UTILISATION OF HEALTH RESOURCES AND SOCIAL STRATIFICATION
Chapter 5:

UTILISATION OF HEALTH RESOURCES
AND SOCIAL STRATIFICATION

A variety of resources for health care are available to people in the village. These agencies are: (1) Primary Health Centre (PHC), (2) Private Practitioners (3) Folk Healers (4) Medical Shops (5) Community Health Volunteers (CHV) etc.
The field personnel of PHC such as Auxiliary Nurse Midwife (ANM), Multipurpose Health Worker (MPW) also dispense tablets, render advice etc. to the people, whenever needed. In nearby towns, specialists in various disciplines of medicine such as paediatrics, cardiology, ophthalmology are available for consultation. The details about these various resources are given elsewhere. In this chapter, the pattern of utilisation of these resources by different caste and class groups is discussed.

All the respondents were asked to report any visit made to these agencies by them or their family members during the period of two months preceding the date of interview approximately. Similarly, they were also asked to report about the visits made by ANM and MPW to their family during the
preceding six months period from the date of interview approximately. The variables included here are: the type of services used at PHC, type of experience about the services and personnel of PHC, type of preference for PHC and reasons for consulting PHC, type of preference and reasons for consulting other resources such as private practitioners, CHV, medical shops etc., items of medicinal value generally kept in house, use of water resources etc.

This chapter is divided into two sections: the first one deals with use of health services among caste and class groups and the second one discusses the relationship between the stratification and utilization.

SECTION 1

USE OF HEALTH SERVICES

VISITS TO VARIOUS HEALTH AGENCIES/PRACTITIONERS:

During the period of two months preceding the date of enquiry, the health resources visited by the sample households were (1) PHC (2) CHV (3) Private doctors outside the village (4) RMPs within the village (5) Folk healers and (6) Medical shops within the village.
In general, it is observed that PHC was mostly consulted by all social groups. During the period of investigation, 62.5 per cent of the sample households visited PHC for getting their various ailments cured. Next to PHC, 44 per cent of the sample households consulted RMP within the village. Consultation of private doctors outside the village (39%), folk healers (25.5%) and CHV (14.5%) followed PHC and RMP. Some differences are observed in consultation of these various health resources by different caste and class groups. The Low Caste (68.7%) and the Low Class (65.6%) groups consulted PHC slightly more frequently than the High Caste (59.1%) and the High Class (54.3%) groups. The High Class group (59.6%) and the High Caste group (46.9%) consulted private doctors outside the village substantially more frequently than the Low Caste (27%) and the Low Class (33.3%) groups. RMPs within the village were utilised by the High Class group (63.1%) more than any other caste/class group (High Caste 45.9 per cent, Low Class 42.7 per cent and Low Caste 41.6 per cent). Interestingly, both the High Caste (32.6%) and the High Class (33.3%) groups visited folk healers more frequently than the Low Caste (20.8%) and the Low Class (22.9%) groups. However, the CHV was consulted much more by the Low Caste group (41.6%) than any other group (Low Class 21.8 per cent, High Caste 9.1 per cent and High Class 3.5 per cent). Figure 5.1 presents these differences for visual comparison.
FIG. 5.1 UTILIZATION OF HEALTH RESOURCES IN CASTE AND CLASS GROUPS.
In all, the local PHC was consulted in greater frequency than any other health resource available by all social groups. Private doctors outside the village (59.6%) and the local private practitioners (63.1%) were consulted by the High Class group more frequently than any other group. On the other hand, CHV is largely consulted by the Low Caste group (41.6%) compared to any other group. As far as folk healers are concerned it is interesting to note that the High Caste and the High Class groups consulted them slightly more frequently than the Low Caste and the Low Class groups. (Data is reported in Table 5.1 in the appendix)

Use of any Services of Primary Health Centre (PHC)—Ever used by Sample Households:

In order to understand the extent of utilisation of the services of PHC, all the respondents were asked to report whether he himself or any member of his family ever visited PHC for any type of ailment or advice since it started functioning in the village more than twenty years (established in 1962) ago.

In general, about 85 per cent of the households in the sample reported having ever availed of any type of services at the PHC since its inception (ever used). The extent of utili-
zation of the services of the PHC varied in different social groups. While all the Low Caste group households (100%) in the sample ever used the services of PHC, only about 75 per cent of the households in the High Class group ever availed the services of PHC. Similarly, while nearly 80 per cent of the households in the High Caste group ever used the services of PHC, about 90 per cent of the households in the Low Class group ever used the services. Thus, while all the Low Caste group households reported having used the PHC services since its inception, only 75 per cent of the High Class group households have ever used these services (Table 5.2).

Various types of special services other than O.P.D. are rendered to the community at the local Primary Health Centre. All the heads of the households were asked to report whether any member in their household ever used the following special services during the period under investigation: (1) Maternal care (2) Delivery (3) Immunization (4) Family Planning (5) Hospitalization and (6) Special treatment such as leprosy, tuberculosis etc.

