

Health Care and Social Stratification : A Study in Health Behaviour in Rural Andhra Pradesh

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By
S.N.M. KOPPARTY

DEPARTMENT OF SOCIOLOGY AND ANTHROPOLOGY
SCHOOL OF SOCIAL SCIENCES
UNIVERSITY OF HYDERABAD
HYDERABAD
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Department of Sociology
School of Social Sciences
University of Hyderabad
Hyderabad - 500 134

Dated : 30.6.1988

This is to certify that I, S.N.M. KOPPARTY have carried out the research embodied in the present thesis for the full period prescribed under Ph.D. Ordinances of the University.

I declare to the best of my knowledge that no part of this thesis was earlier submitted for the award of research degree of any University.



Signature of Candidate
(S.N.M. KOPPARTY)

Enrolment No. GS-1128



Signature of Supervisor



Head of the Department

PREFACE

Health and illness are universal phenomena. Health is an indicator of the effective functioning of the biological system. According to World Health Organisation (WHO) health is a 'state of complete physical, mental and social well-being and not mere absence of disease or illness'. While the physical and mental aspects are taken care of by medical profession, the social-well being dimension has been neglected so far. This aspect requires a closer understanding of the underlying complex relationships between health and social, economic, political and cultural aspects of society.

India is committed to achieve the goal of 'Health for All' by 2000 AD in accordance with the Alma-Ata declaration, 1978. A close look at the present health status of the population in our country reveals glaring inequalities. The distribution of health resources - practioners, dispensaries, hospitals, equipment, beds etc.- is highly uneven between urban and rural populations. Health indices such as high infant mortality, high birth rate, high morbidity rate etc. reflect the gravity of the health problems in our country. In addition to these

problems, aspects such as social status, economic standing, power relationships, culture, age, sex etc. play their role in accentuating these problems. Against this background, the present study was undertaken to understand the relationship between health care and social stratification at micro-level. This study will be of interest to social scientists, policy-makers and development functionaries working in the health field.

The study was conducted in village, Rangampeta in East Godavari District of Andhra Pradesh. It explores the relationship between social stratification and patterns of morbidity, health action, utilisation of health resources and observance of health practices in the community.

The present study is divided into seven chapters. The problem, its importance and review of literature were discussed in the First chapter. In the Second chapter, the objectives and methodology were spelt out. In the Third chapter, the study village and the characteristics of the sample population were described. Patterns of morbidity and health action in relation to social stratification was discussed in the Fourth chapter. In this chapter, acute and chronic morbidities and

caste, class, age and sex variables were analysed. Utilisation of various health resources available to the community by caste and class groups was discussed in the Fifth chapter. In the Sixth chapter, health practices and their relationship to caste and class was presented. Conclusions and summary were presented in the last chapter.

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INTRODUCTION

Chapter 1

INTRODUCTION

"Medicine is a social science
in its very bone and marrow"

-Rudolf Virchow

SOCIAL ASPECTS OF HEALTH :

Health and Illness are universal phenomena. Both are variously understood or defined in different societies or communities. The most widely accepted definition of health given by WHO is "a state of complete physical, mental and social well-being and not mere absense of disease and illness". While the physical and mental aspects of health are taken care of by medical profession, the 'social well-being' dimension has not been properly attended to so far. This aspect needs a closer look to understand the underlying complex relationships of health to other spheres of life such as social, economic, political, environmental and technological dimensions.

An individual is not an isolated entity but lives in and part of his primary group, kingroup, neighbourhood, community and the wider society. Not only he is a biological organism but also a social being interacting with his immediate

physical and social environment regularly and constantly.

In order to sustain himself, he has to exploit the physical resources around and create necessary conditions for his well-being. For this, he has to work on his physical environment, develop suitable technology and social relations in the process. All these factors influence his well-being in the society. The people from primitive to modern societies have evolved different physical, social and material environments appropriate to the conditions surrounding their daily life and routine and in accordance with their resources and aspirations.

Health, an integral and essential part of life, has been viewed differently at different stages of development of society. Further, within the society, different social groups have evolved their own conception of health. Health is to be seen not merely in terms of curing a disease but as an indicator of the level of social, economic, material and environmental development. What is needed is an understanding of those various conditions, situations and behaviour patterns which not only determine the health status of a group but are also necessary to understand their health and illness behaviour. Thus, 'health is a socially produced natural reality'. (Djurfeldt and Lundberg, 1980). "Diseases exist and abound where human habits and social conditions foster them" (Kocher, 1979).

Health can be seen as a strategic resource of a society because of its crucial bearing on the ability of individuals to perform their roles. Health and Medicine like economy, religion, politics etc. constitute a sub-system in the social system of a society. A health system is "a set of relationships among institutions, social groups and individuals that is directed towards maintaining and improving the health status of a population" (DeMiguel, 1979). The health system can be seen both as a structure and process. The main task of a health system is to cope with the threats and consequences of illness. To achieve this, the health system provides a series of services consisting of prevention, diagnosis, treatment, rehabilitation, custody and health education (Field, 1973).

The response to illhealth and its consequences can be seen as cultural and sociological. The cultural consequences refer to the development of attitudes and perceptions regarding health and illness and lay strategies to deal with problems of health. The sociological consequences refer to progressive development of health institutions which produce knowledge, personnel and technology for proper management of illness. Health personnel and health facilities operate within the context of a health system (Field, 1973). A health system transforms given inputs into health service outputs (DeMiguel, 1979).

The main goal of a health system is to improve the health status of a population in a given area. The health status of a population is the net effect of a health system. It can be measured by indicators such as mortality and morbidity rates, longevity or lifespan, decline of causes of death, social and mental health, etc. The health status of a particular group in a society, therefore, partly depends on how the group stands in relation to the resources, personnel and programmes of a health system.

Health system contains three social arenas in which lay persons experience and respond to episodes of illness. ✓ These are popular, folk and professional arenas. The popular arena comprises essentially of the family context of sickness and care including the community setting. The folk arena consists of non-professional healers. The professional arena consists of professional scientific (western or cosmopolitan) medicine and professionalised indigenous healing traditions (Kleinman, 1978). People perceive and respond to the day to day problems of health and illness in light of their beliefs, their needs and the social situation in which they act. These aspects are reflected in their health and illness behaviour. The terms "health behaviour" and "illness behaviour" refer to the practices

and actions directed at achieving better health, prevention of health risks, and the management of the episodes of illness experienced.

HEALTH SYSTEM IN INDIA :

India is a signatory to the Alma - Ata declaration (1978) which pledges 'Health for All' by 2000 A.D. It has become a charter of health throughout the world and a hope for mankind, particularly in the developing countries.

The distribution of health resources -- practitioners, dispensaries, hospitals, equipment, beds etc. - is highly uneven between rural and urban populations in India. With 76.3% of its population living in over 5,75,993 villages (NIRD, 1983), India is served by 20% of its doctor population and a network of primary health centres with ineffective referral system while the small urban population is served by highly equipped health care institutions and well-trained personnel. The distribution of hospitals, beds, nurses, ANMs, drugs, equipment, referral services is all the more glaring. Further, health indices such as high infant morbidity and high mortality rates, birth rates etc. in the rural populations reflect the gravity of the health problems in villages. "The problem is further compounded by the gross neglect by the

Government in allocation of resources to health in its five-year plans. Areas such as education were given greater allocation, though seemingly health is more important. It is because health is not considered politically a very important area. Behind smaller allocations for health lies the kind of cynicism almost unknown elsewhere" (Sethi, 1980).

The draft sixth plan (1978-83) identified some of the weaknesses which resulted into the inequitous health care structure and medical education in India since independence. Some of these are :

"....(b) it is divorced from social, economic and ecological factors, conditions of work, social stratification (c) it is unrelated to such other important issues as nutrition, water supply, dietary requirements and habits, food preservation practices etc. (d) health services have been concentrated mostly in urban areas and here too, these services have been largely used by the affluent classes i.e. the structure is largely inequalitarian (e) it is based on medical education system which prepared doctors not for the care of the health of the people, but instead for medical practice that is unrelated to any-thing except disease and technology dealing with it (g) it has seriously undermined and at places destroyed whatever traditional methods of health care system that existed for centuries in the country (h) it is based on the growing use of drugs instead of their avoidance by improving physical condition of living and hence is largely influenced by the interests and philosophy of drug industry...." (Govt. of India, 1977).

The need to improve the health services is stressed by the ICSSR-ICMR study group in its report and it suggested the following priority areas of research :

1. "Health services research should have very high priority. Of social interest in this regard is primary health care whose different aspects (such as information support, manpower development, appropriate technology, management and community involvement) need close and continuous study. Since administration has been a weak spot, research for improving administrative practices is very relevant."
2. "Studies on different aspects of the health system is urgently needed. Very little work is being done, for instance to study the relationship of health to society, and fields like sociology or economics of health are still in their early infancy."
3. "...recommended emphasis on research into indigenous systems of medicine and health consequences of industrial development (including studies of work place environment)" (Health for All, 1981)

Thus, in the context of structural and functional imbalance of health care delivery system in rural India, any study which explores linkages between health care and other aspects like social structure, economic conditions, technology

etc. assumes significance. With this background, the present study is aimed at understanding the relationship between health care and social stratification in a rural community in Andhra Pradesh.

Health is the most valued asset for performing one's role effectively. Health depends in part, upon the status which a group or individual enjoys or is bestowed upon in a given community. It may be seen that health as well as health behaviour is governed by the position a person (or group) occupies in the system of social differentiation existing in a society. Social stratification differentially limits the accessibility to health resources and knowledge on health care. It also determines the living conditions privileges and obligations, and the cultural traditions surrounding the life of a person.

THE FOCUS OF THE PRESENT STUDY :
HEALTH AND SOCIAL STRATIFICATION

Sociological and Anthropological researches have revealed the universality of social stratification in one form or other. It is a "generalised aspect of the structure of all social

systems" (Parsons, 1953). Social stratification refers to the arrangement of various groups in a hierarchy indicating the relations of superiority or inferiority with respect to property, status and power. These relations are governed by a value system, ascription and achievement, reward and punishment. It provides differential status and role to individuals and groups that constitute a basis for human behaviour in relation to each other. It confers differential possession of goods and services, differential access to resources and differential utilization of facilities and opportunities.

Davis and Moore (1945), Davis (1948), Tumin (1953), Buckley (1958), Wesoloswski (1962), Huaco (1970) and several others have approached stratification from functional perspective. For them, the most important positions are filled in by the most talented persons and to fill in these positions, there should be a system of rewards as inducements to occupy these positions. These rewards and their distribution among various positions constitute stratification system.

Karl Marx has viewed stratification from a dialectical perspective. For him, the history of all hitherto existing societies is the history of class struggles. Classes emerge on the basis of different positions or roles which individuals

perform the same function in the organisation of production. Means of production is the determinant of relations of production. It would give rise to two classes in a society -- owners of means of production (bourgeoisie) and owners of mere labour power (proletariat) with the former exploiting the latter. Thus, the interests of these two classes are mutually antagonistic and would draw them into a class-struggle leading eventually to the establishment of a classless society. For Marx, the ownership of property is the substructure and its all other aspects such as religion, power, culture, art, education, law etc. are superstructures. Attributes such as class consciousness, class solidarity and class conflict are important to understand the nature of class relations in a society.

Max Weber went further and conceptualised stratification in terms of "class, status and party". For him property, power and prestige are three separate though closely interrelated bases on which hierarchies are formed in a society. Differences based on property, power and honour give rise to class, power and status respectively. Unlike Marx, for Weber class is a product of a market situation and there are as many classes as there are market situations. A class shares in common one or more causes of life-chances which determine the supply of goods, living conditions and life experiences. Other thinkers such as

Ralf Dahrendorf (1959), Lenski (1966), Warner (1960), Parsons (1953) have also put forth their ideas on stratification.

In India, various scholars view stratification in terms of either caste or caste and class or caste, class and power. Indian society is "Caste-society" characterised by hereditary membership, endogamy, commensal restrictions, common traditional occupation and hierarchy as held by Davis (1948), Hutton (1963) and Ghurye (1950). Various scholars analysed caste stratification from different perspectives - as a cultural system (Dumont, 1970 ; Leach, 1960) as a structural phenomenon (Barth, 1960; Berreman, 1967) as closed system (Bailey, 1953); as segmentary (Beteille, 1966) etc.

Among numerous studies mention may be made of Kosambi (1955), Thapar (1974) and Desai (1948) who have analysed Indian society from class point of view. The phenomena of caste, class and power was studied by Beteille (1955) and Bhat (1974) explicitly applying Weber's trilogy.

Some theoretical aspects of Caste and Class as ideal types make them distinctive categories. Caste is ascribed by birth while Class is achievable. Class is closer to economic relationship, to means of production and economic status.

Class signifies status in terms of power and influence one enjoys by virtue of one's income, property and social standing irrespective of birth. Caste signifies a traditional pattern of social interaction by inclusion and exclusion irrespective of one's economic standing.

However, empirically there is a striking overlap : Both Caste and Class are linked to occupation which determine economic standing. Social standing accrues to an individual by both Class and Caste considerations. It is difficult to separate the status and power a person enjoys because of Caste and Class affiliation.

The Caste identity being an emic category is socially visible much more than the Class identity which is more of an etic construction. The consciousness of Class affinity bond, political alignment in common cause among Class members across caste identities is perhaps still weak against the back drop of strong Caste loyalties. Caste being age old institution is linked to all facets of community life including occupation, income, property, land and social standing which are achievable attributes in Class framework.

Empirically, therefore there is bound to be a strong overlap in Caste and Class identities. Some observers have noted that caste system mirrors or mimics class relationships and class dynamics such as the problems of economic domination and subjugation, privileges and deprivations, conspicuous affluence and bare survival (Sharma 1977; Mencher, 1974). Others have observed that new class related questions and social actions are being absorbed and enacted within the garb of caste identities and alliances.

Three empirical assumptions can be safely made for our purpose.

1. While Caste represents the domain of traditional and ascriptive framework of life conditions, values and social choices, class represents achievable social status and new life conditions or social choices that are cosmopolitan i.e. which cut across caste identities. Caste represents traditional framework of social behaviour while class represents emergent patterns of social relationships and behaviour.
2. While Caste Status embodies many dimensions of social relationships and social status, Class status is more directly and exclusively related to economic factors reflected in land, property, income and occupation.

3. When we empirically classify the same households by Caste and Class there is bound to be strong association between the two variables. Yet the differences are going to be very suggestive because some High Caste households will rank with Low Class households and some Low Class households will rank among the High Caste households. (Beteille, 1965). Analytical implications of these assumptions are identified later in the second chapter where such class-caste classification of the sample households is presented.

HEALTH ASPECTS IN VILLAGE STUDIES

Having delineated broadly the focus of this study we may briefly review the village studies in India many of which include material on health and illness. It may be mentioned here that some British administrators and those interested in rural development focussed their attention on health problems in India. Brayne (1937), Advisor on Indian Affairs to the Welfare General of India, describing the health situation in pre-Independent India, mentioned in his book 'Better villages' "If you run your eye down the tabulated list of diseases in a rural dispensary, you will find that well over a half are caused by dirt, the absense of light and air are more responsible for a lot more, then malaria and its by products, and finally absense of the knowledge of how to plan and cook a

balanced diet." Similarly, Pillay (1931) said "The general uplift and health questions have to be dealt with as a whole and not in separate compartments. The aim should be to see that while health work is assisting other branches of state activities, it is automatically helped by them and thus becomes an aspect of concerted attempt at general lift." He discussed the problems of rural welfare (including health) and suggested measures for organization of systematic work. Spencer Hatch (1938), Krishna Swami (1947) also expressed their concern about the appalling health conditions in the country.

Few early studies on village life described aspects related to health briefly while their main focus was to study social structure, kinship, economy, religion, communication etc. Datey (1948) described the standard of life in village, Madhan, in Maharashtra. He categorised the families in the village into seven groups depending on their per capita expenditure. He gave a detailed account of how each group spent its resources on food, clothing, housing, comforts and luxuries. He observed that as the family income increases, the proportion of expenditure on food decreases and that on the comforts and luxuries increased. This supports the Engle's law of family expenditure which states that as the family

income increases, the proportion of expenditure on food decreases, while the proportion of expenditure on other non-essential items increases.

Majumdar (1958) described sanitation, water supply, food habits, drainage system, diseases and their treatments in the village Mohana in Uttar Pradesh. Chattopadhyaya (1963) briefly mentioned about cleanliness, sanitation, food, causes of morbidity and death in Ranjana, a village in West Bengal. Madan (1959) presented the changing situation in the field of health - medical care and public health, maternity and child health, family planning, health education, water supply and sanitation etc. in some Indian villages. Desai (1966) discussed health and medical facilities, consumption pattern and levels of living in village, Hasteda, in Rajasthan. He observed that there was a significant relationship between economic well-being and the type of food consumed and that not only did the consumption of superior cereals increase but also the tendency to turn to protective foods became more marked with the increase in income. He has, however, added that the level of income was not the only determinant but factors such as degree of enlightenment and social status also influenced the quality of food consumed. Mukherjee (1971) gave an account of health and diseases in six villages in West Bengal. He discussed about sanitation and water supply and

gave a list of diseases which incapacitate a person for less than a week and those for more than a week. Bhowmick (1976) presented a profile of diseases prevalent and practitioners consulted in some villages in West Bengal.

Ishwaran (1967) discussed health and illness in village, Shivpur, in Karnataka. He described how the villagers perceive health and illness, the common diseases and their cure, purity - pollution and health, native practitioners etc. Carstairs (1955) discussed the obstacles in acceptance of Western medicine in two villages - Sujarupa and Delwara - in Rajasthan. Illness is viewed as much a moral crisis as a physical crisis. The practitioner should serve as a link between mortal men and cosmos. After a restudy of these villages, (1983) he described the progress and failures in rural health care. He pointed out that "mutual misunderstanding is bound to arise between rural patients who believe in the supernatural cause of illness and doctors trained in scientific medicine, unless the doctor takes pains to show how he respects his patients understanding of illness while tactfully indicating that his own approach is different, but can yield good results". (Carstairs, 1983). Marriott (1958) studied the impact of Western medicine in Kisangarhi, a village in Western U.P.. He presented the contrast between Western

and Indian medicine in terms of doctor-patient relationship. Lewis, (1958) studied concepts of disease causation and cure in village, Rampur.

There are a very few holistic village studies on health situation in India. Hasan (1967) studied socio-cultural factors associated with health in village 'Chinaura' in Uttar Pradesh. He described sanitary habits, personal hygiene, food habits and food taboos, concepts of etiology and illness etc. Matthews (1979) studied nutrition, maternal and child welfare, family planning, disease classification etc. with the purpose to undertake health education work later in a village in Tamil Nadu. Banerji (1974) studied health behaviour of rural people in seven states covering sixteen villages. He observed that most of the villagers, irrespective of their social, economic and occupational status, favored western (allopathic) medicine. This is in contrast to the observations of Carstairs and Mariott. Availability of western (allopathic) medical services and capacity of patients to meet the expenses are the two major constraints. There is considerable unmet felt need for the services of ANM (Auxiliary Nurse Midwife) at the time of child birth. The family planning program projected an image of coercion by the Government.

These studies, except a few, indicate a lack of focus on health problems in India. This has been equally evident in the concern by Gunnar Myrdal (1968) while describing health conditions in South Asia. He writes : "Ideally, we would like to see health censuses of all or a representative sample of the inhabitants of individual South Asian countries, with the data analysed in terms of differences in sex, age, occupation, social and economic status. Indeed, a health survey of this kind for even a few villages or a few blocks in a city would contribute significantly to our knowledge. But no such studies have been made. The rapidly accumulating village surveys show an astonishing lack of interest in local health conditions, or in demographic changes and their social and economic consequences".

With this understanding of the situation, we will review the material available on health and social stratification in India.

HEALTH AND SOCIAL STRATIFICATION IN RURAL INDIA : LITERATURE REVIEW

The relationship between health and social stratification has been demonstrated in terms of occurrence of mortality, differential incidence and prevalence of morbidity, differential

perceptions of symptoms and their interpretation, differential occurrence of illness, differential use of health practitioners and health services, differential accessibility of health resources, etc. All these aspects are related to caste, class, ethnicity, age, sex etc.

In India, many studies of rural/tribal communities have made some reference to selected aspects of health while focussing their attention mainly to some other problems. Here, an attempt has been made to review the available studies related to aspects of health and social stratification in India. These studies are discussed below under two headings - (a) caste and health; and (b) class or socio-economic status and health.

CASTE AND HEALTH

The caste has its role in curing of diseases or ailments, shaping one's beliefs related to health, food habits etc.

Health Roles

In traditional India, certain castes are associated with different roles in health action -- any activity undertaken to maintain, promote or restore health to an individual. Midwifery

is practised by females belonging to Jhusia or Dhusiya, a subsect of Chamars in Bihar, Basors or Baksors lower than Chamars in UP, Haris or Sahis in West Bengal, Mongs in Gujarat, and Barbers in Andhra Pradesh, Tamil Nadu and Karnataka (Fuchs, 1981; Russel 1975; Beteille, 1965).

Some of the members of Barber caste (Ambattan) act as healers in Tamilnadu. This role accords them a special privelege of carrying the title Vadyar meaning physician (Beteille, 1965). In Karnataka (Misra, 1982), Punjab (Ibbetson, 1974) and Rajasthan (Lambert, 1987) the Barbers used to act as village surgeons for dressing wounds and setting bones. In Northern India, Baids practise the profession of medicine and in some places, they used to hold hereditary state pensions (Sherring, 1974, 1975; Kurian and Bhanu, 1980).

Some castes engage themselves in collecting ingredients used in preparation of medicines and or hawk the same in villages and small towns. The castes Mandula, Pitchikuntla, Golla in Andhra Pradesh and Karnataka and Nats in North India belong to this category. The section among caste Gollas which sells medicines claim a higher status than other sections, by avoiding inter-dining and inter-marriage with them (Fuchs,1981).

Through exorcism, sorcery and devil-dancing various kinds of illnesses are cured. Some castes specialise in these methods of healing. In Kerala the main occupation of Malayans is exorcism. The Kanians in Malabar are astrologers and exorcists. The pulluvans are engaged in medicine, astrology and priesthood (Fuchs, 1981).

Most of the lower castes are associated with the cult of godlings and evil spirits which derive its strength from animistic beliefs. There are different godlings and evil spirits associated with the cause of different diseases. For example, a godling who protects children upto five years is known as Panchanan who is propitiated with simple offerings if they have a small ailment and presented with the sacrifice of a goat in case of serious illness (O'Malley, 1935). It is rare among Brahmins to be possessed by local spirits existing outside the Great tradition as they are considered impure and of low status (Nichter, 1977; Claus, 1979). The evil spirits of the dead are also classified according to their caste and manner of death. Brahm Pisach and Churail - women died in child birth - fall within this category.

Health Beliefs

Caste variations are also reflected in health beliefs. An analysis of the concept Jamoga (Tetanus) in a village in

UP (Khare, 1963) revealed a gradual sanskritization and elaboration of ideas regarding diseases as one moves from lower to higher castes. The higher castes think of a disease more with the help of ideas in greater tradition whereas the lower castes seek explanations in tribal gods, spirits and magic which are localised (Lewis, 1958). As regards functioning of body and maintenance of health, there are distinct Brahmin and Non-Brahmin ideologies in Karnataka (Nichter, 1977).

Breach of intercaste relations is attributed to occurrence of certain diseases in rural areas. Illicit sexual relations with a woman of lower caste is considered responsible for the cause of venereal diseases. Harassment of poor, weak and helpless persons is believed to cause leprosy. Milking in a container with water for adulteration is considered to be the cause for Leprosy (Hasan, 1967).

Khare (1962) observed that there exists a relationship between the ritual states of purity and pollution and the physical states of cleanliness and uncleanness in domestic surroundings. This relationship helps in clarifying the role played by Choot-Pak (ritual purity-pollution) concepts in domestic sanitation. There has been a change occurring in

ritual purity and pollution in three stages as evident in his study in Gopalpur. In the first stage, the details of practices connected with ritual purity - pollution are dropped. For example, the Choot-Pak complex in the kitchen is becoming less rigid though the majority of them do not disregard it completely. The second stage consists in practising the atrophied version of ritual purity-pollution with occasional resort to modern methods of cleanliness. The use of soap, the wearing of leather band wrist watches and leather shoes by the people are examples. The third stage consists in dropping out the old practices of purity and pollution without systematic replacement by the new ones. The educated 'elite' of the village dropped several practices of choot-pak as superstition, but did not replace it with sanitary practices. He further observed that some people like Kayasthas are fast undergoing modernization and westernization. Others like Kurmi, Ahir and Pasi are undergoing sanskritization as well as modernization. Youth are claiming what-ever is modern, while old people, especially of lower castes, are observing the details of ritual purity in the rules of commensalism and in the activities of kitchen.

Food Habits

Taking specific kinds of foods is associated with caste. The high caste Brahmins are vegetarians while the non-Brahmins

are generally non-vegetarians. Two kinds of food habits are observed in Tamil Nadu : the high caste vegetarian style and the Harijan non-vegetarian type. Most of the castes fall within these two extremes (Djurfeldt and Lundberg, 1980).

Variations in cooking are reflected in different castes depending upon the position of caste/cluster of castes within the social hierarchy. In West Bengal (Sengupta, 1979) people of very low and lowest categories seldom use spices for cooking. They cook food either by steaming or boiling. Others cook food by frying in oil, roasting or boiling with due addition of spices. The castes of very low and lowest categories add salt to the rice at the time of cooking. The high and very high categories of castes consider it ento i.e. polluting. The utensils used for cooking, items of food prepared and the quantity of food consumed also differ significantly from very low and lowest categories to high, very high and highest categories.

Food Distribution

In rural areas, the rich appropriate the provisions meant for the poor. Whatever quota the poor get in rationing, they give it to rich people so that they can be engaged as casual labourers when required. Whatever quota of rationing is allotted to them, it is hardly distributed to them and that too, only

after meeting the requirements of the dominant and powerful people in the community. In a study of the homogeneous stratum of agricultural labourers belonging to high caste Marathas and Buddhists who belonged to Mahar caste formerly, it was observed that food consumption patterns and employment opportunities differed considerably between the two sections. Caste has its own influence in restricting Buddhists to certain types of occupations (Kamble, 1979).

Access to Health Resources

Caste determines to a certain extent occupation, social status, residential pattern, values and norms and in a way the whole way of life of its members. The principle of exclusion and inclusion and purity and pollution regulate the accessibility of a particular caste to the resources in the community. The "untouchables", the lowest in the social hierarchy, are denied access to essentials of life. They are excluded from using wells, tanks etc. by the rest of the village community (Desai, 1976). In Kerala, they are excluded from private bathing pools and temples which are, however, open to all high-caste people. In a village in Kerala, the political power was manipulated by the high-caste Hindu Panchayat President in digging the well sanctioned to Harijans in the village (Mencher, 1980).

The discrimination and exclusion is not confined to the high caste Hindus and untouchables alone, but a similar practice is observed among untouchables themselves. In Tanjore district, Pallas do not draw water from Paraiyan wells, nor do they allow Paraiyans to use their wells (Beteille, 1972).

The exclusion is also extended to places where services are supposed to be provided to all. In hotels, the untouchable Adi-Karnatakas have to drink coffee in containers specially meant for them. The high caste Hindus strictly enforce the restrictions (Epstein, 1978; Mishra, 1982).

Health Practices

Caste status and level of living (measured by an index comprising selected material possessions owned combined with type of housing) have an important role in adoption of health practices. Thorat (1969) in his study on the influence of traditional and non-traditional status on the adoption of health practices observed that higher the caste of the respondent greater was the level of adoption of health practices. Similarly, those with higher level of living adopt greater number of health practices.

Perception of a Good Physician

Rai, in his study of illness behaviour, in rural Uttar Pradesh, found that while most of the non-economic criteria like good-behaviour, knowledge, experience and capacity of making a sharp diagnosis and high academic qualifications were evaluated as desirable traits of a good physician by the high caste people, economic criteria like inexpensive treatment, providing immediate relief, were reported as good traits of a physician by lower castes (Rai, 1983).

B. CLASS, SOCIO-ECONOMIC STATUS AND HEALTH :

Class, Food and Disease

The system of bonded labour in some parts of Bihar and Madhya Pradesh accounted for the distribution of Khesari dal, a kind of pulse which causes Lathyrism, a disease of nervous system in people. The bonded labourers mostly belonged to tribals and untouchable castes. The Khesari was given in lieu of wages. The pattern of disease in the population is quite revealing. It strikes men mostly between the ages of 11-35 years crippling them to do any productive work at their prime life leading to ill health, indebtedness and misery.

Among women, this disease is less common probably because of the defense properties of the hormone 'oestrogen'. The disease occurs either at puberty or after menopause. The men-women ratio of this disease is 10 : 1. The disease is not simply a physical problem but is closely related to social, commercial, economic and political structures of the region (Joshi, 1982).

Class and Medical Care

Yesudian (1981) studied the health behaviour of four social classes - High, Middle, Low and Very Low - in utilisation of health services in Bombay city. He observed that as the Low and Very Low Social Class households are educationally backward, their knowledge level of diseases, available health services and their perception to seek health services are found to be lower than that of Middle and High class Households. Since all the four social classes differ in their life-styles in terms of income, housing and environment, their health status also differs. While the High and Middle classes mostly suffer from chronic diseases, the Low and Very Low classes suffer from communicable diseases.

The Low and Very Low social classes use mostly the government health services because of their poverty. Here also, they are not aware of all the services available in General Hospitals and as a result their use is restricted to out-patient department mostly (Yesudian 1981). The awareness of medical facilities is lowest among scheduled castes and scheduled tribe groups. They prefer government hospital, choose a place where the treatment is offered free of cost and rarely go to a private practitioner (Rao, 1981).

Economic Strata and Food

The expenditure pattern on food and other items reveals conspicuous gap in the standard of living among various groups. Studying some case studies representing various economic strata in some villages in Karnataka, Epstein (1978) observed that more than 50% of the income is spent on food alone among Adi-Karnatakas without any savings, little more than 40 per cent of income is spent on food among peasants with 4 percent marginal savings and 10 per cent of the income is spent on food among rich peasants.

In a village in Andhra Pradesh, food consumption pattern, malnutrition and undernutrition among the non-owning and non-cultivating agricultural families belonging to all the castes were studied. Though the scheduled castes, backward castes and

high castes show deficiency in the intake of calories, this deficiency decreases as one moves from the scheduled castes to the high castes. The calorie intake in pulses, sugar and jaggery, and meat among the three categories is conspicuous and raises from the scheduled castes to the advanced castes. The extent of malnutrition in children among the scheduled castes is higher than the backward castes and advanced castes. (Rao, 1977). A study of under-fives (children) in the villages of Punjab shows that compared to the land-owning jats, the Ramdasia (Harijan) children not only have higher prevalence of malnutrition but also higher morbidity (Kielman and Oberoi, 1972).

Economic Strata and Medical Care

In a study of some villages of North Arcot district (Tamilnadu) it was observed that for common ailments at initial stages, a larger proportion of respondents with low income preferred home treatment than the respondents with higher income. The higher the income the higher the preference for a qualified physician. The decision-making regarding choice and treatment is done by the head of the household in greater proportion in low income groups than in higher income groups. A higher proportion of those in higher occupation chose a place of treatment from where they could get quick relief while a greater

proportion of those in lower occupation groups preferred a source from which they could get treatment free of cost. The proportion who consult health personnel or physicians for immunisation of children has increased corresponding to the increase in income. (Rao, 1981)

Poverty also contributes to the people's inability to pay for transportation for a patient cannot walk despite the availability of free medical service and the inability to miss work to take the child to the health centre (Matthews, 1979). The structural constraints like poor image of PHC due to lack of medicines, over-crowding, and long-queues and the cultural and social gap between the health worker and the patient also limits utilization of health services (Banerji, 1973).

Social Status and Seeking Medical Care

In Thaiyur, a village in Tamilnadu, the high caste Hindus were found reluctant to use the medical services provided by a voluntary organization (SWALLOWS) because they felt humiliated in treating them at par with Harijans ignoring their caste status in the local community. Though it fits well with the norms of medical service, but treating all equally conflicts

with the values of the society being served (Djurfeldt and Lundberg, 1980). Lower castes in Kodiur in Tamilnadu mostly used the services of PHC because they were free while the higher castes availed the services of certain practitioners as they were able to afford their charges. The type of disease also affected the utilization and mostly specialists of that particular disease are consulted (Matthews, 1979).

Socio-economic Status and Nutrition

The data collected by the National Nutrition Monitoring Bureau (NNMB) in ten states during 1975-1978 on diet survey have revealed an interesting relationship between socio-economic variables of families and their protein - calorie intake (NIN, 1980).

It was observed that lowest levels of nutrient intakes (2020 k cals and 53 g.) were found among families of labourers. Mean intakes of calories and proteins were found to be the highest (2450 k cals and 68 g) in families of cultivators followed by those classified under the category of 'others' which included families of artisans, small traders and service groups (2220 k cals and 59g.).

Among families having no land, the mean intake of proteins and calories is lower whereas it is highest in those who owned land equal to or more than 10 acres. A consistent positive relationship was reported between the extent of landholdings and nutrient consumption. The intake levels of nutrients was better in families of those cultivators who effectively utilized their lands for raising crops when compared to those who did not raise any crops. The households possessing cattle showed higher consumption of nutrients when compared to those without any cattle.

The hospital data in various cities of the country indicate low-birth weight among low socio-economic groups compared with the high socio-economic groups. Birth-weight in turn is a consequence of nutrition (Swaminathan, 1974).

In all, drawing upon the above, one may note that most of the studies, with few exceptions, are fragmentary in nature and are off-shoots of larger studies conducted on themes which are not directly connected with health. However, the brief review has conclusively proved the decisive role of caste, class and other dimensions like landholdings, occupation etc. in health behaviour. The role of a healer/physician associated with certain castes/sections of a caste has conferred social mobility and a high status in the society.

It is, therefore, seen that there has been no systematic study taking into account the major forms of social stratification and their consequences in regard to health behaviour. The present study is an attempt in this direction.

FRAMEWORK OF THE PRESENT STUDY :

Caste, Class and Health Care

Based on these and other studies available, a tentative framework of relationship between stratification and health care variables has been adopted. As shown in the diagram (Figure 1.1) stratification variables (Caste, Class, Ethnicity, etc.) existing in a given cultural and environmental setting interact with health care variables (nutrition, health practices, use of health resources, use of health care facilities etc.) to produce a given pattern of morbidities among the respective groups. However, the objective of this study is not to causally explain the differences in morbidities (health status) but merely to examine what important caste and class differences do exist in the study village with regard to occurrence of morbidities and prevalence of health care practices. The aim of the present study is to examine the relative influence of caste/class status in relation to health care practices. Implications of this approach are discussed later.

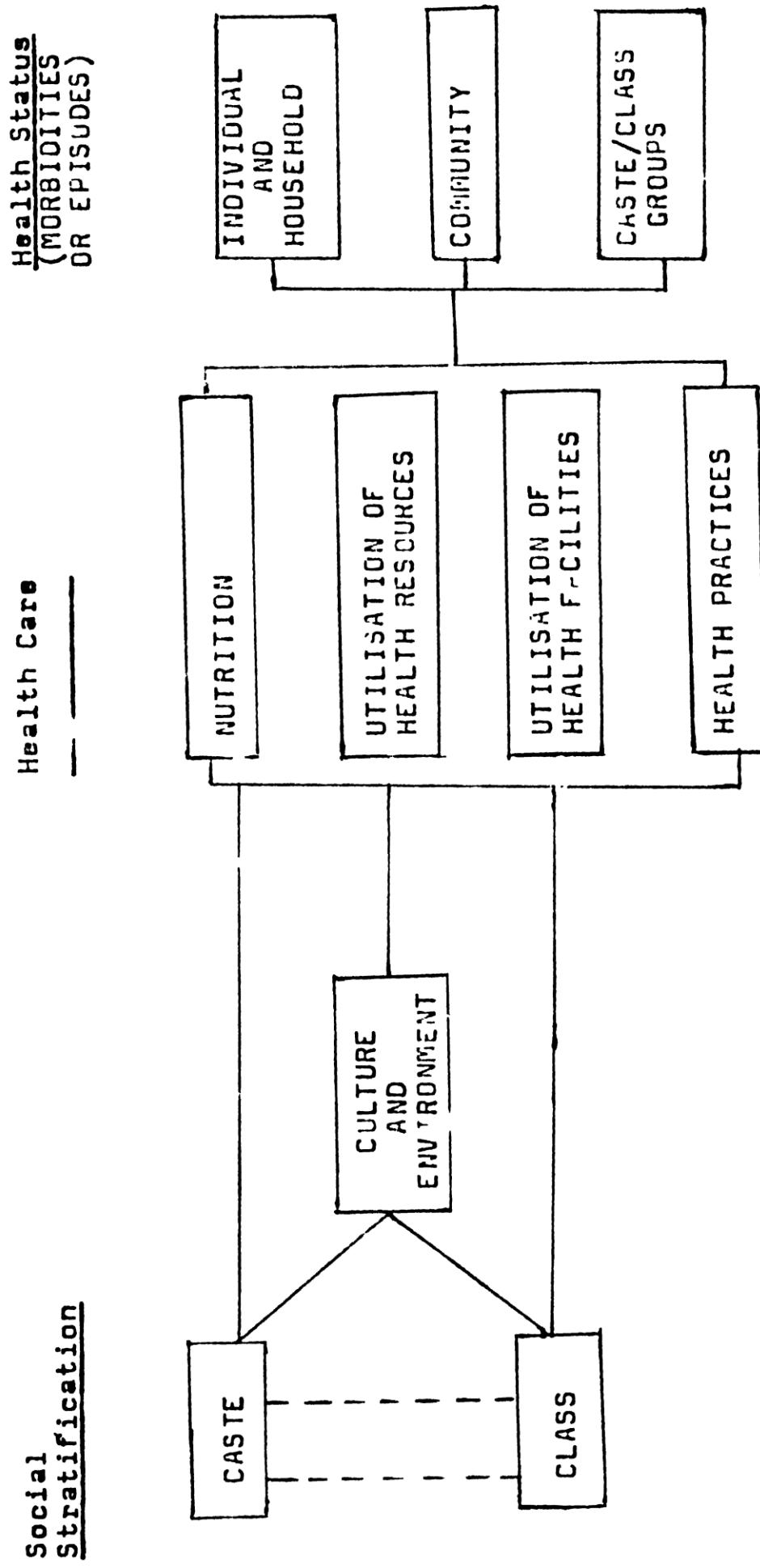


Fig. 14: Interaction of social stratification, culture health care and health status.

For our study, social stratification is taken in its both caste and class dimensions. Class is conceptualised by using 'attributional' method. Land, income and occupation are grouped for analysing class status (see details in second chapter). It is assumed that a cumulative index of all these class attributes will have a decisive impact on one's choice, access and ability to use various health resources and facilities available in the community and outside it.

The contrasting life-styles of the high and low castes or class are expected to produce differential health profiles. The Low Castes and Class are exposed to greater risk of contracting diseases in view of their congested residence, lack of education, adherence to superstitions, lack of accessibility to and awareness of health facilities, etc. In view of the differential advantages or disadvantages associated with life conditions of high and low castes/class, their health status is also likely to differ. Similarly either because of greater adherence to traditional values, norms and practices or because of better living conditions social status and cosmopolitan influences, the high caste/class groups are likely to show differences in various health care practices.

Caste status :

Various sociologists and anthropologists conceptualised caste in different ways. Barth (1960) and Berreman (1967) emphasize that caste is a structural phenomenon while Dumont (1970) and Leach (1960) consider it as a cultural system. Senart (1963) treats caste as an organic structure of relations whereby a society is divided into a number of self-contained and completely segregated units (castes), the mutual relations between which are ritually determined in a graded scale. Ghurye (1950) emphasises endogamy as the essential character of caste. Weber (1946) considers it as a status group. D'Souza (1967) treats it as a hereditary group. Mencher (1974) treats caste as a system of interdependence or reciprocity and that it inhibits the development of 'class conflict' or a proletarian consciousness.

For the purpose of our study caste is conceptualised as a hereditary group which follows a specific occupation and enjoys a certain status in caste hierarchy in the village.

Sociologists and Anthropologists employed different approaches to study caste hierarchy. These approaches are of two types : (i) caste hierarchy as constructed by the

researcher; and (ii) caste hierarchy as constructed by people themselves. In the former type, three methods were adopted :

(a) Varna model in which caste hierarchy is having two (Srinivas, 1961) or three broad divisions (Ghurye, 1960; Beteille, 1969);

(b) Ceremonial values and ideas of purity and pollution (Dube 1956; Bailey, 1958; Marriott, 1960; Mathur, 1964); and (c) Constitutional provisions which divide rural community into upper castes, backward castes and scheduled castes (Sachchidananda 1972; Rao Hanumantha, 1977). In the latter type, researchers have employed three different methods: (a) status as claimed by the caste members themselves; (b) mutual ranking of castes by the lay members of the community as generally agreed among them; (c) ranking of castes by judges (key informants) selected from the community to arrive at a statistically derived rank order. In the present study, the latter type has been used because of the advantages over the former. Under this type, the method of ranking of castes by Judges (Key informants) has been adopted. There are advantages in adopting this method. Due to the factor of subjectivity involved, the method of status claimed by castes was not adopted. The method of mutual ranking or the status given to a caste by members of the community was found inadequate due to following reasons:

- (1) difficulty in involving all members of a community if it has a large population.
- (2) laymen do not think rationally

and as a result use criteria other than caste status in ranking which results in using different criteria by different people. On the otherhand, the method of caste ranking by Judges provides relatively a fair view of caste hierarchy since it eliminates disagreement about the status of a caste following its economic and political achievements (Lewis, 1958; Bailey 1958; Chouhan 1967). Further, it was not practicable to use the first two methods under the latter type because the village under this study has a very large population (6,000) spread over a wide geographical area.

We have broadly classified various castes in a village into High, Middle and Low Castes on the basis of their status approximations. The High Castes are better placed than the Low Castes in terms of their residence, diet, landholding, occupation, education and power. The High Castes are expected to conform to the normative prescriptions of purity and pollution, observe more restrictive social interactions, follow vegetarian diet, follow traditional rules and rituals on major occasions. But many of them also happen to own same amount of land, attain higher education, live better life and wield some power in the community. The Low Castes reside in a segregated area in the village, live in small and congested houses, mostly thatched, follow unclean or menial occupations, observe non-

vegetarian diet including beef, pork etc., mostly landless or own very small amounts of land, mostly illiterate and powerless. Between these two extremes there are a number of middle castes with varying amounts of small land holdings, follow a variety of occupations such as agriculture, trade, crafts, services, etc. The middle castes have relatively low educational attainments, are mostly non-vegetarian (excluding pork and beef).

Class status :

There are two main conceptions of Class in sociological literature : (1) subjective or socio-psychological and (2) objective or economic. Warner used the former concept in his researches. He used reputation and prestige among people for constructing classes. Three main approaches have been adopted under this type: (1) community's evaluation; (ii) self-evaluation; and (3) researcher's evaluation. Under the economic concept, two approaches to study class are adopted: (1) single index; and (2) composite index. The 'single index' approach makes use of only one variable as a sole indicator of one's class position (Smith, 1943; D'Souza, 1967; Beteille, 1969). There are problems of status-inconsistency and lack of universally effective single determinant of class under this approach. To avoid the lacunae in this approach, investigators have used

composite view of one's statuses based on two or more status giving variables. This provides an overall view of one's class position (Freeman, 1961; Pareek and Trivedi, 1965).

In the present study the economic concept of class is used as none of the subjective approaches to study class is possible in rural India because class itself is an alien concept to the rural people and one's status is determined by caste. People may use different criteria in judging one's class position. Further, classes cannot be conceptualised in Marxian sense since the basic characters proposed by Marx - class unity, class interest and class conflict - are absent. In addition, today's society is much more complex than what he visualised in his period. Further, use of such categories as landlords, rich peasants, landless labourers etc. is not worthwhile in our study as it is not an attempt to study only stratification system in a community.

Health care practices :

In the present study the term health care is defined as any action(s) taken by an individual or a group to prevent and cure illness, promote and maintain health and to rehabilitate the affected. This concept includes, in the

present study, the following aspects : (a) nutrition (b) access to and utilization of various health services (facilities and resources) given by the government through primary health centre (c) access to and utilization of health services offered by the private practitioners, folkhealers, medical shop (d) health practices followed by the people (e) morbidity and its remedial health action.

Every member of the society is expected to follow certain practices regularly in order to enjoy a healthy life. Broadly, three types of health practices were examined in the study: (1) practices related to personal hygiene, drinking and smoking (2) practices related to maternal and child care and (3) food practices. Under personal hygiene, care of teeth, body and hair were discussed. Under maternal and child care, actions related to diet, work during pregnancy, and after child birth, prenatal check up, weaning etc. were presented. Under food practices, the intake of various food items was described. Under utilisation of health resources and facilities, the use of PHC, ANM, MPW, CHV, private practitioners, medical shop, pond and tap was discussed. Further, the extent of preference for these resources was also examined.

METHODOLOGY

Chapter 2

METHODOLOGY

As indicated before, the present study aims at understanding the relationship between differences in health care and caste and class differences in a rural community in Andhra Pradesh. Social stratification plays an important role in determining an individual's/group's life conditions, access to and use of various facilities, resources and opportunities available in a community. It also largely regulates one's interaction in economic, political, social, religious and other fields, with members of other sections, groups etc. in the community. It has been amply demonstrated that social stratification plays a significant role in functioning of rural development programmes. In the field of health care a number of studies have indicated in this direction but no study has been specifically aimed to examine this problem. The present study is an effort in this direction.

OBJECTIVES OF THE STUDY :

The following objectives have been set forth for this study:

1. To describe differential distribution of morbidities and various health care practices among the caste, class and age-sex groups in the study village.

2. To examine whether the differential distribution of health care practices has any consistent patterns in relation to caste and class differences.
3. To find out whether there is any evidence of systematic deprivation or exclusion from health facilities and resources in the study village.
4. To discuss the nature and implications of differences between class and caste groups as observed in the study.

No specific hypothesis has been adopted for varification through a quantitative causal analysis. However, a number of plausible propositions have been identified based on literature review briefly reported in the previous chapter. The following tentative propositions or questions are to be kept in view for examining the data.

1. The Low Caste/Class group has higher prevalence of morbidity than the High Caste/Class group.
2. The Low Caste/Class takes less health action than the High Caste/Class group.
3. The Low Caste/Class group has a poorer nutritional status than the High Caste/Class group.

4. The High Caste/Class has better health care than Low Caste/Class group.
5. The High Caste/Class group is able to restrict or appropriate health services and resources against the Low Caste/Class group.
6. Do the Low Caste/Class group make greater use of Government health services and the High Caste/Class group make greater use of private health care services?
7. Is the image, perception and knowledge of PHC services different among the different Caste/Class groups?
8. Are females given less attention for their health problems than males?

OPERATIONALISATION OF
CONCEPTS :

We have presented above a brief theoretical outline of the key concepts involved (namely, caste, class and health care practices) and indicated the framework we have selected for describing or measuring these variables. Further details of operationalizing these variables in the context of study village are given below.

1. Caste

Caste is the most pervasive form of social stratification in India. It has great influence in almost all the fields of life. Its continuance is facilitated greatly by observance of endogamy, commensality, passage of food, ritual purity-pollution, exclusion and inclusion, rules of social distance, and restricted mobility. With the spread of education and modern outlook, there is some laxity in private circles and among youth in observance of commensal relations and purity-pollution norms. However, the older generation is still scrupulous in their strict observance and public image of caste status is intact largely. For the purpose of broad comparisons, it was decided to classify all the 20 castes present in the study village into three broad groups namely High Castes, Middle Castes and Low Castes. Small groups of elders belonging to different castes were chosen and were asked to rank all the 20 castes in the study village into three broad categories by reading out a list of castes present in the village (details given in the next chapter). There was consensus in placing the highest two castes - Brahman and Vysya into High Caste and Mala and Madiga into Low Caste groups. The Kamma and Kapu castes were also placed in High Caste group largely because of the acceptance of raw food items

such as rice, oil, flour, vegetables etc. by the Brahmins from them. The Kamma is a dominant caste-numerically, economically and politically - in the study village. It may be mentioned here that Kapu is the dominant caste in the region largely, but in the study village, only few households of Kapu are present. The Brahmins attend the ceremonies of both these castes on invitation but do not dine with them. From other castes, they do not accept any type of food-raw or cooked, nor will they attend their ceremonies. The Low Castes are the untouchables. On the other hand, the problem arose in ranking of castes in the Middle group as to who should rank above whom. There are fourteen castes in this group, some represented by few households while others with considerable numbers. Since our purpose is not to establish a composite caste hierarchy, it was sufficient to establish three broad groups for the sake of our study.

2. Class

Class is viewed here as an economic concept. For this, primary indicators of economic status such as land owned, occupation and income were chosen. Class variable is constructed by using a composite index of these three variables. Dak (1982) used a similar procedure in constructing class in

his study in rural Haryana. In the first instance, score for each of these three variables was assigned as follows:

- a) Land: The total land owned by a household in all the sample households is taken into account. Necessary cut off points were made depending upon their spread in the sample and the likely income they enjoy. Accordingly, five categories were created. These are : landless; upto 2 acres; 2.1 - 5 acres; 5.1 - 10 acres and 10.1 - and above. All the five categories were given scores from 1 to 5 respectively.
- b) Income: The total earnings of a household during the previous year from all the sources - land, occupation, wage, rent, etc. - was taken into consideration. The net annual income of all the households was divided into five categories: upto Rs. 4,000/-; Rs. 4001 - 6000; Rs. 6001 - 10000; Rs. 10001 - 50000 and Rs. 50000 and above. These categories were given scores from 1 to 5 respectively.
- c) Occupation: In our sample, there are 27 occupations ranging from teaching, priesthood, agriculture to cobblery. A list of these occupations were read out to small groups in the village and were asked to rank them. The highest named occupation was scored 1 and the lowest occupation 27 with other occupations being assigned the corresponding score as ranked by the villagers. The scores thus assigned by all the groups to a particular occupation

were totalled. All the occupations were arranged in ascending scores. Then, meaningful cut off points were made depending upon the gap in the score between one set of occupations and the other. Accordingly, five categories of occupations were identified. The highest ranked set of occupations were put in category 1 followed by next highest ranked in category 2 and so on. In all five categories were created. The highest ranked category was given score 5, followed by next highest ranked category with score 4 and so on. The scores thus ranged from 1 to 5.

- d) Composite Class Index: In the next stage, the scores assigned to each household on land, income and occupation variables were totalled. The composite score for class of all the sample households ranges from 3 to 15. The range was divided into three categories depending upon the spread of households. The score 3 to 6 was categorised as Low Class group; 7-11 as Middle Class group and 12 to 15 as High Class group.

The purpose of this procedure was only to broadly classify the sample households into three broad class groups based on land ownership, income and occupation. Unweighted 5-point scale were converted into score and added up into an index. This simple procedure provides a relative placement of households into three broad groups. A finer and more valid weighted scores would have been desirable if an interval scale was intended. However, even with such refinement the relative position of the households in 3 groups would have broadly

remained more or less the same. Since health care practice variables are mostly based on 3 point or 5 point qualitative rank, little advantage would have served if class as independent variable were constructed as refined interval scale.

3. Caste and Class interactions

It has been noted above that strong overlap exists between Caste and Class variables. In so far as these variables overlap they empirically measure the same thing and there would be little justification for seeking differences between the two variables that signify the same empirical property space.

The value of these two variables for analysis, is therefore, confined to the extent they empirically signify different things and thereby display some measure of lack of overlap.

The table 2.1 gives caste/class classification of 200 sample households using the procedures indicated above. As expected, chi-square test shows significant association at .001 level. However, measure of correlation ($c = .61$) indicates

Table : 2.1

Caste-Class distribution of households in the sample

| Class | <u>CASTE</u> | | | | Total |
|--------------|--------------------------|--------------------------|--------------------------|---------------|--------|
| | High | Middle | Low | | |
| High Class | 50 (87.7%) (51.0%) | 3 (5.6%) | 4 (8.3%) | 57 (28.5%) | (100%) |
| Middle Class | 30 (63.8%) (30.6%) | 14 (29.8%) (25.9%) | 3 (6.4%) (6.3%) | 47 (23.5%) | (100%) |
| Low Class | 18 (18.8%) (18.4%) | 37 (38.5%) (68.5%) | 41 (42.7%) (85.4%) | 96 (48.0%) | (100%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (100%) | 200 (100%) | (100%) |

C = .61
(Coefficient of Contingency)

(Mueller and Schneller(1961): Statistical Reasoning in Sociology, p. 266)

about 60% overlap. This means there is lack of overlap (perfect correlation) to the extent of about 40%. This is sufficient to justify treatment of these two variables as separate independent variables.

Percentages give a good indication of this difference. Assuming that class is more inclusive than caste (the latter being ascriptive and birth dependent) we find peculiar dilemma - while 85.4% of Low Caste households are in Low Class group (as expected) but among the Low Class households Low Castes are only 42.7% i.e. about 57% of the Low Class households belong to the higher castes (High & Middle) indicating relative polarisation of the two variables. However, picture is quite different with regard to High Castes. While only 51% of the High Caste households belong to the High Class, among the High Class households as many as 87.8% belong to the High Castes. The High Class is virtually confined to the High Castes (only 12% belong to the other Castes). However, about half of the High Caste households do not fall in the High Class group but to lower class groups. On the other hand about 7% of the Low Caste households belong to the High Class group. These indicate the extent of economic mobility in the Low Caste group.

The table shows that 68.6% of the Middle Caste households belong to the Low Class group. Thus Middle Caste households are likely to display a profile of health care practices similar to the Low Caste households generally. Location of Middle Caste or Middle Class will not provide a middle position on a linear scale because of the pattern of distribution shown in table above.

RESEARCH TECHNIQUE :

For this study, questionnaire survey technique was chosen. It was supplemented by informal interviews with all those connected with health problems in the village such as PHC staff including doctors, folk-practitioners, RMP's, informal leaders, etc. This technique was chosen in view of the nature of data required, problems related to vast geographical spread of the study village etc. Other techniques such as participant observation were found to be less helpful as the households were spread over a wide geographical area with highly uneven socio-economic status. It may be mentioned here that access to the High Class households was found more difficult than to the Low Class households. Further, since the respondents were not easily available due to their preoccupation with agriculture, construction work, etc., throughout the year this technique was deemed suitable.

DEVELOPING QUESTIONNAIRES
FOR SURVEY RESEARCH

In view of the objectives of our study, detailed discussions were held with the experts in the field. On the basis of the available literature and the suggestions of the experts, a questionnaire was developed covering aspects related to social and economic status, morbidity, utilization of health facilities and resources, nutrition, health practices etc. The questionnaire was pretested in a village 'Gopulayalapalli' in Nalgonda district in Andhra Pradesh. On the basis of this pretest, it was felt that the questionnaire was quite lengthy and required to be split up into smaller units so that these could be managed in a shorter time without placing a heavy demand on the time and patience of the respondents though it necessitated a number of visits to each respondent. Further, on the basis of the experience, the questionnaire was split up into smaller units and made necessary changes in them either by reframing, deleting or adding some questions. These questionnaires were further pretested in a village 'Siriwada' in East Godavari District in Andhra Pradesh. On the basis of this pretest, the questionnaires were edited, revised and finalised. Further, a check-list of common illnesses and their local terms was prepared by interviewing small groups of elderly and knowledgeable informants (Appendix A).

Keeping in view the kind of data required for both dimensions - health care and social stratification - five questionnaires were finally prepared. The first one was aimed at collecting all the basic information about the sample households in terms of its composition of members, their age, sex, education, occupation, landowned, income and the facilities owned like latrine, water source, electricity, bathroom, kitchen etc. The second one deals with morbidity both in its chronic and acute forms. This also covers aspects such as periodicity, type of illness - not clinical type but symptoms or complaints in their own knowledge (respondents) - and health action resorted to. The third one pertains to nutritional status and food habits of the household. The fourth one focusses on utilization of various health resources and facilities located within the village and outside the village. ~~THE~~ FIFTH questionnaire deals with health practices in three parts (i) practices followed by the head of household (ii) practices of the mothers, and (iii) general practices followed by the household members (such as children).

Informal interviews were also held with practitioners, PHC personnel, informal leaders and others in the village to collect data on various aspects which have a bearing on the problem under investigation. Though a separate interview guide

was not prepared, the interviews were carried keeping in view the relevant aspects of the problem under investigation.

