MORBIDITY AND SOCIAL STRATIFICATION
Chapter 4

MORBIDITY AND SOCIAL STRATIFICATION

Morbidity is one of the indices of health status in a community. A person is considered morbid when he shows symptoms reflecting onset of a disease. A disease may be seen as a change in the body system toward a morbid state (pathology) brought about by some external or internal agent acting on body functions directly or indirectly. The U.S. Department of Health for its National Health Survey defined morbidity as:

Morbidity is basically a departure from a state of physical or mental well-being, resulting from disease or injury, of which the affected individual is aware. It includes not only active or progressive disease but also impairments, that is chronic or permanent defects that are static in nature, resulting from disease, injury or congenital malformation. The existence of morbidity in an individual caused by a particular disease, injury or impairment is called "morbid" condition or simply a "condition" (U.S. Deptt. of Health, 1958).

Morbidities can be categorised broadly as (1) Acute and (2) Chronic depending upon the duration and the degree of severity.

Acute disease is the one which starts abruptly, reaches its formation quickly and terminates in a limited duration. Chronic diseases develop insidiously over a long duration and continue for prolonged periods with periodic flare-ups and progressive deterioration. Episodes lasting for more than 30 days duration are treated for the purpose of this study as chronic morbidity episodes while episodes lasting for less than 30 days are treated as acute morbidity episodes after Seal (1971: 329, 564). Acute morbidities are further differentiated as (1) Minor (less than 2 days) (2) Mild (3–6 days) (3) Moderate (7 to 30 days). This refers only to the duration and not to the seriousness of the episode.

Data on morbidity episodes experienced over a three month period were collected from all the 200 sample households consisting of 1000 individuals. Information for each respondent was obtained about all episodes of illnesses that each member of a family suffered during the preceding three months from the date of interview. The head of the household and/or other elderly male member in the same household were interviewed to obtain this information. A check-list of diseases/symptoms was used to help the respondents to recollect the episodes suffered by all the family members as accurately as possible. As generally happens in a rural setting, other members of the
family as well as neighbours also used to gather around whenever data were collected. They often used to help the respondent to recollect the missing information. A three-month recall period was fixed after preliminary explorations which showed that in longer recall period (such as one year) only serious and prolonged morbidity episodes are reported. This leads to underreporting of short-term morbidity episodes.

In this chapter relationship of social stratification to morbidity is examined in terms of differences in prevalence of morbidities (chronic and acute) among the different caste/class groups. In light of literary evidence we expect that High Caste/Class groups will have lower prevalence of morbidity than the Low Caste/Class groups.

Following parameters of morbidity are discussed separately:

a) Number of morbidities in a group;
b) Duration of morbidity episodes;
c) Number of persons sick (reporting morbidities);
d) General morbidity rate;
e) System-wise distribution of complaints;
f) Frequency of complaints.

This chapter is divided into three sections: the first section presents the distribution of morbidities in the sample
population; the second one deals with remedial health action and the third one discusses the impact of social stratification on morbidity and health action.

SECTION 1

DISTRIBUTION OF MORBILITIES

Results in the distribution of morbidities are presented in three sub-sections:

1.1 Morbidity patterns in the sample population in general covering the above mentioned six aspects separately (a to f);

1.2 Acute and chronic morbidities examined by Caste/Class group differences;

1.3 Age sex differentiation of morbidities in Caste/Class groups.

1.1 Morbidities in the Sample Population in General:

1.1(a) Distribution of Morbidities:

Before discussing morbidity parameters in relation to social stratification under sub sections 1.2 and 1.3, a general description of morbidity parameters is briefly reported here in sub-section 1.1.
Practically, all the sample households (99 per cent) reported occurrence of one or more acute morbidities (of less than 30 days duration). Chronic morbidities (of more than 30 days duration) were reported by 68.5 per cent (137) households in the sample for a three month recall period. Details are discussed later.

In all, 1230 morbidity episodes of both acute and chronic types were reported from the sample households for a three month period. Of these, 1012 episodes (82.3 per cent) were of acute and 218 (17.7 per cent) were of chronic type. In other words, for every four acute morbidities reported in the sample, there was approximately one chronic morbidity.

1.1(b) Duration of morbidity episodes:

By and large, of the three types of acute morbidities, minor morbidity episodes accounted for 31.8 per cent of the total morbidities reported in the sample followed by moderate (26.9 per cent) and mild (23.6 per cent) morbidity episodes while chronic morbidity episodes (17.7 per cent) were substantially lower.
1.1(c) **Number of persons sick**

*(reporting morbidities)* :

As shown in the table below there were 601 (60.1 per cent) persons who reported morbidity episodes in the sample. Of the total number of persons reported sick 41 (6.8 per cent) persons reported only chronic morbidities while the remaining 560 (93.2 per cent) reported both acute and chronic morbidities. (see also table 4.1 A in appendix)

<table>
<thead>
<tr>
<th>Type of Morbidity</th>
<th>High Caste</th>
<th>Low Caste</th>
<th>High Class</th>
<th>Low Class</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute and Chronic</td>
<td>270 (92.2%)</td>
<td>142 (95.3%)</td>
<td>172 (92.0%)</td>
<td>261 (94.2%)</td>
<td>560 (93.2%)</td>
</tr>
<tr>
<td>Only Chronic</td>
<td>23 (7.8%)</td>
<td>7 (4.7%)</td>
<td>15 (8.0%)</td>
<td>16 (5.8%)</td>
<td>41 (6.8%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>293 (100%)</td>
<td>149 (100%)</td>
<td>187 (100%)</td>
<td>277 (100%)</td>
<td>601 (100%)</td>
</tr>
</tbody>
</table>
1.1(d) **General Morbidity rate**:

I) The "Morbidity-prevalence rate" for analysis here refers to the number of episodes for 100 persons over a 3 month period. "Annual Morbidity rate" is used sparingly for expressing prevalence of morbidities per person over a period of one year. The latter has been avoided for the present analysis due to the problem of seasonality and poor reliability of long recall period. The survey period was September-November and it cannot be assumed that morbidity prevalence during other seasons was the same.

The three-month prevalence rate was calculated by using the following formula:

\[
\frac{\text{No. of episodes}}{\text{Total No. of persons in the sample}} \times 100 \text{ (over a 3 month period)}
\]

The morbidity-prevalence rate over a three month period for the sample was 123.

II) The morbidity-prevalence rate can be further analysed in terms of number of morbidities suffered per 100 sick persons in the sample over a three month period. The denominator in this case is total number of sick persons in the sample population. The three-month morbidity prevalence rate per 100 sick persons in the sample is 204.6.
1.1(e) **Disease system-wise frequency of complaints**

More than 80 types of specific complaints (morbidities) of both acute and chronic types were reported by the sample respondents. A list of these complaints (morbidities) with their frequency of occurrence in the sample can be seen in Appendix B. For the purpose of analysis and clear understanding, all these complaints were classified with the help of a physician into ten major types of morbidity categories on the basis of biological system related to the reported complaints. Although this procedure is somewhat arbitrary it provides some broad idea about the frequency of various types of morbidities. Only those complaints which could not be categorized without a proper clinical examination or affect different biological systems simultaneously were placed under the category "Others". All these complaints were reported by the respondents themselves. Some of the morbidities were already diagnosed by the doctors and the respondents were, therefore, able to report specific diagnosis such as heart enlargement, leprosy, jaundice, etc. Some difference in categorization of complaints on the basis of "self-reporting" by the respondents and the actual medical diagnosis, though expected, is unavoidable. The different types of system-wise categories used here are (1) Musculo-skeletal system
(2) Digestive system (3) Respiratory system (4) Circulatory system (5) Excretory system (6) Reproductive system (7) Nervous system (8) ENT and sense organs (9) Mental disorders and (10) Others.

In general, the complaints related to ENT and sense organs were the most frequently reported (21.5%) followed by the complaints of digestive system (16.5%) and musculo-skeletal system (12.4%). Complaints of circulatory and reproductive systems accounted for about 7 per cent each. Respiratory complaints comprised 5 per cent. Excretory, mental and nervous disorders were reported in a very small proportion and all of these together constituted 1.5 per cent of the total complaints reported.

1.1(f) Frequency of complaints:

In all, more than 80 complaints of both acute and chronic types were reported in the sample. A list of these complaints with frequency of their occurrence in the sample can be seen in appendix B. The ten most common complaints are given in the following table (Table 4.2).

