METHODOLOGY
Chapter 2

METHODOLOGY

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

OBJECTIVES OF THE STUDY:

The following objectives have been setforth for this study:

1. To describe differential distribution of morbidities and various health care practices among the caste, class and age-sex groups in the study village.
2. To examine whether the differential distribution of health care practices has any consistent patterns in relation to caste and class differences.

3. To find out whether there is any evidence of systematic deprivation or exclusion from health facilities and resources in the study village.

4. To discuss the nature and implications of differences between class and caste groups as observed in the study.

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

1. The Low Caste/Class group has higher prevalence of morbidity than the High Caste/Class group.

2. The Low Caste/Class takes less health action than the High Caste/Class group.

3. The Low Caste/Class group has a poorer nutritional status than the High Caste/Class group.
4. The High Caste/Class has better health care than Low Caste/Class group.

5. The High Caste/Class group is able to restrict or appropriate health services and resources against the Low Caste/Class group.

6. Do the Low Caste/Class group make greater use of Government health services and the High Caste/Class group make greater use of private health care services?

7. Is the image, perception and knowledge of PHC services different among the different Caste/Class groups?

8. Are females given less attention for their health problems than males?

OPERATIONALISATION OF CONCEPTS:

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

Caste is the most pervasive form of social stratification in India. It has great influence in almost all the fields of life. Its continuance is facilitated greatly by observance of endogamy, commensality, passage of food, ritual purity-pollution, exclusion and inclusion, rules of social distance, and restricted mobility. With the spread of education and modern outlook, there is some laxity in private circles and among youth in observance of commensal relations and purity-pollution norms. However, the older generation is still scrupulous in their strict observance and public image of caste status is intact largely. For the purpose of broad comparisons, it was decided to classify all the 20 castes present in the study village into three broad groups namely High Castes, Middle Castes and Low Castes. Small groups of elders belonging to different castes were chosen and were asked to rank all the 20 castes in the study village into three broad categories by reading out a list of castes present in the village (details given in the next chapter). There was consensus in placing the highest two castes - Brahman and Vysya into High Caste and Mala and Madiga into Low Caste groups. The Kamma and Kapu castes were also placed in High Caste group largely because of the acceptance of raw food items
such as rice, oil, flour, vegetables etc. by the Brahmins from them. The Kamma is a dominant caste—numerically, economically and politically—in the study village. It may be mentioned here that Kapu is the dominant caste in the region largely, but in the study village, only few households of Kapu are present. The Brahmins attend the ceremonies of both these castes on invitation but do not dine with them. From other castes, they do not accept any type of food—raw or cooked, nor will they attend their ceremonies. The Low Castes are the untouchables. On the other hand, the problem arose in ranking of castes in the Middle group as to who should rank above whom. There are fourteen castes in this group, some represented by few households while others with considerable numbers. Since our purpose is not to establish a composite caste hierarchy, it was sufficient to establish three broad groups for the sake of our study.

2. **Class**

Class is viewed here as an economic concept. For this, primary indicators of economic status such as land owned, occupation and income were chosen. Class variable is constructed by using a composite index of these three variables. Dak (1982) used a similar procedure in constructing class in
his study in rural Haryana. In the first instance, score for each of these three variables was assigned as follows:

a) **Land**: The total land owned by a household in all the sample households is taken into account. Necessary cut off points were made depending upon their spread in the sample and the likely income they enjoy. Accordingly, five categories were created. These are: landless; upto 2 acres; 2.1 - 5 acres; 5.1 - 10 acres and 10.1 - and above. All the five categories were given scores from 1 to 5 respectively.

b) **Income**: The total earnings of a household during the previous year from all the sources - land, occupation, wage, rent, etc. - was taken into consideration. The net annual income of all the households was divided into five categories: upto Rs. 4,000/-; Rs. 4001 - 6000; Rs. 6001 - 10000; Rs. 10001 - 50000 and Rs. 50000 and above. These categories were given scores from 1 to 5 respectively.

