INTRODUCTION
Chapter 1

INTRODUCTION

"Medicine is a social science in its very bone and marrow"

--Rudolf Virchow

SOCIAL ASPECTS OF HEALTH:

Health and Illness are universal phenomena. Both are variously understood or defined in different societies or communities. The most widely accepted definition of health given by WHO is "a state of complete physical, mental and social well-being and not mere absense of disease and illness". While the physical and mental aspects of health are taken care of by medical profession, the 'social well-being' dimension has not been properly attended to so far. This aspect needs a closer look to understand the underlying complex relationships of health to other spheres of life such as social, economic, political, environmental and technological dimensions.

An individual is not an isolated entity but lives in and part of his primary group, kingroup, neighbourhood, community and the wider society. Not only he is a biological organism but also a social being interacting with his immediate
physical and social environment regularly and constantly.
In order to sustain himself, he has to exploit the physical resources around and create necessary conditions for his well-being. For this, he has to work on his physical environment, develop suitable technology and social relations in the process. All these factors influence his well-being in the society. The people from primitive to modern societies have evolved different physical, social and material environments appropriate to the conditions surrounding their daily life and routine and in accordance with their resources and aspirations.

Health, an integral and essential part of life, has been viewed differently at different stages of development of society. Further, within the society, different social groups have evolved their own conception of health. Health is to be seen not merely in terms of curing a disease but as an indicator of the level of social, economic, material and environmental development. What is needed is an understanding of those various conditions, situations and behaviour patterns which not only determine the health status of a group but are also necessary to understand their health and illness behaviour. Thus, 'health is a socially produced natural reality' (Djurfeldt and Lundberg, 1980). "Diseases exist and abound where human habits and social conditions foster them" (Kochar, 1979).
Health can be seen as a strategic resource of a society because of its crucial bearing on the ability of individuals to perform their roles. Health and Medicine like economy, religion, politics etc. constitute a sub-system in the social system of a society. A health system is "a set of relationships among institutions, social groups and individuals that is directed towards maintaining and improving the health status of a population" (DeMiguél, 1979). The health system can be seen both as a structure and process. The main task of a health system is to cope with the threats and consequences of illness. To achieve this, the health system provides a series of services consisting of prevention, diagnosis, treatment, rehabilitation, custody and health education (Field, 1973).

The response to illhealth and its consequences can be seen as cultural and sociological. The cultural consequences refer to the development of attitudes and perceptions regarding health and illness and lay strategies to deal with problems of health. The sociological consequences refer to progressive development of health institutions which produce knowledge, personnel and technology for proper management of illness. Health personnel and health facilities operate within the context of a health system (Field, 1973). A health system transforms given inputs into health service outputs (DeMiguél, 1979).
The main goal of a health system is to improve the health status of a population in a given area. The health status of a population is the net effect of a health system. It can be measured by indicators such as mortality and morbidity rates, longevity or lifespan, decline of causes of death, social and mental health, etc. The health status of a particular group in a society, therefore, partly depends on how the group stands in relation to the resources, personnel and programmes of a health system.

Health system contains three social arenas in which lay persons experience and respond to episodes of illness. These are popular, folk and professional arenas. The popular arena comprises essentially of the family context of sickness and care including the community setting. The folk arena consists of non-professional healers. The professional arena consists of professional scientific (western or cosmopolitan) medicine and professionalised indigenous healing traditions (Kleinman, 1978). People perceive and respond to the day to day problems of health and illness in light of their beliefs, their needs and the social situation in which they act. These aspects are reflected in their health and illness behaviour. The terms "health behaviour" and "illness behaviour" refer to the practices
and actions directed at achieving better health, prevention of health risks, and the management of the episodes of illness experienced.

HEALTH SYSTEM IN INDIA:

India is a signatory to the Alma-Ata declaration (1978) which pledges 'Health for All' by 2000 A.D. It has become a charter of health throughout the world and a hope for mankind, particularly in the developing countries.

The distribution of health resources -- practitioners, dispensaries, hospitals, equipment, beds etc. -- is highly uneven between rural and urban populations in India. With 76.3% of its population living in over 5,75,993 villages (NIRD, 1983), India is served by 20% of its doctor population and a network of primary health centres with ineffective referral system while the small urban population is served by highly equipped health care institutions and well-trained personnel. The distribution of hospitals, beds, nurses, ANMs, drugs, equipment, referral services is all the more glaring. Further, health indices such as high infant morbidity and high mortality rates, birth rates etc. in the rural populations reflect the gravity of the health problems in villages. "The problem is further compounded by the gross neglect by the
Government in allocation of resources to health in its five-year plans. Areas such as education were given greater allocation, though seemingly health is more important. It is because health is not considered politically a very important area. Behind smaller allocations for health lies the kind of cynicism almost unknown elsewhere" (Sethi, 1980).

