Original Article

Childhood Illness and Social Support among a Migrant Tribal Community in an Eastern Indian City

Suchismita Mishra, MA, PhD
Department of Anthropology, Sambalpur University, Sambalpur, India

Yadlapalli S. Kusuma, PhD, PgD in Applied Statistics
Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi, India

Bontha V. Babu, PhD, PgD in Applied Statistics
Health Systems Research Division, Indian Council of Medical Research, New Delhi, India

Correspondence: Dr. Bontha V. Babu, Health Systems Research Division, Indian Council of Medical Research, New Delhi – 110 029, India; Telephone: 91 11 2658 9277; Email: babubontha@gmail.com

Abstract

Social support and health are two important factors help the overall wellbeing of the individual and society. The capacity of individuals to cope with transitional situation is facilitated by the presence of social support. The study explores the extent of social support during illness of children among tribal migrant families living in an Indian city, with a focus on gender bias. This study is based on data collected through interviewing 175 mothers of children aged 14 years and below. A community level support system to support the sick through panchayat existed in this community. However, very small proportion of households received monitory and other support from relatives and other community members. Relatively more families of male children received support than those of female children revealing overt gender discrimination. It is the resultant of poverty and acculturation of this tribal community. As migrants' health is a priority, it is emphasised the need to consider the social circumstances of the tribal migrant people along with their cultural beliefs and practices while planning health care.

Key words: indigenous population, migration, urban slum, child health, social support

Introduction

Social support and health are two important factors help the overall wellbeing of the individual and society. Also, the social support essentially predicts the physical and mental health of the people (Broadhead et al., 1983). Literature revealed that strong social support is necessary to help succeed in achieving the traits of physical and mental well-being (Uchino et al., 1996; Salovery et al., 2000). This may be because social support produces positive experiences and a sense of stability and self-worth (Aneshensel, 1992). It reflects in the emotional support and companionship made available by the members of the society. Informational and physical resources also can be crucial to health if trusted members of the network promote healthier behaviours, help with daily needs, or provide necessary material resources (Lu, 2012). The term social support has been used widely to refer to the mechanisms by which interpersonal relationships presumably buffer one against a stressful environment (Cohen and McKay, 1984).

One's socio-economic status also is a major factor in whether or not an individual gets enough social support. Migrants are one of the vulnerable groups in urban environment. They suffer from low socio-economic profile and alienation in the new environment. People do not have enough resources in their environment available to assist with social support. Studying migration as a social process with societal implications helps enrich our knowledge of the mechanisms accounting for the influences of family and social support on health. However, the existing work largely concentrates on Western societies and immigrants in their settings. Little knowledge is available on how these paradigms function among internal migrants within developing countries like India. Internal migration is an important livelihood

strategy in India, where higher rates of internal migration is reported. In India, rural to urban migration is in rise due to rural impoverishment, erosion of traditional livelihoods and lack of employment (Kundu, 1997; Alredaisy, 2012). The National Sample Survey Organization of India estimated that in 2007-08 there were 326 million internal migrants (i.e., 28.5% of the population) (National Sample Survey Organization, 2010). The urban population in India has touched 377 million and 31.16% of the total population are living in urban areas against 27.78% in 2001 (Government of India, 2011a). In India for instance, about 60 per cent of growth in the urban population is due to natural increase, while rural–urban migration has contributed to about 20 per cent of increase in urban population (Government of India, 2011b).

