CHAPTER - IX

CASE STUDY - 1

The present case is one of an acute diabetic patient who has been suffering from the disease for the past 10 years. His right leg is very badly affected by the disease. Pussy wound is there on his leg and this creates a lot of pain and inconveniences to him. Moreover he is suffering from hypertension and coronary ailment. Occasionally he becomes unable to move around and hence bed ridden.

The researcher has attempted to establish association between the diseased condition and the socio-economic and cultural backgrounds of the patient and substantiate his central proposition that they are associated.

Accordingly, environmental and social background of the patient was probed. The physical environment in which he lives is not very healthy the dwelling unit is a two-bed room structure. A kitchen and a small work area are appended to it. Eight members of the family share the house. Naturally, we could understand the congestion that the members experience. The house is ill ventilated and the family is not in the habit of opening the windows. Polluted air is repeatedly inhaled and the situation is conducive for the spread and aggravation of respiratory diseases.
Source of drinking water is an unprotected well. Washing, bathing and cleaning of utensils are carried out by the side of the well. The water is contaminated and the chances for water borne diseases are very high. The leach pit is very nearer to the well. The latrine is squatting type and not fitted with fleshing type closet. On the whole, it is unhygienic.

The small piece of land is smeared with waste materials and wastewaster. Occasionally the materials are broomed and burned. So intermittently the atmosphere around becomes clogged with smoke and fumes. Inside the house also the air is smoky due to burning of firewood for cooking purposes and lack of proper ventilation. The head of the household is a chain smoker and the members of the family are forced to experience passive smoking. Unpleasant smell of cigar, clog around, creating nausea for occasional visitors.

The economic status of the family is fragile. On an average the family secure Rs.5000 per month and it is to cater to the needs of 8 members. The earning members are the two sons of the diseased person. They are employed in private firms. The income per capita is an indicator of their poor nutritional standard.

The social status indicators reveal a grim condition. The family belongs to backward Hindu community, which had been, as we know, victims of social stigma and backwardness. The diseased person is 58 and his wife is 50,
both illiterate. None of the family has got education beyond primary level. The educational backwardness of the family gives boost for blind believes. Regarding the cause of diseases they believe that past sins are responsible for them. Therefore, medicine and treatment have very little role in keeping people healthy – they believe. They have faith in manthravatha (black magic). So they prefer manthravatha for curing disease.

They have certain unfounded faith regarding food habit too. Rice is unavoidable, wheat and other cereals are insufficient. By and large, they take non vegetarian food items. Leafy vegetables are given very little importance in their diet. The family is also under the clutches of much folk beliefs relating to health and food habit. Male members are to take food first; the left over food are to be consumed by female members. Pregnant woman shall not be given fatty and nutritious food for they shall complicate the delivery. Pregnant woman is not allowed to take rest she has to do hard work, then only the delivery will be normal.

Analysing the socio cultural background of the family and the disease of the head of the household on the basis of scientific principles, it can be strongly believed that they are related. As known to modern medicine diabetic has a genetic cause for its occurrence. However, lack of awareness about the disease and its management are aggravating factors of it. Here it is seen that the personal and environmental hygiene of the patient are seen very low. Further, he is a chain smoker, which is a supporting factor for the occurrence of many ailments like
hypertension, heart and lungs problem. Blockade of proper blood circulation and decay of body cells (diabetes patients problem) are also attributable to the smoking habit.

Their strong faith in mantravatham is a supporting factor for the continuance and aggravation of the body decay. This is because of physical cleanliness is must for preventing the body from decaying. As we know mantravatham performances themselves are capable of making the surroundings and the performers and the client’s body unclean. They will give little importance to the hygiene aspects because the spirit that is propitiated through mantravatham will take care of disease whatever be the casual factor.

Their over dependence on rice and non-vegetarian food materials and negligence to take green and leafy vegetables are certainly promoting the disease. Another background factor that helps augment the disease is the unsatisfactory medical facilities and know-how available in their neighbourhood. Since the person is having very poor economic background, he is depending on the local PHC for knowledge on sanitation and medical assistance. The ill-equipped PHC is incapable of disseminating awareness about managing disease like diabetics, which though seems to be simple to common people, is a very complicated one. The PHC is not capable of giving proper medical attention for the reason that medical and health care expert are in acute shortage.
On the whole, it is to be seen that the personal and social factors are playing important roles in the causation and continuance of the diseases of the person.