The draft sixth plan (1978-83) identified some of the weaknesses which resulted into the inequitous health care structure and medical education in India since independence. Some of these are:

"....(b) it is divorced from social, economic and ecological factors, conditions of work, social stratification (c) it is unrelated to such other important issues as nutrition, water supply, dietary requirements and habits, food preservation practices etc. (d) health services have been concentrated mostly in urban areas and here too, these services have been largely used by the affluent classes i.e. the structure is largely inequalitarian (e) it is based on medical education system which prepared doctors not for the care of the health of the people, but instead for medical practice that is unrelated to anything except disease and technology dealing with it (g) it has seriously undermined and at places destroyed whatever traditional methods of health care system that existed for centuries in the country (h) it is based on the growing use of drugs instead of their avoidance by improving physical condition of living and hence is largely influenced by the interests and philosophy of drug industry...." (Govt. of India, 1977).
The need to improve the health services is stressed by the ICSSR-ICMR study group in its report and it suggested the following priority areas of research:

1. "Health services research should have very high priority. Of social interest in this regard is primary health care whose different aspects (such as information support, manpower development, appropriate technology, management and community involvement) need close and continuous study. Since administration has been a weak spot, research for improving administrative practices is very relevant."

2. "Studies on different aspects of the health system is 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."

3. "...recommended emphasis on research into indigenous systems of medicine and health consequences of industrial development (including studies of work place environment)" (Health for All, 1981)

Thus, in the context of structural and functional imbalance of health care delivery system in rural India, any study which explores linkages between health care and other aspects like social structure, economic conditions, technology
etc. assumes significance. With this background, the present study is aimed at understanding the relationship between health care and social stratification in a rural community in Andhra Pradesh.

Health is the most valued asset for performing one's role effectively. Health depends in part, upon the status which a group or individual enjoys or is bestowed upon in a given community. It may be seen that health as well as health behaviour is governed by the position a person (or group) occupies in the system of social differentiation existing in a society. Social stratification differentially limits the accessibility to health resources and knowledge on health care. It also determines the living conditions privileges and obligations, and the cultural traditions surrounding the life of a person.

THE FOCUS OF THE PRESENT STUDY:
HEALTH AND SOCIAL STRATIFICATION

Sociological and Anthropological researches have revealed the universality of social stratification in one form or other. It is a "generalised aspect of the structure of all social
systems" (Parsons, 1953). Social stratification refers to the arrangement of various groups in a hierarchy indicating the relations of superiority or inferiority with respect to property, status and power. These relations are governed by a value system, ascription and achievement, reward and punishment. It provides differential status and role to individuals and groups that constitute a basis for human behaviour in relation to each other. It confers differential possession of goods and services, differential access to resources and differential utilization of facilities and opportunities.

Davis and Moore (1945), Davis (1948), Tumin (1953), Buckley (1958), Wesolowski (1962), Huaco (1970) and several others have approached stratification from functional perspective. For them, the most important positions are filled in by the most talented persons and to fill in these positions, there should be a system of rewards as inducements to occupy these positions. These rewards and their distribution among various positions constitute stratification system.

Karl Marx has viewed stratification from a dialectical perspective. For him, the history of all hitherto existing societies is the history of class struggles. Classes emerge on the basis of different positions or roles which individuals
perform the same function in the organisation of production. Means of production is the determinant of relations of production. It would give rise to two classes in a society — owners of means of production (bourgeoisie) and owners of mere labour power (proletariat) with the former exploiting the latter. Thus, the interests of these two classes are mutually antagonistic and would draw them into a class-struggle leading eventually to the establishment of a classless society. For Marx, the ownership of property is the substructure and its all other aspects such as religion, power, culture, art, education, law etc. are superstructures. Attributes such as class consciousness, class solidarity and class conflict are important to understand the nature of class relations in a society.

Max Weber went further and conceptualised stratification in terms of "class, status and party". For him property, power and prestige are three separate though closely interrelated bases on which hierarchies are formed in a society. Differences based on property, power and honour give rise to class, power and status respectively. Unlike Marx, for Weber class is a product of a market situation and there are as many classes as there are market situations. A class shares in common one or more causes of life-chances which determine the supply of goods, living conditions and life experiences. Other thinkers such as
Ralf Dahrendorf (1959), Lenski (1966), Warner (1960), Parsons (1953) have also put forth their ideas on stratification.

In India, various scholars view stratification in terms of either caste or caste and class or caste, class and power. Indian society is "Caste-society" characterised by hereditary membership, endogamy, commensal restrictions, common traditional occupation and hierarchy as held by Davis (1948), Hutton (1963) and Ghurye (1950). Various scholars analysed caste stratification from different perspectives - as a cultural system (Dumont, 1970; Leach, 1960) as a structural phenomenon (Barth, 1960; Berreman, 1967) as closed system (Bailey, 1953); as segmentary (Beteille, 1966) etc.

Among numerous studies mention may be made of Kosambi (1955), Thapar (1974) and Desai (1948) who have analysed Indian society from class point of view. The phenomena of caste, class and power was studied by Beteille (1955) and Bhat (1974) explicitly applying Weber's trilogy.