For life transition of migrants both personal characteristics and contextual factors will play a role (Elder, 1998). Of the contextual factors, the amount of social support or social capital available to the migrants' families is important. The capacity of individuals to cope with transitional situation is facilitated by the presence of social support (Cohen and Wills, 1985; Levitt, 2005). However, the migration induced stress intensify the need for social support at a time when the act of migration itself is likely to disrupt the individual's support network (Siantz, 1997; Waters, 1997). The gender of the child, to whom the support is addressed is also important as gender of the child influences access of individuals to health care, and is one of the major social determinants of health (Jain et al., 2006; Patel et al., 2010; Borooah, 2004, Ganatra and Hirve, 1994; Pandey et al., 2002; Varma et al., 2009). Gender disparities perpetuate more in the background of poverty (Hasan and Khanum, 2000; Kaur et al., 2013). The strong preference for sons over daughters and resulting gender discrimination in India is well known (Patra, 2008). However, some studies undertaken among Indian tribal communities revealed that the status of women in tribal society is better. The tribal girl child is treated as almost equal to male child and this is obvious right from the birth of the child in the family (Deogaonkar and Deogaonkar, 1991). However, migration from original habitat, contact with non-tribes and the resulting acculturation might have affected their perspectives on gender and child care seeking behaviour (Srivastava, 2010; Mishra et al., 2013).

In this context, the present study explored the extent of social support during the illness of children among the tribal migrant families living in urban area, with a focus on gender difference. It is a part of a major gender-based study on the health care seeking for the children among a migrant tribal community in Bhubaneswar, an eastern Indian city.

Methodology

Study Area and People

This study was undertaken among Santal tribe living in Bhubaneswar, the capital city of Odisha, an Eastern Indian State. The Republic of India is a federal state with twenty-nine states and seven union territories. Odisha is one of the states of India, having a population of 4,19,47,358 (Government of India 2011a). In India, there are about 705 tribes with 104.3 million population constituting 8.6 per cent of the country's population. The total tribal population of Odisha is 95,90,756 (which is 22.8 per cent of its total population) (Government of India 2013). The State harbours a total of 62 tribes. The Santals are third largest tribal community in India after the Gond and the Bhil. Numerically, the tribe is one of the largest tribes of Odisha. Their population is 8,94,764 (Government of India 2013). The district of Mayurbhanj claims 76.01% of the total Santal population of the state, followed by Balasore (11.20%) and Keonjhar districts (7.76%). Their language, Santali, belongs to the Munda branch of the Austro-Asiatic language family. However, at present most of the Santals can speak Odiya, the local language of Odisha.

Study Participants and Research Methods

Tribal dominated slums were first identified after a pilot study and four slums were selected on the basis of predominance of Santals. Most of these tribal families have migrated from hilly forest areas of the Mayurbhanj district of Odisha state, and a few are from its neighbouring districts and have been staying here for the past 12 years. All the households of the slums were enumerated, and the information on the total number of family members, their age, education, years of living in the urban area and occupation were collected.

Data were collected through interviews with mothers of children aged 0-14 years, by using a pretested questionnaire. There were 175 mothers available during the study period and they were

interviewed for the collection of quantitative data.

The mother tongue of this community is *Santali*, however, a majority knew Odiya, the local language of the state. If the participant could not understand Odiya, another family member or neighbour who could speak both languages was used as translator. The questions on whether or not the family members received any support from other family and community members during illness of their children. And if any support is received, the details of such support in terms of person provided support and type of support received were recorded. The study protocol was approved by the Doctoral Committee of Sambalpur University, Sambalpur, India, which reviewed ethical issues while approving the research program. Prior to interviewing, consent was obtained from each participant by explaining the purpose of the study.

Data Management and Analysis

Data were entered into a computer through Microsoft Excel and analyses were done using SPSS for windows v.16.0. The questionnaire consisted of both open-ended and closed-ended questions with some alternative responses. Percentages were computed for different responses.

Results

Data revealed the extent of social support received from relatives, neighbours and other community members during illness of the children. The study covered 175 children (94 male children and 81 female children), and of them 138 children (77 male children and 61 female children) experienced at least one episode of illness during last one year.

Table 1 revealed the support received by the households, in terms of monitory help, during illness of the child. Of the 138 households of children experienced illness, 20 households (14.5%) received monitory help for getting treatment. It is to be noted that more households of boys (18.2%) than of girls (9.8%) received this support. Monitory help was mainly received from grandparents (5.8%), followed by other relatives (2.9%).