c) **Occupation**: In our sample, there are 27 occupations ranging from teaching, priesthood, agriculture to cobblerly. A list of these occupations were read out to small groups in the village and were asked to rank them. The highest named occupation was scored 1 and the lowest occupation 27 with other occupations being assigned the corresponding score as ranked by the villagers. The scores thus assigned by all the groups to a particular occupation
were totalled. All the occupations were arranged in ascending scores. Then, meaningful cut off points were made depending upon the gap in the score between one set of occupations and the other. Accordingly, five categories of occupations were identified. The highest ranked set of occupations were put in category I followed by next highest ranked in category 2 and so on. In all five categories were created. The highest ranked category was given score 5, followed by next highest ranked category with score 4 and so on. The scores thus ranged from 1 to 5.

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

The purpose of this procedure was only to broadly classify the sample households into three broad class groups based on land ownership, income and occupation. Unweighted 5-point scale were converted into score and added up into an index. This simple procedure provides a relative placement of households into three broad groups. A finer and more valid weighted scores would have been desirable if an interval scale was intended. However, even with such refinement the relative position of the households in 3 groups would have broadly
remained more or less the same. Since health care practice variables are mostly based on 3 point or 5 point qualitative rank, little advantage would have served if class as independent variable were constructed as refined interval scale.

3. **Caste and Class interactions**

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

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

The table 2.1 gives caste/class classification of 200 sample households using the procedures indicated above. As expected, chi-square test shows significant association at .001 level. However, measure of correlation (c = .61) indicates
<table>
<thead>
<tr>
<th>Class</th>
<th>Total</th>
<th>Low</th>
<th>Middle</th>
<th>High</th>
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<td>(%)</td>
<td>(%)</td>
</tr>
<tr>
<td>100%</td>
<td>200</td>
<td>48</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.0%</td>
<td>27.0%</td>
<td>49.0%</td>
<td></td>
</tr>
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<td></td>
<td>48.0%</td>
<td>37</td>
<td>18.4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>42.7%</td>
<td>18.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>23.5%</td>
<td>6.3%</td>
<td>30.6%</td>
<td></td>
</tr>
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<td>47</td>
<td>6.4%</td>
<td>29.8%</td>
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<td>28.5%</td>
<td>8.5%</td>
<td>51.0%</td>
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</tr>
<tr>
<td></td>
<td>57</td>
<td>8.3%</td>
<td>5.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7.0%</td>
<td>5.3%</td>
<td>87.7%</td>
<td></td>
</tr>
</tbody>
</table>

Table 2.1: Case-Class distribution of households in the sample.
about 60% overlap. This means there is lack of overlap (perfect correlation) to the extent of about 40%. This is sufficient to justify treatment of these two variables as separate independent variables.

Percentages give a good indication of this difference. Assuming that class is more inclusive than caste (the latter being ascriptive and birth dependent) we find peculiar dilemma — while 85.4% of Low Caste households are in Low Class group (as expected) but among the Low Class households Low Castes are only 42.7% i.e. about 57% of the Low Class households belong to the higher castes (High & Middle) indicating relative polarisation of the two variables. However, picture is quite different with regard to High Castes. While only 51% of the High Caste households belong to the High Class, among the High Class households as many as 87.8% belong to the High Castes. The High Class is virtually confined to the High Castes (only 12% belong to the other castes). However, about half of the High Caste households do not fall in the High Class group but to lower class groups. On the other hand about 7% of the Low Caste households belong to the High Class group. These indicate the extent of economic mobility in the Low Caste group.
The table shows that 68.6% of the Middle Caste households belong to the Low Class group. Thus Middle Caste households are likely to display a profile of health care practices similar to the Low Caste households generally. Location of Middle Caste or Middle Class will not provide a middle position on a linear scale because of the pattern of distribution shown in table above.

