CONCLUSIONS AND
SUMMARY
Chapter 7

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INTRODUCTION

The aim of the present study is to understand the relationship between social stratification and health care in a rural community in Andhra Pradesh. The emphasis has so far been on the biological side of health ignoring other aspects such as social, economic, political and technological forces which are equally important in promotion and maintenance of health. Thus, health is to be understood as 'a socially produced natural reality'. The need to understand this relationship is emphasised in the 'Health For All' report by ICMR-ICSSR: "Studies on different aspects of health system are urgently needed. Very little work is being done, for instance to study the relationship of health to society and fields like sociology or economics of health are still in their early infancy". This assumes greater significance in the context of our national commitment to achieve 'Health For All' by 2000 AD through the universal provision of primary health care services. In this context, the present study was taken up.
In view of this, the following objectives were set forth in this study:

1. To describe differential distribution of morbidities and various health care practices among the caste, class and age-sex groups in the study village.

2. To examine whether the differential distribution of health care practices has any consistent patterns in relation to caste and class differences.

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

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

In this study, social stratification includes both 'Caste and Class' forms. Though 'Power' is another form of stratification, its role in health care is minimal at village level and as a result, it is omitted from our study. The term 'Health care' is conceptualised as any action(s) taken by an individual/group to prevent and cure illness, promote and maintain health and rehabilitate the affected. It includes (a) morbidity and its treatment (b) nutrition (c) utilization of various health resources and health facilities and (d) health practices.
METHODS:

Keeping in view the aim and objectives of our study, a village was selected in East Godavari, the most populous district in Andhra Pradesh after satisfying the following criteria:

1. There is enough scope to identify sufficient number of respondents from landless to rich landowner categories.

2. The village is multi-caste in its social composition.

3. A Primary Health Centre (PHC) is located either within the village or in a nearby village and is functioning for a very long period.

4. The Primary Health Centre has its full strength of medical staff.

5. The village is connected with nearby towns where better health facilities are available.

6. The village has a number of folk-healers and private practitioners.

Several visits to various primary health centres in the district were made to explore and identify a village which
satisfies the above criteria after having discussions with primary health centre staff, local villagers, informal leaders etc. Finally, two villages were selected to conduct a preliminary field exploration. A list of households with their social, occupational status along with the size of their land holdings was prepared. After a preliminary analysis of the data it was found that the village, Rangampeta, is ideally suited for our study compared to the other village 'Virava'. In both the villages, PHCs are located. The study village is having a hamlet, Chandroda, at a distance of 3 kilometers from the main village.

There are 1050 households in the study village. For each household, the caste status, occupation and the size of land holding were recorded. Separate lists of households for High Castes (540), Middle Castes (270) and Low Castes (240) were prepared. From each group, a sample of 20 per cent of households was selected for our study. The distribution of sampled households among caste groups shows that 98 households belong to High Castes, 54 to Middle Castes and 48 to Low Castes respectively. Similarly, among classes, 57 belong to High Class group, 47 to Middle Class and 96 to Low Class group respectively.

Five types of questionnaires were used to collect necessary data from the respondents. The first one was
aimed at collecting all the basic information about the sample household in terms of its size, sex, age, education, occupation, land holding, income, assets, etc. The second one deals with morbidity both in its acute and chronic forms. The third one pertains to nutritional status, food habits etc. The fourth one focusses on utilization of various health resources and facilities in the village and outside the village. The fifth and last one deals with health practices in the household. Interviews were held with practitioners, PHC personnel, informal leaders and others in the village to collect data on aspects relevant to the study.

THE VILLAGE AND THE SAMPLE

The village Rangampeta is located in Rangampeta Mandalam in East Godavari District of Andhra Pradesh. The village has two portions - the main village Rangampeta and the hamlet Chandredu. The distance between these two is 3 kilometers. The area is purely rainfed. Of the three types of soils in the village - black clay, black sandy and red loams - red loams constitute major surface area. The major crops grown are paddy, tobacco, groundnut, redgram, blackgram, coriandrum, budama etc.
There is a Primary Health Centre (PHC) in the main village. There are two drug shops in the main village. The village has a number of Allopathic (7), some Ayurvedic (3) registered medical practitioners besides a variety of healers and folk practitioners (22). The village has a number of institutions including banks, schools, veterinary hospital, telephone exchange, hotels etc. A lot of developmental programs under Integrated Rural Development Programme (IRDP) are being implemented to benefit SC, ST and other weaker sections of the society.