Table 1: Social support in terms of money received by the child's family during illness of the child

	Male children	Female children	Total children
Number of children	94	81	175
Number of children experienced illness	77 (100.0)	61 (100.0)	138 (100.0)
Number of children/family received help in terms of money	14 (18.2)	6 (9.8)	20 (14.5)
From neighbours	1 (1.3)	2 (3.3)	3 (2.2)
Grandparents	5 (6.5)	3 (4.9)	8 (5.8)
village person	2 (2.6)	0 (0.0)	2 (1.4)
Relatives	3 (3.9)	1 (1.6)	4 (2.9)
Others	3 (3.9)	0 (0.0)	3 (2.2)
Number of children didn't receive any help in terms of money	63 (81.8)	55 (90.2)	118 (85.5)

Figures in parentheses are percentages.

Table 2: Social support in terms of help in domestic work to the child's family during illness of the child

	Male children	***Female children***	***Total children***
Number of children	94	81	175
Number of children experienced illness	77	61	138
Number of children/family received help in terms of help in domestic work	5 (6.5)	0 (0.0)	5 (3.6)
Maternal grand parents	5 (100.00)	0 (0.00)	05 (100)
Number of children didn't receive any help in terms of work	72 (93.5)	61 (100.0)	133 (96.4)

Figures in parentheses are percentages.

Table 3: Social support in terms of taking care of other children of the child's family during illness of the child

	Male children	***Female children***	***Total children***
Number of children	94	81	175
Number of children experienced illness	77 (100.0)	61 (100.0)	138 (100.0)
Number of children/family received help in terms of taking care of other children	11 (14.3)	9 (14.7)	20 (14.5)
Husband	0 (0.0)	2 (3.3)	2 (1.4)
From neighbours	3 (3.9)	0 (0.0)	3 (2.2)
Maternal grand parents	4 (5.2)	2 (3.3)	6 (4.3)
Relatives came from village	3 (3.9)	1 (1.6)	4 (2.9)
Other children	1 (1.3)	3 (4.9)	4 (2.9)
Sister-in-law	0 (0.0)	1 (1.6)	1 (0.7)
Number of children didn't receive any help in terms of taking care of other children in the family	66 (85.7)	52 (85.2)	118 (85.5)

Figures in parentheses are percentages.

Table 4: Social support in terms of other sorts of help to the child's family during illness of child

	Male children	*Female children*	*Total children*
Number of children	94	81	175
Number of children experienced illness	77 (100.0)	61 (100.0)	138 (100.0)
Number of children/family received other help	20 (26.0)	8 (13.1)	28 (20.3)
Number of children didn't receive any other help	57 (74.0)	53 (86.9)	110 (79.7)

Figures in parentheses are percentages.

Table 5: Person accompanied the child during treatment by gender of the child

Person accompanied*	*Male children*	*Female children*	*Total children*
Number of children	94	81	175
Number of children experienced illness and visited health care source	87	61	148
Mother	58 (66.7)	39 (63.9)	97 (65.5)
Father	59 (67.8)	39 (63.9)	98 (66.2)
Maternal grand father	1 (1.1)	0 (0.0)	1 (0.7)
Maternal grand mother	1(1.1)	1(1.6)	2 (1.3)
Paternal grand father	0 (0.0)	0 (0.0)	0 (0.0)
Paternal grand mother	1(1.1)	0 (0.0)	1 (0.7)
Maternal relatives	4 (4.6)	0 (0.00)	4 (2.7)
Neighbours	3 (3.4)	0 (0.0)	3 (2.0)
Friends	1 (1.1)	1(1.6)	2 (2.0)

Figures in parentheses are percentages. *Multiple responses are given.