Participant observation is ideal to be carried out in small populations in a compact geographical area. The village under study is spread over a vast geographical area including its hamlet. The population is highly differentiated which is reflected in their varied life-styles in terms of their housing, occupation, behaviour etc. The access to fairly rich and very rich farmers was difficult in view of their limited availability and that too at particular hours in the day. And in their absense, other family members were rarely willing to cooperate. On the otherhand, it was far easier to establish sound rapport in a short time with poorer sections of the population, especially the Low Castes. They were quite cooperative and ready to talk to the researcher more openly on various issues. In fact, it became difficult to convince and avoid those who were not listed in our sample households. With these handicaps, the participant observation technique could not be carried out.

SELECTION OF THE STUDY VILLAGE

The topic of our study demands an extremely careful selection of the village since both the dimensions - health care

and social stratification - are to be adequately represented. To satisfy this main criterion, a set of guidelines were framed to select a village. The district East Godavari in Andhra Pradesh was chosen to conduct this study as the researcher is familiar with the language and culture of this region and that it was one of the first few districts selected for implementation of Multipurpose Health Worker (MPW) scheme in the state.

The guidelines framed for selecting the village were :

1. The village is multi-caste in its composition;
2. There is enough scope to identify sufficient number of respondents from landless to rich land owner categories;
3. A primary health centre is located either within the village or in a nearby village and has been functioning for a very long period, at least for 10-15 years;
4. The Primary Health Centre has its full strength of medical staff and most of them reside within the village;
5. The village has a number of folk-healers and private practitioners;
6. The village is connected with nearby towns where better health facilities are available.

With these criteria in mind, the District Medical and Health Department was consulted and a list of PHCs in the district with their coverage of the population and the services offered was obtained. After detailed discussions with the authorities in the department, it was decided to visit some PHCs to judge their suitability for our study. In this exploratory exercise, visits were made to Primary Health Centres located at Kandrakota in Peddapuram Taluk, Virava in Pithapuram Taluk and Rangampeta in Rangampeta Taluk. In all these villages, the PHC personnel including doctors, well-informed people and village elders were interviewed to have a firsthand knowledge about the population, numerical strength of various castes, pattern of land-ownership, availability of health facilities both within the village and outside the village, communication facilities etc. Upon careful consideration of various factors associated with the above mentioned villages in East Godavari District finally village Rangampeta was selected for our study. Results of my preliminary explorations in various villages is reported below.

VILLAGE KANDRAKOTA :

First, a visit was made to Kandrakota village in Peddapuram taluk. Here, the PHC has been functioning since 1960. Most of the staff of the PHC do not reside within

the village but reside in Peddapuram, the taluk headquarters of Samalkot, another nearby town, because of lack of proper housing facilities, communication facilities, educational opportunities, remoteness etc. Communication facilities to nearby taluka head quarters, though at a distance of 6 Kms, are extremely poor. The road is kachcha, bumpy and heavily dusty. Only two buses of the Andhra Pradesh State Road Transport Corporation (APSRTC) ply at highly irregular intervals in the day. After 5 p.m. in the evening there is no bus service. Barring RTC bus service, there is no other motor transport. Only cycles or rickshaws can be used as a means of transport depending upon their availability. Needless to say, it is very remotely connected. There are 19 sub-centres under its jurisdiction. Since it did not satisfy our criteria, it was dropped.

VILLAGE VIRAVA :

Next, a visit to another village, Virava in Pithapuram taluk was made. The nearest town, Pithapuram is its taluk headquarters and is about five miles away from it. It is a commercial town and has good hospital facilities. Buses ply regularly between Pithapuram and Divili, a major village and

a recreational centre, via this village. Rickshaws are available to reach nearby towns and the road, though kachcha, is fairly good. After having met some of the criteria laid down for selection of a village, further information was collected. The Panchayat President was approached and explained our purpose and sought his help and cooperation. He provided the researcher with all the registers from his office where information on all houses in terms of their location, type, tax levied etc. was available. A master list of all the houses in the village was prepared. Later, some well informed people including the Panchayat clerk, were contacted to obtain the caste and occupational status of all the heads of the households in the village. Then, the Karanam (village accountant) was approached to get the data on land-holdings of all the heads of households. His records were consulted in his presence and his cooperation was sought to know about the changes in landholding pattern, if any, but not recorded in the registers or about those persons who migrated or died on the basis of his personal knowledge. Then, a master list of all houses with their respective caste, size of land holding and occupational status was prepared. Then the data were analysed to see the distribution pattern of households in various economic categories and castes.

The village is having a population of 4,165 as per 1981 census. The PHC covers a population of 73,991 spread over 11 sub-centres in 27 villages over an area of 58 square kilometers. It was established in 1960. The total coverage of land under this village is around 800 acres. This village was chosen as one of the three PHCs by the Ranga Raya Medical College, Kakinada for extending the specialist services as per their programme.

The analysis of the data revealed a heavy concentration of households with small holdings below 2 acres. Most of them are engaged in agricultural labour. Very few households are found in the category of 5 or more than 5 acres. Since this village presented a largely homogeneous picture and much less differentiated pattern of land holdings and occupation, this village was also not chosen for our study.

VILLAGE RANGAMPETA :

Next, exploratory visits were made to the village, Rangampeta in Rangampeta taluk. In this village, the PHC has been functioning since 1962 covering an area of 208 square kilometers with a population of 1,25,022 in 52 villages in 18 sub-centres. This village, like the above village, is also one of the three villages selected by Ranga Raya Medical College, Kakinada to extend the specialist services. Also a

voluntary organization, Jeeva Karunya Sangham, Rajahmundry used to visit this village earlier. This organization treats leprosy patients. This village is well connected by the road to the nearest taluka head-quarters, Peddapuram and a major town and a business centre, Rajahmundry. This village lies on the way between Kakinada, the district head-quarters and Rajahmundry. Transport facilities are fairly good. The State Road Transport buses, private buses and other motor vehicles and rickshaws ply through this village althrough the day and thinly during the night. It has now become the head-quarters of the Rangampeta Mandalam on recent introduction of Mandal system by the state government. There is a large number of institutions and facilities like banks, schools, post-office, veterinary hospital etc. Further, most of the PHC staff reside within the village either in government quarters or in private accommodation.

The total population in this village is 5,807. The total land coverage is around 3,000 acres. When compared to the previous two villages, this village has a better representation of graded land holding pattern, diverse occupations and different castes. A brief visit around the village shows the uneven prosperity where one finds well-built houses, tractors,

gobar gas plants, scooters on the one hand and on the other small thatched houses, dirty surroundings with pigs moving around freely etc. This village is also having a hamlet, Chandredu, at a distance of about 3 kms. with a population of about 2,000.

As done for the previous village, a master list of all households with their caste status , landholding pattern and occupation followed was prepared. After a detailed analysis of the data it was found that there is a well-differentiated distribution of households interms of ownership of landholding, occupational structure and number of castes. Since this village fulfilled all our guidelines, this village was chosen finally to conduct our field study. Next step was selection of households for our study.

Selection of sample households

There are 1050 households in the study village. For each household, the caste status, occupation and the size of land holding were recorded.

After examining the caste, occupation and land holding of all the households it was decided to draw separate samples

from each caste group. Separate lists of all the households in the village for High Castes, Middle Castes and Low Castes were prepared. Among the High Castes, Middle Castes, and Low Castes, there are 540, 270 and 240 households respectively. From each group, a sample of 20 percent of households was selected for our study. From each list, every fifth household was chosen for our sample. If a sampled household was not willing to cooperate or migrated elsewhere, the next household was taken. However, there were some drop outs from High Castes. The distribution of the sample households among the caste groups shows that 98 sample households belong to High Castes, 54 to Middle Castes and 48 to Low Castes respectively. In terms of Class, 57 belong to High Class group, 47 to Middle Class and 96 to Low Class group respectively. Relative comparison of sample households by Caste and Class groups is shown in table 2.2. Below.

TABLE ; 2.2

Distribution of Sample Households by
Caste and Class Groups

| Class | <u>Caste</u> | | | TOTAL |
|--------------|--------------|-----------|-----------|------------|
| | High | Middle | Low | |
| High Class | 50 | 3 | 4 | 57 |
| Middle Class | 30 | 14 | 3 | 47 |
| Low Class | 18 | 37 | 41 | 96 |
| <u>TOTAL</u> | <u>98</u> | <u>54</u> | <u>48</u> | <u>200</u> |

CONDUCT OF FIELDWORK AND
FIELDWORK EXPERIENCES :

The field work was conducted in the study village during the period of August 83 to July 84. Both the secondary and primary data were collected. Secondary data were collected from district health authorities, panchayat office, block office, primary health centre etc. Primary data were collected from both the main village and its hamlet-Chandredu. The respondents were spread over in both the areas. For the purpose of analysis, data for both the main village and the hamlet were clubbed, analysed and presented as one unit.

After selecting the respondents, they were approached and explained the purpose of our study. In the first instance some were convinced and some were not. Each selected household was visited at least twice or more to collect the required data as it was not possible for the respondents to spare their time continuously. It was found difficult to contact those again who gave their data partly in an earlier sitting because of their preoccupation with agricultural operations. It was noticed that throughout the year, people are busy either in agricultural operations or in activities related to construction, selling etc. Hence, the difficulty in collection of data from the respondents. In some cases,

if the head of the household was not present, the other members in the family especially women were not willing to talk to us. Some respondents thought that we came from some tax department and were collecting information for imposing new taxes. One respondent was suspicious of our activities till the end of our fieldwork presuming that there had been something deeper than what we were apparently telling them inspite of our sustained efforts to convince him of the purely academic nature of our pursuit on several occasions.

Access to High Class households was found little difficult as they were not forthcoming to cooperate with us in giving the required data. On the other hand, the Low Class households were more than willing to give us the necessary data. Some of the people belonging to Low Caste/Class group who were not in our list of selected respondents persuaded us to record their data also hoping that they will not be deprived of any material benefits that may accrue out of our exercise. Sometimes it became difficult for us to avoid such people.

Incidentally, no map of this village was available either in Panchayat office or in Mandal headquarters. As a result, the researcher had to practically survey every street to

prepare a rough sketch showing various houses, institutions, temples etc. After drawing a rough sketch of small areas of the village on small sheets of paper, these were all put together and finally prepared a master map of the entire village. These maps are given in the next chapter.

FRAMEWORK OF THE REPORT AND PRESENTATION OF DATA :

Chapter three provides a description of the study village and a profile of the sample population. Chapter four examines the prevalence of morbidities reported by the sample households. Chapter five describes the patterns of usage of different types of practitioners and agencies. Chapter six reports on various health practices including personal hygiene. The final seventh chapter presents a summary of the findings.

Each chapter reporting results (Ch. 4-6) is organised in two sections. The first section presents the observations pertaining to a variety of variables particularly indicating differences within caste and class groups and also differences among class and caste groups. The second section summarises important caste-class differences reflected in data and makes brief comments about the broad patterns reflected in the data.

For each variable data is reported in a uniform way. First of all overall distribution of households as per categories of a variable is reported. Then for each variable castewise distribution is reported noting absence or presence of differences within caste groups. Next distribution by class groups for the same variable is examined to identify (a) such classwise distributions which are different from the castewise distribution (b) class differences substantially more than the magnitude of castewise differences. Most of the tables are given in the appendix and only important or abridged tables/charts are given in the text. It may be noted that although only High-Low Caste/Class groups are discussed in the report, the tables in the Appendix give original data on all the three caste/class groups. Reasons for this analytical procedure are noted below. Materials based on informal interviews or observations are presented wherever relevant. Chapter three is largely based on these sources.

ANALYSIS PROCEDURES :

Some general remarks about the analytical procedures used in this work are presented here.

As indicated above our objective is not to test a hypothesis or validate a theoretical model. The purpose of

analysis is primarily to describe differences in morbidities and health care practices in relation to Caste/Class categories. In doing so important within - class/caste and among-caste/class differences have been identified. An effort will be made, wherever possible to discuss or explain important observations.

Hand tabulations were carried out for all the questionnaire data. All the variables pertaining to morbidity and health care practices were processed and cross-tabulated by Caste Groups and Class Groups separately. The totals provided the overall frequency distribution. Percentages have been calculated by treating Caste and Class as independent variables thereby equalising totals for each Caste/Class group and providing comparisons among Caste/Class categories in terms of percentage values. Values of less than 5 per cent difference were ignored. Differences of 5-10 per cent were treated minor and differences of more than 10 per cent were considered noteworthy. However, sometimes consistent patterns even with minor differences have been discussed.

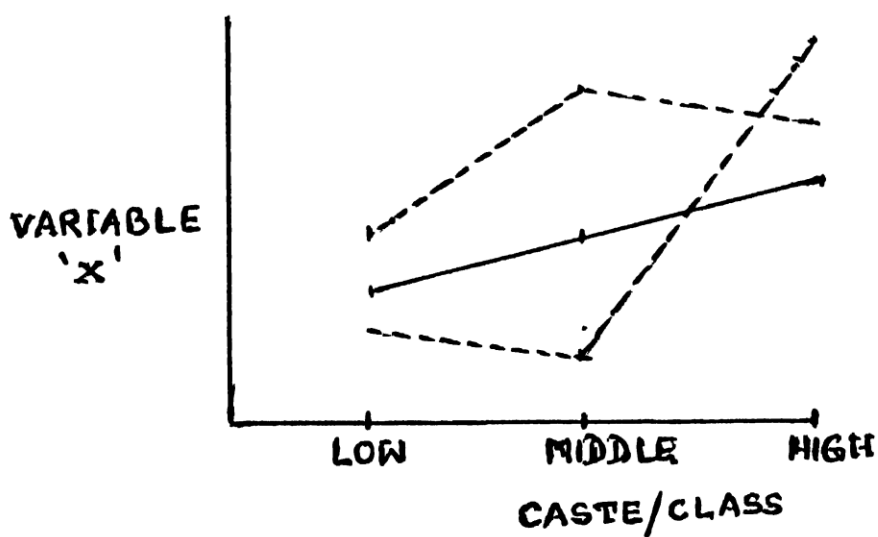
In this study comparisons among the High Caste, High Class, Low Caste and Low Class groups are presented for analysis and interpretation of data. The data for Middle

Caste and Middle Class groups have also been collected and analysed but not presented in the text. After a careful consideration of the data, it was felt that a comparison of High Caste/Class and Low Caste/Class groups will be more meaningful and sharper since the inclusion of Middle Caste/Class group has often resulted into a confusing pattern for interpretation of health care and stratificational variables.

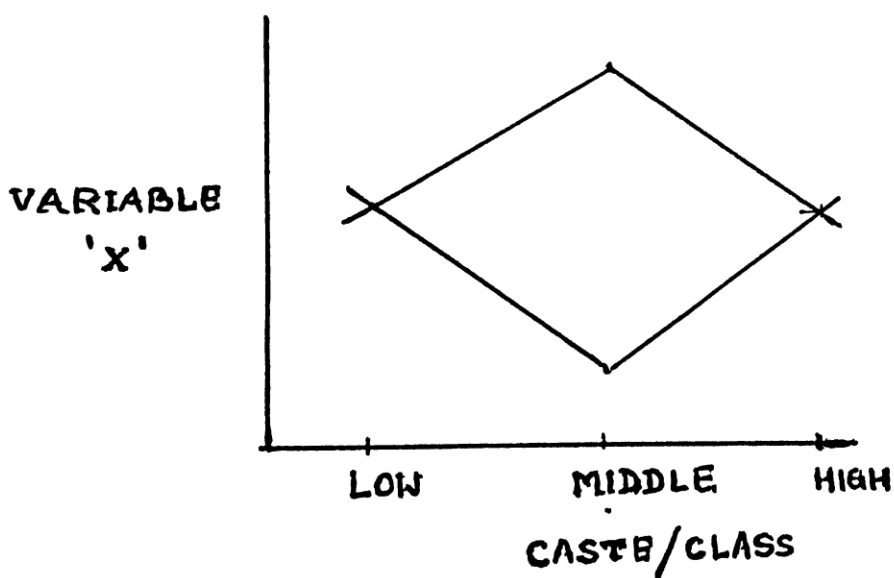
Two options were open to us . One was to quantitatively establish degree of linear association between stratification variables and differences in health care variables or morbidities as dependent variables. The other option was to examine relative influence of Caste and Class status using polar contrast of High and Low extremes of the scale.

We have discussed above the overall pattern of Caste and Class cross-tabulation (Table 2.1) and noted that only 25-29 per cent of the Middle Caste/Class overlap exists i.e. 75 per cent of the Middle Caste do not belong to Middle Class and 70 per cent of Middle Class do not belong to the Middle Caste. By and large 69 per cent of the Middle Caste households belong to the Low Class group and 64 per cent of the Middle Class households belong to the High Castes (see table 2.1).

Because of such relationship sometimes Middle Caste/Class group displays affinity with High Caste/Class, sometimes with Low Caste/Class. Middle Class/Caste groups have rarely displayed linear middle position in the distribution as shown in the diagram below :



To further confuse the matter the Middle Class/Caste have at times shown non-linear relationship as shown below in contrast to High/Low Caste/Class groups. Interpretation of such results would have involved far more detailed coombing of data than was practical for our purpose.



Since the exact nature of Caste/Class bearings on the dependent variables was not clear and because of the confusing profile of Middle Caste/Class group it was decided to take the second option. Besides, we suspected that because of overlap between the two variables (Caste/Class) a 3 or 4 point scale would present a confusing picture of marginal differences or inconsistent trends. We were interested in examining those variables for which Caste/Class differences were striking. The upper-lower ends of scale provide such exploratory contrast. Besides, we also wanted to examine in what variables Caste differences were greater and in what variables class differences presented greater contrast. This is because of our assumption noted above that Caste differences would be more in case of traditionally regulated practices while the Class differences would represent economically attainable cosmopolitan behaviour patterns. We shall not examine whether or not a given pattern of health care practices actually explains variance in morbidity patterns. Such epidemiological study would require medically justifiable morbidity data and also more rigorous measurement of a limited set of significant variables.

We have presented our analysis exclusively in terms of percentages. Quantitative data is often subjected to more sophisticated statistical procedures. Although it was initially considered to undertake computer analysis but the idea was

given up because of practical difficulties and our suspicion that interpretations will become difficult. When we subject a crosstable to a particular test we get a measure of overall association or correlation between the two variables. But the questions we are interested in, refer to regression or the slope for a 3 x 3 nominal variables regression exercise does not tell much more than percentages or Charts.

The lay out of our data is unusual. Normally a research design has one or few dependent variables and a series of independent or intervening variables. One can then pool or combine the independent variables to find how much they together explain the key dependent variable. But in our framework caste/class are the two independent variables and whole range of health care practices are seen as dependent variables. We have to examine variables separately and discern identical patterns among sets of variables.

THE STUDY VILLAGE AND THE
SAMPLE HOUSEHOLDS

Chapter 3

THE STUDY VILLAGE AND THE SAMPLE HOUSEHOLDS

LOCATION

As mentioned earlier, the village Rangampeta is located in Rangampeta Mandalam in East Godavari district of Andhra Pradesh. There are three culturally distinct geographical regions in the state with the nine districts of the erstwhile Hyderabad known as Telangana, southern plateau districts of Kurnool, Cuddapah, Anantapur and Chittoor known as Rayalaseema and the rest as the Coastal region. The East Godavari district falls within the coastal region. The village is situated on the route between Kakindda and Rajahmundry. It is about 20 miles away from Kakinada, the district head-quarters and also of a similar distance from Rajahmundry, a major town and a commercial centre in the district. The village is spread on either side of the main road at the village bus stop. The village^{age} also has a hamlet, Chandredu, at about a distance of 3 kilometers. on the same route. The hamlet is located on the right side of the bus stop near Panchayat Samiti office of Rangampeta on the Kakinada-Rajahmundry route. For our study both the main village and the hamlet were chosen. With the introduction of the Mandal system by the state Government this village became the head-quarters of Rangampeta Mandalam. Earlier, it was in

Rangampeta taluk and was the headquarters of Rangampeta Panchayat Samiti.

There is always a heavy traffic of vehicles - Andhra Pradesh State Road Transport Corporation (APSRTC) buses, tractors, lorries, cars, private vehicles, rickshaws, bullock carts etc. - althrough the day and most of the night. This village is the main centre for most of the interior villages which are not connected by bus and other motor communications. There is a rickshaw stand at the village bus stop. The rickshaws can be hired if one wants to go . to remote villages like Mukundavaram, Subhadrapeta, Doddigunta, Gandepalli, Murari etc.

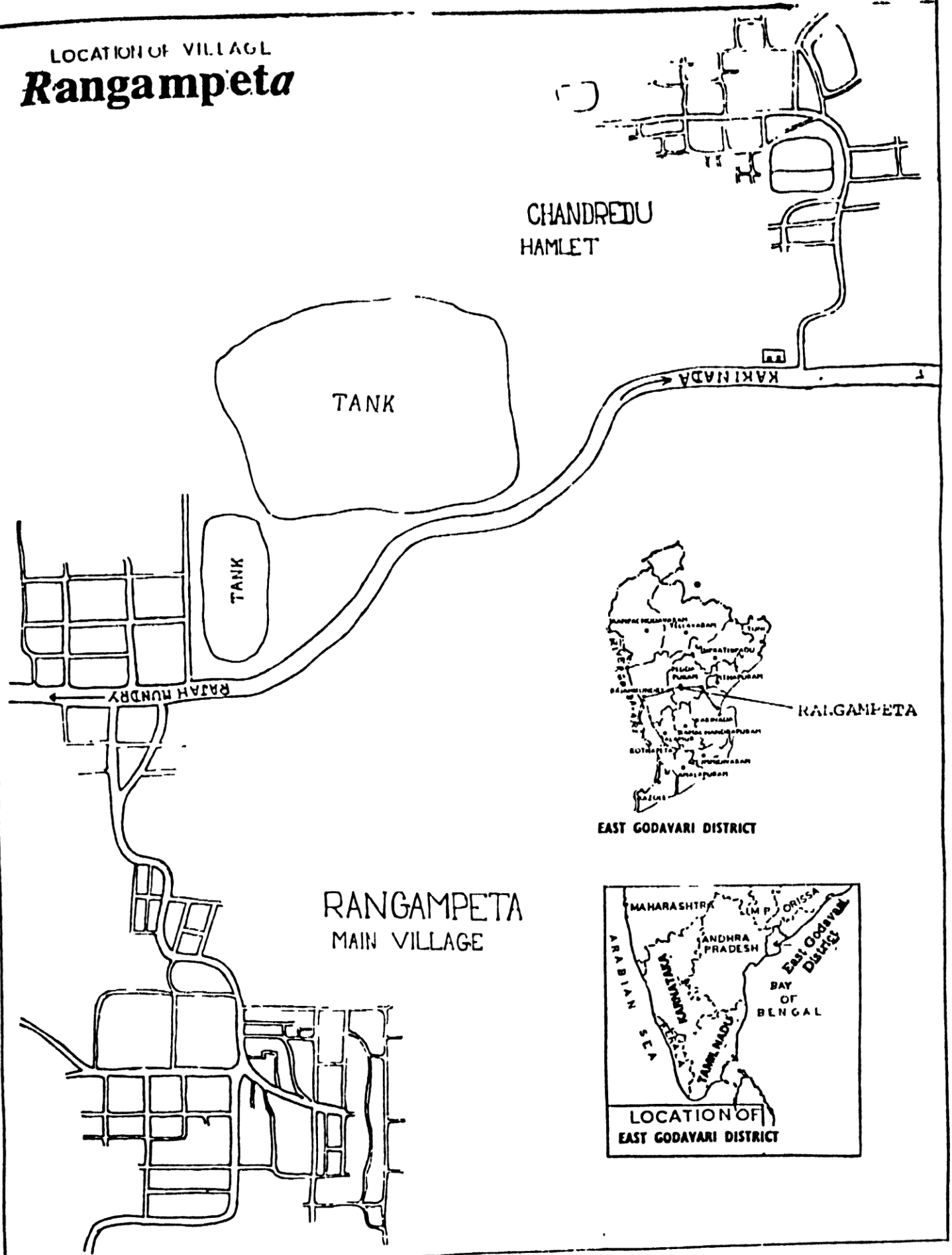
HISTORY :

Though many elderly people were contacted for information about the origin of this village, they could not provide a satisfactory explanation. However, one person gave the following explanation: "Some Kammas from Rangoon (Burma) came and founded this village. After the place of their origin, it came to be known as 'Rangoonpeta'. In due course of time, this word 'Rangoon' became Telugised into 'Rangam'. We cannot take this as an adequate explanation of the origin of this village, unless an investigation of seconary sources confirms it.

PHYSICAL STRUCTURE :

The village has two portions - the main village Rangampeta and a hamlet Chandredu. The main village is spread over a vast area with the houses mostly clustering towards one end of the village. (Maps 1-3). It is having very well-laid out streets and the main-road is a tar road connecting the route between Kakinada - Rajahmundry while others are unmetalled roads. The main village is divided into four parts - China Kotturu (new settlement), Pata Ooru (old settlement), Gandhi nagar and Raja-gopalapuram. During the last 10-15 years, a new settlement came up and is known as China Kotturu. Here, mostly the well-to-do Kammas live though other castes also reside. The old settlement - consists of houses mainly belonging to untouchable castes Madiga and Mala. There are other castes also living in Pata Ooru. Gandhinagar is also of recent origin and starts from the Gandhi statue till the main route. Raja-gopalapuram is on the other side of the main route. Interestingly, in this village, as in other villages, the untouchables are not completely segregated, though they are living towards one end of the village. Closeby, there are also other castes. But the social interaction is minimum. It is not surprising to find Harijans working as servants in High Caste households and fetching water for them. There are no streets after any

LOCATION OF VILLAGE
Rangampeta



Map 1 - Location of village Rangampeta

particular caste name, except the untouchable settlements, known as Mala Palli and Madigapalli. Kamma is the most populous and the rich land owning caste in the village. All castes are widely scattered though the concentration of Kamma households is greater.

Even in the hamlet Chandredu, the streets are well laid out and unmetalled. There are no streets after any particular caste name here also. The untouchable castes are settled in the sites given by the government. Some households of these castes are located at one end of the hamlet.

A conspicuous feature of this village is the presence of a large number of barns spread over the entire main village and the hamlet. These are used for curing tobacco in the season and as store houses for agricultural products and implements in the lean period.

RELIGION :

Hindus are the most predominant group in the village. One household belongs to a Muslim. There are few households belonging to Christians and most of them are converts from Mala and Madiga castes. There is a large number of temples in the village either constructed by raising donations by a single caste or by donations from the entire village. The

following temples are present in the village :

1. Lord Venkateswara temple
2. Lord Vinayaka temple
3. Lord Subbarayudu temple
4. Lord Anjaneya temple
5. Lord Rama temples (3)
6. Lord Shiva temple
7. Goddess Dandu Gangamma temple.

Out of the three Rama temples in the village, two were constructed by Settibalji (toddy-tapper) caste. The Venkateswara temple was constructed by a Kamma person who became highly affluent due to the wide patronage for his Butavaidyam(exorcism). This village is famous for Butavaidyam i.e. exorcising evil spirits. People from far off places visit this village to get their illnesses cured. There is also another village nearby at a distance of four kilometers known as 'Vadisaleru' which is also widely known for Butavaidyam in the district and outside. The Vinayaka temple was constructed by Kapus. They celebrate "Vinayaka Chaturdhi" celebrations annually. The Anjaneya temple was constructed by Kammas. The Subbarayadu temple is the oldest of all the temples in the village and every year, there is an annual celebration of the deity lasting for few days. This festival is very famous

in the region and attracts people from far off places. There is a small temple for Dandu Gangamma, the village Goddess on the outskirts. Its maintenance is very poor.

In the hamlet Chandredu also, there are two Rama temples and one Velupulamma temple. Out of these two Rama temples, one was constructed by Settibaljis. There is a small temple for Velupulamma, the village Goddess in the heart of the village. It was observed that Settibaljis constructed in both the main village and the hamlet only Rama temples. On enquiry it revealed that the installation of the idol of Lord Rama does not require the regular offering of food and services like puja by a Brahmin priest to the God whereas these are to be scrupulously observed in case of other Gods and Goddesses. Since they cannot afford the services of a Brahmin priest due to lack of sufficient financial resources, they preferred to have Rama temple only.

There is one church in Rangampeta and a small chapel in Chandredu. Some of the households are converts to christianity. It is interesting to observe that some converts do not report their having accepted the faith because of their apprehension that they may lose advantages provided by the government to them in case they reveal their faith. On many occasions it

was observed that children will be called after two names - one name for calling within the family and the other for enrolment in school for the sake of securing the constitutional benefits.

CLIMATE :

The area around this region is known as uplands. The area is purely rainfed. There are few tanks here and there but their coverage for irrigation is very limited. There is no irrigation system. Water was not struck despite drilling of bores in the region. Many farmers tried unsuccessfully in the past as there is a heavy rock formation beneath the soil at certain depth over a vast area. Very rarely one may be lucky to get water by drilling a bore. The summer is very hot and the winter is very pleasant. The rainfall is the only source for irrigation in this area. June to September are the months where the rainfall is heavy mostly. The average rainfall, temperature and humidity in this region can be seen in tables 3.1, 3.2 and 3.3 respectively as obtained from the Panchayat office.

SOIL AND CROPS :

Three types of soils are recognised in this village. These are (1) Black Clay (2) Black Sandy and (3) Red Loams. Red Loams constitute major surface area. One comes across

vast stretches of red soil in the region. The crops grown in these types of soils are :

| | <u>Soil type</u> | <u>Crops</u> |
|----|-------------------------------|--|
| 1. | Black clay (<u>Dampa</u>) | Paddy |
| 2. | Black sandy (<u>Revadi</u>) | Gingily |
| 3. | Red loams (<u>Garuvu</u>) | Gingily, ground nut Red-gram, pulses, tobacco |

The major crops are Paddy, Tobacco, Groundnut, Redgram, Blackgram, Gingily, Coriandrum, Bengal Gram, Budama etc. The usual cropping pattern is as follows :

| <u>Kharif</u> | <u>Rabi</u> |
|-----------------------------|--|
| Gingily followed by..... | Tobacco |
| Groundnut followed by | Tobacco |
| Budama followed by | Tobacco |
| Paddy followed by..... | Pulses (or groundnut, gingily etc). |

Tobacco is the major commercial crop grown in the village. Farmers belonging to all sizes of landholdings cultivate this crop because of the large profit it fetches in the market depending upon the rate prevailing in a particular year. In some years, the farmers will get huge profits while in others they somehow manage to escape the loss. This crop was introduced some 15-20 years back into the region. Till then the major crops in the region were jowar and bajra. Now, the farmers completely gave up these crops and took to other crops like tobacco. It is interesting to note that in 1980-81, while paddy was sown in 1282 acres, tobacco was sown in 1330 acres. With the introduction of tobacco in this area, there has been a sea-change in the life-styles of farmers. More employment opportunities have been opened up. Most of the neo-rich farmers branched out to new occupations like business, industry etc.

HOUSING :

Most of the houses are tiled and the rest are thatched. Here and there, one finds a "daba" or a concrete roof building. In some cases, a part of the house may be kept tiled and the rest thatched. Thatched households mostly belong to untouchable castes with generally one living room and a small veranda outside

for cooking. In some cases, though the roof is tiled, the flooring is not done. Regular plastering of the floor with cowdung is done till permanent flooring is laid out.

WATER SUPPLY AND
SANITATION :

There are three ponds in the main village, one for drinking purpose and the other two for washing clothes or cleaning cattle. In the drinking water pond, there are steps at three places to collect water. There is a watchman appointed by the village Panchayat to guard against any individuals or cattle polluting the drinking water in the tank. Most of the villagers use pond water for drinking purpose as it is considered tasty.

There is also a safe drinking water supply and a large number of taps were installed at different places in the village. Some households have their own taps. The taps are mostly used for non-drinking purposes as the water is quite insipid.

Some people have wells in their houses. There are few public wells in the village. Only those who cannot walk the distance to tap or tank will use water from the wells. Some

of the public wells were abandoned because the water was contaminated due to dropping of various kinds of objects by the naughty children in the neighbourhood and poor maintenance by the panchayat.

In the hamlet Chandredu also there are two ponds, one for drinking purpose and the other for washing cattle and clothes. Unlike the main village, there is no watchman in the hamlet to guard the drinking water pond against it being polluted by people and cattle. There is also a safe drinking water supply in the hamlet. There is a huge storage tank with ten taps fixed around. There are no street taps as found in the main village. Some households have their own wells. There are some public wells for use by the people.

In between the main village and the hamlet, on one side of the main route there is a very big pond known as 'Nalla Cheruvu'. Its water is used for drinking purpose, cultivation, raising fish and washing of clothes. Some acres of land are cultivated from this pond.

There are no drainage facilities both within the main village and the hamlet. However, since the soil is dry it absorbs waste-water very quickly. Stagnation of water was,

therefore, not found anywhere during the period of study. Mosquito menace is little in this village since no water-logged areas or waste lands exist.

There are a few community latrines for women both in the main village and the hamlet. There are five community latrines in the main village and four in the hamlet. Some households have their own septic latrines. The male members in these households generally do not use household latrine except in emergency, while the females in the household use it regularly. Generally, the open fields and the roadside shrubs and ditches are used for defecation.

In Malapeta ward in the main village the Government has constructed community bathrooms for use by the untouchable castes. But they were abandoned and are now in a very bad condition.

HEALTH FACILITIES :

There is a Primary Health Centre (PHC) in the main village which was established in 1962. In addition the Rangampeta sub-centre specifically caters to a population of 8,500 in three villages - Rangampeta, Pedarayavaram and Venkatapuram. The specialists from Ranga Raya Medical College,

Kakinada, visit PHC twice a week in their mobile clinic. A Non-Medical Assistant (NMA) of Leprosy Eradication programme also conducts his clinic on scheduled days in Rangampeta.

There are two drug shops in the village. While one shop sells only medicines, the other is a general store selling other provisions also.

This village has a number of allopathic (7) and some Ayurvedic (3) registered medical practitioners. Some of them prepare special medicines to cure venereal diseases. The Ayurveds advertise through pamphlets. Others have discontinued their practice due to lack of sufficient patronage from the villagers and the increasing cost of raw materials to prepare medicines. As the following table (3.4) shows a variety of healers and folk practitioners were also identified in the village (numbering 22) including birth attendants, bone setters and bite curers.

Table 3.4

Private Practitioners available in the Village

| S.No. | Name | Location |
|-------|------------------------------|------------|
| 1. | Tirumala Rao RMP (Allopathy) | Rangampeta |
| 2. | Sharma " " | " |
| 3. | Surampudi Venkat Rao " | " |
| 4. | Suryam (also CHV) " | Chandredu |

| | | | |
|-----|-------------------------------------|---------------------|---|
| 5. | Narayan Rao | RMP (Allopathy) | Resides in Rayavaram, adjacent to Chandredu visits Chandredu daily |
| | (Known popularly as Mangali doctor) | | |
| 6. | Gollaprolu doctor | " " | visits once a week and is famous for curing children's complaints. |
| 7. | Korukonda doctor | " " | visits a neighbouring village (2 kms.) once a week. Patients will be taken there. |
| 8. | Chinta Surya Prakasa Rao | RMP (Ayurveda) | Rangampeta |
| 9. | Mylavarapu Venkat Rao | " " | " |
| 10. | Munduri Bhadram | " " | " |
| 11. | Potula Satyanarayana | Folkhealer | Rangampeta |
| 12. | Butala Saheb | " | " |
| 13. | Panuganti Somulu | " | " |
| 14. | Parvathanma | " | " |
| 15. | Konujula Chellamma | " | " |
| 16. | Rajamma | " | " |
| 17. | Sirigina Venkata Rao | " | " |
| 18. | Nadi Surayya | " | Chandredu |
| 19. | Korumilli Nagayya | " | " |
| 20. | Mangali Chinnayya | " | " |
| 21. | Kummari Appala Raju | Bone Setter | Rangampeta |
| 22. | Nalla Bhadram | Scorpion-bite curer | " |
| 23. | Pendyala Satyavati | " | " |
| 24. | Kantipudi Abbulu | " | " |
| 25. | Kosuri Ramacharyulu | " | " |
| 26. | Boddu Venkat Rao | " | Chandredu |
| 27. | Yeddala Nagamma | Birth attendant | Rangampeta |
| 28. | Amaldasu Suramma (Yerukula tribe) | " | " |
| 29. | Vonumi Nukayamma | " | " |
| 30. | Pitani Danamma | " | " |
| 31. | Puli Mangamma | " | Chandredu |
| 32. | Chollangi Ramulu | Folk-healer | Rangampeta |

SERVICES AND FACILITIES
AVAILABLE IN THE VILLAGE

The presence of a large number of institutions reflects the overall development of the village. A large number of facilities are available to the people in the village. These are : (1) Andhra Bank (2) Kakinada Cooperative Central Bank (3) Rytu Sahakara Parapati Sangham (4) Primary Health Centre (PHC) (5) Veterinary Hospital (6) Mahila Mandal (7) Post-Office (8) Adult Education Centre (9) High School (10) Four Primary Schools (11) Convent (12) Telephone Exchange (13) Hostel for SC Boys (14) Hostel for SC Girls (15) Picture House (16) Safe-Drinking Water Supply System (17) Sewing Centre (18) Rice-Mill (19) Oil Press Hill (20) Welding Work Shop (21) Scooter Repair Shops (22) Saw Mill (23) Medical Shops (24) Coffee Hotels (25) Meals Hotel etc.

DEVELOPMENTAL PROGRAMMES :

A lot of developmental programmes under Integrated Rural Development Programme (IRDP) through District Rural Development Agency (DRDA) are being implemented under the aegis of Panchayat Samiti to benefit SC, ST and other Weaker Sections of the Society. Some of the items supplied under these various programmes are (1) Bullocks and Cart (2) Milch Cattle

(3) Sewing Machine (4) Iron (5) Horse and Cart etc. The "Apple" (Agro-Pumpsets and Implements Limited) implements gobar gas plant scheme in the village. There are 12 gobar gas plants presently working in the village. Gramodaya scheme is also being implemented. A tooth-powder manufacturing unit is functioning under this scheme in the village. Sericulture, Pisciculture and Intensive manure scheme are also being implemented. Crop loans are provided to farmers by the cooperative institutions and banks.

SOCIO-DEMOGRAPHIC PROFILE OF
THE SAMPLE HOUSEHOLDS :

The total population in the study village is 5,807¹. Out of this, 2,903 are males and 2,904 are females and the sex ratio is more or less the same (1:1). This corresponds closely to the sex-ratio of the East Godavari District which is 993 females for 1000 males.² Since the population in this village is large and spread out no census was attempted.

1. As per 1981 census (Panchayat records)

2. Kutumba Samkshema Nayakula Sibiralu, Pamphlet issued by the District Medical and Health Authorities, 1984, p. 2.

SAMPLE POPULATION :

A sample of 200 households covering all castes in the village was selected. The total number of persons in the sample is 1000 and the average size of a household is 5. The sample population forms about $\frac{1}{6}$ th or 16 per cent of the total population. The total number of households in the village is 1050. Thus, our sample households constitute about 20 per cent of the total households.

As shown in the table 3.5 out of all the age groups 5-14 age group is the largest and constitutes about $\frac{1}{4}$ th of the total population. The children and youth below 24 years constitute nearly half of the total population. The old people above 65 are very few (4.1 per cent).

The sex-composition in the population is more or less even except that the males outnumber females in older age groups (Table 3.5). The number of males is 515 and females 485 in the sample.

There are 156 students in the sample pursuing their education at various levels at the time of data-collection. One student belonging to low castes is doing her post-graduation in social work. Four students are doing their

graduation. There are 72 children below school going age. There are 454 illiterates and 318 literates (who completed their education) (Table 3.6).

HOUSING IN THE SAMPLE

Majority of the houses (67.5 per cent) are tiled and the rest are thatched (30.5 per cent) with the exception of four (2 per cent) houses which are dabas (with concrete roof).

Most of the households manage either in one or two rooms (58 per cent). Very few (5 per cent) are having very big houses with more than six rooms (Table 3.7).

Generally, in this area bathrooms are not constructed. Interestingly, in this village about 40 per cent of the households are having bathrooms in some form or other. However, only 18 per cent of the households are having pucca bathrooms (Table 3.8).

About 3/4th of the sample households do not have their own domestic source for water. Some of the households (25 per cent) are having wells. Very few houses (3 per cent) have taps (Table 3.9).

In the absence of a separate kitchen most of the households manage their cooking in a small open space available in the varandah. This practice has the risk of getting the food contaminated by flies, fowls or dogs. Having a separate kitchen also indicates better food hygiene. Majority (60 per cent) of the sample households do not have any separate kitchen and the rest are having either kachcha or pacca kitchen (Table 3.10).

Greater percentage of households (41 per cent) use water from pond, while the rest use either tap or well (Table 3.11).

ASSETS IN THE SAMPLE :

Possession of assets indicates one's social and economic status in the community. Cycle and transistor have become very common for quick transport, better communication and entertainment during leisure hours. That's why about fifty per cent of all the households are having these two assets. This village is having electricity and about 40 per cent of the sample households are having domestic connections. Twenty-percent of the households are even having electric fans (Table 3.12).

Having domestic latrine is a rare thing in this area. In this village there are a number of community latrines for women. Only those households which command a higher social status in the community have their own latrines. Only twelve percent of the sample households have their own latrines. (Table 3.12).

Very few households are owning costly and prestigious assets such as sprayer (8.5 per cent), gobar gas plants (2.5 per cent), scooters (3.5 per cent) and tractors (2.5 per cent) (Table 3.12).

CASTE COMPOSITION :

There are 20 castes in the village. Few families of Yerukula tribe are also present. They are mainly engaged in pig-rearing and agricultural labour. As mentioned earlier, for the purpose of our study all the castes in the village are grouped into three broad categories based on the majority opinion of small groups of well informed villagers into High, Middle and Low Caste groups. The High Caste group consists of Brahmin (3),³ Vysya (3), Kamma (83), and Kapu castes (9).

3. Number of households in our sample is given in brackets.

The Middle Caste group includes 14 castes namely Perikeelu (4), Settibalji (24), Senapatulu (1), Padmasali (1), Kamsali (5) Vadrangi (1), Telakulu (2), Kaikabattulu (2), Telaga Upparlu (1), Mangali (1), Chakali (5), Golla (1) Kummari (3) and Dasarlu (3). The untouchable castes Madiga (23) and Mala (25) constitute the Low Caste group. Out of all the castes, Kamma is the most preponderant group in our sample followed by Mala, Settibalji and Madiga castes. Thus, only one caste each in the High and Middle Caste groups and both the castes in Low Caste group are the numerically significant castes. These four castes together constitute more than 75 per cent of the sample households (Table 3.13).

Of the sample population of 1000, about 50 per cent of the sample belong to High Castes (505) and the rest is Middle (268) and Low Castes (227) (Table 3.13).

It was observed that not only there is a vertical stratification on the basis of caste but also a horizontal stratification within the caste on the basis of sects. The relationships and interactions depend not only on the position of individuals on the vertical stratification of caste but also on the horizontal stratification within the caste. The higher the position of a caste in the caste hierarchy, the greater is its observance of the principles

of endogamy and commensal relations among its different sects. Exchange of cooked food items between different castes is also governed by the rank they occupy in caste hierarchy. Brahmins do not accept cooked food from other castes but accept only the raw food items in a package called "Swayampakam" from certain touchable castes like Vysya, Kamma and Kapu which are ranked just next to them. However, the younger generation does not strictly observe these practices, and sometimes they dine with members of other castes also depending upon the extent of their association. It is interesting to note that the artisan group of castes, known collectively as "Panchabrahma" group, occupy a unique place in caste hierarchy. They do not accept food even from Brahmins. They claim structural equality with Brahmins by wearing the sacred thread like the twiceborn and adopt the vegetarian food habits like the Brahmins. Among the Low Castes, both Mala and Madiga claim higher status over each other and do not have any commensal relations.

SOCIAL PROFILE OF CASTE GROUPS

Caste and Occupation

The economy is based on agriculture. Most of the sample households (72.5 per cent) are engaged in agriculture either

as land owners,, tenants, share-croppers (together 40 per cent) or as agricultural labourers (32.5 per cent). The other occupations followed in the village are : teaching, priesthood, government service, cloth or fish or ice vending, shop-keeping, masonry, tailoring, rickshaw-pulling, contractorship, washing of clothes, pottery, cobblery, folk-practitioner, etc.

While among the High Castes, over 80 per cent of the sample households are engaged in agriculture, only 50 per cent are involved in agriculture among Middle Castes. Among Low Castes, 75 per cent of the sample households are working as agricultural labourers. There is polarisation of cultivators and agricultural labourers in the High and Low Castes with over 70 per cent of cultivators in High Castes and 75 per cent of agricultural labour in Low Castes. Over 50 per cent of the Middle Caste households are in other occupations as many of them are in service or are artisans (Table 3.14).

Caste and Land :

Land ownership is a crucial factor in rural society as it not only determines the social status of a household but also its life style. In the sample, about 40 per cent

of the households are not having any land. About 36 per cent of the households are having less than 5 acres of land and 15 per cent have more than 10 acres.

Caste-wise distribution of land holdings reflects the unevenness glaringly. Among the Low Castes most of them (68 per cent) are land less. On the other hand, among the High Castes only 17 per cent are land less and the rest are having varied amounts of landholdings. Even among the Middle Castes 50 per cent households are landless. Interestingly, in Middle and Low Castes, there is not a single household possessing more than 10 acres of land. The degree of landlessness progresses sharply from High to Low Castes (Table 3.15).

Caste and Income :

Income (annual) distribution pattern reflects heavy concentration of households in certain categories. While thirty percent of households in the sample has an annual income of less than Rs. 4,000, an equal percentage of households are concentrated in the category of Rs. 10,000 and above. Majority of the households in the Low Castes (52 per cent) and substantial proportion (41 per cent) of the

Middle Castes are having a low income of less than Rs. 4,000. Majority of the households in High Castes (53 per cent) are concentrated in the High income category of Rs. 10,000 and above.

There is not a single household in the highest income category of Rs. 50,000 and above from Middle and Low Castes (Table 3.16).

Caste and Education :

In comparison to the literacy rate of 35.12 per cent for East Godavari District 47.4 per cent of the sample population in the village is literate (excluding 8.2 per cent population below school going age). About 20 per cent of the sample are having primary education. In other levels, (from 6th standard onwards) few people are represented. There are 12 pre-degree holders, 10 graduates and 2 post-graduates. Both the post graduates and seven of the ten graduates belong to High Castes (Table 3.17).

The percentage of literacy is high among High Castes (56.7 per cent) followed by Low Caste (40.1 per cent) and Middle Castes (36.2 per cent). The percentage of children below school going age is lowest among High Castes

(4.9 per cent) followed by Low Castes (8.4 per cent) and Middle Castes (10.4 per cent). It may be inferred that greater the percentage of literacy in a group, lesser the number of children and vice-versa. This may be due to the greater awareness of the advantages of a small-family among parents (Table 3.18).

MORBIDITY AND SOCIAL
STRATIFICATION

Chapter 4

MORBIDITY AND SOCIAL STRATIFICATION

Morbidity is one of the indices of health status in a community. A person is considered morbid when he shows symptoms reflecting onset of a disease. A disease may be seen as a change in the body system toward a morbid state (pathology) brought about by some external or internal agent acting on body functions directly or indirectly. The U.S. Department of Health for its National Health Survey defined morbidity as :

Morbidity is basically a departure from a state of physical or mental well-being, resulting from disease or injury, of which the affected individual is aware. It includes not only active or progressive disease but also impairments, that is chronic or permanent defects that are static in nature, resulting from disease, injury or congenital malformation. The existence of morbidity in an individual caused by a particular disease, injury or impairment is called "morbid" condition or simply a "condition" (U.S. Deptt. of Health, 1958).*

Morbidities can be categorised broadly as (1) Acute and (2) Chronic depending upon the duration and the degree of severity.

*U.S. Department of Health, education and welfare, Public Health Service, Series A-3, 1958 : Health Statistics from the US National Health Survey - concepts and definitions in the health household interview survey.

Acute disease is the one which starts abruptly, reaches its formation quickly and terminates in a limited duration. Chronic diseases develop insidiously over a long duration and continue for prolonged periods with periodic flare-ups and progressive deterioration. Episodes lasting for more than 30 days duration are treated for the purpose of this study as chronic morbidity episodes while episodes lasting for less than 30 days are treated as acute morbidity episodes after Seal (1971 : 329, 564). Acute morbidities are further differentiated as (1) Minor (less than 2 days) (2) Mild (3-6 days) (3) Moderate (7 to 30 days). This refers only to the duration and not to the seriousness of the episode.

Data on morbidity episodes experienced over a three month period were collected from all the 200 sample households consisting of 1000 individuals. Information for each respondent was obtained about all episodes of illnesses that each member of a family suffered during the preceding three months from the date of interview. The head of the household and/or other elderly male member in the same household were interviewed to obtain this information. A check-list of diseases/symptoms was used to help the respondents to recollect the episodes suffered by all the family members as accurately as possible. As generally happens in a rural setting, other members of the

family as well as neighbours also used to gather around whenever data were collected. They often used to help the respondent to recollect the missing information. A three-month recall period was fixed after preliminary explorations which showed that in longer recall period (such as one year) only serious and prolonged morbidity episodes are reported. This leads to underreporting of short-term morbidity episodes.

In this chapter relationship of social stratification to morbidity is examined in terms of differences in prevalence of morbidities (chronic and acute) among the different caste/class groups. In light of literary evidence we expect that High Caste/Class groups will have lower prevalence of morbidity than the Low Caste/Class groups.

Following parameters of morbidity are discussed separately:

- a) Number of morbidities in a group ;
- b) Duration of morbidity episodes ;
- c) Number of persons sick (reporting morbidities);
- d) General morbidity rate ;
- e) System - wise distribution of complaints ;
- f) Frequency of complaints.

This chapter is divided into three sections : the first section presents the distribution of morbidities in the sample

population; the second one deals with remedial health action and the third one discusses the impact of social stratification on morbidity and health action.

SECTION 1

DISTRIBUTION OF MORBIDITIES

Results in the distribution of morbidities are presented in three sub-sections :

- 1.1 Morbidity patterns in the sample population in general covering the above mentioned six aspects separately (a to f);
- 1.2 Acute and chronic morbidities examined by Caste/ Class group differences ;
- 1.3 Age sex differentiation of morbidities in Caste/ Class groups.

1.1 Morbidities in the Sample Population in General :

1.1(a) Distribution of Morbidities :

Before discussing morbidity parameters in relation to social stratification under sub sections 1.2 and 1.3, a general description of morbidity parameters is briefly reported here in sub-section 1.1.

Practically, all the sample households (99 per cent) reported occurrence of one or more acute morbidities (of less than 30 days duration). Chronic morbidities (of more than 30 days duration) were reported by 68.5 per cent (137) households in the sample for a three month recall period. Details are discussed later.

In all, 1230 morbidity episodes of both acute and chronic types were reported from the sample households for a three month period. Of these, 1012 episodes (82.3 per cent) were of acute and 218 (17.7 per cent) were of chronic type. In other words, for every four acute morbidities reported in the sample, there was approximately one chronic morbidity.

1.1(b) Duration of morbidity
episodes :

By and large, of the three types of acute morbidities, minor morbidity episodes accounted for 31.8 per cent of the total morbidities reported in the sample followed by moderate (26.9 per cent) and mild (23.6 per cent) morbidity episodes while chronic morbidity episodes (17.7 per cent) were substantially lower.

1.1 (c) Number of persons sick
(reporting morbidities) :

As shown in the table below there were 601 (60.1 per cent) persons who reported morbidity episodes in the sample. Of the total number of persons reported sick 41 (6.8 per cent) persons reported only chronic morbidities while the remaining 560 (93.2 per cent) reported both acute and chronic morbidities. (see also table 4.1 A in appendix)

Table : 4.1

Number of persons with Morbidity Episodes
in Caste and Class groups

| Type of Morbidity | High Caste | Low Caste | High Class | Low Class | TOTAL |
|-------------------|----------------|----------------|----------------|----------------|----------------|
| Acute and Chronic | 270 (92.2%) | 142 (95.3%) | 172 (92.0%) | 261 (94.2%) | 560 (93.2%) |
| Only Chronic | 23 (7.8%) | 7 (4.7%) | 15 (8.0%) | 16 (5.8%) | 41 (6.8%) |
| TOTAL | 293 (100%) | 149 (100%) | 187 (100%) | 277 (100%) | 601 (100%) |

1.1 (d) General Morbidity rate :

I) The "Morbidity-prevalence rate" for analysis here refers to the number of episodes for 100 persons over a 3 month period. "Annual Morbidity rate" is used sparingly for expressing prevalence of morbidities per person over a period of one year. The latter has been avoided for the present analysis due to the problem of seasonality and poor reliability of long recall period. The survey period was September-November and it cannot be assumed that morbidity prevalence during other seasons was the same.

The three-month prevalence rate was calculated by using the following formula:

$$\frac{\text{No. of episodes}}{\text{Total No. of persons in the sample}} \times 100 \text{ (over a 3 month period)}$$

The morbidity - prevalence rate over a three month period for the sample was 123.

II) The morbidity - prevalence rate can be further analysed in terms of number of morbidities suffered per 100 sick persons in the sample over a three month period. The denominator in this case is total number of sick persons in the sample population. The three-month morbidity prevalence rate per 100 sick persons in the sample is 204.6.

1.1(e) Disease system-wise frequency
of complaints :

More than 80 types of specific complaints (morbidity) of both acute and chronic types were reported by the sample respondents. A list of these complaints (morbidity) with their frequency of occurrence in the sample can be seen in Appendix B. For the purpose of analysis and clear understanding, all these complaints were classified with the help of a physician into ten major types of morbidity categories on the basis of biological system related to the reported complaints. Although this procedure is somewhat arbitrary it provides some broad idea about the frequency of various types of morbidity. Only those complaints which could not be categorised without a proper clinical examination or affect different biological systems simultaneously were placed under the category "Others". All these complaints were reported by the respondents themselves. Some of the morbidity were already diagnosed by the doctors and the respondents were, therefore, able to report specific diagnosis such as heart enlargement, leprosy, jaundice, etc. Some difference in categorisation of complaints on the basis of "self-reporting" by the respondents and the actual medical diagnosis, though expected, is unavoidable. The different types of system-wise categories used here are (1) Musculo-skeletal system

(2) Digestive system (3) Respiratory system (4) Circulatory system (5) Excretory system (6) Reproductive system (7) Nervous system (8) ENT and sense organs (9) Mental disorders and (10) Others.

In general, the complaints related to ENT and sense organs were the most frequently reported (21.5%) followed by the complaints of digestive system (16.5%) and musculo-skeletal system (12.4%). Complaints of circulatory and reproductive systems accounted for about 7 per cent each. Respiratory complaints comprised 5 per cent. Excretory, mental and nervous disorders were reported in a very small proportion and all of these together constituted 1.5 per cent of the total complaints reported.

1.1(f) Frequency of complaints :

In all, more than 80 complaints of both acute and chronic types were reported in the sample. A list of these complaints with frequency of their occurrence in the sample can be seen in appendix B. The ten most common complaints are given in the following table (Table 4.2).

These ten complaints alone accounted for half (51.74 %) of the total complaints (1230) reported in the sample.

Table : 4.2

Frequency of complaints reported often
in the sample

| S.No. | Complaint | Frequency (per centage) |
|-------|--------------------|----------------------------|
| 1. | Fever | 9.75 |
| 2. | Head-ache | 8.29 |
| 3. | Dental caries | 5.77 |
| 4. | Motions | 5.04 |
| 5. | Cough | 4.95 |
| 6. | Pain in leg joints | 4.63 |
| 7. | Heart complaints | 4.14 |
| 8. | Back-pain | 3.41 |
| 9. | Ear-complaints | 2.92 |
| 10 | Stomach pain | 2.84 |
| | TOTAL | 51.74 |

1.2 Acute and Chronic Morbidities

In this sub-section, we shall examine finer differences within the total, acute and chronic morbidities among caste and class groups.

1.2(a) Distribution of morbidities and stratification :

As mentioned earlier, in all 1230 morbidity episodes of both acute and chronic types were reported by the sample house-

holds for a three month period. Of those, 1012 (82.3%) episodes were of acute and 218 (17.7%) were of chronic illness. Small differences were observed in distribution of both acute and chronic morbidities within the caste and class groups. As shown in the following table with regard to distribution of acute morbidities, the Low Caste group had slightly more (87.3%) morbidities than the High Caste group (80.0%). Similar trend was observed in class groups also. In contrast to this, with regard to the distribution of chronic morbidities, the High Caste group reported slightly more chronic morbidities (20%) than the Low Caste group (12.7%). Similar pattern was observed in class groups also.