CASE STUDY – 2

In this analysis the case of a person suffering form Tuberculosis (TB) is discussed. The person is 50 years old. He is a member of the Scheduled Caste. His family consists of his 45 year old wife, two daughters and two sons. The eldest child (son) is 23 years and the youngest (also son) is 12 years old a seventh standard student. The two daughters are aged 20 and 18 years.
The husband and wife have primary education. The person was a coolie but during the last 5 years his ailment interfered with his occupation and now he is keeping himself idle and confined to the domestic environment. His wife is suffering from severe asthma and she also has no gainful occupation. She attends to the domestic duties whenever she is free from the severe problem. The earning members of the family are the eldest son and first daughter. The former is a tailor and the later a domestic servant. The total monthly earning of the family is around Rs.3500/- per month and it is to be shared by the six members.

In terms of income the family is living in poverty. The family owns a piece of land (5 cents) and a small tiled house. The unit consists of two small bedrooms, a kitchen and a work area. The house is poorly ventilated and whatever provisions for it are seldom open. So the air inside is totally polluted. The pollution is increased due to the burning for the firewood for cooking purpose. Another polluting agent is the smoking of the person under consideration. He smokes beedi, causing passive of other members of the family. Since six members share the unit that itself is creates poor quality living environment in the unit.

The source of the drinking water is an unprotected well. It is close to the leach pit and waste ditches. The ditches are breeding places of mosquitoes and harmful flies.
The male members of the family use a pit type latrine without water seal. The female members go pretty away in the company of female members of the other families for open defection. The people of the locality think that female members do not require latrine since they are leisure group. Naturally, this practice is conducive for environmental pollution.

The social habits and beliefs are significant to be mentioned here. Even if the member of the family is infected with disease like TB and leprosy, it is kept confidential as far as possible because it has social stigma. So treatment is also delayed which necessitates prolonged future treatment. Hence the treatment cost is increased. The family also upholds the concept of Kaippuniyam (unexplained expertise of the medical practitioner) and prefers Ayurveda.

The awareness level of the family about the disease is very low. They do not know how the disease is spread out and can be controlled.

Now let us look into the possible relationship between the diseases and the social and the personal factors that influence them. According to medical insights both TB and asthma have connections with contaminated air space. TB is an infection disease spread out through bacteria present in the air. Asthma, though not an infectious disease, polluted air can aggravate its symptoms. In the case of the present persons (husband and wife) the environmental factors creating the disease are strongly present. Polluted air is adversely affecting both the patients.
We see that there is congestion in the house, poor ventilation, smoke created and presence of germs due to open deification in the air. Water is almost certainly contaminated.

Poor nutrition due to poor economic status is a harsh reality for the family and it is definitely casual for TB and Asthma. Early detection and treatment are also blocked due to blind belief and social stigma related to the disease. More over economic status of the family prevents the patient from seeking better treatments. They only approach the local PHC for treatment where basic health delivery facilities even are scarce. The folk belief of the family regarding Kaippuniyam and auspicious day observance of starting with treatment are adverse factors for the control of the diseases.

As in the case study, the personal and social factors are found to be intimately related to the awareness about the diseases and management of them. Here we are once again reminded the observation of a Prudue University Health Communication expert that “improving a persons health in India, or in any country, need to start with an understanding of culture”.
The present case reveals how style of life and cultural factor become causal for diseases. This is a case of the wife of the head of the household of a Muslim family. She is suffering from hypertension that was identified some three years ago when she fainted and fell down. She is now an acute sufferer of the disease.

The head of the household is a shopkeeper, 58 years old. He resides in his own house with his 50 year old wife, four sons and an unmarried daughter. His sons are married and all except the last one have children. The last son is expecting a baby soon. In the family altogether there are fourteen members residing under the same roof.
The family is residing in a semi-permanent house having three bedroom, a kitchen and work area. The congestion in the house is quite clear, roughly five members have to share a small room. By habit they are averse to open the ventilators and windows of the house. They use firewood and smoke remains stagnant in the rooms. Inside the house there is full of sound produced by the children and grand children. The orchestration is augmented by the sound produced by the mothers and grandmother. The congestion and sound inside the house aggravate the health problem of the woman (spouse of the head of the household).