Some theoretical aspects of Caste and Class as ideal types make them distinctive categories. Caste is ascribed by birth while Class is achievable. Class is closer to economic relationship, to means of production and economic status.
Class signifies status in terms of power and influence one enjoys by virtue of one's income, property and social standing irrespective of birth. Caste signifies a traditional pattern of social interaction by inclusion and exclusion irrespective of one's economic standing.

However, empirically there is a striking overlap: Both Caste and Class are linked to occupation which determine economic standing. Social standing accrues to an individual by both Class and Caste considerations. It is difficult to separate the status and power a person enjoys because of Caste and Class affiliation.

The Caste identity being an emic category is socially visible much more than the Class identity which is more of an etic construction. The consciousness of Class affinity bond, political alignment in common cause among Class members across caste identities is perhaps still weak against the backdrop of strong Caste loyalties. Caste being age old institution is linked to all facets of community life including occupation, income, property, land and social standing which are achievable attributes in Class framework.
Empirically, therefore there is bound to be a strong overlap in Caste and Class identities. Some observers have noted that caste system mirrors or mimics class relationships and class dynamics such as the problems of economic domination and subjugation, privileges and deprivations, conspicuous affluence and bare survival (Sharma 1977; Mencher, 1974). Others have observed that new class related questions and social actions are being absorbed and enacted within the garb of caste identities and alliances.

Three empirical assumptions can be safely made for our purpose.

1. While Caste represents the domain of traditional and ascriptive framework of life conditions, values and social choices, class represents achievable social status and new life conditions or social choices that are cosmopolitan i.e. which cut across caste identities. Caste represents traditional framework of social behaviour while class represents emergent patterns of social relationships and behaviour.

2. While Caste Status embodies many dimensions of social relationships and social status, Class status is more directly and exclusively related to economic factors reflected in land, property, income and occupation.
3. When we empirically classify the same households by Caste and Class there is bound to be strong association between the two variables. Yet the differences are going to be very suggestive because some High Caste households will rank with Low Class households and some Low Class households will rank among the High Caste households. (Beteille, 1965). Analytical implications of these assumptions are identified later in the second chapter where such class-caste classification of the sample households is presented.

HEALTH ASPECTS IN VILLAGE STUDIES

Having delineated broadly the focus of this study we may briefly review the village studies in India many of which include material on health and illness. It may be mentioned here that some British administrators and those interested in rural development focussed their attention on health problems in India. Brayne (1937), Advisor on Indian Affairs to the Welfare General of India, describing the health situation in pre-Independent India, mentioned in his book 'Better villages' "If you run your eye down the tabulated list of diseases in a rural dispensary, you will find that well over a half are caused by dirt, the absense of light and air are more responsible for a lot more, then malaria and its by products, and finally absense of the knowledge of how to plan and cook a
balanced diet." Similarly, Pillay (1931) said "The general uplift and health questions have to be dealt with as a whole and not in separate compartments. The aim should be to see that while health work is assisting other branches of state activities, it is automatically helped by them and thus becomes an aspect of concerted attempt at general lift." He discussed the problems of rural welfare (including health) and suggested measures for organization of systematic work. Spencer Hatch (1938), Krishna Swami (1947) also expressed their concern about the appalling health conditions in the country.

Few early studies on village life described aspects related to health briefly while their main focus was to study social structure, kinship, economy, religion, communication etc. Datey (1948) described the standard of life in village, Madhan, in Maharashtra. He categorised the families in the village into seven groups depending on their per capita expenditure. He gave a detailed account of how each group spent its resources on food, clothing, housing, comforts and luxuries. He observed that as the family income increases, the proportion of expenditure on food decreases and that on the comforts and luxuries increased. This supports the Engle's law of family expenditure which states that as the family
income increases, the proportion of expenditure on food decreases, while the proportion of expenditure on other non-essential items increases.

Majumdar (1958) described sanitation, water supply, food habits, drainage system, diseases and their treatments in the village Mohana in Uttar Pradesh. Chattopadhyaya (1963) briefly mentioned about cleanliness, sanitation, food, causes of morbidity and death in Ranjana, a village in West Bengal. Madan (1959) presented the changing situation in the field of health - medical care and public health, maternity and child health, family planning, health education, water supply and sanitation etc. in some Indian villages. Desai (1966) discussed health and medical facilities, consumption pattern and levels of living in village, Hasteda, in Rajasthan. He observed that there was a significant relationship between economic well-being and the type of food consumed and that not only did the consumption of superior cereals increase but also the tendency to turn to protective foods became more marked with the increase in income. He has, however, added that the level of income was not the only determinant but factors such as degree of enlightenment and social status also influenced the quality of food consumed. Mukherjee (1971) gave an account of health and diseases in six villages in West Bengal. He discussed about sanitation and water supply and
gave a list of diseases which incapacitate a person for less than a week and those for more than a week. Bhownick (1976) presented a profile of diseases prevalent and practitioners consulted in some villages in West Bengal.

