CHAPTER VII
HEALTH AND CULTURE

Man is unique in having cultural environment. This includes all the conditions in which men are born, live, work, procreate and die. Culture as an environment is deeply related to the health of human beings. Human culture everywhere includes patterns of social organisation designed to regulate a particular society, the members can understand the behaviour of most people and they can predict how an individual will react in a given situation. With our knowledge of medicine, it perhaps seems strange that the treatment of diseases among non-literate peoples so frequently calls for praying, wearing of amulets or in consulting an exorcist who recites certain verbal formula in the process of treatment. To many people illness and disease are unexpected events, not controllable by ordinary means. And it should not be overlooked that many members of our own society quite sincerely believe that disease is best cured whereas epidemics may be controlled by prayer and faith rather than by medical knowledge.¹ Worship of deities followed by feasting in calamities like epidemics of Cholera an exorcist in certain types of illness or going for a holy bath in other places are still practised in folk societies.

Simply defined, a culture is inclusive of the beliefs and customs of a society which have developed in attempting to manage

its shared problem, a part of which concern the occurrence of illness and the need for medical treatment. By analysing the characteristics of culture of a society, we can understand the health care system. First, most of the beliefs and customs are cultural when they are quite commonly shared by the people of the society. We have a majority of cultural traits with beliefs and customs (including those pertaining to health, illness and treatment) shared by a large number of masses of people; and we have numerous sub-cultures, large groups of peoples who share somewhat different cultural beliefs and customs.

The pattern of health care and health institutions differs from society to society and from time to time. The differences depend to a large extent upon cultural views and norms to the disease. The medical institutions have a long history and have developed over a considerable time. They have undergone changes with the rise of technology, varying social needs and the pressures of a variety of interest groups. Of the institution, i.e., hospital developed as an important health institution of human society. Previously hospitals were centred around religious monasteries and temples. But the modern health services depend on the argument recognise that hospitals should have a community base. The hospital arises out of the needs of the community and it should serve the community with its best.

Levinski and Corwin¹ observe 'hospitals have been coexistent with man's settlement in large aggregations, the rise, decay and recurrence reflect the development of Man's culture, social ideals, religious spirit and scientific achievement'.

Variations in cultural environment may be noted among the people of two different groups. For example, in India, in the north milk is considered to be an important food and is given to growing children, sick and weak persons. In the south, on the other hand, its use is much less.² Healing practices as well as ideas regarding disease also vary considerably. Therefore, it is very important for understanding the health problems in relation to the people, their hygiene understanding, attitudes towards diseases, their orientation or action pattern when somebody falls ill and his/her own remedies to cure certain diseases. In view of this, it is desirable for the social scientists to understand and study the health care of the society and the methods of healing which are no less important for a complete understanding of the total way of life (or culture) of people than its other social institutions. The study of cultural environment of a community may help the health administration in framing social policies.

In order to study medicine it is important to keep in the foreground the question of whether specific behaviour patterns

are universal, reflecting the exigencies of the human situation, or whether they are the special product of configurations of a specific culture. One can assume that the problems which people face and the psychological needs that arise from these problems are everywhere, at least, similar despite differences in theories about the technique for coping with them. Thus, study of our society with respect to an important problem that of illness in the context of different cultural settings is important. The development of a conceptual scheme, of course, depends, in part on the availability of accurate descriptions of different systems of medical care, their techniques and functions.

The development of such a conceptual framework, however, has at least two practical consequences. It provides us with a better understanding of our own system of medicine and medical practice. Second, it provides insights in the application of western scientific medicine in non-industrial societies. The present deals with the study of attitudes and beliefs towards (medicine and medical care systems and organisations in two different areas, i.e., urban and rural situated in the state of Haryana. The specific objectives are as follows:

1. To identify the beliefs or conception and orientation about health and medical care of the people which influence their attitudes in seeking medical care.

2. To understand the importance of food in a cultural context in terms of food habits, serving habits and eating habits.
3. To analyse people's beliefs towards causes and treatment of some common diseases.

4. To analyse the dimension of non-rational or super-rational beliefs such as God and supernatural causes and rational beliefs, those which showed a respect, understanding and appreciation for the medically advanced causes and treatment.

The cultural structure of a particular society regarding perception, preference, evaluation and satisfaction shows the pattern of health care. Thus, it becomes imperative to find out personal hygiene, food habits and nutritional status in relation to its culture. How far the beliefs, ideas, values and practices are directly related with the phenomena of health care. The cultural setting of a society influences directly or indirectly people's understanding of the problems of disease, its treatment, prevention and the pattern of health care. A person's attitudes, daily routine decisions regarding health maintenance, food habits and food serving practices are reflective of efforts on his or her part to maintain or restore himself or herself to his or her normal state. Even when we know how to prevent some illness or to seek medical care for cure of various diseases, the utilisation of such services will depend on the notion people have of health and illness, actions they take in the event of sickness and on their understanding of the etiology of a disease. Thus, the attitude of the members towards disease, health, food and eating.
habits form the picture of health pattern. The notion about the local medicines which they use during their illness comes under the framework of ethno-medicine. What sort of knowledge people have towards diseases and what do they do to combat these will also be analysed in the present chapter.

Conception of Health:

Whenever we talk about health care immediately it comes to our mind, 'What is health' ? We have discussed below the elements of normal health as perceived by our respondents living in rural and urban areas. An individual's response to this concept is likely to be influenced by his background and awareness. Since these perceptions are mostly subjective in nature, one has to define these normatively. Because norms provide standard of adequacy relevant to capacities, state of feeling and biological functioning needed for the performance of those activities expected from the members of a society.

Health, like happiness is a elusive concept. It has been defined in a number of ways. But none of the different definitions is entirely satisfactory. To answer the seemingly single question : Who is healthy ? The World Health Organisation, in 1946, defined health as, "state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity". Good health can be experienced positively or negatively, as something tangible or as an absence of health
related problems. One respondent in a research to attitudes to health and illness,¹ said of the health that, it is to feel in good form, happy content, with a good appetite, sleeping well, wanting to be up and doing; it is to feel well and strong; that's what good health is. However, another remarked: "when you are in good health you don't think about it, you think of other things".

A different definition, given from a sociological perspective comes from Parsons² who describes health as a state of optimum capacity for the effective performance of valued task. Parsons focusses attention on the social importance of health: healthy individuals are able to function well in order to perform social roles; ill health reduces their ability to do so.

To some respondents of our study, the term health does not connote anything obscure and elusive. The local equivalent for this is 'tandrusti' which means right condition of the body. We have observed that health is hardly ever a subject of talk among the people when they gather at public places at their leisure time. We never heard people talking about their health, unless we asked questions on health.

In the present chapter, we analyse the attitudes towards health based on lay conception of health by the respondents. The

following composite answers offer an important illustration of how differently these persons reacted to and perceived about their health. We recorded their multiple responses in certain categories. The factor which was preferred first was kept in first response category, and so on. We have taken a number of factors including physical, biological, socio-cultural and environmental, punctuality in different habits, economic and psychological, but primarily health is identified through physical and biological standards.

(1) Physical : Out of the total number of respondents in the sample, 66 (44.0 per cent) persons perceived health on the basis of looks; e.g., "handsome or beautiful". Similarly "a person is healthy who is neither fat nor thin, or bodily fit in terms of height and weight". Some others feel that a healthy person should have "sufficient amount of energy, stamina, efficiency". Further "sufferings and injuries should have no effect on their body and able to fight if necessary". Lastly, a healthy person should be "fat (mota), bones should be well-built and stout".

(2) Biological : 62 (41.3 per cent) respondents considered biological characteristics for good health. A healthy person is one who has no disease in his body and different functions of the organs work properly. Some reacted "a person is healthy who keeps normal temperature or not suffering from any disease", etc.

(3) Others : 6 (4.0 per cent) people believed that a healthy persons is one who can adjust in diverse situations including
capable of taking different food, water at different places. It means that a healthy person should be in a position to adjust mentally and physically in diverse situations. According to them healthy persons are mentally fit, social, extrovert, polite and they are capable to fulfil their basic needs. 5 (5.3 per cent) emphasized that for maintaining good health, a person should have regular habits in eating, exercise, sleep, work and consumption of balanced diet including vitamins and tonics. Some remarked: "a healthy person should not get tired after doing regular hard work". Similarly, "person who is able to follow daily routine things like getting up early in the morning, doing exercises, taking bath daily and have sound sleep". Furthermore, some others also said: "a person is healthy who is good at studies and play, a person is healthy who takes balanced diet and digest it properly." Four (2.7 per cent) persons considered accumulation of wealth for ensuring good health. They conceive 'wealth is health' contrary to the common saying 'health is wealth'. There is no casual correlation between perception of health and economic conditions here. 4 (2.7 per cent) respondents feel that for good health one should be happy mentally because mental illness generally leads to physical illness. Hence, the basic characteristics of health are: confidence, satisfaction and absence of worries, etc. These people provided the following responses for their arguments. These are: "a person who has got confidence, satisfaction, no worries, honest", "a person who
remains happy and cheerful, has good thought in mind", "a person who does not have any fear" and "a person who does not have any inferiority complex", etc. (See TABLE-1).

<table>
<thead>
<tr>
<th>Characteristics of health</th>
<th>Number of Respondents*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>66(44.0)</td>
</tr>
<tr>
<td>Biological</td>
<td>62(41.3)</td>
</tr>
<tr>
<td>Other (Socio-cultural, Economic, Psychological, etc.)</td>
<td>20(13.3)</td>
</tr>
<tr>
<td>No response</td>
<td>34(45.3)</td>
</tr>
</tbody>
</table>

* Multiple Response
(Figures in the bracket represent percentage)

A perusal of above response suggests that respondents have diverse views of the concept of proper health, sometimes having contradictory opinions. Nevertheless, a majority of the respondents identified good health with physical and biological characteristics. Socio-cultural, environmental and punctuality in different habits also play role in their perception of good health. Given the higher per capita income in field of our study as compared to backward regions, economic variable does not enter into the perception of the people.

Orientation and Health:

While analysing the religious aspects of the concept of
disease and its causation. Valunjkar and Chaturvedi state that the basic principle of Hinduism of "Karma" and "rebirth" play vital role. They argue that health and illness are reward and punishment for one's action in previous birth. It reflects the fatalistic attitudes towards health. Dube in his study of Shamirpath (Andhra Pradesh) finds that "although indigenous herbs and magico-religious practices are still continued in treatment of diseases, the efficacy and utility of Allopathic drugs and injections have greatly changed the attitude of people towards modern medicine". This is a move from fatalistic to rationalistic approach of health as people do not merely believe the supernatural causes of disease but also go for modern treatment. We discuss below the beliefs of our respondents in regards to fatalistic and rationalistic approaches of health.

Generally, one comes across two types of beliefs towards medical practices at different cultural levels. First, at the level of primitive or pre-literate people, there is the practice of "primitive medicine", i.e., medicine based predominantly on the supernatural theory of causation of disease and seeking

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therapy by magico-religious means. At the folk culture level there is "folk medicine" where the theory of illness involves

1. To Djurfeldt and Lindberg (1975, op.cit), religious theory is a cognitive instrument which answers to the practical necessity of coping with those infrastructures which are not directly manipulative. This view is inspired by Godelier's article "Muthe et histoire" which attempts to account for the formal and abstract structure of myths but which we have taken the liberty of extending to our problematics (Godelier, Maurice, 1973 Horizon, trajets Marxiste en anthropologie). Maspero, Paris. Extending Godelier's analysis we postulate that religious theory represents the uncontrolled and unknown domain to itself in the only way accessible to it, by thinking or imagining the unknown in analogy with the known. To quote: "La Pense mythique est la Pensee Sauvage within a materialist framework by specifying the infrastructural and epistemological situation which generates this type of thought. By analogy, the invisible causes which generates this type of human world (culture) are equipped with consciousness, but differing from him in one respect: They are superior to him; they know what man does not know, they do what he can not do, they control what he does not control. Weber saw a process of rationalization, because in modern societies, action ideal-typically tends to be instrumentally rational, zwekrational, while in traditional societies it is guided by 'ingrained habituation' (see Weber, Max, 1976) Economy and Society: An outline of Interpretative Sociology. (Edited by Guenther Roth and Claus Wittich) New York: Bedminster Press, pp.24-25). In both the societies, superstructure have a primacy over infrastructures because actions, in Weber's view, are determined by conscious or unconscious motives, and Weberain sociology aims at understanding actions (Verstehen) by laying bare these determinants. Talcott Parsons retains this basic Weberian perspective, but in his social system actions have been replaced by roles as constituent units, and motives by values, norms and beliefs expressed in institutionalized behaviour (Parsons, Talcott, 1951). The Social System, Glencoe, Ill. Free Press, pp.3-67. He has himself employed his famous pattern variables in the analysis of the sick role" and doctor-patient relations (1); and the variables are supposed to be applicable to any role system (Parsons, Ibid, p.58 ff.). In a recent work he has specified the direction of societal evolution as leading to an "enhancement of adaptive capacity", a term which could be seen as a counterpart to Weber's rationalization (Weber, op.cit., p.22).
both supernatural and physical therapy. Thus, people of "primitive culture" and "folk culture" have fatalistic attitude towards their good health. Second, in traditional and modern societies, "traditional" or "indigenous" medicine and "modern medicine" respectively recognize natural rather than supernatural causation of disease. This view reflects the rationalistic attitude towards good health.