Table : 4.3

Distribution of acute and chronic morbidities in caste and class groups

| Type of Morbidity | High Caste | Low Caste | High Class | Low Class | TOTAL |
|-------------------|----------------|----------------|----------------|----------------|-----------------|
| Acute | 432 (80.0%) | 343 (87.3%) | 268 (79.8%) | 528 (83.3%) | 1012 (82.3%) |
| Chronic | 108 (20.0%) | 50 (12.7%) | 68 (20.2%) | 106 (16.7%) | 218 (17.7%) |
| TOTAL | 540 (100%) | 393 (100%) | 336 (100%) | 634 (100%) | 1230 (100%) |

The magnitude of difference in class groups in distribution of both acute and chronic morbidities was less than the magnitude of difference between the caste groups.

1.2(b) Duration of Episodes and stratification :

As noted earlier, episodes lasting for less than 30 days were classified as acute morbidities. Following Seal, (1971), we distinguished three categories of acute morbidities - Minor (less than 2 days), Mild (3-6 days) and Moderate (7-30 days). As the following table shows, by and large, minor episodes accounted for about 32% of the total morbidity episodes in the sample followed by Moderate (26.9%) and Mild (23.6%) episodes. The chronic morbidities (more than one month duration) were substantially lower (17.7%). Break-up for chronic episodes is as follows : less than one year 4.2 per cent, 1-3 years - 4.4 per cent and more than 3 years - 9.1 per cent.

There are few caste-wise differences of minor nature. Among the Low Caste group, the proportion of minor episodes was highest (37.7%) in comparison to the High Caste group (29.6 %) and correspondingly, the proportion of Chronic

Table : 4.4

Distribution of Acute and Chronic morbidities
(Durationwise). in Caste and Class groups

| Type of Morbidities | High Caste | Low Caste | High Class | Low Class | TOTAL |
|-----------------------------|----------------|----------------|----------------|----------------|----------------|
| <u>ACUTE MORBIDITIES</u> | | | | | |
| Minor (less than 2 days) | 160 (29.6%) | 148 (37.7%) | 92 (27.4%) | 201 (31.7%) | 391 (31.8%) |
| Mild (3-6 days) | 115 (21.3%) | 92 (23.4%) | 67 (19.9%) | 161 (25.4%) | 290 (23.6%) |
| Moderate (7-30 days) | 157 (29.1%) | 103 (26.2%) | 109 (32.4%) | 166 (26.2%) | 331 (26.9%) |
| <u>CHRONIC MORBIDITIES</u> | | | | | |
| Less than 1 year | 23 (4.2%) | 12 (3.0%) | 13 (3.9%) | 31 (4.9%) | 52 (4.2%) |
| 1-3 years | 30 (5.6%) | 7 (1.8%) | 22 (6.6%) | 17 (2.7%) | 54 (4.4%) |
| More than 3 years | 55 (10.2%) | 31 (7.9%) | 33 (9.8%) | 58 (9.1%) | 112 (9.1%) |
| TOTAL | 540 (100%) | 393 (100%) | 336 (100%) | 634 (100%) | 1230 (100%) |

morbidity in the Low Caste group, was less (12.7%) in comparison to about 20% of the chronic morbidities in the High Caste group. Further break-up of chronic and acute morbidities showed that there was no consistent pattern of

small differences in caste groups. Chronic morbidities of more than 3 years duration were around 9 per cent in all the caste groups. Similar trend was observed in class groups also. (See details in table 4.4 A in Appendix)

The magnitude of difference in the class groups in distribution of both acute and chronic morbidities was less than the magnitude of difference between caste groups.

1.2(c) Number of persons sick (reporting morbidities) and Stratification :

As shown in the following table (4.5), in all, 56 per cent of the respondents reported illness with acute morbidities during the period of investigation. Among caste groups, in the Low Caste group slightly more number of persons (62.6%) reported sick than the High Caste group (53.5%). Similar is the case with the class groups also. Thus, in the Low Caste and Low Class groups slightly more number of persons reported sick than in the High Caste and High Class groups.

In chronic morbidities, 18.4 per cent of the respondents reported chronic morbidities. There is not much difference in the number of persons reported sick in caste and class groups. (see also table 4.5 A in appendix).

Table : 4.5

Number of persons with Morbidities in
Caste and Class groups

| Type of Morbidity | High Caste N=505 | Low Caste N=227 | High Class N=343 | Low Class N=431 | TOTAL N=1000 |
|-------------------|---------------------|--------------------|---------------------|--------------------|-----------------|
| Acute | 270 (53.5%) | 142 (62.6%) | 172 (50.1%) | 261 (60.6%) | 560 (56.0%) |
| Chronic | 91 (18.0%) | 42 (18.5%) | 58 (17.0%) | 89 (20.6%) | 184 (18.4%) |

1.2(d) Morbidity - prevalence
rate and stratification :

i) Morbidity-prevalence rate per
100 persons in the sample :

As shown in the following table, in general, the morbidity - prevalence rate per 100 persons in the sample was 123 for total morbidities. It was found that there were marked differences in prevalence rate for caste and class groups. Largely, the Low Caste (173.1) and the Low Class (147.1) groups had a higher prevalence rate than the High Caste (106.9) and the High Class (98) groups. This clearly indicates the negative relationship between caste/class status and morbidity prevalence : the lower the caste/class status, greater the prevalence rate.

Table : 4.6

Morbidity Prevalence rate (per 100 persons/
3 month period) in Caste and Class groups

| Type of Morbidity | High Caste | Low Caste | High Class | Low Class | TOTAL |
|-------------------|------------|-----------|------------|-----------|-------|
| Acute | 85.5 | 151.1 | 78.1 | 122.5 | 101.2 |
| Chronic | 21.4 | 22.0 | 19.8 | 24.6 | 21.8 |
| TOTAL | 106.9 | 173.1 | 98.0 | 147.1 | 123.0 |

For acute morbidities, the morbidity prevalence rate per 100 persons in the sample was 101.2. As observed for total morbidities, the Low Caste and Low Class groups had higher rates of prevalence than other groups. While the Low Caste group had a morbidity prevalence rate of 151.1, the Low CLASS group had 122.5 as against the prevalence rate of 85.5 for the High Caste and 78.1 for High Class groups. Thus, it is seen that of all the caste and class groups, the High Class group had the lowest prevalence rate and the Low Caste, the highest prevalence rate.

For chronic morbidities, the morbidity prevalence rate per 100 persons was 21.8 in general. In caste and class groups not much difference was observed in the morbidity rate.

However, the Low Class group had slightly a higher prevalence rate (24.6) than other groups.

Though there is not much difference in the morbidity prevalence rate per 100 persons both for total morbidities and for acute morbidities between the High Caste and the High Class groups, the difference between the Low Caste and the Low Class groups is quite marked. (See also table 4.6 A in appendix)

ii) Morbidity prevalence rate
per 100 sick persons :

The following table shows that in general, the morbidity prevalence rate per 100 sick persons in the sample for total morbidities was 204.6. As observed for morbidity prevalence rate per 100 persons in the sample, the morbidity rate per 100 sick persons was also higher in the Low Caste (263.7) and the Low Class (228.9) groups than the High Caste (184.3) and High Class (179.6) groups. Of all the groups, while the Low Caste group had the highest morbidity prevalence rate (263.7), the High Class group had the lowest morbidity prevalence rate (179.6).

For acute morbidities, the morbidity prevalence rate per 100 sick persons was 168.3. Similar trend as observed for total morbidities above was observed for acute morbidities also. The Low Caste (230.2) and the Low Class (190.6) groups had a higher rate of prevalence than the High Caste (147.4) and the High Class (143.3) groups.

Table : 4.7

Morbidity prevalence rate (per 100 sick persons/3 month period) in Caste and Class groups

| Type of Morbidity | High Caste N=293 | Low Caste N=149 | High Class N=187 | Low Class N=277 | TOTAL N=601 |
|-------------------|---------------------|--------------------|---------------------|--------------------|----------------|
| Acute | 147.4 | 230.2 | 143.3 | 190.6 | 168.3 |
| Chronic | 36.8 | 33.5 | 36.3 | 38.2 | 36.2 |
| TOTAL | 184.3 | 263.7 | 179.6 | 228.9 | 204.6 |

It was observed that though there was not much difference in the morbidity prevalence rate per 100 sick persons for total morbidities in the sample between the High Caste and the High Class groups (4.7), the difference between the Low Caste and the Low Class groups (34.8) was quite marked. Similar was the case with acute morbidities also.

For chronic morbidities, the morbidity prevalence rate per 100 sick persons was 36.2. Unlike the trend observed for total and acute morbidities, not much difference for chronic morbidity prevalence rate in caste and class groups was found. (see also table 4.7 A in appendix)

By and large, the caste differential in morbidity prevalence rate (both per 100 persons and 100 sick persons) for total and acute morbidities is greater than the class differential. For chronic morbidities, the differential is not marked as found in total and chronic morbidities.

iii) Morbidity - prevalence,
sex and stratification :

In order to understand the magnitude of the prevalence of acute morbidity episodes, the number of acute morbidities suffered by a sick person among males and females in caste and class groups was taken for analysis. This is obtained by dividing the total number of episodes by total number of sick persons in a particular group. The figures in the following table represent average morbidities per sick person in the respective group.

Table : 4.8

Number of acute morbidities suffered by
a sick person in caste and class groups

| Sex | High Caste | Low Caste | High Class | Low Class | TOTAL |
|--------|---------------|--------------|---------------|--------------|-------|
| Male | 1.69 | 2.27 | 1.75 | 1.83 | 1.78 |
| Female | 1.50 | 2.56 | 1.39 | 2.22 | 1.82 |
| TOTAL | 1.60 | 2.40 | 1.55 | 2.02 | 1.80 |

The above table shows that in general, in the Low Caste group, a sick person on the average suffered more acute morbidities (2.4) than a sick person in the High Caste group (1.6). Interestingly, while a sick person both in the High Caste and the High Class groups suffered similar number of episodes (1.6), a sick person in the Low Caste group suffered more episodes (2.4) than a sick person in the Low Class (2.0) group.

In all it was observed that the average acute morbidities per sick male was (1.78) almost the same as the average acute morbidities per sick female (1.82). However, there are small male-female differences within caste and class groups. Both the sick males (2.27) and the sick females (2.56) in the Low

Caste group suffered slightly more number of episodes than the sick males and the sick females in other groups. Of the total sick persons in the sample, while the sick females in the Low Caste group suffered more number of episodes (2.56) sick females in the High Class group suffered less number (1.4) of morbidities.

It is also observed from the following table that the number of chronic morbidities suffered by a sick person are much uniformly distributed in caste and class groups as well as among males and females.

Table:4.9

Number of chronic morbidities suffered by a sick person in caste and class groups among males and females

| Sex | High Caste | Low Caste | High Class | Low Class | TOTAL |
|--------|------------|-----------|------------|-----------|-------|
| Male | 1.20 | 1.26 | 1.20 | 1.18 | 1.20 |
| Female | 1.17 | 1.13 | 1.14 | 1.20 | 1.15 |
| TOTAL | 1.18 | 1.19 | 1.17 | 1.19 | 1.18 |

1.2(e) System-wise frequency of Morbidities and Stratification :

In general, complaints related to ENT and sense organs were the most frequently reported morbidities (21.5%) in the sample

followed by complaints of digestive system (16.5%) and musculo-skeletal system (12.4%). There are some differences in distribution of total morbidities in caste and class groups. The musculo-skeletal complaints were marginally higher in the Low Caste group (16.3%) than in the High Caste group (10.2%) while the circulatory ailments were slightly more among the High Caste group (7.6%) than in the Low Caste group (4.8%). Class groups also showed similar differences (Table. 4.10).

The systemwise distribution of acute morbidities followed more or less the same pattern as reported above. Complaints related to ENT and sense organs (23.3%) accounted for a larger proportion of all acute morbidities followed by disorders of digestive system (18.1%) and musculo-skeletal system (10.6%). Disorders of other systems were found in less proportion : Reproductive system 7.4%, circulatory system 4.1%, respiratory system 4.0% and nervous system 0.3%. Broadly, an identical trend of distribution of system-wise morbidities was observed among different caste and class groups. There is not much difference among the High and Low Caste/Class groups in particular in this regard.

With regard to the system-wise distribution of chronic morbidities, disorders of musculo-skeletal system formed the largest segment (21.1%) followed by complaints of circulatory

system (18.8%) and ENT and sense organs (13.3%). Disorders of other systems were found in a small measure : respiratory (9.6%), digestive (9.2%), nervous (5%), reproductive (3.2%), mental disorders (1.8%) and excretory system (0.4%). As regards distribution of systemwise chronic morbidities in caste and class groups, some differences were observed. Disorders of circulatory system in the High Caste group (22.2%) accounted for a larger proportion compared to the Low Caste group (10%). In contrast to this, disorders of ENT and sense organs in the Low Caste group (22%) were of a larger proportion than in the High Caste group (12%). Respiratory disorders were also slightly more in the Low Caste group (16%) than in the High Caste group (5.5%). Similar trend was observed in class groups also.

In all, while the disorders of ENT and sense organs and of digestive system were predominant in acute morbidities (41.4%) the disorders of musculo-skeletal and circulatory systems were predominant in the chronic morbidities (40%). The three most frequently reported system-wise acute and chronic morbidities in caste and class groups are given in the following table.

It is seen from the above table that while the three most frequently reported categories of complaints-ENT and sense organs, digestive system and musculo-skeletal-remains

Table: 4.11

Three most frequently reported system-wise complaints of acute and chronic morbidities by caste and class groups

| Type of Morbidity | High Caste | Low Caste | High Class | Low Class | TOTAL |
|-------------------|---|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| ACUTE | ENT & sense organs (23.6%) | ENT & sense organs (23.6%) | ENT & sense organs (24.6%) | ENT & sense organs (22.3%) | ENT & sense organs (23.3%) |
| | Digestive disorders (19.2%) | Digestive disorders (18.4%) | Digestive disorders (19.8%) | Digestive disorders (18.0%) | Digestive disorders (18.1%) |
| | Musculo-Skeletal (7.2%) | Musculo-Skeletal (15.7%) | Reproductive (7.4%) | Musculo-Skeletal (13.3%) | Musculo-Skeletal (10.6%) |
| CHRONIC | Musculo-skeletal or circulatory (22.2%) | ENT & sense organs (22.0%) | Circulatory (28.0%) | Musculo-skeletal (24.5%) | Musculo-skeletal (21.1%) |
| | ENT & sense organs (12.0%) | Musculo-skeletal (20.0%) | Musculo-skeletal (14.7%) | ENT & sense organs (17.0%) | Circulatory (18.8%) |
| | Digestive (7.4%) | Respiratory (16.0%) | ENT & sense organs (13.2%) | Respiratory (13.2%) | ENT & sense organs (13.3%) |

largely the same for caste and class groups in acute morbidities, there are some differences with regard to chronic morbidities. In the first place, while the musculo-skeletal or circulatory disorders were predominant in the High Caste group (22.2%) disorders of ENT and sense organs (22%) were predominant in the Low Caste group. Similarly, while the circulatory disorders occupied first place in the High Class group (28%), musculo-skeletal disorders were predominant in the Low Class group (24.5%). Similar differences were observed in the second and third ranked most frequent disorders in caste and class groups also.

1.3 Morbidities by sex, age and Stratification :

In this sub-section, we shall examine the age and sex variables in distribution and duration of morbidities among caste and class groups.

1.3(a) Distribution of morbidities :

It is observed from the following table that in general the number of morbidities among males were slightly more (51.4%) than among females (48.6%). This corresponds very closely to their respective proportions in the sample. There were small differences in distribution of morbidities among

males and females in different caste and class groups. In the High Caste group, morbidities were slightly more (54.4%) among males than among females (45.6%). In contrast to this, in the Low Caste group morbidities were slightly more among females (51.7%) than among males (48.3%). Similar trend was observed in class groups also. (see also table 4.12 A in appendix)

It is further observed that the distribution of acute morbidities among males and females was identical. (around 50%). In distribution of chronic morbidities more complaints were found among males (56.4%) than among females (43.6%) (Table 4.13)

Table : 4.12

Distribution of total Morbidity episodes
among males and females in caste & class groups

| Sex | High Caste | Low Caste | High Class | Low Class | TOTAL |
|--------|----------------|----------------|----------------|----------------|----------------|
| Male | 294 (54.4%) | 190 (48.3%) | 176 (52.4%) | 306 (48.3%) | 632 (51.4%) |
| Female | 246 (45.6%) | 203 (51.7%) | 160 (47.6%) | 328 (51.7%) | 598 (48.6%) |
| TOTAL | 540 (100%) | 393 (100%) | 336 (100%) | 634 (100%) | 1230 (100%) |

The age-sex-specific distribution of morbidities (per 100 persons) reveals interesting trends. It is calculated as follows :

$$\frac{\text{No. of morbidities in an age-sex group}}{\text{No. of persons in the same age-sex group}} \times 100 \text{ (3 months)}$$

By and large, the age-sex specific morbidity rate (per 100 persons) is found highest in the age group of 45-54 (212), closely followed by the age groups of 55-64 (199) and 35-44 (177).

The highest age-sex specific morbidity rate was found in the age-group of 55-64 (215) among males and in the age group of 45-54 among females (219). Similarly, the next highest rate was found in the age group of 45-54 among males (205) and in the age group of 35-44 among females (197). In other words, the age specific groups of 45-64 among males and 35-44 among females experienced more morbidities (Table 4.14 and Fig. 4.1)

It was observed that more or less a similar trend as noted above for total morbidities was found for the age-sex specific rates for acute morbidities also (Table 4.15).

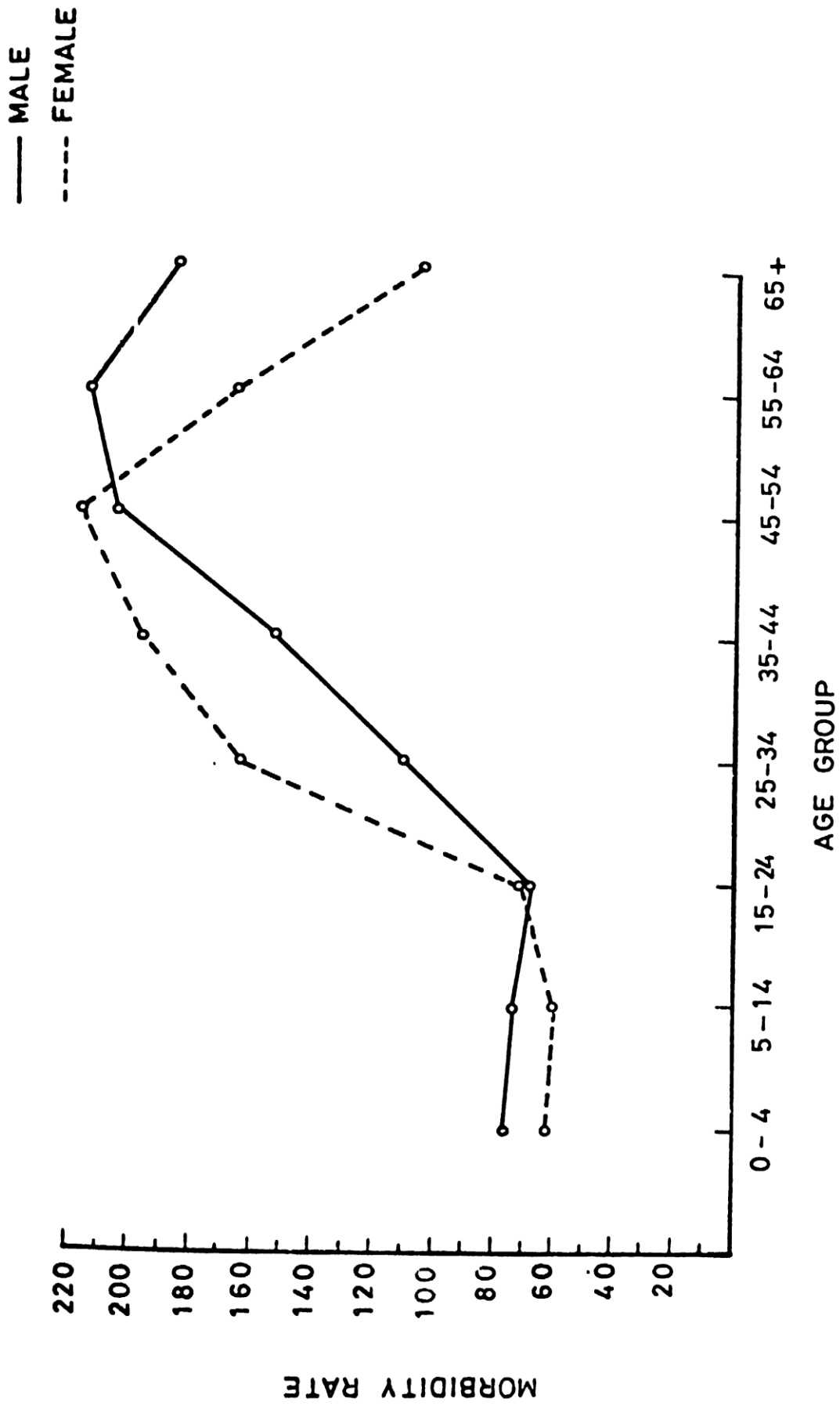


FIG. 4.1 DISTRIBUTION OF MORBIDITY RATE AMONG MALES AND FEMALES IN AGE GROUPS.

For chronic morbidities, the age-sex-specific-morbidity rate (per 100 persons) was found highest in the age-group of 55-64 (63), closely followed by the age-group of 65+ (54). Among males, the highest morbidity rate was found in the age group of 65+ (78) followed by 55-64 age group (67) while among females, the highest morbidity rate was found in the age group of 55-64 (57) followed closely by the age group of 45-54 (44) (Table 4.16)

In all, the age groups of 45-54 and 55-64 were more vulnerable to morbidities. In terms of acute and chronic morbidities, it was observed that while the age group of 45-54 was more vulnerable to acute morbidities, the age-group of 55-64 was more vulnerable to chronic morbidities.

In terms of male-female difference it was observed that the age-groups of 45-54 and 55-64 among the males and the age-groups of 35-44 and 45-54 among the females are susceptible to more morbidities. A similar trend was observed for acute morbidities also. On the other hand, in chronic morbidities, it was found that the age-groups above 55 among the males and the age-groups of 45-54 and 55-64 among the females were more vulnerable to morbidities.

1.3(b) Duration of morbidities by
Sex and Stratification :

In general as reported above, 82.3 per cent of morbidities were of acute type and 17.7 per cent of the morbidities were of chronic type.

In other words, for every four acute morbidities in the sample there was one chronic morbidity. Of all types of acute morbidities, Minor illness, (of short duration and simple in nature) was found slightly more (31.8%) in the sample than the Moderate (27%) and Mild (23.5%) types of morbidities. This trend was broadly observed in both caste and class groups. However, moderate morbidities were found slightly more (31.8%) in the High Class group than minor (27.4%) and mild (20.5%) morbidities (Table 4.17).

Minor to moderate differences were observed among age-sex specific groups classified by caste and class for total and acute morbidities. (For details see table 4.17 and 4.18).

In distribution of chronic morbidities it was found that nearly half (51.4%) of them were of longer duration, i.e. more than 3 years while the rest were either of less than one year (23.4%) or of 2-3 years (25.2%) duration. There are some

differences in distribution of these morbidities in caste and class groups. Chronic morbidities of longer duration (3+ years) were slightly more in the Low Caste group (62%) than in the High Caste group (50.9%). In contrast to this, chronic morbidities of less than 3 years duration were more in the High Caste (49.1%) than in the Low Caste (38%) group. More or less a similar pattern was observed in class groups also (Table 4.19).

In terms of distribution of chronic morbidities among males and females, it was observed that these were slightly more (56.1%) among males than among females (45.3%). Chronic morbidities of shorter duration, that is less than one year were more in females (34.7%) than in males (14.6%). In all, chronic morbidities of more than one year duration were more among males (85.4%) than among females (65.3%).

Of males and females, in caste and class groups, chronic morbidities of longer duration were more among males (66.7%) and females (57.7%) in the Low Caste group than their counterparts in the High Caste group (males 55%, females 45.8%). Similar trend was observed in class groups also.

On comparison of chronic and acute morbidities individually, it was observed that among females chronic morbidities of less

than one year duration (34.7%) and minor morbidities (41.2%) were more than among males (Chronic morbidities 14.6% minor morbidities (36.1%). In contrast to this, among males chronic morbidities of longer duration of more than one year (85.4%) were more than among females (65.3%).

1.3(c) Distribution of Morbidities
by Age and Stratification :

In general, with the exception of the age group of 15-24 years, morbidity increased with each successive age group till 54 years and then declined sharply. The distribution of morbidities in various age-groups is as follows : -4 years (4.4%); 5-14 years (12.7%), 15-24 years (10.2%), 25-34 years (15.1%), 35-44 years (17.4%), 45-54 years (21.9%), 55-64 years (13.3%) and 65 years and above (5.0%). In the age-groups of 35-44 and 45-54 morbidities were found slightly higher than in other age-groups. Similarly, morbidities were found less in the age-group of 65+ (5.0%) and in children below 4 years (4.4%). (Table 4.20 and Fig. 4.2).

In distribution of morbidities small differences were observed in caste and class groups. Morbidities in the Low Caste in the age-group of 45-54 years (25.2%) were slightly more

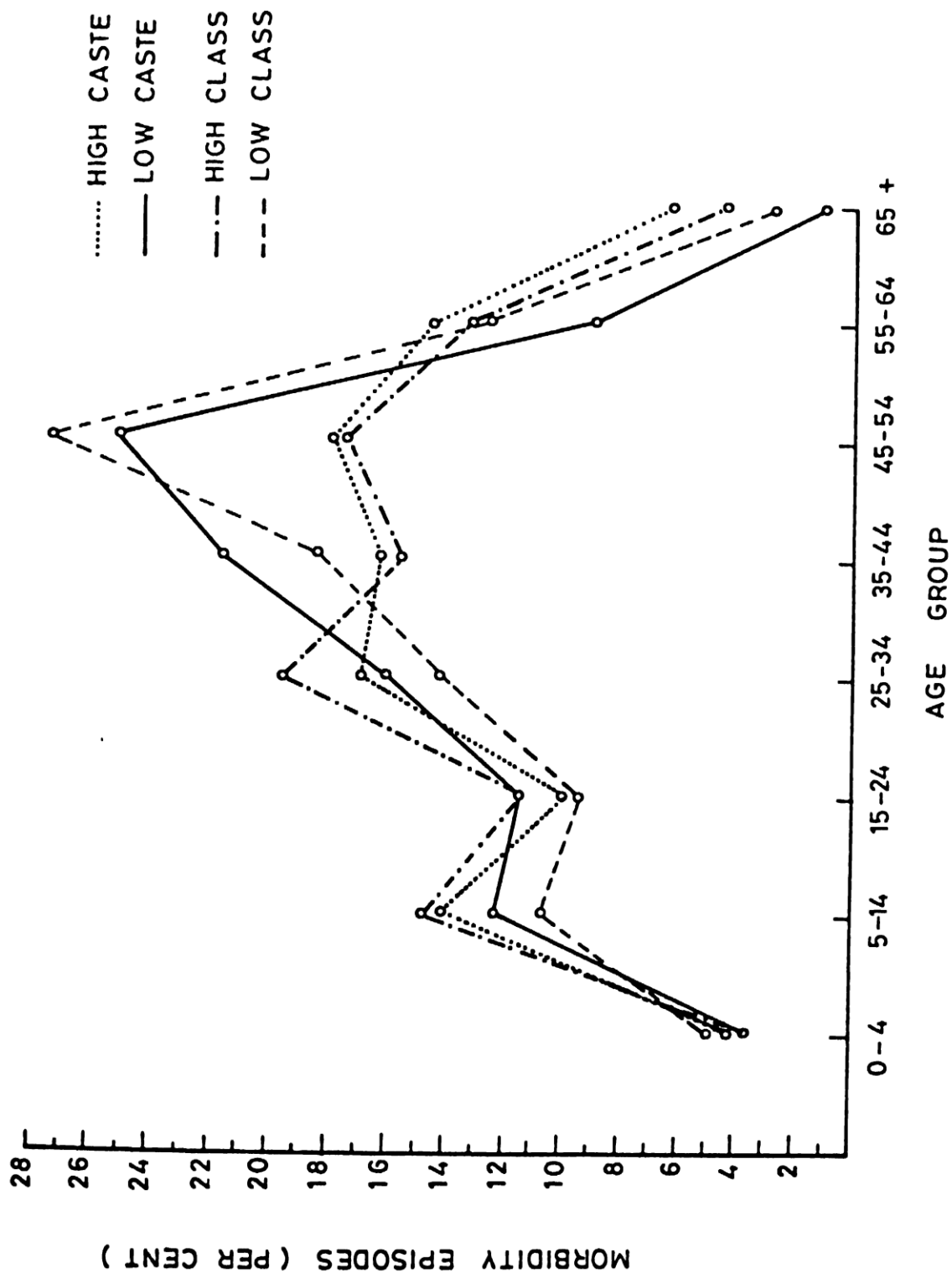


FIG. 4.2 DISTRIBUTION OF MORBIDITY EPISODES IN AGE GROUPS AMONG CASTE AND CLASS GROUPS.

than morbidities in the same age group in the High Caste group (18.0%). Similar trend was observed in the age-group of 35-44 also. In contrast to this, slightly more morbidities were found in the High Caste in the age group of 55-64 years (14.4%) and 65+ (6.3%) than in the Low Caste group (55-64: 8.9%; 65+ : 1%). In other words, in the Low Caste group morbidities were more (46.8%) largely in middle-age (35-54) than in the High Caste group (34.3%). On the other hand, in the High Caste group morbidities were more (20.7%) in old age (55+) than in the Low Caste group (9.9%). In class groups, an identical pattern was observed. High-Low Class difference is marginally more than the High-Low caste difference for some age groups (0-4; 5-14; 15-24; 25-34; 45-54).

It was observed that both in the Low Caste and Low Class groups morbidities were more in middle age than in the High Caste and High Class groups respectively. Similarly, in old-age morbidities were slightly more in the High Caste and the High Class groups than in the Low Caste and Low Class groups respectively. Greater morbidity in middle age in the Low Caste and Low Class groups reflect their susceptibility to illness which in turn is associated with factors such as their working pattern, nature of environment in which they live, response to illness etc.

The distribution of acute morbidities by age-groups in different caste and class groups was similar to the trend described above for total morbidities. (Table. 4.21) However, with regard to age-wise distribution of chronic morbidities among caste groups some differences were observed. As expected, chronic morbidities tend to increase with advancement in age. The distribution of chronic morbidities by age-groups is as follows : - 0-14 years (6.9%); 15-24 years (3.7%); 25-34 years (14.2%); 35-44 (18.8%); 45-54 (22.4%); 55-64 (23.9%) and 65+ (10.1%). Chronic morbidities were found more in old age i.e. 55 years and above (34.0%) than in other age groups (Table 4.22).

Small differences in distribution of chronic morbidities between caste and class groups were observed. In the High Caste group, more chronic morbidities (36.1%) were reported in the age group of 55 and above than in the Low Caste group (14.0%). On the other hand, in middle age (35-54) more chronic morbidities were found in Low Caste group (52.0%) than in the High Caste group (37.0%). It is emphasised here that about one-third of total chronic morbidities in the Low Caste group were concentrated in 35-44 age group (30.0%) alone while in the same age-group in the High Caste group these accounted for only 16.7 per cent of the total chronic morbidities in that group. In children also, chronic morbidities were slightly more in the Low Caste

group (14.0%) than in the High Caste (6.5%) group. In class groups also, more or less a similar trend was observed. In all, both in the Low Caste and Low Class groups in middle age more chronic morbidities were found than in the High Caste and High Class groups (Table 4.22).

On comparing the distribution of acute and chronic morbidities in different age-groups, it was observed that in old-age (55+) chronic morbidities were more (34.0%) than acute morbidities (15.0%). In contrast to this, in children (- 14 years) acute morbidities (19.2%) were more than chronic morbidities (6.9%). Similarly, in the age group of 15-24, acute morbidities (14.2%) were more than chronic morbidities (3.7%). In other age groups, more or less a similar proportion both in acute and chronic morbidities were found. In caste and class groups, the Low Caste and Low Class groups had more acute morbidities in the age group of 45-54 years and more chronic morbidities in the age group of 35-54 years when compared to the High Caste and High Class groups respectively.

1.3(d) Duration of morbidities by Age and Stratification :

For the sake of analysis and better understanding the various age-groups were categorised into four broad groups - 14 years; 15-34 years; 35-54 years and 55+ and these were called as children, youth, middle-aged and old-aged respectively.

The distribution of morbidities in these groups is as follows: 17.0 per cent in children, 25.4 per cent in youth, 39.3 per cent in middle age and 18.3 per cent in old age. This shows that morbidities increased from children to middle age and then declined in old age. This pattern was observed in all types of morbidities-minor, mild, moderate and chronic - in caste and class groups (Table 4.23).

Some differences were observed in distribution of various types of morbidities among children, youth, middle-aged and old people in caste and class groups. In the Low Caste and Low Class groups morbidities in middle-age were more (around 45%) than in the High Caste and High Class groups (around 33%). In the Low Caste group in old-age morbidities were less (9.9%) than in the High Caste (20.7%) group.

In children, minor morbidities were slightly more in the High Caste group (21.3%) than in the Low Caste group (10.8%). In contrast to this, chronic morbidities in children in the Low Caste group (14%) were more than in the High Caste group (6.5%). Similar trend was observed in class groups also.

Among youth, moderate morbidities were more in the High Class group (37.4%) than in the Low Class group (15.4%).

In middle-age, moderate (45.6%) and chronic (52.0%) morbidities were slightly more in the Low Caste group than in the High Caste group (moderate 30.8% , chronic 37.0%). Similar trend was observed in class groups also.

In old age, chronic morbidities were more in the High Caste group (36.1%) than in the Low Caste (14.0%) group. Similar trend was observed in Class groups also. However, the difference in class groups was very small. In the High Class group, chronic morbidities were slightly more (36.8%) than in the Low Class (30.2%) group.

1.3(e) Morbidities (person-wise)
by age and sex :

The distribution of persons suffering from morbidities (sick persons) in various age groups reveals interesting patterns. In all, 601 persons out of a sample of 1000 reported morbidities (60.1%). The largest number of sick persons out of the total number of the sick were children of 5-14 years of age (18.3%) , followed closely by the age-group of 45-54 (17.8%). The proportion of sick persons in various age-groups out of the total number of sick persons in the sample is as

follows :

| Age group | Percentage | Age group | Percentage |
|---------------|------------|---------------|------------|
| - 4 years | 5.8 | 35 - 44 years | 14.5 |
| 5 - 14 years | 18.3 | 45 - 54 years | 17.8 |
| 15 - 24 years | 13.3 | 55 - 64 years | 11.3 |
| 25 - 34 years | 14.5 | 65+ | 4.5 |

There are small differences in distribution of sick persons among males and females in various age-groups. In children (-14 years) slightly more number of sick persons were found among boys (26.7%) than among girls (21.5%). In the age-groups ranging from 15-54 slightly more sick females were found (66.3%) than males (53.8%). In 35-44 age-group, sick females were found slightly more (17.4%) than males (11.6%). In the age-group of 55-64 more sick males were found (14.5%) than females (8.2%) (Table 4.24).

If we look at the number of persons sick and the number of morbidity episodes occurred sex-wise among children, youth, middle-aged and old-people, it reveals interesting trends. Among males, sick persons were more in children (26.7%) and middle aged (29.1%) whereas among females they were more in

youth (30.8%) and middle-aged (35.6%). This pattern was largely found both in acute and chronic morbidities. Among old people (55+) more sick males were found with chronic morbidities (42.1%) than females (20.7%). In terms of distribution of morbidity episodes it was found that there was greater concentration of total morbidity episodes among females in middle age (45.1%) than males (33.7%). This pattern was found both in acute and chronic morbidities. Of the acute and chronic morbidity episodes, concentration of chronic morbidity episodes was slightly more (49.5%) than the acute morbidity episodes (44.3%) among females in middle age. Similarly, there was greater concentration of morbidity episodes among males in old age (25.2%) than among females (11.1%). This trend was observed both in acute and chronic morbidity episodes. Of these two, concentration of chronic morbidity episodes in old age among males was more (43.9%) than acute morbidity episodes (20.6%) (Table 4.25).

In all, in terms of distribution of persons sick, middle age was the group largely affected followed closely by youth, children and old people. In terms of distribution of morbidity episodes, as observed above, middle age group was predominantly affected followed closely by youth. Thus, middle-age and youth were the largely affected groups in terms of morbidity distribution both by persons-wise and episodeswise.

SECTION 2

HEALTH ACTION

In this section, the extent of health action taken by various social groups was presented. Age and sex variables were also taken into consideration.

2.1 Presence of Health Action :

Health action is defined here as any action taken by a sick person to restore one's own health. It includes consulting medical practitioners, healers, application of self-medication and any other means resorted to for recuperation of health. In about 80 per cent of reported morbidities some form of health action was taken. In other words, 20 per cent of morbidities were neglected by not taking any health action.

The extent of health action resorted to among various groups for total, acute and chronic morbidities reveals interesting trends. While the High Caste group resorted to health action for 85.4 per cent of total morbidities, the Low Caste group resorted to health action for only 70.2 per cent of total morbidities. Similar trend was observed in case of class groups also. The difference in extent of health action taken between High Caste and Low Caste groups is greater than the extent in High Class and Low Class groups. It was observed

that there was a positive trend of association between health action taken and the caste and class status - higher the caste/class status, greater the extent of health action taken (Table 4.26, Fig. 4.3).

In case of acute morbidities, more or less the same trend as observed for total morbidities was found. But in case of chronic morbidities only 65.6 per cent of morbidities were taken care of by health action in general. While the High Caste group reported health action for 75 per cent of the chronic morbidities, the Low Caste group reported health action for only 52.0 per cent of the chronic morbidities. Similar trend was observed in class groups also. The difference in the extent of health action resorted to by the class groups is smaller than in caste groups as observed above for acute and total morbidities.

2.2 Health Action by Sex and Stratification :

Health action taken by various social groups among males and females shows interesting trends.

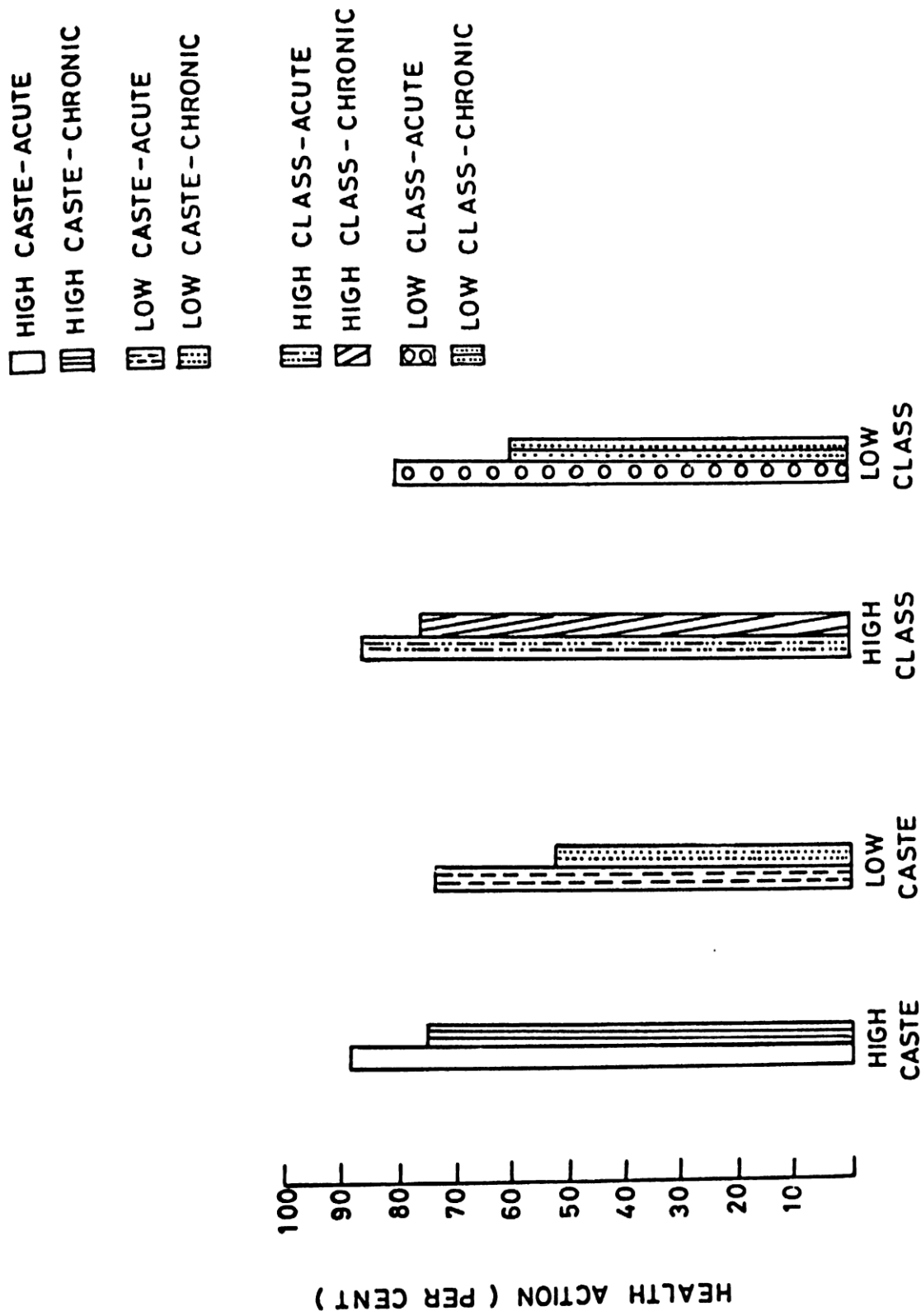


FIG. 4.3 DISTRIBUTION OF HEALTH ACTION IN CASTE AND CLASS GROUPS FOR ACUTE AND CHRONIC MORBIDITIES.

2.2(a) Total Morbidities

In general, nearly 80 per cent of the morbidities both among males and females were taken care of by health action. It was observed that there are some differences in the proportion of health action taken by males and females in caste and class groups. In caste groups, among males less health action was reported in the Low Caste group (73.7%) than in the High Caste group (83.7%). Similarly, among females in the Low Caste group less health action (67.0%) was reported than in the High Caste group (87.4%). Similar trend was observed in class groups also. The difference in extent of health action taken by caste groups is more than the difference in class groups. It is further observed that females in the Low Caste group not only took less health action when compared to females in other caste groups, but also in the population in general (Table 4.27 and Fig. 4.4). This can be better understood if we take into consideration the number of morbidities taken care of by health action in proportion to each morbidity neglected among males and females in caste and class groups.

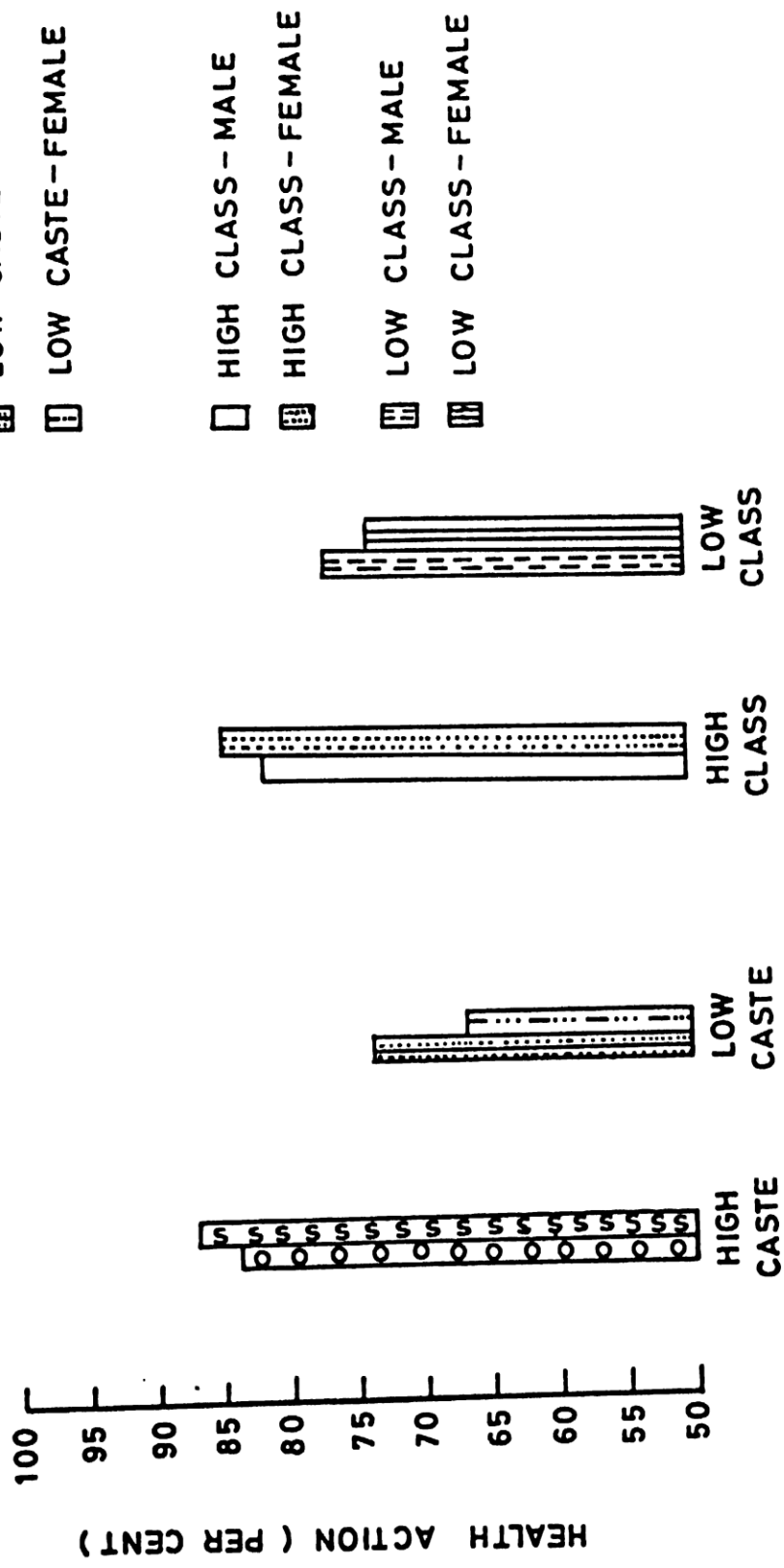


FIG. 4.4 HEALTH ACTION TAKEN BY MALES AND FEMALES IN CASTE AND CLASS GROUPS.

Table : 4.28

Ratio of morbidities taken care of by health action to each morbidity neglected in caste and class groups among males and females

| Sex | High Caste | Low Caste | High Class | Low Class | TOTAL |
|--------|------------|-----------|------------|-----------|-------|
| Male | 5.1 | 2.8 | 4.5 | 3.3 | 4.0 |
| Female | 6.9 | 2.0 | 5.7 | 2.8 | 3.7 |
| TOTAL | 5.8 | 2.4 | 5.0 | 3.0 | 3.8 |

The above table indicates that the Low Caste and Low Class groups took less health action than the High Caste and High Class groups respectively. In the Low Caste group while 2.4 morbidities were taken care of by health action per morbidity neglected, 5.8 morbidities were taken care of by health action in the High Caste group. Similarly, in the Low Class group, while 3 morbidities were taken care of by health action for each morbidity neglected, 5 morbidities were taken care of by health action in the High Class group. It is thus seen that of all the caste and class groups, while the Low Caste group reported least extent of health action (2.4) the High Caste group reported greater extent of health action (5.8).

Among males and females, while females in the Low Caste group reported least extent of health action (2.0), females in the High Caste group reported highest extent of health action (6.9) which are the least and highest extents of health action taken not only among females but in the population in general. This indicates that in general among females there is a greater neglect of morbidities in the Low Caste group while there is greater health action for morbidities in the High Caste group.

In all, males and females in the High Caste group took more health action than males and females in the Low Caste group. Similar trend was observed in class groups also. The extent of difference in health action in class groups is smaller than the difference in caste groups. This indicates a clear trend of association in taking health action and caste/class status: higher the caste/class status, greater the extent of health action taken.

2.2(b) Acute Morbidities :

Out of 1012 acute morbidities, 509 were reported by males (50.3%) and 503 (49.7%) by females. Of the 509 morbidities in males, 431 (84.7%) were taken care of by health action while among females, out of 503 episodes, 403 (80%) were taken care of by health action (Table 4.29).

In order to have a clear picture of the extent of health action taken, the number of acute morbidities taken care of by health action to one acute morbidity neglected among males and females in caste and class groups has been analysed.

Table : 4.30

Proportion of acute morbidities taken care of by health action to each acute morbidity neglected in caste and class groups among males and females

| Sex | High Caste | Low Caste | High Class | Low Class | TOTAL |
|--------|------------|-----------|------------|-----------|-------|
| Male | 6.8 | 3.5 | 6.4 | 4.5 | 5.5 |
| Female | 8.0 | 2.1 | 5.4 | 3.1 | 4.0 |
| TOTAL | 7.3 | 2.7 | 5.9 | 3.7 | 4.6 |

The above table shows that greater health action was taken in the High Caste and High Class groups than in the Low Caste and Low Class groups. Of all the caste and class groups, the High Caste group reported greater extent of health action (7.3) and the Low Caste group least extent of health action (2.7). In general, among males and females, slightly greater extent of health action was taken by males (5.5) than females (4.0). Of all the groups, both among males and females, females in the High Caste group took greatest extent of health action (8.0). In contrast to this, females in the

Low Caste group took least extent of health action (2.1) in the population in general. This trend is similar to the trend observed above for total morbidities. In class groups, the pattern is slightly different. Of both males and females, males in the High Class group took greater extent of health action (6.4). In caste groups, while females in the High Caste group took greatest extent of health action (8.0), among class groups males in the High Class group took greatest extent of health action (6.4). It is observed that the differences in the extent of health action in class groups both among males and females were of lesser magnitude than the differences in health action in caste groups. Further, it may be inferred that illness among females in Low Caste and Low Class groups is viewed with less concern and anxiety.

Both in morbidity and health action, caste/class status is reflected - higher the Caste/Class status lesser the extent of morbidity and greater the extent of health action. Further, in general the difference in the extent of morbidities prevalent and the extent of health action resorted to is of lesser magnitude in class groups than in caste groups.

2.2(c) Chronic Morbidities :

Out of the 218 chronic morbidities reported in the sample, 123 (56.4%) belonged to males and 95(43.6%) to females. Of the 123 chronic morbidities among males, 75 (61.0%) were taken care of by health action. Among females, out of 95 chronic morbidities, 68 (71.6%) were taken care of by health action. This means that of males and females, females resorted to health action for larger number of chronic morbidities than males. This observation is contrary to the one noted above for acute morbidities where slightly greater extent of health action was resorted to among males (84.7%) than females (80.0%) (Table : 4.31).

To have a better understanding of the extent of health action taken among males and females in caste and class groups, the number of chronic morbidities taken care of by health action to one chronic morbidity neglected has been analysed.

Table : 4.32

Proportion of chronic morbidities taken care of by health action to each chronic morbidity neglected in caste and class groups among males and females

| Sex | High Caste | Low Caste | High Class | Low Class | TOTAL |
|--------|------------|-----------|------------|-----------|-------|
| Male | 2.3 | 0.8 | 1.7 | 1.2 | 1.5 |
| Female | 4.3 | 1.3 | 7.0 | 1.6 | 2.5 |
| TOTAL | 3.0 | 1.0 | 3.0 | 1.4 | 1.9 |

The above table shows that in the High Caste and High Class groups, three chronic morbidities each were taken care of by health action to every one chronic morbidity neglected which is the maximum extent of health action taken in any caste/class group. In the Low Caste and Low Class groups, the number of chronic morbidities taken care of by health action to one chronic morbidity neglected were 1.0 and 1.4 respectively. Thus, out of all the caste/class groups, while the Low Caste group took least extent of health action, the High Caste and the High Class groups took maximum extent of health action.

Among males and females, for one chronic morbidity neglected, females took care of 2.5 chronic morbidities while males took care of only 1.5 chronic morbidities. In Caste and Class groups, females took care of more number of chronic morbidities than males. While females in the High Class group took care of as many as seven chronic morbidities for one chronic morbidity neglected, females in the Low Caste group took care of only 1.3 chronic morbidities. Thus, while females in the High Class group reported highest extent of health action (7.0) females in the Low Caste group took least extent of health action (1.3). Among males, males in the High Caste group took care of larger number of chronic morbidities (2.3) than in

any other caste/class group. On the other hand, males in the Low Caste group took least health action (0.8) where the number of morbidities neglected are more than the number of morbidities taken care of. Thus, while females in the High Class group took greater extent of health action, males in the Low Caste group took least health action of both males and females in caste and class groups. The difference in health action taken by females between High and Low Class groups is greater than the difference in health action taken by females between the High and Low Caste groups.

The above observation is contrary to the observation made earlier for acute morbidities. In acute morbidities while females in the Low Caste group took least extent of health action (2.1), in chronic morbidities males in the Low Caste group took least extent of health action (1.2). On the other hand, in acute morbidities while females in the High Caste group took greater extent of health action (8.0), it is females in the High Class group who took greater extent of health action (7.0) for chronic morbidities. It is interesting to note that while the maximum difference in the extent of health action in High Caste (8.0) and Low Caste (2.1) groups for acute morbidities is more among females, it is also more among females for chronic morbidities in the High Class (7) and Low Class (1.6) groups. The differential in health action reflects differential perception of acute and

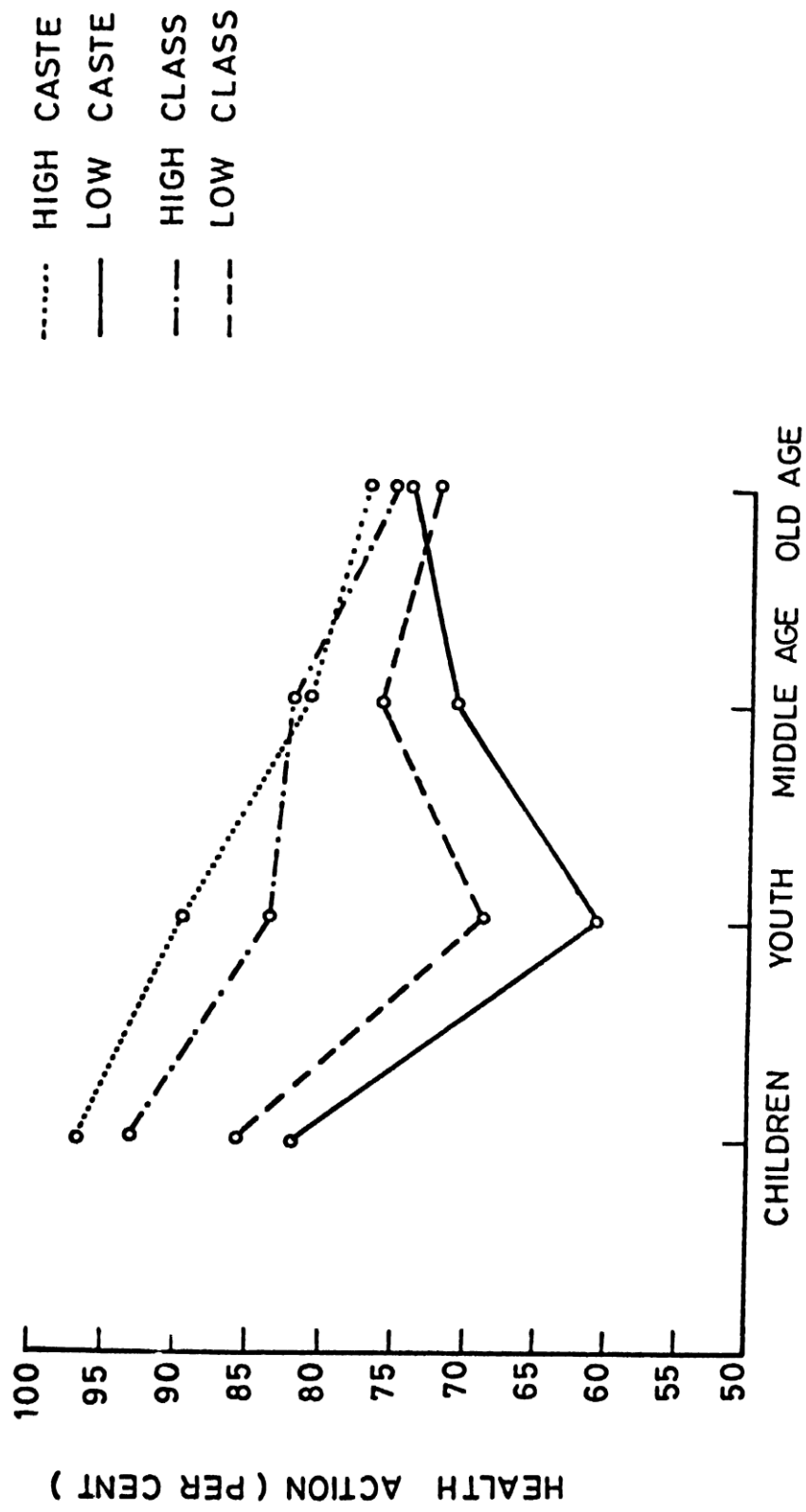


FIG. 4.5 HEALTH ACTION TAKEN AMONG CHILDREN, YOUTH, MIDDLE AGED AND OLD PEOPLE IN CASTE AND CLASS GROUPS.

chronic morbidities by males and females in caste and class groups. While the females in the Low Caste group perceived acute morbidities with less concern, the males in the same group perceived chronic morbidities with less concern. Of all the groups the Low Caste followed by Low Class took least extent of health action. This indicates their lack of concern and anxiety for remedial health action for morbidities which can be attributed to their poor living conditions, lack of awareness and negligence.