Ishwaran (1967) discussed health and illness in village, Shivpur, in Karnataka. He described how the villagers perceive health and illness, the common diseases and their cure, purity - pollution and health, native practitioners etc. Carstairs (1955) discussed the obstacles in acceptance of Western medicine in two villages - Sujarupa and Delwara - in Rajasthan. Illness is viewed as much a moral crisis as a physical crisis. The practitioner should serve as a link between mortal men and cosmos. After a restudy of these villages, (1983) he described the progress and failures in rural health care. He pointed out that "mutual misunderstanding is bound to arise between rural patients who believe in the supernatural cause of illness and doctors trained in scientific medicine, unless the doctor takes pains to show how he respects his patients understanding of illness while tactfully indicating that his own approach is different, but can yield good results". (Carstairs, 1983). Marriott (1958) studied the impact of Western medicine in Kisangarhi, a village in Western U.P.. He presented the contrast between Western
and Indian medicine in terms of doctor-patient relationship. Lewis, (1958) studied concepts of disease causation and cure in village, Rampur.

There are a very few holistic village studies on health situation in India. Hasan (1967) studied socio-cultural factors associated with health in village 'Chinura' in Uttar Pradesh. He described sanitary habits, personal hygiene, food habits and food taboos, concepts of etiology and illness etc. Matthews (1979) studied nutrition, maternal and child welfare, family planning, disease classification etc. with the purpose to undertake health education work later in a village in Tamil Nadu. Banerji (1974) studied health behaviour of rural people in seven states covering sixteen villages. He observed that most of the villagers, irrespective of their social, economic and occupational status, favored western (allopathic) medicine. This is in contrast to the observations of Carstairs and Mariott. Availability of western (allopathic) medical services and capacity of patients to meet the expenses are the two major constraints. There is considerable unmet felt need for the services of ANM (Auxillary Nurse Midwife) at the time of child birth. The family planning program projected an image of coercion by the Government.
These studies, except a few, indicate a lack of focus on health problems in India. This has been equally evident in the concern by Gunnar Myrdal (1968) while describing health conditions in South Asia. He writes: "Ideally, we would like to see health censuses of all or a representative sample of the inhabitants of individual South Asian countries, with the data analysed in terms of differences in sex, age, occupation, social and economic status. Indeed, a health survey of this kind for even a few villages or a few blocks in a city would contribute significantly to our knowledge. But no such studies have been made. The rapidly accumulating village surveys show an astonishing lack of interest in local health conditions, or in demographic changes and their social and economic consequences".

With this understanding of the situation, we will review the material available on health and social stratification in India.

HEALTH AND SOCIAL STRATIFICATION IN RURAL INDIA: LITERATURE REVIEW

The relationship between health and social stratification has been demonstrated in terms of occurrence of mortality, differential incidence and prevalence of morbidity, differential
perceptions of symptoms and their interpretation, differential occurrence of illness, differential use of health practitioners and health services, differential accessibility of health resources, etc. All these aspects are related to caste, class, ethnicity, age, sex etc.

In India, many studies of rural/tribal communities have made some reference to selected aspects of health while focussing their attention mainly to some other problems. Here, an attempt has been made to review the available studies related to aspects of health and social stratification in India. These studies are discussed below under two headings - (a) caste and health; and (b) class or socio-economic status and health.

**CASTE AND HEALTH**

The caste has its role in curing of diseases or ailments, shaping one's beliefs related to health, food habits etc.

**Health Roles**

In traditional India, certain castes are associated with different roles in health action -- any activity undertaken to maintain, promote or restore health to an individual. Midwifery
is practised by females belonging to Jhusia or Dhusiya, a
subsect of Chamars in Bihar, Bators or Bakors lower than
Chamars in UP, Haris or Sahis in West Bengal, Mong in
Gujarat, and Barbers in Andhra Pradesh, Tamil Nadu and
Karnataka (Fuchs, 1981; Russel 1975; Beteille, 1965).

Some of the members of Barber caste (Ambattan) act as
healers in Tamilnadu. This role accords them a special
privilege of carrying the title Vadyar meaning physician
(Beteille, 1965). In Karnataka (Misra, 1982), Punjab (Ibbetson,
1974) and Rajasthan (Lambert, 1987) the Barbers used to act as
village surgeons for dressing wounds and setting bones. In
Northern India, Baida practise the profession of medicine and
in some places, they used to hold hereditary state pensions
(Sherring, 1974, 1975; Kurian and Bhanu, 1980).

Some castes engage themselves in collecting ingredients
used in preparation of medicines and or hawk the same in villages
and small towns. The castes Mandula, Pitchikuntla, Golla in
Andhra Pradesh and Karnataka and Nats in North India belong to
this category. The section among caste Gollas which sells
medicines claim a higher status than other sections, by
avoiding inter-dining and inter-marriage with them (Fuchs, 1981).
Through exorcism, sorcery and devil-dancing various kinds of illnesses are cured. Some castes specialise in these methods of healing. In Kerala the main occupation of Malayans is exorcism. The Kanians in Malabar are astrologers and exorcists. The pulluvans are engaged in medicine, astrology and priesthood (Fuchs, 1981).