To analyse the extent of orientation of different respondents we have divided statements into four broad categories. They are as follows: Fatalistic, non-fatalistic, rationalistic and non-rationalistic. The statements like good health is due to 'blessings of God', 'good deeds of past' 'by offering things to God' were identified as fatalistic orientation. The respondents who gave initial priority to these statements were kept in the category of fatalistic orientation, but others, who did not prefer them were classified as non-fatalistic persons. In the same way, we classified respondents with another set of factors like: 'health is the result of good nutrition and hygiene', 'hereditary factor' and 'good medical care' are some of them which reflect rationalistic orientation. This orientation also analysed in terms of rationalistic and non-rationalistic oriented people. It is very difficult to categorize people in two exclusive categories of rationalistic and non-rationalistic or fatalistic or non-fatalistic, therefore, we
tried to give them rank order.\textsuperscript{1}

**Fatalism and Health:**

Fatalism is a concept which combines belief in God, attributes of irrational practices such as superstitions or religious prescriptions. The remedy for a disease caused by God is simple: people promise to offer Gods the things they like best, for example, their hair, their children, and even if God is not the cause of illness, he may be prayed to help in curing it. Therefore, a person may go to the temple and pray to God for relief from his illness. After his ailment is cured he will visit the temple once again and offers prayer to God alongwith the offerings. Besides, whenever disease is perceived as a result of failure to fulfil obligations to God, the patient will go to a temple and try to improve his relations with God. Often a priest prescribes the means necessary to rectify these relations.\textsuperscript{2}

**Rationalism and Health:**

Rationalism is a concept which tries to understand the things in terms of scientific perspective, logic or cause and

\begin{itemize}
  \item \textsuperscript{1} The preference for each item in terms of one, two, three, four, five and six was obtained. These preferences were given the weightage to first preference, five to second preference, four to third preference and three to fourth preference and two to fifth preference and one to sixth preference. The total number of score given to each statement was added separately and divided by the number of respondents. Thus, the mean was calculated. Higher the mean score, the higher was the priority given to the statement.
  \item \textsuperscript{2} Djurfeldt and Lindberg (1975), \textit{op.cit.}, p.145.
\end{itemize}
effect relationship. The diseases which are caused by various types of infection and accounts for a majority of deaths and bad health: fever, intestinal infection, tetanus, small-pox, cholera, tuberculosis, coughs, colds, diptheria, etc. Most of the diseases are traced as a cause of malnutrition, nutritional deficiencies (Vitaminosis, anaemia, etc.), aspects of living standard, inadequate public sanitation and hygiene (worms, stomach diseases, skin diseases, eye and ear infection etc.). A person's good health is also attributed to the hereditary factors as each individual is related to his generation in terms of his physiological constitution of the body. Generally, it is believed that if an individual has a good health, it is attributed due to his hereditary factor. Thus, good health is viewed in the rationalistic perspective, in view of 'good medical care', 'good nutrition and hygiene', and 'hereditary factors'.

It is apparent from TABLE-2 that people in general gave more preference to the rationalistic factors for their good health as the total mean value of the factors which show rationalistic dimension weighs more. But if we analyse each factor separately than 'God nutrition and hygiene' was ranked in the first position of rank order and 'hereditary factor' scored the third position. On further analysis, it is interesting to note that a large number of rural respondents gave more weightages to fatalistic factor as compared to urban respondents. Urban respondents were more in view of analysing good health in
terms of good nutrition and hygiene as it stands in the first rank of rank order.

**TABLE-2**

**Ranking of Different Factors by the Respondents Which Affect Good Health**

<table>
<thead>
<tr>
<th>Factors Required for</th>
<th>Rural</th>
<th>Urban</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Rank</td>
<td>Mean</td>
</tr>
<tr>
<td>Good Deeds of Past</td>
<td>1.82</td>
<td>I</td>
<td>1.11</td>
</tr>
<tr>
<td>Blessings of God</td>
<td>1.56</td>
<td>II</td>
<td>1.62</td>
</tr>
<tr>
<td>By Offering Things to God</td>
<td>1.08</td>
<td>V</td>
<td>1.02</td>
</tr>
<tr>
<td>Good Nutrition and Hygiene</td>
<td>1.43</td>
<td>III</td>
<td>1.90</td>
</tr>
<tr>
<td>Hereditary Factor</td>
<td>1.34</td>
<td>IV</td>
<td>1.57</td>
</tr>
<tr>
<td>Good Medical Care</td>
<td>0.82</td>
<td>VI</td>
<td>1.85</td>
</tr>
</tbody>
</table>

(Figures in the Table represent mean score)

**Habits, Food and Health:**

Anthropologists view eating habits as a whole complex of culinary activities, likes and dislikes folk wisdom, beliefs, taboos, and superstitions associated with the production, preparation, and consumption of food in a word, as a major cultural category. And, as a major cultural category, they see food impinging on and related to many other cultural categories. Although they recognise that food is essential to life, it is ultimately a physiological phenomenon. Cultural anthropologists at least, are particularly interested in the role of food in
culture as an expressive activity that reaffirms social relationships. Sanctions, beliefs and religion, determine many economic patterns, and govern a large part of the daily round of life. In other words, just as medical systems play roles that transcend health and illness, so do dietary and, serving customs play basic social roles that for transcend mere nourishment of the human body. Some of these roles, and cultural characteristics of food as revealed by our respondents are discussed below.

Food Habits and Health:

In rural India people subsist on agriculture and the larger part of the diet is obtained from locally produced foods. It is widely recognised that the diet of the people of a particular area is greatly influenced by local conditions of soil and climate, the density of population, extent of urban contacts, local religious customs and traditions relating to fasts, feasts and taboo. Audrey I. Richards1 has brought out numerous social and cultural factors involved in the dietary of tribals of Northern Rhodesia and has shown that the methods of storage, distribution system of production and cooperation, economic incentives or traditional attitudes and values in relation to food stuffs are at the root of special deficiency in diet.

The purpose of a dietary survey which aims at collecting qualitative information on dietary pattern and food habits is to

provide information on the views of healthy food. How food is served in the family? Is there any difference between male and female in terms of serving the food? What are the sources of contamination of food? Do they believe in them and what precautions they take to prevent it? Overall satisfaction and dissatisfaction from the food which they were taking was also recorded. Food habits and eating habits of individual grow up practice and eventually become part of culture. The present section deals with the qualitative aspects of the problem of food, customs, practices, values, ideas, beliefs, taboos of the people and how these characteristics are related to good health in the survey area.

An important aspect of our study is to delineate the factors considered essential for the healthy food. A set of factors was considered on the basis of conception of healthy food viewed by the respondents. They were asked to give three responses in order of priority. The higher the mean score, the higher was the healthy food for the health of the people. It is apparent from the TABLE-3 that people in Haryana considered milk and milk products, fat, ghee and green vegetables as more essential for the health of the people than the items like

1. Each Respondent give five preferences in order of priority. A score of 5 was given to 1st, a score of 4 to 11nd, and a score of 3 to 111rd response, a score of 2 to IVth response and a score of 1 to Vth response. The total score of each item was added and divided by number of respondents. Thus mean was calculated.
### TABLE - 3

Mean Score of the Items for the Healthy Food Viewed by the Respondents in Descending Order

<table>
<thead>
<tr>
<th>Items</th>
<th>Rural Mean</th>
<th>Rural Rank</th>
<th>Urban Mean</th>
<th>Urban Rank</th>
<th>Total Mean</th>
<th>Total Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk and Milk Products</td>
<td>1.19</td>
<td>I</td>
<td>0.97</td>
<td>I</td>
<td>2.16</td>
<td>I</td>
</tr>
<tr>
<td>Fat and Ghee</td>
<td>0.92</td>
<td>II</td>
<td>0.54</td>
<td>III</td>
<td>1.46</td>
<td>II</td>
</tr>
<tr>
<td>Green Vegetables</td>
<td>0.27</td>
<td>III</td>
<td>0.63</td>
<td>II</td>
<td>0.90</td>
<td>III</td>
</tr>
<tr>
<td>Pulses and Cereals</td>
<td>0.26</td>
<td>IV</td>
<td>0.37</td>
<td>IV</td>
<td>0.63</td>
<td>IV</td>
</tr>
<tr>
<td>Fruits and Dry Fruits</td>
<td>0.02</td>
<td>V</td>
<td>0.24</td>
<td>V</td>
<td>0.26</td>
<td>V</td>
</tr>
<tr>
<td>Meat, Fish and Egg</td>
<td>0.006</td>
<td>VI</td>
<td>0.17</td>
<td>VI</td>
<td>0.18</td>
<td>VI</td>
</tr>
</tbody>
</table>

(Figures in the Table represent mean score)

Pulses, cereals, meat, fish, eggs, fruits, and dry fruits. Moreover, milk and ghee were easily available to rural people. Generally, every family in rural area had buffaloes in their houses and they utilize milk for their consumption and prepare ghee at home. Urban people also keep buffalo in their house for consumption of pure milk and ghee. However, urban people considered green vegetables as an important item of the healthy food as compared to rural people. This is also a substitute for want of milk. Meat, fish, egg are insignificant in the given responses as a large segment of people in rural Haryana are vegetarians. Though, fruits and dry fruits are the important items for the healthy food, the responses were not significant as these were beyond the reach of the lower and middle classes.
There is rural-urban difference though slight in the perception of healthy food. Fat and ghee is less viewed important in term of healthy food whereas green vegetables are regarded as important items for the healthy food. They consume them in the form of Salad also. The significant thing is to notice that non-vegetarianism is not associated with healthy food, as respondents gave least value attached to meat, fish and eggs. It expresses the cultural heritage of state as such. Thus, it appears that milk and milk products are dominating items of food in the field of our survey. It is not only the items of food which are important for good health, but also the food habit that may influence health. We turn to this below.

Eating Habits and Health:

It is the general habit in the rural area that people take their meals twice a day whereas in the urban area they take thrice a day. Those engaged in agriculture go to their fields early in the morning and work there till evening. The general practice is that workers don't carry their food along with them when they go to field in the morning. In the mid-day any member of the family especially the female who cooks food carries it to the field for the male workers. Sometimes children also carry food to the fields. The workers eat the food under the shade of a tree and after a while again start working. They do not carry their food in the morning itself. The reason is that after doing hard work they like to take hot food to remove their tiredness.
Further, it becomes inconvenient to eat dry chappati (which is the staple food in the area) in the absence of curry vegetables. Besides, hot roti and onion they take "lassi" for proper digestion.

Persons who are living in urban areas and engaged in services or shop-keeping, usually preferred to have breakfast. Breakfast consists of Parotha, curd, milk, tea, pickle, etc. The combination of these items depends on individual preferences. People for the day time carry their lunch or those who are near to their working places, take their lunch at home. The items in the lunch varies according to their economic condition, choices and suitability in preparation at home.

Tea has become common for both rural and urban folks. People in villages have also started taking tea. They say that it removes tiredness and in the cold season serves as hot drink. Foods are generally eaten with the help of hands. There is no system of eating food with spoons, knives and forks in the village. However, in the urban area some families use spoons for semi-liquid meals. Washing of hands is not so common before eating food in the rural as well as in the urban area. But washing of hands is common after eating the food.

The members belonging to Jat caste background generally, have milk or milk products in breakfast. They also do not eat much vegetables in either dinner or lunch but prefer to have milk
or lassi or ghee. There is no restriction for children in villages, that how many times they eat in a day. Generally parents feel that children need eating many times because after playing they often feel hungry. In the urban area, the educated families give the reason that eating many times a day disrupts the digestive system of children. They, therefore, restrict their children from eating many times. Some people in urban area give the feed to their infants according to doctor’s advice.

Food and Nutrition:

Adequate diet tends to be thought of in terms of quantity, not quality, of sufficient staple food, not a balance of many foods. Consequently, malnutrition may exist where the potential exists for an adequate diet. To illustrate Hasan1 found that in the north Indian village of Chaura, "people generally believe that it is the adequate quantity of food that is important. The idea of quality is restricted to certain food recognised to be strengthening ..." No distinction is made between protective and energy producing foods. We have noted the frequent beliefs that children should not be forced to do anything against their will. So mothers rarely force children to eat certain foods. In this way they themselves develop their own taste.

On the other hand, if they force him/her to take that

particular type of food, the child will vomit, or may have diarrohea or pain, etc. This establishes a relationship between unwanted food and illness. Thus, new food is no longer given. Other "blocks" to adequate infant nutrition in West Bengal are based on the classification of foods as "hot" and "cold". Food classified as garam (hot) which include eggs, meat, milk, honey, sugar, and cod-liver oil, are not given to children during hot weather (which lasts during a large part of the year) or when children are suffering from illness classified as garam (hot). In all of these ways cultural practices add to the already serious limitations in nutritional possibilities open to poor, village mothers in West Bengal. The above description of food values shows that the eating habits of rural people are qualitatively different from the habits of urban people. The adult rural people restrict their eating to twice but allow children to eat more times whereas in urban area the frequency of it is more.

There are strong cultural beliefs about the food given to mothers who gave births to a child. For example, after delivery of child energetic (especially fat) food is given. However, there are some families who cannot afford this kind of diet because of their low income. They reduce the quantity and variety. Even though they have knowledge about the types of food necessary at different times for the body, they provide contradictory reasons

for not been in a position to arrange the same. Poverty may be a reason for not been in a position to provide desired foods at different times.