The following table shows that in general 68.5 per cent of the households used these PHC special services. Of the above mentioned services, maternal care was utilised more
(45.5 %) than any other service (immunization 37.5%, Family Planning 29%, Hospitalization 18.5%, Delivery 13.5% and Special Treatment 2.5%) (see also table 5.3A in appendix)

<table>
<thead>
<tr>
<th>Service Used</th>
<th>High Caste N=98</th>
<th>Low Caste N=48</th>
<th>High Class N=57</th>
<th>Low Class N=96</th>
<th>TOTAL N=200</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td>PHC special service used by the households in general</td>
<td>64 (65.3%)</td>
<td>41 (85.4%)</td>
<td>34 (59.6%)</td>
<td>70 (72.9%)</td>
<td>137 (68.5%)</td>
</tr>
<tr>
<td>Maternal Care</td>
<td>33 (33.6%)</td>
<td>31 (64.5%)</td>
<td>18 (31.5%)</td>
<td>51 (53.1%)</td>
<td>91 (45.5%)</td>
</tr>
<tr>
<td>Delivery</td>
<td>10 (10.2%)</td>
<td>10 (20.8%)</td>
<td>4 (7.0%)</td>
<td>16 (16.6%)</td>
<td>27 (13.5%)</td>
</tr>
<tr>
<td>Immunization</td>
<td>35 (35.7%)</td>
<td>28 (58.3%)</td>
<td>20 (35.0%)</td>
<td>38 (39.5%)</td>
<td>75 (37.5%)</td>
</tr>
<tr>
<td>Family Planning</td>
<td>29 (29.5%)</td>
<td>14 (29.1%)</td>
<td>14 (24.5%)</td>
<td>28 (29.1%)</td>
<td>58 (29.0%)</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>17 (17.3%)</td>
<td>6 (12.5%)</td>
<td>8 (14.0%)</td>
<td>20 (20.8%)</td>
<td>37 (18.5%)</td>
</tr>
<tr>
<td>Special treatment</td>
<td>2 (2.0%)</td>
<td>-</td>
<td>-</td>
<td>3 (3.1%)</td>
<td>5 (2.5%)</td>
</tr>
</tbody>
</table>
There are some differences in using these services in various social groups. Of all the groups, the Low Caste group used these PHC services most (85.4%) (High Caste 65.3%, High Class 59.6% and Low Class 72.9%). Both the Low Caste and Low Class groups used these special services of PHC more frequently than the High Caste and High Class groups. Maternal care, delivery and immunization services were utilised more frequently by the Low Caste group (65.5%) than any other groups. The Low Caste group (64.5%) used the maternal care about twice as frequently as the High Caste (33.6%) or the High Class (31.5%) In using delivery services also, the Low Caste group used PHC (20.8%) more than any other group (High Caste 10.2%, High Class 7.0%) and Low Class (16.6%). Further, immunization service was also utilised substantially more by the Low Caste group (58.3%) than other groups (35.0%). Family Planning is the only service which was used by all the groups more or less in similar proportion (around 29.0%). On the whole, except for family planning services, the Low Caste and the Low Class groups used maternal care, delivery, and immunization services about twice more than the High Caste and High Class groups. It is interesting that no difference is observed in use of family planning services.
It is assumed sometimes that the type of experience one gets while seeking treatment or advice from any health resource influences the choice or preference for subsequent health behaviour of the people. Keeping this in mind, all the respondents were asked about the type of experience they had about the services rendered at PHC. The variables were examined in polar contrast. Those indicating a favourable opinion about the PHC are (1) Prompt service (2) Good medicine (3) Good behaviour of staff (4) Satisfactory services and (5) Usefulness of PHC. The contrasting indicators show negative opinion.

It is found in general that a majority of the respondents reported a favourable opinion about the services of PHC (Prompt service 50.8%, Good medicine 60.8%, Good behaviour of staff 76.0%, satisfied with services 57.3% and PHC useful 61.9%). It is observed that the High Caste and the High Class groups had a more favourable experience than the Low Caste and Low Class groups in general although they used these services to a lesser extent. Of the High Caste and High Class groups it is the High Class (Prompt service 62.8%, Good medicine 74.4%, Good behaviour of staff 79.0%, satisfied with services 74.4%, PHC useful 74.4%) which holds a more favourable image than the High Caste group (Prompt service 50%, Good medicine 60.2%, Good behaviour of staff 75.6%, Satisfied with
services 60.2%, PHC useful 62.8%). Both the Low Caste and Low Class groups hold more or less similar opinion about the services of PHC (Prompt service 43-48%, Good medicine 50-55%, Good behaviour of staff 73%, satisfied with services 50%, PHC useful 54-56%). Thus the Low Caste and Low Class groups have less favourable experience compared to the High Caste and High Class groups about the services of PHC although they used PHC services more often out of necessity (Table 5.4).

The preference one shows for a particular health resource reflects not only one's own choice but also the extent of faith and accessibility for the resource itself. In order to understand this, all the respondents were asked to state their preference to consult a health resource and the reason for it in the event of illness in their family. The preferences rated are first, second, third and none. The health resources included for such rating are: (1) PHC (2) CHV (3) Private Practitioner and (4) Medical Shop. In general, about 60.5 per cent of the sample respondents showed some preference (Ist, IIInd and IIIrd) for PHC. Of this, most of the respondents expressed second preference (36.5%) followed by the first (19.5%) and the third (8.5%) preferences. About 35% of the respondents did not express any preference for PHC (Table 5.5).
While the general trend is reflected in all social groups, there are small differences in caste and class groups. While 45 per cent of the respondents in the High Caste group expressed no preference for PHC, it is only 23 per cent, (about half of the preference expressed by the High Caste group) in the Low Caste group who expressed no preference. Similarly, while nearly 50 per cent of the High Class group expressed no preference for PHC, it is only 28 per cent in the Low Class group. Thus, by and large, while nearly 50 per cent of the respondents in the High Caste and the High Class groups showed no preference for PHC, only about 25 per cent of the respondents showed no preference in the Low Caste and Low Class groups. It reflects greater dependence on PHC by the Low Caste and Low Class groups than the High Caste and the High Class groups. This shows that higher the caste and class status, lesser the preference for PHC (Table 5.5).