RESEARCH TECHNIQUE:

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

In view of the objectives of our study, detailed discussions were held with the experts in the field. On the basis of the available literature and the suggestions of the experts, a questionnaire was developed covering aspects related to social and economic status, morbidity, utilization of health facilities and resources, nutrition, health practices etc. The questionnaire was pretested in a village 'Gopulayalapalli' in Nalgonda district in Andhra Pradesh. On the basis of this pretest, it was felt that the questionnaire was quite lengthy and required to be split up into smaller units so that these could be managed in a shorter time without placing a heavy demand on the time and patience of the respondents though it necessitated a number of visits to each respondent. Further, on the basis of the experience, the questionnaire was split up into smaller units and made necessary changes in them either by reframing, deleting or adding some questions. These questionnaires were further pretested in a village 'Siriwada' in East Godavari District in Andhra Pradesh. On the basis of this pretest, the questionnaires were edited, revised and finalised. Further, a check-list of common illnesses and their local terms was prepared by interviewing small groups of elderly and knowledgeable informants (Appendix A).
Keeping in view the kind of data required for both dimensions - health care and social stratification - five questionnaires were finally prepared. The first one was aimed at collecting all the basic information about the sample households in terms of its composition of members, their age, sex, education, occupation, landowned, income and the facilities owned like latrine, water source, electricity, bathroom, kitchen etc. The second one deals with morbidity both in its chronic and acute forms. This also covers aspects such as periodicity, type of illness - not clinical type but symptoms or complaints in their own knowledge (respondents) - and health action resorted to. The third one pertains to nutritional status and food habits of the household. The fourth one focusses on utilization of various health resources and facilities located within the village and outside the village. The fifth questionnaire deals with health practices in three parts (i) practices followed by the head of household (ii) practices of the mothers, and (iii) general practices followed by the household members (such as children).

Informal interviews were also held with practitioners, PHC personnel, informal leaders and others in the village to collect data on various aspects which have a bearing on the problem under investigation. Though a separate interview guide
was not prepared, the interviews were carried keeping in view the relevant aspects of the problem under investigation.

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

**SELECTION OF THE STUDY VILLAGE**

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

The guidelines framed for selecting the village were:

1. The village is multi-caste in its composition;
2. There is enough scope to identify sufficient number of respondents from landless to rich land owner categories;
3. A primary health centre is located either within the village or in a nearby village and has been functioning for a very long period, at least for 10-15 years;
4. The Primary Health Centre has its full strength of medical staff and most of them reside within the village;
5. The village has a number of folk-healers and private practitioners;
6. The village is connected with nearby towns where better health facilities are available.
With these criteria in mind, the District Medical and Health Department was consulted and a list of PHCs in the district with their coverage of the population and the services offered was obtained. After detailed discussions with the authorities in the department, it was decided to visit some PHCs to judge their suitability for our study. In this exploratory exercise, visits were made to Primary Health Centres located at Kandrapota in Peddapuram Taluk, Virava in Pithapuram Taluk and Rangampeta in Rangampeta Taluk. In all these villages, the PHC personnel including doctors, well-informed people and village elders were interviewed to have a firsthand knowledge about the population, numerical strength of various castes, pattern of land-ownership, availability of health facilities both within the village and outside the village, communication facilities etc. Upon careful consideration of various factors associated with the above mentioned villages in East Godavari District finally village Rangampeta was selected for our study. Results of my preliminary explorations in various villages is reported below.

**VILLAGE KANDRAPOTA**

First, a visit was made to Kandrapota village in Peddapuram taluk. Here, the PHC has been functioning since 1960. Most of the staff of the PHC do not reside within
the village but reside in Peddapuram, the taluk head-
quar ters of Samalkot, another nearby town, because of lack
of proper housing facilities, communication facilities,
educational opportunities, remoteness etc. Communication
facilities to nearby taluka head quarters, though at a
distance of 6 Kms, are extremely poor. The road is kachcha,
bumpy and heavily dusty. Only two buses of the Andhra
Pradesh State Road Transport Corporation (APSRTC) ply at
highly irregular intervals in the day. After 5 p.m. in the
evening there is no bus service. Barring RTC bus service,
there is no other motor transport. Only cycles or rickshaws
can be used as a means of transport depending upon their
availability. Needless to say, it is very remotely connected.
There are 19 sub-centres under its jurisdiction. Since it
did not satisfy our criteria, it was dropped.