2.3 Health Action by Age and Stratification :

For the purpose of clear understanding of health action taken, the various age-groups were grouped into four broad categories, namely children (- 14 years), youth (15-34 years), middle aged (35-54 years) and old aged (55+).

2.3(a) Total Morbidities :

Among all age categories, children were better taken care of by health action. Among them, 90.0% of the morbidities were taken care of. In rest of the categories, only about 75.0% of the morbidities were taken care of by health action (Table 4.33 and Fig. 4.5).

There are some differences in the extent of health action taken for total morbidities in caste and class groups among children, youth, middle-aged and old people. In general, greater proportion of health action (84.4%) was taken in the High Caste group than in the Low Caste group (70.2%). Similar trend of health action taken by caste groups was more than the difference in class groups. In both the High Caste and High Class groups, the proportion of health action taken in children was more than the health action taken in other categories-youth, middle-aged and old people. Same is the case with the Low Caste and Low Class groups. Among old people the proportion of health action taken in both the caste and class groups was more or less of the same order(around 74-76%). It is interesting to note that among youth, the proportion of health action taken was very less (61.1%) in the Low Caste group than in the High Caste group (89.7%). Similar was the trend with the class groups also. Further, the proportion of health action taken among youth in the Low Caste group(61.1%) was the lowest compared to the proportion of health action taken among children, middle-aged and old people in all other caste and class groups. In contrast to this, the proportion of health action taken for children was the highest in the High Caste group(96.9%) when compared to the proportion of health action taken in other categories in all other caste and class groups. The difference in the extent of health action taken in caste groups was more than those of class groups.

2.3(b) Acute Morbidities :

More or less a similar pattern of health action as observed for total morbidities was found for acute morbidities for caste and class groups also. As observed for total morbidities, 90.0 per cent of the acute morbidities in children were taken care of by health action. In other categories, about 80 per cent of acute morbidities were taken care of. (Table 4.34).

2.3(c) Chronic Morbidities :

For chronic morbidities, only 65.6 per cent of the morbidities were taken care of by health action in general (Table 4.35).

There were some differences in the extent of health action taken in various categories in caste and class groups. In children while 86.7 per cent of the morbidities were taken care of by health action, among youth only 56.4 per cent of morbidities were taken care of. Incidentally, the proportion of health action among youth is the least proportion of health action taken compared to all other categories - children, middle-aged and old people.

It is observed that among children greater proportion of health action (86.7%) was taken than in other categories. Among youth, least extent of health action (56.4%) was taken. In general, less proportion of health action was reported (52%) in the Low Caste group than in the High Caste group (75%). Similar was the pattern in class groups also. It is emphasised here that youth in Low Caste (30%) and Low Class groups (35.7%) took least extent of health action when compared to health action taken by other categories (children, middle-aged and old people) in the High Caste, High Class, Low Caste and Low Class groups. Old people in the Low Caste group took less proportion of health action (42.8%) when compared to the proportion of health action taken by old people in other caste and class groups (High Caste 76.9 per cent, High Class 76 per cent and Low Class 59.4 per cent). In general, the differences in the extent of health action taken in caste groups are more than the differences in the class groups among various categories.

On comparing the extent of health action taken for chronic and acute morbidities, it was observed that less number (65.6%) of chronic morbidities were taken care of by health action than acute morbidities (82.4%). This shows that the extent of negligence of chronic morbidities is about (34.4%) twice that of acute morbidities (17.6%).

In terms of health action taken in various categories it was observed that in children both for chronic and acute morbidities a greater proportion of health action (nearly 90%) was resorted to than in other categories. In middle-aged and old people while 80 per cent of acute morbidities were taken care of only about 66 percent of chronic morbidities were taken care of by health action. It is of interest to note that among youth, while nearly 80% percent of acute morbidities were taken care of, only 56.4 per cent of chronic morbidities were taken care of. The difference in the extent of health action taken between acute and chronic morbidities in the Low Caste group was more than in other caste groups. Among youth in the Low Caste group, greater negligence of both acute and chronic morbidities was observed (acute morbidities 30 per cent against overall average of 56.4 per cent). These differences would be more glaring when compared with the High Caste group. Similar trend was observed among youth in the Low Class group also. The greater negligence of morbidities in general and chronic morbities in particular among youth in the Low Caste group indicates their less concern for health action because of lack of economic means, lack of awareness, negligence etc. This inturn will have a serious impact on the productivity in general and the income of the households in particular. The magnitude of difference in health action both in acute and chronic morbidities is less in the class groups than in the caste groups.

Difference in health action in proportions between High Caste and Low Caste groups and High Class and Low Class groups for Selected variables

In general, it was observed that the magnitude of difference in proportions between the High Caste and Low Caste groups for a large number of variables was more than the magnitude of difference in proportions between High Class and Low Class groups (Table 4.36).

For some variables, the proportion in the High Caste group was more than the proportion in the Low Caste group. Similar was the trend with regard to class groups for these variables. These variables are: distribution of chronic morbidities, health action taken among males, health action taken among females, health action taken among children, youth, middle-aged and old people, distribution of morbidities among children and old people etc. This can be represented as:

| | | |
|------------|---|-----------|
| High Caste | > | Low Caste |
| High Class | > | Low Class |

For some variables, the proportion in Low Caste group was more than the proportion in the High Caste group. Similar was the trend with class groups as well. These variables

are : distribution of acute morbidities, distribution of morbidities in middle-age etc. This can be represented as:

| | | |
|-----------|---|------------|
| Low Caste | > | High Caste |
| Low Class | > | High Class |

In some variables, the difference in proportions between the High Caste and Low Caste groups is about the same as the difference in proportion between the High Class and Low Class groups. These variables are : health action taken by old people, distribution of morbidities in children, middle-aged people etc. This can be represented as :

$$\text{High Caste} \gtrless \text{Low Caste} = \text{High Class} \gtrless \text{Low Class}$$

It is interesting to observe further that for some variables, the proportions in the High Caste and Low Caste and the High Class and Low Class groups are more or less of the same order. These variables are : Health action taken by old people and morbidity in children. This can be represented as:

| | | |
|------------|---|-----------|
| High Caste | = | Low Caste |
| High Class | = | Low Class |

In sum, it is observed that for a large number of variables caste differences were more than class differences.

SECTION 3

DISCUSSION

In the previous sections, the influence of social stratification in prevalence of morbidity and in taking health action was presented. In this section, the relative influence of caste and class in the prevalence of morbidity and in taking health action is discussed. For some variables, the Low Caste group had greater proportion than the High Caste group and vice-versa. Similar is the case with the Low and High Class groups also. For some variables there is marginal difference in caste/class, caste and class groups. Age and sex variables also influence the pattern of morbidity and health action.

The Low Caste group had greater proportion of morbidity than the High Caste group in the following aspects :

1. The Low Caste group had slightly more morbidity episodes than the High Caste group.
2. Persons reported sick were more in Low Caste group than in the High Caste group.

3. The Low Caste group had a higher morbidity prevalence rate than the High Caste group. Incidentally, the Low Caste group had the highest morbidity prevalence rate among all the caste and class groups. Similarly, it had also the highest prevalence rate per 100 sick persons of all the caste and class groups.
4. A sick person in the Low Caste group suffered more number of episodes than a sick person in the High Caste group. Here also, the Low Caste group is the one which suffered larger number of episodes than any other group. Further, both the sick males and sick females in the Low Caste group suffered more number of morbidity episodes than sick males and sick females in other groups.
5. As regards distribution of systemwise morbidity episodes, musculo-skeletal complaints were slightly higher in the Low Caste group than in the High Caste group. Further, chronic morbidities of ENT and sense organs and respiratory system were more in the Low Caste group than in the High Caste group.
6. As far as duration of morbidity episodes is concerned, minor illness episodes were more in the Low Caste group than in the High Caste group. In the Low Caste group minor illness was more among females than among males. Incidentally, this group had the highest proportion of minor morbidity episodes of all the caste and class groups. Similarly, chronic morbidities of more than three years duration were more in the Low Caste group than in the High Caste group. Both males and females in the Low Caste group had more chronic morbidities of longer duration than the males and females in the High Caste group respectively.

7. With regard to the distribution of morbidities in age groups, it was observed that morbidity episodes were more in middle-age (35-54) in the Low Caste group than in the High Caste group. Further, more chronic morbidities were found in middle age in this group than in the High Caste group. It is emphasised here that about one-third of total chronic morbidities in the Low Caste group were concentrated in 35-44 age group alone while in the same age group in the High Caste these were much less (about 1/6th only). By and large, morbidities particularly moderate and chronic in middle-age were more in the Low Caste group than in the High Caste group. In old age, in the Low Caste group, morbidities were less than in the High Caste group. In children, in the Low Caste group, chronic morbidities were more than in the High Caste group.
8. In general, less health action was taken in the Low Caste group than in the High Caste group. Of all the caste and class groups, while the Low Caste group took least extent of health action, the High Caste group took greater extent of health action. Further, in the Low Caste group the number of chronic morbidities neglected are equal to the number of chronic morbidities taken care of by health action.

Less health action was taken among males and females in the Low Caste group than males and females in the High Caste group respectively. It is interesting to note that of both males and females in all caste and class groups, least health action was taken among females in the Low Caste group while greatest extent of health action was taken among females in the High Caste group.

9. It is also interesting to note that among youth, the proportion of health action taken was very less in the Low Caste group than in the High Caste group. Further, the proportion of health action taken among youth in the Low Caste group was the lowest compared to the proportion of health action taken among children, middle aged and old people in all caste and class groups.

In the High Caste group, the following aspects of morbidity were more than in the Low Caste group.

1. The High Caste group experienced slightly more chronic morbidities than the Low Caste group.
2. In general, circulatory disorders were more in the High Caste group than in the Low Caste group. This is more so with regard to chronic circulatory disorders.
3. In the High Caste group, morbidities were more among males than among females.
4. In old age group (55+) more chronic morbidities were reported in the High Caste group than in the Low Caste group.
5. In general, the High Caste group reported health action for more number of morbidities than the Low Caste group. Further, more chronic morbidities were taken care of in the High Caste group than in the Low Caste group.

6. For acute morbidities, females in the High Caste group took more health action than males not only in the same group but also in the total population in general.
7. In the High Caste group, greater proportion of health action was taken for chronic morbidities than in the Low Caste group. In particular, health action taken among youths in the High Caste group was much greater than in the Low Caste group.
8. In all, males and females in the High Caste group took more health action than males and females in the Low Caste group. Further, the health action taken by males and females in the High Caste group is the highest extent of health action in the sample in general.

More or less a similar trend was observed in class groups also.

For some variables, the difference in proportions in Caste or Class groups, Caste and Class groups is very marginal. For chronic morbidities, the morbidity prevalence rate (21.8) was more or less the same in all the caste and class groups. There is a small difference in morbidity prevalence rate per 100 sick persons in the High Caste and High Class groups. A sick person both in the High Caste and High Class groups suffered more or less similar number of episodes. The number of chronic morbidities suffered by a sick person are much uniformly distributed in caste and class groups.

In addition to caste and class differences, there are sexwise differences also in some of the aspects of morbidity and health action. In general, the number of morbidities among males, were slightly more than among females. The distribution of acute morbidities among males and females was more or less equal. In distribution of chronic morbidities more complaints were found among males than among females.

As regards distribution of morbidities by duration is concerned, minor illness was slightly more among females than among males while mild and moderate illnesses were found in the same proportion both among males and females. Chronic morbidities among males were slightly more than among females. Further, chronic morbidities of longer duration were more among males than among females. In general, of males and females, slightly greater extent of health action was taken by males than females. Of all the groups, both among males and females, females in the High Caste group took greatest extent of health action. In contrast to this, females in the Low Caste group took least extent of health action in the population in general.

In caste and class groups females took care of more number of chronic morbidities than males while males took care of more number of acute morbidities than females.

There are also age-wise differences in some aspects of morbidity and health action.

In general, with the exception of the age-group of 15-24 years, morbidity increased with each successive age-group till 54 years and then declined sharply. In the age-groups of 35-44 and 45-54, morbidities were found slightly higher than in other age-groups. The distribution of morbidities in various age-categories was: children 17 per cent, youth 25.4 per cent, middle-age 39.3 per cent, and old-aged 18.3 per cent. This shows that morbidities increased from children to middle-age and then declined in old-age. This pattern was observed in all types of morbidities - minor, mild, moderate and chronic - in caste and class groups.

The largest number of sick persons out of the total number of sick were children of 5-14 years of age (18.3%) followed closely by the age-group of 45-54 (17.8%).

Among all the age-categories, children were better taken care of by health action. Among them, 90 per cent of the morbidities were taken care of. In rest of the categories, only about 75 per cent of the morbidities were taken care of. For chronic morbidities, among children while 86.7 per cent of the morbidities were taken care of by health action, among

youths only 56.4 per cent of the morbidities were taken care of, which are the highest and least extents of health action taken in all age groups.

In children, both for chronic and acute morbidities, greater proportion of health action (nearly 90%) was resorted to than in other age-categories. In middle-aged and old people while 80 per cent of acute morbidities were taken care of, only about 66 per cent of chronic morbidities were taken care of by health action. It is interesting to note that among youth, while nearly 80 per cent of acute morbidities were taken care of, only 56.4 per cent of chronic morbidities were taken care of. This shows that there is less concern for health action for chronic morbidities than for acute morbidities among youth.

There are some age-sex wise differences in some aspects of morbidity. In terms of male-female vulnerability to morbidities it was observed that the age-groups of 45-54 and 55-64 among males and the age-groups of 35-44 and 45-54 among females were susceptible to greater morbidities. A similar trend was observed for acute morbidities also. On the other hand, in chronic morbidities, it was found that the age groups

of 55-64 and 65⁺ among males and the age groups of 45-54 and 55-64 among females were more vulnerable to greater morbidities. In other words, females were susceptible to larger number of morbidities earlier than males by an age-group of 10 years.

Among children and old people slightly more sick males were found than sick females. In the age-groups ranging from 15-54, more sick females were found than sick males. Among old people, more sick males were found with chronic morbidities than sick females.

In terms of distribution of morbidity episodes it was found that there was greater concentration of morbidity episodes among females in middle-age than males. This pattern was found both in acute and chronic morbidities. Similarly, there was greater concentration of morbidity episodes among males in old-age (25.2%) than among females (11.1%).

The middle-aged and youth were the largely affected groups in morbidity distribution both in terms of persons as well as episodes.

In all, it was observed that there is a negative trend of relationship between stratification and prevalence of morbidity: lower the caste/class status, greater the morbidity. This is

reflected both in morbidity prevalence rate and the number of morbidities suffered by a sick person. In terms of health action, there is a positive trend of relationship between stratification and health action: Higher the caste/class status, greater the extent of health action. In other words, there is greater negligence of morbidities in Low Caste and Low Class groups. Further of these two, it is the Low Caste group which neglected more number of morbidities than the Low Class group.

In general, females took slightly less health action than males. But the caste and classwise results show interesting trends. While females in the High Caste and High Class groups took more health action than males in their respective groups, females in the Low Caste and Low Class groups took less health action than males in their respective groups. In general, health action taken by females in the Low Caste group followed by Low Class group was the lowest extent of health action taken in the population. Thus, the females in the Low Caste group suffered both caste and sex-wise disadvantages. Broadly, the Low Caste and Low Class groups are susceptible to the disadvantage of greater morbidities which is in turn closely related to their living conditions, perception of illness etc. Comparatively less health action among these groups show their lack of enough economic means to attend to the morbidities, lack of awareness

of the health facilities available, superstitions, sex-bias etc. In contrast to this, more health action was taken by the High Caste and High Class groups, both among males and females. Of males and females, it is females who took care of more morbidities than males both for acute and chronic morbidities. The difference in the extent of health action taken is more in the High and Low Caste groups than in the High and Low Class groups. In all, factors such as living conditions, beliefs, norms, values, occupations, economic means, education, superstitions etc. that are associated with stratification system in a community determine the extent of a group's susceptibility to morbidity and its resort to remedial health action.

**UTILISATION OF HEALTH RESOURCES
AND SOCIAL STRATIFICATION**

Chapter 5.

UTILISATION OF HEALTH RESOURCES AND SOCIAL STRATIFICATION

A variety of resources for health care are available to people in the village. These agencies are : (1) Primary Health Centre (PHC), (2) Private Practitioners (3) Folk Healers (4) Medical Shops (5) Community Health Volunteers (CHV) etc. The field personnel of PHC such as **A**uxiliary Nurse Midwife (ANM), Multipurpose Health Worker (MPW) also dispense tablets, render advice etc. to the people, whenever needed. In nearby towns, specialists in various disciplines of medicine such as paediatrics, cardiology, ophthalmology are available for consultation. The details about these various resources are given elsewhere. In this chapter, the pattern of utilisation of these resources by different caste and class groups is discussed.

All the respondents were asked to report any visit made to these agencies by them or their family members during the period of two months preceding the date of interview approximately. Similarly, they were also asked to report about the visits made by ANM and MPW to their family during the

preceding six months period from the date of interview approximately. The variables included here are : the type of services used at PHC, type of experience about the services and personnel of PHC, type of preference for PHC and reasons for consulting PHC, type of preference and reasons for consulting other resources such as private practitioners, CHV, medical shops etc., items of medicinal value generally kept in house, use of water resources etc.

This chapter is divided into two sections : the first one deals with use of health services among caste and class groups and the second one discusses the relationship between the stratification and utilization.

SECTION 1

USE OF HEALTH SERVICES

VISITS TO VARIOUS HEALTH AGENCIES/PRACTITIONERS :

During the period of two months preceding the date of enquiry, the health resources visited by the sample households were (1) PHC (2) CHV (3) Private doctors outside the village (4) RMPs within the village (5) Folk healers and (6) Medical shops within the village.

In general, it is observed that PHC was mostly consulted by all social groups. During the period of investigation, 62.5 per cent of the sample households visited PHC for getting their various ailments cured. Next to PHC, 44 per cent of the sample households consulted RMP within the village. Consultation of private doctors outside the village (39%), folk healers (25.5%) and CHV (14.5%) followed PHC and RMP. Some differences are observed in consultation of these various health resources by different caste and class groups. The Low Caste (68.7%) and the Low Class (65.6%) groups consulted PHC slightly more frequently than the High Caste (59.1%) and the High Class (54.3%) groups. The High Class group (59.6%) and the High Caste group (46.9%) consulted private doctors outside the village substantially more frequently than the Low Caste (27%) and the Low Class (33.3%) groups. RMPs within the village were utilised by the High Class group (63.1%) more than any other caste/class group (High Caste 45.9 per cent, Low Class 42.7 per cent and Low Caste 41.6 per cent). Interestingly, both the High Caste (32.6%) and the High Class (33.3%) groups visited folk healers more frequently than the Low Caste (20.8%) and the Low Class (22.9%) groups. However, the CHV was consulted much more by the Low Caste group (41.6%) than any other group (Low Class 21.8 per cent, High Caste 9.1 per cent and High Class 3.5 per cent). Figure 5.1 presents these differences for visual comparison.

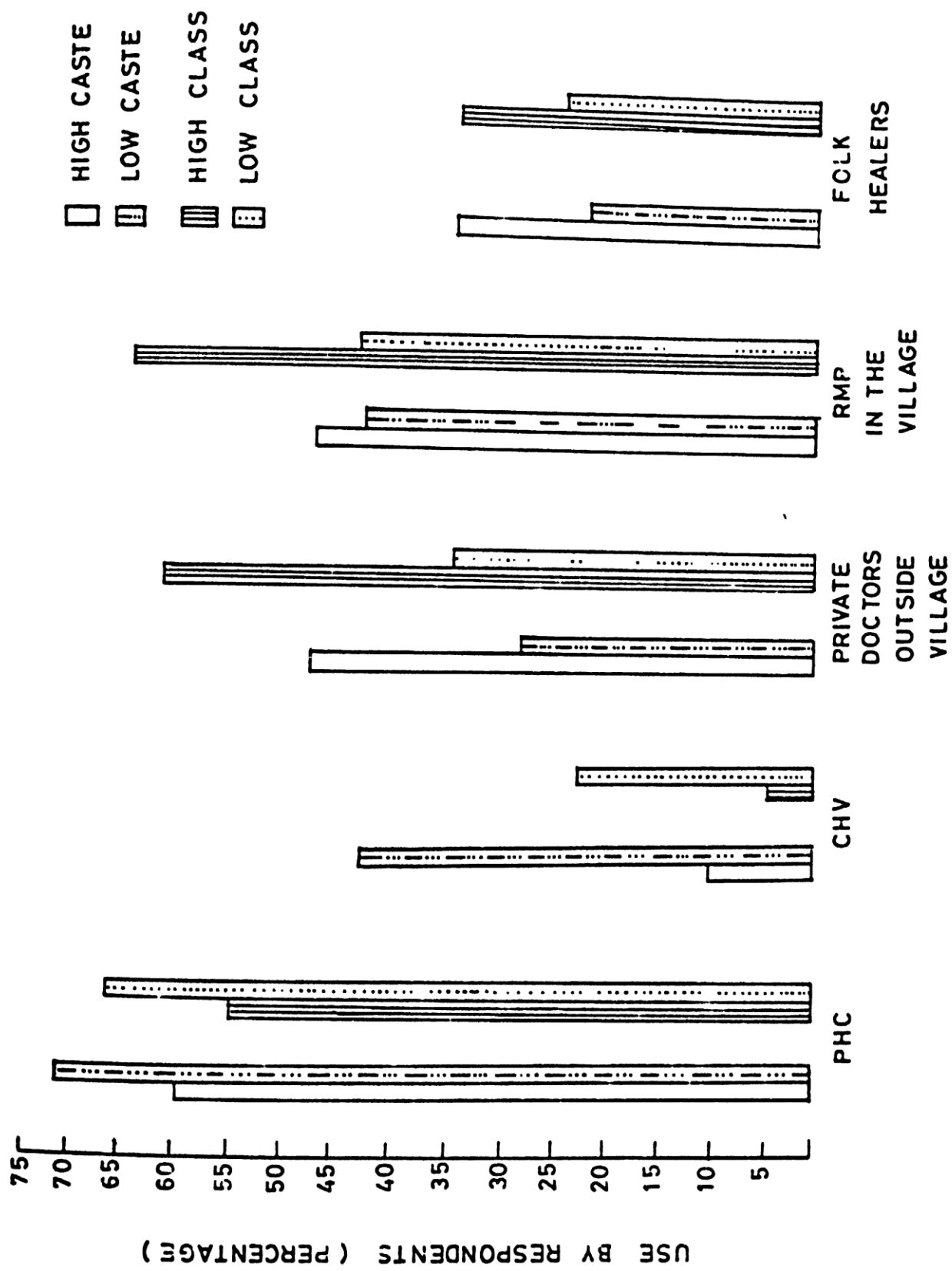


FIG. 5.1 UTILIZATION OF HEALTH RESOURCES IN CASTE AND CLASS GROUPS.

In all, the local PHC was consulted in greater frequency than any other health resource available by all social groups. Private doctors outside the village (59.6%) and the local private practitioners (63.1%) were consulted by the High Class group more frequently than any other group. On the other hand, CHV is largely consulted by the Low Caste group (41.6%) compared to any other group. As far as folk healers are concerned it is interesting to note that the High Caste and the High Class groups consulted them slightly more frequently than the Low Caste and the Low Class groups. (Data is reported in Table 5.1 in the appendix)

Use of any Services of Primary
Health Centre (PHC)-Ever used
by Sample Households :

In order to understand the extent of utilisation of the services of PHC, all the respondents were asked to report whether he himself or any member of his family ever visited PHC for any type of ailment or advice since it started functioning in the village more than twenty years (established in 1962) ago.

In general, about 85 per cent of the households in the sample reported having ever availed of any type of services at the PHC since its inception (ever used). The extent of utili-

zation of the services of the PHC varied in different social groups. While all the Low Caste group households (100%) in the sample ever used the services of PHC, only about 75 per cent of the households in the High Class group ever availed the services of PHC. Similarly, while nearly 80 per cent of the households in the High Caste group ever used the services of PHC, about 90 per cent of the households in the Low Class group ever used the services. Thus, while all the Low Caste group households reported having used the PHC services since its inception, only 75 per cent of the High Class group households have ever used these services (Table 5.2).

Various types of special services other than O.P.D. are rendered to the community at the local Primary Health Centre. All the heads of the households were asked to report whether any member in their household ever used the following special services during the period under investigation: (1) Maternal care (2) Delivery (3) Immunization (4) Family Planning (5) Hospitalization and (6) Special treatment such as leprosy, tuberculosis etc.

The following table shows that in general 68.5 per cent of the households used these PHC special services. Of the above mentioned services, maternal care was utilised more

(45.5 %) than any other service (immunization 37.5%, Family Planning 29%, Hospitalization 18.5%, Delivery 13.5% and Special Treatment 2.5%) (see also table 5.3A in appendix)

TABLE: 5.3

Type of PHC special service used by Caste and Class groups during the period of 2 months preceding the date of interview

| Service Used | High Caste N=98 | Low Caste N=48 | High Class N=57 | Low Class N=96 | TOTAL N=200 |
|---|--------------------|-------------------|--------------------|-------------------|----------------|
| PHC special service used by the households in general | 64 (65.3%) | 41 (85.4%) | 34 (59.6%) | 70 (72.9%) | 137 (68.5%) |
| Maternal Care | 33 (33.6%) | 31 (64.5%) | 18 (31.5%) | 51 (53.1%) | 91 (45.5%) |
| Delivery | 10 (10.2%) | 10 (20.8%) | 4 (7.0%) | 16 (16.6%) | 27 (13.5%) |
| Immunization | 35 (35.7%) | 28 (58.3%) | 20 (35.0%) | 38 (39.5%) | 75 (37.5%) |
| Family Planning | 29 (29.5%) | 14 (29.1%) | 14 (24.5%) | 28 (29.1%) | 58 (29.0%) |
| Hospitalization | 17 (17.3%) | 6 (12.5%) | 8 (14.0%) | 20 (20.8%) | 37 (18.5%) |
| Special treatment | 2 (2.0%) | - | - | 3 (3.1%) | 5 (2.5%) |

There are some differences in using these services in various social groups. Of all the groups, the Low Caste group used these PHC services most (85.4%) (High Caste 65.3%, High Class 59.6% and Low Class 72.9%). Both the Low Caste and Low Class groups used these special services of PHC more frequently than the High Caste and High Class groups. Maternal care, delivery and immunization services were utilised more frequently by the Low Caste group (65.5%) than any other groups. The Low Caste group (64.5%) used the maternal care about twice as frequently as the High Caste (33.6%) or the High Class (31.5%). In using delivery services also, the Low Caste group used PHC (20.8%) more than any other group (High Caste 10.2%, High Class 7.0%) and Low Class (16.6%). Further, immunization service was also utilised substantially more by the Low Caste group (58.3%) than other groups (35.0%). Family Planning is the only service which was used by all the groups more or less in similar proportion (around 29.0%). On the whole, except for family planning services, the Low Caste and the Low Class groups used maternal care, delivery, and immunization services about twice more than the High Caste and High Class groups. It is interesting that no difference is observed in use of family planning services.

It is assumed sometimes that the type of experience one gets while seeking treatment or advice from any health resource influences the choice or preference for subsequent health behaviour of the people. Keeping this in mind, all the respondents were asked about the type of experience they had about the services rendered at PHC. The variables were examined in polar contrast. Those indicating a favourable opinion about the PHC are (1) Prompt service (2) Good medicine (3) Good behaviour of staff (4) Satisfactory services and (5) Usefulness of PHC. The contrasting indicators show negative opinion.

It is found in general that a majority of the respondents reported a favourable opinion about the services of PHC (Prompt service 50.8%, Good medicine 60.8%, Good behaviour of staff 76.0%, satisfied with services 57.3% and PHC useful 61.9%). It is observed that the High Caste and the High Class groups had a more favourable experience than the Low Caste and Low Class groups in general although they used these services to a lesser extent. Of the High Caste and High Class groups it is the High Class (Prompt service 62.8%, Good medicine 74.4%, Good behaviour of staff 79.0%, satisfied with services 74.4%, PHC useful 74.4%) which holds a more favourable image than the High Caste group (Prompt service 50%, Good medicine 60.2%, Good behaviour of staff 75.6%, Satisfied with

services 60.2%, PHC useful 62.8%). Both the Low Caste and Low Class groups hold more or less similar opinion about the services of PHC (Prompt service 43-48%, Good medicine 50-55%, Good behaviour of staff 73%, satisfied with services 50%, PHC useful 54-56%). Thus the Low Caste and Low Class groups have less favourable experience compared to the High Caste and High Class groups about the services of PHC although they used PHC services more often out of necessity (Table 5.4).

The preference one shows for a particular health resource reflects not only one's own choice but also the extent of faith and accessibility for the resource itself. In order to understand this, all the respondents were asked to state their preference to consult a health resource and the reason for it in the event of illness in their family. The preferences rated are first, second, third and none. The health resources included for such rating are : (1) PHC (2) CHV (3) Private Practitioner and (4) Medical Shop. In general, about 60.5 per cent of the sample respondents showed some preference (Ist, IInd and IIIrd) for PHC. Of this, most of the respondents expressed second preference (36.5%) followed by the first (19.5%) and the third (8.5%) preferences. About 35% of the respondents did not express any preference for PHC (Table 5.5).

While the general trend is reflected in all social groups, there are small differences in caste and class groups. While 45 per cent of the respondents in the High Caste group expressed no preference for PHC, it is only 23 per cent, (about half of the preference expressed by the High Caste group) in the Low Caste group who expressed no preference. Similarly, while nearly 50 per cent of the High Class group expressed no preference for PHC, it is only 28 per cent in the Low Class group. Thus, by and large, while nearly 50 per cent of the respondents in the High Caste and the High Class groups showed no preference for PHC, only about 25 per cent of the respondents showed no preference in the Low Caste and Low Class groups. It reflects greater dependence on PHC by the Low Caste and Low Class groups than the High Caste and the High Class groups. This shows that higher the caste and class status, lesser the preference for PHC (Table 5.5).

All the respondents who expressed some preference for PHC were asked to indicate the reasons for their preference. The various reasons mentioned have been classified into the following broad categories : (1) Not satisfied with treatment by other agencies/cures (2) Free treatment (3) Personal network (4) Faith (5) Others. In general 45 per cent of the respondents mentioned 'dissatisfaction with treatment from other agencies'

as the main reason for their preference for PHC while a similar proportion (43.4%) expressed 'free treatment' as another reason. These two are the main reasons for their preference for PHC. The other reasons reported in a small measure are : personal network (3.8%), faith (1.6%) and others (6.2%) which include factors such as the non-availability of certain materials (like bandage etc.) with local RMPs, advice by friends etc. This pattern holds true more or less for all the caste and class groups. However, some interesting trends were observed. While 'dissatisfaction with treatment by other agencies/cures' is the main reason among the Low Caste group (46.0%) for their preference for PHC, it is free treatment which is the main reason among the Low Class group (50.7%) (Table 5.6). Similar is the case with the High Caste and High Class groups. Thus, it is observed that while free treatment is found associated more with class groups, dissatisfaction with treatment by other agencies/cures is more associated with caste groups.

In order to know the actual reason that made them visit PHC, the respondents were asked the following question on the basis of morbidity data collected for the household earlier.

"As you said, you consulted primary health centre for some (give details) ailments? Why didn't you consult a private doctor? (give actual illustration from morbidity schedule)"

In case anyone in the family visited PHC for specific morbidity episode during the period under study, (August 1983 to October 1983) the respondents were asked to state the reason for their having done so. This question was put to the respondents on the basis of morbidity data recorded earlier. Out of the 200 sample households only 134 consulted PHC during the period under study (See table 5.7 for details). Among the caste groups 63 (64.3%) households from the High Caste group and 34 (71%) from the Low Caste group consulted PHC. Among class groups, 35 (61%) households in the High Class group and 66 (68.8%) in the Low Class group consulted PHC. The various reasons mentioned were categorised broadly into the following :

(1) Service free of cost (2) Good image of resources and services (3) Personal network (4) Good image of certain doctor/specialist services (5) Limitations of some kind and (6) Others. Out of all these, in general, service free of cost was reported as the major reason (56.7%) for consulting PHC. Other reasons were reported in a small measure : Limitations of some kind (13.4%), Good image of certain doctor/specialist services (10.4%) good image of resources and services (6.7%), personal network (6%) and others (6.7%). There are some differences in the

extent of various reasons reported for visiting PHC in different caste and class groups. In the High Caste group while service free of cost (52.4%) and good image of certain doctor or specialist services (14.3%) are the prominent reasons, it is the service free of cost (47.0%) and limitations of some kind (16.4%) are the main reasons in the Low Caste group.

Among class groups, it is different. In the High Class group though service free of cost is the main reason (40.0%) other reasons such as good image of services and resources, good image of certain doctor or specialist services and limitations of some kind were also reported each in the same measure (14.3%). On the other hand, service free of cost is the most predominant reason (70.0%) reported in the Low Class group followed by limitations of some kind (13.6%) etc. Thus, service free of cost was reported as the main reason by all social groups in different proportions varying from 70.0 per cent in the Low Class group to 40.0 per cent in the High Class group. Other reasons were reported in small proportions. While "service free of cost" and "limitations of some kind" were reported as the main reasons among the Low Caste and the Low Class groups, "service free of cost" and "good image of certain doctor/specialist" were the main reasons in the High Caste and High Class groups (see details in Table 5.7). Cost factor

weighed greatly with all groups. However, the Low Class group is associated with cost factor in greater measure (70%) than other groups (High Caste 52.4%, Low Caste 47.0% and High Class 40.0%).

It is observed that though the High Caste and High Class groups had reported more favourable image of PHC than the Low Caste and Low Class groups, they actually preferred it and used it less than the Low Caste and Low Class groups. This is perhaps because they have wider choice and can afford more convenient and more satisfying services.

To understand the extent of services rendered to the people by the field staff of PHC at sub-centre such as ANM, MPW etc. the respondents were asked to report how frequently they were visited by ANM or MPW during the past six months preceding the date of interview approximately. It was found that about 80 per cent of the households reported that they were not visited by ANM during the past six months. The remaining households were visited either once (5%), twice (2.5%), thrice (3.0%) or more than thrice (10.5%). This pattern was found more or less in all social groups. However, the Low Caste group households were visited "at least once or more" in somewhat greater frequency (35.0%) than other groups

in general (20.0%). This can be due to the accessibility and the subjective factor of her (ANM) belonging to the same caste group. She visited the High Class group slightly more frequently than the High Caste and Low Class groups (Table 5.8). In the context of availability of better services at the PHC and private practitioners within the village ANM's services do not appear to have much significance and demand.

ANM's service to the people mostly consisted of giving tablets, motivating people for family planning, preparation of lists for immunization camps, advice for minor ailments, etc. Mostly her service to the community was in the form of some advice (Table 5.9). This pattern was observed more less in all social groups.

As regards Multipurpose Health Worker (MPW) is concerned the picture is better. 55 per cent of the respondents reported that they were visited by him either once (9.5%), twice (6.0%) thrice (6.0%) or more than thrice (33.5%). The remaining respondents (45.0%) reported that they were not visited during the six months preceding the date of interview. This pattern was observed more or less in all caste and class groups. However, it was observed that the Low Caste group was visited by him in a greater proportion (67.0%) than other groups in general (45.0%).

The greater frequency of his visits to the Low Caste group are due to the same factors as explained for ANM above (Table 5.10)

With regard to the type of service rendered by MPW, only 21.0 per cent of the households were given some form of concrete help (18.5% tablets, 1.5% family planning work, 1.0% blood/sputum examination). 34 per cent of the households were given some advice regarding health problems (Table 5.11). This pattern was found more or less in all social groups.

In view of the experience people generally had while seeking medical care at PHC, they developed different types of images about staff and services of PHC. Some of the reactions informally expressed about PHC by the people during the investigation are given below.

"They prefer to treat rich people. Only after their turn, the doctors examine labour. Even the medicines they give are hardly effective. They will examine only those who give bribes in the form of agricultural produce such as redgram, greengram, blackgram, vegetables, ghee etc. In consideration, they examine them first with greater care. Those who cannot afford to give them anything, they will not be examined properly".

"They give medicines from the same bottle for all ailments".

"Earlier, there used to be a health visitor here. She is the wife of a local scheduled caste teacher. Now, she has been transferred to another place. As long as she was here, we had no problems. She used to give us good and effective medicines. She was very helpful to us. Now, after her transfer, we lost a good source of help".

"There is no proper treatment at PHC. They give injections with infected needles. Once I had an injection. With the same needle, he gave injections for ten other people in front of me. For three days I suffered from pain".

"Once I took an injection. It developed into sepsis. When I asked them they said it was not due to injection. I consulted a private doctor at Korukonda, a nearby small town. He said that it was due to injection only and gave medicines. It was cured subsequently. Later, I went to PHC and argued with the staff including the doctor about their negligence which resulted into my suffering unnecessarily. They could not convince me that it was not due to their injection. Since then I became indifferent and allergic to consult PHC for any type of ailment".

"The patient has to be taken daily. It is not possible for us to take the patient daily. For private practitioners, it is enough to take the patient once or twice."

"The doctor who comes from Rajahmundry, a nearby town where he resides, examines the patients well. He gives good medicines. On the days of his duty at PHC, there will be a lot of rush of patients. On the other hand, while other doctors were on duty, hardly few patients turn up. Some times, patients will postpone their visit to PHC till the day of the ~~duty of~~ 'Rajahmundry doctor'".

"The medicines given at PHC are not effective. It is better to have few tablets from medical shop which will relieve the ailment faster. This saves one's time and effort".

"The PHC is meant for labour/poor people. If we go to PHC, the labour people think that we are robbing them of their facility".

These statements are in contrast to more favourable opinions expressed during the formal interviews reported above (particularly Table 5.4). However, the questionnaire survey also shows that only 15-23 per cent respondents consider PHC as agency of first preference (Table 5.5).

USE OF COMMUNITY HEALTH
VOLUNTEER (CHV) :

In October 1977, a new Rural Health Scheme was launched by the Central Government to meet the health needs of the rural masses. Under this scheme, a cadre of non-professional health workers called Community Health Volunteer (CHV) was created to provide adequate health care to rural people and educate them in matters of preventive and promotive health. The main idea of this scheme is to provide simple medical aid within the reach of every citizen. Generally, there is one CHV for a population of 1000 and for the sake of convenience, smaller villages may be grouped or larger villages may be broken into sectors. The duties of CHV include treatment of minor ailments, giving first aid in emergencies, identification of causes of malaria, smallpox and other communicable diseases, helping para-medical staff in work related to communicable disease, immunization, family planning, maternity and child health, nutrition and mental health, creating awareness among the community in problems of environmental sanitation and personal hygiene and assisting the paramedical staff in carrying out activities in these fields, and finally participating in activities related to health education. In the field of medical care, his role is limited to first aid and treatment of simple ailments and beyond this, he is expected to refer all cases of illnesses to PHC, rural dispensaries or district hospitals.

All the respondents were asked to indicate the rank of their preference for consulting CHV. There are four CHVs available to the community - three in the main village and one in the hamlet. It is found that only 15 respondents out of the sample of 200 indicated some preference (1st preference 12, and 2nd preference 3). Of these 15 respondents, 11 belonged to the Low Caste group and 4 to the High Caste group. In class groups, 11 belonged to the Low Class group and 4 to the High Class group. This indicates poor preference for and acceptability of CHV in the community in general and whatever little preference indicated was reported mostly by the Low Caste (23.0%) and the Low Class (11.5%) groups. Incidentally, all the CHVs belong to the Low Caste group and this factor increases their accessibility for the Low Caste group (Table 5.12). Further, three out of four CHVs are working as agricultural labourers and one in postal department in a nearby town. They are not available for most of the time. Their low social and economic status coupled with the low profile of their professional skills act as a barrier for utilization of their services. In the context of availability of various professional resources such as PHC, private practitioners etc., their presence and services in the community are not taken seriously.

When asked for the reason for preference for consulting CHV, it was reported generally that proximity was the predominant reason (80%). The other reasons mentioned in a small measure were free treatment (13.3%) and faith (6.7%). More or less similar was the extent of preference in caste and class groups also (see table 5.13 for details).

USE OF PRIVATE PRACTITIONERS :

It is found that a good majority of the respondents (88.5%) expressed some preference for private practitioners which include RMPs within the village, Private doctors outside the village and folk practitioners. Of these, 26.0 per cent indicated first, 41.0 per cent second and 21.5 per cent third preferences for private practitioners. There are some differences in the rank of preference indicated by various social groups. While the High Class group expressed first preference (45.6%) in greater proportion, followed closely by second preference (35.1%), the High Caste group indicated first and second preferences more or less in the same proportion (36.0%). On the other hand, in the Low Caste and the Low Class groups, second preference was indicated in greater proportion (41.0%). Thus, while the High Caste and High Class groups indicated mainly either first or second preference, the Low Caste and

Low Class groups indicated second preference largely. This is due to the affordability of the expensive treatment of private practitioners by the High Caste and the High Class groups (Table 5.14).

All the respondents were asked to mention the reasons for their preference for private practitioners. The reasons mentioned are (1) Not satisfied with treatment by other agencies/cures (2) Personal network (3) Family physician (4) Faith and (5) accessibility.

In general, majority of the respondents mentioned 'Not satisfied with other agencies/cures' as the main reason (55.4%). The other reasons were mentioned in a small measure (faith 19.2%, accessibility/proximity 15.3%, family physician 7.3%, and personal network 2.8%). There are some differences observed in the extent of preferences in different social groups, though the general trend is broadly reflected. The Low Caste (67.5%) and the Low Class (63.0%) groups indicated dissatisfaction with treatment from other agencies as the main reason for their preference for private practitioner in greater proportion than the High Caste (51.0%) and the High Class (41.8%) groups. Greater accessibility/proximity was reported in slightly greater frequency by the High Caste (19.0%) and High Class (21.8%)

groups than the Low Caste and Low Class groups (12.0%).

"Family Physician" was reported as one of the reasons by the High Caste (14.4%) and the High Class (18.2%) groups in greater proportion than the Low Class group (1.2%) while it was not reported at all by the Low Caste group (Table 5.15).

Among some of the households mostly belonging to the High Caste/High Class groups, the system of family physician is followed. The local RMPs pay personal visits to these families whenever any medical help is sought. For their services, they are generally paid annually either in cash or kind as per their convenience and tradition. One of the local RMP works on part-time in a panchayat dispensary in a nearby village (Vadisaleru) which is about 3 miles away. He established good rapport with the local rich High Caste families. These families seek medical treatment from him whenever required. In case the ailment is not cured by him, he will take the patient to a specialist in a nearby town and follow up his prescriptions and treatment at home carefully. Generally, his 'touch' is considered 'auspicious' and therefore, they repose great faith in him. Incidentally, one of the medical shops in the village is run by one of his sons. The system of 'family physician' is not practised by the Low Caste group as they cannot afford it. Besides, the caste factor also acts as a barrier. Since the

local RMPs belong to the caste Brahmins, they do not generally want to visit their families because of purity-pollution norms. Only in rare and exceptional circumstances, they may visit them. Further, the High Caste/Class households have greater accessibility to them than the Low Caste/Low Class households mostly. These two reasons together account for larger extent of preference next to dissatisfaction with other agencies among the High Caste (33.0%) and High Class (40.0%) groups than in the Low Caste (12.5%) and the Low Class (13.5%) groups (Table 5.15).

In order to understand the reasons as to why they consulted a private practitioner they were asked the following question :

"As you said, you consulted a private doctor for some (Give details) ailment? Why you did not consult primary health centre then? (Give actual illustration from morbidity schedule)".

The question was put to those who actually consulted a private practitioner on the basis of their morbidity record collected earlier. The reasons mentioned by the respondents were categorised into: (1) Limitations of resources and facilities of PHC (2) Accessibility (3) Poor image/dissatisfaction of services/personnel of PHC (4) Personal network (5) Better satisfaction.

Out of the 200 sample households, 52 (26%) did not utilise the services of private practitioners during the period under investigation. Those who utilised the services of private practitioners reported poor image/dissatisfaction of services/personnel of PHC as the major reason (54%). Better satisfaction (14.9%) and accessibility (14.9%) were the other main reasons. Limitations of resources and facilities (8.1%) and personal network (8.1%) were mentioned in a small measure. Thus, lack of resources/facilities coupled with poor service at PHC is the major reason for seeking the services of private practitioners in the community. More or less the same pattern is observed in all caste and class groups (Table 5.16). Thus, it is observed that lack of availability of good governmental resources locally is the main reason for seeking the services of private doctors which are expensive.

USE OF MEDICAL SHOP FOR CONSULTATION :

Nearly half (45.5%) of the respondents expressed no preference for medical shop for seeking medical care. Of those who expressed preference for medical shop, most of them reported (46.5%) first preference. Few respondents indicated second (7.5%) and third (0.5%) preferences. Small differences are observed in the preferences expressed by different caste and class groups. While majority of the Low Class group

respondents (63.5%) expressed preference for medical shop, few High Class group respondents expressed some preference (42%). In both the High Caste (48.0%) and the Low Caste (58.3%) groups, nearly majority of the respondents expressed NO preference. While half of the Low Class group respondents (53.0%) expressed first preference, only one third of the Low Caste group (33.3%) respondents expressed the same. Largely, it shows that Higher the class status, lesser the preference for medical shop and vice versa. On the other hand, the High Caste group has shown slightly greater preference (52.0%) than the Low Caste group (42.0%) (Table 5.17).

The reasons reported for their preference were (1) Accessibility (47.7%) (2) Less cost (38.5%), (3) Not satisfied with alternative agencies/cures (11.0%) and (4) others (2.8%). Accessibility (47.7%) was the main reason for preference followed closely by less cost (38.5%). More or less the same pattern was observed in caste and class groups also (Table 5.18).

RESORT FOR MINOR AILMENTS :

In order to understand the health behaviour, all the respondents were asked to report as to what they would like to do in case of minor ailments in the family. The reactions

were to consult either the local medical shop (63.5%), private practitioner (16.0%), home remedy (10.5%) and PHC (10.0%). Small differences were observed in the extent of resort for minor ailments in various social groups though the general trend was reflected largely. The Low Caste group (16.7%) and the Low Class group (14.6%) reported their desire to visit PHC in slightly larger measure than the High Caste (7.1%) and the High Class (3.5%) groups. On the other hand, the High Caste group (23.5%) and the High Class group (30.0%) desired to visit private practitioners in larger measure than the Low Caste (10.4%) and Low Class (7.3%) groups. The Low Class group (70.8%) desired to visit medical shop in greater measure than the Low Caste group (60.4%). Incidentally, the Low Class group reported their desire to visit medical shop in greater measure (70.8%) than any other group. Thus, medical shop is the main source of consultation for minor ailments in all caste and class groups. While medical shop as the main resource followed by PHC to some extent were the main resorts for minor ailments in the Low Caste and the Low Class groups, medical shop as the main resource followed by private practitioners were the resources for seeking medical care in the High Caste and the High Class groups (Table 5.19).

In general, it was observed that people start their shopping for cure with medical shop. Medical shop here is seen not only as a store for medicines, but also a place where advice/prescription can also be had freely. Sometimes, the medical shop keepers dispense of their expired medicines under the cover of prescription. Since visiting medical shop helps a person in avoiding standing in queue at PHC or paying dearly for the private practitioner, it has become the most popular source of health action (Table 5.19).

The following table (5.20) shows that of the first preferences for seeking treatment from various health resources it is seen that the High Caste, Low Caste and Low Class groups expressed their first preference for medical shop in greater proportion than for other sources of health care. Of all the groups the Low Class (53.1%) expressed greater preference than other groups for medical shop. The High Class showed, of all the groups, greater preference for private practitioners than any other group, though the High Caste group also expressed greater preference for private practitioner, but it comes next to medical shop only. The Low Caste and Low Class preferred PHC next to medical shop in greater measure than the other two groups. It is only the Low Caste group which showed greater preference for CHV than any other group. Thus, while the Low Class group sought services from medical shop largely, it is private practitioners in High Class group.

Table : 5.20

Extent of First Preference expressed for
various health sources in Caste and Class groups

| CASTE/CLASS GROUP | <u>SOURCE PREFERRED</u> | | | | TOTAL |
|----------------------|-------------------------|--------------|---------------|---------------|--------------|
| | PHC | CHV | PP | MED.SHOP | |
| High Caste | 16 (16.3%) | 3 (3.0%) | 35 (35.7%) | 44 (44.9%) | 98 (100%) |
| Low Caste | 13 (27.1%) | 9 (18.8%) | 10 (20.8%) | 16 (33.3%) | 48 (100%) |
| High Class | 9 (15.8%) | 1 (1.8%) | 26 (45.6%) | 21 (36.8%) | 57 (100%) |
| Low Class | 22 (22.9%) | 9 (9.4%) | 14 (14.6%) | 51 (53.1%) | 96 (100%) |

ITEMS OF MEDICINAL VALUE KEPT
BY THE SAMPLE HOUSEHOLDS :

In order to know the health consciousness among people, the respondents were asked to report the kind of items of medicinal value they keep generally for their ready use in case of necessity such as ointment, tablet/mixture, bandage/cotton thermometer, herbs, dettol/phenol, bleaching powder, tonics etc. Herbs (37.0%) and ointment (33.0%) were kept by about one-third of the respondents. About 1/6th of the respondents kept honey (17.5%) and tablets/mixtures (16.5%). Other items were kept by a very small percentage of respondents in general. The High

Caste and High Class groups kept herbs, ointments, honey, and tablets in greater measure than the Low Caste and Low Class groups. Of the High Caste and High Class groups, it is the High Class group which kept these items in a greater measure than the High Caste group (Table 5.21). In general, keeping these items reflects caste/class hierarchy : Higher the Caste/Class status, greater the number of households keeping them. Further, of the High Caste and High Class groups, it is the High Class group which kept these items in greater measure than the High Caste group. The following table (5.22) shows this trend.

Table : 5.22

Availability of selected items of medicinal value in Caste and Class group households

| Item | High Caste | Low Caste | High Class | Low Class | TOTAL |
|----------------------|------------|-----------|------------|-----------|-------|
| Herbs | 58.1% | 4.2% | 72.0% | 12.5% | 37.0% |
| Ointment | 46.0% | 14.6% | 59.6% | 16.6% | 33.0% |
| Honey | 27.5% | 2.1% | 38.6% | 3.1% | 17.5% |
| Tablets/ mixtures | 18.3% | 12.5% | 31.6% | 8.3% | 16.5% |

SAFE DRINKING WATER SOURCES

There are two ponds - one in the main village and the other in the hamlet - for drinking purpose. Some people drink either well water or tap water. Though there is safe drinking water supply system in the village, the tap water is used by very few households because they feel the water is tasteless. On the otherhand, pond water is largely used due to its good taste despite greater chances of its being contaminated. In the main village, there is a watchman appointed by the local panchayat board to guard the drinking water pond from its being polluted by animals and human beings. On the other hand, in the hamlet, there is no watchman and the drinking water pond is left to the mercy of people and animals alike. Since most of the influential and rich people and officials reside in the main village there is greater consciousness and vigilance in keeping the pond protected while the hamlet is neglected because of lack of a strong protest from the people.

The following table shows that about 3/4ths of the people use pond water for drinking purpose, while 17.5 per cent and 8.0 per cent people drink tap and well water respectively in general. The Low Caste group use pond water

in greater measure (93.7%) than other groups (High Caste 67.3% , High Class 66.7 per cent and Low Class 77.1%). About 1/4th of the respondents in the High Caste and the High Class groups use tap water while the Low Caste group (2.1%) and the Low Class group (13.5%) use it in a small measure. (see also table 5.23 A in the appendix)

Table : 5.23

Use of water sources for drinking
among Caste and Class groups

| Type of source | High Caste | Low Caste | High Class | Low Class | TOTAL |
|----------------|---------------|---------------|---------------|---------------|----------------|
| Well | 10 (10.2%) | 2 (4.2%) | 4 (7.0%) | 9 (9.4%) | 16 (8.0%) |
| Tap | 22 (22.4%) | 1 (2.1%) | 15 (26.3%) | 13 (13.5%) | 35 (17.5%) |
| Pond | 66 (67.3%) | 45 (93.7%) | 38 (66.7%) | 74 (77.1%) | 149 (74.5%) |
| TOTAL | 98 (100%) | 48 (100%) | 57 (100%) | 96 (100%) | 200 (100%) |

SECTION II

DISCUSSION

In the previous section, the influence of social stratification in utilization of health resources available

to the community such as PHC, private practitioners, CHV, medical shop etc. and their preferences and reasons for their use have been presented. In this section, the relative influence of stratification variables on utilisation of health resources is discussed.

While some health resources/services were utilised more or less in equal measure, other resources/services were utilised in varying proportions by the Caste and Class groups. It is observed that family planning services of the local PHC were utilised by all caste and class groups in more or less the same measure. This is due to the wide promotional activities including incentives by the Government. / Further, there is greater awareness among people about the value of having a small family for their happiness and over all prosperity. Lately, the high premium placed generally in having a son is played down considerably. People have now realised the need of bringing up their children as useful citizens whether they be males or females. Though, the dowry for females is a big problem among the High Caste group, it was found that people prefer to adopt permanent methods of family planning even if they have girls in the first two issues without taking any further chance for the sake of getting a boy.

In utilisation of other resources it was found that either a particular caste/class group utilised a particular health resource/service more frequently than the other and vice versa. The High Caste group used the following in greater measure than the Low Caste group: (1) visit to private doctors (2) consulted folk healers (3) expressed more favourably about the services of PHC and (4) kept items of medicinal value in house. On the other hand, the Low Caste group utilised the following in greater measure: (1) visited PHC (2) visited CHV (3) used maternal care, delivery and immunization services of local PHC (4) visited by ANM and MPW more frequently (5) kept items of medicinal value such as tonic, tablets etc. in house in a small measure and (6) depended on pond water more.

Similarly, the High Class group utilised the following to a greater extent than the Low Class group: (1) visited private doctors (2) visited RMP (3) visited folk healers (4) visited by ANM and MPW (5) kept items of medicinal value in a larger measure. On the other hand, the Low Class group utilised the following more frequently: (1) visited PHC (2) visited CHV (3) used maternal care, delivery and immunization services of local PHC more (4) resorted to medical shop for minor ailments. (5) depended on pond water.

It was observed that there is differential use of health agencies and resources by the High Caste and Class and Low Class groups. On comparison between the High Caste group and the High Class group , it was observed that :

1. The High Class group visited private doctors and RMPs more often than the High Caste group.
2. The High Class group had a more favourable image of the kind and extent of experience about the services of PHC than the High Caste group.
3. While the High Class group expressed first preference for private practitioners, the High Caste group expressed second preference as is the case with other groups also.

Similarly, on comparison between the Low Caste and the Low Class groups, it was observed that :

1. The Low Caste group utilised the services of CHV more than the Low Class.
2. The Low Caste group utilised the local PHC more than the Low Class group in general and in particular the maternal care and immunization services of PHC.