The population in the village is 5807. The total number of households in the village is 1050. A sample of 200 households covering all castes in the village was selected. The total number of persons in the sample is 1000 and the average size of a household is 5. There are 515 males and 485 females in the sample.

There are 20 castes in the village. For the purpose of our study, all the castes are categorised into three broad groups - High, Middle and Low Castes. The High Caste group comprises Brahmin, Vysya, Kapu and Kamma and the Low
Caste group consist of Mala and Madiga. The rest of the castes numbering 14 are grouped into Middle Caste category. Of all the castes, Kamma is the most preponderant group in our sample followed by Mala, Settibalji and Madiga Castes. Of the sample population of 1000, about 50 per cent of the sample belong to High Castes (505), and the rest is Middle (268) and Low Castes (227).

The economy is based on agriculture. Most of the sample households (72.5%) are engaged in agriculture either as land owners, tenants, share-croppers (together 40%) or as agricultural labourers (32.5%). While among High Castes, over 80 per cent of the sample households are engaged in agriculture, only 50 per cent are involved in agriculture in Middle Castes. Among the Low Castes, 75 per cent of the sample households are engaged in agricultural labour.

In the sample households, 38.5 per cent of the households are landless. About 20 per cent of the households are having land-holding up to 2 acres. About 25 per cent of the households are having landholdings between 2-10 acres and the rest (15%) are having more than 10 acres. Among the Low Castes, most of them (68%) are landless while among the High Castes only 17 per cent are landless. In the Middle Castes, 50 per cent of them are landless.
Income (annual) distribution pattern reflects heavy concentration of households in certain categories. While 30 per cent of households in the sample had an annual income of less than Rs. 4,000/-, an equal percentage of households are concentrated in the category of Rs. 10,000/- and above. Majority of the households in the Low Castes (52%) and substantial portion (41%) of the Middle Castes are having a low income of less than Rs. 4,000/-. Majority of the households in the High Castes (53%) are concentrated in the high income category of Rs. 10,000/- and above.

In the sample, there are 454 illiterates (45.4%) and 72 children (7.2%) who were below school going age. Of the remaining 474 people, 156 (15.6%) were studying at the time of collection of data and 318 (31.8%) completed their education. The percentage of literacy is high among the High Castes (56.7%) followed by the Low Castes (40.1%) and the Middle Castes (36.2%).

RESULTS:

The following are the major findings of our study:

A. MORBIDITY:

While almost all households (99%) reported acute morbidities, only about 70% of the households reported chronic morbidities.
82.3 per cent of the episodes were of acute type and the rest 17.7 per cent were of chronic type. In other words, approximately for every four acute illnesses, there is one chronic illness.

As regards distribution of morbidities, acute morbidities were found slightly in greater proportion in the Low Caste and Low Class groups than in the High Caste and High Class groups. On the other hand, chronic morbidities were found slightly in greater proportion in the High Caste and High Class groups.

The prevalence rate of sickness was higher in the Low Caste and Low Class groups than in the High Caste and High Class groups. Of all the groups, while the Low Caste group had the highest prevalence rate (173.1), the High Class had the lowest prevalence rate (98).

More than 80 types of morbidities of both chronic and acute type were reported. Fever (9.75%), headache (8.29%), dental caries (5.77%), cough (4.95%), motions (5.04%) were the most frequently reported acute illnesses. Among the chronic illnesses pain in leg joints (4.63%), heart complaints (4.1%), blood pressure (2.2%), filariasis (1.38%) were reported most frequently.
In general, complaints related to ENT and sense organs were most frequently (21.5%) reported illnesses followed by complaints of digestive system (16.5%) and musculo-skeletal system (12.4%). This general pattern was observed for acute morbidities also. In all caste and class groups, more or less a similar trend was observed.

With regard to chronic morbidities, disorders of musculo-skeletal system form the largest segment of morbidities (21.1%), followed by disorders of circulatory system (18.8%) and ENT and sense organs (13.3%). Disorders of other systems were found in a small measure.

Complaints of circulatory system were found in a greater proportion in the High Caste and High Class groups than in Low Caste and Low Class groups. On the other hand, disorders of ENT and sense organs were found in greater measure in the Low Caste and Low Class groups than in the High Caste and High Class groups.

Minor illness (less than 2 days) accounted for one-third of the total illnesses, followed by moderate (1 to 4 weeks) and mild (3-6 days) illnesses while chronic illness was substantially lower. Nearly, half of the chronic illnesses
were of more than 3 years duration while the rest were of less than 1 year and 2-3 years.

