CHAPTER-IV

PUBLIC HEALTH PROGRAMS IN THE VILLAGE

Evidence shows that since economic liberalization, there have been improvements in the lives of the rural populations in India. In rural India, the number of people living below the poverty line has fallen from 63% to 42% between 1991 and 2001. Life expectancy rates have also risen steadily since independence. However, these changes went hand in hand with policies and movements, such as the Green Revolution, that focused on alleviating poverty in rural regions. In direct contrast, there have not been any health policies that have brought about sweeping changes in the country. Instead of improvements in health-care delivery, we are actually seeing increasing costs and health related debt that is actually driving millions of people further into poverty each year (Gudipati 2006).

The population in rural India continues growing larger, and they are also dying at a greater rate than in urban India. The death rate is almost 50% greater in rural India, and Infant Mortality is nearly twice as much. Maternal mortality rates (MMR) are also significantly high at 407 deaths/100,000 live births. In fact, MMR has actually risen over the last decade. Research also shows that maternal and child health is one of the largest health issues in rural India. There are many reasons for this some of which are outlined below:

51% of deliveries are conducted at home by an untrained attendants
75% of women have their first pregnancy before they turn 18 Only 67% of
women complete their antenatal checkup Only 30% of women get postnatal check-ups.

The good news out of all of this is that most rural deaths are preventable. They arise from infections and communicable, parasitic and respiratory diseases. The bad news is that mortality and morbidity rates in rural India have not shown significant improvement over time. Due to these failings, there is a need to focus on health-care delivery systems that will reduce these glaring inequities (ibid).

Public health-care system is an integration of preventive, promotive, curative and rehabilitative health services to be made accessible and available to the people. The primary health-care is the responsibility of the state. It is recognized that health is influenced by a multitude of factors and not just the health services. It is also recognized that there is need for a multi sectoral approach to health and it is understood that primary health-care has to be linked to other sectors (WHO 1978).

4.1 Public Health-Care System and Its Need:

The primary health centers are the cornerstone of the rural health-care system. By 1991, India had about 22,400 primary health centers, 11,200 hospitals, and 27,400 dispensaries. These facilities are part of a three-tiered health-care system that funnels more difficult cases into urban hospitals while attempting to provide routine medical care to people. Primary health centers and sub-centers rely on trained paramedics to meet most of their health needs. However, the National Health Policy Report of 2002 found that the current
infrastructure of public health needs to increase by 16% in order to adequately serve the population (Ministry of Health and Family Welfare). The basic infrastructure of the public health-care system has potential, but without proper funding and resources it will continue to fail to deliver on its promise of quality health-care.

The World Health Report, summit at Alma-Ata and declaration of the goal of “Health For All” (HFA) –2000 AD, the concept of three-tier health-care system was framed. Being a signatory to HFA-2000, the three tier system was rolled out in India under the rural services with the fifth-five year-plan in 1978. This system was based on the concept of primary health-care, defined as ‘essential health-care’ made universally accessible to individuals and acceptable to them, through their full participation and at a cost the community and country can afford”.

Since India got independence, several health programmes have been undertaken by the central government with the co-operation of state governments to improve the health of the people. The objectives of these national health programmes, are to eradicate communicable disease, improvement of environmental sanitation, raising the standard of nutrition, population control and improving rural public health. Hence several national health programmes have been implemented by health ministry of government of India, which has implemented the three tier system on the basis of the population to provide doorstep health-care services to rural people. The three tier system is as follows
1) Sub-center – for a population of 5,000

2) Primary Health Center (PHC) – for a population of 30,000

3) Community Health Center (CHC) – for a population of 120,000

The primary health-care infrastructure provides the first level of contact between the population and health-care providers. The sub-centers that are often the first point of contact for the people and are only staffed by auxiliary nurse midwife (ANM). An ANM is required to have completed at least twelve years of education plus a certification program that trains them to handle a limited set of health conditions. Those who cannot handle get referred to a PHC. For all practical purposes often primary health center (PHCs) are the first port of call for the sick and an effective referral system. It forms the primary level of contact and a link between individuals and the national health system; bringing health-care delivery as close as possible to where people live and work.

Each PHC is targeted to cover a population of approximately 25,000 to 30,000 and is charged with providing promotive, preventive, curative and rehabilitative care. This implies offering a wide range of services such as health education, promotion of nutrition, basic sanitation, the provision of mother and child family welfare services, immunization, disease control and appropriate treatment for illness and injury.

The PHCs are hubs for 5-6 sub-centers that cover 3-4 villages and are operated by an auxiliary nurse midwife (ANM). These facilities are a part of the three tier health-care system; the PHCs act as referral centers for the
community health centers (CHCs), 30-bed hospitals and higher order public hospitals at the taluk and district levels.

The primary health center (PHC) of Mallapur village is located about 2 km from the actual settlement of the village and it consists of one doctor (male), nine paramedical staff and two non-paramedical staff. The paramedical staff includes two supervisors ladies health visitor (LHV) and male health visitor (MHV), two staff nurse (one male and one female), four ANMs, and one pharmacist (male). The non-paramedical staff is an outreach worker (female) and there is one attendants (male) for the PHC.

The doctor of PHC has an MBBS degree. One male and one female supervisor are working under this PHC. Once in a month on every last Tuesday a meeting is conducted at the PHC. Doctor, ANMs, and anganwadi teachers are resent in the meeting and they discuss the work done in the month, special cases and problems. The collected information about new cases of pregnancy (hottile eddavaru), birth (huttu), death (savu) are reviewed. The records maintained by the ANMs and anganwadi teachers are verified by the doctor and signed. One copy of these documents is kept at the PHC and another copy is submitted to the community health center by supervisor. There are two staff nurses working as assistants to the doctor. There is one pharmacist and he gives medicines to patients prescribed by doctor and maintains the records of medicines.

Mallapur PHC has five sub-centers and they are in Navalihala, Kempawad, Lokur, Shedabala, and Shedabala-station and each sub-center covers a population of 5,000. Out of five sub-centers, four have their own
The ANM’s position is vacant in Shedabala-station sub-center for the last three years. ANM of the Shedabala sub-center is catering to Shedabala-station sub-center and she visits once in a week to provide health services. The ANMs the respective sub-centers attend deliveries and maintain birth and death records of the people.

There is a female outreach worker in the PHC and she makes house to house to collect the information regarding health problems (arogya tondaregallu) of the people of Mallapur village. The attendants in the PHC hospital maintains the cleanliness.

The doctor at the PHC is 34 years of age and belongs to Lingayatharu caste. He is appointed by the government on contract basis for the past 5 years. Earlier he was living in the village itself but now he has shifted to Athani for the sake of his children’s education. He travels every day from Athani, and is in the PHC from 10 am to 5 pm.

Ten rupees is the service fee at the PHC. This is official amount to be charged. This amount is used in case of shortage and supply of medicines. The PHC has four beds and patients are admitted only during the day. They have to go home at night because no staff stays in the center after the working hours that is, 10 am to 5 pm. For providing saline Rs.50/- is charged at the PHC.

Earlier the PHC was situated in the village itself. A building was rented and it was convenient for the people to access services. Therefore deliveries were also conducted in the PHC. In 2003 a five-room building was constructed for the PHC. People as well as health providers say that when the PHC was in
the village (ooru) people accessed health services in greater percentage compared to the present situation. However this building is two kilometers away from the actual settlement. And it also faces shortage of water supply therefore deliveries are no longer conducted in the PHC. There is no transportation facility to reach the PHC and people say there is not even a single tree to sit under the shade while waiting for the doctor to come. They say ‘we cannot even get water to drink (kudiyava niru) after reaching there walking two kilometers’. Further the lower caste people say the doctor does not show much concern to them he is very attentive to rich people. The “dayees” (sulgitti) who help in delivery also ask us for money. They say you are willing to give money to the doctor then why don’t you pay us money’ (doctor esta hellatara asta rokka kodatiri namagyaka kodaka illa antiri).

So going to PHC creates uncertainty in the minds because the doctor may not be present, medicine may not be there and doctor may prescribe to buy from outside, and generally the staff members are always busy with something or the other and patients have to wait for a long period of time.

Health picture of rural areas constitutes a cause for serious and urgent concern. The high rate of population growth continues to have an adverse effect on the health of people and the quality of their lives. The mortality rates for women and children are distressingly high; almost one third of the total deaths occur among children below the age of 5 years; infant mortality is around 129 per thousand live births. Efforts at raising the nutritional levels of our people have still to bear fruit and the extent and severity of malnutrition continues to be exceptionally high. Communicable and non-communicable diseases have still to be brought under effective control and eradicated.
Blindness, Leprosy and TB continue to have a high incidence and are affecting people’s health and lives.

The details of the integrated mother and child development report April -2004 to March -2005 are given below (MMR program for rural and tribal and urban project). (This study has attempts to present the data which available during the filed work from the PHC of the Mallapur is given as below). The reported numbers of birth and deaths (2004-2005) in the village are as follows:

- live birth-5
- still birth -0
- 3-5 years -0
- 5-6 years- 0
- death of pregnant women -0
- during labour-0
- during PNC within 45 days -0
- children with diarrhoea-692
- TT pregnant women-660

Table 4.1 Name of the Health Services provided by the PHC of Mallapur and it Achievements during the Year (2000 to 2005)

<table>
<thead>
<tr>
<th>Health Services of the PHC</th>
<th>Health Services and Achievements of the PHC During the Year (2000-2006) %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2000-01</td>
</tr>
<tr>
<td>TBU</td>
<td>84</td>
</tr>
<tr>
<td>Copper-T</td>
<td>84</td>
</tr>
<tr>
<td>CC</td>
<td>45</td>
</tr>
<tr>
<td>IFA</td>
<td>82</td>
</tr>
<tr>
<td>BCG</td>
<td>98</td>
</tr>
<tr>
<td>DPT % Polio</td>
<td>96</td>
</tr>
<tr>
<td>Measles</td>
<td>95</td>
</tr>
<tr>
<td>DPT booster dose</td>
<td>75</td>
</tr>
<tr>
<td>TT for Pregnant Women</td>
<td>95</td>
</tr>
</tbody>
</table>
TBU-tubectomy (*holagi aparation*), CC- condom, IFA- iron folic acid tablets, BCG- vaccination against TB (*kshaya*), DPT-Diptheria, Partussis and Tetanus (*mangana bavu, nayee kemmu and nanju*), Measles (*gobbara*), DPT booster dose (*mangana bavu, nayee kemmu and nanju balavardaka*), TT-tetanus injection for pregnant women (*danurvayu injection*) and also for children below 16 years of the age.

The table 4.1 reveals that the progress in achievement of the health services in Mallapur. The comparison of date with 2000 to 2005, there is significant progress in the achievement of the health services. The percentage of TBU 84, Caper-T- 84, CC-45, IFA-84, BCG-98, DPT-96 meases-95, DPT booster dose -75 and TT-95 during the year 2000-01 where as it has increased in the year 2004-05 with a following percentage : TBU-19, Caper-T-15, CC-7, IFA-8, BCG-2, DPT-4, meases-3, DPT booster dose and polio-4 and TT- 2.

The table 4.1 represents that, there is gradual progress in the utilization of contraception, antenatal-care and immunization services and are provided through primary health center in the village.

Even though there is a considerable improvements in the health care services have been brought by the government these are failing to fulfill their purposes in the village. According to the public health-care providers, people of Mallapur are not utilizing public health-care services properly because of lack of literacy and excess belief on traditional system of medicine. However, some of the health-care services are utilized by the people. Caste, age group and sex are the key differentials that appear prominently in the utilization of
services by the people of Mallapur. For example; the programme of universal immunization is utilized by people of all castes, but in case of the health services such as antenatal-care and family planning there are differences in the utilization by people belonging to different castes.

In the year 1996 national health programmes viz, TB, Malaria, AIDs and immunization programme are implemented in the village.

Health programmes and services provided to people under national health programmes in the PHC of Mallapur village, are:

4.1.1) National Malaria Control Programme
4.1.2) National Tuberculosis Control Programme
4.1.3) National AIDS Control Programme
4.1.4) Universal Immunization Programme
4.1.5) Antenatal Care (check-ups and iron folic acid tablets)
4.1.6) Postnatal Care
4.1.7) National Family Planning Programme
4.1.8) Training of Birth Attendants
4.1.9) IEC (Information Education and Communication) programme.

4.1.1. National Malaria Control Programme:

Malaria, a vector-borne disease transmitted by the female Anopheles mosquito, is one of the major communicable diseases. It can be controlled by controlling breeding of mosquitoes and it is cured by appropriate medical treatment. The Health Ministry of Government of India has launched “National Malaria Control Programme” in the year 1953 to eradicate malaria. Before that
the cases of malaria per year in the country was 75 million, of which 800,000 cases resulted in deaths. The “National Malaria Control Programme” was reshaped into the “National Malaria Eradication Programme” in 1958, and by 1965, efforts made to control malaria by using DDT were successful. In 1965 there were 100,000 malaria cases in India and no death was reported. However, from the 1970s onwards, malaria has reemerged as an epidemic disease in India and has become a major public health problem. In 2000, 2.01 million malaria cases were reported and around the same number were reported in 2001 (Park 2002). Therefore, Government of India is making efforts to eradicate Malaria at grassroots level through PHC under the “National Malaria Control Programme” in the village.

Malaria is locally called as *urithandi*. *Uri* means fever and *thandi* means cold. Because of the shivers experienced by the person suffering from malaria, the symptom of *thandi* is used to qualify the nature of fever. Number of malaria cases is few in Mallapur village, however the outreach worker of the PHC takes smear from symptomatic patients during her field visit and sends it to taluk health center at Athani for clinical laboratory test. The patient who has tested positive for malaria receives treatment from PHC.

As a preventive measure, DDT is sprayed during rainy season by staff of Gram Panchayath of Mallapur in the places where the possibilities of mosquito breeding is more viz., pits (*tippi*), gutters (*gater*) and surrounding the houses (*manisuttalu*). Since it is necessary to maintain cleanliness by keeping gutter, pits and surrounding of the houses clean, gram panchayath takes
measures and also makes public announcement (*dangra saruvadu*) in the village to take precaution to prevent malaria. *Dangra saruvadu* is a traditional means of beating drums and making announcements. The drummer goes to every street beating drum to attract attention and loudly announces about the measures that are to be taken or in case a public meeting is called he tells people about the day, time and venue.

People also take precautions against malaria in their own ways, by using mosquito coil (*solle batthi*), mosquito net (*machharadani*) and create smoke of incense stick of a specific kind (*lobana*) to avoid mosquito bite.

As discussed in the previous chapter sanitation and hygiene are not prioritized as such there is scope for breeding of mosquitoes which provides scope for preventable diseases like malaria.

Most people of Mallapur are engaged in agricultural work and they do not find sufficient time to attend the public health programmes. Hence they are unaware of mode of transmission of malaria and ways to prevent it.

4.1.2. National Tuberculosis Control Programme:

According to doctor of the PHC tuberculosis (TB) is a serious bacterial disease which is infectious. It causes swelling of the lungs and other parts of the body. However it can be controlled by proper medical treatment. It is a curable disease and requires simple, inexpensive treatment with involvement of the people. The National Tuberculosis Programme (NTP) was launched in 1962 but it was not able to achieve any significant control over TB
even after several years of implementation. The reasons for failure of the NTP were: over-dependence on X-rays for diagnosis, practice of non-standard treatment, and lack of maintenance of systematic records of treatment outcomes. The NTP was ineffective due to poor program implementation and inadequate funds. The Revised National Tuberculosis Control Programme (RNTCP) was launched in 1993 wherein the use of the DOTS (Directly Observed Treatment, Short Course) strategy recommended by the World Health Organization. The DOTS uses microscopic sputum diagnosis and prescribes a standardized routine treatment. It emphasizes the use of quality drugs, direct observation of the patient and proper maintenance of records of treatment outcomes.

The RNTCP is one of the largest public health programmes and it has been successful in eradicating TB in India. Before 1993 out of ten TB patients, the success rate was three. By 2001 the curative success rate of TB has risen to eight out of ten. In India on an average, 2 million TB cases occur in a year. TB causes more deaths (421,000) annually in comparison with the deaths resulted by malaria, nutritional deficiencies, sexually transmitted diseases (STD) and hepatitis which will be around 258,000 per year (World Health Report 1999).

