CHAPTER-I
INTRODUCTION

Anthropology aims to understand the meaning of people's ideas and practices. The anthropological approach to gain understanding of a certain subject is to study it in its context. People's ideas and practices can be meaningful only when it seen in its context. Therefore when anthropologists speak about understanding and studying culture in context, it implies trying to discover how people view their own situation and how they solve their problems. Furthermore, anthropologists are not only interested in ideas, meanings and beliefs but also in what people do, as actual practices reflect what people believe in.

Cultural anthropologists gathering data on indigenous societies also collected information on medical beliefs and practices, along with cultural values and social forms and their knowledge about the dynamics of social stability and change. This provided the needed key to many of the problems encountered in these early public health programs. Anthropologists were in a position to explain to health personnel how traditional beliefs and practices conflicted with western medical assumption, how social factors influenced health-care decisions and how health and disease are simple aspects of total culture patterns, which change only in the company of broader and more comprehensive socio-cultural changes. As a result medical anthropology gained great significance.
“Medical anthropology” is viewed by medical anthropologists as a biocultural discipline concerned with both the biological and sociocultural aspects of human behavior, and particularly with the ways in which the two interact and have interacted throughout human history to influence health and disease” (Foster and Anderson 1978:3). Fabrega (1972) in his definition of medical anthropology says that a “Medical Anthropological Inquiry” as one that elucidates the factors, mechanisms, and processes that play a role in or influence the way in which they respond to illness and disease (cited in Foster and Anderson 1978:9).

The history of medical anthropology shows excellent contributions and emergence of anthropological and other behavioral scientific interests in the field of health and disease. The first major study was published in 1953 by Caudill, the title of the study was “Applied Anthropology in Medicine”. Later on, the article (1963) “medical anthropology” by Scotch and also Paul spoke of “medical anthropologists” in an article on medicine and public health and it created a great deal of interest in the field of medical anthropology (cited in Foster and Anderson 1978:9). In early 1950s many anthropologists were able to suggest ways to improve programs in the field of international public health. Anthropological approach was acceptable in this field because, it did not threaten the professionals. Some of the significant contributions are Adams (1953), Erasmus (1952), Foster (1952), Paul (1950) and Weaver (1968).

Epidemiology has currently gained currency, and is seen as a method of studying disease and illness phenomenon of all types, which is based on the
assumption that the cause, distribution, conception and treatment of particular
disease are a result of combined biological, environmental, social and cultural
factors.

It is also important to understand that while anthropologists emphasize
the importance of culture, there is weariness to avoid cultural stereotypes and
blaming. That is to say, for instance, poor health of a population, or presence of
diseases is not solely the result of culture. For instance, in a society if mothers
hold specific beliefs about the causes of diarrhea, these beliefs are often
dismissed as superstition by health professionals. And this belief is held
responsible for mortality among children. Health and disease should also be
considered in the light of socio-economic factors such as accessibility, lack of
service provision and not that indigenous knowledge should be blamed blindly
(Hardon 1995).

The present study focuses on the public health-care system in a rural
scenario. Beliefs and practices relating to ill-health are central feature of any
society. And it is medical anthropology which provides an approach to
understand the 'medical phenomena'. In spite of an early break through, the
growth of medical anthropology has not been very impressive in India. Until
recently, Indian studies were heavily oriented towards studying hospitals and
public health policies and programs.

As Rizvi points out ‘anthropologists’ interest in the study of health is as
old as their interest in culture. The study of health-care system is concerned
with the ways in which people organize care of the patient and utilize disease
'knowledge' to aid the patients. This system involves the interaction of people, minimally the patient and curer (Rizvi 1991).

In the past three decades, interest in the public health-care system has increased owing to the role UN agencies, funding and pressures on governments of the developing countries to focus on health and overall well-being of every individual. And in this direction, public health-care system plays a pivotal role in taking health to the people. In this pursuit, understanding of health-care is not constrained to understanding diseases, but understanding it as a social and cultural phenomenon. As a result, there is focus on various socio-economic factors (UNDP 1998).