All the respondents who expressed some preference for PHC were asked to indicate the reasons for their preference. The various reasons mentioned have been classified into the following broad categories: (1) Not satisfied with treatment by other agencies/cures (2) Free treatment (3) Personal network (4) Faith (5) Others. In general 45 per cent of the respondents mentioned 'dissatisfaction with treatment from other agencies'
as the main reason for their preference for PHC while a similar proportion (43.4%) expressed 'free treatment' as another reason. These two are the main reasons for their preference for PHC. The other reasons reported in a small measure are: personal network (3.8%), faith (1.6%) and others (6.2%) which include factors such as the non-availability of certain materials (like bandage etc.) with local RMPs, advice by friends etc. This pattern holds true more or less for all the caste and class groups. However, some interesting trends were observed. While 'dissatisfaction with treatment by other agencies/cures' is the main reason among the Low Caste group (46.0%) for their preference for PHC, it is free treatment which is the main reason among the Low Class group (50.7%) (Table 5.6). Similar is the case with the High Caste and High Class groups. Thus, it is observed that while free treatment is found associated more with class groups, dissatisfaction with treatment by other agencies/cures is more associated with caste groups.

In order to know the actual reason that made them visit PHC, the respondents were asked the following question on the basis of morbidity data collected for the household earlier.
"As you said, you consulted primary health centre for some (give details) ailments? Why didn't you consult a private doctor? (give actual illustration from morbidity schedule)"

In case anyone in the family visited PHC for specific morbidity episode during the period under study, (August 1983 to October 1983) the respondents were asked to state the reason for their having done so. This question was put to the respondents on the basis of morbidity data recorded earlier. Out of the 200 sample households only 134 consulted PHC during the period under study (See table 5.7 for details). Among the caste groups 63 (64.3%) households from the High Caste group and 34(71%) from the Low Caste group consulted PHC. Among class groups, 35 (61%) households in the High Class group and 66(68.8%) in the Low Class group consulted PHC. The various reasons mentioned were categorised broadly into the following:

(1) Service free of cost  
(2) Good image of resources and services  
(3) Personal network  
(4) Good image of certain doctor/specialist services  
(5) Limitations of some kind and  
(6) Others.

Out of all these, in general, service free of cost was reported as the major reason (56.7%) for consulting PHC. Other reasons were reported in a small measure: Limitations of some kind (13.4%), Good image of certain doctor/specialist services (10.4%), good image of resources and services (6.7%), personal network (6%) and others (6.7%). There are some differences in the
extent of various reasons reported for visiting PHC in different caste and class groups. In the High Caste group while service free of cost (52.4%) and good image of certain doctor or specialist services (14.3%) are the prominent reasons, it is the service free of cost (47.0%) and limitations of some kind (16.4%) are the main reasons in the Low Caste group.

Among class groups, it is different. In the High Class group though service free of cost is the main reason (40.0%) other reasons such as good image of services and resources, good image of certain doctor or specialist services and limitations of some kind were also reported each in the same measure (14.3%). On the other hand, service free of cost is the most predominant reason (70.0%) reported in the Low Class group followed by limitations of some kind (13.6%) etc. Thus, service free of cost was reported as the main reason by all social groups in different proportions varying from 70.0 per cent in the Low Class group to 40.0 per cent in the High Class group. Other reasons were reported in small proportions. While "service free of cost" and "limitations of some kind" were reported as the main reasons among the Low Caste and the Low Class groups, "service free of cost" and "good image of certain doctor/specialist" were the main reasons in the High Caste and High Class groups (see details in Table 5.7). Cost factor
weighed greatly with all groups. However, the Low Class group is associated with cost factor in greater measure (70%) than other groups (High Caste 52.4%, Low Caste 47.0% and High Class 40.0%).

It is observed that though the High Caste and High Class groups had reported more favourable image of PHC than the Low Caste and Low Class groups, they actually preferred it and used it less than the Low Caste and Low Class groups. This is perhaps because they have wider choice and can afford more convenient and more satisfying services.

To understand the extent of services rendered to the people by the field staff of PHC at sub-centre such as ANM, MPW etc., the respondents were asked to report how frequently they were visited by ANM or MPW during the past six months preceding the date of interview approximately. It was found that about 80 per cent of the households reported that they were not visited by ANM during the past six months. The remaining households were visited either once (5%), twice (2.5%), thrice (3.0%) or more than thrice (10.5%). This pattern was found more or less in all social groups. However, the Low Caste group households were visited "at least once or more" in somewhat greater frequency (35.0%) than other groups.
in general (20.0%). This can be due to the accessibility and
the subjective factor of her (ANM) belonging to the same caste
group. She visited the High Class group slightly more
frequently than the High Caste and Low Class groups (Table 5.8).
In the context of availability of better services at the PHC
and private practitioners within the village ANM's services
do not appear to have much significance and demand.

ANM's service to the people mostly consisted of giving
tablets, motivating people for family planning, preparation of
lists for immunization camps, advice for minor ailments, etc.
Mostly her service to the community was in the form of some
advice (Table 5.9). This pattern was observed more less in all
social groups.