People call TB as ‘kshaya’. In the village, under RNTCP, treatment is given for the detected TB patients through the PHC. New TB cases are detected by collecting the sputum of symptomatic patients by the outreach worker who is locally known as sister. In a day she takes at least sputum (kafa) from two symptomatic patients who visit the PHC, especially from those who complain
of cough for more than two weeks and sends it to the taluk health center’s clinical laboratory. She also collects the sputum of other symptomatic patients on slides during her routine visits in the village. Treatment is given free of cost for TB patients and the daily intake of the drug by the patients is monitored by the outreach worker for one year. It is organized in such a manner that the patients collect the drugs once in a month on a fixed date from the PHC. If patient does not collect the drugs, home visits are made by the outreach worker to give the drugs to the patient. Before distributing the drugs, the outreach worker counsels them about the dosage.

The number of cases reported as per the record of the Mallapur PHC in the year 2005 is 5 males and 3 females.

As there is social stigma associated with TB patients to those who have the symptoms of TB hesitate to take treatment from the PHC. They are afraid about their social status in the village being affected. This happens even when the health worker gives assurance to the patients that their names will be kept confidential. The outreach worker makes efforts to motivate them to go for diagnosis and to take treatment for TB.

Patients ignore the counseling and often refuse treatment as they believe that it is caused due to bad habits of a person like consuming tobacco products.

It is also believed that TB is caused due to bad fate (karma). If a person has offended somebody physically or mentally in their previous life, it results in bad fate. And as a result of this bad fate, the person suffers from TB in his present life.
The notions and beliefs regarding the etiology of the disease is crucial in this case. Because what people believe affects how they behave. With regard to TB which is a life threatening disease yet curable disease, the beliefs put the people’s life to threat. Because a person feels that he is suffering from TB owing to his bad fate (*karma*), he becomes resigned to take appropriate action. That is he does not take medicines as required, he is not consistent in taking medicines for prolonged period as required in case of curing TB. The person takes treatment for the immediate cure and as soon as he feels a little better he discontinues the treatment.

Further since the disease is associated with stigma, there is great of hesitation to even seek treatment. As long as the problem is just ‘cough’ the problem is not threatening. But as soon as it labeled as TB, people feel threatened and fear social stigma. Because, the stigma affects a person’s social relationships in the village. He fears that people will avoid him and they will keep him away from the social network. Further, it will be difficult to marry off their children if a family member is suffering from TB.

As a result of all these beliefs, children are also at times not vaccinated for prevention of TB. People feel that when the reasons for TB are bad habits and *karma*, how can a vaccination prevent something which happen when the child grows up. People also often fail to understand the need to take treatment for a prolonged period of time.

4.1.3. National HIV/AIDS Control Programme:

Acquired Immune Deficiency Syndrome (AIDS) is an illness which attacks the body’s ability to resist infection and usually results in death. HIV is
a virus, which acts slowly on the host body over a period of time and people with HIV can survive for many years in good health before they develop full-blown AIDS; in the meantime, they can spread this disease to many people. HIV converts genetic material RNA to DNA when it enters into a host's cell where it multiplies very rapidly. Unsafe sex is the main channel of transmission of HIV/AIDS. According to the National AIDS Control Organization, there are 4 million people, or 3.8 persons per 1000 living with HIV/AIDS in India (Kadiyala and Barnett, 2004). In this direction National AIDS Control Programme was launched in 1987 by the Ministry of Health and Family Welfare.

The symptomatic patients are sent to Taluk Health Center or the nearest voluntary testing center (VCTC) for testing and counseling. As there is social stigma attached to HIV/AIDS, names of the patients will be kept confidential. The patient irrespective of whether he is HIV positive or negative, receive counseling for behavioral change. For the cases where in Anti Retroviral Therapy is required, the patient is sent to the nearest center or follows the directions of the counselor at the VCTC.

Since the problem of HIV/AIDS has negative connotations associated when compared to other communicable diseases, people do not go to PHC for treatment. There is a great deal of social stigma associated with HIV/AIDS and this prevents people from taking appropriate steps. There are also various misconceptions associated with HIV/AIDS such as taking alternative treatments from indigenous healers can cure the disease. People also feel that
eating and sharing things with a person who is positive spreads the disease. Children are also discriminated against in the schools in case the community comes to know that a person in the family is suffering from HIV/AIDS. As such there are various fears and misconceptions associated with HIV/AIDS.

The beliefs are strong and deep-rooted and therefore bringing about behavioral change is extremely challenging. However people have gained awareness to certain extent. They demand disposable syringes when they go to a doctor. And people do not hesitate to two rupees for new syringe when they immunize their children, since there is shortage of supply in the PHC.

Public health programmes are conducted by PHC and in these programmes efforts are made to create awareness and increase the level of knowledge of people about the modes of transmission of HIV/AIDS viz., use of infected syringe or needles, unsafe-blood transmission, unsafe sex and transmission of HIV/AIDS from infected mother to child. The PHC also gives awareness about preventive measures against HIV/AIDS viz., using of condoms for safe sex, safe blood transmission, proper use of syringes/needles, and prevention of transmission from mother to child.

PHC supplies condoms for controlling HIV/AIDS. People can obtain condoms from a box which is fixed on the front wall of the entrance room of the PHC. There are also posters pasted on the walls (gode) to create awareness about HIV/AIDS. On the World HIV/AIDS day (1st December) the school children organize a rally to create awareness through messages to people in the village regarding HIV/AIDS.
4.1.4. Universal Immunization Programme:

The Universal Immunization Programme in India aims to reduce infant and child mortality due to six vaccine-preventable diseases by immunizing all children less than one year old. The Health Ministry of Government of India launched Universal Immunization Programme (UIP) in the year 1985. Its two vital components are:

4.1.4.1. Immunization of children in their first year of life against six deadly diseases under “Expanded Programme on Immunization” (EIP) and dose are most common and preventable childhood diseases viz, Tuberculosis, Diptheria, Partussis Tetanus, Measles and Polio, and

4.1.4.2. Immunization of pregnant women against tetanus.

4.1.4.1 Immunization of Children:

The basic and compulsory immunization to be given to the children within the first year of life is provided by the PHC at Mallapur. Along with this, the vaccinations to be given to the children who are below 14 years of age are also provided. The vaccinations are not only given in the PHC, but also at the anganwadi and the government school. Table 4.2 represents about the immunization for children.
### Table 4.2: Immunization for Children

<table>
<thead>
<tr>
<th>Place of vaccination</th>
<th>Period / age</th>
<th>Injection</th>
<th>Drops</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Health Center</strong></td>
<td>Soon after birth or at 6 weeks</td>
<td>B.C.G</td>
<td>‘0’ Polio</td>
</tr>
<tr>
<td>&quot;</td>
<td>1 ½ months</td>
<td>D.P.T I</td>
<td>Polio I</td>
</tr>
<tr>
<td>&quot;</td>
<td>2 ½ months</td>
<td>D.P.T II</td>
<td>Polio II</td>
</tr>
<tr>
<td>&quot;</td>
<td>3 ½ months</td>
<td>D.P.T III</td>
<td>Polio III</td>
</tr>
<tr>
<td>&quot;</td>
<td>9 months</td>
<td>Measles</td>
<td>Vitamin ‘A’ I</td>
</tr>
<tr>
<td>&quot;</td>
<td>Within 16 to 24 months</td>
<td>D.P.T Booster</td>
<td>Vitamin ‘A’ II and III</td>
</tr>
<tr>
<td><strong>Anganwadi</strong></td>
<td>All children below 5 years of age</td>
<td>---</td>
<td>Pulse Polio</td>
</tr>
<tr>
<td><strong>Primary school and high school</strong></td>
<td>Above 6 years to below 14 years age</td>
<td>T.T</td>
<td>--</td>
</tr>
</tbody>
</table>

Various vaccinations have to be given to the children under the age of 14 years to prevent different preventable diseases. B.C.G injection is given against tuberculosis (*kshaya*), D.P.T - Diptheria (*nayee kemmu*), Partussis (*mangana bavu*) and Tetanus (*nanju*), and measles immunization for protection against measles (*gobbara*) and polio drops for prevention of polio (*polio*). Along with vaccinations, Vitamin ‘A’ drops are given to prevent blindness among children.

The vaccination programme is locally referred to as *polio-dose* as the people are generally unaware of other diseases except polio. Since majority of the village do not have idea about the names of the vaccines they call all
vaccines as *polio-dose*. Vaccination is given on every Tuesday at PHC of Mallapur. The teacher and helper of *anganwadi* remind the parents of the children to bring their children for vaccinations. Two rupees are collected from parents of each child for new syringe. Since there is no regular supply of needles (*sujee*) to the PHC, she collects money from them to use disposable needles. On every Tuesday, ANM or LHV gives vaccinations to the children under the age of 5 years. People bring their children to PHC for vaccination. Some people say it is difficult to go to PHC since it is 2 kilometres away from the actual settlement of the village. However majority of the people say that compared to earlier days, it is very convenient to take their children for vaccination because earlier they had to go to Ugar PHC, which is 8 km away from the village.

Vaccination cards are issued through PHC to each child during the first visit. Parents of the children are supposed to bring the vaccination card at the time of every vaccination to know which vaccine has already been given to their children. For the people polio is one of the new diseases as compared to other diseases like Diptheria, Partussis, Tetanus and Measles.

Table 4.3 Summarizes the different vaccinations received by the children of 0 to 14 year of age among different castes.
Table-4.3: Number of children (0 to 14 years) who have received immunization by castes

<table>
<thead>
<tr>
<th>Sl No</th>
<th>Castes</th>
<th>Hindu</th>
<th>Jain</th>
<th>Muslim</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No. of children</td>
<td>BCG &amp; polio-0</td>
<td>DPT-I &amp; polio-I</td>
</tr>
<tr>
<td>I</td>
<td></td>
<td>SI No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Brahmanaru</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>Hoogara/ Gurav</td>
<td>20</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>3</td>
<td>Vishwakarma</td>
<td>271</td>
<td>265</td>
<td>253</td>
</tr>
<tr>
<td>4</td>
<td>Lingayatharu</td>
<td>176</td>
<td>169</td>
<td>152</td>
</tr>
<tr>
<td>5</td>
<td>Maratharu</td>
<td>47</td>
<td>45</td>
<td>40</td>
</tr>
<tr>
<td>6</td>
<td>Kurubar/Dhanagar</td>
<td>71</td>
<td>64</td>
<td>54</td>
</tr>
<tr>
<td>7</td>
<td>Waddaru</td>
<td>25</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>8</td>
<td>Byadaru/Nayakaru</td>
<td>26</td>
<td>24</td>
<td>21</td>
</tr>
<tr>
<td>9</td>
<td>Bajantri/Korvi</td>
<td>39</td>
<td>35</td>
<td>31</td>
</tr>
<tr>
<td>10</td>
<td>Madarur</td>
<td>94</td>
<td>86</td>
<td>73</td>
</tr>
<tr>
<td>11</td>
<td>Samagaru</td>
<td>54</td>
<td>53</td>
<td>51</td>
</tr>
<tr>
<td>12</td>
<td>Holiyaru</td>
<td>147</td>
<td>140</td>
<td>135</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>980</td>
<td>931</td>
<td>855</td>
</tr>
<tr>
<td>II</td>
<td></td>
<td>SI No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Jainaru</td>
<td>41</td>
<td>41</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Total</td>
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</tr>
<tr>
<td>III</td>
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<td></td>
<td></td>
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<tr>
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<td>Musliyaru</td>
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<tr>
<td></td>
<td>Total</td>
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<td>58</td>
<td>52</td>
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<tr>
<td></td>
<td>Grand total</td>
<td>1082</td>
<td>1030</td>
<td>946</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>95.2</td>
<td>87.4</td>
<td>84.5</td>
</tr>
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</table>
Table 4.3 show that, the total number of children (0-14 years) in the village is 1082, out of which 1030 (95.2%) have received B.C.G. vaccination. Out of the total number of the children, 946 (87.4%), 914 (84.5%) and 878 (81.1%) have received DPT I and polio I, DPT II and polio II, and DPT III and polio III vaccinations respectively. 799 (73.8%) children have received measles vaccination and vitamin ‘A’ I drops, 635 (58.7%) have received DPT booster dose and vitamin ‘A’ II drops and 533 (49.3%) have received DT booster dose and vitamin ‘A’ III drops.

Immunization for B.C.G, DPT I - III along with polio drops and measles are not generally missed. However in case of DPT booster dose and DT booster dose along with vitamin ‘A’II and ‘ A’ III which are given the children of 12 and 15 months, upper castes children get immunized and in case of lower castes and lower economic strata they are likely to be missed. Because the first set of immunization is generally in a continuous series, one after the other every month. However, the booster dose and other immunizations are given after a gap of months and as such those who are not aware do not immunize their children. Generally, they are the daily-wage workers. In case of the first batch of vaccination, the *anganwadi* teacher makes house visits and reminds the people. But for the second batch the parents are told to bring the children after they complete one year of age. Therefore, parents tend to get busy with their work and forget.

The table reveals that the people belonging to Brahmanaru, Vishwakama, Maratharu, Lingayatharu, Hoogaru, Jainaru and Muslyaru
castes have given attention to all the vaccinations compared to people belonging to Kurubaru, Waddaru, Bajantri, Madaru, Samagaru and Holiyaru castes who have immunized their children for BCG, DPT I - III and measles. Among these castes there is a higher level of illiteracy and as such they are not aware of seriousness of the diseases and the need for immunization.

Anand is a 9 month old baby. He belongs to Brahmanaru caste. His parents are both educated. He has been immunized as per the schedule. His parents wanted him to be immunized for the opt vaccines also therefore, they went to Miraj to a child specialist and immunized the child for vaccines like hepatitis B.

People believe that a child suffers from measles as a result of wrath of deity (devara kopa). And for curing measles it is believed that one should pacify the deity with appropriate offerings and observances. Therefore people find it difficult to associate vaccination and prevention of measles. They feel that wrongs done are bound to result in the wrath of deity and therefore children will be affected. Since, they believe that tuberculosis occurs due to bad habits like chewing tobacco (tambaka tinnuvadu) and drinking alcohol (dharukudiyuvadu) which are not related to children, they do not feel any necessity for immunization. People recognize symptoms of Diptheria and pertussis as cold and cough (kemmu-negadi) along with fever (uri). These are felt to be common diseases during the rainy and winter seasons. The villagers believe that tetanus occur only when a person gets injured. Therefore most people believe that all these vaccinations are given only to prevent polio.
Subsequently all the childhood diseases have been controlled except polio. In order to prevent and eradicate polio, government of India has undertaken further steps and has started pulse polio programme for 0 to 5 years children twice in a year. The first round of pulse polio is organized in the month of December and second round in the month of January. The campaign center is the anganwadi. Because, during these months there is more possibilities of spread of polio virus. If a child is affected then it spreads from one to another. The only way therefore to prevent this disease is through proper immunization of children. People bring their children for pulse polio on the scheduled days. On next day after the pulse polio programme, health worker and the anganwadi worker go to door-steps (manibagilige) of all houses to find out if any children have not been given polio drops. The purpose of this visit is not to miss even a single child out of this programme.

As compared to illiterates, the people who are literates are more aware of immunization and they also know the names as well as the purpose of each vaccination. The people who are illiterate believe that, children will be affected by polio, if they vaccinate their children. Therefore, they do not want to take any risk regarding vaccination of their children and avoid vaccinating their children.

A ten year old boy from Kurubar caste is affected by polio. His parents are both uneducated and daily wage laborers. They blame the ANM and the vaccination program for their child becoming a handicap (angavikala). They say that their child had fever even then the ANM gave polio injection to the
child and he became affected. The child was continuously suffering from fever and they took the child to the ANM she said the child was suffering from fever but it was not due to the vaccination. Then when the child became inactive, they took him to a private doctor in the neighboring village. The doctor said he was affected by polio. He said the child should not have been given injection when he was suffering from fever.

According to medical officer and the health worker, if the children have fever during the vaccination, there might be chances of any mishap. During fever nerve cells will not be active and due to which children become susceptible to reactions. If children are suffering from fever, the health worker should not give any vaccine. People of Mallapur pay more attention to children who are below five months of age and provide vaccinations to them. They say they do so because it is not possible to understand problems of infants just by looking at them and hence people think that there is a need to give vaccinations during this period. After the children become more than five months old, people do not pay much attention about the vaccinations.