With regard to support received in terms of help for domestic work during illness of the child, only 3% of mothers got help during illness of their children (Table 2). Surprisingly all of these are mothers of male children, and none of the mothers of girl children could get such support. There is no such difference found between male and female children with regard to support in terms of taking care of other children in the family of sick child (Table 3). Only 14.5% of mothers received support out of 138 mothers. Mostly maternal grandparents provided such support. The other types of help reported by mothers (described below) are also favourable for male children (Table 4). The other types of help includes visiting and consoling the family of sick child, providing vehicle to take the child to hospital, performing rituals and sacrifices on behalf of the family of the sick child, procuring herbal medicine, suggesting on care to be taken, accompanying to hospital, purchasing food items, etc. About 20% of families received such support from maternal uncle, relatives, neighbours, friends and grandparents.

Another issue examined to understand the social support during the sickness of children is providing help by accompanying the child to the health care source. Of the 148 visits to a health source, either father or mother or both accompanied the child in about 66% of instances

(Table 5). The other people accompanied the child are grandparents, other relatives, neighbours and friends. These people provided support by accompanying 9.5% of sick children. It is interesting to note that more of these people accompanied male children than female children.

Discussion

The present studied tribal migrant community received low level of support from the community and other relatives. Migrant status, tribal affiliation and poverty make tribal migrants' vulnerability many fold compared to any other group in India. This combined vulnerability pushes the risk of low access to health care. And most of these households depend largely on private health care sources (Mishra et al., 2015). This leads to high household treatment costs. Hence, these poor people need monetary support in addition to emotional support. Help-seeking behaviours are associated with specific problems; without problems or difficulties, there is nothing from which to provide relief or remedy, nothing from which one should get out (Lee, 1997). To get well from illness in adverse situation, people need support from various sources and for various purposes. Help-seeking behaviours are fundamentally interpersonal and involve more than one person; in the act of seeking help, one person searches for another to provide assistance and relief (Grable and Joo, 1999). Among the various sources, family members and relatives are considered as first helping hand, which can support financially as well as emotionally. Families are important social contexts within which illness occurs, lingers or resolves (Cardol et al., 2005). In general practice, the family was long considered as a starting point for treatment. Families share the same lifestyle and home environment, and they share beliefs and behaviours relating to illness and health, thereby influencing each other's use of medical care (Schor et al., 1987; Wilcox-Gok, 1983; Bosch, 1992). Family members show similar help seeking behaviour with regard to morbidity over time (Hippisley-Cox et al., 2002) and the relation between morbidity and attendance (Starfield et al., 1984) while consultation patterns within the family are even transferred to succeeding generations (Huygen, 1978). It is therefore important to consider patients' social contexts with a view to prevention, diagnosis, and treatment in general practice.

Next to the family members, relatives, neighbours and other community members are supposed to come forward for supporting the patients and their family. Mother's kin network plays an important role in case of help seeking. It is observed that maternal-side relatives helped more during illness period. The social network of parents also determines which human resource one should draw when their child is ill. Gordon et al. (2003) supported this finding and pointed out from their study that existing social arrangements between the mother, the father and the mother's families, and the broader community affect the response to a child's illness. They highlighted that although diagnosis, treatment and care may be distributed among various members of the community, certain elements of response to illness are predictable and consistent with patterns of social relations. It is also observed that only male children got help financially from the community members during their last episode of illness. The community as a whole helps only when the illness is perceived as severe. Also, it is clearly visible that male child's health is considered as more important as compare to that of female child. Due to this reason, male children got more financial support from the community members.

The human resource capital in terms of assisting in domestic work to the family members of a sick child but it is only available if the sick child is male. For female children this supportive mechanism fails to provide help in domestic work. Of course very few mothers reported of getting help even the girl child became sick. The neighbours and the community members provide moral support like accompanying the child to the health care centre or provide vehicle to take the child to hospital. Relatives from native place also come and stay for some days to support the sick child's family. The elderly people of the community also help in providing herbal treatment and suggest which health care services should be sought to the sick child. Delgado et al. (1994) stated that advice of the elder women in the house is also very instrumental and cannot be ignored. They play a crucial role as principal participants in the treatment process. People visit the sick child and presenting food items like fruits, biscuits, bread, etc. for him/her is another type of social support mechanism existing in this community. Sacrificing animals and performing some rituals on behalf of the sick child's family are found to be a social support in the

community. Many of these ritualistic activities are in consonant with the health-related beliefs and practices that exist in this community (Mishra et al., 2013). Hence the social support system is as a system of formal and informal relations through which the people get sources to master stress situations (Caplan, 1974), and it provides a specific form of assistance according to the need (Whittmore et al., 2000).