Perhaps the most widespread of all food classification, and particularly significant with respect to health, is the "hot-cold" dichotomy. Whatever the local qualities ascribed to each food, the common theme is that through judicious balancing of foods and the avoidance of excessive amounts of heat and cold, health is the most apt to be maintained. Thus, in our study, hot foods include raw sugar, buffalo milk, eggs, ghee, meat, garlic, etc. It is believed that milk must not be taken with either meat or fish because of the heat produced. Cold foods include leafy vegetables, carrots, and curd.

Food and Satisfaction:

Furthermore, respondents of our survey area were generally satisfied from the availability of food as shown in the TABLE-4.

<table>
<thead>
<tr>
<th>Nativity</th>
<th>Satisfied</th>
<th>Not Satisfied</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>52(69.3)</td>
<td>23(30.7)</td>
<td>75(50.0)</td>
</tr>
<tr>
<td>Urban</td>
<td>52(69.3)</td>
<td>23(30.7)</td>
<td>75(50.0)</td>
</tr>
<tr>
<td>Total</td>
<td>104(69.3)</td>
<td>46(30.7)</td>
<td>150(50.0)</td>
</tr>
</tbody>
</table>

(Figures in the bracket represent percentage)

1. For evidence from other areas see Matthew, C.M.E. (1979), Health, Culture in a South Indian Village, New Delhi: Sterling, p.109.
Furthermore, when we look at the satisfaction from caste-wise distribution among the population, we find that as many as 70 (77.77 per cent) jats are satisfied with the available food, whereas scheduled caste and backward caste population 15 (68.18 per cent) is not satisfied with the available food. It may be due to their poor economic conditions in comparison to jats. (TABLE-5)

**TABLE-5**

<table>
<thead>
<tr>
<th>Caste Structure</th>
<th>Satisfied</th>
<th>Not Satisfied</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jat</td>
<td>70(77.77)</td>
<td>20(22.22)</td>
<td>90(60.0)</td>
</tr>
<tr>
<td>Brahmin</td>
<td>6(42.85)</td>
<td>8(57.14)</td>
<td>14(9.33)</td>
</tr>
<tr>
<td>Other Castes</td>
<td>20(86.95)</td>
<td>3(13.04)</td>
<td>23(15.33)</td>
</tr>
<tr>
<td>Scheduled Castes and Backward Castes</td>
<td>7(31.81)</td>
<td>15(68.18)</td>
<td>22(14.66)</td>
</tr>
<tr>
<td>Muslim</td>
<td>1(100.0)</td>
<td></td>
<td>1(0.66)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>104(69.3)</td>
<td>46(30.7)</td>
<td>150(50.0)</td>
</tr>
</tbody>
</table>

(Figures in the bracket represent percentage)

Education is also a significant variable in interpreting the relationship between educational level and satisfaction from available food. TABLE-6 clearly shows that when we move from illiteracy level towards higher educational level, the dissatisfaction starts increasing. That is why as many as 44 (83.01 per cent) respondents are satisfied with the available food whatever they get, but among the respondents who had highly
professional education were dissatisfied from the available food. Thus, there is a significant relationship between the availability of food and educational level. It is due to it that educated persons are very conscious and aware of their rights and privileges.

**TABLE-6**

<table>
<thead>
<tr>
<th>Educational Qualification</th>
<th>Satisfied</th>
<th>Not Satisfied</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illiterate</td>
<td>44(83.01)</td>
<td>9(16.98)</td>
<td>53(35.33)</td>
</tr>
<tr>
<td>Primary</td>
<td>10(71.42)</td>
<td>4(28.57)</td>
<td>14(9.33)</td>
</tr>
<tr>
<td>Middle</td>
<td>13(81.25)</td>
<td>3(18.75)</td>
<td>16(10.66)</td>
</tr>
<tr>
<td>Matriculate</td>
<td>20(74.07)</td>
<td>7(25.92)</td>
<td>27(18.0)</td>
</tr>
<tr>
<td>Graduate</td>
<td>9(69.23)</td>
<td>4(30.76)</td>
<td>13(8.66)</td>
</tr>
<tr>
<td>Post-Graduate</td>
<td>4(4.0)</td>
<td>6(60.0)</td>
<td>10(6.66)</td>
</tr>
<tr>
<td>Professionally Trained</td>
<td>4(28.57)</td>
<td>10(71.42)</td>
<td>14(9.33)</td>
</tr>
<tr>
<td>High Professional Education</td>
<td>-</td>
<td>3(100.0)</td>
<td>3(2.0)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>104(69.3)</td>
<td>46(30.7)</td>
<td>150(50.0)</td>
</tr>
</tbody>
</table>

(Figures in the bracket represent percentage)

Besides food, proper drinking water is equally important for maintenance for good health. Adequate supply of safe drinking water and sanitary disposal of human excreta were not only essential for the prevention of some of the common diseases but also for the provision of facilities for a descent standard of
living. In countries where water supply and waste disposals have been properly attended, cholera, typhoid fever, and dysentery have almost disappeared. These measures not only affect infant mortality but also check intestinal parasitic infection rate among the adults.

Infrastructural conditions of water supply are unsatisfactory in the area as (both rural and urban) practically water in the city was used from tubewells which were not deeply dugged. As such it contains lots of soils and other dust particles and other contamination. In the village also people do not prefer to have medicine which purifies the water in the well. They start quarreling with the health visitor, as to why they have put up medicines in their wells. It has destroyed the taste of their water. They say that "Lal Dawai" (Potassium Permanganate) is not good, rather it is detering the taste of their water. Pond is also common in the village. To drink a pond water, means to have a lot of diseases. There is no flow of water and it is exposed to all impurities. So from all the sides it is not safe drinking. Animals also come to this pond. They use it for drinking purpose. People wash their animals and clothes here. Thus, it becomes totally impure but people still use it and become victims of poor health. Access to drinking water for the high class is high as compared to backward and Scheduled castes.

On the whole safe drinking water which is essential for
health is not satisfactory in the area inspite of the fact that 1285 number of villages in the state have been covered during 1982-83 under drinking water to the rural areas is deceptive as only 820 villages have been covered out of 3440 villages.¹

Food and Gender:

The sex bias in nutrition for the male against female infants, girls and women, has been brought out by several studies. Girls enter into marriage and motherhood from their pre-existing malnutrition and impair their health further. Cultural traditions of intra-family distribution of food rooted in rural areas, compel women to eat last and often eat least both in quantity and quality. While the low nutrient intake may help to maintain her own health and nutritional status, such as it may be the demands on the body during pregnancy and lactation drastically deplete her already scarce reserves leading to entrenched deficiencies and ill health.

This is equally true in urban as well as rural areas. The improved economic conditions in the state is an important reason for that is why three fourth of our respondents are satisfied with the availability of food. Therefore, economic betterment has brought tremendous improvement in their health than as a result

¹. Govt. of India (1985), Health Statistics of India, Central Bureau of Health Intelligence, New Delhi: Ministry, of Health and Family Welfare.
of the advancement of medical sciences.1

It is not only the intake of food, but the norms of eating that are also important for good health.

Norms of Eating Habits:

In India, the habit of washing hands before and after meals is common among different communities including Hindus and Muslims, although hands are washed simply with water. Besides, this similarity, Hindus and Muslims differ markedly with regard to their eating habits. Among Hindu castes, no two persons can eat together out of the common utensils while this is prevalent among Muslims. According to Muslims togetherness promotes affection and cordial relations among the individuals. That is why Muslims do not mind eating a thing already eaten partly by another family member while such a practice is not prevalent among Hindus except that a married Hindu woman usually takes her meals in the same utensils in which her husband has just taken his meals, without washing the utensils. The habit of eating from the common utensils is unhygienic as this may transfer infection from a sick to a healthy individual.

Norms of eating of the food and practices of drinking water is followed by the practice of serving the food among the family members in the family is another norms which is important in understanding the health of the individual.

In our study, 64 per cent rural respondents as compared to 38.6 per cent of urban respondents stated that even today the difference is kept in the distribution of food items between males and females in the family (TABLE-7). In the overall sample the 50 per cent respondents who do not serve the same food to all family members in the family gave the reasons for the same in the multiple form.

**TABLE-7**

Serving of Food among the Family Members by the Respondents

<table>
<thead>
<tr>
<th>Norms of Serving Food</th>
<th>Rural</th>
<th>Urban</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>They do not serve the same food to all members in the family</td>
<td>48(64.0)</td>
<td>29(38.6)</td>
<td>77(50.7)</td>
</tr>
<tr>
<td>They serve the same food to all the members in the family</td>
<td>27(36.0)</td>
<td>46(61.3)</td>
<td>73(48.7)</td>
</tr>
<tr>
<td>Total</td>
<td>75(100.0)</td>
<td>75(100.0)</td>
<td>75(100.0)</td>
</tr>
</tbody>
</table>

(Figures in the bracket represent percentage)

The most important reason for this kind of behaviour was that the males need more energy as compared to females because they work hard (26 or 17.3 per cent), and they are the chief earners in the family (19 or 12.7 per cent). Besides, the work of rural males is tenous as they have to work under the Sun in the
field (11 or 14.7 per cent). Another reason for providing more food to male is that the male child will continue to stay at home thereby they will support the parents in old age (7 or 4.7 per cent). The common sensical belief that the girls are discriminated from getting good food is not substantiated by our data. As we can see from TABLE-8 that hardly one of the 77 respondents has given the reason.

**TABLE-8**

Reasons for not Serving the same Food among the Males and Females in the Family

<table>
<thead>
<tr>
<th>Reasons for not serving the same food among males and females in the family</th>
<th>Rural</th>
<th>Urban</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males are given more food in the family as their work is hard/males need more energy</td>
<td>13(17.3)</td>
<td>13(17.3)</td>
<td>26(17.3)</td>
</tr>
<tr>
<td>Males are chief earners in the family</td>
<td>13(17.3)</td>
<td>6(8.0)</td>
<td>19(12.7)</td>
</tr>
<tr>
<td>Boys are given more food as they remain in the same family</td>
<td>7(9.3)</td>
<td>6(8.0)</td>
<td>13(8.7)</td>
</tr>
<tr>
<td>Males do hard work in the fields</td>
<td>11(14.7)</td>
<td>—</td>
<td>11(7.3)</td>
</tr>
<tr>
<td>They think that sons are helpful in old age</td>
<td>3(4.0)</td>
<td>4(5.3)</td>
<td>7(4.7)</td>
</tr>
<tr>
<td>If girls are given more they will have fast growth and will create problem of early marriage</td>
<td>1(1.3)</td>
<td>—</td>
<td>1(0.7)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>27(36.0)</td>
<td>46(61.3)</td>
<td>73(48.7)</td>
</tr>
<tr>
<td>Total</td>
<td>75(100.0)</td>
<td>75(100.0)</td>
<td>75(100.0)</td>
</tr>
</tbody>
</table>

(Figures in the bracket represent percentage)
It is to be noted that about 73 (49.0 per cent) of the respondents do not discriminate between male and female inserving the same food (TABLE-8) as such half of our respondents do not discriminate. Given relatively the better economic conditions in the study area even this amount discrimination is not expected. Illiteracy of females may also be the probable reason for this. As a result they hardly assert for this. It seems to be a cultural subordination of females in the decision making otherwise who manage the distribution of foods in the family and with sufficient amount, this discrimination is called for investigation.

After discussing the manner, amount, type and distribution of foods, we turn to discuss the influence of evil spirits and bad eye on the food. This is an important belief in the rural area as such it requires attention.

Effects of Evil Spirits and Bad Eyes on Food:

A widely accepted belief connected with health and disease is the effect of evil eye. Some individuals including certain animals are believed to be in possession of certain amount of supernatural power. Children are considered to be most susceptible to the effect of evil spirit and bad eye. But it is not confined to them. It is believed that as soon as a person, including a close relative, utter the sentence that the child is very beautiful, latter is supposed to have a mysterious evil effect on his health. They identify the evil impact when the
child suffers from diarrhoea, dysentery, develops fever, and cries loudly and continuously and becomes weak within a short time.

In the village, the common observation was that when the child is under the influence of evil eye, he is not taken to physician, because the physician does not know how to cure such evil spirit. On the contrary, the physician ridicules the patient and their relatives when they talk about it. Accordingly, Jharphook (blowing and whiffing) is the therapy suggested for such evil spirits.

As many as 52 per cent of respondents have no such belief in evil eye and spirits on the contamination of food. It is relatively higher in urban area (60 per cent) as compared to rural area (44.0 per cent) (TABLE-9). One can notice that even in a relatively developed society such as that of Haryana the believers of bad eyes and evil spirits on food persists even today.

**TABLE-9**

<table>
<thead>
<tr>
<th>Nativity</th>
<th>Belief in Evil Spirits and Bad Eyes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never (44.0)</td>
</tr>
<tr>
<td>Rural</td>
<td>33</td>
</tr>
<tr>
<td>Urban</td>
<td>45</td>
</tr>
<tr>
<td>Total</td>
<td>78 (52.0)</td>
</tr>
</tbody>
</table>

(Figures in the bracket represent percentage)
After identifying the belief about the evil spirits in the causation of certain ailments, certain practices about the belief in the evil spirits and bad eyes in relation to the food were also observed. These practices are the product of experiences of generations without any change. It is interesting to note that even among the urban respondents certain bad eye and evil spirits contaminate the food which further results in certain types of illnesses. However, the belief in evil spirit and bad eye is lower among the urban respondents as compared to rural sample respondents. As can be seen from the TABLE-9 that 60 per cent of the urban people as compared to 40 per cent of rural people never believe in such practice.