These ten complaints alone accounted for half (51.74%) of the total complaints (1230) reported in the sample.
Table: 4.2

Frequency of complaints reported often in the sample

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Complaint</th>
<th>Frequency (per centage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Fever</td>
<td>9.75</td>
</tr>
<tr>
<td>2.</td>
<td>Head-ache</td>
<td>8.29</td>
</tr>
<tr>
<td>3.</td>
<td>Dental caries</td>
<td>5.77</td>
</tr>
<tr>
<td>4.</td>
<td>Motions</td>
<td>5.04</td>
</tr>
<tr>
<td>5.</td>
<td>Cough</td>
<td>4.95</td>
</tr>
<tr>
<td>6.</td>
<td>Pain in leg joints</td>
<td>4.63</td>
</tr>
<tr>
<td>7.</td>
<td>Heart complaints</td>
<td>4.14</td>
</tr>
<tr>
<td>8.</td>
<td>Back-pain</td>
<td>3.41</td>
</tr>
<tr>
<td>9.</td>
<td>Ear-complaints</td>
<td>2.92</td>
</tr>
<tr>
<td>10</td>
<td>Stomach pain</td>
<td>2.84</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>51.74</td>
</tr>
</tbody>
</table>

1.2 Acute and Chronic Morbidities

In this sub-section, we shall examine finer differences within the total, acute and chronic morbidities among caste and class groups.

1.2(a) Distribution of morbidities and stratification:

As mentioned earlier, in all 1230 morbidity episodes of both acute and chronic types were reported by the sample house-
holds for a three month period. Of those, 1012 (82.3%) episodes were of acute and 218 (17.7%) were of chronic illness. Small differences were observed in distribution of both acute and chronic morbidities within the caste and class groups. As shown in the following table with regard to distribution of acute morbidities, the Low Caste group had slightly more (87.3%) morbidities than the High Caste group (80.0%). Similar trend was observed in class groups also. In contrast to this, with regard to the distribution of chronic morbidities, the High Caste group reported slightly more chronic morbidities (20%) than the Low Caste group (12.7%). Similar pattern was observed in class groups also.

<table>
<thead>
<tr>
<th>Type of Morbidity</th>
<th>High Caste</th>
<th>Low Caste</th>
<th>High Class</th>
<th>Low Class</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>432 (80.0%)</td>
<td>343 (87.3%)</td>
<td>268 (79.8%)</td>
<td>528 (83.3%)</td>
<td>1012 (82.3%)</td>
</tr>
<tr>
<td>Chronic</td>
<td>108 (20.0%)</td>
<td>50 (12.7%)</td>
<td>68 (20.2%)</td>
<td>106 (16.7%)</td>
<td>218 (17.7%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>540 (100%)</td>
<td>393 (100%)</td>
<td>336 (100%)</td>
<td>634 (100%)</td>
<td>1230 (100%)</td>
</tr>
</tbody>
</table>
The magnitude of difference in class groups in distribution of both acute and chronic morbidities was less than the magnitude of difference between the caste groups.

1.2(b) **Duration of Episodes and stratification**

As noted earlier, episodes lasting for less than 30 days were classified as acute morbidities. Following Seal, (1971), we distinguished three categories of acute morbidities - Minor (less than 2 days), Mild (3–6 days) and Moderate (7–30 days). As the following table shows, by and large, minor episodes accounted for about 32% of the total morbidity episodes in the sample followed by Moderate (26.9%) and Mild (23.6%) episodes. The chronic morbidities (more than one month duration) were substantially lower (17.7%). Break-up for chronic episodes is as follows: less than one year 4.2 per cent, 1–3 years - 4.4 per cent and more than 3 years - 9.1 per cent.

There are few caste-wise differences of minor nature. Among the Low Caste group, the proportion of minor episodes was highest (37.7%) in comparison to the High Caste group (29.6 %) and correspondingly, the proportion of Chronic
### Table 4.4

Distribution of Acute and Chronic morbidities (Durationwise) in Caste and Class groups

<table>
<thead>
<tr>
<th>Type of Morbidities</th>
<th>High Caste</th>
<th>Low Caste</th>
<th>High Class</th>
<th>Low Class</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACUTE MORBIDITIES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor (less than 2 days)</td>
<td>160 (29.6%)</td>
<td>148 (37.7%)</td>
<td>92 (27.4%)</td>
<td>201 (31.7%)</td>
<td>391 (31.8%)</td>
</tr>
<tr>
<td>Mild (3-6 days)</td>
<td>115 (21.3%)</td>
<td>92 (23.4%)</td>
<td>67 (19.9%)</td>
<td>161 (25.4%)</td>
<td>290 (23.6%)</td>
</tr>
<tr>
<td>Moderate (7-30 days)</td>
<td>157 (29.1%)</td>
<td>103 (26.2%)</td>
<td>109 (32.4%)</td>
<td>166 (25.2%)</td>
<td>331 (26.9%)</td>
</tr>
<tr>
<td><strong>CHRONIC MORBIDITIES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>23 (4.2%)</td>
<td>12 (3.0%)</td>
<td>13 (3.9%)</td>
<td>31 (4.9%)</td>
<td>52 (4.2%)</td>
</tr>
<tr>
<td>1-3 years</td>
<td>30 (5.6%)</td>
<td>7 (1.8%)</td>
<td>22 (6.6%)</td>
<td>17 (2.7%)</td>
<td>54 (4.4%)</td>
</tr>
<tr>
<td>More than 3 years</td>
<td>55 (10.2%)</td>
<td>31 (7.9%)</td>
<td>33 (9.8%)</td>
<td>58 (9.1%)</td>
<td>112 (9.1%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>540 (100%)</td>
<td>393 (100%)</td>
<td>336 (100%)</td>
<td>634 (100%)</td>
<td>1230 (100%)</td>
</tr>
</tbody>
</table>

Morbidities in the Low Caste group was less (12.7%) in comparison to about 20% of the chronic morbidities in the High Caste group. Further break-up of chronic and acute morbidities showed that there was no consistent pattern of
small differences in caste groups. Chronic morbidities of more than 3 years duration were around 9 per cent in all the caste groups. Similar trend was observed in class groups also. (See details in table 4.4 A in Appendix)

The magnitude of difference in the class groups in distribution of both acute and chronic morbidities was less than the magnitude of difference between caste groups.

1.2(c) **Number of persons sick (reporting morbidities) and Stratification**

As shown in the following table (4.5), in all, 56 per cent of the respondents reported illness with acute morbidities during the period of investigation. Among caste groups, in the Low Caste group slightly more number of persons (62.6%) reported sick than the High Caste group (53.5%). Similar is the case with the class groups also. Thus, in the Low Caste and Low Class groups slightly more number of persons reported sick than in the High Caste and High Class groups.

In chronic morbidities, 18.4 per cent of the respondents reported chronic morbidities. There is not much difference in the number of persons reported sick in caste and class groups. (see also table 4.5 A in appendix).
Table: 4.5

Number of persons with Morbidities in Caste and Class groups

<table>
<thead>
<tr>
<th>Type of Morbidity</th>
<th>High Caste N=505</th>
<th>Low Caste N=227</th>
<th>High Class N=343</th>
<th>Low Class N=431</th>
<th>TOTAL N=1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>270 (53.5%)</td>
<td>142 (62.6%)</td>
<td>172 (50.1%)</td>
<td>261 (60.6%)</td>
<td>560 (56.0%)</td>
</tr>
<tr>
<td>Chronic</td>
<td>91 (18.0%)</td>
<td>42 (18.5%)</td>
<td>58 (17.0%)</td>
<td>89 (20.6%)</td>
<td>184 (18.4%)</td>
</tr>
</tbody>
</table>

1.2(d) Morbidity - prevalence rate and stratification:

1) Morbidity-prevalence rate per 100 persons in the sample:

As shown in the following table, in general, the morbidity-prevalence rate per 100 persons in the sample was 123 for total morbidities. It was found that there were marked differences in prevalence rate for caste and class groups. Largely, the Low Caste (173.1) and the Low Class (147.1) groups had a higher prevalence rate than the High Caste (106.9) and the High Class (98) groups. This clearly indicates the negative relationship between caste/class status and morbidity prevalence: the lower the caste/class status, greater the prevalence rate.
Table: 4.6
Morbidity Prevalence rate (per 100 persons/3 month period) in Caste and Class groups

<table>
<thead>
<tr>
<th>Type of Morbidity</th>
<th>High Caste</th>
<th>Low Caste</th>
<th>High Class</th>
<th>Low Class</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>85.5</td>
<td>151.1</td>
<td>78.1</td>
<td>122.5</td>
<td>101.2</td>
</tr>
<tr>
<td>Chronic</td>
<td>21.4</td>
<td>22.0</td>
<td>19.8</td>
<td>24.6</td>
<td>21.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>106.9</td>
<td>173.1</td>
<td>98.0</td>
<td>147.1</td>
<td>123.0</td>
</tr>
</tbody>
</table>

For acute morbidities, the morbidity prevalence rate per 100 persons in the sample was 101.2. As observed for total morbidities, the Low Caste and Low Class groups had higher rates of prevalence than other groups. While the Low Caste group had a morbidity prevalence rate of 151.1, the Low Class group had 122.5 as against the prevalence rate of 85.5 for the High Caste and 78.1 for High Class groups. Thus, it is seen that of all the caste and class groups, the High Class group had the lowest prevalence rate and the Low Caste, the highest prevalence rate.