VILLAGE VIRAVA:

Next, a visit to another village, Virava in Pithapuram
taluk was made. The nearest town, Pithapuram is its taluk
headquarters and is about five miles away from it. It is a
commercial town and has good hospital facilities. Buses ply
regularly between Pithapuram and Divili, a major village and
A recreational centre, via this village. Rickshaws are available to reach nearby towns and the road, though 'kachcha, is fairly good. After having met some of the criteria laid down for selection of a village, further information was collected. The Panchayat President was approached and explained our purpose and sought his help and cooperation. He provided the researcher with all the registers from his office where information on all houses in terms of their location, type, tax levied etc. was available. A master list of all the houses in the village was prepared. Later, some well informed people including the Panchayat clerk, were contacted to obtain the caste and occupational status of all the heads of the households in the village. Then, the Karanam (village accountant) was approached to get the data on land-holdings of all the heads of households. His records were consulted in his presence and his cooperation was sought to know about the changes in landholding pattern, if any, but not recorded in the registers or about those persons who migrated or died on the basis of his personal knowledge. Then, a master list of all houses with their respective caste, size of land holding and occupational status was prepared. Then the data were analysed to see the distribution pattern of households in various economic categories and castes.
The village is having a population of 4,165 as per 1981 census. The PHC covers a population of 73,991 spread over 11 sub-centres in 27 villages over an area of 58 square kilometers. It was established in 1960. The total coverage of land under this village is around 800 acres. This village was chosen as one of the three PHCs by the Ranga Raya Medical College, Kakinada for extending the specialist services as per their programme.

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

VILLAGE RANGAMPETA:

Next, exploratory visits were made to the village, Rangampeta in Rangampeta taluk. In this village, the PHC has been functioning since 1962 covering an area of 208 square kilometers with a population of 1,25,022 in 52 villages in 18 sub-centres. This village, like the above village, is also one of the three villages selected by Ranga Raya Medical College, Kakinada to extend the specialist services. Also a
voluntary organization, Jeeva Karunya Sangham, Rajahmundry used to visit this village earlier. This organization treats leprosy patients. This village is well connected by the road to the nearest taluka head-quarters, Peddapuram and a major town and a business centre, Rajahmundry. This village lies on the way between Kakinada, the district head-quarters and Rajahmundry. Transport facilities are fairly good. The State Road Transport buses, private buses and other motor vehicles and rickshaws ply through this village although the day and thinly during the night. It has now become the head-quarters of the Rangampeta Mandalam on recent introduction of Mandal system by the state government. There is a large number of institutions and facilities like banks, schools, post-office, veterinary hospital etc. Further, most of the PHC staff reside within the village either in government quarters or in private accommodation.

The total population in this village is 5,807. The total land coverage is around 3,000 acres. When compared to the previous two villages, this village has a better representation of graded land holding pattern, diverse occupations and different castes. A brief visit around the village shows the uneven prosperity where one finds well-built houses, tractors,
gobar gas plants, scooters on the one hand and on the other small thatched houses, dirty surroundings with pigs moving around freely etc. This village is also having a hamlet, Chandredu, at a distance of about 3 kms. with a population of about 2,000.