3. Free treatment was reported as the main reason for consulting PHC in greater measure by the Low Class group than the Low Caste group.
4. ANM and MPW visited the Low Caste group more frequently than the Low Class group.
5. The Low Class group expressed first preference for medical shop in greater measure than the Low Caste group or for that matter any other group.
6. For minor ailments, the Low Class group visited medical shop in greater measure than the Low Caste group.
7. The Low Caste group used pond water more than the Low Class group.

It is also found that some services/resources were utilised by the High Caste and High Class groups more or less in the same measure. Similar is the case with the Low Caste and Low Class groups also.

The High Caste and the High Class groups utilised the following more or less in the same measure :

1. Visited PHC and folk-healers during the period under study.
2. Utilised services of PHC such as maternal care, delivery, immunization, family planning, hospitalization etc.

3. MPW visited both groups more or less in the same measure.
4. Used water resources more or less in the same measure.

Similarly, the Low Caste and the Low Class groups utilised the following more or less in the same measure :

1. Visited PHC, RMP and folk healers during the period under study.
2. Both the groups had more or less the same extent and kind of experience of PHC.

After having noted various patterns of utilization of various health resources/services by different caste and class groups the following observations were made in general.

On the whole, while the High Class and High Caste groups utilised services of private doctors, local RMP and folk healers more than the Low Caste and Low Class groups, the Low Caste and Low Class groups used services of PHC and CHV more often than the High Caste and High Class groups.

Since inception of PHC in the village, the Low Caste and Low Class groups utilised its services in greater measure than the High Caste and High Class groups.

The Low Caste group utilised the services of PHC (followed closely by Low Class group) such as maternal care, delivery, immunization, family planning etc. more than High Caste and High Class groups. It may be mentioned here that the High Class group and High Caste group utilised the services of PHC more or less in the same proportion.

While nearly half of the High Caste and High Class group households did not express any preference for PHC, it is only about 25.0 per cent in the Low Caste and Low Class groups.

While dissatisfaction with other agencies is the main reason for both High Caste and Low Caste groups for preference for PHC, it is free treatment with both High and Low Class groups.

Though 'service free of cost,' is the main reason in all caste and class groups for consulting PHC there is greater differential in class groups, (High class 40%, Low Class 70%) while it is more or less the same in caste group.

ANM visited the Low Caste group in greater measure than any other group. In class groups, she visited the High Class group more frequently (next to Low Caste group) than Low Class group.

Like ANM, MPW also visited the Low Caste group more frequently than any other group.

Only the Low Caste group expressed preference for consulting CHV in greater measure (23.0%) than other groups. Proximity is the main reason for consulting CHV in Low Caste and Low Class groups.

Though second preference is expressed in greater measure in Low Caste and Low Class groups, first preference is expressed in greater measure in High Class group for consulting private practitioners. In High Caste group, both first and second preferences are more or less of the same order.

The Low Caste and Low Class groups expressed "dissatisfaction with treatment by other agencies/cures" as the main reason for consulting private practitioners in greater frequency than the High Caste and High Class groups. The system of "family physician" is patronised largely by High

Class and High Caste groups only. Accessibility contributes to a larger extent in consulting private practitioner in the High Caste and High Class groups more than the Low Caste and Low Class groups. Poor image, and dissatisfaction with services of PHC are the main reasons for consulting private practitioners in all caste and class groups.

Of those who expressed preference for medical shop most of them gave first preference. By and large, the Low Class group expressed greater preference for medical shops than any other group.

While accessibility followed by less cost are the main reasons for consulting PHC in all caste and class groups, dissatisfaction with other sources/cures counts slightly more in Low Caste and Low Class groups than in High Caste and High Class groups.

Though medical shop is the main resort for minor ailments in all caste and class groups, PHC is the next main resort in the Low Caste and Low Class groups while it is private practitioners in the High Caste and High Class groups.

In, general, the High Caste and High Class groups kept items of medicinal value such as honey, ointment, tablets, tonics, herbs, thermometer etc. in greater measure than the Low Class and Low Caste groups. Of the High Caste and High Class groups it is the High Class group which kept them in a greater measure than the High Caste group. There is not much difference observed in the Low Caste and Low Class groups.

The Low Caste group used pond water more than any other caste/class group. Tap is used by the High Class group in greater measure than any other group.

By and large, it is observed that both the High Class and High Caste groups utilised the services of private doctors (in nearby towns), local RMPs, folkhealers more often than the Low Caste and Low Class groups. On the other hand, the Low Caste and Low Class groups utilised the services of PHC, AM, MPW in greater measure. ANM and MPW visited more frequently the Low Caste group than any other group due to their belonging to the same social group and better accessibility. The Low Caste group utilised services of PHC in greater measure than Low Class group. While the cost factor is the main reason for Low Class group for

visiting PHC, factors such as dissatisfaction with other agencies/cures, limitations of some kind etc. are the main reasons (alongwith cost factor) for consulting PHC in Low Caste group. For all minor ailments, majority in all social groups consulted medical shop followed by private practioners in High Caste and High Class groups and PHC in Low Caste and Low Class groups. The High Caste and High Class groups kept items of medicinal value in larger measure than the Low Caste and Low Class groups. Though pond water is ued for drinking purposes by the majority in all social groups, other resources such as tap, well were utilised in a small measure. While Low Caste group largely used pond, High Class group used it to a lesser extent in comparison to other groups. Thus, while the Low Caste and Low Class groups largely relied on inexpensive and local health resources, the High Caste and High Class groups, more so the High Class group, relied on private practitioners, local RMPs more which are expensive. The system of 'family physician' and the 'caste' factor (RMPs belong to High Caste group) weigh favourably in favour of High Caste and High Class groups in utilising the services of RMPs. In a way, the High Caste and High Class groups used private health resources more than Governmental health resources such as PHC, MPW, ANM etc, while the Low Caste

and Low Class groups depended on Governmental health resources. Though the Low Caste and Low Class groups do not have favourable opinion about the services of the Government health resources due to their poor services, they have no better option in view of their low social and economic status in the community. If the Governmental resources have to cater to the needy and the poor, the orientation of personnel and the efficiency of services need to be improved greatly.

HEALTH PRACTICES AND
SOCIAL STRATIFICATION

Chapter 6HEALTH PRACTICES AND
SOCIAL STRATIFICATION

Health is highly valued in all cultures. In order to maintain good health, every culture has prescribed certain practices, norms, values etc. for its members and proscribed those which are believed to be injurious to health. Since culture is all pervasive, every member of the society is expected to follow certain practices regularly in order to enjoy a healthy life. In the light of modern medical knowledge, these practices may be helpful, harmful or neutral for the health of an individual. Similarly, the social structure determines the position and status of its different sections and members resulting in manifestation of varying patterns of health behaviour due to differences in living conditions and group differences in cultural perceptions and life style. Thus, the culture and social structure of a community regulates the varying patterns in which health practices are observed at large. There can be purely individual variations due to one's own choice.

The observance of health practices differs from one stratum to another depending upon the degree of conformity to the norms. Some health practices are observed by most of

the members of the community cross cutting all sections while some are practised mostly by a section(s) of the rural community. This partly depends upon the fitness or congruence between the routine life situations of the different sections of rural community and the given patterns of health practices.

In this chapter, observance of different health practices among the different social groups is discussed. Broadly, three types of health practices are examined (1) practices related to personal hygiene, drinking and smoking (2) practices related to maternal and child care, and (3) food practices. Under personal hygiene care of teeth, body and hair are presented. Under maternal and child care, actions related to diet, work during pregnancy and after childbirth, prenatal check up, weaning, etc. are described. Under food practices the intake of various food items is discussed.

The heads of the family in the sample households were interviewed to collect data on personal hygiene. For maternal and child care and food practices the wife of head of the household or any elderly female member in the sample households were interviewed.

This chapter is divided into two sections - the first section presents differential distribution of health practices in different caste/class groups. The second section on "Discussion" briefly examines the implications of the observed similarities and differences.

SECTION - 1

HEALTH PRACTICES

PERSONAL HYGIENE

Personal hygiene deals with the maintenance and promotion of individual health, both mental and physical, and involves him/her into certain practices which enable him/her to lead a healthy life. This forms the baseline for community hygiene.

Use of Twig, Tooth powder and Tooth paste

All the respondents were asked as to what material they regularly use for cleaning their teeth. It is found that majority of the members (84 per cent) use twig regularly. In rural areas, due to the availability of a large number of plants of different species in abundance, people mostly resort to plucking of small branches and use them for brushing their

teeth. It is not only convenient but also economical for them. In terms of its use by different social groups, small differences are, however, observed. The Low Caste group resorted to its use slightly more (89.5 per cent) than the High Caste group (77.5 per cent). On the other hand, among the class groups, the Low Class group used twig more often (93.7 per cent) than the High Class (75.4 per cent) group. By and large the class differential is slightly more than the caste differential indicating the negative trend of its greater use by the Low Caste and Low Class groups.

Other materials such as tooth powder and tooth paste are reported to be used by a small number (16 per cent) of respondents. While 6.5 per cent of the respondents reported the use of tooth powder, 9.5 per cent of the respondents reported use of tooth paste. As regards the use of tooth powder by different social groups, not much difference is observed. However, with regard to the use of tooth paste, some difference which is of interest is noted. Compared to the use of tooth paste by the Low Caste group (6.3 per cent) the High Caste group used it slightly more (14.3 per cent). On the other hand, among class groups the differential is much sharper. While only 2.1 per cent of the respondents of the Low Class group reported the use of tooth paste, 21.1 per cent of the High Class group respondents reported its use.

In general, there is a clear trend of greater use of tooth paste by the High Caste and High Class groups than the Low Caste and Low Class groups. The differential is sharper in class groups than in caste groups.

It is observed that while the Low Caste/Low Class groups are associated with greater use of twig, the High Caste and High Class groups are associated with greater use of tooth paste in addition to the use of twig. (Table 6.1 and Fig. 6.1) If use of tooth paste is considered a progressive change in health behaviour, then class status/membership plays greater role in this change than caste membership/status.

Body bath/Head bath

In order to understand the keenness shown in maintaining the cleanliness of the body, all the respondents were asked as to what type of bath they take regularly - the head bath or body bath. According to customary usage in study area, body bath is referred to the one in which an individual takes bath without pouring water on the head. For head bath, one pours down water on his or her head and cleans the entire body. It is observed that majority (93 per cent) of the respondents resort to body bath and only a small number (7 per cent) take head bath. This pattern is more or less found in all the caste and class groups (Table 6.2).

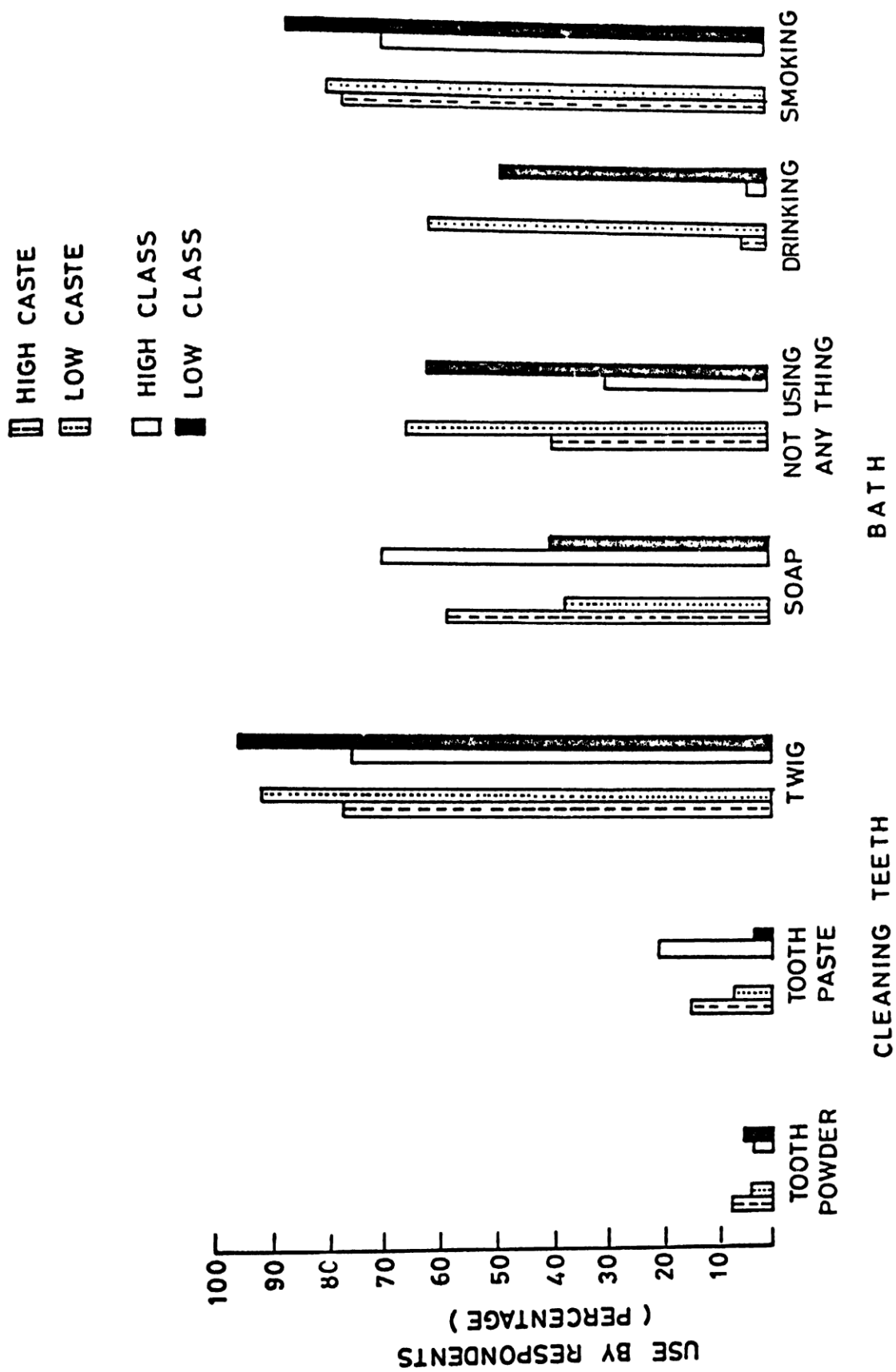


FIG. 6.1 USE OF MATERIALS FOR CLEANING TEETH, BATHING AND HABITS OF DRINKING AND SMOKING IN CASTE AND CLASS GROUPS.

The respondents were further asked to report as to how regularly they take head bath - once in 2 days, once a week, once a fortnight, once a month and rarely. It is observed that majority of the respondents (54 per cent) reported taking head bath once in a week, followed by once a fortnight (18.5 per cent), once in a month (14.5 per cent) rarely (7.5 per cent). Only 5.5 per cent respondents reported head bath once in 2 days. However, there are notable difference in the frequency of observing this practice among the different social groups. While 62.2 per cent of the respondents belonging to the High Caste group took head bath once a week, only 31.2 per cent of the Low Caste group respondents resorted to this practice. Similarly, while 68.4 per cent of the High Class group respondents reported observance of this practice once a week, only 41.7 per cent of the Low Class group respondents observed this practice. It is interesting to observe that both the Low Caste and Low Class groups reported taking head bath less frequently, while both the High Caste and High Class groups resort to headbath far more frequently than the Low Caste and Low Class groups. This can be attributed partly to the greater consciousness of personal hygiene among the High Caste and High Class groups which is, to a certain extent, related to the observance of purity - pollution norms, rituals, and their daily routine (Table 6.3).

It was also observed that most of the adults working in fields take bath on their return from work in the evening. Those who are engaged in other occupations such as supervision of agricultural farms, business, governmental service, etc. take bath in the morning.

Material used for bathing

The respondents were asked to report the material they use commonly for bathing. It is interesting to note that only about half (51.5 per cent) of the respondents used soap. Only a negligible proportion of the respondents (1.5 per cent) reported using indigenous soap nut (Kunkudu kaya). Nearly half (47 per cent) of them are not using anything.

There are significant differences in use of soap among various social groups. While majority of the High Caste group respondents (58.2 per cent) reported use of soap, only 35.4 per cent of the Low Caste group respondents used soap. Similarly, while 70.2 per cent of the respondents belonging to the High Class group reported use of soap, only 38.5 per cent of the Low Class group respondents used soap. In contrast to this, majority of the Low Caste and the Low Class (about 62 per cent) group respondents have not used any material for cleaning their body while bathing. They simply pour water on

their body and rub it with their hands or may use coconut fibre sometimes. Thus, there is a clear trend of greater use of soap both by the High Caste and the High Class groups. It is further observed that the High Class group resorted to the greater use of soap (70.2 per cent) than the High Caste (58.2 per cent) group. On the other hand, about 2/3rds of both the Low Caste and the Low Class groups are not using any thing to clean their body while bathing. This itself indicates greater concern for bodily cleanliness among the High Caste and High Class groups than among the Low Caste and the Low Class groups (Table 6.4 and Fig. 6.1). Since class differences are notably larger than caste differences these practices appear to partly depend upon affordability and higher socio-economic status in addition to health consciousness and traditional concern for purity or personal hygiene.

Use of Hair Oil :

It is popularly believed that applying oil daily to one's hair keeps the head cool besides giving him/her a presentable appearance. The respondents were asked as to how regularly they apply oil to their hair (daily, once

in 2 days, once in a week, twice a week and rarely). In general, it is observed that a small proportion of respondents (16.5 per cent) apply oil to their hair daily. Most of them apply oil to their hair once in 2 days (44 per cent) or twice a week (20 per cent), followed by once a week (15 per cent) and rarely (4.5 per cent) (Table 6.5).

There are marked differences in regularity of this practice among the different caste and class groups. As the following table suggests (Table 6.6) while 71.4 per cent of the respondents in the High Caste group reported applying oil to their hair regularly (either daily or once in 2 days) only 39.5 per cent of the respondents in the Low Caste group reported so. Most of the respondents from the Low Caste group are irregular in this practice. Similar difference is observed in class groups also. While in the High Class group, 86 per cent reported applying oil to their hair regularly, in the Low Class group only 40.6 per cent of the respondents reported so. When comparing Caste and class groups, it is significant to note that although among the High Class group 86 per cent reported regular use of hair oil, while among the High Caste group only 71.4 per cent reported so. No such Caste-Class

difference among the Lower Caste/Class group is observed. In case of practices like using hair oil or combing, affordability is less important while concern for one's appearance in fitness with one's class status is more important. Such concern for appearance is perhaps itself a class related behaviour. In absence of such concern among the Low Class group we do not observe any caste-class difference.

Table 6.6

Regular and Irregular Practice of
Oiling Hair in Caste and Class groups

| Frequency of applying oil to hair | High Caste N = 98 | Low Caste N=48 | High Class N=57 | Low Class N=96 | TOTAL |
|---|-------------------------|----------------------|-----------------------|----------------------|-------|
| Regular | 71.4% | 39.6% | 86% | 40.6% | 60.5% |
| Irregular | 28.6% | 60.4% | 14% | 59.4% | 39.5% |
| TOTAL | 100% | 100% | 100% | 100% | 100% |

DRINKING :

Drinking is a social evil widely prevalent in rural areas. This habit not only drains off sizeable portion of their income but also affects the health of the individual

to the extent of incapacitating him either for a shorter period or for a longer duration depending upon the quantity and the frequency of liquor consumed. This in turn has a severe impact on the consumption pattern in the household sometimes leading to deprivation of essential items such as food, medicines etc. to the members in the family.

About one-fourth (24.5%) of the respondents in general reported that they drink. While only 3.1 per cent of the respondents belonging to the High Caste group reported having drinking habit, 58.3 per cent of the Low Caste group respondents reported this habit. Similar pattern is observed in class groups (High Class group 1.8 per cent and Low Class group 45.8 per cent). In other words, out of those who reported drinking habit, most of them belong to the Low Caste, Low Class groups. (Table. 6.7 and Fig. 6.1) It is possible that more respondents than the reported number are having this habit but did not actually report it due to the fear of getting them bracketed as drunkards.

To understand the extent of drinking habit prevailing in various social groups, the respondents using liquor were asked to report the frequency of their consumption of liquor--regularly (more than thrice a week), frequently (thrice or less than thrice a week) or occasionally (twice or once a month)

Among the Low Caste about 20 per cent admitted drinking regularly, 40 per cent frequently, while 40 per cent occasionally. In all, about 60 per cent of the drinkers in the Low Caste group drink liquor regularly or frequently while only 3 per cent of the drinkers in the High Caste group drink liquor regularly or frequently. When it comes to Low Class group, about 68 per cent admitted drinking liquor frequently or regularly. This suggests that regular drinking habit is admitted more in the Low Class group than in the Low Caste group. Drinking liquor is considered bad in the High Caste and any one indulging in this habit is looked down upon by the community (Table 6.8).

The type of liquor (Sara or toddy) one consumes depends upon one's affordability and taste. There are few shops in the village which sell both sara and toddy. A large number of palmyra trees are available around the region for tapping toddy. Incidentally, Settibaljis (toddy - tappers) are the most populous group next to the Kammas, (the dominant caste of the village). Their main occupation is to tap toddy from palmyra trees and sell it in the market. They also engage in other occupations such as agricultural labour, construction work, etc.

All the drinkers were asked to report the type of drink they prefer. In general, about half (51 per cent) of the drinkers prefer toddy, 28.6 percent sara and 18.4 per cent like both sara and toddy. Only 2.2 per cent take other types . of drink. Majority of the drinkers in the Low Caste group (60.7 per cent) reported drinking toddy. Only about 18 per cent of the Low Caste drinkers reported taking Sara only while nearly 20 per cent reported taking both of them. Similar pattern is observed in class groups also.

It is found that there are some provision shops in the village which sell whisky, rum, etc., stealthily at a premium for the rich and influential persons in the village. Being the head quarters of Mandal (Taluk), this village has a number of government offices. The officials and the rich usually patronise these brands.

As regards the quantity of liquor consumed, it is found that majority (53 per cent) of the drinkers usually take one unit only (Dokku). About 26.5 per cent take 2-3 units while 20.5 per cent take more than 3 units. This pattern is more or less the same among the Low Caste and the Low Class groups.

SMOKING :

Smoking is a very common habit among people in this village. Incidentally, tobacco is grown in this village and

in some villages around as a cash crop. There is no taboo associated with smoking as in case of drinking. About 78 per cent of the respondents reported smoking regularly. In both the High Caste and the Low Caste groups smoking is prevalent equally (about 75 per cent). Smoking is more prevalent among Low Class group respondents (84 per cent) than the High Class group respondents (70 per cent) (TABLE 6.7)

The extent of smoking further depends upon the number of cigars smoked per day usually. To understand this, all the smokers were asked to report the number of cigars they smoke generally per day. It is found that half of them smoke three to five cigars a day, followed by more than 5 (27 per cent), 2 cigars (15.5 per cent) and one cigar (7.7 per cent). About 81 per cent of the smokers in High Caste group, smoke 3 or more cigars daily while only 70 per cent of the smokers in the Low Caste group do so. On the other hand, about 85 per cent of the smokers in the High Class group smoked 3 or more cigars daily. This is partly because of the affordability by the High Caste and High Class groups (Table 6.9)

In the Low Caste and Low Class groups, smoking by females and children is a common practice and they also smoke one or two cigars a day. On the other hand, smoking by females in the High Caste and High Class groups is a taboo and is looked down

upon. To understand the extent of smoking by females, all the respondents were asked to report whether any female member(s) in their household smoke. In general 21.5 per cent of respondents informed that female member(s) in their household do smoke. Both the High Caste and High Class group respondents replied in the negative. On the other hand 52 per cent of respondents in the Low Caste group and 43 per cent in the Low Class group informed that their female members do smoke.

Some respondents reported smoking cigarettes but their number is very small.

In this area there is a practice of smoking in which the smoker keeps the burning end of a cigar inside the mouth and this is locally known as 'Addapoga'. This is considered carcinogenic. 23 per cent of smokers resorted to Addapoga. The following table (6.10) shows that in both caste groups, about 20 per cent of smokers observed this practice. But in class groups, it is different. In the High Class group, only 8 per cent of the smokers reported using Addapoga, while in the Low Class group it is four times higher (32 per cent). On the whole, larger number of respondents in the Low Class (32 per cent) reported smoking Addapoga than any other group while a small number of respondents in the High Class (8 per cent) reported so. Thus, in observance of addapoga, the class differential is greater while the differential in caste

groups is negligible (see also Table 6.10 A in appendix).

It is observed that most females who smoke resort to "addapoga" in greater frequency than the males.

Table : 6.10

Pattern of smoking in Caste & Class groups

| Pattern of Smoking | High Caste N=98 | Low Caste N=47 | High Class N=57 | Low Class N=96 | TOTAL N=200 |
|--|--------------------|-------------------|--------------------|-------------------|----------------|
| Burning end outside the mouth | 59 (80.8%) | 29 (78.4%) | 36 (92.3%) | 55 (67.9%) | 120 (77.4%) |
| Burning end inside the mouth (Addapoga) | 14 (19.2%) | 8 (21.6%) | 3 (7.7%) | 26 (32.1%) | 35 (22.6%) |
| TOTAL | 73 (100%) | 37 (100%) | 39 (100%) | 81 (100%) | 155 (100%) |

MATERNAL AND CHILD CARE PRACTICES :

MATERNAL CARE :

Maternal care is an important aspect of health care given to the expectant women in order to help them maintain good health both before and after delivery. It was aimed at facilitating delivery of a healthy baby and help the mother maintain good health.

Some of the health practices taken into account under maternal care are : Special diet given to women before delivery and after delivery, period of working outside the home say in fields by pregnant women and the period after delivery at which work outside the home is resumed and prenatal check-up. For maternal care, only those women (wife of head of a household) who have a child /children were interviewed. Out of the 200 sample households, only 190 women fulfilled the above criterion and the remaining 10 did not have any children. Of these ten, five belong to the High Caste group, one to the Middle Caste group and four to the Low Caste group. In terms of their distribution among class groups, two belong to the High Class group, three to the Middle Class group and five to the Low Class group.

Special care is taken normally in providing diet in the form of certain special items of food preparations, fruits, sweets etc. This depends upon the extent of consciousness in the family and its ability to provide them to the expectant women.

There is a differential pattern of observance of maternal care practices. In providing special diet before delivery, only 27.4 per cent of the households in the sample reported

observance of the practice. In other words, about 73 per cent of the households were not keen in providing special diet before delivery. While nearly 40 per cent of the households in the High Caste group reported providing special diet before delivery, it is only about 20 per cent of households in the Low Caste group observed this practice. On the other hand, the picture is still glaring in class groups. While majority of the households (55 per cent) in the High Class group provided special diet before delivery, it is only just 11 per cent of households in Low Class group (1/5th of the High Class group) which reported observance of this practice. The differential in class groups is sharper than in caste groups.

The picture is different when it comes to providing special diet after delivery. In general, nearly half (48.4 per cent) of the households in the sample observed this practice.

In the High Caste group, while nearly 60 per cent of the households reported observance of this practice, only 23 per cent of households in the Low Caste group followed this practice. Among class groups, while in the High Class group, about 60 per cent of the households reported observance of

this practice only about 35 per cent of households in the Low Class group followed this practice. The differential in caste groups is sharper than in class groups.

In general, it is observed that there is less consciousness in providing special diet before delivery than after delivery. Out of all social groups, only in the High Class group, majority of the households provided special diet both before and after delivery. In the Low Class group, while only 11 per cent of the households provided special diet before delivery. 34 per cent of households provided special diet after delivery. But in the Low Caste group only about 20 per cent of households provided special diet both before and after delivery. The Low Class group took greater care in providing special diet after delivery than before delivery while the Low Caste group showed the same extent of concern both before and after delivery. The High Caste group showed greater concern in providing special diet after delivery than before delivery (Table 6.11 and Fig. 6.2).

Period of Working outside home
before and after delivery :

Some women were engaged in agricultural labour, construction work etc. During pregnancy, women are permitted to work only upto a certain period so that they can maintain good health to facilitate an easy delivery. Out of those who are interviewed (190) only 61 women (32.1 per cent) reported

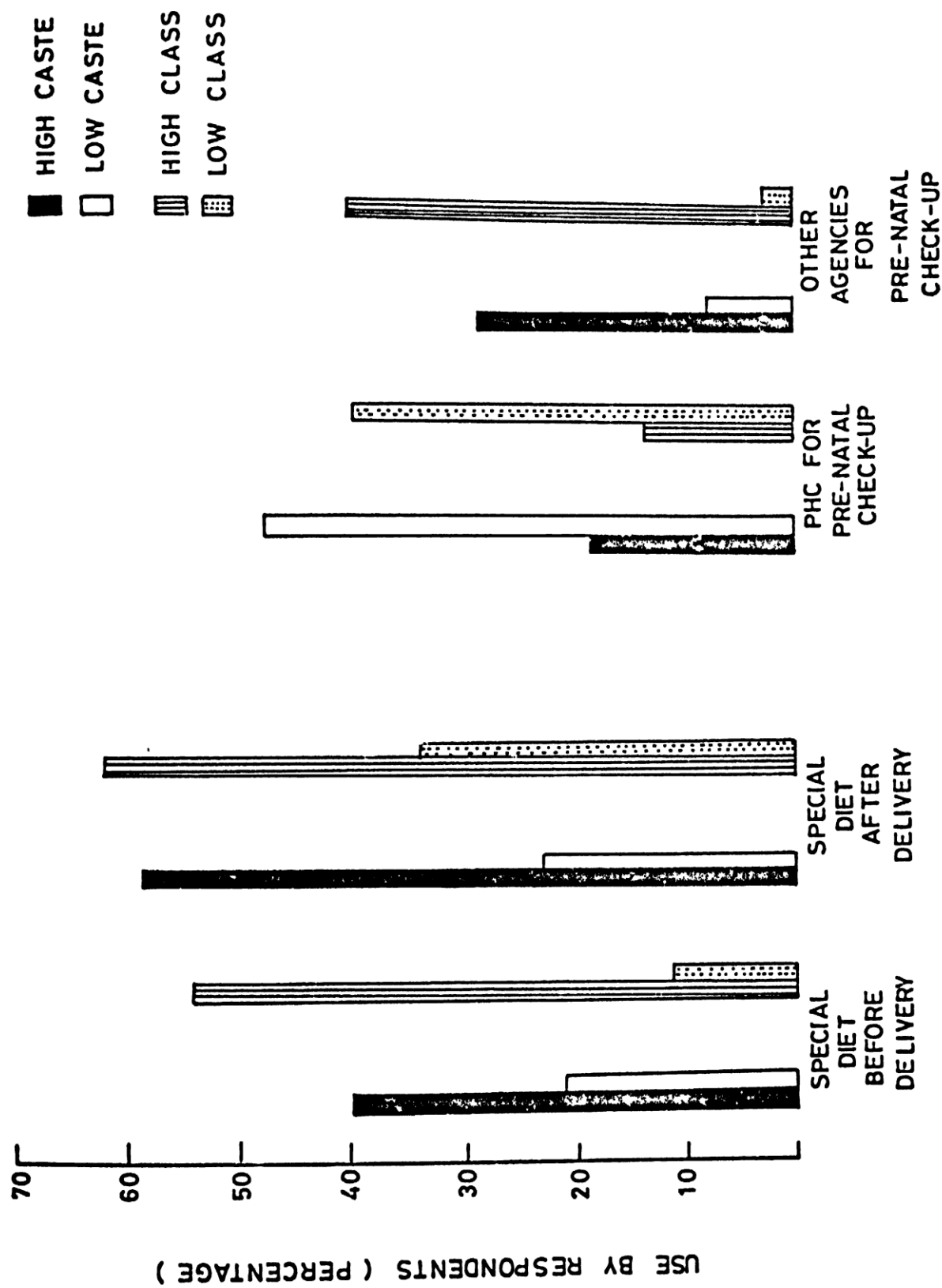


FIG. 6-2 USE OF SPECIAL DIET BEFORE AND AFTER DELIVERY, PHC AND OTHER AGENCIES FOR PRE-NATAL CHECK-UP IN CASTE AND CLASS GROUPS.

working in fields, construction work etc. Most of them belong to the Low Caste group. While in Low Caste group, 84.1 per cent of women were engaged in agricultural labour, construction work etc. outside their home, only 2.2 per cent of women in High Caste group were engaged in these activities. On the other hand, in High Class group no woman reported working outside the home. In contrast to this, 60.5 per cent of the women in the Low Class group reported engaged in these activities. Thus, we find that while no woman in the High Class group was engaged in work outside the home, nearly 84 per cent of the women in the Low Caste group were engaged in agricultural labour, construction work etc (Table 6.12).

Out of the pregnant women who worked outside their home 75.4 per cent worked till 7-9 months of their pregnancy followed by 23 per cent upto 4-6 months, and 1.6 per cent upto three months. Both in the Low Caste group (70.3 per cent) and in the Low Class group (76.4 per cent) majority of the women worked till 7-9 months of their pregnancy (Table 6.13).

To understand the pattern of resumption of work outside the home after delivery all the mothers who reported working during their pregnancy were asked to indicate the period when they resumed their work. In general, about 40 per cent of

mothers reported resumption of work within three months of their delivery followed by 21.3 per cent in 4-6 months, 11.5 per cent in 7-9 months and 27.9 per cent after 10 months of delivery. This pattern is found both in the Low Caste and the Low Class groups (Table 6.14).

It is observed that women in the High Caste group are not allowed to work in fields or in any other activity other than household work as it is firmly believed that indulgence in any such activity will invite stigma and disrepute to the family. Eventhough one is very poor and the need to earn money by way of working outside the home is felt, one is hesitant to allow their females to do so because of the ridicule likely to be received from their caste people. It is found that only in rare circumstances, women are allowed to work and that too, in the fields/houses of very close relatives so that there will be less criticism from their caste people.

In addition, the tradition in the dominant High Caste group in this village (Kamma) also plays a significant role in the work pattern. In this caste the females generally own some amount of land given in the form of dowry at the time of marriage by their parents. This land is cultivated by their husbands or any other member in the family along

with the family's own share of land. He had to give her the money collected by selling the produce obtained from her share of the crop. She has exclusive right to spend this money the way she desires. Hence, the females in the High Caste group are having some source of getting money and therefore, they do not feel any need to go outside the home for work. Besides, the management of keeping buffaloes/cows and selling milk and milk products is largely done by females in the house. The proceeds of the sale of milk or milk products are generally kept by the females themselves. Thus, the economic independence coupled with the tradition in the group keeps the females in the High Caste engaged in household work mostly. (Out of the 98 . . households belonging to High Caste Group, 83 belonged to Caste Kamma alone and the rest to Brahmin, Vysya and Kapu castes). Even in these castes, there is a strict observance of not allowing the females to work outside their home despite one's very poor economic position.

It is further enquired from well informed members of the dominant High Caste (Kamma) whether this pattern is found in all parts of the state. It is reported that females in their caste in other parts of the state - Krishna and Guntur districts especially - work as hard as males in the management of their

agricultural fields. The males in their caste are, therefore, left with enough time to engage themselves in other more rewarding occupations such as business, industry etc. However, the dominant High Caste people in this village consider them low in social status in view of their women being engaged in participation of work outside the home. As a result, they do not generally enter into any matrimonial alliance with them.

Prenatal check-up

Pre-natal check up for pregnant women is necessary for maintenance of good health of both the mother and the baby. In general, nearly half of the pregnant women (52.6 per cent) reported to have no check up during their pregnancy (Table 6.15 and Fig. 6.2). Those women who had a prenatal check up consulted either the local PHC or other agencies such as private doctors, private maternity homes in towns etc. The analysis of the pattern of consultation of these health resources by the pregnant women show interesting results. In general, majority of them (66.7 per cent) visited PHC and the rest consulted other resources for pre-natal check up. However, there are significant differences in use of these health resources in caste and class groups. While in the High Caste group only 38.6 per cent of pregnant women had a prenatal check up at PHC, 87.5 per cent of pregnant women in

the Low Caste group had prenatal check-up at this health resource. In contrast to this, while only 12.5 per cent of pregnant women had prenatal check up at other agencies in the Low Caste group, 61.4 per cent of pregnant women in the High Caste had pre-natal check-up at other sources. Similar pattern is observed in class groups also. It is significant to note that while 76 per cent of pregnant women in the High Class group visited other agencies, only 5.3 per cent pregnant women in the Low Class group visited these agencies for prenatal check up. On the contrary, while about 95 per cent of the pregnant women in the Low Class group consulted PHC for prenatal check up, it is only 24.1 per cent in the High Class group. Thus, while the Low Caste and Low Class groups depended heavily on local PHC for pre-natal check up, the High Caste and High Class groups sought services from private agencies. The Low Class group (95 per cent) depended more on PHC than the Low Caste group (87 per cent). Similarly, the High Class group sought services from other agencies (76 per cent) in greater measure than the High Caste group (61 per cent). The wide differential in seeking services either from PHC or from other agencies in Caste and Class groups is due to one's economic position and their perception of services rendered in these agencies. The High Caste/High Class group women can not only afford the expensive medical care in private nursing homes

in nearby towns but also hold a 'not-so-favorable' image about the services rendered at local PHC. Absence of a lady doctor at PHC is also a factor in their seeking maternal care services outside the village. On the other hand, the Auxiliary Nurse Midwife (ANM) of local PHC belongs to the Low Caste group and this factor helps her to communicate better and to persuade the pregnant women of this group to seek services from PHC. In addition to this, lack of sufficient means to seek expensive care outside the village is another contributing factor that makes them visit PHC. Though some of them may also not have a favourable image about the services of PHC, they cannot help but to visit PHC due to their lack of sufficient means (Table 6.16).

CHILD CARE PRACTICES :

Under child care practices, weaning and age of the baby when solid foods were given were studied.

Early weaning practice reflects not only the health consciousness on the part of mothers but also the customs in the group. In general, nearly half (49.5 per cent) of the mothers started weaning when their babies reached the age of 9-12 months. About 20 per cent of mothers continued to breastfeed till their babies reached more than 2 years. About 14.2 per cent mothers weaned their babies between the age of 1 to 1½ years and about 12 per cent between the age of 1½ to 2 years.

There are significant differences in observance of weaning in different caste and class groups. While nearly 60 per cent of mothers in the High Caste group weaned their babies on their reaching 9-12 months, only 18.1 per cent mothers in the Low Caste group observed this practice. On the other hand, 45.4 per cent of mothers in the Low Caste group weaned their babies when they reached more than 2 years. Among class groups, while 60 per cent mothers in the High Class group weaned their babies when they were in the age of 9-12 months, about 40 per cent of mothers in the Low Class group observed this practice at the same age. However, 35.2 per cent mothers in Low Class group weaned their babies when they are more than 2 years old, while only 1.8 per cent mothers practised this in the High Class group. On the whole, while majority of the High Caste and High Class group mothers practised weaning when their babies reached the age of 9-12 months most of the mothers in the Low Caste group (45.4 per cent) and the Low Class group (35.2 per cent) practised weaning when their babies were more than 2 years old. Of the Low Caste and Low Class groups, while 40 per cent of mothers in the Low Class group weaned their babies when they were in the age of 9-12 months only 18 per cent of mothers in the Low Caste group observed this practice. Thus, of all the caste and class groups, the Low Caste group practised weaning after a prolonged

period, that is after the age of 2 years of their babies. This itself reflects their lack of proper health consciousness and laxity in enforcing early weaning practice (Table 6.17).

As far as giving solid foods to babies is concerned it is observed that in general, 41.6 per cent of the mothers practised giving solid foods when their babies are 10-12 months old. More or less a similar percentage of mothers (39 per cent) gave solid foods to their babies below the age of 9 months. Thus, nearly 80 per cent of the mothers practised giving solid foods when their babies were below the age of 12 months. A small number of mothers (18.4 per cent) gave solid foods when their babies were more than one year old. This pattern is found more or less in all caste and class groups. However, in the Low Caste group, only 63.7 per cent of mothers gave solid foods when their babies were below the age of 12 months. In rest of the cases, they gave solid foods when their babies became more than 1 year old. Thus, in the Low Caste group, there is less consciousness in observance of accustoming the baby to solid foods early (Table 6.18).

As far as the use of baby foods such as Amul, Nespray etc. is concerned, very few mothers reported using them. Only 7 mothers out of 93 in the High Caste group and 1 mother out of

44 in the Low Caste group used them. Similarly only 6 out of 55 mothers in the High Class group used them. None of the mothers in the Low Class group reported using them (Table 6.11).

FOOD PRACTICES :

In order to estimate the calorie intake in different social groups, data were collected on consumption of food items such as rice, wheat, sugar(including jaggery), oil, pulses and non-vegetarian food items such as meat, fish, egg. etc. In each household, the lady of the household or any other female member involved in cooking in the household was asked as to how much of these items were required for a week for consumption in the family except rice for which daily requirement was estimated because of the convenience in recall. All members of the household belonging to different age groups and sex were converted into standard consumption units by using the table in the book "Nutritive Value of Indian Foods", National Institute of Nutrition, Hyderabad 1984. The following classification has been adopted in this study:

| | |
|--------------------------|-----------|
| Adult (Male) | 1.2 units |
| Adult (Female) | 0.9 units |
| Adolescents(12-21 years) | 1.0 units |
| Children below 12 yrs. | 0.6 units |

The quantity of different items of food consumed per day in the household was divided by the number of units in the household to obtain per unit per day consumption of the various items of food. By using the caloric value of foods (NIN, 1984) the items were converted into calories. For non-vegetarian food items, half of the total quantity of consumption is treated as fish and meat and the remaining half as egg since it was found difficult to obtain data precisely.

It was found difficult to obtain data on milk consumption precisely since most of the households in the poor sections of the community used milk and the milk products either irregularly or bought them for small amounts of money such as 25 NP, 50 NP etc. Similarly, data regarding the use of vegetables was also found difficult to obtain precisely.

The following table (6.19) shows that in general, each unit in the sample consumed 2241 calories per day. There is marginal differential consumption of calories per unit per day in different social groups. While the per unit per day in take of calories found highest in the High Class out of all social groups, it is the lowest in the Low Class group. Of the High Caste/High Class groups it is the High Class which is having slightly better calorie intake. The Low

Caste and Low Class groups are having more or less similar intake of calories per unit per day (Table 6.20 and 6.21).

Table : 6.19

Consumption of calories in Caste and Class Groups

| Itemwise calorie intake per unit per day in general | | Per unit consumption of calories per day in Caste and Class groups | |
|---|-------------|--|--------------------------------------|
| Item | Calories | Caste/Class | Average per unit consumption per day |
| Rice | 1797 | High Caste | 2287 |
| Wheat | 35 | Low Caste | 2225 |
| Pulses | 59 | High Class | 2381 |
| Oil | 187 | Low Class | 2217 |
| Suagar (Jaggery) | 119 | | |
| Egg. Fish, Meat | 44 | | |
| | <u>2241</u> | | |

Broadly, the Low Caste and Low Class groups have less consumption of calories (2217-2225) per day per unit than the High Caste and High Class groups (2281-2287). This indicates a broad trend of nutritional status in the Low Caste/Class and the High Caste/Class groups. Since all the items of nutrition

could not be taken into account due to methodological problems, the results could only indicate broadly the trends in nutritional status in different groups. It may largely be inferred that the Low Caste/Low Class groups have poorer nutritional status than the High Caste and High Class groups.

Table:6.22

Consumption of calories per day per Unit from
Rice and other items in Caste and Class groups

| Item | CALORIES | | | | TOTAL |
|-------|-----------------|-----------------|-----------------|-----------------|-----------------|
| | High Caste | Low Caste | High Class | Low Class | |
| Rice | 1756 (76.8%) | 1899 (85.3%) | 1775 (74.5%) | 1903 (86.0%) | 1797 (80.2%) |
| Other | 531 (23.2%) | 326 (14.7%) | 606 (25.5%) | 314 (14.0%) | 445 (19.8%) |
| TOTAL | 2287 (100%) | 2225 (100%) | 2381 (100%) | 2217 (100%) | 2242 (100%) |

It is interesting to note from the table that the percentage of consumption of calories drawn from rice and other items out of total intake of calories is more or less the same in the High Caste and the High Class groups (Rice nearly 75%, other items nearly 25%). Similarly, the percentage of calories

drawn from rice and other items out of total intake of calories is more or less the same in the Low Caste and Low Class groups (Rice nearly 86%, other items nearly 14%). Further, of the total consumption of calories, the Low Caste and Low Class groups have drawn more calories from rice (86%) than the High Caste and High Class groups (75%).

SECTION II

DISCUSSION

In the previous section, the influence of social stratification in observance of some selected health practices related to personal hygiene, smoking, drinking, maternal and child care and food has been presented. In this section, the relative influence of caste and class in observance of these practices is discussed. While some health practices are observed by all caste and class groups more or less in equal proportion, other health practices are observed in different proportions in the caste and class groups.

Health practices such as the use of toothpowder, taking head bath, body bath and extent of smoking(cigars 3-5) have been observed by all the caste and class groups more or less in the same proportion.

In observance of rest of the health practices studied it is found that either the High Caste group observed a particular health practice more frequently than the Low Caste group or vice versa. Same is the case with the class groups as well.

Some health practices have been observed by a particular caste or class group only. On the other hand, some health practices have been observed by both the caste groups in more or less equal proportion.

It is found that the High Caste and the High Class groups observed the following health practices, which are beneficial to maintenance of good health, more frequently than the Low Caste and Low Class groups respectively. These are: (1) use of tooth paste (2) regularity in taking head bath (3) use of soap (4) regularity in oiling hair (5) taking special diet both before and after delivery (6) visiting other agencies (private lady doctors or nursing homes in nearby towns) for prenatal check up and (7) comparatively early weaning at the age of 10-12 months of the baby.

Similarly, the Low Caste and the Low Class groups observed certain health practices, some of which are conducive to illhealth, in greater measure than the High Caste and the

High Class groups. These are : (1) Use of twig (2) Irregularity in taking headbath (3) Not using any material for cleaning the body at the time of bath (4) Irregularity in oiling hair (5) Drinking (6) Working in fields or any other activity outside home by pregnant women upto 7-9 months of their pregnancy mostly (7) resumption of work by the new mothers outside the home within three months after delivery largely. They depended mostly on local PHC for prenatal check up. Greater amount of calories out of the total consumption of calories is drawn from rice in these groups. Their intake of calories is less than the High Caste/High Class groups.

Some health practices have been observed by either a particular caste or class group in greater frequency than others. These are :

1. The High Class group had slightly greater prenatal check up than the High Caste group.
2. The Low Caste group women observed weaning mostly when their babies are around 2 years old than the High Caste women who observed weaning when their babies are 10-12 months old.
3. The Low Class group practised "addapoga" more frequently than the Low Caste group.
4. The Low Caste group visited PHC for prenatal check up slightly in greater measure than the Low Class group.

Some health practices have been observed by both caste and class groups more or less in the same proportion. The High Caste and the High Class groups observed the following practices in more or less equal measure :

1. Very few (or no woman) reported working outside the home;
2. Weaning was observed when their babies are 9-12 months old;
3. Negligible (less than 3 per cent) drinking.

The following health practices have been observed by the Low Caste and the Low Class groups in more or less equal measure :

1. Use of soap and
2. per unit per day consumption of calories.

The practice of Addapoga has been observed in equal measure by both the High Caste and the Low Caste groups.

It is of interest to note that while the High Caste and the Low Caste groups have observed some health practices more or less in equal proportion, the High Class and the Low Class groups have not observed any health practice in more or less equal proportion.

By and large, it is seen that the High Class group is associated with observance of health practices in a measure which is conducive to better health in comparison to the High Caste group. These practices are (1) use of tooth paste (2) use of soap (3) regularity in taking head bath (4) regularity in oiling hair (5) less use of 'addapoga' (6) providing special diet both before and after delivery to women (7) greater prenatal check up (8) visiting private doctors/nursing homes in nearby towns where better facilities are available for prenatal check up and (9) negligible drinking.

On the other hand, neither the Low Caste group nor the Low Class group is distinctly ahead of each other in observance of health practices conducive to better health. Each one of them observed certain practices in a measure which is conducive to better health to a certain extent. The Low Class group is ahead of Low Caste group in taking head bath regularly, and providing special diet after delivery. The Low Caste group provided special diet before delivery and prenatal check up in greater measure. However, certain health practices which are injurious to health are found practised in greater measure by either of these groups. While the Low Class group uses 'addapoga', more frequently, less pre-natal check up, less special diet before delivery than the Low Caste group, the Low Caste group drinks liquor in greater measure than the Low Class group.

In general, both the High Caste and the High Class groups observed these health practices in such a measure which is conducive to better health. In all, it is found that the High Class group observed health practices in a greater measure which is conducive to better health than all other groups - High Caste, Low Caste and Low Class. In the Low Caste and Low Class groups only some practices observed by them are conducive to better health. It can be, therefore, inferred that as one's class status improves, one's health status is also likely to improve.

CONCLUSIONS AND SUMMARY

Chapter 7

CONCLUSIONS AND SUMMARY

INTRODUCTION

The aim of the present study is to understand the relationship between social stratification and health care in a rural community in Andhra Pradesh. The emphasis has so far been on the biological side of health ignoring other aspects such as social, economic, political and technological forces which are equally important in promotion and maintenance of health. Thus, health is to be understood as 'a socially produced natural reality'. The need to understand this relationship is emphasised in the 'Health For All' report by ICMR-ICSSR : "Studies on different aspects of health system are urgently needed. Very little work is being done, for instance to study the relationship of health to society and fields like sociology or economics of health are still in their early infancy". This assumes greater significance in the context of our national commitment to achieve 'Health For All' by 2000 AD through the universal provision of primary health care services. In this context, the present study was taken up.

In view of this, the following objectives were set forth in this study :

1. To describe differential distribution of morbidities and various health care practices among the caste, class and age-sex groups in the study village.
2. To examine whether the differential distribution of health care practices has any consistent patterns in relation to caste and class differences.
3. To find out whether there is any evidence of systematic deprivation or exclusion from health facilities and resources in the study village.
4. To discuss the nature and implications of differences between class and caste groups as observed in the study.

In this study, social stratification includes both 'Caste and Class' forms. Though 'Power' is another form of stratification, its role in health care is minimal at village level and as a result, it is omitted from our study. The term 'Health care' is conceptualised as any action(s) taken by an individual/group to prevent and cure illness, promote and maintain health and rehabilitate the affected. It includes (a) morbidity and its treatment (b) nutrition (c) utilization of various health resources and health facilities and (d) health practices.

METHODS :

Keeping in view the aim and objectives of our study, a village was selected in East Godavari, the most populous district in Andhra Pradesh after satisfying the following criteria :

1. There is enough scope to identify sufficient number of respondents from landless to rich land-owner categories.
2. The village is multi-caste in its social composition.
3. A Primary Health Centre (PHC) is located either within the village or in a nearby village and is functioning for a very long period.
4. The Primary Health Centre has its full strength of medical staff.
5. The village is connected with nearby towns where better health facilities are available.
6. The village has a number of folk-healers and private practitioners.

Several visits to various primary health centres in the district were made to explore and identify a village which

satisfies the above criteria after having discussions with primary health centre staff, local villagers, informal leaders etc. Finally, two villages were selected to conduct a preliminary field exploration. A list of households with their social, occupational status alongwith the size of their land holdings was prepared. After a preliminary analysis of the data it was found that the village, Rangampeta, is ideally suited for our study compared to the other village 'Virava'. In both the villages, PHCs are located. The study village is having a hamlet, Chandredu, at a distance of 3 kilometers from the main village.

There are 1050 households in the study village. For each household, the caste status, occupation and the size of land holding were recorded. Separate lists of households for High Castes (540), Middle Castes (270) and Low Castes (240) were prepared. From each group, a sample of 20 per cent of households was selected for our study. The distribution of sampled households among caste groups shows that 98 households belong to High Castes, 54 to Middle Castes and 48 to Low Castes respectively. Similarly, among classes, 57 belong to High Class group, 47 to Middle Class and 96 to Low Class group respectively.

Five types of questionnaires were used to collect necessary data from the respondents. The first one was

aimed at collecting all the basic information about the sample household in terms of its size, sex, age, education, occupation, land holding, income, assets, etc. The second one deals with morbidity both in its acute and chronic forms. The third one pertains to nutritional status, food habits etc. The fourth one focusses on utilization of various health resources and facilities in the village and outside the village. The fifth and last one deals with health practices in the household. Interviews were held with practitioners, PHC personnel, informal leaders and others in the village to collect data on aspects relevant to the study.

THE VILLAGE AND THE SAMPLE

The village Rangampeta is located in Rangampeta Mandalam in East Godavari District of Andhra Pradesh. The village has two portions - the main village Rangampeta and the hamlet Chandredu. The distance between these two is 3 kilometers. The area is purely rainfed. Of the three types of soils in the village - black clay, black sandy and red loams - red loams constitute major surface area. The major crops grown are paddy, tobacco, groundnut, redgram, blackgram, coriandrum, budama etc.

There is a Primary Health Centre (PHC) in the main village. There are two drug shops in the main village. The village has a number of Allopathic (7), some Ayurvedic (3) registered medical practitioners besides a variety of healers and folk-practitioners (22). The village has a number of institutions including banks, schools, veterinary hospital, telephone exchange, hotels etc. A lot of developmental programs under Integrated Rural Development Programme (IRDP) are being implemented to benefit SC, ST and other weaker sections of the society.

The population in the village is 5807. The total number of households in the village is 1050. A sample of 200 households covering all castes in the village was selected. The total number of persons in the sample is 1000 and the average size of a household is 5. There are 515 males and 485 females in the sample.

There are 20 castes in the village. For the purpose of our study, all the castes are categorised into three broad groups - High, Middle and Low Castes. The High Caste group comprises Brahmin, Vysya, Kapu and Kamma and the Low

Income (annual) distribution pattern reflects heavy concentration of households in certain categories. While 30 per cent of households in the sample had an annual income of less than Rs. 4,000/-, an equal percentage of households are concentrated in the category of Rs. 10,000/- and above. Majority of the households in the Low Castes (52%) and substantial portion (41%) of the Middle Castes are having a low income of less than Rs. 1,000/-. Majority of the households in the High Castes (53%) are concentrated in the high income category of Rs. 10,000/- and above.

In the sample, there are 454 illiterates (45.4%) and 72 children (7.2%) who were below school going age. Of the remaining 474 people, 156 (15.6%) were studying at the time of collection of data and 318 (31.8%) completed their education. The percentage of literacy is high among the High Castes (56.7%) followed by the Low Castes (40.1%) and the Middle Castes (36.2%).

RESULTS :

The following are the major findings of our study :

A. MORBIDITY :

While almost all households (99%) reported acute morbidities, only about 70% of the households reported chronic morbidities.

82.3 per cent of the episodes were of acute type and the rest 17.7 per cent were of chronic type. In other words, approximately for every four acute illnesses, there is one chronic illness.

As regards distribution of morbidities, acute morbidities were found slightly in greater proportion in the Low Caste and Low Class groups than in the High Caste and High Class groups. On the other hand, chronic morbidities were found slightly in greater proportion in the High Caste and High Class groups.

The prevalence rate of sickness was higher in the Low Caste and Low Class groups than in the High Caste and High Class groups. Of all the groups, while the Low Caste group had the highest prevalence rate (173.1), the High Class had the lowest prevalence rate (98).

More than 80 types of morbidities of both chronic and acute type were reported. Fever (9.75%), headache (8.29%), dental caries (5.77%), cough (4.95%), motions (5.04%) were the most frequently reported acute illnesses. Among the chronic illnesses pain in leg joints (4.63%), heart complaints (4.1%), blood pressure (2.2%), filariasis (1.38%) were reported most frequently.

In general, complaints related to ENT and sense organs were most frequently (21.5%) reported illnesses followed by complaints of digestive system (16.5%) and musculo-skeletal system (12.4%). This general pattern was observed for acute morbidities also. In all caste and class groups, more or less a similar trend was observed.

With regard to chronic morbidities, disorders of musculo-skeletal system form the largest segment of morbidities (21.1%), followed by disorders of circulatory system (18.8%) and ENT and sense organs (13.3%). Disorders of other systems were found in a small measure.

Complaints of circulatory system were found in a greater proportion in the High Caste and High Class groups than in Low Caste and Low Class groups. On the other hand, disorders of ENT and sense organs were found in greater measure in the Low Caste and Low Class groups than in the High Caste and High Class groups.

Minor illness (less than 2 days) accounted for one-third of the total illnesses, followed by moderate (1 to 4 weeks) and mild (3-6 days) illnesses while chronic illness was substantially lower. Nearly, half of the chronic illnesses

were of more than 3 years duration while the rest were of less than 1 year and 2-3 years.