For chronic morbidities, the morbidity prevalence rate per 100 persons was 21.8 in general. In caste and class groups not much difference was observed in the morbidity rate.
However, the Low Class group had slightly a higher prevalence rate (24.6) than other groups.

Though there is not much difference in the morbidity prevalence rate per 100 persons both for total morbidities and for acute morbidities between the High Caste and the High Class groups, the difference between the Low Caste and the Low Class groups is quite marked. (See also table 4.6 A in appendix)

ii) Morbidity prevalence rate per 100 sick persons:

The following table shows that in general, the morbidity prevalence rate per 100 sick persons in the sample for total morbidities was 204.6. As observed for morbidity prevalence rate per 100 persons in the sample, the morbidity rate per 100 sick persons was also higher in the Low Caste (263.7) and the Low Class (228.9) groups than the High Caste (184.3) and High Class (179.6) groups. Of all the groups, while the Low Caste group had the highest morbidity prevalence rate (263.7), the High Class group had the lowest morbidity prevalence rate (179.6).
For acute morbidities, the morbidity prevalence rate per 100 sick persons was 168.3. Similar trend as observed for total morbidities above was observed for acute morbidities also. The Low Caste (230.2) and the Low Class (190.6) groups had a higher rate of prevalence than the High Caste (147.4) and the High Class (143.3) groups.

Table : 4.7
Morbidity prevalence rate (per 100 sick persons/3 month period) in Caste and Class groups

<table>
<thead>
<tr>
<th>Type of Morbidity</th>
<th>High Caste N=293</th>
<th>Low Caste N=149</th>
<th>High Class N=187</th>
<th>Low Class N=277</th>
<th>TOTAL N=601</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>147.4</td>
<td>230.2</td>
<td>143.3</td>
<td>190.6</td>
<td>168.3</td>
</tr>
<tr>
<td>Chronic</td>
<td>36.8</td>
<td>33.5</td>
<td>36.3</td>
<td>38.2</td>
<td>36.2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>184.3</td>
<td>263.7</td>
<td>179.6</td>
<td>228.9</td>
<td>204.6</td>
</tr>
</tbody>
</table>

It was observed that though there was not much difference in the morbidity prevalence rate per 100 sick persons for total morbidities in the sample between the High Caste and the High Class groups (4.7), the difference between the Low Caste and the Low Class groups (34.8) was quite marked. Similar was the case with acute morbidities also.
For chronic morbidities, the morbidity prevalence rate per 100 sick persons was 36.2. Unlike the trend observed for total and acute morbidities, not much difference for chronic morbidity prevalence rate in caste and class groups was found. (see also table 4.7 A in appendix)

By and large, the caste differential in morbidity prevalence rate (both per 100 persons and 100 sick persons) for total and acute morbidities is greater than the class differential. For chronic morbidities, the differential is not marked as found in total and chronic morbidities.

iii) Morbidity - prevalence, sex and stratification:

In order to understand the magnitude of the prevalence of acute morbidity episodes, the number of acute morbidities suffered by a sick person among males and females in caste and class groups was taken for analysis. This is obtained by dividing the total number of episodes by total number of sick persons in a particular group. The figures in the following table represent average morbidities per sick person in the respective group.
<table>
<thead>
<tr>
<th>Sex</th>
<th>High Caste</th>
<th>Low Caste</th>
<th>High Class</th>
<th>Low Class</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1.69</td>
<td>2.27</td>
<td>1.75</td>
<td>1.83</td>
<td>1.78</td>
</tr>
<tr>
<td>Female</td>
<td>1.50</td>
<td>2.56</td>
<td>1.39</td>
<td>2.22</td>
<td>1.82</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1.60</td>
<td>2.40</td>
<td>1.55</td>
<td>2.02</td>
<td>1.80</td>
</tr>
</tbody>
</table>

The above table shows that in general, in the Low Caste group, a sick person on the average suffered more acute morbidities (2.4) than a sick person in the High Caste group (1.6). Interestingly, while a sick person both in the High Caste and the High Class groups suffered similar number of episodes (1.6), a sick person in the Low Caste group suffered more episodes (2.4) than a sick person in the Low Class (2.0) group.

In all it was observed that the average acute morbidities per sick male was (1.78) almost the same as the average acute morbidities per sick female (1.82). However, there are small male-female differences within caste and class groups. Both the sick males (2.27) and the sick females (2.56) in the Low
Caste group suffered slightly more number of episodes than the sick males and the sick females in other groups. Of the total sick persons in the sample, while the sick females in the Low Caste group suffered more number of episodes (2.56) sick females in the High Class group suffered less number (1.4) of morbidities.

It is also observed from the following table that the number of chronic morbidities suffered by a sick person are much uniformly distributed in caste and class groups as well as among males and females.

<table>
<thead>
<tr>
<th>Sex</th>
<th>High Caste</th>
<th>Low Caste</th>
<th>High Class</th>
<th>Low Class</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1.20</td>
<td>1.26</td>
<td>1.20</td>
<td>1.18</td>
<td>1.20</td>
</tr>
<tr>
<td>Female</td>
<td>1.17</td>
<td>1.13</td>
<td>1.14</td>
<td>1.20</td>
<td>1.15</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1.18</td>
<td>1.19</td>
<td>1.17</td>
<td>1.19</td>
<td>1.18</td>
</tr>
</tbody>
</table>

1.2(e) **System-wise frequency of Morbidities and Stratification:**

In general, complaints related to ENT and sense organs were the most frequently reported morbidities (21.5%) in the sample.
followed by complaints of digestive system (16.5%) and musculo-
skeletal system (12.4%). There are some differences in
distribution of total morbidities in caste and class groups.
The musculo-skeletal complaints were marginally higher in the
Low Caste group (16.3%) than in the High Caste group (10.2%)
while the circulatory ailments were slightly more among the
High Caste group (7.6%) than in the Low Caste group (4.8%).
Class groups also showed similar differences (Table. 4.10).

The system-wise distribution of acute morbidities followed
more or less the same pattern as reported above. Complaints
related to ENT and sense organs (23.3%) accounted for a larger
proportion of all acute morbidities followed by disorders of
digestive system (18.1%) and musculo-skeletal system (10.6%).
Disorders of other systems were found in less proportion:
Reproductive system 7.4%, circulatory system 4.1%, respiratory
system 4.0% and nervous system 0.3%. Broadly, an identical
trend of distribution of system-wise morbidities was observed
among different caste and class groups. There is not much
difference among the High and Low Caste/Class groups in parti-
cular in this regard.

With regard to the system-wise distribution of chronic
morbidities, disorders of musculo-skeletal system formed the
largest segment (21.1%) followed by complaints of circulatory
system (18.8%) and ENT and sense organs (13.3%). Disorders of other systems were found in a small measure: respiratory (9.6%), digestive (9.2%), nervous (5%), reproductive (3.2%), mental disorders (1.8%) and excretory system (0.4%). As regards distribution of systemwise chronic morbidities in caste and class groups, some differences were observed. Disorders of circulatory system in the High Caste group (22.2%) accounted for a larger proportion compared to the Low Caste group (10%). In contrast to this, disorders of ENT and sense organs in the Low Caste group (22%) were of a larger proportion than in the High Caste group (12%). Respiratory disorders were also slightly more in the Low Caste group (16%) than in the High Caste group (5.5%). Similar trend was observed in class groups also.

In all, while the disorders of ENT and sense organs and of digestive system were predominant in acute morbidities (41.4%), the disorders of musculo-skeletal and circulatory systems were predominant in the chronic morbidities (40%). The three most frequently reported system-wise acute and chronic morbidities in caste and class groups are given in the following table.