Another significant finding of this study is that overt gender discrimination even in supporting the families when they were in need. The help seeking behaviour of people is also gender dependant. It was reported among this community that gender discrimination in favour of boys is visible in health care seeking and health care related expenditures (Mishra et al., 2017). The tribal girl child is treated as almost equal to male child. Currently reporting gender bias may be due acculturation these people are experiencing and due to adopting new cultural beliefs of the host Hindu culture. Thus, migration and culture contact resulted in introduction of new lifestyles and along with this are introduced new concepts related to gender norms, roles and statutes. The economic position of these households is not in favour of investing in health. Hence, along with the influence of host community, poverty pushes the parents towards favouring sons over daughters in providing better health care and spending more for treatment.

Conclusion

At present, migrant health care is a priority of the Indian government and its National Urban Health Mission envisages to meet the health care needs of the urban population with a focus on urban poor, by making the government health care services available to them. Internal migrants, who constitute the vulnerable social group among the urban poor with specific health needs, and their health and health care seeking behaviour are influenced by several factors including poor social support and acquired disadvantaged features due to culture contact and acculturation. Gender discrimination is one of those features. Hence, it is emphasised the need to consider the social circumstances of the tribal migrant people along with their cultural beliefs and practices while planning measures to improve their health. The gender based discrimination needs to be addressed during health care planning for reaching female children and women, along with the efforts by the state towards poverty alleviation and improving educational standards of both genders.

Place of work: Department of Anthropology, Sambalpur University, Sambalpur –768 019, India

References

Alredaisy, S.M.A.H. (2012). "Escaping Rural Impoverishment to Urban Poverty, Delta Toker Migrant Farmers Squat Port Sudan Town, Eastern Sudan". *Academic Research International* 2: 571-84.

Aneshensel, C. (1992). "Social Stress: Theory and Research". *Annual Review of Sociology* 18:15-38.

Borooah, V.K. (2004). "Gender Bias among Children in India in their Diet and Immunisation against Disease". *Social Science and Medicine* 58 (9): 1719-31.

Bosch, W.J.H.M. Van De. (1992). *Epidemiological Aspects of Morbidity in Children*. Ph.D. thesis, Nijmegen: University of Nijmegen.

Broadhead, W. E., Kaplan, B. H., James, S. A., Wagner, E. H., Schoenbach, V. J., Grimson, R., Heyden, S., Tibblin, G. & Gehlbach, S. H. (1983). "The Epidemiologic Evidence for a Relationship between Social Support and Health". *American Journal of epidemiology* 117 (5): 521-537.

Caplan, G. (1974). "*Support Systems and Community Mental Health*". New York: Behavioural Publications.

Cardol, M., Groenewegen, P.P., Bakker, D.H. de, Spreeuwenberg, P., Dijk, L. van, Bosch, W. (2005). "Shared Help Seeking Behaviour within Families: A Retrospective Cohort Study". *BMJ* 330: 882-885.

Cohen, S., McKay, G. (1984). "Social Support, Stress and the Buffering Hypothesis: A theoretical Analysis". In: Baum A, Taylor SE & Singer JE (eds). *Handbook of Psychology and Health*, Hillsdael JJ: Lawrence Erlbaum, pp. 253-267.

Cohen, S., Wills, T.A. (1985). "Stress, Social Support, and the Buffering Hypothesis". *Psychological Bulletin* 98: 310-357.

Delgado, E., Sorenson, S.C., Van der Stuyft, P. (1994). "Health Seeking Behaviour and Self Assessment for Common Childhood Symptoms in Rural Guatemala". *Annales De la Societe Belge De Medecine Tropicale* 74**:** 161-168.