As regards Multipurpose Health Worker (MPW) is concerned
the picture is better. 55 per cent of the respondents reported
that they were visited by him either once (9.5%), twice (6.0%)
thrice (6.0%) or more than thrice (33.5%). The remaining
respondents (45.0%) reported that they were not visited during
the six months preceding the date of interview. This pattern
was observed more or less in all caste and class groups. However,
it was observed that the Low Caste group was visited by him in a
greater proportion (67.0%) than other groups in general (45.0%).
The greater frequency of his visits to the Low Caste group are due to the same factors as explained for ANM above (Table 5.10)

With regard to the type of service rendered by MPW, only 21.0 per cent of the households were given some form of concrete help (18.5% tablets, 1.5% family planning work, 1.0% blood/sputum examination). 34 per cent of the households were given some advice regarding health problems (Table 5.11). This pattern was found more or less in all social groups.

In view of the experience people generally had while seeking medical care at PHC, they developed different types of images about staff and services of PHC. Some of the reactions informally expressed about PHC by the people during the investigation are given below.

"They prefer to treat rich people. Only after their turn, the doctors examine labour. Even the medicines they give are hardly effective. They will examine only those who give bribes in the form of agricultural produce such as redgram, greengram, blackgram, vegetables, ghee etc. In consideration, they examine them first with greater care. Those who cannot afford to give them anything, they will not be examined properly".
"They give medicines from the same bottle for all ailments."

"Earlier, there used to be a health visitor here. She is the wife of a local scheduled caste teacher. Now, she has been transferred to another place. As long as she was here, we had no problems. She used to give us good and effective medicines. She was very helpful to us. Now, after her transfer, we lost a good source of help."

"There is no proper treatment at PHC. They give injections with infected needles. Once I had an injection. With the same needle, he gave injections for ten other people in front of me. For three days I suffered from pain."

"Once I took an injection. It developed into sepsis. When I asked them they said it was not due to injection. I consulted a private doctor at Korukonda, a nearby small town. He said that it was due to injection only and gave medicines. It was cured subsequently. Later, I went to PHC and argued with the staff including the doctor about their negligence which resulted into my suffering unnecessarily. They could not convince me that it was not due to their injection. Since then I became indifferent and allergic to consult PHC for any type of ailment."
"The patient has to be taken daily. It is not possible for us to take the patient daily. For private practitioners, it is enough to take the patient once or twice."

"The doctor who comes from Rajahmundry, a nearby town where he resides, examines the patients well. He gives good medicines. On the days of his duty at PHC, there will be a lot of rush of patients. On the other hand, while other doctors were on duty, hardly few patients turn up. Some times, patients will postpone their visit to PHC till the day of the duty of 'Rajahmundry doctor'."

"The medicines given at PHC are not effective. It is better to have few tablets from medical shop which will relieve the ailment faster. This saves one's time and effort."

"The PHC is meant for labour/poor people. If we go to PHC, the labour people think that we are robbing them of their facility."

These statements are in contrast to more favourable opinions expressed during the formal interviews reported above (particularly Table 5.4). However, the questionnaire survey also shows that only 15-23 per cent respondents consider PHC as agency of first preference (Table 5.5).
USE OF COMMUNITY HEALTH
VOLUNTEER (CHV):

In October 1977, a new Rural Health Scheme was launched by the Central Government to meet the health needs of the rural masses. Under this scheme, a cadre of non-professional health workers called Community Health Volunteer (CHV) was created to provide adequate health care to rural people and educate them in matters of preventive and promotive health. The main idea of this scheme is to provide simple medical aid within the reach of every citizen. Generally, there is one CHV for a population of 1000 and for the sake of convenience, smaller villages may be grouped or larger villages may be broken into sectors. The duties of CHV include treatment of minor ailments, giving first aid in emergencies, identification of causes of malaria, smallpox and other communicable diseases, helping paramedical staff in work related to communicable disease, immunization, family planning, maternity and child health, nutrition and mental health, creating awareness among the community in problems of environmental sanitation and personal hygiene and assisting the paramedical staff in carrying out activities in these fields, and finally participating in activities related to health education. In the field of medical care, his role is limited to first aid and treatment of simple ailments and beyond this, he is expected to refer all cases of illnesses to PHC, rural dispensaries or district hospitals.
All the respondents were asked to indicate the rank of their preference for consulting CHV. There are four CHVs available to the community - three in the main village and one in the hamlet. It is found that only 15 respondents out of the sample of 200 indicated some preference (1st preference 12, and 2nd preference 3). Of these 15 respondents, 11 belonged to the Low Caste group and 4 to the High Caste group. In class groups, 11 belonged to the Low Class group and 1 to the High Class group. This indicates poor preference for and acceptability of CHV in the community in general and whatever little preference indicated was reported mostly by the Low Caste (23.0%) and the Low Class (11.5%) groups. Incidentally, all the CHVs belong to the Low Caste group and this factor increases their accessibility for the Low Caste group (Table 5.12). Further, three out of four CHVs are working as agricultural labourers and one in postal department in a nearby town. They are not available for most of the time. Their low social and economic status coupled with the low profile of their professional skills act as a barrier for utilization of their services. In the context of availability of various professional resources such as PHC, private practitioners etc., their presence and services in the community are not taken seriously.
When asked for the reason for preference for consulting CHV, it was reported generally that proximity was the predominant reason (80%). The other reasons mentioned in a small measure were free treatment (13.3%) and faith (6.7%). More or less similar was the extent of preference in caste and class groups also (see table 5.13 for details).