In general, morbidities were slightly more among males than among females. In the High Caste and High Class groups, morbidities among males were slightly more than among females. On the otherhand, morbidities were slightly more among females in the Low Caste and Low Class groups.

A sick person in the Low Caste and Low Class groups suffered more episodes than a sick person in the High Caste and High Class groups.

In general, there was not much sex-wise difference in the number of episodes suffered. However, the sick males and the sick females in the Low Caste group suffered slightly more number of episodes than the sick males and sick females in general. Further, the sick females in the Low Caste group suffered more number of episodes while the sick females in the High Class group suffered fewer episodes in the entire sick population.

In distribution of chronic morbidities, slightly more complaints were found among males than among females while

acute morbidities were more or less equally distributed among males and females.

In terms of distribution of morbidities in age-groups between males and females, it was found that the morbidities were more among females in the age-group of 35-44 and among males in the age-group of 55 and above and below 4 years. In chronic morbidities, males suffered more episodes than females. While females suffered more morbidities in the age-group of 25-34 and 45-54, males suffered more morbidities in the age group of 55 and above. It is further observed that in both acute and chronic morbidities males in the age-group of 55 and above were vulnerable to greater morbidity than females in the same age-group.

In general, except the age group of 15-24 years, morbidities increased with age till 54 years and then declined sharply. In the age group of 35-54, morbidities were found slightly higher than in other age groups. In Middle age, morbidities were more in the Low Caste group than in the High Caste group, while morbidities were more in old-age (55+) in the High Caste group than in the Low Caste group. Similar trend was observed in class groups also.

Both in the Low Caste and Low Class groups, in middle age more chronic morbidities were found than in the High Caste and High Class groups. In the High Caste group, more morbidities were reported in the age group of 55+ than in the Low Caste group. In children also, more chronic morbidities were found in the Low Caste and Low Class groups than in the High Caste and High Class groups.

In the age group of 45-54, morbidities were reported more both among males (20.4%) and females (23.4%). Morbidities in females in the age group of 25-44 were higher than morbidities among males. Similarly, morbidities among males in the age group of 55 and above and under four were slightly higher than in females.

In general, among males the distribution of morbidities in terms of persons was more in children (- 14 years) and old people whereas it was more in youth and middle age category among females. This pattern was largely found both in distribution of acute as well as chronic morbidities. In old age (55+) more sick males were found with chronic morbidities than females.

In terms of distribution of morbidities (spells) there was greater concentration of morbidities among females in middle-age category than males. Similarly, there was greater concentration of morbidities (spells) among males in old-age than among females. This trend was observed both in acute and chronic morbidities. Of these two, concentration of chronic morbidities in old-age among males was more than acute morbidities.

Minor illness among females was slightly more than among males. In contrast to this, chronic illness among males was slightly more than among females. This pattern was found largely both in caste and class groups.

While minor illness was found more in the Low Caste and Low Class groups than in the High Caste and High Class groups, moderate illness was found more in the High Caste and High Class groups than in the Low Caste and Low Class groups. It was further observed that minor illness in the Low Caste and Low Class groups was more than moderate illness in their respective groups.

Among males and females, in caste and class groups, chronic morbidities were slightly more in males than in

females. But in the Low Caste group, slightly more chronic morbidities were found in females than in males. Chronic morbidities of longer duration were more in the Low Caste group among males and females than their counterparts in the High Caste group. Similar trend was observed in class groups also.

B. HEALTH ACTION

In general, for about 80 per cent of morbidities, some form of health action was taken. But in case of chronic morbidities, only 66 per cent of the morbidities were taken care of.

The Low Caste and Low Class groups reported less extent of health action than the High Caste and High Class groups.

Of all the caste and class groups, while it was the Low Caste which took least extent of health action, the High Caste took greater extent of health action. Males and females in the High Caste group took greater extent of health action than the Low Caste group. Similar trend was observed in class groups also. Further, health action taken by females in the Low Caste group was not only least among females but also

in the population in general. Thus, the females in Low Caste group were the most neglected in the population while the females in the High Caste group were the most cared for. There was a clear trend of association of social status and health action : Higher the Caste/Class status, greater the extent of health action taken.

Both in morbidity and health action, caste/class status was reflected : Higher the Caste/Class status, less the extent of morbidity and greater the extent of health action.

Among males and females, slightly greater extent of health action was reported by males than females. However, females in the High Caste group reported greater extent of health action in the population in general. In contrast to this, females in the Low Caste group reported least extent of health action in the population in general. Less morbidity and more health action was reported among the High Caste females while it was contrary among the Low Caste females.

Among males and females, females resorted to health action for a larger number of chronic morbidities than males. This was contrary to acute morbidities where slightly greater extent of health action was reported among males than females.

In Caste and Class groups, females took care of greater number of chronic morbidities than males. While females in the High Class group took care of greater number of chronic morbidities, females in the Low Caste group took care of less number of morbidities.

In acute morbidities while females in the Low Caste group took least extent of health action, in chronic morbidities males in the Low Caste group took least extent of health action. On the other hand, in acute morbidities while females in the High Caste group took greater extent of health action, females in the High Class group took greater extent of health action for chronic morbidities.

Among all categories, children were better taken care of by some form of health action. Among them, 90 per cent of the morbidities were taken care of. In other categories, only about 75 per cent of the morbidities were taken care of.

In general, in all categories greater proportion of health action was taken in the High Caste group than in the Low Caste group. More or less a similar trend was observed in class group also. In general for chronic illness, only

65.6 per cent of morbidities were taken care of by health action while for acute illness 82 per cent of the morbidities were taken care of.

Among youth in the Low Caste and Low Class groups, least extent of health action was reported both for acute and chronic morbidities compared to other age categories in caste and class groups. In contrast to this, least health action was reported in old-age category in the High Caste and High Class groups. Greater morbidity remaining unattended to among youth in the Low Caste and Low Class groups makes a serious dent on productivity and results in their low earnings. This in turn will affect adversely their consumption pattern in the family.

C. UTILIZATION :

In general, local PHC was consulted mostly by all Caste and Class groups. Next to PHC comes the visits to RMP, private doctors outside the village, folk-healers and CHV. The Low Caste and Low Class groups consulted PHC more frequently than the High Caste and High Class groups. The High Caste and High Class groups consulted private doctors outside the village more frequently than the Low Caste and Low Class groups.

While all the households in the Low Caste group availed of the services of local PHC since its functioning in the village, only about 3/4th of the households in the High Caste group utilised PHC. More or less a similar situation was observed in class groups also.

The Low Caste and Low Class groups used the services of PHC such as maternal care, delivery, immunization etc. more than the High Caste and High Class groups.

Family Planning was the only service which was utilised by all social groups more or less in the same proportion.

The High Caste and High Class groups had more favourable experience of PHC than the Low Caste and Low Class groups. When it comes to preference for PHC, only 50 per cent of the respondents expressed their preference for PHC in the High Caste and High Class groups while 75 per cent of the respondents expressed their preference in the Low Caste and Low Class groups. When they were asked to state the reason for their visits to PHC on the basis of their morbidity record, it was found that "service free of cost" as the main reason in all caste and class groups. While 'free service' and

'limitations of some kind' were reported as the main reasons among the Low Caste and Low Class groups, 'free service' and 'good image of certain doctor/specialist services of the PHC were the main reasons in the High Caste and High Class groups.

ANM did not visit nearly 80 per cent of the households during the preceding six months from the date of enquiry. MPW did not visit 45 per cent of the households during the same period.

Very little preference was expressed for consulting CHV. The reason for the preference was proximity. All CHVs belonged to the Low Caste group and mostly the Low Caste group respondents expressed their preference for them.

For private practitioners, most of the respondents expressed their preference. While the High Caste and High Class groups indicated either first or second preference, the Low Caste and Low Class groups expressed second preference largely. In general, majority of the respondents mentioned "Not satisfied with other agencies/cures" as the main reason for their preference. On the basis of morbidity record, when they were asked to state the actual reason for

their visits to private practitioners, it was mentioned that 'poor image/dissatisfaction of services/personnel of PHC' as the major reason.' Better satisfaction' and 'accessibility' were mentioned in a small proportion.

Nearly half of the respondents expressed no preference for medical shop. Of those who expressed preference for medical shop, most of them reported their first preference. The other reasons for their preference were accessibility and less cost.

For minor ailments, generally most of the people consulted local medical shop. While medical shop as the main resource followed by PHC to some extent were the major resorts for minor ailments in the Low Caste and Low Class groups, medical shop as the main resort followed by private practitioners were the main resources for seeking medical care in the High Caste and High Class groups.

Of the first preference for various health resources for medical care indicated by caste and class groups, it is observed that the Low Caste and Low Class groups expressed their first preference for medical shop followed by PHC. The High Caste group expressed their first preference for medical

shop followed by private practitioners while the High Class group expressed their first preference for private practitioner, followed by medical shop.

The High Caste and High Class groups kept most of the items of medicinal value in their homes for ready use compared to the Low Caste and Low Class groups.

In general, about 3/4ths of the people in the village depended on local pond for drinking water while the rest used either tap or well. The Low Caste group depended on pond water to a greater extent than any other group. It was observed that no systematic effort or attempt was made by any particular group to deprive other group (3) for utilizing any health resource in the community.

D. HEALTH PRACTICES :

The Low Caste and Low Class groups used twig more than the High Caste and High Class groups. The High Caste and High Class groups used tooth paste more than the Low Caste and Low Class groups.

Majority of the respondents took body bath and only a small number took head bath generally in all caste and class groups. Both the Low Caste and Low Class group respondents reported taking head bath less frequently i.e. either once a fortnight or even at longer intervals than the High Caste and High Class group respondents.

About half of the respondents are using soap for bath while the rest are not using any thing. Further, the High Caste and High Class group respondents are using soap in greater proportion than the Low Caste and Low Class group respondents. Nearly two-thirds of the Low Caste and Low Class group respondents are not using anything to clean their body while bathing.

The High Caste and High Class group respondents applied oil to their hair regularly (once in 2 days or daily) in greater proportion than the Low Caste and Low Class group respondents.

Of those who reported drinking habit, most of them belonged to the Low Caste and Low Class groups. Majority of them were drinking liquor regularly.

Majority (80%) of the respondents reported having smoking habit. Further, most of the High Caste and High Class group respondents smoked slightly heavily (more than 3 cigars per day) compared to the Low Caste and Low Class group respondents. In the Low Caste and Low Class groups smoking by females and children is a common practice while it is taboo in the High Caste and High Class groups. Addapoga (keeping the burning end of the cigar inside the mouth) is more common in the Low Caste and Low Class groups especially among women.

In providing special diet before delivery, only about 1/4th of the pregnant women were provided special diet before delivery. Of those who provided special diet before delivery majority of them belonged to the High Caste and High Class groups.

In providing special diet after delivery nearly half of the households provided special diet after delivery. Here also, the High Caste and High Class groups provided special diet after delivery in greater proportion than the Low Caste and Low Class groups. In general, there is less consciousness in providing special diet before delivery than after delivery.

Almost all the pregnant women who worked in fields, construction work etc. belonged to the Low Caste and Low Class

groups. Most of them worked till 7-9 months of their pregnancy. After delivery nearly 40 per cent of the new mothers resumed their work within three months of their delivery and about 30 per cent resumed work after ten months of delivery.

Nearly half of the pregnant women had no pre-natal check up. The Low Caste and Low Class group pregnant women depended on local PHC for prenatal checkup, while the High Caste and High Class group pregnant women sought services from other agencies such as private doctors/nursing homes in nearby towns.

In general, nearly half of the new mothers started weaning when their babies reached the age of 9-12 months, while majority of mothers in the High Caste group weaned their babies on their reaching 9-12 months. Nearly half of the mothers in the Low Caste group weaned their babies when they reached more than 2 years.

Most of the mothers started giving solid foods to their babies when they were below the age of 9-12 months.

The average per unit per day consumption is 2241.5 calories. There is differential consumption of calories per unit per day in different social groups. While the per unit per day intake of calories is found highest in the High Class out of all social groups, it is the lowest in the Low Class group. Of the High Caste/High Class groups, it is the High Class which is having a better caloric intake. The Low Caste and Low Class groups are having more or less a similar intake of calories per unit per day.

The percentage of consumption of calories drawn from rice and other items out of total caloric intake is the same in the High Caste and High Class groups. In the Low Caste and Low Class groups, the percentage of calories taken out of consumption of rice is slightly more in comparison to the High Caste and High Class groups. Broadly, the consumption of calories per unit per day is less in the Low Caste and Low Class groups than the High Caste and the High Class groups. It may be inferred that the Low Caste/Class has poorer nutritional status than the High Caste/High Class groups.

SUMMARY OF CASTE-CLASS

DIFFERENCES :

Differences noted above suggested the following implications of Caste-Class status :

1. Habits and practices linked to affordability and improved living conditions show greater contrast by class such as calorie intake, use of doctors and private practitioners, use of soap, use of special diet both before and after delivery etc.
2. Habits and practices linked to greater awareness, progressive attitude, contacts with modern way of living benefits of new types of agencies and services also show greater prevalence by Class than by Caste such as use of tooth paste, soap, use of immunization services, early weaning, etc.
3. In contrast the habits and practices linked to traditional way of life and traditional norms show greater association to Caste status than Class status or show greater contrast in terms of High-Low Caste status than High-Low Class status. Examples are - taking headbath working outside home during pregnancy, late weaning etc.
4. Data also suggest that habits and practices which imply strong value or and normative compulsions are not influenced by affordability reflected in Class status. For example drinking habit and non-vegetarianism are linked to affordability and new life style but strongly related to traditional norms. These show greater linkage to Caste status than to Class status. 13 per cent more respondents from the Low Caste habitually drink than the Low Class because some respondents in the Low Class group are from the Middle and High Caste groups who traditionally abstain from drinking.

5. Similarly, data generally show that since greater proportion of High Class group is from High Castes, these two show substantially lesser difference in comparison to differences among Low Class and Low Caste group because greater proportion of Low Class respondents belong to Middle and High Castes, (see table 2.1 in chapter two). Examples of such pattern where High Caste-Class differences are less than Low Caste-Class differences are - drinking, smoking, regularity in taking the bath (once in 2 days/ and in a week), use of special diet after delivery, not having any pre-natal check-up, use of PHC services (during the period of two months preceding the date of interview), use of immunization services of PHC, home visits by ANM, MPW, use of pond, frequency of health action taken, etc.
6. There are some instances which seem to support the idea of Sanskritisation. When the Low and Middle Caste respondents move to High Class status they emulate traditional norms of High Castes rather than reflecting new pattern of modern secular life style. For example 3 per cent respondents in the High Caste group drink but only 1.8 per cent respondents in the High Class group (many of whom are from middle and low castes) declare that they drink.
7. Practices which are neither associated strongly to affordability nor to secular life style nor to traditional norms of purity are shared in all caste/class groups to similar extent such as smoking.

8. Factors of systematic exclusion or deprivation of Low Caste/Class groups are not brought out in our data although such processes do occur. Greater use of pond water by the Low Castes (94 per cent) in comparison to 77 percent among the Low Class suggests that Caste factor is stronger in this exclusion process than the Class factor.
9. There is some interesting information on how different castes and class groups relate to government health services in villages. There is little difference between High/Low Caste and Class groups in actual use or performance of PHCs. However, there is substantial difference among the Low Class and Low Caste groups in use of or visits from ANM, MPW and CHV i.e. these workers have discernible linkages to the Low Caste in comparison to the Low Class households. As explained before it is partly because of the caste status of these health workers, it appears, the High and Middle Caste respondents in the Low Class group do not identify with these health workers in the same way as do the Low Caste members.
10. It has been suggested above that the High Class/High Caste groups show a number of important differences in a variety of health practices in comparison to the Low Class/Low Caste groups. High prevalence of presumably health promoting practices among the High Caste/Class groups is taken as a progressive pattern. However, a closer look shows two overlapping patterns. There are some health practices which are desirable in terms of traditional norms or purity and pollution (such as bathing, special foods during pregnancy, etc.) or notions of decency linked to caste status (pre/post delivery

prohibitions). These variables are slightly more prevalent among High Castes in comparison to High Class. There are some practices which are desirable in terms of modern secular life style or status. Such factors show marginal to moderate predominance among the High Class (use of toothpaste, use of soap, comparatively less smoking, use of private agencies for pre-natal check-up) in comparison to the High Caste group.

The Caste vs Class differences are to be seen in the background of inter-relationship between these two variables illustrated in Chapter 2 (table 2.1).

The table 2.1 shows that redistribution of Low Castes by Class status makes only marginal difference in so far as only 14.6 per cent of them move up the ladder into Middle and High Class group. But classwise reclassification of High Castes has the opposite effect. As many as 49 per cent of the High Caste households move down the class ladder to Middle and Low Class groups. While only 8 per cent of the Low Castes move to High Class status, about 18 per cent of the High Castes move to Low Class status. The Middle Caste households have more or less the same classwise profile as the Low Caste households. As many as 68.5 per cent of the Middle Caste households belong to the Low Class although 26 per cent of

them retain the Middle Class status. It is, therefore, expected that the Middle Caste households may display a profile of health care practices similar to the Low Caste households or sometimes similar to the High Caste households. Middle Castes do not represent mid-point linear position in the Class scale reflected by the fact that overlap between Middle Class and Middle Caste is only 26 to 30 per cent and that 63.8 per cent of the households in Middle Class belong to the High Castes.

Reclassification of Castes by Class effects High Caste and Middle Caste, much more but the effect on redistribution of Low Castes by Class is only marginal. Proportion of High Castes within High Class is much more than the proportion of Low Castes within Low Class. On the other hand, higher proportion of Low Castes fall in Low Class in comparison to proportion of High Caste remaining within High Class.

From the above discussion, it is seen that social stratification plays a vital role in prevalence of morbidity, resort to health action, observance of health practices and utilisation of various health resources available to the community. High Caste and High Class groups are associated with practices such as use of toothpaste, soap, regularity in

taking head bath, regularity in oiling hair (daily/once in two days), special diet both before and after delivery, intake of calories in greater proportion, negligible drinking and early weaning practices compared to Low Caste and Low Class groups. In utilisation of health resources, both the High Caste and High Class groups used the private doctors outside the village, local RMPs and local folk-healers in larger measure than the Low Caste and Low Class groups. Further, both the High Caste and High Class groups took health action for more number of morbidities than the Low Caste and Low Class groups. Both the High Caste and High Class groups are endowed with living conditions such as spacious housing, higher income, cleaner surroundings, more literacy etc. On the other hand, both the Low Caste and Low Class groups are associated with practices such as irregular taking of head bath, irregular use of oiling hair, less use of soap, drinking of liquor in greater proportion, less use of special diet both before and after delivery, late weaning, comparatively less calorie intake and less extent of health action for morbidities. Both the Low Caste and Low Class groups used special services of PHC such as maternal care, delivery and immunisation in greater proportion than the High Caste and High Class groups. However,

in informal interviews they expressed dissatisfaction over the services and personnel of PHC. It is interesting to note that the services of ANM and MPW were utilised by the Low Caste group more than any other group due to the subjective factor of these personnel belonging to their own caste. Both the groups used pond water more than the High Caste and High Class groups. Further, both the Low Caste and Low Class groups took less extent of health action than the High Caste and High Class groups.

It is significant to note that both males and females in the Low Caste group, particularly females, took least extent of health action in the population in general. Further, youth in the Low Caste and Low Class groups, particularly in Low Caste group, took less extent of health action than other categories - children, middle-aged and old-aged in the population in general. Both these groups are bestowed with living conditions such as crowded housing, unclean surroundings with greater risk of contamination and pollution due to domestication of fowls, pigs etc, low income, less literacy etc.

It is interesting to note that family planning services of PHC were utilised by all caste and class groups more or less in the same proportion due to the impact of the promotional

activities by the government and greater awareness of the advantages of a small family among people.

Thus, both the High Caste and High Class groups are associated with practices which contribute to maintenance and promotion of better health than the Low Caste and Low Class groups. Of the High Caste and High Class groups the High Class group observed the above practices in greater measure than the High Caste group due to their affordability and greater awareness. On the other hand, both the Low Caste and Low Class groups were not found associated with observance of health practices which would help in their maintenance of good health, in greater proportion than the High Caste and High Class groups. On the other hand, both these groups were found associated with the habit of drinking liquor to a much greater extent.

In Indian society, as the caste status is ascriptive, the alternative open to members of a community is to improve one's achievable (class) status. As it has been already noted, the High Class status is associated with observance of such practices/norms/values etc. which are conducive to good health. It may, therefore, be argued that as one improves one's class status, one is likely to discard/reduce the observance of such practices which are harmful to health. Improvement in class

status itself calls for a rise in general standard of living which in turn is dependent on factors such as provision of gainful employment, education, communication facilities, implementation of land reforms, agricultural production, health facilities, environmental sanitation, housing etc. Further, there is a need for improvement in the quality of the governmental health services such as PHC, specialist services so as to enhance their acceptability and utilization in the community. The community in general should be educated for better health consciousness so as to enable them to take appropriate care. To meet this, suitable strategies should be developed with the help of social scientists and medical experts. Target specific programs for youths and females in Low Caste/Class groups should be prepared to meet their health needs. Necessary measures need to be taken by the state government to inculcate service orientation and work ethic among personnel of PHC. A sympathetic understanding of the problems of patients will create a good image of PHC and its personnel in the community. The people should be communicated well in advance and motivated to utilise the specialist services rendered by the medical college experts who visit the PHC as per their schedule.

Thus, improvement in health status in a community calls for a closer integration of health sector with other sectors of rural development such as education, employment, communications, agriculture, health facilities etc.

SUGGESTIONS FOR FURTHER RESEARCH

1. Since the present study is limited to a single village, we cannot generalise for the entire region/state. There is, thus, a need to conduct more such studies to confirm these findings.
2. It will be helpful if a cluster of villages is taken for study so that an equal number of households can be represented in the sample for all caste and class groups for better comparison and understanding. Caste-Class and Class-Caste analysis can be made if the sample is adequate.
3. For morbidity, it will be helpful if data are collected prospectively with the help of a medical practitioner.
4. For proper assessment of nutritional status of a group, weighment method will be more appropriate though it may have its operational problems.
5. The above findings can generate hypotheses for further research.

SUMMARY :

The present study aims at understanding the relationship between social stratification and health care in a rural community in Andhra Pradesh. The basic objective of this study was to describe differential distribution of morbidities and various health care practices among the caste and class groups in the study village in order to examine whether the differential distribution of health care practices has any consistent patterns in relation to caste and class differences.

A village was selected in East Godavari District of Andhra Pradesh for the study after satisfying certain criteria. This village has two portions - the main village 'Rangampeta' and hamlet 'Chandrudu' which is located at a distance of 3 kilometers from the main village. This has a population of 5807. A systematic random sample of 200 households was chosen out of the total number of 1050 households in the study village.

Stratification includes both caste and class dimensions. All the sample households were categorised into High, Middle and Low Caste and Class groups. The class status of a household was arrived at on the basis of an index constructed from three variables, namely, land, income and occupation.

Information was collected from the sample households by using various questionnaires on socio-economic background, morbidity, food habits, utilization of health resources and facilities and various health practices. Informal interviews were also held with practitioners, PHC personnel, informal leaders and others in the village to collect data on some general aspects relevant to our study.

Important findings are noted below :

A. MORBIDITY :

Almost all households reported some acute morbidities during 3 months period and about 70 per cent households reported chronic morbidities. Of all the episodes recorded, only 17.7 per cent were chronic morbidities. More than 80 different types of morbidities or complaints were reported. Fever (9.75%), head-ache (8.29%), dental caries (5.77%), cough (4.95%) and motions (5.04%) were the most frequently reported complaints. In general, complaints related to ENT and sense organs were most frequently (21.5%) reported illnesses followed by complaints of digestive system (16.5%) and musculo-skeletal system (12.4%).

The Low Caste and Low Class groups reported more morbidities than the High Caste and High Class groups. In the High Caste and High Class groups, morbidities among males were reported slightly more than among females. On the other hand, morbidities were reported slightly more among females in the Low Caste and Low Class groups. A sick person in the Low Caste and Low Class groups suffered more episodes than a sick person in High Caste and High Class groups.

Minor illness among females were reported slightly more than among males. In contrast to this, chronic morbidities among males were reported slightly more than females. A similar pattern was found both in caste and class groups.

B. HEALTH ACTION :

In case of about 80 per cent of morbidities some form of health action was taken. But in case of 34 per cent of chronic morbidities no action was taken.

Both in prevalence of morbidity and health action inverse relation to caste/class status was reflected. In High Caste/Class groups, morbidity was lower but health action was greater in comparison to Low Caste/Class groups.

C. UTILIZATION :

In general, local PHC was consulted most frequently by all the caste and class groups. Next to PHC comes use of RMP, private doctors, folk-healers and CHV in the order of frequency. The Low Caste and Low Class groups however, consulted PHC more frequently than the High Caste and High Class groups. The High Caste and High Class groups consulted private doctors outside the village more frequently than the Low Caste and Low Class groups.

For minor ailments generally people consulted local medical shop. The High Caste and High Class groups often kept some items of medicinal value in their homes.

D. HEALTH PRACTICES :

Personal hygiene habits like use of soap, tooth brush and paste, use of oil etc. were clearly better among the High Class/Caste groups. However, most of those used to drinking regularly belonged to the Low Caste/Class groups.

Only about 1/4th of the pregnant women in general were provided special diet before delivery but nearly half were

provided special diet after delivery. Majority of women who were provided special diet before delivery belonged to High Caste/Class groups.

Here also, the High Caste/Class mothers received special diet before and after delivery in greater proportion.

Nearly half of the pregnant women had no pre-natal check-up. Pregnant women in the Low Caste/Class groups depended on local PHC for pre-natal check up, while in the High Caste/Class group they depended on services from other agencies such as private doctors/nursing homes in the nearby town.

The findings of our study indicate that social stratification reflects important differences in health action, observance of health practices and utilisation of various health resources. It was found that the High Caste/Class groups were associated with practices such as lesser prevalence rate of sickness, greater extent of health action, greater use of soap, tooth paste, use of hair oil regularly, providing special diet before and after delivery, early weaning, greater pre-natal check up, negligible use of liquor, keeping items of medicinal value such as bandage, cotton, tablets, tonics etc. and better economic position etc. which are conducive to maintenance or promotion of better health.

The position of a social group in the community reflects its health behaviour. In order to bring about a desired change in health behaviour in the rural community, target oriented programs are needed for the Low Caste/Class groups to improve their living conditions and to create consciousness for maintenance and promotion of health.

APPENDICES

APPENDIX ACHECKLIST OF COMPLAINTS

| S.No. | Type of System | Complaint |
|-------|------------------|-------------------------------------|
| 1. | Musculo-skeletal | Back pain |
| 2. | | Chest pain |
| 3. | | Dokkalo-noppi |
| 4. | | Fracture |
| 5. | | Gantu pain |
| 6. | | Neck pain (Cervical spondylosis) |
| 7. | | Pain in legs (Muscle cramps) |
| 8. | | Pain in leg joints |
| 9. | | Pain in shoulders |
| 10. | | Vatam |
| 11. | Digestive | Anasa (Childhood Cirrhosis) |
| 12. | | Constipation |
| 13. | | Gastric trouble |
| 14. | | Hiccups |
| 15. | | Indigestion |
| 16. | | Jaundice |
| 17. | | Motions |
| 18. | | Notilo-pokkulu (Stomatitis) |
| 19. | | Pain in throat |
| 20. | | Redness in lips |
| 21. | | Sore-mouth |
| 22. | | Stomach pain |
| 23. | | Vomitting |
| 24. | | Worms |

| | | |
|----|-------------------------------|---|
| 25 | Respiratory | Asthma |
| 26 | | Cold |
| 27 | | Konaa-naluka (Uvula) |
| 28 | | Sneezing |
| 29 | | Tuberculosis |
| 30 | Circulatory | Anemia |
| 31 | | Blood pressure |
| 32 | | Heart complaints |
| 33 | | Heart enlargement |
| 34 | Excretory | Kidney trouble |
| 35 | | Urinary complaints |
| 36 | Reproductive | Abortion |
| 37 | | Complaints related to Family Planning |
| 38 | | Delivery |
| 39 | | Gynic problems |
| 40 | | Hydrocil |
| 41 | | Pregnancy complaints |
| 42 | Nervous | Fits |
| 43 | | Hysteria |
| 44 | | Nervous weakness |
| 45 | | Paralysis |
| 46 | | Polio |
| 47 | ENT & special sense ORGANS | Blind |
| 48 | | Blood oozing from mouth (Scurvy/ gingivitis) |
| 49 | | Boils |
| 50 | | Chap_i (Eczema) |
| 51 | | Cracks/pain in soles (peripheral neuritis) |
| 52 | | Deafness |
| 53 | | Dental caries |
| 54 | | Dumb |
| 55 | | Ear-ache/Ear complaints |

| | | |
|----|------------------|---|
| 56 | | Eye complaints |
| 57 | | Gums |
| 58 | | Itching (Scabies) |
| 59 | | Loss of an eye |
| 60 | | Ringworm |
| 61 | | Skin problems (Scabies/Eczema/ fungal infections) |
| 62 | | Tonsils |
| 63 | | Ulcers |
| 64 | | Vertigo (Head swinging) |
| 65 | Mental disorders | Mental disorders |
| 66 | Others | Blood from mouth |
| 67 | | Cancer |
| 68 | | Cough |
| 69 | | Diabetes |
| 70 | | Dog-bite |
| 71 | | Fever |
| 72 | | Filariasis fever |
| 73 | | Gali |
| 74 | | Galvada Billalu (Mumps) |
| 75 | | General weakness |
| 76 | | Head-ache |
| 77 | | Heat effect |
| 78 | | Injury |
| 79 | | Insect-bite |
| 80 | | Leprosy |
| 81 | | Malaria |
| 82 | | Piles |
| 83 | | Scorpion-bite |
| 84 | | Sleeplessness (Insomnia) |
| 85 | | Typhoid |
| 86 | | Unspecified |

APPENDIX BFREQUENCY OF COMPLAINTS REPORTED
IN THE SAMPLE

| S.No. | Name of the Complaint | Number of episodes reported | Frequency percentage |
|-------|----------------------------|-----------------------------|----------------------|
| 1. | Allergy | 1 | 0.08 |
| 2. | Abortion | 1 | 0.08 |
| 3. | Asthma | 21 | 1.70 |
| 4. | Anasa(Childhood Cirrhosis) | 1 | 0.08 |
| 5. | Anemia | 2 | 0.16 |
| 6. | Back pain | 42 | 3.41 |
| 7. | Blind | 1 | 0.08 |
| 8. | Boils | 30 | 2.43 |
| 9. | Blood Oozing from mouth | 6 | 0.48 |
| 10 | Blood oozing from teeth | 2 | 0.16 |
| 11 | Blood Pressure | 28 | 2.27 |
| 12 | Cancer | 1 | 0.08 |
| 13 | Chestpain | 1 | 0.08 |
| 14 | Cold | 27 | 2.19 |
| 15 | Cough | 61 | 4.95 |
| 16 | Cracks/pains in soles | 20 | 1.62 |
| 17 | Chappi (Eczema) | 5 | 0.40 |
| 18 | Constipation | 17 | 1.38 |
| 19 | Diabetes | 5 | 0.40 |
| 20 | Dental caries | 71 | 5.77 |
| 21 | Dokkalo-noppi | 14 | 1.13 |
| 22 | Dog-bite | 6 | 0.48 |
| 23 | Dumb | 1 | 0.08 |
| 24 | Ear-ache/Ear complaints | 36 | 2.92 |
| 25 | Eye complaints | 30 | 2.43 |
| 26 | Family planning operation | 1 | 0.08 |

| | | | |
|----|------------------------|-----|------|
| 27 | Fever | 120 | 9.75 |
| 28 | Filariasis Fever | 17 | 1.38 |
| 29 | Fits | 4 | 0.32 |
| 30 | Gali | 2 | 0.16 |
| 31 | Gantupain | 2 | 0.16 |
| 32 | General weakness | 33 | 2.68 |
| 33 | Gums | 3 | 0.24 |
| 34 | Gynic problems | 8 | 0.65 |
| 35 | Gast trouble | 2 | 0.16 |
| 36 | Heart complaints | 51 | 4.14 |
| 37 | Hick-ups | 1 | 0.08 |
| 38 | Hysteria | 2 | 0.16 |
| 39 | Headache | 102 | 8.29 |
| 40 | Heart-enlargement | 2 | 0.16 |
| 41 | Hydrocil | 8 | 0.65 |
| 42 | Deafness | 4 | 0.32 |
| 43 | Itching (Scabies) | 10 | 0.81 |
| 44 | Injury | 18 | 1.46 |
| 45 | Indigestion | 27 | 2.19 |
| 46 | Insect-bite | 2 | 0.16 |
| 47 | Jaundice | 2 | 0.16 |
| 48 | Kidney trouble | 1 | 0.08 |
| 49 | Konda-Naluka (Uvula) | 3 | 0.24 |
| 50 | Loss of an eye | 1 | 0.08 |
| 51 | Leprosy | 6 | 0.48 |
| 52 | Malaria | 4 | 0.32 |
| 53 | Mental disorders | 4 | 0.32 |
| 54 | Lotions | 62 | 5.04 |
| 55 | Mumps (Gavada-billalu) | 2 | 0.16 |
| 56 | Nervous weakness | 2 | 0.16 |
| 57 | Neckpain | 8 | 0.65 |
| 58 | Pain in Legs | 21 | 1.70 |
| 59 | Pain in Legjoints | 57 | 4.63 |

| | | | |
|----|-----------------------------|----|------|
| 60 | Pain in shoulders | 8 | 0.65 |
| 61 | Pain in throat | 13 | 1.05 |
| 62 | Piles | 12 | 0.97 |
| 63 | Paralysis | 1 | 0.08 |
| 64 | Polio | 5 | 0.40 |
| 65 | Pregnancy complaints | 3 | 0.24 |
| 66 | Redness on lips | 1 | 0.08 |
| 67 | Ringworm | 5 | 0.40 |
| 68 | Scorpion-bite | 17 | 1.38 |
| 69 | Skin problems | 21 | 1.70 |
| 70 | Sleeplessness | 1 | 0.08 |
| 71 | Sneezing | 3 | 0.24 |
| 72 | Sore-mouth (Notiputa) | 16 | 1.30 |
| 73 | Stomach pain | 35 | 2.84 |
| 74 | Stomatitis (Notilo-pockalu) | 1 | 0.08 |
| 75 | Tonsils | 5 | 0.40 |
| 76 | Tuberculosis | 6 | 0.48 |
| 77 | Typhoid | 1 | 0.08 |
| 78 | Ulcers | 2 | 0.16 |
| 79 | Vatam | 2 | 0.16 |
| 80 | Vertigo (He-d swinging) | 18 | 1.46 |
| 81 | Vomitting | 19 | 1.54 |
| 82 | Worms | 6 | 0.48 |
| 83 | Others | 7 | 0.56 |

TOTAL

1230

100.00

TABLES
(CHAPTERS 3 - 6)

Table : 3.1 MONTHLY AVERAGE RAINFALL (IN MILLI METERS)

| MONTH | <u>YEARS</u> | | | |
|-----------|--------------|-------|-------|-------|
| | 1980 | 1981 | 1982 | 1983 |
| January | 0 | 13.0 | 0 | 0 |
| February | 0 | 0 | 0 | 16.0 |
| March | 0 | 14.8 | 0 | 0.8 |
| April | 0 | 0 | 4.2 | 0 |
| May | 12.4 | 108.4 | 34.7 | 85.2 |
| June | 200.1 | 136.4 | 175.2 | 206.6 |
| July | 114.4 | 207.6 | 156.4 | 97.1 |
| August | 119.8 | 174.4 | 196.2 | - |
| September | 115.9 | 228.6 | 103.6 | - |
| October | 180.8 | 45.4 | 230.2 | - |
| November | 56.2 | 17.4 | 11.8 | - |
| December | 8.9 | 2.4 | - | - |

(Source: Panchayat Records, Rangampeta)

Table : 3.2 : YEARLY AVERAGE TEMPERATURE

| Temperature | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 | 1977 | 1978 | 1979 | 1980 | 1981 |
|------------------|------|------|-------|------|-------|-------|-------|-------|-------|------|------|------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 |
| Maximum (0°c) | 32 | 30 | 34 | 32 | 33 | 33.08 | 34.18 | 35.41 | 35.41 | 35 | 34.5 | 34.6 |
| Minimum (0°c) | 21 | 24 | 22.45 | 20 | 20.73 | 22.58 | 21.36 | 21.08 | 22.83 | 23.2 | 22.5 | 21.5 |

(Source: Panchayat Records, Rangampeta)

Table : 3.3 : YEARLY AVERAGE HUMIDITY

| Humidity (percentage) | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 | 1977 | 1978 | 1979 | 1980 | 1981 |
|--------------------------|------|------|------|------|-------|-------|-------|-------|------|------|------|------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 |
| Maximum | 90 | 78 | 84.7 | 84 | 73.83 | 85.5 | 84.63 | 89.58 | 84 | 87.4 | 86 | 78.9 |
| Minimum | 51 | 68 | 49 | 59 | 60.16 | 56.16 | 54.09 | 57.58 | 55 | 49.5 | 50 | 45.9 |

(Source: Panchayat Records, Rangampeta)

Table:3.5: AGE SEX GROUP COMPOSITION IN THE
SAMPLE HOUSEHOLDS

| Age-Group (years) | Males | Females | Total |
|----------------------|----------------|---------------|----------------|
| Below 4 | 43 (8.3%) | 34 (7%) | 77 (7.3%) |
| 5 - 14 | 114 (22.1%) | 121 (25%) | 235 (23.5%) |
| 15 - 24 | 90 (17.5%) | 90 (18.5%) | 180 (18%) |
| 25 - 34 | 73 (14.2%) | 64 (13.2%) | 137 (13.7%) |
| 35 - 44 | 55 (10.7%) | 66 (13.6%) | 121 (12.1%) |
| 45 - 54 | 63 (12.2%) | 64 (13.2%) | 127 (12.7%) |
| 55 - 64 | 54 (10.5%) | 28 (5.8%) | 82 (8.2%) |
| 65 + | 23 (4.5%) | 18 (3.7%) | 41 (4.1%) |
| TOTAL | 515 (100%) | 485 (100%) | 1000 (100%) |

TABLE 3.6 : Castewise Educational Status of
Population in the Sample Households
(Studying at present)

| EDUCATIONAL STATUS | High Castes | Middle Castes | Low Castes | Total |
|-----------------------|----------------|------------------|----------------|----------------|
| 1 | 2 | 3 | 4 | 5 |
| Below school age | 25 (4.9%) | 28 (10.4%) | 19 (8.4%) | 72 (7.2%) |
| Upto 5th | 57 (11.3%) | 19 (7.1%) | 19 (8.4%) | 95 (9.5%) |
| 6th-8th | 17 (3.4%) | 4 (1.5%) | 9 (4.0%) | 30 (3.0%) |
| 9th-10th | 7 (1.4%) | 8 (3.0%) | 6 (2.6%) | 21 (2.1%) |
| Intermediate | 4 (0.8%) | - | 1 (0.4%) | 5 (0.5%) |
| Graduate | 2 (0.4%) | 1 (0.4%) | 1 (0.4%) | 4 (0.4%) |
| Post-graduate | - | - | 1 (0.4%) | 1 (0.1%) |
| Not applicable* | 393 (77.8%) | 208 (77.6%) | 171 (75.3%) | 772 (77.2%) |
| TOTAL | 505 (100%) | 268 (100%) | 227 (100%) | 1000 (100%) |

* Includes illiterates (454) and those who
completed their education (318)

Table 3.7 : NUMBER OF ROOMS AVAILABLE IN THE
SAMPLE HOUSEHOLDS

| Number of rooms | Number of Households | Percentage |
|---------------------|-------------------------|------------|
| One room | 50 | 25.0 |
| Two rooms | 66 | 33.0 |
| Three rooms | 35 | 17.5 |
| Four to six rooms | 39 | 19.5 |
| More than six rooms | 10 | 5.0 |
| TOTAL | 200 | 100.0 |

Table 3.8 : TYPE OF BATH ROOM IN THE
SAMPEE HOUSEHOLDS

| Type of Bath rooms | Number of Households | Percentage |
|-----------------------|-------------------------|------------|
| No bath room | 116 | 58.0 |
| Kachcha bath room | 48 | 24.0 |
| Pucca bath room | 36 | 18.0 |
| TOTAL | 200 | 100.0 |

Table : 3.9 : TYPE OF DOMESTIC WATER SOURCE
IN THE SAMPLE HOUSEHOLDS

| Type of Water source | Number of Households | Percentage |
|--------------------------|----------------------|------------|
| No domestic water source | 142 | 71.0 |
| Domestic well | 50 | 25.0 |
| Domestic tap | 6 | 3.0 |
| Well + Tap | 2 | 1.0 |
| TOTAL | 200 | 100.0 |

Table : 3.10 : TYPE OF KITCHEN IN THE
SAMELE HOUSEHOLDS

| Type of Kitchen | Number of Households | Percentage |
|---------------------|----------------------|------------|
| No Separate Kitchen | 119 | 59.5 |
| Thatched enclosure | 44 | 22.0 |
| Tiled enclosure | 37 | 18.5 |
| TOTAL | 200 | 100.0 |

Table : 3.11 : MAJOR WATER SOURCE USED BY THE
SAMPLE HOUSEHOLDS

| Water Source | Number of Households | Percentage |
|--------------|----------------------|------------|
| Pond | 82 | 41.0 |
| Tap | 61 | 30.5 |
| Well | 57 | 28.5 |
| TOTAL | 200 | 100.0 |

Table: 3.12: POSSESSION OF ASSETS IN THE
SAMPLE HOUSEHOLDS

| Type of Asset | NOT OWNING | | OWNING | | No. of House holds | Percent age |
|---------------------|--------------------|-------------|--------------------|-------------|--------------------|-------------|
| | No. of House holds | Percent age | No. of House holds | Percent age | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Latrine | 176 | 88.0 | 24 | 12.0 | 200 | 100 |
| Electricity | 121 | 60.5 | 79 | 39.5 | 200 | 100 |
| Transistor | 109 | 54.5 | 91 | 45.5 | 200 | 100 |
| Cycle | 82 | 41.0 | 118 | 59.0 | 200 | 100 |
| Fan | 160 | 80.0 | 40 | 20.0 | 200 | 100 |
| Sprayer | 183 | 91.5 | 17 | 8.5 | 200 | 100 |
| Gobar Gas Plant | 195 | 97.5 | 5 | 2.5 | 200 | 100 |
| Scooter/ Vehicle | 193 | 96.5 | 7 | 3.5 | 200 | 100 |
| Tractor | 195 | 97.5 | 5 | 2.5 | 200 | 100 |

**Table : 3.13: CASTE AND SEX-COMPOSITION OF THE
SAMPLE HOUSEHOLDS**

| Caste | No. of House- holds | No. of Males | No. of Females | TOTAL |
|-------------------------------|------------------------------------|-------------------------|---------------------------|----------------|
| <u>HIGH CASTES</u> | | | | |
| Brahmin | 3 (1.5%) | 9 (1.7%) | 6 (1.2%) | 15 (1.5%) |
| Vysya | 3 (1.5%) | 11 (2.1%) | 6 (1.2%) | 17 (1.7%) |
| Kamma | 83 (41.5%) | 213 (41.3%) | 216 (44.5%) | 429 (42.9%) |
| Kapu | 9 (4.5%) | 26 (5.0%) | 18 (3.7%) | 44 (4.4%) |
| <u>MIDDLE CASTES :</u> | | | | |
| Perikeelu | 4 (2.0%) | 12 (2.3%) | 11 (2.3%) | 23 (2.3%) |
| Settibalji | 24 (12.0%) | 49 (9.5%) | 52 (10.7%) | 101 (10.1%) |
| Senapatulu | 1 (0.5%) | 2 (0.4%) | 1 (0.2%) | 3 (0.3%) |
| Padmasali | 1 (0.5%) | 9 (1.7%) | 6 (1.2%) | 15 (1.5%) |
| Kamsali | 5 (2.5%) | 12 (2.3%) | 13 (2.7%) | 25 (2.5%) |
| Vadrangi | 1 (0.5%) | 4 (0.8%) | 1 (0.2%) | 5 (0.5%) |
| Telakulu | 2 (1.0%) | 8 (1.5%) | 4 (0.8) | 12 (1.2%) |
| Kaikabattulu | 2 (1.0%) | 9 (1.7%) | 7 (1.4%) | 16 (1.6%) |
| Telaga Upparlu | 1 (0.5%) | 1 (0.2%) | 2 (0.4%) | 3 (0.3%) |
| Mangali | 1 (0.5%) | 3 (0.6%) | 2 (0.4%) | 5 (0.5%) |
| Chakali | 5 (2.5%) | 16 (3.1%) | 15 (3.1%) | 31 (3.1%) |
| Golla | 1 (0.5%) | 2 (0.4%) | 1 (1.2%) | 3 (0.3%) |
| Kummari | 3 (1.5%) | 7 (1.4%) | 6 (1.2%) | 13 (1.3%) |
| Dasarlu | 3 (1.5%) | 7 (1.4%) | 6 (1.2%) | 13 (1.3%) |
| <u>LOW CASTES :</u> | | | | |
| Madiga | 23 (11.5%) | 55 (10.7%) | 59 (12.2%) | 114 (11.4%) |
| Mala | 25 | 60 | 53 | 113 |

Table : 3.14: CASTE AND OCCUPATION OF THE
SAMPLE HOUSEHOLDS

| Occupation | High Castes | Middle Castes | Low Castes | TOTAL |
|---------------------------|----------------|------------------|---------------|---------------|
| 1 | 2 | 3 | 4 | 5 |
| Cultivators | 72 (73.5%) | 8 (14.8%) | - | 80 (40.0%) |
| Agricultural Labourers | 10 (10.2%) | 19 (35.2%) | 36 (75.0%) | 65 (32.5%) |
| Others | 16 (16.3%) | 27 (50.0%) | 12 (25.0%) | 55 (27.5%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (100%) | 200 (100%) |

Table : 3.15: CASTE AND LAND OWNERSHIP IN THE
SAMPLE HOUSEHOLDS

| Category | High Castes | Middle Castes | Low Castes | TOTAL |
|------------------|----------------|------------------|---------------|---------------|
| 1 | 2 | 3 | 4 | 5 |
| No land | 17 (17.3%) | 27 (50.0%) | 33 (68.7%) | 77 (38.5%) |
| Upto 2 acres | 14 (14.3%) | 16 (29.6%) | 11 (22.9%) | 41 (20.5%) |
| 2.1 - 5.0 acres | 21 (21.4%) | 7 (13.0%) | 3 (6.3%) | 31 (15.5%) |
| 5.1 - 10.0 acres | 16 (16.3%) | 4 (7.4%) | 1 (2.1%) | 21 (10.5%) |
| 10.1- 15.0 acres | 9 (9.2%) | - | - | 9 (4.5%) |
| 15.1- 20.0 acres | 7 (7.1%) | - | - | 7 (3.5%) |
| 20.1- 30.0 acres | 7 (7.1%) | - | - | 7 (3.5%) |
| 30.1 + acres | 7 (7.1%) | - | - | 7 (3.5%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (100%) | 200 (100%) |

Table : 316 : CASTE AND INCOME (ANNUAL) DISTRIBUTION
IN THE SAMPLE HOUSEHOLDS

| Annual income (Rupees) | High Castes | Middle Castes | Low Castes | TOTAL |
|---------------------------|----------------|------------------|---------------|---------------|
| 1 | 2 | 3 | 4 | 5 |
| - 4000 | 13 (13.2%) | 22 (40.7%) | 25 (52.1%) | 60 (30.0%) |
| 4,001 - 6,000 | 14 (14.3%) | 12 (22.2%) | 12 (25.0%) | 38 (19.0%) |
| 6,001 - 10,000 | 19 (19.4%) | 13 (24.1%) | 7 (14.6%) | 39 (19.5%) |
| 10,001 - 50,000 | 45 (46.0%) | 7 (13.0%) | 4 (8.3%) | 56 (28.0%) |
| 50,000 + | 7 (7.1%) | - | - | 7 (3.5%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (100%) | 200 (100%) |

TABLE 3. 17 : Castewise eudcational status of Population
in the sample households (Education completed)

| Educational Status | High Castes | Middle Castes | Low Castes | TOTAL |
|-----------------------|----------------|------------------|----------------|----------------|
| 1 | 2 | 3 | 4 | 5 |
| Illiterate | 194 (38.4%) | 143 (53.4%) | 117 (51.5%) | 454 (45.4%) |
| Upto 5th | 131 (25.9%) | 44 (16.4%) | 28 (12.3%) | 203 (20.3%) |
| 6th-8th | 32 (6.3%) | 15 (5.6%) | 9 (4.0%) | 56 (5.6%) |
| 9th-10th | 23 (4.6%) | 3 (1.1%) | 9 (4.0%) | 35 (3.5%) |
| Intermediate | 4 (0.8%) | 2 (0.7%) | 6 (2.6%) | 12 (1.2%) |
| Graduate | 7 (1.4%) | 1 (0.4%) | 2 (0.9%) | 10 (1.0%) |
| Post-graduate | 2 (0.4%) | - | - | 2 (0.2%) |
| Not applicable* | 112 (22.2%) | 60 (22.4%) | 56 (24.7%) | 228 (22.8%) |
| TOTAL | 505 (100%) | 268 (100%) | 227 (100%) | 1000 (100%) |

*Includes 72 children below school going
age 156 children studying at present

Table : 3.18 : LITERACY IN THE
SAMPLE HOUSEHOLDS

| Educational Status | High Castes N=98 | Middle Castes N=54 | Low Castes N=48 |
|---------------------------|------------------------|--------------------------|-----------------------|
| Illiterates | 38.4% | 53.4% | 51.5% |
| Literates | 56.7% | 36.2% | 40.1% |
| Below School going age | 4.9% | 10.4% | 8.4% |
| TOTAL | 100% | 100% | 100% |

Table : 4.1A: NUMBER OF PERSONS WITH MORBIDITY EPISODES
IN CASTE AND CLASS GROUPS

| Type of Morbidity | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|-------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Acute and Chronic | 270 (92.2%) | 148 (93.1%) | 142 (95.3%) | 172 (92.0%) | 127 (92.7%) | 261 (94.2%) | 560 (93.2%) |
| Only Chronic | 23 (7.8%) | 11 (6.9%) | 7 (4.7%) | 15 (8.0%) | 10 (7.3%) | 16 (5.8%) | 41 (6.8%) |
| TOTAL | 293 (100%) | 159 (100%) | 149 (100%) | 187 (100%) | 137 (100%) | 277 (100%) | 601 (100%) |

Table : 4.4A: DISTRIBUTION OF ACUTE AND CHRONIC MORBIDITIES IN
CASTE AND CLASS GROUPS

| Type of Morbidities | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|----------------------------|----------------|---------------|----------------|----------------|---------------|----------------|----------------|
| <u>ACUTE MORBIDITIES</u> | | | | | | | |
| Minor (less than 2 days) | 160 (29.6%) | 83 (27.9%) | 148 (37.7%) | 92 (27.4%) | 98 (37.7%) | 201 (31.7%) | 391 (31.8%) |
| Mild (3-6 days) | 115 (21.3%) | 83 (27.9%) | 92 (23.4%) | 67 (19.9%) | 62 (23.8%) | 161 (25.4%) | 290 (23.6%) |
| Moderate (7-30 days) | 157 (29.1%) | 71 (23.9%) | 103 (26.2%) | 109 (32.4%) | 56 (21.5%) | 166 (26.2%) | 331 (26.9%) |
| <u>CHRONIC MORBIDITIES</u> | | | | | | | |
| Less than 1 year | 23 (4.2%) | 17 (5.7%) | 12 (3.0%) | 13 (3.9%) | 8 (3.1%) | 31 (4.9%) | 52 (4.2%) |
| 1-3 years | 30 (5.6%) | 17 (5.7%) | 7 (1.8%) | 22 (6.6%) | 15 (5.8%) | 17 (2.7%) | 54 (4.4%) |
| More than 3 years | 55 (10.2%) | 26 (8.9%) | 31 (7.9%) | 33 (9.8%) | 21 (8.1%) | 58 (9.1%) | 112 (9.1%) |
| TOTAL | 540 (100%) | 297 (100%) | 393 (100%) | 336 (100%) | 260 (100%) | 634 (100%) | 1230 (100%) |

TABLE : 4.5A : NUMBER OF PERSONS WITH MORBIDITIES IN CASTE AND CLASS GROUPS

| Type of Morbidity | High Caste N=505 | Middle Caste N=268 | Low Caste N=227 | High Class N=343 | Middle Class N=226 | Low Class N=431 | TOTAL N=1000 |
|-------------------|---------------------|-----------------------|--------------------|---------------------|-----------------------|--------------------|-----------------|
| Acute | 270 (53.5%) | 148 (55.2%) | 142 (62.6%) | 172 (50.1%) | 127 (56.2%) | 261 (60.6%) | 560 (56.0%) |
| Chronic | 91 (18.0%) | 51 (19.0%) | 42 (18.5%) | 58 (17.0%) | 37 (16.3%) | 89 (20.6%) | 184 (18.4%) |

TABLE : 4.6A : MORBIDITY PREVALENCE RATE (per 100 persons/3 months) IN CASTE & CLASS GROUPS

| Type of Morbidity | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|-------------------|------------|--------------|-----------|------------|--------------|-----------|-------|
| Acute | 85.5 | 88.4 | 151.1 | 78.1 | 95.6 | 122.5 | 101.2 |
| Chronic | 21.4 | 22.4 | 22.0 | 19.8 | 19.5 | 24.6 | 21.8 |
| TOTAL | 106.9 | 110.8 | 173.1 | 98.0 | 115.0 | 147.1 | 123.0 |

TABLE : 4.7A : MORBIDITY-PREVALENCE RATE (per 100 sick persons/3 months) IN CASTE AND CLASS GROUPS

| Type of Morbidity | High Caste N=293 | Middle Caste N=159 | Low Caste N=149 | High Class N=187 | Middle Class N=137 | Low Class N=277 | TOTAL N=601 |
|-------------------|---------------------|-----------------------|--------------------|---------------------|-----------------------|--------------------|----------------|
| Acute | 147.4 | 149.0 | 230.2 | 143.3 | 157.6 | 190.6 | 168.3 |
| Chronic | 36.8 | 37.7 | 33.5 | 36.3 | 32.1 | 38.2 | 36.2 |
| TOTAL | 184.3 | 186.8 | 263.7 | 179.6 | 189.8 | 228.9 | 204.6 |