Most of the lower castes are associated with the cult of godlings and evil spirits which derive its strength from animistic beliefs. There are different godlings and evil spirits associated with the cause of different diseases. For example, a godling who protects children up to five years is known as Panchanan who is propitiated with simple offerings if they have a small ailment and presented with the sacrifice of a goat in case of serious illness (O'Malley, 1935). It is rare among Brahmins to be possessed by local spirits existing outside the Great tradition as they are considered impure and of low status (Nichter, 1977; Claus, 1979). The evil spirits of the dead are also classified according to their caste and manner of death. Brahm Pisach and Churail - women died in childbirth - fall within this category.

Health Beliefs

Caste variations are also reflected in health beliefs. An analysis of the concept Jamora (Tetanus) in a village in
UP (Khare, 1963) revealed a gradual sanskritization and elaboration of ideas regarding diseases as one moves from lower to higher castes. The higher castes think of a disease more with the help of ideas in greater tradition whereas the lower castes seek explanations in tribal gods, spirits and magic which are localised (Lewis, 1958). As regards functioning of body and maintenance of health, there are distinct Brahmin and Non-Brahmin ideologies in Karnataka (Nichter, 1977).

Breach of intercaste relations is attributed to occurrence of certain diseases in rural areas. Illicit sexual relations with a woman of lower caste is considered responsible for the cause of venereal diseases. Harassment of poor, weak and helpless persons is believed to cause leprosy. Milking in a container with water for adulteration is considered to be the cause for Leprosy (Hasan, 1967).

Khare (1962) observed that there exists a relationship between the ritual states of purity and pollution and the physical states of cleanliness and uncleanliness in domestic surroundings. This relationship helps in clarifying the role played by Choot-Pak (ritual purity-pollution) concepts in domestic sanitation. There has been a change occurring in
ritual purity and pollution in three stages as evident in his study in Gopalpur. In the first stage, the details of practices connected with ritual purity - pollution are dropped. For example, the Choot-Pak complex in the kitchen is becoming less rigid though the majority of them do not disregard it completely. The second stage consists in practising the atrophied version of ritual purity-pollution with occasional resort to modern methods of cleanliness. The use of soap, the wearing of leather band wrist watches and leather shoes by the people are examples. The third stage consists in dropping out the old practices of purity and pollution without systematic replacement by the new ones. The educated 'elite' of the village dropped several practices of choot-pak as superstition, but did not replace it with sanitary practices. He further observed that some people like Kayasthas are fast undergoing modernization and westernization. Others like Kurmi, Ahir and Pasi are undergoing sanskritization as well as modernization. Youth are claiming whatever is modern, while old people, especially of lower castes, are observing the details of ritual purity in the rules of commensalism and in the activities of kitchen.

Food Habits

Taking specific kinds of foods is associated with caste. The high caste Brahmans are vegetarians while the non-Brahmins
are generally non-vegetarians. Two kinds of food habits are observed in Tamil Nadu: the high caste vegetarian style and the Harijan non-vegetarian type. Most of the castes fall within these two extremes (Djurfeldt and Lundberg, 1980).

Variations in cooking are reflected in different castes depending upon the position of caste/cluster of castes within the social hierarchy. In West Bengal (Sengupta, 1979) people of very low and lowest categories seldom use spices for cooking. They cook food either by steaming or boiling. Others cook food by frying in oil, roasting or boiling with due addition of spices. The castes of very low and lowest categories add salt to the rice at the time of cooking. The high and very high categories of castes consider it en to i.e. polluting. The utensils used for cooking, items of food prepared and the quantity of food consumed also differ significantly from very low and lowest categories to high, very high and highest categories.

Food Distribution

In rural areas, the rich appropriate the provisions meant for the poor. Whatever quota the poor get in rationing, they give it to rich people so that they can be engaged as casual labourers when required. Whatever quota of rationing is allotted to them, it is hardly distributed to them and that too, only
after meeting the requirements of the dominant and powerful people in the community. In a study of the homogeneous stratum of agricultural labourers belonging to high caste Marathas and Buddhists who belonged to Mahar caste formerly, it was observed that food consumption patterns and employment opportunities differed considerably between the two sections. Caste has its own influence in restricting Buddhists to certain types of occupations (Kamble, 1979).

Access to Health Resources

Caste determines to a certain extent occupation, social status, residential pattern, values and norms and in a way the whole way of life of its members. The principle of exclusion and inclusion and purity and pollution regulate the accessibility of a particular caste to the resources in the community. The "untouchables", the lowest in the social hierarchy, are denied access to essentials of life. They are excluded from using wells, tanks etc. by the rest of the village community (Desai, 1976). In Kerala, they are excluded from private bathing pools and temples which are, however, open to all high-caste people. In a village in Kerala, the political power was manipulated by the high-caste Hindu Panchayat President in digging the well sanctioned to Harijans in the village (Mencher, 1980).
The discrimination and exclusion is not confined to the high caste Hindus and untouchables alone, but a similar practice is observed among untouchables themselves. In Tanjore district, Pallas do not draw water from Paraiyan wells, nor do they allow Paraiyans to use their wells (Beteille, 1972).