In general, morbidities were slightly more among males than among females. In the High Caste and High Class groups, morbidities among males were slightly more than among females. On the other hand, morbidities were slightly more among females in the Low Caste and Low Class groups.

A sick person in the Low Caste and Low Class groups suffered more episodes than a sick person in the High Caste and High Class groups.

In general, there was not much sex-wise difference in the number of episodes suffered. However, the sick males and the sick females in the Low Caste group suffered slightly more number of episodes than the sick males and sick females in general. Further, the sick females in the Low Caste group suffered more number of episodes while the sick females in the High Class group suffered fewer episodes in the entire sick population.

In distribution of chronic morbidities, slightly more complaints were found among males than among females while
acute morbidities were more or less equally distributed among males and females.

In terms of distribution of morbidities in age-groups between males and females, it was found that the morbidities were more among females in the age-group of 35-44 and among males in the age-group of 55 and above and below 4 years. In chronic morbidities, males suffered more episodes than females. While females suffered more morbidities in the age-group of 25-34 and 45-54, males suffered more morbidities in the age group of 55 and above. It is further observed that in both acute and chronic morbidities males in the age-group of 55 and above were vulnerable to greater morbidity than females in the same age-group.

In general, except the age group of 15-24 years, morbidities increased with age till 54 years and then declined sharply. In the age group of 35-54, morbidities were found slightly higher than in other age groups. In Middle age, morbidities were more in the Low Caste group than in the High Caste group, while morbidities were more in old-age (55+) in the High Caste group than in the Low Caste group. Similar trend was observed in class groups also.
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. In the High Caste group, more morbidities were reported in the age group of 55+ than in the Low Caste group. In children also, more chronic morbidities were found in the Low Caste and Low Class groups than in the High Caste and High Class groups.

In the age group of 45-54, morbidities were reported more both among males (20.4%) and females (23.4%). Morbidities in females in the age group of 25-44 were higher than morbidities among males. Similarly, morbidities among males in the age group of 55 and above and under four were slightly higher than in females.

In general, among males the distribution of morbidities in terms of persons was more in children (-14 years) and old people whereas it was more in youth and middle age category among females. This pattern was largely found both in distribution of acute as well as chronic morbidities. In old age (55+) more sick males were found with chronic morbidities than females.
In terms of distribution of morbidities (spells) there was greater concentration of morbidities among females in middle-age category than males. Similarly, there was greater concentration of morbidities (spells) among males in old-age than among females. This trend was observed both in acute and chronic morbidities. Of these two, concentration of chronic morbidities in old-age among males was more than acute morbidities.

Minor illness among females was slightly more than among males. In contrast to this, chronic illness among males was slightly more than among females. This pattern was found largely both in caste and class groups.

While minor illness was found more in the Low Caste and Low Class groups than in the High Caste and High Class groups, moderate illness was found more in the High Caste and High Class groups than in the Low Caste and Low Class groups. It was further observed that minor illness in the Low Caste and Low Class groups was more than moderate illness in their respective groups.

Among males and females, in caste and class groups, chronic morbidities were slightly more in males than in
females. But in the Low Caste group, slightly more chronic morbidity were found in females than in males. Chronic morbidity of longer duration were more in the Low Caste group among males and females than their counterparts in the High Caste group. Similar trend was observed in class groups also.

B. **HEALTH ACTION**

In general, for about 80 per cent of morbidity, some form of health action was taken. But in case of chronic morbidity, only 66 per cent of the morbidity were taken care of.

The Low Caste and Low Class groups reported less extent of health action than the High Caste and High Class groups.

Of all the caste and class groups, while it was the Low Caste which took least extent of health action, the High Caste took greater extent of health action. Males and females in the High Caste group took greater extent of health action than the Low Caste group. Similar trend was observed in class groups also. Further, health action taken by females in the Low Caste group was not only least among females but also
in the population in general. Thus, the females in Low Caste group were the most neglected in the population while the females in the High Caste group were the most cared for. There was a clear trend of association of social status and health action: Higher the Caste/Class status, greater the extent of health action taken.

Both in morbidity and health action, caste/class status was reflected: Higher the Caste/Class status, less the extent of morbidity and greater the extent of health action.

Among males and females, slightly greater extent of health action was reported by males than females. However, females in the High Caste group reported greater extent of health action in the population in general. In contrast to this, females in the Low Caste group reported least extent of health action in the population in general. Less morbidity and more health action was reported among the High Caste females while it was contrary among the Low Caste females.