It is seen from the above table that while the three most frequently reported categories of complaints—ENT and sense organs, digestive system and musculo-skeletal—remains
### Table: 4.11

Three most frequently reported system-wise complaints of acute and chronic morbidities by caste and class groups

<table>
<thead>
<tr>
<th>Type of Morbidity</th>
<th>High Caste</th>
<th>Low Caste</th>
<th>High Class</th>
<th>Low Class</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACUTE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT &amp; sense organs (23.6%)</td>
<td>ENT &amp; sense organs (23.6%)</td>
<td>ENT &amp; sense organs (24.6%)</td>
<td>ENT &amp; sense organs (22.3%)</td>
<td>ENT &amp; sense organs (23.3%)</td>
<td></td>
</tr>
<tr>
<td>Digestive disorders (19.2%)</td>
<td>Digestive disorders (18.4%)</td>
<td>Digestive disorders (19.8%)</td>
<td>Digestive disorders (18.0%)</td>
<td>Digestive disorders (18.1%)</td>
<td></td>
</tr>
<tr>
<td>Musculo-Skeletal (7.2%)</td>
<td>Musculo-Skeletal (15.7%)</td>
<td>Reproductive (7-4%)</td>
<td>Musculo-Skeletal (13.3%)</td>
<td>Musculo-Skeletal (10.6%)</td>
<td></td>
</tr>
<tr>
<td><strong>CHRONIC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculo-skeletal or circulatory (22.2%)</td>
<td>ENT &amp; sense organs (22.0%)</td>
<td>Circulatory (28.0%)</td>
<td>Musculo-skeletal (24.5%)</td>
<td>Musculo-skeletal (21.1%)</td>
<td></td>
</tr>
<tr>
<td>ENT &amp; sense organs (12.0%)</td>
<td>Musculo-skeletal (20.0%)</td>
<td>Musculo-skeletal (14.7%)</td>
<td>ENT &amp; sense organs (17.0%)</td>
<td>Circulatory (18.8%)</td>
<td></td>
</tr>
<tr>
<td>Digestive (7.4%)</td>
<td>Respiratory (16.0%)</td>
<td>ENT &amp; sense organs (13.2%)</td>
<td>Respiratory (13.2%)</td>
<td>ENT &amp; sense organs (13.3%)</td>
<td></td>
</tr>
</tbody>
</table>
largely the same for caste and class groups in acute
morbidities, there are some differences with regard to
chronic morbidities. In the first place, while the muscle-
skeletal or circulatory disorders were predominant in the
High Caste group (22.2%) disorders of ENT and sense organs
(22%) were predominant in the Low Caste group. Similarly,
while the circulatory disorders occupied first place in the
High Class group (28%), musculo-skeletal disorders were
predominant in the Low Class group (24.5%). Similar differences
were observed in the second and third ranked most frequent
disorders in caste and class groups also.

1.3 **Morbidities by sex, age**

and Stratification:

In this sub-section, we shall examine the age and sex
variables in distribution and duration of morbidities among
caste and class groups.

1.3(a) **Distribution of morbidities**:

It is observed from the following table that in general
the number of morbidities among males were slightly more
(51.4%) than among females (48.6%). This corresponds very
closely to their respective proportions in the sample. There
were small differences in distribution of morbidities among
males and females in different caste and class groups. In the High Caste group, morbidities were slightly more (54.4%) among males than among females (45.6%). In contrast to this, in the Low Caste group morbidities were slightly more among females (51.7%) than among males (48.3%). Similar trend was observed in class groups also. (see also table 4.12 A in appendix)

It is further observed that the distribution of acute morbidities among males and females was identical. (around 50%). In distribution of chronic morbidities more complaints were found among males (56.4%) than among females (43.6%) (Table 4.13)

**Table 4.12**

Distribution of total Morbidity episodes among males and females in caste & class groups

<table>
<thead>
<tr>
<th>Sex</th>
<th>High Caste</th>
<th>Low Caste</th>
<th>High Class</th>
<th>Low Class</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male</strong></td>
<td>294 (54.4%)</td>
<td>190 (48.3%)</td>
<td>176 (52.4%)</td>
<td>306 (48.3%)</td>
<td>632 (51.1%)</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>246 (45.6%)</td>
<td>203 (51.7%)</td>
<td>160 (47.6%)</td>
<td>328 (51.7%)</td>
<td>598 (48.9%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>540 (100%)</td>
<td>393 (100%)</td>
<td>336 (100%)</td>
<td>634 (100%)</td>
<td>1230 (100%)</td>
</tr>
</tbody>
</table>
The age-sex-specific distribution of morbidities (per 100 persons) reveals interesting trends. It is calculated as follows:

\[
\frac{\text{No. of morbidities in an age-sex group}}{\text{No. of persons in the same age-sex group}} \times 100 \text{ (3 months)}
\]

By and large, the age-sex specific morbidity rate (per 100 persons) is found highest in the age group of 45-54 (212), closely followed by the age groups of 55-64 (199) and 35-44 (177).

The highest age-sex specific morbidity rate was found in the age-group of 55-64 (215) among males and in the age group of 45-54 among females (219). Similarly, the next highest rate was found in the age group of 45-54 among males (205) and in the age group of 35-44 among females (197). In other words, the age specific groups of 45-64 among males and 35-44 among females experienced more morbidities (Table 4.14 and Fig. 4.1).

It was observed that more or less a similar trend as noted above for total morbidities was found for the age-sex specific rates for acute morbidities also (Table 4.15).
FIG. 4.1 DISTRIBUTION OF MORBIDITY RATE AMONG MALES AND FEMALES IN AGE GROUPS.
For chronic morbidities, the age-sex-specific-morbidity rate (per 100 persons) was found highest in the age-group of 55-64 (63), closely followed by the age-group of 65+ (54). Among males, the highest morbidity rate was found in the age group of 65+ (78) followed by 55-64 age group (67) while among females, the highest morbidity rate was found in the age group of 55-64 (57) followed closely by the age group of 45-54 (44) (Table 4.16).

In all, the age groups of 45-54 and 55-64 were more vulnerable to morbidities. In terms of acute and chronic morbidities, it was observed that while the age group of 45-54 was more vulnerable to acute morbidities, the age-group of 55-64 was more vulnerable to chronic morbidities.

In terms of male-female difference it was observed that the age-groups of 45-54 and 55-64 among the males and the age-groups of 35-44 and 45-54 among the females are susceptible to more morbidities. A similar trend was observed for acute morbidities also. On the other hand, in chronic morbidities, it was found that the age-groups above 55 among the males and the age-groups of 45-54 and 55-64 among the females were more vulnerable to morbidities.
1.3(b) **Duration of morbidities by Sex and Stratification**:

In general as reported above, 82.3 per cent of morbidities were of acute type and 17.7 per cent of the morbidities were of chronic type.

In other words, for every four acute morbidities in the sample there was one chronic morbidity. Of all types of acute morbidities, Minor illness, (of short duration and simple in nature) was found slightly more (31.8%) in the sample than the Moderate (27%) and Mild (23.5%) types of morbidities. This trend was broadly observed in both caste and class groups. However, moderate morbidities were found slightly more (31.8%) in the High Class group than minor (27.4%) and mild (20.5%) morbidities (Table 4.17).

Minor to moderate differences were observed among age-sex specific groups classified by caste and class for total and acute morbidities. (For details see table 4.17 and 4.18).

In distribution of chronic morbidities it was found that nearly half (51.4%) of them were of longer duration, i.e. more than 3 years while the rest were either of less than one year (23.4%) or of 2-3 years (25.2%) duration. There are some
differences in distribution of these morbidities in caste and class groups. Chronic morbidities of longer duration (3+ years) were slightly more in the Low Caste group (62%) than in the High Caste group (50.9%). In contrast to this, chronic morbidities of less than 3 years duration were more in the High Caste (49.1%) than in the Low Caste (38%) group. More or less a similar pattern was observed in class groups also (Table 4.19).

In terms of distribution of chronic morbidities among males and females, it was observed that these were slightly more (56.1%) among males than among females (45.3%). Chronic morbidities of shorter duration, that is less than one year were more in females (34.7%) than in males (14.6%). In all, chronic morbidities of more than one year duration were more among males (85.4%) than among females (65.3%).

Of males and females, in caste and class groups, chronic morbidities of longer duration were more among males (66.7%) and females (57.7%) in the Low Caste group than their counterparts in the High Caste group (males 55%, females 45.8%). Similar trend was observed in class groups also.

On comparison of chronic and acute morbidities individually, it was observed that among females chronic morbidities of less
than one year duration (34.7%) and minor morbidities (41.2%) were more than among males (Chronic morbidities 14.6% minor morbidities 36.1%). In contrast to this, among males chronic morbidities of longer duration of more than one year (85.4%) were more than among females (65.3%).

1.3(c) **Distribution of Morbidities by Age and Stratification**

In general, with the exception of the age group of 15-24 years, morbidity increased with each successive age group till 54 years and then declined sharply. The distribution of morbidities in various age-groups is as follows: 0-4 years (4.4%), 5-14 years (12.7%), 15-24 years (10.2%), 25-34 years (15.1%), 35-44 years (17.4%), 45-54 years (21.9%), 55-64 years (13.3%) and 65 years and above (5.0%). In the age-groups of 35-44 and 45-54 morbidities were found slightly higher than in other age-groups. Similarly, morbidities were found less in the age-group of 65+ (5.0%) and in children below 4 years (4.4%). (Table 4.20 and Fig. 4.2).