The exclusion is also extended to places where services are supposed to be provided to all. In hotels, the untouchable Adi-Karnatakas have to drink coffee in containers specially meant for them. The high caste Hindus strictly enforce the restrictions (Epstein, 1978; Mishra, 1982).

**Health Practices**

Caste status and level of living (measured by an index comprising selected material possessions owned combined with type of housing) have an important role in adoption of health practices. Thorat (1969) in his study on the influence of traditional and non-traditional status on the adoption of health practices observed that higher the caste of the respondent greater was the level of adoption of health practices. Similarly, those with higher level of living adopt greater number of health practices.
Perception of a Good Physician

Rai, in his study of illness behaviour, in rural Uttar Pradesh, found that while most of the non-economic criteria like good-behaviour, knowledge, experience and capacity of making a sharp diagnosis and high academic qualifications were evaluated as desirable traits of a good physician by the high caste people, economic criteria like inexpensive treatment, providing immediate relief, were reported as good traits of a physician by lower castes (Rai, 1983).

B. **CLASS, SOCIO-ECONOMIC STATUS AND HEALTH**:

Class, Food and Disease

The system of bonded labour in some parts of Bihar and Madhya Pradesh accounted for the distribution of Khesari dal, a kind of pulse which causes Lathyrism, a disease of nervous system in people. The bonded labourers mostly belonged to tribals and untouchable castes. The Khesari was given in lieu of wages. The pattern of disease in the population is quite revealing. It strikes men mostly between the ages of 11-35 years crippling them to do any productive work at their prime life leading to ill health, indebtedness and misery.
Among women, this disease is less common probably because of the defense properties of the hormone 'oestrogen'. The disease occurs either at puberty or after menopause. The men-women ratio of this disease is 10 : 1. The disease is not simply a physical problem but is closely related to social, commercial, economic and political structures of the region (Joshi, 1982).

Class and Medical Care

Yesudian (1981) studied the health behaviour of four social classes - High, Middle, Low and Very Low - in utilisation of health services in Bombay city. He observed that as the Low and Very Low Social Class households are educationally backward, their knowledge level of diseases, available health services and their perception to seek health services are found to be lower than that of Middle and High class Households. Since all the four social classes differ in their life-styles in terms of income, housing and environment, their health status also differs. While the High and Middle classes mostly suffer from chronic diseases, the Low and Very Low classes suffer from communicable diseases.
The Low and Very Low social classes use mostly the government health services because of their poverty. Here also, they are not aware of all the services available in General Hospitals and as a result their use is restricted to out-patient department mostly (Yesudian 1981). The awareness of medical facilities is lowest among scheduled castes and scheduled tribe groups. They prefer government hospital, choose a place where the treatment is offered free of cost and rarely go to a private practitioner (Rao, 1981).

**Economic Strata and Food**

The expenditure pattern on food and other items reveals conspicuous gap in the standard of living among various groups. Studying some case studies representing various economic strata in some villages in Karnataka, Epstein (1978) observed that more than 50% of the income is spent on food alone among Adi-Karnatakas without any savings, little more than 40 per cent of income is spent on food among peasants with 4 percent marginal savings and 10 per cent of the income is spent on food among rich peasants.

In a village in Andhra Pradesh, food consumption pattern, malnutrition and undernutrition among the non-owning and non-cultivating agricultural families belonging to all the castes were studied. Though the scheduled castes, backward castes and
high castes show deficiency in the intake of calories, this deficiency decreases as one moves from the scheduled castes to the high castes. The calorie intake in pulses, sugar and jaggery, and meat among the three categories is conspicuous and raises from the scheduled castes to the advanced castes. The extent of malnutrition in children among the scheduled castes is higher than the backward castes and advanced castes. (Rao, 1977). A study of under-fives (children) in the villages of Punjab shows that compared to the land-owning jats, the Ramdasia (Harijan) children not only have higher prevalence of malnutrition but also higher morbidity (Kielman and Oberoi, 1972).

Economic Strata and Medical Care

In a study of some villages of North Arcot district (Tamilnadu) it was observed that for common ailments at initial stages, a larger proportion of respondents with low income preferred home treatment than the respondents with higher income. The higher the income the higher the preference for a qualified physician. The decision-making regarding choice and treatment is done by the head of the household in greater proportion in low income groups than in higher income groups. A higher proportion of those in higher occupation chose a place of treatment from where they could get quick relief while a greater
proportion of those in lower occupation groups preferred a source from which they could get treatment free of cost. The proportion who consult health personnel or physicians for immunisation of children has increased corresponding to the increase in income. (Rao, 1981)

Poverty also contributes to the people's inability to pay for transportation for a patient cannot walk despite the availability of free medical service and the inability to miss work to take the child to the health centre (Matthews, 1979). The structural constraints like poor image of PHC due to lack of medicines, over-crowding, and long-queues and the cultural and social gap between the health worker and the patient also limits utilization of health services (Banerji, 1973).