Among males and females, females resorted to health action for a larger number of chronic morbidities than males. This was contrary to acute morbidities where slightly greater extent of health action was reported among males than females.
In Caste and Class groups, females took care of greater number of chronic morbidities than males. While females in the High Class group took care of greater number of chronic morbidities, females in the Low Caste group took care of less number of morbidities.

In acute morbidities while females in the Low Caste group took least extent of health action, in chronic morbidities males in the Low Caste group took least extent of health action. On the other hand, in acute morbidities while females in the High Caste group took greater extent of health action, females in the High Class group took greater extent of health action for chronic morbidities.

Among all categories, children were better taken care of by some form of health action. Among them, 90 per cent of the morbidities were taken care of. In other categories, only about 75 per cent of the morbidities were taken care of.

In general, in all categories greater proportion of health action was taken in the High Caste group than in the Low Caste group. More or less a similar trend was observed in class group also. In general for chronic illness, only
65.6 per cent of morbidities were taken care of by health action while for acute illness 82 per cent of the morbidities were taken care of.

Among youth in the Low Caste and Low Class groups, least extent of health action was reported both for acute and chronic morbidities compared to other age categories in caste and class groups. In contrast to this, least health action was reported in old-age category in the High Caste and High Class groups. Greater morbidity remaining unattended to among youth in the Low Caste and Low Class groups makes a serious dent on productivity and results in their low earnings. This in turn will affect adversely their consumption pattern in the family.

C. **UTILIZATION:**

In general, local PHC was consulted mostly by all Caste and Class groups. Next to PHC comes the visits to RMP, private doctors outside the village, folk-healers and CHV. The Low Caste and Low Class groups consulted PHC more frequently than the High Caste and High Class groups. The High Caste and High Class groups consulted private doctors outside the village more frequently than the Low Caste and Low Class groups.
While all the households in the Low Caste group availed of the services of local PHC since its functioning in the village, only about 3/4th of the households in the High Caste group utilised PHC. More or less a similar situation was observed in class groups also.

The Low Caste and Low Class groups used the services of PHC such as maternal care, delivery, immunization etc. more than the High Caste and High Class groups.

Family Planning was the only service which was utilised by all social groups more or less in the same proportion.

The High Caste and High Class groups had more favourable experience of PHC than the Low Caste and Low Class groups. When it comes to preference for PHC, only 50 per cent of the respondents expressed their preference for PHC in the High Caste and High Class groups while 75 per cent of the respondents expressed their preference in the Low Caste and Low Class groups. When they were asked to state the reason for their visits to PHC on the basis of their morbidity record, it was found that "service free of cost" as the main reason in all caste and class groups. While 'free service' and
'limitations of some kind' were reported as the main reasons among the Low Caste and Low Class groups, 'free service' and 'good image of certain doctor/specialist services of the FHC were the main reasons in the High Caste and High Class groups.

ANM did not visit nearly 80 per cent of the households during the preceding six months from the date of enquiry. MPW did not visit 45 per cent of the households during the same period.

Very little preference was expressed for consulting CHV. The reason for the preference was proximity. All CHVs belonged to the Low Caste group and mostly the Low Caste group respondents expressed their preference for them.

For private practitioners, most of the respondents expressed their preference. While the High Caste and High Class groups indicated either first or second preference, the Low Caste and Low Class groups expressed second preference largely. In general, majority of the respondents mentioned 'Not satisfied with other agencies/cures' as the main reason for their preference. On the basis of morbidity record, when they were asked to state the actual reason for
their visits to private practitioners, it was mentioned that 'poor image/dissatisfaction of services/personnel of PHC' as the major reason. Better satisfaction' and 'accessibility' were mentioned in a small proportion.

Nearly half of the respondents expressed no preference for medical shop. Of those who expressed preference for medical shop, most of them reported their first preference. The other reasons for their preference were accessibility and less cost.

For minor ailments, generally most of the people consulted local medical shop. While medical shop as the main resource followed by PHC to some extent were the major resorts for minor ailments in the Low Caste and Low Class groups, medical shop as the main resort followed by private practitioners were the main resources for seeking medical care in the High Caste and High Class groups.

Of the first preference for various health resources for medical care indicated by caste and class groups, it is observed that the Low Caste and Low Class groups expressed their first preference for medical shop followed by PHC. The High Caste group expressed their first preference for medical
shop followed by private practitioners while the High Class group expressed their first preference for private practitioners followed by medical shop.

The High Caste and High Class groups kept most of the items of medicinal value in their homes for ready use compared to the Low Caste and Low Class groups.

In general, about 3/4ths of the people in the village depended on local pond for drinking water while the rest used either tap or well. The Low Caste group depended on pond water to a greater extent than any other group. It was observed that no systematic effort or attempt was made by any particular group to deprive other group(s) for utilizing any health resource in the community.