On further analysing the respondents' belief in spirits and bad eye in contamination of food in relation to their educational status, as many as 39 (73.58 per cent) out of 53 illiterate always believe in bad eye and the rest of the 14 (26.4 per cent) illiterate respondents believe in bad eye and spirits in some conditions, whereas among the educated people 31 (77.5 per cent) out of 40 respondents who are graduate or post-graduate or had professional degrees were in the opinion of that there are no spirits and bad eye as such which contaminate the food, only 8 (20.0 per cent) of these people believed that in certain conditions it contaminates the food (TABLE-10). Thus, it seems that there is an impact of education on belief in spirits and bad eye.
TABLE - 10

Education-wise Belief in Spirits and Bad Eyes in Contamination of Food

<table>
<thead>
<tr>
<th>Educational Status</th>
<th>Belief in Evil Spirits and Bad Eyes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never (Figures in the bracket represent percentage)</td>
</tr>
<tr>
<td></td>
<td>With some conditions</td>
</tr>
<tr>
<td>Illiterate</td>
<td>14(26.4)</td>
</tr>
<tr>
<td>Primary/ Middle/Matric</td>
<td>9(15.78)</td>
</tr>
<tr>
<td>Graduate/ Post-Graduate/ Professional Qualification</td>
<td>8(20.0)</td>
</tr>
<tr>
<td>Total</td>
<td>78(52.0)</td>
</tr>
</tbody>
</table>

Respondents' belief in evil spirits and bad eyes in contamination was viewed in relation to different caste background. In all majority of the Jats i.e., 65 (72.22 per cent) and 13 (56.52 per cent) other castes never believed in evil spirit and bad eye in contamination of food. All the backward caste and scheduled caste members either believed in contamination of food by evil spirit and bad eye in some conditions or always. Thus, it appears that lower caste people favour these beliefs. It is also surprising to note that all the Brahmin respondents are in favour of the contamination of food by evil spirits and bad eye in some conditions and always. (Table-11) It may be due to their inherent belief in their cultural moorings or the same socialization pattern for these traditions.
TABLE-11

Caste-wise Belief in Evil Spirit and Bad Eye in Contamination of Food

<table>
<thead>
<tr>
<th>Caste</th>
<th>Belief in Evil Spirit and Bad Eye</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
</tr>
<tr>
<td>Brahmins</td>
<td>—</td>
</tr>
<tr>
<td>Jats</td>
<td>65(72.22)</td>
</tr>
<tr>
<td>Other Castes (excluding Brahmin, Jat, Backward and Scheduled Castes)</td>
<td>13(56.52)</td>
</tr>
<tr>
<td>Backward Castes</td>
<td>—</td>
</tr>
<tr>
<td>Scheduled Castes</td>
<td>—</td>
</tr>
<tr>
<td>Muslims</td>
<td>—</td>
</tr>
<tr>
<td>Total</td>
<td>78(52.0)</td>
</tr>
</tbody>
</table>

(Figures in the bracket represent percentage)

Privacy and Food:

On further probing, the respondents who had belief in evil spirits and bad eye gave multiple answers for the practices of serving the food among their members for avoiding the effect of evil spirits. The most frequent practice was observed to serve the food to their members inside the house where nobody from outside could watch them so that bad eye may not contaminate the quality of food (22 or 14.7 per cent). This belief was confined to the delicious foods only for some respondents. For instance, 8
per cent of the total respondents have such view (TABLE-12). Similarly, the tendency was found to hide the food when somebody visits the house. This practice was more prevalent among rural (12 or 16.0 per cent) as compared to urban (3 or 4.0 per cent). It was believed by the 13 (8.7 per cent) respondents that milk should not be left at mouth as it attract evil spirit. It was also found that one should not count the edible items. This practice was more prevalent among rural respondents (7 or 9.3 per cent) as compared to urban (3 or 4.0 per cent).

**TABLE-12**

Forms of Special Practices in Serving the Food Reported by the Respondents

<table>
<thead>
<tr>
<th>Forms of Special Reactions</th>
<th>Rural</th>
<th>Urban</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food is given inside the House</td>
<td>10(13.3)</td>
<td>12(16.0)</td>
<td>22(14.7)</td>
</tr>
<tr>
<td>If somebody comes in the House from outside, they hide the food</td>
<td>12(16.0)</td>
<td>3(4.0)</td>
<td>15(10.0)</td>
</tr>
<tr>
<td>After milk it is necessary to wash mouth</td>
<td>7(9.3)</td>
<td>6(8.0)</td>
<td>13(8.7)</td>
</tr>
<tr>
<td>Delicious food is served inside the house</td>
<td>6(8.0)</td>
<td>6(8.0)</td>
<td>12(8.0)</td>
</tr>
<tr>
<td>They do not count the edible items</td>
<td>7(9.3)</td>
<td>3(4.0)</td>
<td>10(6.7)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>33(44.0)</td>
<td>45(60.0)</td>
<td>78(52.0)</td>
</tr>
<tr>
<td>Total</td>
<td>75(100.0)</td>
<td>75(100.0)</td>
<td>150(100.0)</td>
</tr>
</tbody>
</table>

(Figures in the bracket represent percentage)
The Concepts of Disease and Illness:

Disease is not purely a bio-physical phenomenon. It cannot be isolated from the socio-cultural milieu. The perception of disease and its cure assumes different dimensions in different societies. Cultural patterns and typical ways of living give substances to the manner in which disease is perceived, expressed and reacted. To some extent, the cultural context defined what conditions are recognised to, assess and define the illness conditions. Interaction of individuals, disease and society is crucial for the total understanding of health and disease phenomena. The interactional aspect of the problem has revolutionised the medical science in modern times. Though the biological malfunctioning is very much responsible for the disease yet its interaction with the socio-cultural matrix cannot be ignored.

Causation of Disease:

Disease is a consequence of the interaction between environmental conditions, specific agents and wide variety of aspects of the host. A known agent may or may not produce disease depending on the conditions of the environment and the host. Genetic factors, nutrition, immune mechanism, social roles, stress, personality, climatic and atmospheric conditions, and the

like are all made part of a single concept. Tuberculosis is a disease resulting from an attack of the tuberculo-bacillus on the host; that is, without the bacillus serve as a necessary but not a sufficient cause for the disease called tuberculosis. It appears that social and psychological conditions may play some part in affecting a person's residence. While it is obvious that crowd conditions and lack of clean lines lead to the transmission of disease, and equally obvious that poverty may affect nutrition and the probability of receiving treatment when afflicted, it is not as well recognised that the attitudes of men may affect their abilities to withstand physical attack. Although we may not understand the cause of a particular disease, changing conditions associated with disease help to control it indirectly.

Matthews\(^1\) provides classification of diseases, their symptoms, causes, prevention and treatment. The causes for various diseases are due to visitiation of the Goddess Mariamma hot, dirty surroundings, eating of certain things, infection, hereditary, and so on. For prevention there is some improvement of knowledge in the service area. Matthews also observes that immunization is a method of preventing typhoid, measles, whooping cough and tetanus. It is found that allopathic treatment is not taken for diseases which are believed to have a supernatural causes or for which there is no clear Allopathic equivalent to

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the traditional concept of disease. It also shows that most of the diseases which are common causes of the death in small children are treated mainly by non-Allopathic methods. We also tried to find out from the respondents that what they feel about the causes for the diseases. We turn to this below.

**TABLE-13**

Perception of the Causes for the Emergence of Diseases

<table>
<thead>
<tr>
<th>Factors</th>
<th>Rural</th>
<th>Urban</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Rank</td>
<td>Mean</td>
</tr>
<tr>
<td>Adulteration in Food Items</td>
<td>1.50</td>
<td>I</td>
<td>1.4</td>
</tr>
<tr>
<td>Stresses and Strains in Modern Life</td>
<td>1.42</td>
<td>II</td>
<td>1.40</td>
</tr>
<tr>
<td>New Insecticide and Fertilizers</td>
<td>1.38</td>
<td>III</td>
<td>1.28</td>
</tr>
<tr>
<td>Weak Constitution of the Body</td>
<td>1.36</td>
<td>IV</td>
<td>1.21</td>
</tr>
<tr>
<td>Dwelling Conditions</td>
<td>1.03</td>
<td>VII</td>
<td>1.28</td>
</tr>
<tr>
<td>New Drugs</td>
<td>1.1</td>
<td>V</td>
<td>1.06</td>
</tr>
<tr>
<td>Industrial Pollution</td>
<td>0.82</td>
<td>VI</td>
<td>1.19</td>
</tr>
<tr>
<td>New Food Products</td>
<td>0.81</td>
<td>IX</td>
<td>0.84</td>
</tr>
</tbody>
</table>

(Figures in the table represent mean score)

What are the main causes for the emergence of new disease in the sample area of study? A set of responses was given to the respondents. It is apparent from TABLE-13 that respondents

1. Respondents were asked to rate the given factors on a three point scale: agree, doubtful and disagree. A factor rates (Contd. ...
considered adulteration in food as the single most important factor that affects health. Eating wrong kind of food is the most common cause of disease.¹ In their study Djurfeldt and Lindberg² stress the lack of food as also the most important cause of disease, while common sense gives equal weight reverse, namely, too much food. In fact, the effects of scarcity are also the cause of mental illness as Djurfield and Lindberg³ view: "having nothing to eat may also produce mental illness. If a man keeps thinking that he is unable to support his children and family, he may get mentally ill".

The second important factor that was rated to be stresses and strains in modern life as the cause for the emergence of new disease. Modern life has weaken the social relations due to increasing economic interests of the people which create mental problems in the minds of the people. Now-a-days, no one is at the receiving end of the listening of problems of any one. If any one listens the problem, he exaggerates it rather than solving it.

as "agree" was given a score of three; a factor rates as "doubtful" was given a score of two; a factor rated as "disagree" was given a score of one. A mean score was worked out to see the relative importance of these factors for the causes of diseases. The higher the mean score, the higher was the factor in the rank order and preferred for the cause for the diseases.

People believed that the quality of food has gone down due to new insecticide and too much fertilizer in vegetables and grains. This was rated as the third important cause of diseases. Fourthly, weak constitution does not have power of resistance and hence susceptible to any outside effects. Therefore, if a person is very weak and thin, he is likely to get more disease than the strong and sturdy person. Sometimes, hard work and under-nutrition and mal-nutrition form the weak constitution of the body. To strengthen our point we may give the example of observation made by Djurfeldt and Lindberg as: "there were great health risks both in the paddy fields (hookworm) and in the salt factory (accidents), and the resistance of the workers is low due to under-nutrition".

The fifth set of factor for the cause of diseases was attributed by the respondents to dwelling conditions that is dirty surroundings or lack of hygienic conditions, e.g., cholera, malaria and scabies. Therefore, bad sanitation and hygiene is perceived as an important cause of illness. Thus, lack of cleanliness leads to illness. Moreover, it is less known worm infestation that stagnant water breeds insects and germs. Getting soaked by rain is also a frequent theme. It may cause cold, cough and fever.

Moreover, it is also believed that purgatives are not given regularly that dirt accumulates in the "stomach" and causes

1. Ibid, p.124.
diseases (the stomach, intestines and other internal organs are not distinguished). For example, is said by some to be due to not taking purgatives.¹

New drugs were rated as sixth important cause for the emergence of diseases. A variety of drugs with different brands, level and name confuse the masses. These drugs are prescribed by the doctors to the patients on the basis of its publicity, availability and accessibility rather than its characteristics of curability. Many a times these new drugs are the causes for the emergence of new diseases when they have side effects or reactions to the body of a patient.

Quite a few respondents mention the importance of environmental sanitation. For example, flies spread diseases. They are nasty, dirty and fowl things. Industrial pollution was rated as the seventh important factor of the causes for the emergence of diseases. However, urban people were much more victims of the industrial pollution as compared to rural pollution. Environmental factor is more emphasized by urban people than rural. (See TABLE-13)

New food production are also seen as a health risk. A variety of new food products attract through advertisement on the basis of cheap availability, easy accessibility with different gift schemes, high in the quantity. Therefore, the quality of new

¹. Matthews, C.M.E. and V.Benjamin (1981) op.cit., p.11.
food products is not good which harms to the body of the people. This last point is recognised by the common sense of our respondents.

Medical Beliefs and Practices:

Home medicine is literally medicine of the people. It is comprised of medical operative beliefs and practices which are, in principle, available to all the members of a society without reference to their incumbency in a differentiated role or achievement in specialized course of training. In other words, home medicine represents the uninstitutionalised aspects of the medical cultural pattern. Thus, home medication is an analytical category restricted to the use of gharelu dawa (traditional or modern medicine and home-made medicinal recipes) and excludes such aspects as parhez and 'rituals'. Home medication may be defined as the taking of treatment without consulting a medical practitioner-qualified or unqualified and may be based on traditional recipes or even modern medicine.

How did they develop? To begin with, it has probably always been the case that people have tried, mostly through trial and error, to cure themselves when they fall sick. Thus, cures which someone reported as effective would tend to remain in practice; as with magic, it is difficult to disconfirm a cure (except under experimental conditions). Folk beliefs are part of the oral tradition, passed on from parents to children, from
older generations to the young; they thus develop the potent sanction of the tradition. Then, too much reliance on natural remedies developed from the close relationship of people to their land, especially in agrarian areas. Consequently, in traditional societies, the common person's knowledge about medicinal plants and herb is frequently extensive. Therefore, we take medicines for prevention as well as for cure. For the people of the sample area it depends heavily on the natural resources around them.