The Rockefeller Foundation has been engaged in international public health work since decades. US government initiated cooperative health programs with the governments of a number of Latin American countries as a part of a broader technical assistance program. With the end of the war and with the extension of US technical aid programs to Africa and major bilateral and multilateral public health programs in developing nations became a part of the world picture (UNDP 1998).

It is evident in many cases, (such as malaria control) though vertical programs are intended to treat people and though they have benefited to certain extent, the people would fall prey to other disease due to the poor environment conditions in which they are forced to live. Even if a particular disease is controlled for the time being, one cannot rule out that some other disease owing to poor nutrition will not occur, considering the fact that poverty gives rise to a
chain of diseases. It is certainly a ‘no-end’ task to treat the diseases one by one and it is necessary to address the causes of disease rather than only the disease (ibid). Health infrastructure is just one aspect of the reports in Alma-Ata declaration of Health for All and ICMR/ICSSR joint report (1980). They propose incorporation of integrated development, including poverty eradication. Health programs can be made successful by decentralization and creation of the rural infrastructure. The commitment to rural health does not end with the creation of infrastructure but should begin from there (ICMR/ICSSR report 1980).

This study is an attempt to contribute to understand the role public health-care system plays in a rural scenario. There have been a number of attempts to define public health. As early as in 1920, Winslow described it as the science and art of preventing disease, prolonging life and promoting health and efficiency through organized community efforts, the development of the social machinery which will insure to every individual a standard of living adequate for the maintenance of health (Rizvi 1991). In this context, it is important to understand what health itself means WHO defines “Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (Park 2002:12).

Public health-care systems are conceptually different from medical services. They have, as a key goal reducing a population’s exposure to disease (for example through assuring food safety and other health regulations, vector-control and health education). These services are largely invisible to the public
typically the public only becomes aware of the need for them when a problem develops (ex: an epidemic occurs). Yet, unlike most personal medical services, these services produce public goods and are of high priority for assuming good health outcomes. When primary health-care system falters, people pay a price in illness, debility, death and if full-fledged outbreak occurs, the economic costs can be very large (for example; WHO 1999 estimates that Surat plague epidemic resulted in losses of $1.3 billion).

When one tries to understand the Indian scenario, one finds that India has made notable achievements in medical and health services since independence. Nearly 70% of the population resides in rural and tribal areas and is catered through the health services of the public health-care system. Indian government like the rest of the world has recognized that the development of human resources includes two key components that is, health and education. Health is an important factor in the human resource development. Health plays a pivotal role in increasing labor productivity and entrepreneurial ability. Therefore any measure aiming at development in a nation must reflect the state of individual’s health of its citizens.

India has made remarkable progress in reducing death rates and controlling diseases like small-pox, cholera, malaria and so on. However much needs to be done in the health sector as to benefit the masses at the grass-root level. Studies such as the present research throw light on the working of public health-care system, its advantages, and limitations. Further such anthropological studies provide insights into the workings of the system through the people’s perspective.
The allopathic system of medicine was introduced by the British by opening hospitals and dispensaries. They introduced the western medicine in the later half of the eighteenth century, principally to serve their colonial aims and objectives. Medical services were needed to support the British army and personnel living in India. Later on medical services were made available to a very tiny segment of native population. At the time of independence, only the affluent and the ruling classes get adequate medical services. Of the rest constituting more than 90% of the population, only small fraction could get some form of medical care from hospitals run by government agencies, missionaries, philanthropic institutions and private practitioners.

Banerji (1978) in his article on ‘Political dimension of health and health services’ says that the colonial powers used the health services for strengthening their grip over the population of the subjugated countries. He also noted that most of the third world countries have followed colonial pattern of health services and also privileged-class-oriented health services are absorbed more and more resources as they developed strong overtones of dependence and commercialization of health services of the ex-colonial power.