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

Selection of sample households

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

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

**TABLE 2.2**

Distribution of Sample Households by Caste and Class Groups

<table>
<thead>
<tr>
<th>Class</th>
<th>Caste</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High</td>
<td>Middle</td>
</tr>
<tr>
<td>High Class</td>
<td>50</td>
<td>3</td>
</tr>
<tr>
<td>Middle Class</td>
<td>30</td>
<td>14</td>
</tr>
<tr>
<td>Low Class</td>
<td>18</td>
<td>37</td>
</tr>
<tr>
<td>TOTAL</td>
<td>98</td>
<td>54</td>
</tr>
</tbody>
</table>
CONDUCT OF FIELDWORK AND
FIELDWORK EXPERIENCES:

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

After selecting the respondents, they were approached and explained the purpose of our study. In the first instance some were convinced and some were not. Each selected household was visited at least twice or more to collect the required data as it was not possible for the respondents to spare their time continuously. It was found difficult to contact those again who gave their data partly in an earlier sitting because of their preoccupation with agricultural operations. It was noticed that throughout the year, people are busy either in agricultural operations or in activities related to construction, selling etc. Hence, the difficulty in collection of data from the respondents. In some cases,
if the head of the household was not present, the other members in the family especially women were not willing to talk to us. Some respondents thought that we came from some tax department and were collecting information for imposing new taxes. One respondent was suspicious of our activities till the end of our fieldwork presuming that there had been something deeper than what we were apparently telling them inspite of our sustained efforts to convince him of the purely academic nature of our pursuit on several occasions.

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

Incidentally, no map of this village was available either in Panchayat office or in Mandal headquarters. As a result, the researcher had to practically survey every street to
prepare a rough sketch showing various houses, institutions, temples etc. After drawing a rough sketch of small areas of the village on small sheets of paper, these were all put together and finally prepared a master map of the entire village. These maps are given in the next chapter.

FRAMEWORK OF THE REPORT AND PRESENTATION OF DATA:

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

Each chapter reporting results (Ch. 4-6) is organised in two sections. The first section presents the observations pertaining to a variety of variables particularly indicating differences within caste and class groups and also differences among class and caste groups. The second section summarises important caste-class differences reflected in data and makes brief comments about the broad patterns reflected in the data.
For each variable data is reported in a uniform way. First of all overall distribution of households as per categories of a variable is reported. Then for each variable castewise distribution is reported noting absence or presence of differences within caste groups. Next distribution by class groups for the same variable is examined to identify (a) such classwise distributions which are different from the castewise distribution (b) class differences substantially more than the magnitude of castewise differences. Most of the tables are given in the appendix and only important or abridged tables/charts are given in the text. It may be noted that although only High-Low Caste/Class groups are discussed in the report, the tables in the Appendix give original data on all the three caste/class groups. Reasons for this analytical procedure are noted below. Materials based on informal interviews or observations are presented wherever relevant. Chapter three is largely based on these sources.

**ANALYSIS PROCEDURES :**

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

As indicated above our objective is not to test a hypothesis or validate a theoretical model. The purpose of
analysis is primarily to describe differences in morbidities and health care practices in relation to Caste/Class categories. In doing so important within - class/ caste and among-caste/class differences have been identified. An effort will be made, wherever possible to discuss or explain important observations.

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

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

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

We have discussed above the overall pattern of Caste and Class cross-tabulation (Table 2.1) and noted that only 25-29 per cent of the Middle Caste/Class overlap exists i.e. 75 per cent of the Middle Caste do not belong to Middle Class and 70 per cent of Middle Class do not belong to the Middle Caste. By and large 69 per cent of the Middle Caste households belong to the Low Class group and 64 per cent of the Middle Class households belong to the High Castes (see table 2.1).
Because of such relationship sometimes Middle Caste/Class group displays affinity with High Caste/Class, sometimes with Low Caste/Class. Middle Class/Caste groups have rarely displayed linear middle position in the distribution as shown in the diagram below:

![Graph showing relationship between Caste/Class and Variable 'x'.]

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

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

We have presented our analysis exclusively in terms of percentages. Quantitative data is often subjected to more sophisticated statistical procedures. Although it was initially considered to undertake computer analysis but the idea was
given up because of practical difficulties and our suspicion that interpretations will become difficult. When we subject a crosstable to a particular test we get a measure of overall association or correlation between the two variables. But the questions we are interested in, refer to regression or the slope for a 3 x 3 nominal variables regression exercise does not tell much more than percentages or Charts.

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