We discuss below the treatment of common diseases prevalent in the field of our study. Every culture consist of a vast collection of "recipes" concerning what to do for various ailments. These recipes may involve herbal concoctions, often of a very or unpleasant variety; prescriptions concerning rest or activities; prayers, charms, or a combinations of these. Quite often, these recipes are but loosely related to folk theories concerning disease; they pass on from generation to generation because they are thought to work effectively.

Nevertheless, people were not aware of the emergence of new diseases, their symptoms or causes and treatment as they were found in the earlier societies. Some illnesses and many injuries, however, were believed to require a doctor's attention. This was particularly true for sudden, severe illness or for chronic symptoms that did not respond to home remedies. People with injuries, such as deep cuts, gunshot wounds, broken bones
were usually taken directly to a physician for treatment, including anti-tetanus injections. At the same time villagers and urban people have their own name for diseases which do not necessarily correspond exactly to the Allopathic diseases. The most important or the diseases which were usually experienced by the people were mentioned with their treatment procedure. The causes for certain important diseases were also replied by the respondents. (See Appendix TABLE-1) Still some people of both (rural and urban) the areas believe in goddess Sitla mata for visitation and causing measles and small-pox. In small pox, their belief is that the disease does not require any treatment except some natural treatment (such as cooling the body or displaying neem leaves on the door) and propitiating the Sheetala goddess. In measles and small pox they stop giving any treatment and when the downfall comes they simply make some prasad for presenting to Sitla Mata. Thus, immunization against measles and other diseases was viewed with suspicion, in part because the theory was unacceptable to the populace.

The important point is that knowledge about the preparation and use of these home medication (see Appendix TABLE-1) was widespread throughout the community. Everyone seemed to have a favourite recipe for a cure specific ailments, and there was a great deal of exchanging of information and testimony about the efficacy of various concoctions. The use of these remedies was tied to some pseudo-scientific belief about the causes of disease.
A healthy state is thought to exist when one maintains a balance between "hot" and "cold" forces. Disease and illness occur when these opposing phenomena become unbalanced. Certain objects such as food, liquid or even states of nature are described as inherently "hot" or "cold", depending upon cultural definitions. Thus, the general rule is that one should balance the intake of "hot" with something "cold" and vice-versa. Similarly, one takes "hot" medicine for "cold" illnesses and so on. The balance concept also extends to body fluids, especially blood. To be healthy, one must maintain a proper balance not only between fluids, but also maintain them in proper amounts and densities. Thus, if the nature of body is cold or in cold season one should avoid food which increases the coldness in the body, for example, curd, raddish, lemon, orange, guava, etc.

Anthropological study by Hitchcock and Minturn¹ in Khapapur (UP) village describes medical practices being followed in the village and examines the importance of "hot" and "cold" foods, the relationship between small-pox, chicken-pox, measles and cholera and particular God-Goddesses, etc. Gould² and Hasan³ attempt


similar type of studies in Chattisgarh setting of Madhya Pradesh. They note a "connection between heat and cold. The physical and temperamental dimensions of human life is also found in accidental civilizations". Home medication which includes an enormous range of drugs, potions, balms, salves — both home remedies and patent medicines. Thus, one takes Aspirin or Saridon for headaches, Novalgin for tiredness and mild fever, fomentation with water, messages in reducing swelling, and puts ghee, coconut oil salt, etc. on burns ad insect bites. Home medical beliefs usually contain many prescriptions for special potions and medicines. For example, a natural substance widely used by people in variety of illness is honey. Honey is used as tonic, as a sedative for nervous conditions, as cold syrup, as a medicine for treatment for eye. Honey is also used in folk belief for preventing bed-wetting including sleep, cleaning stuffy nose, and even reducing pain from arthritis. Moreover, it has variety of uses with other substances in different combinations for the treatment of different diseases. In Ayurvedic treatment, usually, many prescriptions of special potions are given for the treatment.

In the areas of folk obstetric ad paediatric beliefs, Eaton has described the practices of the Hutterites, which


reveal a curious mixture of understanding of cause-and-effect relationships and beliefs in supernatural causes. For example, there was some suggestions by our respondents that pregnant women were expected to eat special diets of food such as milk, ghee, and eggs which are rich in protein, calcium and other growth promoting nutrients, and they refrain from certain chores such as heavy lifting which could cause miscarriage. At the same time, they are careful to think "pure" thought to avoid "making" the foetus and they believed that if a mother sees mice and rats, her child may have birth marks as found by Eaton in the practices of Hutteries. After the infant is born, certain other precautions were followed, such as wearing a black thread around the wrist and waist, marking a black point of kajal (collyrium) on forehead and also apply of kajal in eyes to avoid the evil eye.

Besides the use of drugs, there were suggestions to support various procedures followed to maintain one's health. These procedures include diets, eating healthy foods, regular exercise, sleeping with wide-open windows, and taking cold showers, etc. by our respondents. For example, it has also been attributed that stomach ache caused by over eating, indigestion and something intake of unusual food, uncooked or semi-cooked food. The remedies suggested to avoid food for sometime, or take light food. Garlic, Asafoetida, Thymel (Ajwayan) etc. were suggested for the proper functioning of stomach. The practice of bath with

1. Ibid, p.218.
neem leaves, dettol, massages of almond or sandal oil, etc. has been used for the problem of skin diseases of scabies, rashes, boils etc. Tuberculosis and leprosy were attributed by infection and heredity. It was also thought that leprosy was a later stage of veneral disease. That is why they keep distance from the patient of tuberculosis and leprosy. Onions have been widely used for the prevention of Loo (Sun stroke) in hot summer. It was also suggested that the use of turmeric helps in purifying the blood and brightening the colour for the face beauty.

The suggestions, therefore were given to take sound sleep for rest, or one should go for light entertainment or change of atmosphere to avoid tensions. For some, Yoga exercises were also suggestive methods for treatment. Thus, the practices of all these procedures were not helpful for the physical treatment but also reduce the mental tension of human beings in our society. Nonetheless, these operative traditional beliefs and practices were rationalised in terms of lay person's conception either one does not have faith in scientific medicine or for want of modern medicine.

Summary:

Conception of good health by the respondents suggested diverse views, sometimes also contradictory. A majority of the respondents identified good health with physical and biological characteristics. Psychological and social characteristics play
insignificant role in their perception of good health. Given the higher per capita income in the field of our study as compared to backward regions economic variable does not enter into the perception of the people. Attitudes towards good health are positively rationalistic as we move from rural to urban area. It is due to the fact that with the exposure of modern scientific knowledge in urban area their attitudes are also changing in rationalistic direction. With regards to the dietary habits, it appears that milk and milk products are considered dominating items for healthy food in the field region. Our data also reveal that most of the respondents are satisfied with the availability of food, as the economic condition in the state is quite good compared to other states.

It is not only the intake of food, but the norms of eating habit is also important for good health. Majority of person wash their hands after eating their meals but not before. Eating out of one plate is generally not observed among the people. Besides, supply of safe drinking water is unsatisfactory in both areas. In the villages most of the water is obtained from the open ponds and wells which are equally used for animals and washing clothes, whereas in the urban areas very little water is supplied through the municipal committee, therefore, people use water from hand pumps which contains lot of soil. Norms of eating of food and practice of drinking water are followed by the norms of serving the food among the family members.
More than 60 per cent of rural respondents stated that even today they keep the difference in distribution of food items between males and females in the family. The most frequent reason stated was that males need more energy as they do hard work, and they are the chief earners in the family. It is to be noted that about 60 per cent urban respondents who do not discriminate between male and female in distributing the same food. The relatively educated better economic conditions in the study area is responsible for this outlook. Overall, it seems that cultural subordination of females in the decision makings is responsible for unequal distinction of food because why the females who are also managing the distribution of foods in the family are themselves discriminating this. Beliefs and faith in the evil spirits and bad eyes affect the health and disease treatment. People in the villages identify the belief about the evil spirits in the causation of certain ailments like, dysentery, diarrhoea, fever, etc. They also observe certain practices especially for the child in curing of such diseases. Practices regarding food protection from evil spirits and evil eyes are also noticed. It was observed that these practices are the product of experiences of generations without any change. 60 per cent of the rural people as compared to 40 per cent of urban people observe these practices. The practices they follow for protecting the food from evil spirits and bad eyes varied. The most frequent practice was to observe to serve the food to their members inside the house
where nobody from outside can watch them and their food may not be contaminated from their evil eyes. Hiding of food, delicious food should be eaten inside the house, milk and white edible things should not be left in the mouth, are other practices which are followed by our respondents. One can notice that even in a relatively developed society such as that of Haryana the believers of evil eyes and evil spirits on food persists even today.

Culture consists of a vast collection of recipes concerning what to do for various ailments. These recipes may involve herbal concoctions, prescription of rest or a particular activity, prayers, or combinations, of these, etc. People in the field reported that they are not aware of symptoms, cause and the prevention of new diseases. But they are aware of certain common and older diseases and their method for prevention is also handed over from generation to generation. They realised that certain diseases like injuries, deep cuts, operations, etc. require doctor's advise. Generally, the common diseases which are treated by the people are: measles, small-pox, cough and cold, mild fever, boils, headaches, allergy, diarrhoea, dysentry, simple eye treatment, swelling, etc. The prevention of these diseases followed by our respondents varies from avoidance of certain food, taking of certain specific food, use of certain herbs, leaves, potions, balms and salves. There is certain use of patent medicine like Saridon, Novalgin, Crocin etc. for headache,
backache and fever. Certain types of oils are used on swelling burns and insect bites. Honey is also widely used for eye and cough and in mixing with some other medicines. Besides this, certain regular practices are followed in the child delivery period of women, for the infant, etc. Moreover, some exercises to prevent from diseases are also practised by them. Sound sleep for rest, light entertainment, avoid tension or change of atmosphere are also helpful in the avoidance of mental tensions. Thus, our respondents believe that these remedies not only cure the individual but also involve less expenses, easy availability and more or less do not have any side effects. Nonetheless, these operative traditional beliefs and practices were rationalised in terms of lay person's conception either one does not have faith in scientific medicine or for want of modern medicine.
CHAPTER VIII

MEDICAL PROFESSION

Like any profession the Allopathic medical system has its own normative pattern of recruitment, training and acquisition of skills, certain specified working conditions and finally the value and normative structures which hold the practitioners to gather and keep the system ongoing. The medical profession has a very short history of its development. As we find it today, its roots lie in the British system of medical organisation. Much transformation is witnessed in the profession for the last more than four decades since we got Independence. Earlier the recruitment to profession remained restricted to the higher ups in the society. The specializations were few and far between. The diploma holders were licensed to run the practice among the general masses of people. The services, especially in this profession, were limited to the big cities and the elites. There was not much of technological input in the profession. Much depended on diagnostic capacity of the doctor himself. Now the growth of profession has been spectacular and what ever drugs and technical know-how are invented in advanced countries are borrowed without any loss of time. On the other hand, wider scope is given for carrying out research on the indigenous plants and herbs available in the country. The development of medical profession, therefore, in the country makes a synthesis of the western medical practices as well as the indigenous know-how.
We have stressed all through the preceding account that profession of medicine has grown and developed within the societal framework of our country. The doctors who are involved in the task of general practice (GP) after all belong to some ethnic group, they have a social background of caste and class, they belong to some religious sects and what is more they are ideologically oriented to the realms of voluntary services and party dogma. They are in fact product of the prevailing education system — along with both its merits and demerits. They have a family life. His performance as general practitioners (henceforth GP) is thus determined by his social conditioning including his economic status.

Yet another important factor which conditions the professionals in medicine are the working condition of the hospital system. Whether a doctor is employed in government run hospitals, charitable hospitals, public health centres, dispensaries or privately run clinics, they have some system of reward. They wish to get some satisfaction out of the job they are doing. They would also aspire for accumulation of money. There are a number of inducements and incentives which enable him to do his job successfully. What we argue is that if the practitioners do not get satisfaction from the available working conditions, namely, salary scale, remuneration, opportunities of promotion facilities for the upbringing of family, the outcome of their practice would not be satisfactory.
The medical profession, therefore, has multi-dimensions. It is inclusive of the social background of the medical practitioners, the processes of admission to medical education, training and acquisition of skills, working conditions and above all, importantly enough the ethics of the profession. In the present chapter we would make an attempt to dwell on some of these aspects of the profession on the strength of data generated by us from the field. The field data as are available with us have been generated by employing the techniques of observation of some of the performances of the doctors and the behavioural responses given by the respondents. We have also conducted a few case studies of doctors working both in rural and urban areas. By way of conducting case studies, we missed no opportunity to sit with them at the outdoor patient chamber and at the patient's bed. Besides conducting case studies of the doctors we have been able to make case studies of some of the events which normally take place within the hospital — on the bed or in the theatre. Such events include the performance of doctors in emergency situations. The events also include accidents, child delivery and cardiac arrest. Some of the techniques which we have used have provided us enough data to interpret some of the vital aspects and constituents of the medical profession.