Banerji (1974) traces the socio-cultural foundation of health services systems. He has written that, India has a long history of health services systems. After independence, the new leadership though committed to provide health services to one and all, did not consider it necessary to bring out any basic changes in the existing systems. The medical colleges and number of doctors grew rapidly but they were alienated from the rural masses. The leaders
being persuaded by foreign consultants set aside large amounts for running of mass campaign against specific diseases like malaria, small-pox and leprosy. He opines that these campaigns have hindered the development of permanent health systems in rural areas and at the same time many of these programmes have failed to achieve the set goals. Based on carefully conducted empirical study of health behavior of rural population, Banerji states that there is no significant cultural resistance to the acceptance of modern medicine as long as they are efficacious, available and accessible to the people. But the existing health services are working at grossly low level of efficiency which has led to considerable under-utilization (Banerji 1974).

After independence various committees were formed for the planning and implementation of health-care policies. India’s health-care policy planning has always had to struggle with gigantic target population and limited resources and socio-cultural impediments. A great deal of planning has gone into the policy making for public health-care system. The recommendations and contributions of various committees since their constitution are summed up as follows:

- Bhore committee was set up by the British India government (1943) to draw a blueprint of health services for India. Its recommendations include development of elaborate health service system for the country giving key importance to preventive aspects with rural areas as the focal point. The recommendations led to the establishment of Primary Health Care Centers (PHCs) for making medical and health services available to the rural population.
• The Health Survey and Planning Committee (Mudalior committee 1959) reviewed the developments since Bhore committee and formulated further plans for the future on similar lines.

• The Mukherjee committee (1955) spelt out the details of basic health services for strengthening the PHCs at the block level.

• Srivasthav committee (1975) recommended selection of part-time health worker to work for the health of her own community under the scheme (Community Health Worker) CHW. The purpose is to provide preventive, promotive family planning and basic curative services and to act as a link between the multi-purpose worker at the sub-center and the community. The CW scheme was launched in 1977 and the worker was called the Community Health Volunteer (CHV) later as Health Guide. A lack of commitment and proper understanding of the potential of the village health worker resulted in the failure of the CHV scheme.

With the recommendations of various committees five year plans formulated different plans for health. Health and medical infrastructure facilities were expanded with a view to improve accessibility of services. However despite all efforts, in the first four-five year plans only some visible improvements were found and they fell short of the expectations and did not meet the objectives adequately.

From an analysis of health policies and five year plans, one understands the plan allocation to different heads relating to health and identification of priority areas. Planners since the first five year plan have identified different health trends, needs and problem areas. They are as follows:
• Nearly 40% of the total deaths are among children under ten and half it is under five mortality.

• High maternal mortality that is 20/1000.

• Need for expansion of health program to increase the reach.

• Quantity and quality, and distribution and integration to be kept foremost in proving health-care services.

• Nutrition is the single most important factor in maintenance of health especially for vulnerable groups of population like expectant mothers, pubescent girls, children under five and nursing mothers.

• Need to create significant linkage between health and productivity.

• Provision of effective base for health services in rural area by strengthening the PHCs.

• Provision of minimum health facilities integrated with family planning and nutrition for vulnerable groups.

• Training required to create special functionaries like multi-purpose health workers to deliver the integrated health-care services.

• Making up deficiencies in numbers, buildings, staff, equipments, drugs, of the PHC complex in a coordinated way.

• Adoption of National Health Policy and restructuring of Health-Care Programs.

• Extension and expansion of rural health infrastructure through a network of Community Health Centers (CHCs), Primary Health-Care Centers (PHCs) and sub-centers.
• Commitment to attain the goals of Health for All by 2000 A.D.

• Priority to rural water supply and family welfare programs.

• Increased allocation to services and supplies and to Maternal and Child Health (MCH) program for obvious reasons.

• Comprehensive Reproductive and Child Health (RCH) program development.

• Focus on prevention and control of HIV/AIDS and IEC programs.

• Increased emphasis on polio eradication, adolescent health education, and reproductive health.