Therefore vaccinations for measles and booster dose, are often missed. They think that their children are healthy on the basis of their physical appearance and do not feel the need for any vaccinations. So the people of Mallapur are more concerned about the children who are below five months of age. There is a lack of understanding about the preventive aspect of vaccinations, that missing of vaccines may cause various diseases to their children in the later age of their life.
It has been documented by NFHS (1999), and various research studies conducted that partial immunization is commonly found in rural and tribal areas. The significance of completion of all the mentioned vaccines is often lost to the people. Studies chart out different variables which influence partial or incomplete immunization. The factors which most frequently identified are education, place of residence (rural/tribal/urban/slum), caste and socio-economic status.

4.1.4.2 Immunization of Pregnant Women:

The immunization of pregnant women is a part of the services provided for the antenatal care. Antenatal care provides an opportunity for a variety of preventive interventions during pregnancy, including Tetanus Toxoid injections, educating women about nutrition, safe delivery and postpartum care (Govindasamy 1993). Once in a month anganwadi teacher registers the names of pregnant women in the village. Soon after that the pregnant woman is sent to the PHC for antenatal check-ups.

As a part of antenatal care package, TT injections are given to the pregnant woman, to protect her from tetanus, which is a bacterial disease. The pregnant woman receives two TT injections at PHC during the course of her pregnancy. The purpose of TT injection is to prevent women from injuries during the cutting of umbilical cord after the delivery. The pregnant woman receives the first TT injection during the 3rd month of her pregnancy, when she visits the doctor regarding the confirmation of her pregnancy. Generally the second TT injection is given to the pregnant woman after a month’s interval from the first TT injection.
Women generally take both injections and only in some cases the second injection is missed. The first injection is given when the woman visits for the first time so she gets the first dose. However since the pregnant women do not complete all the required visits, the second injection may be missed. Those who go to private doctors, get both without fail.

The PHC records (2005) show that the number of women who have received TT immunization from the PHC are 660.

According to WHO the women belonging to 15 to 49 years age group have been considered as reproductive age group. Keeping the WHO framework in the present study, information has been collected from the women belonging to this group. Reproductive age group means the woman of this age group is physically able to carry pregnancy and give birth to the child. Legally the marriage age for girl is 18 years, however generally people of Mallapur marry a girl at the age of 15 years. Therefore information is given about women who have had at least one pregnancy. The women can be classified into three generations as per the reproductive age group.

For analysis of the utilization of services, age group classification has been done in terms of considering women as belonging to three groups that is 15 to 25, 26 to 35 and 35 to 45 and above. For those who are now 45 and above the question of utilization of services is not significant because the programs and services were not in operation. Further the analysis also shows that the utilization of services has increased over a period of time because of increase in awareness as well as exposure to services.
Out of the interviewed women who have had at least one pregnancy, 524 women have received at least one TT during their pregnancy and remaining 363 women have not received TT during pregnancy.

Table shows the number of TT immunization by age group.

98 women have received TT and 29 have not received TT under 15-25 years of the age group. There are 215 women have received TT and 71 have not received in the age group 26-35 years, whereas 97 women have received and 86 have not received TT in the age group of more than 36-45 years.

4. 1. 5. Antenatal Care:

Under the programme of Child Survival and Safe Motherhood, antenatal care services were started in the year 1992 for giving priority care for pregnant women. The primary aim of antenatal care services is ‘healthy mother and a healthy baby’. Antenatal care is provided to each pregnant woman either from the doctor or ANM of the PHC. It starts soon after the confirmation of pregnancy and continues throughout pregnancy. Basically antenatal care aims to promote, protect and maintain the health of the mother during pregnancy, and also to detect high risk cases. Special attention is paid to pregnant woman to remove anxiety associated with delivery, to reduce maternal mortality, infant mortality and morbidity.

The pregnant woman has to visit the PHC for three compulsory visits during her pregnancy for antenatal care. The pregnant woman’s first visit to the PHC is during the 3rd month of pregnancy and during this visit doctor does a
thorough physical examination and prescribes certain laboratory tests. The physical examination includes recording weight and blood pressure of the pregnant woman and, laboratory examination includes blood and urine test for knowing the blood sugar level and also for confirmation of pregnancy. The second and third visits to PHC are in the 5th and 6th month of pregnancy. During the second and third visit of pregnant women, TT injection and iron and folic acid tablets are given by the ANM. The health worker provides awareness to pregnant woman about antenatal care, intake of nutritious food and also about maintenance of personal hygiene.

Pregnant women are advised to take nutritious food which includes milk, fruits, green vegetables and meat and fish in case the woman is non vegetarian in food practice. They are advised to take sufficient rest and avoid strenuous work.

Antenatal Identity Card will be issued by the PHC to the pregnant woman during her first visit and she should produce this card during her next visits, so that health worker is able to look into the previous history. All the records of the pregnant women’s visits will be maintained in a PHC of Mallapur as well as CHC at Athani.

The women who are pregnant before attaining 18 years of age and those who are above the age of 35 years are considered as high risk cases and their list will be sent to PHC by the anganwadi teacher. Special attention is paid to the identified high risk cases of pregnant women in order to improve their health and to prevent chances of mortality, morbidity and stillbirth.
Identification of anemia among pregnant women is also done by *anganwadi* teacher by observing the symptoms. Double the amount of IFA tablets and nutritious food are provided to severely anemic women.

### 4.1.5.1 Supply of Iron Folic Acid Tablets:

The supply of Iron folic acid tablets to pregnant women is an important part of the services of the antenatal care. The health department is providing IFA tablets to pregnant women to prevent anemia. The deficiency of iron component in the blood of a person leads to anemia, which is generally found among pregnant women. The early detection of anemia among pregnant women provides a chance to avoid various complications viz, abortion, low birth weight of the baby and maternal mortality.

The health worker provides 90 IFA tablets to each pregnant woman between 5<sup>th</sup> to 8<sup>th</sup> months of pregnancy. People believe that intake of tablets before 5<sup>th</sup> month may lead to abortion and that if pregnant women take tablets after 8<sup>th</sup> month the fetus might grow large in size and it may lead to complications in delivery. Hence they do not take any kind of tablets during this period in order to avoid complications during pregnancy and delivery. A woman needs more energy during pregnancy to take care of herself and her fetus and she should have to take more additional nutritious foods viz., milk, (*halu*), vegetables (*kayepalye*) green leaves (*tappala palle*) germinated seeds (*mallaki kallu*) and fruits (*hannu*). If she do not take additional care during her pregnancy, she may become physically weak and it may lead to complication during delivery either for her or for her new born baby.
The pregnant women belonging to lower and middle economic condition in the village are not able to take any kind of nutritious food stuff which are expensive. Generally they prefer to eat bread of jowar (rotti), bread of wheat (chapati), cooked rice (anna), and vegetables (kayeepalye) which are not very expensive. Hence according to the health personnel, the pregnant women belonging to lower and middle economic condition suffer from anemia during pregnancy to a greater extent as compared to the pregnant women belong to higher economic condition.

The government has taken into consideration the economic condition of the pregnant women and has started to provide IFA tablets free of cost to the people who are not able to take nutritious food during pregnancy. But the pregnant women avoid intake of IFA tablets which have been supplied through PHC because the people have their own notions about IFA tablets. People believe that intake of IFA tablets creates excess heat in the body of the pregnant women and as a result they suffer from indigestion, loose motion and vomiting sensation.

According to doctors iron folic acid tablets do tend to cause stomach ailments for a few days, until the body gets adjusted. But the women generally do not give a chance and discontinue consumption of tablets. And also more importantly, they believe that the fetus grows bigger in size, which leads to complications during the delivery. The women associate the tablets with strength (shakti) and they feel this strength makes the baby grow bigger in size. As a result of the bigger size of fetus, they feel normal delivery will not occur. And if there are complications, they feel that the pregnant women will have to
go to hospital for delivery. Going to hospital delivery means more expenses which they can ill-afford. The color of the tablets is red and they have a pungent smell and the women say they do not like both these things.

Further, when women are living in joint families, mother in law and other elderly women in the family say, there is no need to consume such things and they say they cause only problems. They say they did not consume such things and they delivered so many children without any problems.

The health workers of the PHC persist in providing knowledge to the pregnant women about importance of IFA tablets, which prevent anemia during pregnancy. However, the pregnant women do not show interest and are not concerned about the consumption of IFA tablets.

Those few women who visit private hospitals for regular checkup take the tablets which are prescribed by private doctors. The people believe that the medicines prescribed by the private doctor are good rather than the medicines provided through the PHC, even though both the medicines are same.

The medical and paramedical staff say that, the women in the region are generally suffering from deficiency of iron and are facing various problems like miscarriage, low birth-weight of the baby, premature birth and still birth. All these problems are associated with deficiency of iron.

Refusal to take iron folic acid tablets or partial consumption of tablets is more or less common in Indian villages. Various studies viz., Hutter (1998) and NFHS (1999) show that the concepts regarding the effects of iron folic acid tablets are similar. Most often the beliefs are pertaining to the size of the baby
or fears about miscarriage. Both these beliefs signify the importance associated with fertility and notions regarding modern allopathic medicines. Notions regarding heat creating effect of allopathic medicines often play significant role in consumption of medication in general and iron folic acid tablets in particular.

Most of the women in Mallapur village are working as laborers and they come under below poverty-line-category. Therefore, they cannot afford money for antenatal care, postnatal care and neonatal care. The antenatal care, postnatal care and neonatal care provided through public health programmes become extremely relevant. Due to the deficiency of nutrients in pregnant women, several health problems such as low-birth-weight, morbidity, mortality, miscarriage and still-births are occurring. Therefore, to combat this problem, nutritious food is being provided once in a month, to the pregnant women who come under below poverty line category, through *anganwadi* to enable them to cater to their dietary requirements. However, because of the lower level of education and low awareness and prevailing belief systems women do not utilize the services provided to them appropriately.

When it comes to delivery, institutional delivery reduces the risk of maternal and child mortality. As regards to the place of delivery, over 60 per cent of the deliveries were at home in both Andhra Pradesh and Karnataka. The percentage was only 36 in Tamil Nadu. About three quarters of the deliveries were assisted by medical personnel (doctor, nurse or midwife, ANM/LHV, trained birth attendants) in Tamil Nadu, but in Karnataka and Andhra Pradesh
the proportion was only one-half. The order of birth was found to be an important predictor of receiving antenatal care in Andhra Pradesh but not in Karnataka. If the order of birth was 4 and above, the probability of a woman receiving antenatal care was reduced by 60 percent compared to births of second order. There was no difference in the likelihood of obtaining antenatal care between first and second order births. Having had a still birth did not affect women’s likelihood of receiving antenatal care in both Andhra Pradesh and Karnataka.

The PHC data (2005) reveals that 380 institutional deliveries have been conducted. This data includes only the deliveries conducted by the PHC personnel.

Majority of women in Mallapur give preference to non-institutional deliveries (1648) and the number of institutional deliveries is 663 in the village. Majority of the people belong to below poverty line category and give preference to non-institutional deliveries. People say that if they go to hospital for delivery it costs more money compared to home-delivery. Therefore they give preference to home deliveries.

As the place of delivery is an important determinant for reducing the risk of infant and maternal deaths, so is assistance at the time of delivery. Assistance during delivery is also an important component in the reproductive health-care services because it can reduce the risk of obstructed labor during delivery. Assistance during delivery is highly associated with place of delivery; who has assisted during delivery, health personnel viz, doctor, Auxiliary Nurse
Midwife (ANM), midwife, trained or traditional birth-attendant and non-health personnel viz., untrained traditional birth attendants, friends or relatives. This is an important factor.

Prema is a 17 year old girl who has studied till 5th standard. She belongs to Holiyaru caste. She lives in nuclear family and belongs to low economic condition. Her husband lives in the nearby village Ugar and when she became pregnant she took the ANC services at the Ugar PHC. Since the PHC did not have scanning facilities, she went to a private doctor for scanning. Everything was normal and she came to her natal place for delivery since this was her first pregnancy.

There she visited the PHC and said that she would like to deliver in the hospital. The doctor said there was shortage of water and the deliveries were not being conducted in the PHC, so he would ask one of the trained dayee's to assist the delivery. She met the dayee near her house twice, and the dayee said she should be informed as soon as the pains begin. Her delivery date came nearer and she started getting pains. The pains began at regular intervals and her mother called a neighbor to stay with her and sent for the dayee.

The dayee came and saw that there was bleeding. She tried to deliver for half an hour and then said that the case had to be taken to the doctor. One of the neighbor’s had a motor-bike and she was taken to the doctor. They went to the private doctor in the village. He looked into the case and said either the mother or the baby could be saved since there was great deal of blood loss. It was decided that the priority should be given for mother’s life. Though Prema’s life
could be saved, the baby died. The doctor said that had they come early, both could have been saved.

In Mallapur village 1135 deliveries have been attended by trained personnel and 1446 deliveries have been attended by untrained persons.

4.1.6. Postnatal Care:

The care of the mother after delivery is called postnatal care. The purpose of the postnatal care is to reduce morbidity and to promote breastfeeding and family planning. The puerperal women receive postnatal care from ANM, LHV and *anganwadi* teachers. They provide knowledge and awareness to puerperal women about taking care of herself and her new born baby and also regarding nutritious food, family planning and vaccination of children.

Nutritious food is provided to puerperal women who are below poverty line through the *anganwadi*. The list of puerperal women will be sent to PHC by *anganwadi* teacher. The people of Mallapur are not satisfied with the postnatal care services of the PHC because the ANM does not visit the village regularly.

Postnatal care services as provided by the public health care system are often felt as unnecessary by the people. They feel that the necessary care that is required to the parturient woman is given by the family as per the traditional beliefs and practices. They are considered to be more important than any other services like IEC regarding post-partum care. Even though there are differences between different castes regarding post partum care, they are not significant. However it is generally felt that post partum care is crucial for the first
delivery. For the subsequent deliveries it varies depending on the economic status of the woman’s family. People feel that as the woman gives birth to children, her body becomes accustomed to the process and not much care is required. The basic care for at least fifteen days to forty five days is given irrespective of the caste and economic status.

4.1.7. National Family Planning Programme:

The United Nations conference on Human rights at Teheran in 1968 recognized family planning as a basic human right. Family planning is the only way to limit the size of the family, to control the spacing between births and to improve the health of the mother.

There are several definitions about family planning. A comprehensive definition is given by WHO. An expert Committee (1971) of the WHO defined family planning as “a way of thinking and living that is adopted voluntarily, upon the basis of the knowledge, attitudes and responsible decisions by individual and couples, in order to promote the health and welfare of the family group and thus contribute effectively to the social development of a country” (Park 2002:335).

Government of India lunched the family planning programme in the year 1970. There are mainly two types of methods of family planning and they are:

4.1.7.1 Permanent method of family planning

4.1.7.2 Temporary method of family planning
Permanent Method of Family Planning:

There are two types of permanent method of family planning for women and one for men; tubectomy and laparoscopy for women and vasectomy for men.

Temporary Method of Family Planning:

Intra Uterine Device (IUD) and pills are the temporary methods for women and condoms for men.

The women of Mallapur village prefer permanent method of family planning to temporary methods. The majority of the women have undergone tubectomy which is locally called holagi operation. Usually women take rest for 3 months after tubectomy. Some women have undergone laparoscopic operation which is locally called current operation. The people of Mallapur village give priority for these two methods of family planning depending on the economic condition of the family. Usually the people who are economically well off give preference to tubectomy and the people who are economically poor give preference to laparoscopy. According to the people, tubectomy is safer compared to laparoscopy because people believe that laparoscopic method of family planning causes weakness in the body and also there are possibilities of failure of the laparoscopic method.

Gangu is 32 years old she belongs to Maratharu caste. She underwent laparoscopy after four children. However, after two to three years, she again conceived. Therefore, she had not only to give birth but also to undergo operation again. This time around, she opted for tubectomy (holagi operation).
People who are not economically well-off go in for laparoscopic method of family planning. They say that tubectomy method requires longer duration of time for recuperating and also is more expensive in terms of nutritious food required during the recuperating period. Usually, people who are not economically well-off are dependent on labor work, which is on daily wages as their source of income. Since one has to take rest for minimum of 3 months it is not possible for them to afford to stay away from work for such a long period of time.

Majority of the people belonging to higher economic condition go in for tubectomy method of family planning. Some of the women who are educated and are working in various services go in for laparoscopy since they do not find enough time to take rest after the operation.

People of Mallapur village have given preference for permanent method of family planning, particularly people give priority to tubectomy as a method of family planning compared to laparoscopy method of family planning.