Social Background of Doctors:

In order to get insight we have made case studies and interviewed fifty per cent of the doctors of the total sample.
Thus, the data interpreted here consists of 104 doctors. It is found that twenty (19.2 per cent) doctors belong to rural areas, the remaining 84 (80.8 per cent) from the urban centres. Out of twenty doctors who belong to rural areas, 6 (11.5 per cent) were male doctors and 14 (26.9 per cent) female doctors. Among the doctors belonging to urban nativity, 46 (88.5 per cent) were male doctors while 38 (73.1 per cent) were females. It is evident from the data that less than one-fourth of doctors belong to villages. The percentage of doctors from urban nativity is overwhelmingly high. In term of sex-ratio it may be said that at both the levels the females constitute a viable percentage. It could also be observed that there is not much gap in the male and female educational level, however, a larger number of female doctors compared to their counterparts in the rural nativity constitute larger percentage. The imbalance, obviously is due to the better availability and social conditioning of female education in the urban areas. Our findings in this respect are substantiated by Madan also.

The Medical education comparatively takes longer period of study. Normally it takes eight years for post-graduate medical education. Considering the lapses in terms of repeat failure, by and large a student who is a post-graduate stays in the college upto ten years. In such a situation marriage normally takes place

when the student is at MBBS level. In our study it is found that out of 104 doctors, 69.2 per cent are married, 30.8 per cent being unmarried. Such a finding gets support from the studies conducted by Madan and Venkatratnam.\(^1\) In the total sample of 104, 72 doctors who were married had a ratio of 42 males to 30 females. Of the remaining 22 female doctors were unmarried as compared to 10 male doctors. The striking imbalance in the unmarried females to the males is largely due to the fact that the females find it difficult to get appropriate match from among their own caste. This became evident during the course of interview. The scheduled caste students who were females largely do not find a suitable match within their endogamous group. This keeps them waiting for marriage.

In our sample out of the married male doctors, 6 got married when they entered into medical college. However, 22 male doctors were already married when they entered in medical service. Those who got married after entering in medical service constitute a size of 14 persons only. Among married female doctors, 4 got married before taking to medical course, 4 after the entry in the medical course, 6 before entering into medical service and 12 after their taking up the medical job. Interestingly enough an overwhelmingly size of both male and female doctors (62 per cent) had one or two children.

\(^1\) Ibid; Venkatratnam, R. (1979), *Medical Sociology in an Indian setting*, Madras: The Macmillan Co. of India Ltd.
In terms of family orientation it could be observed that 22 doctors belonged to joint family, the remaining professing the family of procreation. The doctors belonging to joint family expressed their comfort by observing that the joint family keeps them away from worries pertaining to their wives. Economically also they found themselves most comfortable. However, the doctors belonging to the family of procreation express one or the other family strain.

An overwhelming percentage of doctors (98.1 per cent) belonged to Hindu religion, the remaining two doctors professing Sikhism as their religion. Among the followers of Hinduism, a large number of doctors belong to high caste. Their castewise distribution shows that 20 doctors belonged to Brahmin caste, 14 to Mahajans and 30 to Arora and Khatri. The number of scheduled caste account for 8 only. Thus it becomes clear that the members belonging to higher caste groups and professing Hinduism make their entry into medical education.

The educational background is varying. The data are interesting in the sense that a little less than half of the sample size of 104 doctors had their education in government schools which are supposed to be poorly equipped both in infrastructure and the potentiality of faculty. The public schools which are supposed to be sophisticated and modern contribute only 15.4 per cent doctors to the profession.
Interestingly enough the corporation schools also have a meagre share of 19 per cent in the admission of doctors.

Normally, a student is admitted to medical class when he has passed his 12th standard or Part I of B.Sc. In this respect it is found that a large number of students 80.8 per cent joined the medical courses before fulfilling their graduation. However, a meagre percentage of 13.5 took to medical courses after completing their graduation. In our sample of doctors 79.2 per cent held post-graduate degree of M.D. (Master in Medicine) or M.S. (Master in Surgery) Super-specialization in Neuro-surgery was obtained by two doctors. Those having specialization in pediatrics constituted a size of 14. Doctors specializing in diploma and gynaecology and diploma in ophthalmology respectively constituted a size of eight doctors. The interviews with doctors indicate that there are better possibilities of GP in the field of general medicine. The competition in this field, therefore, is tough and cut throat. Pediatrics and gynaecology are other areas which pay well to general practitioners. These fields therefore, are also thought to be paying. With the increase in industrialization and mechanization, the accidents due to automobiles and factories are more than common. This provides a rich field for surgical practice. And hence preference for MS. The minor specialities such as ophthalmology, radiology, and pathology have declining status in the medical profession. It is found during the interview that the doctors tend to think in
terms of "commercializing" their specialities. They are drawn for a particular speciality because of the incentive of earning more and more money. The commercialization of profession has assumed a crucial dimension in the contemporary medical education and medical practice. The rapid emergence of nursing homes and clinics with all the advanced instruments indicates the recent trend in the profession. We shall have occasion to provide some details about the vulgar use of commercialization in the profession when we discuss the ethical commitment of the practitioners to the profession.

It is often observed that medical education is quite costlier in our country. Normally, on an average the government spends more than one lakh rupees in the education of a doctor. Perhaps an equivalent amount is also spent by the students. Expenditure on the purchase of books and equipment along with the expenses on lodging and boarding approximately amount to Rs.10,000 per year at the minimum per student. During a period of 5 to 8 years a student thus spends more than a lakh rupees. Financial assistance to the student is normally given by the parents. In our sample 30.8 per cent get assistance from their parents and partly from the award of scholarship generated by government or charitable institutions. Those getting financial support from brothers and brothers and parents both respectively account for 19.2 and 17.3 per cent.
The family background gives a very interesting set of data. It is found that about half of the doctors come from families which have some doctors who work as financial supporters and motivators. It is also found that there tends to be a good partnership between doctors in terms of husband and wife. If there is a doctor in the family, the possibility of giving medical education tends to increase.

The occupational background of the sample group of our study is diverse. Out of 104 doctors, 36.5 per cent had their fathers in high professional occupation such as engineering, medicine, law and university teachers. A large bulk of doctors are drawn from high professional groups. Only 19.2 per cent of the doctors in our sample hail from the occupation of school teaching and police and army. A meagre percentage of doctors (13.5) belonged to the class of businessman and secretarial assistance. The doctor belonging to the peasantry class was exceptional, to be exact one only.

Considering the total social conditioning of the doctors it could be observed on a general place that the practitioners to medicine are drawn from high caste Hindus, nuclear family, education in ordinary schools and professionally rich classes. Their background largely is oriented to urban middle classes. It should further be stressed that they have qualified the medical course after spending a good amount of money and burning a
mid-night oil. The share of the government in providing skills to the doctors is also in no way small.

Training and Acquisition of Skills:

In the medical studies the student begins to attain ward when he has completed his initial readings during the first year of his education. In the ward he gets access to the beds. He makes case-studies and case-histories of different illnesses. It is his first interaction with the patient and his attendants. At the graduate level he is asked to work intensively in the ward. On definite days of the week he sits alongwith the senior doctor in the out-patient ward. Here he writes the prescription given by the senior doctor. This enables him to diagnose what illness is disposed on the outdoor table. Here he is in contact with a number of patients suffering from a variety of diseases.

After qualifying the graduate course he is put under the internship for a period of nine months. During this period he is required to work in different hospitals. In his capacity of intern he gets some remuneration for his maintenance and out-pocket expenses. Occasionally he is given independent access to the bed. The internship period is meant to prepare the medical student to tackle ordinary illnesses independently. This training is for practical experience. When the internship period is over he gets final clearance for his degree. If he chooses to opt for his degree of post-graduation he has to appear for pre-post-
graduate examination. Notwithstanding his graduation merit he is considered eligible for post-graduation courses on the basis of his achievement in the examination. There are limited seats for each post-graduate course. It is at this level that he learns to work independently under the supervision of senior teachers.

His stay at the post-graduation level is three years only. It is a crucial period of his medical career. He has not only to obtain practical experience but has also to manage all kinds of patients following within his specialised course. One of the interns relating to post-graduation study observes:

"No other year in a doctor's life to compare with internship, no year so crucial to his growth as a doctor, no other single year which so powerfully moulds and influences his entire life ..., it is during his internship year that he thinks himself as a competent physician. This year is the proving ground, for the first time he takes upon himself the burden of responsibility, and his handling of determines his success or failure".

The acquisition of new knowledge and technical skills is, perhaps, the most obvious characteristics of post-graduate studies. Although the intern assumes responsibility for the care of the patients of his ward he does so wholly under the direct and close supervision of the Assistant Resident doctor, House surgeon or Resident doctor. Here the interns are the most busy persons. Gradually, they are allowed to perform independently most of the tasks associated with medical care of the patient. Much of the time the tasks are of routine nature but there are always occasions when the emergency seizes upon him for immediate
and quick decision for diagnosis and management of patient. On these occasions the intern often learns from his senior colleagues. One of the doctors interviewed by us illustrates the point vividly:

"One day' when I was in the ward, at about mid-night I had managed a patient who had massive cardiac arrest. Initially, when I examined him the seemingly symptoms were altogether different from the usual ones. Diagnosis became a difficult task for me. And if I missed a little, the collapse was impending. I got suggestion from the nurse for giving X type of injection. When the nurse was asked to bring for the injection meanwhile I had a sweep of all that I had learnt in the books about the cardiac arrest. It flushed to my mind that the case could definitely of cardiac ailment. Gradually my diagnosis became firm the more I thought about the symptoms of cardiac arrest. This helped me to save the patient. The fact is that the intern shall have to be at his toes wherever he is on duty. Relax while on duty is denied during post-graduation training."

The post-graduate medical student has another irony of fate. He has not only to manage his patients, complete his routine check-ups before the senior doctors take a round of the ward, he has also to keep his superior and immediate senior always in good humour. This personal relationship in some cases weighs higher than the learning aspect. It is because of the fact his future — his post-graduate results solely depends on the sweet will of his professor. The terror of doing well in the examination makes him sometimes extra ordinarily submissive to his superiors. One of the doctors comments:

"If learning and doing in the ward was concerned, I have never stained myself. What has strained me much is to 'tame' myself to the desires of my seniors. Submission to the seniors is the basic ethos of medical education. Without submission one can not learn. And, therefore, I had not only to be meek to my assistant to my seniors. I
had also to be in the service of my seniors family. Believe me, I have never taken my breakfast leisurely all through the period of post-graduate education.

After completing the three year period of post-graduation the doctor is asked to work as Resident doctor, sometimes also as a registrar. All the junior doctors work under his supervision. He is twenty four hours in charge of the ward. It is under his supervision that the patients are managed in the ward. If there is any flaw in the ward the responsibility lies on his head. When this registrarship is over he takes to his profession for earning.

At the super-specialization level the competition is very serious. First, the super-specialization is not ordinarily available at medical colleges. This facility is restricted to a few medical university only. For instance, for the doctors of Haryana State, super-specialization are available at All India Institute of Medical Sciences, Delhi and at Post-Graduate Institute of Medical Sciences, Chandigarh. Second, there are many including those who are in-service to compete for admission to super-specialization courses. The period of super-specialization consists of two years. The student at this stage has to work from 15 to 20 hours a day. He is required to engage himself both in library and ward. Super-specialization is the top most training which one can have in our country.

The interview reveals that, an overwhelming number of
graduate doctors intend to do post-graduation. The most often repeated argument given by them is that once a person enters into service, he gets cut off from theory and at a later stage it becomes all most difficult for him to complete his post-graduation. Besides this, those who do post-graduation are likely to return to district headquarters at an earlier time. They also get an incentive of two yearly increments. Post-graduation also puts them in the category of junior or senior specialist. It also equips them to take independently general practices.

Those who drop post-graduation course, either do not fair play in the pre-test or have lesser financial resources. Sometimes the needs of the family also compel him to drop post-graduate courses. However, the trend of doing post-graduation is much in vogue. As mentioned earlier the case studies show that the first preference in post-graduation is for general medicine. This choice is stronger among males than females. The females on the other hand by and large, prefer to have Gynaecology courses. For them it is the first preference. Gynaecology practice yields richer dividends. The second general preference is for the branch of Pediatrics. It is preferred by both the sexes. It was argued by those who gave second high priority to this branch by saying that in contemporary India when there is move for small family, one can not afford to neglect any longer the illness of infants. And, therefore, the patients of
pediatrician are assured.

Surgery is the third preference for both the sexes of doctors. However, these course are taken with some caution. Qualified doctors in surgery have largely to opt for service. Actually, as freshers after obtaining MS degree they are not experienced to take up major operations. And this discourages them to establish an independent clinic or nursing home. In all possibility they have to wait for some years to gain experience by working with some seniors on the surgical table. Besides these bottlenecks, establishment of a theatre in private capacity involves investment of huge money, say from 7 to 15 lakhs. The discouragement is more than enough. It is because of this that the choice of surgery occupies rear position.

There are some minor specialities also which include ophthalmology, orthopaedics, social medicine, radiology, pathology and psychiatry. Our case studies and interviews very vividly indicate the lower preferences about these minor specialities. The importance of a specialization at post-graduation level is primarily determined on the seriousness of the diseases included in the branch and the return which is expected from the patients.

Doctors involved in cardiac disorders have higher reputation because there is great possibility of the patient succumbing to an attack. This seriousness of disease enhances
both the status of the doctors and his economic returns. The basic criterion therefore, is that which has its base in the social background of the society.

Recruitment Pattern:

There are two important structural aspects of recruitment to medical services. After qualifying from the Medical College the student is considered to be a full-fledged doctor. First, his entry is sought in the medical profession, for this the incumbent has to get himself registered from the Medical Council which is state based. The Council consists of high level experts and registrar. It registers the prospective practitioners. After going through the formalities the doctor obtains his registration number. This is a permit of doing practice. It validates his entry into the profession.