D. HEALTH PRACTICES:

The Low Caste and Low Class groups used twig more than the High Caste and High Class groups. The High Caste and High Class groups used tooth paste more than the Low Caste and Low Class groups.
 Majority of the respondents took body bath and only a small number took head bath generally in all caste and class groups. Both the Low Caste and Low Class group respondents reported taking head bath less frequently i.e. either once a fortnight or even at longer intervals than the High Caste and High Class group respondents.

About half of the respondents are using soap for bath while the rest are not using anything. Further, the High Caste and High Class group respondents are using soap in greater proportion than the Low Caste and Low Class group respondents. Nearly two-thirds of the Low Caste and Low Class group respondents are not using anything to clean their body while bathing.

The High Caste and High Class group respondents applied oil to their hair regularly (once in 2 days or daily) in greater proportion than the Low Caste and Low Class group respondents.

Of those who reported drinking habit, most of them belonged to the Low Caste and Low Class groups. Majority of them were drinking liquor regularly.
Majority (80%) of the respondents reported having smoking habit. Further, most of the High Caste and High Class group respondents smoked slightly heavily (more than 3 cigars per day) compared to the Low Caste and Low Class group respondents. In the Low Caste and Low Class groups smoking by females and children is a common practice while it is taboo in the High Caste and High Class groups. Addapoga (keeping the burning end of the cigar inside the mouth) is more common in the Low Caste and Low Class groups especially among women.

In providing special diet before delivery, only about 1/4th of the pregnant women were provided special diet before delivery. Of those who provided special diet before delivery majority of them belonged to the High Caste and High Class groups.

In providing special diet after delivery nearly half of the households provided special diet after delivery. More also, the High Caste and High Class groups provided special diet after delivery in greater proportion than the Low Caste and Low Class groups. In general, there is less consciousness in providing special diet before delivery than after delivery.

Almost all the pregnant women who worked in fields, construction work etc. belonged to the Low Caste and Low Class
groups. Most of them worked till 7-9 months of their pregnancy. After delivery nearly 40 per cent of the new mothers resumed their work within three months of their delivery and about 30 per cent resumed work after ten months of delivery.

Nearly half of the pregnant women had no pre-natal check up. The Low Caste and Low Class group pregnant women depended on local PHC for prenatal checkup, while the High Caste and High Class group pregnant women sought services from other agencies such as private doctors/nursing homes in nearby towns.

In general, nearly half of the new mothers started weaning when their babies reached the age of 9-12 months, while majority of mothers in the High Caste group weaned their babies on their reaching 9-12 months. Nearly half of the mothers in the Low Caste group weaned their babies when they reached more than 2 years.

Most of the mothers started giving solid foods to their babies when they were below the age of 9-12 months.
The average per unit per day consumption is 2241.5 calories. There is differential consumption of calories per unit per day in different social groups. While the per unit per day intake of calories is found highest in the High Class out of all social groups, it is the lowest in the Low Class group. Of the High Caste/High Class groups, it is the High Class which is having a better calorie intake. The Low Caste and Low Class groups are having more or less a similar intake of calories per unit per day.

The percentage of consumption of calories drawn from rice and other items out of total calorie intake is the same in the High Caste and High Class groups. In the Low Caste and Low Class groups, the percentage of calories taken out of consumption of rice is slightly more in comparison to the High Caste and High Class groups. Broadly, the consumption of calories per unit per day is less in the Low Caste and Low Class groups than the High Caste and the High Class groups. It may be inferred that the Low Caste/Class has poorer nutritional status than the High Caste/High Class groups.

**SUMMARY OF CASTE-CLASS DIFFERENCES**

Differences noted above suggested the following implications of Caste-Class status:
1. Habits and practices linked to affordability and improved living conditions show greater contrast by class such as calorie intake, use of doctors and private practitioners, use of soap, use of special diet both before and after delivery etc.

2. Habits and practices linked to greater awareness, progressive attitude, contacts with modern way of living benefits of new types of agencies and services also show greater prevalence by Class than by Caste such as use of tooth paste, soap, use of immunization services, early weaning, etc.

3. In contrast the habits and practices linked to traditional way of life and traditional norms show greater association to Caste status than Class status or show greater contrast in terms of High-Low Caste status than High-Low Class status. Examples are—taking headbath working outside home during pregnancy, late weaning etc.