Though the family is not very affluent, the style of life of women in the family is somewhat leisure prone. None of the female members go for work outside. Household tasks of a small house are attended by six adult female members. This gives no scope for physical exercise for them the members use pardha and do not usually expose themselves to outside world.

The household has fairly good income earned by the male members. However, mental tension may be much experienced by the female members, due to the lower status ascribed by male members on whom they much depend upon. The spouse of the head of the household is the patient here. Her mental agony may be many fold due to the reason that she has coordinate the joint family which consists of many sons and daughter-in-laws and her own daughter.
The food habit of the family is conducive for the occurrence of disease like B.P and hypertension. They quite often take non-vegetarian food materials. Their menu very rarely consists of vegetable items.

The analysis very well reveals the relationship between the socio-cultural background of the patient and her ailment.

A second component of this case study focused on another reality. That is over all religious ethics and low educational standard of couples may create unhealthy environmental sanitation, which can create severe health hazards.

Here as has been pointed out the head of the household is only primary educated. So too the educational background of his spouse – a third standard women. The family has satisfactory income. Rs.4000/-is the income reported by the head of the household from his own shop. Other three sons have their own individual income, which are pooled together. However, when the environmental sanitation, food habit, childbirth pattern and personal hygiene are analysed we understand that the income by them is not capable of generating good living condition. Instead, socio-cultural factors are very much a determinant of the matter.

The family is residing in very congested and badly maintained house. Suffocating atmosphere is created inside the dwelling unit by bad
ventilation and smoke from the hearth. The women are practicing purdha. They are not permitted to freely mingle with the outside world.

Their food consists mainly of non-vegetarian stuffs, which shall create fatty bodies and complaints of cholesterol. As we have seen, the spouse of the head of the household is a hypertension patient.

When we analyse the strength of the family and the childbirth history of the women, it is seen that she had given birth to the first child at the age of 18. By 31 years of age she gave birth to 5 children. The facts indicate the mental and physical strain faced by the woman.

Naturally, when strength of the family is higher other infrastructural and sanitation facilities are to be enhanced so that a peaceful and healthy life can be ensured. But these matters have been given scant attention.

Drinking water is taken from an unprotected well and hence the danger of water born diseases exists. The family is using water seal latrine. The female members are very particular in this regard. However, it can be inferred that, since there are many members using one latrine, the hygiene condition is very low.
Waste disposal is carried out in a very careless manner. Solid waste is either burned or dumped here and there. Liquid waste is collected in ditches, which become breeding places of varieties of harmful flies and insects.

This discussion concurs with the observation of a Purdue University expert that, “today’s healthcare technology that is used to communicate and to treat people is amazing, but there are many cultural barriers that prevent some rural groups accessing this benefits”. It can be stated with great confidence that the religious ethics and educational standards of the leading members of the households are mainly determining the demographic profile and environmental sanitation (healthy living) of rural families.
CASE STUDY - 4

The present case demonstrates how life styles coupled with cultural lag affect health and hygiene of rural people. The case of head of the household under analysis is a female, 52 year of old and member of forward community (Nair). Economic prosperity is at it’s zenith. Husband and her two sons are employed in gulf. The daughters–in–law are residing with the woman and there are no other members in the family. The educational status of the members is not very high. Her sons are completed technical education. The head is only illiterate. The daughters–in–law are completed pre-degree.

However, economic prosperity is high, as gulf money has been pouring in for the last 10 years. They built a very good house with European type toilets, water supply system etc. LPG and firewood are using for cooking purposes. The lower educational status is reflected in the up keeping of the toilets, washbasins, kitchen sinks, bathroom towels and such other facilities. The windows and ventilators are rarely opened. They have excuse for not opening them - the absence of male caretakers.

The cultural lag lies in the fact that there are modern arrangements and gadgets in the household, but the inmates are not used to them and are maintained in a very bad shape. Though not very acute, the members are every
now and then are affected by air born and water born diseases like malaria, cholera, dysentery, typhoid etc.

Coming to the life style disease, all the female members are suffering from obesity, which is considered as the consequences of over eating (particularly fatty food), lack of bodily exercise. The obsess person becomes fatty and unduly gain weight.