Second, the registered practitioner is now free to opt his career as employee of government health department or any charitable institution. He could also opt for running his own clinic or nursing home. Wherever he may choose to work, the only essential thing is that he should possess his registration number from the Medical Council.

The sample group of doctors which we have studied intensively through case-studies and interview belong to the government service of the state of Haryana. The normal practice with the doctors is to seek ad-hoc appointment from the
government. Their appointment continues till a candidate selected by State Public Service Commission joins. A person is considered, on the completion of the probation period of one year, to be a permanent doctor. This entitles him to enjoy all the privileges which are due to his status. Initially, he is put in the pay scale of Rs. 2200-4000. His first packet consists of Rs. 3050.

The general practice in the state is that the new appointee is required to work for a period of five years in the rural area. He is either posted at a dispensary or at Primary Health Centre. He is not allowed to have his general practice as is found in some of the neighboring states. However, in lieu of his general practice he is granted a petty amount as non-practising allowance. His promotions as junior specialists and senior specialists depend on the seniority of his service. Merit is also added as one of the criterion. From senior specialists his status is raised to District Medical and Health Officer. In this capacity he is the highest official at the district level.

All this procedure sounds well considered on theoretical plane. Our interviews reveal that there is much clandestine behaviour in the total process of recruitment. Evidence was provided to demonstrate the fact that the rule of merit was violated more than often in the ad-hoc appointments. One of the doctors observed that he had to grease the palm of the authorities to get his appointment though it was due to him on
merit basis. In his words:

"This profession has now become fully vulgar. There are admissions by donations and there are appointments in consideration of clandestine money. All is bad with the profession."

When a doctor is established at a particular place and runs his practice unauthoritatively, he is likely to be transferred. Such transfers are avoided by the influence of political bosses or money. There are doctors, as our interviews reveal, who have completed a large number of years at village level and have not got any opportunity to move to urban hospital. On the other hand there are doctors in the urban hospitals who are freshers. It must be appreciated that quite a good number of doctors did not hesitate to plug some of the serious violations in the administration of recruitment, transfer and promotion. In most of the cases if a doctor has earned reputation in a particular community, pressures are pulled to outplace him. And in the whole affair much money passes through hands.

Those who are practitioners in the clinics and nursing homes make best of the bargain. If their practice is successful they earn quite good amount of money. Interestingly the District Medical and Health Officer who is supposed to intervene in situations of malpractice done by the doctors, never intervenes. The professional brotherhood compels him to observe total non-interference in the working of private practitioners.
Working Conditions:

The working conditions of doctors normally include an adequate library, journals, a well equipped laboratory along with trained nurses and compounders and better conditions of emoluments including the facilities of housing and educating the children. The salary scale which the doctors get is comparatively good looking to the neighbouring states of Punjab and Rajasthan. Most of the doctors based at urban centres are provided housing facility. In the same way the technological equipment at the district level is said to be by and large satisfactory.

The Medical College Hospital located at Rohtak has a well equipped laboratory. It has a capacity of 2100 beds. Besides, it provides hostel accommodation to both the junior and senior medical students. But when we turn to dispensaries and the Primary Health Centres at rural level the scene is dismal. There are public health centres where ordinary tests of blood and urine can not be made. In some villages the medicines prescribed by doctors can not be purchased as there is no chemist to cater to their needs. The working conditions of Primary Health Centres do not provide the basic infrastructure which is essential for the working of the doctor.

The working conditions as we found at the level of hospital, dispensary or primary health centre, in fact, varies from place to place. This creates much of dissatisfaction to the
doctors. Their another level of dissatisfaction steamed from the physical conditions of the village where the doctors work. Doctor is not an individual only. He has a family — wife and children. The facilities of fuel, transport, housing, school, recreation etc. create much problem for him. It becomes all the more difficult for him to provide any comparably good education to his children. One of the doctors in strong anguish observed:

"What kind of service is this? My wife has been living away from me for the last more than one year. She has to reside in the city because my children have to be taught in some reasonably good school. I have been funding for two hearths. And for me, I do not know cooking. Neither there is hotel in the village. Just surviving".

There are some of the basic hurdles which come in the way of the successful working of a doctor at the Primary Health Centre level. It utterly lacks in the provision of infrastructure and at the home level he is left all alone to face the grim situation. Transfer for him is something beyond his power. He is supposed to take resort to some of the clandestine measures to overcome the difficulty. This has vulgarised the profession.

Job satisfaction for the urban and rural doctors is differential. At the urban level most of the doctors interviewed by us get a high measure of satisfaction. This also puts them into the elite circle of the city. They derive a sense of satisfaction when they visit the library and work in the laboratory. It is found that those urban doctors who are involved
in degree and post-graduate teaching derive a large measure of satisfaction. They have a strong feeling that they are abreast in the stock of knowledge in the medical science. Different is the irony of fate of rural doctors who day by day tend to forget what they had learnt at the college.

Even in the Rural Primary Health Centres where there are some facilities available, the doctors hardly derive any satisfaction. The patients which they receive come with ordinary ailments. Treatment of such ailments which can also be normally treated by folk medicine, hardly give them any satisfaction. A doctor stationed at urban hospital and having a post-graduate degree considers it to be below his status to treat any ordinary ailment. On the other hand, the same MD holding doctor provides treatment day in and day out to such common diseases. The comparison when made with the perspective of satisfaction all the more becomes ghastly when the doctor is not permitted to leave his headquarters without the permission of higher authorities. Thus, there are levels of satisfaction among the doctors belonging to rural and urban areas.

A smaller part of doctor suffers from a different kind of intervention in their work. Normally, any intervention in medical profession worsens the illness. In the villages this simple norm is overlooked by the people. The potential intervention demands from the doctor to provide all kinds of medicine without any
cost. The political bosses also expect from the doctor to deviate from their ethics in issuing medical certificate in cases of suicide and murders. Occasionally the intervention becomes so acute that the poor doctor finds himself between devil and deep sea. And what is worse, the sword of transfer to a bad place always hangs over his head. Pointing to the politicization of medical profession one of the doctors remarks:

"I am an outsider. I do not know what are the factions of this village. But now and then I am associated with one or the other faction. I would take a sigh a relief when I quit this village."

A doctor at the village level, therefore, is no comparable entity to his counterparts at the urban level. With so many things to worry upon — right from public health centre to his family and village, the doctor is worse than what he was at least in terms of medical standard when he joined. Yet another plight of the village doctor, as most of the village doctor complain that government does not require their medical health services. What they are asked to do is to motivate the masses for admission to vasectomy operations. They are in fact reduced to the status of social and health workers. Then, they are also asked by the authorities at the district level to provide all sorts of statistic regarding the action taken on family planning. They are more administrative assistants than medical doctors. When a doctor resides in countryside for a longer period, more or less he seizes to be a doctor.
Medical Ethics:

The all pervading ethos of the medical profession is to help the patient to the best possible way to get rid of the diseases. For a doctor, therefore, the patient is above everything else. Even if the deadliest enemy of the doctor makes an approach to him the latter is obliged to help him in curing the disease. Service to patient therefore, is the ultimate ethics for a doctor. It is this ethic which keeps the practitioners of professions held together. Another binding force is to consider the professional members in the ties of kinship bonds. Normally, if the dictates ethics are followed a doctor would not charge any fee to examine the close relations of another doctor — anywhere — any place. Besides, there are certain other norms also which keep the profession and its practitioners autonomous. For instance, if one is under the treatment of a particular doctor — the other would not intervene.

The Medical Council of India and the State Level Medical Council are the guardians of the rightful observation of the normative ethics of the profession. In fact, one of the objectives of the Medical Council of India is to monitor the profession at various levels. However, whenever such offences are committed the office of the Council does not take any cognizance unless complaints are lodged in writing. In routine way no such complaints are lodged to the council. However, the Medical Council of India has sought amendment on the Medical
Council Act, 1954 in the year 1974 by amending that any contravention of medical ethics is a cognizable offence. The Medical Council is also empowered to set up to decide suitable punishment to the offenders. Thus, the observation of medical ethics laid down by the council have statutory strength.

Our interviews with the doctors show that in normal course of treatment they observe the general idiom of professional ethics. However, there are cases where one can find deviance from the ethics. For instance, it is expected of a doctor not to administer heavy doses to a patient which might result in side effects. But to get money they resort to give heavy dose alongwith polytherapy. A patient who is victim of such treatment in the long run gets his health shattered. This is obviously a violation of ethics.

Yet another ethic of a doctor is to take the patient into his confidence. During the course of treatment, ethically the doctor should make it clear to the patient about the nature of his ailment. He should be told boldly that the consequences of ailment should be fatal or not. Ethically he is entitled to take the patient in his confidence.

However, the ethics of medical profession should not come in conflict with the larger interest of the society. Take for instance, the case of vasectomy and medical termination of child. Both these operations have a wider connotation in the interest of
the country. But any leakage of such operation has worse social consequences. Hypothetically, if after vasectomy the wife happens to conceive a child, she would be ridiculed by the society. In the same way if the secret about the medical termination is disclosed, it might brand the woman as that of bad character. Though the operations are a reality but it is the ethical obligation of the doctors to maintain the secrecy. Similarly, is the case of leprosy and venereal diseases. When a patient approaches a doctor he is a person and he discloses everything to the doctor. If the doctor leaks out the personal secret it is not only violation of the professional ethic but also a betrayal of the patient. Such ethical norms, we found in the field were thoroughly observed by the doctors. However, black sheeps are everywhere.
CHAPTER IX
SUMMARY AND CONCLUSIONS

Modern society, the world over, is characterized today by a fast-developing conviction that sound and wholesome medical care should be easily accessible to all human beings. It is in this light that, an attempt has been made to understand the various systems of medicines in a particular region and find out the accessibility to, and preferences for, these systems.

Different medical systems have emerged during different historical periods. India is a vast country and it has had a chequered history. During its long period of continuity, society developed four major medical systems mainly, Ayurvedic, Unani, Allopathy and Homoeopathy. Besides these major systems in different regions of the country, there also existed a broad arena of folk-medicine. Though folk-medicine may have less of formal scientific rigour and tighter grasp, it has acceptance and faith among diverse people.

The Ayurvedic system which dates back to ancient India was a part of a wider religious syndrome. The Vaidyas were meant for the ruler and his kinsfolk. However, the skills of Ayurveda remained restricted to the ruling groups and the high-caste Hindus. In most cases, the Vaidyas were Brahmins. The nature of treatment in the Ayurvedic system, though cheap, remained confined to the elite.
The Unani system of medicine had entered India during the period of Muslim invasion. It did not have much impact on the larger masses of people. Generally, it had acceptance with the Muslims and the areas having larger Muslim concentration. Unani medicine did not have access to people living in Southern India. North-Eastern India also remained beyond its influence. However, the Unani system, like the Ayurvedic system, had its access to the power-groups of Muslims, and their clansmen. For a longer period of history, vast masses of people who were regarded or treated as the 'wretched of the earth' were, by and large, deprived of the facilities rendered by Ayurvedic and Unani medicine. They had to reconcile on the folk medicine, or the medicine which was prescribed by the elders of a community. All through these periods of history, the diseases which infected human beings were interpreted as 'results' of the earlier birth or 'misdeeds' of the past. The psyche was instilled into the minds of the people that ill-health was a part of the life-game, and the course left to them was just to perpetually endure it.

During the British period, the health-facilities did not constitute the mandatory function of the state. The British Raj minimally provided these facilities, and therefore, they were more of a religious, than a secular, right or privilege of the people, or the obligation of the state. With the attainment of Independence, the Allopathic system of medicine got introduced to India through the British system of medicine. It was the first
historical occurrence of the borrowed western Allopathic system.

In the aftermath of Independence, following the constitutional provisions laid down by the Directive Principles of State Policy, it is the obligation of the State government to deliver health services. Whenever the state find economic resources, it provide facilities for health. But what the government does for the spread and propagation of a particular medical system constitutes National Health Policy. A review of Five-Year Plans makes it obvious that both the central and state governments have spent most of their budgetary allocations in the spread of Allopathic medical system. It is, in this context, worthwhile to ask the question: What led the government to provide an overall patronage to Allopathic medicine? If we seriously attempt to answer the question, it could be said that there are no scientific data having any reliability and rigour which promoted the government to stand by the propagation of Allopathic medicine. Perhaps it has been an impression with the ruling group that the Allopathic system of medicine is most potent and effective in so far as the prevention and cure of disease is concerned. Seen in the context of a wider global society, it also appears that with the accumulation of medical researches and inventions, the Allopathic system has acquired a broader status. It has gained wide "communism". Acceptance of Allopathy also enables the people to benefit from inventions made in other parts of the world too. Perhaps these are some of the
considerations which have motivated the state-policy to provide facilities, skills and expertise in the realm of the Allopathic system.