Plans and policies have also identified causes for low state of health and priority areas to focus. The main causes identified are as follows:

• Unhygienic environment due to inadequate housing

• Bad water supply

• Improper removal of human and other wastes

• Low resistance due to poor nutrition

• Lack of medical care availability and accessibility

• Lack of health and general education

• Lack of adequate resources

The priorities set by the Government from the various learning’s and reports of the various recommendations can be summed up as follows:

• Preventive health-care to rural areas

• Utmost importance to maternal and child health
• Family planning and population control
• Enhancing the nutritional status of vulnerable groups
• Sanitation and water supply
• Control/eradication of communicable diseases (malaria, smallpox, TB, leprosy etc)
• Health education
• Training of ancillary personnel
• Integration of indigenous system of medicine
• Integration of health, family planning and nutrition program
• Training of special functionaries like multipurpose health workers
• Reproductive and child health and HIV/AIDS

Provision of iron folic acid tablets to pregnant women and immunization of children under five have been the hallmark achievements of the Public Health-Care System in India. The folic acid tablets are provided to pregnant women to prevent nutritional anemia and it forms an integral part of reproductive health-care program. The TT immunization program for pregnant women was integrated with expanded program on immunization in 1975-76. To step up the pace of immunization program, universal immunization program was initiated in 1985-86. The vaccination of children against six deadly diseases is considered the corner stone of the Public Health-Care System in India.

With regard to nutrition program Integrated Child Development Services (ICDS), is the largest nutrition program implemented by the
government of India. It caters to 22.36 million beneficiaries with supplementary nutrition. This includes 18.2 million children and 3.8 million expectant and nursing mothers from poor socio-economic groups. This scheme was launched in 1975 in pursuit of national policy for children in 33 experimental blocks (NFHS 99).

The purpose of public health-care system with various programs is to improve quality and quantity of services provision, increasing accessibility, correcting regional imbalance, development of referral services by providing specialists attention to common diseases in rural areas. From the view point of curative needs, health-care system has greatly expanded in the country. Under the minimum needs program, population norms were revised for CHCs, one CHC for every 100000 population, and a PHC for every 30000 population and a sub-center for every 5000 population.

However it is often seen that beyond 5kms radius people do not seek services. Posts remain vacant as doctors are reluctant to stay in rural/tribal/remote areas. There are often complaints that drugs are not available. The appointment of multipurpose workers has been a turning point however the work load and the training process are of questionable quality. One of the major issues with the health-care delivery system in the rural scenario is that the people have little confidence in the government health-care system those who can afford to go to private doctors for treatment (Ramachandrudu 1997). Nichter (1981) in his study of rural health-care delivery system in India suggested that the practice of medicine should be in
the cultural framework. He opines that Indian educated doctors to be more sensitive to people’s ideas and needs and pass on valuable health ideas in the manner the people can understand and adopt. Karkal (1991) analysis of health and health-care services in India, lays bare the cold statistics to show how and why errors in conception, and formulation of policy leading to poor health status. In spite of many achievements Karkal concludes, that the health situation is far from satisfactory.

Utilization of health-care services is a crucial indicator of the effectiveness of the services. A number of studies have been conducted in this direction. The studies are not only useful in understanding the situation but also provide direction for the betterment of the situation.

Yesudian (1999) writes regarding pattern of utilization of health services and policy implication. The study has collected information by conducting survey in two areas in Mumbai. This study reveals that differential utilization pattern of health services did not take place, even though there are differential socio-economic conditions, differential mortality and health services in the two communities. This study also shows that both public and private sectors have definite roles in providing health services for the poor. The poor are extensively utilizing the private sector and the quality of health services is questionable. The author has suggested that strengthening of public sector will alert the private sector to provide good quality of health services for poor.

Yesudian note in the study that various health services were utilized more by the people of rich economic condition than by the poor. The selection
of health center by the well to do persons was on the basis of their personal knowledge of the doctor in the center and at the same time they utilized private health services too. The poor on the other hand, depended entirely on public health services for all their health needs. Lack of resources and ignorance were the causes for the poor being unable to utilize properly the health services.

Kakkar (1981) conducted a study in rural Rajasthan on Differential Utilization of Health-Care Services. It is apparent from the findings of the study that social inequalities played an important role in the utilization of health services. The members of lower classes and scheduled castes remained deficient not only in terms of possessing adequate knowledge about disease etiology but also about seeking medical care in time, while their counterparts belonging to higher classes or non-scheduled-castes seemed to have drawn greater benefit from the government health services. They found dualism in health-care services i.e. on one hand there were hospital oriented services run by specialists and super specialists who followed sophisticated western technology, on the other hand the primary health center network primarily looked after by ill-trained and ill-equipped paramedical workers who lacked supportive supervision. The consequence of this situation is that the poor whose medical needs were the greatest were put to maximum deprivation in terms of provision of health services as well as their utilization.