USE OF PRIVATE PRACTITIONERS:

It is found that a good majority of the respondents (88.5%) expressed some preference for private practitioners which include RMPs within the village, private doctors outside the village and folk practitioners. Of these, 26.0 per cent indicated first, 41.0 per cent second and 21.5 per cent third preferences for private practitioners. There are some differences in the rank of preference indicated by various social groups. While the High Class group expressed first preference (45.6%) in greater proportion, followed closely by second preference (35.1%), the High Caste group indicated first and second preferences more or less in the same proportion (36.0%). On the other hand, in the Low Caste and the Low Class groups, second preference was indicated in greater proportion (41.0%). Thus, while the High Caste and High Class groups indicated mainly either first or second preference, the Low Caste and
Low Class groups indicated second preference largely. This is due to the affordability of the expensive treatment of private practitioners by the High Caste and the High Class groups (Table 5.14).

All the respondents were asked to mention the reasons for their preference for private practitioners. The reasons mentioned are (1) Not satisfied with treatment by other agencies/cures (2) Personal network (3) Family physician (4) Faith and (5) accessibility.

In general, majority of the respondents mentioned 'Not satisfied with other agencies/cures' as the main reason (55.4%). The other reasons were mentioned in a small measure (faith 19.2%, accessibility/proximity 15.3%, family physician 7.3%, and personal network 2.8%). There are some differences observed in the extent of preferences in different social groups, though the general trend is broadly reflected. The Low Caste (67.5%) and the Low Class (63.0%) groups indicated dissatisfaction with treatment from other agencies as the main reason for their preference for private practitioner in greater proportion than the High Caste (51.0%) and the High Class (41.8%) groups. Greater accessibility/proximity was reported in slightly greater frequency by the High Caste (19.0%) and High Class (21.8%)
groups than the Low Caste and Low Class groups (12.0%). "Family Physician" was reported as one of the reasons by the High Caste (14.4%) and the High Class (18.2%) groups in greater proportion than the Low Class group (1.2%) while it was not reported at all by the Low Caste group (Table 5.15).

Among some of the households mostly belonging to the High Caste/High Class groups, the system of family physician is followed. The local RMPs pay personal visits to these families whenever any medical help is sought. For their services, they are generally paid annually either in cash or kind as per their convenience and tradition. One of the local RMP works on part-time in a panchayat dispensary in a nearby village (Vadisaleru) which is about 3 miles away. He established good rapport with the local rich High Caste families. These families seek medical treatment from him whenever required. In case the ailment is not cured by him, he will take the patient to a specialist in a nearby town and follow up his prescriptions and treatment at home carefully. Generally, his 'touch' is considered 'auspicious' and therefore, they repose great faith in him. Incidentally, one of the medical shops in the village is run by one of his sons. The system of 'family physician' is not practised by the Low Caste group as they cannot afford it. Besides, the caste factor also acts as a barrier. Since the
local RMPs belong to the caste Brahmins, they do not generally want to visit their families because of purity-pollution norms. Only in rare and exceptional circumstances, they may visit them. Further, the High Caste/Class households have greater accessibility to them than the Low Caste/Low Class households mostly. These two reasons together account for larger extent of preference next to dissatisfaction with other agencies among the High Caste (33.0%) and High Class (40.0%) groups than in the Low Caste (12.5%) and the Low Class (13.5%) groups (Table 5.15).

In order to understand the reasons as to why they consulted a private practitioner they were asked the following question:

"As you said, you consulted a private doctor for some (Give details) ailment? Why you did not consult primary health centre then? (Give actual illustration from morbidity schedule)."

The question was put to those who actually consulted a private practitioner on the basis of their morbidity record collected earlier. The reasons mentioned by the respondents were categorised into: (1) Limitations of resources and facilities of PHC (2) Accessibility (3) Poor image/dissatisfaction of services/personnel of PHC (4) Personal network (5) Better satisfaction.
Out of the 200 sample households, 52 (26%) did not utilise the services of private practitioners during the period under investigation. Those who utilised the services of private practitioners reported poor image/dissatisfaction of services/personnel of PHC as the major reason (54%). Better satisfaction (14.9%) and accessibility (14.9%) were the other main reasons. Limitations of resources and facilities (8.1%) and personal network (8.1%) were mentioned in a small measure. Thus, lack of resources/facilities coupled with poor service at PHC is the major reason for seeking the services of private practitioners in the community. More or less the same pattern is observed in all caste and class groups (Table 5.16). Thus, it is observed that lack of availability of good governmental resources locally is the main reason for seeking the services of private doctors which are expensive.

**USE OF MEDICAL SHOP FOR CONSULTATION:**

Nearly half (45.5%) of the respondents expressed no preference for medical shop for seeking medical care. Of those who expressed preference for medical shop, most of them reported (46.5%) first preference. Few respondents indicated second (7.5%) and third (0.5%) preferences. Small differences are observed in the preferences expressed by different caste and class groups. While majority of the Low Class group
respondents (63.5%) expressed preference for medical shop, few High Class group respondents expressed some preference (42%). In both the High Caste (48.0%) and the Low Caste (58.3%) groups, nearly majority of the respondents expressed no preference. While half of the Low Class group respondents (53.0%) expressed first preference, only one third of the Low Caste group (33.3%) respondents expressed the same. Largely, it shows that Higher the class status, lesser the preference for medical shop and vice versa. On the other hand, the High Caste group has shown slightly greater preference (52.0%) than the Low Caste group (42.0%) (Table 5.17).

The reasons reported for their preference were (1) Accessibility (47.7%) (2) Less cost (38.5%), (3) Not satisfied with alternative agencies/cures (11.0%) and (4) others (2.8%). Accessibility (47.7%) was the main reason for preference followed closely by less cost (38.5%). More or less the same pattern was observed in caste and class groups also (Table 5.18).