4. Data also suggest that habits and practices which imply strong value or and normative compulsions are not influenced by affordability reflected in Class status. For example drinking habit and non-vegetarianism are linked to affordability and new life style but strongly related to traditional norms. These show greater linkage to Caste status than to Class status. 13 per cent more respondents from the Low Caste habitually drink than the Low Class because some respondents in the Low Class group are from the Middle and High Caste groups who traditionally abstain from drinking.
5. Similarly, data generally show that since greater proportion of High Class group is from High Castes, these two show substantially lesser difference in comparison to differences among Low Class and Low Caste group because greater proportion of Low Class respondents belong to Middle and High Castes, (see table 2.1 in chapter two). Examples of such pattern where High Caste-Class differences are less than Low Caste-Class difference are drinking, smoking, regularity in taking he bath (once in 2 days and in a week), use of special diet after delivery, not having any pre-natal check-up, use of PHC services (during the period of two months preceding the date of interview), use of immunization services of PHC, home visits by ANM, NPW, use of pond, frequency of health action taken, etc.

6. There are some instances which seem to support the idea of Sanskritization. When the Low and Middle Caste respondents move to High Class status they emulate traditional norms of High Caste rather than reflecting new pattern of modern secular life style. For example 3 per cent respondents in the High caste group drink but only 1.8 per cent respondents in the High Class group (many of whom are from middle and low castes) declare that they drink.

7. Practices which are neither associated strongly to affordability nor to secular life style nor to traditional norms of purity are shared in all caste/class groups to similar extent such as smoking.
8. Factors of systematic exclusion or deprivation of Low Caste/Class groups are not brought out in our data although such processes do occur. Greater use of pond water by the Low Castes (94 per cent) in comparison to 77 percent among the Low Class suggests that Caste factor is stronger in this exclusion process than the Class factor.

9. There is some interesting information on how different castes and class groups relate to government health services in villages. There is little difference between High/Low Caste and Class groups in actual use or performance of PHCs. However, there is substantial difference among the Low Class and Low Caste groups in use of or visits from ANM, MPW and CHV i.e. these workers have discernible linkages to the Low Caste in comparison to the Low Class households. As explained before it is partly because of the caste status of these health workers. It appears, the High and Middle Caste respondents in the Low Class group do not identify with these health workers in the same way as do the Low Caste members.

10. It has been suggested above that the High Class/High Caste groups show a number of important differences in a variety of health practices in comparison to the Low Class/Low Caste groups. High prevalence of presumably health promoting practices among the High Caste/Class groups is taken as a progressive pattern. However, a closer look shows two overlapping patterns. There are some health practices which are desirable in terms of traditional norms or purity and pollution (such as bathing, special foods during pregnancy, etc.) or notions of decency linked to caste status (pre/post delivery
prohibitions). These variables are slightly more prevalent among High Castes in comparison to High Class. There are some practices which are desirable in terms of modern secular life style or status. Such factors show marginal to moderate predominance among the High Class (use of toothpaste, use of soap, comparatively less smoking, use of private agencies for pre-natal check-up) in comparison to the High Caste group.

The Caste vs Class differences are to be seen in the background of inter-relationship between these two variables illustrated in Chapter 2 (table 2.1).

The table 2.1 shows that redistribution of Low Castes by Class status makes only marginal difference in so far as only 14.6 per cent of them move up the ladder into Middle and High Class group. But classwise reclassification of High Castes has the opposite effect. As many as 49 per cent of the High Caste households move down the class ladder to Middle and Low Class groups. While only 8 per cent of the Low Castes move to High Class status, about 18 per cent of the High Castes move to Low Class status. The Middle Caste households have more or less the same classwise profile as the Low Caste households. As many as 68.5 per cent of the Middle Caste households belong to the Low Class although 26 per cent of
them retain the Middle Class status. It is, therefore, expected that the Middle Caste households may display a profile of health care practices similar to the Low Caste households or sometimes similar to the High Caste households. Middle Castes do not represent mid-point linear position in the Class scale reflected by the fact that overlap between Middle Class and Middle Caste is only 26 to 30 per cent and that 63.8 per cent of the households in Middle Class belong to the High Castes.

Reclassification of Castes by Class effects High Caste and Middle Caste, much more but the effect on redistribution of Low Castes by Class is only marginal. Proportion of High Castes within High Class is much more than the proportion of Low Castes within Low Class. On the other hand, higher proportion of Low Castes fall in Low Class in comparison to proportion of High Caste remaining within High Class.