In the family the problem of obesity is very seriously faced by the mother-in-law. Since they have very good income none of them is needed to attend to even house hold task. The mother-in-law is particularly “taken care of“ by the two daughters-in-law. The mother-in-law is not getting opportunity even for washing a spoon in her kitchen; she consumes very high calorie food, watches TV and sleeps at intervals. What else is needed for getting fatty? Her daughters-in-law are also getting obsess. Obesity has been linked to several diseases like heart diseases, cancer, and diabetes. Many risk factors are associated with these diseases, such as high cholesterol and blood pressure.

This is a common problem faced by rural households in Kerala. People are migrating to the west and middle-east. There they do very hard, good work and remit good amount to the NRI accounts. Back in their homes the family members enjoy all sort of material comforts. In India obesity is typically characterized as the consequence of irrational eating. The prevalence of over
weight and obesity are seen related to the level of education particularly among women.
CASE STUDY - 5

Here is another case of a small family consisting of 62-year-old mother; her 45-year-old divorced daughter and her two children aged 15 and 12 years respectively. The elder grandchild is a son and the other, a daughter.

The daughter was divorced by her husband’s ill-treatment, ten years ago. The divorce is a case of ultimate end point of a story of confusion created by traditional belief of the mother, ideological difference between the spouses and all the more the, behavioural problems of the two parties. The details are not very relevant in our discussion and are avoided. Any way one thing is to be noted down very painfully; that is the status of the divorcee ascribes her social stigma and she is not welcome in public and social situations. Being a divorcee she is looked upon as a deficient woman. The stigma transcends to her children and mother too.

The family is living in a small dwelling unit consisting of a two-room tenement. The physical environment is quiet shabby-water clogged and mosquito breeding. The bathing and washing are carried out near well that is not properly fenced and protected. The wastewater stagnates around the house making it marshy.

The income of the family is around two hundred rupees earned through their work as domestic servants. Both of them have to work hard to earn
the amount and buy some food items, both prepared and raw. The returns are hardly sufficient to feed their younger ones. The children are studying in 10th and 7th standards and they are to be given uniforms and study materials from this meagre income.

The study is to be focussed on their health care practices since they are closely related their traditional beliefs in the power of gods and goddesses. Incidentally it may be pointed out that they are members of Hindu backward community. The mother is suffering from asthma, acidity and swelling on the leg (limbhoedema disease). Any one who has visited her dwelling place can understand that the problems are caused due to the unhealthy condition, particularly air pollution and presence of vectors. The family is highly under mental stress. The hyper acidity experienced by the mother and daughter is directly related to the stress and lack of proper food. The swelling on the mother’s leg is due to bad environmental condition and may be due to filariasis.

Being these are the conditions, the mother and daughter do not know the real reason for their health problem, instead, they believe that they (diseases) are the incarnation of the wrath of gods and goddess. So they spend on visiting temples and shrines and great offering to propitiate the deities.

Their rationality is eclipsed by blind faith in black magic and crude religious practices. Their educational backwardness (the mother is illiterate and
the daughter is only third standard) may be the major reasons for their blind faiths and practices related to them.

They very much like the revelations by Sooth Sayers and manthravadies. For the curing of their diseases they also consult with such persons. In addition, they call back on religious faiths and practices. Occasional relief got to their health problems that are the nature of certain diseases, is interpreted by their problem solvers as the blessings of the super natural forces that create the turbulence. This reinforces the faith of the victims in the godly persons’ interpretations. They accept remedies suggested by them like certain threads, powder that are claimed to have magical curative powers.

Whenever they use medicines they resort to traditional medicines like Ayurvedic and Unani preparations. Modern medicines are not much welcome by the mother and daughter.

Here we see the health problems that are created by the poor socio-economic backgrounds of a small family who are under the clutches of blind faiths related to diseases and curing methods. These cases are representatives of a section of rural Keralites who strongly believe that supernatural forces can become healers of their diseases and act accordingly. Good education and over all development of the incumbents only can help tide over the situation.
Conclusion

The case studies strongly support the central hypothesis of this research, that personal and socio-cultural backgrounds are determinants of the concept of health and practices related to it.