Social Status and Seeking Medical Care

In Thaiyur, a village in Tamilnadu, the high caste Hindus were found reluctant to use the medical services provided by a voluntary organization (SWALLOWS) because they felt humiliated in treating them at par with Harijans ignoring their caste status in the local community. Though it fits well with the norms of medical service, but treating all equally conflicts
with the values of the society being served (Djurfeldt and Lundberg, 1980). Lower castes in Kodiur in Tamilnadu mostly used the services of PHC because they were free while the higher castes availed the services of certain practitioners as they were able to afford their charges. The type of disease also affected the utilization and mostly specialists of that particular disease are consulted (Matthews, 1979).

**Socio-economic Status and Nutrition**

The data collected by the National Nutrition Monitoring Bureau (NNMB) in ten states during 1975-1978 on diet survey have revealed an interesting relationship between socio-economic variables of families and their protein - calorie intake (NIN, 1980).

It was observed that lowest levels of nutritient intakes (2020 k cals and 53 g.) were found among families of labourers. Mean intakes of calories and proteins were found to be the highest (2450 k cals and 68 g) in families of cultivators followed by those classified under the category of 'others' which included families of artisans, small traders and service groups (2220 k cals and 59g.).
Among families having no land, the mean intake of proteins and calories is lower whereas it is highest in those who owned land equal to or more than 10 acres. A consistent positive relationship was reported between the extent of landholdings and nutrient consumption. The intake levels of nutrients was better in families of those cultivators who effectively utilized their lands for raising crops when compared to those who did not raise any crops. The households possessing cattle showed higher consumption of nutrients when compared to those without any cattle.

The hospital data in various cities of the country indicate low-birth weight among low socio-economic groups compared with the high socio-economic groups. Birth-weight in turn is a consequence of nutrition (Swaminathan, 1974).

In all, drawing upon the above, one may note that most of the studies, with few exceptions, are fragmentary in nature and are off-shoots of larger studies conducted on themes which are not directly connected with health. However, the brief review has conclusively proved the decisive role of caste, class and other dimensions like landholdings, occupation etc. in health behaviour. The role of a healer/physician associated with certain castes/sections of a caste has conferred social mobility and a high status in the society.
It is, therefore, seen that there has been no systematic study taking into account the major forms of social stratification and their consequences in regard to health behaviour. The present study is an attempt in this direction.

**FRAMEWORK OF THE PRESENT STUDY:**

*Caste, Class and Health Care*

Based on these and other studies available, a tentative framework of relationship between stratification and health care variables has been adopted. As shown in the diagram (Figure 4) stratification variables (Caste, Class, Ethnicity, etc.) existing in a given cultural and environmental setting interact with health care variables (nutrition, health practices, use of health resources, use of health care facilities etc.) to produce a given pattern of morbidities among the respective groups. However, the objective of this study is not to causally explain the differences in morbidities (health status) but merely to examine what important caste and class differences do exist in the study village with regard to occurrence of morbidities and prevalence of health care practices. The aim of the present study is to examine the relative influence of caste/class status in relation to health care practices. Implications of this approach are discussed later.
Fig. 14: Interaction of social stratification, culture, health care and health status.
For our study, social stratification is taken in its both caste and class dimensions. Class is conceptualised by using 'attributitional' method. Land, income and occupation are grouped for analysing class status (see details in second chapter). It is assumed that a cumulative index of all these class attributes will have a decisive impact on one's choice, access and ability to use various health resources and facilities available in the community and outside it.

The contrasting life-styles of the high and low castes or class are expected to produce differential health profiles. The Low Castes and Class are exposed to greater risk of contacting diseases in view of their congested residence, lack of education, adherence to superstitions, lack of accessibility to and awareness of health facilities, etc. In view of the differential advantages or disadvantages associated with life conditions of high and low castes/class, their health status is also likely to differ. Similarly either because of greater adherence to traditional values, norms and practices or because of better living conditions social status and cosmopolitan influences, the high caste/class groups are likely to show differences in various health care practices.
Caste status:

Various sociologists and anthropologists conceptualised caste in different ways. Barth (1960) and Berreman (1967) emphasize that caste is a structural phenomenon while Dumont (1970) and Leach (1960) consider it as a cultural system. Senart (1963) treats caste as an organic structure of relations whereby a society is divided into a number of self-contained and completely segregated units (castes), the mutual relations between which are ritually determined in a graded scale. Ghurye (1950) emphasises endogamy as the essential character of caste. Weber (1946) considers it as a status group. D'Souza (1967) treats it as a hereditary group. Mencher (1974) treats caste as a system of interdependence or reciprocity and that it inhibits the development of 'class conflict' or a proletarian consciousness.

For the purpose of our study caste is conceptualised as a hereditary group which follows a specific occupation and enjoys a certain status in caste hierarchy in the village.