But our argument is different from that of the Allopathic system which is getting massive state patronage. In point of fact, it is not indigenous to the people. It is a borrowed technology of curing the ailment. What is different for our country is that it has had a rich tradition of the Ayurvedic system of medicine. It is rooted in the soil, it has its own historicity of tradition, while the Allopathic system has come into interaction with the Ayurvedic system. There are possibilities of both system getting wider acceptance, or else, one of the two would have had hegemony over the other. What is certain is that a medical system which is promoted on public money should have a real potency and effectiveness to prevent diseases and also to cure people. Qualitatively, the potency of medicine should correspond to the cultural and societal constraints of the people. A good and sound medical system, rightly enough, should grow from the soil of that people, or within the historical conditioning and social and cultural background of the people for which it is meant. This very argument that the medical systems should fit in with the social structure has guided our research endeavour to show that the Allopathic medical system, besides being therapeutic, chemical and biological, is also a social and cultural phenomenon.
In the existing system, the entire programme of health services, has been built up with the metropolitan and capital cities as centres, and tries to spread itself out in rural areas through intermediate institutions, such as rural hospitals, primary health centres and its sub-centres. Very naturally, the quantum and quality of services are, at best, at the centre only, and these fail at the periphery which, unfortunately, comprises about 80 per cent of the total population.

A review of the obtainable literature on the subject shows the recent trend in terms of data. Most of the studies heretofore have used only a structural-historical approach to an analysis of medical practices. The trend of research in the field of illness and disease has both theoretical and practical relevance. The present inquiry tries to supply some threads missing from the available hypotheses and data. We have studied both rural and urban segments. We have a few studies on a scheduled castes and scheduled tribes. The nature of these studies is by and large descriptive. What we have taken as our strategy of research is to compare and contrast the rural communities with the urban ones. And, in doing so, we have analyzed our field-data along with the wider development and policy formulations of the government both at the state and centre levels. This has helped us to widen the scope of the currently available data and constructs. In fact, the present inquiry has pledged certain theoretical formulations from the earlier studies made in the domain of medical sociology.
Admittedly, there is rich scientific literature in the field. A large number of inquiries have been made in the field of village life, as also on the urban side. We have constructed our problem out of the trends available in the existing literature. Making a departure from the mainstream of medical sociology, we have made intensive studies in both the areas of rural and urban life. The intensive study has been focussed on the interaction with the government policy on health and disease. The trinity of interaction: rural, urban and government policy have provided us with an insight into the people’s acceptance of particular systems of medicine.

In our entire study, the inquiry has been to find out the extent of acceptance by the people for varying medical systems. What we are trying to find out today is to identify the groups in society, the categories of medicine and the system of medicine which are really potential for providing the people with the desired status for attaining the national goals. The medical system and the diverse groups of people in society are not the only partners in interaction in a situation of ill-health. What we have argued is that in the interaction between illness and medicine the state is also involved, for it is committed to fulfil the basic need of health of the people, besides other needs, such as food, shelter, cloth and education. Our concern for the acceptance and the development and consolidation of a particular medical system is to provide appropriate health to the
people. Therefore, the present inquiry tries to understand the health delivery system as in vogue in different medical systems from the perspective of social structure, culture and above all the wider societal point of view. While doing this, we referred to the plans, policies and perspective of the government along with the voluntary agencies. Thus, we examined the nexus in terms of acceptance of a particular system with these perspectives: The perspective of the practitioners of health care; the perspective of the beneficiary of medicine or treatment; and the perspective of government in terms of providing state patronage to a particular system of medicine. Besides these perspectives, our stress has been on finding out the social and economic background of the practitioners of different systems. How does this socio-economic background correspond to socio-economic background of the people? Furthermore, we have also tried to study and establish the relation between disease and culture in different social segments. It also attempts to identify the folk medicine which has traditionally been in practice for the diseases found in the social segment. Has the introduction of the Allopathic system of medicine weakened the folk medicine? Our objectives of the inquiry include the generation of data from two levels: Rural and Urban. For the urban level, we have drawn the city of Rohtak as a community for intensive study. The rural study is carried out in a single village characterized by most of the facilities
of health delivery system. The data for the inquiry, therefore, relate to the rural and urban areas of the state of Haryana.

We have made certain broader comparisons between rural and urban communities. Despite there being some obvious differences in terms of attending development, technology and education, it is found that for both the communities, it is not the preference which works but it is a matter of immediate access to a particular system of medicine. People in rural and urban communities, provided they have the money, would like to go for Allopathic treatment. However, at the village level, when suitable Allopathic facilities, or even if Ayurvedic treatment is not available, they readily opt for any system of treatment which is within their access. If the case is of surgery, a villager would consult his friends and relatives to indentify a surgeon who has obtained specialization in the concerned area of disease. Thus, to allege that a villager is invariably an orthodox person buried deep in the mumbo-jumbo and hocus-pocus of the traditional treatment does not find any substantial data from our field.

We have enough data to demonstrate that both on the country and city sides, the Allopathic prescriptions cost quite a bomb. The popularity of Allopathic medicine at both the levels — rural and urban is upheld by those who can afford to have Allopathic treatment. There are some sectors, such as banking institutions, universities, government employees and factories which reimburse
the expenses made on Allopathic medicine. The popularity of Allopathic medicine is thus upheld only by the higher-educated, the privileged employees and the traders who can afford to have the benefit of Allopathic treatment.

Furthermore, to understand the needs of the people in terms of health care, the availability of physician or doctor was the most important item of the analysis. Free availability of drugs, facilities of laboratory, testing of blood, operation facility, physical proximity, arrangement for blood and need for specialized treatment for specific diseases were ranked in the descending order of importance for medical care. In our investigation we discovered that the maximum number of respondents who ranked the quality of a good doctor as one who would listen carefully to the problems reported by the patients. The doctors who examine thoroughly and carefully, prescribe different tests and spend enough time on proper diagnosis — were other qualities ranked by the people. Another thing at the back of their mind was that the traditional doctors neither meet out polytherapeutic treatment, nor refer their patients to other doctors, in difficult and complicated cases.

Views regarding the simultaneous existence of traditional and modern doctors clearly elucidate that more than eighty percent of the respondents favour the co-existence of both. Furthermore, the responses in favour of the co-existence of the
two exhibit either system may be useful for a particular type of disease, the availability of both the doctors increases the choice of selection according to one's need, and the economic consideration in choosing the doctor and judging them as good or bad. Those respondents who did not favour the co-existence give their reasons in terms of the fact that 'both the doctors' co-existence decreases the efficiency of a particular doctor', value and ideological conflict in both, as their conception of treatment is quite different.

On a broad plain, it could be said that the government has given all its patronage to the spread of the Allopathic system of medicine. And this is not without good reason. If the people did not accept Allopathy, the Allopathic health centres, dispensaries and hospitals would have become weaker in their functioning. There is much evidence in our field-data which abundantly shows that despite the seeming higher cost of Allopathy it is imperatively the only choice, in crucial and critical situations. This is because of this that there are occasional demands from voluntary organizational and political parties to increase the bed-capacity of hospitals. In the situation of illness, it is not an alternative for a particular system of medicine. Nor is there a hierarchy of systems. What is meaningful for a physician is to cure a disease at the earliest. To do this, he would perhaps administer simultaneously the medicines from one or more systems. He would practise home-medicine and at the same time, prescribe
anti-biotics. In fact, the process of healing is not a straight-jacket and, therefore, it is difficult to cram up in categorical and clear-cut terms the orientation or inclination of people to one system or the other.

The health situation in the countryside is very bad as compared to that in the urban communities. The secondary data marshelled on this account amply indicate that the rate of birth and mortality is higher in the village compared to that in the city. This can be accounted for the reason that the extent of poverty in the villages is greater, which results in the lower intake of nutritive food. In the Haryana villages, perhaps the poor intake of nutrition is much due to the traditional food-habits of the people. Being agriculturists, they have no idea of a balanced diet. One is apt to consume more of milk and curds than vegetables. Most village-folk largely depend on wheat and bajra. Rice-preparation is usually substantially excluded from their diet. It is only occasionally taken. The ceremonial food-preparation also lacks nutritive value. Thus, the food-habits appear to be largely responsible for an unbalanced diet in the region. Consequently, they result in the occurrence and breaking out of several diseases. At the urban level, though, there is no poverty. People tend to take food which is not rich in nutrients. But here, though the mortality-rate is lower, the categories of diseases vary from those in the country-side. Many of the diseases relate to hypertension and stomach-disorders.
However, urban people somehow manage to maintain their health, largely because of the easy availability of and accessibility to medical facilities at the right hour.

It is not only the intake of food, but also the norms of eating-habits which are vitally important for good health. A preponderating majority of people wash their hands after eating their meals, but not before. Eating out of one plate is generally not observed among the people. Besides, supply of safe drinking-water is unsatisfactory in both urban and rural areas. In the villages, water is mostly obtained from the bare ponds and uncovered wells which are simultaneously used for animals and washing clothes; whereas in the urban areas very little water is supplied by the municipal committee. People, therefore, use water from hand-pump which contain a lot of soil. Norms of eating food and practice of drinking-water are only equalled by the norms of serving the food among the family-members. Even today, people in rural areas indulge in discrimination in the distribution of food-items between males and females within the family. The most obvious and commonest reason stated is that males need more energy as they do hard work, and they are the bread-winners and chief earners in the family. Overall, it seems that cultural subordination of females in decision-making is responsible for unequal distribution of food. Why, even the females themselves who are also managing the distribution of food in the family are guilty of discrimination to their own kind. Isn't this rather
One can notice that even in a relatively developed society such as that of Haryana, the gullible and credulous people, the believers in 'evil eyes' and 'evil spirits' in the matter of food persists even today. It was observed that these practices are the product of experiences of generations, with little or no change in their outlook on modern, civilized life. The practices they followed for protecting the food from 'evil spirits' and 'evil eyes' varied. The most frequent practices observed is to serve the food to their members inside the house where nobody from outside could watch them, and their food might not be contaminated by any 'evil eyes'. Furthermore, some village-people still believe that it is the 'evil spirits' who are responsible for causing certain ailments like, dysentery, diarrhoea, fever etc. Nonetheless, these operative traditional beliefs and practices were rationalized in terms of laymen's conception of either, not evincing any faith in scientific medicine, or for want of modern medicine.

The doctors who enter into the medical profession largely belong to high-caste Hindus and urban communities. However, a substantial number of doctors also include females, backward classes and rural people. The entry of the females and weaker classes is due largely to their reservation in the courses. Despite the protective concession given to the weaker classes, considering all the benefits from the state, it could safely be
said, on the strength of field data that medical education is considerably expensive. The government spends more on the student than the parents do, because the expenses are normally beyond the capacity of middle class people to bear. Another feature of the medical system is that it is highly capital intensive. For some branches of medicine such as surgery and gynaecology, the establishment of a theatre warrants a large amount of money. This discourages the doctors to enter into any entrepreneurship. Yet another drawback of the system is that it is oriented to the rich class and the elite, both at the rural and urban levels. Medical elitism is so strong that it discourages the doctor to stay for any longer period in the village. The duration of medical education being longer, shapes the style of life of a doctor in such a way that he develops a liking for living an urban life. Consequently, the rich harvest of benefits accruing from Allopathic medicine are largely reaped by the urban people. Whatever is left over for the rural community is consumed by the rural elite, rural employees and the trading class. The masses are deprived of any slice of the cake in the development of medicine.

The doctors who have invested much in their education look askance at the profession when they enter into it, and they wish to make amends and to gain as much as possible. There is enough evidence to the hypothesis that there is a small percentage of doctors who take to malpractices in the delivery and rendering of
health services. Illicit medical termination of a child, issuance of false, fictitious and forged medical certificates and administration of polytherapy consisting of higher doses without looking into the would-be health status of the person are some of the manifestation of the malpractices employed by these avariciously extortionate doctors. The ethical commitment in such situations is put heavily at stake.

In the field of private practice, the doctors take to the medical profession to run it purely along commercial lines. Their assumption is simple: the more the investment in medical input, the greater the output. It is this commercial aspect of the profession which has reached an alarming stage, on the urban side. At the rural level, however, there is no place for having private clinics. The medical profession, it must be observed, is established very well both in villages and urban areas. Gynaecologists are prepared to Dais. The specialization in medicine has also received recognition from the people. Even rural people differentiate an eye-surgeon from a cardiac physician. The legitimacy of the specialization too indicates the acceptance of Allopathy as a profession. The government has given legitimacy to expert advice of doctors in matters of illnesses and deaths. Thus, the legitimacy given both by the people and the government to the Allopathic medicine puts it on a rather high pedestal and accords it a firm status as a viable profession.
The working conditions of the doctors have recently drawn the attention of the society. During the last decade, there have been serious agitations stirred by the doctors. Generally, they demanded higher pay-scale and better working conditions. What is important in this respect is that a large number of them to go and stay in a village, descending on the sullied soil from the limpid skies of a big hospital, where all laboratory and technological facilities are easily available. It is something like coming down from the sublime to the ridiculous. Their grievances are that their stay at a village is the beginning of the process of their 'unlearning'. The more they stay in villages, the more they 'unlearn' their profession. The transfer policy has also become quite complicated when viewed from the perspective of an appointment and a possible transfer. In the coming years, with intervention of bureaucracy and political bosses, much instability among the doctor is likely to occur.

To sum up, it must be said that in the wider process of interaction between the people, the system of medicine and the government policy, the beliefs, norms and values of the people towards a system should not be lost sight of. Even if a system of medicine is fool-proof, people would not accept it when it intervenes in, or interferes with, the fabric of the people's value-structure. Surely, the old value-system of modernity, democracy and scientific ethics. But so far as the beliefs related to religion, continue to exist, a particular medical
system will have to correspond with it. In the villages, much stress is put on orthodox values and traditions. Their influence on the acceptance of a particular system carries substantial weight. We would argue that so far the old values and beliefs survive, the medical system shall have to make some "adjustment".