RESORT FOR MINOR AILMENTS:

In order to understand the health behaviour, all the respondents were asked to report as to what they would like to do in case of minor ailments in the family. The reactions
were to consult either the local medical shop (63.5%), private practitioner (16.0%), home remedy (10.5%) and PHC (10.0%). Small differences were observed in the extent of resort for minor ailments in various social groups though the general trend was reflected largely. The Low Caste group (16.7%) and the Low Class group (14.6%) reported their desire to visit PHC in slightly larger measure than the High Caste (7.1%) and the High Class (3.5%) groups. On the other hand, the High Caste group (23.5%) and the High Class group (30.0%) desired to visit private practitioners in larger measure than the Low Caste (10.4%) and Low Class (7.3%) groups. The Low Class group (70.8%) desired to visit medical shop in greater measure than the Low Caste group (60.4%). Incidentally, the Low Class group reported their desire to visit medical shop in greater measure (70.8%) than any other group. Thus, medical shop is the main source of consultation for minor ailments in all caste and class groups. While medical shop as the main resource followed by PHC to some extent were the main resorts for minor ailments in the Low Caste and the Low Class groups, medical shop as the main resource followed by private practitioners were the resources for seeking medical care in the High Caste and the High Class groups (Table 5.19).
In general, it was observed that people start their shopping for cure with medical shop. Medical shop here is seen not only as a store for medicines, but also a place where advice/prescription can also be had freely. Sometimes, the medical shop keepers dispence of their expired medicines under the cover of prescription. Since visiting medical shop helps a person in avoiding standing in queue at PHC or paying dearly for the private practitioner, it has become the most popular source of health action (Table 5.19).

The following table (5.20) shows that of the first preferences for seeking treatment from various health resources it is seen that the High Caste, Low Caste and Low Class groups expressed their first preference for medical shop in greater proportion than for other sources of health care. Of all the groups the Low Class (53.1%) expressed greater preference than other groups for medical shop. The High Class showed, of all the groups, greater preference for private practitioners than any other group, though the High Caste group also expressed greater preference for private practitioner, but it comes next to medical shop only. The Low Caste and Low Class preferred PHC next to medical shop in greater measure than the other two groups. It is only the Low Caste group which showed greater preference for CHV than any other group. Thus, while the Low Class group sought services from medical shop largely, it is private practitioners in High Class group.
Table: 5.20

Extent of First Preference expressed for various health sources in Caste and Class groups

<table>
<thead>
<tr>
<th>CASTE/CLASS GROUP</th>
<th>SOURCE PREFERRED</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PHC</td>
<td>CHV</td>
<td>PP</td>
<td>MED. SHOP</td>
<td>TOTAL</td>
</tr>
<tr>
<td>High Caste</td>
<td>16</td>
<td>3</td>
<td>35</td>
<td>44</td>
<td>98 (100%)</td>
</tr>
<tr>
<td>(16.3%)</td>
<td>(3.0%)</td>
<td>(35.7%)</td>
<td>(44.9%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Caste</td>
<td>13</td>
<td>9</td>
<td>10</td>
<td>16</td>
<td>48 (100%)</td>
</tr>
<tr>
<td>(27.1%)</td>
<td>(18.8%)</td>
<td>(20.8%)</td>
<td>(33.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Class</td>
<td>9</td>
<td>1</td>
<td>26</td>
<td>21</td>
<td>57 (100%)</td>
</tr>
<tr>
<td>(15.8%)</td>
<td>(1.8%)</td>
<td>(45.6%)</td>
<td>(36.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Class</td>
<td>22</td>
<td>9</td>
<td>14</td>
<td>51</td>
<td>96 (100%)</td>
</tr>
<tr>
<td>(22.9%)</td>
<td>(9.4%)</td>
<td>(14.6%)</td>
<td>(53.1%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ITEMS OF MEDICINAL VALUE KEPT BY THE SAMPLE HOUSEHOLDS:

In order to know the health consciousness among people, the respondents were asked to report the kind of items of medicinal value they keep generally for their ready use in case of necessity such as ointment, tablet/mixture, bandage/cotton thermometer, herbs, dettol/phenol, bleaching powder, tonics etc. Herbs (37.0%) and ointment (33.0%) were kept by about one-third of the respondents. About 1/6th of the respondents kept honey (17.5%) and tablets/mixtures (16.5%). Other items were kept by a very small percentage of respondents in general. The High
Caste and High Class groups kept herbs, ointments, honey, and tablets in greater measure than the Low Caste and Low Class groups. Of the High Caste and High Class groups, it is the High Class group which kept these items in a greater measure than the High Caste group (Table 5.21). In general, keeping these items reflects caste/class hierarchy: Higher the Caste/Class status, greater the number of households keeping them. Further, of the High Caste and High Class groups, it is the High Class group which kept these items in greater measure than the High Caste group. The following table (5.22) shows this trend.

