Understanding Parental Theories about Children's Health

by

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ABSTRACT

Understanding Parental Theories about Children's Health

Using a comparative ethnographic design, 19 mothers and fathers of children aged 13 to 15 years were interviewed on their lay theories of health and illness of adolescents. Participants were recruited through government-aided, private schools in Bombay (now Mumbai), India, and included educated parents of different economic backgrounds. The interview included open-ended questions and measures like the Parental Health Locus of Control. Transcribed data was analysed in MaxQDA using an inductive thematic analysis approach.

When presented with known risk conditions such as HIV/AIDS, smoking tobacco and drugs parents minimised the likelihood of these to school-going children. Their explanations were similar to *le cordon sanitaire* observed in persons with risky sexual behaviours. Parents viewed school as safe and reported such conditions were more likely when children enter college.

In contrast, parents were more concerned about road accidents. They also associated risk to adolescent health with the influence of bad friends and mass media. These could cause premature sexual awareness in adolescent children and could possibly distract the child from the approved goal of education. Parental lay or ethnotheory pertaining to health of adolescents appeared to place an overwhelming importance on good educational choices and performance to the point where good health might

sometimes be compromised to give the child an educational advantage. Children's education also caused much stress and anxiety in terms of pressure of syllabus and inability to approach teachers with concerns.

Christian parents in the sample were marginally more aware of adolescent health concerns than Hindu parents. They also had better knowledge of resources through the institutional church. No major gender influences were observed.

The implications of minimising risks to adolescent health could mean that parents are less likely to recognise or seek professional help for such health conditions unless they interfered with academic work. Further, parents are more likely to rely on personal and familial resources. This indicates a need for better parent education. Social workers and health workers also need to reflect on how to reduce the stress associated with education, and how to enable and empower parents to work in greater partnership with schools.

Chapter 1

Introduction

My dissertation explored how parents in India conceptualise the health of their adolescent children. In this chapter I first give some background to the study of adolescent health in India. Next I describe the literature on lay theories, addressing specifically two types of lay theories: those pertaining to health and illness, and to parental ethnotheories. For each of these theories, I describe the state of research in the Indian context.

Adolescent Health in India

There is not much clarity in India about who exactly constitutes an adolescent (United Nations Fund for Population Activities [UNFPA], 2003). The term 'youth' appears to be more popular, especially in policy discussions. Apart from clarity over terminology, Indian census findings do not even list separately the population figures for this important group on their website, and most government policies in India do not address the needs of this age group separately (UNFPA, 2003). This may be one reason which has led some social scientists to question whether adolescence as a developmental stage exists in Indian society, especially in rural areas (Jayaram, 2000; Saraswathi, 1999). Some like Saraswathi opine that adolescence as a developmental period is less relevant to rural areas where young people often enter the workforce very early in life.

According to UNFPA estimates, there are around 239 million young people in India between 10 and 19 years of age. They account for 22.8% of the population (UNFPA, 2003).

Adolescents face many health-related challenges: During this period of rapid, physical change, poor nutrition is a potential hindrance to bodily growth (UNFPA, 2003). In addition, some developmental challenges have the potential to endanger the health of the child. One such challenge is that of making healthy sexual choices: to initiate sexual

behaviour or not, choice of sexual partners, number of sexual partners, and finally how to maintain good health when sexually active. Consequences of early sexual initiation include a greater number of sexual partners, higher risk of sexually transmitted infections such as HIV/AIDS, higher risk of pregnancy, abortion and possibly maternity-related death for young women, or risk of fatherhood for young men (Coker et al., 1994). Young people who begin to have sex early are more likely to engage in unsafe sexual practices that increase their risk of infection, in part because they are developmentally less capable of managing these sexual choices wisely (Smith, 1997). In addition, some risks that face older individuals have magnified effects in young teens. For instance, compared with women aged 20 to 25 years, female teenagers experience more pregnancy-related complications such as increased risk of pre-term delivery and increased risk of developing hypertension (Stallworth et al., 2004). Also, they may have a greater physiological vulnerability to cervical problems such as chlamydia and cervical cancer (Awasthi, Mishra, & Shahi, 2006; Centers for Disease Control, 2004).

Research related to the health of adolescents in India is fairly inadequate. There are very few studies that look at the state of youth all over the country. Many health-related articles focus on specific conditions such as epilepsy or diabetes (e.g., Misra, Basit, Vikram, & Sharma, 2006; Pal, Das, Sengupta, & Chaudhury, 2002). To understand the bigger picture I turned to a situational analysis by UNFPA (2003). The key health concerns for adolescents are drug use and dependence, tobacco consumption, violence and abuse, undernutrition and anaemia, infectious diseases, and HIV/AIDS. In addition, obesity among urban youth seems to be an emerging concern. There is some overlap between this summary and the mortality figures derived from the Global Burden of Disease (World Health Organization, 2002) in the South-East Asia region, of which India comprises a substantial part. Among the various causes of death for young people aged 15 to 29 years, the most important are injuries (both intentional and unintentional), infectious conditions (including tuberculosis, syphilis, gonorrhoea and HIV/AIDS), respiratory conditions, maternal conditions for women, cancer and cardiovascular diseases. Both reports provide a broad understanding of the important health issues. But it should be noted that they pertain to a very broad age range: 10 to 19 years for the UNFPA study and 15 to 29 years for the Global Burden of Disease.

It is thus evident that adolescent health is an important issue for a developing country like India given their large numbers in the populace, as well as given that this vulnerable group faces many significant health risks. However, to date, there has been little systematic, in-depth effort to study the health concerns of this group.

It has been noted that most Indian adolescents live in a familial context and that family affects their views of key issues such as marriage (Jayaram, 2000; Saraswathi, 1999; UNFPA, 2003). However, research related to family in relation to the health of adolescents in India is almost non-existent. Prior to data collection, I sought out relevant research through online databases as well as through publications available in a print-only form at the University of Michigan and at a university library in India with vast holdings. However, my efforts yielded very little in this area.

Research on parenting in India appears to focus almost exclusively on variables such as parenting style, academic achievement and socialisation of children's behaviour (see Appendix A). Some of the studies are not clear about the research methods used to elicit information. Others rely on attitudinal measures, checklists and scales, some indigenous and some from the U.S. Other researchers have also bemoaned the limited nature of such research as it relates to youth (e.g., Jayaram, 2000). Even the National Family Health Survey - a representative sample study in 26 out of 28 Indian states – restricts itself to eliciting information from mothers about traditional indicators of health such as maternal and infant mortality (International Institute for Population Sciences & ORC Macro, 2001). Nowhere does it ask for information about adolescent health beyond noting the early age of marriage and childbearing of many Indian women.

Religion and Health in India

Another observation is that the studies on parenting in India largely limit themselves to an analysis of their results by gender. Few discuss their results in terms of variation by religion. Studies such as the one by Awasthi, Mishra, and Shahi (2006) note the influence of Hindu beliefs on the cognitions of participants, yet fail to break down the sample by religious affiliation. At a minimum, researchers should explicitly state what religious groups comprise their samples, just as is current standard practice in the U.S. to report the sample composition by gender and race.

My recommendation in the previous paragraph relates to the reality of many religious groups in India. The three major ones are Hindus, Muslims and Christians and they respectively comprise 80.5%, 13.4% and 2.3% of the population (Registrar General and Census Commissioner, Government of India, 2001). Further, there is evidence that health status in India is related to this variable. For instance, the National Family Health Survey (International Institute for Population Sciences & ORC Macro, 2000) found that Christian children are better nourished and are less likely to be anaemic than the two other religious groups. They are more likely to be vaccinated against all the necessary childhood diseases. Christian women are more likely than their Hindu and Muslim counterparts to marry later, to have a first child later and to have a doctor attend them during childbirth. Similarly, Gupta, Gupta, Prakash, Sarna, and Sharma (2002) found differences in the prevalence of coronary heart disease and diabetes among Hindus and Muslims.

While the NFHS did collect data related to socio-economic status, it did not present any analysis about whether these differences are related to improved conditions of living, better access to health care, or greater awareness. So, it is not clear the pathways through which religious status affects health in India. Research into the relationship between religion and health indicates that there may be various mechanisms that might link the two constructs. For instance, religious attendance could increase a person's exposure to potential support networks as well as provide greater opportunities for exchange of information (Benjamins, Trinitapoli, & Ellison, 2006). Belonging to a religious community might involve acceding to pressure to avoid health-damaging behaviours and to adopt health-enhancing ones, while meditative practices associated with religion might enhance health (Yeager et al., 2006). Given that the Indian population has such religious diversity, the failure to report such data in research studies is an omission that might otherwise add to our understanding.

Parents and Adolescent Health

Do parental beliefs matter? There is some evidence to show that parental cognitions do affect younger children (Bush & Iannotti, 1988; Dielman et al., 1982). With adolescents, the picture is less clear. Parental expectations can provide a protective

effect against early smoking (Huver, Engels, & de Vries, 2006; Simons-Morton, 2004). Parental behaviour such as dietary practices and beliefs can be passed on to adolescents (Rimal, 2003; Rossow & Rise, 1994; Uzark, Becker, Dielman, Rocchini, & Katch, 1988). It has been demonstrated that parents can affect alcohol intake in their offspring (Patock-Peckham, Cheong, Balhorn, & Nagoshi, 2001) but not their patterns of exercise (Anderssen, Wold, & Torsheim, 2006). With adolescents, research in general, and research in India specifically, has tended to focus more on parental behaviours and not on parental beliefs. It is still not clear how, and if, parental beliefs about health affect adolescents. There could also be regional variations in this regard. Given that parental and familial beliefs about marriage are so influential in the thinking of youth in India (Saraswathi, 1999; UNFPA, 2003), it is likely that cognitions about health might also be related in parents and their offspring in this country.

What are Lay Theories?

The lay theory perspective states that lay people hold assumptions or theories about how the world operates (Heider, 1958; Kelly, 1991). Heider contended that commonsense, lay explanations are useful because, firstly, they guide behaviour, and secondly, because they sometimes contain truths not found in scientific writing. Just as scientific theories guide the efforts of scientists, folk theories help lay people to interpret and predict the world, and, in turn, determine their behaviour. These theories are often visible in everyday social intercourse as well as in popular magazines and television programmes. However, despite the plethora of studies in this area, no researcher has attempted to succinctly define a lay or “naïve” theory (from Heider’s “naïve psychology”).

Furnham (1988) stated that lay theories differ in sharp contrast to scientific theories in that they are rarely explicit, rarely consistent, and are based on the processes of verification (rather than falsification) and inductivism. Further, they are often content-oriented and general, with a tendency to confuse cause and effect. In addition, Goodnow (2006) pointed out that such theories are often not amenable to being elicited through direct questions. The ‘naïve’ in naïve theories implies less sophistication, and theorists espousing this approach are likely to operate on the principle that a gap between such a

folk theory and a scientific theory must be closed by altering the folk theory in the direction of the scientific one.

Other theorists would disagree with the notion of such theories being inconsistent or unscientific. For instance, Harkness and Super (2006) contend that through observational studies of actual behaviour, it is possible to deduce, from different behavioural practices and goals, guiding beliefs that are consistent. Dweck, Chiu, and Hong (1995) point out that an individual may hold opposing lay theories for different domains or abilities such as intelligence and moral judgment. However, the expectation is that beliefs within a domain would be consistent with each other and with behaviour (Dweck, 1999).

The interpretive perspective from sociology would also hold out for the logic and integrity of such folk theories, arguing that their meaning is consistent within the individual's own complex body of knowledge and beliefs which, in turn, is situated within that individual's social context (Calnan, 1987). This approach treats the lay person as active, discriminating and critical rather than inconsistent and idiosyncratic. Another perspective from sociology points out that sometimes lay people develop theories from their own observations that foreshadow professional knowledge and provide inspiration for it (Brown, 1996). This perspective views the two kinds of knowledge as working side-by-side.

Lay theories have been a topic of research interest to scientists from the fields of social psychology (e.g., Furnham, Reeves, & Budhani, 2002), developmental psychology (e.g., Goodnow, 2006), cultural psychology (e.g., Super & Harkness, 2003), anthropology (e.g., Kleinman & Petryna, 2001), and sociology (e.g., Mechanic, 1973). Lay or folk theory research has studied folk theories about varying aspects of human life such as psychology, medicine, child development, law, statistics and economics (Furnham & Henley, 1988; Furnham, 1988; Furnham, 1999; Parmar, Harkness, & Super, 2004; Weaver, 2006), and corresponding with various branches of science we find areas such as folk mathematics, folk psychology and folk medicine.

Approaches to Studying Lay Theories

There are various approaches to studying lay theories. One common approach to understanding the content of such belief structures involves surveying a large group of people within a particular context on their views using a questionnaire and then submitting those views to a factor analysis in order to isolate key dimensions that underpin the folk theory. The end product of such a method may be a descriptive taxonomy. For instance, Furnham (1994b) found that when presented with a large number of attitude statements about health, the concepts of Caucasian British people tend to map onto the dimensions of internal causal factors (e.g., psychological issues like self-esteem and control) and external ones (e.g., climate, living standards, and fate). This reductionist approach to studying folk theories is only successful to the extent that the researcher begins with a large bank of statements covering a diverse range of aspects related to the particular phenomenon. Applying this method might miss out on key dimensions relevant to particular groups or concepts if the statement bank is not comprehensive enough. However, too large a statement bank may also have the effect of causing the respondents fatigue.

Another method of studying the content of folk theories involves observation of actual behaviours and analysis of diary records to identify implicit cultural models. For instance, Harkness and Super (2006) compared the daily diaries of parents in Boston and in Holland to understand their theories of effective child-rearing. This approach holds that such views are consistent because they are influenced by culture, that they tend to manifest in different activities, and that a careful study of these activities and the participants' explanations for these activities will reveal the underlying theory. Thus, using the observed cross-cultural differences in the family activities, the researchers expect to uncover underlying differences between the parenting philosophies of the parents from different cultural backgrounds. While basing a theory on actual behavioural observations often means a rich, descriptive theory, the researcher is constrained to spend a large amount of time in the field, in order to be confident that she/he has sampled enough of the behaviour on which to formulate the theory (even though Harkness and Super would claim that there is a redundancy in behaviours which makes identifying the

behaviours easy). However, the theory that is thus generated has the advantage of using terminology that is as close to the source as possible. Yet, despite obtaining a rich, informed discussion, these findings may often be limited to the particular groups under study, and even sometime to the historical context in which the data was elicited.

A similar approach from the field of public health focuses on population groups with undesirable behaviours or dangerous diseases. Researchers study the narrative accounts of these individuals to understand the personal theories underlying and/or justifying their activities. For instance, Rhodes and Cusick (2002) conducted in-depth interviews with persons living with HIV infection and their partners specifically to understand how and why they engage in unprotected sex. They found that people either shared "stories of agency" or "stories of acceptability" (p. 211). Stories of agency were narrated as a way to abdicate oneself from personal responsibility using circumstances such as condom-related accidents and coercion. On the other hand, stories of acceptability used issues such as both partners being infected or both being committed to the relationship to justify unprotected sex as acceptable.

All these approaches relate to the content of lay theories. Goodnow (1988; 2006) suggests that content-based approaches could benefit from focusing on the quality of such theories. This involves looking at the consistency of such ideas and beliefs across generations and across groups, inter-idea consistency, the degree to which individuals are committed to those theories, the degree of accessibility of these ideas, and finally the ease with which new information or experience can alter an idea.

Apart from the content-based approaches, some theorists have attempted to study the antecedents of such lay explanatory beliefs. For anthropologists like Super and Harkness, the answer lies in the cultural context of participants. Psychologists seek their answers in more proximal factors: Cognitive developmental psychologists would explain such theories in terms of individual factors while social psychologists may place the explanation in the context of the individual's relationship to other individuals (Goodnow, 1988). An example of how an explanatory approach might be incorporated is the previously discussed study by Furnham (1994b). Not only did he identify key dimensions in his participants' theories about health, he also found individual differences in their

explanations of health and illness based on their political affiliation and their religiosity. That is, respondents with more right-wing beliefs tended to emphasise ‘orthodox’ medical approaches to alternative ones. Other theorists have intentionally taken different groups and elicited their theories. For instance, expert geneticists show a lesser tendency to essentialise biological differences than lay people (Mahalingam, Philip, & Akiyama, 2001, July). While it is useful to know the antecedents or sources of lay beliefs with regard to influencing such cognitions, it may be difficult for lay people to express clearly where they gained a particular notion as many of these implicit beliefs are often unarticulated and preconscious.

Furnham (1992) describes the approach of social psychologists as process-oriented in that they seek not just to understand how ordinary people make sense of the world, but also how frequently and consistently they make errors. This approach, thus, focuses on the fallibility of the lay theorist. It often relies on experimentation and, is restricted to laboratory studies. While such studies provide useful ways to understand lay theories, their face validity is limited to the extent that they remain confined to laboratory situations and controlled environments where many of the variables that might act on an individual are held constant.

A related approach consists of experimental studies to change or manipulate lay theories. For instance, Haslam and Ernst (2002) provided study participants summaries of “new scientific evidence” purporting to show that particular mental disorders were homogenous, biologically-based and immutable. Then they measured the extent to which this evidence altered the beliefs of the participants about the nature of the disorders. As expected, this manipulation did cause participants to make essentialist inferences about these particular disorders. This approach to studying lay theories has not attracted much attention despite its potential use in fields like health education and counselling.

Researchers have also looked at specific theories and the effects they have on behaviour. Dweck’s (1999) implicit theory approach to folk theories, for instance, is a well-researched paradigm that sought first to understand whether people theorise a particular quality such as intelligence or personality as malleable or otherwise (that is “incremental” views versus “entity views”), and later to study the impact of these

theories. First, implicit theories have been found to affect the goals people pursue: People with malleable or incremental views of a quality like intelligence are more likely to persevere in working toward a goal (Dweck, 1991). Second, implicit theories influence the perception and judgment of others: People with entity views are more likely to demonstrate prejudice against groups that they are essentialising (Levy, Stroessner, & Dweck, 1998). Third, they affect resource allocation: Believing that intelligence is a fixed quality may cause a teacher to expend less effort on a student who is known to be less intelligent. The influence of such implicit theories has been observed in the laboratory as well as in real-world contexts. For instance, Grand (2001) found that patients seeking substance abuse treatment were more susceptible to early drop-out from treatment if they held an entity view to getting better, namely that their substance abuse condition was impervious to change. They were less confident about the efficacy of treatment and their own ability to handle their substance abuse problems. They anticipated more costly and negative effects from giving up their addiction. Knee (1998) found that people who had an incremental view of romantic relationships (believing that their relationships could grow over time) were more likely to work at improving them. Looking at specific types of folk beliefs like the implicit theory approach builds up a significant body of work touching on different domains. In the case of Dweck's (1999) initial formulation, this body of literature has been applied widely to fields like education. She would argue that this is a key dimension of people's lay theories.

A final approach which appears to have been barely used is that of eliciting folk theories and then comparing them with standard scientific findings. For instance, Furnham and Weir (1996) asked participants to estimate the ages at which normal healthy children could complete various developmental tasks and then discussed how realistic these estimates were.

Lay Theories of Health and Illness

Lay theories of health and illness are one specific content-type lay theory. They fall into the area of folk medicine or ethnomedicine. Such theories may influence formal definitions of disorders as well as policy decisions to expend or withhold resources (Haslam & Giosan, 2002). Further, they may reveal the lack of perfect congruence with

theories held by experts in the field, and consequently suggest areas for educating the public. For instance, one interest of medical sociologists in lay definitional issues related to health and illness is the underutilisation of health services (Calnan, 1987). Their aim is practical: to improve service utilisation behaviours. Further, with current professional trends towards the necessity of cross-cultural competence in medicine and social work, research in these two areas has stretched to study the beliefs of client populations from other countries as well as those from isolated communities (e.g., Applewhite, 1995; Juckett, 2005; Weaver, 2006). While these trends increase empirical knowledge on these topics, it appears that the vast majority of studies overwhelmingly focus on the "other" – people who are different from the "mainstream." This approach ignores the "naïve" theories that people from mainstream society carry with them into the treatment room, thus, perhaps, limiting the efficacy of treatment approaches for these groups.

Some medical sociologists have sought to understand folk theories about illness, health and medicine as social representations (Gabe, Bury, & Elston, 2004). Sociologists in this tradition such as Herzlich and Pierret (1987) argue that such collectively held "naïve" beliefs reflect both medical ideas about illness causation as well as a wider theorisation of health and illness in relation to society. This perspective proposes that through lay theories of health and illness, ordinary individuals are trying to make sense of health and illness in themselves, their families and their communities, as well as situating their individual experiences of such crises against the larger canvas of morality, politics and cosmology (Gabe et al., 2004).

Most studies on folk medicine focus on illness rather than on health (Calnan, 1987). The Furnham (1994b) study in the U.K. is one of very few that look at health rather than its absence. His participants demonstrated firm views on a number of health related issues. As previously described, they conceptualised health on external and internal dimensions. The external dimension consisted of environmental factors and those who endorsed these items tended not to be fatalistic. On the internal dimension, respondents highlighted psychological and behavioural determinants of health and illness.

Lay theories of specific illnesses have centred on people's causal theories of different health conditions such as schizophrenia, paraphilias and neuroses (sic.)

(Furnham, 1997; Furnham & Chan, 2004; Twohig & Furnham, 1998). Cause has been attributed to factors such as inner control or will power (Furnham & Henley, 1988; Furnham, 1997). Further, as could be expected, lay theories in some groups more closely represent current scientific knowledge compared with other social groups. For instance, lay participants demonstrated biomedical views of causation for conditions such as autism, and psychological views for others such as obsessive compulsive disorders (Furnham & Buck, 2003). But it is worth noting that the very conditions that are selected in such studies compared with those that are ignored are a reflection of societal trends (Furnham, 1988).

Another strand of lay theory research related to illness pertains to risk perceptions of individuals vis-à-vis different illness conditions (Calnan, 1987). These flow from epidemiological studies that catalogue at-risk populations. Eliciting people's personal conceptions of their risk directly assists professionals to devise better health programmes. However, people's perceptions of their own risk may often be underestimated and experienced researchers attempt to understand these issues in more than just one way (e.g., combining self-report with observational studies).

The study of folk medicine also includes views about treatment. For instance, Furnham (1994a) found that his participants conceptualised treatment as external (consisting of orthodox and alternative medical treatments) and internal (appropriate mind set and behaviours). Such folk theories of treatment tend to differ based on professional expertise and cultural background (Furnham, Wardley, & Lillie, 1992; Furnham & Murao, 2000). They are also domain-specific. For instance, Furnham and Henley (1988) showed that inner control or willpower was considered more important in overcoming some psychological problems such as compulsive gambling than others like schizophrenia.

Another avenue of research concerns whether illness conditions are believed to be relatively open to change or alteration. Here, there appear to be differences based on professional expertise (E.J.M. Campbell, Scadding, & Roberts, 1979; Kuyken, Brewin, Power, & Furnham, 1992) and type of illness or domain (Vaz & Mahalingam, 2006).

In terms of mental disorders, lay people were found to view conditions diagnosed by the Diagnostic and Statistical Manual (DSM) as immutable and biologically grounded (Haslam & Giosan, 2002). Further, those conditions that were thought to have a biological cause were not associated with beliefs about social or environmental causes. They were less likely to be viewed as amenable to change, and were more likely to be judged as being extreme or severe. This was contrasted with participants' perceptions of conditions or behaviours that do not map on to any DSM diagnosis but that possibly border on being pathological (e.g., character flaws).

A final approach looks at people's perceptions of control over health. Researchers have worked on measurement tools to capture participants' locus of control vis-à-vis health (Dielman, Leech, Lorenger, & Horvath, 1984; Pachter, Sheehan, & Cloutier, 2000). These studies and the ones related to whether various illness domains are changeable provide key data which can explain important behaviours such as patient compliance with treatment. They are critical for all clinical fields. However, a broader selection of statements at the initial stages is necessary to be able to capture a greater variability in people's beliefs (and to avoid ceiling and/or floor effects).

There is some evidence of differences in theories of health based on personal characteristics such as political and religious beliefs (Furnham, 1994b), native-born versus immigrant populations (Jobanputra & Furnham, 2005) and social class (Calnan, 1987). In India, religious affiliation has been found to influence the lay beliefs about causation of conditions like thalassaemia (Roy & Chatterjee, 2007).

According to Mechanic (1973), some differences in folk theories are the result of larger societal influences such as increased technologisation of medicine. Societies which are more technologically sophisticated would have lay people whose notions of health and illness would be more closely aligned with those of medical professionals. However, they would also have some people with beliefs that converge less with "mainstream" ideas and which do not surface in a conventional situation. Further, cross-cultural differences could be explained in terms of levels of technological sophistication of different societies. Related to this is the interest of medical sociologists in how lay theories change as a result of medicalisation of more and more "health" conditions (Gabe

et al., 2004). One example could be the relative ease with which parents and teachers invoke a “diagnosis” of ADHD.

It is worth noting the caution of researchers such as Calnan and Mechanic that the biomedical model may not hold the same relevance in all cultural situations, or even within a particular society. As a result, only carefully-worded neutral statements related to alternate beliefs would be likely to elicit alternate or non-mainstream views. For instance, health beliefs lend themselves more particularly to explanations involving fate (Pepitone, 1997). However, people are less likely to express these ideas unless explicitly asked. For instance, Jobanputra and Furnham (2005) showed that British immigrants from India did voice beliefs about fate but only when asked. Similarly, Calnan (1987) found that the manner of asking the question affected the type of answer: Concepts of health elicited through inquiring about the state of the person's own health showed a preponderance of negative definitions compared with positive definitions. In contrast, asking in abstract about health and illness tended to produce slightly more positive dimensions in at least some participants. He suggested that this may be related to the perceived differences between the interviewer and the interviewee.

The scope of lay theories of health and illness is, thus, both large and likely to elicit much variation depending on personal characteristics of the lay theorist and the opportunities presented for expressing her/his beliefs. In India, early lay theory research pertaining to health appears to be restricted to pregnancy and early childhood illnesses (e.g., Chand & Bhattacharyya, 1994; Nichter, 1989). Much of this work has focused on rural populations and has been initiated by anthropologists. The theory of humours is one framework that appears to underlie folk medical beliefs in India (e.g., Pool, 1987; Weiss et al., 1988).

Parental Ethnotheories

Parental ethnotheories are another type of lay theory. Apart from a few isolated studies such as those by Furnham (1995; 1999) on spanking and economic socialisation, folk theories of parents and parenting have largely been the province of cognitive anthropologists and cultural psychologists. They study such theories in the form of ethnotheories - “presupposed, taken-for-granted models of the world that are widely

shared by the members of a society and that play an enormous role in their understanding of that world and their behaviour in it" (Quinn and Holland as cited by Chao, 1995, p. 4). Like most lay theories, ethnotheories are usually not well-developed, conscious theories with a set of scientific corollaries (Segall, Dasen, Berry, & Poortinga, 1999).

Parental ethnotheories have their roots in the observations by adults of child development (Segall et al., 1999). They are also instrumental in influencing that development process, and are somewhat circular and difficult to detect. These belief structures influence child development by determining the contexts for behaviour. Parents may not always act according to the normative rules they claim to espouse. However, ethnotheories serve as models for adults within a particular group to follow (Bornstein & Cheah, 2006).

For the most part, the content of such theories has included aspects related to child care, desirability of child characteristics and appropriateness of parenting practices (Bornstein & Cheah, 2006). Segall et al. (1999) have included under parental ethnotheories: developmental theories (e.g., nature vs. nurture), notions about religion (e.g., reincarnation), developmental timetables, types of competencies expected, levels of skill mastery, evaluation procedures, final stage and definitions of intelligence.

Parental ethnotheories have been studied by comparing groups of parents from different cultural groups on dimensions of interest. Many of these studies initially looked at parenting practices through cross-cultural comparisons. For instance, Keller, Yovsi and Voelker (2002) studied the role of parents in motor stimulation from contexts as diverse as Cameroon and Germany. Some researchers study different cultural groups within a single society, such as Chao's (1995) comparison of mothers in America from a Caucasian background with those from a Chinese American background. This is a result of recognition that the meaning of phenomena does not just differ for people across various cultures but that it may differ for people within a single context as well, and that understanding such within-culture differences could lead to a deeper understanding of such social-cognitive phenomena (Goodnow, 2006; Molden & Dweck, 2006).

Goodnow (2006) explains that studying parental ethnotheories may be useful in three ways: The theories may cast light on how people think even if they express

themselves in a variety of ways. Secondly, they promote understanding of strange behaviours. Lastly, knowledge of such theories may assist in the process of changing these ideas.

Parental ethnotheories have been integrated into the developmental niche framework (Harkness & Super, 1994; Super & Harkness, 2002). This framework arose from the concern of anthropology to understand the influence of culture through the mediation of the household (or microsystem). The developmental niche has 3 subsystems that comprise the child's daily environment: the physical and social settings of the child, parenting customs, and psychological characteristics of the caretakers. Parental ethnotheories fall into the third subsystem. These three subsystems work together to create "ecological redundancies," and to regulate the development process of the child and mediate his/her experience within the larger cultural context.

Most of the research thus far appears to focus on parenting beliefs and practices with children under age ten (e.g., Brooker, 2003; Chao, 1995). There appears to be barely any empirical work on older children. One could speculate that perhaps, it is easier for researchers to isolate or identify these parenting variables when the children are involved in a limited fashion with the external world. Yet, by ignoring adolescence as a stage of development, we are, perhaps, missing some critical and interesting understanding of parenting in the later years. Socialisation does not end at age ten.

Another limitation in the study of parental ethnotheories is that it has largely confined itself to how parents socialise their children in areas such as education and personal habits like sleeping and eating. Harkness and Super (1994) did extend their work to explain how the concept of the developmental niche can be used to study household production of health. For instance, they illustrated how various child care customs and practices might enhance or mitigate the risk of Bangladeshi children to diarrhoea; and how the cultural tradition of 'son preference' as a psychological theory affects the survival of female children in Northern India. However, these ideas have not been adopted for research to date.

Parental Ethnotheories in the Indian context

In the Indian context, Saraswathi and Pai (1997) have focused on parental ethnotheories using the psychoanalytical perspective of Sudhir Kakkar. Saraswathi's approach has been to review adolescent development against a traditional viewpoint derived from ancient Hindu treatises. She views certain enduring themes which perpetuate themselves even in situations where the original significance is lacking. Some such beliefs are about *dharma* (natural law or duty), *karma* (action), *gunas* (qualities) and *samskaras* (innate propensities as well as rituals at different stages).

The belief in *ashramadharma* sees Indians as progressing through life stages such as *balya* (early childhood or prehistory), *brahmacharya* (apprenticeship/celibate life of youth), *grihastashrama* (life of the householder), *vanaprasthashrama* (life of withdrawal) and *sanyasashrama* (life of renunciation). Progress from one stage to the next is marked by *samskaras* or ceremonies dedicated to rites of passage. During the early childhood period, some such rituals are the *namakarna* or naming ceremony and the *annaprasana* ceremony which marks the occasion of the first solid food (marking the individuation of the child).

The period of *brahmacharya* or apprenticeship corresponds roughly to the period of adolescence. It is marked by the *upanayana* or the ceremony of the sacred thread. Until this ceremony occurs somewhere between age five and ten, the individual is not considered to be culpable. In ancient times, males were expected to separate from their families during the period of *brahmacharya* and live in close proximity to their teacher (*guru*) where they lived a life of celibacy and learning. Sexual gratification was meant to be enjoyed only within marriage in the following stage of the householder.

Saraswathi is of the opinion that this perspective imbues the parenting of most Indians irrespective of religious beliefs. However, she is not without critics. For instance, Gore (as cited by Jayaram, 2000) points out that this theory really is a perspective related to the growth of males, and specifically upper-caste males. Also, given that lay beliefs change as a function of societal change (Mechanic, 1973), it is entirely possible that these traditional views may exist side-by-side with other more "modern" beliefs or be almost replaced by them. Thirdly, over-applying a Hindu perspective to members of other

religious groups is a kind of cultural blindness that ignores how beliefs in other religions influence behaviour. For instance, in an unpublished study in India by Desai-Carroll (1989) on the relative responsibility of societal conditions, individuals and culture for events such as criminal convictions, sex-discrimination and unemployment, Hindus more than Muslims and Christians allotted highest responsibility to the individual rather than societal conditions.

Thus there is not only need to understand parental theories in India, but also to distinguish between such theories as held by members of major cultural groups.

Studying Parental Ethnotheories Related to Adolescent Health

I reviewed two broad and well-researched traditions of research: one from social psychology by Furnham and colleagues and the other from cultural psychology associated with researchers like Super, Harkness, Goodnow and Keller. My dissertation relates to each of these. As a social worker from India, I hoped to understand these issues so as to inform policy which, to date, has barely addressed the needs of young people, nor involved parents in this endeavour. My research questions were:

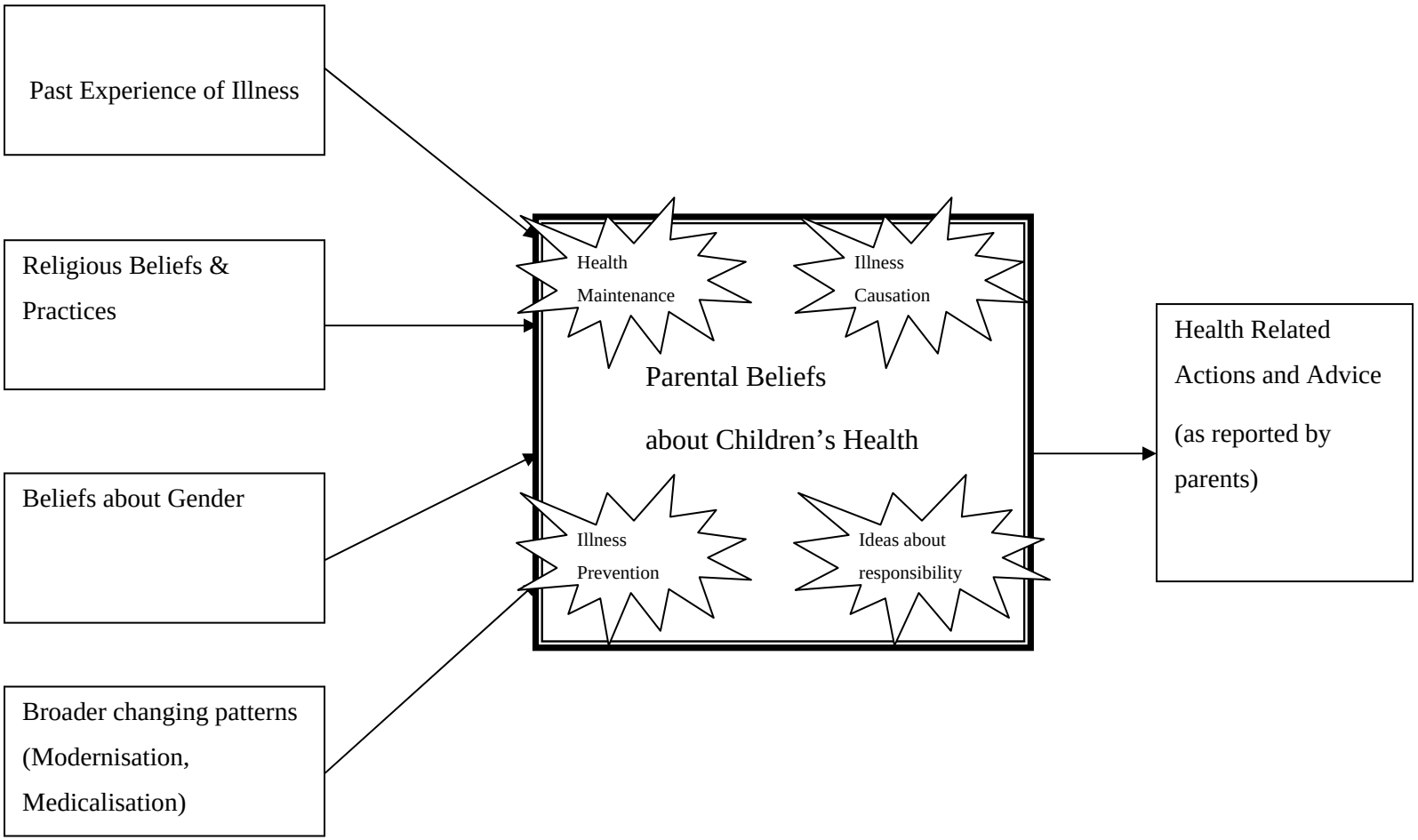
- What lay theories do Indian parents hold about adolescents' health?
- Given that the health risks for adolescents are slightly different for boys and girls, would there be any gender differences in such parental theories?
- How does past or present familial experience with illness affect these lay theories?
- Given that India has many religious groups, and that nearly all Indians profess to belong to one of these groups, how does religion affect parental theories about health?

Some possible domains based on the lay theory literature include: illness causation, health maintenance, health promotion, illness/disease prevention, health-related responsibility of parent, health-related responsibility of child, health-related responsibility of school, health-related responsibility of government, changing health patterns, influence of modernisation, and impact of personal/familial experience with

illness. Some theorists advocate having an initial formative model before data collection to guide the initial analysis (Schensul, Schensul, & LeCompte, 1999). My initial formative model (see Figure 1.1) mapped parental beliefs about teenagers' health as flowing from previous experiences of illness (personal or family), religious beliefs and practices, beliefs about gender (e.g., Girls are tied to the home and so are less susceptible to smoking) as well as societal trends toward modernisation and medicalisation. Parental lay theories about health cover several broad areas or sub domains such as causation of illness, prevention of illness, ideas about responsibility, risk assessment and promotion of health. In turn, I believe that the folk theories expressed by parents will explain the actions they report.

Figure 1.1. My initial formative model

(Based on the premise that there is a consistency between parental reports of their lay theories and their actions)



Chapter 2

Methods

I began my study with these research questions.

- What lay theories do Indian parents hold about adolescents' health?
- Given that the health risks for adolescents are slightly different for boys and girls, would there be any gender differences in such parental theories?
- How does past or present familial experience with illness affect these lay theories?
- Given that India has many religious groups, and that nearly all Indians profess to belong to one of these groups, how does religion affect parental theories about health?

To answer them, I decided to use ethnographic research. Ethnography is ideal for examining shared patterns among a cultural group where the ethnographer's focus is on values, behaviours, beliefs, and language (Creswell, 2007; LeCompte & Schensul, 1999b). It appeared to be a suitable choice because barely anything was known at the outset about parental lay beliefs about health of adolescent children, especially in the context of India. Further, I was keen to explore how religious affiliation of parents might affect their view of the health of their children. Given this dearth of information, I decided to use an ethnographic approach to unearth the meaning of various beliefs related to domains such as risk perceptions, causation of illness, health maintenance and promotion. Further, according to LeCompte (1999b), ethnography is useful when the research topic is not clear as well as when it is likely to be embedded in multiple systems. This lack of initial data also meant that framing the research tools would be guided more heavily by researcher intuition, rather than by existing theory.

I designed this as a comparative ethnographic study (LeCompte & Schensul, 1999b) because I looked at parents from two different religious groups. I thought it important to undertake such a comparative approach because health policies in India tend to take a "one-size fits all" approach to most health problems. The few exceptions are in

terms of programmes targetted at groups that are epidemiologically at risk of certain diseases such as HIV/AIDS. Given the religious diversity in India, this assumption may be expensive in terms of underutilisation of health programmes.

My study was also "compressed" in that it attempted to collect information about a limited set of domains in a short period of time. LeCompte and Schensul recommend this design only if the ethnographer is really familiar with the cultural context they are attempting to study.

Population of the Study

I situated my study in Bombay (now called Mumbai), India – a city that I am familiar with from having lived, worked and studied there for more than 30 years. Greater Mumbai is the world's fourth most populous city with 14,282,000 inhabitants in 2005 (Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, 2007). Here, I planned to locate parents belonging to both the Hindu and Christian faiths.

One approach in ethnographic research is to identify the "typical case' – the mean or average set of characteristics of the population of interest, and use those criteria to select representative participants (LeCompte & Schensul, 1999b). So, prior to entering the field, I decided that my typical case (participant) was a father or a mother of a child aged 13 to 15 years, was either Hindu or Christian, spoke English reasonably well and was communicative and articulate. I chose this age group because it was at the lower end of the adolescent period. Adolescents who were older than 15 years would be in college, and their parents' lay theories would likely be different. Also, as some questions in my interview schedule sought to elicit parental concepts and theories using comparisons between male and female children, I sought parents who had at least one child of each gender.

Sites for the Study

Having extensive experience with the private school system, I sought to "recruit" my sample from private high schools. It is important to clarify that a private high school does not connote an elite school serving only people of means as it does in the United

States. The designation ‘private school’ in India refers to institutions established and administered by private groups and cultural associations in contrast with those administered directly by the government. The syllabus is common in both types of schools. Some private schools receive a government grant-in-aid towards staff salaries and/or other expenditure such as maintaining library facilities. The government grant makes it possible for such schools to offer education at low fees. It is possible for a school to have some sections (like the secondary classes from Std. V to Std. X – approximately ages 10 to 15) funded through a grant while other sections are managed through fees collected from parents. Some private schools are non-aided and manage their finances entirely through student fees. As the relative cost of attending such non-aided schools is high, they tend to serve students who are relatively more affluent. Among such non-aided private schools are the so-called “International schools” that offer the International Baccalaureate system of education. These schools with their high fee structure service the elite section of Indian society (Sharma & Anisha, 2006). Government schools such as those run by the Brihanmumbai Mahanagar Palika (Bombay Municipal Corporation [BMC]) tend to serve poor students (Vacha Kishori Project Team, 2002). Another distinction is that the BMC is more likely to run schools where teaching is conducted in various Indian languages.

Among the private aided schools, there are many where the medium of instruction is English. I opted to confine myself to parents from such schools. By limiting myself to interviews in English (in order to manage time better as well as to avoid issues related to translation), I was aware that I was likely to limit myself to middle and upper-class parents because speaking English is a relative sign of privilege in an ex-colonial country. But it was necessary to “bound” my population in some way in order to maintain the feasibility of my project. Wolcott (2001), for instance, states that attempting to study breadth by including too many comparison angles may reduce depth of findings and halve the time available to study each group.

I chose to approach private schools that are part of the Archdiocesan Board of Education (ABE). Once again, this was a context which was familiar given my previous professional involvement from 1997 through 2002 with the School AIDS programme run

jointly by the BMC School Health Department and the ABE. (From 1999 to 2002, I held a non-paid position of Course Coordinator for the ABE where my primary responsibility was to organise and conduct training for teachers as well as to coordinate with an interdisciplinary team to frame the school AIDS programme curriculum. By the year 2002, I was engaged in 30 calendar days of work for the ABE - in addition to my "day job" as a social worker at a local school of social work). While schools run by the Archdiocesan Board of Education have a legal mandate to reserve 50% of their positions for Christian students, this quota is barely filled up, and these schools have a mixed population of students from different religious backgrounds. Further, from my work in this context, I knew that the schools do serve students from diverse economic backgrounds.

I approached the principals of four schools for permission to access and contact parents. I identified the schools from the Catholic Directory of Bombay (Archdiocese of Bombay, 2006) based on geographical convenience. These were not schools where I had previously worked. I was aware though that it was possible I would encounter teachers who had been trainees at my courses.

At each school, I presented a self-introduction letter on stationery (letterhead) of the School of Social Work. This letter introduced the study aims and activities (see Appendix B). I carried a copy of my C.V. for school principals who asked for it. I also had obtained and received permission to use the name of the former secretary of the ABE as a reference. This 'name dropping' was useful even when principals had not held their office long enough to actually be acquainted with the former secretary. It was relatively easy to obtain permission because of my past association with the ABE. Three out of the four schools I approached agreed to participate in the study. Access might also have been easy because of my shared religious background as a Christian. The school that refused permission cited lack of time in the school schedule to organise a parent meeting. This was the last school I had contacted. Though school principals agreed verbally, obtaining a formal letter of permission from them for the Institutional Review Board and parents necessitated multiple visits in the months of August and September 2007.

School One was a co-educational school run by a religious society of priests. It was located on the edge of one of Asia's largest slum settlements. School Two was a boys-only school run by a religious order of priests while School Three served girls and was run by a society of Catholic nuns. Schools Two and Three were located in a municipal city ward characterised by unemployment from cotton-spinning mills that are now defunct due to both a crippling 30-year unresolved mill strike and a fall in the demand for cotton fabric (Fernandes, 2003). Both geographical locations are currently undergoing redevelopment as the local city and state governments attempt to modernise and improve housing. All three schools were part of the island city (that is not in the suburbs) and are more than 30 years old. They face very busy arterial roads in the city. Based on my visits to the homes of the parents during the interviews, it would be fair to add that students' transit time to school could range anywhere from a five-minute walk to a 20- to 30-minute public bus ride.

All three school principals reported receiving a grant-in-aid from the state government towards salaries of staff for the secondary section. All three were fortunate to have an open space for the students to engage in sports and other cultural activities. I was able to meet teachers in two schools who had interacted with me through the School AIDS programme in the past. This eased my entry in at least one school.

Recruitment of Participants

Each principal suggested a different strategy for meeting with parents of their students. School One asked me to invite a speaker to address the parents on the topic of 'Assisting Students with Better Study Habits.' The principal then made announcements to the students that there was to be a mandatory meeting for parents on Saturday when the school had its weekly holiday. At the session, the principal introduced my research study to the parents after the session. I passed out recruitment forms to the parents who filled them and returned them to me at the end of the talk (see Appendix C). Parental attendance was monitored by the school through a sign-up sheet. Such mandatory sessions appear to be customary for the school because I witnessed another parent session organised in a similar manner.

School Two asked me to contact parents of Std. IX students on Open Day. This is an occasion for parent-teacher conferences after an exam. There are two such meetings held annually on a Saturday morning. Parents who work on Saturdays may come to school first before proceeding to work. For this meeting, I hired a social worker to assist me in approaching parents to participate in my study.

In School Three, the principal explained that due to lack of assembly space, she did not organise frequent parent meetings. The next parent meeting scheduled would occur well after the period of data collection. Instead, she provided me with a letter of permission and the names and telephone numbers of the class representatives of Parent-Teacher Association. The telephone numbers she shared were of those who she perceived as being more engaged and helpful, rather than those who represented the classes I had selected. When I contacted these individuals, they were very helpful and separately gave me the names of the representatives of the classes VII to IX. Some of these representatives were exceedingly co-operative and assisted me in recruiting other members. As I had not introduced myself to the parents at the school, and instead contacted them via telephone before meeting them directly at their homes, I faced a slightly higher level of questioning and suspicion from them. The Principal's Letter of Permission as proof of my genuineness was really important for parents recruited in this manner. For instance, Mayuri asked for some proof and on reading the letter of permission said, "This is quite a reliable thing," and Bhavana said, "I trust Sister."