Shrinivasan (1984) made an attempt to study the perception of rural population in utilization of health-care services. Observation and interview technique were employed. This study revealed that 65% of the respondents did
not utilize health-care services of the selected health centers. It is significant to find that the people preferred the traditional practices and conducted delivery at home.

Banerji (1991) in his writing on trends in health services development in India, sees, access to health services as a part of wider struggle. Dependency has been created on medical technology which he calls as ‘techno-centric’ programme. He says such programmes have no relationship to the people, and population growth is due to poverty. Banerji says the health services in India have moved away from the people for whom it was and is being planned.

Barn in his ‘Private Health-Care in India’ has analyzed and criticized the process of privation of medical care in India and its implications for health services. The author has made a study of social background of the entrepreneurs which suggests the movement of capital from agriculture and business into medical care in Andra Pradesh. The study shows how the growth of the private sector has a negative impact on the public sector and in the process raises questions regarding quality of care, efficiency of services and the social responsibility of medical professions (1998).

Gupta in his ‘Public Health in India; Dangerous Neglect’, says public health policies in India have focused largely on medical services. But vector control; monitoring waste disposal and water system; improving slaughterhouse hygiene and cattle-keeping practices, cleaning irrigation canals to discourage vector breeding and applying public health recommendations have been grossly neglected. Study reveals that services do not reach public
and people pay attention to the services only when they actually suffer from problems as when an epidemic occurs (2005).

Murali and Bhatia's (1984) evaluative report on the mobile medical team (MMT) scheme initiated by Tamil Nadu state government shows interesting trends in utilization of services. The scheme of MMT was a new approach to make health services available and accessible to the hitherto uncovered to the rural population, inadequately covered population in interior villages. The study findings, clearly indicated effectiveness of the scheme whereby there was manifold increase in the number of patients seen and treated in farthest village.

The findings of this evaluation study by and large indicated that the new strategy of delivery of health-care to rural mass through MMT was effective in improving the coverage of population for different components of health-care, particularly curative medical care, maternal and health-care and some community based preventive services. However, there was no obvious improvement in national health programme of malaria and tuberculosis.

Verma (2002) discussing the behavior of medical and paramedical staff tries to describe the satisfaction of patients. He has analyzed the patients' satisfaction by using four variables; satisfaction with the outcome, continuity of care, patients explanations and the doctor-patient communication. He says that the patient-oriented approach of the doctors will help in enhancing the patient's satisfaction. And this depends upon a number of factors, such as performance of doctors and paramedical staff, better communication, promptness in
delivering the services, responsiveness to customers needs, information and report requirement of the patients, clean atmosphere and the available of drugs and other facilities.

The studies on health policies framed by the government enable one to understand the advantages and drawbacks. That is, they focus on the critical analysis of the policies. Research on primary health-care policy analysis has been going on for decades and there are great many studies available in sociology, economics, political science.

Social scientists including anthropologists have studied public health-care system but most of the studies focus on lacunae or on the quantititative side of the picture, or they focus on polices and programs. Some of the anthropological studies have focused on public health-care system as part and parcel of health studies and have contributed to the understanding of the system and problems encountered and also provided culturally viable solutions.

The existing literature provides a broad framework to understand the existing macro-level scenario of the Public Health-Care System in India. Further the micro-level studies by various social scientists, data provided by various polices and programs, and statistics, enables one to understand lacunae in the existing system as well as areas where systems are in place. Simmons (1957) has classified public health-care system into three areas on the basis of social class and status: 1) the differential distribution of disease and consequent evaluation of appropriate foci of public-health interest and activity; 2) the
functioning of interpersonal relations within the health team and between team
and public and 3) The congruence between public-health precepts and felt-
needs of the public of whom these precepts are directed.