Table: 5.22

<table>
<thead>
<tr>
<th>Item</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>Herbs</td>
<td>58.1%</td>
<td>4.2%</td>
<td>72.0%</td>
<td>12.5%</td>
<td>37.0%</td>
</tr>
<tr>
<td>Ointment</td>
<td>46.0%</td>
<td>14.6%</td>
<td>59.6%</td>
<td>16.6%</td>
<td>33.0%</td>
</tr>
<tr>
<td>Honey</td>
<td>27.5%</td>
<td>2.1%</td>
<td>38.6%</td>
<td>3.1%</td>
<td>17.5%</td>
</tr>
<tr>
<td>Tablets/mixtures</td>
<td>18.3%</td>
<td>12.5%</td>
<td>31.6%</td>
<td>8.3%</td>
<td>16.5%</td>
</tr>
</tbody>
</table>
SAFE DRINKING WATER SOURCES

There are two ponds - one in the main village and the other in the hamlet - for drinking purpose. Some people drink either well water or tap water. Though there is safe drinking water supply system in the village, the tap water is used by very few households because they feel the water is tasteless. On the otherhand, pond water is largely used due to its good taste despite greater chances of its being contaminated. In the main village, there is a watchman appointed by the local panchayat board to guard the drinking water pond from its being polluted by animals and human beings. On the other hand, in the hamlet, there is no watchman and the drinking water pond is left to the mercy of people and animals alike. Since most of the influential and rich people and officials reside in the main village there is greater consciousness and vigilance in keeping the pond protected while the hamlet is neglected because of lack of a strong protest from the people.

The following table shows that about 3/4ths of the people use pond water for drinking purpose, while 17.5 per cent and 8.0 per cent people drink tap and well water respectively in general. The Low Caste group use pond water
in greater measure (93.7%) than other groups (High Caste 67.3%, High Class 66.7% per cent and Low Class 77.1%). About 1/4th of the respondents in the High Caste and the High Class groups use tap water while the Low Caste group (2.1%) and the Low Class group (13.5%) use it in a small measure. (see also table 5.23 A in the appendix)

<table>
<thead>
<tr>
<th>Type of source</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>Well</td>
<td>10 (10.2%)</td>
<td>2 (4.2%)</td>
<td>4 (7.0%)</td>
<td>9 (9.4%)</td>
<td>16 (8.0%)</td>
</tr>
<tr>
<td>Tap</td>
<td>22 (22.4%)</td>
<td>1 (2.1%)</td>
<td>15 (26.3%)</td>
<td>13 (13.5%)</td>
<td>35 (17.5%)</td>
</tr>
<tr>
<td>Pond</td>
<td>66 (67.3%)</td>
<td>45 (93.7%)</td>
<td>38 (66.7%)</td>
<td>74 (77.1%)</td>
<td>149 (74.5%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>98 (100%)</td>
<td>48 (100%)</td>
<td>57 (100%)</td>
<td>96 (100%)</td>
<td>200 (100%)</td>
</tr>
</tbody>
</table>

**SECTION II**

**DISCUSSION**

In the previous section, the influence of social stratification in utilization of health resources available
to the community such as PHC, private practitioners, CHV, medical shop etc. and their preferences and reasons for their use have been presented. In this section, the relative influence of stratification variables on utilisation of health resources is discussed.

While some health resources/services were utilised more or less in equal measure, other resources/services were utilised in varying proportions by the Caste and Class groups. It is observed that family planning services of the local PHC were utilised by all caste and class groups in more or less the same measure. This is due to the wide promotional activities including incentives by the Government. Further, there is greater awareness among people about the value of having a small family for their happiness and overall prosperity. Lately, the high premium placed generally in having a son is played down considerably. People have now realised the need of bringing up their children as useful citizens whether they be males or females. Though, the dowry for females is a big problem among the High Caste group, it was found that people prefer to adopt permanent methods of family planning even if they have girls in the first two issues without taking any further chance for the sake of getting a boy.
In utilisation of other resources it was found that either a particular caste/class group utilised a particular health resource/service more frequently than the other and vice versa. The High Caste group used the following in greater measure than the Low Caste group: (1) visit to private doctors (2) consulted folk healers (3) expressed more favourably about the services of PHC and (4) kept items of medicinal value in house. On the other hand, the Low Caste group utilised the following in greater measure: (1) visited PHC (2) visited CHV (3) used maternal care, delivery and immunization services of local PHC (4) visited by ANM and MPW more frequently (5) kept items of medicinal value such as tonic, tablets etc. in house in a small measure and (6) depended on pond water more.

Similarly, the High Class group utilised the following to a greater extent than the Low Class group: (1) visited private doctors (2) visited RMP (3) visited folk healers (4) visited by ANM and MPW (5) kept items of medicinal value in a larger measure. On the other hand, the Low Class group utilised the following more frequently: (1) visited PHC (2) visited CHV (3) used maternal care, delivery and immunization services of local PHC more (4) resorted to medical shop for minor ailments. (5) depended on pond water.
It was observed that there is differential use of health agencies and resources by the High Caste and Class and Low Class groups. On comparison between the High Caste group and the High Class group, it was observed that:

1. The High Class group visited private doctors and RMs more often than the High Caste group.

2. The High Class group had a more favourable image of the kind and extent of experience about the services of PHC than the High Caste group.

3. While the High Class group expressed first preference for private practitioners, the High Caste group expressed second preference as is the case with other groups also.

Similarly, on comparison between the Low Caste and the Low Class groups, it was observed that:

1. The Low Caste group utilised the services of CHV more than the Low Class.

2. The Low Caste group utilised the local PHC more than the Low Class group in general and in particular the maternal care and immunization services of PHC.
3. Free treatment was reported as the main reason for consulting PHC in greater measure by the Low Class group than the Low Caste group.

4. ANM and MPW visited the Low Caste group more frequently than the Low Class group.

5. The Low Class group expressed first preference for medical shop in greater measure than the Low Caste group or for that matter any other group.

6. For minor ailments, the Low Class group visited medical shop in greater measure than the Low Caste group.

7. The Low Caste group used pond water more than the Low Class group.

It is also found that some services/resources were utilised by the High Caste and High Class groups more or less in the same measure. Similar is the case with the Low Caste and Low Class groups also.