From the above discussion, it is seen that social stratification play a vital role in prevalence of morbidity, resort to health action, advancement of health practices and utilisation of various health resources available to the community. High Caste and High Class groups are associated with practices such as use of toothpaste, soap, regularity in
taking head bath, regularity in oiling hair (daily/once in two days), special diet both before and after delivery, intake of calories in greater proportion, negligible drinking and early weaning practices compared to Low Caste and Low Class groups. In utilisation of health resources, both the High Caste and High Class groups used the private doctors outside the village, local RMPs and local folk-healers in larger measure than the Low Caste and Low Class groups. Further, both the High Caste and High Class groups took health action for more number of morbidities than the Low Caste and Low Class groups. Both the High Caste and High Class groups are endowed with living conditions such as spacious housing, higher income, cleaner surroundings, more literacy etc. On the other hand, both the Low Caste and Low Class groups are associated with practices such as irregular taking of head bath, irregular use or oiling hair, less use of soap, drinking of liquor in greater proportion, less use of special diet both before and after delivery, late weaning, comparatively less calorie intake and less extent of health action for morbidities. Both the Low Caste and Low Class groups used special services of PHC such as maternal care, delivery, and immunisation in greater proportion than the High Caste and High Class groups. However,
in informal interviews they expressed dissatisfaction over the services and personnel of PHC. It is interesting to note that the services of ANM and MPW were utilised by the Low Caste group more than any other group due to the subjective factor of these personnel belonging to their own caste. Both the groups used pond water more than the High Caste and High Class groups. Further, both the Low Caste and Low Class groups took less extent of health action than the High Caste and High Class groups.

It is significant to note that both males and females in the Low Caste group, particularly females, took least extent of health action in the population in general. Further, youth in the Low Caste and Low Class groups, particularly in Low Caste group, took less extent of health action than other categories - children, middle-aged and old-aged in the population in general. Both these groups are bestowed with living conditions such as crowded housing, unclean surroundings with greater risk of contamination and pollution due to domestication of fowls, pigs etc, low income, less literacy etc.

It is interesting to note that family planning services of PHC were utilised by all caste and class groups more or less in the same proportion due to the impact of the promotional
activities by the government and greater awareness of the advantages of a small family among people.

Thus, both the High Caste and High Class groups are associated with practices which contribute to maintenance and promotion of better health than the Low Caste and Low Class groups. Of the High Caste and High Class groups the High Class group observed the above practices in greater measure than the High Caste group due to their affordability and greater awareness. On the other hand, both the Low Caste and Low Class groups were not found associated with observance of health practices which would help in their maintenance of good health, in greater proportion than the High Caste and High Class groups. On the other hand, both these groups were found associated with the habit of drinking liquor to a much greater extent.

In Indian society, as the caste status is ascriptive, the alternative open to members of a community is to improve one's achievable (class) status. As it has been already noted, the High Class status is associated with observance of such practices/norms/values etc. which are conducive to good health. It may, therefore, be argued that as one improves one's class status, one is likely to discard/reduce the observance of such practices which are harmful to health. Improvement in class
status itself calls for a rise in general standard of living which in turn is dependent on factors such as provision of gainful employment, education, communication facilities, implementation of land reforms, agricultural production, health facilities, environmental sanitation, housing etc. Further, there is a need for improvement in the quality of the governmental health services such as PHC, specialist services so as to enhance their acceptability and utilization in the community. The community in general should be educated for better health consciousness so as to enable them to take appropriate care. To meet this, suitable strategies should be developed with the help of social scientists and medical experts. Target specific programs for youths and females in Low Caste/Class groups should be prepared to meet their health needs. Necessary measures need to be taken by the state government to inculcate service orientation and work ethic among personnel of PHC. A sympathetic understanding of the problems of patients will create a good image of PHC and its personnel in the community. The people should be communicated well in advance and motivated to utilize the specialist services rendered by the medical college experts who visit the PHC as per their schedule.
Thus, improvement in health status in a community calls for a closer integration of health sector with other sectors of rural development such as education, employment, communications, agriculture, health facilities etc.

SUGGESTIONS FOR FURTHER RESEARCH

1. Since the present study is limited to a single village, we cannot generalise for the entire region/state. There is, thus, a need to conduct more such studies to confirm these findings.

2. It will be helpful if a cluster of villages is taken for study so that an equal number of households can be represented in the sample for all caste and class groups for better comparison and understanding. Caste-Class and Class-Caste analysis can be made if the sample is adequate.

3. For morbidity, it will be helpful if data are collected prospectively with the help of a medical practitioner.

4. For proper assessment of nutritional status of a group, weighment method will be more appropriate though it may have its operational problems.