**Vasectomy:**

Vasectomy is the permanent method of family planning for men in which, at least 1 cm vas-tube of men is removed after clamping. It is locally called *gandasara operation*.

The people of Mallapur village do not like to go in for vasectomy because they have fears about this method of family planning. They believe that if a person undergoes vasectomy, he loses his energy and as a result he will become physically weak and he will not be able to do hard or heavy work.
Most of the families in Mallapur are dependent on the income of the men who are the head of the households and most of them are working on agriculture land which requires hard physical labor. Therefore, they fear that if men undergo vasectomy they will not be able to do hard physical labor on the agriculture land. As such, it is always the women who undergo operation that is, either tubectomy or laparoscopy.

According to the people, if something happens to a woman, it is not a big issue because men work and earn money to take care of the family. Whereas the men are the main providers for the family. In case if something goes wrong after vasectomy, it is very difficult to take care of the family only on earnings of women because the wages of women are less compared to men.

Permanent method of family planning for men is also not socially accepted because the people of Mallapur believe that matters of family planning are related to women and not men. If a man undergoes vasectomy, he should rest for a few days. Sitting in the house without doing any work creates bad impression about a man and as a result people gossip about him. However there are no social restrictions for women to undergo permanent method of family planning. it is in fact accepted as well as expected that the woman should undergo family planning operation or use contraceptive as is the required case.

4.1.7.2 Temporary Method of Family Planning:

There are two types of temporary contraceptive methods for women and one for men; they are as follows:

- Intra Uterine Device (IUD) and Pill for women and
- Condom for men
**Intra Uterine Device (IUD):**

Intra Uterine Device Copper-T is locally called *vanki*. Few women use IUD for birth control and spacing between children in the village. Generally women (45) who are educated have adopted Copper-T and very few women (7) who are not educated have adopted the same to avoid pregnancy.

People have various notions regarding copper-T. That is, if Copper-T is used, it is not possible to conceive again and also that the woman loses strength. They believe that if Copper-T remains in the body for long it goes inside the uterus and it causes pain in the abdominal region and operation is required to take it out. Women also cite examples where even though the women had Copper-T inserted, they become pregnant. A similar thing happened as illustrated by this case study.

A woman of 35 years old, belonging to *Holiyaru* caste had IUD inserted to prevent pregnancy. She had 5 children, 1 male and 4 females. She wanted to undergo permanent method of family planning but her husband did not agree and did not allow her to undergo operation as he wanted one more male child. However, the woman decided on her own to prevent further chances of conception and had IUD inserted without the knowledge of her husband. However because of the failure of IUD, she became pregnant.

**Contraceptive Pills:**

Contraceptive Pill is a tablet which is used to prevent pregnancy. The ANMs supply the pills to women who want to use them to avoid pregnancy.
Very few women (25) use contraceptive pills. Particularly women who are educated use tablets as contraceptive method. Majority of the women discontinue intake of pills because they believe that taking any kind of allopathic medicine for long increases heat in the body which in turn causes mouth ulcers and also there are also chances of miscarriage when the woman wants to conceive later on. Majority of women say that taking pill to avoid pregnancy is not convenient as they are busy with their household work and often forget to take tablets regularly and as a result there are chances of conceiving.

**Condom:**

The PHC of Mallapur has a condom outlet. The objective of promoting condom use by PHC is not just contraception but also prevention of HIV/AIDS. Even though, the health worker gives awareness to men about proper use of condoms, very few men use condoms.

The records of the PHC (2005) reveal the following statistical data with regard to type of family planning in Mallapur.

- Vasectomy - 0
- Tubectomy-298
- Lapraroscopy-20
- Intra Uterine Device-294
- Condom -195 and
- Oral pills-193.
4.1.8. Training of Birth Attendants:

Under the ICDS programme, the government of India has started training of birth attendantss to reduce stillbirths, neonatal mortality and maternal mortality. In the village training is given to those, who are interested in serving as birth attendantss voluntarily. The purpose of this training is conducting safe deliveries surakshith herige, maintaining hygiene during cutting of umbilical cord hokkala huri and reducing mortality and morbidity rate among rural pregnant women. As a part of this training, a delivery kit will be given to birth attendantss. The kit contains gloves, plastic sheet, blades, clothes, stethoscope and thread and Rs.150 per day will be given to birth-attendants as stipend during the training period.

The purpose of training the existing midwives is that they are socially accepted as a part of the system and are already practicing. If their practices are improved people do not resist. But if a new person is introduced people will not accept her easily. As per the PHC records, 61 dayee’s have been trained so far.

There are a total of 11 birth-attendant (sulagitti/dayee) in the village, out of which 10 are trained and one is traditional birth attendant. The traditional birth-attendant has not undergone any training. She has been conducting deliveries for the last 45 years and she considers herself an expert, and even better than doctors in conducting deliveries. She says that she attends to deliveries to help people and not for the sake of making money.

The trained attendants get monthly payment through PHC depending on the number of deliveries conducted by them and as such Rs.25 will be paid for
each delivery. People of Mallapur who are below poverty line do not call birth attendants to conduct the deliveries because birth attendants ask for money (Rs.250) to conduct delivery.

The trained dayees say though they received training, there is no profit in working as a dayee because the government does not pay for the work they do and people also refuse to pay. Most of the dayees are daily wage workers and they do not want to work for free. They say that the government may pay for the services. They were selected on the basis of their experience of assisting older traditional dayees. The anganwadi workers asked for those however interested to participate in the training and they underwent training. They say the payment made by the government for each delivery is less.

Lower caste and lower economic category people say health personnel ask them to come to the hospital for delivery or take the assistance of trained dayee but both are not feasible. There is no one in hospital after five o’clock and the dayee charge so much which we cannot afford. Therefore, deliveries are often assisted by the kith and kin of the woman. The second priority is given to doctor and third to trained dayee.

Anganwadi:

Anganwadi’s were started in the year 1982 and a teacher and an assistant dayee were the part of the anganwadi’s. These workers are selected from community itself, as they understand the needs and the notions of their community. Under the ICDS (Integrated Child Development Service), several national health programmes and services have been provided at grassroots level
by government of India. The *anganwadi* acts as an informal educational institution for children under six and comes under ICDS. The provision of supplying supplementary food for children and pregnant women is one of the important aspects of the *anganwadi*.

Every 1,000 population has one *anganwadi* and there are 8 *anganwadi's* which are engaged in giving informal education to children (below 6 years of the age) in the village. Basically supplying of nutritious food for children, maintaining the records about morbidity, mortality, and collecting family details are part of the main services of the *anganwadi*. The *anganwadi* teacher and assistant visit all the houses in the village once in a month for collecting particulars of the individuals and they weigh children who are below 6 years old and record and maintain the weight records.

**Nutritious Food:**

Under the ICDS programme, nutritious food is supplied to pregnant women who are below poverty line and the children who come to *anganwadi*. Several studies on pregnant women and children reveal that in India, majority of pregnant women and children are suffering from malnutrition in rural and urban slum areas. As an outcome of this understanding, the health planners implemented the nutrition program. Government has therefore started to supply nutritious food to vulnerable populations such as the pregnant women and children to improve the health status and to prevent anemia. The *anganwadi* plays a vital role in distributing the nutritious food. The information about pregnant women who belong to below poverty line is collected once in a month
by the *anganwadi* teacher while collecting the family particulars of the people residing in the village which includes their annual income. Based on the annual income of the family of the pregnant women, *anganwadi* workers distribute nutritious food.

The nutritious food, which is locally called *poushtika aahara* (meaning nutritious food) consists of energy food (*shakti aahara*). It includes jaggery (*bella*), wheat flour (*godhi hittu*) and flour of ragi (*ragihittu*) and also grains viz., rice (*akki*), green gram (*hesara*), bengal gram (*kadale*) and black gram (*uddu*). The food is distributed through the *anganwadi*.

Earlier, the *anganwadi* was distributing prepared food consisting of boiled rice (*anna*). Later on rice was distributed to the pregnant women and puerperal women. The reason for this change was that the women refused to eat the prepared food. The reason for the rejection of prepared food was that the food was not cooked properly and as such spoiled their health and created several health problems like indigestion and vomiting. All these problems of the pregnant and puerperal women were taken into consideration by the health department and it began to supply food grains in order to enhance nutritional status. The nutritious food which is supplied to the children consists of boiled rice (*anna*), spicy rice (*chitranna*), egg (*tatti*) and energy food (*shakthi aahara*).

Based on the details collected once in a month, the *anganwadi* teacher sends list of high risk pregnant women and children to MO (Medical Officer) of the PHC. The high risk pregnant women are those who are below age of 18 years and above 35 years of age and are pregnant. And the high risk children
are those who are below 6 year of age are of low-weight compared to the standard weight as mentioned in the weight charts. Then, further steps will be taken by the higher authorities like the medical officer regarding the high risk cases.

The grading of children according to their weight are given below (PHC 2005).

Classification of status No. of children weight (sum of all weight)

<table>
<thead>
<tr>
<th>Classification</th>
<th>No. of Children</th>
<th>Weight (sum of all weight)</th>
</tr>
</thead>
<tbody>
<tr>
<td>With normal weight</td>
<td>1225</td>
<td></td>
</tr>
<tr>
<td>In grade-I</td>
<td>1240</td>
<td></td>
</tr>
<tr>
<td>In grade-II</td>
<td>352</td>
<td></td>
</tr>
<tr>
<td>In grade-III</td>
<td>000</td>
<td></td>
</tr>
<tr>
<td>In grade-IV</td>
<td>01</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2827</strong></td>
<td></td>
</tr>
</tbody>
</table>

To create awareness among parents about health of children, ‘Healthy Baby Show’ is conducted at anganwadi. The anganwadi assistant informs all parents of the children of below one year of age regarding the show. On the mentioned day, all the parents have to gather in anganwadi and in the presence of the MO and LHV, children are weighed by the anganwadi teacher. The selection of ‘healthy baby’ is done by considering weight and activities of the baby. The selected baby gets certain amount of money as an encouragement. It is handed over by the medical officer as an encouragement and incentive to the parents of the baby. During this programme, MO addresses the parents about vaccination and family planning. The program is not only for encouraging the parents but also provides a platform for imparting awareness.
The *anganwadi* teacher along with LHV conducts mothers’ meeting (*tayandira sabhe*) at *anganwadi* once in a month to create awareness among mothers about breast feeding, family planning, spacing between child-birth, personal hygiene and public health. The women are told about the importance of feeding colostrums to the new-born infants. Because, generally the new-born babies are not fed colostrums. The mothers are told to feed breast milk exclusively for the first 4-5 months. They are also told about the ways and means of maintaining hygiene with regard to taking care of the children. The necessity of maintaining spacing between children, and the risk of early pregnancy are also explained. The number of meetings conducted is 138 as per the records at the PHC (2005).

Awareness is also created about safe drinking water and other hygienic practices since the women are the main caretakers of the family. As PHC is little away from the habitation area, some of the pregnant women also consult *anganwadi* teacher regarding confirmation of their pregnancy and also ask for help for registration of their names. Generally the confirmation of pregnancy will be done after 45 days and the women count the days and consider the last menstrual period for confirmation of pregnancy.

Apart from providing awareness to women, making them healthy and strong physically, the government also aims at making them financially empowered. Because, it has been identified by the government that economic empowerment is found to be directly related to making health care decisions among many decision making abilities. Since the women are closely associated
with the *anganwadi*, the responsibility of promoting savings and forming Self Help Groups is entrusted to the *anganwadi*, under the IDS programs.

In 1974, the Government of India started India Development Service (IDS) which is a rural development service and it focuses on grassroots level development of the poor people on the basis of their needs and priorities. Under IDS programme, several programmes have been undertaken to improve economic condition of the rural people. Among them, the implementation of the Self-Help Group (*swa sahaya sanga*) is one of the basic programs. In the village, each *anganwadi* has four self-help groups and the purpose of this group is to empower the rural women economically.

Each self-help group has 10 members, a secretary and a president. Once in a week they gather at *anganwadi* and the group collects Rs.20 from each member of the group. The collected money will be deposited in the bank for a period of one year. These groups also give loans to members for different purposes viz., education, construction of the houses, marriage, self employment and purchasing of household materials at a very low rate of interest.

There are many nuclear families where only the head of the family is working and as such the income of the family is less. And since the women are generally dependent on income of the head of the family, the self help groups are not working effectively. Because of the low level of income of the family, the women are not able to contribute Rs.20 per week.

Thus *anganwadi* plays a key role in the public health sector for the care of both mother and child. It not only provides informal education to children
but also is a channel through which nutrition supplementation is provided, growth of children are monitored, women are provided awareness, and also it plays a role in economic empowerment of women. Thus *anganwadi* has a close linkage with the primary health center and is vital in the successful implementation of various health-care programs, implemented by the government.

4. 1. 9. Information, Education and Communication (IEC):

Government of India started Information, Education and Communication (IEC) programme in order to impart knowledge to people living in rural areas with a view of not only increasing the knowledge level but also for bringing about behavioral change. Under the IEC programme, several health programmes are conducted at the community level.

Once in a month ANM and LHV conduct IEC meeting at *anganwadi* in the village. In every meeting health worker gives knowledge to women regarding health and public health for ex: awareness about iodine, safe drinking water, breast feeding, immunization for mother and child, personal hygiene, sanitation, nutritious food, information about family planning, gender discrimination, institutional delivery, early marriage, healthy baby show, HIV/AIDS and TB. During these meetings, the people clarify their doubts regarding health and public health by asking questions to ANM and LHV.

Thus, Government of India has implemented three-tier system of for catering to public health that is PHC, CHC and DHC on the basis of population to eradicate communicable diseases and promote over all health in rural areas.
Several health programs and services have been provided to the people such as National malaria control programme, TB control programme, HIV/AIDS control programme, antenatal care, postnatal care, immunization programme and family planning programme.

People are not completely aware of the health programmes and are not utilizing these programmes properly as intended. It is necessary therefore to create public awareness among people particularly regarding cleanliness in and around the residential areas and use of safe-water in order to reduce communicable diseases like malaria, TB. As there is social stigma attached to various diseases in rural areas, it is necessary to dissociate stigma about disease and treatment by bringing about behavioral change. And also there is a need to motivate the people to utilize modern health care services.

Because of lack of awareness, people believe polio can occur due to vaccinations given to them. It is necessary to convince people to bring their children for vaccinations to protect them from various preventable diseases. People are not accepting modern health care services such as intake of IFA tablets because of the beliefs associated with them. They believe that intake of IFA tablets creates heat in the body which may result in abortion. Therefore, health workers should act on such beliefs of the people and create awareness and bring about a behavioral change. Because some of the problems like anemia, low birth-weight babies, various childhood diseases can be easily solved by the existing programs. Therefore, the focus has to be shifted to increasing the level of acceptance by the people for whom the programs are
intended. Linkages between the problem and the existing solution in the health care system should be made clear to the people. Unless they begin to understand the linkages, there will be lack of acceptance or partial acceptance.

In India, fertility, mortality and morbidity remain unacceptably high, both compared to countries in the region and those at similar income levels. Although poverty and low levels of education are the root causes, poor stewardship over the health system bears some responsibility. India’s primary healthcare system is based on the Primary Health Center (PHC) which is not spared from issues such as the inability to detect diseases early due to lack of multi-disciplinary medical expertise and laboratory facilities and insufficient quantities of general medicines. At the same time, patients usually do not visit PHCs in the early stages of their diseases, while healthcare providers (if at all present) are forced to focus only on seriously ill patients due to the volume of cases.

It is also necessary to appreciate that the effective delivery of health care services would depend very largely on the nature of education, training and appropriate orientation towards community health of all categories of medical and health personnel and their capacity to function as an integrated team, each of its members performing given tasks within a coordinated action programme.

Through the media like television, radio, newspapers and magazines serve as source to acquire knowledge about modern health care system they have helped only the education people who posses the basic modern ideas about health-care. For them, it is enrichment of their idea as well as adding to
their existing knowledge. The people who are uneducated gain less awareness through television and radio because, the messages, which are passed through radio or in television by portraying the stories and pictures, are the information which are given by the health providers like ANM. Sometimes it reinforces their beliefs and notions through the pictures that are displayed on the television screen. A woman who delivers a baby which is big, for instance, after consuming the complete course of Iron-Folic Acid tablets makes the people to continue to carry the notion that the iron tablets leads to overgrowth of the fetus. In this way, media have helped either to continue their notions or not helped at all in providing awareness about modern health care system.