The High Caste and the High Class groups utilised the following more or less in the same measure:

1. Visited PHC and folk-healers during the period under study.

2. Utilised services of PHC such as maternal care, delivery, immunization, family planning, hospitalization etc.
3. MPW visited both groups more or less in the same measure.

4. Used water resources more or less in the same measure.

Similarly, the Low Caste and the Low Class groups utilised the following more or less in the same measure:

1. Visited PHC, RMP and folk healers during the period under study.

2. Both the groups had more or less the same extent and kind of experience of PHC.

After having noted various patterns of utilization of various health resources/services by different caste and class groups the following observations were made in general.

On the whole, while the High Class and High Caste groups utilised services of private doctors, local RMP and folk healers more than the Low Caste and Low Class groups, the Low Caste and Low Class groups used services of PHC and CHV more often than the High Caste and High Class groups.

Since inception of PHC in the village, the Low Caste and Low Class groups utilised its services in greater measure than the High Caste and High Class groups.
The Low Caste group utilised the services of PHC (followed closely by Low Class group) such as maternal care, delivery, immunization, family planning etc. more than High Caste and High Class groups. It may be mentioned here that the High Class group and High Caste group utilised the services of PHC more or less in the same proportion.

While nearly half of the High Caste and High Class group households did not express any preference for PHC, it is only about 25.0 per cent in the Low Caste and Low Class groups.

While dissatisfaction with other agencies is the main reason for both High Caste and Low Caste groups for preference for PHC, it is free treatment with both High and Low Class groups.

Though 'service free of cost,' is the main reason in all caste and class groups for consulting PHC there is greater differential in class groups, (High class 40%, Low Class 70%) while it is more or less the same in caste group.
ANM visited the Low Caste group in greater measure than any other group. In class groups, she visited the High Class group more frequently (next to Low Caste group) than Low Class group.

Like ANM, MPW also visited the Low Caste group more frequently than any other group.

Only the Low Caste group expressed preference for consulting CHV in greater measure (23.0%) than other groups. Proximity is the main reason for consulting CHV in Low Caste and Low Class groups.

Though second preference is expressed in greater measure in Low Caste and Low Class groups, first preference is expressed in greater measure in High Class group for consulting private practitioners. In High Caste group, both first and second preferences are more or less of the same order.

The Low Caste and Low Class groups expressed "dissatisfaction with treatment by other agencies/cures" as the main reason for consulting private practitioners in greater frequency than the High Caste and High Class groups. The system of "family physician" is patronised largely by High
Class and High Caste groups only. Accessibility contributes to a larger extent in consulting private practitioner in the High Caste and High Class groups more than the Low Caste and Low Class groups. Poor image, and dissatisfaction with services of PHC are the main reasons for consulting private practitioners in all caste and class groups.

Of those who expressed preference for medical shop most of them gave first preference. By and large, the Low Class group expressed greater preference for medical shops than any other group.

While accessibility followed by less cost are the main reasons for consulting PHC in all caste and class groups, dissatisfaction with other sources/cures counts slightly more in Low Caste and Low Class groups than in High Caste and High Class groups.

Though medical shop is the main resort for minor ailments in all caste and class groups, PHC is the next main resort in the Low Caste and Low Class groups while it is private practitioners in the High Caste and High Class groups.
In general, the High Caste and High Class groups kept items of medicinal value such as honey, ointment, tablets, tonics, herbs, thermometer etc. in greater measure than the Low Class and Low Caste groups. Of the High Caste and High Class groups it is the High Class group which kept them in a greater measure than the High Caste group. There is not much difference observed in the Low Caste and Low Class groups. 

The Low Caste group used pond water more than any other caste/class group. Tap is used by the High Class group in greater measure than any other group.

By and large, it is observed that both the High Class and High Caste groups utilised the services of private doctors (in nearby towns), local RMs, folkhealers more often than the Low Caste and Low Class groups. On the other hand, the Low Caste and Low Class groups utilised the services of PHC, ANM, MPW in greater measure. ANM and MPW visited more frequently the Low Caste group than any other group due to their belonging to the same social group and better accessibility. The Low Caste group utilised services of PHC in greater measure than Low Class group. While the cost factor is the main reason for Low Class group for
visiting PHC, factors such as dissatisfaction with other agencies/cures, limitations of some kind etc. are the main reasons (alongwith cost factor) for consulting PHC in Low Caste group. For all minor ailments, majority in all social groups consulted medical shop followed by private practitioners in High Caste and High Class groups and PHC in Low Caste and Low Class groups. The High Caste and High Class groups kept items of medicinal value in larger measure than the Low Caste and Low Class groups. Though pond water is used for drinking purposes by the majority in all social groups, other resources such as tap, well were utilised in a small measure. While Low Caste group largely used pond, High Class group used it to a lesser extent in comparison to other groups. Thus, while the Low Caste and Low Class groups largely relied on inexpensive and local health resources, the High Caste and High Class groups, more so the High Class group, relied on private practitioners, local RMPs more which are expensive. The system of 'family physician' and the 'caste' factor (RMPs belong to High Caste group) weigh favourably in favour of High Caste and High Class groups in utilising the services of RMPs. In a way, the High Caste and High Class groups used private health resources more than Governmental health resources such as PHC, MPW, ANM etc, while the Low Caste
and Low Class groups depended on Governmental health resources. Though the Low Caste and Low Class groups do not have favourable opinion about the services of the Government health resources due to their poor services, they have no better option in view of their low social and economic status in the community. If the Governmental resources have to cater to the needy and the poor, the orientation of personnel and the efficiency of services need to be improved greatly.