Deogaonkar, S., Deogaonkar, S.G. (1991). *The Tribal Girl Child Book Girl Child in India.* New Delhi: Ashish Publishing House.

Elder, G.H. Jr. (1998). "The Life Course and Human Development". In: Damon W, Lerner RM (Eds.), *Handbook of Child Psychology*: *Vol. 1. Theoretical Models of Human Development* New York: Wiley, pp. 939-992.

Ganatra, B., Hirve, S. (1994). "Male Bias in Health-Care Utilization for Underfives in a Rural-Community in Eastern India". *Bulletin of the World Health Organization* 72: 101-104.

Gordon, A.L., McKinley, S.E., Satterfield, M.L., Curtis, P.A. (2003). "A First Look at the Need for Enhanced Support Services for Kinship Caregivers". *Child Welfare* 82 (1): 77-96.

Government of India. (2011a). *Census of India 2011. Provisional Population Totals. Paper 1 of 2011. India, Series 1*. New Delhi: Registrar General and Census Commissioner of India, Government of India.

Government of India, (2011b). "*Report on Indian Urban Infrastructure and Services of High Powered Expert Committee (HPEC) for Estimating the Investment requirement for Urban Infrastructure Services*". New Delhi: Ministry of Urban Development, Government of India.

Government of India. (2013). *Statistical Profile of Scheduled Tribes in India-2013*. New Delhi: Statistics Division, Ministry of Tribal Affairs, Government of India, Accessed at: http://tribal.nic.in/WriteReadData/userfiles/file/Statistics/StatisticalProfileofSTs2013.pdf on 1st May 2015.

Grable, J.E. and Joo, S. (1999). "Financial Help-Seeking Behaviour: Theory and Implications". *Financial Counseling and Planning*, 10 (1): 14-25.

Hasan, I.J., Khanum, A. (2000). "Health Care Utilization during Terminal Child Illness in Squatter Settlements of Karachi". *Journal of Pakistan Medical Association* 50: 405-9.

Hippisley-Cox, J., Coupland, C., Pringle, M., Crown, N., Hammersley, V. (2002). "Married Couples' Risk of Same Disease: Cross Sectional Study". *BMJ*, 325: 636-640.

Huygen, F.J.A. (1978). *Family Medicine; the Medical Life History of Families*. Amsterdam: Dekker & Van de Vegt-Nijmegen.

Jain, M., Nandan, D., Misra, S.K. (2006). "Qualitative Assessment of Health Seeking Behaviour and Perceptions Regarding Quality of Health Care Services among Rural Community of District Agra". *Indian Journal of Community Medicine*, 31 (3): 140-144.

Kaur, M., Sodhi, S.K., Kaur, P., Singh, J., Kumar, R. (2013). "Gender Differences in Health Care Seeking Behaviour of Tuberculosis Patients in Chandigarh". *Indian Journal of Tuberculosis* 60: 217-222.

Kundu, A. (1997). "Trends and Structure of Employment in the 1990s: Implication for Urban Growth". *Economic and Political Weekly* 32: 1399-1405.

Lee, F. (1997). "When the Going Gets Tough, Do the Tough Ask for Help? Help-Seeking and Power Motivation in Organizations". *Organizational Behaviour and Human Decision Processes* 72: 336-363.

Levitt, M.J. (2005). "Social Relations in Childhood and Adolescence: The Convoy Model Perspective". *Human Development* 48, 28-47.

Lu, Y. (2012). "Household Migration, Social Support, and Psychosocial Health: The Perspective from Migrant-Sending Areas". *Social Science and Medicine* 74 (2): 135–142.

Mishra, S., Kusuma, Y.S., Babu, B.V. (2013). "Concepts of Health and Illness: Continuity and Change among Migrant Tribal Community in an Eastern Indian City". *Anthropological Notebooks* XIX/III, 61.