It is therefore, of crucial importance that the entire basis and approach towards medical and health education at all levels is reviewed in terms of national needs and priorities and the curricular and training programmes restructured to produce personnel of various grades of skill and competence, who are professionally equipped and socially motivated (to face barriers) to effectively deal with day-to-day problems, within the existing constraints

Thus this chapter makes an effort to understand the health care programs operating in the village and their impact. With this understanding the next chapter focuses on the various illnesses and the underlying etiology as explained by the people and the role of primary health care system in dealing with the problems.
CHAPTER- V

UTILIZATION OF HEALTH-CARE SERVICES IN PUBLIC AND PRIVATE SECTOR

In seeking the answer for the question of people's choice of seeking a particular treatment, a number of factors come into picture. Public health sector occupies a position in this picture, but not the sole position. When one analyses the health scenario through the people's perspective, indigenous healers, medicine men, supernatural factors, home-remedies all figure with differing importance at various times. In one instance, if primary health center is the role player in curing an ailment, in another instance indigenous treatment is prominent and PHC plays a secondary role. However, public health sector is playing an ongoing role because it is working behind the scene constantly for ensuring promotion of health in the form of various programs as seen in the previous chapter.

The promotive and preventive aspects are often invisible services. Visible are the curative services. Therefore when it comes to health seeking for the day to day common health problems, people have the option of deciding between private and public sector. Therefore the quality of services provided by the PHC and the expectations of the people from the PHC play a role in the utilization of services. The extent of utilization of services indicates the efficiency of services provided by the Public health-care sector.

Further when one looks at the programs offered by the public health-care sector, such as TB, Malaria, HIV/AIDS, and some people say 'of course
government is providing such services but they are not common problems, two or three people among hundreds suffer from such problems, we are more concerned about our day to day health problems, the health of our children. Therefore what we need is the round the clock presence of government doctor in the village’.

This indicates that the preventive services are not the felt needs of the people. Therefore the utilization of immunization programs, ANC (Antenatal care) and PNC (postnatal care) care are not recognized as the important services provided by the public health-care system. They are the unfelt needs and part of preventive measures. However, understanding the health-care concerns of the people shows that people do not link the services and diseases. For them they are receiving the services, because the government is making them to accept them. Those who are educated and aware of the linkages understand the situation. But those who lack awareness link public health-care only with the curative aspect that is provided by the primary health-care center.

Sanitation services are provided by the panchayath though the linkages are with health department but people recognize them as the services provided by the panchayath. The linkage with health is often lost. And the quality of services provided by the panchayath is also not satisfactory to the people and therefore the consequences are in terms of diseases. Thus a vicious circle appears. Public health-care system is therefore not an identified service provider. The PHC, as a concrete entity, is what the people take into account and have opinions about and utilize.
The availability of the services provided by the public health-care system and the extent of accessibility of those services is crucial in the utilization of the services. People often say ‘we go all the way to the PHC and we find that the doctor is not available or that he is in a meeting and then we sit for hours (ttasagattale kuttagolluṣuvaḍu) and come without any use. But instead if we go to private doctor we are certain that he will attend to us immediately.

Further, the medicines that are given at the PHC are often not more than 3 rupee cost (muru rupayee vallagina gullagi). Such quality medicines are not useful and we do not get well quickly (aram lagu agudilla). Even though the private doctor prescribes costly medicines, we become better quickly and this is what matters’. The time factor is important for most people especially those who are daily-wage laborers, because the day wasted due to ill-health is an economic loss. If one does not work, one does not earn the day’s wages. Further they also have to spend on getting better.

When it comes to lower castes and lower economic groups of people emotional aspects also come into the picture. The public health-care sector health providers are often prejudiced about them and look down upon them. They consider them uneducated and lacking awareness so they do not accord the same level of respect they have for upper castes and educated people. They consider the as ‘ignorant’ and do not behave properly with them.

Further people say that when the PHC was situated in the village itself the doctor was easily available. It was not out of the way, so easily accessed the PHC. But now, since it is out of the way and two kilometers away, it is difficult
to go to PHC. Further, earlier the doctor was living in the village itself. This had created a positive impression about the doctor among the people. He was available always and as such people had favorable attitude towards the PHC itself.

However, since the work load increased for the doctor because of his presence round the clock and also because he was not made a permanent staff by the government after two years of service and continued on contract basis, he shifted to Athani. People say ‘he gives the excuse of education of his children as the reason for his shifting but in reality, he no longer wants to work all the time and also since he is not a permanent staff, he is not bothered about what the higher authorities say’.

Similar pattern is observed with regard to the ANMs. Earlier the ANM was living in the village. She was given a room in the janata-plot. People living in the janata-plot are generally those who belong to below poverty level and as such services provided by her, such as conducting deliveries, giving medication, and so on were useful to the people. However, after she got transferred the post was vacant for two years. In the meanwhile, the room for ANM began to be used by the people for various purposes like tying cattle (dana kattalu) and so on. When the new ANM was appointed, she refused to stay in the room. She comes from a nearby village and would rather travel everyday than stay in the derelict room. She says ‘I cannot afford to spend on making the room worth living again and also with the payment I get I cannot afford to live here. If I stay at my place and travel I will not be making any expenditure apart from traveling but staying on my own is expensive for me’. 

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Whenever higher authorities visit they warn the staff to stay in the village and say that the rules have been made strict and it is compulsory for the staff to stay in the village and provide round the clock services. But the warnings are not paid attention. People say ‘they know that strict action will not be taken so they neglect and do whatever they want. They do not have any concern about serving people. However they work, they will get payment from the doctor so they do not suffer in anyway, it is only we poor people (badavru) who suffer the most’.

The pharmacist who is a resident of the village says people have good opinion about him because he stays in the village. He says ‘when doctor and ANM were staying the village, people had good opinion about them, but after they left, the opinion about the PHC itself changed. The staff is not on time. They come late and leave early. They are on time only when there are meetings or any higher authority is visiting. They look after their own personal convenience. The doctor also makes me do his personal work and if the higher authorities complain that the records are not maintained properly, I cannot say that I was using the time for some other work, I dare not complain against the doctor’.

The doctor knows that the paramedical-staff not always works with the commitment that is required. Often at the meetings, he finds that there is no coordination between the data of the ANM, LHV and the anganwadi worker. He says ‘when the records and data are not maintained properly and when there is no co-ordination between data of different staff members, it indicates that
they are not working efficiently and properly'. He scolds them saying that if higher authorities take any action on them he is responsible because he has warned them to work properly and maintain records properly. He says if the people are not utilizing the services provided by the public health-care sector it is also the responsibility of the grass-root level health personnel. If they do not provide proper information and awareness to the people, they do not utilize the services.

When it comes to seeking treatment, the options include indigenous, homeopathic, ayurvedic and allopathic system of medicine. As a health care-provider, PHC makes treatment provision available and accessible at a low-cost. Private practitioners also play a role in providing services. The system of medicine which the people go in for, depends on the situation and perceived notion regarding a particular disease.

In this context, the people of Mallapur people say, they have their own beliefs and practices regarding health and illness. Since generations, ailments are being cured by indigenous methods which include home-remedies, traditional healers, shaman and priests. Along with the existing systems with the introduction of modern health-care system, allopathic system has also been brought into hierarchy of resorts. The health seeking behavior and the decision of seeking a particular system of health-care depends on people’s economic status, education, knowledge about modern health-care services and availability of these health services.
There are six private doctors who are providing health-care in the village. 55 year old Allopathic doctor with MBBS degree is practicing in the village from past 25 years. He has set up a hospital in the village with 4 beds and provides round the clock service. He conducts deliveries in the hospital and also visits houses to attend delivery cases. He charges Rs.15/-per injection (sujee) and prescribes medicines to be brought from outside. People respect him a lot. They say that he has a healing touch (kaigunna). He charges Rs.200 per room and charges 250 rupees for conducting delivery either at home or in the hospital.

His son is also a doctor, who has MBBS MD degree. He is a pediatrician. He lives in Ugar village and visits Mallapur on Thursdays in the morning. He charges Rs.30/- as consultation fees. In case lab tests are required, he asks the person to bring the child to Ugar where he has a lab and other facilities.

There is another full time doctor in the village. He belongs to Lingayatharu caste and is 45 years of age. He has finished his tenth standard and then learnt homeopathy by practicing under a homeopathy doctor in Miraj for ten years. Since past 15 years, he has been practicing in the village. He practices both Allopathy and homeopathy. He has also been trained under an allopathic doctor. He charges Rs. 10 for an injection (sujee). He generally gives allopathic medicine and in case the patients ask for homeopathy medicine, he gives homeopathy treatment. House visits are made by the doctor in case it is required. And they charge Rs-50 for house visits.
There is also an ayurvedic doctor with a BAMS degree in the village. He is 65 years old and belongs to Lingayatharu caste. He was earlier practicing in a different village. Now for the past two years he has settled in the village. He says he practices for serving people and is not interested in it as a source of income. He does not charge a fee as such and takes whatever people give in terms of cash or kind. Sometimes people pay after the harvest (rashi), some give grains (kallu) and so on.

There is another MBBS doctor practicing in the village. He belongs to Korvi caste. He is 35 years of age. He provides service in the village and also goes to Athani. He has been practicing medicine for the past 10 years. He conducts deliveries.

Another MBBS doctor comes to the village from Kempwad and has been providing service for the past five years. He belongs to Lingayatharu caste and provides service in the morning at village and in the evening in Kempwad.

All the regular doctors make house visits and charge the patients only in case an injection (sujee) is given. When one compares the service provided by the public health-care sector and private sector, one finds that though it is the allopathic system that is sought, people’s decision of choice depends on factors of availability, accessibility and cost. People prefer the private doctors because they are certain that they will be available and also that they will get their money’s worth in terms of psychological satisfaction as well as physical relief. Private doctors do not look down upon people, further they make house visits in case it is required further, they are available round the clock.
Foster and Anderson point out acceptance of any or a combination of therapies depends on a variety of factors. They modify the practices depending on:

- the perceived economic, social, psychological and other advantages
- the economic costs being within or outside their capabilities
- given the social costs do not outweigh the advantages
- etiology is the defining factor in treatment decisions (1978).

Based on the perceived etiology appropriate measures are taken. Etiology refers to an understanding of the cause of diseases. Understanding etiology enables one to understand a great deal about the belief systems of the people. Across cultures, one finds that people have disease causation beliefs which affect their treatment seeking behavior. People of Mallapur classify causes of diseases into three categories and they are:

- Environment *(vatavarana)*
- Body constitution *(sharira gunna)*
- Life style *(jeevana shayli)* and
- Supernatural sphere *(mata mantra)*

Environment is an important factor of disease causation. Climatic conditions and germs/organisms *(krimi/keetagallu)* are affecting aspects. Hot-cold dichotomy is the ruling factor in the climatic condition. Seasons create the conditions of heat *(bisi)* and cold *(tampu)*. The external heat and cold created by the climatic conditions affect the individual. The individual’s body is believed to be in equilibrium, with the presence of both hot and cold aspects.
And when there is a change in the external environment in the form of climatic changes, it affects the individual’s equilibrium and results in diseases. Environment also includes visible and invisible organisms/germs (*hulla* or *jantu*) that affect the health of an individual. They may be carried through water (*niru*) or food (*aahara*) or it may be mosquitoes (*gungadu*) or intestinal worms (*kita*).

Any change in climatic conditions causes sickness, for example, cold (*negadi*) and cough (*kemmu*) during rainy and winter seasons, and mouth ulcers (*bayee novu*) during summer season. Fever (*uri*) when there is extreme heat or cold or getting wet during rainy season. If micro-organisms such as worms enter into the body of a person through food or through water, the individual suffers from diseases like, loose motion (*sandas hattudu*), vomiting (*vanti*) and jaundice (*kaamni*).

The body constitution is another aspect of etiology. This category is influenced by the ayurvedic system. Generally broad classification is used for explaining the etiology. However the finer details are explained and understood by those who practice the system. People only refer to them as terminologies with definite connotations in order to find reasons for a given ill-health condition and to seek appropriate measures. An individual’s body is believed to constitute air (*vata*), bile (*pitta*), and phlegm (*kafa*). Their nature is inherited by an off spring from the parents. A healthy body is said to have all the three elements in equilibrium (*sama pramanna*). If these elements are not in balance then the person suffers from diseases. The equilibrium may be affected due to
variation in food or climatic condition or behavior. For instance, consuming excessive ‘bile’ producing foods such as spicy foods, results in the individual to suffer from ‘pitta’ or working in the fields when it is raining and getting drenched may increase kafa and the person may suffer from severe cough.

In addition lifestyle of a person can also affect the individual’s health and result in diseases. Strenuous work, malnutrition, lack of rest and bad habits are the factors often mentioned with relation to lifestyle and are believed to cause ill-health. Certain jobs are believed to be strenuous by nature like lifting heavy things, working in the sun through out the day, lead to problems like back ache (bennovu) and head ache (talinovu). However, since one has to work in order to earn, these problems are considered to be a part of life. Bad habits according to people are smoking (sigaret seduvadu), drinking alcohol (darukudiyudu) and chewing tobacco (tambak timudu) and so on. Elderly people often say, have control on your life so that health remains good (nimma jeeva nimma niyantranadalli ettakondara adu arogyavagi chalo erastaitti).

When a person suffers from any illness, he resorts to not only to indigenous remedies and but also seeks treatment from doctors. However, the treatment seeking behavior does not end there. It includes another dimension, which is the supernatural sphere. People believe that a number of supernatural causes like wrath of deity (devara-kata), spirits (hireyara kata), evil-eye (nedaru) may also be the reason for the cause of disease.

The supernatural sphere includes wrath of deity (devara-kata), evil-eye (nedaru), evil-spirits (galli) and trouble of dead ancestors spirits (hireyara
The negligence in worshiping of the deities or spirit of dead persons or ancestors and also evil-eye of human beings and animals can cause diseases. People say it is often difficult to say what wrong done and when against deities and ancestors results in occurrence of diseases. However with evil-eye one can be more certain.

People believe that spirits of the dead, especially those who have died unnatural death, are malevolent in nature and cause diseases. Also sins committed in the previous life (hindina janmnada paapa) of a person are said to result in ill-health conditions. For instance, when a person is constantly affected by one or the other health problem, he or she is said to be suffering from the results of sins committed in the previous life.

People say that, if they neglect worshipping their family deity or miss any religious rituals of the family, deity becomes angry and it results in illness. For instance, people believe that, measles (gobbara) and chicken-pox (ganajali) are caused due to wrath of deity. Vision (nedaru) of certain people and animals viz., cats (bekku) and dogs (nayee) is believed to have the power to cause certain illnesses viz, fever (uri), vomiting (vanti), loose motion (sandas). This effect is called nedaru which means vision of evil-eye. Certain people in certain situations are said to be more vulnerable to the effect of evil eye. For instance, bride (madumagallu) and bridegroom (madumaga) at the wedding (maduve), girl during puberty (mainere) ceremony, puerperal (bannanti) women and children (makkallu) and especially babies are more vulnerable to evil-eye. For babies (koosagallu), warding-off of evil-eye is done everyday so that the baby’s health
is not affected. People say that, during these occasions and crucial life stages people are decorated and are the center of attraction and hence are affected by evil-eye.

According to people, if a soul/spirit (aatma) of dead person enters into a person’s body, it makes the person to behave in an abnormal manner and the condition is called gali ageti meaning ‘wind has affected’. People say that, when a person dies without fulfilling his desires, his soul wanders on earth and it enters into the body of a person. Particularly, puerperal women (bannanti), children (makkallu), bride (madumagallu) and bridegrooms (madumaga) are vulnerable to evil-spirit. People say that, evil-spirits are present in places such as area around the funeral ground (smashan), places where accidents have occur frequently killing people (apagatagallu) and places where waved off lemon is thrown (nimbikeyi- ellisi-vagadalli) (it is generally thrown where three roads meet). When people walk across such places, they may be affected by evil-spirits.

As a result of effect of spirits, a person becomes sick and he starts to behave abnormally, for example, he may start screaming (chirodu) and getting scared (hedarodu) without reason. By observing this kind of behavior, people suspect that, the person may be affected by evil-spirit. In order to confirm if the behavior is the result of spirit effect, traditional healers who are (devva bidisoru) experts in exorcising evil-spirit possession are consulted.