Recruitment through the schools was an effective strategy. However, I had particular trouble finding Christian fathers. To do so, I visited all three schools again and requested assistance from the school principals. I also spoke with personal acquaintances from my parish to help me locate suitable males. Finally, I was able to recruit a couple of Christian males through a personal appeal by one school principal who accompanied me from class to class.

A couple of parents who participated in my study were so involved with the research process that they referred me to other acquaintances who I might interview. I found three parents in this manner.

Though I originally started with the intention of finding parents with one child of each gender at least, it became apparent from the recruitment forms I received that many parents do not fall into such “cookie cutter” families. Some families appeared to have adopted the two-child or one-child norm and did not necessarily have one child of each gender. I had to drop this requirement when recruiting parents.

I started with intending to interview parents of children aged 13 to 15, which I operationalised as being students from classes VII through IX. This did not map out neatly. For instance, one parent I interviewed had a daughter in the appropriate class who had not yet reached her 13th birthday. Similarly, I met with one parent whose son was 14 years old but who studied in Std. X.

In all, four Hindu fathers and two Christian fathers, six Christian mothers and seven Hindu mothers participated in my study.

Issues related to Power

One problem associated with recruitment through the school context was how I was perceived by the students themselves. Though I had taken care to ensure that parents were aware of all their rights as participants in a research study, it became apparent to me at one interview planned with a Christian mother that approaching parents through the school system often connotes a power differential. In this case, the boy whose mother I was scheduled to interview expressed his unhappiness that I wanted to talk to his mother about him. Given his distress, I decided not to conduct the interview that day. Instead, I spoke with him personally and showed him my questionnaire. I explained to him how his mother’s replies would help social workers to improve health services for adolescents. Showing him the interview schedule lessened his anxiety, and he then expressed his willingness to have his mother participate. However, I felt that it was more appropriate to give the family a cooling period. When I recontacted the family a couple of weeks later for an interview, they declined using the reason of the mother’s demanding work as a domestic worker (The day she had agreed to participate was during her employer’s vacation). There are two possible reasons besides the stated one for refusal to participate: one is concern about the son’s reaction (though I think this reason is less likely given the cordial nature of the phone call) and the second is the difference in our respective social

statuses (It was obvious that I was a highly educated middle-class professional while this family lived in a *chawl* – a one-room home with a common toilet outside the house).

Recruiting parents to participate through the schools does bear the potential for tilting the power balance in favour of the researcher. I recruited parents using a form and through a follow-up telephone call. In the school with the mandatory sign-up sheet as in other schools, I explicitly informed parents that there was no compulsion to participate and that I would not inform the school about whether or not they participated. Many parents did not turn in the form, or stated outright that they were too busy. Further, some parents who were later contacted over the telephone stated their lack of intention to participate for various reasons like time. A few asked me to call back when they were free. Having cell phone numbers appeared to be a way for parents to equalise the power differential. On recognizing my telephone number, it is my belief that some people simply did not "accept" the call. To make sure that this was not just a break in service, I persisted with about four calls, recording the calls in my note book.

Timing of the Study

The timing of my study was appropriate. Permission from the Institutional Review Board was granted around the time of the First Semester Exam. Although I had already announced the project to the parents at the school before the permission was granted, I was only, therefore, able to contact them after the examination. This worked well for many parents because they were home on leave for the three-week *Diwali* vacation immediately after the exams. Some parents who were out of the city, gave me appointments for when they returned to the city and to work.

Data Collection

In all, I met with 19 parents at their homes. All interviews except one were conducted in one sitting. Interview times varied from 88 minutes to a maximum of 179 minutes. Parents were offered the option of stopping at the previously contracted time of 90 minutes. All but two opted to complete the interview as they were interested in answering the questions. The parents with the longest interview times were obviously the most vocal. Further, the interview times mentioned above sometimes include long interruptions for the serving of refreshments and answering the phone or the doorbell. In

one case, I actually spent almost double the actual interview time at one home because the parent interviewed had caretaking responsibilities of her own parent which required assisting her in moving from room to room, or to the bathroom. The recorder was not always switched off during such interruptions. One interview was physically interrupted because the parent was distressed by ongoing family problems. This parent opted to meet me outside the home to complete the interview despite being offered the possibility of discontinuing the interview completely. She made it clear that she was keen to do the interview. I surmised that her difficult life situation caused her to experience being interviewed as a welcome relief. I was able to make a referral to an appropriate woman-centred counselling centre and through follow-up phone calls I ascertained that some measures were instantly undertaken to ensure her personal safety.

Parents were comfortable with being interviewed at their homes. Other family members were often present during the interview. These other family members sometimes volunteered details to supplement what the participating parent was explaining. However, they were very responsive to a request from me that this was an individual interview, and would desist from entering into the conversation. The presence of family members was both a help and a hindrance. Family members could be counted on to free the respondent from answering the doorbell. They were, on some occasions, a source for recall of facts that were on the tip of the interviewee's tongue. However, during one interview, a father expressed discomfort and created an excuse to send his daughter out of the room, so he could speak more freely about his concerns related to sexual abuse.

Issues related to consent

With regard to signed informed consent, my own experience and that of other researchers indicates that in India there is a poorly established tradition of informed consent – even for medical procedures (e.g., V.V. Nadkarni, personal communication, June 8, 2007; Pilgaokar & Mamdani, 1999). This is coupled with the observation that signing papers has connotations of giving away property rights, etc. (Patil, 2004; Vissandjee, Abdool, & Dupere, 2002). Added to this is the fact that most people in India are "research-naïve" (as I observed in this current study) and the strangeness of a research

situation causes people to be additionally suspicious and sceptical. Bandewar (2003) suggests that urban respondents may be more suspicious than rural ones.

A draft code of conduct on research ethics in India (Ethics in social sciences and health research: A draft code of conduct, 2000) suggests that researchers should seek informed consent not to protect the researchers who are usually in a position of greater privilege and power over participants, but to protect the rights of would-be participants. The code of conduct also acknowledges that sometimes written consent might be difficult to obtain. It recommends, nevertheless, that participants be given simply worded information sheets with adequate details of the research project and associated stakeholders, along with a verbal explanation.
Thus, some researchers in India have respected the need of participants to avoid signing by obtaining verbal consent instead (e.g., Bandewar, 2003; V.V. Nadkarni, personal communication, June 8, 2007).

Anticipating this, I sought IRB permission to waive written informed consent and instead read from a verbal script to the parents who had consented to be interviewed (see Appendix D). Further, detailed information about the study was made available to potential participants in the form of a sheet of Frequently Asked Questions about my study (see Appendix E). This contained details of how people could contact me.

Parents were explicitly informed about the digital recording of the interview. Only one parent indicated that she would prefer not to be recorded over the telephone. But on meeting me in person, she changed her mind without prompting. I surmise that meeting with me in person was less threatening than she anticipated. Further, her responses did not appear to be guarded in any form. She was one of only two people in my study with actual experience of a research study as her brother works as a social researcher for a respected NGO in Bombay. The other parent reported having been interviewed by another PhD student. Another parent with familiarity of interview situations albeit on the opposite side was a journalist. One father confessed at the end of our meeting that he thought I intended selling him health insurance. On further questioning, he stated that he was positive towards the interview process, and even went on to make suggestions for further questions to include in the questionnaire. A couple of mothers mentioned that they

had participated in the interview because they had daughters at the university level who were keen to major in psychology and they sought clarifications about future career paths. So on two occasions, I found myself advising these college-level students. Another couple of parents were interested in knowing about IQ and aptitude testing for their children. I had already prepared a resource list of child guidance centres with this information (see Appendix F). But as I was on the spot, I was also able to give them detailed guidance on accessing the service. This personal recommendation generally carries weight in India based on the "I know someone who knows someone" pattern.

None of the parents were paid for their participation as this is not a cultural norm in India (Vissandjee et al., 2002). On the contrary, as per their cultural practices, parents treated me as a guest in their home and gave me refreshments. It would be culturally insensitive to refuse such light refreshments. Social work training in India advises students during fieldwork orientation to consume a cup of tea in the community when it is offered. I did not, however, eat a meal at any one's place. I was not present in most homes for that length of time. Secondly, as a meat eater, it would be inappropriate to take for granted that I might comfortably eat off the family plates in Hindu households. While I saw no signs of such discomfort on the part of the families and this does not appear to be part of the "Bombay culture," I was sensitive to food taboos in the city.

The parents interviewed were comfortable with the digital recorder. Some showed concern about data loss when I accidentally switched off the recorder during interruptions in the interview and had to begin a new recording. This tended to happen more often during the first interviews when I was still familiarizing myself with the Pause function. Finally, I just kept the recording going unless the interruption appeared to be a personal matter or a really long one that might drain the power of the recorder.

During the interviews, I tried to be conscious of how my shared background might cause me to take for granted things that parents were saying. So I engaged in asking for "cultural translations," that is explanations of certain terms and practices that parents mentioned. To the Hindu parents, I would ask outright how they undertook certain customs. To the Christian parents, I (being a practising Christian) would ask them to explain, saying that I wanted to be sure when their practices were similar to what my

own family might have done. I used my cultural familiarity with Bombay city and its various communities to break the ice by asking after familial celebrations for festivals around the time of data collection, namely *Diwali* (the festival of lights) and Christmas. As practical matters related to happy occasions that were relatively unthreatening, they served the function of putting the participants at ease.

Issues related to English

Particular problems arose related to the issue of English. Despite informing parents that the interviews were in English, and requesting them to turn in a form with information about the languages they spoke, a few parents wrote English as one of the languages they used when they were not actually fluent. In one case, an interview with a father began with questions in English and answers in English. However, as the complexity of the questions grew the interviewee grew more uncomfortable and despite receiving permission to carry on in Hindi (which I speak fluently), he opted to discontinue. However, he arranged for his wife to participate in his stead. So the interview of this father has not been included in the analysis. In another interview, the mother interviewed who I renamed as Namrata suggested that I ask the questions in English which she would then answer in Hindi. I opted to keep this interview in the study because it was a complete interview and it was clear that she followed the questions. Also, in this instance, I translated some questions in an impromptu manner to ensure that certain nuances of English were clear. Where necessary in the analysis, I will indicate clearly, this interviewee.

All the Christian parents spoke fluent English as most of them have benefitted from having an education at schools like those run by the ABE which often instruct students in English. However, it would be incorrect to see this as an absolute mark of privilege. Some parents clearly lived in less affluent surroundings as I will report later in this chapter.

Post-interview Follow-up

After each interview, I dictated my reactions related to the interviews into the digital recorder. I listened to all the interviews and made notes on them for the data meeting with the parents. It was not possible to transcribe more than one interview in the

field because I was unable to find a social worker to assist me with on-going research tasks.

After conducting about six interviews, I incorporated a few additional questions about the schedule of the child and about where the family actually accesses health services. This necessitated recontacting some parents by telephone. Only three out of the six parents gave this information. The others cited lack of time as the reason for not doing so.

Four parents attended the data meeting held at the end of my visit to Bombay when all interviews had been collected. A couple more had shown interest in attending but expressed possible reservations about time conflicts which I read as a polite but definite "No." Three other mothers had expressed to me at the time of the interview that while they were willing for me to visit them at home and interview them, they would not be willing to go outside the house for a meeting. This is culturally appropriate role-behaviour for many Indian home-makers. Two mothers who work outside the house cited work as a reason for not attending. The data meeting itself was approximately one hour long and focused on the impact of academic goals on parental expectations and views related to health.

I visited each of the three schools at the end of my data collection, as a final check-in with the school principal, as well as to clarify some aspects of the school's services that had emerged through the interviews with the parents.

Interview Schedule

The questions in the interview schedule (see Appendix G) covered demographic data about the interviewees as well as their attitudes and beliefs about health in general. They related to past, present and hypothetical situations. A previous study of lay theories by Calnan (1987) was specifically responsible for questions related to maintenance of health and contributory factors to illness. There were several behavioural situations which sought to elicit responses that might illuminate parental theories about adolescent health: For instance, if a family friend called you up and said that they had seen your child holding hands with a boy/girl outside tuition classes, what would you do/say?

I embedded in the interview schedule the following standardised measures: Parental Health Beliefs Scale, Global Self Rated Health and two measures of religiosity. I also asked parents to indicate the level of perceived risk from various health challenges stated in public health literature relevant to India.

I administered these measures verbally with the five-point scales printed out on a placard that I placed before the interviewees. I read out each item and asked the participants to call out the number that came close to their opinion. At the end of reading out the items in a particular scale I asked them to comment on the scale itself and its applicability to health in India. I followed this because I felt that verbal measures would make my participants more comfortable, while having to read and mark something might remind them of an examination system and cause them more stress. Further, the verbal process enabled me to capture things that motivate the responses through involuntary comments that parents made and the clarifying questions they asked.

Parental Health Beliefs Scale

This was originally developed by Tinsley and Holtgrave (1989). It consists of three subscales: "Internality" (the belief that the parent has a great deal of control regarding their child's health: e.g., "It is my job as a mother/father to keep my child from getting sick."), "Chance" (the belief that chance events have an overpowering effect on the health of children: e.g., "My child's good health comes from being lucky") and "Powerful others" (the belief that health is largely determined by other powerful entities: e.g., "Only the dentist can take care of my child's teeth"). To this I added more statements about the role of government (e.g., "The government is responsible for the effects of quality of food on my child's health.") and the nature of sickness being caused by divine powers such as God or the devil (e.g., "Even the most healthy child can be affected by the evil eye or *nazar* of a jealous person."). Participants had to rate these statements on a five-point scale ranging from 1 (*Strongly agree*) through 3 (*No opinion*) to 5 (*Strongly disagree*).

Tinsley and Holtgrave reported an average test-retest reliability of 0.96, ranging from 0.83 to 1.00 across all 20 questions. Other studies have demonstrated alpha levels of 0.72 and 0.80 for the whole scale (Pachter et al., 2000 respectively; Trabert & Misra,

2007). Alpha figures for the Internality, Powerful Others and Chance subscales were 0.65, 0.57 and 0.60 respectively (Bates, Fitzgerald, & Wolinsky, 1994).

Pachter et al. (2000) suggested an alternative subscale break-up based on their standardisation of this scale on Puerto-Rican mothers: External/luck (Alpha=0.70), Internal (Alpha=0.45), External/others (Alpha=0.40), External/professional others (Alpha=0.43) and External/just happens (Alpha=0.66). In their study, they wanted to make distinctions among various "powerful others" to better reflect the belief systems in this group of parents. DeVellis et al. (1993) adapted Tinsley and Holtgrave's scale (1989) to include new subscales: Child, Divine and Media. They reported that alpha figures ranged from .76 to .92, and test-retest reliability figures from 0.60 to 0.96.

Global Self-rated Health

This is a commonly-used single item measure in health studies which is a good, independent predictor of mortality in various countries (Idler & Benyamini, 1997). It is an economical self-assessment of health and has been used in several studies (e.g., Bjorner & Kristensen, 1999; Borrell et al., 2008). It consists of a single question: "In general would you say that your own health is Excellent, Very good, Good, Fair or Poor?" where 1 is rated as *Excellent* and 5 as *Poor*. I adapted this question to also ascertain the respondents' perceptions specifically of their mental health.

Religiosity

The items related to religiosity have been incorporated from two sources: The measure used with Christian populations had a Cronbach alpha of .75 (Jang, Borenstein, Chiriboga, Phillips, & Mortimer, 2006). Sample questions include: "How important is it for you to rely on religious teaching when you have a problem?" which were rated on a five-point scale ranging from 1 (*Not at all important*) to 5 (*Very important*). A similar measure used with Hindu populations (Tarakeshwar, Pargament, & Mahoney, 2003) identified four religious pathways with alphas close to or greater than .90 – namely devotion, ethical action, knowledge and physical restraint/*yoga*. It included open-ended questions such as: "Do you observe a vegetarian diet?" and attitudinal statements such as "At work I do my job and treat my colleagues in accordance with my religious principles," which were rated on a five-point scale ranging from 1 (*Strongly agree*)

through 3 (*No opinion*) to 5 (*Strongly disagree*). I asked these questions of all participants.

Handling the Data

I maintained digital copies of my interviews on my computer as well as backed them up on an external hard drive. All paperwork related to recruitment was shredded before I left India to return to the U.S. The interviews were transcribed by two research assistants as well as me using Soundscriber. This is a free programme available on the University of Michigan website which permits transcribers to set the speed and number of times a segment of audio recording replays in a loop. Pauses and inarticulate sounds were indicated as well as interruptions in the flow of the interview process. This was important especially for understanding how much parents comprehended the scales. All but three interviews were checked by a person other than the transcriber to ensure accuracy and faithful recording of participants' words because the quality of the original transcription by this transcriber was found to contain almost no errors in other interviews.

Names of interviewees were changed after the transcription process using common Christian and Hindu names from two websites: http://www.babynamesworld.com and http://www.indiaexpress.com/specials/babynames.

Some parents used phraseology that is peculiar to Bombay in what is called Bombay English or Bombay Hindi. For instance, Mayuri states "[G]enerally children are *fasaoing* in such type of things." While completely comfortable with English as her second or third language, it was only this word (which demonstrates characteristic Anglicisation of Hindi through the suffix 'aoing') that captured her connotation of children getting enmeshed and swamped down. It has been pointed out that the act of translation sometimes alters the meaning of a phenomenon as the original language may indicate things peculiar to a particular setting. This is particularly true when the original script is in colloquial lingo which may translate poorly into another language structure as well as into the 'high' form of the same language (Sareen & Gupta, 2000).

I opted to retain in the transcripts such Hindi vernacular in a transliterated, italicised Roman script with a translation in a double box bracket next to it. English newspapers and magazines in India often carry transliterated and italicised quotations

given that most people speak at least two languages. I followed this trend here because some of the terms used simply do not translate well into English. Also, there are certain aspects of parent-child interaction that may only surface in a research interview when a parent is permitted and even encouraged to report exactly what they would say or do, even if it is not in English. These segments provide a useful insight into language issues that could be useful in planning programmes in a multi-lingual society.

The manner of retaining both the original and the translation in an interview transcript would make for clumsy reading for someone unfamiliar with English and Hindi (and occasionally Marathi and Gujrati). So while writing this thesis, I reduced the usage of these references. But I retained them as much as was possible during the data analysis because I was striving to reduce my role as an editor to a later stage in the research process. The only interview where a primary translation took place during transcription was the one with Namrata in Hindi. This was one of the transcripts that was *not* checked by a second transcriber. But I listened to the interview more than a few times to ensure that the translated transcript was as faithful as possible to her intended meaning. Further, I may say here that she was prototypical in her comments.

The reliability of the transcription process was ascertained by an independent research assistant in India who was familiar with the Bombay accent. For this purpose, I used Audacity - a free-source, sound editing programme - to create smaller .mp3 files. This was done for 2% of the interview recording. As the independent research assistant was familiar with the languages used, she also commented that the translation in the double box brackets captured the essence of the interviewee's meaning when she saw these particular segments.

Coding and Analysis

Quantitative Data

The standardised measures and the quantitative data were coded into a database using SPSS 16.0 GP. I obtained means and standard deviations for the scales and subscales for the entire sample as well as for my comparison groups of Hindu versus Christian parents, and fathers versus mothers. I ran t-tests to compare these groups with

each other on all the measures. The results of these are reported in Chapters Three and Six.

Qualitative Data

The interview transcripts were saved as .rtf files and imported into MaxQDA – a text-based analysis programme. I created a table of attributes based on my variables of interest: gender of parent and religion of parent.

Boyatzis (1998) contrasts three different styles of coding in qualitative research which lie on a continuum from theory-driven to data-driven coding: theory-driven, prior research-driven and inductive approaches. Inductive codes are constructed from the raw information and often carry labels that are close to the syntax and words of the original data. They may exhibit innovative categories that have not been discussed in literature before. The first two approaches, by contrast, use coding categories that emerge directly from a theory or from a classification that was derived in a previous research study of a similar nature.

Question-level Coding

In my project, I had questions that had been asked as part of previous research studies. One such example was the Global Health Self-rating that has been used as a prompt for more expansive information about how people view their own health. For these items, I conducted question-level coding (Lewins & Silver, 2007) and compared the codes I developed with those of the previous research studies such as that by Calnan (1987). This approach falls somewhere in between Boyatzis' inductive approach and the other styles because I did not use a priori classification schemes developed in these earlier studies. However, it is not broadly inductive across all the interview data because I restricted the process of classification to the limited universe of responses to a specific question.

Inductive Coding from Word Searches

I also undertook inductive coding across all the interview data. Through a process of constantly comparing, contrasting and note-taking that has been labelled 'crystallisation and immersion' (Crabtree & Miller, 1992), I identified certain recurrent

themes which kept surfacing in the interviews. I used the Lexical Search function of MaxQDA for specific words that referred to these themes. I created codes labelled with those words and coded whole paragraphs. The next step involved combined clubbing together word-level codes into overarching categories. For instance, the lexical word searches for friend, circle, peer and company were clubbed as sub-codes under a higher-level code simply called Friends.

The next process of analysing involved separating those segments where parents were referring to the target child and when they were not. This separation involved creations of separate codes. So 'Friends' was subdivided into 'Friends of child' and 'Friends of parent.'

Within each of these sub codes, I then created different schemata of further sub-coding. One simply related to whether the reference was positive to the notion of health, negative or neutral. Other classificatory schemata described the content of the sub codes. Thus under the code 'Friends of the child,' I developed sub codes related to the parents' perceptions of various roles that friends play with regard to health.

Inductive Coding from Disparate Segments

I also identified certain ideas that recur but are not identifiable through specific words. These would be missed through a Lexical Search. One such code was *le cordon sanitaire* – instances when parents report that their adolescent offspring are safe from health risks because of their geographical location. This type of inductive coding sometimes emerged from the previously derived inductive codes based on the Lexical searches and sometimes from my familiarity with the data through the process of immersion and crystallisation. In the latter instance, it wasn't always possible to identify flag words. Insider knowledge of the geographical context of the research study also helped to locate some of these concepts that hang well together. For instance, shorthand references to specific governmental hospital such as LTMG and KEM each commanded their own sub-codes which I then put into an overarching theme of government. This overarching theme also contained "Use of the public distribution system/the ration shop" and "Non-specific references to the government" (see Appendix M for the code system).

Reliability of the Codes

The reliability of the codes was ascertained by an independent research assistant in India who was familiar with the Bombay context. She read segments of transcripts from 6 interviews which contained examples of all three types of codes as well as segments that did not have much coding.

Analysing through Cross-tabbing and Complex Forms of Text Retrieval.

I used the Cross-tab function to analyse the lay theories of parents as they related to my variables of interest, namely gender and religion. I exported the cross-tab output to Microsoft Excel where I converted the numbers to percentages. Then I imported the table into Microsoft Word where I inserted text examples of the different sub codes. Each quotation in this report bears the pseudonym of the parent. Tables present sub codes along with their percentages in terms of the sample size and the subsample sizes.

I used more complex forms of text retrieval to identify certain co-occurring ideas among the codes and presented them in tabular form.

Memos and Hyperlinks

I developed Code memos which identified the code label, definition, description of when the code occurs (which in the case of lexical searches was the word itself) and descriptions of qualifications and exceptions. Please see Appendix H for an example of a detailed code memo.

I also wrote and attached some memos to the text. Here I reflected on parents' usage of language, their approach to problems, etc. This was also the place to write some explanatory notes for things that are unique to an Indian sample such as *chyavanprash* – an *Ayurvedic* preparation to maintain well-being (The Western equivalent could be vitamin supplements). When a respondent appeared to use very similar language to describe what somebody else had also mentioned, I created hyperlinks between the two segments. MaxQDA, however, is limited to hyperlinking two segments in such a manner.

Negative cases

One specific use of memos and hyperlinks was to identify parents who are like or unlike each other with regard to specific ideas. The latter consists of negative instances or negative cases. Constant searching for, and awareness of, these negative instances helps to prevent a researcher from reaching premature conclusions (LeCompte & Schensul, 1999a).

Basic Demographic Information about the Sample

My sample consisted of nineteen parents: thirteen mothers and six fathers. Of these individuals, eight practised Christianity, and eleven professed to be Hindus. Among the Hindu parents, two belonged to the Jain subgroup and one was a Vaishnavite. Their average age was 42.56 years (*SD*=5.32 years). Table I.1 in Appendix I provides a summary of the basic demographic information about this sample.

The sample included 16 parents who were still married. Two women had been widowed in the first year of their marriage, and one woman was divorced after eight years of marriage. Parents who still had a living spouse, had been married for a mean of 17.31 years (*SD*=3.30 years).

Family Composition

Family size was generally small with an average of 4.89 people (*SD*=2.47 people). The sample included one joint family of thirteen members, a family of seven members (including two live-in servants) and eight single-child families. One of the initial specifications for the study was to interview parents who had at least one son and one daughter. But this condition was difficult to implement given the predominance of the one-child families. Among those parents with two or more children, only five could be located who had a child of each sex.

The target children about whom I interviewed parents consisted of ten boys and nine girls. The mean age of these target children was 13.42 years (*SD*=1.21 years). They studied in classes VII to X. While I had initially intended to interview parents of children aged 13 to 15, these ages did not map on neatly to the classes VII to IX in school. Some

parents mentioned that they had sought early school admission for their children. Hence they were young for their class.

Family Education and Occupation

This was a group of educated individuals who had completed an average of 15.11 years of education (*SD*=1.91 years). There was only one participant with a high-school education, namely S.S.C (that is had successfully completed Std. X exams). Fifteen interviewees had a college degree--that is they had completed the 10+2+3 system of schooling. The spouses of the participants (male and female) also had a similar range of education with a mean of 13.95 years (*SD*=2.66 years). Thus none of the target children in the study were first-generation learners. Further, families subscribed to an average of 3.21 newspapers and magazines (*SD*=2.28 newspapers). These were not always English-language publications.

The occupational status of parents varied. All the male participants were employed outside the home in various private industries and government employment. Of the female interviewees, only three were exclusively full-time homemakers. Four women were employed at home in giving private tuitions (private educational tutoring), and one woman served as a substitute teacher in a neighbouring school when her services were required.

Socio-Economic Description

It has been noted that a direct question about income to research participants in India may not provide reliable information (e.g., Gupta, 2005) as people may either over-estimate or under-estimate their income. One approach that has been proposed is to assess other indicators of wealth such as aspects related to housing and tangible assets. This approach is embodied in work by Tiwari, Kumar and Kumar (2005). They created seven profiles or indicators. The first one assessed people's physical housing including type of walls and flooring. The second profile was developed based on household gadgets and conveyance facilities. Three profiles assessed socio-economic status based on education, occupation and actual reported per capita income. The last two used more social style indicators like understanding of social issues and participation in social organisations.

The approach to assess socio-economic status using asset ownership has also been used in conducting the Census of India (2007).

To obtain a rough idea of the socio-economic background of my sample, I had included various questions about family housing and assets. The average number of rooms in the family home was 3.39 rooms (*SD*=1.36 rooms). However, the average covers up for the large range: There was one family of four people living in a one-room house while the large joint family of 13 members inhabited a seven-room house.

In terms of assets, all respondents reported whether they owned a television, radio, VCR, DVD player, walkman, iPod, CDman, computer, microwave and convectional oven. I simply generated an index of family assets by summing up the number of such assets. Family asset ownership ranged from 1 to 11 such items with a mean of 6 assets (*SD*=3.09 items). Among the larger families, it was common to find more than one television.

As part of my post-interview notes I also noted the type of flooring in the homes of the interviewees. As building standards improve in Bombay, people tend to engage in home improvements. One such improvement is to upgrade flooring. The top-of-the-line apartments or flats in Bombay often advertise marbonite flooring. This is an innovation that is about 10 years old. Marble flooring is another expensive improvement. At the low end of the scale is simple cement flooring. Looking over these notes, it was obvious that family asset ownership 'correlated' well with my observations of family flooring. This was very evident when I found myself visiting two parents who were next-door neighbours after an interval of a month. Neither family knew I was visiting the other household. Their housing society appeared to be about 30 or 40 years old. The first flat belonged to a parent who worked in a well-paid position for an airline. It had marbonite flooring. The next-door flat belonged to a family whose sole earner worked in a technical position in industry. The flooring in the home appeared to be a cheaper, older type that was commonly used in the 1950s and 1960s.

A further indication of family socio-economic status was whether they used the public distribution system (PDS) via the Ration card. The PDS had been established in the early years after India obtained independence to ensure equitable distribution of

essential food grains such as rice, wheat and sugar as well as kerosene (a domestic cooking fuel). In the recent years, its scope has been heavily restricted to people who live below the poverty level (Johnson, 2003). It is still important however to obtain a card as a proof of identity. It could be viewed as parallel to a state-issued driver's licence in the U.S. For instance, Uttara's interview was postponed once because she had received an appointment at the local PDS office to alter her home address. She reported that she needed to prioritise this because having clear paperwork was essential to her son's future admission to college.

The original interview schedule did not include questions about the ration card. This was added later on. I was able to ask 11 out of the 19 interviewees about their use of the PDS system either through the interview or through follow-up telephone calls. They all reported having a ration card but were ineligible to purchase ration supplies because of their current income level. This included the four-member family who lived in the single-room house and reported only one household asset--an old black-and-white television. Many parents spontaneously reported that they had used the card in the past to obtain food grains such as sugar and rice. As the rationing system is now only open to those families who live below the poverty line, I treated this as another indicator of the socio-economic status of the families.

Thus it was evident from all these indicators of socio-economic status that none of my target children fell below the poverty line. However, there were some families that were more economically advantaged than others. Families also differed somewhat in their educational and cultural resources (see Table I.2 in Appendix I for a descriptive profile of all the 19 participants).

Chapter 3

Parental Theories of Health: Some Direct Answers

My first research question focused on the content of lay theories held by Indian parents vis-à-vis the health of their adolescent children. I approached this topic in two different ways. In this chapter, I will focus primarily on analysing responses to specific questions that I asked during the interviews. These questions were inspired directly by previous research studies in this field with other populations. I will describe the responses I elicited and attempt to place them against the results of these earlier studies. Lewins and Silver (2007) calls this question-level coding. The coding is inductive in the limited sense that it does not use an a priori coding system from these previous research projects.

In Chapters 4 and 5, I will discuss specifically the inductively-derived recurrent themes that appear to be unique to my study and my participants: food, friends, mass media and education. My other research questions relate to the effects of religion, gender and experience of illness in the past and present. I will discuss them in Chapter 6. Throughout this chapter, however, I will present cross-tabulations for religion and gender and discuss them where relevant. I will also present prototypical statements to explain the categorisation of the responses. Each quotation carries the pseudonym of the interviewee.

The question-level analysis I report in this chapter concern:

- Parents' self-reports on family history of illness
- Parents' self-ratings of health
- Parents' self-ratings of mental health
- Parents' estimates of the health of their adolescent child
- Parents' estimates of the mental health of their adolescent child
- Parents' reports of factors to maintain health
- Parents' reports of factors to maintain mental health
- Parents' assessments of risks to health of adolescent children

- Parental Health Locus of Control Scale

One approach I deliberately did not use was to ask the direct question, "What is health?" My previous research experiences with Indian adults demonstrated that this is too abstract a concept for them to describe and often produces discomfort (unpublished data).

Parents' Self-Reports on Family History of Illness

This was a relatively healthy sample. None of the 19 parents interviewed smoked cigarettes. Six of them occasionally consumed alcoholic beverages. This included two Hindu fathers. None of the Hindu mothers drank alcohol.

One Christian mother, Zena, reported currently living with diabetes and nine other parents reporting a family history of the same (see Table J.1 in Appendix J). It was not surprising to see so many families with diabetes given the high incidence of diabetes in the Indian population (Mohan et al., 2008; Ramachandran, Snehalatha, & Vijay, 2004).

Eight parents each reported family members who had suffered heart conditions and blood pressure. This included one Hindu mother, Varsha, who had suffered a minor heart attack some years before. She also reported that her husband had been under psychiatric treatment for depression and often disrupted the household with his erratic behaviour.

Cancer was an issue for four families. Carolina's husband was suffering from cancer while Nikita (another Christian mother) revealed that not only did her family display a very strong history of cancer but also her husband had expired within a year of their marriage because of the same.

One mother had extensive care-taking responsibility for an aging mother. Other problems mentioned included neonatal jaundice, tonsillitis, epilepsy, tuberculosis and respiratory conditions like asthma and bronchitis.

In general, parents were quite candid about reporting family illness, especially when it exhibited a dominant influence on family health:

> I: What are some of the major health problems that your family has experienced?
> R: Major thing is… blood pressure, heart attacks… These are two major concerns.

I: So who all have had heart attacks in the family?
R: Dad has got. Mum has got a quite a…
I: Heart condition or heart attack?
R: Heart attack, my Dad has got... He had a mild attack… [H]is brother also died recently of a heart attack. He was shocked. Then I think… my Mum's parents and my Dad's parents also have. At least… my grand-fathers have died of heart... And then… cousin of mine also… died of a heart attack… My Mom's youngest brother died just last year.
(Floyd)

But there were some conditions that were only revealed after much probing and when time had elapsed in the interview. For instance, two mothers, Mayuri and Zena, revealed that a close family member had suffered from tuberculosis only after several "Anything else?" prompts. This might be related to stigma surrounding this illness because other research studies have also shown that Indians tend to conceal tuberculosis (e.g., Nair, George, & Chacko, 1997). That tuberculosis is still dreaded was apparent when Zena said that her husband wanted her father (the TB patient) to leave the family home – even though her father was the owner of the house!

Parents' Self ratings of Health

Asking people to rate their own health is a common strategy used in lay theory research. It has been demonstrated in multiple studies that an individual's self-rating of health is a good predictor of mortality (Benyamini & Idler, 1999; Idler & Benyamini, 1997). In order to elicit lay understanding of health status, some researchers have then gone on to ask people to explain how they arrived at their estimates of their health (e.g., Williams, 1983). While discussing the accuracy of self-rated health as a predictor of mortality, Idler et al. speculated that this may derive from the possibility that it encompasses the individual's awareness of the full range of illnesses that she/he is currently suffering from, or might suffer in future. It may also reflect family history. Further, this measure may reflect the individual's view of both his/her current and future health trajectory, as well as the individual's awareness of the availability or paucity of resources to improve health. In sum, the simple question, 'Would you say that your health is Excellent, Very Good, Good, Fair or Poor?' could generate many different lines of thought.

The 19 parents I interviewed reported relatively good health on this five-point scale ranging from 1 (*Excellent*) through 3 (*Good*) to 5 (*Poor*). Their average self-rating on this measure was 2.68 (*SD*=.89); that is they thought their health ranged from *Good* to *Very good*.

This perception of enjoying good health was not surprising given that this was a healthy sample that was recruited from the community through the school system. As seen in the previous section, with the exception of one mother who had diabetes and another who had a long-standing heart condition, everyone else was relatively healthy at the time of the interview.

Parents, after rating their own health, had to explain why they had assigned themselves that particular rating. (Three Hindu mothers were not asked these questions because of lack of time in the interview.) This generated a list of 'signs' for health and ill-health (see Tables J.2 and J.3 in Appendix J).

The presence or absence of illness was a major marker of whether parents saw themselves as healthy or not. Nine parents who reported being troubled frequently by minor ailments cited this as a reason for saying they did not enjoy excellent or very good health, and four parents who had no major illness said they felt healthy. One mother explained being healthy as the ability to persevere with work even when sick.

Two parents reported good food habits as an indication of good health. Notably, it was fathers who spoke of physical fitness, weight and body musculature. Thus, it appeared that fathers were more concerned about personal fitness than mothers.

Parents also appeared to censor their self-ratings in the direction of being less positive or appeared to be conscious of giving a high rating. This did not appear to be caused by a sense of being unhealthy. Rather, it was an unwillingness (that may be cultural in nature) to use superlative terms.

> R: I can't say Excellent but it is... Very good I can say.
> I: Why would you choose Very good and not Excellent?
> R: (Laughs) Because... generally people are, you know, like what? (Asks her daughter for a proper translation for a Gujrati term.)
> Daughter: They are vain. They say, "You are proud and then you become vain." She doesn't want to get there.

(Mayuri)

I: OK. Why do you say Uttara that your own health is excellent?
R: Excellent. (Laughs in an embarrassed manner) I have to praise myself now. (Uttara)

There are two possible explanations for this unwillingness to rate health as *Excellent.* One is the finding from social psychology that individuals from Eastern cultures are less likely to engage in self-enhancement – that is to maintain a persistently positive image of the self (Kitayama, Markus, Matsumoto, & Norasakkunkit, 1997). Health could be one such area as we see from Mayuri's unwillingness to be perceived as vain. The other is the possible superstition that claiming excellent health might invoke poor health or the evil eye.

Except for the two respondents who spoke of good eating habits and the three fathers who emphasised physical fitness, all these parental notions of their own health could be termed as negative ones.

The extent to which parents based their assessment on past and present illnesses bore out the suggestions by Idler et al. (1997). Further, the discussion of food-related habits indicates that food is one resource that parents have at their disposal to maintain their good health. However, none of the parents discussed the broader health system and its facilities.

Only Uttara defined her health in functional terms, that is, she described being able to complete her daily activities. This was different from the functional descriptions of health that have been observed in other studies such as one by Evans and Lambert (1997) with sex workers in Calcutta, an East-coast city in India and by Calnan (1987) with British women of professional and lower class backgrounds. Calnan found that functional definitions of health abound in lower class women. The sex workers in the Indian study were certainly lower-class. My sample was largely middle-class. This may explain why they responded differently. In addition, given that this was a middle-aged group of adults who were relatively healthy, it was not surprising that they failed to mention presence or absence of disability as a dimension of health status. This dimension does permeate self-ratings of health by much older adults (Williams, 1983).

Parents' Self-ratings of Mental Health

I asked parents to apply the same five-point scale ranging from 1 (*Excellent*) through 3 (*Good*) to 5 (*Poor*) specifically to their mental health and to explain their reasons for their ratings (I could not ask this question of three Hindu mothers because of lack of time). Here the average self-rating was 1.95 (*SD*=.85). Once again this was a high self-estimate which was closer to *Very good* than *Good*.

When citing reasons for their self-ratings here (see Tables J.4 and J.5 in Appendix J), parents did not emphasise the presence or absence of mental illness. Rather they emphasised the presence or absence of stress and worry. Further, the ability to handle one's tasks and responsibilities successfully distinguished a mentally healthy adult from an unhealthy person for parents like Isabella and Puneet. On the positive side, parents described their personal abilities of reasoning out, evaluating their behaviour and maintaining balance in life. On the negative side, one mother described mental confusion.

Two mothers who had very difficult home situations reported extreme levels of stress. Varsha, the Hindu mother who lived with a mentally depressed spouse reported occasional suicidal feelings. The other, Bhavana, was a divorced woman who was raising two teenage daughters in her father's home where she was constantly troubled by her father and other relatives. She kept repeating that she was mentally tired.

One father, Lakshman, cited a chess grandmaster as an example of an individual with excellent mental health. He further went on to state that such an individual would also possess an excellent memory. This would appear to put good mental health beyond the reach of most people. He also reported knowing someone with a mental illness at work. This individual had to take medication to induce sleep.

As with physical health, parents here did not emphasise the functional aspect of mental health. Instead they focused on their intellectual abilities and their ability to manage stress. Overall, there appeared to be less consensus among the interviewees on this question than the one pertaining to recognition of physical health.

What is striking among these descriptions of how parents recognise mental health is that they use psychological language. This is not a uniform feature across the Indian

population. For instance, a community-based survey in the same geographical area as my study found that adults described mental health of children in psychological terms such as stress and tension (Mane & Vaz, 1993). But women in Goa--an Indian state on the West coast with relatively good health indicators--tend to use somatic language to describe their complaints when presenting initially at health centres with mental problems, and they develop a more psychological model as treatment progresses (Patel, Pereira, & Mann, 1998). The samples in both studies were not highly educated. But the former was conducted in the city of Bombay whereas the latter was in a state that is more rural in composition. Another possible explanation for the difference in their results could be that the Mane et al. study was a community assessment by a child guidance centre in a geographical locality where they were conducting awareness activities. Thus, the adult members of this community might have had a chance to acquire a psychological model of mental problems just as the female patients did in Goa through contact with mental health professionals. Participants in my study spoke of learning about these issues from media such as the newspaper or through health professionals.

Worry and stress have also been associated by people living in Bombay with other health problems such as tuberculosis (Nair et al., 1997). It could be a core element in the perception of other physical conditions as well.

In general, parents' understanding of mental health was less clear and distinct than that related to physical health. When asked the follow-up question to the self-rating: "Do you know the names of any mental health problems?" most were unable to recall any. This could have been because parents might have been confused by the wording of the question. Three parents were able to mention depression.

> See depression is the most nowadays, you know… And depression also is… of many kinds. Suppose if we go to see, there are different reasons… Child is tensed, always tensed … due to some reason. That is also one kind of mental health problem because that tension affects the health both ways, mentally as well as physically.
> (Mayuri)

One parent mentioned schizophrenia citing the case of a well-known Indian film star who was then in the news on account of a custody battle over his adult sibling who

suffered from that illness. One mother mentioned the possibility of children being sexually abused by school teachers.

Other parents stated that they did not know any names of particular mental illnesses, or they gave general terms like emotional pressure and instability. Carolina recalled an uncle who 'spoke rubbish.' Cesar narrated a lengthy story of how he had to hospitalise his mother in a special in-care facility when she began behaving in a strange manner. Even he was unable to put a label on his mother's condition calling it '*shak*' or suspicion. Bhavana, in response to this question, stated the term 'psychic.'

Parents' Estimates of the Health of their Adolescent Child

With regard to health of children, parents reported conditions such as neonatal illness (2), epilepsy (1), fracture (1), migraines (1), bronchitis (1) and anaemia (2). Some of these conditions were current and some dated back to when the target children were much younger. Except for Carolina's son who suffered from bronchitis, none of these illnesses caused the child to lose more than a day or two at school.

When asked whether their children were physically healthy in comparison to other children of a similar age, 14 parents answered affirmatively, 3 parents answered negatively and 2 parents said that their children were neither healthy nor unhealthy.

Here too, I requested parents to explain to me the reasons for stating that their children were healthy or unhealthy. As Tables J.6 and J.7 show there was some similarity between how parents viewed their own health and how they view their children's health. The presence or absence of illnesses, especially minor ones was a primary reason for labelling children as healthy or not for half the parents. The absence of major illnesses in this sample appeared also to reduce the salience of health-related thoughts for some parents.

> Actually Camren has no problem as such so far as health is concerned. So actually I have not given it a… thought.
> (Floyd)

Interestingly, three mothers were inclined to view their children as being relatively unhealthy in the light of ill-health they experienced at the time of birth. This

bears out what Idler et al. (1997) stated about the full range of illness contributing to evaluation of health status.

Good or nutritious food habits were viewed as a “make-or-break” factor by nine parents, that is, they were present in healthy children and absent in those who were not. This includes lack of fussiness in eating.

> He comes… home… he eats his food and all. He doesn’t make fuss. (Isabella)

Apart from this, five parents spoke of physical growth appropriate to the age of the child. This extended beyond just height and weight to expected pubertal changes:

> Because I have seen girls. Means first of all, there are many pro[blems]. This will start now. At this age… periods and all this stuff. So basically on that we have to be very careful that it is coming, what age it is coming. Sometimes it gets delayed. So that way I feel she is okay. Everything is fine. It has come at the right age. (Manjusha)

Moreover, physically healthy children not only manage their responsibilities such as education with its attendant stress but also are capable of going beyond it. They also enjoy good social interactions. Children who are physically ill, by contrast, are weak and sometimes over-weight. This may leave them unable to withstand extreme weather conditions and fall ill easily. Some parents also reported that their own responsiveness in parenting was a major ‘sign’ of children being healthy. This could be viewed as consistent with Idler et al.’s (1997) notion of awareness of health resources available to the child. The same concept could also be stretched to encompass Cesar’s notion of other children being healthier than his son because he is unable to afford the best educational resources.

Compared with their own self-assessment, parents’ notions of the health of adolescent children were slightly more functional in nature. They spoke, for instance, of the ability to undertake school-work successfully and the ability to grasp studies.

Further, parents also generated many more ‘signs’ for recognising states of being healthy/unhealthy in children (average of 4.11 reasons) compared with such signs related to themselves (average of 1.44 reasons). This has been observed in other comparisons of

parent and child health (J. D. Campbell, 1975). The suggested reason for this difference was the individual's motive to preserve and protect the self from threats such as evaluations of illnesses that might negatively affect the individual's well-being. Another possible reason in this cultural context is that Indians are socialised to think less of themselves and more about others given that this is a collectivist culture.

Parents' Estimates of the Mental Health of their Adolescent Child

With regard to mental health, fourteen parents felt their children were healthy and one parent felt that their child was not so. Three parents opined that their children fell in between.

They struggled to give voice to the reasons underpinning their ratings of their child's mental health (see Tables J.8 and J.9 in Appendix J). They appeared to view mentally unhealthy children as showing abnormal behaviours and depressed or disturbed reactions. Some of these behaviours manifest suddenly as a change in responsiveness and obedience. Another signal to parents was when school-work was affected by the child not wanting to attend or showing poor concentration.

In contrast, mentally healthy children were seen as possessing positive traits such as 'happy,' 'confident' and 'open.' They are able to successfully manage stress and handle responsibility such as school-work. Some parents spoke of 'maturity' but did not describe what that meant. As was the case with physical health, a couple of parents felt that their own responsive nature and availability for their children was a "sign" of their children being healthy.

In the area of mental health as well, parents' descriptions of their children's health were more rich and varied than those of their own health status. They gave more reasons justifying their assessment of their children's mental health/ill-health than they gave for their own (average of 3.06 and 1.75 reasons respectively). While one parent had said that he knew he was mentally healthy because he did not receive any social feedback to the contrary, parents as observers themselves were clearly able to identify many instances of behaviours that they considered to be unhealthy. They were not, however, always explicit about what they meant.