Table: 4.10 : SYSTEM-WISE DISTRIBUTION OF MORBIDITIES IN CASTE AND CLASS GROUPS

| System Category | HIGH CASTE | | | MIDDLE CASTE | | | LOW CASTE | | | HIGH CLASS | | | MIDDLE CLASS | | | LOW CLASS | | | TOTAL | | |
|------------------------|--------------|---------------|--------------|--------------|--------------|--------------|-------------|--------------|--------------|--------------|--------------|---------------|--------------|--------------|--------------|--------------|---------------|---------------|--------------|---------------|---------------|
| | C | A | T | C | A | T | C | A | T | C | A | T | C | A | T | C | A | T | C | A | T |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| Musculo-Skeletal Total | 31 (22.2) | 55 (7.2) | 22 (9.3) | 12 (10.2) | 22 (9.3) | 34 (11.4) | 10 (20) | 54 (15.7) | 64 (16.3) | 10 (14.7) | 17 (6.3) | 27 (8) | 10 (22.7) | 20 (9.2) | 30 (11.5) | 26 (24.5) | 70 (13.3) | 96 (15.1) | 46 (21.1) | 107 (10.6) | 153 (12.4) |
| Digestive | 83 (7.4) | 91 (19.2) | 37 (15.6) | 6 (16.8) | 6 (10) | 43 (14.4) | 6 (12) | 63 (18.4) | 69 (17.6) | 5 (7.4) | 53 (19.8) | 58 (17.3) | 6 (13.6) | 35 (16.2) | 41 (15.8) | 9 (8.5) | 95 (18) | 104 (16.4) | 20 (9.2) | 183 (18.1) | 203 (16.5) |
| Respiratory | 6 (5.5) | 14 (3.2) | 12 (11.7) | 7 (3.7) | 12 (5) | 19 (6.4) | 8 (16) | 15 (4.4) | 23 (5.8) | 5 (7.3) | 11 (4.1) | 16 (4.7) | 2 (4.5) | 11 (5.1) | 13 (5) | 14 (13.2) | 19 (3.6) | 33 (5.2) | 21 (9.6) | 41 (4) | 62 (5) |
| Circulatory | 24 (22.2) | 17 (3.9) | 11 (4.6) | 12 (7.6) | 11 (20) | 23 (7.7) | 5 (10) | 14 (4.1) | 19 (4.8) | 13 (28) | 13 (4.8) | 32 (9.5) | 11 (25) | 6 (2.7) | 17 (6.5) | 11 (10.4) | 23 (4.3) | 34 (5.4) | 41 (18.8) | 42 (4.1) | 83 (6.7) |
| Excretory | - | - | - | - | - | - | 1 (2) | - | 1 (.2) | 1 (1.4) | - | 1 (.3) | - | - | - | - | - | - | 1 (4) | - | 1 (.1) |
| Reproductive | 30 (6.9) | 30 (5.5) | 20 (8.4) | 4 (6.7) | 20 (8.4) | 24 (8.1) | 3 (6) | 25 (7.3) | 28 (7.1) | - | 20 (7.4) | 20 (6) | - | 14 (6.5) | 14 (5.4) | 7 (6.6) | 41 (7.8) | 48 (7.6) | 7 (3.2) | 75 (7.4) | 82 (6.7) |
| Nervous | 7 (6.5) | 7 (1.3) | 1 (1.7) | 1 (.3) | 1 (.3) | 1 (.3) | 3 (6) | 3 (.9) | 6 (1.5) | 5 (7.3) | - | 5 (1.5) | 3 (6.8) | - | 3 (1.1) | 3 (2.8) | 3 (.5) | 6 (.9) | 11 (5) | 3 (.3) | 14 (1.1) |
| ENT & Sense Organs | 13 (12) | 102 (23.6) | 53 (22.4) | 5 (8.3) | 53 (22.4) | 58 (19.5) | 11 (22) | 81 (23.6) | 92 (23.4) | 9 (13.2) | 66 (24.6) | 75 (22.3) | 2 (4.5) | 52 (24.1) | 54 (20.8) | 18 (17) | 118 (22.3) | 136 (21.4) | 29 (13.3) | 236 (23.3) | 265 (21.5) |
| Mental disorders | 2 (1.8) | 2 (.4) | 2 (3.3) | 2 (.7) | 2 (.7) | 2 (.7) | - | - | - | - | - | - | 2 (4.5) | - | 2 (.7) | 2 (1.9) | - | 2 (.3) | 4 (1.8) | - | 4 (.3) |
| Others | 24 (22.2) | 155 (35.9) | 82 (34.6) | 11 (18.3) | 82 (34.6) | 93 (31.3) | 3 (6) | 86 (25.6) | 91 (23.1) | 14 (20.6) | 38 (32.8) | 102 (30.3) | 8 (18.2) | 78 (36.1) | 86 (33) | 16 (15.1) | 159 (30.1) | 175 (27.6) | 38 (17.4) | 325 (32.1) | 363 (29.5) |
| TOTAL | 108 (100) | 432 (100) | 237 (100) | 60 (10) | 237 (100) | 297 (100) | 50 (100) | 343 (100) | 393 (100) | 68 (100) | 268 (10) | 336 (100) | 44 (100) | 216 (100) | 260 (100) | 106 (100) | 528 (99.9) | 634 (99.9) | 218 (100) | 1012 (100) | 1230 (100) |

C = Chronic Morbidities
A = Acute Morbidities
T = Total Morbidities

*Percentage in parentheses

Table: 4.12A: DISTRIBUTION OF TOTAL MORBIDITY
EPISODES AMONG MALES AND FEMALES
IN CASTE AND CLASS GROUPS

| Sex | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|--------|----------------|-----------------|----------------|----------------|-----------------|----------------|----------------|
| Male | 294 (54.4%) | 148 (49.8%) | 190 (48.3%) | 176 (52.4%) | 150 (57.7%) | 306 (48.3%) | 632 (51.4%) |
| Female | 246 (45.6%) | 149 (50.2%) | 203 (51.7%) | 160 (47.6%) | 110 (42.3%) | 328 (51.7%) | 598 (48.6%) |
| TOTAL | 540 (100%) | 297 (100%) | 393 (100%) | 336 (100%) | 260 (100%) | 634 (100%) | 1230 (100%) |

Table : 4.13 : DISTRIBUTION OF SICK PERSONS AND NUMBER OF EPISODES
(ACUTE AND CHRONIC)
AMONG MALES AND FEMALES IN CASTE AND CLASS GROUPS

| Sex | Type of morbidity | HIGH CASTE | | | MIDDLE CASTE | | | LOW CASTE | | | HIGH CLASS | | | MIDDLE CLASS | | | LOW CLASS | | | TOTAL | |
|-------------|-------------------|---------------------|-----------------|---------------------|-----------------|---------------------|-----------------|---------------------|-----------------|---------------------|-----------------|---------------------|-----------------|---------------------|-----------------|---------------------|-----------------|---------------------|-----------------|---------------------|-----------------|
| | | No. of sick persons | No. of episodes | No. of sick persons | No. of episodes | No. of sick persons | No. of episodes | No. of sick persons | No. of episodes | No. of sick persons | No. of episodes | No. of sick persons | No. of episodes | No. of sick persons | No. of episodes | No. of sick persons | No. of episodes | No. of sick persons | No. of episodes | No. of sick persons | No. of episodes |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | | | | | | |
| Male | Acute | 138 (51.1%) | 234 (54.2%) | 74 (50.0%) | 109 (46.0%) | 73 (51.4%) | 166 (48.4%) | 80 (46.5%) | 140 (52.2%) | 70 (55.1%) | 121 (56.0%) | 135 (51.7%) | 248 (47.0%) | 285 (50.9%) | 509 (50.3%) | | | | | | |
| | Chronic | 50 (55.0%) | 60 (55.6%) | 33 (64.7%) | 39 (65.0%) | 19 (45.0%) | 24 (48.0%) | 30 (51.7%) | 36 (53.0%) | 23 (62.1%) | 29 (65.9%) | 49 (55.0%) | 58 (54.7%) | 102 (55.4%) | 123 (56.4%) | | | | | | |
| Female | Acute | 132 (48.9%) | 198 (45.8%) | 74 (50.0%) | 128 (54.0%) | 69 (48.6%) | 177 (51.6%) | 92 (53.5%) | 128 (47.8%) | 57 (44.9%) | 95 (44.0%) | 126 (48.3%) | 280 (53.0%) | 275 (49.1%) | 503 (49.7%) | | | | | | |
| | Chronic | 41 (45.0%) | 48 (44.4%) | 13 (35.3%) | 21 (35.0%) | 23 (54.8%) | 26 (52.0%) | 28 (48.2%) | 32 (47.0%) | 14 (37.8%) | 15 (34.1%) | 40 (45.0%) | 48 (45.3%) | 82 (44.6%) | 95 (43.6%) | | | | | | |
| TOTAL Acute | | 270 (100%) | 432 (100%) | 148 (100%) | 237 (100%) | 142 (100%) | 343 (100%) | 172 (100%) | 268 (100%) | 127 (100%) | 216 (100%) | 261 (100%) | 528 (100%) | 560 (100%) | 1012 (100%) | | | | | | |
| Chronic | | 91 (100%) | 108 (100%) | 51 (100%) | 60 (100%) | 42 (100%) | 50 (100%) | 58 (100%) | 68 (100%) | 37 (100%) | 44 (100%) | 89 (100%) | 106 (100%) | 184 (100%) | 218 (100%) | | | | | | |

Table : 4.14 : DISTRIBUTION OF AGE-SEX SPECIFIC MORBIDITY RATES
(per 100 persons) FOR TOTAL MORBIDITIES

| Age Group | <u>MALES</u> | | | | <u>FEMALES</u> | | | | <u>TOTAL</u> | |
|-----------|----------------------------|-------------------|--|----------------------------|-------------------------------|--|----------------------------|-------------------|-------------------|--|
| | No. of morbidi- ties | No. of persons | No. of morbidi- ties per 100 persons | No. of morbidi- ties | No. of morbidi- persons | No. of morbidi- ties per 100 persons | No. of morbidi- ties | No. of persons | No. of persons | No. of morbidi- ties per 100 persons |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| - 4 | 33 | 43 | 77 | 21 | 34 | 62 | 54 | 77 | 70 | |
| 5 - 14 | 84 | 114 | 74 | 72 | 121 | 60 | 156 | 235 | 66 | |
| 15 - 24 | 62 | 90 | 69 | 64 | 90 | 71 | 126 | 180 | 70 | |
| 25 - 34 | 81 | 73 | 111 | 105 | 64 | 164 | 186 | 137 | 136 | |
| 35 - 44 | 84 | 55 | 153 | 130 | 66 | 197 | 214 | 121 | 177 | |
| 45 - 54 | 129 | 63 | 205 | 140 | 64 | 219 | 269 | 127 | 212 | |
| 55 - 64 | 116 | 54 | 215 | 47 | 28 | 168 | 163 | 82 | 199 | |
| 65 + | 43 | 23 | 187 | 19 | 18 | 106 | 62 | 41 | 151 | |
| TOTAL | 632 | 515 | 123 | 598 | 485 | 123 | 1230 | 1000 | 123 | |

Table : 4.15 : DISTRIBUTION OF AGE-SEX SPECIFIC ACUTE MORBIDITY RATES
(per 100 persons)

| Age Group | MALE | | | | FEMALES | | | | TOTAL | |
|-------------|----------------------------|-------------------|---|---|---|---|---|---|-------------------|-------------------|
| | No. of morbidi- ties | No. of Persons | No. of morbidity per 100 persons | No. of morbidity per 100 persons | No. of morbidity per 100 persons | No. of morbidity per 100 persons | No. of morbidity per 100 persons | No. of morbidity per 100 persons | No. of persons | No. of persons |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| - 4 yrs. | 32 | 43 | 74 | 19 | 34 | 56 | 51 | 77 | 66 | |
| 5- 14 yrs. | 78 | 114 | 68 | 66 | 121 | 54 | 144 | 235 | 62 | |
| 15- 24 yrs. | 56 | 90 | 62 | 62 | 90 | 69 | 118 | 180 | 65 | |
| 25- 34 yrs. | 68 | 73 | 93 | 87 | 64 | 136 | 155 | 137 | 113 | |
| 35- 44 yrs. | 62 | 55 | 113 | 111 | 66 | 168 | 173 | 121 | 143 | |
| 45- 54 yrs. | 108 | 63 | 171 | 112 | 64 | 175 | 220 | 127 | 173 | |
| 55- 64 yrs. | 80 | 54 | 148 | 31 | 28 | 111 | 111 | 82 | 135 | |
| 65 + yrs. | 25 | 23 | 109 | 15 | 18 | 83 | 40 | 41 | 98 | |
| TOTAL | 509 | 515 | 99 | 503 | 485 | 104 | 1012 | 1000 | 101.2 | |

Table: 4.16 : DISTRIBUTION OF AGE-SEX SPECIFIC CHRONIC MORBIDITY
RATES AMONG MALES AND FEMALES

| Age Group (Years) | MALES | | | | FEMALES | | | | TOTAL | | | |
|----------------------|----------------------------|-------------------|--|----------------------------|-------------------|--|----------------------------|-------------------|--|-------------------|--|--|
| | No. of morbidi- ties | No. of persons | No. of morbidi- ties per 100 persons | No. of morbidi- ties | No. of persons | No. of morbidi- ties per 100 persons | No. of morbidi- ties | No. of persons | No. of morbidi- ties per 100 persons | No. of persons | No. of morbidi- ties per 100 persons | No. of morbidi- ties per 100 persons |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | | | |
| - 4 | 1 | 43 | 2 | 2 | 34 | 6 | 3 | 77 | 4 | | | |
| 5 - 14 | 6 | 114 | 5 | 6 | 121 | 5 | 12 | 235 | 5 | | | |
| 15 - 24 | 6 | 90 | 7 | 2 | 90 | 2 | 8 | 180 | 4 | | | |
| 25 - 34 | 13 | 73 | 18 | 18 | 64 | 28 | 31 | 137 | 23 | | | |
| 35 - 44 | 22 | 55 | 40 | 19 | 66 | 29 | 41 | 121 | 34 | | | |
| 45 - 54 | 21 | 63 | 33 | 28 | 64 | 44 | 49 | 127 | 39 | | | |
| 55 - 64 | 36 | 54 | 67 | 16 | 28 | 57 | 52 | 82 | 63 | | | |
| 65 + | 18 | 23 | 78 | 4 | 18 | 22 | 22 | 41 | 54 | | | |
| TOTAL | 123 | 515 | 24 | 95 | 485 | 20 | 218 | 1000 | 218 | | | |

Table: 4.17 : DISTRIBUTION OF MORBIDITIES (DURATION WISE) AMONG MALES AND FEMALES
IN CASTE AND CLASS GROUPS

| Duration of morbidity/ Sex | HIGH CASTE | | | MIDDLE CASTE | | | LOW CASTE | | | HIGH CLASS | | | MIDDLE CLASS | | | LOW CLASS | | | TOTAL | | |
|-------------------------------------|------------|--------|--------|--------------|--------|--------|-----------|--------|--------|------------|--------|--------|--------------|--------|--------|-----------|--------|--------|--------|--------|--------|
| | Male | Female | Total | Male | Female | Total | Male | Female | Total | Male | Female | Total | Male | Female | Total | Male | Female | Total | Male | Female | Total |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| Minor 89* | 160 | 71 | 231 | 36 | 47 | 83 | 59 | 89 | 148 | 42 | 50 | 92 | 57 | 41 | 98 | 85 | 116 | 201 | 184 | 207 | 391 |
| | (29.6) | (28.9) | (29.3) | (24.3) | (31.5) | (27.9) | (31.1) | (43.8) | (37.7) | (23.9) | (31.3) | (27.4) | (38) | (37.3) | (37.7) | (27.8) | (35.4) | (31.7) | (29.1) | (34.6) | (31.8) |
| Mild | 66 | 50 | 116 | 35 | 46 | 81 | 49 | 43 | 92 | 45 | 24 | 69 | 33 | 29 | 62 | 72 | 86 | 158 | 150 | 139 | 289 |
| | (22.4) | (20.3) | (21.5) | (23.6) | (30.9) | (27.3) | (25.8) | (21.2) | (23.4) | (25.6) | (15) | (20.5) | (22) | (26.4) | (23.8) | (23.5) | (26.2) | (24.9) | (23.7) | (23.2) | (23.5) |
| Mod- erate | 79 | 77 | 156 | 38 | 35 | 73 | 58 | 45 | 103 | 53 | 54 | 107 | 31 | 25 | 56 | 91 | 78 | 169 | 175 | 157 | 332 |
| | (26.9) | (31.3) | (29.1) | (25.7) | (23.5) | (24.6) | (30.5) | (22.2) | (26.2) | (30.1) | (33.7) | (31.8) | (20.7) | (22.7) | (21.5) | (29.7) | (23.8) | (26.7) | (27.7) | (26.3) | (27) |
| Chro- nic | 60 | 49 | 109 | 39 | 21 | 60 | 24 | 26 | 50 | 36 | 32 | 68 | 29 | 15 | 44 | 58 | 48 | 106 | 123 | 95 | 218 |
| | (20.4) | (19.5) | (20) | (26.4) | (14.1) | (20.2) | (12.6) | (12.8) | (12.7) | (20.4) | (20) | (20.2) | (19.3) | (13.6) | (16.9) | (19) | (14.6) | (16.7) | (19.5) | (15.9) | (17.7) |
| Total | 294 | 246 | 540 | 148 | 149 | 297 | 190 | 203 | 393 | 176 | 160 | 336 | 150 | 110 | 260 | 306 | 328 | 634 | 632 | 598 | 1230 |
| | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) |

*Percentage in parentheses.

MALES AND FEMALES IN CASTE AND CLASS GROUPS

| Duration of acute morbidity/ Sex | HIGH CASTE | | | MIDDLE CASTE | | | LOW CASTE | | | HIGH CLASS | | | MIDDLE CLASS | | | LOW CLASS | | | TOTAL | | | |
|-------------------------------------|------------|--------|--------|--------------|--------|--------|-----------|--------|--------|------------|--------|--------|--------------|--------|--------|-----------|--------|--------|--------|--------|--------|--------|
| | Male | Female | Total | Male | Female | Total | Male | Female | Total | Male | Female | Total | Male | Female | Total | Male | Female | Total | Male | Female | Total | |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| Minor illness(38) | 89 | * 71 | 160 | 36 | 47 | 83 | 83 | 59 | 89 | 148 | 42 | 50 | 92 | 57 | 41 | 98 | 85 | 116 | 201 | 184 | 207 | 391 |
| | | (35.9) | (37) | (33) | (35.7) | (35) | (35) | (35.5) | (50.3) | (43.1) | (30) | (39.1) | (34.3) | (47.1) | (43.2) | (45.4) | (34.3) | (41.4) | (38.1) | (36.1) | (41.2) | (38.1) |
| Mild illness(28.2) | 66 | 50 | 116 | 35 | 46 | 81 | 81 | 49 | 43 | 92 | 45 | 24 | 69 | 33 | 29 | 62 | 72 | 86 | 158 | 150 | 139 | 289 |
| | | (25.2) | (26.9) | (32.1) | (36) | (34.2) | (34.2) | (29.5) | (24.3) | (26.8) | (32.1) | (18.7) | (25.7) | (27.3) | (30.5) | (28.7) | (29) | (30.7) | (29.9) | (29.5) | (27.6) | (28.1) |
| Mode-rate illness(33.8) | 79 | 77 | 156 | 38 | 35 | 73 | 73 | 58 | 45 | 103 | 53 | 54 | 107 | 31 | 25 | 56 | 91 | 78 | 169 | 175 | 157 | 332 |
| | | (38.9) | (36.1) | (34.9) | (27.3) | (30.8) | (30.8) | (35) | (25.4) | (30) | (37.9) | (42.2) | (40) | (25.6) | (26.3) | (25.9) | (36.7) | (27.9) | (32) | (34.4) | (31.2) | (32.2) |
| TOTAL | 234 | 198 | 432 | 109 | 128 | 237 | 237 | 166 | 177 | 343 | 140 | 128 | 268 | 121 | 95 | 216 | 248 | 280 | 528 | 509 | 503 | 1012 |
| | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) |

Table: 4.19 : DISTRIBUTION OF CHRONIC MORBIDITIES (DURATION WISE) AMONG MALES AND FEMALES IN CASTE AND CLASS GROUPS

| Duration of Chronic morbidity/ Sex | HIGH CASTE | | | MIDDLE CASTE | | | LOW CASTE | | | HIGH CLASS | | | MIDDLE CLASS | | | LOW CLASS | | | TOTAL | | | |
|---------------------------------------|------------|--------|--------|--------------|--------|--------|-----------|--------|-------|------------|--------|--------|--------------|--------|--------|-----------|--------|--------|--------|--------|--------|-------|
| | Male | Female | Total | Male | Female | Total | Male | Female | Total | Male | Female | Total | Male | Female | Total | Male | Female | Total | Male | Female | Total | |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| Below 1 year | 14 | 23 | (23.2) | 6 | 10 | (15.4) | 16 | 3 | 9 | 12 | 2 | 11 | 13 | 5 | 3 | 8 | 11 | 19 | 30 | 18 | 33 | 51 |
| | (15) | (23.2) | (23.2) | (15.4) | (47.6) | (26.7) | (12.5) | (34.6) | (24) | (5.5) | (34.4) | (19.1) | (17.2) | (20) | (18.2) | (19) | (39.6) | (28.3) | (14.6) | (34.7) | (23.1) | |
| 2-3 yrs | 12 | 30 | (27.8) | 13 | 5 | (23.8) | 18 | 5 | 2 | 7 | 14 | 8 | 22 | 9 | 6 | 15 | 13 | 5 | 18 | 36 | 19 | 55 |
| | (25) | (27.8) | (27.8) | (33.3) | (23.8) | (30) | (20.8) | (7.7) | (14) | (38.9) | (25) | (32.3) | (31) | (40) | (34.1) | (22.4) | (10.1) | (17) | (29.3) | (20) | (25.1) | |
| More than 3 yrs. | 33 | 22 | (55) | 20 | 6 | (23.6) | 26 | 16 | 15 | 31 | 20 | 13 | 33 | 15 | 6 | 21 | 34 | 24 | 58 | 69 | 43 | 112 |
| | (55) | (45.8) | (50.9) | (51.3) | (23.6) | (43.3) | (60.7) | (57.7) | (62) | (55.6) | (40.6) | (48.5) | (51.7) | (40) | (47.7) | (58.6) | (50) | (54.7) | (56.1) | (45.3) | (51.1) | |
| TOTAL | 60 | 48 | (100) | 39 | 21 | (100) | 60 | 24 | 26 | 50 | 36 | 32 | 68 | 29 | 15 | 44 | 58 | 48 | 106 | 123 | 95 | 218 |
| | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) |

*Percentage in parentheses.

Table : 4.20 : DISTRIBUTION OF MORBIDITY EPISODES AMONG AGE-GROUPS
IN CASTE AND CLASS GROUPS

| Age-Group | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOT. |
|---------------|---------------|---------------|---------------|---------------|---------------|----------------|---------------|
| 0 - 4 years | 22 (4.1%) | 18 (6.1%) | 14 (3.6%) | 12 (3.6%) | 11 (4.2%) | 31 (4.9%) | 54 (4.4%) |
| 5 - 14 years | 76 (14.1%) | 32 (10.8%) | 48 (12.2%) | 49 (14.6%) | 40 (15.4%) | 67 (10.6%) | 156 (12.7) |
| 15 - 24 years | 54 (10.0%) | 27 (9.1%) | 45 (11.5%) | 39 (11.6%) | 28 (10.8%) | 59 (9.3%) | 126 (10.2) |
| 25 - 34 years | 91 (16.9%) | 32 (10.8%) | 63 (16.0%) | 66 (19.6%) | 30 (11.5%) | 90 (14.2%) | 186 (15.1) |
| 35 - 44 years | 88 (16.3%) | 41 (13.8%) | 85 (21.6%) | 52 (15.5%) | 46 (17.7%) | 116 (18.3%) | 214 (17.4) |
| 45 - 54 years | 97 (18.0%) | 73 (24.6%) | 99 (25.2%) | 59 (17.6%) | 37 (14.2%) | 173 (27.3%) | 269 (21.9) |
| 55 - 64 years | 78 (14.4%) | 50 (16.8%) | 35 (8.9%) | 44 (13.1%) | 39 (15.0%) | 80 (12.6%) | 163 (13.3) |
| 65 + years | 34 (6.3%) | 24 (8.1%) | 4 (1.0%) | 15 (4.5%) | 29 (11.2%) | 18 (2.8%) | 62 (5.0%) |
| TOTAL | 540 (100%) | 297 (100%) | 393 (100%) | 336 (100%) | 260 (100%) | 634 (100%) | 1000 |

Table : 4.21 : DISTRIBUTION OF ACUTE MORBIDITIES IN AGE-GROUPS AMONG
CASTE AND CLASS GROUPS

| Age-Group | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|--------------|---------------|---------------|---------------|---------------|---------------|----------------|---------------|
| - 4 yrs. | 21 (4.8%) | 18 (7.6%) | 12 (3.5%) | 11 (4.1%) | 11 (5.1%) | 29 (5.5%) | 51 (5.4) |
| 5 - 14 yrs. | 70 (16.2%) | 31 (13.1%) | 43 (12.5%) | 47 (17.5%) | 38 (17.6%) | 59 (11.2%) | 144 (14) |
| 15 - 24 yrs. | 50 (11.6%) | 24 (10.1%) | 44 (12.8%) | 36 (13.4%) | 25 (11.6%) | 57 (10.8%) | 118 (11) |
| 25 - 34 yrs. | 73 (16.9%) | 28 (11.8%) | 54 (15.7%) | 52 (19.4%) | 25 (11.6%) | 78 (14.8%) | 155 (15) |
| 35 - 44 yrs. | 70 (16.2%) | 33 (13.9%) | 70 (20.4%) | 45 (16.8%) | 34 (15.7%) | 94 (17.8%) | 173 (17) |
| 45 - 54 yrs. | 75 (17.4%) | 57 (24.0%) | 88 (25.7%) | 43 (16.0%) | 32 (14.8%) | 145 (27.4%) | 220 (21) |
| 55 - 64 yrs. | 50 (11.6%) | 32 (13.5%) | 29 (8.5%) | 26 (9.7%) | 30 (13.9%) | 55 (10.4%) | 111 (11) |
| 65 + yrs. | 23 (5.3%) | 14 (6.0%) | 3 (0.9%) | 8 (3.0%) | 21 (9.7%) | 11 (2.1%) | 40 (4.4) |
| TOTAL | 432 (100%) | 237 (100%) | 343 (100%) | 268 (100%) | 216 (100%) | 528 (100%) | 1011 (100) |

Table : 4.22 : DISTRIBUTION OF CHRONIC MORBIDITIES IN AGE-GROUPS
AMONG CASTE AND CLASS GROUPS

| Age-Group | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|--------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| - 14 yrs. | 7 (6.5%) | 1 (1.7%) | 7 (14.0%) | 3 (4.4%) | 2 (4.5%) | 10 (9.4%) | 15 (6.4%) |
| 15 - 24 yrs. | 4 (3.7%) | 3 (5.0%) | 1 (2.0%) | 3 (4.4%) | 3 (6.8%) | 2 (1.9%) | 8 (3.4%) |
| 25 - 34 yrs | 18 (16.7%) | 4 (6.7%) | 9 (18.0%) | 14 (20.6%) | 5 (11.4%) | 12 (11.3%) | 31 (14.4%) |
| 35 - 44 yrs | 18 (16.7%) | 8 (13.3%) | 15 (30.0%) | 7 (10.3%) | 12 (27.3%) | 22 (20.8%) | 41 (18.1%) |
| 45 - 54 yrs | 22 (20.3%) | 16 (26.7%) | 11 (22.0%) | 16 (23.5%) | 5 (11.4%) | 28 (26.4%) | 49 (22.0%) |
| 55 - 64 yrs | 28 (26.0%) | 18 (30.0%) | 6 (12.0%) | 18 (26.5%) | 9 (20.5%) | 25 (23.6%) | 52 (23.3%) |
| 65 + yrs. | 11 (10.1%) | 10 (16.6%) | 1 (2.0%) | 7 (10.3%) | 8 (18.1%) | 7 (6.6%) | 22 (10.0%) |
| TOTAL | 108 (100%) | 60 (100%) | 50 (100%) | 68 (100%) | 44 (100%) | 106 (100%) | 218 (100%) |

Table:424 : DISTRIBUTION OF SICK PERSONS AMONG
MALES AND FEMALES IN AGE-GROUPS

| Age-Group | Male | Female | TOTAL |
|--------------|---------------|---------------|----------------|
| - 4 yrs. | 21 (6.9%) | 14 (4.7%) | 35 (5.8%) |
| 5- 14 yrs. | 60 (19.8%) | 50 (16.8%) | 110 (18.3%) |
| 15 -24 yrs. | 37 (12.2%) | 43 (14.4%) | 80 (13.3%) |
| 25 -34 yrs. | 38 (12.5%) | 49 (16.4%) | 87 (14.5%) |
| 35 - 44 yrs. | 35 (11.6%) | 52 (17.4%) | 87 (14.5%) |
| 45 - 54 yrs. | 53 (17.5%) | 54 (18.1%) | 107 (17.8%) |
| 55 - 64 yrs. | 44 (14.5%) | 24 (8.2%) | 68 (11.3%) |
| 65+ yrs. | 15 (5.0%) | 12 (4.0%) | 27 (4.5%) |
| TOTAL | 303 (100%) | 298 (100%) | 601 (100%) |

Table: 4.25 : DISTRIBUTION OF MORBIDITIES (PERSONS-WISE AND EPISODES-WISE) AMONG MALES AND FEMALES IN AGE GROUPS FOR ACUTE, CHRONIC AND TOTAL MORBIDITIES

| Age- Category | ACUTE MORBIDITIES | | | | | | CHRONIC MORBIDITIES | | | | | | TOTAL MORBIDITIES | | | | | |
|----------------------------|-------------------|--------------|---------------|---------------|---------------|---------------|---------------------|--------------|---------------|--------------|--------------|--------------|-------------------|---------------|---------------|---------------|---------------|---------------|
| | SICK PERSONS | | | EPISODES | | | SICK PERSONS | | | EPISODES | | | SICK PERSONS | | | EPISODES | | |
| | M | F | T | M | F | T | M | F | T | M | F | T | M | F | T | M | F | T |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 |
| Children (- 14 yrs.) | 79 (27.7)* | 61 (22.2) | 140 (25) | 110 (21.6) | 85 (16.9) | 195 (19.3) | 7 (6.9) | 7 (8.5) | 14 (7.6) | 7 (5.7) | 8 (8.4) | 15 (6.9) | 81 (26.7) | 64 (21.5) | 145 (24.1) | 117 (18.5) | 93 (15.5) | 210 (17.1) |
| Youth (15 - 34 yrs.) | 72 (25.3) | 89 (32.3) | 161 (28.8) | 124 (24.4) | 149 (29.6) | 273 (27) | 17 (16.7) | 16 (19.5) | 33 (17.9) | 19 (15.4) | 20 (21) | 39 (17.9) | 75 (24.7) | 92 (30.8) | 167 (27.8) | 143 (22.6) | 169 (28.3) | 312 (25.3) |
| Middle-age (35-54 yrs.) | 83 (29.1) | 97 (35.3) | 180 (32.1) | 170 (33.4) | 223 (44.3) | 393 (38.8) | 35 (34.3) | 42 (51.2) | 77 (44.8) | 43 (35) | 47 (49.5) | 90 (41.3) | 88 (29.1) | 106 (35.6) | 194 (32.3) | 213 (33.7) | 270 (45.1) | 483 (39.3) |
| Old-age (55+ yrs.) | 51 (17.9) | 28 (10.2) | 79 (14.1) | 105 (20.6) | 46 (9.1) | 151 (14.9) | 43 (42.1) | 17 (20.7) | 60 (32.6) | 54 (43.9) | 20 (21.1) | 74 (33.9) | 59 (19.5) | 36 (12.1) | 95 (15.8) | 159 (25.2) | 66 (11.1) | 225 (18.3) |
| TOTAL | 285 (100) | 275 (100) | 560 (100) | 509 (100) | 503 (100) | 1012 (100) | 102 (10) | 82 (99.9) | 184 (99.9) | 123 (100) | 95 (100) | 218 (100) | 303 (100) | 298 (100) | 601 (100) | 632 (100) | 598 (100) | 1230 (100) |

M = Male
F = Female
T = Total

*Percentage in parentheses

Table: 4.26 : DISTRIBUTION OF HEALTH ACTION FOR CHRONIC, ACUTE AND TOTAL MORBIDITIES IN CASTE AND CLASS GROUPS

| Health Action | HIGH CASTE | | | MIDDLE CASTE | | | LOW CASTE | | | HIGH CLASS | | | MIDDLE CLASS | | | LOW CLASS | | | TOTAL | | |
|---------------|------------|-------|--------|--------------|--------|--------|-----------|--------|--------|------------|--------|--------|--------------|-------|--------|-----------|--------|--------|--------|--------|--------|
| | Caste | | | Caste | | | Caste | | | Caste | | | Caste | | | Caste | | | Caste | | |
| | A | T | C | A | T | C | A | T | C | A | T | C | A | T | C | A | T | C | A | T | C |
| 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| Health Action | 81 | 461 | 36 | 204 | 240 | 26 | 250 | 276 | 51 | 229 | 280 | 29 | 190 | 219 | 63 | 415 | 478 | 143 | 834 | 977 | |
| Health Action | (75)* | (88) | (85.4) | (60) | (86.1) | (80.8) | (52) | (72.9) | (70.2) | (75) | (85.4) | (83.3) | (65.9) | (88) | (84.2) | (59.4) | (78.6) | (75.4) | (65.6) | (82.4) | (79.4) |
| Health Action | 27 | 52 | 79 | 24 | 33 | 57 | 93 | 117 | 17 | 39 | 56 | 15 | 26 | 41 | 43 | 113 | 156 | 75 | 178 | 253 | |
| Health Action | (25) | (12) | (14.6) | (40) | (13.9) | (19.2) | (48) | (27.1) | (29.8) | (25) | (14.6) | (16.7) | (34.1) | (12) | (15.8) | (40.6) | (21.4) | (24.6) | (34.4) | (17.6) | (20.6) |
| Health Action | 108 | 432 | 540 | 60 | 237 | 297 | 343 | 393 | 68 | 268 | 336 | 44 | 216 | 260 | 106 | 528 | 634 | 218 | 1012 | 1230 | |
| Health Action | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) | (100) |

C = Chronic Morbidities
A = Acute Morbidities
T = Total Morbidities

* Percentage in parentheses

Table: 4.27 : HEALTH ACTION TAKEN AMONG MALES AND FEMALES
IN CASTE AND CLASS GROUPS

| Sex/ Health Action | HIGH CASTE | | | MIDDLE CASTE | | | LOW CASTE | | | HIGH CLASS | | | MIDDLE CLASS | | | LOW CLASS | | | TOTAL | |
|--------------------------|--|---|---|--|---|---|--|---|---|--|---|--|---|--|---|--|---|--|---|--|
| | Health action taken for No. of episodes | Total No. of episodes taken for No. of episodes | Total No. of episodes taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes taken for No. of episodes | Total No. of episodes taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes taken for No. of episodes | Total No. of episodes taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes taken for No. of episodes | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | | | | | | |
| Male | 246 (83.7%) | 294 (100%) | 120 (81.1%) | 148 (100%) | 140 (73.7%) | 190 (100%) | 144 (81.8%) | 176 (100%) | 127 (84.7%) | 150 (100%) | 235 (76.8%) | 306 (100%) | 506 (80.0%) | 632 (100%) | | | | | | |
| Female | 215 (87.4%) | 246 (100%) | 120 (80.5%) | 149 (100%) | 136 (67.0%) | 203 (100%) | 136 (85.0%) | 160 (100%) | 93 (84.5%) | 110 (100%) | 242 (73.8%) | 328 (100%) | 471 (78.8%) | 598 (100%) | | | | | | |
| TOTAL | 461 (85.4%) | 540 (100%) | 240 (80.8%) | 297 (100%) | 276 (70.2%) | 393 (100%) | 280 (83.3%) | 336 (100%) | 220 (84.6%) | 260 (100%) | 477 (75.2%) | 634 (100%) | 977 (79.4%) | 1230 (100%) | | | | | | |

Table: 4.29 : HEALTH ACTION TAKEN BY MALES AND FEMALES IN CASTE AND CLASS GROUPS
FOR ACUTE MORBIDITIES

| Sex/ Health Action | HIGH CASTE | | | MIDDLE CASTE | | | LOW CASTE | | | HIGH CLASS | | | MIDDLE CLASS | | | LOW CLASS | | | TOTAL | |
|--------------------------|--|-----------------------------|--|--|-----------------------------|--|--|-----------------------------|--|--|-----------------------------|--|--|-----------------------------|--|--|-----------------------------|--|-----------------------------|--|
| | Health action taken for No. of episodes | Total No. of episodes | Health action taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes | Health action taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes | Health action taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes | Health action taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes | Health action taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes | Health action taken for No. of episodes | Total No. of episodes | Health action taken for No. of episodes |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | | | | | | |
| Male | 204 (87.2%) | 234 (100%) | 98 (90.9%) | 109 (100%) | 129 (77.7%) | 166 (100%) | 121 (86.4%) | 140 (100%) | 107 (88.4%) | 121 (100%) | 203 (81.9%) | 248 (100%) | 431 (84.7%) | 509 (100%) | | | | | | |
| Female | 176 (88.9%) | 198 (100%) | 106 (83.0%) | 128 (100%) | 121 (68.4%) | 177 (100%) | 108 (84.4%) | 128 (100%) | 83 (87.3%) | 95 (100%) | 212 (75.7%) | 280 (100%) | 403 (80.0%) | 503 (100%) | | | | | | |
| TOTAL | 380 (88.0%) | 432 (100%) | 204 (86.1%) | 237 (100%) | 250 (73.0%) | 343 (100%) | 229 (85.4%) | 268 (100%) | 190 (88.0%) | 216 (100%) | 415 (78.6%) | 528 (100%) | 834 (82.4%) | 1012 (100%) | | | | | | |

Table: 4.31 : HEALTH ACTION TAKEN BY MALES AND FEMALES IN CASTE AND CLASS GROUPS
FOR CHRONIC MORBIDITIES

| Sex/ Health Action | HIGH CASTE | | | MIDDLE CASTE | | | LOW CASTE | | | HIGH CLASS | | | MIDDLE CLASS | | | LOW CLASS | | | TOTAL | |
|--------------------------|--|-----------------------------|--|--|-----------------------------|--|--|-----------------------------|--|--|-----------------------------|--|--|-----------------------------|--|--|-----------------------------|--|-----------------------------|--|
| | Health action taken for No. of episodes | Total No. of episodes | Health action taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes | Health action taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes | Health action taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes | Health action taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes | Health action taken for No. of episodes | Health action taken for No. of episodes | Total No. of episodes | Health action taken for No. of episodes | Total No. of episodes | Health action taken for No. of episodes |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | | | | | | |
| Male | 42 (70.0%) | 60 (100%) | 22 (56.4%) | 39 (100%) | 11 (45.8%) | 24 (100%) | 23 (63.9%) | 36 (100%) | 20 (69.0%) | 29 (100%) | 32 (55.2%) | 58 (100%) | 75 (61.0%) | 123 (100%) | | | | | | |
| Female | 39 (81.2%) | 48 (100%) | 14 (60.7%) | 21 (100%) | 15 (57.7%) | 26 (100%) | 28 (87.5%) | 32 (100%) | 10 (66.7%) | 15 (100%) | 30 (62.5%) | 43 (100%) | 68 (71.6%) | 95 (100%) | | | | | | |
| TOTAL | 81 (75.0%) | 108 (100%) | 36 (60.0%) | 60 (100%) | 26 (52.0%) | 50 (100%) | 51 (75.0%) | 68 (100%) | 30 (68.2%) | 44 (100%) | 62 (53.5%) | 101 (100%) | 143 (55.6%) | 218 (100%) | | | | | | |

Table: 4.33 : HEALTH ACTION TAKEN AMONG CHILDREN, YOUTH, MIDDLE AGE AND OLD AGE CATEGORIES
IN CASTE AND CLASS GROUPS FOR TOTAL MORBIDITIES

| Age group/ Health Action | HIGH CASTE | | MIDDLE CASTE | | LOW CASTE | | HIGH CLASS | | MIDDLE CLASS | | LOW CLASS | | TOTAL | |
|--------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| | Health action taken for No. of episodes | Total No.of episodes taken for No. of episodes | Health action taken for No. of episodes | Total No.of episodes taken for No. of episodes | Health action taken for No. of episodes | Total No.of episodes taken for No. of episodes | Health action taken for No. of episodes | Total No.of episodes taken for No. of episodes | Health action taken for No. of episodes | Total No.of episodes taken for No. of episodes | Health action taken for No. of episodes | Total No.of episodes taken for No. of episodes | Health action taken for No. of episodes | Total No.of episodes taken for No. of episodes |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| - 14 yrs. (Children) | 95 (96.9%) | 98 (100%) | 43 (86.0%) | 50 (100%) | 51 (82.3%) | 62 (100%) | 57 (93.4%) | 61 (100%) | 48 (94.1%) | 51 (100%) | 84 (85.7%) | 98 (100%) | 189 (90.0%) | 210 (100%) |
| 15-34 yrs (Youth) | 130 (89.7%) | 145 (100%) | 45 (76.3%) | 59 (100%) | 66 (61.1%) | 108 (100%) | 88 (83.8%) | 105 (100%) | 50 (86.2%) | 58 (100%) | 103 (69.1%) | 149 (100%) | 241 (77.2%) | 312 (100%) |
| 35-54 yrs. (Middle age) | 150 (81.1%) | 185 (100%) | 95 (83.3%) | 114 (100%) | 130 (70.7%) | 184 (100%) | 91 (82.0%) | 111 (100%) | 65 (78.3%) | 83 (100%) | 220 (76.1%) | 289 (100%) | 375 (77.6%) | 483 (100%) |
| 55 + yrs. (Old age) | 86 (76.8%) | 112 (100%) | 57 (77.0%) | 74 (100%) | 29 (74.4%) | 39 (100%) | 44 (74.6%) | 59 (100%) | 57 (83.8%) | 68 (100%) | 71 (72.4%) | 98 (100%) | 172 (76.4%) | 225 (100%) |
| TOTAL | 461 (85.4%) | 540 (100%) | 240 (80.8%) | 297 (100%) | 276 (70.2%) | 393 (100%) | 280 (83.3%) | 336 (100%) | 220 (84.6%) | 260 (100%) | 478 (75.4%) | 634 (100%) | 977 (79.4%) | 1230 (100%) |

Table : 4.34 : HEALTH ACTION TAKEN AMONG CHILDREN, YOUTH, MIDDLE-AGED AND OLD PEOPLE IN CASTE AND CLASS GROUPS FOR ACUTE MORBIDITIES

| Age Category/ Health Action | HIGH CASTE | | | MIDDLE CASTE | | | LOW CASTE | | | HIGH CLASS | | | MIDDLE CLASS | | | LOW CLASS | | | TOTAL | | |
|--------------------------------|---|-----------------------|-------------|---|-----------------------|------------|---|-----------------------|-------------|---|-----------------------|------------|---|-----------------------|-----|---|-----------------------|-----|---|-----------------------|-----|
| | Health action taken for No. of episodes | Total No. of episodes | (%) | Health action taken for No. of episodes | Total No. of episodes | (%) | Health action taken for No. of episodes | Total No. of episodes | (%) | Health action taken for No. of episodes | Total No. of episodes | (%) | Health action taken for No. of episodes | Total No. of episodes | (%) | Health action taken for No. of episodes | Total No. of episodes | (%) | Health action taken for No. of episodes | Total No. of episodes | (%) |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | | | | | | | |
| Children (- 14 yrs.) | 88 (96.7%) | 91 (100%) | 42 (85.7%) | 49 (100%) | 46 (83.6%) | 55 (100%) | 54 (93.1%) | 58 (100%) | 46 (93.9%) | 49 (100%) | 76 (86.4%) | 88 (100%) | 176 (90.2%) | 195 (100%) | | | | | | | |
| Youth (15-34 yrs.) | 113 (91.8%) | 123 (100%) | 43 (82.7%) | 52 (100%) | 63 (64.3%) | 98 (100%) | 77 (87.5%) | 88 (100%) | 44 (88.0%) | 50 (100%) | 98 (72.6%) | 135 (100%) | 219 (80.2%) | 273 (100%) | | | | | | | |
| Middle-aged (35-54 yrs.) | 123 (84.8%) | 145 (100%) | 78 (86.7%) | 90 (100%) | 116 (73.4%) | 158 (100%) | 73 (83.0%) | 88 (100%) | 54 (81.8%) | 66 (100%) | 190 (79.5%) | 239 (100%) | 317 (80.6%) | 393 (100%) | | | | | | | |
| Old-aged (55+ yrs.) | 56 (76.7%) | 73 (100%) | 41 (89.1%) | 46 (100%) | 25 (78.1%) | 32 (100%) | 25 (73.5%) | 34 (100%) | 46 (90.2%) | 51 (100%) | 51 (77.3%) | 66 (100%) | 122 (80.8%) | 151 (100%) | | | | | | | |
| TOTAL | 380 (88.0%) | 432 (100%) | 204 (86.1%) | 237 (100%) | 250 (72.9%) | 343 (100%) | 229 (85.4%) | 268 (100%) | 190 (88.0%) | 216 (100%) | 415 (78.6%) | 528 (100%) | 834 (82.4%) | 1012 (100%) | | | | | | | |

Table : 4.35 : HEALTH ACTION TAKEN AMONG CHILDREN, YOUTH, MIDDLE-AGED AND OLD PEOPLE IN CASTE AND CLASS GROUPS FOR CHRONIC MORBIDITIES

| Age Category/ Health Action | HIGH CASTE | | | MIDDLE CASTE | | | LOW CASTE | | | HIGH CLASS | | | MIDDLE CLASS | | | LOW CLASS | | | TOTAL | | |
|--------------------------------|---|-----------------------|------------|---|-----------------------|-----------|---|-----------------------|------------|---|-----------------------|------------|---|-----------------------|-----|---|-----------------------|-----|---|-----------------------|-----|
| | Health action taken for No. of episodes | Total No. of episodes | (%) | Health action taken for No. of episodes | Total No. of episodes | (%) | Health action taken for No. of episodes | Total No. of episodes | (%) | Health action taken for No. of episodes | Total No. of episodes | (%) | Health action taken for No. of episodes | Total No. of episodes | (%) | Health action taken for No. of episodes | Total No. of episodes | (%) | Health action taken for No. of episodes | Total No. of episodes | (%) |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | | | | | | | |
| Children (- 14 yrs.) | 7 (100%) | 7 (100%) | 1 (100%) | 1 (100%) | 5 (71.4%) | 7 (100%) | 3 (100%) | 3 (100%) | 2 (100%) | 2 (100%) | 8 (80.0%) | 10 (100%) | 13 (85.7%) | 15 (100%) | | | | | | | |
| Youth (15 - 34 yrs.) | 17 (77.3%) | 22 (100%) | 2 (28.6%) | 7 (100%) | 3 (30.0%) | 10 (100%) | 11 (64.7%) | 17 (100%) | 6 (75.0%) | 8 (100%) | 5 (35.7%) | 14 (100%) | 22 (56.4%) | 31 (100%) | | | | | | | |
| Middle-aged (35-54 yrs.) | 27 (67.5%) | 40 (100%) | 17 (70.8%) | 24 (100%) | 15 (57.7%) | 26 (100%) | 18 (78.3%) | 23 (100%) | 11 (64.7%) | 17 (100%) | 30 (60.0%) | 50 (100%) | 59 (65.2%) | 70 (100%) | | | | | | | |
| Old-aged (55 + yrs.) | 30 (76.9%) | 39 (100%) | 16 (57.1%) | 28 (100%) | 3 (42.8%) | 7 (100%) | 19 (76.0%) | 25 (100%) | 11 (64.7%) | 17 (100%) | 19 (59.4%) | 32 (100%) | 49 (62.5%) | 74 (100%) | | | | | | | |
| TOTAL | 81 (75.0%) | 108 (100%) | 36 (60.0%) | 60 (100%) | 26 (62.0%) | 50 (100%) | 51 (75.1%) | 68 (100%) | 30 (68.2%) | 44 (100%) | 62 (58.5%) | 106 (100%) | 143 (65.6%) | 173 (100%) | | | | | | | |

TABLE : 4.36 : DIFFERENCE IN PROPORTIONS IN HIGH CASTE AND LOW CASTE AND HIGH CLASS AND LOW CLASS GROUPS FOR SELECTED VARIABLES

| Variable | High Caste %age | Low Caste %age | Difference | High Class %age | Low Class %age | Difference |
|------------------------------------|-----------------|----------------|------------|-----------------|----------------|------------|
| Acute Morbidity (episodes) | 80 | 87.3 | - 7.3 | 79.8 | 83.3 | - 3.5 |
| Chronic morbidity (episodes) | 20 | 12.7 | 7.3 | 20.2 | 16.7 | 3.5 |
| Prevalence Rate | 106.9 | 173.1 | -66.2 | 98 | 147.1 | -49.1 |
| Health Action | 85.4 | 70.2 | 15.2 | 83.3 | 75.4 | 7.9 |
| Health action by males | 83.7 | 73.7 | 10.0 | 81.8 | 76.8 | 5.0 |
| Health action by females | 87.4 | 67.0 | 20.4 | 85.0 | 73.8 | 11.2 |
| Health action in children | 96.9 | 82.3 | 14.6 | 93.4 | 85.7 | 7.7 |
| Health action in youths | 89.7 | 61.1 | 28.6 | 83.8 | 69.1 | 14.7 |
| Health action in middle age people | 81.1 | 70.7 | 10.4 | 82.0 | 76.1 | 5.9 |
| Health action in old age people | 76.8 | 74.4 | 2.4 | 74.6 | 72.4 | 2.2 |
| Morbidity in children | 18.1 | 15.8 | 2.3 | 18.1 | 15.5 | 2.6 |
| Morbidity in youth | 26.9 | 27.5 | - 0.6 | 31.3 | 23.5 | 7.8 |
| Morbidity in middle age category | 34.3 | 46.8 | -12.5 | 33.0 | 45.5 | -12.5 |
| Morbidity in old age category | 20.7 | 9.9 | 10.8 | 17.6 | 15.5 | 2.1 |

Table : 5.1 : Visit to various health resources in caste and class groups during the preceding 2 months from the date of interview

| Visit to Health Resource | High Caste N=98 | Middle Caste N=54 | Low Caste N=48 | High Class N=57 | Middle Class N=47 | Low Class N=96 | TOTAL N=200 |
|--|--------------------|----------------------|-------------------|--------------------|----------------------|-------------------|----------------|
| Visited PHC | 58 (59.1%) | 34 (62.9%) | 33 (68.7%) | 31 (54.3%) | 31 (65.9%) | 63 (65.6%) | 125 (62.5%) |
| Visited CHV | 9 (9.1%) | - | 20 (41.6%) | 2 (3.5%) | 6 (12.7%) | 21 (21.8%) | 29 (14.5%) |
| Visited Private Doctors out-side the village | 46 (46.9%) | 19 (35.1%) | 13 (27.0%) | 34 (59.6%) | 12 (25.5%) | 32 (33.3%) | 78 (39.0%) |
| Visited RMP within the village | 45 (45.9%) | 23 (42.5%) | 20 (41.6%) | 36 (63.1%) | 11 (23.4%) | 41 (42.7%) | 88 (44.0%) |
| Visited folk-healers | 32 (32.6%) | 9 (16.6%) | 10 (20.8%) | 19 (33.3%) | 10 (21.2%) | 22 (22.9%) | 51 (25.5%) |

Note : Column totals do not add because of multiple responses

Table : 5.2 : Use of PHC Services (ever used) by households
in caste and class groups

| PHC services ever used/ not used | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|--|---------------|-----------------|----------------|---------------|-----------------|---------------|----------------|
| Ever used | 78 (79.6%) | 45 (88.3%) | 48 (100.0%) | 43 (75.4%) | 40 (85.1%) | 88 (91.7%) | 171 (85.5%) |
| Never used | 20 (20.4%) | 9 (16.7%) | 0 (0.0) | 14 (24.6%) | 7 (14.9%) | 8 (8.3%) | 29 (14.5%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (100%) | 57 (100%) | 47 (100%) | 96 (100%) | 200 (100%) |

Table : 5.3A : Type of PHC special service used by caste and class groups during the period of 2 months preceding the date of interview

| Service used | High Caste N=98 | Middle Caste N=54 | Low Caste N=48 | High Class N=57 | Middle Class N=47 | Low Class N=96 | TOTAL N=200 |
|---|--------------------|----------------------|-------------------|--------------------|----------------------|-------------------|----------------|
| PHC special service used by the households in general | 64 (65.3%) | 32 (59.2%) | 41 (85.4%) | 34 (59.6%) | 33 (70.2%) | 70 (72.9%) | 137 (68.5%) |
| Maternal care | 33 (33.6%) | 27 (50.0%) | 31 (64.5%) | 18 (31.5%) | 22 (46.8%) | 51 (53.1%) | 91 (45.5%) |
| Delivery | 10 (10.2%) | 7 (12.9%) | 10 (20.8%) | 4 (7.0%) | 7 (14.8%) | 16 (16.6%) | 27 (13.5%) |
| Immunization | 35 (35.7%) | 12 (22.2%) | 28 (58.3%) | 20 (35.0%) | 17 (36.1%) | 38 (39.5%) | 75 (37.5%) |
| Family planning | 29 (29.5%) | 15 (27.7%) | 14 (29.1%) | 14 (24.5%) | 16 (34.0%) | 28 (29.1%) | 58 (29.0%) |
| Hospitalization | 17 (17.3%) | 14 (25.9%) | 6 (12.5%) | 8 (14.0%) | 9 (19.1%) | 20 (20.8%) | 37 (18.5%) |
| Special treatment | 2 (2.0%) | 3 (5.5%) | - | - | 2 (4.2%) | 3 (3.1%) | 5 (2.5%) |

Table : 5.4 : Type of Experience at PHC in caste and class groups

| Type of Experience at PHC | High Caste N=78 | Middle Caste N=45 | Low Caste N=48 | High Class N=43 | Middle Class N=40 | Low Class N=88 | TOTAL N=171 |
|----------------------------------|----------------------------|------------------------------|---------------------------|----------------------------|------------------------------|---------------------------|------------------------|
| Prompt Service | 39 (50.0%) | 25 (55.5%) | 23 (47.9%) | 27 (62.9%) | 22 (55.0%) | 38 (43.1%) | 87 (50.8%) |
| Good Medicine | 47 (60.2%) | 33 (73.3%) | 24 (50.0%) | 32 (74.4%) | 23 (57.5%) | 49 (55.6%) | 104 (60.8%) |
| Good behaviour of staff | 59 (75.6%) | 36 (80.0%) | 35 (72.9%) | 34 (79.0%) | 32 (80.0%) | 64 (72.7%) | 130 (76.0%) |
| Satisfied with services | 47 (60.2%) | 27 (60.0%) | 24 (50.0%) | 32 (74.4%) | 22 (55.0%) | 44 (50.0%) | 98 (57.3%) |
| PHC useful | 49 (62.8%) | 31 (68.8%) | 26 (54.1%) | 32 (74.4%) | 25 (62.5%) | 49 (55.6%) | 106 (61.9%) |

Table : 5.5 : Rank of preference in consulting PHC in caste and class groups

| Rank of preference | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|--------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| First preference | 16 (16.3%) | 10 (18.5%) | 13 (27.1%) | 9 (15.8%) | 8 (17.0%) | 22 (22.9%) | 39 (19.5%) |
| Second preference | 33 (33.7%) | 20 (37.0%) | 20 (41.6%) | 16 (28.1%) | 19 (40.4%) | 38 (39.6%) | 73 (36.5%) |
| Third preference | 5 (5.1%) | 8 (14.8%) | 4 (8.3%) | 4 (7.0%) | 4 (8.5%) | 9 (9.4%) | 17 (8.5%) |
| No preference | 45 (44.9%) | 16 (29.6%) | 11 (23.0%) | 28 (49.1%) | 16 (34.0%) | 27 (28.1%) | 71 (35.5%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (100%) | 57 (100%) | 47 (100%) | 96 (100%) | 200 (100%) |

**Table : 5.6 : Reasons for preference in consulting PHC in
caste and class groups**

| Type of reason | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|--|-----------------------|-------------------------|----------------------|-----------------------|-------------------------|----------------------|---------------|
| Not satisfied with treat- ment by other agencies/ cures | 27 (51.0%) | 14 (35.9%) | 17 (46.0%) | 11 (38.0%) | 18 (58.0%) | 29 (42.0%) | 58 (45.0%) |
| Free treatment | 21 (39.6%) | 24 (61.5%) | 11 (29.7%) | 13 (44.8%) | 8 (25.8%) | 35 (50.7%) | 56 (43.4%) |
| Personal | 3 (5.7%) | 1 (2.6%) | 1 (2.7%) | 2 (6.9%) | 2 (6.5%) | 1 (1.5%) | 5 (3.8%) |
| Faith | - | - | 2 (5.4%) | 2 (6.9%) | - | - | 2 (1.6%) |
| Others | 2 (3.7%) | - | 6 (16.2%) | 1 (3.4%) | 3 (9.7%) | 4 (5.8%) | 8 (6.2%) |
| TOTAL | 53 (100%) | 39 (100%) | 37 (100%) | 29 (100%) | 31 (100%) | 69 (100%) | 129 (100%) |

