocate various domains of well-being to different agents. Responsibility may or may not be linked with the material or social-political means to effect wellness goals. Such differential efficacy of agents may be compounded by beliefs about causes and preventability of disease (see following section). Beliefs and practices about what can be done about child illnesses, and by whom, can be integrated into hierarchies of resort. In practice such hierarchies can become complex, especially when clashing systems of agency and efficacy (customary, biomedical, educational) require parents to pick their way among multiple conceptual-evaluative systems, with each of these linked to access to valuable social and material resources (e.g., medication, child care, social status).

**Illness concepts in relation to disease experience and base rates.** Within societies, mode and complexity of explanation, as well as level of concern attached to illness, often vary by disease. Among adults in Western society, there is some evidence that symptoms which are widespread, as with common or endemic diseases, tend to be regarded as less serious than those that are atypical. The least sophisticated explanations of specific illnesses are apparently given for those which have multiple causes, invisible etiology, and diverse symptomatology. Thus, experienced degree of endemity or prevalence and virulence of a disease can influence local notions of etiology, agency, and efficacy. The presence of such variations tends to be lost in the characterization of cultural constructions of “illness” for a society in general, but may have tremendous implications for culturally-differentiated responses to widespread maladies (such as malaria, measles, diarrhea). One may predict, for example, that views of and responses to malaria will vary in areas of differing incidence of malaria.

In general, then, understanding of local illness concepts has been repeatedly shown to be crucial to understanding health-related caregiver decisions and actions. But this needs to be embedded in an analytic framework that also relates these decisions and actions to roles, values, and norms concerning child development and caregiving. Reciprocally, local diversity in beliefs about illness, agency, and efficacy is affected by people’s specific histories of illness and health care system experiences.

**Biological and social bases of developmental sequences.** Cultures differ in their notions of developmental progression and how it occurs. Conversely, developmental progression varies across populations and is affected by cultural practices and social conditions. The influence of local, culturally-constructed conditions on biological development and function is a second sense of the term “local biology.”

Comparative analysis will require careful characterization of varying ideas about developmental sequences, how progression is expressed, and how it is driven and altered. We need to know the terms used for children.
differently valued in various groups; the Kaluli of New Guinea, for instance, place high value on a child's ability to speak and use proper forms of address.

The parental frame of values informs differential interpretation of a child's development and well-being. Thus one would not expect the Kaluli to respond negatively to a child's early speech, as do some other Pacific groups. We need, then, to find ways to relate frames of value to the interpretation of developmental sequences and individual differences. Further, a hierarchy of values ranking child, parental, and other material or social needs implicitly or explicitly informs allocation of scarce resources. In other words, understanding the cultural frame of values is key to understanding differential parental and community allocation of care and other limited resources among individual children and at different developmental stages.

Co-constitution of human development by biological and contextual factors. A key element of the ethnoplastic perspective is that human development is not simply an automatic matter of unfolding biological programs, but occurs through interaction between individual and context. Child health and development are interdependent with social processes; they track, and are often used as an index of, environmental quality. Thus, measures of developmental status and physical status can provide a useful basis for cross-cultural comparison. From the outset, well-being relies in part on others. Whether those others are parents, pediatrians, or policy-makers, the beliefs, values, and intentions which inform their behaviors and decisions are important determinants of health and development. Often, those beliefs and values become so self-evident, natural, and transparent a part of the "right way" to do things that one does not even consider that they might be done differently or that accepted practices may have some unintended or negative effects on child

---


---

**March 1992**

---

**Notes:**

1) A related theme is how various individual differences, for example within gender and age groups, are accounted for in various cultures and how such accounts are related to the cultural frame that directs the course of development.

2) Such measures can be used as independent and dependent vari-
health and development.

An important corollary of a biosocial view of development is that, beyond a universal base of physical sustenance, children and adults' bodies age not strictly biologically around the world, and their physical condition and needs must be viewed in a local context. That is, because human development emerges through biosocial interaction, details of physiology and morphology differ across populations, from variable growth rates and size to metabolic and body compositional differences. Large population differences in infant growth and mortality due to contrasting infant feeding practices illustrate this point. Culture thus contributes not only to psychological and behavioral variation, but also to biological variation. Ethnopediatrics, therefore, deals with these two aspects: the social practices, values, and conditions concerning child well-being, and the biological variation that arises through these different social ecologies.

Having covered most of the ideas outlined in the conceptual framework above, the workshop discussion revealed several important, supplementary issues. These include the following: (1) Infants and children need also to be viewed as actors in their own health and development, and their goals and perceptions require greater attention. (2) Understanding the complete caregiving "package" is key to uncovering proximate factors in infant and child well-being; this will require considerable multi-level (micro to macro), cross-disciplinary research that is both closely attentive to local variation and tightly tied to everyday settings. (3) Methodologically, the previous point underscores the importance of quantitative and qualitative methods, of direct observations and epidemiological, as well as interpretative, analyses of behavior. (4) Social change can have complex and at times unpredictable effects on ethnopediatric systems influencing child well-being. (5) The effects of social-material constraints and competing demands on caregiver decisions and behaviors deserve greater attention: thus, workload can significantly constrain maternal care, as could other demands on and availability of resources (such as time, food, energy, attention), and access to additional caregivers. (In such a context child labor remains a widespread but neglected factor.) (6) Directions for further work may include: biocultural perspectives on the "new frontiers" of childhood (homelessness, asthma, accidents, violence, developmental impairments in relations of the child and the state from a critical perspective; and the need for culturally informed and nuanced measures and research on childhood mental health.

What then, emerges from these exploratory discussions and analyses? We are persuaded that an ethnopediatric perspective does raise a rich range of conceptual and research challenges pertaining to issues of child well-being, as much in the U.S. as elsewhere. We thus plan to continue to engage the challenge of how competing cultural ideals, biological ideals and everyday realities in child health and development might be framed and negotiated. Pluralistic views on what are acceptable health and development outcomes need to be critically evaluated and perhaps modified via these competing frames.

It is, in the end, worth remembering that one-third of the world's people are children, and that their survival, health and development are viewed as the bequest of humanity's future. But programmatic efforts to improve outcomes for children have been hampered by conceptual polarities and bureaucratic exigencies, so that their needs and care are balkanized among disciplines and agencies. The adoption of an ethnopediatric perspective would, in the first instance, problematize received views and call into question existing institutional structures: but it should then allow us to identify and open negotiations among conflicting goals and values, and better mobilize existing resources for child welfare. The committee thus seeks to uncover the disciplinary-conceptual barriers to articulation across the domains of theory, knowledge and praxis related to child health (broadly conceived as both functional and developmental well-being). Overcoming balkanization in how we conceptualize and study child well-being may, in the end, promote more integrated, real-world policy and programmatic approaches.

---

24 In the context of children, being the workshop participants also concluded that education between "basic" and "applied" social science is vital to a degree because basic research provides independent analysis and unique that can inform and support programs and policy.

---

1977 Mar

N. 4, p. 374, N. 1