During the process of interviewing, as well as while analysing, I wondered whether parents were labelling as mentally undesirable those behavioural changes that accompany adolescent development. For instance, under the category of 'wrong priorities,' one mother spoke of boy-girl attractions. Among the 'abnormal behaviours' described by parents is Varsha's worry that her son is "getting very sharp in speaking." I tried as much as possible to avoid introducing to the participants these hypotheses that jumped to my mind. However, during one particular interview, the pressure to raise this issue was overwhelming:

> I: Bhavana, both Jahnavi and Hansa are in the teenage ages... And this is when a lot of teenagers rebel against their parents. Do you think that some of Jahnavi's behaviour can be explained as a teenager rebelling against her parent?
> R: I don't … believe in teenage… What is teenage? Everybody is telling, "Teenage, teenage." What is teenage? *Arrey!* Even I was a teenager. Everybody has teenage. So what? That means you have to do whatever you want? It is not like that.
> (Bhavana)

Another mother raised the same issue without any prompting:

> This is an age wherein they don't know… means in between maturity and in between innocence, that is this age. So they don't know how to behave. They still… continue to behave like small childrens (sic.) sometimes. Or they... try to be mature, over-cautious. So maybe they behave something differently only in this particular age.
> (Manjusha)

While Bhavana dismissed the notion of teenage behaviours, and Manjusha offered it as a possible explanation, the question still remains unanswered because some of the descriptions given by parents could go either way. For instance, Namrata's "getting angry frequently, fighting constantly" could have a more innocuous explanation than being mentally unhealthy.

However, this uncertainty about what constitutes normal behaviour for a child may also be linked with the deeper existential issue raised by Indian social scientists about adolescence in Indian folk psychology (Jayaram, 2000; Saraswathi, 1999). It is viewed as more or less absent in rural areas where children are expected to enter the

workforce earlier than in the city. Beliefs about adolescence among urban Indians may be a more deliberately acquired modern conceptualisation. Zena, for instance, in another section of the interview describes a conversation with her physician where he expounded on how hormonal changes are likely to affect her daughter's behaviour.

> But sometimes she does get very low. She gets very depressed. She gets very upset. But then I leave her to herself. I don't this. And one of the doctors where I go, he told me that they have lot of mood swings especially when they are getting their periods. Either 15 days before that or 15 days after that. So that I have learnt… He's got a girl. So he's turning to me, "Zena, I've gone [through this] So I know what it is. So you… have to just be cool. You should just turn this." So I leave it to them. And now growing age… You say anything, they don't like. They do… they… She has a lot of mood swings. Especially at this time, she gets angry very fast. So she keeps quiet.
> (Zena)

This calls to mind once again the suggestion that Indians tend to acquire a more psychological theory of mental health through interaction with formal, Western systems of medical care (Patel et al., 1998). The same explanation might hold true for Indian parents' views about adolescence.

Another possible reason for this lack of clarity is offered by cross-cultural research by Rose, Dalakasb, and Kropp (2002). In a study across five countries, they found that Indian parents in cities report a later developmental timetable than their counterparts in Western countries such as the U.S. and Australia. Thus, teenage children in India may experience developmental changes similar to their counterparts in other countries but these are not recognised as such by their parents.

These two studies may appear to be contradictory. However, a prolonged childhood with its accompanying delayed adolescence in city children does not have to contradict a missing adolescence in rural individuals. Parents in both contexts may be influenced by a sense of children progressing from childhood to adult life. But in Indian cities where children are expected to take the path of education to success, they are absolved of adult responsibilities until much later, and, given that city parents are just a couple of generations removed from rural life, they might also mentally defer the possibility of adolescence. It should be recalled that the measuring stick in the Rose et al. study was the developmental timetable as it has evolved in the West.

Parents' Reports of Factors to Maintain Health

What Parents do for Children

In order to understand what parents think is critical for the health of adolescent children, I asked them what they as fathers and mothers respectively do to maintain the health of the child, what their spouse does and what the child does himself/herself. It was apparent that there was a lot of overlap in their answers to these questions. So I analysed the answers to these questions together to distill the factors that parents consider important to the health of the target child (see Table J.10 in Appendix J).

The key factor contributing to health in a teenage child, as reported by all parents, was food. As this aspect of health surfaced repeatedly, it was apparent right at the beginning that it was a major theme in the research. As such, I will discuss it in detail in Chapter 4. Here I will just note that parents, both fathers and mothers, spoke at length of the need for a balanced, nutritious diet as well as the need to encourage children to eat home-cooked food.

Both fathers and mothers spoke of the need for play and exercise. Some children were involved in sports and games. Those who lived within reach of the school such as Isabella's son and Jeannie's daughter went to the school grounds to play during their free time.

In particular, I must mention the case of Bhavana's daughter. The girl had to travel some 45 minutes to a suburb for hockey practice (Bhavana lives in the city). On my first visit to her home, I was present when her daughter returned home in hockey gear. I was particularly struck by the contrast between the girl's clothing and the neighbourhood. Bhavana's home is situated on the edge of a busy market area in a lower-class neighbourhood which once housed mostly mill workers. Even though this is a big city, in such communities, people tend to watch the movements of other individuals. For instance, when I entered the building the first time, I was actually stopped and asked to state my purpose by a neighbour who I could only characterise as nosey. Further, a person dressed in an unusual manner would invite both notice and comment among the shopkeepers and other people in the locality. This would include a young school girl in sports uniform such as shorts, shirt and long socks (Notes on Bhavana interview).

But not all parents displayed such support for sports. There were parents who reported the need to balance or in some cases curtail it in favour of paying more attention to studies. Often these activities get edged out because of the busy schedule of the child.

> Even he should give time… for music or TV or playing. But at the same time… he should give sufficient time for his studies.
> (Chandan)

> He likes to do cycling and all that. Now we've brought the cycle up and kept it because his studies… get… disturbed, no? So it's lying on top now. He doesn't have the time basically.
> (Floyd)

Nikita reported withdrawing her daughter from basketball because the school did not have proper changing rooms and her daughter sometimes had to sit in class in wet clothing. In this instance, the withdrawal from the sports activity was motivated by health reasons.

Among other factors that contribute to health in children are compelling them to get sufficient rest, and to maintain personal hygiene such as washing their hands before eating. Parents appeared to be guided by past experience with their children in ensuring certain specific practices were undertaken diligently. For instance, Cesar had noted that his son perspired profusely around the head, and would insist that he dry his head thoroughly. Kishori was particular about her son's acidity issue. Mayuri was happy that her daughter had learned to gargle with salt water for a sore throat. In the same vein, three parents felt that it was important to treat small ailments to prevent them from worsening into bigger issues. For the same reason, some parents sought medical assistance whenever the child fell ill.

It was not surprising to note that few Indian parents place an absolute value on play-related exercises. A comparative study between Indian parents of pre-schoolers with parents born in the U.S. showed that the former attached less significance to play as a necessary developmental activity (Parmar et al., 2004). Indian parents may deem other aspects more significant.

What Parents do for Themselves

With regard to maintaining their own health, parents emphasised the same issues of food, exercise and rest (see Table J.11 in Appendix J). They spoke of using medications for specific problems such as headaches. However, six parents reported that they did not do anything particular to maintain their current health status. Four parents reported that they did not have the luxury of time to undertake specific things to maintain their health. Two mothers even reported that for lack of time, they consistently missed meals.

> R: I am having food only for one time, afternoon time (laugh).
> I: *Accha.* You don't have dinner?
> R: No. I don't take because my job… is that I have to sit here at 7:30 till 12:30, then 2 o'clock till 8:30.
> (Uttara)

In the previous quotation, the lack of time was also implicated in the inability to exercise consistently. In fact for some parents exercise was an ideal that was impractical given their life circumstances or the circumstances of their child.

> But there is no time. Yeah. It is okay. In the magazine, we also read… we should do yoga everyday, we should sit for ten minutes for concentration… But practically it is very difficult to give time to all these… things, no? Now he doesn't have time because three hours he goes for tuition, then six hours to the school, lunch and breakfast at least one hour. Then there's no time to go for all these things. Practically it is very difficult… Early morning we should take… warm water. Then we should take… juice. After some time we should go for fruits. See all this… In the magazine it's okay for your diet and for your sleep and for your relaxation… But practically for a child … even for me also it is very difficult to follow all these things strictly.
> (Chandan)

> Exercise is a dead-end duty
> (Varsha)

Parents' Reports of Factors to Maintain Mental Health

What Parents do for Children

Parallel to what parents do to maintain physical or general health of children, I asked them to report what they did in particular to maintain mental health of the child,

what their spouse did and what the child did for the same (see Table J.12 in Appendix J). In this area as well, parents saw the need for the child to have good food and to get proper sleep and rest. Lakshman, in particular, spoke of almonds as a particular food item that improves mental health, namely it is a type of 'brain' food.

Additionally, they mentioned recreational activities and communicating better with the child. Recreation could take the form of television entertainment or a family outing or play activities. However, some parents again cautioned the need to balance these recreational activities with sufficient time for studies.

> So sometimes I tell her, unlike other mothers, "Surotama, now it's okay. Don't study. Now you... recreate yourself like watch TV."
> (Mayuri)

> Go out together… maybe some shopping or... just to go out have some snack,
> (Floyd)

> So she tries to… have a recreation like… chatting with her friends,... going to... movies after exams, ... then play computer games.
> (Ravi)

Seven parents spoke about improved communication with their kids. Some emphasised an attitude of openness on the part of parents.

> Normally girls are scared, afraid of their fathers. OK. Suppose… they want permission, they won't ask. They… won't be able to speak. They will tell mothers, 'Mummy, please you…' But in my family it's not like that. They are never afraid... of their father. He is so friendly. So without hesitation they can ask anything, or they can take permission.
> (Mayuri)

For some parents, it was important to improve their child's awareness.

> She knows everything. Everything is clear to her. And that way I try to make her alert.
> (Mayuri)

For a couple of parents, communication with children was a way to motivate or inspire them to a higher purpose or independent behaviour.

R: I will… make her listen to religious hymns, teachings, inspirational stories of heroes, warriors, and serials we do watch together.
I: OK... Can you give me the name of some inspirational hero that you … often quote to her?
R: … One is Shivaji (a famous king).
I: What about Shivaji did you like that you tell her that she must emulate?
R: ... One thing what he did is… he rose from the humble beginnings and established himself, made his own identity, gave protection to the entire society… He had respect for the women folk … He went on to establish the empire, fight the Mughals as well as Britishers.
(Ravi)

Two mothers spoke of consulting with a counsellor if required. Surprisingly, one mother, Sara, advocated that the child study as this would increase her general knowledge and awareness. She equated this with mental health. This echoes what Lakshman, the Hindu father, mentioned about a chess player being a mentally healthy individual. It is possible this is a type of functional definition of mental health, though these parents might be mixing cause and effect.

With regard to children's emotions, some parents felt that they should leave children alone when they are mentally upset. Others stated that they would teach their children to regulate these disturbing feelings, in particular anger.

Some parents felt it was important to keep a close watch on the activities of their children. They used open communication to check in frequently with the child. On the other hand, a couple of parents sought to alter or control the environment of the child. For instance, one mother Mayuri spoke of the pressures that come from living in a joint family and speaking to other family members to change the environment if she thought that would help the child feel better.

What Parents do for Themselves

Parental activities to maintain their own mental health mirrored what they would do for their children such as food and rest (see Table J.13 in Appendix J). Recreational activities were high on the list of priorities. Such activities as watching television served to distract the parent from the pressing concerns in their life. Three parents also reported a similar reason for undertaking meditation or spending time alone. One mother spoke of escaping her intolerable home environment by taking a walk to the local market (Varsha).

Parents also mentioned using strategies to manage their emotions and their worry. Three parents reported doing nothing at all.

Religious activity was a new idea mentioned here that was not present in parents' narratives about children's health. Parents spoke of the mental peace associated with religious practices--an idea that has been observed in other studies (e.g., Yeager et al, 2006)

> I do visit temples. I... listen to religious hymns, *mantras* (sacred Hindu chants). (Ravi)

> I: How does prayer help you to protect your mental health?
> R: Prayer helps me because I just lift my problems up.
> (Jeannie)

> I try to spend little more time maybe in the chapel there.
> (Floyd)

When looking across what parents mention as being necessary to maintain mental and physical health for adults and children, the common ideas are food, exercise, rest, and recreation. Another theme that appears bound up with these factors is children's school-related activities as either something that limits the extent to which they can adopt some of these measures or as something that helps the child.

Parents' Assessments of Risks to Health of Adolescent Children

A major strand of lay theory research in health and illness focuses on whether ordinary individuals see various health concerns as personally affecting them. From a pragmatic standpoint, researchers have been interested in this aspect of lay theory research because it relates to whether individuals will seek help, and having sought it, whether they will follow the prescribed treatment consistently (Calnan, 1987; Davison, Smith, & Frankel, 1991). I elicited risk perceptions of my parents in two ways.

Free Listing of Risks

First, I asked parents what they thought were the biggest issues facing adolescents between the ages of 13 and 15, especially with regard to health. The free-listing produced a long list of conditions that concern modern-day Indian parents (see Table J.14 in

Appendix J). Chief among them are very pressing concerns that parents have about unhealthy food, and, related to it, obesity. Parents also expressed deep concern about their children's friends, about television-viewing and about attraction in the teenage child to persons of the opposite sex. All of these were linked to the development of bad habits or addictions that might distract the young person from his chief goal in life, namely education. These issues appeared to be significant not just because parents said so, but also because they recurred throughout the interview. Hence, I explore them separately in subsequent chapters.

Parents also mentioned being concerned about pressures related to school, sexual abuse, lack of exercise, and negative moods and behaviours. Two parents mentioned issues related to being a girl, though one father mistakenly called it 'monopause.' Coughs and colds were associated with poor weather and with living in a polluted city like Bombay.

> Common problem they will have… in Mumbai… is cough and cold… These are the normal problems.
> (Mayuri)

Two mothers, Varsha and Zena, worried that adolescence meant increased distance between parent and child, that the latter would stop being open and sharing their inner thoughts.

Rating Risks from Known Causes of Mortality and Morbidity

The second way I studied risk assessment was through the participants' responses to a list of conditions from the Global Burden of Disease (World Health Organization, 2002) that cause mortality and illness in adolescents and a situational analysis by the United Nations Fund for Population Activity (UNFPA, 2003). While the Global Burden of Disease lists conditions for the entire South-East Asian region of which India accounts for a large population segment, the UNFPA study focused specifically on India. I asked parents to report on a scale ranged from 1(*No worry at all*) to 5 (*A great deal of worry*), how much they worry about these problems in relation to their adolescent child's health. The mean rating for each condition is presented in Table J.15 (see Appendix J).

Interviewees reported worrying most about accidents on roads and in schools and working places (*M*=4.11, *SD*=1.04). The least amount of worry was caused respectively by maternal conditions due to early marriage and childbirth (*M*=2.67, *SD*=2), and by sexually transmitted diseases like syphilis and gonorrhoea (*M*=2.84, *SD*=2.01). The item related to maternal conditions was relevant only to the nine parents who were interviewed about their teenage daughters.

When parents thought of road accidents, the increased road traffic in Bombay was quick to come to mind. Further, accidents were not perceived as something which they could control or prevent. So this appeared to cause them increased concern. Parents' perception appears to match official reports of an increase in road-related fatalities and injuries (Mohan, 2006).

> I: You said 5. You were very quick with that
> R: Yeah. Because road accidents now… The traffic is nowadays very… dangerous. It's increasing… In Mumbai also, that traffic sense is not there.
> (Chandan)

> We can [grapple] with all the rest. But with accidents... problems increase, disturbance increases… The rest of the things we can attend to.… That item we cannot attend to.
> (Lakshman)

Parents also appeared to be worried about road accidents because they were not an occurrence that could be foreseen and prevented. We see this somewhat in the previous quotation by Lakshman and in the following one by Manjusha.

> It is a part of fate I feel. But one which is… under our control is iron deficiency… If you drink less water, then all those body *ka* systems will stop… Yeah. Other risks are definitely there [w]hich … is not under our control… One… is this accidental (sic.) and all those things. Whenever they go out, you cannot predict anything.
> (Manjusha)

Parents were more likely to see a higher risk from the health conditions presented in the list if they had experienced family history of these conditions, or if the child had displayed vulnerability in that area before.

(Speaking of heart conditions) It's a great worry actually because we have got a family history (Laughs) of… hypertension and… heart problems.
(Floyd)

I: Undernutrition which means inadequate food and anaemia which means iron deficiencies in the blood.
R: I'll say 2 because she … has a tendency to have an iron deficiency from birth.
(Nikita)

Le Cordon Sanitaire-type Thinking in Parents' Risk Assessments

Parents tended to view many of the conditions on the list derived from the Global Burden of Disease as not risky or worrisome. They saw these as more likely to affect college students. School was perceived as a relatively safe place.

It is in between - Three number because I cannot say absolutely I don't worry. Now she is eating because I am forcing upon her… After colleges or something… they change. Then it will be worry for me.
(Manjusha)

I: Using drugs like brown sugar and *charas*. How much would you worry?
R: Just now 'Absolutely no worry' because they have not been exposed to it and they have not come to it.
I: OK. Would there be some point at which you *would* worry?
R: Probably. Depending upon her circle in the college.
(Zena)

According to these quotations parents appear to believe that school provides a kind of safe place or *cordon sanitaire* for their children. The term was coined when European colonial powers sought to create a geographical zone in the Belgian Congo that was safe from sleeping sickness (Lyons, 1985). In the AIDS era, this term made its way into public health literature related to perceived sexual risk of contracting HIV.

According to Waldby, Kippax and Crawford (1993), a *cordon sanitaire* is "an imaginary margin of safety" from the infectiousness or danger that surrounds an individual (p. 31). They discussed how young men who were sexually active protected themselves from risk of HIV infection by confining sexual activity to young women within a tight circle of friends. This gave them the confidence that they could judge the possible infectiousness of both their female sexual partner and her other male sexual

partners. The *cordon sanitaire* was perceived as being breached if someone from this network had sex with someone outside.

While the Waldby et al. study participants placed their *cordon sanitaire* around individuals, other studies have demonstrated that it could also have a geographical referent: Sites of sex work fit into the circle of safety when they give the appearance of concern for health and hygiene, and when they appear to exercise discrimination and some level of exclusivity regarding the patrons to whom they extend service (Plumridge, Chetwynd, Reed, & Gifford, 1996).

These earlier studies have observed these discourses in narratives of personal behaviour. I, however, have applied it to parental reports of their children's risk.

The purpose of the *cordon sanitaire,* according to Waldby et al., is to protect the individual from anxiety that would result if he/she actually faced up to the very real possibility of danger. But they further go on to say that such a barrier is only an imaginary one as it does not really keep the individual safe. In this study, parents reported wanting to control their children's environments in an effort to keep them safe.

For instance, Zena, in the following quotation, acknowledges the possibility of boy-girl interactions. She immediately rejoices in the fact that she was able to get her daughter into an all-girls tuition class, thus limiting the possibility of meeting boys there. But despite this, she is aware that her control is limited. (Tuition classes refer to private tutoring in addition to regular school work. I explain this in greater detail in Chapter 5.)

> R: Yeah. Like going about with the boys and the vice versa. Now they are going for classes and all. Now what goes on [there]…
> I: What classes does she go for? Which subjects? And how many hours?
> R: All. All. Now Monday, Wednesday, Friday, she goes for three hours for Maths, Science, English and all, and she goes to Mr. C. And she goes to Mr. A. … only for Hindi, Marathi. That is two hours. So there what... See that chances are very high. But to my good luck, these two classes I have got [a girls-only] section. Not that I want only girls and only boys. In a way it's good they are interacting… But at the same time risk is high because we don't know what is wrong.
> (Zena)

School for Zena provides some comfort because there is some social distance among children on the lines of social class. This isolates her daughter from children living in less healthy places like 'hutments' (slums). Later in the interview she states that such social separation may not exist in college.

> R: From our family point of view, I mean middle class family, we don't have this problem of, you know, mixing about like other low-income from the hutments when they interact, mix with people with having what you call that contagious disease, sicknesses, illnesses. I'm not saying it won't be in us. OK? But the school that she goes to and all that, chances are bleak. You never know somebody may be having some skin disease, something and all that… So at least from that point of where Zara is concerned, I think they are on the safer side… The ones who are little from a lower class. Actually the 'free' children… coming from the *ekdum* (absolutely) lower… cadre, there could be some chance. And these girls have their own group.
> I: Are there 'freeship' children in school?
> R: *Hanh*. There are many. And there many from the hutments also… But Zara will not enter that, with them... Chances are bleak at this age and this point in the school time. Now once she enters college I don't know.
> (Zena)

When discussing risk to her much younger son, she estimates this to be high because his school is opposite a college.

> Drugs in [my son's school] is bad, because [of] the college opposite, and I've heard a lot of things going on there.
> (Zena)

For some parents, negating the possibility of risk and danger elicited very strong and forceful rebuttals. Puneet, a father of a 13-year-old girl in a co-ed school, condemned the inclusion of the item "Maternal conditions due to early marriage and child birth." He persisted in this response even when I explained where I had derived the source information for the list of items, and pointed out that the most current National Family Health Survey had spoken of early marriages as a condition still affecting the health outcomes of many Indian women (International Institute for Population Sciences & ORC Macro, 2001). In this instance, he lays a *cordon sanitaire* around the whole country.

> No. I don't think because... your last question I don't want to say… Still our Indian... society, ... I never heard that in... 12 or 13-years girl, those who are going [to] schools, they are pregnant with their colleagues or their school mates. Even…

> in Mumbai, or even in Delhi, I never heard this. So this question is there… Question is correct. I'm not saying that question is not correct. But the questions... behind this... thinking is only keeping Western culture, Western not Indian… Western culture. So just keep it.
> (Puneet)

In addition to contrasting schools as safe places against college as sites where drugs and premature sex lurk, there was also a sense among some parents that cities might be safer places.

> Rural area would go in for all kinds of things… Everybody will be having all this … tobacco and… all… I think so in rural areas more of it. More than that there would be this... TB… and anaemia. I think health problems would be more, no? because of cleanliness.
> (Nikita)

Rural areas were contrasted as being dirty and lacking in hygiene. But there was less consensus on this dimension. There are no malls and theatres in villages to tempt children (Nikita). Villages are healthier in that more fresh food is available. But there is also a greater possibility of receiving more adulterated products foods (Floyd).

Gender and Religious Differences in Parents' Assessment of Risks

Are there significant differences between the ratings of fathers and mothers, and between Hindu and Christian parents? I performed t-tests to check this (see Tables J.18 and J.19 in Appendix J). I found no differences except that fathers tended to rate 'Violence outside the house such as riots and political disturbances' as a greater concern and worry than mothers $t(17)=-2.34$, $p < .05$. It was not apparent why fathers found this item more alarming than mothers. One possibility is that all 6 fathers worked outside the home whereas many of the mothers were stay-at-home parents. Even some of the mothers who worked did so in the house by offering private tuitions to children in the locality. Given this reality, fathers may be more exposed than mothers to the sometimes unpredictable political climate in Bombay city.

At first glance, it is obvious how different this list, based on the Global Burden of Disease, was from the list of risks freely generated by the parents. While parents did mention bad habits, these were not described in detail. Sexual abuse, iron deficiency and

accidents were generated through the free-listing. However, the vast majority of parents did not view them as important. This difference between parental perception and epidemiological data highlights how parents might receive health education messages focused on issues that are apparently a matter of less importance for them relative to other issues.

Parental Health Locus of Control Scale

The Parental Health Locus of Control Scale (Pachter et al., 2000) is a measure of the individual's beliefs about the relative influence exerted in the domain of health by herself/himself and by external forces such as fate and powerful others (Wallston, 2001). A person with a high score on the internal locus of control believes that he/she can do much to influence health. A person with a high score on the external locus of control is likely to believe herself/himself as being powerless with regard to personal health.

As there were only 19 participants in this study, I did not perform a factor analysis on the scale data. Instead I used the Pachter et al. factor structure (see Table J.20 in Appendix J for the Cronbach alpha figures and the means for this sample). The Cronbach alpha figures for internal consistency are close to those obtained in the Pachter et al. study.

Internal Subscale

Evidently, this was a sample that strongly believed that they could influence their child's health through their actions. They had a mean score of 2.00 on the Internal locus of control for health (*SD*=1.88), that is they were more likely to Agree strongly that they could influence their children's health. When asked they could list several health–promoting activities.

> I: I can make many choices about my child's health.
> R: Yeah. Two…
> I: Can you… give me examples of … what choices you feel you can make?
> R: Yeah. Because … [we can] see to it that they … brush teeth morning, night. You see to it that they have their bath. Very often… they are tired … Insist on going to the loo, however tired you are, before going to sleep. It's a healthier thing. Washed your feet before going to sleep, even if you have had your bath earlier. These are choices that you can make to see to their health.
> (Nikita)

External/Luck Subscale

Being high on an internal locus of control does not guarantee that a person would be low on an external locus of control (Wallston, 2001). However, in this sample, the participants were more likely to reject the influence of luck on health. Endorsing luck appeared to be on the same level as irresponsibility.

> See luck and health, they don't at all go together. Health is from what you do, what you eat. So health does not come from being lucky. In fact we can just by proper self-discipline, doing proper things, we can as far as possible avoid them from being sick
> (Manjusha)

> R: [F]irst things are all senseless.
> I: Why are they senseless?
> R: Because see… 'My child's good health comes from being lucky.' All superstitions like… the parent … does not want to become responsible.
> (Cesar)

Luck is "the belief in an extraordinary ability to bring about positive or negative outcomes… [It] is used to interpret life events in which the positive and negative outcomes are *not* the result of random fluctuations, an act of will, intelligence, or social influence" (Pepitone & Saffiotti, 1997, p. 26). In this study, even parents who had scores that were very close to Strongly disagree mentioned the possibility of luck in certain unpredictable events. We saw earlier in this chapter that accidents cause parents much more worry because they are unpredictable. These are the type of incidents that attract an attribution of luck.

> Then 'Violence outside the home like being involved in riots and political disturbances.' … As I told you... we cannot say this … It's on your luck. You can be in that Sabarmati train (referring to a train that was a flashpoint in a string of communal riots).
> (Zena)

But while Indian parents reject overall the possible influence of luck in the domain of health, they spontaneously use it in relation to other events such as opportunities available. So it was not a concept that they rejected completely. They just rejected it with regard to health.

As I said my daughter's been pretty lucky because she's... given an opportunity to rise, to shine, to get confidence... Them making her a Headgirl, and... making her plan out activities, do the whole Teacher's day thing on her own, and, you know, giving her the support.
(Nikita)

But to my good luck, these two classes I have got only-girls section.
(Zena)

I mean … luckily … I'm blessed with a daughter who's good.
(Nikita)

External/Professional Others Subscale

Parents were also less likely to wait for other people to tell them what to do. For instance they were measured about the influence of professionals such as doctors. They spoke of weighing the need for the doctor before seeking help. They also stated that they would first try to do something themselves.

I: Only the dentist can take care of my child's teeth.
R: Even my child has to take care.
(Kishori)

I: I take my child to the doctor right away if my child gets hurt.
R: Of course I would take but not right away. [S]uppose primarily … I should do something to stop the blood or something that I have to do, *na*? ... Then I will go the doctor.
(Mayuri)

I: I take my child to the doctor right away if my child gets hurt.
R: No opinion.
I: Why do you have no opinion about that?
R: Because sometimes even if they get a little hurt… we have some medicines and all. So we try [to] treat them at home only.
(Isabella)

Parents first tried to explore the extent of the injury mentioned in the trigger statement. They reported the doctor's intervention as secondary to their own efforts. However, a delay in care-seeking for illness is consistent with some other studies on adults in Indian populations. Some of these studies show that Indians try home remedies first and watch for symptom persistence before visiting a doctor (e.g., Nair et al., 1997;

Nichter, 1985). Other reasons for delaying care-seeking are reputation of the care provider, unaffordability of the service and lack of physical access (Ager & Pepper, 2005). But with very young children parents might be more prompt in going to a medical professional (de Zoysa, Bhandari, Akhtari, & Bhan, 1998).

Earlier, I reported that parents underscored the need to get small ailments checked in order to prevent it from worsening. This subscale, however, contradicts that slightly in that parents reported trying home remedies if the situation so warranted.

Just Happens Subscale

The items from the 'Just Happens' subscale may have been misinterpreted by some parents to mean that illness affects *only* children. This was noted in other studies as well (Pachter et al., 2000).

> I: Getting sick just happens to children.
> R: No. Disagree. Happens to everyone.
> (Ravi)

Child and Divine Influence Subscales

Food played a key role in helping parents to maintain control over their child's health. This was evident in all the sub-scales including the ones related to control by the child over their own health and the influence of God. God was not perceived as someone who directly influences health. Individuals had choices that they could exercise.

> R: Why blame God for illness? *Galti ho sakti hai* (Illness happens through our fault). Then only illness happens. I don't think it's because of somebody's work.
> I: When you say '*galti'* can you say what types of fault?
> R: Now like if we have too much cold stuff, we might catch cold. God does not tell you to eat cold stuff... So it's our fault. We have to protect… ourselves "What to eat? What not to eat?" We have to decide. Like that, deciding ourselves, and then blaming a second person, will not help anything.
> I: Can you give me some other instances of *galti*?
> R: Not taking medicine on time, if he has … an illness… Because it is necessary to take proper care of this, and if proper care is not taken, then injury could occur, so … it is not necessary to blame anyone.
> (Lakshman)

Evil eye or Nazar

There is some evidence that people make distinct differential attributions to fate, God, luck, chance and justice (DeRidder, Hendriks, Zani, Pepitone, & Saffiotti, 1999; Pepitone & Saffiotti, 1997). In India, many people hold beliefs about the evil eye or *nazar*. Since the Locus of Control measure did not contain any item related to this, I asked parents about this. While the sample tended to disagree with it (M=3.88, SD=1.4), parents did acknowledge that some parents do believe this. But they saw it as somewhat irrelevant in the context of living in a big city like Bombay.

> They say that evil eye and all… I think in Bombay we don't believe that much.
> (Isabella)

> Evil eye on a child. They say when the child is small... But I don't know what to believe or not. So I better put it as Three.
> (Nikita)

For Floyd, evil-eye practices were contradictory to the Christian religion.

> R:[W]e don't encourage… all these type of black bangles and… black marks
> I: *Deesht*? (Konkani word for evil eye)
> R: *Deesht.*.. My wife and myself… give… prebaptism classes to the parents who come. And then we speak very… openly… because we see all the children... We… give them our opinion about it... See basically… we ask them, "Why do you want to give them baptism?… If you have faith… in Jesus Christ… you don't have to keep faith in these type of… black marks and things like that which have got nothing inside.
> (Floyd)

But if Floyd does not believe it, there are other Christian parents like Cesar and Zena who report taking protective measures to counter the effect of the evil eye. Cesar even encourages his children to dress in simple clothing so that they do not attract envy from companions. Among the Hindu parents as well there is a division: Ravi and Puneet reject the notion of the evil eye. But Uttara related an incident where her son developed a couple of health problems after her neighbours admired him. In the absence of any other explanation, she accepted her grandmother's suggestion. While still not convinced, she adopted the practice because she saw no harm in adopting it side by side.

R: And another thing is this *nazar*… Actually I was not agreeing but … [d]ue to one incident I… agreed… Arjun was small … and he was... cute … [N]eighbours used to say, "Gorgeous child…." After that he was not well for one hour. Even after cleanliness, after taking... care from all the sides he was hospitalised. And after that... one of my grandmother[s]… told me… "This may be the reason. *Nazar utaarne ka* (Remove the evil eye)." [T]hat time I started believing it because … I suffered like anything… First tonsil operations and after that … he suffered from typhoid… Actually I was doing for his good, because there is no harm … in doing that… Because of their faith I (removed the evil eye with mustard seeds) and after that I never saw… such problems.

I: Do you… do anything for protecting his well-being now?

R: No. Now I am not doing anything. When he was four months... old, *na*? that time I used to do.

(Uttara)

The last part of her statement also highlights some differences among those parents who hold these beliefs. While Uttara worried about the evil eye only when her child was young, Cesar was quite candid about taking precautionary steps even when his children were older.

Finally I ran t-tests comparing the fathers and mothers on these Locus of Control subscales. I also compared Hindu and Christian parents. Neither gender nor religion influenced parental beliefs about control (see t-tests in Tables J.22 and J.24 in Appendix J).

Conclusion

In this chapter I specifically discussed several direct ways in which I sought to explore the folk theories of adolescent health among Indian adults vis-à-vis adolescent health. Each question elicited distinctly different answers though food appeared to be a common denominator in many of the questions.

One clear comparison could be made between free-listed health risks and ratings of health conditions that cause a significant number of deaths or illness episodes among young people as per the Global Burden of Disease. The latter contain the hard data of what actually affects health of young people. However, parents were careful to distance their children from these problems because their children were still in school where they believed the risk of exposure was non-existent. I extended the public health theory of *le*

cordon sanitaire to explain this. Parents' independent perception of danger included food, friends and possible sexual attractions. It did not require any sophisticated analysis to confirm that parents devoted much more "air-time" to their free-listed concerns than those on the Global Burden of Disease.

What does this mean for intervention? Health education programmes aimed at parents on some of these issues are likely to fall far from the mark. Parents are likely to dismiss these messages as irrelevant because of '*le cordon sanitaire.*' By contrast, parental worry is directed in other directions that are not on the radar of health professionals.

Another important aspect to note is how inarticulate parents appear to be in response to direct questions on health. While they are able to describe health problems faced by the family in the past, recognizing in an organised, articulate manner the difference between a healthy and unhealthy child is a greater challenge. In particular, we saw the "language barrier" with regard to mental health. So health professionals need to listen carefully and probe judiciously for parental concerns.

Further, I attempted to report without too much "cleaning up" the statements of parents. These quotations often included misleading English words. As the doctor-patient conversation in India often takes place between individuals whose first languages may differ greatly, this dialogue becomes even more fraught with difficulties.

Chapter 4

Lay Theories of Health Related to Food, Friends, and Media

In this chapter, I discuss what parents list as the biggest challenges and risks to the health of teenage children between ages 13 and 15: food, sexual attractions, friends, mass media and obesity--in order of decreasing importance. These were recurrent themes through all the interviews. They differed from the list of health concerns that I had presented to parents as a stimulus for discussion. However, parents had elaborate explanations about why their free-listed concerns were worrisome. At the end of the chapter, I will present what appears to be a model of risk permeating the theories of parents.

Food

Food was a theme that dominated the interviews. Every one of the 19 participants referred to this aspect of health. They referred to it an average of 12 times per interview. It was clearly a critical issue for parents of adolescents, and was viewed as inextricably linked with health.

> 13 to 15, major problem is they just like to eat Chinese, Maggie (noodles), and because of that they might face any problem in future.
> (Uttara)

Other lay theory studies have also demonstrated that food is important. They referred to it as one of many lifestyle factors that lay people mention as being critical to health (MacInnes & Milburn, 1994). But my study appears to be unique in terms of how central food is to parents' understanding of health of adolescent children.

After performing a lexical search for 'food' and variants of the term 'eat' I obtained 214 relevant paragraph segments across the 19 interviews. There appeared to be two broad dimensions in parental narratives: types of food and factors related to food.

Types of food

There was some overlap among the different types of food that parents mentioned (see Table K.1 in Appendix K). But as they had certain distinct qualities, I describe them separately.

Home food versus Outside food

Outside food was the most frequently mentioned type of food. It was usually mentioned as a contrast to home food. The general view was Home food = Good for health and Outside food = Bad for health.

> I: Talking about the risk to health for a person of 14-15 years, would you say that your daughters today face the same risk to health that you faced when you were 14-15 years old?
> R: No. It is different. I was … eating home food.
> I: So you… feel that … you had more risk or less risk?
> R: Less risk.
> (Bhavana)

> Village, I don't think health problem will be there because in [a] village there is no chance of outside food.
> (Uttara)

It did not matter whether the health under consideration was that of an adult or that of a child.

> I don't like to eat on the roadside… though sometimes I indulge. But as far as possible I avoid.
> (Floyd)

Further, the 'bias' towards home food may be one that parents have inherited from their parents.

> [M]y mum is basically against us eating out… That's the reason why … I've just carried it with me.
> (Jeannie)

The trend towards outside food is associated with modern life, and to some extent this trend is seen as inevitable, namely parents feel they have to compromise where their children are concerned.

> We were not allowed to eat outside food. Many choices we had in the house only. … Now I am taking all ready-made things. That time they used to cook in the house only, no? So those choices they used to have… Only thing is now everything is available. We are giving it ready-made. They used to cook in the house only… [T]here are some disadvantages also of the globalisation.
> (Manjusha)

> Means in city [children] are crazy about this outside food. So … once in a week or... 15 days we are giving them.
> (Uttara)

Given that parents prefer home food to outside food, some appeared to be willing to support school policies that would ensure that children consume home-cooked food at school.

> Many of the schools have their own rules that no outside food is allowed. But in … her school in the... recess, they bring *samosas* and other… small items from outside and giving childrens (sic.). So that is a bad thing… If you pressurise or you ask students to bring *chapatti*, *bhaji* and … home food, then definitely we'll take care of the student's health.
> (Puneet)

> R: (in response to a question about school and food) Nothing. That must be in the Municipality schools, which I am not aware of. They were giving rice which everyone took and gave it to their servants. Some made *dosas* and *polas*. They stopped. Then they wanted to give cooked rice. [My son's school] said, "Our children are capable of eating their own food, and our children are not going to eat outside food." … So they stopped it. Yeah. They took letters… that we are not interested in cooked food.
> I: Who was providing the cooked food?
> R: Government only… Education department.
> I: When was this?
> R: Three years back… Second or third standard... Two years back they gave rice… two packets.
> I: Cooked rice?
> R: No. No. Plain rice in a packet… Substandard rice. I don't know. They used to say you can make *dosas* and *polas* [and] *idlis*... I used to give to my servant (Many Indians employ domestic workers for cleaning the house because labour is cheap).
> (Zena)

Zena was referring to the Mid-day Meal scheme or the National Programme of Nutritional Support for Primary Education which was implemented by the state government of Maharashtra on a directive from the Supreme Court of India (Khera, 2006). The aim was to operationalise the right to food by providing a cooked meal to reduce "classroom hunger." Khera reported that states were given a free hand in implementing the programme and it was successful in some states but not in Maharashtra.

I had also asked the three school principals about this programme based on this report from Zena. They confirmed that neither parents nor school authorities had found the programme desirable. One principal explained that the scheme was meant to incentivise rural children so that they would come to schools. This was obviously not a factor that operated with the parents in my study as all of them underscored the importance of education. (The principals also mentioned that poor quality food grains were another factor that caused the programme to fail as did the fact that the scheme did not factor in other issues such as cooking facilities and storage. Further, the scheme should have targetted children who were 'deserving' or 'needy.')

Zena's concern here is about the quality of the food, the raw materials. This is apparently so poor that even home cooking could not transform it into an acceptable meal. The unspoken assumption is that parents can offer better options to their children.

Good/Proper Food

'Good' was a generic catch-all term. 'Good' obviously implied nutritious. In another sense, it sometimes implied good quality items that were fresh or not adulterated. As we saw in the previous section, provision of good quality food items was just as important to parents as preparing them at home.

> Just he wouldn't get the good fruits to eat, good food and whatever he likes. The parent [c]ould not afford that… when he… stays in village.
> (Varsha)

> So we can pressurise government also that you should apply as a law... to control pollution, to… keep vigil for good food.
> (Puneet)

Thirdly, ‘good’ implied ‘rich’ or ‘special.’ Such foods were associated with festive occasions.

> I: Are there any special foods that your family prepares for… festive occasions?
> R: So good food only, no? As you make *pulav*, *biryani* whatever you cook.
> (Sara)

Finally, ‘good’ food also implied not ‘junk’ food.

> I: In what way are we partly responsible?
> R: See keeping the environment clean. Helping in giving proper, good food… Don’t encourage them to have junk food.
> (Zena)

Junk/Fast Food

Junk food or fast food was not the same as outside food. But most outside food was junk. This type of food was seen as particularly problematic.

> Junk food problem is there.
> (Puneet)

It was associated with the contemporary city lifestyle. Partly, this might be explained by easy access which was absent in rural areas.

> [I]n urban... areas children… easily... go to the market and take junk food.
> (Puneet)

Like outside food, it is tempting. But junk food is also something that affects health negatively and, is, therefore, to be avoided. Parents named several bodily malfunctions which they attributed to eating junk food.

> See today’s world, *na*? … [T]oday… [teenage] girls… have problem regarding periods. I have marked. It is maybe because of the junk food.
> (Mayuri)

> He got only the constipation problem … [b]ecause of his bad habit of eating [junk] food… like chips.
> (Varsha)

> [T]hose days we used to eat home food. Now they are very crazy about, you know, MacDonalds, Maggi [Two-minute noodles] and all - all fast food items … For health-wise, those days are very safe compared to today’s life of child.

(Chandan)

But there is a healthy way to indulge in junk/fast food – transform it by preparing it at home.

> Basically we've not eaten out or we rarely go out to restaurants or things like that... Whatever we wanted… was made at home and given to us… Even this *pani puri* (popular road-side snack), my mum makes it at home and gives it to us, so that we don't miss out.
> (Jeannie)

Oily/ Fried Foods and Sweet/Sugary Foods

Oily or fried foods were generally to be avoided.

> I: What would you change if you could?
> R: I would try and reduce the fried foods that I eat… Foods prepared in oil.
> (Namrata)

This was especially true for Varsha, a Hindu mother who had experienced a mild heart attack a few years before the interview. Another Hindu mother also mentioned, however, that it was preferable to cook for a growing child with *ghee* (clarified cooking butter) as a strengthening agent.

> [My son] should eat *chapatti* with more *ghee* to maintain good health.
> (Uttara)

The notion of oil as strengthening is not new in Indian culture. Newborn babies and post-natal mothers are often massaged with oil externally to strengthen them. In fact, while I was interviewing Zena, the Christian mother with the infirm, house-bound parent, one of the several interruptions was due to an interview with a potential massage woman for the latter.

Sugar-laden foods were mentioned by only five parents. It was implicated in connection with worm trouble by Floyd. Bhavana implied that her ex-husband was responsible for spoiling her daughter's teeth by indulging her food desires. But she did not spell out what kinds of foods were responsible. Nikita and Zena spoke of sugary foods without specifying what problems they created. Zena's dislike of such food items,

however, was so virulent that she reported not even stocking soda-type drinks in the home (Zena).

One question that occurred to me was whether parents who mentioned fried foods and oily foods were inspired by a past family history of heart disease or diabetes respectively. To ascertain this, I used the Code-Matrix Browser function to cross-tabulate parents' reported family history of these two conditions against whether they mentioned these foods (see Tables K.2 and K.3 in Appendix K). Would we find more parents who report say family history of heart disease mentioning fried or oily foods in comparison with those who do not report such history? However, this did not appear to be the case either for heart disease or diabetes. One possibility could be that parents who report such family illness are attempting to avoid the possibility that they might also be at risk, and therefore avoid mentioning foods that might enhance that risk. One perspective from medical sociology states that individuals make personal risk-assessments about specific diseases in a very nuanced manner (Hunt, Davison, Emslie, & Ford, 2000). This permits them to avoid taking health actions if they feel it does not apply to them. In the context of an Indian sample, there might also be the possibility of two competing lay theories of health. Here, certain foods that are believed by allopathic medicine to exacerbate conditions like diabetes and heart problems may be recommended by another system of health beliefs (Bradby, 1997). We already noted that some parents believe that preparing food in oil is nutritious and strengthening.

Seasonal Foods and Hot-Cold Foods

These were two related categories. Parents either referred to the hot or cold nature of food or to whether it was seasonal.

> Now like if we have too much cold stuff, we might catch cold.
> (Lakshman)

> R: Their... food should be according to the season.
> I: OK. Can you give me an example?
> R: If … it is a very hot season... they … should avoid eggs and they should prefer… *dahi* (yoghurt), *chaas* (buttermilk), *lassi*, all these things… At the same time … other way round in the cold season… Cold season… have hot... milk with some flavours and turmeric and all.
> (Cesar)

This discussion is consistent with previous health research in India. Hot-cold is a common explanatory framework and Indian adults can describe both food and illnesses as hot and cold (Pool, 1987). It is linked with the ancient *Ayurvedic* theory of humours (Weiss et al., 1988). Research shows that these beliefs persist in modern groups of Indian adults even if they are not able to explicitly state the reasons for their suggestions and practices (Bradby, 1997).

Religion-related Foods

My research included many questions about religion. As such, it was not surprising that participants spoke at length about foods in connection with religion.

Firstly, they described foods connected with specific festivals

> We are non-vegetarians. So during that *Dussehra* time for ten days we don't eat meat, and *Shravan*, we don't eat non-veg.
> (Kishori)

Secondly, they spoke of food in terms of fasting.

> The *Margashirsh* month… comes in December… Four Thursdays we have that *vrat* (fast)… [T]hroughout the day, you have to eat fruits only. In the evening, you have to cook sweets… and eat with the family.
> (Manjusha)

Lastly, one Hindu mother spoke about food offerings to God.

Vegetarian and Nonvegetarian Food

Five parents reported following strict vegetarianism. They were all Hindus. Interestingly, some parents who originally reported being vegetarian revealed, after some probing, that they ate fish.

> We don't eat any kind of non-veg thing. Plus eggs also, we don't eat.
> (Mayuri)

However, parents' eating habits are not always dictated by religious beliefs and practice. For instance, a Hindu father Chandan described how he returned to vegetarianism a year before the interview to explore any potential health benefits. He explicitly denied that this conversion was related to his religious beliefs.

Further, I was intrigued to note that some parents had children whose dietary patterns were the opposite of what they practised themselves.

> She's a… veg. So that's a problem. She won't eat any non-veg at all... So she gets a little less of proteins. Whereas we get it in the meat, she doesn't. So she tends to sometimes go down.
> (Nikita)

In some instances, parents permitted children to indulge these habits by eating in restaurants. The reason for this tolerance was not apparent. Do parents want to encourage children to eat everything? Or is it likely that this tolerance is an extension of the occasional indulgence that children enjoy with regard to outside food?

> And then it stopped. Non-veg stopped totally. Then after six months or after … one year … he (referring to his son) told me, "Now I want to… eat chicken." So OK. Then he went to the hotel. He had chicken also, fish also. And then again he started. So now he is non-veg... But we still, both of us (referring to self and wife), we are still vegetarian.
> (Chandan)

> Then he should eat *paneer*, or if he likes chicken he can have it in the hotel when we are going out, otherwise my husband never [eats]… So he is giving him... when we are going out.
> (Uttara)

It is worth noting, however, that both Chandan and Uttara are Hindu parents and the indulgence towards their respective children eating non-vegetarian food occurs in a restaurant context. Further, both reported family contexts where they did consume non-vegetarian food, particularly fish.

Factors Related to Food

Food Affects Health

> Health is from what you do, what you eat.
> (Manjusha)

The quotation above captures a central idea in this study. Sixteen parents explicitly stated that physical health is affected by food. In some cases, they named specific complaints including: black teeth (Bhavana), acidity (Kishori) and pressure

(Manjusha). We have already seen this idea in the section on junk food. Food could affect health either through irregular food habits or through lack of specific items.