People say that, some of the problems related to reproductive health like, infertility (banji), abortion (hotti hogodu) and excessive bleeding during
menstruation (*maimele hogodu*) and white discharge (*billiseragu hogodu*) are due to the trouble of dead ancestors (*hirera kaata*). People say that, the souls of their ancestors wander around their house. If any family member of the dead person forgets to offer food to the ancestors during rituals and ceremonies, the souls become angry. As a result, people face problems affecting their health.

The failure of the modern medicine to cure the person is said to be the indicator that there is a supernatural cause for the person’s condition. People say that, unless the supernatural measures are taken, the person cannot be restored to health because whatever alternative measures are taken, they become useless because of the supernatural powers acting on the person. Only when the supernatural powers are dealt with, do the other healing measures can become effective. Therefore it is important to understand the cause of the disease in order to cure a person’s sickness. Otherwise no amount of modern treatment can help the person.

And in certain castes like, *Kurubaru*, treatment seeking behavior decisions are taken only after getting guidance from their deity *Beerappa*. People go to the temple of *Beerappa* and ask the question they have on their minds to seek guidance. This is called *kavala hachchudu*. The priest keeps flowers on either side of shoulders of the idol (*murti*) of the deity. And then the person seeking guidance asks the question (*prasne kelluvadu*) and if the flower on the right side (*balagade*) falls it means that the deity has given approval (*vappige*). And in case the flower on the left side (*edagade*) falls the deity is not approving (*vappalilla*).
In a case, a couple belonging to Kurubaru caste was married for five years and did not beget any children. Since the woman did not conceive, the elders decided to seek the guidance of the deity whether to seek medical help. When the couple asked the deity if they should seek medical help, the flower fell from the left side which means that the deity did not approve (devaru vappige kodalilla), so the matter was left as it is. Again after six months, the couple sought guidance and the deity answered positively as the flower fell from the right side. Then sought a specialist doctor in Miraj and took treatment for six months and the woman conceived.

The health problems caused generally due to environment are cold (negadi) and cough (kemmu), fever (uri), mouth ulcers (bayeenovu) and malaria (urithandi). Whereas, jaundice (kaamni), boils (gulli) are due to bile (pitta), asthma (dammu), toothache (hallunovu), loose motion (sandas) and diabetes (sakri) are caused due to change in the body constitutions. The ailments believed to be caused due to supernatural causes are measles (gobbara) and chicken-pox (ganajali), behavior which are considered abnormal like depression (aayasa), and infertility (makkallagadirudu), abortions (hottihogudu), maternal death (bannanti-savu), child death (makkalla-savu) and stillbirth (hittyag-makkalla-sattabarudu). Body pain (mai-kai-novu) due to strenuous work (vajje kelasa) and backache (bennovu) is said to be caused due to lack of rest during postnatal period among women. Malnutrition (shakti-eralarada-ahara-thinodu) causes weakness (ashakthpana) whereas skin diseases, tuberculosis (kshaya), leucoderma (billapu), and
paralysis (lakva) are believed to be caused due to sins committed in previous life of a person (hoda-janmad-karma). Some of the health problems like HIV/AIDS are believed to be caused due to bad habits.

5.1 Treatment Seeking Behavior:

It is difficult to classify diseases on the basis of a single influencing factor or causative factor because the causes of diseases are at times associated with more than one influencing factor. Further, the same disease may be caused to due one causative factor at one time and another cause at another. For example, vomiting may be due to evil-eye or it may also be due to indigestion (ajeerna) at another time. That means supernatural causes as well as environmental factors can both result in a single disease.

Similarly, tuberculosis and paralysis are believed to be due to sins committed in the previous life of a person but people also say that, these problems are also due to consuming of tobacco products and alcohol. Sins committed in the previous life come into picture when a person has no bad habits yet he suffers from TB or paralysis. Thus people of Mallapur try to diagnose illness based on causation theory they hold, and depending on this causation theory the course of treatment is decided upon.

In all contemporary societies, a wide variety of health-care options exist. This is referred to as the medical pluralism by medical anthropologists. Contemporary medical anthropologists use the concept to focus attention on people as active, rational decision makers who select from a range of

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alternative behaviors depending on their knowledge, resources, experiences, network interactions and other sources (Hardon 1995).

Treatment seeking behavior of people of Mallapur includes indigenous, and allopathic system of medicine. The indigenous system includes natural as well as supernatural healing. Allopathic treatment is provided by both public health-care sector as well as private doctors. Those practicing homeopathy and ayurveda system also provide allopathic medicines.

Public health-care system as a provider figures at different levels in the treatment seeking of the people. It depends on their diagnosis of the disease and the need of the hour and affordability and also level of education. People seek the public health-care as soon as soon as one is found to be ill in certain instances and in certain instances at a later step. This becomes clear as one understands the treatment seeking behavior pattern for different diseases. Even though home remedies are taken as the immediate step depending on the situation decisions are taken as to whether other kind of treatment is required or not.

There are two types of treatment seeking behavior pattern found among people:

5.1.1 Simple path to restoring health and
5.1.2 Complex path to restoring health

5.1.1 Simple path to restoring health:

In case of simple path to health seeking behavior, people begin with treatment in one system of medicine and they find relief and the path ends there
or in case if there is no relief, they shift to another system of medicine. This path can be represented in a straight line, because there is shifting from one treatment to another. Generally there are no confusions regarding the causation of these illnesses in case of simple path. Whereas, in complex path to health seeking behavior, people begin treatment simultaneously from more than one system of medicine and try all possible ways and means of restoring health. The path may be crisscrossing and or even be going in parallel lines. Complex path of health seeking behavior indicates that the illness is severe and also indicates that there could be lack of certainty with regard to causation.

Simple path to health seeking behavior is generally in case of cough (kemmu) and cold (negadi) or fever (uri) or mouth ulcers (bayee novu) for example. In these cases, people are certain of what has caused the disease and by doing what the condition will be cured. Most often, the path to cure begins with home-remedies/indigenous medicine and ends there itself in case of minor illnesses. In case the condition is severe the person may directly seek treatment from modern medicine and get cured. Therefore there is only one step (involved) towards seeking cure. For instance, when a person is suffering from mouth ulcers, he associates it with increase in heat. He therefore consumes poppy seeds (kasakasi) and cardamom (yalakki) soaked overnight either in curds (masaru) or milk (halu). This is believed to reduce heat in the body because, poppy seeds, cardamom, curds and milk are all considered to be cold producing in nature. For two days, he follows this regimen and is cured and the path ends there. In case he does not find relief, he goes to allopathic doctor and seeks treatment and finds relief. Thus the path moves in a single direction and there can be shifts from one system to another depending on the
success of the treatment. Thus the simple path to restoring health followed by the people of Mallapur is shown in figure 5.1.

Figure 5.1: Simple Pattern of health seeking behavior

The figure 5.1 shows that, the people of Mallapur start treatment for any ailment with indigenous system of medicine particularly in the form of home-remedies (traditional and modern). If there is no relief, depending on the perceived nature of illness cure is sought from other system of medicine. If the illness is very severe, they directly seek treatment from modern medicine.

This can be seen with an example. If a person is suffering from stomach-ache (hottinovu), he takes a concoction called kaade and then takes rest. If he is not cured in a day or two, he goes to the doctor for treatment. In case, for instance, there is high temperature and the person is suffering from high fever (uri), he directly goes to the doctor and takes treatment. The path taken to restore health is therefore straight forward with just one or two stops depending on the severity of the illness.
5.1.2 Complex path to restoring health: Here in order to restore health, all possible steps are taken and sometimes they are taken simultaneously, even though the remedies are from different medical systems. The figure 5.2 shows the complex pattern of health seeking behavior.

Figure 5.2: Complex path to health seeking behavior

The pattern of treatment seeking behavior to cure ailments like paralysis is an illustration for such a pattern. In case of paralysis, people start treatment simultaneously from indigenous, and then seek allopathic treatment. If there is no visible difference, they also simultaneously take ayurvedic or homeopathic treatment. According to people, paralysis is a serious ailment. The complex pattern reveals that for serious ailments, more than one system is required for cure. As people say, it is not possible to cure serious diseases using single system of medicine. Hence people use multiple systems of medicine. In case any one of these systems is found to be effective then again the simple path of restoring health comes into picture.
There is some variation in treatment seeking behavior among people depending on their level of education, economic status, and knowledge about modern health care services. People who have education up to high school or junior college level manifest awareness about modern health care services and they give preference for modern health care services. People who are not educated have less awareness about modern health care services and they give preference for indigenous treatment.

Figure 5.3: Treatment seeking behavior among the uneducated and economically poor people

Figure 5.4. Treatment seeking behavior among the educated and economically well-off people.

The people who are not educated begin their treatment with indigenous home-remedies and warding-off of evil-eye for all health problems. If they do
not get relief from this, they go to doctors. People who are educated start treatment with modern home-remedies and if not cured, they go to hospital for treatment. They consult priest to know whether the problem is due to supernatural causes. As one of the educated informants says, people take modern as well as supernatural treatments simultaneously because there is no harm, if both the treatments are taken together.

The pattern of treatment-seeking behavior becomes more meaningful when the people’s notions of severity of ailments are understood. People categorize diseases (roga or byani or jaddu) as minor (sanna) and major (dodda). According to them, those ailments which are cured by indigenous home-remedies (traditional and modern) are considered to be minor ailments (sanna jaddu). Whereas, ailments which are not cured by indigenous home-remedies and they find a need to go to hospital are considered to be major ailments (roga or byani or jaddu).

According to the people, there is no particular fixed duration for the major ailments to get cured. Time taken for the disease to get cured depends on the basis of severity of the ailments. Whereas, minor ailments remain for a shorter duration of time like, approximately for one or two days to about a week. The ailments, which exist for a longer duration and are severe in nature are considered major ailments. People say that, at times it is not possible to draw a definite line between minor and major ailments, because sometimes minor ailments may become major diseases.

A person suffering with running temperature (mai bisi ageti), the person takes rest and applies cold swab on his forehead and in case if the whole body
is burning (mai uriyuvadu), then, the entire body is rubbed with wet cloth (hasi arabi) to reduce body temperature. If fever continues, medicine is taken. In case there is no medication at home, people buy from the druggist by explaining the symptoms. The person is given medicines for a day or two. If fever is cured within a week, it is considered to be a minor fever (mai bisi ageti). If fever continues with high temperature, people go to hospital for treatment and this condition is called ‘balla uri bandavu’. And in case if the fever turns out to be typhoid, then it is said to be one of the major diseases. It not only requires expert treatment but also requires longer duration for cure.

In order to cure the condition, therefore options are available for people. They choose the option which they see as best suited for the present condition depending on a number of factors like, severity, availability of treatment, ability to spend, past experiences, advice of the social network. The primary goal of any medical system is to organize the health services so as to optimally utilize the available resource, knowledge to cure the sufferings of the people.

Home-remedy in the form of indigenous medicines is often the first-step taken by the people. People say these medications can be effective, and do not cost much and are also effective because they do not cause any side-effects as modern medicine do. Since indigenous medicines play a significant role, an effort has been made to understand the medicines used along with different sorts of health resorts. The symptoms guide the treatment seeking behavior. Home-remedies also include modern allopathic medicines along with the indigenous remedies. They may include a range of remedies viz, painkillers,
basic paracetemol tablets, various balms and ointments and also medicines stored from previous visits to the doctor for particular problems.

Home-remedies have been discussed in detail here because the first resort is the home-remedy. People use various indigenous medicines and often these are the basic things found in any kitchen. They say these things are easily available in any house and experience shows that they are effective in curing different conditions. Further, the next stop in the treatment seeking depend on the people’s understanding of the causation as discussed in the pathway to health restoration.

For all the diseases that are discussed here treatment from PHC is taken or the private doctor is sought at some point or the other. Because sometimes the illness may be cured by home-remedy alone and at another time it may require further treatment. Therefore, both public and private sectors figure in the treatment seeking picture. Depending on the perceived severity, ability to afford treatment, availability of the doctor, previous experiences, and suggestions from the social network decisions about who should be sought is made.

Negadi and Kemmu:

Cold (negadi) and cough (kemmu) is said to be a common ailment and is considered as minor illness. People say that, cold and cough are caused usually during winter and rainy season. It is the cold that prevails during these seasons that causes these conditions. The common symptoms of cold and cough are running nose (moogu sorodu), deposition of mucus in the chest (kafagattudu)
and blocking of nose (moogu gattudu). Along with these symptoms, headache (talenove) and fever (uri) are also seen among those who are suffering from cold and cough.

People drink hot water when they are suffering from cold and cough. Ointments such as Vicks and Amrutanjan are applied on the forehead (hanni), nostrils (moogin-holli), throat (gantalu), chest (yadi) and sole (aangalu) to get relief. People inhale steam (ugi) and also some people put flour (hittu) of wheat or jowar in the fire (kichhu) and inhale the smoke. They also warm their soles and palms on the same spark.

Concoctions (kaade) made by boiling turmeric powder (arishina-pudi), coriander seeds (kotambri kallu), garlic (ballolli), ginger (shunti), sugar (sakri) and salt (uppu) in water is consumed twice in a day in order to get relief from cold and cough. In addition to this people eat ginger with jaggery and some people also eat a paste made of pepper powder (menasin-pudi) and jaggery.

All these remedies are said to be heat creating in nature and since cold and cough are caused due to cold, heat creating things should be consumed.

Savitri is a 17 year old girl. She belongs to Jainaru caste, she is studying in junior college. She was suffering from cold and cough. At first, she tried hot water and concoction. But by next day she was not feeling better so she applied vicks vaporub. But that also did not provide her with any relief. So she got medication for cold from the medical shop and consumed them and became well.
According to people, if a person’s body becomes hot (mai- bisi-ageti), the person is suffering from fever. People say that, usually fever is caused due to change in climatic condition and physical strain. Sometimes, fever is one of the symptoms associated with other diseases such as cold and cough.

Usually people put a piece of cloth, which is dipped in water (tannir patti) on the forehead of the person, who is suffering from fever. The whole body is also rubbed with wet cloth. People say that by doing so, body’s temperature becomes regulated. The person suffering from fever is advised to avoid taking bath (jallaka). People avoid eating of wheat products during fever because they produce heat in the body and as a result body temperature rises. Modern medicines are taken by taking the advice of the pharmacist. If the fever persists they go to the doctor.

Bayee Hunnu:

Mouth ulcer is a wound in mouth believed to be caused by excessive heat in the body. Appearance of red colored small blister (kempu gulli) on the surface of the tongue (nalige) is the main symptom, and the person finds it difficult to swallow.

Poppy seeds (kasakasi) and cardamom (yalikki) are soaked either in curds (masaru) or milk (halu) overnight and next day morning, this mixture is given to the person suffering from ulcers. This mixture is said to reduce heat in the body. Because, opium seeds, cardamom, curds and milk are considered to be cold producing items.
Cumin seeds (jeergi) and dry kernel of coconut (onakobri) are given for chewing. The patient keeps the cumin seeds and dry kernel of coconut for some time in his mouth (bayee) till he feels smoothness on the tongue and is able to eat and drink easily.

**Hallu-novu:**

A person suffering from toothache experiences pain in the teeth (hallu) and gums (vasadi). The other symptoms of toothache are difficulty in chewing, swelling in the cheek area and bleeding of gums and often these problems are accompanied by bad breath. Consumption of excess sweets is said to be one of reasons for toothache. Some people say that irregular cleaning of teeth is responsible for toothache.

A peace of green ginger (alla) or a clove (lavang) is kept on the affected tooth for some time or till one finds relief. Keeping a small ball of cotton (hatti) dipped in oil of ajwai (ajjvan enni) on the affected tooth is also in practice. People say that green ginger, clove and oil of ajwain have pungent taste and they help in killing the germs present in the tooth. In addition to these, some people keep tobacco in the affected tooth to get relief from pain. Since tobacco is toxic, people believe that it kills the germs present in the tooth.

**Sandas Hattodu:**

When the frequency of defecation (sandas hattudu) is more than the normal routine and when it is loose, then a person is said to be suffering from loose motion. Frequent defecation is believed to cause weakness (ashakthpana) and the person also suffers from stomach spasms (hotti hinduvadu).
Eating of spicy food in excess, consuming stale food (hallasiddu), and drinking of contaminated water (hollasuniru) are said to be the causes for loose motion.

People drink black tea (kari chaha) mixed with few drops of lime juice (nimbu rasa) twice in a day to cure loose motion. A mixture of Jaggery (bella) and green ginger (alla) is roasted in ghee (tuppa) and it is given once in a day to stop loose motion. Ghee, jaggery and green ginger are said to have qualities that control loose motion. The person suffering from loose motion avoids drinking milk because people consider that consuming milk increases the frequency of loose motion.