This basic understanding obtained through secondary data provides the
broad framework for the present research. The strength of the present research
lies in the in-depth understanding of the research area by utilizing
anthropological methodology.

The theoretical framework for the present study is a synthesis of
theories; it is called the 'critical anthropology'. Critical anthropology integrates
politico-economic, cognitive/symbolic views and tries to connect macro and
micro-level insights in social processes (Hardon 1995). This approach is of
significance in studies such as the present one, because analysis needs to be
done from various perspectives as a number of socio-economic equations are
present.

As Scheper, Hughes and Lock (1978) remark, illness is presented as the
embodiment of society's most basic problems and conflicts. Minocha says, the
subject of health-care delivery is as much a sociological change as a medical
one. She objects to the conceptualization of village as a harmonious,
homogenous, united and self conscious entity with its members participating in
joint action for the welfare of all (1986).
• At the individual level are the home-remedies

• At the household level, the family members are involved in the decision-making regarding the course of treatment and finances planning

• At the level of immediate social network, the belief system operating, experience, knowledge influence the behavior

• At the community level are the various service providers-public, private, indigenous

• At the national level are the policies and program intended for the people
The diagram [the Philippine Problem Analysis Diagram (cited in Hardon 1995)] helps in understanding the complexities involved in health-care and also to understand the layers of health seeking behavior. It is not only the individual or the immediate environment which influences the health-care but also the national and international policies.

Within a health system, one may distinguish various levels of organization-starting from a household at which people organize their ideas and activities to restore health, to local and national level. The concept of different levels within a health system is also useful to understand internal contradictions in the health-care delivery. Often a tension exists between national policy and local practices.

The diagram represents the relationship between micro-levels within the macro-level. It represents politico-economic, belief and practice system at the community level and tries to connect macro and micro-level insights in social processes. The panchayath, the economic system, the level of education and income which are the different socio-economic equations present operate and affect individual's health seeking behavior. The socio-economic, political processes are the complexities which influence planning and implementation of health-care programs on one level and individual behavior on the micro-level. All these factors are analyzed critically in order to understand public health-care system in the rural setting.

Hasan (1967) says, health of a community is affected by two types of cultural factors:
1) the factors that directly affect the health of the community because of certain customs, practices, beliefs, values and religious taboos and create an environment that helps in the spread or control of certain diseases and

2) the factors that indirectly affect the health of the community as they are related to the problem of medical-care provided to the sick.

On the same lines, Trakroo, Dayal and Kapoor (1981) in one of their important articles highlight the accepted models of health behavior and their usage in explaining illness, sickness and utilization pattern of health facilities. They describe the limitations of each health behavior model with the view of Indian health-care system.

Foster and Anderson state that medical systems consist of a ‘disease theory system’ which embrace belief, nature of health, the causes of illness, and the remedies and other curing techniques used by the medical professionals. They also note that, “a dual division is sufficient to distinguish major categories, or systems”. They suggest that these are called ‘personalistic’ and ‘naturalistic’ systems. According to them personalistic medical system is one in which illness is believed to be caused by the active, purposeful intervention of a sensate agent who may be a supernatural being (a deity or a god), a non–human being (such as a ghost, ancestor or evil spirit), or a human being (a witch or sorcery’s). The sick person is literally a victim, the object of aggregation or punishment directed specifically against him, for reasons that concern him alone. In naturalistic systems, illness is explained in impersonal, systematic terms; it can be caused by natural forces or by imbalance within the individual, the view taken by people involved (Foster and Anderson, 1978: 53).
With this understanding, objectives laid out for the present study are as follows:

- Understanding the working of the programs of Public Health-Care System
- Understanding people’s perception of health and illness, with emphasis on influence of environmental factors on health
- Understanding the choice of treatment and utilization of public health-care system

The present study utilizes “emic” perspective and holistic approach to understand the Public Health-Care System in the rural setting. As it is frequently pointed out, developmental projects have failed because they do not take the community’s own ideas and preferences into account. “Emic” perspective helps to correct this shortsightedness. It is the holistic approach which provides an in-depth understanding of the Public Health-Care system, because the Public Health-Care System does not exist in isolation. Various socio-political, cultural-economic factors are playing influential roles. Only when all these factors are understood, the working of the Public Health-Care system makes due sense.