> I don't fall sick very easily [except] maybe for some tummy upsets. That way it's also because due to my irregular eating habits.
> (Floyd)

> I: If you thought that... Menaka had anaemia, what would you do?
> R: ...I will compel upon her to eat green vegetables.
> (Manjusha)

One special health problem was obesity. However, only Christian parents mentioned this concern.

> Basically… children of her age are obese. It's because of… maybe the food or … eating out, their burgers and their pizzas.
> (Jeannie)

It is possible that there may be a differential acceptance of weight problems in these two groups. The other possibility is that there actually could be a differential problem with regard to obesity in these two groups. A third possibility is that Christian children have a higher consumption of obesity-related foods. The latter is likely given that most Christians eat meat, including red meat while some Hindus do not eat meat at all.

Though not as central as the effect of food on physical health, some parents acknowledge the effect of food on mental health.

> Means if you make good food… or if you listen to good music... it helps to maintain your mood also.
> (Chandan)

Parents' narratives made clear that the food-health connection is important at all ages.

> He was unhealthy … between ages of... 6 to 9 months old… At that time... mother feeding was not there. So I given him outside milk from the bottle… That makes him harm and his stomach was so bulky and he was looking so thin and many… problem[s] created.
> (Varsha)

I: What are some of the things that you can do to make sure that your child has a healthy appearance?
R: As I said … I can develop good food habits.
(Ravi)

So obviously, I have to see my food… There is… blood sugar, blood pressure, cholesterol … I have to take care of… those diseases. Even my wife also. Because we are… 40-plus.
(Chandan)

This knowledge of the food-health connection also permitted parents to rectify the situation by altering those food practices.

Suppose if she has indigestion or loose motions so she should not … take heavy food. What should she eat, like curds with rice or some apple or that pomegranate. It all helps in … loose motions.
(Mayuri)

Special food when they are sick, we try to maintain their… no? See that they don't have any nonveg or… you know just have some soup or maybe some diet, special diet you know that they are sick or something.
(Floyd)

Home remedies were one specific way that parents used to influence health through food.

He's carrying that tonsils ailment... She takes care that he is doing a gargle.
(Cesar)

R: If she had a cold … you'll give her *tulsi* (holy basil) leaves.
I: How do you prepare these *tulsi* leaves?
R: We have a *tulsi* plant with us. So we wash off the leaves and just squeeze out the juice of that and give it to her, or give her just the leaves to eat.
(Jeannie)

Food Contributes to Growth

This was a fairly self-explanatory idea: Proper or nutritious food enhances growth.

I mean… she's grown … sufficiently according to her age. And we are … after her food habits also so that she gets a sufficient amount of proteins or whatever is essential for her growth.

(Ravi)

Fussiness in Eating

Given the food-health connection and that food influences growth, it is not surprising that parents worry about children not eating properly. We have already seen this mentioned as one criterion that some parents use to judge if their children are healthy.

> I am buying... fruits for him but… he is not eating properly (Laugh).
> (Uttara)

Note the following conversation with Isabella. She contrasts her two teenage sons as healthy and not healthy on the basis of their eating habits.

> I: OK. Why do you say that Akash is healthy and Arvind is not healthy?
> R: No. Because Akash has got … more, you know, eating habits, more … healthier than Arvind. Arvind is little backward in eating and all.
> I: When you say he's backward in eating, what do you mean?
> R: 'Backward' means he… takes such a long time to eat his food and… [c]ertain things he doesn't want.
> I: Anything else makes you say that… one boy is more… healthy than the other? That Akash is more healthy?
> R: No. Akash… as he comes home… he eats his food and all. He doesn't make fuss.
> (Isabella)

For Hindu father, Lakshman, the concern that his child is not eating properly is sufficient for him to visit a doctor. As we have seen in the previous chapter most parents in the sample mention visiting a doctor for a health problem only after they have tried home remedies of their own. So we could imagine the extent of his distress related to the fact that his child is not eating properly.

> Actually, he eats less. That's why, we took him to the doctor, so he could write [a prescription] for a tonic or something.
> (Lakshman)

Parental Suggestions Related to Food

Not surprisingly, parents have specific and elaborate recommendations about the type of food that would be appropriate.

> I always tell him, "You take complete food. Early morning, you take milk… If you don't want plain milk, you can add something like chocolate… [W]hen you come home, don't drink water immediately… Have a five-ten minutes gap. Then you take water
> (Chandan)

However, they are aware that it may not always be feasible to meet these recommendations especially in the school which is a primary context for the child.

> I: Is the canteen a good influence or a not so good influence?
> R: They don't have a variety of things first of all for the children to eat.
> (Floyd)

> See! You don't… expect these things from the school canteen because everybody is nowadays business-mind… [T]hat canteen owner … He will see his profit. So you don't expect from him that he will provide good quality and good proteins and calories. I don't think so… Only he should see the quality. Means he should not give stale food. That's all. I don't think you can expect much more from him.
> (Chandan)

Context

Parents were concerned not only about the type of food children eat but also about the context of the meal. They required that children should wash hands before eating. Some parents did not think that it was good to eat before the television. They did not explain what they found problematic about this.

> Washing hands before intake of food.
> (Ravi)

> And again sitting in front of the TV, eating…, wafers and all those things… So this is definitely going to affect the health.
> (Manjusha)

Some of these injunctions were based on the parent's religious beliefs and practices.

> According to the rules, we have to… finish eating everything before sunset.
> (Mayuri)

That these concerns may not have a clear reason was evident when Zena expressed difficulty in explaining to her child why her husband does not follow her rule about not eating in front of the television.

However, not all context rules lack reasons. For Jeannie, eating outside during the monsoon season is banned because of the diseases transmitted by flies.

Age Implications

Earlier, I wrote that food affects health irrespective of the age of the individual. This category of statements, however, covers the idea of how age or age-relevant issues relate to food intake. So Floyd points out how his teenage son has a great appetite for food whereas Ravi underscores how poor calcium intake when young can have a deleterious effect later. Other parents spoke of how they reduce their food intake as they approach middle-age.

> That age he wants to eat and eat.
> (Floyd)

> Besides this, problems will… arise later on, not now, like osteoporosis. Lack of calcium will result in osteoporosis during old age.
> (Ravi)

Adulteration/Substandard Food

Concern was expressed about the quality of food. Food was thought to have poor quality if it was adulterated or if it was substandard. While Mayuri mentions hormonal drugs, this is not a generally widespread notion among the interviewees.

> And the milk [that] used to come... if we dip the finger, it won't fall. It was such pure milk. And not adulterated… It did not contain any hormonal drugs or any other chemicals.
> (Mayuri)

However, while parents were generally agentic about their role in maintaining quality of food at home, this was one area where they perceived the government could step in and act.

> Stricter norms, no? for … preparation of food and the quality of ingredients being used and the substandard material being used.

(Floyd)

Money Affects Options

Money played a mixed role. While possessing money permits parents to buy good quality food, the same money in the hands of the children is worrisome because it gives them access to junk food.

> If you give the children money, they are… having access to whatever they can have.
> (Jeannie)

The latter problem was particularly acute for Bhavana who faced a great deal of interference from her family. On the one hand, her father would not permit her to cook in the house. On the other hand, other family members from outside the house would give her daughters money. So not only did the girls lack a supply of nutritious home-cooked food, they also had the means to eat outside.

> They were listening before … Money was not there in their hands… Now they are not listening me. And what my father is doing? Means he told me not… to… cook here. Then what will children do? They are hungry. They will eat whatever they want because money is there… in hand.
> (Bhavana)

Affects Studies/Affected by Studies

This code intersects another major theme that participants mentioned recurrently--education or studies. Whether studies affect eating or eating affects studies, the ultimate 'victim' is the health of the individual.

> They spend half their life on tuitions… and then everything suffers. They don't eat properly. They don't get… sufficient rest… which leads to health problems.
> (Nikita)

> Basically nowadays educational pressure is arising more and more. So... childrens (sic.) are not taking a proper food.
> (Puneet)

Food as the Basis of Health

Thus, when discussing food in the context of health, Indian parents have three types of concerns: Children who do not eat sufficiently, children who eat too much and, largely, children who eat the wrong things. While other studies on health of children do acknowledge the myriad ways in which parents influence the health of the child through food habits (e.g., Alderson & Ogden, 1999; Savage, Fisher, & Birch, 2007), my study is perhaps unique with regard to the degree of importance parents attach to it. Previous studies in India have examined the beliefs around food and health, especially with regard to hot-cold theories (Pool, 1987). These beliefs are well and alive in India. Given that these concepts have been extended by its adherents to modern food items such as carbonated drinks like Pepsi (Manderson, 1987), and given that Indian children do consume these products, ascertaining relevant parental beliefs and practices is useful. Also, when asked to describe ways in which they can improve their children's health, parents in this study made many references to their food-related actions. Food is thus seen as a preventive measure and a cure. Health workers who interact with parents would be more effective if they are able to ascertain what parents believe and do about food habits.

Friends

Parents used several terms in the study to denote their own friends and friends of their children including: colleague, classmate, playmate, circle, companion and peer (see Table K.5). The term 'peer' was used by Christian parents exclusively. The term 'company' appears to have been adopted into Bombay Hindi--a local form of Hindi that is less formal (Sareen & Gupta, 2000). This can be seen in an excerpt from the interview with Lakshman, a Hindu father who occasionally lapsed into Hindi during the interview. The translation is in the parentheses.

> He has a good company. Company *achhi rahni hoti. Uske dost log achhe ho*.
> ('Company' should be good. His friends should be good.)
> (Lakshman)

The particular use of the term 'company' to refer to the influence of friends in a health context in India has been noted in other studies (Mishra et al., 2005).

Parents noted the different contexts where friends might play a role for children:

> I have to find out what is the reason... You can go to [the] teacher and… you can ask her, “Any… problem is there in school or company, school company or tuition company?”
> (Chandan)

And for themselves:

> The thing is we are travelling by train. We don’t have just office colleagues as such. We have train friends. We have office friends. We have outside friends… So it is not just limited to one source.
> (Jeannie)

Parents’ View of Children’s Friends

However, parents tended to use more evaluative terms when discussing the friends of teenage children than when discussing their own friends. They frequently applied terms such as ‘good’ and ‘bad’ to their children’s friends or they mentioned things being ‘right’ or ‘wrong’ in connection with their children’s friends. This tendency was much less in evidence when discussing their own friends. I attempted to confirm this through a complex text retrieval within these segments for the four evaluative terms. First, I coded these evaluative words separately. Then I used a Within Code retrieval strategy to confirm that parents did indeed make more evaluative judgments with regard to friends of adolescent children (see Table K.6 in Appendix K).

Further, I analysed every segment pertaining to children’s friends into positive, negative or neutral categories. Parents appeared to dwell more on the negative side than on the positive side: Approximately 80% spoke of negative aspects of adolescent friendships while a little more than half mentioned positive aspects (see Table K.7). A neutral value was applied when the parent’s use of the term ‘friend’ was an incidental piece of information (e.g., when a parent reports, “My sister told her to play with her friends.”).

Why did Interviewees Overwhelmingly see Teenage Friendships in a Negative Light?

Nearly half the parents associated these friendships with bad or undesirable habits.

I: But what if she was conned into drinking *bhang*, what would you say?
R: That would be a lesson for her. What friends, I mean your company that you're keeping. There's nothing you can do. If she has done it, she has done it. She would not do it on her own. If she was given something without knowing, then… But then next day onward she should realise that … those are her friends. So … they are not your friends if they could give you something like that.
(Nikita)

It is noteworthy that parents also appeared to distance themselves verbally from such friends by referring to 'them' or 'those people.' They frequently also advised their offspring to physically distance themselves from such 'bad' friends.

I warn… Swapnil… not to interact with those guys.
(Lakshman)

'Bad friends' or 'bad company' are associated with a wide range of undesirable habits: cigarette smoking, *gutkha* (smokeless tobacco), *paan paraag* (betel leaf), *bhang* (traditional intoxicant from cannabis leaves), drugs, aimlessness and spending too much time in cybercafés. One Hindu father used a rather evocative Hindi term '*awaragardhi*'[1] which connotes aimlessness.

I: What do you mean by 'good company'?
R: Good company in the sense *koi awaragardi mein nahin rahna mangta hai. Aisa.* (Good company in the sense he should not be an aimless vagrant. Like that.)
I: *Awaragardi* like?
R: Means… standing on the road and talking, means teasing girls, and, if not, going to some cybercafé or other…
(Lakshman)

Bad attraction means nowadays... this... internet. Most of the childrens (sic.) are going to internet to watch that bad sites. Even ninth-tenth [class] childrens are going.
(Uttara)

R: At this age, not really. I think after two years I can say something because … [y]our child will go to colleges and all. He may see the outside world. That time… we can say, "Bad habits, bad company."
I: Bad company. Bad habits. Can you elaborate on that?
R: Bad habits means… Bad company means … you can take smoking or you can take that chewing tobacco, or nowadays, you know that *paan paraag*. What?

Sometimes alcoholic also … You can't say … Because… of bad company … risk is there.
(Chandan)

In addition to developing bad habits, 'bad friends' may also cause an adolescent to get entangled in premature relationships with the opposite sex. This was also one of the free-listed health risks or concerns. One parent even termed this 'wrong relations.'

Gets into bad company… and this is the age where they get… very easily attracted to the opposite sex.
(Floyd)

Related to this, one parent also mentioned the possibility of visiting sex workers in the company of friends.

Other parents described thoughtless, one-off acts that are inspired by peers such as driving off on a bike with a friend despite the high risk of accidents. With regard to the latter, Floyd related an incident where his son who was in Class VII had been egged on by a classmate to give a chocolate to a female classmate. This relatively innocent action attracted the wrath of the class teacher. Floyd and his wife had to visit the school in order to clarify that this act was not intended to cause harm. Floyd ended by thanking God for the fact that the girl's parents were not involved. The result was that he kept checking in with his son to avoid a repeat of this incident.

'Bad friends' also influence adolescent behaviour in another area that causes parents to worry, namely food habits. Two parents used the term 'peer pressure' to refer to this – the only time, the words 'peer' were used by any of the interviewees.

I: How did she come up with this topic of... vegetarianism.
R: This pressure in school. Peers. They must be having some discussion in the class.
(Zena)

Right now I think the peer pressure is so much in school, no? that they want to have a pizza, they want to have a burger, they want to have a lot of things.
(Floyd)

R: The friends are telling this thing. And they don't know.
I: Friends are telling what things?

R: Means chocolates, giving chocolates, going outside.
(Bhavana)

It was interesting to note that both the Christian mothers whose daughters obviously knew each other from school, mentioned that their daughters were vegetarians. This perhaps lends even more currency to parental notions of the influence of peers.

One parent voiced the notion that a child's friend was a possible standard against which to measure the behaviour of the child, and to judge whether it was normal or not. Chandan who mentions this idea uses it in three ways. The last two are clearly undesirable.

Compared to his … friends, he's not that much up to the level. (Speaking of his son's health)
(Chandan)

Teacher should know how the child is, the student is and accordingly she should react. If you ask one question and Nishad is not giving proper answer and … his friend, he's … excellent... So she should not expect the same thing from the Nishad.
(Chandan)

You want to send your child to particular doctor, even particular school, particular tuition, particular institution. But you can't. So that sometimes child thinks, "*Arrey*! My friend is going to that school. I can't. My friend has a car..." It affects your child's mind, psychology. "I don't have… that particular thing."
(Chandan)

One concern underlying most of those I have already mentioned were the fear that these behaviours and actions would distract or divert the adolescent child from more worthwhile pursuits such as their academic work or even their ultimate purpose in life.

I: So what would worry you when you think about him?
R: Towards drugs, tobacco, sex, and going to the wrong track due to colleagues what he is associated with.
(Cesar)

What contributed to a positive view of friends?

These ideas were less frequent since the negative view of friends was much more dominant. One idea concerned the friend as a person who provides information and advice.

> No. She always asks me questions and getting answers from me or mother, or many of times... myself and my wife ask her to just discuss with your friends: What is their opinion, what they are going to do, what they are… And she dialogues with the friends.
> (Puneet)

Children might rely on friends to understand things that they learn on television or in newspapers. While I listed this as a positive function, it was evident that parents did not always see this as a positive thing. Parents might also tap their children's friends to gain insight into their own children's behaviours, especially when the latter is experiencing some problem.

Friends might also go a step further and offer emotional support to the child.

> Often she's… stressed out when in school, during exams. So she tries to … have a recreation like… chatting with her friends.
> (Ravi)

Despite a predominance of negative views of peers of adolescent children, parents still appear to endorse the fact that it is important for them to be friends to their children. This is seen as important in order to maintain a good rapport with children.

> I: What does your husband do to... protect or maintain Johana and Sabrina's good mental health?
> R: Mental health. He is very friendly with them. He'll sit, he'll crack jokes. He is like a friend to them.
> (Sara)

Mayuri, a Hindu mother, also spoke of the reverse scenario where one of her best friends is her college-going daughter.

Figure 4.1 is a map based on the connections that parents make between friends and various aspects of their children's lives. In this map, the numbers on the arrows indicate the number of parents who made a verbal connection between the concepts

mapped out. The direction of the arrow indicates the directionality of the action. What emerge are parents' perceptions of the pathways through which children's friends affect their lives. As mentioned, parents focused more on the negative pathways than the positive ones.

Parental perceptions of their own friends

Parents tend to view their own friends in a comparatively more positive light than the friends of their adolescent children. The only apparently negative note in Table K.9 (see Appendix K) was sounded by Floyd. But he was narrating an incident in his own youth when he was unknowingly fed *bhang* by friends and had a bad reaction.

On the positive side, parents mentioned friends as a source of information and ideas. Some of these relate to health.

> I: What is … *tulsi kada*?
> R: No, no. They are leaves. They are some leaves, and mixture '*kada'* we are getting in… medicines shop… Means my friend suggested, "You should give this."
> (Uttara)

Special value was placed on the advice and information imparted by personal friends with a professional background. They could be sources of referral or connection to other resources.

> Like I have a friend of mine who is at Nanavati [Hospital]. So they have got the best of doctors and counsellors there.
> (Jeannie)

Puneet narrated how he had been able to get treatment for a health condition that was troubling him for a long time. In some instances, these "professional" friends were important because their advice was helpful or because they were allied with reputed institutions.

Some friends provided assistance beyond mere advice. They were supportive in times of crisis. They provided practical or instrumental help.

> Now two months ago, I was operated… I had got a cyst in my mouth… I didn't want to tell anybody because everybody's out and I didn't want. So I said, "Let me just... no? go and get it done." So a friend of mine came and I got it operated.

(Nikita)

Friends were also people one could interact with socially.

(Referring to family vacations) Sometime we go with my friends… So we two couples… we go normally - four persons only.
(Chandan)

Do friends matter for Indian children?

The importance of friends in the life of the child has been the subject of much study. One perspective that gained some currency was the Group Socialisation Theory of Harris (1995). She demonstrated using several diverse cultural and developmental examples the overwhelming role of peers in the life of the child over that played by the parents. The majority of participants in my study would probably agree whole-heartedly with her views.

However, there has been little direct empirical focus on the influence of friends among Indian children. Studies have shown how they provide information about specific issues such as HIV (McManus & Dhar, 2008; Sachdev, 1998) and sexual matters (Family Planning Association of India, 1998; Saksena & Saldanha, 2003). There is also some indication of how influential peers are from studies on tobacco consumption by youth in India. Among school children in New Delhi, lower class children consumed tobacco more than those from the middle-class (Mishra et al., 2005), and they had lower self-efficacy and ability to resist the influence of peers. The study reported that they possibly also had greater exposure to peers who use tobacco. The same group of authors also found matching results in Chennai - another major Indian city (C. Mathur, Stigler, Perry, Arora, & Reddy, 2008). The Global Youth Tobacco Survey (Siziya, Muula, & Rudatsikira, 2008) also reported how peers influence tobacco usage in slightly older youth. This study also pointed out that having a parent who smoked was associated with smoking in young people. (My study involved all non-smoking respondents with only one mother reporting heavy cigarette use by her husband.) All the studies discussed thus far reported gender differences with girls being less likely to smoke at all.

All these studies suggest that parents might be right to express concern about the influence of peers. However, they also point out to the influence of parents themselves. Parents are likely to influence children's tobacco consumption by serving as role models. In the sexuality studies, the participants who reported that they gained their information from friends, also reported that parents failed to provide them such input.

Sexual attractions

In the previous chapter, I had reported that six parents of boys and girls stated explicitly that their greatest worry was that their offspring would get into a sexual relation early in life. However, this concern was also shared by many of the other parents, even if they did not overtly label it as a risk.

> That is the biggest risk what I'm having is, I'm very much worried that they will go towards wrong sex before age.
> (Cesar)

> As mothers we are always protective of our daughters that they don't get in, you know, with boys.
> (Nikita)

There was a sense that some parents viewed this as a particularly vulnerable age for boy-girl relationships.

> I can't explain but I think so… Means... most of the... boys of that age are facing some sexual problem. Means they are… they wants to know it, what it is actually. So because of that they are doing… something... which they should not do.
> (Uttara)

> R: In this age the children can go for outside.
> I: Go outside for?
> R: Any wrong, ba[d] … friendship.
> (Varsha)

> Between the14 to 17 age the children are attracting (sic.) with the girls. The child is attracting. That means the girl is attract with the boy and the boy is attract with the girl.
> (Varsha)

Sometimes, these particular discussions were marked with parents being unable to complete their sentences or to spell out the thought. But the context of the statement made it clear that they were referring to sexual or romantic liaisons.

Further, we are reminded again that some of the parental concern is motivated by the possible distraction or diversion from their ultimate goal in life, namely education (see Figure 4.1).

> This is the age where they get … very easily attracted to the opposite sex. They want to have a lot of, you know, friendship. Friendship is OK. But then beyond that relationship is… That is one concern. That might take him away from his studies and his own… may change his good direction. That is one concern. And we have seen it happening around the place.
> (Floyd)

Floyd, in another part of the interview informed me that he was engaged in a lot of volunteer work with young people and with Sunday school. So the last part of the quotation perhaps takes on even more significance than just that of a concerned father.

Nikita narrated an incident involving her niece who at age 16 or 17 got friendly with a boy in the neighbourhood. As part of the related discussion, the girl's parents reminded her of her educational goals and how this relationship might distract her.

Many interviewees appeared to magnify the possibilities of boy-girl relationships. This was visible in a question I put to all parents about their response if they discovered their child holding hands with a person of the opposite sex. There was some variability in responses. Some found it difficult to relate to the question.

> Then… I might get angry… I don't know because nothing like this has happened till now.
> (Mayuri)

> This has not happened. So I cannot say.
> (Namrata)

A couple of mothers of boys were casual and accepting as was one father of a girl:

> I don't make… any worry. By holding the hand, nothing is happens.
> (Varsha)

I: So say somebody called you up, phoned you up and said, "You know, Carolina, I saw your son, Jordan, and he was holding hands with a girl outside his tuition class, what would you say, what would you do?
R: I don't know. Nothing. Nowadays everything is... Because now like even friends they hold hands, as a friend, as some girl friend, not talk to them.
I: OK. What about if somebody told you that your eldest son, Dominick, right? If they had seen Dominick holding hands with a girl outside college.
R: (laughing) He's already holding hands with his girlfriend. Before I would not believe it because he was such a boy. But now, "Nothing new," I would say.
(Carolina)

I'm not… orthodox. If Samiksha is holding, or if somebody is holding Samiksha's hand that means they have some any wrong relations. I'm not... thinking like that. Though even… my wife may take an objection, but … I won't say that.
(Puneet)

It may be noted that Carolina's original response might have been disbelief. Also Puneet reports that his wife may not agree with his view.

The two Hindu fathers of boys both dismissed the possibility of their sons engaging in such activity. Their reason was that their sons would not do such a thing.

I: Say a family friend called you up and said that they had seen Nishad outside tuition class holding hands with a girl, what would you say? What would you do?
R: I will speak to him directly and I will try to know what is the case. Means that's all. That depends on… what is his reply.
I: OK. What… What do you think the possible replies might be?
R: I don't think because he's… not of that character, that type… means bold… It is not applicable to him at least at this stage at this moment.
(Chandan)

This can be contrasted with the response of the two Christian fathers of boys. They described in detail what they would do. Cesar, in particular, described dramatically how he would deal with each of his three sons in a different way to suit their personality. Here is his proposed response to dealing with the target child, the child who was the focus of the interview.

I'll set up myself to think, you know. Second thing... when he comes home I will not… ask him anything that time. When he is coming in a playing mood with me, he comes and plays with me, he comes and punches me… After the meal there is a time where we fight with each other… *maja masti* (mischief, fun). We test each

> others' strength (roughhouse). So… that time, without his knowledge, I will... put this subject. That is, for example, I'll tell you, "What's the use! You're making a big show of hitting me. But when you see girls, you hold their hands and roam about. Beat them and show me." So automatically he will go one side and start thinking, "Did Daddy hear about that day when I held her hand? Did Daddy find out?" Now he is in a confusion. "Did Daddy find out? If he found out, how did he find out? Did Daddy have this in mind when he spoke? But I can't ask Daddy. If I ask, and he doesn't know, then he'll find out" (Claps his hands) I have put him in a confusion stage. That is indirectly he will… know that roaming around hand-in-hand with a girl… there is some mistake in that.
> (Cesar)

But few parents had such elaborate schemata for handling the potential problem of their child holding hands with someone. Mother of two daughters, Sara stated that she has generally advised her daughters to report to her what is happening in their lives so that she does not have to hear from other people. Most parents reported they would speak to the child directly. Some parents mentioned the need to tackle the issue sensitively and delicately. But almost half of them mentioned cautioning the child in various ways, or related this incident to a formal match between the boy and the girl. (Arranged marriages are still very common in India, including urban areas.) This appeared to be a magnification of the issue. Further, when speaking about boy-girl relationships, one mother recalled an incident of a jealous boyfriend shooting an actress girlfriend--something that was a headline news item.

> I: If they say, "Yes I was holding hands with a boy," what would you say then?
> R: Now… see... broadminded parents will say, "OK. Come on… Call him home… Means you introduce him to us. Then we'll see if it is a right boy for you or what."
> (Sara)

Lay Candidacy and Lay Epidemiology

The idea of perceived vulnerability can also be expressed as a theory of lay candidacy. This is a concept from studies on lay epidemiology. Lay epidemiology refers to the "scheme in which individuals interpret health risks through the routine observation and discussion of cases of illness and death in personal networks and the public arena, as well as from formal and informal evidence arising from other sources, such as television and magazines" (Frankel, Davison, & Smith, 1991, p. 428). It was coined by Davison,

Smith and Frankel (1991) in an ethnographic study of lay beliefs about health in Wales. The term was originally used with regard to coronary heart disease. But since then it has been applied to other health issues such as smoking (e.g., Lawlor, Frankel, Shaw, Shah, & Smith, 2003). Lay epidemiology has often been invoked to explain why health messages do not have the desired effect, or why they are more effective for some issues than for others.

In the same study, Davison, Smith and Frankel (1991) introduced the notion of the 'coronary candidate'--that is the kind of person who gets heart trouble. Using notions of lay candidacy, lay people assess their personal risks and decide what personal behaviours are appropriate. Deciding whether one is a likely candidate or not could have serious consequences. For instance, deciding that men make ideal coronary candidates implies conversely that women are not coronary candidates, resulting in the latter not receiving timely attention (Lockyer & Bury, 2002).

In my study, parents tended to repeat that their offspring were at an age where the risk of interpersonal attraction was particularly high. They used terms such as "This is the age where" or "At this age." Parents also saw this as the age where children were attracted to other bad things. This makes it likely that they would be attentive to signs of these impending issues at the cost of other situations.

> I: Why do these things affect children more?
> R: Because that is the age at which children can get spoilt.
> I: When you say 'the age at which children get spoilt' what does that mean?
> R: The minds of teenage children between the age of 13 and 15 are easily influenced by these things – cigarettes, alcohol. Kids could get spoilt. They catch these bad things very easily. They are really susceptible. They don't think too much at this age. They lack sufficient maturity at that time.
> (Namrata)

Some parents spoke of children being 'innocent' or 'curious' and particularly open to such corrupting influences. There was a sense of malleability to this developmental age.

> R: Ryan is yet quite innocent to the calamites. Then he is a very fast copier…
> I: He imitates, you mean?

R: Yeah. For example I used to send him [for] tuition to Dharavi side (referring to a big slum pocket near his home). He started bringing the qualities of Dharavi. I left it and started tuition-giving this side. He changed totally.
(Cesar)

Parents could do more than just state that the teenage period was susceptible to these problems. They could also state when something was not likely to be a problem and the reasons for the same.

I: Does watching TV affect you?
R: No.
I: As you said that today's young kids watch TV, and then watching TV introduces thoughts in their head.
R: When we watch TV, we don't have those thoughts.
I: So you are not at risk from TV.
R: Not at risk.
(Namrata)

As noted before, notions of lay epidemiology and lay candidacy could result in real-life outcomes. Since the participants in my studies were concerned about premature sexual relationships, some of them believed that an appropriate response might be school sex-education programmes.

Sexual education… What is … sex education? What is … sex? The ... meaning of [those] words. It is all the problems comes in 13 to 15 years ... Any kind of children, that means ... man or female, both are facing the same problems. And … I think ... at this period, student or children should … [be given] education.
(Puneet)

Further, the lay epidemiological ideas of the participants also determined the appropriate timing for such a programme. For instance, Hindu mother Varsha put off the idea of sexual/romantic involvement for her son till he reached college. She thought that sex education was appropriate for the tenth standard (age 15)--the last class in school.

The '*cordon sanitaire*' is also a type of lay epidemiological concept though its genesis occurred in a different context. While lay candidacy causes people to acknowledge the likelihood of risk, '*le cordon sanitaire*' permits them to feel protected from those risks. They are the lay version of risk and protective factors that are so common to social work intervention. Risk factors are characteristics that make it more

likely that an individual will develop a disorder and protective factors mitigate this possibility of illness (Institute of Medicine, 1994). Parallel to these factors, lay notions of what are risky and protective activities affect the actions that lay people undertake. For instance, believing that teenagers are likely to engage in premature sex causes parents to support sex education. It also influences their notion of the appropriate timing for the same.

Do adolescents behave in the manner that adults worry about?

There is extremely limited information on health behaviours of young people in India. What is available is somewhat mixed. The average age of sexual initiation was reported as 16 for urban males and 18 for urban females (Family Planning Association of India, 1998). The latter figure should be measured against the fact that for many young women, sex first occurs within marriage (Jejeebhoy, 1998). Two studies on school students cast further light: McManus and Dhar (2008) and Selvan, Ross, Kapadia, Mathai, and Hira (2001). Both were conducted through the school system on upper middle-class students (average age of 15 years) and involved self-reports. McManus and Dhar studied only girls in New Delhi, while Selvan et al. covered both boys and girls in Bombay city. Selvan et al. reported that 4% of their respondents reported having any sexual experience at all. For the girls in the New Delhi study, the figure was 9%. While it is possible that both figures could be low due to under-reporting, they are still lower than figures of sexual experience in Western countries like the United States but probably higher than parents' perceptions.

However, both studies also highlighted behavioural norms and perceptions that could increase risk. For instance, 15% of the New Delhi school girls endorsed the belief that it is not necessary for a girl to be a virgin until she married (McManus & Dhar, 2008). The Bombay youth were more likely to report sexual experience if they also perceived that their peers had also had such encounters while perceiving that peers had avoidant norms inspired them to abstain from sex (Selvan et al., 2001). Other inhibitory factors noted in this study were parent education and gender of the child: Girls were less likely to have sex.

An unpublished study among lower class youth in New Delhi reported that despite strict parental oversight, young boys and girls still found opportunities to meet and, sometimes, have sex (Mehra, Savithri, & Coutinho, 2002). Here too there were gender differences with boys admitting to more sexual opportunities than girls. In focus groups, boys noted that peer influence was a key factor. This appears to match findings by Bhende (1994) with a similar low-income group in Bombay. She reported that boys were more likely to have opportunities to engage in sex than girls. Girls' behaviour was often closely scrutinised by parents and other family members, and their sexuality closely guarded. Both girls and boys reported that they were less likely to respect a 'bad boy' or a 'bad girl.' A 'bad boy' was described as engaging in the '*awaragardhi'* type behaviour described by Lakshman in the previous section. A 'bad girl' was one who talked and mixed with boys. These perceptions appeared to hinder, to some extent, sexual involvement in girls. But Bhende reported behavioural observation of informal opportunities for boy-girl interaction through communal celebrations of festivals.

Influence of Mass Media

> Now computer has become a big risk. Like they watch all these dirty things. So that's another risk, when parents are not at home.
> (Carolina)

> The TV programmes which is going on nowadays and I'm very much worried.
> (Cesar)

> Even the paper you read. Now there's no point giving in the Bombay Mirror (local supplement to a major daily which carries the gossip columns) about the actors and actresses marrying hundred times and then showing nude pictures like that. The write-ups they write. I want my children to read the paper. But sometimes I read all that rubbish, I'm ashamed to tell them to read. Especially at this age when my son is ten-eleven years old.
> (Zena)

Parents expressed deep misgivings about the influence of mass media such as television, the internet via the computer and newspapers. They feared that these media would affect the attitude of their children in negative ways. Note how the last section of the following dialogue with Namrata echoes what Lakshman described as *awaragardhi* or being aimless.

R: And what all they see on TV, all the channels…
I: What risk is there from watching TV?
R: That only. Their attitude. Watching the songs that are shown on MTV, V Channel, they affect the mind of the child.
I: What risk could be there from that?
R: Their attitude, their thinking goes along that type.
I: Meaning? What… attitudes on these channels do you not like?
R: Where [people] wear few clothes, that affects our children if they see it time after time… Copying those fashions… Watching pictures. *Mauj shauk*. (Fun and frolic)… Roaming.
(Namrata)

Music channels such as MTV which aired music videos were seen as particularly troublesome challenges to good parenting.

There are some channels which is... not worthy to watch… You can say FTV (Fashion TV which often shows images of scantily clad models). Then there are some... music channels like... now 9X has come… New channel has come. 9X. A very new channel… 9X which is full of... music. [O]ne or two good songs come but in between they push off some songs which is... The dance itself is so vulgar… Of course my children are very much under… my guidance, but still there is a worry being a parent. At least if not my child, other children also get troubled.
(Cesar)

Parents were also concerned about news stories featuring sexual aspects of film stars, and advertisements related to sexuality products. This is coupled with a sense that these are new challenges to parenting that their own parents did not have to face. So parents appear to lack guidance on how to deal with these issues.

See! Yesterday, I took the paper the first page I got annoyed, you know. The first page I saw is Zeenat Aman (sex symbol Bollywood actress) without wearing proper clothes. Of course, the topic is OK. But on the first page only you are showing Zeenat Aman. *Hanh*? Further, you know everything. *To* it just hurts me very badly.
(Cesar)

Even…normal channel… Sanitary napkins. There are so many… You know when we were in school, these type of advertisement[s], actually I don't remember
(Chandan)

Even on the TV, they see children's programme, but the advertisement between the children's programme is all-adult. Now that condom advertisement. What to

explain to that child about condoms. Now pads. What to tell him about pads. Sanitary napkins. We didn't have all that, no?
(Zena)

Respondents' concern largely sprang from the premature sexual awareness and activity that mass media created in their sons and daughters, that is parents worry about that the mass media like television and internet may sexualise their children.

Like nowadays you know everything is open… through internet, and there are so many you know … bad things which are attracting them. They are always at the doorstep...
(Mayuri)

I: Now when you talk about 'wrong sex' can you tell me what you mean by 'wrong sex'?
R: Wrong sex means... they see everything before age. They see everything before age either practically, personally or they find it in TV, and they... get into wrong sense and they get into sex, without knowing what it is.
(Cesar)

Basically we have to take more care as I've said because of this all awareness and all on the TV, what all serials they show, what all they show.
(Manjusha)

Further, once a young boy or girl engages in such media-induced activities, it might be difficult to discontinue.

They can get into any type of addiction related with the internet.
(Floyd)

The television created additional problems such as disrupting sleep and providing a poor substitute for play.

Any sleep, lack of sleep is there … nowadays because of television and computers… [C]hildren don't get… sufficient time to sleep. So next day she may not feel fresh while going to school.
(Ravi)

We didn't … have that much of TV. TV had just come in that time. We didn't have that many channels or programmes or any such thing. So we did a lot of playing.
(Nikita)

It is not as if these mass media were rejected completely. Some fathers and mothers did speak also of various positive ways in which they could be used to enhance the life of their child. For instance, Cesar spoke of computer-based instruction that could give his son an edge in school. More common was the idea that the television or the computer could be used to help improve mental health, relax, or provide intellectual stimulation.

> Camren … grabs every opportunity, I think, to relax himself by watching the TV, or … by sleeping, or … by [watching a] movie… on the computer, playing some games.
> (Floyd)

> To protect their mental health, you can say… they... sit with their studies or they watch TV. That way they divert their mind.
> (Sara)

> Do they read the newspaper? Means newspaper. Are they really updated? That will help you to get the mental background of the child.
> (Manjusha)

The social power of these institutions was also recognised and allotted some respect. For instance, in the following segment, Zena was describing a confrontation with an abusive teacher at her daughter's school. By saying she wanted to put it in the papers, she was referring to a then-current trend among the local city newspapers to highlight abusive and dangerous situations in the city schools. (Besides highlighting problems, these articles also appeared to give parents a sense of potential power, and raised expectations about what was normal.)

> *Arrey*! "I'll suck the blood from your eyes. And I don't know from which families you come." I made such a big issue about it. I wanted to put it in the papers. This is not the way to talk. She makes the children cry.
> (Zena)

But the potential power is also accompanied by distinct disadvantages.

> Development is because of this TV. This developments are really good. We are becoming more exposed. Globalisation, everything is there. But there are some disadvantages also of the globalisation.
> (Manjusha)

Mass media diverts youth off their path

Once again we see the notion that these activities could distract youngsters from their direction in life (see Figure 4.2).

> Like you see that Channel V, music channel, MTV… Certain songs or certain programmes are not good … at this… age because this is the age where you can fall. You know that particul[ar] company or bad company, by watching this all… your thinking power also can maybe divert… to the wrong track. So… what I feel is there … should be some control.
> (Chandan)

> Only thing is the difference is because of the development of the society… [A]ll this sexual interactions and all these things, that was very less. So the innocence was more in our age... But now… [t]hey are showing all this sexual… [I]n fact they are… taking towards a wrong direction.
> (Manjusha)

Parents offered two types of solutions to handle the effects of mass media. One solution was to limit the exposure to television. While Chandan wanted someone else to impose this control, Zena was quite clear that she could turn off the switch.

> They should make a separate channel for adult, separate channel for student or teenagers, whatever, so that at home you can, what you can control, you can see. OK. You need not watch that particular channel.
> (Chandan)

> See the… the child is innocent, you know. So his curiosity will be there. "What is this product? Why they are advertising? Why such dialogue is there?" There are so many things he will ask himself. Means in his mind. Then he will discuss the same thing in the school, in the class or whatever, when he go down... Actually government should see something… do something to control this.
> (Chandan)

> I read in the paper there was a boy of a high class family, of a rich family or a very high class family, who got AIDS because he landed in a red-light area and he didn't have the face to tell his parents. And he has the full control on TV. School has started. Cable is out. That's because I'm in the house. I can control it. And when they see, I see what channel they are.
> (Zena)

The other solution was to counter the exposure with opposing ideas through sex education.

> These are social evils (She is referring to premature sexual relations) which our children should know. And there's nothing that they should know… They are watching TV, and they know what is happening. You're exposing them to TV and not warning them. It's wrong and they know much more than what you and I don't know. So they need to be educated.
> (Jeannie)

Do parent concerns match research?

The concern parents voice about television-related health disturbances are not uncommon. Other studies have linked excessive television viewing with lack of sleep (Owens et al., 1999) and have studied it in relation to aggressive behaviour (Browne & Hamilton-Giachritsis, 2005; Ponnuswami, 2002). Indian children in cities, on an average, watch about 2 to 3 hours of television per day (Cardoza, 2002; Gupta, Saini, Acharya, & Miglani, 1994). Indian parents have noted changes in sleeping habits of children related to television viewing for both young children and adolescents (Gupta et al., 1994). Several of the studies on sexuality cited earlier in this chapter also mention that young people do learn about sexual matters from mass media (e.g., Cultural settings affect adolescence, 2000; Family Planning Association of India, 1998; Saksena & Saldanha, 2003). The same studies also report that parents are barely mentioned as a source of information. Helping parents in this activity is one area for intervention. This is especially true given that few Indian parents actually exert control over children's exposure to mass media. Studies show that they rarely vet the programmes that children watch (Cardoza, 2002; Rose et al., 2002). Cardoza suggests that parents may not engage in an actual dialogue with children over what is appropriate programming because the television is in the main family room and that Indian homes are small. Further, there are other family members constantly present and this may prove to be a deterrent to the child. However, some middle-class parents in my sample had more than one television in the home, and a couple of mothers who work at home pointed out that parents are not always at home.

Where are the germs?

As I progressed through the analysis of the various key concepts raised by the interviewees, it slowly became evident that the lay theories of these Indian adults seemed

to be missing discussions of germs and microbes. So I ran lexical searches for terms like germ, virus, infection and contagion and their variants (see Table K.10).

It was clear that most participants were aware of the germ theory. This is not surprising because they all had at least high school education and the science syllabus covers the germ theory adequately. But it was also clear that germs were not a salient element of their folk theory of adolescent health.

> I don't make her leave the house without breakfast. "No breakfast? Don't go to school. But eat." I have told them, "We are surrounded with all hospitals. Early morning you go when the germs are very high." You know even my son. He goes at nine but he has to have breakfast and go.
> (Zena)

This quotation demonstrates that the germ theory does cause parents to undertake certain health actions. So does the following quote by Jeannie. Though she does not use the term 'germs,' she mentions 'flies' who could be seen as a proxy for germs since they are a known vector (or carrier)

> The thing is if I'm going to let her eat whatever trash, that is eat from the roads specially during monsoon and all when there are flies sitting on it. So I… cannot say whether she's going to come back with dysentery or food poisoning.
> (Jeannie)

In Bombay, a common health complaint is 'viral fever.' A parallel notion would be the flu' in winter in the U.S. Viral fever is particularly common during the monsoon season.

The question is why do parents not mention this more frequently? The answer could be that they value food so much, especially food cooked at home. If they are able to control the way food is prepared and served to their teenagers, then they would automatically have children who were germ-free. Another explanation has been tendered by another lay theorist, Raman (Raman & Gelman, 2004). She suggests that Indians are aware of germs but tend to focus more on the issue of contamination. Once again, this is something that parents can control through home-cooked food.

Conclusion

What stands out from this chapter is where parental perceptions of risks to adolescent health differ from epidemiological studies and where they are relatively congruent. For a middle-class urban parent, sexual behaviour among young people is something that is likely only among college students. Research appears to support this perception. However, there is also a small minority of students who do initiate sex while still in school.

Parents appear to ascribe responsibility for undesirable behaviours to their children's friends and to mass media. Other research shows that these two social influences are indeed strong in the lives of the children, but what is not evident is whether this is the case because parents do not intervene explicitly.

Footnote

1. An iconic, celebrated image of being '*awara'* or aimless is that of a yesteryears' Bollywood film star dressed like a Charlie Chaplinesque tramp complete with knapsack singing, "*Awara hoon*" (I'm aimless)

Figure 4.1. Parental notion of how friends influence the adolescent child

Figure 4.2. Parental notion of how mass media influence the adolescent child

Chapter 5

Education as a Health Issue

Children's education was an issue that was predominant in the interviews. Parents routinely drew linkages between health and education. For instance, in Chapter 3, we read that some parents stated that school studies were important to mental health of the child. In Chapter 4, parents named friends, premature sexual relations and mass media as health problems for adolescents, which were responsible for diverting them from their path, namely education and subsequently a successful career.

As this was a research study focused on health, the questions posed to the interviewees centred on health and illness of teenage children. Participants provided information on all the questions. However, when solicited for feedback on the research process at the end of the interview, two parents suggested that I had failed to ask questions about the child's education.

> I: Was this interview what you expected?
> R: It's different.
> I: What did you think I would ask you?
> R: About… how to make [the] child cope with his exam fear and everything..., how to… take the exams and everything.
> (Kishori)

> I feel that you did not ask much about the educational field… Education is most important. It depends on what class the child is in. To question where he is on the educational basis.
> (Lakshman)

Thus another research question emerged during the analysis: What value do Indian parents place on health in relation to education? This chapter explores this question. First, I explore lay beliefs related to school and health. Then I describe how parents appeared to privilege education in the lives of children. Finally, I explore parental descriptions of health as a functional quality.

School and Good Health

The domain of school was a key aspect of education. A lexical search of the term 'school' had 199 'hits.' Exploring these paragraph segments for the relationship to health showed that parents thought of school in somewhat contradictory terms (see Table L1 in Appendix L). In response to a direct question about the influence of school on the child's health, 15 parents said that the school did not help the child. Their collective response could only be described as dismissive.

> I: Does the school actually do anything?
> R: They cannot do anything.
> (Varsha)

> I: Are you aware of anything that the school… does for mental health?
> R: No. I don't know of anything.
> (Namrata)

> I: What does the school do… to… protect her?
> R: (Snorts) Nothing. They don't even know whether she's living or dead there. Nothing. School is zero, absolute zero.
> (Zena)

One possible reason for this was the perception of the lack of health programmes:

> I: What about the school… do to protect or maintain Akash and Ashwin's health?
> R: They also don't do anything. They also doesn't (sic.) have any medical checkups and all. Nothing they do.
> (Isabella)

Another reason suggested by some parents for the lack of a positive role in health was the limited role that school had in providing food. This is likely because most schools in Bombay, and all three schools where I recruited participants, worked on a shift system with secondary schools operating from approximately 7 a.m. to 1 p.m. So children generally eat breakfast and lunch at home with a small mid-morning snack at school.

> Means they are not doing directly. Means they are not giving food directly.
> (Bhavana)

Some also felt that the health of the child was a sphere of parental action where the school had no responsibility.

> More… than the government and the school… I feel is the home circumstances. The home should bring the child up more because… most of the eating part and the sickness part is the home has to run through it, go through it. School… is not going to look into anything.
> (Zena)

Although interviewees negated the role of the school in relation to health, they were able to describe different related actions that could have a positive impact. One such arena was the school canteen that provides the mid-morning snack.