Mishra, S., Kusuma, Y.S., Babu, B.V. (2015). "Migration and Health-Care Access: Barriers to Access Government Health Services by Migrant Tribal Community Living in an Eastern Indian City". *International Journal of Medical Science and Public Health* 4 (1): 101-108.

Mishra, S., Kusuma, Y.S., Babu, B.V. (2017). "Treatment seeking and out of pocket expenditures for childhood illnesses among a migrant tribal community in an eastern Indian city". *Paediatrics and International Child Health* 37 (3): 181-187.

National Sample Survey Organization. (2010). *Some Characteristics of Urban Slums, NSS 65th Round (July 2008-June 2009)*. Report No. 534(65/0.21/1). New Delhi: National Sample Survey Organization.

Pandey, A., Sengupta, P.G., Mondal, S.K., Gupta, D.N., Manna, B., Ghosh, S., Sur, D., Bhattacharya, S.K. (2002). "Gender Differences in Healthcare-Seeking during Common Illnesses in a Rural Community of West Bengal, India". *Journal of Health, Population and Nutrition* 20: 306-311.

Patel, R.K., Trivedi, K.N., Nayak, S.N., Patel, P. (2010). "Treatment Seeking Behaviour of Peri-Urban Community of Chandkheda". *National Journal of Community Medicine*1: 35-36.

Patra, N. (2008). *State Wise Pattern of Gender Bias in Child Health in India.* MPRA Paper No. 21435. New Delhi: Centre for Economic Studies and Planning, Jawaharlal Nehru University. Accessed at: http:/mpra.ub.uni-muenchen.de/21345/, on 20th May 2015.

Salovey, P., Detweiler, J.B., Steward, W.T., Rothman, A.J. (2000). "Emotional States and Physical Health". *American Psychologist* 55: 110-121.

Schor, E., Starfield, B., Stidley, C., Hankin, J. (1987). "Family Health". *Medical Care* 25: 616-626.

Siantz, M.L. (1997). "Factors that Impact Developmental Outcomes of Immigrant Children". In: Booth A, Crouter AC, Landale N (Eds.), *Immigration and the Family: Research and Policy on U.S. Immigrants.* Mahwah, NJ: L. Erlbaum, pp. 149-161.

Starfield, B., Katz, H, Gabriel, A., Livingstone, G., Benson, P., Hankin, J., Horn, S., Steinwachs, D. (1984). "Morbidity in Childhood: A Longitudinal View". *New England Journal of Medicine* 310: 824-829.

Srivastava, V.K. (2010). *Socio-Economic Characteristics of Tribal Communities that Call*

Themselves Hindus. Religions and Development India. Working Paper Series, 1 (3). New Delhi: Indian Institute of Dalit Studies and Religion and Development Research Programme. Indian Institute of Dalit Studies.

Uchino, B.N., Cacioppo, J.T., Kiecolt-Glaser, J.K. (1996). "The Relationship between Social Support and Physiological Processes: A Review with Emphasis on Underlying Mechanisms and Implications for Health". *Psychological Bulletin* 119: 488-531.

Varma, G.R., Bhavani, P.S.V., Mishra, S., Babu, B.V. (2009). "Gender Bias in Utilization of Healthcare among Rural and Tribal Children of Visakhapatnam District, Andhra Pradesh". *South Asian Anthropologist* 9: 165-168.

Waters, M.C. (1997). "Immigrant Families at Risk: Factors that Undermine Chances for Success". In: Booth A, Crouter AC, Landale N (Eds.), *Immigration and the Family: Research and Policy on U.S. Immigrants.* Mahwah, NJ: L. Erlbaum, pp. 79-87.

Whittmore, R., Rankin, S.H., Callahan, C.D., Leder, M.C., Carroll, D.L. (2000). "The Peer Advisor Experience Providing Social Support". *Qualitative Health Research* 10 (2): 260-276.

Wilcox-Gok, V.L. (1983). "Sibling Data and the Family Background Influence on Child Health". *Medical Care* 21: 630-638.