**Pitta-gadari:**

Pitta-gadari are small boils (gadari) in the skin of a person produced by increase in bile and they are red in color. A person with ‘pitagadari’ feels itching sensation all over his body and often ‘pitta-gadari’ are seen throughout the body. They are caused due to excessive heat in the body of a person and also due to excessive secretion of bile (pitta).

The people give juice of pomegranate (dallambri rasa) to the patient to drink. If fruits of pomegranate are not available, people give leaf juice of pomegranate to patient. People considered that, pomegranate leaves and its fruits are cold producing products and also these reduce the ‘bile’ content in the body of a person.

A paste made from mud from the place where nothing grows (hallmannu) and water (neeru) is applied on the body of a patient in the early
morning and he dries his body by exposing it to sun-rays for 30 minutes. Since water and the mud are cool, people use to apply the paste of it to reduce the heat content in the body which is one of the causes for *pitta-gadari*.

Supriya is a 14 year old girl, she is studying in 8th standard. During summer holidays she works in the agricultural field. During summer one night, her whole body started itching. Her mother wiped her with cold cloth thinking it was some allergy. But soon she started to suffer from vomiting and loose motion. Her mother recognized it as *pitta-gadari*. Because her daughter had worked for long hours in the sun and it had caused an imbalance in the ‘*pitta*’ in her body. She fed her lemon juice to help her feel better. By morning supriya had red boils (*kempu gulli*) all over her body. This confirmed her mother’s diagnosis that it was *pitta-gadari*.

So early morning, she applied *halu-mannu* (mud from old house) mixed with water all over her body and made her to sit in the sun light for the mud to dry. She also fed her pomegranate leaves juice to reduce *pitta* in her body. However Supriya became averse to food and developed weakness. So her mother decided that she needed saline to make her feel better. So she took her to the PHC and supriya was given a bottle of saline costing rupees fifty. Then by next day supirya was better.

### Dammu or Vata:

Person suffering from asthma finds it difficult to breath. Main symptoms of asthma are phlegm (*edyaga kafa*), difficulty in breathing (*usiraduvaga trasa*) and cough (*kemmu*). Cold climatic condition (*tamp vatavarna*), cold air (*tamp vata-varna*)...
hava), cold water (tannir), dust (dulla), certain kinds of food (vaggada adagi) and smoke (hogi) are causes of asthma.

The leaves of basil (tulasi eli) are boiled in water and the concoction is given to asthma patient drinking, this is believed to help in breathing. Garlic (balolli), ginger (shunti) and basil leaves (tulasi eli) are to be consumed to keep the body warm. In addition to these, boiled drumsticks (muggikayee) are added to the person’s regular diet. Since drumsticks have heat creating content it is believed to provide relief to asthma patients. Some people drink alcohol (dharu) to get relief from asthma. It is considered that alcohol produces heat. The people avoid oily food and milk products as they are believed to enhance asthma.

Paravva is a 52 year old vegetable seller and belongs to Lingayatharu caste. She has not attended school. She belongs to middle economic category. She had asthma since she was an adolescent. However it has increased with age. With work load and weather, the symptoms increased. She has tried all the resorts suggested by those in her social network like ayurvedic, homeopathy, indigenous. Once when the symptoms had become severe, a neighbor advised her to take indigenous medicine from a place called Deshingpur. She became alright for a week and again the problem increased. However when there was increase in the severity of the symptoms, she resorted to allopathic medicine from PHC. Again someone told her about another indigenous treatment given in Hyderabad in Andhra Pradesh State. This treatment involved leaving fish in the throat and the fish eat away all the phlegm and the person becomes all right. She went there along with her husband. Because of this treatment she says she
had no symptoms for about 6-8 months. However again after about 8 months, she developed severe cough (*kemmu*) and asthma and resorted to medicine provided by the doctor at the PHC.

**Urithandi:**

According to people, it is a disease that causes fever (*uri*) and shivering (*nadugu*). It is caused by mosquito bite. In the initial stages of malaria, patient feels headache (*talenovu*), backache (*bennovu*) and cold (*negadi*). In the later stage, patient gets fever repeatedly every two days and there is shivering.

In the early stage, home-remedies are given for headache, backache, cold and fever, the person suffering starts shivering along with the presence of fever, people cover him with woolen blanket (*kambli*) to stop the shivering. As a result, the person starts sweating and fever is reduced. If it continues, people go to hospital for the treatment. Doctor suspects malaria, he gives treatment for fever and if malaria is confirmed by clinical test, doctor starts treatment for malaria.

**. . Kaamni:**

According to people, there are three main causes for jaundice:

- Eating oily food (*enni dinasu*) when a person is suffering from fever
- Drinking contaminated water (*holasu niru*) and
- Eating state food items (*hallasidda adagi*).

The symptoms of jaundice are over sleeping (*jasti niddi*), consuming less food (*kadime oota maduvadu*), vomiting (*vanti*), yellow urine (*haladi kalmadi*) and nails and eyes become yellow. In early stages of jaundice, person
does not eat properly and feels weak (*ashaktapana*) there is mild fever. Gradually person starts to vomit and eyes and nails become yellow. Looking into these symptoms, people identify the condition as jaundice (*kaamni*).

People take treatment for jaundice from a neighboring village, Ainapur which is 16 km away from Mallapur. This medicine man (*gauti aushada kodavru*) belongs to *Jainaru* caste. He is 40 years old. His family has been giving medication for jaundice for generations.

A cup of juice made from leaves of a particular plant is given to the patient. It has to be consumed on empty stomach early in the morning for three consecutive days. Medicine man advises the patient to eat jaggery (*bella*) and sugar cane (*kabba*), and also drink sugar cane juice (*kabbinarasa*). On third day of the treatment medicine man looks at the color of nails and eyes of the patient. If the color of the nails and eyes of the patient is still yellow, medicine man continues the same treatment for two more days. The Medicine man charges Rs.5/- for a patient.

The method of preparation of medicine (*oushadi tayarsudu*) and the name of the plant (*gidada hesaru*) are guarded secretly by the medicine man and his family. Medicine man says that if he discloses the name of plant and method of preparation of medicine, medicine looses its potency (*ushadada shakti kalkontaiti*). Studies reveal that medicine men across cultures guard the names of the plants, herbs, and medicines they give.

People say that, there is no medicine for jaundice in allopathic system of medicine therefore they take treatment from the indigenous medicine man.
People generally say that, diabetes is caused due to intake of excess sweets and some people also say that, it is an inherited disease (vansha-parampary). Drinking excess alcohol, consuming of sweets (belachu/sihee), irregular food habits (timesariyagi tinnuvudilla) and drinking excess tea (hechhu chaha kudiyodu) are said to be habits that lead to diabetes. Feeling of increased hunger (hechhu hasivu), and thirst (hechhu niradike), excess sweating (hechhu bevrodu), frequent urination (hechhu kalmadi hogodu), giddiness (chakra barodu), burning sensation in the soles (angal uriyodu), haziness of eyes (kannu manjkanudu), and wound not healing quickly (gaya mayaka bala time beku) are said to be the symptoms of diabetes.

In the early stage of the disease, people say they are not able to identify it as diabetes. People think that the symptoms viz., feeling of hunger, feeling of thirst and excess sweating are due to strenuous work. When they experience dizziness, burning sensation in the soles and haziness of eyes, they go to local doctor for checkup and doctor gives medicines for the symptoms.

If the problems continue, the person goes to the doctor again for treatment. The second visit generally makes the doctor to suspect the case as a case of diabetes and he prescribes blood and urine test. If the report shows blood sugar level as not being normal, doctor prescribes the medicine to bring the blood sugar level under control. He advises the patient to take medicine regularly and to avoid eating food stuffs that contains sugar.
When a person finds out that he has diabetes, he starts to eat bitter gourd (hagal kayee) and ash gourd (boodhagumballa-kayee) as a part of the diet because it is believed that these vegetables decrease the sugar level in the body.

_Vanti Aguvadu:_

One of the effects of evil-eye (drusti agodu) is said to be vomiting. There are also said to be natural causes for vomiting is due to indigestion (ajeerna). The symptoms of vomiting due to indigestion are bloating of stomach after eating food and heartburn. If a person vomits repeatedly soon after eating food and drinking any fluid it is said to be effect of evil-eye.

In order to ward-off the effect of evil-eye, people take salt (uppu), chilli (vana-menasinakayee) and broom-stick (kasabaragi-kaddi) in left hand and move it from forehead to feet of evil-eye affected person three times. The people believe that by doing this, evil-eye effect transfers from affected person to items present in the left hand and these are then thrown into the hearth to burn in the fire. They believe that evil-eye burns along with these items. Even after taking these indigenous home-remedies if vomiting continues, people take tablets brought from medical shop or go to doctor.

The person suffering from vomiting is given lime juice along with soda and salt to drink and is also ajwain (ajjavana) with salt (uppu). Consuming of Lime juice (neembu rasa), soda (soda) and ajwain (ajjavana) is believed to help in digestion of food and causes the person to burp. As a result of burping, the person gets relief from vomiting as well as vomiting sensation. Even after
giving all these treatments, if a person continues vomiting repeatedly, people think that it is due to affect of evil-eye.

--- Mai-Kai-Novu:

The people say that, heavy work like lifting of loaded gunny bags (tumbida cheela) causes physical strain (danivu) leading to body pain (mai-kai-novu). It is usually seen among adults who are engaged in agricultural work and other kinds of labor work.

People apply coconut oil (kobari enni) on the body or the body part, where they feel pain and then pour hot water on the body. They take rest for some time to get relief from pain. If pain continues, they apply pain relief ointments such as, Moov, Iodex and Zandu balm and they also take tablets from medical shop to get relief.

Daily wage workers and construction workers also drink alcohol as a remedy for body pain. They say it helps them to sleep better and wake up feeling better in the morning.

--- Talenovu:

According to people, headache is caused by acidity (pitta). People apply a paste of ginger (shunti) on the forehead of the person suffering from headache and some people also apply medicated ointment on their forehead and take rest to get relief from headache. Ginger is said to have heat creating ability, and therefore the paste of ginger helps to exude sweat from the body of a person through which, headache is cured. The people consider that, exuding of sweat from the body is an indication of headache being cured.
**Bennu or Sont Novu:**

Backache is generally found among women who have not taken sufficient rest during the postpartum period and it is caused due to weakness (ashaktapana). In case of backache, people massage the back with coconut-oil (kobri enni) and then they pour hot water (bisniru) to get relief from pain (novu). Since the massage of coconut-oil soothes the muscles, people say it provides relief from backache. If there is no relief, then they apply ointments like Moov, Iodex and Zandu-balm on their back to get fast relief from the pain.

**Keel Novu:**

It is commonly seen among the elderly and is said to be a problem associated with old age. People say that, excessive ‘air’ (vata) in the body causes joint pain. Usually joint pain is seen in elbows (mollakai), wrists (mungai), fingers (berallu), knees (molakalu) and toes (kalberallu). People who are suffering from joint pain in knee and toes, experience discomfort while walking, whereas, the people who have joint pain in elbow, wrist and fingers, experience uneasiness while lifting and holding things. In case of joint pain, people use the same treatments which they use in case of backache that is use of coconut oil, hot water and pain relief balms.

People also believe that wearing copper ring on index finger and toe, given by the indigenous medicine man at Nagaramunuvalli relieves joint pain. Therefore they bring these rings and wear them. Since copper is considered as heat creating it is believed that it increases heat in the body as a result of which air attains equilibrium in the body and the person finds relief from pain.
**Hotti Novu:**

Presence of round worms (*jantu*) in stomach causes stomachache. Another reason stomachache is indigestion. The symptoms of stomachache due to indigestion are bloating of stomach (*hotti ubbuvadu*), heart-burn (*hulli suduvadu*) and burping with release of gas with foul smell (*kamaru darki*). People say that, stomachache due to round worms is usually found among children since children eat lots of sweets (*belachu*) like jaggery (*bella*), sugar (*sakri*), chocolates (*chakaletu*) and biscuits (*bisketu*).

When children feel severe stomachache (*hotti muriyuvadu*) and start to consume more food, people suspect the presence of worms in the stomach. In addition to these symptoms, children start defecating frequently. People feed castor oil to children. People believe that, castor oil cleans the stomach and removes worms in through the stools.

Girls suffering from abdominal pain during menstruation drink buttermilk (*majjigi*) with salt and asafoetida (*eng*).

**Billapu:**

In early stages of *bilupu*, small white patches are seen on the body of a person. People believe that, it is caused due to the wrath of goddess Yellamma (*devara kata*) and they take vow (*harake horu*) to the deity that they will fast for five Tuesdays and Fridays, since these days are considered as auspicious days for worshiping Goddess Yellamma. On the fifth day, they go to Yellamma temple and worship by offering coconut (*kayee*) and camphor (*karpura*).
After worshiping the deity, people go to indigenous medicine man of neighboring village called Ainapur. Medicine man gives medicine which is in the form of liquid, to drink there itself. He advises the person to eat onion, curd, milk, bitter gourd and other green vegetables along with their regular food and avoid non vegetarian food.

Before taking bath, people suffering from leucoderma usually apply a paste of neem leaves and turmeric powder on the affected parts of the body. They allow the paste to dry as per the advice of medicine man. People also take treatment from allopathic doctors who are specialists in treating Leucoderma. They generally go to Miraj for taking treatment. Doctor advice the patients to consume green vegetables and milk and milk products. In addition to this, they also advise patient to expose his body to sunlight everyday in the early morning. Since, deficiency of vitamin ‘D’ causes leucoderma, by exposing the body to morning sun rays vitamin D is absorbed by the body.

Mallamma is 62 year old woman belonging to Holeyer caste. She has not attended school. She is living in joint family. Before a few years back she developed white spots on her hand. Her family member said it may be due to Yallamma and asked her to observe fast for five weeks. However it did not cure the spots. Further she went to a shaman to ask about white spots, the shaman suggested her to go to Goddesses Yallamma temple of Saudatti and also he asked her to apply neem paste mixed with turmeric. She followed all the instruction of the shaman, but it did not cure and she feels much about this. Because, her neighbors started to gossip about her disease and then she started taking indigenous medicine from Ainapur.
Later on, her family took her to the PHC and the doctor said that her condition could not be treated at the PHC, however the doctor could refer her to some other specialist. Since the family could not afford to spend money on the specialist, they asked for a reference at a government hospital. The doctor referred her to the nearest civil hospital. She started taking treatment there and was asked to come every month on a regular basis for treatment. She underwent treatment for six months and could see no visible reduction. The family could no longer afford even the government treatment, because they had to spend on travel of two people every time, because somebody would accompany her each time.

She started taking indigenous medicines from the medicine man of a near by village, which is not expensive.

**Kshaya Roga:**

People believe that TB is caused due to bad habits of a person such as consuming tobacco and its products. They also believe that ‘bad fate’ is responsible in causing tuberculosis. People believe that, if a person has done something wrong to others either physically or mentally in his previous life, it results in bad fate. As a result of the wrong doing in the past life of that person, he suffers from ‘kshaya’ in the present life.

The symptoms of tuberculosis are prolonged duration of cough (balla deevasa kemmudu), weakness (ashaktapana), fever (uri) and phlegm (kafa). Initially, people consider these symptoms as the symptoms of cough and fever and they take home-remedies to treat the symptoms. If there is no remission
from symptoms, owing to these home-remedies, they go to hospital for treatment.

Doctor asks the patient about the symptoms and enquires as to how long he has been suffering them. The doctor suspecting tuberculosis prescribes clinical testing of blood and phlegm (kafa). If it is diagnosed as tuberculosis, he starts the treatment for tuberculosis. Doctor also advises the patient to avoid oily food and to keep the living environment hygienic (swachha vatavarn) and to have sufficient light and air available in the living area.

Paravva is 35 year old woman belonging to Holeyer caste. She has not attended school and is an agricultural labor. She was suffering from cough and went to the PHC which is near from her home. She always goes to PHC as she feels that it is less expensive than going to the private doctor. And she also feels that the medicines given there help her get better soon. She was advised sputum test. When the result was positive, she was asked to take treatment for 3 months. She was required to visit PHC for a month for injection (sujee) and she had to take medicines for three months. She followed the regimen prescribed by the doctor and at the end of three months she was again advised sputum test. However, the report showed that it was still severe. So her treatment was continued for three more months after which, she became well.