> They have their own canteen for themselves there. There's somebody who takes care of the canteen. There's nothing that is allowed [from] outside. So I know that my child is not… eating anything from out. That much responsibility the school is taking.
> (Jeannie)

> R: The canteen is run over there. They see that they have been given… good... snacks.
> I: What would be a good snack provided by the school?
> R: They have... sandwiches, *pattis*. They have these *idlis*, then *samosa*... Now bad snack means it has been kept out in [the] open, or they are not using good oil and that same oil they'll keep on frying. So that is a bad snack. Stale bread for sandwiches.
> (Sara)

> See, you don't… expect these things from the school canteen because everybody is nowadays business-mind. Means… that canteen owner … He will see his profit. So you don't expect from him that he will provide good quality and good proteins and calories. I don't think so… Only he should see the quality. Means he should not give stale food. That's all. I don't think you can expect much more from him.
> (Chandan)

The school canteen thus offered an alternative to outside food which reassured some parents. However, as pointed out in the previous chapter, some parents like Chandan had mixed feelings about it, opining that its quality was limited by the mercenary motives of the canteen owner.

Similarly, though parents felt that school provided physical activities like sports they stated that this was not sufficient, and rather inadequate in execution. Note Nikita's

narration of how the poorly-organised basketball practice actually endangered her daughter's health.

> They have this school's [sports] period and all that. That much they do. Yoga. Once in a week.
> (Kishori)

> R: What happens is she plays basketball, sweats and then goes to class. And [there is] the fear always of getting a chest cold and she did go in for pneumonia once because of... playing in the rain. They make them play in the rain and then go to class. They sit in the wet clothes … Basically I took her out of basketball also. She's very good. But the problem is that the [school] makes you come in, early morning, and go straight to class after that.
> I: They don't have changing facility.
> R: No, no. And she tends to fall sick. Plus they play in the rain saying that makes you stronger. But my daughter only gets weaker. (Laughs) So… I tell her that, "Rainy season, no play, because then after that there is medicines."
> (Nikita)

> Lay more importance on exercise in school.
> (Namrata)

Schools also educate children about health matters. But this is limited to self-care issues in the syllabus. Moreover, it is not something that secondary students are likely to receive. (The School AIDS education is an add-on, special programme rather than a regular class.)

> I: What does the school do to maintain Ryan's health?
> R: From the part of the school, if you ask me, whatever they teach [is] from the books. That's all. Other than that nothing.
> I: So healthwise what do they teach?
> R: Healthwise they teach what is in the book. If in the book they say *ki*... you should cut your nails regularly, they teach that… Because they are supposed to teach they teach. Otherwise… whether there is a goal, what is its importance, that they should create a realisation about that, apart from the book they should have some activities, there is nothing like that… All syllabus.
> (Cesar)

> R: Then school also because I think … they also teach students, no? How to take care… Not… at this age. But primary school they teach everything. So school also they have some role initially when child [goes] to first standard or nursery or second standard…

I: So at the primary section the school has a role. But at this age?
R: At this age? No. No.
(Chandan)

The school also provides opportunity for growth and development beyond academic work. Parents see this as important for health.

School [has] now started this Personality Development.
(Floyd)

But they are offering these … activities. Healthy mind.
(Bhavana)

She's got self-confidence in her... In the beginning she was not that self-confident in her younger years. Now she has got self-confidence to do whatever she wants to do. And … she kind of shines in the school. She shines even with the bigger children. I mean competes like. For example, now there's an inter-school elocution competition. They chose her even though there were older girls. They yet chose her. Or even other things like, you know, whenever they have a show and all, compere and all, they'll take all the bigger girls, and they'll take one from a younger group.
(Nikita)

School can Negatively Impact Health

On the other hand, while school may be perceived as having a limited or insignificant role with regard to keeping an adolescent child healthy, it is also associated with a negative impact.

School-related stress

Academic work creates stress and pressure. As we saw in Chapter 3, mental health definitions of parents rely heavily on the presence or absence of stress and pressure.

Because the stress is more of their studies, that is the only problem there.
(Kishori)

Because of school and pressure of… the studies.
(Floyd)

Some of this pressure is related to a new system of assessment which was meant to alleviate stress. Instead, because of its unfamiliar demands and, what parents appeared to view as, its unreasonable expectations, this new system was adding to the existing stress.

> R: Now project work, this work, that work. And they don't get the time. Half the time we are doing the projects. Just ask them to source out things on the 'net and things like that.
> I: Can you give me an example of a project that he's had to do that you've had to work on?
> R: Recently he did one, just 2-3 days back on self esteem. So he doesn't even know the meaning [of] self-esteem.
> I: What subject was this?
> R: Personality development or something.
> (Floyd)

> In school, there is a new syllabus… Zara is the second batch appearing… Every five years they are trying to bring in changes... But in the bargain, they are making more mess… All our parents, all our children are not so very highly educated as to take this. Now, for example, now they have come up with projects so that the burden doesn't come up on getting the totals. OK? Now they've got one group project, one individual project. Now we are not at all able to do a group project. Those who are rich will give it to an outsider. Those who are talented, one person will do and give. So that becomes difficult...
> (Zena)

This perception may be shared by some teachers and not others as we see in the following quotations by Nikita and Isabella who were both teachers.

> The education they say has become simpler with the new method. But according to me, both as a parent as well as a teacher, it's only… put too much of pressure on the kids.
> (Nikita)

> I: Do you have… to watch over their homework?
> R: No, no, no. I don't take because I… am so tired when I come back. So I tell them whatever is there you'll do on your own… I prefer that they do it on their own because you know sometimes teachers… tell to do certain things and boys go off with higher marks but only… because the parents have done [it]... But I am happy. I tell my sons, "Even if you get… less marks, [it's] okay, fine. But it is you who you have done it. I have not helped you in anything." So whatever, even the newspaper cuttings and… the project and

all, everything they have done. I never help them because I feel when it comes out from them [it's] better.
(Isabella)

Other Negative Aspects of School

Stress in school is also associated with negative behaviours from teachers.

R: Maybe the sirs [are] mentally abusing the boys… Sirs with the male child like…
I: Can you give me an example of what you mean by a sir mentally abusing the child?
R: …I had heard that one sir… he was... you know mentally means abusing the boys in the class like… very harsh words. Or you know when the parents speak to the children about their problem, then they put back upon the child itself. So that mentally disturbs the child.
(Isabella)

In the last line Isabella was referring to how some teachers handle negative feedback, namely by victimising students whose parents have complained.

Zena spoke at length about a teacher who was similarly abusive with students in what she described as an ongoing pattern. Among other things, the teacher purportedly said things like "I'll suck the blood from your eyes," and "I don't know from which families you come." (The latter insult is particularly hurtful in the Indian context where family reputation is held dear.) Like Isabella, Zena also described the backlash parents face when attempting to communicate with teachers about these issues. She described her confrontation with this teacher. These two mothers were discussing different schools. So this is not a localised problem.

One consequence is that children appear to advise parents not to come to school and interact with teachers. This tendency on the part of children to keep parents apart from teachers has been noted in other Indian literature pertaining to school (Vacha Kishori Project Team, 2002). The reason is the same--the fear of being victimised for daring to complain.

Sexual abuse and harassment is another possible problem that could occur in schools, though parents appear to search for protective factors associated with their particular school--another instance of *cordon sanitaire*-style thinking.

> See! Sometimes … girls are sexually harassed in school. See! Ours is a convent school. There are no male teachers. But then also, some or the other way it may happen, or sometimes… you know that they are tortured or beaten.
> (Mayuri)

Boy-Girl Interactions through School

One concern that parents have about schools is the possibility of boy-girl interactions. This, as we have already seen in Chapter 4, is one of the big worries of Indian parents. Christian father, Floyd, is the only parent who stated intentionally seeking admission for all his three children in a co-educational school.

> I: So you feel like having many relatives that the children can turn to means that they can express themselves better.
> R: That's one thing. And that's… why I put them in a co-ed school also. That is one reason that I put them there. Not just you know boys' school, girls' school… They have a sort of a holistic growth… There's a very important role there.
> (Floyd)

Floyd may be relatively laid-back because, by his own admission, he is accustomed to dealing with youth through his work with his church. The more common reaction from parents is to view boy-girl interactions as problematic.

> Two girls gave some love letter to Arjun… That time I directly went to Father's cabin and showed that… Father took action against them… Arjun is monitor in the class and he is very good in playing piano and other activities. So… [the] girls might have [been] attracted, but they used to call on *my* mobile and send SMS to Arjun.
> (Uttara)

> In school also, he had told me one or two girls had an intention [to befriend him]. But he got rescued because from the third person he came to know that… her intention is something else. *To* he told *ki* "I think of you as a sister, as a friend." … And some girls could absorb that and they are still talking with [him]. Some girls could not absorb.
> (Cesar)

Those parents who spoke of this problem had children in co-educational schools. Even Floyd, while espousing a laid-back attitude, described an incident where his son got into trouble because he was instigated to give a chocolate to a female classmate. While

Floyd was understanding about how this situation arose, he now checks in frequently with his son. It was interesting to note that these parents were all speaking of their sons. There was one parent, Puneet whose daughter was in a co-educational school. However, he did not mention this concern. Instead he vehemently challenged me about the possibility of school-age girls getting pregnant. Was he, perhaps, trying to avoid a thought that might be too worrisome to consider?

In contrast with parents recruited from co-educational schools, parents from single-sex schools comforted themselves with the fact that their off-spring (especially daughters) were protected from this concern -- another expression of *le cordon sanitaire*.

> She is not [in] a co-ed. If there's a co-ed, I would have to be a little concerned also.
> (Zena)

No Time to Eat, Sleep or Play

One health-related consequence of school work is that children's activities shrink to the point where even basic needs like sleep and food get affected.

> They won't play because study material is long, extra, more pressurizing… so they won't get... proper... When I was in school, I used to play at least one and half hour. But nowadays this private tuition classes, then schools. Students are running here and there… Around 16 and 17… hours, they are studying only. So how they can play? They can't go out of their house or school premises.
> (Puneet)

> Children… Parents want them to compete. Parents want them to do well, put them for tuitions. They spend half their life on tuitions, learn nothing basically in tuitions either, and then everything suffers. They don't eat properly, they don't get… sufficient rest... which leads to health problems. They're not sleeping well.
> (Nikita)

Both Puneet and Nikita mention tuition classes. These are private tutoring sessions that almost all urban school children attend in addition to school. Puneet's calculation of 16 to 17 hours is good estimation of the time some children spend on academic pursuits per day. From his description of his own daughter's routine, we can calculate how much time his daughter spends out of the home for educational pursuits: 47 hours per week. This does not include home-work time.

I: Can you tell me about your daughter's daily routine?
R: She wakes up at 5.30 a.m. and leaves home for school at 6.30 a.m. She returns home at 1.30 p.m. and has lunch. After that, from 3 to 5 p.m., she sits for her studies. At 5.30, she goes to play and get refreshed. From 7 to 9 p.m. she goes to private tuition class in colony. At 9-9.30, she has her dinner. The she watches TV, completes her homework. At 10.30-11.30, she goes to bed… She takes all subjects' tuitions. She has tuitions for six days in a week with the same person.
(Puneet)

Through similar calculations, it was obvious that children were undertaking many hours of work: Chandan's son = 52.5 hours; Floyd's son = 60.5 hours; Lakshman's son = 45 hours; Ravi's daughter = 44 hours; Uttara's son = 57.8 hours; Carolina's son= 45 hours; Isabella's son= 45 hours; Jeannie's daughter=52.25 hours; Zena's daughter= 50 hours. Uttara's son was a Std. X student (that is Class 10) whose academic year would culminate in his first public examination. The pressure generated by this fact could be seen in the extent to which his mother reported going to give him a competitive edge – even at the expense of his sleep and hers.

Morning I get up at three o'clock… three to six, I am sitting with Arjun, because I can't give much time in the afternoon as my [own] students are attending.
(Uttara)

By their parents' report, the students are undertaking a tremendous amount of work. One way to understand the extreme nature of their burden is to compare it to an objective standard. The labour law in the state of Maharashtra is the Bombay Shops and Establishments Act, 1948. According to Section 14 of this legislation, "an employee in a shop or commercial establishment cannot be required or allowed to work for more than 9 hours in a day and 48 hours in a week" (Excel Consultancy Services, 2007). Any work over and above this qualifies for overtime at double the rate of ordinary wages. If we used this standard to quantify the academic work of the children, some of them would qualify for over-time.

Yet despite all the hard work and stress involved, parents struggle to give their children all the advantages possible through the best tuitions available.

I can go for... many more classes or tuitions or teachers or books which is very costlier (sic.)... I can tell you one example… There was a proposal for computer

> teaching through... this… projector… So what they did is, they show… some picture, then the teacher can [ask] any question and that child knows it… [W]hat they say is through visualisation, they get to learn it very fast. So that tuition was through visualisation. They show pictures. He learns it. You close it up, You question him. He answers it… I was very much interested but since I was not... in [a]... strong financial situation to go with that, I advised my elder brother to go for it.
> (Cesar)

How ubiquitous and essential tuitions have become to conferring an educational advantage is evident in the fact that there is competition to get the best students into the top-rated tuition classes.

> Nowadays, classes are more than schools and competition starts with [tuition] classes only. Say Ramchandra classes in Ghatkopar, if they are doing well, their students [top the] merit list, then next year Mahesh Tutorials will definitely fight for every school administration and ask, "Send your… students to my classes... Then... next... Chatte classes. This competition is only within the private tuition classes, not in schools. When I was in teenage, that time Raje Shivaji Vidyalaya, King George High School, then Bal Mohan Vidya Mandir, they are fighting with each other, that my student will [be] topper or your student.
> (Puneet)

Further, teachers are perceived as encouraging this trend by not providing appropriate instruction.

> In [my daughter's school], I heard that in Tenth standard… teachers are asking their students to, "Go and whatever your problems…, just go and ask your private tuition classes teachers."
> (Puneet)

Parental struggle to provide the best possible educational resources is not an idea unique to my research study (Ranganathan, 2006). Neither is the notion that parents see this as a way to give their children all the advantages possible. Kumar (2005) notes:

> [T]he coaching industry has cracked the code of the country's most prestigious institutes of technology and management. The best coached, and not necessarily the most creative, teenagers end up getting into the merit list which also serves as the social roster for top-end dowry and other fruits. No wonder parents invest, to the best of their capacity, and often beyond it, in admission to coaching institutes which promote themselves by flaunting the names of institutes they usher their clients into. (p. 1937)

The only two parents who bucked this trend were Cesar and Zena. Cesar withdrew his son from his tuition class because of the ill-effects on his health. However, the previous year he was in tuitions throughout the year.

> He was going for tuitions. But we stopped now because we found that it affects his health. Because by one o'clock, he comes from school, then he eats lunch. Hardly he gets one hour rest. Immediately after one hour, it's tuition time He returns from tuition at 6.30-7.00. Then he has some tea and snacks. Tuition homework. School homework. Where is the time?
> (Cesar)

Zena reported that her daughter, the target child for my interview, was in two different types of tuitions. By contrast, her son was not enrolled because of his school set-up. He was not a student in any of the schools where I recruited participants. I happened to know this particular school because I had enrolled my own 12-year-old ward here on account of its excellent reputation. It is one of the few in Bombay city which operates on a whole-day basis. Further, official school policy forbids students from enrolling in tuitions without explicit permission. To compensate for any sense that children are missing an advantage, the school provides services. My ward was encouraged to stay back after school to participate for an hour of extra coaching by one of the school teachers. Zena spoke of newer facilities offered by the school.

> I: Are there aspects about your son's school that are good or bad for his mental health?
> R: My God! Their school is excellent. Their school is no comparison. They have a psychoeducation group. They have remedial classes. They have a psychiatrist coming every Wednesday. They take good care… If you see their exam papers also, the pressure is not there. It's a cakewalk paper. Their school is excellent.
> (Zena)

Exams

This last quotation also highlights another aspect of the educational system that deeply troubles some parents--examinations. All of the herculean labours that the children undergo is aimed at getting them through examinations successfully. Exams, in particular, create a great deal of stress and fear.

> That fear… fear of the exam, fear of the situation, fear of something else.

(Manjusha)

While fear is experienced in the lead-up to the examination, depression and suicide are the result of doing poorly in these situations. The quotation by Zena, in particular, narrates both the high cost of doing poorly as well as the reason why such a high price is tolerated.

> Depressed because maybe [they] didn't do well or something in an exam.
> (Floyd)

> Like now you see for every little thing, a student is committing suicide. Yesterday my daughter did so badly in Hindi. She came home and the way she cried, which all my life I never cried. If I had a red line (a failing grade), I would have not cried. That… sensitivity was very low. I was not so sensitive as she is. The competition was very low. So even if I've got pass marks, I would have survived in this world. Today the competition is very high. So the pressure is so much on her. She cried and cried, and she would have been desperate and done anything, no? We would not have… even had that least inclination to do it… They will think that the easiest way is to… commit suicide… Like yesterday when I told my daughter… she was upset because the whole percent comes down. Unit Test she got 70. Now she went to 60. So that affected her very badly. And then I said, "...There's no point in crying and there's no point committing suicide..." "There should be mercy killing," she's telling me. I said, "Mercy killing. Doctor should kill you." But see how she got that idea.
> (Zena)

While there may be other causes of depression and suicide, it is relatively easy for parents to make a connection to poor school performance.

In Chapter 3, I had pointed out that parents were generally unable to name mental conditions when the question was directly put to them. Depression was the only condition that could be named by more than one respondent. Yet, in the context of school, some parents spoke unprompted about these issues, thus demonstrating that mental health concerns are probably bound up in the school context.

What Parents would like from the School

Parents try really hard to enroll their children into good schools. Living in a city maximises these opportunities.

> Basically, here now she's not exposed to the rural undevelopment and all those things. Here we have power... We get all the things: doctor, medical service. But in rural areas, all these things are not there. The schools are undeveloped.
> (Manjusha)

> I compare [my son's school] to [Zara's]... I said, "If you were a boy, I would have put you there." In girls, we don't have any good school like this.
> (Zena)

They are willing for their child to be enrolled early if it means entry into a good school. The effort to obtain enrollment causes stress to parents (Bhavana).

However, the hope and expectation may be that a good school relieves them of anxiety because the teacher serves as a proxy for the parent. Thus the parent can achieve peace of mind even when absent from the school context. The child is safe in school where the environment is clean and the teachers are caring.

> Because the child is staying with the teacher. The teacher is the whole and sole when the child is in the school.
> (Varsha)

Some parents spoke of expecting the teacher to give individualised attention to the child.

> Teacher should know how the child is, the student is and accordingly she should react. If you ask one question and Nishad is not giving proper answer and… his friend, he's excellent, so she should not expect the same thing from Nishad. She should understand because… his IQ is not... equal to… that other student. So she should expect... from Nishad, as per his level.
> (Chandan)

Other parents question the feasibility of this expectation. In the following quotation, Cesar likens the school to an overcrowded train.

> In the train, the train capacity is of 75 passenger, the train is carrying 150 passengers. The question of taking care if that one person is sitting or not, that never arises in a school. So… there is no place for a school to take care of the child regarding mental health. Even if something happens they simply call the parent and send them home.
> (Cesar)

It is possible that parents seek out tuitions to rectify this lack of individualised attention because some of these classes are organised for smaller groups, especially those that are run in private homes such as that of Uttara or Mayuri.

Parents also reported wanting to see more health programmes in the school. These might be described as existing more as wishes than reality.

> Once in a month, the government can arrange [a health] camp in school.
> (Varsha)

What Lurks outside *Le Cordon Sanitaire*

I have described how parents rated school as a relatively safe zone and ascribed safety to various connected aspects. By that measure, the space outside the school was perceived as dangerous. Half the parents were able to describe difficulties that could ambush their children in this unsafe space between school and home (see Figure 5.1). These were the things that caused them worry: drugs, tobacco, outside food, traffic and garbage.

> Drugs… I think we didn't know even what are drugs … Nowadays… it has come… upto the gate of the schools.
> (Mayuri)

> [The school canteen] does not have a variety of things, first of all, for the children to eat. So that tempts them to go outside… So they get tempted to eat something different out.
> (Floyd)

> Basically now vehicles and all are there. You don't walk down to the school. What we do is we prefer to go by *rickshaw*, send them by *rickshaw*. (three-wheeler taxi)
> (Manjusha)

> Just you walk for five minutes, you find… on the road only *kachra* (garbage)… Definitely it affects health also if you are going on the same road every day. When you go to school, it affects your health.
> (Chandan)

> In rainy season, if you don't see… the manhole [the child can slip into it]. The person has an accident.
> (Chandan)

In addition to these, parents spoke of unusual incidents that are characterised by extreme predictability.

> If she's in school or if she's... on the road, while coming or going and if political disturbances will arise, then definitely [it will be] a concern with her.
> (Puneet)

> Basically, recently in Hyderabad, how it happened *ki* children they had gone for that industrial visit and in that day *bam visfot* (explosion), everything finished. So that way that worry is definitely there.
> (Manjusha)

> I: So you're less likely to worry about Zara because the school is closer than your son's.
> R: Yeah. Yeah… Definitely. How to get him back? How would I…? What would happen? Or where would he be? Or by the time I go where will he be? See! That happened [on] 26th July also. It was a very bad experience.
> I: The day it rained heavily?
> R: Heavily. So long [as] they are in the school, it's okay. I'm there. They are there. It is safe. But… in-between coordination? Then you don't get transport. That becomes a big thing… [a] sword hanging on your head.
> (Zena)

> When you walk on the streets, there is much more vehicle traffic--buses, taxis. Bombs go off. Buildings fall. So from that angle, [danger] has increased.
> (Namrata)

Not at the Cost of Education

Education really is a parent's number one priority. As demonstrated in the interviews, it truly dominates the thoughts of parents in many ways.

When asked about important goals for the children, education-related items were mentioned more frequently (37 times) than any other goals such as career (18 times), religion and good values (11 times), being healthy and being financially sound (9 times each). This configuration of parental goals has been reported in other studies with urban Indian parents (e.g., Sapru, 2006).

Parents mentioned delaying or sacrificing many pleasurable and important activities in favour of examinations and school, especially for Std. IX and X students.

They curtail play. They do not go on vacation. They pull children out of cultural and religious activities.

> There is no typical family vacations… One year we go for three times. Now this year… he is in ninth standard. His cousin is [in] tenth standard. So we plan not to go anywhere for two years at least.
> (Chandan)

> I: What time do you'll say the family rosary?
> R: Actually, first we used to have it outside only at 7.30. But now, you know, because of all these schedules… Some children go for… all these things, no? like classes, tuitions. So now like few months only, this thing has been stopped. Otherwise we used to have a rosary.
> (Isabella)

> To maintain Arjun's health? Nowadays he [does not] get exercise. Earlier I used to send him for cycling [in the] morning.
> (Uttara)

> [R]ight from the first, when they were in first, second standard I had put them in the dance class, *Bharatnatyam*, and they completed their five years, you know? Two more years, actually I wanted them to… complete their seven years. But because of their studies, and, you know, all those tuitions, clashing… Always my… wish was that they should have been a good dancer. But that went off.
> (Sara)

We have already seen in Chapter 4 how overwhelmingly important food was for maintaining health of teenage children. Thus, situations where interviewees are willing to compromise in this critical area enable us to gauge the relative importance of the activity in favour of which that compromise is made. For instance, parents spoke of changing familial patterns related to celebrating festivals where they purchase sweetmeats that were earlier prepared at home because they no longer have time to prepare them on account of work. Manjusha, who works outside the home described how, during her first pregnancy, the long work commute precluded her from preparing by hand suitable foods for her infant daughter, and then how her subsequent job (which was closer to home) enabled her to provide these hand-made foods for her second child.

In the context of education, Zena described how she compromises on home-cooked food in favour of prepping her child for the school exams.

> During exam times, there's no food. Two-three times I have brought food from outside because I sit with him when he comes.
> (Zena)

I also mentioned earlier that there are special food practices related to improving intellectual functioning.

> We try to give him almonds, etc. Almonds make the brain... better.
> (Lakshman)

Health at the service of education

Finally, when asked to describe a healthy person in the abstract, the participants gave very few functional descriptions. However, several parents agreed to the statement, 'Health is only valuable to the extent that it permits me/my child to do several things.' Though there was some misunderstanding about the statement because the English wording was difficult even for the native-English speakers in the sample, some of them responded using functional statements related to education.

> If health is good, you can concentrate. Then you can study. Then you have a good career. Then you have good future. You… earn money, status. So health is a base. If health is not permitting to do all these things, there is no question, no? Health is a base… Suppose I want to… go [to] Vaishnavdevi or I want to climb that … mountain... But I can't… due to my health. So health is must. Health is a base for anything. For study also, if your health is good, you can concentrate… Suppose your eyes are weak, you can't read… If you are sleeping whole day due to this health problem, so how will … you go for your other things? So health is a base.
> (Chandan)

They endorsed the idea that health was critical for the child in order to permit them to undertake their educational activities successfully.

Conclusion

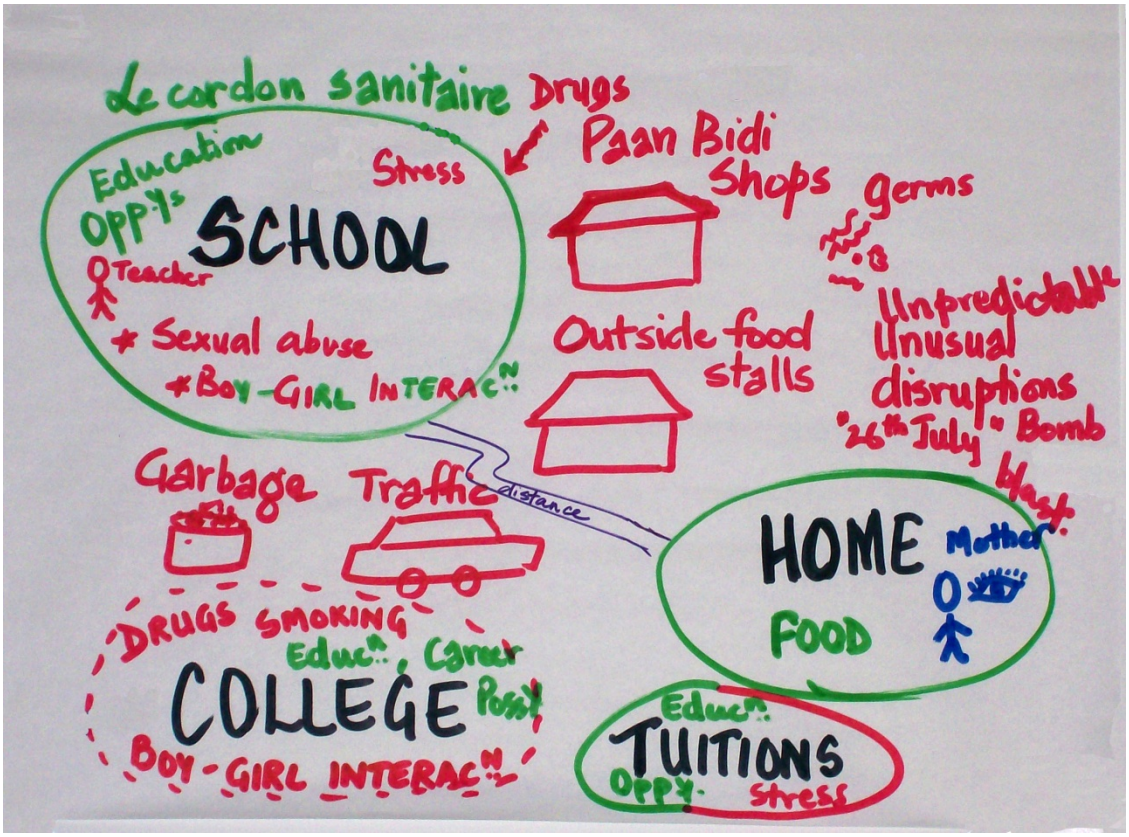
This was a study of adolescent health, and I started out with very little content in my interview schedule pertaining to education. However, as data collection progressed, it became more and more evident how closely bound up parental ethnotheories are with the domain of school. During analysis, it became evident that a new research question was crying out to be answered, namely the relative values of health and education.

In this sample which, for the most part, included healthy children, parents appeared to state that education was the foremost activity for children. They were willing to push children in ways that endangered both physical and mental health. They were willing to defer many other social events if they perceived that the child needed to pursue some educational activity. They were willing to make personal sacrifices to give their children educational advantages. While food was seen as critical to good health, one parent stated explicitly her willingness to forego home-cooked food during examination times.

This drive on the part of Indian parents towards education has been noted elsewhere. For instance, Parmar, Harkness and Super (2004) found that parents born in India were more likely than U.S.-born parents to stress the idea of a head start in early academics as important to the cognitive development of children.

However, the extent to which parents are willing to favour education over health is not a desirable situation, and offers much scope for intervention.

Figure 5.1. Parental lay theory about risks to adolescent health



Chapter 6

Lay Theories: What Influences Them?

According to my initial formative model, I had suggested that influences on parental lay theories included beliefs about religion and gender, experience with illness, and broader societal changes (see Figure 1.1). In this chapter, I discuss variables like gender (female versus male), religion (Christian versus Hindu), family history of illness, mass media and influence of friends and parents. However, it is important to state at the outset that this is a chapter that is difficult to write because the data supporting these ideas is limited in nature. Overall, there was much less consensus over these ideas than the ones developed in Chapters 3 through 5. Therefore, I offer them much more tentatively.

Gender

At the outset, I perceived gender as acting in two different ways: namely that the lay beliefs of parents might differ based on the gender of the parent as well as the gender of the target child.

Did Fathers and Mothers have Different Lay Theories about Adolescent Health?

The answer to this is, mostly "No." It is true that in Chapter 3, it was fathers who describe physical fitness as a dimension of health rather than mothers. But this was a small number of participants. With regard to the assessment of risk of common conditions that cause death and illness in adolescents (World Health Organization, 2002), fathers and mothers held similar views, except for the item, 'Violence outside the home like being involved in riots and political disturbances.' Finally, there were no gender differences on the Parental Health Locus of Control measure.

In the qualitative analysis, there was no difference between fathers and mothers. The key themes related to food, friends, mass media and education were cited equally by both parents.

Would the Gender of the Target Child Alter the Lay Theory?

Directly asking questions of participants about whether they would do different things for male and female children commonly elicited a negative response. This was expected, first, because as anticipated, several parents were unable to identify a possible difference because they did not have children of the opposite gender. Though I had planned to recruit parents who had at least one child of each gender, several of the parents who volunteered for the study had only one child, or children of one gender.

> See we cannot think, you know, like that because when they are boys we only think about boys. We cannot think about a girl. If there was a girl like, then we would have thought.
> (Isabella)

The second possible reason concerned the social desirability of the response. Parents were less likely to mention different actions based on gender. The third possibility is that parents did indeed tend towards more gender-based equality. So, they might have meant it when they reported not intending to treat boys and girls differently.

However, some parents did mention that gender influenced expectations. This occurred with regard to situations involving male-female interactions.

> Basically our society is a male-dominated society. So first it is the girl whose character is going to be named [when a couple is caught holding hands].
> (Manjusha)

Gender was also reported as influencing career choices by Zena. She brutally acknowledged the greater burden of expectations attached to males--a bullet that girls could dodge. Thus, her son could not afford to slack off in his studies or else he would end up as a *Ramu*--a low-paid domestic cook. In contrast, marriage and being a stay-at-home wife was perfectly acceptable for her daughter

Another area where a couple of parents acknowledged some differences based on gender of the child involved restricting the activities of girls while menstruating. This was mentioned by a couple of Hindu parents.

When comparing the ethnotheories related to sons and daughters, three parents mentioned differences between the risk posed by friends of boys and girls. Interestingly,

Puneet and Mayuri had only female children. Zena had a son. But he was just out of primary school. It was interesting to note how two of the participants lapsed into Hindi to capture the flavour of boys' friendships.

> [B]oys get more freedom, you know normally. Suppose if Surotama was a boy, then if he would say, "Mom. Mom. I want to go there," or suppose if he comes late, I won't bother that much. For a girl at least let it… I'm a liberal mother. Then also, I won't allow. Upto some extent only I can allow, no? for a girl... So they get more opportunity, boys. Because generally you know, in India… that mind set is that boys *ko sab chalta hai*, (Anything goes) you know. They get more liberty. They can go. They can roam with the friends. *Agar bara baje bhi aya to* (Even if it's midnight,) it's OK. "Where did you go?" Then…, "I went this… there. I went to… I went with my friend, or I went to movie." For a girl, we won't allow this. We will keep a watch.
> (Mayuri)

> I: What would be different?
> R: This *gutkha* and *bidi*… *tambaku* because her friend circle…
> I: It would be more or less?
> R: More… [H]is friends' circle will be different. So definitely they can easily [get] contacted with *gutkha*. And because… Samiksha is girl so she never go[es] to the… *paan bidi* shop. But if she will be boy…, then he'll definitely go to the any *paan bidi* shop and *gutkha*… Then her… his friend circle will be different. More *chalo hum karke dikhaenge, karenge*… (Let's do it and show them. Let's do it.) So… "We'll do it. Come on, let's go to... any... sex workers' area and…" So they will come closer to HIV or any… So that is the thing.
> (Puneet)

> Now… boys, they are generally not home bound. So exposure outside is there. So those things, where they walk, how they go, whom they interact… So the infection level is much higher in the boys. So that would be a point of concern for me. As soon as he fell sick I'd be more concerned about how did he get infected or is this infection great. But where Zara is concerned she is more home-bound. She's got only… a limited circle [of friends]. She doesn't go here, there and everywhere, whereas boys are not like that.
> (Zena)

A common element in all three narratives is the perception that boys are granted more freedom than girls. This permits them more opportunity to interact with friends outside the home and to access places that pose a threat such as a red-light area or a *paan bidi* (tobacco) shop where they gain access to cigarettes and smokeless forms of tobacco.

Further, Puneet and Mayuri comment on the male attitude: *chalo hum karke dikhaenge* (Let's do it and show them) and *sab chalta hai* (Anything goes). This smacks of willingness to try out anything.

It is curious that parents of boys did not mention such ideas. Which begs the question of why parents of girls (and a young boy) are more likely to view boys at being more at risk. The answer might lie once more in '*cordon sanitaire*' type beliefs: namely that, "My daughter does not have such freedom, such access, such opportunity. So I do not have to worry." The opposite possibility is that parents of male children are able to successfully monitor the behaviour of their children. So the question of such behaviour does not arise in their family context.

Research on Indian adolescents does show that male youth have more freedom than females, and consequently more risky behaviours (e.g., Bhende, 1994; Mehra et al., 2002; Siziya et al., 2008).

Would Lay Theories differ in relation to the role of Fathers and Mothers?

For Indian parents, food is a critical element contributing to good health. Across the board, fathers and mothers endorsed the role of the mother as being in-charge of food.

> R: She makes... more dishes.
> I: Your wife?
> R: Yeah. Of course she is cooker (sic.). I'm not [a] cook. So she makes good food.
> (Puneet)

Fathers were seen as providers. If the mother was the Health manager, then the father was the Purchasing agent. However, given that many more women are now in the workforce, they are unable to carry out these expectations as their mothers would have.

> I told you… his mother and my mother, that generation gap, those times mother was having only one routine - she had to take the role of a mother. But today that mother has to take the role of the financial work system. So it goes a little in a reduced manner.
> (Cesar)

Mothers also appear to be willing to give up their career in order to ensure that the home does not suffer. Thus, the statements by Zena that I discussed earlier in this section are likely close to reality

> [S]ometimes there's a feeling in… ladies… when daughters are born, at a particular age they should leave their job and sit in the house because they have to be more careful for the children, because… most of them, they are going on a wrong track of this drugs and all.
> (Manjusha)

> (Speaking of her mother) She is 84 years old and then like to take her to the bathroom and all, we have to be [there]. That is why… I left my school… job.
> (Sara)

Gender Discrimination

This was a middle-class sample which had access to several resources for the most part. The poorest parent in the sample was a Hindu mother who was divorced and lived with her two daughters and her father in a one-room house. She had recently lost her sales job. However, the major problem in her family was that she was not permitted by her father to cook in the house for herself or her daughters. Other relatives reportedly complicated her situation by giving her daughters money which they used to buy outside food. All through this research, it was evident that food was the most critical factor in maintaining health. So Bhavana's inability to cook home food takes on special significance.

Bhavana also spoke of food-related discrimination where women traditionally eat after men. This leaves them with both smaller portions and less desirable food items. For instance, the fruit are often consumed by the men. She described how older women in the family, such as her mother-in-law, tend to perpetuate this unjust situation.

As I reported in Chapter 2, I was able to make a referral to the Special Police Cell for Women and Children in Distress. She reported to me before I left Bombay, after completing data collection, that she had contacted the social workers at the Cell and that their follow-up caused her father to halt his troublesome behaviour.

However, her situation highlights a problem that has been noted also in the National Family Health Survey (Ackerson & Subramanian, 2008): Indian women and

children often face malnutrition as a form of domestic violence. This affects health status of both the mother and the child. Bhavana's personal situation was markedly different from those of the other parents in my study. She was the obviously the most economically needy participant. It is possible that there are some social class differences with regard to how gender discrimination is practised. In her familial context, it played out through controlling access to the kitchen.

Religion

I described in detail in Chapter 1 how health outcomes in India differ based on religion. This led me to wonder about the pathways through which religion might influence health choices and health status in India. This was especially important given that India is a land of many religions and religion is an important aspect of social life here.

This group of Indian adults was not different. When asked "How important would you say that religion and religious beliefs are to you?" the mean response was 4.18 (*SD*=1.26), that is parents were likely to say it was important. The one dissenting parent who said it was not at all important was (nominally) Hindu father, Puneet. He was raised Hindu but did not practise the religion at all. Throughout the interview, he was able to describe Hindu practices in detail. But he scoffed cynically at all of them.

However, in the realm of health, parents generally reported that religion did not play a critical role. So in response to the statement, "Trying to maintain health is a religious responsibility," parents leaned more towards disagreeing than agreeing (*M*= 3.59, *SD*=1.50).

> I: Trying to maintain health is a religious responsibility.
> R: 4… It does not depend on religion... It all depends on what we people believe. It does not depend on religion. But we people pretend that it is a religious matter. Means we maintain that belief.
> (Lakshman)

Religion Encourages Healthy Behaviour

Individual parents spoke of particular pathways through which religion affect health. One way is that religion encourages people to live lives free of pleasurable yet

dangerous activities (Yeager et al., 2006). A few parents in my study mentioned this aspect.

> I: Do you think that health and religion are connected?
> R: Health and religion… In what way? (laughs)… It can sometime maintain your health also, no? In certain things like, you know, do's and don'ts, religion does play an important role there… Don't overindulge in… eating habits.
> (Floyd)

> I: Can you explain how your daily habits reflect your religion?
> R: Since I am very fond of sweets… I know my health permits that I should not be eating too many. But still I cannot. That's something I cannot… control… Gluttony is a sin… Excess eating is a sin.
> (Jeannie)

Certain religious practices are health-inducing, as we see in this passage where Mayuri describes the significance of drinking boiled water and fasting.

> I: What is the part about boiled water? Does it have a… religious significance?
> R: Yeah. 100%... It is because it doesn't contain any germs. Germ-free water. That is the religious thing. But this is totally a scientific religion.
> (Mayuri)

> Now fasting… What is it? ...To give a rest to the whole system of your body… So by fasting you maintain your health. You rejuvenate because our system needs rest. But... by religious practices you know we'll… willingly do it.
> (Mayuri)

Zena also speaks of a social justice angle to certain religious practices.

> I: You eat vegetarian food on Fridays.... Can you explain to me… the Sacred Heart feast because that I don't understand?
> R: Yeah. Right. Now I was given to understand that generally Fridays was made to have a vegetarian date, even though we eat fish on a Friday not meat because as per the olden days people used to live only on meat. So the fisherfolk never used to get any income. So that one Friday, if we devote it by having fish and vegetable, that means that income, at least once a week they would get to eat… So that abstinence we follow on Fridays.
> (Zena)

But it wasn't possible to find a reason for each and every practice.

> See Hindu religion is more scientific. So probably there is some scientific [reason]… why they say, "[D]uring eclipse, don't cut fish. During eclipse, don't

look at the sun, pregnant [women] and all." Now we have seen lots of cut lips and all. But all this normally takes place only in third world countries, not in advance countries. I don't know why.
(Zena)

Moreover, the belief in the positive power of religion was not uniformly shared by all. Puneet was a case in point. For instance, he rejected outright the practice of fasting because it was undertaken in a thoughtless manner that actually endangered health

> [M]any of the peoples from Kolhapur or Sangli Sattara district, …they are taking concern with their children's health. But at the same time they are saying, "No. Today is *ekadashi*. So you must make fast..." [My] sister who is staying in Kolhapur, she always say, "No, no. Today we are not going to eat so-and-so. I'll take complete fast." You're not well, you have to eat eggs, or you have to take milk or you have to eat something because of doctor's medicine or doctor's advice." "No, no. Today is my fast. I'm not going to take medicine."
> (Puneet)

Another pathway mentioned by Christian parents was through specific practices that improve mental and social well-being. These include retreats and confessions which provide an institutionalised medium for ventilation of personal concerns and worries.

> I: [Y]ou believe that health and religion are connected…And you feel that one of the ways in which it is connected is that when you have bad feelings towards somebody it can work… on you… Are there specific ways in which religion helps you to release these bad feelings?
> R: Yes. When we have a retreat or you have confessions where you just letting go… You know, you have [someone] to talk to and tell them, you know, that these are the things that you have done. It's no longer in. It's out.
> (Jeannie)

> R: We have our confessions that we have to go for.
> I: How do you think confession helps?
> R: You feel that you are forgiven … You realise that you've made a mistake. That is the biggest step. Asking for forgiveness, and the main thing of feeling that you are forgiven by God, that you are cleaner… Everybody makes mistakes… but that you're not being held for it.
> (Nikita)

Religion and Institutional Resources

Christian parents also spoke of certain institutional resources that were available to them. This is one connection that has been well-documented (Chatters, 2000). The priest is the connection point for many of these resources.

> I: How does religion help in keeping the emotional self clean?
> R: [I]n our church, constantly they bring in doctors. They bring in different people… to give talk[s]… Even bring in a heart specialist or surgeon to give talks. Even cancer specialist came to tell us, to keep us aware about, you know, when we have lumps or this.
> (Nikita)

> I: If a friend came and said, "Isabella, my son, he's taking drugs? What would you suggest to them?
> R: …Now they have so many counsellors like you or somebody… Then you can go to meet the doctor or something, and then we can help out. Now there are various institutions… Bandra, there is one. But I cannot get the name now…The priest, they give the letters to [these places]
> (Isabella)

Some of these are specifically youth-oriented.

> I: What steps would a priest suggest for depression?
> R: Counselling. Or they will say, "Go for retreat" or something like that…
> I: How would a retreat help with a mental problem like depression?
> R: Maybe an exclusive retreat for… 14-15-year old… teenagers… Not a… retreat where… [you] pray on your knees … [It's] more… holistic… like the Salesians… what they have. It's a camp. They never like to call this as a retreat. They always call it a camp... Like the Focolare... Very holistic growth… I sent them last time to Roha for a camp. He likes to go for these things.
> (Floyd)

Many Christian parents also appeared to know that if they had a problem with their child, they could approach a priest for help.

> I: What do you do to protect or maintain Penelope's mental health?
> R: … [I]f there was need then I would take her first to a counsellor. First the church, priest where they counsel… They are trained… during priesthood to counsel.
> (Nikita)

But not all Christian participants reported feeling comfortable about approaching a priest with their concerns.

> See actually if you go to see, I don't believe in priests at all because I know. I have been with them. So I think they are of no help actually.
> (Isabella)

Moreover, for some Christian parents, 'counselling' involves a person who is child-friendly and it is not necessary to always seek out a professional counsellor for this quality. They prefer to use such informal resources first.

> I: Now if a friend told you that their teenage child had been sexually abused, what steps would you suggest to them?
> R: First of all, to ascertain… the fact, that is one thing… Put the child onto some type of a counselling… [They] could talk to somebody who… the child can confide in first, who's very comfortable, not necessarily a counsellor or a person who's qualified as such, but somebody's who's very friendly with the child and child will be able to open up and share.
> (Floyd)

> First! Because I wouldn't want to go straight to a psychiatrist or something unless I really feel it necessary. So first a… a counsellor … It doesn't have to be a counsellor. It could be even my Mum or an elder if she is not listening to me. Priest. Unless it's really, absolutely necessary then a psychiatrist which I don't think it's necessary.
> (Nikita)

Most of the previous discussion involved reports from the Christian participants. The pathways through which religion influences health were relatively better defined for this group. It is also possible that being a practising Christian, I found it easier to question the Christian parents in the relevant areas, and was quicker to recognise the implications of certain behaviours.

In contrast to the ease with which Christians utilise the resources of the Christian church, most Hindu parents were unlikely to approach a Hindu priest for succour during an episode of illness in the manner that a Christian adult might consider with a Christian priest.

> I: If your son had a problem with depression what steps would a *pandit* or a *pujari* suggest?
> R: I don't think anything.

(Lakshman)

One other difference between Christian and Hindu parents occurred when discussing their goals for the child. Christian parents spoke of marriage in connection with their daughters as one choice. Hindu parents did not mention it nor did Christian parents speak of it in relation to their sons. It is curious that Hindu parents did not speak of this though a good marriage is certainly a concern for them as well. One possibility that occurs to me is that Christian parents might feel able to voice this because marriage is a religious, sacramental obligation for them. This provides an acceptable way to mention it.

> I: If we were talking about your daughter, would the goals be the same?
> R: I think the goal would be the same… Of course by the time she is 24, we hope that… she's decided to join the convent or get married. Either way she would have made up her mind by that time.
> (Floyd)

Dealing in Stereotypes about Religion

An important aspect is that parents who referred to religious differences in responses often seemed to be describing stereotypes pertaining to members of other religions. Thus, Hindu father, Lakshman, points to Muslims, and Christian father, Floyd, points to Hindus.

> I: Do you think there are people in India who see a connection between health and religion?
> R: Could be... From what I have seen, Muslims who I know, they have more connections about health, I think. Friday prayers and all… About the prayers and all, I think they do a lot of it… There is probably some connection with health.
> (Lakshman)

> [T]hey've started a lot of programmes… I think they have something on sex [education]… Last time they had it even for the parents and for the students also... Of course, for us (referring to self as a Christian), OK, we have been exposed to lot of things. But… for the non-Christians like, you know, it becomes sometimes… like a shocking thing, (Laughs) embarrassment to sit down.
> (Floyd)

Sometimes these stereotypes applied to the parents' sense of their own religious identity. Thus when Christian mother, Nikita, is asked for her possible response to her daughter drinking a local drug during the Hindu festival of colours, she is quick to dissociate herself from it. This raises the question of whether this is yet another manifestation of *le cordon sanitaire*.