Further there is presence of multiplicity in the health system ‘medical pluralism’. There is presence of indigenous system along with biomedical system and therefore to understand the health seeking behavior, one has to also focus on beliefs and practices of indigenous medical system.
The place where the present study was conducted is situated in Belgaum district, Athani taluk. It is interesting to note that earliest allopathic institution in the district which is called the Civil Hospital was established here as early as in 1859, followed by a dispensary in 1871 in Athani.

**Methodology:**

The data presented in this study is based on intensive and first-hand field work carried out in the village of Mallapur from November 2005 to June 2006.

During the research period, I stayed with one of the families in the village. The family once quite large had been recently divided. One unmarried son was working in another city and the landlady who was the head of the family was the only person residing in the house. She was kind enough to accommodate me. In fact, it was through the PHC doctor that I was able to find out about this person. The doctor said that when he had just arrived in the village initially it was this family that let him the house to stay and that they were generous and willing to help.

Further, finding the place to stay not only solved the problem of accommodation but also was a blessing in disguise because the landlady was also a traditional mid-wife and therefore was a source of abundant information and knowledge. And as a single unmarried girl, living with an elderly woman was also ‘acceptable’ to the others. The visits of my mother also made the people to accept me better. Because, people are reluctant to accept a girl from a different place living alone for not so obvious a reason.
Initially they could not understand the purpose of my prolonged stay. They felt I was a government official probably in guise, finding out about their economic status. But when it was made clear that it was not so, they took some time to accept my role as a researcher. The discussions, questions asked about health and the interviews conducted with medical personnel gradually enabled them to understand that I did not have any hidden intent.

The methods that were used to collect data were:

- Census schedule administered to the head of every household for collecting basic household information.
- Interviews were conducted. They were structured as well as unstructured.
- Observation, participant-observation group discussions, case studies, discussions with key informants were also employed.

Visits were regularly made to primary health-care center and household visits were made with the ANMs. In the beginning the ANMs, anganwadi workers were reluctant to let me accompany them. But gradually rapport was established with repeated visits and they allowed me go around the village with them. This helped me in understanding the relationship and interactions between care-giver and people. Visits to the primary health-care center enabled me to understand the mindsets of the patients. Conversation usually began while patients were waiting for the doctor and it gave insight into the pattern of their treatment seeking behavior.
At the end of the day, data collected was organized and reviewed. As per the need of the study, much importance was attributed throughout the field work to understand the various aspect of village life of the people through their perspective.

Collection of quantitative data was difficult because the health workers would give excuses for not providing the data. And at the CHC, they would ask me to get permission from the district health center. However, since the research is of qualitative nature, the interactions and observations were of greater significance. Therefore, one of the limitations of the study is lack of analysis of data recorded, targets achieved, actual targets etc, by the PHC personnel.

The data collected for the present research has been organized in six chapters and they are as below:

Chapter I Introduction:

The chapter deals with understanding of the primary health-care system in the background of anthropological perspective, details out the literature reviewed and focuses on the theoretical framework and methodology.

Chapter II Rural Setting:

The chapter consists of detailed information of the village, especially regarding the layout, food practices, water facilities, health facilities, festivals, transportation and communication of the village, religion, caste, sub-caste, types of house, structure of families, occupation, age, sex, income, land and education.
Chapter III Health and Hygiene:

The chapter deals with village as a physical entity contributing to health and disease. The role of environmental factors in the health and well being of the people are discussed in this chapter.

Chapter IV Public Health Programmes:

The chapter discusses the structure and functioning of the Public Health-Care system in the village. The programs implemented through the primary health-care center, their utilization and acceptance by the people are also discussed.

Chapter V Health Seeking Behavior of the People:

This chapter deals with different diseases and the pattern of health-seeking behavior among people.

Chapter VI Conclusion:

This chapter summarizes the findings of the research and draws conclusions regarding the Public Health-Care system in the village.