In distribution of morbidities small differences were observed in caste and class groups. Morbidities in the Low Caste in the age-group of 45-54 years (25.2%) were slightly more
FIG. 4.2 DISTRIBUTION OF MORBIDITY EPISODES IN AGE GROUPS AMONG CASTE AND CLASS GROUPS.
than morbidities in the same age group in the High Caste
group (18.0%). Similar trend was observed in the age-group
of 35-44 also. In contrast to this, slightly more morbidities
were found in the High Caste in the age group of 55-64 years
(14.4%) and 65+ (6.3%) than in the Low Caste group (55-64:8.9%;
65+: 1%). In other words, in the Low Caste group morbidities
were more (46.8%) largely in middle-age (35-54) than in the
High Caste group (34.3%). On the other hand, in the High Caste
group morbidities were more (20.7%) in old age (55+) than in
the Low Caste group (9.9%). In class groups, an identical
pattern was observed. High-Low Class difference is marginally
more than the High-Low caste difference for some age groups
(0-4; 5-14; 15-24; 25-34; 45-54).

It was observed that both in the Low Caste and Low Clas-
groups morbidities were more in middle age than in the High
Caste and High Class groups respectively. Similarly, in old-
age morbidities were slightly more in the High Caste and the
High Class groups than in the Low Caste and Low Class groups
respectively. Greater morbidity in middle age in the Low
Caste and Low Class groups reflect their susceptibility to
illness which in turn is associated with factors such as
their working pattern, nature of environment in which they
live, response to illness etc.
The distribution of acute morbidities by age-groups in different caste and class groups was similar to the trend described above for total morbidities. (Table 4.21) However, with regard to age-wise distribution of chronic morbidities among caste groups some differences were observed. As expected, chronic morbidities tend to increase with advancement in age. The distribution of chronic morbidities by age-groups is as follows: - 14 years (6.9%); 15-24 years (3.7%); 25-34 years (14.2%); 35-44 (18.8%); 45-54 (22.4%); 55-64 (23.9%) and 65+ (10.1%). Chronic morbidities were found more in old age i.e. 55 years and above (34.0%) than in other age groups (Table 4.22).

Small differences in distribution of chronic morbidities between caste and class groups were observed. In the High Caste group, more chronic morbidities (36.1%) were reported in the age group of 55 and above than in the Low Caste group (14.0%). On the other hand, in middle age (35-54) more chronic morbidities were found in Low Caste group (52.0%) than in the High Caste group (37.0%). It is emphasised here that about one-third of total chronic morbidities in the Low Caste group were concentrated in 35-44 age group (30.0%) alone while in the same age-group in the High Caste group these accounted for only 16.7 per cent of the total chronic morbidities in that group. In children also, chronic morbidities were slightly more in the Low Caste
group (14.0%) than in the High Caste (6.5%) group. In class groups also, more or less a similar trend was observed. In all, both in the Low Caste and Low Class groups in middle age more chronic morbidities were found than in the High Caste and High Class groups (Table 4.22).

On comparing the distribution of acute and chronic morbidities in different age-groups, it was observed that in old-age (55+) chronic morbidities were more (34.0%) than acute morbidities (15.0%). In contrast to this, in children (≤ 14 years) acute morbidities (19.2%) were more than chronic morbidities (6.9%). Similarly, in the age group of 15-24, acute morbidities (14.2%) were more than chronic morbidities (3.7%). In other age groups, more or less a similar proportion both in acute and chronic morbidities were found. In caste and class groups, the Low Caste and Low Class groups had more acute morbidities in the age group of 45-54 years and more chronic morbidities in the age group of 35-54 years when compared to the High Caste and High Class groups respectively.

1.3(d) Duration of morbidities by age and Stratification:

For the sake of analysis and better understanding the various age-groups were categorised into four broad groups - 14 years; 15-34 years; 35-54 years and 55+ and these were called as children, youth, middle-aged and old-aged respectively.
The distribution of morbidities in these groups is as follows: 17.0 per cent in children, 25.4 per cent in youth, 39.3 per cent in middle age and 18.3 per cent in old age. This shows that morbidities increased from children to middle age and then declined in old age. This pattern was observed in all types of morbidities—minor, mild, moderate and chronic—in caste and class groups (Table 4.23).

Some differences were observed in distribution of various types of morbidities among children, youth, middle-aged and old people in caste and class groups. In the Low Caste and Low Class groups morbidities in middle-age were more (around 45%) than in the High Caste and High Class groups (around 33%). In the Low Caste group in old-age morbidities were less (9.9%) than in the High Caste (20.7%) group.

In children, minor morbidities were slightly more in the High Caste group (21.3%) than in the Low Caste group (10.8%). In contrast to this, chronic morbidities in children in the Low Caste group (14%) were more than in the High Caste group (6.5%). Similar trend was observed in class groups also.

Among youth, moderate morbidities were more in the High Class group (37.4%) than in the Low Class group (15.4%).
In middle-age, moderate (45.6%) and chronic (52.0%) morbidities were slightly more in the Low Caste group than in the High Caste group (moderate 30.8%, chronic 37.0%). Similar trend was observed in class groups also.

In old age, chronic morbidities were more in the High Caste group (36.1%) than in the Low Caste (14.0%) group. Similar trend was observed in Class groups also. However, the difference in class groups was very small. In the High Class group, chronic morbidities were slightly more (36.8%) than in the Low Class (30.2%) group.

1.3(e) Morbidities (person-wise) by age and sex:

The distribution of persons suffering from morbidities (sick persons) in various age groups reveals interesting patterns. In all, 601 persons out of a sample of 1000 reported morbidities (60.1%). The largest number of sick persons out of the total number of the sick were children of 5-14 years of age (18.3%), followed closely by the age-group of 45-54 (17.8%). The proportion of sick persons in various age-groups out of the total number of sick persons in the sample is as
follows:

<table>
<thead>
<tr>
<th>Age group</th>
<th>Percentage</th>
<th>Age group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 4 years</td>
<td>5.8</td>
<td>35-44 years</td>
<td>14.5</td>
</tr>
<tr>
<td>5-14 years</td>
<td>18.3</td>
<td>45-54 years</td>
<td>17.8</td>
</tr>
<tr>
<td>15-24 years</td>
<td>13.3</td>
<td>55-64 years</td>
<td>11.3</td>
</tr>
<tr>
<td>25-34 years</td>
<td>14.5</td>
<td>65+</td>
<td>4.5</td>
</tr>
</tbody>
</table>

There are small differences in distribution of sick persons among males and females in various age-groups. In children (-14 years) slightly more number of sick persons were found among boys (26.7%) than among girls (21.5%). In the age-groups ranging from 15-54 slightly more sick females were found (66.3%) than males (53.8%). In 35-44 age-group, sick females were found slightly more (17.4%) than males (11.6%). In the age-group of 55-64 more sick males were found (14.5%) than females (8.2%) (Table 4.24).

If we look at the number of persons sick and the number of morbidity episodes occurred sex-wise among children, youth, middle-aged and old-people, it reveals interesting trends. Among males, sick persons were more in children (26.7%) and middle aged (29.1%) whereas among females they were more in
youth (30.8%) and middle-aged (35.6%). This pattern was largely found both in acute and chronic morbidities. Among old people (55+) more sick males were found with chronic morbidities (42.1%) than females (20.7%). In terms of distribution of morbidity episodes it was found that there was greater concentration of total morbidity episodes among females in middle age (45.1%) than males (33.7%). This pattern was found both in acute and chronic morbidities. Of the acute and chronic morbidity episodes, concentration of chronic morbidity episodes was slightly more (49.5%) than the acute morbidity episodes (44.3%) among females in middle age. Similarly, there was greater concentration of morbidity episodes among males in old age (25.2%) than among females (11.1%). This trend was observed both in acute and chronic morbidity episodes. Of these two, concentration of chronic morbidity episodes in old age among males was more (43.9%) than acute morbidity episodes (20.6%) (Table 4.25).

In all, in terms of distribution of persons sick, middle age was the group largely affected followed closely by youth, children and old people. In terms of distribution of morbidity episodes, as observed above, middle age group was predominantly affected followed closely by youth. Thus, middle-age and youth were the largely affected groups in terms of morbidity distribution both by persons-wise and episodes-wise.
SECTION 2

HEALTH ACTION

In this section, the extent of health action taken by various social groups was presented. Age and sex variables were also taken into consideration.

2.1 Presence of Health Action:

Health action is defined here as any action taken by a sick person to restore one's own health. It includes consulting medical practitioners, healers, application of self-medication and any other means resorted to for recuperation of health. In about 80 per cent of reported morbidities some form of health action was taken. In other words, 20 per cent of morbidities were neglected by not taking any health action.