> I: Say that you found out that Penelope had been involved in drinking *bhang* (preparation of cannabis) on the occasion of *Holi*, what would you say?
> R: She wouldn't … My daughter wouldn't do it. That's the initial thing. She wouldn't do it. We are not against alcohol. We are Catholics. We drink. I mean I'm not saying we don't drink. But she drinks wine. I have not stopped her from drinking wine. She loves wine. She loves liqueur… A liqueur, or wine or… brandy and rum. She doesn't like those also… Definitely, the situation wouldn't rise because she wouldn't take it. She knows the harm of doing something like that.
> (Nikita)

For Nikita, the idea of her daughter drinking bhang is rather far-fetched because she is a Christian, and this is not what Christians do. Similarly, Cesar, a Christian father, tries to preserve his Christian identity. He adopts a health practice of Hindus but tries to make it more Western, and, thereby, more acceptable.

> I do my regular exercise in the morning. I have a copper jug… There's always water at night… [In the] medical field it is very good to keep water. In Hindus they keep a copper *lota* (tumbler)… So same effects. I cannot keep the lota because… we have to maintain our Christian system, you know. So I have purchased a copper jug.
> (Cesar)

However, these same notions pertaining to specific religious groups may also be negative in that they create a norm of what is acceptable behaviour for young people.

> There are many in our own Catholic families also. Parents feel... very great. "Oh, my son knows beer. When I drink beer, he comes and takes the glass." You feel very elated about your son being very mod. But that's where our children are going wrong. (Later referring to a state where there are many Christians) That Goa… 14-15 year old girls, even the small young boys, sometimes even 14 year-old boy is smoking.
> (Zena)

Family Experience of Illness

Family illnesses tend to cause parents to worry about them recurring or repeating, especially when more than one family member has suffered from it.

> [S]ometimes even my Niyati as well as Ameya, they complain of headache. So that thing worries me.
> (Kishori)

> I: Heart diseases and related conditions.
> R: It's a great worry actually because we have got a family history… of hypertension and… heart problems.
> (Floyd)

> When I think of my daughter… my main worry is cancer. First is cancer, then respiratory conditions like pneumonia and all those things. First cancer. (having lost both her father and her husband to the disease)
> (Nikita)

When children experience recurrent problems, parents become alert to specific symptoms pertaining to impending episodes and they take action to prevent or mitigate them.

> Now winter… she gets skin peeling which I also used to have when I was small… So that as soon as skin starts peeling I remember to go and get the medicine and, you know, two-three months of it and she's fine.
> (Nikita)

Nikita also mentioned that, as she has dealt with cancer, she is aware of specific resources that might be of use. Zena spent a lot of the interview time educating me about her mother's condition.

Mass Media

Parents report that mass media such as newspaper and television inform their ideas related to health. This was congruent with earlier reports of mass media as an informational resource for children.

> Now they keep showing in the TVs that… nowadays even small children … are prone to diabetes and blood pressure.
> (Kishori)

> I read in the paper there was a boy of a high class family, of a rich family or a very high class family, who got AIDS because he landed in a red-light area and he didn't have the face to tell his parents.
> (Zena)

Parents' Professional Training

Parental ethnotheories related to health also reflected the impact of their professional training.

> Sometimes… being in a pharmaceutical, that is a habit of mine. Even if I go to visit somebody in the hospital, I look at their medicine. I don't have to ask the person, "What you are suffering from?" (Laughs)… I look at the medicines and tell you for what it is approximately. Mostly I use… a lot of things what I have got knowledge [of].
> (Floyd)

Thus, Mayuri, the parent with training in Microbiology, is the one parent who speaks of germs, and Manjusha who is a trained food technologist, had elaborate suggestions related to food. Ravi who works in water sanitation spoke of the significance of 'potable water.'

Parents, Friends and Professionals

These lay theories of health are also learned from parents, friends and professionals. We have already had a preview of this in Chapter 4.

> When… Arjun was small, three or four months, he was too healthy and he was... [a] cute and very nice child… [N]eighbours used to say, "So gorgeous..." After that he was not well for one hour. Even after cleanliness, after taking care from all the sides he was hospitalised, and after that… my grandmother… told me…, "This may be the reason. *Nazar utaarne ka* (Remove the evil eye)." [T]hat time I started believing it because… I suffered like anything behind it.
> (Uttara)

> The thing is we are traveling by train. We don't have just office colleagues as such. We have train friends. We have office friends. We have outside friends. [P]lus… I have a friend who is at Nanavati [hospital]. So she keeps telling me what are the things... So it is not just limited to one source.
> (Jeannie)

> [M]y mum is basically against us eating out… That's the reason why … I've just carried it with me.

(Jeannie)

I: [W]here do you get your information from?
R: It's basically like through my colleagues… [W]e all are mothers who have kids. So we get our information from our children. We pass it onto each other like there's something… maybe a health problem, or maybe it's a teenager problem.
(Jeannie)

And one of the doctors where I go, he told me that they have lot of mood swings especially when they are getting their periods… And he has also… got a girl. So he's turning to me, "Zena…you have to just be cool."
(Zena)

One reason (or perhaps consequence) why there is less congruence among the various sources that influence and shape lay theories is probably that they are varied, and differ from individual to individual. Another possible reason for the different notions of folk medicine that have been discussed throughout this dissertation is that there are three systems of medicine practised in India: allopathy, *ayurved* and homeopathy. While allopathy is more dominant, the other systems also enjoy a significant degree of acceptance. Some Indian adults appear to pick and choose among the various systems.

I: If Zara had a cold, how would you treat it?
R: Give her medicines… Like normally Crocin… Adolsa is a good syrup… *Ayurvedic* syrup. *Ayurvedic,* homeopathy. See! Homeopathy [you] must give for asthma, which is a long-term like diabetes, asthma, pressure. But if you're getting cough and cold and fever like this flu, change of climate and all, then direct you have to give allopathy. No wasting time.
(Zena)

While this chapter sheds some light on the factors related to lay theories of health, these are tentative suggestions. Certainly, more research is required to explore them further. Moreover, it is not clear why some ideas are more easily accepted by people than others. This is, perhaps, critical given that health professionals hope to shape and influence some of these concepts themselves.

Chapter 7

Discussion and Implications

This dissertation focused on lay or folk theories of parents of adolescent children living in the Indian city of Bombay. The ethnographic approach permitted an in-depth exploration into parental beliefs in this area. My research questions centred on the content of such lay theories, and on how these theories may be influenced by factors such as religion and gender. There were three key findings that emerged: the contrast between adolescent health concerns and what actually worries parents, parental views about food, friends and mass media, and, finally, the overwhelming importance they place on health. I will examine the implications of each of these points.

Parents and health professionals worry about different things

As a professional medical and psychiatric social worker, my focus has always been on health concerns that claim lives and affect health. The list of health conditions used in this study derived from the Global Burden of Disease. It is a good example of health concerns that would dominate the thinking of professionals like me. However, the Indian parents in the study were less worried about such issues as drugs, respiratory illnesses and heart conditions. They were preoccupied with food, friends of their children and mass media, thus manifesting a big mismatch between the concerns of professionals and lay persons. The parents characteristically warded off the possibility that any of the Global Burden of Disease conditions would affect their sons and daughters, explaining that school was not a geographical location where these were likely to be encountered. Rather, they stated that these were more likely to be of concern once the adolescent entered college. Their explanations were similar to the justifications observed in other studies involving people at risk of sexually transmitted infections, namely *le cordon sanitaire*.

Such '*cordon sanitaire*' type explanations could have many repercussions. First, it is likely that health campaigns related to these problems would fall on deaf ears if all parents of Indian adolescents seek to rebut the assertions of such programmes as strongly as did the parents in the study. Second, even if something were amiss with the child, such a lay belief would predispose a parent to dismiss it, and help-seeking would be delayed. Health education would need to be specifically tailored to anticipate such objections--to counter parents' convictions that such things do not happen in schools, and to make these conditions more familiar.

Related to this was the evident fact that parents were relatively confused about mental and behavioural health of youth. There was some confusion about whether good mental health consisted of being able to cope with stress, or whether it meant being intellectually quick. Further, when questioned, parents were not inclined to seek professional assistance. They indicated that they would first attempt to address the problem within the family. Next they would turn to friends and relatives who have a friendly disposition, or to those in their circle who have some level of professional training. As a last resort, if at all, they reported willingness to meet with relevant professionals such as psychiatrists and counsellors. This delay in help-seeking is quite common to the Indian context as has been observed in many other studies (e.g., Nair et al., 1997; Nichter, 1985). So too is the tendency to look to treatment providers with good reputations (Ager & Pepper, 2005). However, the delay in seeking help could be a serious health concern for the adolescent in question, that is if they receive any type of help at all. This is another area for social work intervention--creating awareness about the need for assisting young people with problems, and spreading knowledge of where such services might be available. That there is a need for such awareness was evident also in the fact that several parents in the study carefully noted the list of child services that I distributed at the end of the interview. Some folded it and put it away carefully.

Further, there are some natural helpers in the community that tend to be the recipient of such parental queries. For instance, in the study, two parents mentioned approaching the respective school principals for advice on behavioural issues. These are usually people who are in some position of authority because of their professional

background. In the case of Christian parents, the priest took on specific significance. One recommendation would be to build awareness of recognition of youth concerns among these individuals, as well as awareness of referral resources within the community. Avenues for this could take the form of circulars from the State Education department to the schools or from the Archdiocesan Board of Education to its member institutions. Sensitisation programmes could be incorporated as part of seminary training for priests in training.

It is also important to understand the difference between the perceptions of parents and professionals as a methodological issue. Calnan (1987) noted that the manner of asking a question about health was responsible for the kind of answer he received: positively-worded statements or negatively-worded replies. Other researchers have also cautioned about how the style of questioning tailors the answer (e.g., Schwarz, 1999). In my study, I asked various types of questions. Directly asking parents how to recognise a healthy teen compared with asking them to assess how much of a risk is posed by some behaviour or activity resulted in what I termed as the difference between perceptions of parents and health workers. Leaving out one or the other question would have meant an incomplete sense of what parents actually have on their minds. Large representative sample surveys may ignore or overlook some of these aspects that may be fundamental to parents' world-view. So it is important to frame these enquiries thoughtfully.

What I noted in the context of a research study may also recur in a clinical context. Counselling training modules for social work students should highlight such differences in questioning style, and how they may influence the assessment and interview process.

Implications related to food, friends and mass media

While parents did not report concern over conditions such as drugs and sexual abuse, their theories of adolescent health were bound up around three aspects: food, friends and mass media. The latter two were seen as possibly interfering with good educational performance and also sometimes creating premature sexual involvement.

That parents are concerned about food could be seen as a strength that should be encouraged. As I reported in the Introduction, alongside malnutrition, the National

Family Health Survey has also noted an increase in obesity, especially among urban populations. Linked with this is an increasing problem of diabetes. The parents in the study revealed a great deal of knowledge of what is healthy food consumption and what is not. The conversation around food was also characterised by confidence from the parents. Indeed when designing counselling training modules, inclusion of such a discussion as a rapport-building technique would be a good idea. Further, it would reinforce parents' good practices. In addition, as parents showed concern about the minimal role of school in influencing adolescent health, focus on good food provision through the school canteen could be a good area for school-based social workers to assist parents to build consensus and influence school policy.

However, it is also important to question parental focus on food. For instance, did parents speak so much about food because it was the one area where they were confident about doing the right thing as opposed to other behavioural and community issues (e.g., influence of the internet, road safety)? Further, is it likely that focusing almost exclusively on food would make parents complacent about their role in promoting adolescent health?

Indeed, parents appeared to score really high on the Inner control measure of the Parental Health Locus of Control Scale and they often did cite their role in providing nutritious food as the reason for their sense of control. But perhaps if one were to parse out the effect of good food, the parents might not be left with much else. When referring to other aspects that are damaging to health of young people such as traffic problems, lewd images on television, and readily-available cigarettes, there was not much that parents reported doing. Some parents reported having regular conversations with children about things they may encounter. But parents also expressed inability to influence anything outside the home. This underscores a larger scope for educating parents in how to act to assist their families, as well as to influence their immediate surroundings, for instance, working with parents to ensure that tobacco laws are stringently applied, schools become more responsive, or that mass media develop more family-friendly programming. A first step could be creating awareness among parents about city service

organisations that might be useful to them such as family-friendly bookstores, and semi-legal services.

With regard to parents' views of friends of children, and mass media as being responsible for various problems in children, it appeared that parents held a very malleable view of their young wards, namely any influence at this stage in life would affect them in very definitive ways. Their instinctive response in many cases was to cut out that particular influence that was offensive to them. For instance, they would cut off the 'bad company' of the child or flick off troublesome television programmes. This view of parents of being able to mould and shape the lives of young people under all circumstances is one that is open to question: Are parents really able to influence the behaviour of young people as much as they report? This is a question that should not only be researched more but should also be the subject of parental discussions.

In relation to peers of adolescents, the breadth of problems laid at their door was incredible. While it is true that peers have been implicated in the development of bad habits in various Indian studies, it is also important to acknowledge, as the parents did, that they can also have a positive influence in the lives of children. For instance, some HIV education programmes in the country operate on a peer-to-peer basis. Helping parents to develop a more rounded view of friends would be a positive action. Further, even though peers influence the behaviour of youth in India, this effect is mitigated by other factors such as social class, parental education, and perceived behavioural norms related to that particular behaviour. Further, some of these other studies indicate that there is vacuum in the place of parental action.

Related to this is also the confusion that some parents voiced about adolescent behaviours that were "deviant" or altered from their previous behaviour pattern. Many of these, in the eyes of parents, were seen as the negative influence of peers, such as dressing in "weird" ways or altering hair-styles. Some parents were quick to label these, and other temperamental changes as pathological. This is also an important area for inclusion under parental education and awareness about what constitutes normative adolescent behaviour. Further, creating awareness of just how common some situations are could work towards reducing '*le cordon sanitaire*' type rebuttals.

Parents also need help in expanding their repertoire of actions to deal with adolescent problems. Merely cutting away the bad influence may not be an effective strategy. Parents need to open constructive, two-way dialogues with adolescent children about these and other issues that trouble them. It was evident from the fractured quality of speech that some of the parents in my study did not feel up to the task of such frank conversations. Also, focusing so extensively on external factors could mean not developing internal strengths in the child such as resistance skills. Enabling such parent skills is an area for social work intervention.

It has been suggested that Indian parents have a "cold feet" syndrome--that is they welcome modernisation with all its benefits but then are unprepared for the social changes that accompany these benefits (Saraswathi & Pai, 1997). So at the first hint of social change, they withdraw their earlier, welcoming attitude and become more authoritarian and traditional. However, it should be noted that parents' actions flow from their deep concern for the well-being of their offspring. The so-called "cold feet" probably stems from a perceived inability to handle what is most likely a new and challenging situation. In many instances, these are not situations for which they could look to their own parents as role models as they do for other health-related situations.

Social work intervention in the form of improving parenting through anticipatory guidance would certainly help parents with these concerns. This is a method that seeks to educate and empower families about facts about health problems, risk factors, ways of identifying problems early, and ways to intervene (O'Neal, 1993). One way to address '*le cordon sanitaire*' type thinking is to frame such parental training as preparing them for the period when their children enter college.

Also related to parents' views of friends and mass media is the concern that they may cause premature sexual awareness in children aged 13 to 15. Studies show that the average age of first sexual contact is indeed well-past the time when children are in school (e.g., Family Planning Association of India, 1998). However, it is also likely that these parents may have a later developmental timetable of what is normative adolescent behaviour. Such conclusions have also been reached in other cross-cultural studies (e.g., Rose, Dalakasb, and Kropp, 2002).

Lay candidacy theories are a type of folk medical belief that throws light on why some health measures are more effective than others. When discussing premature sexual awareness created by bad friends and adult-level mass media, parents also reported the view of the child as malleable and open to such influences. This caused some of them to be more likely to support timely school-based sex education programmes as they were themselves unprepared to have such dialogues with their children. Thus, the lay theories of the parents were not necessarily all retrograde.

The compelling influence of education

Parents in India devoted much interview time to discussing education. This hardly comes as a surprise that urban Indian adults place so much importance on education. For instance, studies with Indian teenagers reveal a similar pattern of concerns (Andrew, Patel, & Ramakrishna, 2003). But what was unexpected was how they would conceptualise it as being bound up with health. Despite framing my study as one related to health, and despite introducing myself as a health-based social worker, parents led the conversation back to education. One possible reason could be the manner in which I recruited my interviewees, that is through their child's school. In one school, I actually recruited the parents at a talk on Improving study habits of children. This may have primed the participants to expect questions related to education. However, the interval between the recruitment and the interview was a long one. Moreover, my interview schedule did not mention education in any way. This, combined with findings of other researchers, leads me to believe that education of children was a critical element of parental ethnotheories related to health. It is also possible that since I recruited parents through the schools rather than through a health setting, this was a group for whom health and illness issues were not salient. Possibly, in a less healthy sample, parental folk theories about health may revolve less around education and more around other aspects of functionality. They may focus more on mechanisms of causation and cure. However, this group of healthy urban adults focused on education and food almost to the exclusion of other issues.

While parents worried about how friends and mass media would introduce their children to bad habits that would disrupt their school performance and consequently

blight their future, they also reported how school and private tuition classes laid almost intolerable degrees of stress on the students from Std. VII to X. Parental folk theories of mental health did see stress and worry as unhealthy but were less likely to acknowledge that the over-scheduling of the children's time for educational activities and the minimal time for unstructured play (or any play at all) was detrimental to their overall growth and development. It was interesting to note that even participants who were in the teaching profession often subscribed to these notions, indicating how deeply ingrained was the need for success at all costs. A few parents reported on the relationship between excessive academic demands and mental problems related to suicide and depression. Undoubtedly as children approach Std. X which is the final year in school where they have to appear for their public exam, their stresses increase.

It is important to realise that the parents also experienced worry and concern about this situation. They were focused on how to provide the best possible advantages for their children. Attempts by the Education department to lighten the academic load for the students--through new assessment procedures--only increased the uncertainty and anxiety experienced by the family.

This highlights the fact that while there is dire need for intervention in this area, it is unlikely to be easy to achieve. While parents are unlikely to seek help for behavioural concerns listed in such studies as the Global Burden of Disease, they are more likely to be amenable to messages related to helping students improve their academic performance. This could also explain the entire industry that has sprung up around successful exam prep for the SSC and HSC exams. A social worker is more likely to hear parents complain about children not concentrating on studies. It is also likely that in the case of teenage children, in contrast with younger ones, there could be a weighing of health outcomes against education outcomes. Parents might willingly put off help-seeking for a health concern if the time taken was perceived as interfering with educational activities. Some exceptions might be if this health concern threatened life and safety, or if it hampered educational activity such as poor eye-sight. While such knowledge is not new, my study shows that for some parents this might be a necessary compromise for children to get ahead.

Social work advocacy must centre around recreating visions of different paths to future success for children and parents. The price tag of the one-size fits all method must be made public through explicit reports on how stressful such an overwhelming focus on education can be. Social work advocates could help parents and school teachers to understand this situation in terms of the law of diminishing returns. While schools are regulated by the state education department, there is no such over-sight over the operation of private tuition classes. The question then arises: Should this industry be regularised in order to supervise its functioning? To my mind, this is similar to the issues around legalising prostitution and needle-exchange programmes for public health reasons. A public debate needs to open on this issue. It should involve national child advocacy organisations such as Childline India Foundation which receives support from the Ministry of Social Justice and Empowerment, Government of India.

Related to parental over-concern about education was their perception that schools do not do enough, or that they are sometimes part of the problems. Parents reported feeling relatively helpless in the context of the school. Some voiced concern about how feedback to teachers may rebound on their children. Advocacy in this area must involve both the school community and the parents themselves: Schools need to address parental concerns and create a climate where they can be aired in a mutually respectful manner. Parents would benefit from assistance in learning how to make explicit these concerns in a respectful and non-confrontational manner. Parents may also need to tailor their expectations of what is feasible within the limited time that children spend in school. One area for dialogue between these two opposite sides is to reorient the demands that are placed on the child between school-work and tuition-related work. If parents are to scale back their demands, then schools also need to be prepared to reassure the parents about their own personal involvement and investment in the intellectual success of the student.

From the perspective of theory, my study does add a little more to the Parental ethnotheory perspective of Saraswathi and Pai (1997). This theory of child development has been based on the ancient Hindu stage-based view of the male-child progressing from one stage of life to another where each stage was characterised by a particular duty

(Saraswathi & Pai, 1997). The results from my study do not contradict this particular ethnotheory. Young people in the teen years are expected to devote themselves exclusively to studying--the period of *brahmacharya*. Sexual relations are relegated to the next *ashrama* (stage)--*grihastashrama*, that of the householder. Parents' fears about children going onto the wrong path or moving in the wrong direction appear to fit quite well into this world-view. But it would be difficult to falsify such an ethnotheory.

An alternate explanation for the emphasis Indian parents place on education could be that they are aware that the path to success in a changing world lies in children excelling in education. Indeed there is some data in the study to support this view as well.

Does this Study Tell us Anything New about Religion and Gender?

These were my key variables at the outset. It was difficult to ascertain this because the direct question, as pointed out by Goodnow (2006) failed to elicit credible information. Still, how the parents of the different groups reacted to certain situations suggests that there is room to explore these issues. The small sample size encompassed too much variability to place much confidence on the conclusions from the data relevant to these two variables. However, it was evident that even though the results were not significant, the trends were that Christian parents were more aware of the risks to young people, and also had better access to resources for their problems through the institutional religious structure of the parish. Given the small numbers, it was not possible to identify if this was the result of better education. However, this is a strength that Christian parents could rely on. Alternative strategies are obviously required for Hindu parents.

Parents also did not reveal much by way of gender issues. Parents of girls were more likely to see boys as engaging in "aimless activities." The lack of differences could mean that parents were either trying to conceal something because of concerns related to self-presentation, or that there is indeed no discrimination. It is likely that both these explanations are true. It is not as if parents pretended to a complete equality of the sexes. They reported quite candidly that they viewed the mother as being more important to health than the father. The incident of food-related discrimination could be related to social class of the parent concerned. The vast majority of the other parents were middle-

class. The one mother who reported such discrimination came from a lower middle-class background.

A third variable whose influence I was keen to study was that of past and present family illness. Indeed, parents were more sensitised to physical health problems that were prevalent within the family. This was not the case with mental health problems. This might also throw some light on why parents engage so much in *le cordon sanitaire* justifications. Some of these concerns such as drug use are seen as phenomena of modern life. If parents have not seen much evidence of such concerns in the community, it might be less likely for them to find these issues salient to the lives of their offspring. This, once again, underscores the need to create awareness of the actual prevalence of such behavioural concerns.

Limitations and Future Research

My study is apparently the first one to question parents of teenagers broadly about their perspective on health. Firstly, studies on teenage health were hard to locate, and none of these involved parents. Secondly, the few studies that I located after extensive searching, involved parents with very young children in relation to health conditions such as diarrhoea (e.g., Kapoor & Rajput, 1993; Keller et al., 2005). Oblique cues to teenage health from the parental perspective were visible in the small number of studies asking parents their views about sex education (e.g., Mahajan & Sharma, 2005) or about television (e.g., Gupta et al., 1994). My study makes a unique contribution in this respect.

My study integrates well into existing literature of what is known about lay theories, and adolescent development in Indian settings. However, it is based on a convenience sample of 19 people from the city of Bombay. These findings should not be used to generalize to other population groups. Moreover, research is needed on parents from other Indian cities as well as in rural settings. Parental beliefs provide one view of the situation. It is also necessary to triangulate their reports with those of children and of professionals like teachers, social workers and doctors. Further, theory would be incomplete without information from samples that are less healthy than my study participants.

In addition to a better exploration related to religion and gender, some future research questions include: How will parental lay theories of health adapt and change when students enter college? How do parental lay theories of health affect choice of medical system? How do children perceive and react to parental lay theories of health? Are parents really able to influence the outcomes of their offspring through their actions (or lack thereof)? Are these views shared by parents in other Indian cities?

The self-report method did have its limitations when it came to understanding how religion and gender. Cognitive anthropologists use the daily diary method which I have described at length in Chapter 1. The traditional diary method might not be appropriate to Indian parents given that diary-writing is not a culturally familiar activity for many Indian adults. Cultural norms related to privacy often include parents opening their children's mail. However, social psychologists have been utilising pagers for some time now. For instance, studies have used personal digital assistants to capture fleeting thoughts and emotions of participants in a research design called the Experience Sampling method (e.g., Borell, 1998; Wirtz, Kruger, Scollon, & Diener, 2003). Cell phones are now ubiquitous among Indian adults in the city, and receiving calls and text messaging is a free option available through many service providers. It is commonplace to see people speaking loudly into cell phones. So an alternative method that might be useful is to combine the pager method of social psychologists with cell phones with an urban Indian sample as a replacement to the diary method. Paradoxically, Indian adults are more likely to be comfortable text messaging than writing.

Finally, in relation to the heavy burden that children face related to education, I would also recommend that case-study research be undertaken on schools that successfully provide academic stimulation which does not pit success at the cost of health. My research mentions one such school. It is important, not only that such schools be studied, but also that this research be broadly disseminated to academic circles.

The process of using an in-depth interview also had a couple of other implications. Asking parents about teenage behaviours is not always a peaceable activity (C. Ranganathan, personal communication, October 24, 2008). Though my interview was long, the structure of the interview, namely starting with items related to family data and

religious beliefs and practices, caused parents to relax in what was most likely a strange, new environment. That I succeeded was evident when some interviewees revealed later in the interview material that they may have denied or were silent about at the outset of the process such as stigmatising health conditions. But this comfort was also probably accompanied by fatigue and boredom. At least one interviewee (Mayuri) spoke of the repetitive nature of some questions. However, parental interest was high, and some parents referred me to acquaintances. Also, parents did not have to write anything down which also perhaps put them at ease.

Some personal reflections

When looking back at my own social work practice, I could certainly claim to know that education was important to parents. But the personal revelation from the study was how bound up this activity is to health in adolescent children. As I proceeded through data analysis, it was interesting to note how much my own family practices are influenced by these trends. For instance, my young teenage ward experienced a severe bout of illness on his first job as a seaman, and it soon became clear that he was physically unsuited for this line of work. It was interesting to note how swiftly, the family concern veered from the health of the boy to concern that he would now have to retrain in another profession, and would fall behind members of his age group. That his training as a seaman and the brief work experience had raised his level of independence and confidence were quickly overlooked, and even perhaps dismissed. Most thought was on how he had "lost a year."

Certainly, lay epidemiological beliefs throw some light on current developments. In particular, I refer to the protests surrounding AIDS education in 2007. Bombay city has been running AIDS education programmes for ninth standard students since 1995. After some initial hiccups over what were appropriate messages for school-level children, the programme was implemented relatively hassle-free in all 1000-odd schools in the city. So it struck me as strange that 2007 saw protests against sex education all over the country, including the state of Maharashtra of which Bombay is the state capital. Besides the fact that this is a new generation of parents, one possible reason for this uproar is perhaps the messages that were part of the new syllabus. The parents in my study were

unanimous in stating that sex education should encourage children to delay sex till they are older. The protests against the new syllabus centred on its core messages.

Policy in India has not focused on adolescent health. Youth-related policies focus on employment of rural youth, or efforts to prevent transmission of HIV/AIDS. There is no unified programme or policy that focuses on adolescents. Further, parents are often left out of the policy debate. For instance, two discussions on Solution Exchange, an UN-initiated discussion site for development practitioners in India, pay lip service to the role of parents in sex education (Dhar & Rafique, 2007; Rafique, 2006). One participant was actually noted as saying that parents should not be transmitters of sex education as this may increase the possibility of sexual abuse and incest – a rather ironic twist on parental concern that media images would sexualise their child.

It is important to give a voice to parents' concerns related to the health of their children. I hope that my study will be the first paving stone in this path to understanding.

Appendix A

Table A.1

Review of studies on parenting in India

Authors, Year	Sample	Gender	Research Site	Method	Themes/ Topics	Variables
Bala & Upadhaya (1992)	Parents	Female	No details	Maryland Parent Attitude Survey	Child-rearing patterns	Employment status
Carson, Chowdhury, Perry, & Pati (1999)	Students, teachers, parents, school administrators	Males and females	Behrampur city, Orissa	Parent-Adolescent Communication Inventory, Self-report measures, School Social Behaviour Scales	Parenting style and family competence	Income Gender of students
Devgan, (1997)	Parents	Males and females	No details	Child-rearing scale	Child-rearing practices	Education
Keller et al. (2006)	Mothers	Females	Gujarat & Urban India		Cultural models of parenting	International comparison
Sharma, Punia,	Parents	Females	Ahirwat,	Semi-structured interview	Parenting style of	

& Sangwan (1997)			Haryana		mothers	
Suppal, Roopnarine, Buesig, & Bennett (1996)	Parents	Males and females	No details	Belief assessments	Ideological beliefs about household duties	Single earner vs. dual earner families
Roy Chaudhury & Basu (1998)	Adolescents aged 14	Males	No details	Parent-Child Relationship Scale, Sinha's Adjustment Inventory for School Students, Cattell's Culture Fair Test	Parent-child relationship, school achievement, school adjustment	Gender of parent Intelligence
Pande & Agrawal (1997)	Adolescents aged 14	Males and females	No details	PCRQ	Adolescent perceptions of parental behaviour	Gender of child Gender of parent
Saraswathi & Sundaresan (1980)	Children aged 10 to 15	Males and females	No details	No details	Maternal disciplinary practices, moral judgment	Gender of child Social class
Sood (1998)	Children aged 6 to 11	Males and females	No details	Background Information Schedule, Child Behaviour Checklist, Parental Disciplinary Methods	Parental style, problem behaviours	
Pai (1999)	Parents Children aged 9 to 16		Baroda, Gujarat		Socialisation of emotions, parental ethnotheories	Gender of child Age of child

Mathur (2006)	Families of juvenile under trials	No details	No details	No details	Adolescent problem behaviours	Family pathology, family personal growth dimensions
Bharat (1993)	Family studies				Psychological assessment	
Shah (2005)	Family studies				Methodology	

Appendix B

Introductory letter to school principals

Principal

***** School

Date

Dear Sir/Madam,

Re: Research study with parents of Std. VII to IX students

I am a social worker with an M.A. in Medical and Psychiatric Social Work and an M.S.W. degree. I am currently enrolled in the PhD Programme at the University of Michigan, Ann Arbor, U.S.A. As part of my PhD, I am conducting a research study with Indian parents.

Adolescence is a period filled with many health challenges and risks. I am interested in parental views about the health of teenage children and their understanding of such health issues. Such information would help social workers to work with, and support, more effectively, families of teenagers. Another aim is to develop more tailor-made services. Parents are often ignored in the planning of health programmes for young people. Yet, their perspective is critical. My research tries to elicit information that will fill these gaps in our understanding.

As part of my study, I would like to contact the parents of students from Std. VII to IX in your school through a group meeting where I can explain the aims and activities of the study. My interviews are with parents and not with students. They will be conducted at the home of the student. I require 15 to 20 parents in all. I do not expect the school to pay for any expenses related to my research.

For your reference, I am attaching my resume as well as an information sheet.

Sincerely

Melita Vaz

PhD Student and Social Worker

My contact details:

Address in India

Telephone number in India

Appendix C

Short form asking for parent volunteers

Understanding Parental Theories about Children's Health

My name is Melita Vaz. I am a social worker with an M.A. in Medical and Psychiatric Social Work and an M.S.W. degree. I am currently enrolled in the PhD Programme at the University of Michigan, Ann Arbor, U.S.A. This research study with Indian parents is part of my PhD work.

I am interested in parental views about the health of teenage children because the teenage years are a time when children face many challenges, especially to health. This information would help social workers to work with, and support, more effectively families of teenagers and to improve our clinical and community services.

As part of my study, I am orally interviewing parents at their homes for 90 minutes on their views about health in general and about the health of their children. It is your choice whether to participate or not.

If you are interested in knowing more about the study, please give me details where I may contact you.

Sincerely

Melita Vaz

PhD Student and Social Worker

YOUR NAME:

YOUR AGE:

YOUR CHILD'S AGE:

YOUR RELIGION:

LANGUAGES YOU SPEAK:

YOUR PHONE NUMBER:

BEST TIMES TO CONTACT YOU:

YOUR POSTAL ADDRESS:

YOUR EMAIL (If you have one)

Appendix D

Verbal script for informed consent

(to be read aloud at the beginning of the interview and recorded)

[Name of participant] I want to make sure that you have read [or been informed of] the information in the sheet and that you understand what will happen, namely that I will be asking you questions about your teenage child's health and that you can stop the interview at any time you think you do not want to continue.

I want to make sure that you know that while there are no obvious benefits to you from the interview today, you are still willing to participate in this interview. I want to make sure that you understand I will be recording the interview with an audio recorder and then writing your words down. I will take full care to mask your identity using a false name when writing out the recorded interview, and by keeping records safely locked up. I can forward you a copy of your interview, if you so like. Any paper records that I maintain in India of my work will be destroyed before I leave for the U.S. in December and at the end of my analysis in the U.S. in December 2008. The electronic files will be kept for 5 years. I also want to make sure you know that you can still participate even if you do not want to have the interview recorded.

- Have you understood this and the information sheet?
- Do you have any questions?
- For the record, are you ready and willing to participate in my study?
- Are you willing for this interview to be recorded?

Thank-you.

Appendix E

Frequently Asked Questions about the study

Understanding Parental Theories about Children's Health

Here is some important information about this research study.

Who am I?

My name is Melita Vaz. I am a social worker. I have an M.A. in Medical and Psychiatric Social Work and an M.S.W. degree. I am currently enrolled in the PhD Programme at the University of Michigan, Ann Arbor, U.S.A. This research study with Indian parents is part of my PhD work.

What is this research study about?

I am interested in parental views about the health of teenage children because during the teenage years children face many challenges. Understanding parents' opinions and attitudes about these topics would help social workers to work with, and support, more effectively families of teenagers, and to improve clinical and community services.

What do people who take part in this study have to do?

Only parents of teenage children may participate in this project. People who want to participate in this study must be prepared to answer questions as part of a face-to-face interview at their homes. I can fix this appointment for a time that suits you. Some questions ask for opinions about health issues, some ask for information related to the family situation in general, and the child's health in particular. You can decide what to tell me and what to leave out. I will be using a voice recorder to record the interview.

How long will this interview take?

The interview will take about one and a half hour to two hours, if there are no major interruptions.
Also, with your permission, I may call you later on the phone to check an answer if the recording is not clear. At the end of my field work, I will offer you the chance to get together with other parents. You will be able to listen to the results of an initial analysis of my research and offer comments and suggestions. This is a process frequently followed in qualitative research where the focus is on in-depth views of participants.

Are you likely to face any problems from participating in this study?

I am interested in your opinions about children's health. However, sometimes, speaking about personal problems like health makes a person emotional. If this happens during the interview, you may choose to not answer any question. Besides this, you could stop the interview at any time if you do not like it or start to become uncomfortable.
Sometimes during an interview of this kind, people become eager to know more about a particular health issue. While I am not an expert on all health issues, I would be happy to recommend possible resources that might be helpful (e.g., information websites, books, organisations).

What steps have I taken to lessen any problems from this interview?

If any questions bother you, you can skip them without an explanation to me. I am also maintaining strict confidentiality about things that are mentioned to me during the interview. I have explained this in more detail below.

Are you likely to benefit from this project in any way?

While you may not receive any direct benefit from this study, your interview answers will help social workers like me to plan better health programmes for parents and teenagers. Besides, you will have a chance to participate in a meeting with other parents at the end of my field work in India and comment about it.

Will what you say be kept a secret?

Yes. This refers to confidentiality of data.
First, only I or my research assistants will be able to listen your recorded interview. Any paper records will be kept in a locked cupboard to protect your identity. All paper copies of my work in India will be destroyed when I leave the country in December 2007 and all paper copies of any work in the U.S. will be destroyed in December 2008. The electronic files will be kept for 5 years and they will have a password protection.
As part of the study, I will transcribe (write out) the interview. But at this point I will use an alternative name (a pseudonym) to protect your identity.

When describing the final results of the study, no individual names or identifying markers will be used.

As a social worker and as a researcher, I am ethically bound to keep your information safe, unless there is a situation where someone is being harmed or their life is in danger. For instance, if I learn that someone is experiencing suicidal ideas or that a child is being sexually abused, I will contact either the family or the school in order to create a support network that will reduce the possibility of harm to the individual and ensure safety of this person.
Finally, as part of my university system of checks on researchers, the Institutional Review Board of the University of Michigan may need to inspect my work.

How do you contact me or my research advisor?

Melita Vaz	Prof. (Dr.) Mary Ruffolo
Personal address	Associate Professor
in India	University of Michigan
	School of Social Work
	1080 S. University
Telephone	Ann Arbor, MI 48109, USA.
number in India	001-734-763-2345
vazm@umich.edu	mruffolo@umich.edu

Who else could give you more information about your rights as a research participant?

In case you have questions regarding your rights as a research participant, you could contact the Institutional Review Board, 540 E. Liberty Street, Suite 202, Ann Arbor, MI 48104-2210, (001) 734 936-0933, email: irbhsbs@umich.edu.
Your participation in this project is voluntary. Even after you decide to participate in this project, you may stop the interview at any time.

Appendix F

List of Organisations working on Child Related Issues

NAME & ADDRESS	ADDRESS & TELEPHONE NO.	TIME & DAYS	SERVICES & FEES
Muskaan Child and Adolescent Guidance Center of Tata Institute of Social Sciences	Abhyudaynagar B.M.C. Arogya Kendra, 1st Floor, T.J. Road, Zakariabunder, Cotton Green (West), Mumbai Tel. 2471 1225	Monday to Tuesday; Thursday to Saturday 10 a.m. to 5.30 p.m.	Rs. 50 per month
Child Guidance Clinic	Nagpada Neighbourhood House, Sophia Zuber Road, Byculla, Mumbai 8. Tel. 2307 2571;2301 0287	Monday to Friday 10.30 a.m. to 4.30 p.m.	Testing for IQ, aptitude, interest and personality, vocational and career guidance, counselling, special school (Fees are variable)
Child and Parent Guidance Clinic	Lokmanya Seva Sangh Krishnabai Kampatkon, Ram Mandir Road, Vile Parle (East), Mumbai 57. Tel. 2611 7195	Monday to Friday 10 a.m. to 5 p.m.	Children upto age 16 Testing for IQ, motivation and personality, Remedial teaching, Play and occupational therapy Rs. 150 for intake session, Different fees for other services
Institute of Psychological Health	10th Floor, Ganesh Darshan Bldg., Shiv Smriti Complex, Hari Niwas Circle, LBS Marg, Thane. Tel. 25433270	Monday to Saturday 11 a.m. to 6 p.m.	Psychiatric consultation, Counselling, Deaddiction services, Stress management, Parent groups Rs. 250 for first session and Rs. 100 later

Appendix G

Parents' Interview Schedule

Instruction: Insert Target child's name when there is a blank.

DEMOGRAPHIC INFORMATION

Could you, for the record, give me some information about your family?

Your age:

How long you have been married?

The number of children you have:

Their ages and sex:

Are there other people who live in your home?

[Prompt: Who? Servants?]

What religion do you follow?

What is your educational background?

What kind of work do you do?

About your husband or wife:

How old is he/ she?

What is his/her educational background?

What kind of work does he/ she do?

So I can understand your family and cultural background, could you tell me the following?

Who is the most educated person in your family?

[Prompt: What have they done?]

Who is the least educated adult in your family?

[Prompt: What have they done?]

Do you receive a newspaper?

[Prompt: Which one?]

Do you subscribe to any magazines?

[Prompt: Which one?]

How long have you lived in this house?

How many rooms does your home have?

Some families have more than one home (say an ancestral home). Does your family have more than one home?

What is a typical family vacation/ holiday?

[Prompt: How many days? *Native place*/ elsewhere? Who goes? How do you travel?]

Does your family have any of the following?

- Television
- Radio
- VCR/ DVD Player
- Walkman (for music)
- CDman (for music)
- I-pod (for music)
- Computer
- Laptop
- Washing Machine
- Microwave Machine
- Oven

[Prompt Do you have more than one of any of these items]

How important would you say that religion and religious beliefs are to you?

Not at all important				Very important
1	2	3	4	5

Do YOU go to church or the temple?

[Prompt: How often?]

Does YOUR FAMILY go to church or the temple?

[Prompt: Who? How often?]

What religious festivals does your family observe?

[Prompt: How?]

Are there other religious customs and practices that you follow?

[Prompt: Daily *puja* in the house? Family rosary? Reading scriptures like Bible, *Bhagavad Gita*, stories of *Ramayana*? Practising *Yoga*? Watching religious television serials? Naming rituals, baby's first haircut, entering a new home?]

Do you/ other family members attend other religious gatherings?

[Prompt: Healing services? *Bhajan* recitals]

How much is religion a source of strength and comfort to you?

None				A great deal
1	2	3	4	5

How important is it to you to rely on religious teaching when you have a problem?

[Prompts: rely on prayer, consult a religious guide like a priest/ *pandit*]

Not at all important				Very important
1	2	3	4	5

Please state how much you agree with the following statements

Strongly agree		No opinion		Strongly disagree
1	2	3	4	5

- I organise my life according to the guidelines prescribed by my religion.
- At work, I do my job and treat my colleagues in accordance with my religious principles.
- I perform (or have performed) my duties as a son/ daughter according to the guidelines of my religion.
- My daily habits (e.g., eating, exercising, conduct) reflect the guidelines of my religion.
  [Prompt: Please explain]

Are there religious festivals from other religions that your family might practice/observe?

[Prompt: Which ones? How?]

- Do you observe a vegetarian diet? [Prompt: How strictly]
- Do you smoke cigarettes? [Prompt: How often]
- Do you have alcoholic drinks? [Prompt: How often]
- Do you practice *yoga* or meditate? [Prompt: How often]

As a researcher and social worker working with adolescents and families, I am interested, especially in this study in learning about parental views about the well-being of their teenage children. So could you tell me the following?

What according to you are the most important goals for _____ ?

[Prompt: in the next one year, in the next five years, in the next ten years]

Looking back at what you've told me, could you say, in order of importance, the first five?

[Prompt: Why are these goals more important to you]

If _____ were of a different sex (that is a boy instead of a girl/ a girl instead of a boy), would these goals change?

What according to you is important for your _____ 's happiness?

[Prompt: your child's wellbeing?]

An important aspect of wellbeing and happiness is health

Compared with other kids of ___'s age, would you say he/ she is healthy?

[Prompt: Could you explain? When would you feel that your child is healthy/ unhealthy]

What according to you are the major health risks to a child aged 13 to 15 in today's world?

[Prompt: Please list. Are these risks different or the same as the risks to a younger child (below 10) or an older person (above 40) What about compared to when you were a child/ teenager?]

Besides risks to health, are there other risks that face a child aged 13 to 15?

Do you feel that your son/ daughter _____ is at risk of any of these things?

[Prompt: Please explain why/ why not? What if your child were of a different sex, would these risks change? What if you belonged to a different background, say a different religion or a rural background? Are there other risks that you have not mentioned in the list of major risks that may be of concern/ worry where your son/ daughter is concerned?]

Health data from the World Health Organisation and the UNFPA shows that in our country, young people are at risk of several different conditions. As I list these out, I'd like you to tell me how much of a worry are these to your child.

So please rate each on a scale from 1 to 5

Absolutely no worry				A very great worry
1	2	3	4	5

- Using drugs like brown sugar, *charas*
- Using tobacco like cigarettes, *bidis*, *gutkha*
- Violence in the home like child being beaten or sexually abused
- Violence outside the home like being involved in riots and political disturbances
- Injuries from road accidents, from dangerous environments in schools or working places
- Undernutrition (inadequate food) and anaemia (iron deficiencies in the blood)
- Tuberculosis or *TB*
- Syphilis and gonorrhoea (*Gupta rog*)
- HIV/AIDS
- Respiratory conditions like pneumonia
- Maternal conditions due to early marriage and early child birth
- Cancers of various kinds
- Heart diseases and related conditions

Which of these problems is the most dangerous for your child?

[Prompt: Why? Which is the least dangerous? Which of these mattered when you were a teenager yourself? What if your child was a boy/ girl?]

If a friend came to you and told you that their teenage child had a problem with ____ [Refer to most dangerous risk as identified by the respondent], what steps would you suggest to them?

If you suspect your child, _____ is sick with ____ [Refer to most dangerous risk as identified by the respondent], what steps would you take?

If your child, _____ is sick with ____ [Refer to most dangerous risk as identified by the respondent], what steps would your priest/ *pandit*/ religious figure suggest?

In an imaginary situation,

Say you found your son/ daughter _____ drinking *bhang* (traditional intoxicant from cannabis leaves) on the occasion of *Holi* (Festival of colours), what would you do/ say to ____?

[Prompt: Would it be different if _____ was a boy/ girl?]

In another imaginary situation,

Say a family friend called you up and said that they had seen _____ holding hands with a boy/ girl outside tuition classes, what would you do/ say to _____?

[Prompt: Would it be different if _____ was a boy/ girl?]

Parental Locus of Control Scale for Health

Please rate each statement on a scale from 1 to 5 without thinking too deeply about it.

Strongly agree		No opinion		Strongly disagree
1	2	3	4	5

- My child's good health comes from being lucky.
- There is nothing that I can do to keep my child from getting sick.
- Bad luck makes my child get sick.
- I can only do what the doctor tells me to do for my child.
- Getting sick just happens to children.
- There is nothing I can do to make sure that my child has a healthy appearance.
- Children who never get sick are just plain lucky.
- It is my job as a father/ mother to keep my child from getting sick.
- The government is responsible for the effects of quality of food on my child's health.
- Only a doctor or a nurse keeps my child from getting sick.
- I can make very few choices about my child's health.
- My child's health can improve through self-discipline.
- Accidents just happen to children.
- I can do many things to fight illness in my child.
- Only the dentist can take care of my child's teeth.
- I can teach my child many ways in which to protect their good health.
- The government is responsible for the environmental effects on my child's health.
- Even the most healthy child can be affected by the evil eye or *nazar* of a jealous person.
- The only way I can make my child stay healthy is to do what other people tell me to do.
- I take my child to the doctor right away if my child gets hurt.
- It will be my child's teachers' job to keep my child from having accidents at school.
- Children who never get sick are blessed by God.
- I can make many choices about my child's health.
- If my child feels sick, I have to wait for other people to tell me what to do.
- Whenever my child feels sick, I take my child to the doctor right away.
- There is nothing I can do the make sure that my child has healthy teeth.
- I can do many things to prevent my child from having accidents.

- My child's health can improve through prayer.
- Frequent sickness in children is a sign of being cursed by God or the devil.
- My child's health is affected by living in a bad environment no matter what I do.

Could you tell me from the list of items you read, which was the most important?