5. The above findings can generate hypotheses for further research.
SUMMARY:

The present study aims at understanding the relationship between social stratification and health care in a rural community in Andhra Pradesh. The basic objective of this study was to describe differential distribution of morbidities and various health care practices among the caste and class groups in the study village in order to examine whether the differential distribution of health care practices has any consistent patterns in relation to caste and class differences.

A village was selected in East Godavari District of Andhra Pradesh for the study after satisfying certain criteria. This village had two portions - the main village 'Rangampeta' and hamlet 'Chandr du' which is located at a distance of 3 kilometers from the main village. This has a population of 5807. A systematic random sample of 200 households was chosen out of the total number of 1050 households in the study village.

Stratification includes both caste and class dimensions. All the sample households were categorised into High, Middle and Low Caste and Class groups. The class status of a household was arrived at on the basis of an index constructed from three variables, namely, land, income and occupation.
Information was collected from the sample households by using various questionnaires on socio-economic background, morbidity, food habits, utilization of health resources and facilities and various health practices. Informal interviews were also held with practitioners, PHC personnel, informal leaders and others in the village to collect data on some general aspects relevant to our study.

Important findings are noted below:

A. MORBIDITY:

Almost all households reported some acute morbidities during 3 months period and about 70 per cent households reported chronic morbidities. Of all the episodes recorded, only 17.7 per cent were chronic morbidities. More than 80 different types of morbidities or complaints were reported. Fever (9.75%), headache (6.29%), dental caries (5.77%), cough (4.95%) and motions (5.04%) were the most frequently reported complaints. In general, complaints related to ENT and sense organs were most frequently (21.5%) reported illnesses followed by complaints of digestive system (16.5%) and musculo-skeletal system (12.4%).
The Low Caste and Low Class groups reported more
morbidities than the High Caste and High Class groups. In
the High Caste and High Class groups, morbidities among males
were reported slightly more than among females. On the other
hand, morbidities were reported slightly more among females
in the Low Caste and Low Class groups. A sick person in the
Low Caste and Low Class groups suffered more episodes than a
sick person in High Caste and High Class groups.

Minor illness among females were reported slightly more
than among males. In contrast to this, chronic morbidities
among males were reported slightly more than females. A
similar pattern was found both in caste and class groups.

B. **HEALTH ACTION** :

In case of about 80 per cent of morbidities some form of
health action was taken. But in case of 34 per cent of chronic
morbidities no action was taken.

Both in prevalence of morbidity and health action inverse
relation to caste/class status was reflected. In High Caste/
Class groups, morbidity was lower but health action was
greater in comparison to Low Caste/Class groups.
C. UTILIZATION:

In general, local PHC was consulted most frequently by all the caste and class groups. Next to PHC comes use of RMP, private doctors, folk-healers and CHV in the order of frequency. The Low Caste and Low Class groups however, consulted PHC more frequently than the High Caste and High Class groups. The High Caste and High Class groups consulted private doctors outside the village more frequently than the Low Caste and Low Class groups.

For minor ailments generally people consulted local medical shop. The High Caste and High Class groups often kept some items of medicinal value in their homes.

D. HEALTH PRACTICES:

Personal hygiene habits like use of soap, tooth brush and paste, use of oil etc. were clearly better among the High Class/Caste groups. However, most of those used to drinking regularly belonged to the Low Caste/Class groups.

Only about 1/4th of the pregnant women in general were provided special diet before delivery but nearly half were
provided special diet after delivery. Majority of women who were provided special diet before delivery belonged to High Caste/Class groups.

Here also, the High Caste/Class mothers received special diet before and after delivery in greater proportion.

Nearly half of the pregnant women had no pre-natal check-up. Pregnant women in the Low Caste/Class groups depended on local PHC for pre-natal check up, while in the High Caste/Class group they depended on services from other agencies such as private doctors/nursing homes in the nearby town.

The findings of our study indicate that social stratification reflects important differences in health action, observance of health practices and utilization of various health resources. It was found that the High Caste/Class groups were associated with practices such as lesser prevalence rate of sickness, greater extent of health action, greater use of soap, toothpaste, use of hair oil regularly, providing special diet before and after delivery, early weaning, greater pre-natal check up, negligible use of liquor, keeping items of medicinal value such as bindye, cotton, tablets, tonics etc. and better economic position etc. which are conducive to maintenance or promotion of better health.
The position of a social group in the community reflects its health behaviour. In order to bring about a desired change in health behaviour in the rural community, target oriented programs are needed for the Low Caste/Class groups to improve their living conditions and to create consciousness for maintenance and promotion of health.