The extent of health action resorted to among various groups for total, acute and chronic morbidities reveals interesting trends. While the High Caste group resorted to health action for 85.4 per cent of total morbidities, the Low Caste group resorted to health action for only 70.2 per cent of total morbidities. Similar trend was observed in case of class groups also. The difference in extent of health action taken between High Caste and Low Caste groups is greater than the extent in High Class and Low Class groups. It was observed
that there was a positive trend of association between health action taken and the caste and class status — higher the caste/class status, greater the extent of health action taken (Table 4.26, Fig. 4.3).

In case of acute morbidities, more or less the same trend as observed for total morbidities was found. But in case of chronic morbidities only 65.6 per cent of morbidities were taken care of by health action in general. While the High Caste group reported health action for 75 per cent of the chronic morbidities, the Low Caste group reported health action for only 52.0 per cent of the chronic morbidities. Similar trend was observed in class groups also. The difference in the extent of health action resorted to by the class groups is smaller than in caste groups as observed above for acute and total morbidities.

2.2 Health Action by Sex and Stratification:

Health action taken by various social groups among males and females shows interesting trends.
FIG. 4.3 DISTRIBUTION OF HEALTH ACTION IN CASTE AND CLASS GROUPS FOR ACUTE AND CHRONIC MORBIDITIES.
2.2(a) **Total Morbidities**

In general, nearly 80 per cent of the morbidities both among males and females were taken care of by health action. It was observed that there are some differences in the proportion of health action taken by males and females in caste and class groups. In caste groups, among males less health action was reported in the Low Caste group (73.7%) than in the High Caste group (83.7%). Similarly, among females in the Low Caste group less health action (67.0%) was reported than in the High Caste group (87.4%). Similar trend was observed in class groups also. The difference in extent of health action taken by caste groups is more than the difference in class groups. It is further observed that females in the Low Caste group not only took less health action when compared to females in other caste groups, but also in the population in general (Table 4.27 and Fig. 4.4). This can be better understood if we take into consideration the number of morbidities taken care of by health action in proportion to each morbidity neglected among males and females in caste and class groups.
FIG. 4.4  HEALTH ACTION TAKEN BY MALES AND FEMALES IN CASTE AND CLASS GROUPS.
Table: 4.28

Ratio of morbidities taken care of by health action to each morbidity neglected in caste and class groups among males and females

<table>
<thead>
<tr>
<th>Sex</th>
<th>High Caste</th>
<th>Low Caste</th>
<th>High Class</th>
<th>Low Class</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>5.1</td>
<td>2.8</td>
<td>4.5</td>
<td>3.3</td>
<td>4.0</td>
</tr>
<tr>
<td>Female</td>
<td>6.9</td>
<td>2.0</td>
<td>5.7</td>
<td>2.8</td>
<td>3.7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>5.8</td>
<td>2.4</td>
<td>5.0</td>
<td>3.0</td>
<td>3.8</td>
</tr>
</tbody>
</table>

The above table indicates that the Low Caste and Low Class groups took less health action than the High Caste and High Class groups respectively. In the Low Caste group while 2.4 morbidities were taken care of by health action per morbidity neglected, 5.8 morbidities were taken care of by health action in the High Caste group. Similarly, in the Low Class group, while 3 morbidities were taken care of by health action for each morbidity neglected, 5 morbidities were taken care of by health action in the High Class group. It is thus seen that of all the caste and class groups, while the Low Caste group reported least extent of health action (2.4) the High Caste group reported greater extent of health action (5.8).
Among males and females, while females in the Low Caste group reported least extent of health action (2.0), females in the High Caste group reported highest extent of health action (6.9) which are the least and highest extents of health action taken not only among females but in the population in general. This indicates that in general among females there is a greater neglect of morbidities in the Low Caste group while there is greater health action for morbidities in the High Caste group.

In all, males and females in the High Caste group took more health action than males and females in the Low Caste group. Similar trend was observed in class groups also. The extent of difference in health action in class groups is smaller than the difference in caste groups. This indicates a clear trend of association in taking health action and caste/class status: higher the caste/class status, greater the extent of health action taken.

2.2(b) Acute Morbidities:

Out of 1012 acute morbidities, 509 were reported by males (50.3%) and 503 (49.7%) by females. Of the 509 morbidities in males, 431 (84.7%) were taken care of by health action while among females, out of 503 episodes, 403 (80%) were taken care of by health action (Table 4.29).
In order to have a clear picture of the extent of health action taken, the number of acute morbidities taken care of by health action to one acute morbidity neglected among males and females in caste and class groups has been analysed.

Table : 4,30

<table>
<thead>
<tr>
<th>Sex</th>
<th>High Caste</th>
<th>Low Caste</th>
<th>High Class</th>
<th>Low Class</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>6.8</td>
<td>3.5</td>
<td>6.4</td>
<td>4.5</td>
<td>5.5</td>
</tr>
<tr>
<td>Female</td>
<td>8.0</td>
<td>2.1</td>
<td>5.4</td>
<td>3.1</td>
<td>4.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>7.3</td>
<td>2.7</td>
<td>5.9</td>
<td>3.7</td>
<td>4.6</td>
</tr>
</tbody>
</table>

The above table shows that greater health action was taken in the High Caste and High Class groups than in the Low Caste and Low Class groups. Of all the caste and class groups, the High Caste group reported greater extent of health action (7.3) and the Low Caste group least extent of health action (2.7). In general, among males and females, slightly greater extent of health action was taken by males (5.5) than females (4.0). Of all the groups, both among males and females, females in the High Caste group took greatest extent of health action (8.0). In contrast to this, females in the
Low Caste group took least extent of health action (2.1) in the population in general. This trend is similar to the trend observed above for total morbidities. In class groups, the pattern is slightly different. Of both males and females, males in the High Class group took greater extent of health action (6.4). In caste groups, while females in the High Caste group took greatest extent of health action (8.0), among class groups males in the High Class group took greatest extent of health action (6.4). It is observed that the differences in the extent of health action in class groups both among males and females were of lesser magnitude than the differences in health action in caste groups. Further, it may be inferred that illness among females in Low Caste and Low Class groups is viewed with less concern and anxiety.

Both in morbidity and health action, caste/class status is reflected - higher the Caste/Class status lesser the extent of morbidity and greater the extent of health action. Further, in general the difference in the extent of morbidities prevalent and the extent of health action resorted to is of lesser magnitude in class groups than in caste groups.
2.2(c) Chronic Morbidities:

Out of the 218 chronic morbidities reported in the sample, 123 (56.4%) belonged to males and 95 (43.6%) to females. Of the 123 chronic morbidities among males, 75 (61.0%) were taken care of by health action. Among females, out of 95 chronic morbidities, 68 (71.6%) were taken care of by health action. This means that of males and females, females resorted to health action for a larger number of chronic morbidities than males. This observation is contrary to the one noted above for acute morbidities where slightly greater extent of health action was resorted to among males (84.7%) than females (80.0%) (Table: 4.31).

To have a better understanding of the extent of health action taken among males and females in caste and class groups, the number of chronic morbidities taken care of by health action to one chronic morbidity neglected has been analysed.

Table: 4.32

<table>
<thead>
<tr>
<th>Sex</th>
<th>High Caste</th>
<th>Low Caste</th>
<th>High Class</th>
<th>Low Class</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2.3</td>
<td>0.8</td>
<td>1.7</td>
<td>1.2</td>
<td>1.5</td>
</tr>
<tr>
<td>Female</td>
<td>4.3</td>
<td>1.3</td>
<td>7.0</td>
<td>1.6</td>
<td>2.5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3.0</td>
<td>1.0</td>
<td>3.0</td>
<td>1.4</td>
<td>1.9</td>
</tr>
</tbody>
</table>
The above table shows that in the High Caste and High Class groups, three chronic morbidities each were taken care of by health action to every one chronic morbidity neglected which is the maximum extent of health action taken in any caste/class group. In the Low Caste and Low Class groups, the number of chronic morbidities taken care of by health action to one chronic morbidity neglected were 1.0 and 1.4 respectively. Thus, out of all the caste/class groups, while the Low Caste group took least extent of health action, the High Caste and the High Class groups took maximum extent of health action.

Among males and females, for one chronic morbidity neglected, females took care of 2.5 chronic morbidities while males took care of only 1.5 chronic morbidities. In Caste and Class groups, females took care of more number of chronic morbidities than males. While females in the High Class group took care of as many as seven chronic morbidities for one chronic morbidity neglected, females in the Low Caste group took care of only 1.3 chronic morbidities. Thus, while females in the High Class group reported highest extent of health action (7.0) females in the Low Caste group took least extent of health action (1.3). Among males, males in the High Caste group took care of larger number of chronic morbidities (2.3) than in
any other caste/class group. On the other hand, males in
the Low Caste group took least health action (0.8) where the
number of morbidities neglected are more than the number of
morbidities taken care of. Thus, while females in the
High Class group took greater extent of health action, males
in the Low Caste group took least health action of both males
and females in caste and class groups. The difference in
health action taken by females between High and Low Class
groups is greater than the difference in health action taken
by females between the High and Low Caste groups.