Sociologists and Anthropologists employed different approaches to study caste hierarchy. These approaches are of two types: (i) caste hierarchy as constructed by the
researcher; and (ii) caste hierarchy as constructed by people themselves. In the former type, three methods were adopted:
(a) Varna model in which caste hierarchy is having two (Srinivas, 1961) or three broad divisions (Ghurye, 1960; Beteille, 1969);
(b) Ceremonial values and ideas of purity and pollution (Dube 1956; Bailey, 1958; Mariott, 1960; Mathur, 1964); and (c) Constitutional provisions which divide rural community into upper castes, backward castes and scheduled castes (Sachchidananda 1972; Rao Hanumantha, 1977). In the latter type, researchers have employed three different methods: (a) status as claimed by the caste members themselves; (b) mutual ranking of castes by the lay members of the community as generally agreed among them; (c) ranking of castes by judges (key informants) selected from the community to arrive at a statistically derived rank order. In the present study, the latter type has been used because of the advantages over the former. Under this type, the method of ranking of castes by Judges (Key informants) has been adopted. There are advantages in adopting this method. Due to the factor of subjectivity involved, the method of status claimed by castes was not adopted. The method of mutual ranking or the status given to a caste by members of the community was found inadequate due to following reasons:
(1) difficulty in involving all members of a community if it has a large population. (2) laymen do not think rationally
and as a result use criteria other than caste status in ranking which results in using different criteria by different people. On the other hand, the method of caste ranking by Judges provides relatively a fair view of caste hierarchy since it eliminates disagreement about the status of a caste following its economic and political achievements (Lewis, 1958; Bailey 1958; Chouhan 1967). Further, it was not practicable to use the first two methods under the latter type because the village under this study has a very large population (6,000) spread over a wide geographical area.

We have broadly classified various castes in a village into High, Middle and Low Castes on the basis of their status approximations. The High Castes are better placed than the Low Castes in terms of their residence, diet, landholding, occupation, education and power. The High Castes are expected to conform to the normative prescriptions of purity and pollution, observe more restrictive social interactions, follow vegetarian diet, follow traditional rules and rituals on major occasions. But many of them also happen to own same amount of land, attain higher education, live better life and wield some power in the community. The Low Castes reside in a segregated area in the village, live in small and congested houses, mostly thatched, follow unclean or menial occupations, observe non-
vegetarian diet including beef, pork etc., mostly landless or own very small amounts of land, mostly illiterate and powerless. Between these two extremes there are a number of middle castes with varying amounts of small land holdings, follow a variety of occupations such as agriculture, trade, crafts, services, etc. The middle castes have relatively low educational attainments, are mostly non-vegetarian (excluding pork and beef).

Class status:

There are two main conceptions of Class in sociological literature: (1) subjective or socio-psychological and (2) objective or economic. Warner used the former concept in his researches. He used reputation and prestige among people for constructing classes. Three main approaches have been adopted under this type: (1) community's evaluation; (ii) self-evaluation; and (3) researcher's evaluation. Under the economic concept, two approaches to study class are adopted: (1) single index; and (2) composite index. The 'single index' approach makes use of only one variable as a sole indicator of one's class position (Smith, 1943; D'Souza, 1967; Beteille, 1969). There are problems of status-inconsistency and lack of universally effective single determinant of class under this approach. To avoid the lacunae in this approach, investigators have used
composite view of one's statuses based on two or more status
giving variables. This provides an overall view of one's
class position (Freeman, 1961; Pareek and Trivedi, 1965).

In the present study the economic concept of class is
used as none of the subjective approaches to study class is
possible in rural India because class itself is an alien
concept to the rural people and one's status is determined by
caste. People may use different criteria in judging one's
class position. Further, classes cannot be conceptualised in
Marxian sense since the basic characters proposed by Marx —
class unity, class interest and class conflict — are absent.
In addition, today's society is much more complex than what
he visualised in his period. Further, use of such categories
as landlords, rich peasants, landless labourers etc. is not
worthwhile in our study as it is not an attempt to study only
stratification system in a community.

Health care practices:

In the present study the term health care is defined as
any action(s) taken by an individual or a group to prevent
and cure illness, promote and maintain health and to
rehabilitate the affected. This concept includes, in the
present study, the following aspects: (a) nutrition (b) access to and utilization of various health services (facilities and resources) given by the government through primary health centre (c) access to and utilization of health services offered by the private practitioners, folk healers, medical shop (d) health practices followed by the people (e) morbidity and its remedial health action.

Every member of the society is expected to follow certain practices regularly in order to enjoy a healthy life. Broadly, three types of health practices were examined in the study: (1) practices related to personal hygiene, drinking and smoking (2) practices related to maternal and child care and (3) food practices. Under personal hygiene, care of teeth, body and hair were discussed. Under maternal and child care, actions related to diet, work during pregnancy, and after child birth, prenatal check up, weaning etc. were presented. Under food practices, the intake of various food items was described. Under utilisation of health resources and facilities, the use of PHC, ANM, MPW, CHV, private practitioners, medical shop, pond and tap was discussed. Further, the extent of preference for these resources was also examined.