[Prompt: Why? Which items were not as important? Did any of the statements make no sense to you? If your parents were answering these questions at the time when you were a teenage child, would their answers be different?]

What are some of the major health problems that your family has experienced?

[Prompt: When did this happen? How close was this family member to you? How long did the illness last? How was it resolved? Can you recall other family illnesses? Can you think back further?]

Does your family have a family history of any kind of serious long-term illness (e.g., diabetes running in the family or mental problems?)

[Prompt: When you think of the problems identified by the World Health Organisation?]

In general, would you say that your own health is:

Excellent	Very Good	Good	Fair	Poor
1	2	3	4	5

[Prompt: Please explain]

What do you do to protect or maintain your own health?

[Prompt: What is the most important thing you do? Rest? Diet? Regulated habits? Physical activity? Protection from the elements? Prayer? Avoid bad habits?]

What do you do to protect or maintain _____'s (your child's) health?

[Prompt: What is the most important thing you do? Rest? Diet? Regulated habits? Physical activity? Protection from the elements? Prayer? Avoid bad habits? Would it be different if ____ were a boy/ girl?]

What does your husband/ wife do to protect or maintain _____'s (your child's) health?

[Prompt: your family in general, your child, your child's school, the government]

When thinking about the various people we mentioned, what percentage of responsibility for _____'s (your child's) health falls to each of these people: you, your husband/ wife, your family in general, your child himself/ herself, the school, the government?

What aspects of your home contribute to good health/ illness in _____ ?

[Prompt: What social traditions? what religious traditions? what habits in caring for your children?]

If you were worried about _____'s (your child's) health, who would you speak to?

[Prompt: Please explain. Are there other people you would turn to for help and support?]

Most people interpret health as bodily health, I want to make sure that we also cover mental health.

Compared with other kids of ___'s age, do you think that he/ she is at risk of any mental health problems?

[Prompt: Could you explain? When would you feel that your child is healthy/ unhealthy? Would it be different if they were of a different sex?]

Can you list some common mental health problems?

In general, would you say that your own mental health is:

Excellent	Very Good	Good	Fair	Poor
1	2	3	4	5

[Prompt: Please explain]

What do you do to protect or maintain your own mental health?

[Prompt: What is the most important thing you do? Rest? Regulated habits? Physical activity? Prayer? Avoid bad habits?]

What do you do to protect or maintain _____'s (your child's) mental health?

[Prompt: What is the most important thing you do? Rest? Regulated habits? Physical activity? Prayer? Avoid bad habits?]

What does your husband/ wife do to protect or maintain _____'s (your child's) mental health?

[Prompt: your family in general, your child, your child's school, the government]

When thinking about the various people we mentioned, what percentage of responsibility for _____'s (your child's) mental health falls to each of these people: you, your husband/ wife, your family in general, your child himself/ herself, the school, the government?

If a friend came to you and told you that their teenage child had a problem with ____ [Refer to a problem from the list they generated], what steps would you suggest to them?

[Prompt: Would it be different for a boy/ girl?]

If you were worried about _____’s (your child’s) mental health, who would you speak to?

[Prompt: Please explain]

If you were worried about _____’s (your child’s) mental health, what steps would you take?

If _____ is sick with ____ [Refer to a problem from the list they generated], what steps would your priest/ *pandit*/ religious figure suggest?

What aspects of your home contribute to good mental health in _____ (your child)?

[Prompt: what social traditions? what religious traditions? what habits in caring for your children?]

One of the things I am interested in are traditional and religious beliefs. Many of these we know are really helpful. For example, people place black and white bangles on the wrists of a newborn baby for protection. People use *neem* leaves to reduce itching from chicken pox, and coriander (*dhania*) water for conjunctivitis.

Are there any such traditional practices in your family to guard or protect health and well-being of family members, especially children.

[Prompt: Special foods; Some people say that girls should not have a head bath when they have their periods. Boys should not masturbate]

Do you think that health and religion are connected?

[Prompt: Could you explain?]

Please rate each statement on a scale from 1 to 5.

Strongly agree		No opinion		Strongly disagree
1	2	3	4	5

- “Trying to maintain health is a religious responsibility.”
- “Health is only valuable to the extent that it permits me/ my child to do several things.”

[Prompt: Please explain]

THANK-YOU FOR YOUR PARTICIPATION

Appendix H

Example of a code memo created for Food using the Lexical Search function

Food
All mentions by R of
food
foods
ALSO
eat (whole words only)
eats (whole words only)
eating (whole words only)
[WHOLE WORDS TO AVOID NETTING WORDS LIKE treat, seat]

EXCEPT
invitations to I to eat during the interview

Check the exceptions below and only code those items which have extended discussions on food in the respective sub codes

EXCEPT
WHO item: Undernutrition which means inadequate food
Religiosity item: My daily habits (e.g., eating, exercising and my conduct) reflect the guidelines of my religion
Do you observe a vegetarian diet?

Appendix I

Tables related to Chapter 2

Table I.1

Summary of the basic demographic information about this sample.

	N	Mean	SD	Minimum	Maximum
Age (years)	18	42.56	5.32	34	52
Years of education	19	15.11	1.91	10	17
No. of years of marriage	16	17.31	3.30	14	25
Family size	19	4.89	2.47	2	13
Total no. of children	19	1.79	0.79	1	3
Age of target child (years)	19	13.42	1.21	11	15
Class of target child	19	8.58	0.77	7	10
Age of spouse (years)	16	45.81	6.24	38	60
Years of education of spouse	19	13.95	2.66	10	19
Family readership resources	19	3.21	2.28	0	10
No. of rooms in the house	18	3.39	1.36	1	7
Family asset ownership	19	6.00	3.09	1	11

Table I.2

Descriptive profile of the 19 participants

Name	Participant Parent					No. of kids	Target Child			Spouse			
	Age	Sex	Religion	Educ-ation	Occupation		Sex	Age	Class	Years married	Age	Educ-ation	Occupation
Bhavana	34	F	Hindu	BCom	Lost job (Sales)	2	F	14	9	Divorced	-	SSC	Diamond assorter
Carolina	45	F	Christian	SSC, FYBA	Tuitions	3	M	15	9	25	60	SSC	Not working
Cesar	46	M	Christian	SSC	Office Superintendant	3	M	12	8	19	46	SSC	Telephone Operator
Chandan	44	M	Hindu	BCom	Supervisor	1	M	13	9	14	40	BA	Home-maker
Floyd	99	M	Christian	BCom Mater-ials Manag ement	Manager	3	M	14	8	15	40	BA	Home-maker
Isabella	38	F	Christian	BCom PG course	Teacher	2	M	13	9	15	42	HSC	Martial arts instructor

Jeannie	37	F	Christian	BA	Customer service	1	F	14	9	Widowed	-	BCom	Data processing
Kishori	36	F	Hindu	BA	Home-maker	2	M	11	7	17	42	BA	Runs restaurant
Lakshman	43	M	Hindu	HSC Dipl. Electrical Engin.	Supervisor	1	M	13	9	15	43	BA	Clerical work
Manjusha	40	F	Hindu	BSC	Food technol-ogist	2	F	12	8	14	41	BE, PG course	Factory manager
Mayuri	46	F	Hindu	BSc Dipl	Tuitions	2	F	14	9	21	51	BPharm	Owns factory
Namrata	47	F	Hindu	BA	Home-maker	2	M	15	9	19	48	BCom	Works in share company
Nikita	37	F	Christian	BA, BEd	Teacher	1	F	14	9	Widow-ed	-	BE	Owns business
Puneet	40	M	Hindu	BA, 1 year Law studies	Journalist	1	F	13	8	16	38	HSC	Administrator
Ravi	46	M	Hindu	BE	Engineer (Water works)	1	F	13	8	16	43	MSc Bed	Junior college lecturer

Sara	45	F	Christian	BA, BEd	Substitute teacher	3	F	14	9	17	50	BE, PG Diploma	Technical line
Uttara	38	F	Hindu	MCom	Tuitions	1	M	15	10	14	42	BE	Engineer
Varsha	52	F	Hindu	BA	Tuitions	1	M	12	7	23	55	Intermediate (Class XI)	Laid off (Textile mill)
Zena	52	F	Christian	BA,LLB	Home-maker (Secretary before)	2	F	14	9	17	52	SSC, ITech	Mechanic

SSC = Class X; BA, BCom, BSc = 15 years education; BE = 16 years education

Appendix J

Tables related to Chapter 3

Table J.1:

Family illnesses reported by parents

Family Illness (past and current)	Total N=19	Fathers n=6	Mothers n=13	Christian n=8	Hindu n=11
Diabetes	52.63% (10)	66.67% (4)	46.15% (6)	50% (4)	54.55% (6)
Heart problem	42.11% (8)	66.67% (4)	30.77% (4)	12.5% (1)	63.64% (7)
Blood pressure	42.11% (8)	50% (3)	38.46% (5)	75% (6)	18.18% (2)
Cancer	21.05% (4)	16.67% (1)	23.08% (3)	37.5% (3)	9.09% (1)
Asthma/bronchitis	21.05% (4)	0	30.77% (4)	37.5% (3)	9.09% (1)
Tuberculosis	15.79% (3)	0	23.08% (3)	25% (2)	9.09% (1)
Joint problem/arthritis	15.79% (3)	16.67% (1)	15.38% (2)	0	27.27% (3)
Mental illness	15.79% (3)	16.67% (1)	15.38% (2)	25% (2)	9.09% (1)
Epilepsy	10.53% (2)	16.67% (1)	7.6% (1)	12.5% (1)	9.09% (1)
Jaundice, Hernia, Poor eye-sight, Fractures, Constipation, Paralytic stroke, Meningitis, Tonsilitis, Migraine, Haemoglobin, Cataract, Old age, No problem	5.26% (1 each)	-	-	-	-

Table J.2

Reasons parents stated for their self-rating of being healthy

Parent Signs of Health	Total N=16	Christian n=8	Hindu n=8	Father n=6	Mother n=10
No major or frequent illness Because I am not facing any major problems. (Chandan) Till date, any critical this was not there. (Manjusha)	25% (4)	12.5% (1)	37.5% (3)	33.33% (2)	20% (2)
Food habits I do make it a point to eat... vegetables, fruits, fish in my diet which can give vitamins, proteins etc. (Ravi)	12.5% (2)	12.5% (1)	12.5% (1)	33.33% (2)	0
Keep fit I have learnt to keep my body fit through self discipline." (Ravi)	6.25% (1)	0	12.5% (1)	16.67% (1)	0
Could carry a late-term pregnancy (Manjusha)	6.25% (1)	0	12.5% (1)	0	10% (1)

Daily routine not disturbed by sickness And even if I get fever or cough, if I get tablet immediately... my whole day is not disturbed and my daily routine is also not getting disturbed because of that. I never get sleep. (Uttara)	6.25% (1)	0	12.5% (1)	0	10% (1)

Table J.3

Reasons parents stated for their self-rating of being unhealthy

Parent Signs of ill-health	Total N=16	Christian n=8	Hindu n=8	Father n=6	Mother n=10
Has minor and major ailments At times like I get this leg ache, joint pain and sometimes headache, fever, cough, cold. (Sara) Definitely I have blood pressure something. Maybe I have diabetes. I have not checked it. (Puneet)	56.25% (9)	75% (6)	37.5% (3)	33.33% (2)	70% (7)
Insufficient muscle Weight must be there. One must be a little healthy. (Lakshman)	6.25% (1)	0	12.5% (1)	16.67% (1)	0
Too much weight Not very good because I need to reduce, yeah, my weight. (Floyd)	6.25 % (1)	12.5% (1)	0	16.67% (1)	0

Lack of stamina and energy I… tire… fast... Before... I was not always tired. (Bhavana) Now I don't know… because I don't walk... So I don't know what is my stamina. (Chandan)	12.5% (2)	0	12.5% (1)	16.67% (1)	10% (1)
Not able to manage tension/pressure Because I'm taking lots of pressure on me. So I want to take rest. (Puneet)	6.25% (1)	0	12.5% (1)	16.67% (1)	0

Table J.4

Reasons parents stated for their self-rating of being mentally healthy

Parent Signs of Mental Health	Total N=16	Christian n=8	Hindu n=8	Father n=6	Mother n=10
Able to cope with stress and worry Mentally I've learnt to cope with whatever problems come your way. (Nikita)	25% (4)	25% (2)	25% (2)	16.67% (1)	30% (3)
Able to retain/reason out/evaluate behaviour Because anything whatever I can observe I can keep it in mind. Anytime you can come and ask me, I will tell you anything about the child, in which subject the child is more. (Varsha)	18.75% (3)	12.5% (1)	25% (2)	16.67% (1)	20% (2)
Able to handle many things at once My mental health is excellent because at the same time I'm talking to you... I'm thinking each and every points to insure you that how I can take care of my… child and as well as I'm, at the same time, I'm thinking of my job profession, at the same time I'm thinking of my association's profession, and I'm giving everyone a good equality. (Puneet)	6.25% (1)	0	12.5% (1)	16.67% (1)	0

Be like a chess genius (Lakshman)	6.25% (1)	0	12.5% (1)	16.67% (1)	0
Good memory (Lakshman)	6.25% (1)	0	12.5% (1)	16.67% (1)	0
Balance in life Whatever pleasures or difficulties or any problems in life I'm able to handle efficiently, balance out my life... financially as well as mentally. (Ravi)	6.25% (1)	0	12.5% (1)	16.67% (1)	0
Stable (Jeannie)	6.25% (1)	12.5% (1)	0	0	10% (1)
Don't follow bad things I don't follow that bad... things. Means... I never think about that, and... I think that... there is no use of all these silly things. (Uttara)	6.25% (1)	0	12.5% (1)	0	10% (1)
No complaints from others (Chandan)	6.25% (1)	0	12.5% (1)	16.67% (1)	0
No problems I don't find anything wrong with my health. Mentally fit. (Sara)	6.25% (1)	12.5% (1)	0	0	10% (1)

Table J.5

Reasons parents stated for their self-rating of being mentally unhealthy

Parent Signs of Mental Ill-Health	Total N=16	Christian n=8	Hindu n=8	Father n=6	Mother n=10
Reacts emotionally I don't call it excellent because I get very excited. I go mad. (Zena)	18.75% (3)	25% (2)	12.5% (1)	16.67% (1)	20% (2)
Worry I cannot say it's Excellent because I do worry at times, you know? (Jeannie)	18.75% (3)	25% (2)	12.5% (1)	0	30% (3)
Cannot cope with work and other responsibilities Not good when we are mentally not prepared for something because we have so many assignments and something is come suddenly, then we say no that we cannot do it. So that means we are not mentally prepared for that. (Isabella)	12.5% (2)	25% (2)	0	16.67% (1)	10% (1)
Tired I'm tired actually. Mentally, I'm really tired. Means this situation makes me tired in my house. I'm really tired. I	6.25% (1)	0	12.5% (1)	0	10% (1)

was never… tired like this mentally. (Bhavana)					
Like suicide (Varsha)	6.25% (1)	0	12.5% (1)	0	10% (1)
Mentally confused (Zena)	6.25% (1)	12.5% (1)	0	0	10% (1)
Problems with sleep Lakshman spoke of a work colleague who had a diagnosed mental problem and who had to take medications to induce sleep.	6.25% (1)	0	12.5% (1)	16.67% (1)	0

Table J.6

Reasons parents stated for labelling children as healthy

Child signs of physical health	Total N=19	Christian n=8	Hindu n=11	Father n=6	Mother n=13
No major or frequent illness Because basically… she's never fallen sick. (Jeannie) Till now… she's away from all the sickness. (Manjusha)	52.63% (10)	75% (6)	36.36% (4)	16.67% (1)	69.23% (9)
Food habits Health means... she is taking proper food. (Puneet)	31.58% 6	25% (2)	36.36% (4)	50% (3)	23.08% (3)
Age-appropriate physical growth and changes Now... she's grown sufficiently according to her age. (Ravi)	26.32% (5)	12.5% (1)	36.36% (4)	16.67% (1)	30.77% (4)
Has a responsive family/parent If she feels to express herself in that problem, so she can openly ask me or her mother what to do… Then we are there to solve the problem or to… support her to overcome it. (Puneet)	15.79% (3)	12.5% (1)	18.18% (2)	50% (3)	0

Able to manage responsibilities Because we have seen at least in the last few months that he's got a very hectic schedule, and he has been able to take it. (Floyd)	10.53% (2)	12.5% (1)	9.09% (1)	33.33 (2)	0
Interacts well with other people (Puneet)	5.26% (1)	0	9.09% (1)	16.67% (1)	0
Have good education I: Why do you say that some children are healthier than Ryan? R: They get the best atmosphere for education which perhaps I may not be able to give to my children. (Cesar)	5.26% (1)	12.5% (1)	0	16.67% (1)	0
Goes beyond school syllabus (Puneet)	5.26% (1)	0	9.09% (1)	16.67% (1)	0
Able to handle extremes of weather (Zena)	5.26% (1)	12.5% (1)	0	0	7.69% (1)

Table J.7

Reasons parents stated for labelling children as unhealthy

Child signs of physical ill-health	Total N=19	Christian n=8	Hindu n=11	Father n=6	Mother n=13
Has minor/other ailments like cough and cold	47.39%	50%	45.45%	16.67%	61.54%
When he keeps on falling sick. (Kishori) Sometimes she has… cough and cold. But this we can't avoid in this Mumbai's atmosphere. (Mayuri)	(9)	(4)	(5)	(1)	(8)
Lack of stamina and energy	31.58%	25%	36.36%	16.67%	38.46%
Sometimes when always a child is boring (sic.). She's not energetic. (Manjusha)	(6)	(2)	(4)	(1)	(5)
Poor weight	21.05%	12.5%	27.27%	33.33%	15.38%
He does not have weight. That's why. (Lakshman)	(4)	(1)	(3)	(2)	(2)
Poor food habits	15.79%	12.5%	18.18%	16.67%	15.38%
Because we are not eating good food. So we have to… take… food from outside. (Bhavana)	(3)	(1)	(2)	(1)	(2)

Had problems at time of birth/from birth She is a premature child. (Bhavana)	15.79% (3)	12.5% (1)	18.18% (2)	0	23.08% (3)
Not able to manage tension/pressure My daughter was mentally and emotionally pretty affected and very often would start crying in the night. (Nikita)	5.26% (1)	12.5% (1)	0	0	7.69% (1)
Cannot withstand extremes/changes of weather That way stamina-wise, like he has less stamina. So he can't bear like sun, afternoon sun. (Kishori)	10.53% (2)	12.5% (1)	9.09% (1)	0	15.38% (2)
Poor financial condition (Cesar)	5.26% (1)	12.5% (1)	0	16.67% (1)	0
Not exercising or playing (Puneet)	5.26% (1)	0	9.09% (1)	16.67% (1)	0
Shy He's shy to talk with the girls and all. (Lakshman)	5.26% (1)	0	9.09% (1)	16.67% (1)	0
Lack of sleep Lack of sleep is there because … of television and computers… Children don't get… sufficient time to sleep.	5.26% (1)	0	9.09% (1)	16.67% (1)	0

(Ravi)					
Not able to grasp studies Maybe his grasping power is not so good, so that we have to put him for some extra class or something. (Floyd)	5.26% (1)	12.5% (1)	0	16.67% (1)	0

Table J.8

Reasons parents stated for labelling children as mentally healthy

Child signs of mental health	Total N=18	Christian n=7	Hindu n=11	Father n=6	Mother n=12
Have a responsive family That reason is I never answer… as a dictator. I answer all his questions, feelings and confirm for myself whether he is convinced. (Cesar)	11.11% (2)	28.57% (2)	0	16.67% (1)	8.33% (1)
Confidence He'll be the guy who [says] 'Yes,' you know, [to] any cause, 'I'll do it.' (Floyd)	5.56% (1)	14.29% (1)	0	16.67% (1)	0
Handles responsibility He should take his own responsibility. Means… day-to-day life, he should maintain. (Chandan)	16.67% (3)	14.29% (1)	18.18% (2)	33.33% (2)	8.33% (1)
No emotional/mental disturbance He doesn't have a mental problem. (Namrata)	16.67% (3)	14.29% (1)	18.18% (2)	33.33% (2)	8.33% (1)
Mature according to her age	11.11%	0	18.18%	16.67%	8.33%

I don't except her to be more mature than her age. (Ravi)	(2)		(2)	(1)	(1)
Ability to study/grasp Through her attitude, through her behaviour, with her going about, with her grasping power. (Zena)	11.11% (2)	14.29% (1)	9.09% (1)	16.67% (1)	8.33% (1)
Able to cope with stress If she managed through that one year of hell that we went through and she is yet okay, I think she is good. (Nikita)	5.56% (1)	14.29% (1)	0	0	8.33% (1)
Attitude of openness (Mayuri)	5.56% (1)	14.29% (1)	0	0	8.33% (1)
Happy (Jeannie)	5.56% (1)	0	9.09% (1)	0	8.33% (1)
No financial constraints (Jeannie)	5.56% (1)	14.29% (1)	0	16.67% (1)	0

Table J.9

Reasons parents stated for labelling children as mentally unhealthy

Child signs of mental ill-health	Total N=18	Christian n=7	Hindu n=11	Father n=6	Mother n=12
Abnormal behaviour	50% (9)	42.86% (3)	54.54% (6)	50% (3)	50% (6)
Little bit of weird way of talking. (Sara) Circumstances like throwing tantrums. (Ravi)					
Depressed/Disturbed	44.44% (8)	71.43% (5)	27.27% (3)	33.33% (2)	50% (6)
He gets emotional very… That is something that he'll just sort of… He reacts very fast, you know. (Floyd) She would land up crying or getting irritated, angry, temper. But then it cooled down after like sometime. (Nikita)					
Not responding/obeying	16.67% (3)	0	27.27% (3)	0	25% (3)
Sometimes they become *ekdum* (suddenly) conservative also. Suddenly a child who is blah blah blah blah going around *ekdum se* (suddenly) they become silent. (Manjusha)					

Poor concentration When the child is sitting in front of me, just the book is… before him, his… mind is anywhere else… At that time I think so he is confused mind. (Varsha)	11.11% (2)	0	18.18% (2)	0	16.67% (2)
Poor marks Means basically mental health can be this way, if she's not getting good percentage. (Manjusha)	11.11% (2)	14.28% (1)	9.09% (1)	16.67% (1)	8.33% (1)
Mentally retarded Even these children who are mentally retarded, we could term it as unhealthy mind. I don't know whether I'm right or wrong. (Zena)	5.56% (1)	14.28% (1)	0	0	8.33% (1)
Does not want to go to school (Carolina)	5.56% (1)	14.28% (1)	0	0	8.33% (1)
Wrong priorities Means … this teenage is an age wherein there are many attractions which develop automatically in any boy or any girl... And if they are not concentrating, if they are giving a wrong… this one… priorities, then… (Manjusha)	11.11% (2)	0	18.18% (2)	0	16.67% (2)

Table J.10

Maintaining Child's Physical Health

Maintain Child's Physical Health	Total N=19	Christian n=8	Hindu n=11	Father n=6	Mother n=13
Food Since she is not into vegetables much, I… make her, inspire her to eat vegetables, and I make it a point to give her as much fruits as possible. (Ravi)	100% (19)	100% (8)	100% (11)	100% (6)	100% (13)
Play and exercise So body's exercise is must there because when you have some problem in your house … your mind has to keep… away from … all these things. That is why I put her in activities. (Bhavana)	42.11% (8)	12.5% (1)	63.64% (7)	50% (3)	38.46% (5)
Rest Then his sleep should be proper. That also affects health. If he does not sleep for 7 to 8 hours, then his healthy is affected. (Namrata)	15.79% (3)	12.5% (1)	18.18% (2)	16.67% (1)	15.38% (2)
Hygiene and cleanliness	36.84% (7)	50% (4)	27.27% (3)	50	30.77% (4)

Regulated habits Suppose… they... watch the TV... late night, and then they sleep. They eat then watching TV… All such things you know... we never practice. Like from the childhood only they don't have such types of habits, normally. So normal health is maintained. (Mayuri)	5.26% (1)	0	9.09% (1)	0	7.69% (1)
Attend to minor ailments early to prevent major illness Now she's very cautious like suppose if she… has a bad throat, she won't eat the things which will affect more. (Mayuri)	15.79% (3)	25% (2)	9.09% (1)	0	23.08% (3)
Special procedures He's carrying that tonsils ailment. So she (mother)... gets up early morning. She takes care that he is doing a gargle. (Cesar)	26.31% (5)	37.5% (3)	18.18% (2)	16.67% (1)	30.77% (4)
Counsellor/Doctor That's why, we took him to the doctor, so he could write [a prescription] for a tonic or something. (Lakshman)	21.05% (4)	12.5% (1)	27.27% (3)	16.67% (1)	23.08% (3)
Prayer	5.26% (1)	12.5% (1)	0	0	7.69% (1)
Obeys/cooperates He (child) tries to obey what we have told. He understands the importance.	5.26% (1)	12.5% (1)	0	16.67% (1)	0

(Cesar)					
Boil water (Cesar)	5.26% (1)	12.5% (1)	0	16.67% (1)	0

Table J.11

Maintaining Parent's Physical Health

Maintain Parent's Physical Health	Total N=19	Christian n=8	Hindu n=11	Father n=6	Mother n=13
Food Normally I don't go… for … outside food. That's all. (Chandan)	63.16% (12)	37.5% (3)	81.82% (9)	83.33% (5)	53.85% (7)
Exercise I do not take walks either. But at the time of leaving, I do walk from here to E. station, from C. to [work]... that much of a walk I do get, and in my office, I do walk. (Lakshman)	57.89% (11)	50% (4)	63.64% (7)	83.33% (5)	46.15385
Rest Rest, I compulsory take rest in the afternoons also. (Kishori)	21.05% (4)	12.5% (1)	27.27% (3)	33.33% (2)	15.38% (2)
Medications	15.79% (3)	37.5% (3)	0	0	23.08% (3)
Meditate	10.53% (2)	0	18.18% (2)	0	15.38% (2)
Prayer	10.53% (2)	12.5% (1)	9.09% (1)	0	15.38% (2)

Doctor/Medical services	10.53% (2)	25% (2)	0	0	15.38% (2)
Special procedures And pollution because I'm always on the scooter. So... I wear a mask. (Nikita)	10.53% (2)	25% (2)	0	16.67% (1)	7.69% (1)
Don't smoke (Floyd)	5.26% (1)	12.5% (1)	0	16.67% (1)	0
Keep occupied (Zena)	5.26% (1)	12.5% (1)	0	0	7.69% (1)
Nothing	31.58% (6)	25% (2)	36.36% (4)	33.33% (2)	30.77% (4)
Don't think about it/No time	21.05% (4)	25% (2)	18.18% (2)	0	30.77% (4)

Table J.12

Maintaining Child's Mental Health

Maintain Child's Mental Health	Total 18	Christian n=7	Hindu n=11	Father n=6	Mother n=12
Recreational activities	55.56%	57.14%	54.55%	66.67%	50%
He grabs every opportunity, I think, to relax himself by watching in the TV. (Floyd) I send him to play. (Kishori)	(10)	(4)	(6)	(4)	(6)
Communication with child	38.89	28.57%	45.45%	33.33%	41.67%
When she was away for picnic she (the mother) … tried to be with her till the last moment and be in touch with her on phone when she was away. (Ravi)	(7)	(2)	(5)	(2)	(5)
Food	22.22%	14.29%	27.27%	33.33%	16. 67%
I try to give her different food items as I said. Means by that when I'm talking to her also, I try to see to it that she drinks water early in the morning, that she has something in the morning and she leaves for school. At 10 o'clock also, she should have her proper breakfast, 12 o'clock proper food, in the afternoon also.	(4)	(1)	(3)	(2)	(2)

(Manjusha)					
Manage habits/activities Actually I want him to learn and take the decision whether he should go for that or he should not go for that particular thing... Suppose now exam is there … then he should study. He should understand. 'OK. Tomorrow I've got a paper. So I should not waste my time for watching the TV or going down and playing cricket.' (Chandan)	22.22% (4)	0	36.36% (4)	16. 67% (1)	25
Proper rest and sleep We give him also some type of free time occasionally to rest, sleep it out on Sundays or something like that, in the afternoons and all. Sleep it out. (Floyd)	16.67% (3)	14.29% (1)	18.18% (2)	33.33% (2)	8.33% (1)
Counsellor/Professional help/Priest If there was need then I would take her first to a counsellor. First the church, priest where they counsel… (Nikita)	11.11% (2)	14.29% (1)	9.09% (1)	0	16. 67% (2)
Do their studies To protect their mental health, you can say… they... sit with their studies. (Sara)	11.11% (2)	28.58% (2)	0	0	16. 67% (2)
Keep track of child I have a close watch… and if I'm not present here through telephone communication. And whenever I feel	11.11% (2)	14.29% (1)	9.09% (1)	16. 67% (1)	8.33% (1)

he is alone or when I feel that day I came out … he was in a offensive mood, those times I phone him and [say] "What are you up to, Ryan, my son?" Just I… want to show him that, "I'm present with you." (Cesar)					
Manage emotions I would explain to them not to get angry over small things, not to fight with other children over small things. I would teach them to control themselves. (Namrata)	5. 56% (1)	0	9.09% (1)	0	8.33% (1)
Control child's environment and stress Try as much as I can to remove him out from this environment. (Carolina)	11.11% (2)	14.29% (1)	9.09% (1)	16. 67% (1)	8.33% (1)
Leave child alone But sometimes she does get very low. She gets very depressed. She gets very upset. But then I leave her to herself. (Zena)	11.11% (2)	28.58% (2)	0	0	16. 67% (2)
Do nothing	22.22% (4)	28.58% (2)	18.18% (2)	16. 67% (1)	25% (3)

Table J.13

Maintaining Parent's Mental Health

Maintain Parent's Mental Health	Total N=18	Christian n=7	Hindu n=11	Father n=6	Mother n=12
Recreational activities I: How does reading help you? R: Just helps you to get away and not to think about [problems], not to concentrate on what [the] problem is but to just help. (Jeannie)	38.89% (7)	42.86% (3)	36.36% (4)	50% (3)	33.33% (4)
Religion I pray (Jeannie)	38.89% (7)	71.43% (5)	18.18% (2)	50 (3)	33.33% (4)
Manage emotions Control my temper (Namrata)	16. 67% (3)	28.57% (2)	9.09% (1)	0	25% (3)
Manage habits/activities	16. 67% (3)	14.29% (1)	18.18% (2)	16.67% (1)	16.67% (2)
Face problems It's basically we are born and brought up into this thing of, 'Face each problem and face each day as it comes.	16. 67% (3)	28.57% (2)	9.09% (1)	16.67% (1)	16.67% (2)

Take everything in its stride and carry on. (Nikita)					
Time alone and meditation	16. 67% (3)	14.29% (1)	18.18% (2)	16.67% (1)	16.67% (2)
Food Definitely, diet has a major effect … As I said I am more prone to pressure problems… Suppose if I put a lot of stress on myself… I will get irritated and again I will be affecting the whole things, my excellency, my fitness also, my health, my everything. So diet, it definitely plays a major role. (Manjusha)	11.11% (2)	0	18.18% (2)	16.67% (1)	8.33% (1)
Proper rest and sleep (Chandan)	11.11% (2)	14.29% (1)	9.09% (1)	16.67% (1)	8.33% (1)
Live one day at a time	5. 56% (1)	14.29% (1)	0	0	8.33% (1)
Increase awareness	5. 56% (1)	0	9.09% (1)	0	8.33% (1)
Manage worry Basically I don't let things seep in… I don't let it … set into my being or let the other problems come in. (Jeannie)	5. 56% (1)	14.29% (1)	0	0	8.33% (1)
Respect for family	5. 56%	0	9.09%	0	8.33%

I respect my parents. I respect my brother. Means I respect my elders and I pray God. Their blessings are more than sufficient. (Uttara)	(1)		(1)		(1)
Evaluate myself I evaluate myself. That is the only way I try to... keep myself fit. (Manjusha)	5. 56% (1)	0	9.09% (1)	0	8.33% (1)
Nothing	16. 67% (3)	14.29% (1)	18.18% (2)	33.33% (2)	8.33% (1)

Table J.14

Parental listing of risks to the child's health

Free-listing of Risks to the Child's Health	Total N=19	Father n=8	Mother n=11	Christian n=6	Hindu n=13
Food	42.11% (8)	37.5% (3)	45.45% (5)	66.67% (4)	30.77% (4)
Sexual attraction and awareness too early in life	31.58% (6)	37.5% (3)	27.27% (3)	66.67% (4)	15.38% (2)
Friends	26.32% (5)	37.5% (3)	18.18% (2)	16.67% (1)	30.77% (4)
Addictions/Bad habits	26.32% (5)	25% (2)	27.27% (3)	50% (3)	15.38% (2)
Problems related to the weather/ pollution	21.05% (4)	0	36.36% (4)	50% (3)	7.69% (1)
Obesity	21.05% (4)	12.5% (1)	27.27% (3)	66.67% (4)	0
Television and internet	21.05% (4)	25% (2)	18.18% (2)	50% (3)	7.69% (1)
School pressure	21.05% (4)	25% (2)	18.18% (2)	50% (3)	7.69% (1)
Mental problems	15.79% (3)	12.5% (1)	18.18% (2)	16.67% (1)	15.38% (2)
No exercise/play	15.79% (3)	25% (2)	9.09% (1)	33.33% (2)	7.69% (1)
Negative behaviours and moods	10.53% (2)	0	18.18% (2)	0	15.38% (2)
Distance from parents	10.53% (2)	0	18.18% (2)	16.67% (1)	7.69% (1)
Increase in childhood diabetes/ blood pressure	10.53% (2)	0	18.18% (2)	16.67% (1)	7.69% (1)

Issues specific to females such as menopause (sic.)	10.53% (2)	12.5% (1)	9.09% (1)	0	15.38% (2)
Accidents	10.53% (2)	12.5% (1)	9.09% (1)	0	15.38% (2)
Sexual abuse	10.53% (2)	25% (2)	0.00	16.67% (1)	7.69% (1)
Rash driving	5.26% (1)	0	9.09% (1)	16.67% (1)	0
Use mobile phones	5.26% (1)	0	9.09% (1)	0	7.69% (1)
Drinking less water	5.26% (1)	0	9.09% (1)	0	7.69% (1)
Iron deficiency	5.26% (1)	0	9.09% (1)	0	7.69% (1)
No risk	5.26% (1)	0	9.09% (1)	0	7.69% (1)
No reply	10.53% (2)	12.5% (1)	9.09% (1)	0	15.38% (2)

Table J.15

Mean ratings of the Global Burden of Disease conditions by parents

	Valid	Missing	Mean	Median	SD
Using drugs like brown sugar, charas	19	0	3.42	5.00	1.77
Using tobacco like cigarettes, *bidis*, *gutkha*	19	0	3.18	5.00	1.99
Violence in the home like child being beaten or sexually abused	19	0	3.03	3.00	1.86
Violence outside the home like being involved in riots and political disturbances	19	0	3.58	5.00	1.77
Injuries from road accidents, from dangerous environments in schools or working places	18	1	4.11	4.50	1.04
Undernutrition and anaemia	19	0	3.29	3.00	1.45
Tuberculosis or TB	19	0	3.00	3.00	1.70
Syphilis and gonorrhoea	19	0	2.84	1.00	2.01
HIV/AIDS	19	0	3.18	3.50	1.81
Respiratory conditions like pneumonia	19	0	3.32	3.00	1.53
Maternal conditions due to early marriage and early child birth	9	10	2.67	1.00	2.00
Cancers of various kinds	17	2	3.41	4.00	1.73
Heart diseases and related conditions	18	1	3.39	4.50	1.79

1 means *No worry at all* and 5 means *A great deal of worry*

Table J.16

Mean ratings of the Global Burden of Disease conditions by fathers and mothers

		n	Mean	SD
Using drugs like brown sugar, *charas*	Female	13	3.08	1.89
	Male	6	4.17	1.33
Using tobacco like cigarettes, *bidis, gutkha*	Female	13	2.65	1.97
	Male	6	4.33	1.63
Violence in the home like child being beaten or sexually abused	Female	13	2.58	1.87
	Male	6	4.00	1.55
Violence outside the home like being involved in riots and political disturbances	Female	13	3.00	1.87
	Male	6	4.83	.41
Injuries from road accidents, dangerous environments in schools or working places	Female	12	3.92	1.18
	Male	6	4.50	.55
Undernutrition and anaemia	Female	13	3.35	1.55
	Male	6	3.17	1.33
Tuberculosis or TB	Female	13	2.92	1.89
	Male	6	3.17	1.33
Syphilis and gonorrhoea	Female	13	2.77	2.01
	Male	6	3.00	2.19
HIV/AIDS	Female	13	3.12	1.80
	Male	6	3.33	1.97
Respiratory conditions like pneumonia	Female	13	3.23	1.64
	Male	6	3.50	1.38
Maternal conditions due to early marriage and early child birth	Female	7	2.57	1.99
	Male	2	3.00	2.83
Cancers of various kinds	Female	11	3.27	1.85
	Male	6	3.67	1.63
Heart diseases and related conditions	Female	12	3.08	1.88
	Male	6	4.00	1.55

1 means *No worry at all* and 5 means *A great deal of worry*

Table J.17

Differences between fathers and mothers on mean ratings of the Global Burden of Disease conditions

	df	t	Sig.
Using drugs like brown sugar, *charas*	17	-1.26	.22
Using tobacco like cigarettes, *bidis, gutkha*	17	-1.81	.09
Violence in the home like child being beaten or sexually abused	17	-1.62	.12
Violence outside the home like being involved in riots and political disturbances	17	-2.34	.03*
Injuries from road accidents, from dangerous environments in schools or working places	16	-1.14	.27
Undernutrition and anaemia	17	.24	.81
Tuberculosis or TB	17	-.28	.78
Syphilis and gonorrhoea	17	-.23	.82
HIV/AIDS	17	-.24	.82
Respiratory conditions like pneumonia	17	-.35	.73
Maternal conditions due to early marriage and early child birth	7	-.25	.81
Cancers of various kinds	15	-.44	.67
Heart diseases and related conditions	16	-1.03	.32

* $p<.05$

Table J.18

Mean ratings of the Global Burden of Disease conditions by Hindu and Christian parents

	Religion	n	Mean	SD
Using drugs like brown sugar, *charas*	Christian	8	3.50	2.07
	Hindu	11	3.36	1.63
Using tobacco like cigarettes, *bidis, gutkha*	Christian	8	3.69	1.87
	Hindu	11	2.82	2.09
Violence in the home like child being beaten or sexually abused	Christian	8	3.56	1.76
	Hindu	11	2.64	1.91
Violence outside the home like being involved in riots and political disturbances	Christian	8	3.38	1.99
	Hindu	11	3.73	1.68
Injuries from road accidents, from dangerous environments in schools or working places	Christian	8	4.06	.86
	Hindu	10	4.15	1.20
Undernutrition and anaemia	Christian	8	3.44	1.50
	Hindu	11	3.18	1.47
Tuberculosis or TB	Christian	8	3.00	1.61
	Hindu	11	3.00	1.84
Syphilis and gonorrhoea	Christian	8	3.00	2.12
	Hindu	11	2.73	2.00
HIV/AIDS	Christian	8	3.44	1.84
	Hindu	11	3.00	1.84
Respiratory conditions like pneumonia	Christian	8	3.25	1.75
	Hindu	11	3.36	1.43
Maternal conditions due to early marriage and early child birth	Christian	4	2.75	2.06
	Hindu	5	2.60	2.19
Cancers of various kinds	Christian	8	3.88	1.81
	Hindu	9	3.00	1.66
Heart diseases and related conditions	Christian	8	3.75	1.75
	Hindu	10	3.10	1.85

1 means *No worry at all* and 5 means *A great deal of worry*

Table J.19

Differences Hindu and Christian parents on mean ratings of the Global Burden of Disease conditions

	df	t	Sig.
Using drugs like brown sugar, *charas*	17	1.61	.87
Using tobacco like cigarettes, *bidis, gutkha*	17	-94	.36
Violence in the home like child being beaten or sexually abused	17	1.08	.30
Violence outside the home like being involved in riots and political disturbances	17	-.42	.68
Injuries from road accidents, from dangerous environments in schools or working places	16	-.17	.86
Undernutrition and anaemia	17	.37	.72
Tuberculosis or TB	17	00	1.00
Syphilis and gonorrhoea	17	.28	.78
HIV/AIDS	17	.51	.62
Respiratory conditions like pneumonia	17	-.16	.88
Maternal conditions due to early marriage and early child birth	7	.10	.92
Cancers of various kinds	15	1.04	.31
Heart diseases and related conditions	16	.76	.46

Table J.20

Mean scores on Parental Health Locus of Control subscales

	Cronbach's alphas	Alphas for Pachter et al. (2000)	Mean	SD
Internal e.g., I can do many things to fight illness in my child.	.33	.45	2.00	1.88
External – Luck e.g., My child's good health comes from being lucky.	.72	.70	3.68	0.80
External – Others e.g., If my child feels sick, I have to wait for others to tell me what to do.	.55	.40	4.39	0.68
External – Professional others e.g., I take my child to the doctor right away if my child feels sick.	.47	.43	2.80	0.95
Just happens e.g., Accidents just happen to children.	.85	.66	2.53	1.47
Child e.g., My child's health can improve through self-discipline.	-.07		1.69	1.47
Divine Influence e.g., Children who never get sick are blessed by God.	-.05		3.59	.75
Government e.g., The government is responsible for the effects of quality of food on my child's health.	.54		2.79	1.31
Nazar/Evil eye (single item) e.g., Even the most healthy child can be affected by the evil eye or nazar of a jealous person.			3.88	1.40

1 means *Strongly agree* and 5 means *Strongly disagree*

Table J.21

Mean ratings by fathers and mothers on the Parental Health Locus of Control subscales

	Gender	n	Mean	SD
HLOC External Luck	Female	12	3.66	.89
	Male	6	3.73	.67
HLOC Internal	Female	12	2.08	.89
	Male	6	1.83	.62
HLOC Nazar	Female	11	3.73	1.68
	Male	6	4.17	.75
HLOC External Others	Female	12	4.39	.78
	Male	6	4.39	.49
HLOC External Professionals	Female	12	2.78	.90
	Male	6	2.86	1.12
HLOC Just Happens	Female	12	2.12	1.28
	Male	6	3.33	1.60
HLOC Child	Female	12	1.79	.81
	Male	6	1.50	.63
HLOC Divine Influence	Female	12	3.53	.73
	Male	6	3.72	.83
HLOC Government	Female	12	3.02	1.44
	Male	6	2.33	.93

1 means *Strongly agree* and 5 means *Strongly disagree*

Table J.22

Differences between fathers and mothers on the Parental Health Locus of Control subscales

	t	df	Sig.
HLOC External Luck	-.18	16	.86
HLOC Internal	.61	16	.55
HLOC Nazar	-.60	15	.56
HLOC External Others	.00	16	1.00
HLOC External Professionals	-.17	16	.87
HLOC Just Happens	-1.74	16	.10
HLOC Child	.77	16	.45
HLOC Divine	-.51	16	.62
HLOC Government	1.06	16	.31

Table J.23

Mean ratings by Hindu and Christian parents on the Parental Health Locus of Control subscales

	Religion	n	Mean	SD
HLOC External Luck	Christian	8	3.89	0.70
	Hindu	10	3.51	0.87
HLOC Internal	Christian	8	2.28	0.95
	Hindu	10	1.78	0.62
HLOC Nazar	Christian	8	3.75	1.58
	Hindu	9	4.00	1.32
HLOC External Others	Christian	8	4.17	0.87
	Hindu	10	4.57	0.44
HLOC External Professionals	Christian	8	2.98	1.16
	Hindu	10	2.67	0.77
HLOC Just Happens	Christian	8	2.88	1.48
	Hindu	10	2.25	1.48
HLOC Child	Christian	8	1.94	0.82
	Hindu	10	1.50	0.67
HLOC Divine	Christian	8	3.62	0.78
	Hindu	10	3.57	0.75
HLOC Government	Christian	8	2.84	1.16
	Hindu	10	2.75	1.48

1 means *Strongly agree* and 5 means *Strongly disagree*

Table 3.24

Differences between Hindu and Christian parents on the Parental Health Locus of Control subscales

	t	df	Sig.
HLOC External Luck	1.00	16	.34
HLOC Internal	1.37	16	.19
HLOC Nazar	-0.36	15	.73
HLOC External Others	-1.26	16	.22
HLOC External Professionals	0.68	16	.50
HLOC Just Happens	0.89	16	.39
HLOC Child	1.25	16	.23
HLOC Divine	0.16	16	.88
HLOC Government	0.15	16	.88

Appendix K

Tables related to Chapter 4

Table K.1

Types of food

Types	Total n=19	Father n=6	Mother n=13	Christian n=8	Hindu n=11
Home food Those days we used to eat home food. (Chandan)	47.37% (9)	50% (3)	46.15% (6)	25% (2)	63.64% (7)
Good/Proper food Whatever he eats, he eats … good food. (Floyd)	42.11% (8)	50% (3)	38.46% (5)	25% (2)	54.55% (6)
Junk food/Fast food Childrens (sic.) of 13 to 15 years, they… very much love to take junk food or fast food. (Puneet)	57.89% (11)	66.67% (4)	53.85% (7)	37.5% (3)	72.73% (8)

Outside food Don't eat outside food or something like that. (Kishori)	68.42% (13)	83.33% (5)	61.54% (8)	50% (4)	81.82% (9)
Oily/Fried Eating all the oily stuff. (Zena)	47.37% (9)	50% (3)	46.15% (6)	62.5% (5)	36.36% (4)
Sugary foods/Sweets We don't eat much of sweets. So we basically control our health. (Nikita)	26.32% (5)	33.33% (2)	23.08% (3)	50% (4)	9.09% (1)
Seasonal foods R: *Aavla* (sour fruit) juice… I: How regularly would you give him *aavla* juice? R: During the season. (Kishori)	10.53% (2)	16.67% (1)	7.69% (1)	12.5% (1)	9.09% (1)
Hot-Cold Now like if we have too much cold stuff, we might catch cold. (Lakshman)	15.79% (3)	50% (3)	0	25% (2)	9.09% (1)
Religion-related foods Foods related to worship, festivals and fasting	57.89% (11)	33.33% (2)	69.23% (9)	62.5% (5)	54.55% (6)
Vegetarian food versus non vegetarian food	26.32% (5)	33.33% (2)	23.08% (3)	25% (2)	27.27% (3)

Table K.2

Cross tabulation of times oily food is mentioned against family incidence of heart disease

	Parents who reported family of heart disease	Parents who did not report family of heart disease
Mention oily foods	3	6
Do not mention oily foods	5	5

Table K.3

Cross tabulation of times sugary food is mentioned against family incidence of diabetes