The above observation is contrary to the observation
made earlier for acute morbidities. In acute morbidities while
females in the Low Caste group took least extent of health
action (2.1), in chronic morbidities males in the Low Caste
group took least extent of health action (1.2). On the
other hand, in acute morbidities while females in the High
Caste group took greater extent of health action (8.0), it
is females in the High Class group who took greater extent of
health action (7.0) for chronic morbidities. It is interesting
to note that while the maximum difference in the extent of
health action in High Caste (8.0) and Low Caste (2.1)
groups for acute morbidities is more among females, it is
also more among females for chronic morbidities in the High
Class (7) and Low Class (1.6) groups. The differential in
health action reflects differential perception of acute and
**FIG. 4.5** HEALTH ACTION TAKEN AMONG CHILDREN, YOUTH, MIDDLE AGED AND OLD PEOPLE IN CASTE AND CLASS GROUPS.
chronic morbidities by males and females in caste and class
groups. While the females in the Low Caste group perceived
acute morbidities with less concern, the males in the same
group perceived chronic morbidities with less concern. Of
all the groups the Low Caste followed by Low Class took
least extent of health action. This indicates their lack of
concern and anxiety for remedial health action for morbidities
which can be attributed to their poor living conditions, lack
of awareness and negligence.

2.3 Health Action by Age
and Stratification:

For the purpose of clear understanding of health action
taken, the various age-groups were grouped into four broad
categories, namely children (–14 years), youth (15–34 years),
middle aged (35–54 years) and old aged (55+).

2.3(a) Total Morbidities:

Among all age categories, children were better taken
care of by health action. Among them, 90.0% of the morbid-
ties were taken care of. In rest of the categories, only
about 75.0% of the morbidities were taken care of by health
action (Table 4.33 and Fig. 4.5).
There are some differences in the extent of health action taken for total morbidities in caste and class groups among children, youth, middle-aged and old people. In general, greater proportion of health action (84.4%) was taken in the High Caste group than in the Low Caste group (70.2%). Similar trend of health action taken by caste groups was more than the difference in class groups. In both the High Caste and High Class groups, the proportion of health action taken in children was more than the health action taken in other categories—youth, middle-aged and old people. Same is the case with the Low Caste and Low Class groups. Among old people the proportion of health action taken in both the caste and class groups was more or less of the same order (around 74-76%). It is interesting to note that among youth, the proportion of health action taken was very less (61.1%) in the Low Caste group than in the High Caste group (89.7%). Similar was the trend with the class groups also. Further, the proportion of health action taken among youth in the Low Caste group (61.1%) was the lowest compared to the proportion of health action taken among children, middle-aged and old people in all other caste and class groups. In contrast to this, the proportion of health action taken for children was the highest in the High Caste group (96.9%) when compared to the proportion of health action taken in other categories in all other caste and class groups. The difference in the extent of health action taken in caste groups was more than those of class groups.
2.3(b) Acute Morbidities:

More or less a similar pattern of health action as observed for total morbidities was found for acute morbidities for caste and class groups also. As observed for total morbidities, 90.0 per cent of the acute morbidities in children were taken care of by health action. In other categories, about 80 per cent of acute morbidities were taken care of. (Table 4.34).

2.3(c) Chronic Morbidities:

For chronic morbidities, only 65.6 per cent of the morbidities were taken care of by health action in general (Table 4.35).

There were some differences in the extent of health action taken in various categories in caste and class groups. In children while 86.7 per cent of the morbidities were taken care of by health action, among youth only 56.4 per cent of morbidities were taken care of. Incidentally, the proportion of health action among youth is the least proportion of health action taken compared to all other categories - children middle-aged and old people.
It is observed that among children greater proportion of health action (86.7%) was taken than in other categories. Among youth, least extent of health action (55.4%) was taken. In general, less proportion of health action was reported (52%) in the Low Caste group than in the High Caste group (75%). Similar was the pattern in class groups also. It is emphasised here that youth: in Low Caste (30%) and Low Class groups (35.7%) took least extent of health action when compared to health action taken by other categories (children, middle-aged and old people) in the High Caste, High Class, Low Caste and Low Class groups. Old people in the Low Caste group took less proportion of health action (42.8%) when compared to the proportion of health action taken by old people in other caste and class groups (High Caste 76.9 per cent, High Class 76 per cent and Low Class 59.4 per cent). In general, the differences in the extent of health action taken in caste groups are more than the differences in the class groups among various categories.

On comparing the extent of health action taken for chronic and acute morbidities, it was observed that less number (65.6%) of chronic morbidities were taken care of by health action than acute morbidities (82.4%). This shows that the extent of negligence of chronic morbidities is about (34.4%) twice that of acute morbidities (17.6%).
In terms of health action taken in various categories it was observed that in children both for chronic and acute morbidity a greater proportion of health action (nearly 90%) was resorted to than in other categories. In middle-aged and old people while 80 per cent of acute morbidities were taken care of only about 66 percent of chronic morbidities were taken care of by health action. It is of interest to note that among youth, while nearly 80% percent of acute morbidities were taken care of, only 56.4 per cent of chronic morbidities were taken care of. The difference in the extent of health action taken between acute and chronic morbidities in the Low Caste group was more than in other caste groups. Among youth in the Low Caste group, greater negligence of both acute and chronic morbidities was observed (acute morbidities 30 per cent against overall average of 56.4 per cent). These differences would be more glaring when compared with the High Caste group. Similar trend was observed among youth in the Low Class group also. The greater negligence of morbidities in general and chronic morbidities in particular among youth in the Low Caste group indicates their less concern for health action because of lack of economic means, lack of awareness, negligence etc. This in turn will have a serious impact on the productivity in general and the income of the households in particular. The magnitude of difference in health action both in acute and chronic morbidities is less in the class groups than in the caste groups.
Difference in health action in proportions between High Caste and Low Caste groups and High Class and Low Class groups for Selected variables

In general, it was observed that the magnitude of difference in proportions between the High Caste and Low Caste groups for a large number of variables was more than the magnitude of difference in proportions between High Class and Low Class groups (Table 4.36).

For some variables, the proportion in the High Caste group was more than the proportion in the Low Caste group. Similar was the trend with regard to class groups for these variables. These variables are: distribution of chronic morbidities, health action taken among males, health action taken among females, health action taken among children, youth, middle-aged and old people, distribution of morbidities among children and old people etc. This can be represented as:

- High Caste > Low Caste
- High Class > Low Class

For some variables, the proportion in Low Caste group was more than the proportion in the High Caste group. Similar was the trend with class groups as well. These variables
are: distribution of acute morbidities, distribution of morbidities in middle-age etc. This can be represented as:

Low Caste > High Caste
Low Class > High Class

In some variables, the difference in proportions between the High Caste and Low Caste groups is about the same as the difference in proportion between the High Class and Low Class groups. These variables are: health action taken by old people, distribution of morbidities in children, middle-aged people etc. This can be represented as:

High Caste > Low Caste = High Class ≈ Low Class

It is interesting to observe further that for some variables, the proportions in the High Caste and Low Caste and the High Class and Low Class groups are more or less of the same order. These variables are: Health action taken by old people and morbidity in children. This can be represented as:

High Caste = Low Caste
High Class = Low Class
In sum, it is observed that for a large number of variables caste differences were more than class differences.

SECTION 3

DISCUSSION

In the previous sections, the influence of social stratification in prevalence of morbidity and in taking health action was presented. In this section, the relative influence of caste and class in the prevalence of morbidity and in taking health action is discussed. For some variables, the Low Caste group had greater proportion than the High Caste group and vice-versa. Similar is the case with the Low and High Class groups also. For some variables there is marginal difference in caste/class, caste and class groups. Age and sex variables also influence the pattern of morbidity and health action.

The Low Caste group had greater proportion of morbidity than the High Caste group in the following aspects:

1. The Low Caste group had slightly more morbidity episodes than the High Caste group.
2. Persons reported sick were more in Low Caste group than in the High Caste group.
3. The Low Caste group had a higher morbidity prevalence rate than the High Caste group. Incidentally, the Low Caste group had the highest morbidity prevalence rate among all the caste and class groups. Similarly, it had also the highest prevalence rate per 100 sick persons of all the caste and class groups.

4. A sick person in the Low Caste group suffered more number of episodes than a sick person in the High Caste group. Here also, the Low Caste group is the one which suffered larger number of episodes than any other group. Further, both the sick males and sick females in the Low Caste group suffered more number of morbidity episodes than sick males and sick females in other groups.