Lakva:

People say that paralysis (lakva hodiyodu) is a condition in which a person suddenly becomes unable to move whole or part of his body. According to people, drinking alcohol (da\'u kudiyodu) in excess, eating of fatty items like...
meat (*mamsa*), ghee (*tuppa*) and fried items (*karadaddu*) and anxiety (*chinte*) are the causes of paralysis.

The people ensure the responsiveness of the paralyzed person by touching all parts of the body. If the paralyzed person does not respond to touch in a particular part of the body, then people come to know that, that part is paralyzed. For example, if person does not respond to his leg being touched, people consider that leg is paralyzed (*kalge lakva hodadaiti*). They generally go to local doctor for treatment.

Shankar belongs to *Samagaru* caste and is 45 years old. He is undergoing treatment for paralysis. One day he fell unconscious, and the family members sprinkled water over his face and head and called the private doctor (RMP) to visit. The doctor checked him and said that he was suffering from paralysis attack on the right side. The family asked what should be done next. He advised them to seek treatment from a doctor in Miraj.

Since the family could not afford private doctor, he then advised them to go to civil hospital. Then the family started providing him treatment from government hospital in Miraj. However, they felt this was a disease which responds to indigenous medicine therefore sought the medicine man at Nagarmunavalli. He has started giving him massage and medication every month.
Aids Roga:

According to doctors AIDS is a sexually (laingika) transmitted disease, but it cannot be identified as AIDS in its early stages. Having sexual contact with more than one person (vabbarigintha hechhu mandi jwati laingika sambanda), taking injection (sujee) by needle used for others (hyaredavarige upayogsida sujeele chuchhisikondra) and transfusion of infected blood (rogiruva raktha hakidra) are the causes for AIDS.

Illnesses such as, cold (negadi), cough (kemmu), fever (uri), dysentery (sandas), vomiting (vanti), weakness (ashaktapana), jaundice (kaamni) are seen in the person and people think that these are the symptoms of common diseases and take home-remedies for the same. In the next stage, some of these symptoms are seen together and are present for a longer duration of time and patients go to local hospital. Doctor prescribes medicines and in case he suspects the symptoms as due to HIV/AIDS and, he sends the person for blood test to the nearest Voluntary Testing and Counseling Center. In case the person is confirmed as being HIV +ve, he prescribes medicine to increase the immunity power and he suggests the patient to avoid sexual contact.

Diseases caused due to supernatural reasons can be classified as supernatural based on different aspects, crucial are behavior of the person, responsiveness to treatment, previous incidences. Some illnesses like chickenpox are diagnosed as supernatural without any uncertainty.

Suresh belonged to Byadaru caste and died of HIV/AIDS. He was 23 years of age and was married for 3 years and had a one and a half year old
daughter. He worked as a non-agricultural laborer. When his wife went to her natal place for delivery, he went to another village for work. After some time he came home due to illness. He was suffering from diarrhea and vomiting. He went to a private doctor and sought treatment. After few months, he developed jaundice and was treated with indigenous medicine from the medicine man at Ainapur village as it is the practice.

He remained at home to recover from the illness and in the meanwhile developed severe cough. He went to the PHC and the doctor suspected TB and sent him for sputum test and the report was positive. And seeing all his symptoms, he was also asked to go for blood test. The report revealed that he was HIV +ve. The doctor asked him to take medicines from the PHC for three months. In the meanwhile, he developed fever and dysentery. He was admitted in the private hospital but there was no relief. He became weak and bed-ridden. Fearing that people will start asking questions, the family took him to Athani to be admitted in a private hospital. However, seeing his report they refused to admit him. Then they took him to Miraj and admitted him in a private hospital. However after eight days they could no longer afford the treatment and admitted him in the government hospital. There after two days the doctor said that he would become well and that it was better to take him home.

After coming home the family went to the priest and then to a shaman to see if he would become well. They started supernatural treatment, however within a week he passed away.
**Gobbara and Ganajali:**

Measles (gobbara) and chicken-pox (ganajali) are more commonly found among children below 15 years of age. Gobbara and ganajali are believed to be caused due to wrath of female deity, Maragubayee in the village.

The symptoms of measles and chicken-pox are fever (uri) redness of eyes (kempu kannu) and red colored boils (kempu gulli) on the body. Measles and chicken-pox are distinguished by the people on the basis of the size of boils on the body. In case of chicken-pox, boils are bigger in size (doddu gulli) and are filled with water (niru tumida gulli) whereas, in case of, measles boils are smaller in size (sanna gulli).

People apply ground nut oil (shenga enni) and paste of neem leaves to the entire body of the child suffering from measles and chicken pox and then give bath. As a result, eruption of small boils is believed to increase and remove all the heat from the body. Thus for curing chicken-pox or measles, people give regular bath (jallaka) for seven days after applying oil and paste of neem leaves (bevina eli). On the seventh day, after giving bath to child, people worship the Goddess Maragubayee by offering food (naivedya koduvadu). After seven days, people feed curds to the child to create a cooling effect and also in order to remove excess heat from the body. As a result the boils get reduced.

Shivu’s father is a farmer. He belongs to Jainaru caste. His father is educated and his mother is not. He is six years old. Once, he was suffering
from fever (uri). He was taken to private doctor for treatment. However by next day morning, his eyes were red and he had small boils on his body. His grandmother (ajji) identified the condition as measles (gobbara). She advised the daughter-in-law (sose) to give him ritual bath and that there was no need to take him to the doctor. As a result of the bath the boils erupted and this was said to be good because it removes all the heat from the body. However there was lot of itching sensation and therefore he was taken to the doctor. Doctor gave him an injection (sujee) to provide relief from itching (tinisike). After five days, the deity was worshiped and oil lamp (deepa koduvadu) was lighted and sacred food (naivedya) was offered. He was given fried food to remove heat from the body.

*Sarphunnu:*

Shingles is a band of red blisters found horizontally on the back of a person and there is presence of burning and itching sensation in the area where blisters are present. People associate shingles with serpent (sarpha) and since there are wounds (hunnu) and it is known as sarphunnu. People say that if both ends of this band join in the chest region (yadi hattira kudidra), that person may die.

People say that, there is no treatment for shingles in modern system of medicine. People believe that, it is cured by performing rituals to the point where the serpent (boils) begins on the back of patient by medicine man. People go to a neighboring village called Mole, which is 10 km away from Mallapur for treatment from an indigenous medicine man.
People give puffed rice (*churmuri*), coconut (*tengin kayee*), incense sticks (*uddina kaddi*), vermillion (*kunkuma*) and turmeric (*arishina*) to the medicine man. The medicine man performs rituals of worship where the serpent form is found on the back of the person. The medicine man writes the image of an Eagle (*garuda*) on the patient's back by using red-ochre (*kyavi*). Red-ochre is considered to be cooling in effect and it removes excess heat from the body. It therefore helps by soothing the burning and itching of caused by the wound.

People believe that eagle (*garuda*) is a natural enemy of serpent and it preys on it for food. Therefore by writing eagle, it kills the serpent and the person is cured of shingles. In addition to this, medicine man advices to avoid consumption of pumpkin (*kumballa kayee*), brinjal (*badani kayee*), and ladies-finger (*bendi kayee*) as these vegetables are considered to increase pus (*keeva*). Medicine man also advises patients to avoid milk (*halu*) and eggs (*tatti*) because these food stuffs are believed to promote spreading of shingles. Milk and eggs are considered as food liked by serpent and it is believed if the person consumes them, the serpent remains alive and is not cured of the disease.

Raju a sixteen year old boy from *Samagaru* caste. He has studied till 10th standard. He lives with his widowed mother, who is an agricultural laborer. Once, he developed fever and went to a private doctor for treatment. He was cured but felt burning and irritation on his back. He again went to doctor after two days, there were boils (*gulli*) on his back, and seeing them the doctor thought they are prickly heat boils and gave medication. But he continued to
feel burning sensation. He again went to the doctor and doctor saw that a band of red boils had developed on his back.

He diagnosed it as *sarpa-hunnu* and gave him an injection (*sujee*). However he also told him to get the *barasudu* done (indigenous remedy). Raju’s mother asked a couple of neighbors as to where he should get the indigenous treatment. As per the suggestion, they decided to go to the indigenous medicine man in the Mole village. However they came to know that the medicine man treats only on Sundays. Raju could not bear the burning sensation so he went to PHC. The doctor gave an injection (*sujee*) and advised him to get indigenous treatment.

On Sunday he and his mother went to the medicine man taking all the required things. The medicine man offered worship to the point on the back of the boy where the boils began and said that it is the *God Nagappa* (the snake deity) and it has to be prayed to heal the person. The medicine man then wrote a picture (*barasudu*) of an eagle (*garuda*) on his back. He then advised Raju about the diet and within a week Raju was cured.

This case study reveals that though people believe that certain diseases can be healed only by indigenous methods, in case of severity they resort to modern medicine for the same disease. They believe that modern medicine provides immediate cure.

In situations, when people go to hospital for the treatment of diseases and do not get better, people suspect that, it is due to trouble of dead ancestors. Then they go to priest (*bhatru*) to ask about the affected person’s health and what measures need to be taken to cure the person. People also go to shaman
(devra helovru) to ask about the health condition. The priest or shaman is able to tell them if they are facing problems because of their dead ancestors. When they come to know of this, they appease the ancestors by offering food and worshiping them. As per suggestion of the priest or shaman, they request the ancestors to forgive their wrong-doings.

The shaman in the village is from Kurubaru caste. She is a house-wife with eight children. She has been telling forecasts (devara heludu) for the past 15 years. It is said that she was very religious from the beginning and she says she slowly got this power and started using it for helping people. She says people from all castes come to her seeking supernatural solutions. She has not learnt this but the goddess devi Yallamma has blessed her with the gift. Her youngest daughter who is 19 years old and studied till 3rd standard also tells devara, influenced by her mother.

Apart from shaman there are also priests who offer supernatural healing and consultation. They check for problems in the horoscope and also provide solutions. People go to seek them for not only treatment seeking but also to know whether the person will become alright, and what course of action has to be taken and such other guidance. Even while taking allopathic treatment, supernatural guidance and healing are sought. The Brahmanaru priest in the village is 48 years old and has studied till 12th standard. He has acquired the knowledge astrology from his family only since it is being practiced in his family for generations. He prepares horoscopes and offers solutions for problems in horoscopes, and officiates at different ceremonies.
There is also a Lingayathru priest who is relatively new to the village. He is 24 years old and has studied till 10th standard. Since 5 years he has been providing services in this village. His family has been doing it for generations. He officiates at ceremonies and rituals, and also provides amulets for illnesses.

In order to confirm if the behavior is the result of spirit effect, traditional healers who are experts in evil-spirit possession are consulted. If, it is confirmed as the effect of evil-spirit, traditional healers give sacred turmeric powder to be applied on the forehead of the person affected by evil-spirit. The traditional healers also give sacred lemon to the evil-spirit-affected-person. Keeping this lemon on person is believed to provide relief.

Indigenous remedial measures are taken to ward-off evil-eye and its effects. For example, people take salt (uppu), chilli (vana menasina kayee) and broom stick (kasabaragi kaddi) in left hand and then wave it three times in front of a person from forehead to feet of the affected person. It is believed that by doing the so, evil-eye transfers from affected person to items present in the left hand. Then these items are thrown into the hearth (vali) containing fire (benki) to bum. It is believed that through this process, evil-eyes is burnt in fire.

There is also a belief prevailing in the village that the illness is caused due to witchcraft (mata) and they go to a local indigenous healer, who wards off the effects of witchcraft. Indigenous healer worships goddess Yallamma and he gives sacred turmeric powder (bandara) to apply on the person’s body and also gives a sacred lemon for warding-off (nivallisu) of the effect of witchcraft.
from the person by waving it from head to foot of the affected person. The waved lemon is burnt as suggested by indigenous healer and people believe that witchcraft goes along with lemon.

The treatment-seeking behavior for the various diseases explained above has laid emphasis on indigenous home-remedies because they are the first resorts which people option. In the case where the medicine men figure the rationale and the manner of treatment are explained. For most diseases people opt modern medicines and this is often provided by the public health sector. However their decision to go to the PHC depends on the perceived degree of severity and also how the disease responds to home-remedies.

When one looks into the treatment seeking behavior for the diseases caused by environment, body constitution and life style (for instance, fever, cold and cough, loose motion, boils and ulcers, ache and pains, vomiting, TB, HIV/AIDS), the resort is generally modern medicine. The main treatment provider who figures here is the public health sector. This is so because of the cost effectiveness as well as accessibility. For diseases like sarphunnu, kaamni people believe that there is no cure in the modern medical system so indigenous measures are taken. Where as, in case of supernaturally caused diseases, the treatment resorts are mainly supernatural in nature. It is important to note that multiple treatments are also taken. And depending on the responsiveness of the disease to the treatment, the particular course of treatment is continued or opt. For instance, if mouth ulcers are believed to be cured by ayurvedic medicine, that is the resort which people opt.
People calculate in terms of cost in treating the disease. When they feel that they can no longer take allopathic treatment which is expensive compared to indigenous treatment, they go in for other options that are available for them such as indigenous medicines, supernatural healing. Religious observations and practices therefore often figure as major healing processes. Also when they are taking treatment with allopathic medication, for some diseases, they seek indigenous medication thinking that there is no harm in it. The reverse also happens in case of severity as revealed in the case-studies. When the disease symptoms are unbearable they take modern medicine even when indigenous treatment is going on.

The analysis of the treatment-seeking behavior of the people of Mallapur reveals that there exists the concept of medical pluralism. The analysis of Foster and Anderson (1978) is very useful in this context to understand and explain the treatment-seeking behavior of the people. They point out that under use of existing medical services is not always the result of indigenous beliefs or resistance to western medicine, but can also be explained in terms of cost and availability of services. This is true in the context of the present study because the people do not hold on rigidly to a single line of treatment seeking as it was seen in the analysis of ‘complex path’.

As Foster and Anderson point out, people are pragmatic in evaluating health-care alternatives. The outcome of the individual decision making process is to a large extent the result of cost benefit analysis not only in terms of economics but also social terms. The economic costs are weighed when the
disease it named as minor. When people diagnose the diseases as being minor, they utilize the available resources and make efforts to cure the disease (Foster and Anderson 1978).

The home-remedies, may it be the concoctions, or warding-off of evil-eye, or using allopathic medicines, stored at home are all cost effective. People are not only finding solutions, but are not losing in terms of losing a day's worth of wages which they would if they go to the doctor. Going to the doctor itself is seen as expenditure because, the moment you go you have to spend on consultation, and then for the medication. This is especially true in case of private doctors. Further there is also the peer consultation. People will ridicule a person who runs to the doctor for every minor thing. As it is generally said, there is no need to use an axe where a needle is sufficient.

For the same reason curative medical services are accepted more easily than preventive. People are flexible in reconciling indigenous beliefs with modern western treatment options such as pharmaceuticals. Western and traditional medicines are often seen as complementary and not competitive. This is reflected in the behavior of the people as seen in the complex path to restoring health. Supernatural means of restoring health is a part of the whole complex wherein different systems of health-care come into picture. Western and traditional medicines co-exist for the people. Even though most episodes of illness are self treated, often within the family network, the next course of action shows 'simultaneous resorts' as termed by Klienman (1980 cited in Hardon 1995). Several treatments options are used at the same time. The objective of the individual as well as the community is to restore health.
Therefore the services provided by the public health-care sector becomes very important. The objectives of the public health-care sector are preventive, promotive as well as curative. The objectives of the people and the public health-care sector do not vary essentially. People seek modern health-care provided by the public health-care sector as the first resort or the last resort depending on their understanding of the diseases. Wherever it may lie in the path, public health-care sector is seen to figure as an important actor in the health seeking behavior of the people.

Pelto (1990) analysis sums up significance of the present study. He points out that Medical Anthropology’s focus on micro-level factors that affect decision making has led to the consideration of intra-cultural and intra-community factors. These factors make behavior intelligible by describing both the context in which people reach their decisions and by clarifying the rationality of their decisions. Anthropologists are therefore reluctant to predict people’s health-seeking behavior as health planners would like them to do their descriptions of the context and emic-rationality of people’s therapeutic options may encourage health workers as well as public health system to adopt positive appreciation of people’s reasons of utilization and low utilization of health services (Hardon 1995).

With this understanding of the place of public health-care sector in the perspective of the people and utilization of services in the presence of alternatives, the next chapter sums up the findings of the study.