	Parents who reported family of diabetes	Parents who did not report family of diabetes
Mention sugary foods	2	3
Do not mention sugary foods	8	6

Table K.4

How food affects health

Food	Total N=19	Father n=6	Mother n=13	Christian n=8	Hindu n=11
Food affects physical health	84.21%	83.33%	84.62%	62.5%	100%
So at least have a balanced diet so that she will be able to cope up with … any diseases. (Ravi)	(16)	(5)	(11)	(5)	(11)
Suggestions regarding food	36.84%	50.00%	30.77%	12.5%	54.55%
Basically I want her to eat all sorts of vegetable, cereals. (Ravi)	(7)	(3)	(4)	(1)	(6)
Context	36.84%	33.33%	38.46%	12.5%	54.55%
He’s given his food. He’ll watch TV and eat his food. It causes a problem (Lakshman)	(7)	(2)	(5)	(1)	(6)
Food affects mental health	31.58%	66.67%	15.38%	25%	36.36%
[H]ave a balanced diet so that she will be able to cope up with … stress. (Ravi)	(6)	(4)	(2)	(2)	(4)
Money affects options	31.58%	16.67%	38.46%	50%	18.18%
If you can afford to give your food, you’ll give.	(6)	(1)	(5)	(4)	(2)

(Zena)					
Adulteration/Substandard [I]n the rural area, those people cannot afford the price. Then they get a substandard thing. (Floyd)	26.32% (5)	16.67% (1)	30.77% (4)	37.5% (3)	18.18% (2)
Mother's role I am taking care of all this health *ka*, food, lifestyle, eating, means awareness sort of. (Manjusha)	26.32% (5)	50.00% (3)	15.38% (2)	0	45.45% (5)
Fussiness in eating They like him because he eats over there. They like children who eat. (Floyd)	26.32% (5)	33.33% (2)	23.08% (3)	25% (2)	27.27% (3)
Age implications As the age increases I reduces many a things (Cesar)	26.32% (5)	66.67% (4)	7.69% (1)	25% (2)	27.27% (3)
Food/ eating affected by illness	21.05% (4)	33.33% (2)	15.38% (2)	37.5% (3)	9.09% (1)
Moral value Don’t overindulge in… your eating habits … If you read… the	10.53% (2)	16.67% (1)	7.69% (1)	12.5% (1)	9.09% (1)

scripture, I think Jesus was a biggest psychiatrist himself. (Floyd)					
Food causes weight problems [E]ating all this junk food. Eating all the oily stuff. So you can always get into… cardiovascular problem. Obesity. (Zena)	15.79% (3)	16.67% (1)	15.38% (2)	37.5% (3)	0
Home remedies He's carrying that tonsils ailment. So she ... takes care that he is doing a gargle. (Cesar)	15.79% (3)	16.67% (1)	15.38% (2)	25% (2)	9.09% (1)
Affects studies/Affected by studies	10.53% (2)	16.67% (1)	7.69% (1)	12.5% (1)	9.09% (1)
Food contributes to growth See she's a young girl. She needs… the sprouts, the salads or milk ... These are the things that she needs to grow. (Jeannie)	10.53% (2)	16.67% (1)	7.69% (1)	12.5% (1)	9.09% (1)

Table K.5

Frequency of words that mean ‘friend’

Word	Total frequency	Father n=6	Mother n=13	Christian n=8	Hindu n=11
Friend	210	86	124	98	112
Friends	132	40	92	48	84
Company	56	31	25	24	32
Colleague	46	15	31	21	25
Circle	15	5	10	4	11
Classmate	6	3	3	3	3
Peer	4	2	2	4	0
Playmate	2	0	2	1	1
Companion	2	0	2	0	2

Table K.6

Frequency of times parents use ‘good,’ ‘bad,’ ‘right,’ and ‘wrong’ to describe their friends and those of their children

Frequency of Words	Coded segments related to Child’s Friends	Coded segments related to Parent’s Friends
Good	27	13
Bad	26	2
Right	6	3
Wrong	9	0

Table K.7

Parent's evaluation of child's friends

	Total N=19	Christian n=8	Hindu n=11	Father n=6	Mother n=13
Positive Often she's… stressed out when in school, during exams. So she tries to… have a recreation like… chatting with her friends... after exams. (Ravi)	52.63% (10)	37.5% (3)	63.64% (7)	83.33% (5)	38.46% (5)
Negative Friends … who are surrounding him. Then they force him. At that time, I don't know… what my son will do. But... that time… suppose he goes along with his friends, then that is a matter of really worry, no? (Uttara)	78.95% (15)	75% (6)	81.82% (9)	100% (6)	69.23% (9)
Neutral I: Where does he…? Where do you send him to play? R: Friend's house. (Lakshman)	52.63% (10)	37.5% (3)	63.64% (7)	50% (3)	53.85% (7)

Table K.8

Role of child's friends

	Total N=19	Christian n=8	Hindu n=11	Father n=6	Mother n=13
Bad/undesirable habits	47.37%	50%	45.45%	83.33%	30.77%
I: When would you say that he is mentally not healthy?	(9)	(4)	(5)	(5)	(4)
R: When he won't share what is going on in school or outside, in the classes, or with his friends and when he… will attracted towards bad things… Bad attractions.					
(Uttara)					
Premature boy-girl relationships	21.05%	25%	18.18%	16.67%	23.08%
Then Arjun told me… "[A]ll are having girlfriends, and they are going to their houses when their parents are not there. These are all bad attractions."	(4)	(2)	(2)	(1)	(3)
(Uttara)					
Influence food habits	21.05%	25%	18.18%	16.67%	23.08%
He should take hygienic food. Sometimes friends buy some things near the school.	(4)	(2)	(2)	(1)	(3)
(Kishori)					
Distracts from studies	15.79%	37.5%	0	16.67%	15.39%
I: What… might make it more... likely that they… will not complete school?	(3)	(3)		(1)	(2)

R: Actually now it will all depend on how they take it life to be, and second thing the friends, what… friends' circle they may get or like how will they. (Isabella)					
Wrong track/direction I: Now one of your sons is in the twelfth standard… So what would worry you when you think about him? R: Towards drugs, tobacco, sex... and going to the wrong track due to... colleagues what he is associated. (Cesar)	15.79% (3)	25% (2)	9.09% (1)	50% (3)	0
Not listening to parents (Referring to possible advice from her daughter's friends) "Don't listen to your Mummy." (Bhavana)	10.53% (2)	12.5% (1)	9.09% (1)	0	15.39% (2)
Thoughtless actions that cause child to get into trouble Injuries from road accidents and all. This we are concerned with… however careful you are. And nowadays as soon as you become little big, you want a bike of your own. However much you say 'No,' you may insist. Or sometimes you go with your friends on their bike and we don't know you've gone with them. (Zena)	10.53% (2)	25% (2)	0	16.67% (1)	7.69% (1)
Visit sex workers	5.26% (1)	0	9.09% (1)	16.67% (1)	0
Displace jealousy	5.26%	0	9.09%	0	7.69

	(1)		(1)		(1)
Source of comparison	5.26% (1)	0	9.09% (1)	16.67% (1)	0
Source of information about child They will ask their friends, they will discuss in the group. But this is not correct. (Chandan)	15.79% (3)	12.5% (1)	18.18% (2)	33.33% (2)	7.69% (1)
Help/support I: What does she do to protect her mental health? R: Basically talks it out either to her friends, either to me. (Jeannie)	15.79% (3)	12.5% (1)	18.18% (2)	33.33% (2)	7.69% (1)
Parents and children as friends I: What according to you is most important? R: Is to [be] ideal mother for her... means her friend. (Manjusha)	26.32% (5)	37.5% (3)	18.18% (2)	16.67% (1)	30.77% (4)

Table K.9

Role of parent's friends

	Total N=19	Christian n=8	Hindu n=11	Father n=6	Mother n=13
Source of information and advice I: So as a working mother, where do you get your information from? R: It's basically like through my colleagues. See we all… are mothers who have kids. So we get our information from our children. We pass it onto each other like there's something that is a health… maybe a health problem, or maybe it's a teenager problem. I tell it to my friend so that I discuss it with her. She knows if her child is younger and she knows the kind of problems just to let each other know about it. (Jeannie)	47.37% (9)	50% (4)	45.45% (5)	33.33% (2)	53.85% (7)
Support I: If you have a problem… If you have a problem in your life, who do you normally talk to? R: Just now to my mother only. I find out from my mother, then many of my close friends who are there. (Zena)	36.84% (7)	50% (4)	27.27% (3)	33.33% (2)	38.46% (5)
Social interaction That is Christmas and Muslims' Ramzan and all we celebrate because of my husband's close friend is a Muslim. So we go to their	31.58% (6)	37.5% (3)	27.27% (3)	50% (3)	23.08% (3)

house, they come to ours and all this. (Manjusha)					
Professional advice and help Actually, my friend is a family doctor. So he advises. Actually he is a main person. So we take his advice and then accordingly he sends us to somebody. Means he is referring. Then we go to the particular doctor with his note. (Chandan)	21.05% (4)	25% (2)	18.18% (2)	50% (3)	7.69% (1)
Practical help Morning I get up at 3 o'clock. 3, 3 to 6 I am sitting with Arjun, because I can't give much time in the afternoon as my students are attending. And afternoon time, I have asked one of my friend to take his oral. Just orally she is asking questions. (Uttara)	15.79% (3)	25% (2)	9.09% (1)	0	23.08% (3)
Provide validation through similar views In my profession, many of my friends are thinking like me. (Puneet)	5.26% (1)	0	9.09% (1)	16.67% (1)	0
Bad habits (Floyd)	5.26% (1)	12.5% (1)	0	16.67% (1)	0
Companionship (Cesar)	5.26% (1)	12.5% (1)	0	16.67% (1)	0

Table K.10

Frequency of times germ theory was mentioned

	No of times mentioned	No. of participants
Germ	8	4
Virus	4	3
Infection*	7	6
Contagion	4	1

* Besides these, I had introduced the term in each interview through the item “Sexually transmitted infections such as syphilis and gonorrhoea.” But even when passively responding to the question, did not pick up the word from me.

Appendix L

Table related to Chapter 5

Table L.1

Coded categories related to school

	Total n=19	Father n=6	Mother n=13	Christian n=8	Hindu n=11
School does not help child/does nothing School is not taking any care of... students'... health. (Puneet)	15	66.67% (4)	84.62% (11)	75% (6)	81.82% (9)
Programmes and policies They should have… sex education. (Cesar)	11	66.67% (4)	53.85% (7)	87.5% (7)	36.36% (4)
Difficulties enroute She is also facing problems of travelling to go school and come back. (Puneet)	10	66.67% (4)	46.16% (6)	37.5% (3)	63.63% (7)

Opportunity for exercise and sports Physical Training, PT, and all the other … subjects. (Floyd)	9	16.67% (1)	61.54% (8)	75% (6)	27.27% (3)
Individualised attention and response They give personal attention. (Manjusha)	8	66.67 (4)	30.77% (4)	37.5% (3)	45.45% (5)
Routine of child I: So can you explain to me… what is a typical day for Akash and Arvind? R: They wake up in the morning only in school hours. (Isabella)	7	50% (3)	30.77% (4)	50% (4)	27.27% (3)
School canteen can affect health Because they provide canteen food. (Chandan)	6	33.33% (2)	30.77% (4)	50% (4)	18.18% (2)
Problems Many problems will arise: eye problem, then physical problems, then school bags are heavy, so backache. (Puneet)	6	50% (3)	23.08% (3)	37.5% (3)	27.27% (3)
Pressure and stress This pressure in school. (Zena)	6	33.33% (2)	30.77% (4)	37.5% (3)	27.27% (3)

Social interaction Sometimes they… go [for a] movie. They play with kids in class. (Bhavana)	5	33.33% (2)	23.08% (3)	25% (2)	27.27% (3)
School educates about health I mean school has its role because … see in the teachings, in studies, certain things come which may teach them. (Mayuri)	4	33.33% (2)	15.38% (2)	25% (2)	18.18% (2)
School environment The environment is clean in the school. (Sara)	4	16.67% (1)	23.08% (3)	25% (2)	18.18% (2)
Opportunity for growth and development I think they have some value education and things like that. (Floyd)	4	33.33% (2)	15.38% (2)	25% (2)	18.18% (2)
Sexual abuse Sexual abuse is one thing which is a big concern for everyone... In the schools itself you see sometimes. (Floyd)	4	33.33% (2)	15.38% (2)	25% (2)	18.18% (2)
Children should be safe in school In school, it is the teachers' job… Outside, it's our job. But in school, it is the teacher's job. Teacher has to… look after our children. (Lakshman)	4	16.67% (1)	23.08% (3)	12.5% (1)	27.27% (3)

No time to exercise/play/sleep Now he doesn't have time because 3 hours he goes for tuition, then 6 hours to the school, lunch and breakfast at least 1 hour. Then there's no time to go for all these things. Practically it is very difficult. (Chandan)	3	50% (3)	0	12.5% (1)	18.18% (2)
Want the best school possible You want to send your child to particular doctor, even particular school, particular tuition, particular institution. (Chandan)	3	16.67% (1)	15.38% (2)	12.5% (1)	18.18% (2)
Studies improve health When they are teaching they are caring them … They are asking them questions about lessons and that will be improve their mental health, no? (Varsha)	2	16.67% (1)	7.69% (1)	0	18.18% (2)
Sensitive and approachable Since this is a girls' school at least, all these girls ka usual what all problems are there, the teacher tries to be open to them. (Manjusha)	2	0	15.38% (2)	12.5% (1)	9.09% (1)
Family problems affect school performance In our schools… most of them are coming from a background where… one parent or the father is a drunkard and… they come out with all these problems. So their children are like out of line. They either roam. They fall into	2	0	15.38% (2)	25% (2)	0

some, you know, misbehaving or something like that. (Isabella)					
Willing to put child in school early At that time we put him into school a little early, thinking it was okay because we got admission. (Lakshman)	2	16.67% (1)	7.69% (1)	0	18.18% (2)
Parents delay activities I: Does your family go to the temple? R: Yeah. Yeah. Family means we are 3 only… We go together. At least because of his tuitions and school, not always. (Chandan)	2	16.67% (1)	7.69% (1)	12.5% (1)	9.09% (1)

Appendix M

Code System

Generated through MaxQDA

Family illness
Every instance of family illness mentioned by R

- **old age**
- **meningitis**
- **haemoglobin**
- **jaundice**
- **constipation**
- **TB or tuberculosis**
- **cataract**
- **hernia**
- **asthma/bronchitis**
- **eye-sight**
- **migraine**
- **joint problem/ arthritis**
- **fractures**
- **paralytic stroke**
- **no problem**
- **heart problem**
- **mental illness**
- **tonsil**
- **epilepsy**
- **blood pressure**
- **cancer**
- **diabetes**

Parent ability to name mental problems
Were parents able to name any mental illness?

Parent estimation of own health

- **Parent mentally healthy?**
  Responses to question
  Would you say that your own mental health is Excellent, Very Good, Good, Fair or Poor?
- **Parent physically healthy?**
  Responses to question

Would you say that your own health is Excellent, Very Good, Good, Fair or Poor?

Parent independent risk

All responses to the questions:
What according to you are the major health risks to a child aged 13 to 15 in today's world?
Besides risks to health, are there other risks that face a child aged 13 to 15?

Rash driving
Negative behaviours and moods
Distance from parents
Use mobile phones
No risk
Problems related to living to the weather
Drinking less water
Iron deficiency
Increase in childhood diabetes/blood pressure
No reply
Mental problems
No exercise/play
Issues specific to females
Accidents
Distraction/Disruption from studies
Friends
Sexual abuse
Addictions/Bad habits
Obesity
Television and internet
Sexual attraction and awareness too early in life
School pressure
Food

Parent worst risk

What parents report as the worst risk

Cancer
Sexual harassment
Undernutrition and anaemia
Violence in the home
Political disturbances
Drugs
Respiratory and tuberculosis
Heart
Cigarettes
HIV
Injuries

Parent health signs

Signs of health

Reasons why parents answer Yes to the question

Would you say that your own health is Excellent, Very Good, Good, Fair or Poor?

No major or frequent illness

food habits

Keep fit

Could carry a late-term pregnancy

Daily routine not disturbed by sickness

Signs of ill-health

Reasons why parents answer No to the question

Would you say that your own health is Excellent, Very Good, Good, Fair or Poor?

Has minor and major ailments

Insufficient muscle

Too much weight

Lack of stamina and energy

Not able to manage tension/ pressure

Signs of mental health

Reasons why parents answer Yes to the question

Would you say that your own mental health is Excellent, Very Good, Good, Fair or Poor?

Able to cope with stress and worry

Able to Retain/ Reason out/ Evaluate behaviour

Handles many things at once

Be like a chess genius

Good memory

Balance in life

Stable

Don't follow bad things

No complaints from others

Nothing wrong

Signs of mental ill-health

Reasons why parents answer No to the question

Would you say that your own mental health is Excellent, Very Good, Good, Fair or Poor?

Problems with sleep

Reacts emotionally very fast

Cannot cope with work and other resposibilities

Worry

Like suicide

Tired

Confused

Parent estimation of Target child's health

Child mentally healthy?

Response to question

Compared with other children is your child mentally healthy?

YES
NO
IN BETWEEN

Child physically healthy?

Response to question

Compared with other children is your child physically healthy?

IN BETWEEN
NO
YES

Target child's health signs

Signs of mental ill-health

Reasons why parents answer negatively to the question

Compared with other children is your child mentally healthy?

Abnormal behaviour
Depressed/Disturbed
Not responding/obeying
Poor concentration
Poor marks
Mentally retarded
Does not want to go to school
Wrong priorities

Signs of mental health

Reasons why parents answer positively to the question

Compared with other children is your child mentally healthy?

No financial constraints
Able to study/grasp
Have a responsive parent/family
Not emotionally/ mentally disturbed
Mature according to her age
Handles responsibility
Confidence
Able to cope with stress
Attitude of openness
Happy

Signs of health

Reasons why parents answer positively to the question

Compared with other children is your child healthy?

No major/frequent illness
Food habits
Age-appropriate physical growth and changes
Has a responsive family/parent
Able to manage responsibilities by ownself
Interacts well with other people

Have good education
Able to handle extremes of weather
Goes beyond school syllabus

Signs of ill-health

Reasons why parents answer negatively to the question Compared with other children is your child healthy?

Has minor/other ailments like cough and cold
Lack of stamina and energy
Poor weight
Had problems at time of birth/from birth
Poor food habits
Cannot withstand extremes of heat and rain
Poor financial condition
Not able to manage tension/pressure
Lack of sleep
Not exercising or playing
Shy
Not able to grasp studies

Maintain child mental health

Actions that parents report about maintaining mental health in children

Things in family

Recreational activities

Other
TV
Play
Family outings

Communication with child

Increase awareness
Behave positively towards the cild
Motivating/Inspiring

Food
Manage habits/activities
Proper rest and sleep
Counsellor/Professional help/ Priest
Do their studies
Keep track of child
Manage emotions
Control child's environment and stress
Leave child alone
Nothing

Sectors

Government
School
Child
Father

Mother

Maintain child physical health

Actions that parents report about maintaining physical health in children

Things in Family

Boil water
Food
Nothing
Play and exercise
Special procedures
Counsellor/Doctor
Hygiene and cleanliness
Rest
Attend to minor ailments early to prevent major illness
Regulated habits
Prayer
Obeys/cooperates

Sectors

Government
School
Child
Father
Mother

Maintain parent mental health

Actions that parents report about maintaining their own mental health

Live one day at a time
Increase awareness
Manage worry
Respect for family
Evaluate myself
Face problems
Religion
Food
Proper rest and sleep
Recreational activities

Walk
Music
TV
Other

Manage emotions
Manage habits/activities
Time alone and meditation
Nothing

Maintain parent physical health

Actions that parents report about maintaining their own physical health

Don't smoke
Meditate
Medications
Keep occupied
No time
Don't think about it
Nothing
Prayer
Rest
Exercise
Counsellor/Doctor
Food
Special procedures

Effect of family illness
When parents mention how illness in the family influenced how they think about health (e.g., worrying about something that is common to many family members)

Le cordon sanitaire
Instances when parents mention that the target child is safe from some health condition because of their geographical or social location.

Candidacy theory
Instances when parents suggest that certain age groups are vulnerable or susceptible to specific illness conditions

older people
adolescents
consequences of candidacy theory

Vulnerable age
All mentions of when the target child is vulnerable because of their age

Right age
All mentions of

The right age
The correct age
The proper age
Not the age
That age
This age

PHLOC
Subscales of the Parent Health Locus of Control
Contains both direct answer segments as well as references to the target statement.

My child’s good health comes from being lucky
"My child’s good health comes from being lucky."
Contains both direct answer segments as well as references to the target statement.

There is nothing I can do to keep my child from getting sick.
"There is nothing I can do to keep my child from getting sick."
Contains both direct answer segments as well as references to the target statement.

Bad luck makes my child get sick.
"Bad luck makes my child get sick."
Contains both direct answer segments as well as references to the target statement.

I can only do what the doctor tells me to do for my child.
"I can only do what the doctor tells me to do for my child."
Contains both direct answer segments as well as references to the target statement.

Getting sick just happens to children.
"Getting sick just happens to children."
Contains both direct answer segments as well as references to the target statement.

There is nothing I can do to make sure that my child has a heal
"There is nothing I can do to make sure that my child has a healthy appearance."
Contains both direct answer segments as well as references to the target statement.

Children who never get sick are just plain lucky.
"Children who never get sick are just plain lucky."
Contains both direct answer segments as well as references to the target statement.

It is my job as a father/ mother to keep my child from getting
"It is my job as a father/ mother to keep my child from getting sick."
Contains both direct answer segments as well as references to the target statement.

The government is responsible for the effects of the quality of
"The government is responsible for the effects of the quality of food on my child's health."
Contains both direct answer segments as well as references to the target statement.

Only a doctor or a nurse keeps my child from getting sick.
"Only a doctor or a nurse keeps my child from getting sick."
Contains both direct answer segments as well as references to the target statement.

I can make very few choices about my child's health.
"I can make very few choices about my child's health."
Contains both direct answer segments as well as references to the target statement.

My child's health can improve through self discipline.
“My child's health can improve through self discipline.”
Contains both direct answer segments as well as references to the target statement.
Accidents just happen
"Accidents just happen to children."
Contains both direct answer segments as well as references to the target statement.
I can do many things to fight illness in my child.
"I can do many things to fight illness in my child."
Contains both direct answer segments as well as references to the target statement.
Only the dentist can take care of my child's teeth
"Only the dentist can take care of my child's teeth."
Contains both direct answer segments as well as references to the target statement.
I can teach my child many ways in which to protect their good h
"I can teach my child many ways in which to protect their good health."
Contains both direct answer segments as well as references to the target statement.
The government is responsible for the environmental effects on
"The government is responsible for the environmental effects on my child's health."
Contains both direct answer segments as well as references to the target statement.
Even the most healthy child can be affected by the evil eye
"Even the most healthy child can be affected by the evil eye or nazar of a jealous person."
Contains both direct answer segments as well as references to the target statement.
The only way I can make my child stay healthy is to do what oth
"The only way I can make my child stay healthy is to do what other people tell me to do."
Contains both direct answer segments as well as references to the target statement.
I take my child to the doctor right away if my child gets hurt
"I take my child to the doctor right away if my child gets hurt."
Contains both direct answer segments as well as references to the target statement.
It will be my child’s teacher's job to keep my child from havin
"It will be my child’s teacher's job to keep my child from having accidents at school."
Contains both direct answer segments as well as references to the target statement.
Children who never get sick are blessed by God.
"Children who never get sick are blessed by God."

Contains both direct answer segments as well as references to the target statement.

I can make many choices about my child's health.

"I can make many choices about my child's health."

Contains both direct answer segments as well as references to the target statement.

If my child feels sick I have to wait for other people to tell

"If my child feels sick I have to wait for other people to tell me what to do."

Contains both direct answer segments as well as references to the target statement.

Whenever my child feels sick, I take my child to the doctor rig

"Whenever my child feels sick, I take my child to the doctor right away."

Contains both direct answer segments as well as references to the target statement.

There is nothing I can do to make sure that my child has health

"There is nothing I can do to make sure that my child has healthy teeth."

Contains both direct answer segments as well as references to the target statement.

I can do many things to prevent my child from having accidents

"I can do many things to prevent my child from having accidents."

Contains both direct answer segments as well as references to the target statement.

My child's health can improve through prayer.

“My child's health can improve through prayer.”

Contains both direct answer segments as well as references to the target statement.

Frequent sickness in children is a sign of being cursed by God

"Frequent sickness in children is a sign of being cursed by God or the devil."

Contains both direct answer segments as well as references to the target statement.

My child’s health is affected by living in a bad environment no

"My child’s health is affected by living in a bad environment no matter what I do."

Contains both direct answer segments as well as references to the target statement.

Problems with scales

Anytime it appeared that R had a problem with understanding the scale

e.g. understanding the Likert scale

I had to repeat the instructions

I had to repeat the statement

I had to explain the statement

Everytime the respondent mentions that they are having difficulty with the codes

or

Everytime it is patently obvious that they have misunderstood the meaning of the codes

Germ theory

Germs
All mentions by R of
germ/s

infection
All mentions by R of
infect/ion

virus
All mentions by R of
virus
viral

Luck
All mentions by R of
luck
lucky
unlucky
EXCEPT direct answer segments to
PHLOC: My child's good health comes from being lucky.
PHLOC: Bad luck makes my child get sick.
PHLOC: Children who never get sick are just plain lucky.

Destiny/fate
All segments containing
destiny
fate

Don't believe

Believe

Evil eye
All mentions of
evil eye
nazar
deesht
EXCEPT direct answer segments to
PHLOC: Even the most healthy child can be affected by the evil eye or nazar of a jealous person.

Touch wood
All mentions by R of
touchwood
touch wood

Chyavanprash
All mentions by R of
chyavanprash

Almonds
All mention by R of
almonds
badaam
badam

Parental Goals
All responses to the question:
What according to you are the most important goals for _____ ?

Develop her personality
Eat properly
Marriage
Be healthy
Be financially sound
Understand his responsibilities
Express talents
Career
Education
Religion and values

Goals independently mentioned by R

WHO/ Global Burden of Disease Threats

Using drugs like brown sugar or charas
Responses to item
"Using drugs like brown sugar or charas"
Using tobacco
Responses to item
"Using tobacco like cigarettes, bidis, gutka."
Undernutrition/Anaemia
Responses to item
"Undernutrition (inadequate food) and anaemia (iron deficiencies in the blood)"
Injuries from road accidents, from dangerous environments in sc
Responses to item
"Injuries from road accidents, from dangerous environments in schools and working places"
Tuberculosis or TB
Responses to item
"Tuberculosis or TB"
Heart diseases and related conditions
Responses to item
Heart diseases and related conditions
Cancers of various kinds
Responses to item
Cancers of various kinds

Maternal conditions due to early marriage and early child birth
Responses to item
Maternal conditions due to early marriage and early child birth
Respiratory conditions like pneumonia
Responses to item
"Respiratory conditions like pneumonia"
Syphilis and gonorrhoea
Responses to item
"Syphilis and gonorrhoea"
HIV/AIDS
Responses to item
"HIV/AIDS"
Violence outside
Responses to item
"Violence outside the home like the child being involved in riots and political disturbances."
Violence inside the home
Responses to item
"Violence inside the home like the child been beaten up very badly or sexually abused."

Exams and Mental health
All mentions of how exams affect the mental health, peace of mind of the child
Fear of exams
Depression and exams

Suicide
All mentions by R of
suicide
suicidal

Health and illness clubbed together
Traffic
All mentions by R of
traffic
Road
All mention by R of
road
(when it refers to the street)
(NOT when it refers to the life path of a child/ respondent)
(NOT when it refers to directions to R's home/ someone else's home)
EXCEPT direct responses to
Questionnaire Item: Injuries from road accidents and dangerous environments in schools and working places
Follow-up questions where I asks R to elaborate may be coded here such as Why

do you worry most about road accidents
Accidents
All mentions of
accident
These could be traffic or non-traffic accidents
EXCEPT
WHO Threats:
"Injuries from road accidents, from dangerous environments in schools and working places."
PHLOC
"Accidents just happen to children."
"It will be my child's teacher's job to keep my child from having accidents at school."
"I can do many things to prevent my child from having accidents."
Sexually transmitted infections independently mentioned by R
All mentions by R of
sexually transmitted infections
STDs
syphilis
gonorrhoea
venereal disease
EXCEPT mentions in response to
WHO Threat: Syphilis and gonorrhoea
NS Diabetes
All mentions of
diabetes
Respiratory conditions independently mentioned
Asthma
All mentions by R of
asthma
NS Heart conditions
All mentions of
Heart
such as
Heart and related conditions
Heart conditions
Heart attack
not mentions of
Heart which relate to love affairs or broken relationships
Alcohol
All mentions of
alcohol
daaru
daru
booze
liquor

drinks (as in alcoholic drinks
NOT cold drinks or soft drinks such as coca cola
NOT *bhang*
NOT milk
NOT tea
NOT water)

NS Sexual abuse

All mentions of
sexual abuse
sexual molestation/ molestation
rape
abuse (that from context refers to sexual abuse NOT drug abuse)
In this case it also indicates a confusion between sexual abuse and using swear words.

Maternal conditions

All mentions of
early marriage
teen marriage
teenage marriage
early pregnancy
teen pregnancy
teenage pregnancy
early mother
teen mother
teenage mother

Cancer

All mentions of
cancer
leukemia/ leukaemia

Blood pressure

All mentions of
blood pressure
BP (case sensitive and whole words Options)
hypertension
and all mentions of
pressure - as it relates to a physical condition blood/ vascular pressure
but NOT mentions of
pressure - as it relates to excessive work or problems of daily life such as pressure of work.

Epilepsy/ Fits/Convulsions

All mentions by R of
fits
epilepsy
convulsions

chikungunya

All mentions by R of

chikungunya

Tuberculosis independently mentioned by

All mentions by R of
tuberculosis
TB
Puneet mispronounces tubercolitis
EXCEPT those mentions to the
WHO Threats: Tuberculosis or TB

Undernutrition/Anaemia independently mentioned by R

All mentions by R of
undernutrition
anaemia
EXCEPT
WHO Threats: Undernutrition (Inadequate food) and anaemia (Iron deficiencies in the blood)

Cigarettes and tobacco

All mentions of
cigarette
tobacco
tambaku/ tambacu
smoking
bidi
gutka
gutkha

Drugs independently mentioned by R

All mentions by R of
drugs
brown sugar
charas
ganja
heroin
opium
EXCEPT
WHO Threats: "Using drugs like brown sugar and charas
NOT
mention of drugs which refers to medicines
e.g., I'm aware that there are lot of these umm… type of drugs and this… some type of drugs which umm… For that matter even if you have any cough syrup, it puts you to sleep.
e.g., the germs have been become mutant to the drugs

HIV/AIDS independently mentioned by R

All mentions by R of
HIV
AIDS
HIV/AIDS
EXCEPT

WHO Threat: HIV/AIDS

Child factors

All words that parents use to describe their children

mature

still not got that thinking

innocent

All mentions by R of
innocent
innocence
as it describes the child.
All other mentions are coded under Parallel to child factors: innocent

simple

All mentions by R of
simple
as it describes the child.
All other mentions are coded under Parallel to child factors: simple
NOT simple food
NOT simple question
NOT simple family details

kind-hearted

All mentions by R of
kind-hearted
as it describes the child.
All other mentions are coded under Parallel to child factors: kind-hearted

curious

All mentions by R of
curious
curiosity
inquisitive

shy

All mentions by R of
shy
as it describes the child.
All other mentions are coded under Parallel to child factors: shy

smart

All mentions by R of
smart
as it describes the child.
All other mentions are coded under Parallel to child factors: smart

intelligent

All mentions by R of
intelligent
as it describes the child.
All other mentions are coded under Parallel to child factors: intelligent

sharp

All mentions by R of
sharp
as it describes the child.
All other mentions are coded under Parallel to child factors: sharp
confident
All mentions by R of
confident
confidence
as it describes the child.
All other mentions are coded under Parallel to child factors: emotional
NOT I am confident about my decision
NOT take into confidence
emotional
All mentions by R of
emotional
as it describes the child.
All other mentions are coded under Parallel to child factors: emotional
dependent
All mentions by R of
dependent
independent
All mentions by R of
independent
as it describes the child.
All other mentions are coded under Parallel to child factors: independent
frustrated
All mentions by R of
frustrate
frustrated
frustration
as it describes the child.
All other mentions are coded under Parallel to child factors: frustrated
mediocre
All mentions by R of
mediocre
as it describes the child.
All other mentions are coded under Parallel to child factors: mediocre
sensitive
All mentions by R of
sensitive
as it describes the child.
All other mentions are coded under Parallel to child factors: sensitive
friendly
All mentions by R of
friendly
as it describes the child.

All other mentions are coded under Parallel to child factors: friendly
susceptible to all corrections
All mentions by R of
the child being susceptible to corrections

Parallel to child factors

mature
smart
curious
All mentions by R of
curious
curiosity
other than those coded under Child Factors:Curious
innocent
All mentions by R of
innocent
innocence
other than those coded under Child Factors:Innocent
smart
All mentions by R of
smart
other than those coded under Child Factors:smart
intelligent
All mentions by R of
intelligent
other than those coded under Child Factors:Intelligent
sharp
All mentions by R of
sharp
other than those coded under Child Factors:Sharp
emotional
All mentions by R of
emotional
other than those coded under Child Factors:emotional
frustrated
All mentions by R of
frustrated
other than those coded under Child Factors:Frustrated
sensitive
All mentions by R of
sensitive
other than those coded under Child Factors:Sensitive
friendly
All mentions by R of
friendly
other than those coded under Child Factors:Friendly

Adjectives

All descriptive words that are not applied to a person. If they describe a person, they fit under Child Factors or Parallel to child factors

fresh

All fragments containing
fresh

rotten

All fragments containing
rotten

sufficient/ enough/adequate

All fragments containing
sufficient
enough
adequate

proper

All fragments containing
proper

fast food

All fragments containing
fast food
fast-food

nutritive/nutritious/nutritional

All fragments containing
nutritive
nutritious
nutritional

unhealthy/unhygienic

All fragments containing
unhealthy
unhygienic

healthy/hygienic

All fragments containing
healthy
hygienic

junk

All fragments containing
junk

roadside

All fragments containing
roadside
road-side

outside

All fragments containing
outside

fat/ fatty

All fragments containing
fat
fatty
oil/oily
All fragments containing
oil
oily
fried
All fragments containing
fried
wrong
All fragments containing
wrong
right
All fragments containing
right
bad
All sentences containing word
bad
good
All sentences containing word
good

Food
All mentions by R of
food
foods
ALSO
eat (whole words only)
eats (whole words only)
eating (whole words only)
[WHOLE WORDS TO AVOID NETTING WORDS LIKE treat, seat]
EXCEPT
invitations to I to eat during the interview
Check the exceptions below and only code those items which have extended discussions on food in the respective subcodes
EXCEPT
WHO item: Undernutrition which means inadequate food
EXCEPT
Religiosity item: My daily habits (e.g., eating, exercising and my conduct) reflect the guidelines of my religion
Do you observe a vegetarian diet?
EXCEPT
PHLOC The government is responsible for the effects of quality of food on my child's health.

Food related to health

Calcium/bones
Protein
Vitamin
Milk

Functions of Food

Money affects options
Adulteration/Substandard
Affects studies/Affected by studies
Food contributes to growth
Context: Watches TV, wash hands
Mother's role
Moral value
Fussiness
Recommendations
Food causes weight problems
Food segments that refer to weight
Home remedies
Food affects physical health
Age implications
Food segments that refer to the fact of how age makes a difference in terms of how much or what a person should eat
Food affects mental health
Food segments that refer to the influence of eating/ food on a person non-physically e.g., mood, temper
Food/ eating affected by illness
All mentions of food segments that indicate that some health condition affects ability to eat

Types

Home food
Good/ Proper food
Food segments that refer to good food
Junk food/ Fast food
All food sements that refer to
junk
Outside food
All food sements that refer to
outside
roadside (only 1 Floyd)
Sugary foods/ Sweets
All food segments that refer specifically to the sugary nature of food
Oily/Fried
All food sements that refer to
Oil/y
Fried
Ghee
Hot-Cold

All food segments that explicitly refer to the hot or cold nature of food

Seasonal foods

Foods related to the different seasons

Festival foods

Food segments that refer to eatable items related to festivals like Christmas, Diwali.

Code references to fasting as a separate subcode

Fasting

Veg food versus non veg food

Evaluation

Positive

All food segments that express a positive view with regard to health

Negative

All food segments that express a negative view with regard to health

Neutral

All food segments that express a neutral view with regard to health

e.g.

R: One-hour movie along with the break umm... eating beating and all.

Questions pertaining to Food

WHO Undernutrition and anaemia

WHO Threats

"Undernutrition (inadequate food) and anaemia (iron deficiencies in the blood)"

Religiosity Vegetarian diet

PHLOC Government and effects of the quality of food

"The government is responsible for the effects of the quality of food on my child's health."

Religiosity Daily habits

My daily habits (e.g., eating, exercising and my conduct) reflect the guidelines of my religion

Friend of the child

All mentions of
friend
peer
pal
company (NOT company as place of employment)
colleagues (when it implies friends and not when it refers to workplace -e.g. Xavier interview)
playmate
schoolmate
classmate
companion

Value

Whether parents feel that friends are a good influence or a bad one

Positive

Negative
Neutral

Role that friends play
Functions that friends play in the lives of the children
Bad/ undesirable habits (*fasaoing*)
Premature boy-girl relationships/ Wrong relations
Distracts from studies
Food habits
Thoughtless actions that cause child to get into trouble
Source of comparison
When someone (child or another adult) compares the child to his/ her friends
Displace jealousy
Visit sex workers
Wrong track/direction
Not listening to parents
Source of information about child
Help/support
Parents and children as friends

Words that mean friend
Flags for friend
friend
company
colleague
circle
All mentions by R of
circle
when it refers to friends or acquaintances
NOT Dadar circle
peer
schoolmate
classmate
companion
playmate

Parent friends all clubbed together

Other mentions of friend
All mentions by R of
friend
friends
company
when they do not refer to the child's friends
Practical help/ Instrumental
Provide validation through similar views
Support

Professional advice and help
Source of information and advice
Bad habits
Social interaction
Incidental mention
Company

Syllabus
All mentions of
syllabus
curriculum
portion (as it relates to school)
NOT portion as it relates to section of the questionnaire or interview/ portion of food

Tuitions
All mention by R of
tuition
tuitions
classes - as it refers to classes outside of school
(e.g., NOT classmates, class teacher, classroom, What class is he/she in?)
except when R mentions this as employment for self such as "I give tuitions"

Projects
All mentions of
project - as mentioned in the context of school and homework
NOT project in the context of the research study
NOT work projects of parents

Exams
All mentions by R of
exam
exams
examination
examinations
tests
(NOT medical exams or tests)
papers - as they relate to exams
(NOT newspapers, paper records, paperwork, documentation)

New system of assessment
All discussion of the new system of assessment. Look for mentions of grades, projects, group work.

Parent Teacher Association
All mentions by R of
Parent Teacher Association

PTA

Camps
All mentions by R of
camps

Pressure
All mentions of
pressurise/ pressurize
pressure
NOT pressure related to blood/ vascular pressure
NOT
"they can built up a pressure group on government"

Stress
All mentions by R of
stress
stressed
NOT
"they should be giving more stress in the physical education"
"you should have stressed more on this nutrition"
"so how I can I stress on them that, “No Hindu religious is sacred?"

Child’s profession
Any mentions by R of
profession
professional
which refers to future prospects of the child
e.g. professional course

Direction
All mentions by R of
Direction of the child
NOT
Directions by R or by I to geographic locations

Field
All mentions by R of
field
when it refers to a career choice for C
NOT
when it refers to parent's career
when it refers to I's career

Line
All mentions by R of

line
lines
when referring to a path that C might take
NOT
any reference to Railway lines
any reference to parents' professions
"down the line"
"red line" which means a failing grade

Career
All mentions by R of
career

Path
All independent mentions by R of
path

Track
All mentions by R of
track
tracks
when it refers to the child
NOT when it refers to discussions related to train travel

Concentrate
All mentions by R of
concentrate
concentrating
concentration

Well-settled
All mentions by R of
settle
settled
well-settled
AS it applies to the child
NOT
Hindus are also coming from the others' countries. [OK] Hindus are not origin from this India. [OK] They settled.
NOT
And I got 2 brothers, 2 elder brothers [Umhmm] who are in umm... 10 time above my position. [OK] So you can just understand. I'm just telling you short because I don't want to drag it. But they are not umm... what you say? They are with me. I have not broken the relation but umm... they have just neglected me. [OK] If I call, "What happened? What you want?" [OK] This way they talk. [OK] I have kept the relation but they… one is settled in Qatar and one is in Bombay.

Stand on his/her own feet
All references by R to
standing on his or her feet

Temptations/Attractions/Diversions

Combined

Distract
All mentions by R of
distract
NOT
distraction during interview process

Divert
All mentions by R of
divert

Attract
All mentions by R of
attract
attracting
attractive
NOT in the sense of physical appeal/ looks e.g. She is attractive

Tempt
All mentions by R of
tempt

Trend

What temptations do

Divert as a mental health strategy

Attract negative attention themselves

Bad habits

Outside/Junk Food

Premature boy/girl relationships

Not at the expense of education
Instances where parents report putting off various activities because of children's academic needs

Trying to maintain health is a religious responsibility.
All responses to
Trying to maintain health is a religious responsibility.

Health is only valuable to the extent that it permits me or my
All responses to
"Health is only valuable to the extent that it permits me or my child to do various things"

Government
All mention of

government
Municipal corporation
BMC
Also
KEM Hospital
Sion Hospital

Other mentions of government
All mentions by R of
government
EXCEPT
PHLOC: The government is responsible for the effects of the quality of food on my child's health.
PHLOC: The government is responsible for the environmental effects on my child's health.
What does the government do to protect your child's health?
What percentage of responsibility for C's health is that of the government?
What does the government do to protect your child's mental health?
What percentage of responsibility for C's mental health is that of the government?

Ration
All mentions of rationing system
ration
rations
(e.g., ration card, ration shop)
Public Distribution System

Teacher independently mentioned by I
All mentions by R of
teacher
master (in the sense of a school teacher)
professor
sir (male teacher)

Teacher in response to I's questions
All mentions by R of
teacher
in response to a direct question by I

College
All mentions by R of
college

All schools

School independently mentioned by R
All independent mentions by R of

school
School in response to I's questions
All mentions by R of
school
in response to a question by I
What does the school do to protect your C's mental health?
What does the school do to protect your C's mental health?
School responsibility breakup for C's mental health
School responsibility breakup for C's mental health
School responsibility breakup for C's health
School responsibility breakup for C's health
What does the school do to protect your C's health?
What does the school do to protect your C's health?
It will be my child's teachers' job to keep my child from havin
PHLOC
It will be my child's teachers' job to keep my child from having accidents at school
WHO Injuries from dangerous environments in schools
WHO Threats
Break-up of School Functions
Recoding of school according to its functions
School does nothing
Routine of child
School provides opportunity for exercise and sports
Growth opportunuty
School canteen can affect health
School environment
Social interaction
School educates about health
Sensitive and approachable
Parents delay activities
Studies improve health
Family problems affect school attendance
Sexual abuse
School causes pressure and stress
Difficulties enroute
Drugs, cigarettes, paan bidi
Food outside
Traffic
Has to pass garbage
Class-limited interaction
Willing to put child in school early
Want the best school possible
Children spend time in school
Individualized attention and response
No time to exercise/play/sleep

Boy-girl interaction
Programmes
Problems
Incidental

Education as all important
Education as all important

Mass Media
Computer in response to I's questions
All mentions by R of
computer
laptop
desktop
comp
in response to direct questions by I
Do you have a computer?
Do you have a laptop?
Computer independently mentioned by R
All independent mentions by R of
computer
laptop
desktop
comp
NOT any reference to computer files related to the research study (usually in the first 50 paragraphs of the interview)
NOT any reference to questions/ sections within the research interview (usually in the first and last 50 paragraphs of the interview)
Radio independently mentioned by R
All mentions by R of
radio
radio channels
EXCEPT those in response to direct question
"Do you have a radio?"
Radio in response to I's questions
All mentions by R of
radio
in response to direct questions by I
"Do you have a radio?"
Television independently mentioned by R
All mentions by R of
TV
Cable
television
serial
channel (Make sure this refers to television channel)

EXCEPT segments in response to direct questions by I
"Do you have a television?"
NOT references to sounds of the television playing in the background during the interview process.

Television in response to I's questions

All mentions by R of
television
in response to direct questions by I
"Do you have a television?"

Advertisements

All mentions of
advertisement
ad
billboard

Newspaper in response to I's questions

All mentions by R of
newspaper
paper (as it relates to newspaper e.g. "I read it in the papers")
in response to a direct question by I
e.g., Do you subscribe to a newspaper?
NOT case paper
NOT paper referring to information or consent sheet
NOT paper records
NOT paperwork
NOT paper as it relates to a school exam

Newspaper independently mentioned by R

All mentions by R of
newspaper
paper (as it relates to newspaper e.g. "I read it in the papers")
NOT in response to a direct question by I
e.g., Do you subscribe to a newspaper?
NOT case paper
NOT paper referring to information or consent sheet
NOT paper records
NOT paperwork
NOT paper as it relates to a school exam
examples could be parents complaining of the advertisements in the newspaper

Internet

All mentions of
internet
'net

cybercafe

All mentions by R of
cyber cafe
cybercafe
internet café

Break-up of Mass Media functions
Recoding of mass media according to its functions
Parents find technology beyond their understanding
Aggressive behaviour
Lack of sleep
Lack of exercise and poor health
Bad/ undesirable habits
Distract from studies
create wants and desires
relax and improve health
Inappropriate sexual information
Premature boy-girl relationships
Educational use
Provides information about health matters
incidental

Doctor
All mentions of
doctor
general practitioner
GP
physician
EXCEPT
PHLOC:
"Whenever my child feels sick, I take my child to the doctor right away."
"I take my child to the doctor right away if my child gets hurt."
"Only a doctor or a nurse keeps my child from getting sick."
"I can only do what the doctor tells me to do for my child."

Psychiatrist/ Psychologist
All mentions of
psychiatrist
psychologist

Counsellor
All mentions of
counsellor
counselor
counselling
counseling
NOT Our Lady of Good Counsel

Sex education
All mentions of
sex education
HIV education

AIDS education
HIV/AIDS education
HIV program (me)
AIDS program (me)
seminar (when it refers to some kind of sexual education)

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