5. As regards distribution of system-wise morbidity episodes, musculo-skeletal complaints were slightly higher in the Low Caste group than in the High Caste group. Further, chronic morbidities of ENT and sense organs and respiratory system were more in the Low Caste group than in the High Caste group.

6. As far as duration of morbidity episodes is concerned, minor illness episodes were more in the Low Caste group than in the High Caste group. In the Low Caste group minor illness was more among females than among males. Incidentally, this group had the highest proportion of minor morbidity episodes of all the caste and class groups. Similarly, chronic morbidities of more than three years duration were more in the Low Caste group than in the High Caste group. Both males and females in the Low Caste group had more chronic morbidities of longer duration than the males and females in the High Caste group respectively.
7. With regard to the distribution of morbidity in age groups, it was observed that morbidity episodes were more in middle-age (35-54) in the Low Caste group than in the High Caste group. Further, more chronic morbidities were found in middle age in this group than in the High Caste group. It is emphasised here that about one-third of total chronic morbidities in the Low Caste group were concentrated in 35-44 age group alone while in the same age group in the High Caste these were much less (about 1/6th only). By and large, morbidities particularly moderate and chronic in middle-age were more in the Low Caste group than in the High Caste group. In old age, in the Low Caste group, morbidities were less than in the High Caste group. In children, in the Low Caste group, chronic morbidities were more than in the High Caste group.

8. In general, less health action was taken in the Low Caste group than in the High Caste group. Of all the caste and class groups, while the Low Caste group took least extent of health action, the High Caste group took greater extent of health action. Further, in the Low Caste group the number of chronic morbidities neglected are equal to the number of chronic morbidities taken care of by health action.

Less health action was taken among males and females in the Low Caste group than males and females in the High Caste group respectively. It is interesting to note that of both males and females in all caste and class groups, least health action was taken among females in the Low Caste group while greatest extent of health action was taken among females in the High Caste group.
9. It is also interesting to note that among youth, the proportion of health action taken was very less in the Low Caste group than in the High Caste group. Further, the proportion of health action taken among youth in the Low Caste group was the lowest compared to the proportion of health action taken among children, middle aged and old people in all caste and class groups.

In the High Caste group, the following aspects of morbidity were more than in the Low Caste group.

1. The High Caste group experienced slightly more chronic morbidities than the Low Caste group.

2. In general, circulatory disorders were more in the High Caste group than in the Low Caste group. This is more so with regard to chronic circulatory disorders.

3. In the High Caste group, morbidities were more among males than among females.

4. In old age group (55+) more chronic morbidities were reported in the High Caste group than in the Low Caste group.

5. In general, the High Caste group reported health action for more number of morbidities than the Low Caste group. Further, more chronic morbidities were taken care of in the High Caste group than in the Low Caste group.
6. For acute morbidities, females in the High Caste group took more health action than males not only in the same group but also in the total population in general.

7. In the High Caste group, greater proportion of health action was taken for chronic morbidities than in the Low Caste group. In particular, health action taken among youths in the High Caste group was much greater than in the Low Caste group.

8. In all, males and females in the High Caste group took more health action than males and females in the Low Caste group. Further, the health action taken by males and females in the High Caste group is the highest extent of health action in the sample in general.

More or less a similar trend was observed in class groups also.

For some variables, the difference in proportions in Caste or Class groups, Caste and Class groups is very marginal. For chronic morbidities, the morbidity prevalence rate (21.8) was more or less the same in all the caste and class groups. There is a small difference in morbidity prevalence rate per 100 sick persons in the High Caste and High Class groups. A sick person both in the High Caste and High Class groups suffered more or less similar number of episodes. The number of chronic morbidities suffered by a sick person are much uniformly distributed in caste and class groups.
In addition to caste and class differences, there are sexwise differences also in some of the aspects of morbidity and health action. In general, the number of morbidities among males were slightly more than among females. The distribution of acute morbidities among males and females was more or less equal. In distribution of chronic morbidities more complaints were found among males than among females.

As regards distribution of morbidities by duration is concerned, minor illness was slightly more among females than among males while mild and moderate illnesses were found in the same proportion both among males and females. Chronic morbidities among males were slightly more than among females. Further, chronic morbidities of longer duration were more among males than among females. In general, of males and females, slightly greater extent of health action was taken by males than females. Of all the groups, both among males and females, females in the High Caste group took greatest extent of health action. In contrast to this, females in the Low Caste group took least extent of health action in the population in general.

In caste and class groups females took care of more number of chronic morbidities than males while males took care of more number of acute morbidities than females.
There are also age-wise differences in some aspects of morbidity and health action.

In general, with the exception of the age-group of 15-24 years, morbidity increased with each successive age-group till 54 years and then declined sharply. In the age-groups of 35-44 and 45-54, morbidities were found slightly higher than in other age-groups. The distribution of morbidities in various age-categories was: children 17 per cent, youth 25.4 per cent, middle-age 39.3 per cent, and old-aged 18.3 per cent. This shows that morbidities increased from children to middle-age and then declined in old-age. This pattern was observed in all types of morbidities — minor, mild, moderate and chronic — in caste and class groups.

The largest number of sick persons out of the total number of sick were children of 5-14 years of age (18.3%) followed closely by the age-group of 45-54 (17.8%).

Among all the age-categories, children were better taken care of by health action. Among them, 90 per cent of the morbidities were taken care of. In rest of the categories, only about 75 per cent of the morbidities were taken care of. For chronic morbidities, among children while 86.7 per cent of the morbidities were taken care of by health action, among
youths only 56.4 per cent of the morbidities were taken care of, which are the highest and least extents of health action taken in all age groups.

In children, both for chronic and acute morbidities, greater proportion of health action (nearly 90%) was resorted to than in other age-categories. In middle-aged and old people while 80 per cent of acute morbidities were taken care of, only about 66 per cent of chronic morbidities were taken care of by health action. It is interesting to note that among youth, while nearly 80 per cent of acute morbidities were taken care of, only 56.4 per cent of chronic morbidities were taken care of. This shows that there is less concern for health action for chronic morbidities than for acute morbidities among youth.

There are some age-sex wise differences in some aspects of morbidity. In terms of male-female vulnerability to morbidities it was observed that the age-groups of 45-54 and 55-64 among males and the age-groups of 35-44 and 45-54 among females were susceptible to greater morbidities. A similar trend was observed for acute morbidities also. On the other hand, in chronic morbidities, it was found that the age groups
of 55-64 and 65+ among males and the age groups of 45-54 and 55-64 among females were more vulnerable to greater morbidities. In other words, females were susceptible to larger number of morbidities earlier than males by an age-group of 10 years.

Among children and old people slightly more sick males were found than sick females. In the age-groups ranging from 15-54, more sick females were found than sick males. Among old people, more sick males were found with chronic morbidities than sick females.

In terms of distribution of morbidity episodes it was found that there was greater concentration of morbidity episodes among females in middle-age than males. This pattern was found both in acute and chronic morbidities. Similarly, there was greater concentration of morbidity episodes among males in old-age (25.2%) than among females (11.1%).

The middle-aged and youth were the largely affected groups in morbidity distribution both in terms of persons as well as episodes.

In all, it was observed that there is a negative trend of relationship between stratification and prevalence of morbidity lower the caste/class status, greater the morbidity. This is
reflected both in morbidity prevalence rate and the number of
morbidity suffered by a sick person. In terms of health action,
there is a positive trend of relationship between stratification
and health action: Higher the caste/class status, greater the
extent of health action. In other words, there is greater neg-
ligence of morbidity in Low Caste and Low Class groups. Further
of these two, it is the Low Caste group which neglected more
number of morbidities than the Low Class group.

In general, females took slightly less health action than
males. But the caste and classwise results show interesting
trends. While females in the High Caste and High Class groups
took more health action than males in their respective groups,
females in the Low Caste and Low Class groups took less health
action than males in their respective groups. In general, health
action taken by females in the Low Caste group followed by Low
Class group was the lowest extent of health action taken in the
population. Thus, the females in the Low Caste group suffered
both caste and sex-wise disadvantages. Broadly, the Low Caste
and Low Class groups are susceptible to the disadvantage of
greater morbidities which is in turn closely related to their
living conditions, perception of illness etc. Comparatively,
less health action among these groups show their lack of enough
economic means to attend to the morbidities, lack of awareness
of the health facilities available, superstitions, sex-bias etc. In contrast to this, more health action was taken by the High Caste and High Class groups, both among males and females. Of males and females, it is females who took care of more morbidities than males both for acute and chronic morbidities. The difference in the extent of health action taken is more in the High and Low Caste groups than in the High and Low Class groups. In all, factors such as living conditions, beliefs, norms, values, occupations, economic means, education, superstitions etc. that are associated with stratification system in a community determine the extent of a group's susceptibility to morbidity and its resort to remedial health action.