Table : 5.7 : Reasons for consulting PHC in caste and class groups

| Reason | High Caste N=98 | Middle Caste N=54 | Low Caste N=48 | High Class N=57 | Middle Class N=47 | Low Class N=96 | TOTAL N=200 |
|---|--------------------|----------------------|-------------------|--------------------|----------------------|-------------------|----------------|
| Service free of cost | 33 (52.4%) | 27 (73.0%) | 16 (47.0%) | 14 (40.0%) | 16 (48.5%) | 46 (69.7%) | 76 (56.7%) |
| Good image of resources and services | 3 (4.8%) | 2 (5.4%) | 4 (11.8%) | 5 (14.3%) | 2 (6.1%) | 2 (3.0%) | 9 (6.7%) |
| Personal network | 5 (8.0%) | 2 (5.4%) | 1 (3.0%) | 3 (8.5%) | 3 (9.1%) | 2 (3.0%) | 8 (6.0%) |
| Good image of certain doctor or specialist services | 9 (14.3%) | 5 (13.5%) | - | 5 (14.3%) | 6 (18.1%) | 3 (4.5%) | 14 (10.4%) |
| Limitations of some kind | 8 (12.5%) | 1 (2.7%) | 9 (26.4%) | 5 (14.3%) | 4 (12.1%) | 7 (13.6%) | 18 (13.4%) |
| Others | 5 (8.0%) | - | 4 (11.8%) | 3 (8.5%) | 2 (6.1%) | 4 (6.1%) | 9 (6.7%) |
| TOTAL | 63 (100%) | 37 (100%) | 34 (100%) | 35 (99.9%) | 33 (100%) | 66 (99.9%) | 134 (100%) |

Table : 5.8 : Home visit by ANM in caste and class groups during the preceding six months from the date of interview

| No. of visits | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|-----------------|---------------|---------------|---------------|---------------|---------------|---------------|----------------|
| One | 1 (1.0%) | 1 (1.8%) | 8 (16.7%) | 2 (3.5%) | 1 (2.1%) | 7 (7.3%) | 10 (5.0%) |
| Two | 3 (3.1%) | 1 (1.8%) | 1 (2.1%) | 1 (1.8%) | 2 (4.2%) | 2 (2.1%) | 5 (2.5%) |
| Three | 3 (3.1%) | 1 (1.8%) | 2 (4.2%) | 2 (3.5%) | 2 (4.2%) | 2 (2.1%) | 6 (3.0%) |
| More than three | 10 (10.2%) | 5 (9.3%) | 6 (12.5%) | 9 (15.8%) | 6 (12.8%) | 6 (6.2%) | 21 (10.5%) |
| Not visited | 81 (82.6%) | 46 (85.2%) | 31 (64.5%) | 43 (75.4%) | 36 (76.6%) | 79 (82.3%) | 158 (79.0%) |
| TOTAL | 98 (100%) | 54 (99.9%) | 48 (100%) | 57 (100%) | 47 (99.9%) | 96 (100.%) | 200 (100%) |

Table : 5.9 : Type of services provided by ANM during her home visits in caste and class groups

| Type of service | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|----------------------|---------------|---------------|---------------|---------------|---------------|---------------|----------------|
| Tablets | 5 (5.1%) | 1 (1.8%) | 3 (6.2%) | 2 (3.5%) | 3 (6.4%) | 4 (4.2%) | 9 (4.5%) |
| Family planning work | - | 1 (1.8%) | 2 (4.2%) | - | 2 (4.2%) | 1 (1.0%) | 3 (1.5%) |
| Others | 12 (12.2%) | 6 (11.1%) | 12 (25.0%) | 12 (21.1%) | 6 (12.8%) | 12 (12.5%) | 30 (15.0%) |
| Not visited | 81 (82.7%) | 46 (85.2%) | 31 (64.6%) | 43 (75.4%) | 36 (76.6%) | 79 (82.3%) | 158 (79.0%) |
| TOTAL | 98 (100%) | 54 (99.9%) | 48 (100%) | 57 (100%) | 47 (100%) | 96 (100%) | 200 (100%) |

Table : 5.10 : Home visits by MPW in caste and class groups during the preceding 6 months from the date of interview

| No. of visits | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|-----------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| One | 4 (4.1%) | 5 (9.3%) | 10 (20.8%) | 4 (7.0%) | 2 (4.2%) | 13 (13.5%) | 19 (9.5%) |
| Two | 5 (5.1%) | 4 (7.4%) | 3 (6.3%) | 2 (3.5%) | 3 (6.4%) | 7 (7.3%) | 12 (6.0%) |
| Three | 6 (6.1%) | 2 (3.7%) | 4 (8.3%) | 4 (7.0%) | 3 (6.4%) | 5 (5.2%) | 12 (6.0%) |
| More than three | 35 (35.7%) | 17 (31.5%) | 15 (31.3%) | 22 (38.6%) | 20 (42.6%) | 25 (26.0%) | 67 (33.5%) |
| Not visited | 48 (49.0%) | 26 (48.1%) | 16 (33.3%) | 25 (43.9%) | 19 (40.4%) | 46 (48.0%) | 90 (45.0%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (100%) | 57 (100%) | 47 (100%) | 96 (100%) | 200 (100%) |

Table : 5.11 : Type of services provided by MPW during his home visits in caste and class groups

| Type of service | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|--------------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| Tablets | 18 (18.4%) | 13 (24.1%) | 6 (12.5%) | 8 (14.0%) | 10 (21.3%) | 19 (19.8%) | 37 (18.5%) |
| Family planning work | 1 (1.0%) | 1 (1.9%) | 1 (2.1%) | - | 1 (2.1%) | 2 (2.1%) | 3 (1.5%) |
| Blood/sputum examination | - | - | 2 (4.2%) | - | - | 2 (2.1%) | 2 (1.0%) |
| Others | 31 (31.6%) | 14 (25.9%) | 23 (47.9%) | 24 (42.1%) | 17 (36.2%) | 27 (28.1%) | 68 (34.0%) |
| Not visited | 48 (49.0%) | 26 (48.1%) | 16 (33.3%) | 25 (43.9%) | 19 (40.4%) | 46 (47.9%) | 90 (45.0%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (100%) | 57 (100%) | 47 (100%) | 96 (100%) | 200 (100%) |

Table : 5.12 : Rank of preference in consulting CHV in caste and class groups

| Rank of preference | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|--------------------|---------------|--------------|---------------|---------------|---------------|---------------|----------------|
| First | 3 (3.0%) | - | 9 (18.7%) | 1 (1.8%) | 2 (4.3%) | 9 (9.4%) | 12 (6.0%) |
| Second preference | 1 (1.0%) | - | 2 (4.2%) | - | 1 (2.1%) | 2 (2.1%) | 3 (1.5%) |
| No preference | 94 (96.0%) | 54 (100%) | 37 (77.1%) | 56 (98.2%) | 44 (93.6%) | 85 (88.5%) | 185 (92.5%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (100%) | 57 (100%) | 47 (100%) | 96 (100%) | 200 (100%) |

Table : 5.13 : Reasons for preference of consulting
CHV in caste and class groups

| Type of reason | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|----------------|---------------|--------------|---------------|---------------|---------------|---------------|----------------|
| Free treatment | - | - | 2 (4.1%) | - | - | 2 (2.1%) | 2 (1.0%) |
| Faith | - | - | 1 (2.1%) | - | - | 1 (1.0%) | 1 (0.5%) |
| Proximity | 4 (4.0%) | - | 8 (16.7%) | 1 (1.8%) | 3 (6.4%) | 8 (8.3%) | 12 (6.0%) |
| Not applicable | 94 (96.0%) | 54 (100%) | 37 (77.1%) | 56 (98.2%) | 44 (93.6%) | 85 (88.5%) | 185 (92.5%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (100%) | 57 (100%) | 47 (100%) | 96 (99.9%) | 200 (100%) |

Table : 5.14: Rank of preference in consulting private practitioners in caste and class groups

| Rank of preference | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|--------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| First preference | 35 (35.7%) | 7 (13.0%) | 10 (20.8%) | 26 (45.6%) | 12 (25.5%) | 14 (14.6%) | 52 (26.0%) |
| Second preference | 36 (36.7%) | 26 (48.1%) | 20 (41.7%) | 20 (35.1%) | 21 (44.7%) | 41 (42.7%) | 82 (41.0%) |
| Third preference | 21 (21.4%) | 13 (24.1%) | 9 (18.7%) | 9 (15.8%) | 8 (17.0%) | 26 (27.1%) | 43 (21.5%) |
| No preference | 6 (6.1%) | 8 (14.8%) | 9 (18.8%) | 2 (3.5%) | 6 (12.8%) | 15 (15.6%) | 23 (11.5%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (100%) | 57 (100%) | 47 (100%) | 96 (99.9%) | 200 (100%) |

Table : 5.15 : Reasons for preference of consulting private practitioners in caste and class groups

| Type of reason | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|---|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| Not satisfied with treatment by other agencies/ cures | 46 (51.1%) | 25 (53.2%) | 27 (67.5%) | 23 (41.8%) | 24 (58.5%) | 51 (63.0%) | 98 (55.4%) |
| Personal network | 2 (2.2%) | 3 (6.4%) | - | - | 2 (4.9%) | 3 (3.7%) | 5 (2.8%) |
| Family physician | 13 (14.4%) | - | - | 10 (18.2%) | 2 (4.9%) | 1 (1.2%) | 13 (7.3%) |
| Faith | 12 (13.3%) | 14 (29.8%) | 8 (20.0%) | 10 (18.2%) | 8 (19.5%) | 16 (19.8%) | 34 (19.2%) |
| Accessibility proximity | 17 (18.9%) | 5 (10.6%) | 5 (12.5%) | 12 (21.8%) | 5 (12.2%) | 10 (12.3%) | 27 (15.3%) |
| TOTAL | 90 (99.9%) | 47 (100%) | 40 (100%) | 55 (100%) | 41 (100%) | 81 (100%) | 177 (100%) |

Table : 5.16 : Reasons for consulting private doctors
in caste and class groups

| Type of reason | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|--|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| Limitation of resources and facilities at PHC | 8 (11.0%) | 3 (6.4%) | 1 (3.6%) | 4 (7.8%) | 6 (20.7%) | 2 (2.9%) | 12 (8.1%) |
| Accessibility | 10 (13.7%) | 10 (21.3%) | 2 (7.1%) | 7 (13.7%) | 3 (10.3%) | 12 (17.6%) | 22 (14.9%) |
| Poor image / dissatisfaction of services/ personnel of PHC | 40 (54.8%) | 23 (48.9%) | 17 (60.7%) | 31 (60.8%) | 12 (41.4%) | 37 (54.4%) | 80 (54.0%) |
| Personal network | 7 (9.5%) | 3 (6.4%) | 2 (7.1%) | 5 (9.8%) | 1 (3.4%) | 6 (8.8%) | 12 (8.1%) |
| Better satisfaction | 8 (11.0%) | 8 (17.0%) | 6 (21.4%) | 4 (7.8%) | 7 (24.1%) | 11 (16.2%) | 22 (14.9%) |
| TOTAL | 73 (100%) | 47 (100%) | 28 (99.9%) | 51 (99.9%) | 29 (99.9%) | 68 (99.9%) | 148 (100%) |

Table: 5.17 : Rank of preference in consulting medical shop in caste and class groups

| Rank of preference | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|--------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| First preference | 44 (44.9%) | 33 (61.1%) | 16 (33.3%) | 21 (36.8%) | 21 (44.6%) | 51 (53.1%) | 93 (46.5%) |
| Second preference | 6 (6.1%) | 5 (9.2%) | 4 (8.3%) | 2 (3.5%) | 3 (6.4%) | 10 (10.4%) | 15 (7.5%) |
| Third preference | 1 (1.0%) | - | - | 1 (1.8%) | - | - | 1 (0.5%) |
| No preference | 47 (48.1%) | 16 (29.6%) | 28 (58.3%) | 33 (57.9%) | 23 (49.0%) | 35 (36.5%) | 91 (45.5%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (99.9%) | 57 (100%) | 47 (100%) | 96 (100%) | 200 (100%) |

Table: 5.18 : Reasons for preference of consulting medical shop in caste and class groups

| Type of reason | High Caste | Middle Caste | Low Caste | High Class, | Middle Class | Low Class | TOTAL |
|---|---------------|---------------|--------------|---------------|---------------|---------------|---------------|
| Not satisfied with alternative agencies/cures | 4 (8.2%) | 4 (10.0%) | 4 (20.0%) | 2 (8.3%) | 2 (8.3%) | 8 (13.1%) | 12 (11.0%) |
| Less cost | 20 (40.8%) | 15 (37.5%) | 7 (35.0%) | 10 (41.7%) | 9 (37.5%) | 23 (37.7%) | 42 (38.5%) |
| Accessibility | 24 (49.0%) | 20 (50.0%) | 8 (40.0%) | 12 (50.0%) | 13 (54.2%) | 27 (44.3%) | 52 (47.7%) |
| Others | 1 (2.0%) | 1 (2.5%) | 1 (5.0%) | - | - | 3 (4.9%) | 3 (2.8%) |
| TOTAL | 49 (100%) | 40 (100%) | 20 (100%) | 24 (100%) | 24 (100%) | 61 (100%) | 109 (100%) |

Table : 5.19: Type of resort for minor ailments in caste and class groups

| Type of resort | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|----------------------|---------------|---------------|---------------|---------------|---------------|---------------|----------------|
| Home remedy | 11 (11.2%) | 4 (7.4%) | 6 (12.5%) | 8 (14.0%) | 6 (12.8%) | 7 (7.3%) | 21 (10.5%) |
| Medical shop | 57 (58.2%) | 41 (76.0%) | 29 (60.4%) | 30 (52.6%) | 29 (61.7%) | 68 (70.8%) | 127 (63.5%) |
| Private practitioner | 23 (23.5%) | 4 (7.4%) | 5 (10.4%) | 17 (29.9%) | 8 (17.0%) | 7 (7.3%) | 32 (16.0%) |
| PHC | 7 (7.1%) | 5 (9.2%) | 8 (16.7%) | 2 (3.5%) | 4 (8.5%) | 14 (14.6%) | 20 (10.0%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (100%) | 57 (100%) | 47 (100%) | 96 (100%) | 200 (100%) |

Table : 5.21 : Items of medicinal value kept in caste and class groups

| Item | High Caste N=98 | Middle Caste N=54 | Low Caste N=47 | High Class N=57 | Middle Class N=47 | Low Class N=96 | TOTAL |
|---------------------------------------|--------------------|----------------------|-------------------|--------------------|----------------------|-------------------|---------------|
| Honey | 27 (27.5%) | 7 (13.0%) | 1 (2.1%) | 22 (38.6%) | 10 (21.2%) | 3 (3.1%) | 35 (17.5%) |
| Ointment | 45 (46.0%) | 14 (26.0%) | 7 (14.6%) | 34 (59.6%) | 16 (34.0%) | 16 (16.6%) | 66 (33.0%) |
| Tablets/ mixtures | 18 (18.3%) | 9 (16.6%) | 6 (12.5%) | 18 (31.6%) | 7 (14.9%) | 8 (8.3%) | 33 (16.5%) |
| Bandage/ cotton | 3 (3.0%) | - | 4 (8.3%) | 5 (8.8%) | - | 2 (2.1%) | 7 (3.5%) |
| Herbs | 57 (58.1%) | 15 (27.8%) | 2 (4.2%) | 41 (72.0%) | 21 (44.5%) | 12 (12.5%) | 74 (37.0%) |
| Thermo- meter | 4 (4.1%) | - | 2 (4.2%) | 4 (7.0%) | 1 (2.1%) | 1 (1.0%) | 6 (3.0%) |
| Dettol/Phenyl/ Bleaching Powder | 6 (6.1%) | 1 (1.8%) | 2 (4.2%) | 7 (12.3%) | 2 (4.2%) | - | 9 (4.5%) |
| Tonic | 5 (5.1%) | 2 (3.7%) | 1 (2.1%) | 5 (8.8%) | 3 (6.4%) | - | 8 (4.0%) |

Table: 5.23 A : Use of water sources for drinking
among caste and class groups

| Type of source | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|----------------|---------------|---------------|---------------|---------------|---------------|---------------|----------------|
| Well | 10 (10.2%) | 4 (7.4%) | 2 (4.2%) | 4 (7.0%) | 3 (6.4%) | 9 (9.4%) | 16 (8.0%) |
| Tap | 22 (22.4%) | 12 (22.2%) | 1 (2.1%) | 15 (26.3%) | 7 (14.9%) | 13 (13.5%) | 35 (17.5%) |
| Pond | 66 (67.3%) | 38 (70.4%) | 45 (93.7%) | 38 (66.7%) | 37 (78.7%) | 74 (77.1%) | 149 (74.5%) |
| TOTAL | 98 (99.9%) | 54 (100%) | 48 (100%) | 57 (100%) | 47 (100%) | 96 (100%) | 200 (100%) |

TABLE :6.1:Type of material used for cleaning teeth in caste and class groups

| Material Used | High Caste N=98 | Middle Caste N=54 | Low Caste N=48 | High Class N=57 | Middle Class N=47 | Low Class N=96 | Total N=200 |
|------------------|-----------------------|-------------------------|----------------------|-----------------------|-------------------------|----------------------|-----------------|
| Tooth Powder | 8 (8.2%) | 3 (5.6%) | 2 (4.2%) | 2 (3.5%) | 7 (14.9%) | 4 (4.2%) | 13 (6.5%) |
| Tooth Paste | 14 (14.3%) | 2 (3.7%) | 3 (6.3%) | 12 (21.1%) | 5 (10.6%) | 2 (2.1%) | 19 (9.5%) |
| Twig | 76 (77.5%) | 49 (90.7%) | 43 (89.5%) | 43 (75.4%) | 35 (74.5%) | 90 (93.7%) | 168 (84%) |
| TOTAL | 98 (100.0%) | 54 (100.0%) | 48 (100.0%) | 57 (100%) | 47 (100.0%) | 96 (100.0%) | 200 (100.0%) |

TABLE : 6.2 : Type of bath taken in caste and class groups

| Type of bath | High Caste N-98 | Middle Caste N=54 | Low Caste N-18 | High Class V-57 | Middle Class N-17 | Low Class N-96 | Total N-200 |
|--------------|-----------------|-------------------|----------------|-----------------|-------------------|----------------|----------------|
| Head bath | 8 (8.2%) | 2 (3.7%) | 4 (8.3%) | 4 (7.0%) | 5 (10.6%) | 5 (5.2%) | 14 (7.0%) |
| Body bath | 90 (91.8%) | 52 (96.3%) | 44 (91.7%) | 53 (93.0%) | 42 (89.4%) | 91 (94.8%) | 186 (93.0%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (100%) | 57 (100%) | 47 (100%) | 96 (100%) | 200 (100%) |

TABLE : 6.3 Frequency of head bath taken in caste and class groups

| Frequency of head bath | High Caste N=98 | Middle Caste N=51 | Low Caste N=18 | High Class N=57 | Middle Class N=47 | Low Class N=96 | Total N=200 |
|------------------------|-----------------|-------------------|----------------|-----------------|-------------------|----------------|-------------|
| Once in 2 days | 7 (7.1%) | 3 (5.6%) | 1 (2.1%) | 3 (5.3%) | 3 (6.4%) | 5 (5.20%) | 11 (5.5%) |
| Once in a week | 61 (62.2%) | 32 (59.2%) | 15 (31.2%) | 39 (68.4%) | 29 (61.7%) | 40 (41.7%) | 108 (54%) |
| Once in a fortnight | 11 (11.2%) | 11 (20.4%) | 15 (31.2%) | 5 (8.8%) | 7 (14.9%) | 25 (26.0%) | 37 (18.5%) |
| Once in a month | 11 (11.2%) | 6 (11.1%) | 12 (25.0%) | 6 (10.5%) | 3 (6.4%) | 20 (20.8%) | 29 (14.5%) |
| Rarely | 8 (8.2%) | 2 (3.7%) | 5 (10.4%) | 4 (7.0%) | 5 (10.6%) | 6 (6.3%) | 15 (7.5%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (100%) | 57 (100%) | 47 (100%) | 96 (100%) | 200 (100%) |

TABLE : 6.4: Type of material used for bathing in caste and class groups

| | High Caste N=98 | Middle Caste N=51 | Low Caste N=18 | High Class N=57 | Middle Class N=17 | Low Class N=96 | Total N 200 |
|-----------------------|-----------------------|-------------------------|----------------------|-----------------------|-------------------------|----------------------|----------------|
| Soap | 57 (58.2%) | 29 (53.7%) | 17 (35.4%) | 40 (70.2%) | 26 (55.3%) | 37 (38.5%) | 103 (51.5%) |
| Soapnut | 3 (3.1%) | - | - | - | 3 (6.4%) | - | 3 (1.5%) |
| Not using anything | 38 (38.7%) | 25 (46.3%) | 31 (64.6%) | 17 (29.8%) | 18 (38.3%) | 59 (61.5%) | 94 (47%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (100%) | 57 (100%) | 47 (100%) | 96 (100%) | 200 (100%) |

TABLE : 6.5 Frequency of oiling hair in caste and class groups

| Frequency of applying oil to hair | High Caste N=98 | Middle Caste N=54 | Low Caste N=18 | High Class N=57 | Middle Class N=47 | Low Class N=36 | Total N=200 |
|---|-----------------------|-------------------------|----------------------|-----------------------|-------------------------|----------------------|----------------|
| Daily | 22 (22.4%) | 4 (7.4%) | 7 (14.6%) | 18 (31.6%) | 7 (14.9%) | 8 (8.3%) | 33 (16.5%) |
| Once in 2 days | 48 (49.0%) | 28 (51.9%) | 12 (25.0%) | 31 (54.4%) | 26 (55.3%) | 31 (32.3%) | 88 (44.0%) |
| Once a week | 9 (9.2%) | 8 (14.8%) | 13 (27.1%) | 4 (7.0%) | 2 (4.3%) | 24 (25.0%) | 30 (15.0%) |
| Twice a week | 14 (14.3%) | 13 (24.1%) | 13 (27.1%) | 4 (7.0%) | 9 (19.1%) | 27 (28.1%) | 40 (20.0%) |
| Rarely | 5 (5.1%) | 1 (1.8%) | 3 (6.2%) | - | 3 (6.4%) | 6 (6.3%) | 9 (4.5%) |
| TOTAL | 98 (100%) | 54 (100%) | 48 (100%) | 57 (100%) | 47 (100%) | 96 (100%) | 200 (100%) |

TABLE : 6.7 : Habits of smoking and drinking caste and class groups

| Type of Habit | High Caste N=98 | Middle Caste N=54 | Low Caste N=18 | High Class N=57 | Middle Class N=47 | Low Class N=96 | Total N=200 |
|------------------|-----------------------|-------------------------|----------------------|-----------------------|-------------------------|----------------------|----------------|
| Drinking | 3 (3.1%) | 18 (33.3%) | 28 (58.3%) | 1 (1.8%) | 4 (8.5%) | 44 (45.8%) | 49 (24.5%) |
| Smoking | 73 (74.5%) | 45 (83.3%) | 37 (77.0%) | 39 (68.4%) | 35 (74.5%) | 81 (84.4%) | 155 (77.5%) |

Each category is separate

Table : 6.8: Frequency of Liquor consumed among drinkers
in caste and class groups

| Frequency of consumption | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|--|--------------|--------------|---------------|-------------|--------------|---------------|---------------|
| Regularly (daily or alternately, 15 + times a month) | 1 (33.3%) | 6 (33.3%) | 6 (21.4%) | - | 1 (25.0%) | 12 (27.2%) | 13 (26.5%) |
| Frequently (twice or less than twice a week but more than twice a month (3-15 times a month) | 2 (66.7%) | 7 (38.9%) | 11 (39.3%) | 1 (100%) | 1 (25.0%) | 18 (41.0%) | 20 (40.8%) |
| Occasionally or rarely (twice a month or less) (1-2 times a month) | - | 5 (27.8%) | 11 (39.3%) | - | 2 (50.0%) | 14 (31.8%) | 16 (32.7%) |
| TOTAL drinkers | 3 (100%) | 18 (100%) | 28 (100%) | 1 (100%) | 4 (100%) | 44 (100%) | 49 (100%) |

TABLE : 6.9 : Frequency of smoking cigars in caste and class groups

| No. of cigars smoked perday | High Caste N=98 | Middle Caste N=54 | Low Caste N=48 | High Class N=57 | Middle Class N=47 | Low Class N=96 | Total N=200 |
|-----------------------------|-----------------|-------------------|----------------|-----------------|-------------------|----------------|---------------|
| One | 3 (4.1%) | 5 (11.1%) | 4 (10.8%) | 1 (2.6%) | 4 (11.4%) | 7 (8.6%) | 12 (7.7%) |
| Two | 11 (15.1%) | 6 (13.3%) | 7 (18.9%) | 5 (12.8%) | 1 (2.9%) | 18 (22.2%) | 24 (15.5%) |
| Three to Five | 37 (50.7%) | 19 (42.2%) | 21 (56.8%) | 19 (48.7%) | 17 (48.6%) | 41 (50.6%) | 77 (49.7%) |
| More than Five | 22 (30.1%) | 15 (33.3%) | 5 (13.5%) | 14 (35.9%) | 13 (37.1%) | 15 (18.5%) | 42 (27.1%) |
| TOTAL | 73 (100%) | 45 (100%) | 37 (100%) | 39 (100%) | 35 (100%) | 81 (100%) | 155 (100%) |

TABLE : 6.10A : Pattern of smoking in caste and class groups

| Pattern of Smoking | High Caste 98 | Middle Caste N=54 | Low Caste N=18 | High Class N=57 | Middle Class N=17 | Low Class N=96 | Total N=200 |
|-------------------------------|------------------|----------------------|-------------------|--------------------|----------------------|-------------------|----------------|
| Burning end outside the mouth | 59 (80.8%) | 32 (71.1%) | 29 (78.4%) | 36 (92.3%) | 29 (82.9%) | 55 (67.9%) | 120 (77.4%) |
| Burning end inside the mouth | 14 (19.2%) | 13 (28.9%) | 8 (21.6%) | 3 (7.7%) | 6 (17.1%) | 26 (32.1%) | 35 (22.6%) |
| TOTAL | 73 (100%) | 45 (100%) | 37 (100%) | 39 (100%) | 35 (100%) | 81 (100%) | 155 (100%) |

TABLE : 6.11 : Use of special diet before delivery, after delivery and baby foods in caste and class groups

| Item Used | High Caste N=93 | Middle Caste N=53 | Low Caste N=44 | High Class N=55 | Middle Class N=44 | Low Class N=91 | Total N=190 |
|------------------------------------|-----------------------|-------------------------|----------------------|-----------------------|-------------------------|----------------------|----------------|
| Special diet before delivery | 37 (39.8%) | 6 (11.3%) | 9 (20.5%) | 30 (54.5%) | 12 (27.3%) | 10 (11.0%) | 52 (27.4%) |
| Special diet after delivery | 55 (59.1%) | 27 (50.9%) | 10 (22.7%) | 34 (61.8%) | 27 (61.4%) | 31 (34.0%) | 92 (48.4%) |
| Baby foods | 7 (7.5%) | | 1 (2.3%) | 6 (10.9%) | 2 (4.5%) | | 8 (4.2%) |

Each category is separate

**TABLE : 6.12 : Period of working outside home during pregnancy (general convention)
in Caste and Class groups**

| Period of working outside home | High Caste N=98 | Middle Caste N=54 | Low Caste N=48 | High Class N=57 | Middle Class N=47 | Low Class N=96 | Total N=200 |
|--------------------------------------|-----------------------|-------------------------|----------------------|-----------------------|-------------------------|----------------------|-----------------------|
| Upto 3 months | - | - | 1 (2.3%) | - | - | 1 (1.1%) | 1 (0.5%) |
| 4-6 months | 1 (1.1%) | 3 (5.7%) | 10 (22.8%) | - | 2 (4.5%) | 12 (13.2%) | 14 (7.4%) |
| 7-9 months | 1 (1.1%) | 19 (35.8%) | 26 (59.0%) | - | 4 (9.1%) | 42 (46.2%) | 46 (24.2%) |
| Not worked | 91 (97.8%) | 31 (58.5%) | 7 (15.9%) | 55 (100%) | 38 (86.4%) | 36 (39.5%) | 129 (67.9%) |
| TOTAL | 93 (100%) | 53 (100%) | 44 (100%) | 55 (100%) | 44 (100%) | 91 (100%) | 190 (100%) |

**TABLE : 6.13 : Period of working outside home by pregnant women in the sample
by Caste and Class groups**

| Period of working out side home | High Caste | Middle Caste | Low Caste | High Class | Middle Class | Low Class | TOTAL |
|---------------------------------------|---------------|-----------------|---------------|---------------|-----------------|---------------|---------------|
| Upto 3 months | - | - | 1 (2.7%) | - | - | 1 (1.8%) | 1 (1.6%) |
| 4-6 months | 1 (50%) | 3 (13.6%) | 10 (27.0%) | - | 2 (33.3%) | 12 (21.8%) | 14 (23.0%) |
| 7-9 months | 1 (50%) | 19 (86.4%) | 26 (70.3%) | - | 4 (66.7%) | 42 (76.4%) | 46 (75.4%) |
| TOTAL | 2 (100%) | 22 (100%) | 37 (100%) | - | 6 (100%) | 55 (100%) | 61 (100%) |

**TABLE : 6.14 : Resumption of work outside home after delivery in
Caste and Class Groups**

| Resumption of work outside home after delivery | High Caste | Middle Caste | Low Class | High Class | Middle Class | Low Class | TOTAL |
|---|-----------------------|-------------------------|-----------------------|-----------------------|-------------------------|------------------------|------------------------|
| Below 3 months | 1 (50%) | 10 (43.5%) | 13 (36.1%) | - | 2 (33.3%) | 22 (40%) | 24 (39.3%) |
| 4-6 months | 1 (50%) | 4 (17.4%) | 8 (22.2%) | - | 2 (33.3%) | 11 (20%) | 13 (21.3%) |
| 7-9 months | - | 3 (13%) | 4 (11.1%) | - | - | 7 (12.7%) | 7 (11.5%) |
| After 10 months | - | 6 (26%) | 11 (30.6%) | - | 2 (33.3%) | 15 (27.3%) | 17 (27.9%) |
| TOTAL | 2 (100%) | 23 (99.9%) | 36 (100%) | - | 6 (99.9%) | 55 (100.0%) | 61 (100.0%) |

TABLE : 6.15 : Pre-natal check up in caste and class groups

| Source of pre-natal check up | High Caste -98 | Middle Caste N=51 | Low Caste N=48 | High Class N=57 | Middle Class N=17 | Low Class N=96 | Total N=200* |
|------------------------------|-------------------|----------------------|-------------------|--------------------|----------------------|-------------------|-----------------|
| PHC | 17 (18.3%) | 22 (41.5%) | 21 (47.7%) | 7 (12.7%) | 17 (38.6%) | 36 (39.6%) | 60 (31.6%) |
| Other agencies | 27 (29%) | - | 3 (6.8%) | 22 (40%) | 6 (13.6%) | 2 (2.2%) | 30 (15.8%) |
| No-check up | 49 (52.7%) | 31 (58.5%) | 20 (45.5%) | 26 (47.3%) | 21 (47.7%) | 53 (58.2%) | 100 (52.6%) |
| TOTAL | 93 (100%) | 53 (100%) | 44 (100%) | 55 (100%) | 44 (100%) | 91 (100%) | 190 (100%) |

*10 Women did not have any children

TABLE : 6.16 : Sources of prenatal check up in caste and class groups

| Source of prenatal checkup | High Caste 98 | Middle Caste N-54 | Low Caste N-18 | High Class N-57 | Middle Class N-47 | Low Class N-56 | Total N-200 |
|----------------------------|------------------|----------------------|-------------------|--------------------|----------------------|-------------------|----------------|
| PHC | 17 (38.6%) | 22 (100%) | 21 (87.5%) | 7 (24.1%) | 17 (73.9%) | 36 (94.7%) | 60 (66.7%) |
| Other agencies | 27 (61.4%) | | 3 (12.5%) | 22 (75.9%) | 6 (26.1%) | 2 (5.3%) | 30 (33.3%) |
| TOTAL | 44 (100%) | 22 (100%) | 24 (100%) | 29 (100%) | 23 (100%) | 38 (100%) | 90 (100%) |

TABLE : 6.17 : Age at Weaning in caste and class groups

| Age of the baby when weaning started | High Caste N=98 | Middle Caste N=51 | Low Caste N=48 | High Class N=57 | Middle Class N=47 | Low Class N=96 | Total N=200 |
|--------------------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|-----------------------|
| 9. months | 6 (6.4%) | 2 (3.8%) | 2 (4.5%) | 4 (7.3%) | 3 (6.8%) | 3 (3.3%) | 10 (5.2%) |
| 10-12 months | 49 (52.7%) | 29 (54.7%) | 6 (13.6%) | 29 (52.7%) | 22 (50%) | 33 (36.2%) | 84 (44.2%) |
| Upto 1½ yrs. | 13 (14%) | 7 (13.2%) | 7 (15.9%) | 12 (21.8%) | 6 (13.6%) | 9 (9.9%) | 27 (14.2%) |
| 1½ - 2 yrs. | 13 (14%) | 2 (3.8%) | 7 (15.9%) | 9 (16.4%) | 4 (9.1%) | 9 (9.9%) | 22 (11.6%) |
| More than two years | 9 (9.7%) | 10 (18.8%) | 20 (45.4%) | 1 (1.8%) | 6 (13.6%) | 32 (35.2%) | 39 (20.5%) |
| Baby died soon | - | 1 (1.9%) | 1 (2.3%) | - | 1 (2.3%) | 1 (1.1%) | 2 (1.1%) |
| Mother didn't have milk | 3 (3.2%) | 2 (3.8%) | 1 (2.3%) | - | 2 (4.5%) | 4 (4.4%) | 6 (3.2%) |
| TOTAL | 93 (100%) | 53 (100%) | 44 (100%) | 55 (100%) | 44 (100%) | 91 (100%) | 190 (100%) |

TABLE : 6.18 Age of the baby when normal food supplementation was given in caste and class groups

| Age of the baby | High Caste -98 | Middle Caste N=54 | Low Caste N=18 | High Class N=57 | Middle Class N=17 | Low Class N=96 | Total N=206 |
|---------------------------------|----------------|-------------------|----------------|-----------------|-------------------|----------------|---------------|
| Below 9 months | 39 (4.2%) | 19 (35.8%) | 16 (36.4%) | 16 (29.1%) | 22 (50%) | 36 (39.6%) | 74 (38.9%) |
| 10-12 months | 38 (40.8%) | 29 (54.7%) | 12 (27.3%) | 30 (54.5%) | 12 (27.3%) | 37 (40.6%) | 79 (41.6%) |
| After one yr. | 16 (17.2%) | 4 (7.5%) | 15 (34.1%) | 9 (16.4%) | 9 (20.4%) | 17 (18.7%) | 35 (18.4%) |
| Not applicable (baby died soon) | - | 1 (1.9%) | 1 (2.2%) | - | 1 (2.3%) | 1 (1.1%) | 2 (1.1%) |
| TOTAL | 93 (100%) | 53 (100%) | 44 (100%) | 55 (100%) | 44 (100%) | 91 (100%) | 190 (100%) |

TABLE : 6.20 : Calorie intake contributed by different food items per unit per day in caste and class groups

| Items of Food | (CALORIES) | | | | | Average calorie contribution per day/unit | |
|----------------------|---------------|-----------------|--------------|---------------|-----------------|--|--------------|
| | High Caste | Middle Caste | Low Caste | High Class | Middle Class | | Low Class |
| Rice | 1756.4 | 1786.6 | 1899.5 | 1775.4 | 1649.9 | 1902.8 | 1796.7 |
| Wheat | 36.7 | 32.8 | - | 38.8 | 31.7 | 35.1 | 35.4 |
| Pulses | 71.8 | 44.5 | 47.8 | 85.3 | 54.4 | 40.8 | 59.0 |
| Oil | 231.1 | 146.3 | 137.7 | 256.1 | 202.4 | 122.6 | 187.2 |
| Sugar (+ Jaggery) | 141.1 | 91.2 | 94.4 | 166.4 | 115.3 | 80.7 | 119.4 |
| Egg, Fish & Meat | 47.7 | 34.1 | 46.4 | 59.2 | 36.6 | 34.8 | 43.8 |
| TOTAL | 2287.8 | 2135.5 | 2225.8 | 2381.2 | 2090.3 | 2216.8 | 2241.5 |

TABLE : 6.21 : Consumption of different food items in caste and class groups
- per unit per day (gms.)

| Food Item | High Caste (gms.) | Middle Caste (gms.) | Low Caste (gms.) | High Class (gms.) | Middle Class (gms.) | Low Class (gms.) | All groups average consumption per unit per day |
|------------------|-------------------------|---------------------------|------------------------|-------------------------|---------------------------|------------------------|---|
| Rice | 509.12 | 517.86 | 550.60 | 514.63 | 478.24 | 551.56 | 520.81 |
| Wheat | 10.55 | 9.45 | - | 11.17 | 9.12 | 10.09 | 10.18 |
| Pulses | 21.45 | 13.30 | 14.29 | 25.48 | 16.24 | 12.19 | 17.64 |
| Oil | 25.68 | 16.26 | 15.30 | 28.46 | 22.49 | 13.63 | 20.80 |
| Sugar, Jaggery | 36.21 | 22.92 | 23.73 | 41.83 | 28.98 | 20.28 | 30.00 |
| Egg, Meat & Fish | 32.82 | 23.51 | 31.90 | 40.74 | 25.22 | 23.96 | 30.14 |

QUESTIONNAIRES

HEALTH CARE AND SOCIAL STRATIFICATION : A STUDY
IN HEALTH BEHAVIOUR IN RURAL ANDHRA PRADESH :
INSTRUMENT NO. 1 :

Village Taluk Dist: Date:

1. Name of the head of the household
2. Caste/Sub-Caste
3. Family data

| S.NO. | NAME | AGE | SEX | MARITAL | RELATIONSHIP TO HEAD |
|-------|------|-----|-----|---------|----------------------|
| 3.1 | 3.2 | 3.3 | 3.4 | 3.5 | 3.6 |

| EDUCATION | | OCCUPATION | | INCOME | | OTHER |
|-----------|---------|------------|-----------|--------------|----------------|-------------------------------|
| Completed | Student | Primary | Secondary | Pri- mary | Seco- ndary | INCOME (RENT- ING ETC.) |
| 3.7 | 3.8 | 3.9 | 3.10 | 3.11 | 3.12 | 3.13 |

4. Land Owned

| S.NO. | NO. OF ACRES | CROPS CULTIVATED | TOTAL YIELD | SHARE OF THE YIELD | V. LUE | ANNUAL INCOME (App.) |
|-------|-----------------|---------------------|----------------|-----------------------|--------|-------------------------|
| 4.1 | 4.2 | 4.3 | 4.4 | 4.5 | 4.6 | 4.7 |

5. Land Leased in

| TYPE | NO. OF ACRES | CROPS CULTIVATED | TOTAL YIELD | SHARE OF THE YIELD | VALUE | ANNUAL INCOME (App.) |
|------|-----------------|---------------------|----------------|-----------------------|-------|-------------------------|
| 5.1 | 5.2 | 5.3 | 5.4 | 5.5 | 5.6 | 5.7 |

6. Land leased out:

| TYPE | NO. OF ACRES | CROPS CULTIVATED | TOTAL YIELD | SHARE OF THE YIELD | VALUE | ANNUAL INCOME (App.) |
|------|-----------------|---------------------|----------------|-----------------------|-------|-------------------------|
| 6.1 | 6.2 | 6.3 | 6.4 | 6.5 | 6.6 | 6.7 |

Approx. annual income (Agr.) Rs.

7. Nature of housing: Owned/Rented

- 7.1 Type - Tatched/Tiled/Daba/Storeyed
 7.2 Front yard - Yes/No.
 7.3 Back yard Yes/No.
 7.4 No. of rooms
 7.5 No. of windows
 7.6 Grain depository Yes/No
 7.7 Compost pit Yes/No
 7.8 Is there a seperate structure for bathing Yes/No
 If yes, indicate its nature
 7.9 Latrine Yes/No, if yes (a) service
 (b) septic
 (c) pit
 7.10 Major water source: Well/tap/handpump/pond
 7.11 Domestic(owned) water source- Yes/No
 If yes, indicate its nature
 7.12 Is there a seperate structure for cattle Yes/No
 If yes, indicate its nature:
 7.13 Is there a seperate kitchen : Yes/No
 If yes, indicate its nature
 7.14 Is there a seperate place for dining: Yes/No
 7.15 Electricity Yes/No

8. Assets

- 8.1 Cattle: a) Cows
 b) Bullocks
 c) Buffaloes
 8.2 Others a) Bullock cart
 b) Plough
 c) Thresher
 d) Radio
 e) Transistor
 f) Cycle
 g) House
 h) Fan
 i) Others

9. Social Participation: (Position(s) held by members of the family _____ Panchayat President/Member; President Coop. Society etc.)

| S.NO. | NAME OF THE PERSON | POSITION HELD EARLIER | PERIOD OFFICIATED | POSITION HELD AT PRESENT |
|-------|--------------------|-----------------------|-------------------|--------------------------|
| 9.1 | 9.2 | 9.3 | 9.4 | 9.5 |
| | | | | |

PERIOD OFFICIATED
9.6

10 Observations:

10.1 General cleanliness a) Good
 b) Fair
 c) Poor

19.2 Fecal pollution: Courtyard

10.3 Habitat around the house

HEALTH CARE AND SOCIAL STRATIFICATION: A STUDY
IN HEALTH BEHAVIOUR IN RURAL ANDHRA PRADESH:
INSTRUMENT NO. 2 : MORBIDITY RECORD

Village Taluk Distt: Date:

1. Name of the head of the household
2. Caste or sub-caste
3. Age
4. Sex
5. Agrarian/Occupation category
6. How do you distinguish between a healthy person and a sick person?
7. Have you ever heard about the following diseases?
 1. Leprosy: Yes/No.
 2. T.B. Yes/No.
 3. Cancer Yes/No
 4. Asthama Yes/No
 5. Fillariasis Yes/No
 6. Heart attack Yes/No
 7. Blood pressure Yes/No
8. Is there any one in your family suffering from any of these diseases?

| S.NO. | NAME OF THE PERSON | NATURE OF DISEASE | PERIOD OF ILLNESS | ACTION TAKEN | OUT COME |
|-------|--------------------|-------------------|-------------------|--------------|----------|
| 8.1 | 8.2 | 8.3 | 8.4 | 8.5 | 8.6 |

9. Has any body suffered earlier from a chronic disease in your family?(Pains, Diabetis, Mental illness, eczema etc.)

| S.NO. | NAME OF THE PERSON | NATURE OF DISEASE | PERIOD OF ILLNESS | ACTION TAKEN | OUT COME |
|-------|--------------------|-------------------|-------------------|--------------|----------|
| 9.1 | 9.2 | 9.3 | 9.4 | 9.5 | 9.6 |

10 Persons in household experienced any illness
during the past 3 months: (from to

| S.NO. | NAME OF THE PERSON | AGE | SEX | COMPLAIN'S | CAUSE |
|-------|--------------------|------|------|------------|-------|
| 10.1 | 10.2 | 10.3 | 10.4 | 10.5 | 10.6 |

DURATION10.7

HEALTH
ACTION

EXPENSES

DISRUPTION (DAYS)

10.810.910.10

**HEALTH CARE AND SOCIAL STRATIFICATION : A STUDY
IN HEALTH BEHAVIOUR IN RURAL ANDHRA PRADESH
INSTRUMENT NO. 3 : NUTRITION RECORD**

Village Taluk Distt. Date:

1. Name of the Head of the household
2. Caste or sub-caste
3. Age
4. Sex
5. Aggrarian/Occupation category
6. What does your family eat at?
 - 6.1 Morning Meal
 - 6.2 Day Meal
 - 6.3 Evening Meal
 - 6.4 Night Meal
7. What quality of rice do you use ?

| | |
|---------------------|-------------------|
| a) <u>Source</u> | b) <u>quality</u> |
| 7.1 Own house | |
| 7.2 Open market | |
| 7.3 Fair Price Shop | |
| 7.4 Others | |
8. State the household consumption of the following items:

| | |
|------------------------------------|--------------------|
| a) <u>Item</u> | b) <u>quantity</u> |
| 8.1 Rice (Daily/Weekly) | |
| 8.2 Wheat or Atta (Weekly/Daily) | |
| 8.3 Pulses (Weekly/Daily) | |
| 8.4 Vegetables(Weekly/Daily) | |
| 8.5 Oil and Ghee (Weekly/Daily) | |
| 8.6 Sugar or Sweets (weekly/Daily) | |
| 8.7 Jaggery (Weekly/Daily) | |
| 8.8 Milk(Weekly/Daily) | |
| 8.9 Tea and coffee (Daily/weekly) | |
| 8.10 Fruits (per day requirement) | Frequency: _____ |
| 8.11 a) Meat (per day requirement) | Frequency: _____ |
| b) Fish (per day requirement) | Frequency: _____ |
| c) Egg (per day requirement) | Frequency: _____ |
| 8.12 Spices (Weekly) | |
| 8.13 Others | |

9. How often does your family take curd or butter milk with the meals or otherwise?

| Frequency (No. of items a day) | Time of consumption | Quantity per day |
|-----------------------------------|---------------------|------------------|
| 9.1 | 9.2 | 9.3 |

- 10 Do you or any body in your family drink? No/Yes, specify

| Name of the person | Frequency | Total quantity | Cost | Quantity per week |
|--------------------|-----------|----------------|------|-------------------|
| 10.1 | 10.2 | 10.3 | 10.4 | 10.5 |

- 11 Were there any occasions that you or any of your family members had remained without food? Ask in detail as to no. of days/half days the family had to remain without food.

| | | | |
|---------------------|------------|--------|-------|
| a) Restricted meals | some times | rarely | never |
| b) One meal | some times | rarely | never |
| c) No meal | some times | rarely | never |

- 12 Do your children eat food served in the school?

- 13 Do you keep any servants/servant-maid in your house? Yes/No. If yes:

No. of males
No. of females

13.1 Food given: Daily/frequently/occasionally/never
13.2 Terms of service: contractual/courtesy
13.3 Type of service rendered:

- 14 Is any member of your family working under jajmani system with any landlord? Yes/No.

If yes, give details of contract.

- 15 Is any member of your family working as servant-maid in any house in the village? Yes/No

- 16 Do you or any other member receive food in return for above services? Yes/No

- 16.1 If yes, frequency of food received -
daily/occasionally/regularly.
- 16.2 Type of food received
- 16.3 Quantity of food received
- 17 What kind of vessels do you use for cooking?
 - 17.1 Rice
 - 17.2 Others
- 18 Who cooks food in your family?
 - 18.1 Servant cook
 - 18.2 Family member
- 19 Does she take bath before/after cooking? Yes/No
- 20 After cooking, do you offer food to Gods/Deities?
Yes/No
- 21 Does the person wear separate clothing while cooking:
Yes/No
- 22 Do your children quarrel over distribution of food and
type of food served? Yes/No.
- 23 Describe food consumption practices in your family?
- 24 From which caste members you can accept food? (Record
in detail the nature of food accepted, purity-pollution
notions etc.)
- 25 To which caste members you could offer food (which
castes can accept your food).
- 26 With which caste members you can sit and eat together?
(Such as at ceremonies).

HEALTH CARE AND SOCIAL STRATIFICATION : A STUDY
IN HEALTH BEHAVIOUR IN RURAL ANDHRA PRADESH
INSTRUMENT NO. 4 : ACCESS AND UTILISATION.

(to be administered after completing episode record)

Village Taluk Dist. Date:

1. Name of the Head of the household
- 2) Caste/Sub-Caste
3. Age
- 4) Sex
5. Agrarian/Occupation category
6. When did you visit hospital at _____ (PHC)?
last visit (Reason)
7. How often did your family members visit hospital at _____ (PHC)
during the last 2 months ?(See instrument 2).

| S.No. | Name of the person | Nature of illness/ service | Duration of Treatment/Sickness | No. of visits | Cost | Out- come |
|-------|--------------------|----------------------------|--------------------------------|---------------|------|-----------|
| 7.1 | 7.2 | 7.3 | 7.4 | 7.5 | 7.6 | 7.7 7.8 |

8. Did you or any member of your family visit the hospital at _____ sub-centre during the last two months? Yes/No (See instrument-2)

If yes, what were the services obtained from sub-centre?

| S.No. | Name of the person | Nature of illness/ service | Duration of Treatment/sickness | No. of visits | Cost | Out come |
|-------|--------------------|----------------------------|--------------------------------|---------------|------|----------|
| 8.1 | 8.2 | 8.3 | 8.4 | 8.5 | 8.6 | 8.7 8.8 |

9. Did any member of your family use the following facilities at the Primary Health Centre or sub-centre?

Nature of Service Patient's age sex

- 9.1 Maternal care (check up)
- 9.2 Deliveries
- 9.3 Immunization
- 9.4 Well baby clinic (check up)
- 9.5 Family planning
- 9.6 Hospitalisation
- Special Treatment (National programme)

10 What is your experience of hospital (PHC/Sub-centre) services?

| | | PHC _____ | Sub- centre _____ |
|------------------------------------|------------------------------------|--------------|-------------------------|
| 10.1 Time taken | a) Prompt/b) Long waiting | a/b | a/b |
| 10.2 Medicine given | a) Good/b) bad | a/b | a/b |
| 10.3 Payment made | a) Reasonable/b) Un- reasonable | a/b | a/b |
| 10.4 General behaviour of staff | a) Well treated/b) Not so | a/b | a/b |
| 10.5 Satisfaction | a) Satisfied/b) Not so | a/b | a/b |
| 10.6 Use | a) Useful/b) Not useful | a/b | a/b |
| 10.7 Others | | | |

11 Do you consult Community Health Volunteer for your health Needs? If yes, how many times did you or any member of your family consult him during the last two months)? (Record all persons treated)

| S.No. | Nature of complaint | Name of the person | Nature of service* given | Duration Treat/Sick | Cost | Outcome |
|-------|------------------------|--------------------------|--------------------------------|------------------------|------|---------|
| 11.1 | 11.2 | 11.3 | 11.4 | 11.5 11.6 | 11.7 | 11.8 |

*Includes examination, medicine, ointments, injections, chlorination, bandage etc.

12.1 Among the persons at PHC/Sub-Centre whom do you prefer to consult most often - Community Health Volunteer/Auxiliary Nurse Mid-wife/ Multi-purpose Health Worker/Doctor?

a) (b) (c) (d)

12.2 Why do you prefer him/her particularly?

13 Is any of these Health Workers/Personnel your relative, caste-fellow etc. (e.g. CHV/MPHW/ANM/HV etc.) Yes/No

If yes, specify

| S.No. | Health worker | Type of relationship | Nature of relationship | Reciprocated or not |
|-------|---------------|-------------------------|---------------------------|------------------------|
| 13.1 | 13.2 | 13.3 | 13.4 | 13.5 |

- 18 During the last 6 months how many times did Auxillary Nurse Mid-wife (ANM) or Multipurpose Health Worker (MPHW) or any other Health Worker visit your house? (Give names)

| VISITED BY | PURPOSE OF VISIT | SERVICE PROVIDED |
|------------|------------------|------------------|
| 18.1 | 18.2 | 18.3 |

- 19 As you said, you consulted Primary Health Centre for some (give details) ailments ? Why didn't you consult a private doctor (give actual illustration from instrument No. 2)
- 20 As you said, you consulted a private doctor for some (give details) ailment? Why didn't you consult Primary Health Centre then? (Give actual illustration from instrument No.2).
- 21 Generally, whom do you prefer to consult?

| Health Agency/ Practitioner | Priority | Reason |
|--------------------------------|----------|--------|
| 21.1 | 21.2 | 21.3 |

- a) Primary Health Centre
- b) Community Health Volunteer
- c) Private Practitioner
- d) Folk-Healer

- 22 What will you do for your minor ailments like cough, head-ache, constipation, motion etc. ?

- a) Visit doctors
- b) Self-Medication/Home remedy
- c) Visit Medical Shop
- d) Visit healer
- e) Others

- 23 Have you or your family members (children & ladies) used amulets/charms to Ward off evil spirits, ghosts etc?

| Yes/No. If yes specify | | | | | |
|------------------------|---------|------|----------|------|--------|
| Whom | Age/Sex | When | For what | Cost | Source |
| 23.1 | 23.2 | 23.3 | 23.4 | 23.5 | 23.6 |

24 Which are the following items you keep in your house?

- 24.1 Honey
- 24.2 Ointment
- 24.3 Medicines (Tablets/Mixtures)
- 24.4 Bandage/Cotton
- 24.5 Herbs (Roots, barks etc.)
- 24.6 Thermometer
- 24.7 Dettol/Phenyle/Bleaching Powder
- 24.8 Tonic

25 From where do you get your drinking water ?

| SOURCE | OWNERSHIP | |
|--------|-----------|-----------|
| | Owned | Community |
| A | | B |

- 25.1 Well
- 25.2 Tap
- 25.3 Handpump
- 25.4 Tank
- 25.5 Others

26 Do you strain your drinking water? Yes/No.

27 Do you boil your drinking water? Yes/No.

28 Which source of water do you use for the following purposes?

| PURPOSE (A) | SOURCE (B) |
|-------------|------------|
|-------------|------------|

- 28.1 Bathing
- 28.2 Washing cloths
- 28.3 Washing cattle
- 28.4 Cooking
- 28.5 Others

29 If using community well what are the other communities that also use the same?

30 Do you use community latrine or open space for defecation? Yes/No.

31 Why you use only that particular community latrine or open space?

32 Are you free to use any water source(well, tap, tank, hand-pump

**HEALTH CARE AND SOCIAL STRATIFICATION : A STUDY
IN HEALTH BEHAVIOR IN RURAL ANDHRA PRADESH
INSTRUMENT NO. 5 : HEALTH PRACTICES**

11 a) Where do you sleep ?

1) Floor (2) Mat

3) Cot - (a) Folding Cot
(b) Ribbonded Cot
(c) Coir cot

b) In case of sleeping on floor, ask whether it is his habit right from the beginning or developed on somebody's advice.

12 Do you drink? Yes/No

If yes indicate the following:

| Frequency | Quality of liquor generally taken | Quantity per day/per week |
|-----------|--------------------------------------|------------------------------|
|-----------|--------------------------------------|------------------------------|

No. of times per day

No. of times per week

No. of times per month

13 Do females in your family also drink? Yes/No

If yes, indicate the following

| Frequency | Quality of liquor generally taken | Quantity per day/per week |
|-----------|--------------------------------------|------------------------------|
|-----------|--------------------------------------|------------------------------|

No. of times per day

No. of times per week

No. of times per month

14 Do you smoke? Yes/No

If yes, indicate the following

a) No. of cigars per day/per week

b) No. of bidis per day/per week

c) No. of cigarettes per day/per week

- 15 Do females in your family also smoke? Yes/No.
If yes, indicate the following
a) No. of cigars per day/per week
b) No. of bidis per day/per week
c) No. of cigarettes per day/per week
- 16 How do you smoke? Describe the pattern (e.g. by keeping the burning end inside the mouth).
- 17 How often do you plaster your house with cowdung or mud?
1) Daily (2) Once in a week
3) Twice in a week (4) Once in a fortnight
5) Others
- 18 How often do you wash your house?
1) Once in a week (2) Twice in a week
3) Once in a fortnight (4) Once in a month
5) Others.
- 19 a) What do you use to kill budbugs?
1) Hot water (2) Kerosene
3) Chemical (bed bug killer) (4) Others
b) How frequently do you go for this practice?
1) Once in a week (2) Once in a fortnight
3) Once in a month (4) Others
- 20 Do you use mosquito net? Yes/No.
If no, what do you do to avoid mosquitoes.
- 21 Do you use 'Flit' or any disinfectant? Yes/No.
If yes, how often do you use it?
- 22 How often do you get your well chlorinated?
- 23 Do you boil your drinking water? Yes/No.

- 24 Do you strain your drinking water? Yes/No
- 25 Do you add anything to drinking water for purification?
(a) Alum (b) Paste of some seeds/bark
(c) Others.
- 26 Do you keep a separate vessel to take drinking water from the storing vessel?
- 27 What kind of vessel do you use for storing drinking water?
1) Earthen pot (2) Steel Vessel
3) Brass vessel (4) Aluminium vessel
5) Others.
- 28 During your last pregnancy, were you given any special food (other than the normal one)?
- 29 Upto which month, you kept on working outside your house say in fields, agricultural work etc?
- 30 After how many days of your delivery, you resumed your normal work (outside the house say agricultural work)?
- 31 Were you given any special diet after delivery?
- 32 During your last pregnancy did you go for prenatal check-up to any doctor or PHC?
- 33 Upto what age the mother's milk was given to the baby?
- 34 Was the baby given Glaxo/Amul Spray etc. Milk? Yes/No
- 35 When the baby was given normal food?
- 36 Did you prepare any special item of food for the baby?
(Say potato, porridge etc.)
- 37 Was the child given Tika? What and when?

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